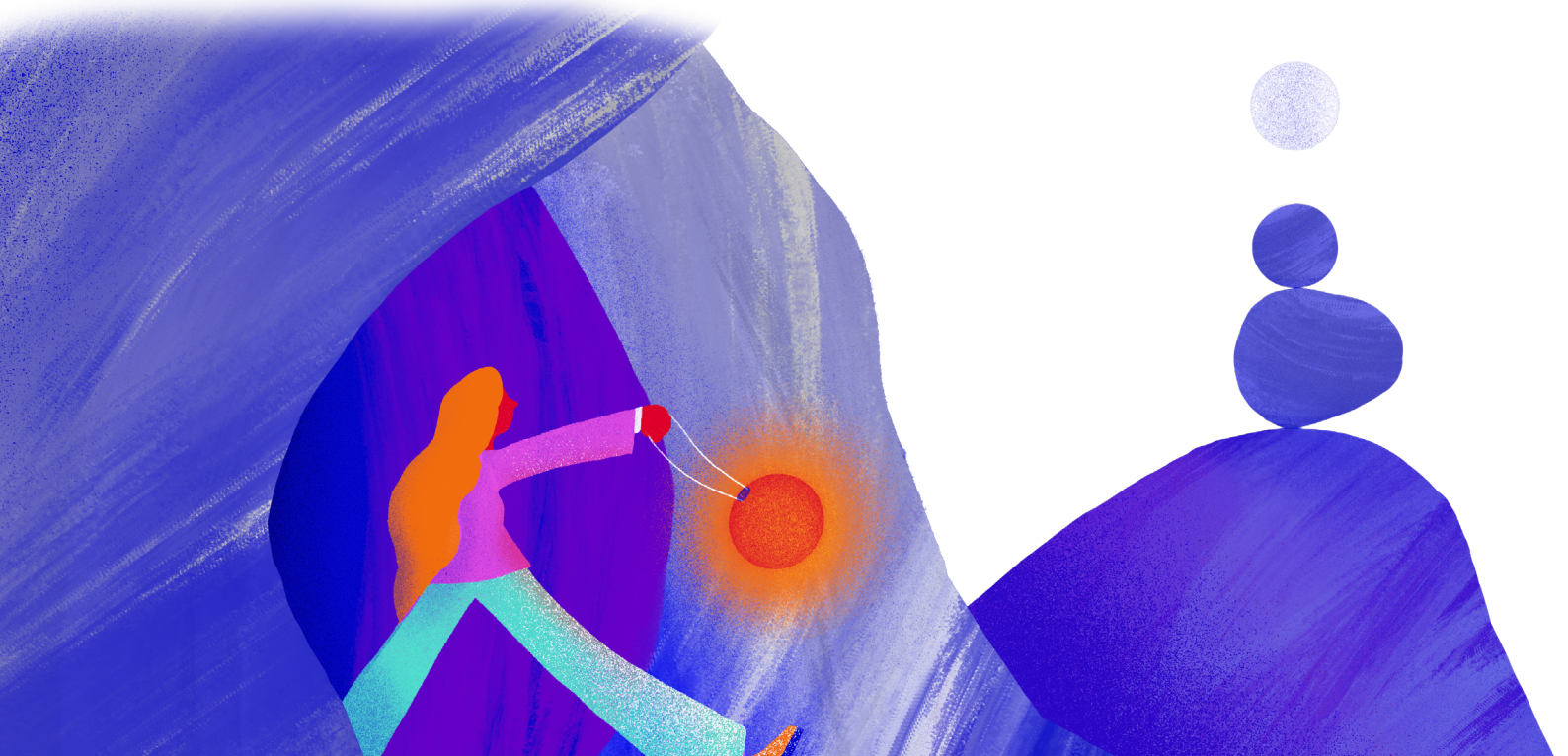
September 2026

STOP violence .brussels

Female genital mutilation

Sheet for professionals



IMPORTANT

As female genital mutilation (FGM) is, by definition, perpetrated on the female genitalia, women are affected the most. However, it can also affect transgender men born with female genitalia.

This sheet uses inclusive writing to refer to both perpetrators and victims. When we use the asterisk with the word “women*”, we mean anyone whose female genital organ has been mutilated or is at risk of being mutilated.

We also use the term “female genital mutilation”, which is the official United Nations denomination, but note that it is preferable to use the term “cutting” with the person concerned, as this is the term commonly used in English to designate the practice within the communities concerned.

