

Female Genital Mutilation in the Netherlands

Prevalence, incidence and determinants

Marja Exterkate

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Colofon

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Author

Marja Exterkate

Pharos
Arthur van Schendelstraat 620
P.O. Box 13318
3507 LH Utrecht
The Netherlands
Telephone + 31 30 234 98 00
E-mail info@pharos.nl
www.pharos.nl

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Samenvatting

In dit rapport vindt u de resultaten van schattingen van het aantal vrouwen en meisjes in Nederland in 2012 dat besneden is of het risico loopt om besneden te worden. Met behulp van gegevens over het vóórkomen van vrouwelijke genitale verminking (vgv) in de landen van herkomst, gegevens over de vrouwelijke migrantenpopulatie in Nederland, informatie uit focusgroep discussies en gegevens uit registratiesystemen bij de Jeugdgezondheidszorg (JGZ) en de Advies en Meldpunten Kinder mishandeling (AMK) zijn deze schattingen tot stand gekomen.

Gezien de grote verschillen in vgv prevalentie tussen, maar ook binnen de landen van herkomst, is gekeken naar vgv op regionaal of provinciaal niveau in de herkomstlanden. Verder is er vooral ook gekeken naar leeftijdsspecifieke vgv cijfers, omdat vgv onder jongere vrouwen lager is dan onder oudere vrouwen. Een systematische zoektocht naar andere determinanten die de verschillen in vgv prevalentie kunnen verklaren heeft geen duidelijke patronen opgeleverd die we hebben kunnen gebruiken bij onze schattingen. De relaties tussen determinanten en prevalentie vgv blijken per gemeenschap te verschillen.

Van het aantal vrouwen in 2012 in Nederland dat afkomstig is uit landen waar van oudsher vgv gepraktiseerd wordt (bijna 70.000, 1% van de vrouwelijke Nederlandse bevolking) is naar schatting 40% besneden. Daarnaast zijn er 2.000 vrouwen in de asielopvang (35% van het totaal aantal vrouwelijke asielzoekers in de opvang), die uit deze landen afkomstig zijn. Van hen is naar schatting 74% besneden. In totaal gaat het naar schatting om 29.120 vrouwen in Nederland die besneden zijn. Het merendeel van deze vrouwen bevindt zich in de reproductieve leeftijdsgroep. Dit vraagt van artsen en andere gezondheidswerkers vaardigheden om het onderwerp bespreekbaar te maken, kennis over de relatie tussen vgv en medische en psychosociale klachten evenals over bestaande medische behandelingen of therapieën.

Vrouwelijk genitale verminking vindt meestal plaats in de leeftijd 4 tot 12 jaar. Om het risico in te schatten dat in Nederland woonachtige meisjes lopen op een besnijdenis, zijn een aantal varianten berekend. Meisjes jonger dan 15 jaar behoren tot de potentiële risicogroep die de kans loopt besneden te worden. De resultaten van de varianten zijn vergeleken met de voorlopige resultaten uit de registraties bij de JGZ en AMK's. Daaruit concluderen we dat er jaarlijks 40 tot 50 in Nederland woonachtige meisjes het risico lopen om besneden te worden. Voor een deel van deze meisjes wordt het risico pas reëel wanneer zij een bezoek brengen aan het land van herkomst. De JGZ speelt een belangrijke rol in de preventie van vgv. JGZ artsen en verpleegkundigen kunnen vgv gedurende meerdere contactmomenten met de ouders en het kind bespreken.

Het betrekkelijk lage risico komt niet alleen door verschillen in waarden en normen tussen Nederland en het land van herkomst. Het is aannemelijk dat dit ook komt door toegenomen kennis onder de doelgroep over medische en psychosociale complicaties van vgv. Deze kennis is verkregen door voorlichtingen ondermeer in Nederland. Verder is vooral de 'enabling environment' belangrijk: preventie, wetgeving en handhaving (de wet blijkt een sterke preventieve werking te hebben), kindbeschermingsmaatregelen en de risicotaxaties vgv bij de JGZ. Deze determinanten bij elkaar zorgen voor een gedrag waar vgv niet meer frequent wordt toegepast.

Summary

This report contains the results of estimations of the number of women and girls living in the Netherlands in 2012, who have undergone female genital mutilation (fgm) or are at risk of fgm. These estimations are based upon data about fgm prevalence in countries of origin, data about female migrant population in the Netherlands, information from focus group discussions and data from registration systems at Youth Health Care and the Advice and Reporting Centres for Child Abuse and Neglect.

Considering the large differences in fgm prevalence between, but also within the countries of origin, we focused on fgm at regional or provincial level in the countries of origin. Furthermore, we included age specific fgm data, since fgm among younger women is lower than among older women. A systematic review of other determinants that may explain differences in fgm prevalence has not yielded an unambiguous pattern that can be used in our estimations. Relations between determinants and fgm prevalence seem to vary at community level.

Of the number of women living in the Netherlands in 2012 and originating from countries where fgm is traditionally practiced (almost 70.000, 1% of the Dutch female population), an estimated 40% have undergone fgm. Next to that, 2.000 women originating from these countries live at the asylum reception centres (35% of the total number of women in the reception centres), of whom an estimated 74% have undergone fgm. In total, there are an estimated 29.120 women with fgm living in the Netherlands. The majority of these women fall within the reproductive ages. This requires from doctors and other health care workers skills to discuss this topic, proper knowledge of the relation between medical and psychosocial complaints and fgm, as well as knowledge of existing medical treatments or therapies.

FGM usually takes place between age 4 and 12. In order to estimate the risk that girls living in the Netherlands run of fgm, several variants are calculated. Girls younger than age 15 fall within the potential population at risk of being subjected to fgm. The resulting figures are compared with tentative registration data from Youth Health Care and the Advice and Reporting Centres for Child Abuse and Neglect. Based on that, we conclude that annually 40 to 50 girls living in the Netherlands, run a risk of fgm. For part of these girls the risk only gets real when they visit their countries of origin. Youth Health Care plays an important role in fgm prevention. Youth health physicians or nurses can discuss the topic during several consultations with the parents and child.

The relatively low risk that girls run is not only due to differences in norms and values between the Netherlands and country of origin. It is likely that this is also related to the increasing knowledge of the target group about medical and psychosocial complications as a result of fgm. This knowledge is gained through awareness campaigns and training in amongst others, the Netherlands. Especially important is the '*enabling environment*': prevention, law and legislation (the law plays a strong preventive role), child protection measures and risk taxations at Youth Health Care. All these determinants together favour a behaviour where fgm is not frequently being practiced anymore.

1. Introduction

Since the 90s, women and girls are living in the Netherlands, who emigrated from countries where female genital mutilation (fgm) - or circumcision - is practiced. Since then, several projects have been implemented in the Netherlands and national policy has been developed in order to prevent fgm among young girls (prevention and repression) and to offer relevant medical and psycho-social health care for women who have been circumcised.

As of yet we do not have a complete picture of the number of girls at risk or the number of women who have been circumcised. In order to obtain a complete and substantiated picture of fgm in the Netherlands, Pharos, Dutch Centre of expertise on Health of Migrants and Refugees, in collaboration with the Department of Public Health of the Erasmus University Medical Centre, and with funding of the Ministry of Health, Welfare and Sport, conducted a study into:

- ✓ the number of women in the Netherlands in 2012 with fgm (prevalence),
- ✓ the number of girls in the Netherlands in 2012 at risk of fgm (incidence).

The results of these estimations can serve as baseline data in order to:

- ✓ determine policy regarding prevention, medical & psychosocial health care, criminal investigation & prosecution,
- ✓ monitor progress of (policy) measures.

2. Background

2.1. Female Genital Mutilation (FGM)

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons, with an increasing severity from partial clitoridectomy to removal and appositioning of the labia minora and/or majora, or other ways of damaging female genitals through e.g. pricking, piercing, incising, scraping and cauterization. Internationally, all forms of fgm are seen as a violation of human, women and children rights (WHO, 2008).

WHO estimates that between 100 to 140 million girls and women worldwide have been subjected to fgm and yearly three million girls in Africa are at risk of fgm (WHO, 2008). It is usually carried out on girls between the age of 4 and 12 years, but in some cultures on newborn babies or just before marriage. FGM is traditionally practiced in at least 27 African countries, Yemen and Iraqi Kurdistan with national prevalence rates from 1% (e.g. Uganda and Cameroon) to more than 95% (e.g. Somalia and Guinea) (see annex I). Even within countries, prevalence may vary regionally between 1% and 99%. According to WHO, studies have documented fgm in some other countries, but no national estimates are available. These countries include India, Indonesia, Malaysia and the United Arab Emirates. In addition, there are anecdotal reports on fgm from several other countries, including Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka (WHO, 2008). Through emigration from countries where fgm is originally practiced, the Western world is also being confronted with fgm. Although hard data on fgm prevalence in the European Union are not available, estimates show that in Europe some 500.000 women have suffered from fgm, and every year approximately 180.000 female immigrants in Europe undergo or are in danger of undergoing fgm (European Resolution, 2009¹).

FGM may have harmful physical, psychosocial and sexual consequences. The procedures can cause severe pain, shock caused by pain, severe bleeding, problems urinating and later on repeated urinary tract infections, menstrual problems, infertility as well as complications in childbirth (WHO, 2008). Possible psychosocial and sexual long-term consequences include fear for sexuality, post-traumatic symptoms, anxiety and depression, painful sexual intercourse (Vloeberghs et al, 2011).

Parents have several reasons for circumcising their daughters. These vary between country and region: tradition, religion (in the mistaken belief that fgm is a religious requirement), protecting virginity, aesthetics and hygiene. In some cultures, girls get circumcised during a *rite de passage*, in which fgm symbolises the transition from childhood to adulthood. Underlying motives are protecting girls, marriageability and saving family's honour. FGM can be seen as a social norm - a social rule of behaviour that members of a community follow *in the belief that others expect them to follow*. Non-adherence stigmatises and isolates girls and their families, resulting in disapproval and loss of social status (Unicef, 2010). Through social and peers' pressure, parents are being convinced that circumcision is the best for their daughters (Unicef, 2005), even if they do not want it.

¹ European Parliament resolution of 24 March 2009 on combating female genital mutilation in the EU.

2.2. FGM in the Netherlands

Since the 90s fgm comes to the Netherlands due to immigration from countries where fgm is practiced. Activities against fgm in the Netherlands start with short-term projects aimed at breaking the taboo through awareness raising, education and development of expertise. In 1993 the Dutch government takes a clear position: *all* forms of fgm are forbidden.

Gradually, projects are implemented aimed at prevention and education. Activities are interconnected, targeting African communities, the Dutch health care sector and fostering dialogue between these two groups. The heart of the work during this period is to set in motion the power of communities themselves (Nienhuis et al, 2008).

In 2005, on advice of the Council for Public Health and Health Care, the government increases the sense of urgency to end this form of violence by an intensive approach with a number of tangible measures. Since then, the State Secretary for Health, Welfare and Sport continuously puts fgm high on the political agenda in the Netherlands. The Dutch policy has two main components: prevention and repression. Since 2010, attention for medical and psychosocial care for women with fgm also increased.

Prevention in the Netherlands

The approach developed with 'key persons' (persons from African communities, living in the Netherlands) and community based migrant organisations, who after training made fgm a subject of discussion in their community, becomes part of the intensive preventive approach of the government during 2006 - 2009.

During this period, action to combat fgm has been taken up in six cities of the Netherlands with above-average concentrations of people from high-risk countries (Amsterdam, Rotterdam, The Hague, Utrecht, Tilburg, Eindhoven). Funding came from the Ministry of Health, Welfare and Sport. Many partners were involved. An integrated chain approach was developed. Since fgm touches several sectors and structures, several key actors in different sectors (formal and informal) were trained and protocols developed. Key actors included representatives of the Somali, Sudanese, Eritrean and Ethiopian communities, home care services, youth healthcare services (GGD), Advice and Reporting Centres for Child Abuse and Neglect (AMK), Child Protection Board (RvdK), the police, obstetric services, the Federation of Somali Associations Netherlands (FSAN) and Pharos (Bussemaker, 2007). All these parties were participating in a concerted effort to prevent fgm. This pilot project was evaluated², and the results of this preventive approach were nationally dispersed throughout the country during 2010 and 2011. Since 2012 municipalities are responsible for preventive fgm activities.

In 2011, a 'Statement opposing female circumcision' was developed and distributed through Youth Health Care centres. Parents can take this statement with them when going abroad. It mentions that fgm in the Netherlands is prosecutable and treated as a form of child abuse. It may help families, who do not want to circumcise their daughter to resist social pressure from their family.

Repression in the Netherlands

FGM is treated in the Netherlands as a very serious and damaging form of child abuse. It is prosecutable under general criminal legislation (section 300-304, 307, 308 of the Penal

² Jessica van Koert, Ruud Rottier, Marieke Bosch-van Toor (2008). *Samen voor één doel: het voorkomen van besnijdenis van dat kleine meisje. Drie jaar pilots VGV en nu? Evaluatie met een handreiking voor beleidsmakers*, B&A Consulting bv. Den Haag.

