Female Genital Mutilation/Cutting:

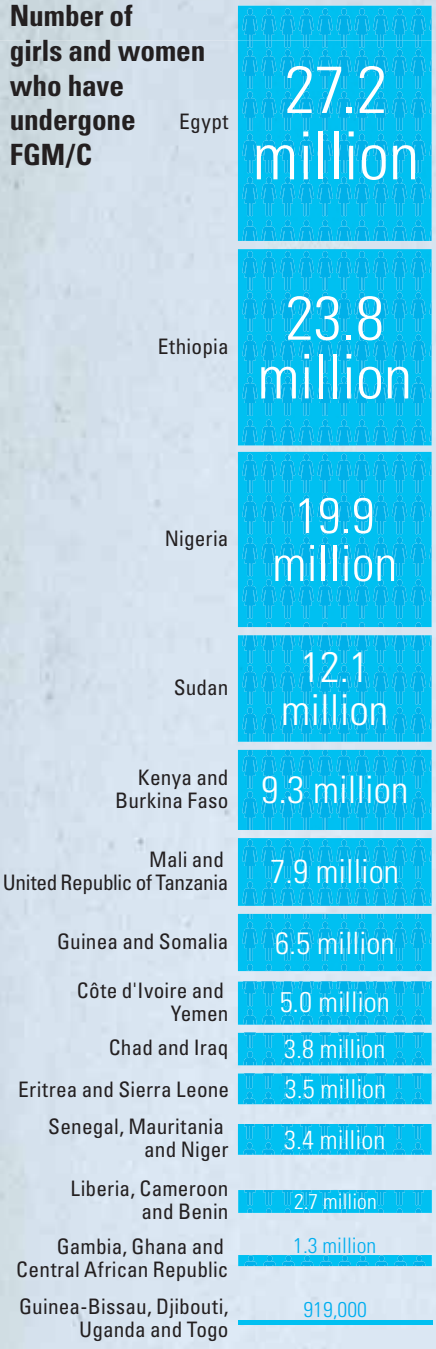
A statistical overview and exploration of the dynamics of change

unite for children

unicef

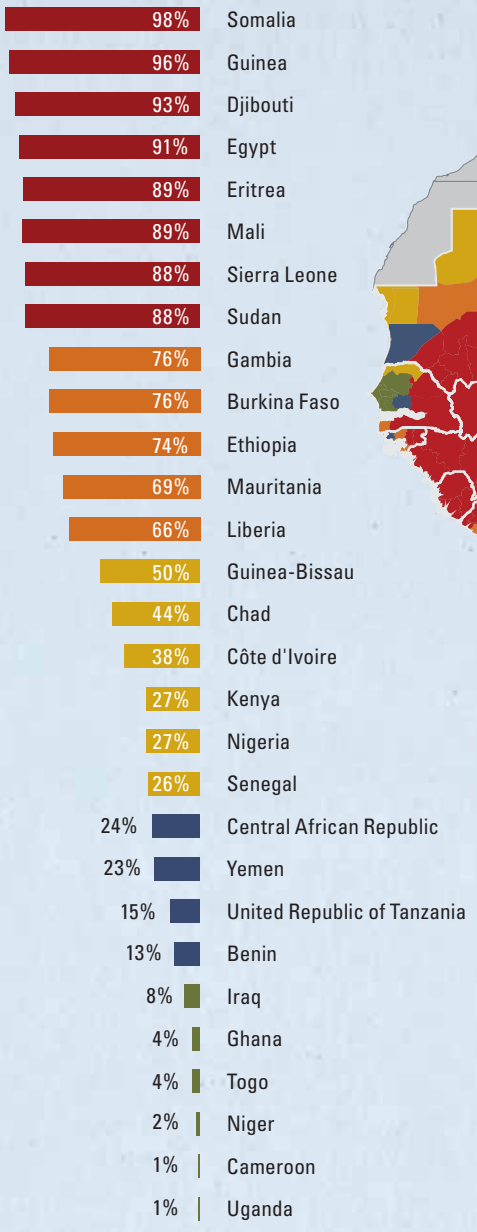
29 countries, more than

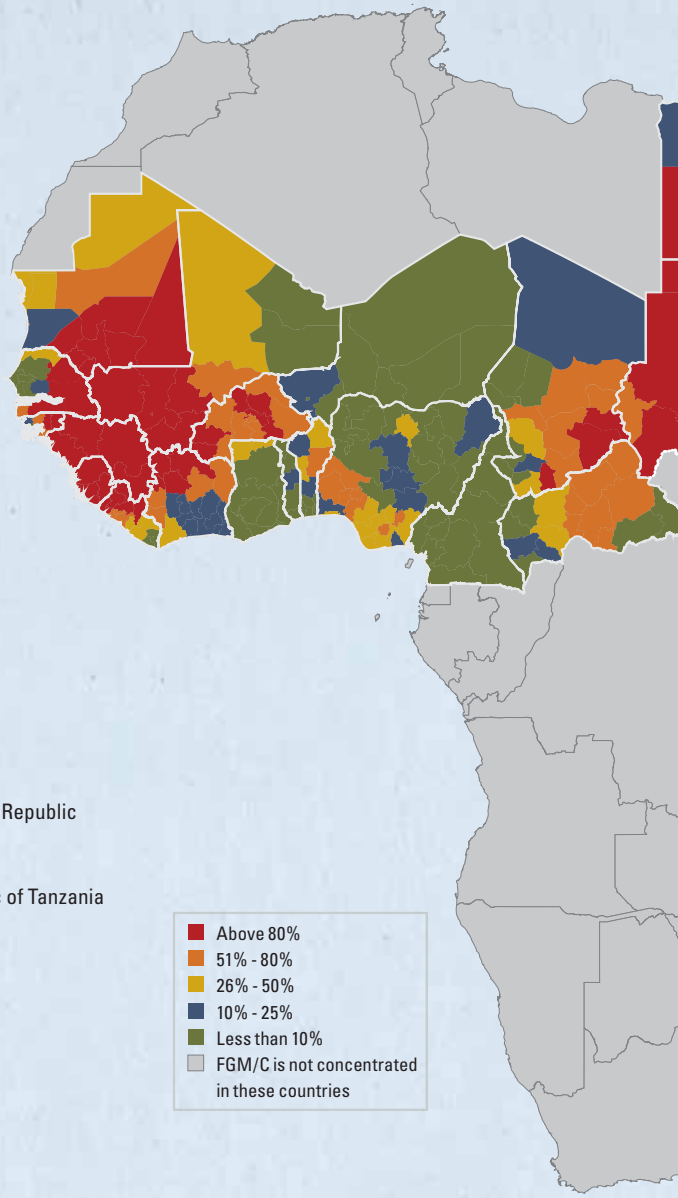
Number of girls and women who have undergone FGM/C



FGM/C is concentrated in a swath of countries from the Atlant

wide variations in the percentage of girls and women cut,





SOMALIA
63% of girls who underwent FGM/C had their genitalia sewn closed

GUINEA
19% of girls and women think FGM/C should stop, compared to 42% of boys and men

DJIBOUTI
62% of cut girls underwent the procedure between the ages of 5 and 9

EGYPT
77% of girls who have undergone FGM/C were cut by a medical professional

ERITREA
60% of girls and women regard FGM/C as a religious requirement

MALI
58% of girls who have been cut are daughters of mothers who oppose the practice

SIERRA LEONE
51% of couples do not agree on whether FGM/C should continue or end

SUDAN
Girls and women with no education are nearly four times more likely to support the continuation of FGM/C than girls and women with secondary or higher education

CÔTE D'IVOIRE
41% of girls and women of Voltaique/Gur background support the continuation of FGM/C, compared to only 3% of Akan girls and women

KENYA
59% of girls and women who have been cut do not see any benefit to the practice

NIGERIA
35% of boys and men and 31% of girls and women report that they do not know what the opposite sex thinks about FGM/C

SENEGAL
FGM/C prevalence among Wolof girls and women ranges from a low of 0% in Diourbel to 35% in Matam

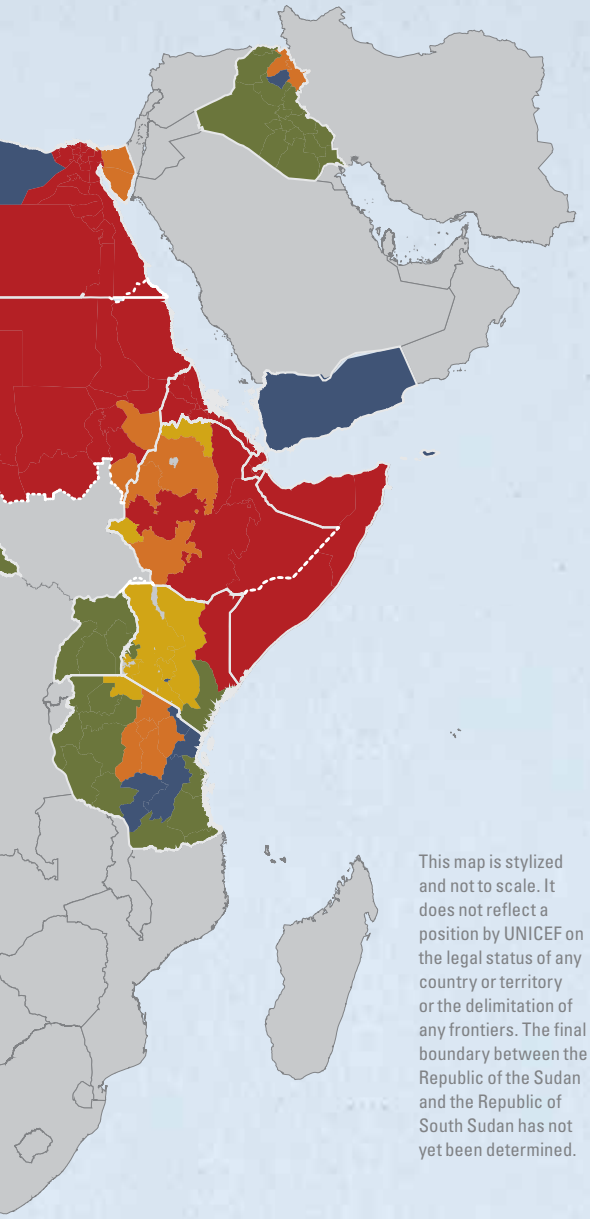
CENTRAL AFRICAN REPUBLIC
52% of cut girls experienced FGM/C between the ages of 10 and 14

YEMEN
In 97% of cases, girls underwent the procedure in their homes and 75% of them were cut using a blade or razor

UNITED REPUBLIC OF TANZANIA
Women aged 45 to 49 are approximately three times more likely to have been cut than girls aged 15 to 19

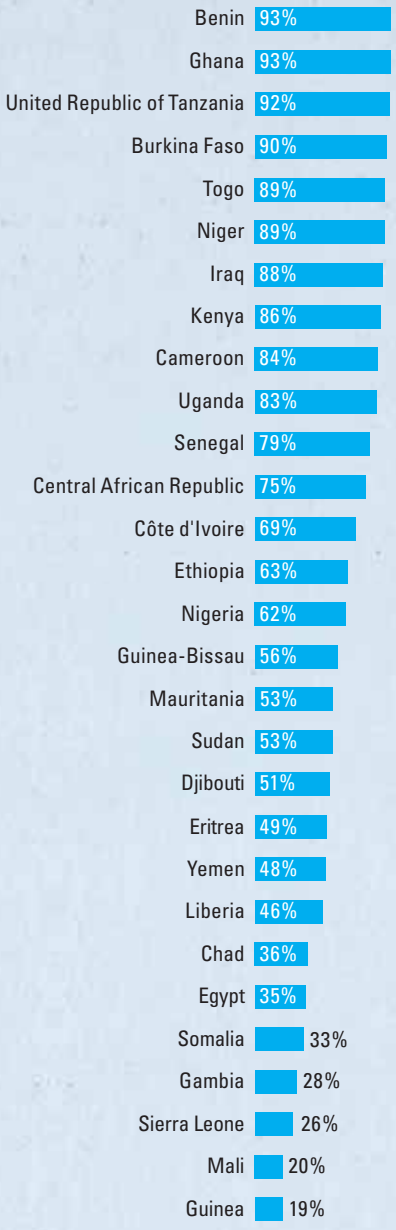
125 million girls and women

tic Coast to the Horn of Africa, with both within and across countries



This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. The final boundary between the Republic of the Sudan and the Republic of South Sudan has not yet been determined.

In most countries where FGM/C is practised, the majority of girls and women think it should end



WHEN

In half of the countries, the majority of girls were cut **before age 5**. In the rest of the countries, most cutting occurs between 5 and 14 years of age

HOW

Across a majority of countries, most daughters have had their **genitalia cut, with some flesh removed**

BY WHOM

In nearly all countries where FGM/C is concentrated, **traditional practitioners** perform most of the procedures

WHY

Social acceptance is the most frequently cited reason for supporting the continuation of the practice

GAMBIA
82% of girls and women who have undergone FGM/C think the practice should continue, compared to 5% of girls and women who have not been cut

BURKINA FASO
76% of girls and women have been cut, but only 9% favour the continuation of FGM/C

ETHIOPIA
41% of girls and women with no education support the continuation of FGM/C compared to 5% of girls and women with secondary or higher education

MAURITANIA
On average, girls are cut when they are just 1 month old

LIBERIA
Girls and women from the poorest households are twice as likely to have experienced FGM/C as those from the richest households

GUINEA-BISSAU
18% of cut girls underwent the procedure after age 15

CHAD
27% of boys and men think FGM/C is required by religion

BENIN
72% of Peulh girls and women have undergone FGM/C, compared to 0% of girls and women of Adja and Fon ethnicity

IRAQ
FGM/C is concentrated in the regions of Erbil and Sulaymaniyah

GHANA
In the highest prevalence region (Upper West), 60% of women aged 45 to 49 have undergone FGM/C compared to 16% of girls aged 15 to 19

TOGO
21% of Muslim girls and women have undergone FGM/C, compared to 1% of Christian girls and women

NIGER
55% of Christian girls and women have undergone FGM/C, compared to 2% of Muslim girls and women

CAMEROON
85% of boys and men think that FGM/C should not be continued

UGANDA
9% of girls and women support the continuation of FGM/C, even though national prevalence is only 1%

Key facts →

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Female Genital Mutilation/Cutting:

A statistical overview and exploration of the dynamics of change

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A women's group listens as an organizer gives a UNICEF-supported sensitization workshop on FGM/C in Bamako, Mali.

Foreword

The adoption by consensus of the United Nations General Assembly resolution *Intensifying global efforts for the elimination of female genital mutilations* in December 2012 is a testimony to the increased commitment by all countries to end this harmful practice. Evidence played a major part in bringing the resolution to fruition, and it will continue to play a central role in global efforts to eliminate the practice.

Evidence on female genital mutilation/cutting (FGM/C) is essential for many reasons – to understand not only the extent of the practice but also to discern where and how the practice is changing. It helps us understand the social dynamics that perpetuate FGM/C and those that contribute to its decline. Only with such knowledge can policies and programmes be effectively designed, implemented and monitored to promote its abandonment.

The collection and analysis of data is a central aspect of UNICEF's mission to enable governments and civil society to improve the lives of children and safeguard their rights. This report, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, promotes a better understanding of the practice in several ways. It examines the largest ever number of nationally representative surveys from all 29 countries where FGM/C is concentrated, including 17 new surveys undertaken in the last three years. It includes new data on girls under 15 years of age, providing insights on the most recent dynamics surrounding FGM/C, while also presenting estimates on prevalence and levels of support for the practice nationally and among selected population groups. A special feature of the report is that it explores the data through the lens of social norms and looks at the ways in which they affect the practice.

Working with a multitude of partners, including through the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change, we have seen how social dynamics can be leveraged to help communities better protect their girls. We have witnessed how accurate information about the dangers of the practice as well as evidence that other communities are questioning or abandoning FGM/C can spark or invigorate a process of positive change. We have witnessed how the voices of individuals and groups who have themselves abandoned the practice can fuel further positive action. And we have seen how girls themselves can play a catalytic role. Learning from these experiences, we have strengthened our support to communities by creating opportunities for discussion on FGM/C locally and nationally. The abandonment of FGM/C is framed not as a criticism of local culture but as a better way to attain the core positive values that underlie tradition and religion, including 'doing no harm to others'. We have found that, addressed in this way, efforts to end FGM/C contribute to the larger issues of ending violence against children and women and confronting gender inequalities.

A girl holds a poster promoting the Saleema Campaign at a community meeting in El Khatmia village, Gadaref State, Sudan. El Khatmia is one of five villages in Gadaref that have agreed to collectively abandon FGM/C. The Saleema Campaign is encouraging community dialogue about the practice. *'Saleema'*, an Arabic word and traditional girl's name meaning 'whole' and 'undamaged', has positive connotations, and hundreds of religious leaders are encouraging parents to 'let every girl grow up *saleema'*.

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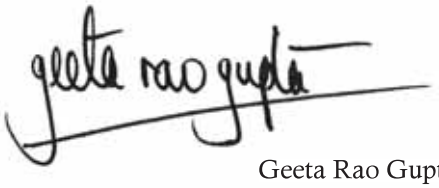
Meaza Garedu, 14, stands outside the Imdibir Secondary School in the town of Imdibir, in Cheha district, Southern Nations, Nationalities and People's Region, Ethiopia. Meaza was subjected to FGM/C when she was 10 years old and now campaigns against the practice. "In my village there is one girl who is younger than I am who has not been cut because I discussed the issue with her parents," Meaza said. "I told them how much the operation had hurt me, how it had traumatized me and made me not trust my own parents. They decided that they did not want this to happen to their daughter."

UNICEF published its first statistical exploration of FGM/C in 2005, helping to increase awareness of the magnitude and persistence of the practice. This report, published eight years later, casts additional light on how the practice is changing and on the progress being made. The analyses contained on the following pages show that social dynamics favouring the elimination of the practice may exist even in countries where the practice is universal and provide clues on how they might be harnessed. The report also makes clear that, in some countries, little or no change is apparent yet and further programmatic investments are needed.

As many as 30 million girls are at risk of being cut over the next decade if current trends persist. UNICEF will continue to engage with governments and civil society, together with other partners, to advance efforts to eliminate FGM/C worldwide. If, in the next decade, we work together to apply the wealth of evidence at our disposal, we will see major progress. That means a better life and more hopeful prospects for millions of girls and women, their families and entire communities.



Geeta Rao Gupta
Deputy Executive Director, UNICEF

Contents

1. Overview

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This report is a comprehensive statistical overview of female genital mutilation/cutting (FGM/C) in the 29 countries where the practice is concentrated. Analysis of the data reflects current perspectives on FGM/C, informed by the latest policy, programmatic and theoretical evidence. The purpose of the report is to generate an in-depth understanding of FGM/C that can be applied to the development of policies and programmes, with the ultimate aim of eliminating the practice.