This sheet does not deal with male circumcision, nor with intersex genital mutilation performed on children born with a variation in sex characteristics. Like FGM, these procedures are usually carried out without the consent of the person concerned and can have serious consequences for their physical and mental health. They are also justified by societal norms, not medical need. If the person you’re supporting is suffering the consequences of one of these practices, you can refer them to the Droit au corps association (France) for circumcision, and Genres Pluriels (Belgium) for intersex genital mutilation.

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A. Recognising female genital mutilation

1. Definitions

Female genital mutilation refers to *"procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons"* (World Health Organization, 2014).

Female genital mutilation (FGM) is recognised as gender-based violence because:

- It is perpetrated against a person on the basis of their sex.
- It is rooted in the representations made of the expected roles (gender) of this person.

Female genital mutilation is a form of gender-based violence aimed at controlling the individual (both physically and mentally).

2. Types of female genital mutilation

Female genital mutilation has been classified into four types. This classification was modified in 2022 to make it clear that the part of the clitoris that is cut is the external part (the glans) and not the whole clitoris.

- **Type 1 or clitoridectomy** is the partial or total removal of the clitoral glans and/or the clitoral hood.
- **Type 2 or excision** involves partial or total removal of the clitoral glans and the inner labia, with or without removal of the outer labia.
- **Type 3 or infibulation** is the narrowing of the vaginal opening with a covering by cutting and repositioning the inner and/or outer labia, with or without removal of the clitoris glans.
- **Type 4** includes **all other harmful procedures** performed on the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterisation.

3. Communities concerned

In 2020, the number of women* or girls affected by female genital mutilation living in the Brussels-Capital Region was estimated at 10,037, of whom 6,630 had (probably) been cut, and 3,406 were at risk (please see the prevalence study here: https://gams.be/en/prevalence-studies/).

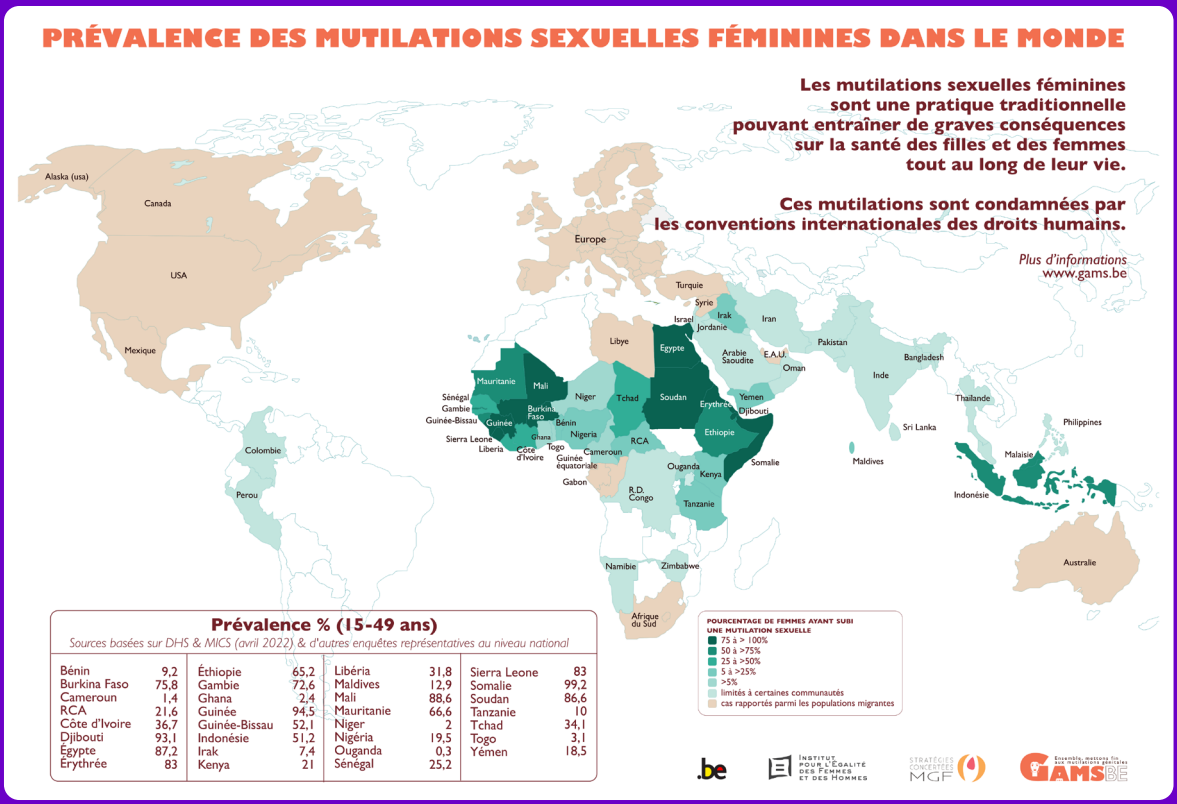
The people concerned do not usually spontaneously mention that they have undergone female genital mutilation, either because it's considered taboo, or because they think that everyone goes through it. To recognise that a woman* has suffered such violence, it's therefore important to ask about the community she grew up in.