A.E. van Burik, A.M. Persoon (2009). *Opbrengsten pilotprojecten VGV. Eindrapport procesevaluatie preventieprojecten meisjesbesnijdenis*. Van Montfoort, Woerden.

Code), with a maximum imprisonment of 12 years or a fine of maximum €76.000,-. In case fgm is done by one of the parents, imprisonment can be increased with one third. In case the parent(s) gave the assignment, pay for it, provide means that will be used for fgm or assist during fgm, they will be punishable as well. This is seen as instigation, aiding and abetting.

An adjustment of the law in February 2006 makes fgm performed abroad punishable too, in case the suspected person has a Dutch nationality or lives in the Netherlands. In July 2009 the period of limitation is prolonged. The period of limitation takes effect with the 18th birthday and amounts to 20 years with serious forms of fgm.

Medical professionals who cooperate in fgm can be judged, based on medical disciplinary rules and based on unauthorised practice of medicine (Penal Code). Professionals in the Netherlands have the 'right to report' in case they suspect any form of child abuse. Next to that, a 'reporting code' will be formalised in 2013 in a law.

Since 2001 minor girls can apply for asylum based on serious threatening in their home country for fgm.

Care in the Netherlands

Gradually, attention for medical and psychosocial care for women with fgm increased as well. Since 2010, a number of projects were implemented, like e.g. a research into psychological, social and relational consequences of fgm (Vloeberghs et al, 2011), developing of a model protocol medical care for women and girls with fgm (2010) and training of midwives as fgm advisors (2010/2011). For the period 2012 - 2014, the Ministry of Health, Welfare and Sport provides funding for a pilot 'Medical and psychosocial care for circumcised women' in six municipalities.

2.3. FGM prevalence studies

Studies on fgm prevalence are available in countries of origin, as well as in countries of immigration. Information can be found in national representative or local surveys or estimations based on secondary data. Relatively little was found on fgm prevalence and its determinants in academic journals ('only' 62 articles with quantitative data were found).

The Netherlands

Two estimates were available up till now:

1. 2005: A study from the Council for Public Health and Health Care (RVZ, *Raad voor de Volksgezondheid en Zorg*) expected that at least 50 girls who are living in the Netherlands are being circumcised annually.
2. 2008: A retrospective survey of fgm prevalence in midwifery practices showed that 40% of pregnant women, originating from so-called risk countries are circumcised (TNO, 2009).

These two estimates need to be interpreted with care, since the first one is based on a small scale survey among health care workers and schools in two Dutch cities and the second one is based on recall of midwives.

Other European countries

Some studies regarding estimates on prevalence of fgm are available at local level, like e.g. in Sweden (Kangoum, 2004), France (Andro, 2009) and Switzerland (Jager, 2002, Thierfelder, 2003). In 2012/2013, new studies take place in Switzerland among health care professionals.

Estimations, based on the number of people originating from a risk country³ are available in e.g. Belgium (Dubourg et al 2010), England and Wales (Dorkenoo et al, 2007) and Ireland (O'Brien et al, 2008). These studies extrapolate the number of women living in the country by the (age specific) prevalence rates of the country of origin. Although these figures may help prioritizing policy measures, the danger of these figures is twofold:

1. Influence of migration on knowledge, attitudes and practices is neglected, whereas we know that migration does have an influence on these.
2. Prevalence rates in countries of origin are national averages or age specific, whereas we know that prevalence also varies between different regions or ethnic groups.

Behrendt (2011) has done a Knowledge, Attitudes and Practice survey among immigrants in Hamburg, Germany. It was estimated that at least 30% of women immigrants from Sub-Saharan Africa underwent fgm before migrating to Europe. 80% of the interviewed immigrants pronounced themselves in support of the abolition of fgm. The report gives an overview of the opinions, perceptions and propositions of immigrants from Sub-Saharan Africa, living in Hamburg regarding the practice of fgm.

In 2012, the European Institute for Gender Equality (EIGE) commissioned a study to map the current situation and trends of fgm in 27 EU Member States and Croatia. The study was carried out by International Centre for Reproductive Health (University of Ghent) and Yellow Window Management Consultants. The report is expected in 2013.

African countries

FGM prevalence in African countries has been estimated from large-scale, national household surveys asking women aged 15 - 49 years if they have been cut. These surveys pose questions that enable a range of inter- and intra-country comparisons to be carried out. They move towards a set of standardised indicators for situation analysis and monitoring progress towards ending fgm, which enhances the potential for comparison. 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).

Articles in academic journals

A systematic review produced 62 articles that reported fgm prevalence: 56 articles related to countries of origin, 6 to countries of immigration (article is forthcoming).

The six articles referring to countries of immigration included: a retrospective study among midwifery practices in the Netherlands which gave an estimated prevalence of 40% in women from high prevalence countries of origin who reside in the Netherlands (Korfker et al, 2012). Two studies, conducted in Sweden, resulted in an fgm prevalence of 62%-92% of the interviewed women (Kangoum et al, 2004, Litorp et al, 2008). Estimates of the number of women with fgm or who are at risk of fgm are available for Belgium: 6.260 women have most probably undergone fgm, 1.975 girls are at risk (Dubourg et al, 2011), Switzerland: a total of 6.711 girls at risk and women with fgm (Jager et al, 2002) and USA (a total of 168,000 girls at risk and women with fgm (Jones et al, 1997).

³ We use the term risk country for a country where fgm is traditionally practiced

3. Research methods

Definitions

1st generation: A person who is born abroad with at least one parent who is born abroad.

2nd generation: A person who is born in the Netherlands, with at least one parent born abroad.

Prevalence fgm: Percentage new and existing fgm cases in a certain period in a certain population. Prevalence of fgm in the Netherlands is a measure of existence of fgm in the Netherlands.

Incidence fgm: Percentage new fgm cases in a certain period in a population who is at risk of getting circumcised. Incidence of fgm in the Netherlands is a measure of risk of new fgm cases in the Netherlands.

In order to estimate the number of women in the Netherlands with fgm and the number of girls in the Netherlands who are at risk of fgm, several methods have been used.

The original proposal of a representative survey among female immigrants in the Netherlands was shared with an international group of experts. A number of dilemmas were discussed: How to obtain valid information of a controversial topic, taking into account the risk of criminal investigation and prosecution?, Can one expect from interviewers that they are able to handle emotions from respondents, due to reliving of fgm?, How to be sure that a representative sample among this population also results in a representative picture of fgm? (Pharos, 2011).

In response to the expert meeting, an alternative approach is chosen. In order to estimate fgm prevalence in the Netherlands, a review of existing literature was carried out and data from national representative surveys in countries of origin were used. We decided for this approach, since for most women, fgm is usually done before migration to the Netherlands. For estimating the risk of fgm among young girls living in the Netherlands, additional information is obtained through focus group discussions and registration at Youth Health Care centres and the Advice and Reporting Centres for Child Abuse and Neglect.

The following research methods have been used:

- a. Systematic review of scientific literature about age specific incidence and prevalence and its determinants. The aim of the review is to obtain more insight into which determinants lead to variations in fgm prevalence between different communities worldwide. In order to delimit the search, we only looked for articles with quantitative information on prevalence and incidence. In a systematic review, which was done in close collaboration with Erasmus Medical Centre in Rotterdam, 62 articles were included and the results will be presented in a scientific article. The obtained information is used in this report for estimating the fgm situation in the Netherlands and to find starting points for tailor made fgm interventions for different groups with regards to origin.
- b. Focus group discussions, in order to retrieve information on social pressure and risk of fgm in the Netherlands. Four focus group discussions with women and men took place: one with Somali and Eritrean women (8 persons), one with Somali women (4 persons), one with women from Sierra Leone (8 persons) and one with Somali and Egyptian men (9 persons).

- c. Estimating the number of women with fgm and the number of girls at risk of fgm, based on secondary data:
- ✓ Data from *national Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS)* on fgm prevalence in countries of origin,
 - ✓ Data from the *Dutch Central Statistical Office (CBS)* about female migrant population in the Netherlands in 2012, originating from countries where fgm is practiced: age, 1st and 2nd generation, place of birth, length of stay in the Netherlands,
 - ✓ Data from the *Central Agency for the Reception of Asylum Seekers (COA)* about female asylum seekers in the reception centres in the Netherlands in 2012, originating from countries where fgm is practiced: age, country of origin,
 - ✓ Information from Youth Health Care (*GGD'en*) and the Advice and Reporting Centres for Child Abuse and Neglect (*AMK; Youth Care Netherlands*) about risk-of-fgm taxation among children under age 19 with one or two parents who originate from a risk country.

4. Systematic Review: determinants of fgm

Data on national fgm prevalence are available for 27 African countries, Yemen and the Kurdish Autonomous Region of Iraq. FGM prevalence varies between countries. From literature review it becomes clear that fgm prevalence even varies strongly within some of the countries, e.g. from 1% to 99%. Also, age at circumcision varies between communities from immediately after birth to 17 years.

What makes all these differences? What are underlying determinants - or risk factors?

Insight into these determinants is important in order to estimate the number of women and girls with fgm or at risk for fgm in the Netherlands and to find starting points for developing intervention programmes for different groups. We conducted a systematic review of scientific articles on prevalence studies in three electronic databases: PubMed, EMBASE and Popline: 137 articles were selected, of which 62 were included in the review.

4.1. Determinants of fgm in countries of origin

From an intervention perspective, determinants can be distinguished between modifiable and non modifiable determinants. When modifiable determinants are changed, they can influence fgm prevalence. Knowledge about non modifiable determinants is important in order to identify the population at risk. In principle, both modifiable as well as non modifiable determinants can provide starting points for interventions.

Modifiable determinants found in the review are educational level, wealth level and work/empowerment status of mother and the educational level of the husband. Non modifiable determinants found are age of mother, fgm status of mother, religion, urbanisation, ethnicity and geographical region or province where the family lives.

Age of mother and her educational level are the most studied determinants in the reviewed articles. In contrast to common presumptions, the relations that were found between most determinants and fgm prevalence vary strongly between different communities and are therefore not unambiguous.

Non modifiable determinants

Age: a more or less clear relation is found between age and fgm prevalence: prevalence among younger women (15 - 19 year) is lower than among older women (45 - 49 year). However, four (out of 45) studies show otherwise: national studies in Gambia and to a lesser extent Guinea Bissau showed that fgm among older women was lower than among younger women, and local studies in Ethiopia and Egypt showed lower fgm among daughters (or lower intention to cut daughters) from older mothers than from younger mothers.

Religion: the general belief is that fgm among Muslims is higher than among other religions. Out of 22 studies, 64% confirm this relation, but 36% of the studies show that fgm among Christians or Protestants is higher (national studies in Niger, Nigeria, local studies in Egypt and Ethiopia).

Urbanisation: the general belief is that fgm among the rural population is higher than among urban citizens. Out of 14 studies, 79% confirm this, but 21% show that fgm in urban areas is higher (national studies in Nigeria, local study in Egypt).

For three determinants, an unequivocal relation with fgm prevalence is observed in the review: fgm status of mother (higher prevalence of fgm among daughters when mother is cut herself), ethnicity and geographical region or province (large differences in fgm prevalence between different ethnic groups or geographical regions).

Modifiable determinants

Educational level of the mother: out of 49 studies, 86% show that no or lower education is associated with higher fgm prevalence, but 14% show the opposite (local studies in Sudan, national studies in Nigeria).

Wealth level of mother was mentioned in 29 studies: 59% show that a lower level is associated with higher fgm prevalence, 41% show the opposite (local studies in Egypt, Nigeria, Sudan, national studies in Nigeria, Burkina Faso).

Work/empowerment status of mother: out of 11 studies 82% show that no or lower level empowerment is associated with higher fgm prevalence, 18% show the opposite (local studies in Gambia and Ethiopia).

10 studies mention educational level of the husband. 80% show that no or lower level education of husband is associated with higher fgm prevalence, 20% show the opposite (national studies in Nigeria).

Other

It was hardly possible to determine the influence of law on the practice of fgm in the countries of origin, due to lack of insight in trends of fgm over time.

The review shows that a decision to circumcise a daughter is not an individual decision, but a collective one. Most important motives for practicing fgm are control of a girls' sexuality, tradition/custom and religion. Other reasons mentioned are hygiene and marriageability.

In brief:

The review does not reveal unambiguous relations between most determinants and fgm prevalence at national level, except for age (more or less), fgm status of mother, ethnicity and geographical region or province. The relation between the other determinants and fgm prevalence varies strongly at community level.

4.2. Determinants of risk of fgm in a migration context

In our review, we found four qualitative studies dealing with changing perspectives concerning fgm of 1st generation women in a migration context (Belmaker, 2011, Gele et al, 2012, Johndotter et al, 2009, Morison et al, 2004). These changing views are related to:

- Support for effective legislation, which may help in order to resist peer pressure.
- Increased knowledge that fgm causes health problems, increased notion that fgm can reduce the opportunity to experience sexual pleasure.
- Increased knowledge that fgm is not a religious requirement.
- Increased notice of the fact that women can be economically independent, that women have rights.
- Changes in the underlying beliefs on sexuality, marriage and religion.
- In the new country, fgm is not the norm and is not associated with social status. Actually, being uncircumcised may get a high status.
- Male respondents stated that uncircumcised women enjoy sex more and are healthier.
- The social or enabling environment is supportive of discontinuation of fgm.