Over the last several decades, efforts to address FGM/C have intensified with the support of many partners, including governments, international institutions, non-governmental organizations, religious and other civil society groups, and local communities *(see Accelerating action against FGM/C: Four countries, nine decades, on page 10)*. These efforts have contributed to and benefitted from an evolving understanding of the practice and of the social dynamics that lead to its abandonment. New insights into FGM/C are informing the design of policies and programmes both in countries where it has been practised for generations and in areas where it is relatively new and associated with immigration.

The growing number of reports of public commitments to end FGM/C and its actual abandonment by population groups across a diverse range of countries are strong indications that the practice can indeed become a vestige of the past. These grassroots movements, in turn, have fuelled international commitment to eliminate FGM/C worldwide.

A new global milestone

The United Nations General Assembly adoption of the resolution *Intensifying global efforts for the elimination of female genital mutilations*, on 20 December 2012, marked a milestone in global efforts to end the practice.[1] The resolution demonstrated the political will of the international community to eliminate FGM/C. It also presented a unified stance on how to move forward, drawing from decades of experience and a 2008 inter-agency statement on the subject involving 10 United Nations organizations.[2] The resolution stressed that a number of countries are using a "coordinated approach that promotes positive social change at community, national, regional and international levels"[3] and are showing signs of progress towards eliminating the practice. It thus urges "States to pursue a comprehensive, culturally sensitive, systematic approach that incorporates a social perspective and is based on human rights and gender-equality principles."[4] In addition, the resolution calls upon "States to develop unified methods and standards for the collection of data on all forms of discrimination and violence against girls, especially forms that are underdocumented, such as female genital mutilations, and to develop additional indicators to effectively measure progress in eliminating the practice."[5]

The importance of data

In many countries, the systematic collection and analysis of data on FGM/C is quite recent. In the 1979 and later editions of *The Hosken Report* (most recently, 1994), Fran Hosken pioneered the estimation of FGM/C prevalence on a country-by-country basis.[6] However, in the absence of large-scale, nationally representative data, she was forced to rely on anecdotal accounts.

Over the last two decades, reliable data on FGM/C have been generated through two major household surveys: Demographic and Health Surveys (DHS), supported by the United States Agency for International Development (USAID), and Multiple Indicator Cluster Surveys (MICS), supported by the United Nations Children's Fund (UNICEF) *(see Box 1.1)*. Data derived from both of these sources provide accurate estimates of FGM/C, which can be used to guide the strategic allocation of resources and the planning of interventions, and to monitor progress towards the elimination of the practice.

This report draws on data from more than 70 nationally representative surveys over a 20-year period and presents the most comprehensive compilation to date of statistics and analyses on FGM/C *(see Table 1.1)*. It reviews all available DHS and MICS data, along with other nationally representative datasets with information on FGM/C, and examines differentials in prevalence according to social, economic, demographic and other characteristics. The report highlights trends across countries, building upon two earlier overviews of DHS data[7] and expanding on a 2005 UNICEF publication called *Female Genital Mutilation/Cutting: A statistical exploration*, which spanned 20 countries.[8] The current report covers all 29 countries in Africa and the Middle East where FGM/C is concentrated and includes, for the first time, statistics from countries where representative survey data were lacking. It is also the first publication to include new data collected on girls under 15 years of age, providing insights on the most recent dynamics surrounding the practice. An innovative aspect of the analysis is the addition of a social norms perspective. The findings are intended to inform the development of policies and programmes aimed at promoting the elimination of this and other practices that are harmful to girls and women.

Box 1.1 The evolution of data collection on FGM/C

Nationally representative data on FGM/C are mainly available from two sources: Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS).[9]

Since 1984, DHS have been carried out about once every five years with technical support from ICF International (formerly Macro International) and funding from USAID. The surveys cover a range of demographic and health issues in Africa, Asia and Latin America, among other regions, providing relatively comparable data on fertility, family planning, child health, morbidity, mortality and HIV/AIDS. A module on FGM/C was developed for the first time for the 1989-1990 survey in the northern part of what was then known as Sudan. After a few years, the module was modified and has been included in DHS for 23 countries to date.

The Multiple Indicator Cluster Survey programme was developed by UNICEF to support countries in monitoring the situation of children and women. Since 1995, MICS have been conducted approximately every five years, resulting in more than 200 surveys in about 130 countries. The first module on FGM/C was included in the 2000 MICS in the Central African Republic, Chad and Sudan. The last two rounds of MICS (mainly conducted in 2005-2006 and again in 2009-2011) generated updated FGM/C data from 16 countries, including seven with no prior data (Djibouti, Gambia, Guinea-Bissau, Iraq, Sierra Leone, Somalia and Togo).

Over the past 10 years, UNICEF and ICF International have worked closely to standardize survey questions on FGM/C in DHS and MICS. Nearly all of the surveys ask women of reproductive age about their own FGM/C status, at what age they were cut and by whom. If a woman has living daughters, the same questions are repeated for her daughters. Most surveys include additional questions related to women's attitudes surrounding FGM/C, including their rationale for the practice and their opinion on whether it should continue. In many surveys, a male view is also solicited, addressing awareness and attitudes about FGM/C in men. A number of countries, such as Egypt, Eritrea and Sudan, instituted mass media campaigns discouraging the practice, and specific questions were added to address the visibility of these campaigns at the community level. Some questionnaires also asked whether or not respondents were aware of domestic legislation outlawing FGM/C. In total, more than 200 questions were posed in various surveys. The complete list can be found in the Appendix on page 126.

Table 1.1 Data on FGM/C are available for all 29 countries where the practice is concentrated

Data sources on FGM/C used in this report

Benin	DHS 2001, DHS 2006
Burkina Faso	DHS 1998-1999, DHS 2003, MICS 2006, DHS/MICS 2010
Cameroon	DHS 2004
Central African Republic	DHS 1994-1995, MICS 2000, MICS 2006, MICS 2010
Chad	MICS 2000, DHS 2004, MICS 2010
Côte d'Ivoire	DHS 1994, DHS 1998-1999, MICS 2006, DHS 2012
Djibouti	MICS 2006
Egypt	DHS 1995, DHS 2000, DHS 2003, DHS 2005, DHS 2008
Eritrea	DHS 1995, DHS 2002
Ethiopia	DHS 2000, DHS 2005
Gambia	MICS 2005-2006, MICS 2010
Ghana	DHS 2003, MICS 2006, MICS 2011
Guinea	DHS 1999, DHS 2005
Guinea-Bissau	MICS 2006, MICS/Reproductive Health Survey (RHS) 2010
Iraq	MICS 2011
Kenya	DHS 1998, DHS 2003, DHS 2008-2009
Liberia	DHS 2007
Mali	DHS 1995-1996, DHS 2001, DHS 2006, MICS 2010
Mauritania	DHS 2000-2001, MICS 2007, MICS 2011
Niger	DHS 1998, DHS/MICS 2006
Nigeria	DHS 1999, DHS 2003, MICS 2007, DHS 2008, MICS 2011
Senegal	DHS 2005, DHS/MICS 2010-2011
Sierra Leone	MICS 2005, DHS 2008, MICS 2010
Somalia	MICS 2006
Sudan	DHS 1989-1990, MICS 2000, Sudan Household Health Survey (SHHS) 2006, SHHS 2010
Togo	MICS 2006, MICS 2010
Uganda	DHS 2006, DHS 2011
United Republic of Tanzania	DHS 1996, DHS 2004-2005, DHS 2010
Yemen	DHS 1997

Notes: When this report was being compiled, final datasets were not available for three surveys with questions on FGM/C for Benin (DHS 2011-2012), Guinea (DHS 2012) and Niger (DHS/MICS 2012). Therefore, the data for these countries refer to the latest available figures: 2005 in the case of Guinea and 2006 in the case of Benin and Niger. Data for Côte d'Ivoire (DHS 2012) are preliminary and have only been used to report on FGM/C prevalence among girls and women aged 15 to 49; for all other indicators, data from older surveys have been used. The DHS conducted in Burkina Faso (2010), in Niger (2006, 2012) and in Senegal (2010-2011) included some MICS modules, but were not part of the MICS global programme. In Somalia, questions on FGM/C were included in the 2011 MICS conducted separately in the Northeast Zone (also referred to as Puntland) and Somaliland. Data are preliminary and have not been used in this report since they do not allow for the calculation of national figures. For Sudan, data on FGM/C were collected only in the northern part of what was known as Sudan prior to the cession in July 2011 of the Republic of South Sudan by the Republic of the Sudan. The SHHS was conducted in 2006 and 2010 by the Government of National Unity and the Government of Southern Sudan, with technical support from the MICS global programme.

2. Focusing on human rights

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Most types of FGM/C involve the cutting and removal of portions of the female genitalia. While programmes to address FGM/C initially focused on associated health risks, the practice was reconceptualized as a human rights violation at the 1993 World Conference on Human Rights in Vienna. National legislation was subsequently established in many countries to prohibit the practice and to step up action against it.

Terminology and definitions

Female genital mutilation, also known as 'female genital cutting' or 'female circumcision', refers to "all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons."[10] The terminology used to describe the practice has potentially offensive connotations and has thus been a subject of ongoing debate.

Many commentators initially used the term 'female circumcision', since in some societies genital cutting is incorporated into both male and female initiation rites. A number of African lan-

guages, in fact, use the same term for cutting performed on both women and men. Starting in the 1970s, some activists objected to the use of this term; one reason is that it erroneously suggests that female circumcision is analogous to male circumcision. To emphasize the different nature of female genital cutting and to create a linguistic distinction, many favour the term 'female genital mutilation' and its acronym.

The term 'female genital mutilation' was adopted in 1990 by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children, and in 1991 the World Health Organization (WHO) recommended that the United Nations adopt it as well.[11] However, objections have been raised because the term also confers judgement and condemnation of what is an age-old practice in many communities.[12] In an effort to become more culturally sensitive, the term 'female genital cutting', or FGC, has become widely used among researchers as well as various international development agencies. In 1999, the UN Special Rapporteur on Traditional Practices called for "tact and patience" regarding this area and drew attention to the risk of "demonizing cultures under cover of condemning practices harmful to women and the girl child."[13] UNICEF and the United Nations Population Fund (UNFPA) currently use a hybrid term, 'female genital mutilation/cutting' or FGM/C. This is meant to capture the significance of the term 'mutilation' at the policy level and highlight that the practice is a violation of the rights of girls and women. At the same time, it recognizes the importance of employing respectful terminology when working with practising communities.[14]

In reality, these are all blanket terms describing a broad range of practices performed on girls and women, mostly before the age of 15 and often in infancy or early childhood. More precise anatomical descriptions are provided by a typology developed by WHO in 1995 and updated in 2007:[15]

Type I: Partial or total removal of the clitoris and/or the prepuce. In medical literature this form of FGM/C is also referred to as 'clitoridectomy'. A number of practising communities also refer to it as *sunna*, which is Arabic for 'tradition' or 'duty'.

Type II: Partial or total removal of the clitoris and labia minora, with or without excision of the labia majora. The 2007 WHO definition recognizes that although this form of cutting is more extensive than Type I, there is considerable variability in the form or degree of cutting. In English, this type of cutting is often referred to as 'excision', although it is important to note that in French the term 'excision' generally refers to all forms of FGM/C.

Type III: Narrowing of the vaginal orifice by cutting and bringing together the labia minora and/or the labia majora to create a type of seal, with or without excision of the clitoris. In most instances, the cut edges of the labia are stitched together, which is referred to as 'infibulation'. The adhesion of the labia results in near complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as 'defibulation'. In some instances, this is followed by reinfibulation.

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Pricking or nicking involves cutting to draw blood, but no removal of tissue and no permanent alteration of the external genitalia. This is sometimes called 'symbolic circumcision', and some communities have described it as a traditional form of FGM/C.[16] Although symbolic circumcision is still highly controversial, it has been proposed as an alternative to more severe forms of cutting in both African and other countries where FGM/C is performed.[17]

While this typology offers a precise anatomical description of varied practices, it may be more useful in clinical observation than in surveys that rely on self-reports. P. Stanley Yoder and colleagues explain that "each society has its own language and ways of classifying types of cutting that are known to members, types of cutting that do not necessarily correspond to the WHO designations. Establishing equivalence between such locally defined types and those proposed as guidelines by the WHO is not a simple matter."[18] Many women may be unaware of the specific procedures performed on them, and in many settings it may be culturally inappropriate to ask detailed questions about such matters, or to show illustrations.[19]

A human rights violation

Global campaigns and other efforts to eliminate FGM/C initially focused on the adverse health consequences of the practice. By the early 1990s, this emphasis had begun to fall from favour for several reasons – primarily because the cam-

paigns did not result in significant reductions in prevalence, but also because the focus on health may have inadvertently promoted the 'medicalization' of the practice, meaning that it is increasingly carried out by medical professionals.[20] It was during this period that FGM/C was reconceptualized as a human rights issue:

> *The 1993 Vienna World Conference on Human Rights was a landmark event in which two important developments occurred. First, 'female genital mutilation' became classified as a form of violence against women (VAW); second, the issue of VAW was for the first time acknowledged to fall under the purview of international human rights law.*[21]

The classification of FGM/C as a human rights violation under the rubric of international law was the subject of ongoing debate through the mid-1990s. Although no international human rights instruments specifically addressed the practice,[22] Article 25 of the Universal Declaration of Human Rights states that "everyone has the right to a standard of living adequate for health and well-being" and has been used to argue that FGM/C violates the right to health and bodily integrity.[23]

With FGM/C considered as a form of violence against women, the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) can be invoked.[24] Similarly, defining it as a form of torture brings it under the rubric of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.[25] Moreover, since FGM/C is regarded as a traditional practice prejudicial to the health of children and is, in most cases, performed on minors, it violates the Convention on the Rights of the Child (CRC).[26] Recent regional treaties specifically address FGM/C, including the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, also known as the 'Maputo Protocol', which was adopted in 2003 and went into effect in 2005.[27]

All countries are party to some or all of the international or regional treaties addressing FGM/C and are required to regularly report to their respective treaty bodies.[28] While national legislation usually supersedes these mandates in terms of civilian protections under the law, international norms are critical in building consensus on the importance of eliminating FGM/C and in developing relevant domestic legislation.

National legislation

Twenty-six countries in Africa and the Middle East have prohibited FGM/C by law or constitutional decree. Two of them – South Africa and Zambia – are not among the 29 countries where the practice is concentrated *(see Table 2.1)*. With the exception of Guinea and the Central African Republic, where bans on FGM/C were instituted in the mid-1960s, the process of enacting legislation or revising the criminal code to outlaw the practice began to take hold in Africa quite recently. Legislation prohibiting FGM/C has also been adopted in 33 countries on other continents, mostly to protect children with origins in practising countries.[29]

Legislation on FGM/C varies in scope. In Mauritania, for example, the law is restricted to a ban on the practice in government health facilities and by medical practitioners.[30] In Mauritania, the United Republic of Tanzania and some non-African countries, including Canada and the United States, FGM/C is illegal only among minors. Laws banning FGM/C at all ages have been passed in the majority of African countries. In Burkina Faso, fines can be levied not only against practitioners of FGM/C, but also against anyone who knows that the procedure has been performed and fails to report it.[31] In 2011, Kenya expanded the 2001 ban on FGM/C among minors to apply to adult women and added an extraterritoriality clause, extending restrictions to citizens who commit the crime outside the country's border.[32] Reports of prosecution or arrests in cases involving FGM/C have been made in several African countries, including Burkina Faso and Egypt.[33]

Debate on the efficacy of legislation banning FGM/C has been largely overtaken by a growing consensus that laws should be one of a set of interventions by governments to support a social movement towards its elimination. A UNICEF report on legislative reform and FGM/C notes that such reform needs to take into account the degree of social support for the practice.[34] In settings where segments of practising populations agree that girls and women should not undergo FGM/C, institutional frameworks can play an important role in supporting social change aimed at ending the practice.[35] However, in communities with broad support for FGM/C, the challenge is to develop legislative reform strategies that complement efforts in the social sphere and contribute to collective abandonment of the practice.

Unless legislation is accompanied by measures to influence

cultural traditions and expectations, it tends to be ineffective, since it fails to address the practice within its broader social context.[36] Nonetheless, legislation can challenge the traditional status quo by providing legitimacy to new behaviours.[37] Programmatic efforts continue to refine the design of legislative reform, including adjusting legislative strategies to reflect evolving degrees of social support for FGM/C.[38]

Table 2.1 Twenty-four of the 29 countries where FGM/C is concentrated have enacted decrees or legislation related to FGM/C

Benin	2003
Burkina Faso	1996
Central African Republic	1966, 1996*
Chad	2003
Côte d'Ivoire	1998
Djibouti	1995, 2009*
Egypt	2008
Eritrea	2007
Ethiopia	2004
Ghana	1994, 2007*
Guinea	1965, 2000*
Guinea-Bissau	2011
Iraq (Kurdistan region)	2011
Kenya	2001, 2011*
Mauritania	2005
Niger	2003
Nigeria (some states)	1999-2006
Senegal	1999
Somalia	2012
Sudan (some states)	2008-2009
Togo	1998
Uganda	2010
United Republic of Tanzania	1998
Yemen	2001

Notes: Bans outlawing FGM/C were passed in some African countries, including Kenya and Sudan, during colonial rule. This table includes only legislation that was adopted by independent African nations and does not reflect earlier rulings.

* Later dates reflect amendments to the original law or new laws.

ACCELERATING ACTION AGAINST FGM/C:

Four countries, nine decades

Egypt (E) | Burkina Faso (BF) | Kenya (K) | Senegal (S)

1920s THROUGH THE 1950s

1920s (E): Efforts against FGM/C are primarily individual initiatives with little backing from established civil society organizations or the government. The first known campaign dates back to the 1920s, when the Egyptian Society of Physicians issues a proclamation outlining the negative health effects of FGM/C and receives support from the Ministry of Health, the press and religious scholars.

1926-1958 (K): For several years, starting in 1929, British Protestant missionaries campaign against FGM/C and are met with fierce resistance by the Kikuyu people, Kenya's largest ethnic group. Over the period 1926 to 1956, the colonial government enacts legislation seeking to lessen the effects of the practice. Parliament holds an enquiry on FGM/C in 1945. Due to ensuing opposition and political outcomes, it is forced to revoke all resolutions related to FGM/C in 1958.

1957-1958 (E): *Hawaa*, a prominent women's magazine, publishes a series of articles advising mothers against forcing their daughters to undergo FGM/C. One article states that "Islam does not support circumcision and does not recommend it."