The most recent estimates suggest that 230 million women and girls have undergone female genital mutilation, and that over 4 million girls are at risk each year worldwide.

While the practice is present in at least 28 African countries, it is also widespread in Asia (Indonesia, Malaysia, etc.), the Arabian Peninsula (Yemen, Oman), the Middle East (Iraq, Iran, etc.) and Latin America (Colombia, Peru).

Prevalence varies widely depending on the region, and even within individual countries. Ethnic group and region of origin are determining factors.

Prevalence map (in French): https://gams.be/wp-content/uploads/2025/03/Carte-prevalence-2025-FR.pdf



In the countries of origin, mutilation is most often carried out by traditional cutters, but also by matrons (traditional birth attendants) or barbers, and sometimes by doctors or midwives, even though the medicalisation of female genital mutilation is forbidden by the WHO.

In Western countries that are home to communities from these countries, girls may still be at risk of being cut. Families call on the services of an expatriate traditional cutter or send their daughters back home on “holiday” to undergo the procedure. The mutilations are generally carried out between the ages of 4 and 14 but can also be performed at a few months of age or just before marriage.

N.B.: In recent years, girls have been being cut at an increasingly young age. One reason for this is the desire to hide the practice from the authorities, as many countries have ruled against it.

4. Motives behind female genital mutilation

Providing tailored, non-judgemental support for those affected by female genital mutilation requires an understanding of the issues involved and the cultural justifications for the practice.

Here is a quick summary of the motives behind FGM:

- **Respect for custom or tradition:** it's always been done, it's natural, it's normal.
- **Social cohesion, social integration:** to be like everyone else, not to be excluded.
- **Marriage:** an uncut girl won't find a husband. Some mothers recognise the dangers of FGM, but admit that not being able to marry in their society is worse than the risk of complications from FGM, so it's the best choice they can make for their daughters.
  N.B.: Some girls are re-cut before marriage if it is proven that it hadn't been "done properly".
- **Virginity, chastity, fidelity:** FGM is a means of preserving the honour of the family by preventing sexual desire and pregnancy before marriage. In polygamous marriages, FGM is seen as a means of preserving the husband's honour.
- **Fertility:** some communities believe that the clitoris, if left uncut, will grow to the size of the penis, or that the clitoris is a dangerous organ that could injure the man during penetration (and render him impotent or sterile) or prevent the smooth progress of childbirth. FGM is supposed to increase fertility and increase the chances of a child's survival.
- **Seduction, beauty:** particularly in ethnic groups that practice infibulation, an "open" or "gaping" vagina is considered ugly. A sewn, closed and shaved vagina is perceived as more hygienic and is supposed to make a woman* more attractive.
- **Purity, cleanliness:** until a girl has been cut or infibulated, she is considered impure and dirty. These women are forbidden from carrying out certain activities, such as preparing or serving food.
- **Religion:** FGM has existed since long before the monotheistic religions and is not required by any religious text, including the Quran. Some Muslim communities mistakenly regard it as a religious obligation, although it is also observed among Christian, Ethiopian Jewish and animist groups. As far as Islam is concerned, in 2006, senior Sunni representatives meeting at al-Azhar asserted that these practices had no basis in Muslim law. The use of the term *Sunna* to designate certain types of FGM fosters confusion. Finally, the social and economic role of traditional cutters contributes to the continuation of these practices, since the practice of FGM provides them with both income and status.

5. Consequences

FGM can have an impact on the quality of life of women* and their families, both physically and psychologically. The possible consequences must be assessed on a case-by-case basis.