It is important to realise that these changes in perspectives of fgm are not only an issue of a sudden change after migration to another area. Countries or areas of origin may also have a history of campaigns against fgm (Johnsdotter et al, 2009). The transition to a new area or country may strengthen and encourage feelings already developed earlier. The study in Britain (Morison et al, 2004) also found that a majority of young women from Somalia, who came to London before the age of circumcision, seem to be uncut.

Once people can withdraw from social pressure, risks of fgm are likely to run lower. But then, some new fears may come in place:

- When visiting the home country, family members may take matters in their own hands and still want to circumcise daughters (Johnsdotter et al, 2009).
- Despite rejection of fgm, the transition from cut to uncut behaviour has generated concerns over the consequences of girl's new behaviour (Gele et al, 2012).

The studies conclude that children who are born in a immigration country (2nd generation) run little risk of fgm, since they grow up with other local youngsters, go to school and get used to individual choices, other parent-child relations and more freedom.

In brief:

Perspectives concerning fgm have changed in a migration context. 2nd generation children run little risk of fgm.

5. Focus group discussions: influence of migration on fgm in the Netherlands

In order to get more insight into the risk that girls run, Pharos conducted focus group discussions with 1st generation (wo)men concerning social pressure and risk of fgm in a migration context.

From these discussions, it becomes clear that there are differences in fgm practices between, but also within countries. FGM was done at a very early age (e.g. before baptism) in Eritrea and at an elder age (6/7 years) in North and South Somalia and Sierra Leone (12/13 years, but a wide variation between 3 to 17 year). A celebration in honour of the circumcised girl is (South Somalia) or isn't held (North Somalia, Eritrea), or fgm is part of a joint initiation into a secret society, known as the *Bundu society* (in Sierra Leone). Participants from Sierra Leone were taken as girls to the bush where they were taught feminine hygiene, sex education, housekeeping and childrearing skills. As part of this *rite de passage* to womanhood, they underwent fgm.

Most important reasons for fgm are virginity and a *rite de passage* from girl to womanhood. Participants see fgm as a cultural phenomenon, not a religious one. During childhood, some were harassed when they were not yet circumcised, since they were seen as impure. Except for the Sierra Leone group, fgm is a 'woman's thing' in their countries of origin: male were not involved. In Sierra Leone, social pressure is felt from men as well.

The relation between knowledge, attitude and behaviour seems not linear within a migration context. Through knowledge about medical and psychosocial consequences of fgm (often gained through awareness raising in the Netherlands), many women are now reticent and adverse to cut their daughters through the most severe form. The attitude has changed only partly. In order to remain faithful to one's own culture, they would like their daughters to get circumcised, but in the lighter version (pricking of the clitoris). But even so, they do not cut their daughters. The fact that they do not cut their daughters (behaviour has changed), has to do with Dutch law which is strict and the belief in enforcement of the law, as well as child protection measures (not necessarily seen as positive: your child can easily be taken away from home). No one wants to take the risk to get separated from their children, let alone go into prison. Dutch law seems to have a strong preventive function. Participants expected that fgm may increase again if there would not be a prohibition and enforcement of the law.

Moreover, there seems to be confusion about the law and the fact that all forms of fgm in the Netherlands are regarded as child abuse. A number of participants do not consider 'pricking of the clitoris' as fgm. It is also not clear to all participants that the law is about 'cutting' and not about 'being cut'. A few women with fgm, who were living in the Netherlands since recently, did not seek medical care, since they were afraid of getting prosecuted because they had undergone fgm during their childhood.

Within the Somali group, there are large differences in socio economic status and mentality between 'oldcomers' (higher education) and 'newcomers' (lower education, grown up in a war-torn country), due to the worsening situation in Somalia. This difference is hardly noticeable among the Eritrean, Sierra Leone and Egypt groups. Currently, all newcomers at the asylum reception centres are informed about punishability of fgm in the Netherlands.

Participants do not expect special problems with raising their uncut daughters, just because they are uncut. On the contrary: their daughters are seen as much healthier, since they are not cut and do not face the same complaints as their mothers had during e.g. menstruation. However, mothers do have other worries with raising their daughters, but those are related to

the culture in which they grow up (the difference between a 'we' and 'I' culture): children go to school, can make individual decisions, child-parent relations are different and youngsters have much more freedom. They have a different perception of sexuality and freedom to choose their own partner. Children almost behave as grown-ups.

When parents visit their home country with their daughters, the majority of men originating from Somalia, had no fear not to be able to resist social pressure. Women had different feelings. Participants from Sierra Leone mentioned they will not visit their home country together with their daughters, since they are afraid they cannot protect their daughters against fgm, because they cannot withstand social pressure back home. Most of these even came to the Netherlands with their daughters in order to be able to protect them against fgm.

What stands out during the focus group discussions, is that Somali women are much better informed about fgm than the women from Sierra Leone, through awareness campaigns already in Somalia, as well as in the Netherlands. In addition, the media - especially BBC - played an important role since 1998. For women from Sierra Leone, it is more difficult to discuss fgm, due to the curse of the secret society: leaders of the society claim they have supernatural power, and frighten girls and women that something terrible will happen to them whenever they speak out loud what they have experienced during their initiation.

FGM practices in the countries of origin change as well (e.g. cutting at younger ages or mildest forms instead of pharaonic circumcision), for the better (decline in fgm) or the worse (increase). Linking between the Diaspora and the family in countries of origin is seen as important. A number of men from Egypt are concerned about the current political changes in their country of origin. There are indications that radical leaders promote fgm again. So far, it had no effects, since people take action against it, but these are worrying developments.

In brief:

From focus group discussions with 1st generation (wo)men, it can be concluded that girls in the Netherlands run little risk of fgm, especially due to the enabling environment (e.g. prevention activities, law and legislation). The risk may increase when parents, together with their daughters, visit their home country due to social pressure from family members to cut their daughters. Participants have an increased knowledge about medical & psychosocial consequences and law, their attitudes have only changed partly, but behaviour has changed (no cutting). Knowledge was not only gained in the Netherlands, but also in some countries of origin as well.

6. Operationalising determinants

Based on the systematic review and focus group discussions, a selection is made of determinants that may have an influence on the number of women with fgm and the number of girls at risk of fgm in the Netherlands. Selection criteria of determinants are:

- ✓ Determinants with more or less unambiguous relations with fgm in countries of origin,
- ✓ Available information regarding that determinant in the Netherlands (e.g. ethnicity is a clear determinant, but since we have no information on ethnicity in the Netherlands, it is - at this moment - not possible to include this variable).

6.1. Data on determinants of fgm in countries of origin

Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) are national representative household surveys, which - where relevant - include modules on fgm. Since data are comparable between the countries, these sources are used (see annex II for all reports used).

Information on fgm is subtracted from recent report(s) from countries with national representative data on fgm (the 'country list' of WHO): Benin, Burkina Faso, Cameroon, Central-African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, (North)Sudan, Somalia, Tanzania, Togo, Uganda, Yemen.

Next to these 28 countries, the Kurdish Autonomous Region of Iraq is included. Information on fgm in the Kurdish Autonomous Region of Iraq is obtained from a report from WADI (2010).

The following determinants are selected:

- ✓ Age of respondent,
- ✓ Age of circumcision,
- ✓ Geographical region or province where respondent lives.

Per country data are available on:

- ✓ FGM prevalence in 5 year age groups between ages 15 and 49. The survey population usually includes women in age group 15 - 49. Four exceptions are Egypt, Sudan and Yemen, where the survey population includes 'ever married women' between 15 and 49, and the Kurdish Autonomous Region of Iraq where the survey includes all women of 14 years and older.
- ✓ Number of girls by age at circumcision in different age groups between age 0 - 15 or 0 - 18.
- ✓ FGM prevalence by region or province where women live.

Data processing includes:

- ✓ In order to estimate incidence and prevalence between ages 0 - 15, the age distribution of 'age at which fgm takes place' is used in combination with fgm prevalence age 15 - 19 (with the exception of Egypt and Togo, where prevalence 0 - 14 is known),
- ✓ Median age⁴ of circumcision was estimated, using frequency tables of age at circumcision by age group between 0 - 15/18,
- ✓ For women above age 50, fgm prevalence of age 45 - 49 was used.

⁴ The age that divides the population at risk of fgm into two numerically equal groups: half the people are below this age at fgm and half are older than this age of fgm. This age is usually lower than the average age of fgm.

- ✓ Since no data were obtained about age specific prevalence per region, the national age distribution of fgm prevalence was used in order to estimate age- and region specific fgm prevalence.

6.2. Data on determinants of fgm in the Netherlands

Data on registered female population at 1-1-2012, originating from these 29 countries are available at the Dutch Central Statistical Office (CBS). Data on the number of female asylum seekers, living at the reception centres on 1-1-2012, originating from the 28 countries from the 'WHO list' are obtained from the Central Agency for the Reception of Asylum Seekers (COA). Iraq is excluded from the country list for asylum seekers, since no data could be obtained about the number of asylum seekers originating from the Kurdish autonomous region.

The following determinants are selected:

Registered female population:

- ✓ Current age,
- ✓ Age of arrival in the Netherlands,
- ✓ 1st or 2nd generation,
- ✓ Geographical region or province of origin of 1st generation

Female asylum seekers living at the reception centres:

- ✓ Current age,
- ✓ Country of origin.

Data are available on:

- ✓ Registered female population in the Netherlands on 1 jan 2012 by country of origin, age, 1st and 2nd generation.
- ✓ Registered female population in the Netherlands on 1 jan 2012 by place of birth in country of origin, age and current place at living (at COROP or regional level) in the Netherlands.
- ✓ Registered female population, 1st generation, in the Netherlands on 1 jan 2011 by country of origin, age and length of stay in the Netherlands.
- ✓ Number of live born female births in the Netherlands in 2011 by country of origin and length of stay mother.
- ✓ Number of female asylum seekers living in the reception centres on 1 jan 2012 by age and country of origin.

Data processing of registered female population includes:

- ✓ Place of birth:
 - Places of birth are categorized in the region, province or other administrative level, as they are used in the DHS/MICS surveys.
 - The number of 'unknown' and other inconsistencies are corrected for the total number of 1st generation by age on 1-1-2012.
 - For the 2nd generation, who are all born in the Netherlands, the distribution across region of origin of 1st generation women age 20 - 50 is used, assuming that these women are the 'potential' mothers of these 2nd generation girls.
 - Until 1993, immigrants from Eritrea were registered as originating from Ethiopia. When looking at the place of birth, it became clear that the number of Eritreans are underreported. For the region specific calculations, we combined the total number of Ethiopians and Eritreans, in order to get a more realistic denominator.
 - Some countries are still recorded under their old names (e.g. Dahomey, Gold coast, Upper Volta, French West Africa, British East Africa, French or Italian Somaliland).

Sometimes in combination with birth places, these countries are re-coded to current names.

- ✓ Based on length of stay and current age, the age of arrival in the Netherlands is estimated. The number is corrected for the total number of 1st generation by age and region of origin on 1-1-2012.

Display of results

Results of the estimations are presented separately for the 28 countries of the 'WHO list' and the Kurdish Autonomous Region of Iraq, since the latter is a new group in the Netherlands regarding prevention of fgm activities and providing medical and psychosocial care for women with fgm.

Age categories in this report are consistent with target groups of health workers and health care providers:

- ✓ Age 0 - 4 and 5 - 19 for prevention activities and care: Youth Health Care, Advice and Reporting Centre for Child Abuse and Neglect (AMK), paediatricians, general practitioners, (children)gynaecologists, childcare and schools.
- ✓ Age 20 - 49 (women at reproductive ages): medical and psychosocial care: general practitioners, midwives, gynaecologists, sexologists, psychotherapists.
- ✓ Age older than 50: medical and psychosocial care for longer term complaints: general practitioners, gynaecologists, psychotherapists.

In brief:

Data are collected from different sources. Processing of data was needed in order to be able to use the data as input in our estimations. Estimations of fgm in the Netherlands are done with the following determinants:

- ✓ age and region specific fgm data from the countries of origin,
- ✓ age, birthplace and age of arrival of female migrants in the Netherlands.

7. Estimated number of women with fgm and girls at risk of fgm

7.1. Study population

The study population is the potential risk population for fgm. On 1-1-2012, 71.800 women from risk countries are living in the Netherlands:

- ✓ Almost 63.400 women originating from one of the 28 countries of the 'WHO list'. They constitute 1% of the total female population living in the Netherlands. 61% is 1st generation, 39% 2nd generation (table 1a).
- ✓ Next to that, 6.400 women from the Kurdish Autonomous Region of Iraq live in the Netherlands. 74% is 1st generation, 26% 2nd generation (table 1b).
- ✓ Almost 2.000 female asylum seekers living in the reception centres, originating from one of the 28 countries (table 1a), 35% of the total number of female asylum seekers. 54% of these women originates from Somalia (data not shown).

Table 1. Number of women living in the Netherlands by age (1-1-2012).