1959 (E): Decree No. 7 from the Ministry of Health stipulates that FGM/C should not be performed in any government-run health units or hospitals. The unintended consequence is that it encourages the medicalization of the practice outside of government hospitals.

1970s

1970s (S): Government programmes begin promoting FGM/C abandonment. Local non-governmental organizations (NGOs) and women's associations bring FGM/C to the public's attention as part of a movement to improve the status of women.

1975 (BF): On the first International Women's Day, information about the harmful effects of FGM/C appears in the popular media for the first time.

1977 (K): The bishop of Mount Kenya East Diocese condemns FGM/C as medically dangerous and appeals to Christians to refrain from going back to customs that are no longer necessary.

1980s

1981 (E): Egypt ratifies CEDAW.

1982 (K): President Moi publically condemns the practice of FGM/C in Baringo district and continues to make public appeals to stop the practice throughout the 1980s and the 1990s. Later in 1982, the director of Medical Services instructs the government and mission hospitals to stop performing FGM/C.

1983 (BF): Four months after seizing power in a popularly supported coup, President Thomas Sankara meets with members of Terre des Hommes to discuss FGM/C, the first such meeting with a sitting president in Burkina Faso.

1984 (K): Kenya accedes to CEDAW.

1984 (S): The National Committee for the Abandonment of Harmful Practices Affecting Women and Children (COSEPRAT) is established. A group

GLOBAL MILESTONES

1979: FGM/C appears for the first time on the international agenda on the occasion of the WHO Seminar on Traditional Practices Affecting the Health of Women and Children, also known as the Khartoum Seminar. UNICEF issues its first statement related to FGM/C.

1979: *The Hosken Report* is released, including first-ever estimations of FGM/C prevalence on a country-by-country basis.

1979: The UN General Assembly adopts the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which explicitly recognizes that practices harmful to women, such as FGM/C, are violations of human rights.

1989: The UN General Assembly adopts the Convention on the Rights of the Child (CRC), which includes provisions to protect children against harmful practices.

of African NGOs meet in Dakar to discuss FGM/C, resulting in the formation of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC). Since that time, IAC national committees have been formed in 28 African countries and affiliates established in 15 countries outside of Africa.

1985 (S): Senegal ratifies CEDAW.

1985 (BF): During the national week of women, women's groups mobilize for the first time to advocate for clear laws against FGM/C.

1987 (BF): Burkina Faso accedes to CEDAW.

1990s

1990 (BF): Burkina Faso ratifies the CRC. The National Committee to Fight the Practice of Excision (CNLPE) is established.

1990 (E): Egypt ratifies the CRC.

1990 (K): Kenya ratifies the CRC. The Kenya National Council on Traditional Practices is established. Over the following decades, Maendeleo Ya Wanawake Organization (MYWO), the national women's organization, becomes one of the most active groups in Kenya working to eradicate FGM/C.

1990 (S): Senegal ratifies the CRC.

1991 (BF): A new constitution is adopted that affirms the human right to physical integrity and the right to health.

1991 (E): The town of Deir al-Barsha in Upper Egypt publicly condemns FGM/C with assistance from the Coptic Evangelical Organization through a grassroots public declaration.

1994 (E): The International Conference on Population and Development (ICPD) and its aftermath galvanize efforts against FGM/C in Egypt in a more concerted and effective manner. A national task force against FGM/C is formed that includes some 60 grassroots organizations. The Ministry of Health issues a decree permitting only doctors in government hospitals to perform FGM/C.

1995 (E): The 1994 decree is reversed in October after women's rights activists critique it as an endorsement of the practice, but only government hospitals are banned from performing FGM/C. Thanks to the newly established task force, which lobbied the Ministry of Health, the third Egypt DHS includes questions on FGM/C for the first time.

1995 (S): A human rights and health education programme is introduced by Tostan in villages around Thies, in partnership with UNICEF.

1996 (BF): A national law (No. 043/96/ADP) against FGM/C is passed.

1996 (K): Maendeleo Ya Wanawake Organization and PATH organize the first 'Circumcision Through Words'. This alternative rite of passage for adolescent girls involves 30 families in the village of Gatunga, not far from Mount Kenya.

1996-1997 (E): The Ministry of Health issues another decree banning the practice of FGM/C in hospitals, both private and governmental, except in cases approved by doctors. The decree provokes intense opposition from hard-line groups and is repealed in June 1997. It is appealed to Egypt's Highest Administrative Court and upheld in December 1997.

1997 (S): President Abdou Diouf openly condemns FGM/C during an international human rights conference in Dakar. The first public declaration against FGM/C takes place in the village of Malicounda Bambara, following intensive Tostan sessions. The declaration sparks national reaction. Months later, it is followed by the first coordinated, inter-village declaration among similar groups.

1998 (K): The third Kenya DHS is conducted and includes questions on FGM/C for the first time.

1998-1999 (BF): The second Burkina Faso DHS is conducted and includes questions on FGM/C for the first time.

1999 (K): The Ministry of Health launches a

1990: The African Charter on the Rights and Welfare of the Child is adopted by the Organization of African Unity (now the African Union) and enters into force in 1999. It calls upon States to take appropriate measures to eliminate harmful social and cultural practices.

1990: CEDAW General recommendation No. 14 elaborates on specific provisions regarding FGM/C.

1993: FGM/C is recognized as a human rights violation at the World Conference on Human Rights in Vienna.

1995: At the Fourth World Conference on Women in Beijing, the elimination of 'harmful cultural practices', with specific reference to FGM/C, is called for in the Platform for Action.

1997: WHO, UNICEF and UNFPA issue a joint statement against FGM/C.

national plan of action for the elimination of FGM/C (1999–2019).

1999 (S): Under the leadership of the women parliamentarians group, the National Assembly passes Law No. 99-05 prohibiting FGM/C.

2000s

2000 (E): The sixth Egypt DHS once again looks at FGM/C and includes questions on exposure to information about the practice.

2000 (S): Government launches the first national plan of action for the abandonment of FGM/C (2001-2005) and commits to eliminate the practice by 2015.

2000s (BF): Mwangaza Action, a local NGO, experiments with the Tostan approach and is evaluated by the Population Council.

2000s (K): Multiple programme approaches are tested to promote FGM/C abandonment, including safe houses for girls, community education, alternative rites of passage, and intergenerational dialogues.

2001 (K): The Ministry of Health issues a policy directive making it illegal to perform FGM/C in health-care facilities. The Parliament passes the Children's Act (No. 8 of 2001). Article 14 criminalizes the practice of FGM/C on girls under age 18 and sets a penalty of 12 months of imprisonment and/or a fine of about $600.

2001 (BF): A national day against FGM/C is adopted for 18 May. Activities to eliminate FGM/C are integrated into the national budget.

2003 (BF): The third Burkina Faso DHS is conducted. It includes, for the first time, questions on the perceived advantages of FGM/C and on health problems resulting from the practice.

2003 (E): The global Cairo Conference is organized and produces the Cairo Declaration for the Elimination of Female Genital Mutilation. The FGM-Free Village Model is implemented by the government's National Council for Childhood and Motherhood. The seventh interim Egypt DHS is conducted, again with questions on FGM/C.

2003 (K): The fourth Kenya DHS is conducted, marking the second time that survey data on FGM/C are collected.

2004 (K): A large public event is held to celebrate the acceptance of 2,000 uncut girls as full members of the Kisii community.

2004 (S): Ousmane's Sembène's film, *Moolaadé*, dramatizes a community's process of abandoning FGM/C, stirring debate.

2005 (BF): A new reproductive health law (No. 049/2005/AN) outlaws harmful practices.

2005 (E): The eighth Egypt DHS is conducted, collecting FGM/C prevalence data on girls under age 18 for the first time.

2005 (S): The fifth Senegal DHS becomes the first national household survey in the country to collect data on FGM/C.

2006 (BF): The first MICS for Burkina Faso is carried out and includes questions on FGM/C.

2006-2007 (E): The Ministry of Health issues Decree No. 271, banning everyone, including health professionals, from performing FGM/C in governmental or non-governmental hospitals and clinics. The Grand Mufti Ali Gomaa issues a fatwa (religious edict) condemning FGM/C, and the Al-Azhar Supreme Council for Islamic Research issues a statement explaining that FGM/C has no basis in Sharia (Islamic law) or any of its partial provisions.

2007 (S): The celebration of the 10th anniversary of the Malicounda Bambara declaration against FGM/C is organized as a summit in Thies to develop a new community-based action plan.

2008 (E): The Parliament agrees to criminalize FGM/C in the penal code, imposing a sentence of a maximum of two years and a fine of up to $1,000 as a penalty for performing FGM/C. The ninth Egypt DHS updates information on FGM/C and

2002: The UN General Assembly, in its resolution on *Traditional or customary practices affecting the health of women and girls*, calls upon all States to adopt national measures to prohibit practices such as FGM/C.

2003: The first International Day of Zero Tolerance to Female Genital Mutilation is commemorated on 6 February.

2005: The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol, enters into effect. It calls upon States to take measures to eliminate FGM/C and other traditional practices that are harmful to women.

2007-2010: The United Nations Commission on the Status of Women adopts resolutions on ending FGM/C in 2007, 2008 and 2010.

2008: *Eliminating Female Genital Mutilation: An interagency statement* is signed by 10 United Nations agencies.

collects data on men's attitudes towards the practice for the first time.

2008 (K): Kenya's Ministry of Gender, Children and Social Development launches a national plan of action for accelerating the abandonment of FGM/C (2008-2012). By this year, through the Fulda-Mosocho Project, the Kisii have organized 52 public events attended by tens of thousands of people to promote FGM/C abandonment.

2008 (S): The national plan of action to eliminate FGM/C is evaluated and a second plan is developed for the years 2010-2015. Senegal hosts a subregional meeting with the Gambia, Guinea, Guinea-Bissau, Mali and Mauritania to share experiences and develop coordinated mechanisms to accelerate the abandonment of FGM/C.

2008-2009 (K): The fifth Kenya DHS is carried out and includes, for the first time, questions on whether respondents believe that FGM/C is required by religion. In August 2009, the Njuri Ncheke Supreme Council of Ameru Elders condemns FGM/C and resolves to fine anyone found to be practising it in the Meru districts of Eastern Province.

2009 (BF): The President of Burkina Faso publically declares his opposition to FGM/C and calls on all religious and traditional leaders to actively engage in ending the practice. A national plan of action to eliminate FGM/C (2009-2013) is adopted. Mwangaza Action scales up its Yam Wékré campaign in 104 villages after an evaluation finds it to be a promising integrated approach.

2010s

2010 (BF): The first combined DHS/MICS is conducted in Burkina Faso, updating information on FGM/C and collecting prevalence data on girls under age 15 for the first time.

2010-2011 (S): The first combined Senegal DHS/MICS is carried out, updating information on FGM/C nationally. Prevalence data on girls under age 10 are collected for the first time. Dakar is the site of a West Africa subregional parliamentary conference on FGM/C, organized in collaboration with the international organization No Peace without Justice.

2011 (BF): Residents of 104 villages in the regions of Boussouma, Kaya, Zorgho and Meguet make a collective and public declaration to abandon FGM/C.

2011 (K): The Prohibition of FGM Act is adopted, updating and expanding the 2001 Children's Act, to criminalize FGM/C. The government updates the national action plan on FGM/C in light of the act. The Pokot Council of Elders and IL Chamus Council of Elders make public declarations against FGM/C in their communities, representing a total of over half a million people.

2012 (BF): Ziniaré, a village in Plateau Central, hosts a public declaration of 25 villages following implementation by GASCODE (Groupe d'appui en santé, communication et développement) of community-based social change activities. According to Ministry of Justice estimates, the cumulative number of people sentenced for violating the law against FGM/C since 2005 is 813, including both cutters and parents of cut girls.

2012 (E): Attempts in Parliament are made to reverse the law criminalizing FGM/C. The National Council for Population and rights groups take a strong stand condemning the attempted reversals. The Egyptian Community of Gynaecology and Obstetrics issues a public statement, endorsed by 500 doctors, declaring their opposition to the attempted repeals. The UNICEF-European Union programme on FGM/C, which began in 2008, concludes. During that period, 17,772 families of girls at risk commit to abandon FGM/C.

2012 (S): Since the Malicounda Bambara declaration in 1997, an estimated 5,315 Senegalese communities have publicly declared their abandonment of FGM/C as of end-2011. The UNICEF-European Union programme also concludes in Senegal.

2008: The largest global programme on FGM/C is launched by UNFPA and UNICEF, with Burkina Faso, Egypt, Kenya and Senegal among the first countries to join.

2011: The Committee on the Rights of the Child, in its general comment No. 13, states that children should be free from harmful practices, including FGM/C.

2012: On 20 December, the United Nations General Assembly passes the first resolution calling on States to intensify efforts to eliminate FGM/C.

2013: The African Committee of Experts on the Rights and Welfare of the Child devotes the 23rd Day of the African Child, commemorated every year on 16 June, to the theme 'Eliminating Harmful Social and Cultural Practices Affecting Children: Our Collective Responsibility.'

3. The social dynamics of FGM/C

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For decades, FGM/C has been regarded as a customary rule of behaviour and is often referred to as a social norm. In the last 10 years, major advances have been made in refining an understanding of how social norms operate. When applied to FGM/C, this provides an additional perspective from which to examine the social forces that perpetuate the practice and that need to be addressed to promote its elimination.

The practice of FGM/C as a social norm

The understanding of how social norms function and how they change has sharpened as a result of policy and programme action as well as advances in social science theory *(see Box 3.1)*.[39] Using the definition articulated by social scientist Cristina Bicchieri,[40] the practice of FGM/C can be considered a social norm in a particular context if it meets the following conditions: First, individuals are aware of the rule of behaviour regarding the cutting of girls and know that it applies to them. Second, individuals prefer to conform to this rule because: a) they expect that a sufficiently

large segment of their social group will cut their daughters, and b) they believe that a sufficiently large segment of their social group thinks that they ought to cut their daughters and may sanction them if they do not *(see Figure 3.1)*. The social group, technically referred to as the reference group, basically includes the people who matter to an individual with respect to FGM/C. Thus, it may include other members of the ethnic group or people of the same faith if the practice is associated with ethnicity or religion.

Determining whether FGM/C is a social norm in a particular situation is important programmatically, because when it is, it is difficult for individual families to stop the practice on their own. There is a social obligation to conform to the practice and a widespread belief that if they do not, they are likely to pay a price that could include social exclusion, criticism, ridicule, stigma or the inability to find their daughters suitable marriage partners. Conversely, families will be encouraged not to cut their daughters if they

Box 3.1 A social norms perspective: Theory, policy and practice

Starting in 2003, UNICEF stepped up its efforts to end FGM/C, undertaking a number of activities to promote an evidence-based approach to the design, implementation and evaluation of specific interventions.[41] The UN agency collaborated with the academic community and drew from state-of-the-art theory on behaviour and social change. In 2005, UNICEF's Innocenti Research Centre published an action-oriented report called *Changing a Harmful Social Convention: Female genital mutilation/cutting*,[42] which drew upon social science theory to explain the persistence of FGM/C. The report also identified corresponding programming components needed to promote its abandonment. These were further elaborated in a Technical Note published in 2008.[43] The subsequent multi-country study, *The Dynamics of Social Change: Towards the abandonment of female genital mutilation/cutting in five African countries*, examined FGM/C as a social norm and explored the social dynamics of its abandonment in Egypt, Ethiopia, Kenya, Senegal and Sudan.[44]

Growing appreciation of the usefulness of a social norms perspective in addressing FGM/C is increasingly reflected in major policy statements by the United Nations and its partners, such as the UN interagency statement on FGM.[45] The UN Secretary-General's 2009 report to the United Nations General Assembly, *The Girl Child*, also highlighted the social norms perspective in the discussion of FGM/C:

It is now widely acknowledged that [FGM/C] functions as a self-enforcing social convention or social norm. In societies where it is practised it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.[46]

The social norms perspective has been applied and further refined in the context of global and national programmes to address FGM/C and to promote gender equality. It is the central feature of an innovative approach developed by UNICEF in the context of a programme with the European Union (2008-2012)[47] that has contributed to progress in the abandonment of harmful practices in five African and one South Asian country. A social norms perspective is also at the core of the programme framework of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change (2008-2013). The programme, which is currently under way in 15 African countries, is expected to embark on a second phase from 2014-2017.[48] An external evaluation of phase 1 of the programme was ongoing at the time this report was being written. Preliminary results from four countries indicate that a social norms perspective has been helpful in guiding the programme's comprehensive approach, which consists of a mix of interconnected strategies conducive to bringing about the elimination of FGM/C.[49]

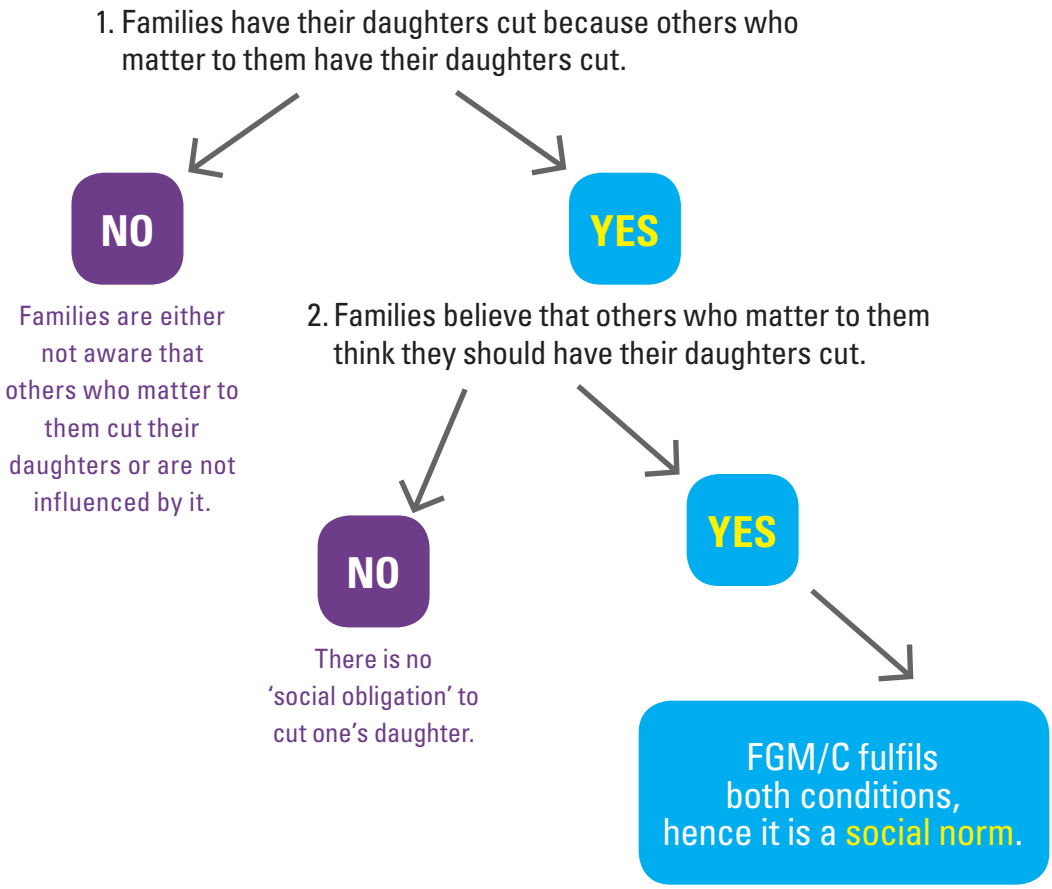
are convinced that a sufficiently large number of other families do not practise FGM/C or are ready to abandon the practice.