Immediate physical complications:

- Intense pain, accompanied by fear and anxiety that can lead to shock
- Life-threatening haemorrhages
- Wound infections
- Urine retention
- Damage to neighbouring organs

Long-term physical complications:

- Urinary tract infections, genital infections, urinary stones, neuromas
- Difficulty urinating, pain during menstruation, incontinence
- Scar pain, cysts, abscesses
- Problems related to pregnancy and childbirth (obstructed labour, tears, fistulas)

Psychological and sexual consequences:

- Post-traumatic stress disorder (shock, dread, helplessness, feelings of strangeness, near-death experience)
- Psychic dissociation
- Feelings of betrayal and, in the long term, loss of confidence, lower self-esteem, mistrust, etc.
- Behavioural disorders
- Post-traumatic stress disorder
- Depression
- Distortion of body image and self-image
- Sexuality disorders (avoidance of sexual relations, isolation, vaginismus[1], inability to feel pleasure, reduced sexual desire, etc.).

[1] Vaginismus is an involuntary, reflexive muscle contraction of the pelvic floor muscles, making vaginal penetration difficult, painful or even impossible.

6. Identification and specific features

6.1. LGBTQIA+

Some of the women* affected by FGM are lesbian or bisexual and have fled their country as a result of violence suffered because of their sexual orientation, to escape cutting, or both.

Indeed, in a patriarchal context where heterosexuality is the norm, these women suffer discrimination specific to their sexual orientation. In some cases, those around them may consider that “the cutting was not done properly”, which can lead to a second procedure being carried out.

Once in Belgium, these women often report difficulties in talking about and living freely with their sexual orientation, for fear of negative reactions within the reception centre and/or from their families and communities.

6.2. Residence and migration status

In Belgium, and therefore in Brussels, the vast majority of women* affected by female genital mutilation are from a migrant background. They may have immigrated for different reasons (work, fleeing violence, family, etc.), but their migratory status brings with it specific needs.

6.2.1. Application for international protection

According to the latest prevalence survey in 2020 (Institute for the Equality of Women and Men and FPS Health, Food Chain Safety and Environment), 1,428 of the women* and girls seeking international protection had undergone FGM, mostly from Guinea and Eritrea.

Belgium recognises FGM as a valid reason for applying for international protection, but not all the people affected state this reason in their application. They generally declare that they have fled violence in their country of origin, whether political (wars, opposition to the regime, etc.) or societal (refusal to enter a forced marriage, refusal to be cut, etc.).

However, the Belgian Office of the Commissioner General for Refugees and Stateless Persons may consider that if FGM has already been performed, the person is no longer at risk of violence and can return to their country of origin. People applying for asylum on these grounds must therefore demonstrate the psychological, medical and social complications of returning to their country of origin or invoke the risk of cutting that their female children may face, if applicable. For example, they may be discriminated against, harassed, ostracised, abused or mutilated again. If a minor has not undergone FGM at the time of applying for international protection, Belgium can protect this child depending on the risk of undergoing FGM if they return to their country of origin.

Applicants for international protection affected by FGM are generally provided with accommodation in a Fedasil or Red Cross reception centre (or other reception network partner). They are cared for by social and medical teams, who are trained on the subject by GAMS Belgium as part of the FGM and Asylum trajectory, which involves identifying needs during a social and medical intake assessment.

6.2.2. Family reunification

A number of the women* and girls affected arrive in Belgium through family reunification, to join a partner or family member. Some were married abroad and arrived in Belgium as part of a family reunification scheme, while others arrived on a short-stay visa, married and applied for family reunification on the territory. These people do not benefit from the same care on arrival as applicants for international protection: they do not undergo a reception interview during which FGM is discussed.



As the majority believe that undergoing FGM is normal (*"Everyone goes through it"*) and the subject is considered taboo, they rarely mention having undergone FGM. It is usually the family doctor or gynaecologist, provided they are trained to recognise FGM, who will identify the trauma suffered and offer dedicated support. The problem can also be identified in young girls at school.

If the women* affected have a residence permit based on family reunification (card A or F), this is dependent on them living together with the person they have joined for the first five years. If their living together comes to an end, the Immigration Office may decide to withdraw the right of residence of the person who has entered the country through family reunification.

This is why many victims are afraid to leave their homes and go to the police to lodge a complaint, due to a lack of information about their rights. They are unaware, for example, that they, like all other women, can access accommodation services, report the violence (physical, psychological or sexual) and apply to the Immigration Office for their residency status to be maintained if they have a residence permit.