1a. Origin 28 countries					1b. Kurdish auton.reg				1c. Total 29 countries			
	Women at the reception centres	Migrants				Migrants				Registered migrants		
		Total	1 st generation	2 nd generation		Total	1 st gen.	2 nd gen.		Total	1 st gen.	2 nd gen.
0-5	261	8.004	606	7.398	0-5	619	12	607	0-5	8.623	618	8.005
5-19	449	19.703	5.574	14.129	5-19	1.663	648	1.015	5-19	21.366	6.222	15.144
20-49	1.145	30.788	27.731	3.057	20-49	3.282	3.230	51	20-49	34.070	30.961	3.108
50+	104	4.875	4.804	71	50+	835	835	1	50+	5.710	5.639	72
Total	1.959	63.370	38.715	24.655	Total	6.399	4.725	1.675	Total	69.769	43.440	26.330

Within the 1st generation, 15% of women is younger than 19 years, 71% between 20 and 49 years and 13% of women is older than 50.

Within the 2nd generation 88% is younger than 19 years, 12% between 20 and 49. Hardly any women are older than 50.

Of the almost 69.800 registered women (table 1c), 75% originate from Somalia, Ghana, Egypt, Kurdish Autonomous Region of Iraq, Ethiopia and Nigeria (figure 1). In some of these countries, fgm prevalence is high (Somalia, Egypt, Kurdish Autonomous Region of Iraq, Ethiopia), but in a number of these countries fgm is lower (Nigeria) or very low (Ghana). From other countries with a high fgm prevalence (e.g. Guinea, Djibouti, Sierra Leone, Sudan, Eritrea and Mali) only a small number of women is living in the Netherlands.

Figure 2 shows that the majority of women lives in two provinces in the western part of the country (Noord Holland, Zuid Holland), especially in the regions of Amsterdam, Rotterdam-Rijnmond and The Hague. Somali people live more dispersed in the Randstad, Arnhem/Nijmegen, Veluwe and Flevoland. The Ghanaian population is clustered in Amsterdam, people from Ethiopia/Eritrea and Egypt are spread over the Randstad and Nigerians mainly live in the Randstad and Flevoland.

Fig 1. Number of women in the Netherlands, by country of origin, generation and fgm prevalence in country of origin (1-1-2012).

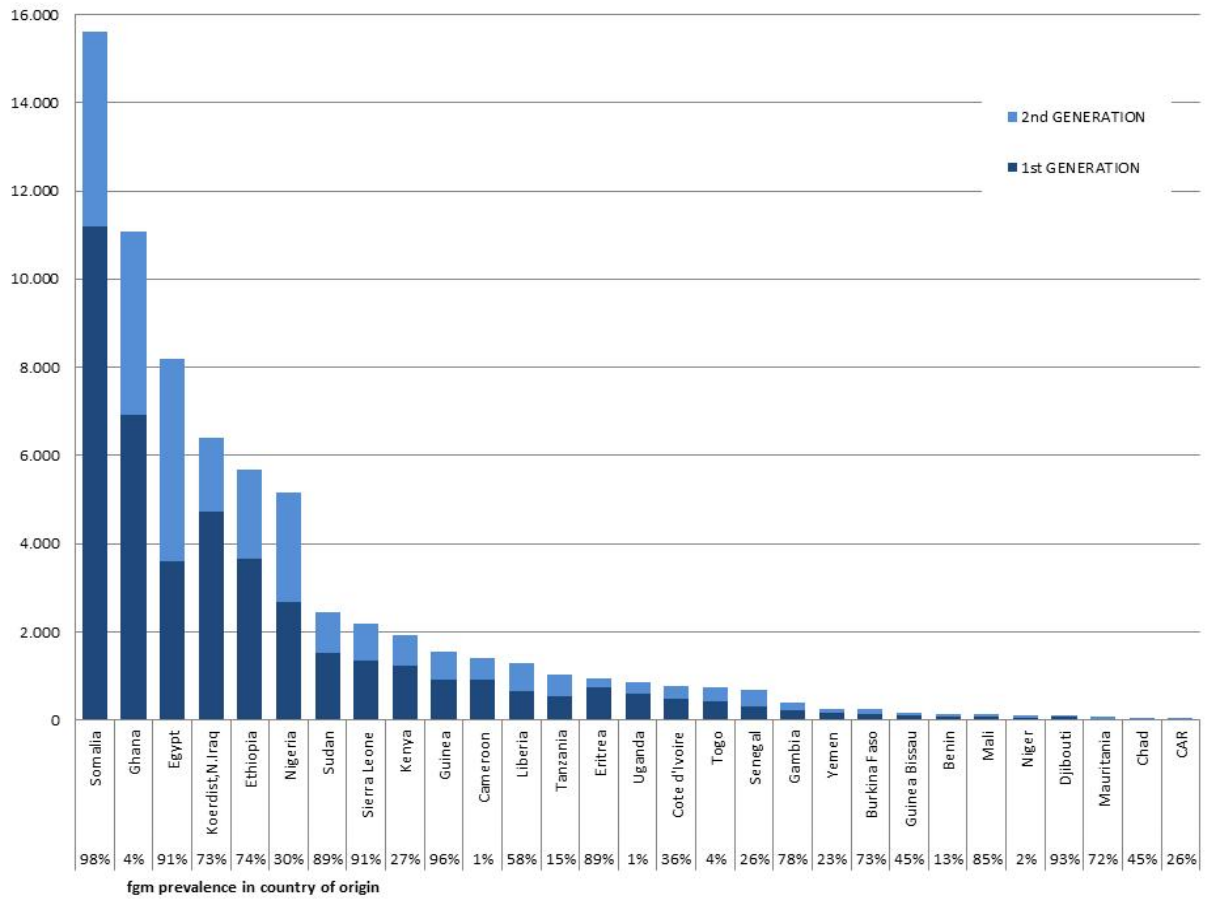
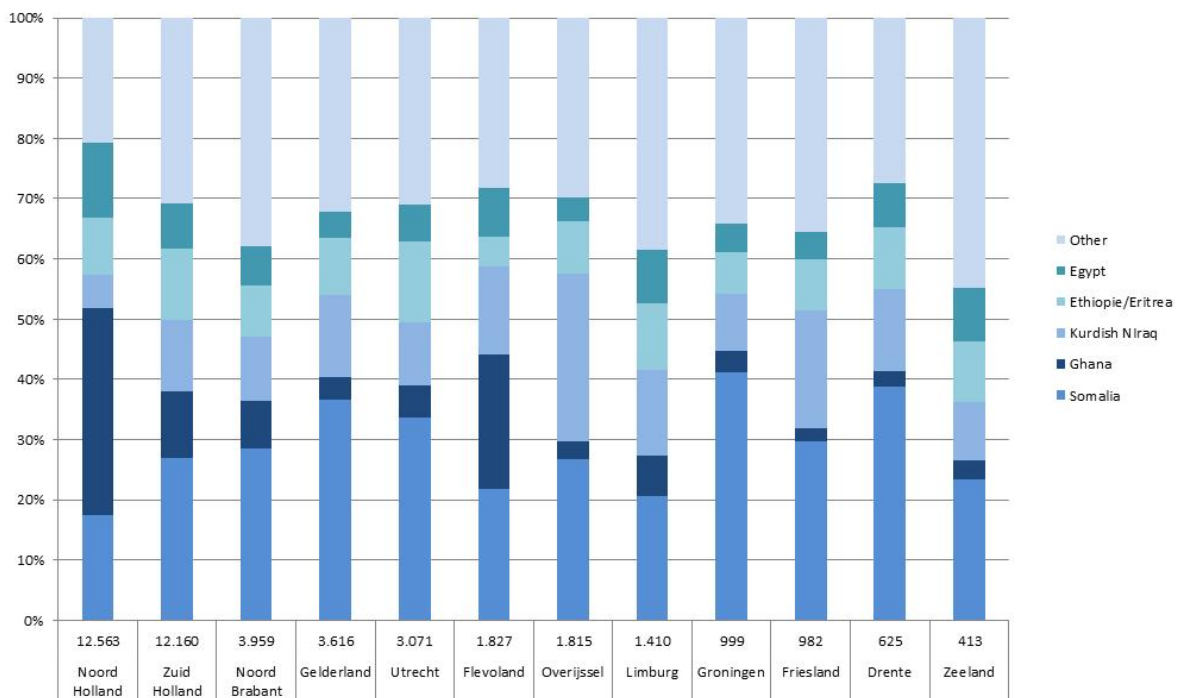


Fig 2. Number of 1st generation women in the Netherlands, by country of origin and current province in the Netherlands (1-1-2012).



7.2. Estimation of the number of women with fgm

A maximum and minimum variant is calculated for the number of women with fgm, in order to estimate the range in which the number of circumcised women falls. The maximum variant is based on no changes in fgm practices, the minimum variant includes assumptions based on literature review and focus group discussions. **Assumptions** are:

1st generation women living in the Netherlands:

Maximum number of women with fgm.

Assumption: no changes in fgm practices.

Calculation: fgm prevalence by age and region of origin are applied to 1st generation women at all ages originating from these countries.

Minimum number of women with fgm.

Assumption: no changes in fgm practices for women who came to the Netherlands after the age of circumcision. Girls who came to the Netherlands before this age (see annex III), are assumed to be still intact, due to either anti-fgm campaigns in the countries of origin, or to the fact that women have fled their country with their daughters in order to protect her against fgm, or to punishability in the Netherlands.

Calculation: fgm prevalence by age and region of origin are applied to 1st generation women originating from these countries, who entered the Netherlands after the median age of fgm, below that age fgm prevalence is 0.

2nd generation women living in the Netherlands:

Maximum number of women with fgm.

Assumption: no changes in fgm practices.

Calculation: fgm prevalence by age and region of origin are applied to 2nd generation women at all ages, who are born from 1st generation women age 20 - 50 who originate from these countries.

Minimum number of women with fgm.

Assumption: no changes in fgm practices for women older than age 15 who are born in the Netherlands from women who originate from risk countries. Age 15 is taken as a cut-off point, since fgm activities in the Netherlands started roughly 15 years ago. It is possible that, girls who were born here longer than 15 years ago, may have been cut during those days. Girls younger than age 15 are assumed to be still intact.

Calculation: fgm prevalence by age and region of origin are applied to 2nd generation women older than age 15, who are born from mothers who originate from these countries. Below that age, fgm is set at 0.

Asylum seekers at the reception centres:

Regarding the number of asylum seekers, only one assumption was made, since no data could be obtained on age of arrival in the Netherlands.

Assumption: women who come to the Netherlands, are circumcised in their country of origin, according to the age and country specific fgm pattern.

Calculation: fgm prevalence by age and country of origin are applied to female asylum seekers at all ages originating from these countries.

Results of these estimations for the 29 countries are given in table 2.

Table 2. Results of minimum and maximum variant of women with fgm in the Netherlands, (1-1-2012).

Estimated number of women with fgm:	Asylum seekers	Registered migrants, 1 st generation			Registered migrants, 2 nd generation		
		Minimum (age arrival)	Maximum (all ages)	difference Max - Min	Minimum (age >15)	Maximum (all ages)	difference Max - Min
From 28 countries	1.441	21.284	23.266	1.982	3.152	8.104	4.952
Kurdistan	?	3.150	3.476	326	100	700	600
TOTAL	1.441	24.434	26.742	2.308	3.252	8.804	5.552

The estimated number of 1st generation women with fgm in the Netherlands lies between 24.434 and 26.742, a difference of roughly 2.300 women or 9%. Much larger is the difference of 2nd generation of women with fgm (between 3.252 and 8.804, a difference of more than 100%). The 2nd generation is a young population, so the different assumptions immediately have an impact on the resulting numbers.

Which of these variants are the most likely within the Dutch context?

For both generations, the minimum variant seems the most realistic. For the 1st generation, this is substantiated by literature review: the influence of the age of circumcision and therefore age of arrival in the Netherlands. For the 2nd generation, this assumption is confirmed by literature review and focus group discussions: the influence of migration (and especially the enabling environment in the Netherlands) on the behaviour of the 1st generation mothers.

Results of the minimum variants with input of the age-and region specific fgm prevalence from the countries of origin, are further elaborated hereunder.

Results of the minimum variant

Of the almost 69.800 'registered' women originating for risk countries (table 1c), 40% have undergone fgm - roughly 28.000 women (table 3c).

Table 3. Estimated number of women with fgm, living in the Netherlands (1-1-2012).