It has long been recognized that people's behaviour can be conditioned by a variety of factors. In the case of FGM/C, these factors include beliefs or knowledge about various aspects of the practice – for example, that it causes harm, which is a correct belief,[50] or that it is mandated by religion, which is an incorrect belief.[51] A social norms perspective draws attention to the fact that the beliefs of individuals about others also condition their behaviour. This perspective enriches the understanding of FGM/C by offering an additional lens for analysing the mechanisms that regulate the practice.

In addition to social norms, mechanisms that regulate behaviour also include legal norms, which may prohibit the practice, and moral norms, such as doing what is best for one's daughter *(see Table 3.1)*. These norms may act in harmony, reinforcing one another, or they may be at odds. Any analysis undertaken to inform policies and programmes aimed at eliminating FGM/C needs to explore the three types of norms and how they interact with one another. That is, it needs to look at the relationship between moral and social norms, between social

Figure 3.1 A behaviour is considered a social norm if it meets certain conditions

Context: A social group in which FGM/C is practised



Source: Adapted from Cristina Bicchieri and Gerry Mackie, from the UNICEF-University of Pennsylvania course on advances in social norms, 2012.

Table 3.1 Social, legal and moral norms each play a role in individual behaviour

Mechanisms that regulate the behaviour of individuals

	Legal norms (enacted by the State)	Social norms (enacted by social groups)	Moral norms (evoked by internalized values of right and wrong)
Motivations and rewards for conformity	Respect for the law	Social acceptance	Self-gratification, 'good conscience'
Sanctions for non-conformity	Legal sanctions spanning from citations to fines and imprisonment	Social disapproval manifested by ridicule, shame, stigma and exclusion	Guilt, 'bad conscience'

Source: Adapted from Mockus, A., 'Co-existence as Harmonization of Law, Morality and Culture', *Prospects*, vol. 32, no. 1, 2002, pp. 19-37.

and legal norms, and between social norms and human rights, and how these relationships can best be leveraged to improve the lives of children, their families and entire communities. For example, legislation prohibiting FGM/C may be enacted with the expectation that it will discourage the practice. However, it should be acknowledged that where the social norm of FGM/C is in place, the fear of social exclusion for not conforming to the norm may be stronger than the fear of fines and imprisonment. If individuals continue to see others cutting their daughters and continue to believe that others expect them to cut their own daughters, the law may not serve as a strong enough deterrent to stop the practice. Conversely, among groups that have abandoned FGM/C, legislation can serve as a tool to strengthen the legitimacy of their actions and as an argument for convincing others to do the same.

The process of changing social norms

Experience in the field[52] suggests that when population groups take a stand towards abandoning FGM/C, it involves a collective process that includes exposure to new information and to possible alternatives, deliberation[53] within the social group, organized diffusion, and public declarations or other manifestations of commitment to a new social rule.[54] This is consistent with the prevailing theoretical framework: For a social norm to change within a community or social group, social expectations must change. The Innocenti Insight on *The Dynamics of Social Change* describes how the process typically takes place within a community:

> *FGM/C abandonment typically begins with an initial core group of individuals who set in motion a dynamic of change. As this group becomes ready to abandon the practice, they then seek to convince others to abandon. The members of this critical mass spread the knowledge of their intention to abandon to others through their social networks – a process known as 'organized diffusion' – until a large enough portion of the intramarrying community is ready to abandon FGM/C, described in this text as the 'tipping point'. After this point, the abandonment would become stable because it would permanently change social expectations. Community members would be expected to not cut their daughters, and would be socially rewarded or sanctioned accordingly.*

But for abandonment to occur, it is essential that people are aware of and trust the intention of others to also abandon. Social expectations will change if people have a guarantee of the commitment of others to abandon. A moment of public affirmation of commitment to abandon the practice is therefore required so that each individual is assured that other community members are willing to end the practice. For the alternative possibility of not cutting to become a reality, new attitudes and a willingness to change need to be made explicit and public. This opens the way for behaviour change and for an actual and stable abandonment. Families are able to maintain their social status and avoid harm to their daughters, while at the same time girls remain eligible for marriage.[55]

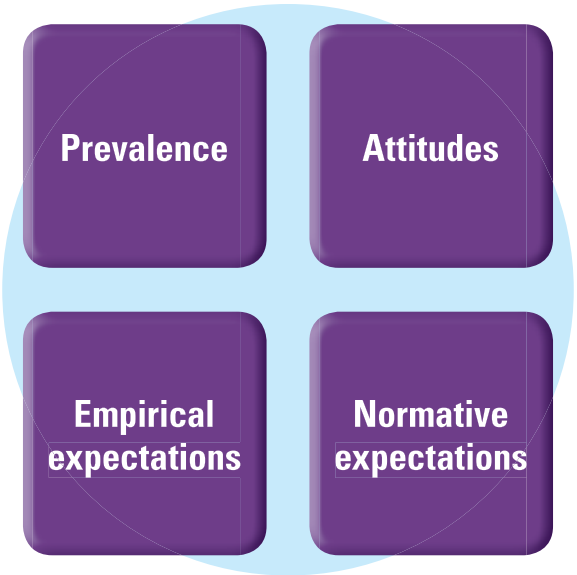
In real life, the process may not be linear, and some of the steps may overlap and be reinforcing. For example, public manifestations of commitment to end FGM/C by a group of communities may influence deliberations in other communities where cutting is still practised. Similarly, the process of change may be easier if practising communities are exposed to non-practising communities with which they have some affinity, such as a shared religion. If no such exposure occurs, the practising community may even assume that FGM/C is universal and have no reason to question it.

Measuring FGM/C through the lens of social norms

To fully grasp the social dynamics that perpetuate FGM/C in a particular context, or encourage its abandonment, data relating to several aspects of the practice should be collected and analysed *(see Figure 3.2)*. These include: the degree to which the practice is occurring (prevalence); individual preferences regarding the continuation of the practice (attitudes); the beliefs of individuals as to whether others are conforming to the practice (empirical expectations);[56] and whether individuals believe they have a social obligation to practise FGM/C (normative expectations).[57] The latter can be ascertained by examining whether individuals believe that they or their daughters will be subject to some form of social sanction

Figure 3.2 Measuring expectations around FGM/C, together with prevalence and attitudes, can shed additional light on the social dynamics of the practice

Key parameters to analyse social norms



– such as ridicule, shame, criticism, stigma or exclusion – for non-conformance.[58]

As the following chapters show, the large body of data available on prevalence and attitudes towards the continuation of FGM/C makes it possible to undertake an in-depth analysis of the discrepancies that may exist between support for the practice and behaviour. As one measure, the report looks at whether stated opinions about the practice in a particular group are consistent with the FGM/C status of girls in that community and their risk of being cut. The report also uses available data that either directly or through proxy provide clues about social expectations, both empirical and normative.

Social expectations

The identification of FGM/C as a social norm implies that the practice is interdependent – that is, the behaviour of an individual or family is conditioned by the behaviour of others. More precisely, it is conditioned by an individual's or family's *perceptions or expectations* of what others do and think, whether or not these are reflected in reality. Power relations also play a role. It is not just what is said or done that is important, but also who says or does it. For example, a visible stand in support of ending the practice may have greater influence on social expectations if articulated by an influential religious leader rather than an adolescent community member. Likewise, if medical professionals are seen to perform and uphold the practice, this may strengthen its legitimacy and the social expectation that it will and should continue.

Some of the questions used in DHS and MICS provide data that can be used to shed light on social expectations. For example, *Are women circumcised in this area/community?* provides information on what the respondent believes about the behaviour of others – her empirical expectations. *Is (Was) there anyone who is encouraging (encouraged) you to have your daughter circumcised?* offers clues about a respondent's normative expectations – that is, what she thinks others expect her to do.

Data from DHS and MICS cannot conclusively determine the presence and scope of social expectations pertaining to FGM/C, or how they change over time. But they do provide important insights that can inform policies and programmes. The report therefore seeks to draw as much information as possible regarding empirical and normative expectations from the available data. For example, it examines women's perceptions of whether men support the practice. This information is key, since the belief that men support FGM/C can be an important motivating factor in women's behaviour with respect to the cutting of their daughters. Also of interest is the degree to which respondents consider social acceptance to be a reason for continuing the practice.

Reference groups

Social norms exist with respect to specific behaviours and specific social groups. Thus, FGM/C may function as a social norm within one population group but not another. Understanding this distinction is of central importance to effective programme design. The report explores the degree of FGM/C prevalence and support for the continuation of the practice in specific geographic areas and among population groups that share the same ethnicity or other socio-economic characteristics. When this analysis is carried out with data that have been disaggregated at the subnational level within and across national borders, it suggests how social forces may be leveraged within and across reference groups.

Prevalence, attitudes and pluralistic ignorance

As noted previously, the behaviour of individuals regarding FGM/C is conditioned by the behaviour of others. It is therefore difficult for any single individuals or families to abandon the practice on their own. In this context, it is highly likely that some individuals or families may not personally support the practice, but feel compelled to go along with the group. This is consistent with the notion that changing individual attitudes towards FGM/C will not be sufficient to bring about large-scale abandonment. Families need to be convinced that enough other people will support – or at least tolerate – a move to end the practice before they will feel sufficiently empowered to forgo cutting their daughters.

The analysis of discrepancies between FGM/C prevalence and support for its continuation provides insights into the question of whether FGM/C is performed as a result of perceived social obligations. In some cases, for example, families may support FGM/C and practise it. In other cases, they may practise FGM/C but not support it. Changes over time in the degree of discrepancy provide an indication of the depth of social change that may be under way, even though it may not be sufficient to motivate large groups of families to stop cutting their daughters.

Discrepancies between support for the continuation of FGM/C and its prevalence also suggest the possibility that the attitudes of individual families are kept in the private sphere and are not known by most other families. If this is true, a significant number of families may, in fact, prefer not to cut their daughters. But since they see others doing it, they infer that others support the practice and are motivated to cut their own daughters to avoid social disapproval. Taken to the extreme, everyone in a community could be personally against the continuation of FGM/C, but also believe that others support it because they practise it. This phenomenon is referred to as 'pluralistic ignorance'[59] and can lead to a vicious circle in which genuine preferences remain hidden for a long time. It can thus be one of the social realities that support the persistence of the practice.

Pluralistic ignorance is perpetuated by a lack of communication among individuals in a social group about their private beliefs, attitudes and preferences that question or contradict prevailing social norms. The opposite of pluralistic ignorance is 'common knowledge',[60] which can be stimulated by facilitating access to information and discussion within communities, by the media and through national events involving various social groups.

The phenomenon of pluralistic ignorance is illustrated in Sara Johnsdotter's research among Somalis living in Sweden.[61] Interviews with women regarding male preference showed that women were convinced that Somali men favoured infibulation, whereas interviews with men revealed their solid opposition to the procedure. The lack of communication between Somali men and women on this sensitive topic led to false beliefs about the preferences of the opposite sex.

This report examines data on attitudes about FGM/C and explores the association between FGM/C prevalence among daughters and support for its continuation among their mothers, providing insights into pluralistic ignorance, as well as clues on the influence of social pressure on the perpetuation of the practice.

Social and economic variables

Social and economic variables, including educational level and wealth, are among the factors that are associated with changes in FGM/C over time. They can also be considered as proxies for the degree of exposure that communities have to factors deemed to contribute to changes in social norms. One such factor is information about the harms of FGM/C and about communities that do not practise or have abandoned FGM/C. Another is the opportunity to engage in discussion about FGM/C with different social groups. To test this understanding, it is useful to explore whether the association between higher levels of education and lower levels of FGM/C prevalence is the same in geographic areas of differing prevalence.

In countries or among ethnic groups with high national prevalence, where exposure to information that encourages the questioning of FGM/C is likely to be limited, one would expect a weaker association between education and FGM/C prevalence. If this is the case, it may not be education, per se, that is the decisive factor in changing behaviour, but exposure to new information and possible alternatives, along with interaction with social networks, which are all associated with higher levels of education.

Similar observations can be drawn with respect to the wealth of a household and urban or rural residence. Lower FGM/C prevalence among wealthy urban residents is likely due to the fact that richer households and those living in urban areas have exposure to a greater number of social networks. Along the same line of reasoning, programmes seeking to encourage the abandonment of FGM/C might focus specifically on bringing the issue into the public sphere, and on giving visibility to communities that have abandoned the practice. These questions and hypotheses are explored in greater detail in the following chapters.

A note on terminology

Throughout this report, the term 'female genital mutilation/cutting' and its acronym are used when referring to the practice. Occasionally other terms are employed, including 'circumcision', 'cutting' and 'excision'. This is done to reflect the original terminology used in the surveys or for easier reading. As noted in Chapter 2, however, these terms have different meanings and reflect different types of practices.

A note on the data

As explained in Chapter 1, data availability varies across countries. In some cases, the last survey with nationally representative and comparable data on FGM/C was conducted in 1997; in other cases, it was conducted as recently as 2012. Data indicate FGM/C status at the time of the survey and do not necessarily reflect the current situation.

The analyses contained in the following chapters are based on data from the most recent survey for each country. When data are not available from the most recent source, the analyses are based on previous surveys. Year ranges provided in the sources for the figures, maps and tables denote the period during which the surveys were conducted. For each country, data refer to most recent year available during the specified range. While the following chapters include only selected findings, complete data can be found in the Statistical tables, starting on page 174.

4. How widespread is the practice?

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Female genital mutilation/cutting has been practised in various forms for centuries. But it is only now that reliable data are available for all 29 countries where the practice is concentrated. Certain key questions can therefore be answered with greater confidence: How many girls and women have undergone FGM/C? Where is the practice most prevalent? How does this concentration vary within countries and across population groups?

The global number

More than 125 million girls and women alive today have been cut in the 29 countries in Africa and the Middle East where FGM/C is concentrated.[62] Of these, around one in five live in just one country: Egypt. Since certain minority groups and immigrant communities continue the practice in other countries as well, including in Europe and North America, the total number of girls and women worldwide who have undergone FGM/C is likely to be slightly higher *(see Box 4.1)*. The actual figure remains unknown, however, since reliable data on the magnitude of the phenomenon in these population groups are largely unavailable.

Box 4.1 Measuring the extent of FGM/C in immigrant communities in North America and Europe

Although no nationally representative data on FGM/C are available for countries including Colombia, Jordan, Oman, Saudi Arabia and parts of Indonesia and Malaysia, evidence suggests that the procedure is being performed.[63] It is also practised in pockets of Europe and North America, which, for the last several decades, have been destinations for migrants from countries where the cutting of girls is an age-old tradition.[64] Interest is growing in measuring the actual extent of the practice in migrant communities, motivated by awareness of the need to provide appropriate medical care to women who have been cut and social services to prevent FGM/C from being performed on their daughters.

For some destination countries, estimates of FGM/C prevalence have been generated by combining figures on the number of immigrant women above a particular age (15 or 18) and the national prevalence in their country of origin. The number of girls who are at risk of being cut is calculated by applying national FGM/C prevalence to the number of daughters of immigrants from these same countries. These are considered maximum estimates of the number of women who have undergone the procedure or girls at risk of being cut, and are problematic for a number of reasons.

First, not all women who emigrate are equally likely to undergo FGM/C, particularly if they are from countries with moderate or low prevalence. The data presented in this chapter document variability in the prevalence of FGM/C along lines including ethnicity, urban/rural residence, education and wealth – factors that are often correlated with the likelihood of emigration. Estimates could be readily improved by knowing a woman's ethnicity and using estimates of FGM/C prevalence for that ethnic group.

Second, using national prevalence levels to estimate the number of girls at risk overestimates the true risk for girls from countries where there has been a decline in FGM/C prevalence. Using prevalence figures for women in the 15-19 age cohort in the country of origin can improve the accuracy of estimates.[65]

Finally, some studies have found that parents' intentions to have FGM/C performed on their daughters fades quickly in certain immigrant communities.[66] Much could be learned through a better understanding of how quickly interest in the practice wanes following immigration, and of factors influencing this decline.

National prevalence

The percentage of girls and women of reproductive age (15 to 49) who have experienced any form of FGM/C is the first indicator used to show how widespread the practice is in a particular country *(see Box 4.2)*. This indicator reflects responses by girls and women about themselves. In the 29 countries where FGM/C is concentrated, almost all girls are cut before the age of 15. Thus, prevalence data among girls and women aged 15 to 49 are considered to reflect their final FGM/C status.[67]

A second indicator of national prevalence measures the extent of cutting among daughters aged 0 to 14, as reported by their mothers. Prevalence data for girls reflect their current – not final – FGM/C status, since many of them may not have reached the customary age for cutting at the time of the survey. They are reported as being uncut but are still at risk of undergoing the procedure. Statistics for girls under age 15 therefore need to be interpreted with a high degree of caution *(see Box 4.3)*.

Box 4.2 Indicators for measuring FGM/C prevalence: Self-reporting by girls and women

The first indicator used to report on the prevalence of the practice is the percentage of girls and women of reproductive age (15 to 49) who have experienced any form of FGM/C.[68] This is calculated from self-reports – that is, responses by girls and women themselves to the question *Are you circumcised?*, or variations on that question, such as *Have you been circumcised?*, *Have you ever been circumcised?*, *Have you ever had your genitals cut?* and *Did you have your external genitals cut?* Exceptions are found in surveys from Liberia and Sierra Leone, where the questions were adjusted to eliminate the direct reference to FGM/C due to the sensitivity of the topic. Respondents were asked instead whether they had been initiated into a women's secret society, such as the Bondo or Sande in Sierra Leone (MICS 2005, DHS 2008) and the Sande in Liberia (DHS 2007), and who initiated them. This provides indirect information on FGM/C since it is performed during initiation into these societies.