If the woman* leaves the marital home, which can happen as a result of refusing to have their children cut, it is essential that they immediately apply to the Immigration Office to retain their residency, providing proof of the violence with the help of a lawyer or a support service.

6.2.3. Illegal residence status

A number of the migrant women* affected by FGM are illegal residents, known as “undocumented migrants”, for a variety of reasons: refusal of international protection, loss of the right of residence in the context of family reunification due to having left a violent partner, transmigration to the UK, or in the Dublin procedure without the right to material assistance.

These paths lead to poverty, with people having difficulty meeting the most basic needs: housing, food, medical care, etc.

Their vulnerable situation exposes them to various types of gender-based violence, and their status makes it almost impossible for them to prevent such violence or obtain adequate support. They avoid organisations that can help them, because they think that if they report the violence, they risk arrest, detention in a closed centre and forced expulsion from the country.

6.3. Language barriers

With little or no knowledge of one of the national languages, some migrant women* or women* with a migrant background that have undergone FGM may find it difficult to communicate in one or more of Belgium’s national languages. This can cause difficulties in seeking help, reporting the psychological or medical consequences of FGM they are experiencing or understanding information about the available resources.

Language barriers can also be encountered in other situations, for example deaf or hard-of-hearing people using sign language, and people with learning disabilities and/or visually impaired people who may find it difficult to fill in and understand administrative documents or use certain media.



Important

To facilitate communication with a woman* affected by FGM who does not speak French, it is necessary to use the services of a trained, neutral interpreter. Relatives or other members of the woman's* own community can help in most cases, but for a subject as sensitive and taboo as female genital mutilation, we recommend hiring interpreters trained in gender-based violence. Indeed, an improvised interpreter (acquaintance, family member, etc.) may not agree with the woman* discussing this subject with a professional, and may refuse to translate certain phrases, distort her words or reprimand her.

The safest way is to ask GAMS Belgium (contact details at the end of this sheet), which will put you in touch with its volunteer pool of Community Voices, people from the communities concerned who act as interpreters and intercultural mediators between front-line professionals and the people concerned. By providing moral support and interpreting traditions, these community relays support people who can identify with them, understand their journey and facilitate communication with others.

6.4. Mental health problems

Female genital mutilation is often a deeply traumatic experience, although psychological reactions vary from person to person.

At the time, it can cause intense shock, especially when the child is uninformed and unprepared, generating feelings of betrayal, fear, powerlessness and even episodes of dissociation, a protective mechanism in the face of unbearable pain and distress.

In the long term, the psychological consequences can become chronic, manifesting themselves in the form of anxiety, depression, behavioural disorders or post-traumatic stress disorder (PTSD), characterised by intrusive memories, nightmares, hypervigilance and avoidance mechanisms.

Women* living with FGM may experience flashbacks, sensory illusions or nightmares, making them relive the cutting procedure and feel distress and terror as if it were happening to them all over again: this is known as traumatic memory. It can be triggered by a variety of situations, such as painful intercourse, childbirth, a conversation or even seeing your own body. For some women*, these triggers revive the initial distress, as if the event were happening all over again.

6.5. Homelessness

Homeless women* affected by FGM are generally illegal residents. They are often caught up in administrative and financial difficulties related to the lack of an address or residency status, leading to a situation of precariousness, stigmatisation and a worsening of their physical and mental health (including addictions). They are particularly vulnerable to all types of violence.

The term “houselessness” is preferred to “homelessness” by some associations, because it reflects the reality of a person in a situation of poor housing or homelessness, but also because it is particularly well-suited to the lives of women* who develop multiple strategies to access shelter. Such women* may, for example, have to provide sexual relations in exchange for shelter, or settle in public places where they are not recognised as being on the street, or where they try to disappear. These places are not really secure, as they do not constitute a real “place of their own”.

6.6. Disability



The physical consequences of FGM include chronic pain, infections, cysts, urinary and menstrual problems, as well as complications during childbirth (which can result in death or have implications for both mother and child). These implications can be recognised as a functional disability and require specific medical follow-up.

In Belgium, the specialist medical centre for FGM victims is CeMAViE: https://www.stpierre-bru.be/service/gynecologie-obstetrique/320-rue-haute/cemavie-mutilations-genitales-feminines/#:~:text=Traitement%20chirurgical%20des%20mutilations%20g%C3%A9nitales%20f%C3%A9minines

In addition, there may also be disabilities unrelated to FGM. Certain types of disability (in particular hearing impairments, visual impairment or blindness, intellectual disability or difficulties in expressing oneself) can lead to communication barriers, social isolation and stigmatisation, making it more difficult for the person to seek help, report having suffered FGM or look for resources. Some support services may simply not be sufficiently accessible, whether in terms of transport, physical infrastructure or communications.