3a. Origin 28 countries

	Women at the reception centres	Migrants		
		Total	of whom:	
			1 st generation	2 nd generation
0-5	43	28	28	0
5-19	337	3.671	2.187	1.483
20-49	967	18.207	16.601	1.607
50+	95	2.530	2.468	62
Total	1.441	24.436	21.284	3.152
% of female asylum seekers from 28 countries:		% of female migrants from 28 countries:		
	74%	39%	55%	13%

3b. Kurdish auton.reg

	Migrants		
	Total	of whom:	
		1 st gen.	2 nd gen.
0-5	0	0	0
5-19	213	151	62
20-49	2.304	2.267	37
50+	732	731	1
Total	3.249	3.150	100
% of female migrants from Kurdish Iraq:			
	51%	67%	6%

3c. Total 29 countries

	Registered migrants		
	Total	of whom:	
		1 st gen.	2 nd gen.
0-5	28	28	0
5-19	3.884	2.338	1.545
20-49	20.511	18.868	1.643
50+	3.262	3.199	63
Total	27.686	24.434	3.252
% of female migrants from 29 countries:			
	40%	56%	12%

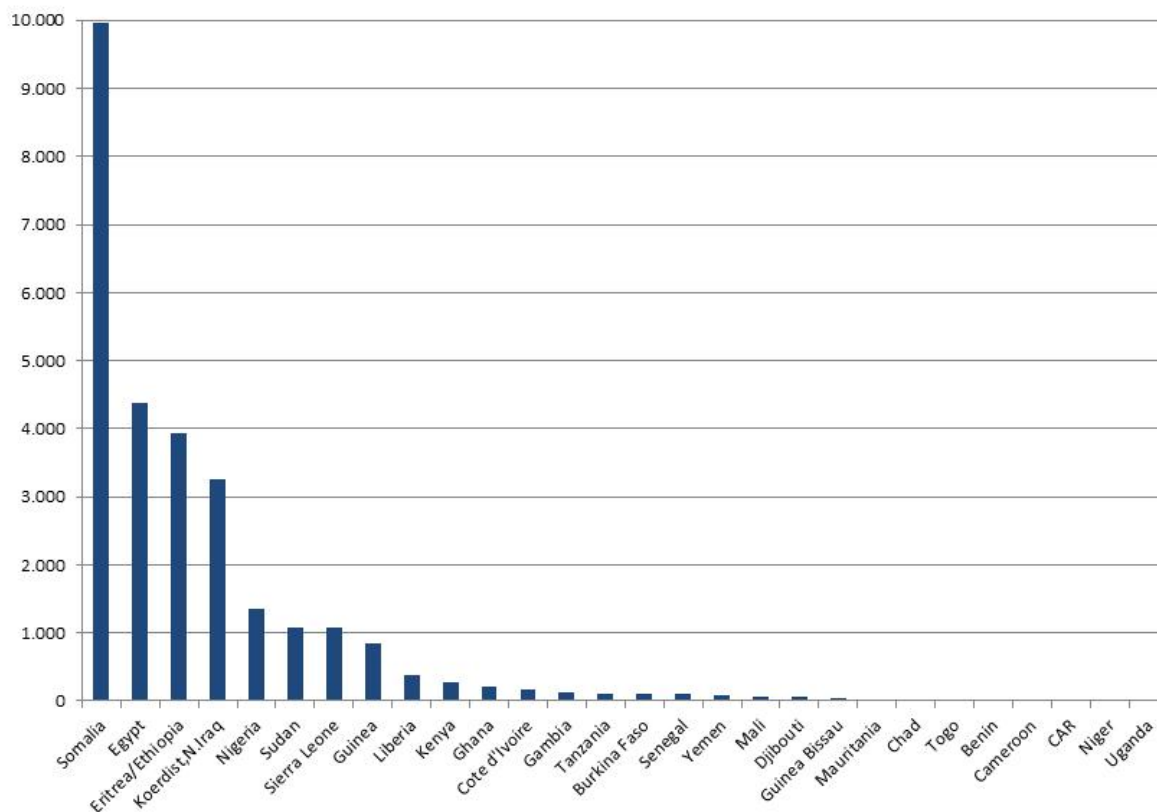
Furthermore, we can see in table 3a, that almost 24.500 of them originate from the 28 countries. 87% women are 1st generation and 13% 2nd generation. 15% is younger than 19 years, 75% between ages 20 and 49, and 10% older than 50 years.

Of the Kurdish women, originating from Northern Iraq (table 3b), who have most probably undergone fgm (nearly 3.300), 97% is 1st generation. 7% is younger than 19 years, 71% between 20 and 49 years and 23% older than 50.

Next to these registered migrants, approximately 1.400 female asylum seekers living at the reception centres are estimated with fgm (table 3a), of whom 26% is younger than 19 years, 67% between 20 and 49 years, and 7% older than age 50.

In figure 3, these number of women are disaggregated by country of origin. One third of the women with fgm originate from Somalia. Almost 80% of the women with fgm originate from Somalia, Ethiopia/Eritrea and Kurdish Iraq.

Fig 3. Estimated number of women with fgm living in the Netherlands by country of origin (1-1-2012).



In brief:

A minimum and maximum variant are calculated in order to estimate the number of women with fgm living in the Netherlands. Additional information from focus group discussions and literature review substantiate the selection of the minimum variant as the most realistic one.

7.3. Estimation of the number of girls at risk of fgm

For the estimation of the number of girls at risk of fgm, three variants are calculated, since risk is more uncertain to estimate. Assumptions are based on the results of the literature review and focus group discussions. **Assumptions** are:

High variant: the practice of fgm among migrant populations has not changed: all girls of the 1st and 2nd generation between ages 0 - 15 and female asylum seekers in the reception centres between 0 - 15 are at risk of fgm, according to the practices in the regions or countries of origin (as far as they have not already been cut in country of origin).

Medium variant: the practice of fgm among the 1st generation of migrant populations has not changed: girls in the 1st generation between ages 0 - 15 and female asylum seekers in the reception centres between 0 - 15 are at risk of fgm, according to the practices in the regions or countries of origin (as far as they have not already been cut in country of origin).
Among the 2nd generation, no fgm will occur anymore as a result of changed behaviour among mothers.

Low variant: the practice of fgm among the 1st generation of migrant populations has changed: girls in the 1st generation between ages 0 - 15 and female asylum seekers in the reception centres between 0 - 15 are not at risk anymore after the age of circumcision (10 years) due to the influence of changed perceptions among the girls themselves, who now live in a free Western society. Only girls between age 0 and 10 are at risk (as far as they have not already been cut in the country of origin).
Among the 2nd generation, no fgm will occur anymore as a result of changed behaviour among mothers.

The total number of girls in the Netherlands who are at risk of fgm, vary between 557 and 3.477 girls originating from one of the 28 countries (tables 6a and 4a), and between 9 and 297 Kurdish girls from Northern Iraq (tables 6b and 4b). Among asylum seekers, between 38 and 42 girls run a risk of fgm (tables 6a and 4a).

Table 4. Estimated number of girls in the Netherlands (1-1-2012), who are at risk of fgm, high variant.

4a. Origin 28 countries

	Girls at reception centres	Migrants		
		Total	of whom:	
			1st generation	2nd generation
0-5	28	1.009	54	955
5-15	14	2.468	633	1.835
Total 0-15	42	3.477	687	2.790
Number per year	3	232	46	186

4b. Kurdish auton.reg

	Migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	176	3	173
5-15	121	10	111
Total 0-15	297	13	284
Number per year	20	1	19

4c. Total 29 countries

	Registered migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	1.185	57	1.128
5-15	2.589	643	1.946
Total 0-15	3.774	700	3.074
Number per year	252	47	205

Table 5. Estimated number of girls in the Netherlands (1-1-2012), who are at risk of fgm, medium variant.

5a. Origin 28 countries

	Girls at reception centres	Migrants		
		Total	of whom:	
			1st generation	2nd generation
0-5	28	54	54	0
5-15	14	633	633	0
Total 0-15	42	687	687	0
Number per year	3	46	46	0

5b. Kurdish auton.reg

	Migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	3	3	0
5-15	10	10	0
Total 0-15	13	13	0
Number per year	1	1	0

5c. Total 29 countries

	Registered migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	57	57	0
5-15	643	643	0
Total 0-15	700	700	0
Number per year	0	0	0
Number per year	47	47	0

Table 6. Estimated number of girls in the Netherlands (1-1-2012), who are at risk of fgm, low variant.

6a. Origin 28 countries

	Girls at reception centres	Migrants		
		Total	of whom:	
			1st generation	2nd generation
0-5	28	54	54	0
5-10	10	503	503	0
Total 0-10	38	557	557	0
Number per year	2	37	37	0

6b. Kurdish auton.reg

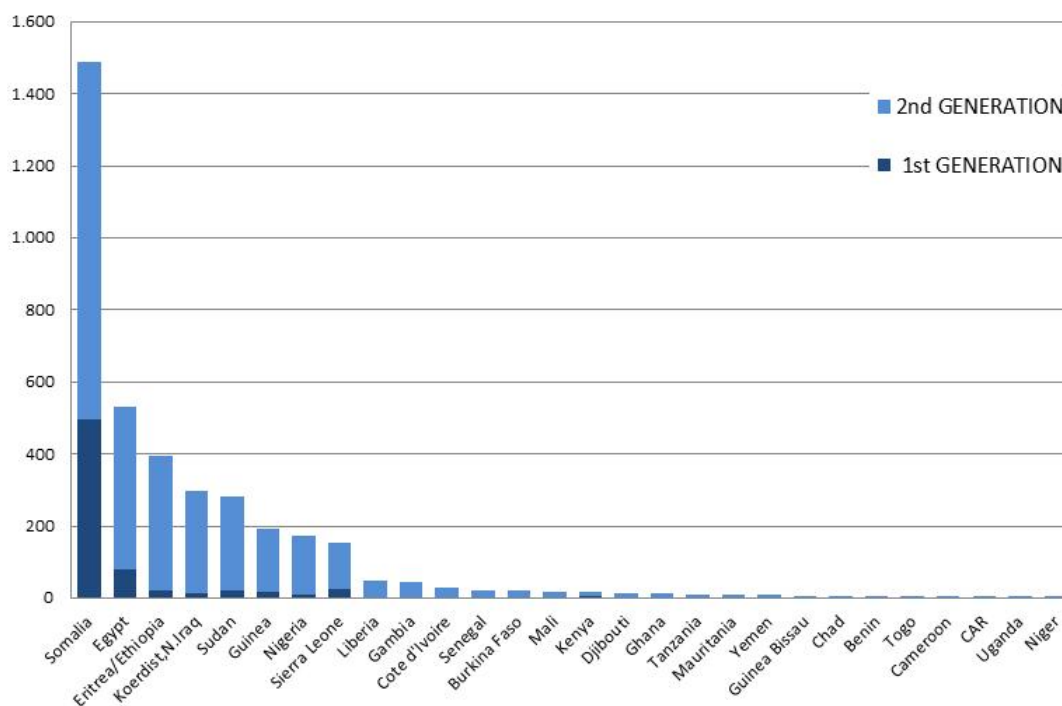
	Migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	3	3	0
5-10	6	6	0
Total 0-10	9	9	0
Number per year	1	1	0

6c. Total 29 countries

	Registered migrants		
	Total	of whom:	
		1st gen.	2nd gen.
0-5	57	57	0
5-10	509	509	0
Total 0-10	566	566	0
Number per year	0	0	0
Number per year	38	38	0

Figure 4 shows these number of girls by country of origin.

Fig 4. Estimated number of girls living in the Netherlands by country of origin, who are at risk of fgm, high and medium variant (1-1-2012).



These estimations are based on the number of girls at 1 jan 2012. Since fgm takes place between 0 and 15 years (girls at risk), the yearly number of girls at risk is:

High variant: $(3.477+297+42)/15 = 255$ girls per year run a risk of fgm. **IF** all parents would continue the practice as they would do in their country of origin, 255 girls annually would be cut.

Medium variant: $(687+13+42)/15 = 50$ girls per year run a risk of fgm, **IF** parents do not cut their daughters who are born in the Netherlands and parents who migrated with their daughters to the Netherlands continue with fgm, as they would have done in their country of origin.

Low variant: $(557+9+38)/15 = 40$ girls per year run a risk of fgm, **IF** parents do not cut their daughters who are born in the Netherlands and parents who migrated with their daughters to the Netherlands will not cut their daughter after her 10th birthday. Before that age there is still a risk as they would have done in their country of origin.

In addition to the above: in 2011, 1.705 baby girls are born in the Netherlands from mothers who originate from one of the 28 countries. When these girls celebrate their 15th birthday, between 0 (low and medium variant) and 939 girls (high variant) will have been cut.

Which of these variants are most likely in the Dutch context?

The literature review and focus group discussions conclude that children of immigrants run a low risk of fgm in a context where preconditions for not-circumcising are favourable. Sporadic cases of fgm may continue to exist, but a high risk as in some countries of origin, seems not likely in a Western context. That makes the low variant the most plausible.

For comparison, 2011 data are requested from Youth Health Care about risk taxation on fgm of girls under age 19. These data appear to be between the low (40 girls per year) and medium variant (50 girls per year). Data are requested from 9 cities where fgm prevention projects have been running during previous years. For 5 of these cities, it was possible to retrieve data out of their registration systems (table 7).

Table 7. Risk taxation fgm at Youth Health Care centres in 2011.

Youth Health Care (GGD)	Number of parents with whom fgm is discussed	Does daughter have fgm?		Does daughter run a risk of fgm?		
		fgm ascertained	fgm suspected	No risk	Doubtful risk	Realistic risk
GGD Amsterdam*	1.095	1	5	1.006	77	6
GGD Rotterdam Rijnmond*	365	2	2	342	18	1
GGD Den Haag	280	6	0	199	69	6
GGD Hart voor Brabant	54	4	0	38	7	5
GG&GD Utrecht	116	0	0	103	0	13
Total	1.910	13	7	1.688	171	31
		1%		89%	9%	2%

* In Amsterdam and Rotterdam Rijnmond the number of children originating from a risk country are being registered instead of whether fgm has been discussed.