In most surveys, eligible respondents are all girls and women aged 15 to 49. Exceptions include Egypt (DHS surveys in 1995, 2000, 2003 and 2005), Sudan (DHS 1989-1990) and Yemen (DHS 1997), where the sample of respondents includes only girls and women aged 15 to 49 who have ever been married.

Self-reported data on FGM/C need to be treated with caution for several reasons. First, women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice.[69] In addition, they may be unaware that they have been cut or of the extent of the cutting, especially if FGM/C was performed at an early age. A number of studies have attempted to determine the reliability of self-reports of FGM/C status by verifying them through clinical examinations. This body of research has assessed two aspects of self-reported data: 1) the reliability of women's self-reports about having been cut or not, and 2) the reliability of self-reports on the type of FGM/C performed.

Studies that have compared women's self-reports of being cut to clinically observed signs of FGM/C have reported variable rates of concordance. While one study in Sudan reported complete agreement between clinical examination and women's own reports,[70] others report variable degrees of discrepancy. Linda Morison and colleagues found 3 per cent disagreement in the Gambia,[71] whereas studies in the United Republic of Tanzania and Nigeria reported discrepancies in more than 20 per cent of women.[72] Nicking would not be expected to produce any clinically observable alteration of the external genitalia, and may account for some degree of difference between self-reports and clinical observations. A longitudinal study in Ghana afforded a unique opportunity to assess the consistency of women's self-reports of FGM/C status over repeat surveys.[73] The data showed that a substantial number of adolescent girls who initially reported having undergone FGM/C later denied being cut. The authors concluded that denial of having undergone the procedure is influenced by exposure to anti-FGM/C interventions and by passage of a law banning FGM/C. In a detailed overview of methodological considerations for measuring change in FGM/C, Ian Askew emphasizes the need to consider the context in which questions on FGM/C status are being asked. In his words, "If FGC is widespread, socially acceptable and there are no well-publicized interventions causing people to question its acceptability and legality…, then self-reporting is likely to be valid. If there are reasons why it would not be attractive for respondents to declare that they are cut…, then self-reported measures should be questioned and ways sought to validate the results."[74] With this warning in mind, there is sufficiently strong evidence that, overall, survey data based on women's self-reports provide reliable information on FGM/C status and can therefore be used to calculate prevalence.[75]

Box 4.3 Indicators for measuring FGM/C prevalence: Mothers report on the status of their daughters

The second indicator used to report on FGM/C prevalence measures the extent of cutting among daughters of girls and women of reproductive age (15 to 49). In surveys up to 1999, female respondents who had at least one living daughter were asked about their eldest daughter: whether she was cut, the age at which FGM/C was performed, the type of FGM/C carried out and the person who did it. If the eldest daughter was reportedly not cut, respondents were then asked if they intended to have their daughter cut. This was the case in surveys carried out in the following countries: Sudan (DHS 1989-1990), Eritrea (DHS 1995), Mali (DHS 1995-1996), United Republic of Tanzania (DHS 1996), Niger (DHS 1998), Kenya (DHS 1998), Côte d'Ivoire (DHS 1998-1999), Burkina Faso (DHS 1998-1999) and Nigeria (DHS 1999).

Starting in 1999, rather than asking about the eldest daughter, DHS began asking respondents whether any of their daughters had undergone FGM/C. Those who answered negatively were asked whether they intended to have any of their daughters cut. Those who answered positively were next asked how many of their daughters were cut. This was followed by questions about the FGM/C procedure (age at cutting, type of FGM/C and practitioner) for the daughter most recently cut.

Survey data on the FGM/C status of only one daughter cannot be used to estimate the prevalence of FGM/C among girls under age 15. To address this limitation, MICS and DHS in 2010 introduced changes in the standard methodology used to collect information on FGM/C. The new module asks all girls and women aged 15 to 49 about the FGM/C status of all of their daughters under age 15. As a result, prevalence estimates can be obtained for girls aged 0 to 14. Since this is the age group most recently cut or at imminent risk of being cut, these data can be used to assess the impact of recent efforts to end FGM/C.

Information on the FGM/C status of daughters is generally regarded as more reliable than women's self-reports, since any cutting would have occurred relatively recently and mothers presumably would have had some involvement in the event.[76] However, even these data need to be interpreted with a degree of caution. In countries where FGM/C has been the target of campaigns or legal measures prohibiting the practice, mothers may be reluctant to disclose the actual status of their daughters for fear of repercussions.

A key point to remember is that prevalence data for girls aged 0 to 14 reflect their current FGM/C status and do not reflect final prevalence for this age group. Some daughters who have not undergone FGM/C may not have reached the customary age for cutting and may still be at risk. These cases can be described as censored observations. Since age at cutting varies in different settings, the amount of censoring will also vary. This must be kept in mind as data on prevalence of FGM/C in early age cohorts are compared.

Censoring also influences whether prevalence data in the 0-14 age cohort can be used to detect recent changes. Corrections are sometimes made by combining figures on daughters already cut with information about mothers' intentions to circumcise their uncut daughters, which has been collected in some surveys. However, the reliability of this method is compromised by the fact that mothers are often not the sole decision-makers in matters regarding FGM/C and may not be able to act upon intent. Moreover, as their daughters grow closer to the age at which they would customarily be cut, mothers may succumb to social pressure to conform to what they believe others expect of them. A more reliable approach to adjust prevalence among girls aged 0 to 14 relies on the use of information on age at cutting, as described in Box 8.6 on page 100.

Prevalence among girls and women aged 15 to 49

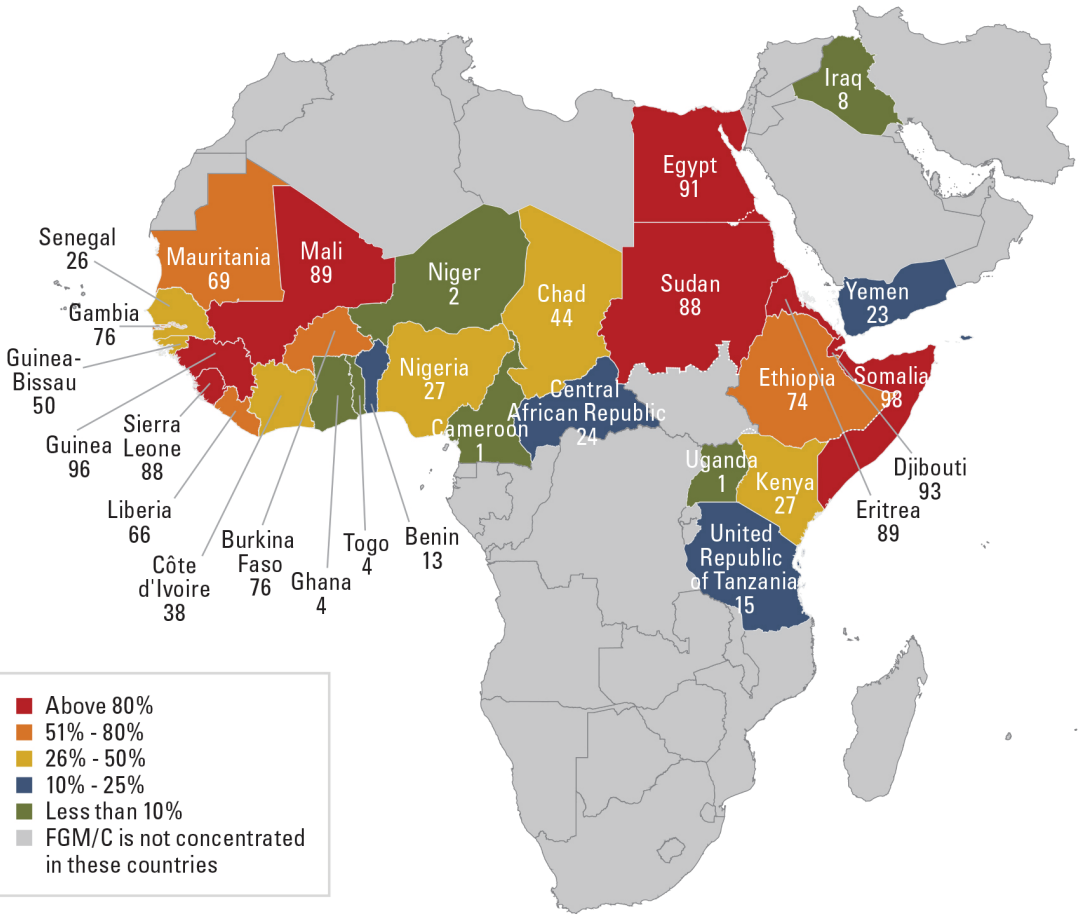
The most recently available data show wide variations in FGM/C prevalence across countries. The practice is almost universal in Somalia,[77] Guinea, Djibouti and Egypt, with prevalence levels above 90 per cent, while it affects only 1 per cent of girls and women in Cameroon and Uganda *(see Map 4.1)*. National FGM/C prevalence among girls and women aged 15 to 49 is used to separate countries into five groups *(see Box 4.4)*.

Prevalence among girls aged 0 to 14

Figure 4.1 shows the percentage of girls aged 0 to 14 who have already been cut, as reported by their mothers, in a subset of 12 countries with available data on all daughters.[78] FGM/C prevalence among girls varies from less than 1 per cent in Togo to more than 50 per cent in Mauritania and the Gambia.[79] These figures do not reflect those who have not yet undergone FGM/C due to their young age, but are likely to be subjected to the practice when they reach the customary age at cutting.

Map 4.1 FGM/C is concentrated in a swath of countries from the Atlantic Coast to the Horn of Africa

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by country



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C since it is performed during initiation into the society, as explained in Box 4.2. Data for Yemen refer to ever-married girls and women. The final boundary between the Republic of the Sudan and the Republic of South Sudan has not yet been determined.
Sources: DHS, MICS and SHHS, 1997-2012.

Box. 4.4 Groupings by prevalence levels among girls and women aged 15 to 49

Group 1: Very high prevalence countries. Eight countries in which more than 80 per cent of girls and women of reproductive age have been cut: Somalia (98 per cent), Guinea (96 per cent), Djibouti (93 per cent), Egypt (91 per cent), Eritrea (89 per cent), Mali (89 per cent), Sierra Leone (88 per cent) and Sudan (88 per cent).

Group 2: Moderately high prevalence countries. Five countries in which FGM/C prevalence is between 51 per cent and 80 per cent: Gambia (76 per cent), Burkina Faso (76 per cent), Ethiopia (74 per cent), Mauritania (69 per cent) and Liberia (66 per cent).

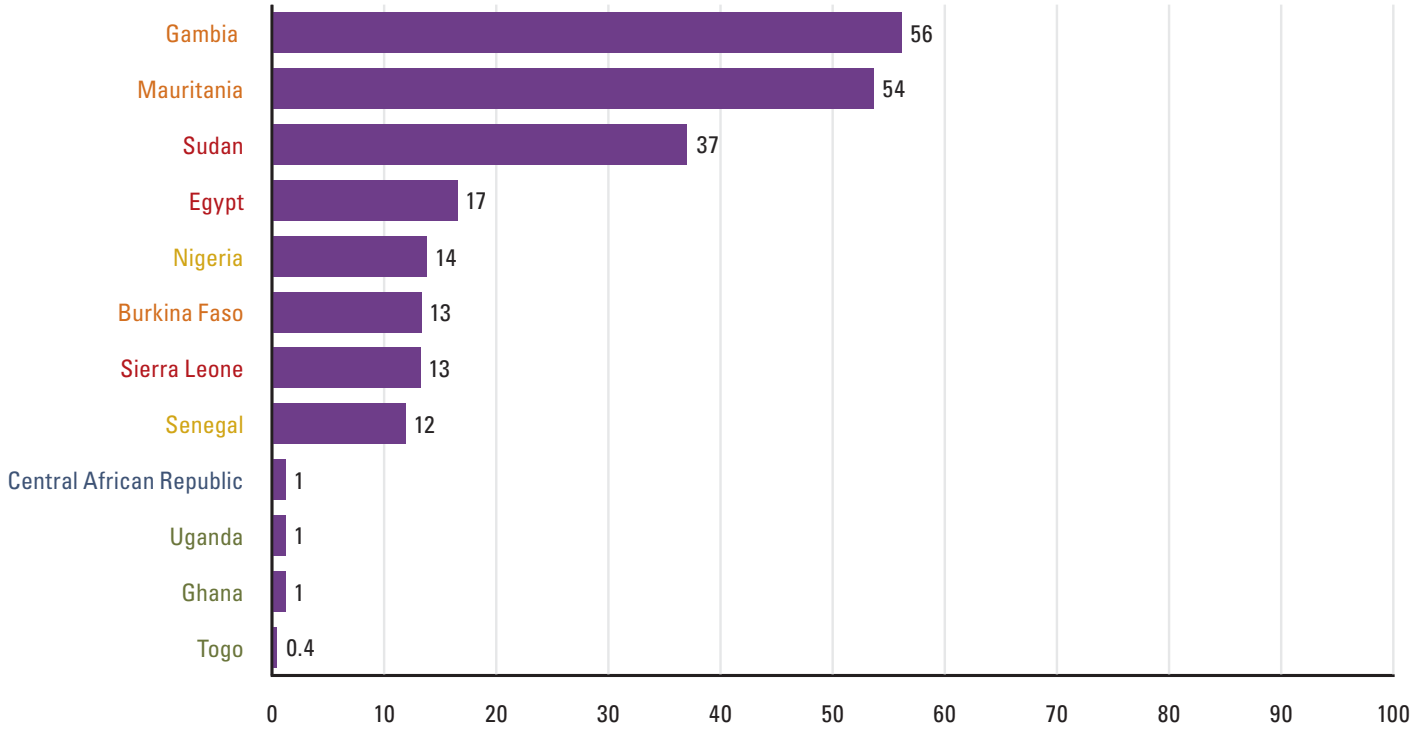
Group 3: Moderately low prevalence countries. Six countries in which FGM/C prevalence is between 26 per cent and 50 per cent: Guinea-Bissau (50 per cent), Chad (44 per cent), Côte d'Ivoire (38 per cent), Kenya (27 per cent), Nigeria (27 per cent) and Senegal (26 per cent).

Group 4: Low prevalence countries. Four countries in which FGM/C prevalence is between 10 per cent and 25 per cent: Central African Republic (24 per cent), Yemen (23 per cent), United Republic of Tanzania (15 per cent) and Benin (13 per cent).

Group 5: Very low prevalence countries. Six countries in which less than 10 per cent of girls and women are cut: Iraq (8 per cent), Ghana (4 per cent), Togo (4 per cent), Niger (2 per cent), Cameroon (1 per cent) and Uganda (1 per cent).

Figure 4.1 FGM/C prevalence levels among girls do not reflect those who have not yet been cut due to their young age

Percentage of girls aged 0 to 14 years who have undergone FGM/C (as reported by their mothers)



Notes: Data for Senegal refer to daughters aged 0 to 9. Data for Egypt have been recalculated for daughters aged 0 to 14. For further details on the estimates presented in this figure, see endnote 79. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 above.
Sources: DHS, MICS and SHHS, 2008-2011.

Population groups that practise FGM/C have usually done so for generations; those who have never practised it tend not to take it up. Thus, the likelihood that a girl will be cut increases significantly if her mother has undergone the procedure. As illustrated in Figure 4.2, girls whose mothers have been cut are considerably more likely to undergo the procedure than girls of uncut mothers.

Subnational prevalence

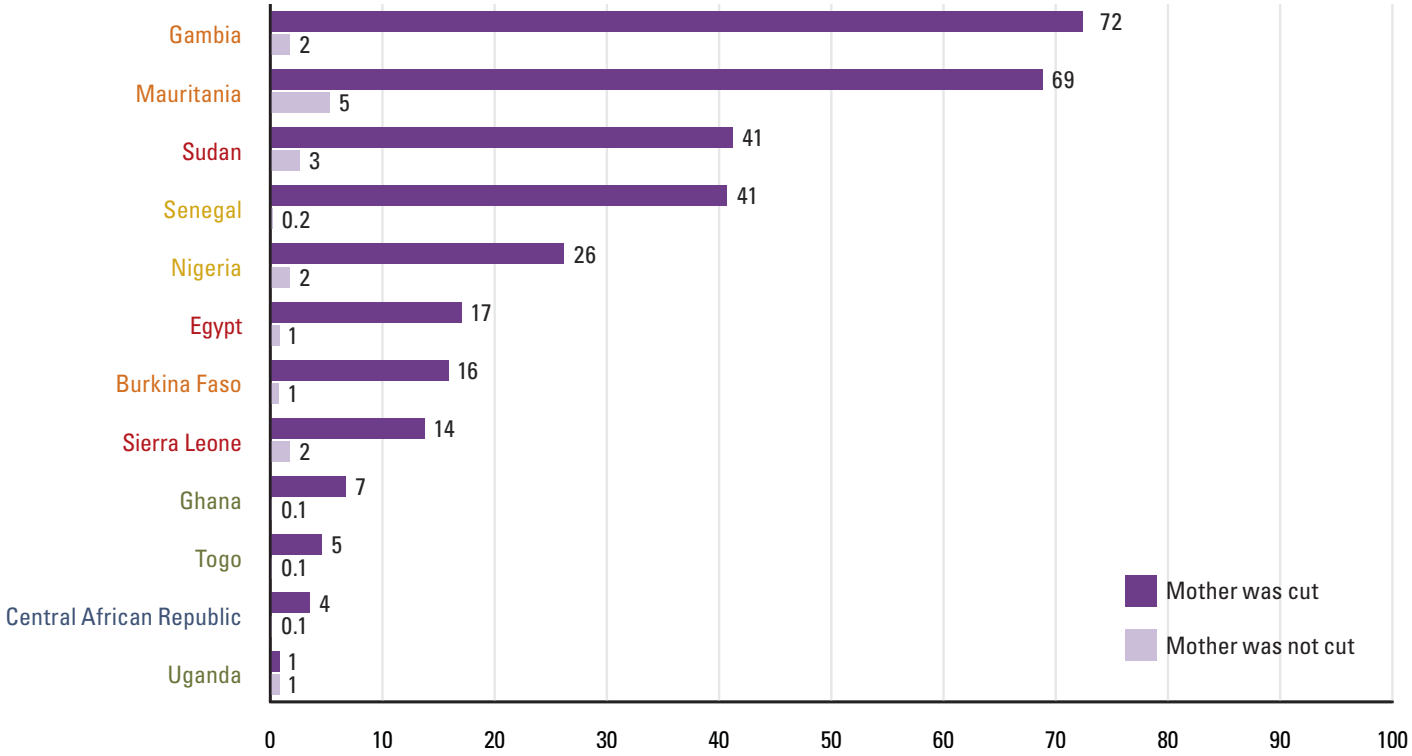
While FGM/C prevalence at the national level is important, it often masks differences among regions within a country. These differences are generally greater in countries where national prevalence is lower. This suggests that the presence or absence of the practice is influenced by factors that are shared among specific population groups within various areas of a country.