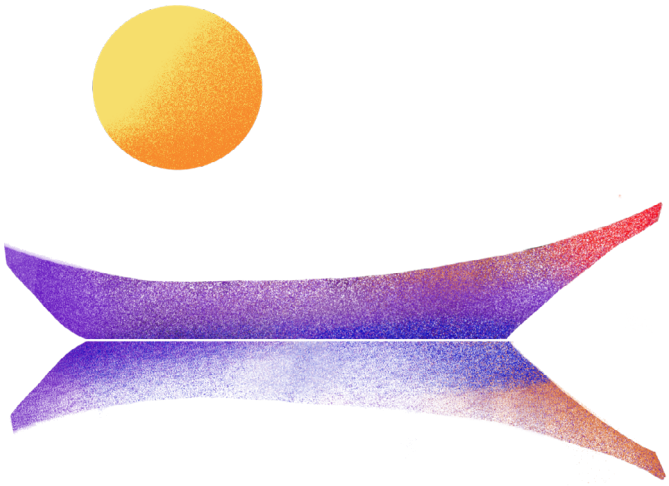
Furthermore, when faced with support services, women* living with FGM and with disabilities may fear being misunderstood, not being believed, and being discredited or shamed. They may be more dependent on their loved ones and their community, and may also fear the consequences of talking about a taboo subject, and finding themselves isolated, deprived of their freedom, harassed, etc.

Important

For women* affected by FGM who communicate via sign language, note that sign language is not universal. In Belgium alone, we use French Belgian Sign Language (LSFB) and the Flemish Sign Language (VGT).

Ideally, you should use the services of a sworn interpreter specialising in rare languages via the National Register of Interpreters > https://justsearch.just.fgov.be/national-registry-search/translator?lang=en

If this isn't possible, you can ask one of the women's* friends or family to translate from sign language into their mother tongue, and then use another interpreter to translate their words into English. This technique is more accessible but poses some risks. Since FGM is a taboo subject, the friend or family member may decide not to translate what the woman* signs, or the woman* may not dare to speak openly.



B. Taking action in the event of female genital mutilation

1. Interview methods

1.1. Set the scene

Put the person, their pace and their needs at the heart of the care and respect their agency:

- If the person needs an interpreter (foreign language or sign language), make sure it is a neutral person from outside the situation, not someone close to the victim, as there is a risk of blocking the victim's speech (see page **11**).
- Bear in mind that certain situations of dependence can be an obstacle to free speech. For example, reporting a situation can have real or imagined consequences for the victim, such as the loss of rights, privileges, freedom, essential care, being placed in an institution, and so on. They risk finding themselves in an even more vulnerable situation.
- Do not judge the person, whatever their specificities or situation and show understanding of any difficulties they may have in expressing themselves.
- Take personal and socio-cultural aspects into account during the meeting. The way to deal with intimate issues varies greatly depending on the individual's specific needs.
- Always pay attention to the victim's behaviour, ask if they want to take a break, have a moment alone in a quiet place, and above all, take their time.

If the victim has disabilities:

- In Belgium, there are no specialist services to support disabled people affected by FGM. They need to be redirected to existing services, despite physical accessibility difficulties (ramps, lift, adapted toilets, circulation, etc.) and communication difficulties (documents in large format, Braille, easy to read, sign language interpreters, etc.).
- Let go of any stereotypes linked to disability (less credible speech, no partner or sex life possible, etc.).
- Remain non-judgemental for a neuroatypical or neurodivergent person, as they are often not believed, and their words, story and behaviour are attributed to their "disorder". The expression of emotions by these people does not necessarily correspond to what is typically expected. For example, they may smile during a serious, tragic situation.

1.2. Build trust

As a prelude to any possible discussion:

- Make sure the conversation is confidential and that the person is in a place where they feel safe. For example, some people cannot stand closed doors, while others need to be sure that no one can hear what is being said.
- Make sure you see the victim alone (no children, no spouse, no relatives) and, if necessary, arrange for a neutral interpreter who is sensitive to gender-based violence.
- The victim may wish to be accompanied if they are vulnerable or a minor.