Risk taxation fgm:

- Unknown
- No risk
- Doubtful risk: at this moment, a girl runs a doubtful risk of fgm, the risk of fgm is not (yet) taken away, but at this moment there is no realistic risk for her to get circumcised.
- Realistic risk: at this moment, a girl runs a realistic risk of fgm, the risk that parents will get their daughter circumcised is not taken away, there are signals (through the consultation or through others) that indicate an imminent circumcision.
- Suspected fgm: there are signals (through the consultation or through others) that presume that a girl is circumcised.
- Ascertained fgm: fgm is ascertained by a Youth Health Care nurse, paediatrician, general practitioner, or other medical specialist who passed the information on to Youth Health Care.

Source: *Standpunt Preventie van Vrouwelijke Genitale Verminking door de JGZ, RIVM 2010.*

In 2011, 20 girls out of 1.910 families had an ascertained or suspected fgm (1%). These girls were most probably cut in their country of origin before they came to the Netherlands (so 1st generation girls).

For 31 families (2%) the risk of fgm was realistic according to the youth health care physician or childhood nurse. For at least five of these families the risk of fgm is only realistic when these families visit their country of origin. These girls do not run a risk as long as they stay in the Netherlands.

Since Youth Health Care in these cities are already involved in prevention of fgm since 2006, we can assume they have adequate knowledge and skills to judge the risk that girls run. We therefore conclude that girls living in the Netherlands run little risk of fgm. However, a nuance needs to be made, since:

- a. youth health care does not reach 10% of the children between age 0 - 4 and 20% of the children 4 - 19.
- b. discussions about fgm have not taken place as of yet with *all* parents of children who have been seen, so risk taxation was not done for *all* girls (this holds for places where children from at risk countries are registered and not whether fgm was discussed during the consultation: e.g. Amsterdam, Rotterdam Rijnmond).
- c. the registration systems are primarily developed as child tracking systems, not directly for research purposes and producing aggregated information. Some items (e.g. fgm, interviewing protocol fgm) can be registered at different places in the digital system and not all topics are countable: sometimes registration is done in textboxes, which are not easily countable.

So it is very well possible that 2% realistic risk is an underestimate, but it nevertheless confirms the assumption that the low and medium variant are more realistic than the higher one.

9% of the girls run a doubtful risk (171 girls), 89% ran no risk at all. When we use doubtful risk, we come close to the higher variant. However, this does not seem likely, since 'doubtful' is sometimes interpreted by a physician as 'unknown'. After signalling of a lasting doubtful risk, a realistic risk or a ascertained fgm, reporting needs to take place to the Advice and Reporting Centre for Child Abuse and Neglect (AMK).

A final check is therefore done with data from AMKs. In 2010/2011, 37 reports were received of threatening or suspicious fgm, 18 in 2010 and 19 in 2011 (Youth Care, Netherlands). These 19 cases in 2011, include 4 suspicious fgm (of which two could be ascertained, both girls were cut before they came to the Netherlands) and 15 cases relate to threatening fgm, of which one could be ruled out. So, in 2011 there have been 14 threats of fgm. These 14 were no acute threats, but a possible fgm in the future could not be excluded. These reports included reports from schools, police, anonymous or family/acquaintances.

From this, we can conclude that 'doubtful' risk taxation at Youth Health Care is not a lasting risk taxation, since we then would expect more reports at the AMKs. 'Doubtful risk' does not seem a good measure for the real risk that girls run of fgm.

In brief:

In order to estimate the number of girls living in the Netherlands at risk of fgm, a high, medium and low variant are calculated. The risk of fgm lies between the low and medium variant (yearly 40 - 50 girls are at risk of fgm). This is substantiated with information from focus group discussions, literature review and registration data.

8. Importance of differentiation by age and region

In our estimations we use age and region specific fgm prevalence data from the countries of origin, since these are two important determinants of fgm prevalence.

In order to find out whether these two determinants really do matter in our estimations, we estimated fgm prevalence in the Netherlands in four different ways: Using:

1. Average fgm prevalence from country of origin,
2. Age specific fgm prevalence from country of origin,
3. Region specific fgm prevalence from country of origin,
4. Age and region specific fgm prevalence from country of origin.

Next to being a determinant of fgm prevalence, equally important, when applying information from countries of origin to migrant populations in the Netherlands, is the fact that a migrant population may or may not be representative for the population in the country of origin regarding age and region.

For the 28 countries, all 4 different ways were calculated. Results of these estimations are given in table 8.

Table 8. Results of different estimations for women with fgm in the Netherlands (1-1-2012), originating from 28 risk countries.

		Estimated number of women with fgm in the Netherlands:						
		Asylum seekers	1 st generation			2 nd generation		
Input: fgm prevalence in country of origin	Minimum (age arrival)		Maximum (all ages)	difference Max - Min	Minimum (age >15)	Maximum (all ages)	difference Max - Min	
1	average fgm	1.652	20.987	23.733	2.746	3.380	14.625	11.245
2	age specific fgm	1.441	21.539	34.453	12.914	3.163	8.075	4.912
3	region specific fgm	-	20.818	23.498	2.680	3.357	14.504	11.147
4	age and region specific fgm	-	21.284	23.266	1.982	3.152	8.104	4.952
difference between different input data:		211	721	11.187		228	6.550	

The differences between different fgm prevalence as input for the estimations (rows 1 to 4 in table 8) are highest in the maximum variant: a difference of 11.187 for the 1st generation and 6.550 for the 2nd generation. This is expected, since all women of all ages are included in the maximum variants, so bias due to age and region is also maximum. Although the variation is low in the lower variants (only 721 and 228), this may be misleading: the difference for the total of the 28 countries is indeed minimal, but differences per country can be substantial. The next example makes this clear (annex IV also gives information for other countries).

Example Ghana

Average fgm prevalence in Ghana for women between 15 and 49 is 4%. FGM among the younger age group is much lower than among the older age group (1,4% among age 15 - 19 versus 7,4% among age group 45 - 49). Furthermore, fgm practices differ between regions, varying from 56% in Upper West Region to 0,5% in Central Region. And finally, fgm practices may change over time in Ghana as well, due to e.g. campaigns, policy or otherwise.

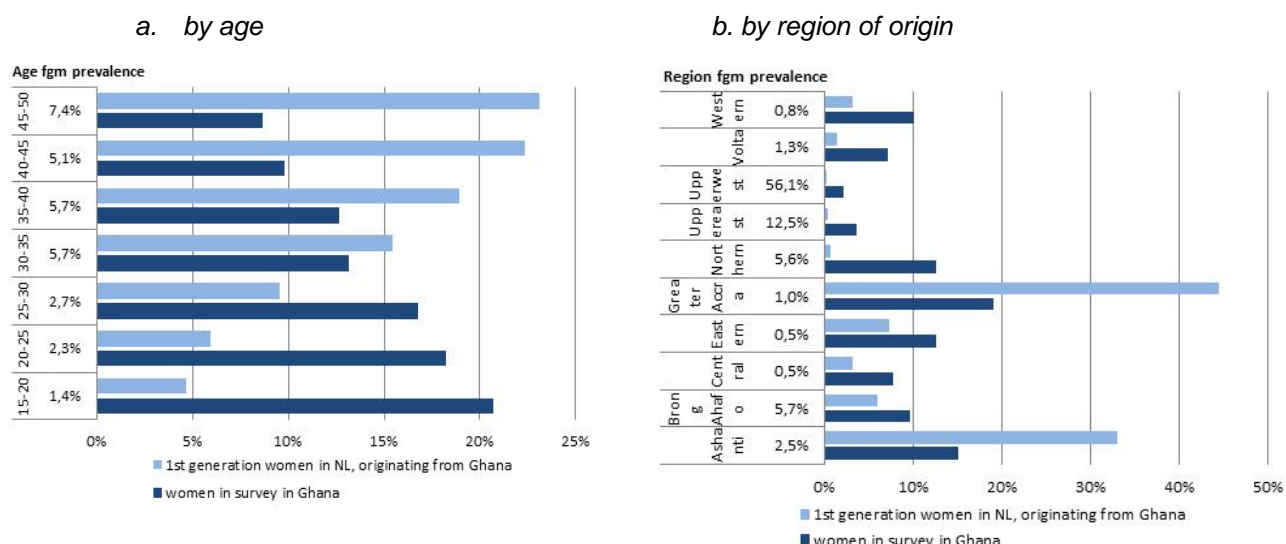
So ideally, in order to be as representative as possible, we need to know:

1. at what age women came to the Netherlands,
in order to know which age prevalence applies to her. E.g. of all women who came to the Netherlands at age 17, most probably 1,4% will be cut.
2. current age of women,
in order to know the age prevalence pattern in country of origin t years ago. E.g. the current age of a woman who entered the Netherlands at age 17, can be 18 or 65. In case she is 18, the most recent data for countries of origin may apply; in case she is 65, we need to go back in history to know fgm prevalence some 50 years ago.
3. from which region women originate,
in order to know which region prevalence applies to her. E.g. of the women who originate from Upper West Region 56% may have undergone fgm, but fgm prevalence is 0,5% for women originating from Central Region.

Since we hardly have any historical data about fgm in countries of origin, we only use most recent data from the countries of origin.

In the figures below we see that the Ghanaian female population living in the Netherlands is **not** representative for the female population who participated in the survey in Ghana.

Fig.5 Women in participating survey in Ghana and Ghanaian women living in Netherlands.



Looking at the age distribution, we see that more older (>35 years) women are living in the Netherlands than participated in the survey in Ghana. Since fgm at higher ages is higher than at lower ages, we expect underestimates for the Dutch Ghanaian population in case we apply average fgm data from Ghana. When looking at region of origin, we see that Dutch women originating from Ghana, come from regions where fgm is hardly at stake (Greater Accra and Ashanti), so when applying average fgm data from Ghana to the Dutch Ghanaian population, the results will be an overestimate of the number of Dutch Ghanaian women with fgm.

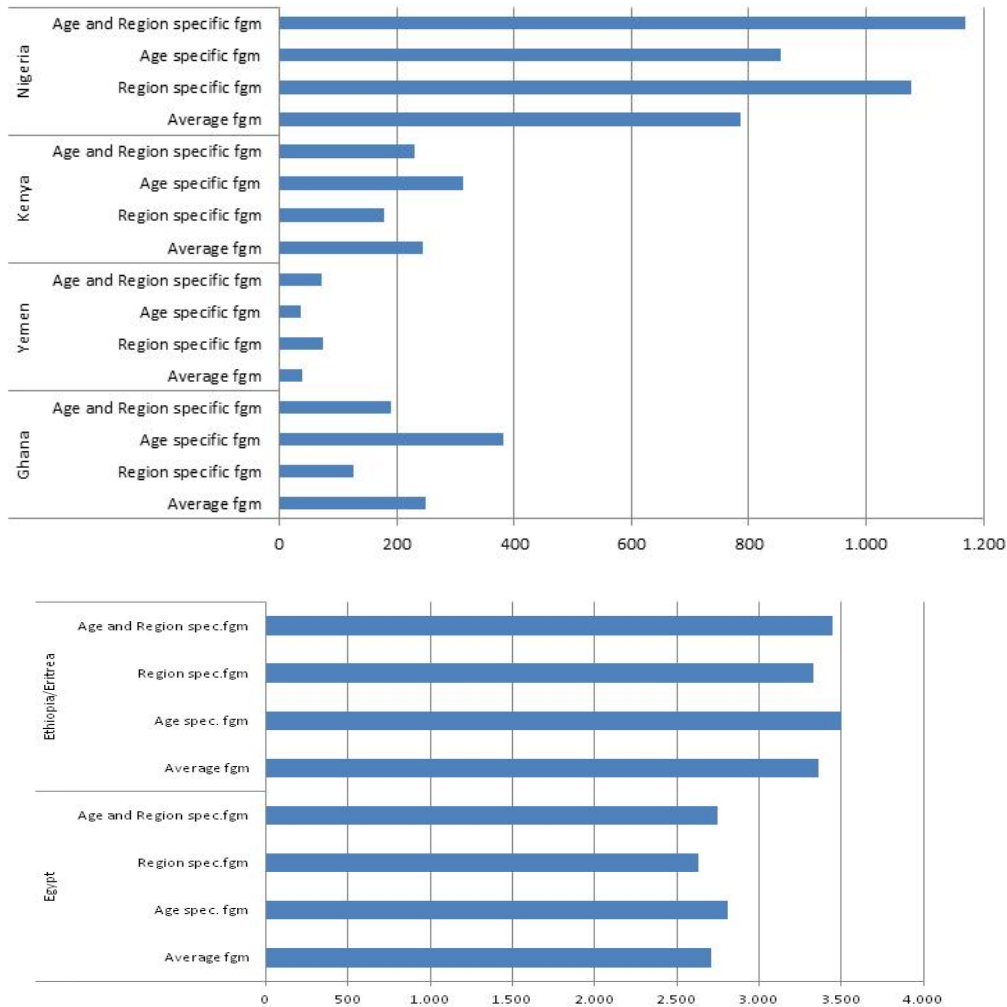
Results for the number of Ghanaian women with fgm living in the Netherlands varied between 250 (based on average fgm), 381 (based on age specific prevalence), 125 (region specific prevalence) and 190 (age and region specific prevalence) (figure 6).