When looking at countries where FGM/C is almost universal (**Group 1**), the data show a lack of substantial variation in prevalence among regions. In Guinea, for example, prevalence is consistently high, with levels of 94 per cent or more in four of five regions of the country *(see Map 4.2)*.

In a pattern similar to that found in Group 1, variations in prevalence in moderately high FGM/C prevalence countries (**Group 2**) also tend to be minor. However, an analysis of subnational data indicates that even in countries where overall prevalence tends to be high, one finds areas where FGM/C is far less widespread. Data from Burkina Faso illustrate this point. Map 4.3 shows that FGM/C prevalence

Figure 4.2 The chances that a girl will undergo FGM/C increase significantly if her mother has been cut

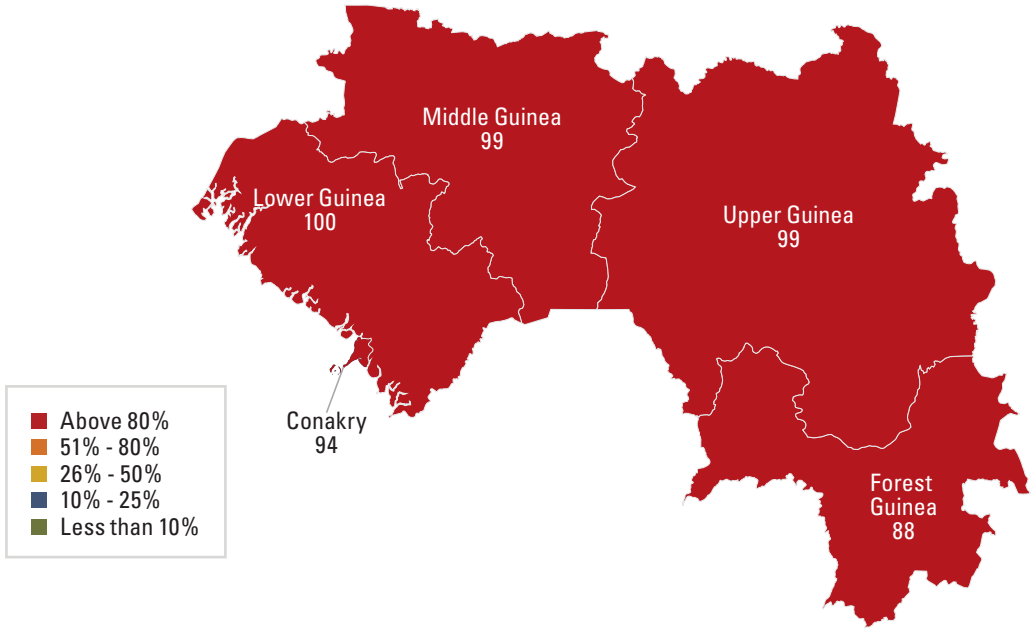
Percentage of girls aged 0 to 14 years who have undergone FGM/C (as reported by their mothers), by their mothers' FGM/C status



Notes: Data for Senegal refer to daughters aged 0 to 9. Data for Egypt have been recalculated for daughters aged 0 to 14. For further details on the estimates presented in this figure, see endnote 79. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 2008-2011.

Map 4.2 Prevalence of FGM/C is 94 per cent or more in four of five regions in Guinea, a very high prevalence country

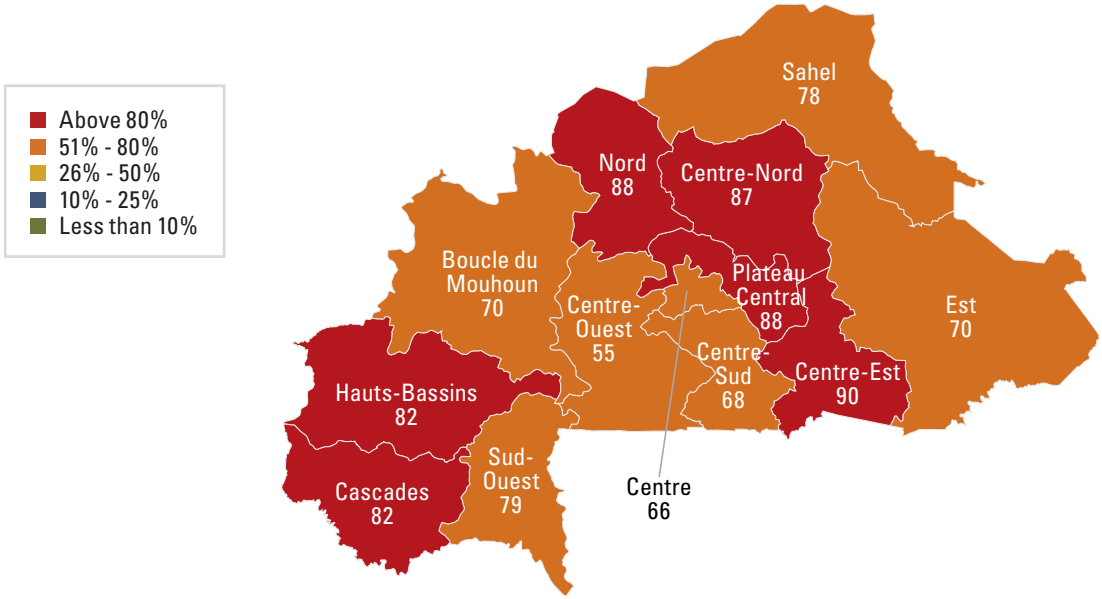
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Guinea, by region



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: DHS 2005.

Map 4.3 Prevalence of FGM/C in regions of Burkina Faso, a moderately high prevalence country, ranges from 55 per cent to 90 per cent

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Burkina Faso, by region



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: DHS/MICS 2010.

ranges from 55 per cent in the region of Centre-Ouest to 90 per cent in Centre-Est.

Countries with moderately low FGM/C prevalence (**Group 3**) show significant variations in prevalence levels by region. For example, data from Senegal show that 26 per cent of girls and women aged 15 to 49 have undergone FGM/C. At the regional level, FGM/C prevalence ranges from a low of 1 per cent in Diourbel (the region with the lowest prevalence) to 92 per cent in Kedougou (the region with the highest prevalence) *(see Map 4.4)*. This suggests that the practice is confined to certain communities concentrated in specific regions of the country.

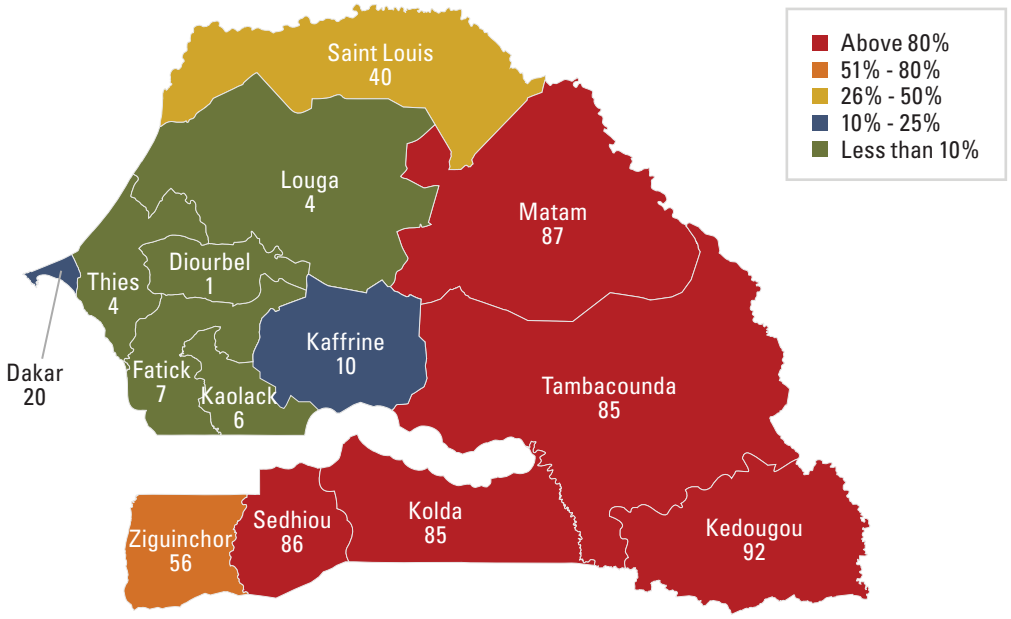
Low prevalence countries (**Group 4)** also present significant variations in FGM/C prevalence by region. Data for the United Republic of Tanzania, for example, show that the practice is mainly concentrated in the central regions *(see Map 4.5)*.

In countries with very low FGM/C prevalence at the national level (**Group 5**), the practice is concentrated within a few select geographic areas. For example, data from Iraq show that FGM/C is only practised in a few northern regions, including Erbil and Sulaymaniyah, where the majority of girls and women have undergone the procedure *(see Map 4.6)*; it is practically non-existent in other areas of the country.

When data on the prevalence of FGM/C at subnational levels are presented for all countries, regional and cross-border patterns become apparent. As shown in Map 4.7, population groups practising FGM/C are distributed more or less contiguously across a zone running from Senegal in the west to the Horn of Africa in the east. Regions of high prevalence correspond to the sites of ancient empires, such as ancient Nubia, Kush or Meroe in the territory of modern-day Sudan and Egypt, and the Mande Empire in West Africa. A number of scholars have attempted to link the current distribution of the practice to places of origin and its diffusion.[80] Gerry Mackie, for example, has proposed a single-source diffusion theory that locates the origins of FGM/C in ancient Meroe, where infibulation was practised in the context of extreme resource inequality. For highly polygynous wealthy males, genital cutting of girls and women signalled controlled fidelity and the certainty of paternity.[81] Mackie hypothesizes that the practice was then diffused across social strata and spread across routes of the female slave trade. Others suggest a dual-source origin, arguing that as infibulation spread

Map 4.4 Variations in FGM/C prevalence in Senegal, a moderately low prevalence country, are dramatic

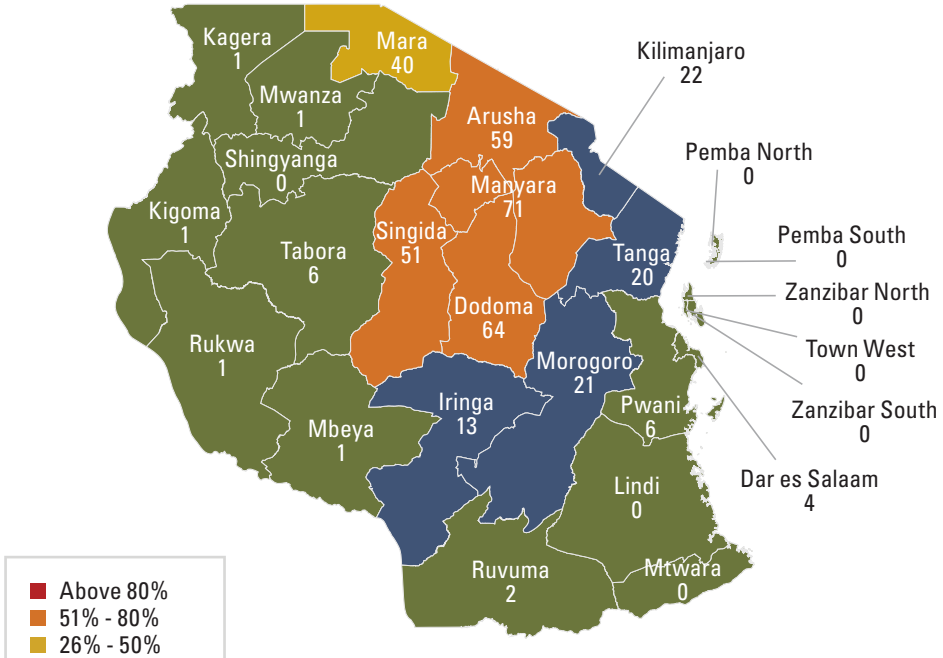
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Senegal, by region



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: DHS/MICS 2010-2011.

Map 4.5 Prevalence of FGM/C in the United Republic of Tanzania, a low prevalence country, is moderately high in four regions

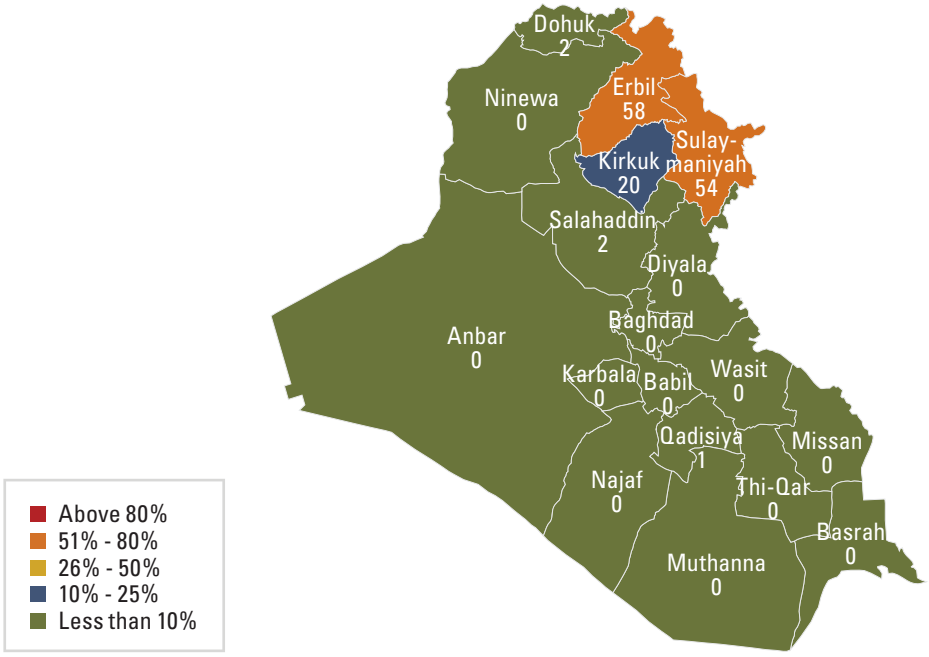
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in the United Republic of Tanzania, by region



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: DHS 2010.

Map 4.6 In Iraq, a very low prevalence country, the practice of FGM/C is concentrated in a few northern regions

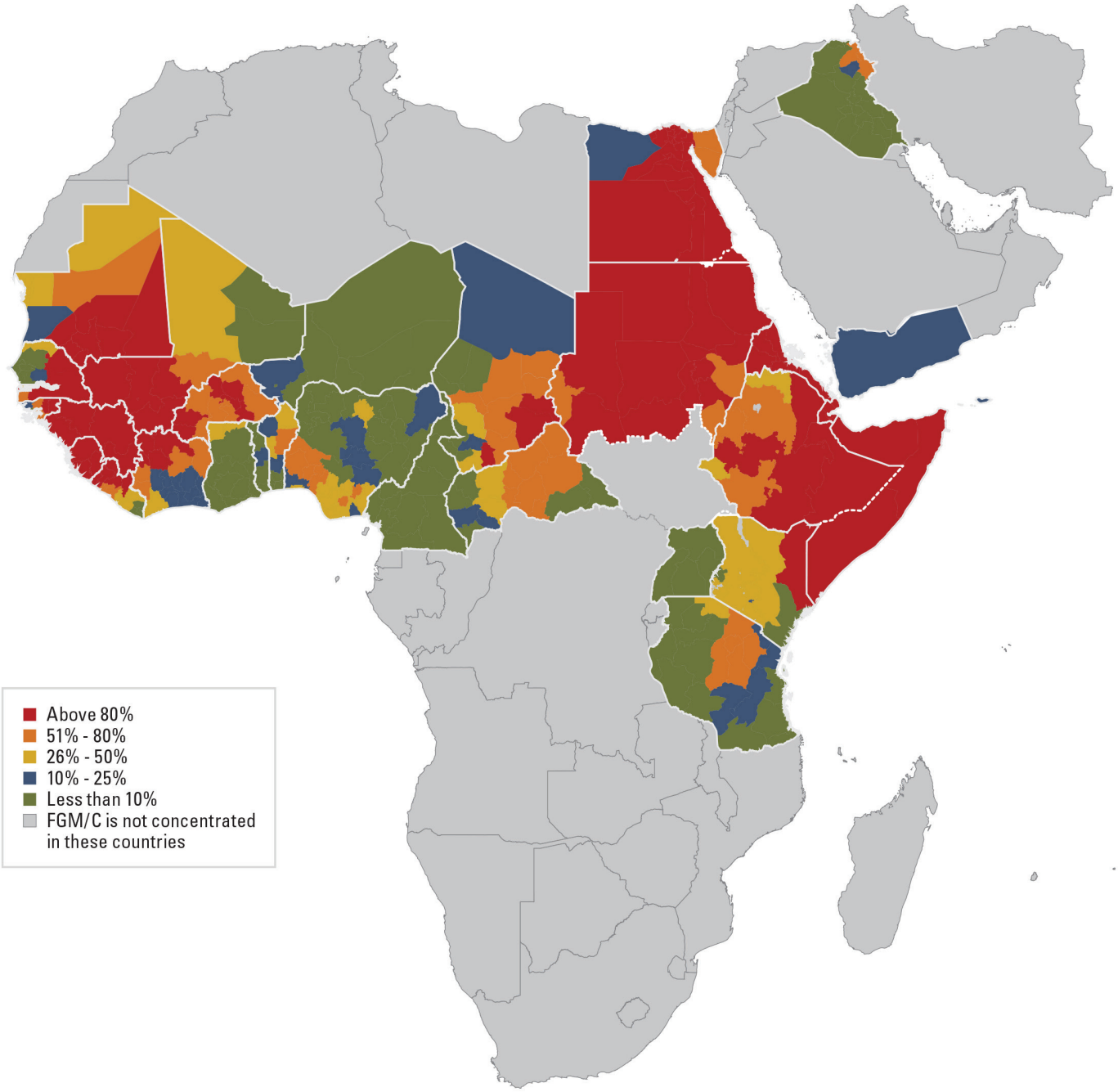
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Iraq, by region



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers.
Source: MICS 2011.