1.3. Conduct the interview in a friendly manner

During the interview:

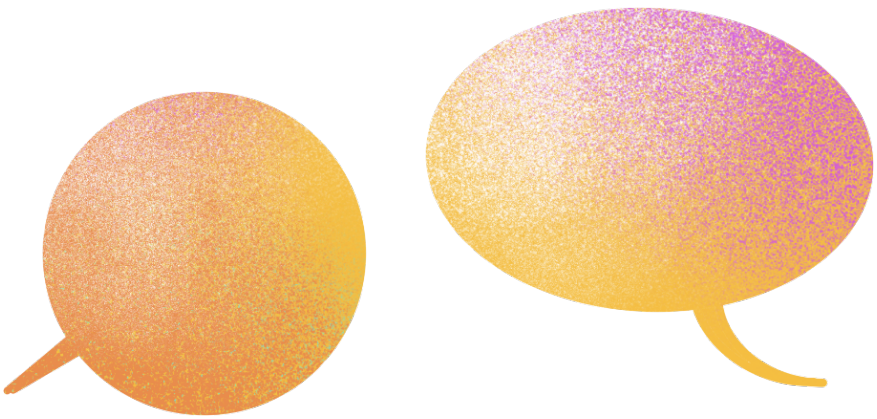
- **Respect the person's pace** and accept that the resources used are not always sufficient for the story to emerge.
- **Let the person give a spontaneous account**, then ask increasingly specific questions to avoid influencing them (especially for vulnerable victims or minors).
- If the victim is a minor, avoid asking specific/leading questions about the facts until a TAM (Techniques for interviewing minors) hearing has been carried out. This avoids the risk of collusion.
  N.B.: TAM hearings are not conducted in cases where the cutting has taken place in the country of origin and the young woman is an asylum seeker.
- **Do not insist that the victim tell the story**, as repetition is a form of secondary violence.
- **Demonstrate that you are available and caring** to avoid secondary victimisation.
- **Bear in mind that this may be the first time** the person has spoken out.
- **Understand that the person talking has already overcome a number of obstacles** before doing so: fear of being judged, shame, guilt, fear of reprisals, fear of doing the wrong thing, etc.
- **Recognise the victim as a victim:** it is vital that the person feels heard and believed because a positive social reaction reduces the risk of post-traumatic stress.

DO NOT...

- ✘ Judge
- ✘ Question what is said
- ✘ Trivialise or minimise statements, for example by saying “everything’s going to be fine”
- ✘ Seek to establish the objective truth of the facts
- ✘ Make promises
- ✘ Insist, try to find out (too much)
- ✘ Ask leading questions
- ✘ Touch the person without their prior consent, including for medical procedures
- ✘ Appear distracted (e.g. by looking at your screen or watch)

INSTEAD...

- ✔ Make yourself available
- ✔ Reassure, be patient and calm
- ✔ Let the person express their fears, difficulties and emotions.
- ✔ Respect the pace of their speech and accept silences
- ✔ Recognise the person’s experiences and their courage to speak out and believe them, regardless of their specific needs.
- ✔ Bring them back to reality with breathing exercises if necessary
- ✔ Explain what happens next
- ✔ Pay attention to who is accompanying the victim and their relationship (it may be a perpetrator of violence)
- ✔ Provide clear and explicit information



As a general rule, ask questions ranging from the most general to the most specific, so that the person doesn't feel they're being interrogated. It's important to build a relationship of trust, and to give them the opportunity to bring in elements you might not have thought of.

Here are some examples of questions that can help you identify whether a woman* has been affected by female genital mutilation:

- You come from (country of origin), and there's a tradition of female genital cutting. Can you tell me about it? (N.B.: Avoid using the term mutilation during the initial discussions).
- Has anyone ever hurt the intimate parts of your body?
- Do you think it would be important to arrange psychological support for difficult situations you may have experienced in relation to your body and intimacy?

This list is non-exhaustive, and the questions asked must correspond to your mandate.

The advice above is intended for interviews with adult women. For children/families, see the *Guide d'entretien pour aborder la question de l'excision lors des entretiens avec les filles et/ou avec leur famille (Guide for addressing the issue of FGM when interviewing girls and/or their families)* developed by the Concerted Strategies against FGM network: https://www.strategiesconcertees-mgf.be/guide-dentretien-pour-aborder-la-question-de-lexcision-lors-des-entretiens-avec-les-filles-et-ou-avec-leur-famille/

2. Action to be taken after identification

In some cases, it may be appropriate to support the person in front of you, respecting their consent and wishes, and giving them the information they need to make free and informed decisions.