Even though there are many Ghanaian women living in the Netherlands, fgm is not such an extensive problem among them as it is under Somali women. This has to do not only with the fact that average fgm prevalence for Ghana is low, but also due to large regional differences

regarding fgm within Ghana. The Ghanaian population in the Netherlands originates mostly from areas in Ghana where fgm is hardly practiced.

Figure 6 also shows three other countries with large differences between the four ways of input of fgm prevalence, as well as two countries where differences are not so significant.

Fig. 6. Differences in the number of women with fgm living in the Netherlands by country of origin, based on different fgm prevalence calculations.



In brief:

Age and region specific fgm data do give the most realistic approximations: it not only takes into account the relations between age and fgm and region and fgm in the country of origin, but also takes into account the (non) representativeness of a migrant population in relation to the population in the country of origin.

9. Restrictions and justification of the methods used

Nothing can be perfect. All methods have their restrictions. The most important ones for this research are mentioned in this chapter. That we nevertheless feel confident with doing it the way we did, is explained as well.

9.1. Restrictions

Results from literature review:

- ✓ We restricted ourselves to a review of articles with quantitative data on fgm prevalence and incidence and its determinants. We are aware that this may not give a complete picture. Especially for more insight into determinants, risk of fgm and behavioural change, other searches may yield additional information.

Data from DHS/MICS surveys:

- ✓ FGM data are hardly available for ages below 15,
- ✓ FGM data are not available for ages above 49,
- ✓ Data on fgm status are self-reported data:
 - Answers may be socially desirable,
 - Answers may suffer from a recall bias (you ask women about something that happened some 20 or more years ago).

Population data in the Netherlands:

- ✓ Within this research we include people living in the Netherlands who are registered and the number of asylum seekers living in the reception centres. Undocumented or illegal people are therefore not included in the research.

Registration of fgm in the Netherlands:

- ✓ At the time of writing it was difficult to obtain national aggregated data on fgm. Only a sample was taken. Registration of (risk of) fgm at this moment may suffer from under-registration.

Risk of fgm taxation in the Netherlands:

- ✓ This remains a difficult topic. Risk taxation is done through checking certain risk factors. No regular medical checks are done. Every now and then discussions blaze in favour of compulsory medical examination among girls. Whether this is a solution remains to be seen: medical checks do not necessarily catch the mildest forms of fgm and not all malformations are fgm.

Is the influence of migration tackled sufficiently in this research?

- ✓ Within our literature review we found four qualitative articles about this topic. Perhaps a more extensive search with different search criteria could retrieve more articles.
- ✓ We conducted four focus group discussions with different groups. This gave us an insight in perceptions, needs, attitudes and behaviour which complemented literature. Listening to more different voices would definitely enrich the information. Whether the conclusions would change is uncertain. This has to do with selection bias (next bullet).

Reaching the target group:

- ✓ A major obstacle is getting a representative sample of the different migrant groups. It is difficult to recruit women for focus group discussions who are not linked to migrant organisations or are already in a network of people who are concerned about fgm. How to reach the unreachable?

9.2. Justification

Although theoretically, estimations with fgm data from the countries of origin may result in prevalence rates among Dutch immigrants as they would have had in Africa, and not necessarily in the Netherlands, this method is justified, since:

- ✓ Broadly speaking, these migrants came to the Netherlands since the mid 90s, 10 to 15 years ago. This means that fgm data for the older age groups are the same as those in Africa, since fgm takes place between approximately 4 and 12 years of age.
- ✓ Next to age and region, DHS and MICS surveys also provide information regarding fgm and other socio demographic data of respondents, e.g. urban/rural living, ethnicity, religion, education and wealth. This information can be taken into account with the analysis. Since we did not find unambiguous relations between these determinants and fgm prevalence in our literature review, nor were all data available for migrants in the Netherlands (e.g. ethnicity) we only refined our analysis with age, age of circumcision, region of origin, birthplace and age of arrival in the Netherlands. That already did reveal large differences for some migrant groups (e.g. Ghanaian, Nigerians).
- ✓ By comparing DHS and MICS surveys over several years, time series can be developed: different survey years can be compared as well as data from mothers with daughters, and older with younger age cohorts. When more studies become available for several years, it is possible to look at fgm trends in the countries of origin.

The use of self reported fgm data (as presented in DHS or MICS) may seem a weakness, but may not necessarily be better or worse than data from medical examinations. The literature review also included eight articles where self reported fgm and clinical examined fgm were compared: Sweden (Kangoum et al, 2004, Litorp et al, 2008), Gambia (Morison et al, 2001), Sudan (Elmusharaf et al, 2006), Nigeria (Adinma et al, 1999, Mandara, 2004, Snow et al, 2002), Tanzania (Klouman et al, 2005). From these articles it becomes clear that information bias may occur, since woman as well as clinicians may incorrectly report women's circumcision status. Clinically examined fgm may also not be 100% reliable, since the mildest forms may not easily be recognisable. When reported and examined *types* of fgm (Elmusharaf et al, 2006, Litorp et al, 2008) were compared, researchers found that the reliability of reported *type* of fgm is low. Some girls or women who reported to have undergone 'sunna' actually had WHO type III.

Type of fgm was not included in our research, since firstly, *all* forms of fgm are forbidden in the Netherlands, secondly, reliability of reported types seems low (literature, personal communication), and thirdly, the classification used by WHO is less obvious in practice, since many different variations of fgm appear.

Furthermore, our original idea of a household survey would not only be too costly, but also faced many dilemma's: how to obtain valid information?, can we expect counselling skills from interviewers?, How to be sure that a representative sample among this population also results in a representative picture of fgm? Due to the dilemma's, results of a survey would not necessarily be better than this estimation.

When we compare our results with the study of RVZ in 2005 (at least 50 girls who are living in the Netherlands are being circumcised annually) and TNO in 2008 (40% of pregnant women, originating from risk countries, are circumcised), our estimates are slightly lower. We estimated 40 to 50 girls are at risk, but this risk becomes only realistic when girls visit countries of origin. As long as they stay in the Netherlands, the risk is low. We furthermore estimated that 39% of the women from the 28 risk countries have been subjected to fgm.

In brief:

Even with all restrictions, we were able to make the best possible guess.

10. Possibilities for monitoring fgm prevalence and incidence

Since 2011, fgm is systematically included in existing digital registration systems. At the time of writing, it is not yet possible to obtain aggregated data, since possibilities for digital registration are not yet in place everywhere. This chapter gives an overview of fgm registration in several sectors, where, in the future, aggregated data can be obtained.

Youth Health Care (JGZ)

Dutch municipalities are responsible for youth healthcare (JGZ) between 0 - 19 years. JGZ reaches 90% of the children between age 0 - 5 and 80% of the children between 4 - 19 years. JGZ plays a crucial role in prevention of fgm. JGZ has several consultations with a child (and his/her parent). FGM can be discussed during each of these contacts. During a visit, JGZ makes a risk taxation, based on a number of risk factors:

- Country of origin of mother is a fgm risk country
- Country of origin of father is a fgm risk country
- Mother of the girl has fgm
- One or more sisters have fgm
- Partner or direct family members think positive about fgm
- Family feels social pressure from family or surrounding
- Family often visits country of origin
- Family is not yet or poorly integrated

The risk increases with an increasing number of risk factors. Risk taxation during a consultation is registered: unknown, no risk, doubtful risk, realistic risk, suspected case of fgm, ascertained case of fgm (Standpunt JGZ, 2010). Registration in the Digital Dossier Youth Health (DD JGZ) takes place since mid 2011. There is an agreement that data are registered in a unambiguous way, but at the moment it is too early to subtract national aggregated data already: not all JGZ organisations register already in a digital way and not all JGZ organisations use the same software. As of yet, data need to be requested at each individual organisation.

Advice and Reporting Centre for Child Abuse and Neglect (AMK) and Child Protection Board (RvdK)

At a suspicion of fgm, advice can be obtained at the AMK. When a doubtful or realistic risk continues or whether a fgm has been taken place, reporting needs to be done at the AMK. The AMK starts an investigation and decides for voluntary assistance, forced assistance or reports at the police or OM. The Child Protection Board (RvdK) investigates whether forced assistance is needed.

AMK does register fgm, but registration is not yet complete: fgm as a reason for investigation is registered, but whether fgm has indeed been taken place or not is not yet registered. Within the next few years this information can be obtained through the system. RvdK has not yet a registration of specifically fgm.

Netherlands Perinatal Registry (PRN)

Midwifery registers fgm through the national perinatal registration. Midwives, gynaecologists and general practitioners can report in the PRN, but registration as of yet is not complete. A new dataset is developed and now being translated into a digital registration system.

Public Prosecution Service (OM)

The OM registers fgm through a combination of the relevant section of the Penal Code in combination with the classification of genital mutilation.

Immigration and Naturalisation Service (IND)

FGM can be a reason for asylum. Electronic registration of motives for asylum (of which fgm is one) is not done. The only way to obtain information is a file search. This was done in 2008 within the framework of an evaluation of gender related immigration policy. FGM played a role in 53 (48% of the dossiers with gender related asylum motives) of the asylum requests in the first quarter of 2007⁵.

In brief:

For the future monitoring of fgm incidence or risk of fgm, data from Youth Health Care and Advice and Reporting Centre for Child Abuse and Neglect can be used. Concerning monitoring of fgm prevalence among all women, this will remain limited to pregnant women, as only PRN registers fgm.

⁵ *INDIAC, 2008. Evaluatie gendergerelateerd vreemdelingenbeleid in Nederland.*

11. Conclusions

- a. Prevalence of fgm in the Netherlands in 2012: an estimated 29.120 women with fgm reside in the Netherlands (minimum variant). Of those are:
 - ✓ 27.680 'registered' women (40% of all registered women originating from risk countries) - 24.430 originate from the 28 'WHO countries', 3.250 from the Kurdish Autonomous Region in Northern Iraq.
 - 14% is younger than 19 years, 74% between 20 and 49 years, and 12% older than 50.
 - About 80% of these women originate from Somalia, Egypt, Ethiopia/Eritrea and the Kurdish Autonomous Region of Iraq.
 - ✓ 1.440 women in the asylum reception centres (74% of female asylum seekers originating from risk countries).
 - 26% is younger than 19 years, 67% between 20 and 49 years, and 7% older than 50.
 - About 80% of these women originate from Somalia, Eritrea and Guinea.
 - ✓ Most of the women with fgm are in their reproductive ages. Health care providers and counsellors need to have skills to discuss the topic and knowledge about the relation of these medical and psychosocial complaints and fgm and be aware of adequate medications, therapy or referral possibilities.
- b. Incidence of fgm in the Netherlands in 2012: yearly, between 40 and 50 girls residing in the Netherlands are at risk of fgm.
 - ✓ This number is based on registration at Youth Health Care, AMK and the most plausible variants based on fgm practices in countries of origin and immigration (between low and medium variant). It is important to realise that the risk for a number of these girls only gets realistic when they visit their country of origin.
 - ✓ About 80% of these girls originate from Somalia and Egypt.
 - ✓ Youth health care plays an important role in prevention.
- c. From literature review, focus group discussions and registration at Youth Health Care and AMK, it turns out that the risk of fgm in the Netherlands is low. Different (Western) values and norms only explain part of this lower risk. More important seems the *enabling environment*: prevention, law and legislation (the law in the Netherlands seems to have a strong preventive function), child protection measures (AMK) and risk taxations at Youth Health Care (JGZ).
- d. Awareness raising and training about fgm is important: partly because of this, women gained more knowledge about e.g. medical and psychosocial consequences of fgm and the Dutch law. However, there is still confusion about the law: not all (wo)men realised that *all* forms of fgm are forbidden and the difference between 'cutting' and 'being cut' was not clear to some of the women, which withheld some women from seeking medical care, since they were afraid for prosecution because they were cut.
- e. In order to monitor the number of girls at risk and women with fgm, national aggregated data are necessary, as is an unambiguous registration.
- f. There are large differences with regards to fgm practices within countries of origin:
 - ✓ Not all countries at the 'WHO list' are high fgm prevalence countries, and not all regions within these countries show a high fgm prevalence.
 - ✓ Relations between determinants and fgm prevalence are not country specific, but community specific. Awareness sessions and other interventions should focus more on specific codes within a certain group, or need to be broad enough in case you do not know your target group.

12. Food for thought and policy implications

Based on the conclusions of the research in combination with on going fgm activities in the Netherlands, some reflections and policy implications can be made.