Map 4.7 Similar prevalence levels for FGM/C extend across national boundaries

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by regions within countries



Notes: This map is stylized and not to scale. It does not reflect a position by UNICEF on the legal status of any country or territory or the delimitation of any frontiers. Subnational data for Yemen could not be displayed due to discrepancies between the regional groupings in DHS and those available in the software used to create the map. The final boundary between the Republic of the Sudan and the Republic of South Sudan has not yet been determined.
Sources: DHS, MICS and SHHS, 1997-2011.

out of its original core area, it encountered and merged with pre-existing practices associated with initiation rites for both males and females.[82]

FGM/C and ethnicity

Variations in FGM/C prevalence across regions are best understood by the ethnic composition of the population in each area. Data from Benin illustrate this point. Table 4.1 shows that the prevalence of FGM/C is highest in the regions of Borgou (59 per cent), Alibori and Donga (48 per cent each) and Atakora (18 per cent). These are areas inhabited by the Bariba, Yoa, Lokpa and Peulh – ethnic groups with some of the highest FGM/C prevalence levels in Benin.

In many settings, FGM/C derives much of its meaning and tenacity from its intimate association with ethnic identity. This association raises a key question: What role does ethnicity play in the persistence of FGM/C? Where a strong link between FGM/C and ethnicity exists, it may be that ethnicity signals reciprocal expectations that hold the practice in place; in this case, ethnicity may be a proxy for shared norms concerning marriageability, sexual restraint, personhood or other common values. For instance, in the Horn of Africa, in some North African countries and in pockets of others, strong honour and modesty codes prescribe a set of values that are symbolized by FGM/C. In many West African and East African societies, FGM/C plays an integral role in defining personhood by its incorporation into coming-of-age rituals that confer the status of adulthood. Fuambai Ahmadu, a Sierra Leonean/American anthropologist, has stated that had she chosen to forgo initiation into women's secret society, which necessitated FGM/C, she would have been permanently relegated to the status of childhood by her extended family.[83] Even in settings where the association of FGM/C with initiation rituals has weakened, the practice appears to remain an important physical marker of insider/outsider status and to be intertwined with shared values such as sexual restraint and respect for one's elders.[84]

Ethnic classifications are not, however, static, and are of-

Table 4.1 Prevalence levels in a geographic area can be explained by the presence of certain ethnic groups

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Benin, by region and ethnicity

Region	Percentage of girls and women aged 15 to 49 years who have undergone FGM/C
Alibori	48
Atakora	18
Atlantique	1
Borgou	59
Collines	11
Couffo	0.1
Donga	48
Littoral	2
Mono	0.1
Oueme	1
Plateau	3
Zou	0.3

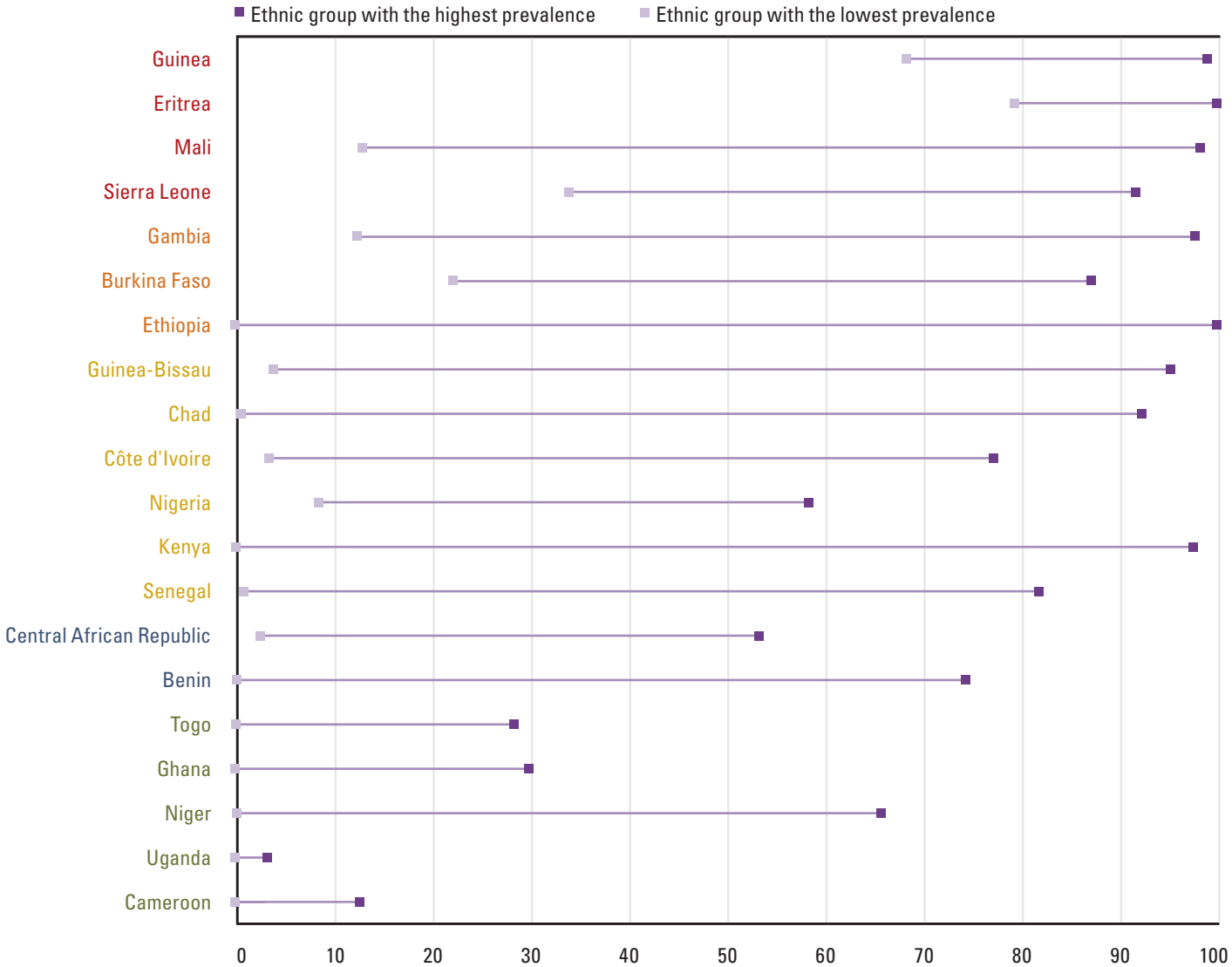
Ethnic group	Percentage of girls and women aged 15 to 49 years who have undergone FGM/C
Adja	0.2
Bariba	74
Dendi	16
Fon	0.2
Yoa and Lokpa	53
Betamaribe	4
Peulh	72
Yoruba	10
Other nationalities	12
Other	24

Source: DHS 2006.

ten more complex than can be summarized through simple measures. Consequently, a number of challenges are encountered in tracing ethnicity from survey data. Ongoing processes of migration, mixing, and social, economic and political change can contribute to the shifting of ethnic definitions over time, and may even contribute to the spread of FGM/C in certain situations. For instance, in writing about class-stratified Sudan, Ellen Gruenbaum describes how FGM/C can serve as an important marker of privileged ethnic group status and has, at times, contributed to the spread of the practice among lower status groups in an assimilative strategy.[85] An additional challenge in examining ethnic identity is posed by the fact that ethnic groups may have subgroups that differ with respect to FGM/C practices. The categorization of ethnic identity is further complicated by the fact that, in certain countries, inter-ethnic marriage has become increasingly common and unproblematic.[86] As a result, a sharp and stable boundary

Figure 4.3 Levels of FGM/C prevalence vary dramatically among ethnic groups

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in the ethnic groups with the highest and lowest FGM/C prevalence



Notes: Only categories with 25 or more unweighted cases are presented. Data for Côte d'Ivoire (ethnic group with highest prevalence), Eritrea (ethnic group with the lowest prevalence) and Ethiopia (ethnic groups with both highest and lowest prevalence) are based on 25-49 unweighted cases. Data for Guinea-Bissau are from MICS 2006 and data for Nigeria are from DHS 2008 since more recent ethnicity data are unavailable. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2002-2011.

may not always exist between practising and non-practising ethnic groups.

Data presented in Figure 4.3 demonstrate the degree of variability in FGM/C prevalence along ethnic lines by contrasting ethnic groups with the highest and lowest prevalence in individual countries.[87] In all settings, prevalence varies substantially. In the two countries with the highest FGM/C prevalence and available ethnicity data, Guinea and Eritrea, all ethnic groups have a high prevalence of FGM/C, but even here the difference between the highest and lowest prevalence groups is significant. As with variations in prevalence levels in different geographic areas, this suggests that the practice is relational and held in place by social or other factors within the ethnic group.

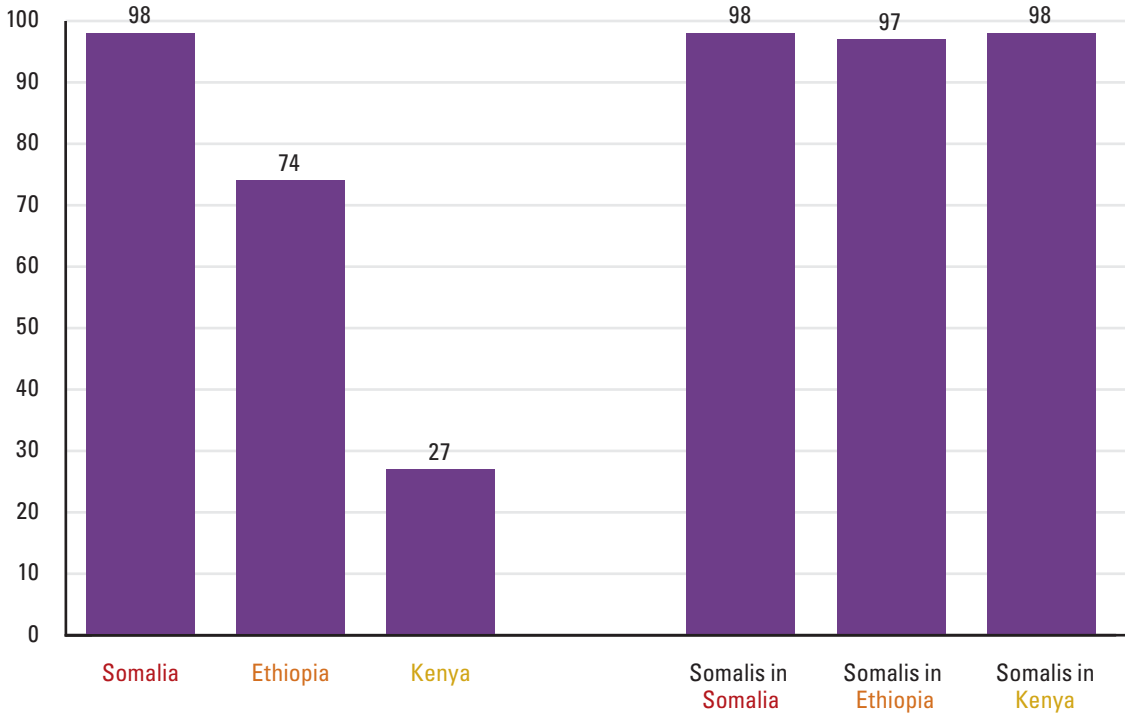
Often, members of certain ethnic groups adhere to the same set of social norms, including whether or not to practise FGM/C, regardless of where they live. In fact, national boundaries often bisect ethnic groups who share social expectations regarding FGM/C. In Somalia, for instance, where there is relatively little ethnic variation, FGM/C is almost universally practised. The FGM/C prevalence among ethnic Somalis living in neighbouring Ethiopia and Kenya bears greater similarity to the national prevalence in Somalia than to that of either neighbouring country *(see Figure 4.4)*.

The opposite may also be true. In some cases, members of certain ethnic groups tend to follow different social norms, including whether or not to practise FGM/C, depending on where they live. The Peulh (also called Poular, Fula, Fulani, Fulbe) are an ethnic group spread over many countries, predominantly in West Africa. Figure 4.5 shows that their prevalence levels are very different depending on the country context.

While these findings may appear paradoxical, they can be understood by considering the social expectations placed upon members of an ethnic group. For instance, when members of a high prevalence ethnic group are found in a low prevalence area, they are less likely to see others around them perform FGM/C and may face less pressure to conform. As a result, their prevalence levels may be lower than the overall prevalence for their ethnic group. And vice versa: Low prevalence

Figure 4.4 Prevalence among Somalis is high regardless of national context

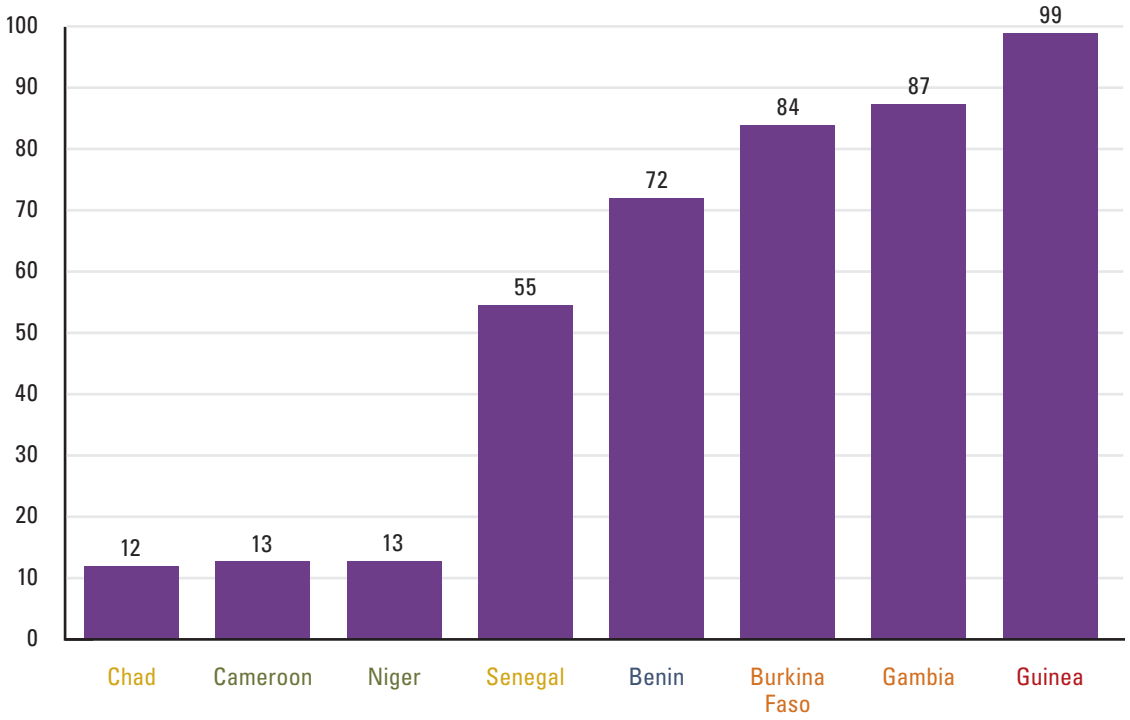
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Somalia, Ethiopia and Kenya, and among Somalis living in these three countries



Note: Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2005-2009.

Figure 4.5 Even among members of the same ethnic group, FGM/C prevalence can vary depending on the country in which they live

Percentage of Peulh girls and women aged 15 to 49 years who have undergone FGM/C, in selected countries



Notes: Data refer to the following groups: in Burkina Faso, Fulfude/Peulh; in Cameroon, Arabe-Choa/Peulh/Maoussa/Kanuri; in Gambia, Fula/Tukulor/Lorobo. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2005–2011.

groups can feel pressured to adopt the practice in areas where it is widespread. Data for Senegal illustrate this point *(see Table 4.2)*. While national FGM/C prevalence among the Wolof is very low, the practice affects Wolof women to different extents depending on where they live – from 0 per cent in Diourbel, where FGM/C is almost non-existent overall, to 35 per cent in Matam, a high prevalence region. Similarly, FGM/C prevalence among the Peulh ranges from 2 per cent among those living in Diourbel to 95 per cent among those living in Kedougou and Sedhiou.

FGM/C and other socio-demographic characteristics

In various contexts, FGM/C has been described as being linked to other factors such as urban or rural residence, economic status and education. While associations may be found, care must be taken in interpreting them, since they may be due to the confounding influence of ethnicity or other variables. Additionally, certain characteristics may be overlapping. More educated women, for example, are also more likely to be living in urban areas or in wealthier households. Nevertheless, this analysis provides a useful starting point for understanding whether socio-demographic characteristics may be related to the social norms that uphold the practice.

Urban or rural residence

It is often assumed that FGM/C is more likely to be carried out in rural than in urban settings, since the former are more likely to be kinship-based communities with limited cultural diversity. In communities where nearly all members favour the continuation of FGM/C, it may be difficult to escape the sanctions of social norms that root the practice. Urban settings, by contrast, may be more culturally diverse, and people may be more likely to associate with multiple reference groups in settings such as work, school, church or the home environment. When this results in a mixing of practising and non-practising groups, urban residents may have greater opportunity to observe that girls and women who are not cut do not experience negative sanctions, such as ostracism. Additionally, membership in multiple social networks may lessen the importance of the lineage social network, whose members share normative expectations for continuing the

Table 4.2 FGM/C affects Wolof and Peulh women differently depending on the region of Senegal in which they live

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Senegal, by region and selected ethnic groups

	Wolof	Peulh	Total FGM/C prevalence
Dakar	0.2	33	20
Ziguinchor	(6)	76	55
Diourbel	0	2	1
Saint-Louis	4	67	40
Tambacounda	17	93	85
Kaolack	0.4	13	6
Thies	0.3	10	4
Louga	0	12	4
Fatick	1	16	7
Kolda	30	92	85
Matam	35	91	87
Kaffrine	1	45	10
Kedougou	*	95	92
Sedhiou	*	95	86
Total FGM/C prevalence	1	55	26

Notes: The asterisks denote figures that are based on less than 25 unweighted cases and were suppressed. Data in parentheses are based on 25-49 unweighted cases.
Source: DHS/MICS 2010-2011.

practice of FGM/C. Ongoing interaction with members of other social networks who do not share such expectations may contribute to shifting opinions regarding the practice.

The association between place of residence and FGM/C should not be interpreted to be a direct influence, since it does not necessarily reflect residence at the time of cutting. It is possible, for example, that women migrated after being cut. To explore a potential link, it is more appropriate to examine FGM/C prevalence among daughters, since young girls are less likely to change their residence than girls and women of reproductive age. Urban-rural comparisons of FGM/C prevalence among daughters are shown in Figure 4.6. In some countries, such as Kenya, FGM/C prevalence among rural girls is four times that of urban girls.