In other cases, the emphasis may be on listening before acting. The person sometimes needs to talk and confide, and needs time before more concrete decisions can be made.

Even if you have identified a person as an alleged victim, they may not feel victimised and therefore will not ask for help.

2.1. Initial measures

Use the detectometer developed by the Concerted Strategies against FGM network to help you identify the actions you need to take to protect girls and ensure the follow-up of a girl who has already been cut and of her sisters at risk of being cut. If possible, this is to be done in dialogue with the parents and children.

> https://www.strategiesconcertees-mgf.be/detectometre-outil-a-destination-des-professionnel-le-s/

N.B.: Given that in the majority of high-risk situations, the girl is still a minor, the detectometer mainly concerns situations where a minor is at risk of being cut. It does, however, contain useful elements regarding prevention and the care of adult women*.

2.2. Risk of female genital mutilation: report to GAMS Belgium

GAMS Belgium is the leading Belgian association for the prevention of female genital mutilation. Contact the association for advice on the steps to take:

- Call 02 219 43 40
- Or email info@gams.be

2.3. Proven female genital mutilation: refer the person to GAMS Belgium, CeMAViE or the Public Prosecutor's Office (depending on their needs)

If the person you are supporting has already undergone FGM, you will need to work with them to identify the priorities for their care. **A good first step is to refer them to GAMS Belgium, for an initial interview.**

The objectives of this interview are to:

- Enable people to express themselves in a secure, non-judgemental environment, with a clear understanding of the cultural issues involved in the practice;
- Carry out an initial assessment of their needs, so that we can provide tailored, individual social, psychological and legal support, and referrals to partner services if necessary.

The support offered by GAMS Belgium is voluntary and tailored to the specific needs of the woman* at any given moment.

If the emergency is of a more medical nature (physical pain), you can refer them directly to CeMAViE at 320 Rue Haute in Brussels. The team, made up of a gynaecologist, a midwife, a sexologist and a psychologist, offers a multidisciplinary approach that combines sexology, psychology, and medicine and surgery. As with GAMS Belgium, there is no obligation.

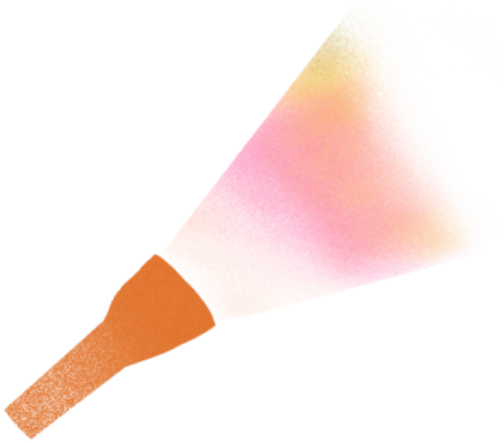
N.B.: CeMAViE offers clitoral reconstructive surgery, but the majority of women* who visit CeMAVIE choose psychological and sexological support without surgery.

You can also report incidents of FGM or an imminent risk of FGM to the Public Prosecutor's Office. Please send an email to mgf.prpkbru@just.fgov.be. Please provide as much detail as possible about the incident, where it took place, and the people involved, to enable the Public Prosecutor's Office to take action if necessary.

2.4. If the person does not want to go to GAMS Belgium, CeMAViE or the Public Prosecutor's Office

If for one reason or another, such as fear of being recognised by someone in their community, the person you're supporting doesn't want to go to GAMS Belgium, CeMAViE or the Public Prosecutor's Office, you can also refer them to a trained family planning organisation.

To identify family planning centres and other organisations that provide care for FGM victims in the Brussels-Capital Region, see the mapping of services on the stop-violence.brussels website: https://stop-violence.brussels/en/mapping-services



3. Competent services

Here is a list of the main competent services:

- **GAMS Belgium** for initial reception and psycho-socio-legal support. Available Monday to Friday, 9:00am to 5:00pm.
  Address: Rue Gabrielle Petit 6, 1080 Brussels
  Email: info@gams.be
  Telephone: 02 219 43 40
- **CeMAViE** for the care of somatic and psychological complications of FGM.
  Consultations on Tuesdays from 8:30am to 12:30pm.
  Address: Rue Haute 320, 1000 Brussels
  Telephone: 02 535 47 14

> To go further: https://stop-violence.brussels/en/mapping-services