Is the attention for fgm still justifiable in the Netherlands? We consider several reasons that it is:

- ✓ Although the risk of fgm in the Netherlands is relatively low, the seriousness of fgm is very high: it is a violation of human rights with harmful medical and psychosocial consequences.
- ✓ The enabling environment in the Netherlands is important: education about medical and psychosocial consequences, law and legislation, prevention activities, child protection measures, national policy. The active involvement of key persons from the communities themselves is a strong anchor in the anti-fgm activities in the Netherlands. All these measures together are likely to support abandonment of fgm in the Netherlands: women in the focus group discussions expected that fgm would have been higher if these measures are not existing in the Netherlands.
- ✓ New migrants from risk countries or new risk groups from (new) risk countries may appear: 'existing' risk groups (e.g. Egypt, Sierra Leone) are not yet optimally reached, 'new' groups (women from the Kurdish autonomous region of Iraq) still need to be reached.
- ✓ Staff turnover is a risk for continuity in knowledge and experiences, therefore knowledge transfer needs to continue regarding prevention, repression and medical and psychosocial care.

Is national policy still needed?

- ✓ Facilitation or political support from national level remains important.
- ✓ Structures (training, capacity development, protocols, law, registration systems, integrated chain approach) have been set up during last years in different sectors. It is now necessary that these structures are being maintained, since the attitudes of 1st generation women have not completely changed, so there still is a potential risk for fgm.
- ✓ FGM needs to be included in national, municipal or organisational policy on child abuse, domestic violence and violence in dependent relationships. FGM is already included in the 'reporting code' ('*meldcode*'). Possibilities of embedding and mainstreaming of fgm preventive activities can take place in e.g. child abuse or parenting courses.
- ✓ Special attention is currently given to medical and psychosocial care: 27.680 'registered' women and 1.440 female asylum seekers have been cut and may need medical or psychosocial care. Three quarters of these women are in the reproductive ages.

Training

- ✓ Education and training about law needs to be maintained. Special attention is needed on the difference between cutting and being cut, and on the fact that all forms of fgm are regarded as child abuse.

Cross border

- ✓ FGM is not a national issue and can therefore not be abandoned at national level only. Several interconnected mechanisms between immigrant communities in different European countries and between immigrant communities and their countries of origin are present: in the countries of origin, strong anti-fgm campaigns can be present or (as we

heard of Egypt) a promotion of fgm. Immigrants can either support fgm again (as a handhold to one's own culture) or may actively try to abandon fgm. The relations are diverse, and attention to these relations need to be tackled.

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Annex I. FGM prevalence (age 15 - 49) in countries of origin

	Most recent (t)	t-1	t-2	t-3	t-4
Somalia	97,9%				
Guinea	95,6%	98,6%			
Djibouti	93,1%				
Sierra Leone	91,3%	94,0%			
Egypt	91,1%	95,8%	97,0%	97,3%	97,0%
Sudan (North)*	89,2%				
Eritrea	88,7%	94,5%			
Mali	85,2%	91,6%	93,7%		
Gambia	78,3%				
Ethiopia	74,3%	79,9%			
Iraqi Kurdish Autonomous Region**	72,7%				
Burkina Faso	72,5%	76,6%	71,6%		
Mauritania	72,2%	71,3%			
Liberia	58,2%				
Chad	44,9%				
Guinea-Bissau	44,5%				
Yemen	38,2%	22,6%			
Cote d'Ivoire	36,4%	41,7%	44,5%	42,7%	
Nigeria	29,6%	26,0%	19,0%	25,1%	
Kenya	27,1%	32,2%	37,6%		
Central African Republic	25,7%	43,4%			
Senegal	25,7%	28,2%			
Tanzania	14,6%	14,6%	17,9%		
Benin	12,9%	16,8%			
Togo	3,9%	5,8%			
Ghana	3,8%				
Niger	2,2%	4,5%			
Cameroon	1,4%				
Uganda	0,6%				

* figure is for 1989/90. The 2000 report did not give a total fgm prevalence

** age 14+

Sources : see annex II

Annex II. Sources of data on fgm in countries of origin

Data on FGM prevalence from the following DHS and MICS surveys

1	Benin	2006	2001		
2	Burkina Faso	<u>2006</u>	2003	1998/99	
3	Cameroon	2004			
4	Central African Rep.	<u>2006</u>	1994/95		
5	Chad	2004			
6	Côte d'Ivoire	<u>2006</u>	2005	1998/99	1994
7	Djibouti	<u>2006</u>			
8	Egypt	2008	2005	2003	2000 1995
9	Eritrea	2002	1995		
10	Ethiopia	2005	2000		
11	Gambia	<u>2005/06</u>			
12	Ghana	<u>2006</u>			
13	Guinea	2005	1999		
14	Guinea-Bissau	<u>2006</u>			
15	Kenya	2008/2009	2003	1998	
16	Liberia	2007			
17	Mali	2006	2001	1995/96	
18	Mauritania	<u>2007</u>	2000/01		
19	Niger	2006	1998		
20	Nigeria	2008	<u>2007</u>	2003	1999
21	Senegal	2010/2011	2005		
22	Sierra Leone	2008	<u>2005</u>		
23	Somalia	<u>2006</u>			
24	Sudan (North)	<u>2000</u>	1989/90		
25	Tanzania	2010	2004/05	1996	
26	Togo	<u>2010</u>	<u>2006</u>		
27	Uganda	2006			
28	Yemen*	2003	1997		
29	Iraqi Kurdish Autonomous Region**	2010			

Sources (2 aug 2012):

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

MICS: http://www.childinfo.org/mics_available.html

* PAPFAM 2003 (Yemen).

** WADI 2010: Female genital mutilation in Iraqi-Kurdistan, an empirical study by WADI, Germany.

Annex III. Median age at circumcision

Country	Median age
Benin	4
Burkina Faso	5
Cameroon	9
Central African Republic	10
Chad	9
Cote d'Ivoire	4
Djibouti*	7
Egypt	10
Eritrea	1
Ethiopia***	0
Gambia*	7
Ghana*	7
Guinea	9
Guinea-Bissau*	7
Kenya	13
Liberia**	14
Mali	5
Mauritania	5
Niger	5
Nigeria	0
Senegal	5
Sierra Leone	14
Somalia	7
Sudan (north)*	7
Tanzania	8
Togo	9
Uganda*	7
Yemen***	0
Iraqi Kurdish Autonomous Region	7


* Data on age at fgm are lacking. Assumption: median age is same as average of median ages from all countries

** Data on age at fgm are lacking. Assumption: median age is same as Sierra Leone, since these two countries have similar practices of *rites de passage* and secret societies

*** Data on age at fgm for respondents are lacking. Median age of fgm among daughters of the respondents are used.


Annex IV. Examples of age and region specific data

Ghana (fgm: 3,8% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Ghana	1st generation women in the Netherlands (2012)			in survey in Ghana	1st generation women in the Netherlands (2012)	
15-20	1,4%	21%	5%	Ashanti	2,5%	15%	33%
20-25	2,3%	18%	6%	Brong Ahafo	5,7%	10%	6%
25-30	2,7%	17%	10%	Central	0,5%	8%	3%
30-35	5,7%	13%	15%	Eastern	0,5%	13%	7%
35-40	5,7%	13%	19%	Greater Accra	1,0%	19%	44%
40-45	5,1%	10%	22%	Northern	5,6%	13%	1%
45-50	7,4%	9%	23%	Uppereast	12,5%	4%	0%
				Upperwest	56,1%	2%	0%
				Volta	1,3%	7%	1%
				Western	0,8%	10%	3%




http://nl.wikipedia.org/wiki/Regio's_van_Ghana

Egypt (fgm: 91,1% of ever married women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Egypt	1st generation women in the Netherlands (2012)			in survey in Egypt	1st generation women in the Netherlands (2012)	
15-20	80,7%	19%	5%	Frontier governorates	66,3%	1%	1%
20-25	87,4%	20%	4%	Lower Egypt	92,9%	44%	26%
25-30	94,3%	16%	11%	Upper Egypt	92,6%	36%	18%
30-35	95,2%	12%	22%	Urban governorates	85,9%	19%	55%
35-40	96,4%	12%	26%				
40-45	96,2%	10%	18%				
45-50	96,0%	10%	14%				



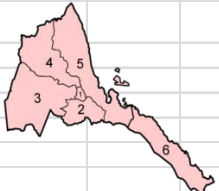
Source: DHS, 2008

Ethiopia (fgm: 74,3% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Ethiopia	1st generation women in the Netherlands (2012)			in survey in Ethiopia	1st generation women in the Netherlands (2012)	
15-20	62,1%	23%	4%	<i>Ethiopia:</i>			
20-25	73,0%	18%	8%	Addis Ababa	65,7%	5%	28%
25-30	77,6%	18%	21%	Affar	91,6%	1%	0%
30-35	78,0%	13%	18%	Amhara	68,5%	25%	5%
35-40	81,2%	11%	18%	Beneshangul Gumuz	67,6%	1%	1%
40-45	81,6%	8%	17%	Dire Dawa	92,3%	0%	2%
45-50	80,8%	8%	14%	Gambela	27,1%	0%	0%
				Harari	85,1%	0%	1%
				Oromiya	87,2%	36%	11%
				SNNP	71,0%	21%	2%
				Somali	97,3%	3%	1%
				Tigray	29,3%	7%	6%



http://en.wikipedia.org/wiki/Ethiopia#Regions.2C_zones.2C_and_districts

Eritrea (fgm: 88,7% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Eritrea	1st generation women in the Netherlands (2012)			in survey in Eritrea	1st generation women in the Netherlands (2012)	
15-20	78,3%	23%	10%	<i>Eritrea:</i>			
20-25	87,9%	17%	13%	Anseba	96,4%	13%	3%
25-30	90,8%	18%	26%	Debubawi Keih Bahri	81,5%	4%	1%
30-35	93,4%	13%	23%	Debub/Southern	92,2%	27%	4%
35-40	92,6%	12%	14%	Gash	94,6%	17%	2%
40-45	94,1%	9%	14%	Meakel/Central	83,5%	26%	32%
45-50	95,0%	8%	6%	Semenawi Keih Bahri	97,7%	13%	1%




http://nl.wikipedia.org/wiki/Regio%27s_van_Eritrea

Annex IV. Examples of age and region specific data - continued


Nigeria (fgm: 29,6% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Nigeria	1st generation women in the Netherlands (2012)			in survey in Nigeria	1st generation women in the Netherlands (2012)	
15-20	21,7%	19%	5%	North Central	11,4%	14%	3%
20-25	26,4%	18%	7%	North East	2,7%	13%	0%
25-30	28,9%	19%	14%	North West	19,6%	24%	3%
30-35	32,8%	14%	21%	South East	52,8%	12%	10%
35-40	33,9%	12%	26%	South South	34,2%	16%	53%
40-45	36,4%	9%	17%	South West	53,4%	20%	30%
45-50	38,1%	9%	11%				

Source: DHS, 2008




Sierra Leone (fgm: 91,3% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Sierra Leone	1st generation women in the Netherlands (2012)			in survey in Sierra Leone	1st generation women in the Netherlands (2012)	
15-20	75,5%	16%	10%	Eastern	92,1%	18%	24%
20-25	89,4%	16%	12%	Northern	97,0%	41%	32%
25-30	95,2%	22%	36%	Southern	91,2%	21%	8%
30-35	94,9%	14%	20%	Western	79,6%	20%	36%
35-40	96,4%	15%	11%				
40-45	96,1%	9%	6%				
45-50	95,9%	7%	4%				

http://nl.wikipedia.org/wiki/Sierra_Leone#Bestuurlijke_indeling




Somalia (fgm: 97,9% of women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Somalia	1st generation women in the Netherlands (2012)			in survey in Somalia	1st generation women in the Netherlands (2012)	
15-20	96,7%	25%	11%	Central South	99,2%	63%	88%
20-25	97,9%	20%	17%	Puntland	98,1%	11%	1%
25-30	97,9%	17%	26%	Somaliland	94,4%	25%	11%
30-35	98,8%	12%	15%				
35-40	98,9%	12%	12%				
40-45	97,9%	9%	11%				
45-50	99,1%	5%	8%				

<http://www.lonelyplanet.com/maps/africa/somalia/>



Sudan (fgm: 89,2% of ever married women age 15-49)							
Age specific fgm prevalence	Distribution of women by age			Region specific fgm prevalence	Distribution of women by region		
	in survey in Sudan	1st generation women in the Netherlands (2012)			in survey in Sudan	1st generation women in the Netherlands (2012)	
15-20	86,8%	6%	9%	Central	94,6%	27%	9%
20-25	89,7%	16%	10%	Darfur	65,3%	18%	4%
25-30	88,6%	23%	19%	Eastern	86,5%	11%	14%
30-35	89,7%	17%	21%	Khartoum	96,1%	21%	44%
35-40	89,0%	18%	19%	Kordofan	95,5%	15%	6%
40-45	89,0%	11%	14%	Northern	98,7%	7%	6%
45-50	90,9%	9%	8%	South Sudan	-		17%

Source: DHS, 1989/1990



Female Genital Mutilation in the Netherlands

Prevalence, incidence and determinants

This report gives estimates of the number of women and girls living in the Netherlands who have undergone female genital mutilation (fgm) or are at risk of fgm. The results are based on a systematic review of literature, focus group discussions and estimations with use of survey data from the countries of origin and the number of women living in the Netherlands, originating from these countries. Results can offer more support for determining policy measures regarding prevention, reporting, medical and psychosocial care.



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