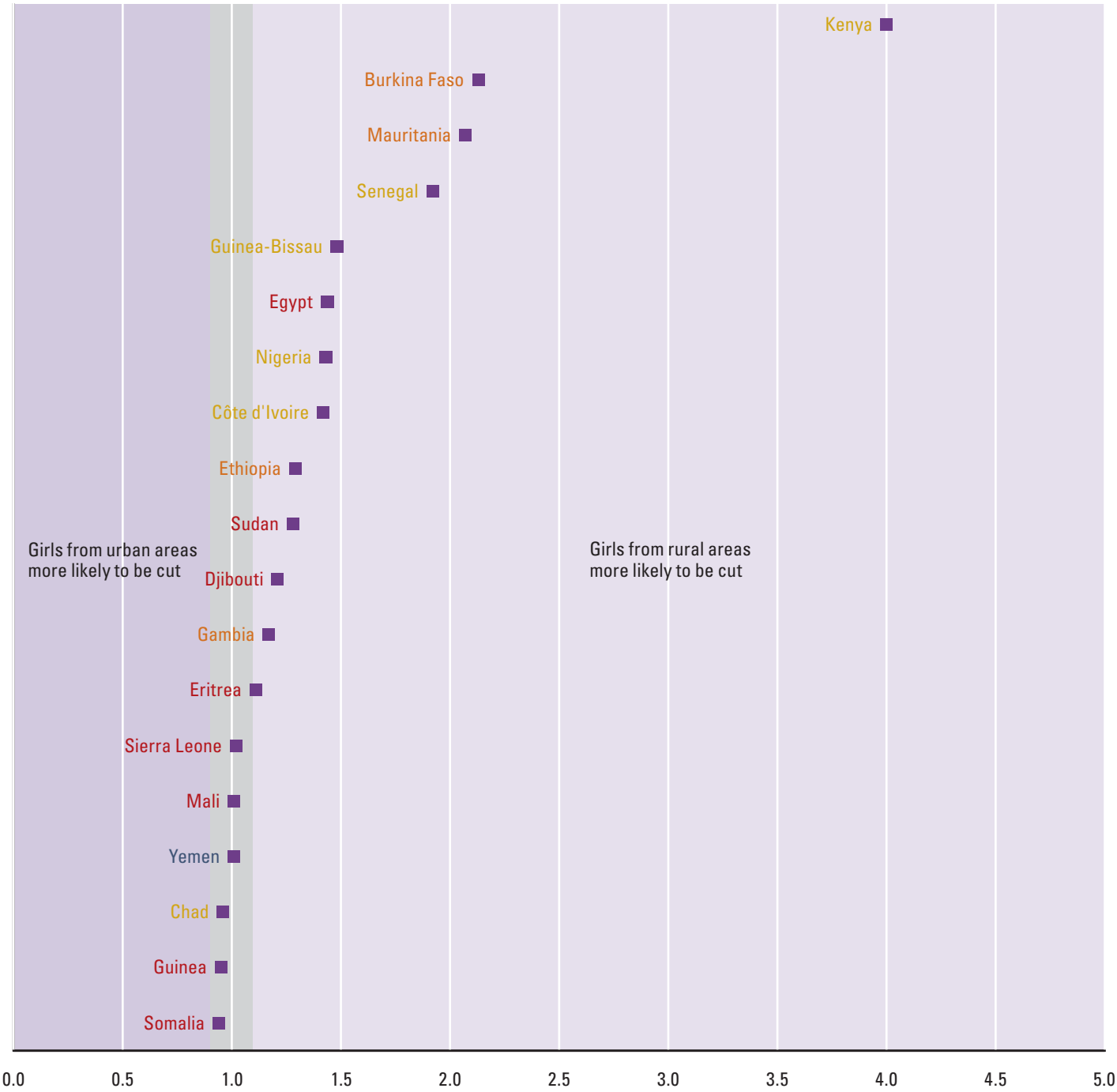
Household wealth

Modernization theory posits that improvements in economic status, particularly for women, will have broad social effects, including a decline in FGM/C. Economic development is likely to be accompanied by increased commerce and migration; it is also suggested that it may weaken traditional family structures and draw women into the labour market, changing their economic and social roles as well as their dependence on FGM/C as a means to ensure a secure future via marriage.[88] If economic development serves to reduce the demand for FGM/C, one would expect to see a lower prevalence among daughters of women from wealthier households.

Prevalence of FGM/C can be broken down by household wealth.[89] This disaggregation is carried out using a wealth index constructed of household assets, such as ownership of televisions and cars, as well as material living conditions, such as sanitation facilities, access to safe drinking water, and the characteristics of a dwelling. Each item is assigned a weight, and individuals are ranked according to the total score of the household in which they reside. The household

Figure 4.6 Although no causal link can be established, FGM/C appears to be more common in rural areas

Ratio of the percentage of girls who have undergone FGM/C (as reported by their mothers), by rural residence over urban residence



Notes: A ratio of 1.0 (0.95–1.04, grey band) indicates that FGM/C prevalence levels in the two groups are equal. A dot to the right of the grey band suggests that girls from rural areas are more likely to have undergone FGM/C, while a dot to the left of the band suggests that urban girls are more likely to have undergone the procedure. Countries with very low levels of prevalence (Benin, Cameroon, Central African Republic, Ghana, Iraq, Niger, Togo, United Republic of Tanzania and Uganda) have been excluded since data bear some level of uncertainty. Data for Egypt refer to all daughters aged 0 to 14 who have undergone FGM/C. Data for Senegal refer to all daughters aged 0 to 9 who have undergone FGM/C. Data for Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Burkina Faso, Gambia, Mauritania, Nigeria, Sierra Leone and Sudan refer to all daughters aged 0 to 14 who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has been cut. For further details on the estimates presented in this figure, see endnote 79. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997–2011.

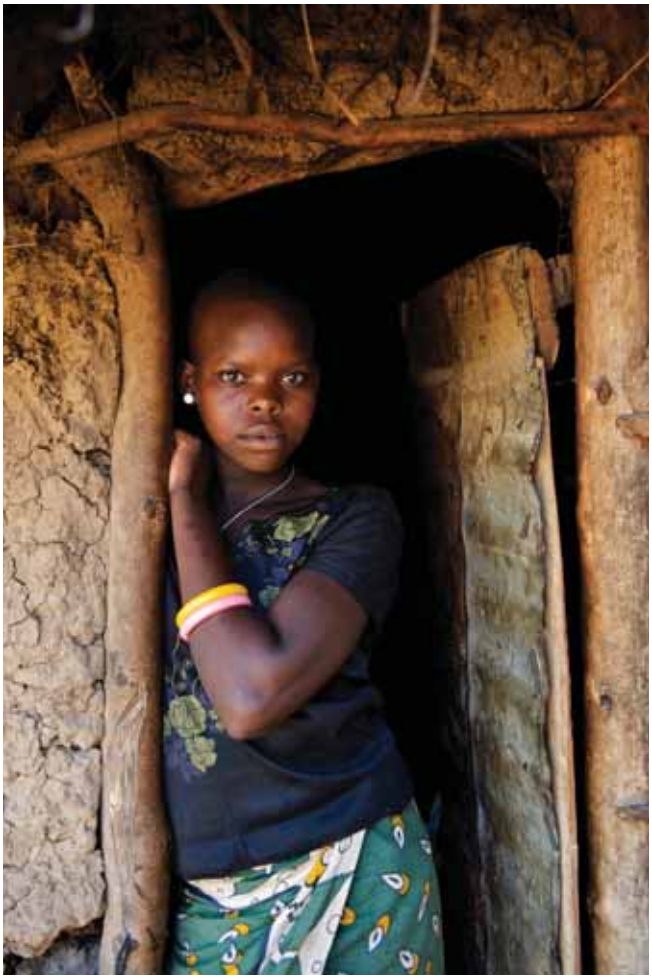
wealth index separates the population into quintiles (fifths), ranging from poorest to richest. This measure is used to determine whether differences in FGM/C prevalence are found among the wealthiest and poorest sectors of society. The interpretation of these findings is complicated, however, by the fact that the wealth index may be that of the marital home, natal home or other residence. Decisions regarding FGM/C are likely to occur, by and large, in the natal home. Therefore, the effect of household wealth on the decision to perform FGM/C is best seen by looking at prevalence among daughters (as reported by their mothers). In most cases, prevalence among daughters is lower in relatively wealthier households *(see Figure 4.7)*. This provides support for the hypothesis that improved economic status leads to a decline in the practice.

As with other socio-economic characteristics, these findings should not be taken at face value. The association between FGM/C status and household wealth may be confounded by the fact that wealthier households tend to have greater exposure to information on FGM/C and opportunities to see and engage with others who do not practise it.

Education

Education is often thought to be associated with FGM/C. The presumed link between FGM/C status and the education of girls and women rests on the assumption that, in comparison to those with little or no education, educated women will be less likely to have their daughters cut. One possible scenario is that, while in school, women develop social ties with peers and mentors who oppose the practice of FGM/C. This could provide a reference group where no normative sanctions exist for failing to comply with FGM/C. Educational settings may also provide an opportunity for discussion and a social environment conducive to the formation of new ideas. Educated women may also have greater exposure to intervention programmes, media messages and international discourse that denounce the practice, potentially creating sanctions for continuing FGM/C.

Genital cutting most commonly occurs well before girls complete their schooling.[90] Therefore the level of education they achieve will not affect their FGM/C status. Additionally, girls are not usually involved in the decision-making process regarding their own cutting. A more useful analysis of the association between education and FGM/C status focuses instead on the decisions in which women may be involved, namely the cutting of their daughters.



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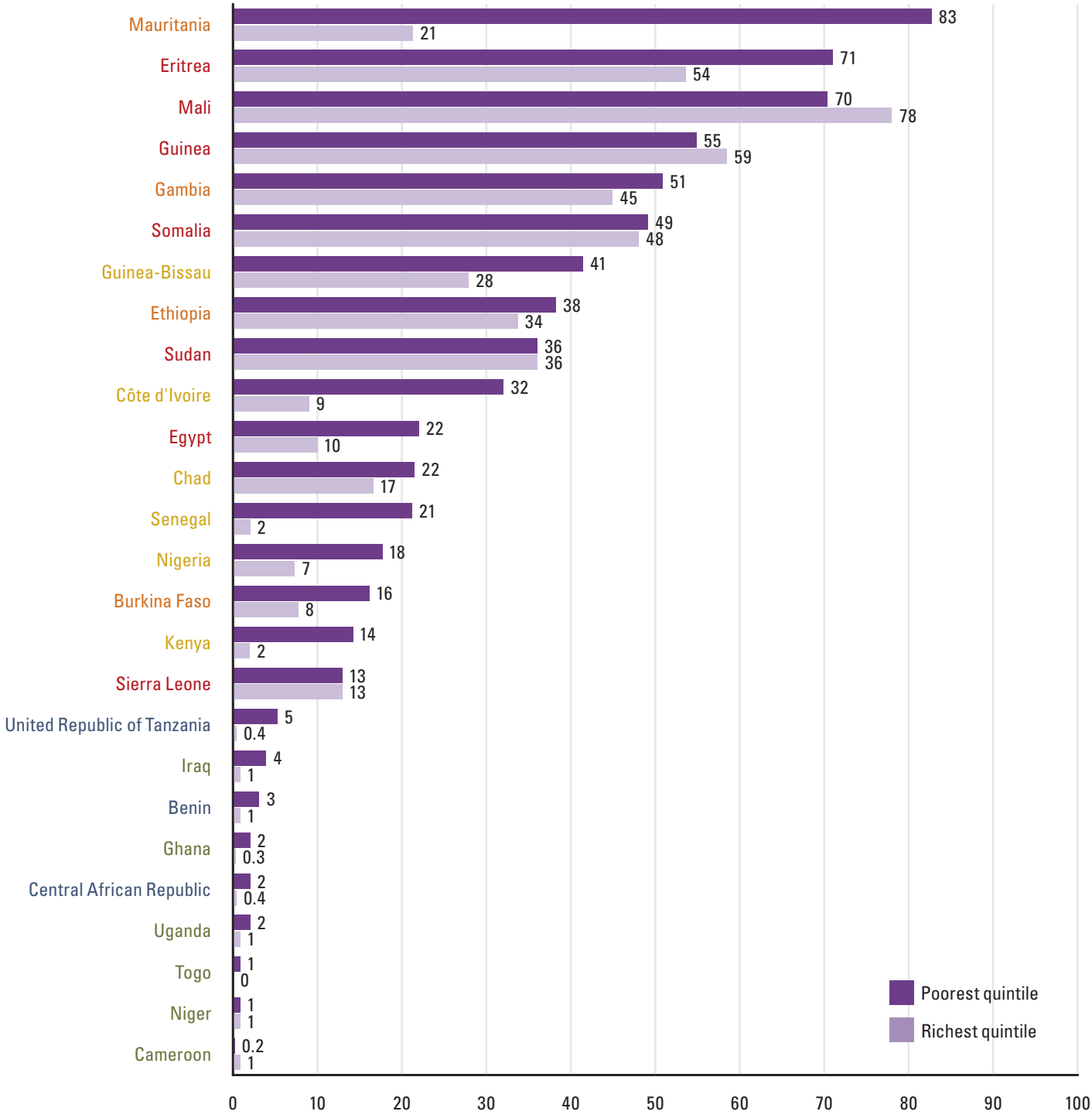
Boke, 12, stands in the doorway of the home she shares with her husband and mother-in-law, in Rebu, a village in Tarime district, Mara region, United Republic of Tanzania. Several months earlier, Boke was subjected to FGM/C.

The assumption that more highly educated women are less likely to have their daughters cut is examined by disaggregating the prevalence of FGM/C among daughters by the educational level of their mothers. Because women who are more educated are likely to be younger, wealthier, live in urban areas and have younger daughters, caution needs to be taken in interpreting the findings since other factors may be at play.

The data show that in high and low prevalence countries alike, the expected prevalence of FGM/C is generally highest among daughters of women with no education, and tends to decrease substantially as a mother's educational level rises *(see Figure 4.8)*. This suggests that even when women have little opportunity to interact with women from non-practising groups, education appears to play an important role in shifting normative expectations around FGM/C and facilitates abandonment of the practice.

Figure 4.7 In most countries, FGM/C prevalence is lower among girls in the wealthiest households

Percentage of girls who have undergone FGM/C (as reported by their mothers), by poorest and richest wealth quintiles

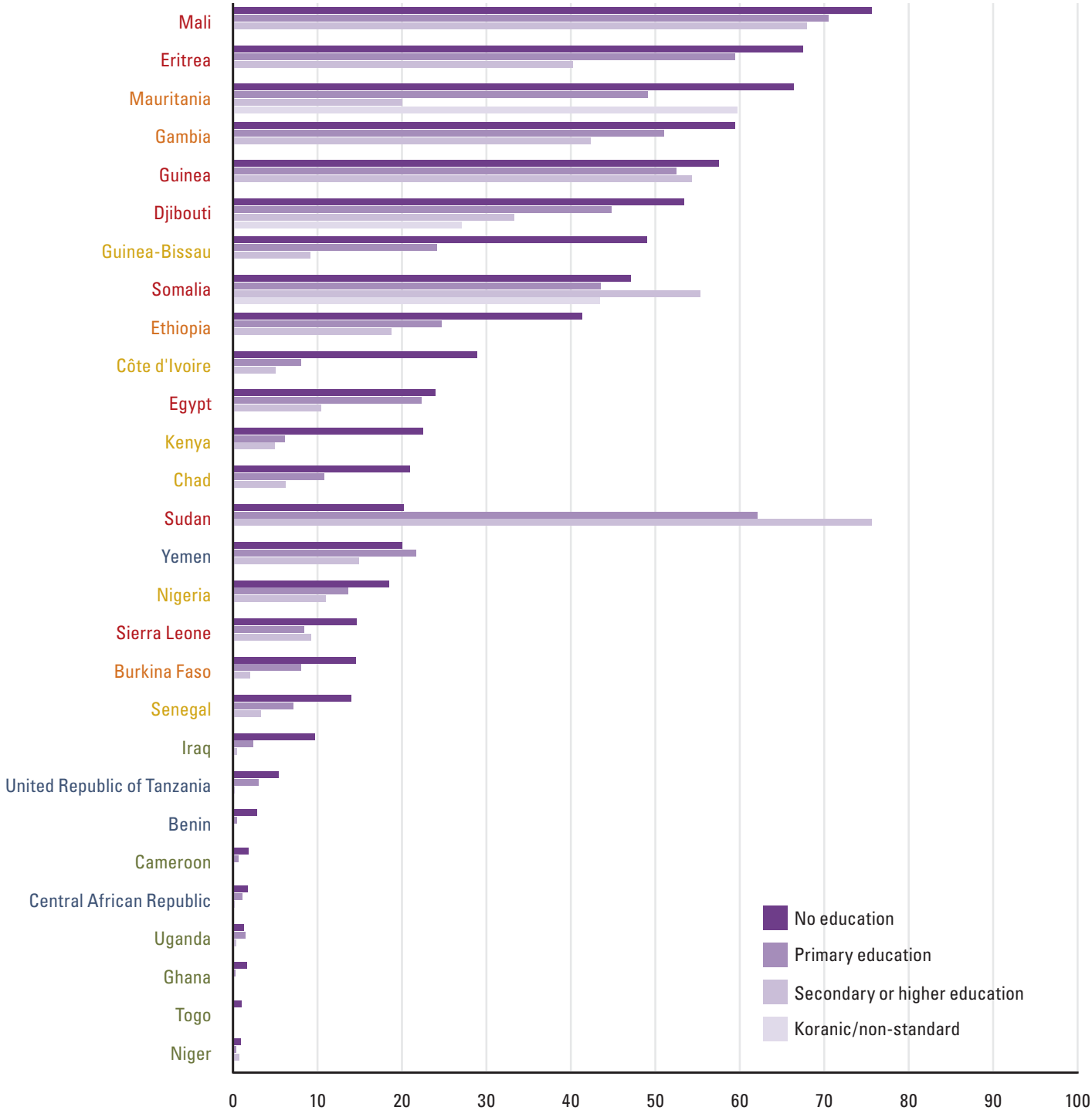


Notes: Data for Egypt refer to all daughters aged 0 to 14 who have undergone FGM/C. Data for Senegal refer to all daughters aged 0 to 9 who have undergone FGM/C. Data for Iraq refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone, Sudan, Togo and Uganda refer to all daughters aged 0 to 14 who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. For further details on the estimates presented in this figure, see endnote 79. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 1997–2011.

Figure 4.8 Daughters of uneducated mothers are significantly more likely to have undergone FGM/C, with the exception of Sudan and Somalia

Percentage of girls who have undergone FGM/C (as reported by their mothers), by mothers' level of education



Notes: Data from Egypt refer to all daughters aged 0 to 14 who have undergone FGM/C. Data for Senegal refer to all daughters aged 0 to 9 who have undergone FGM/C. Data for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data from Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone, Sudan, Togo and Uganda refer to all daughters aged 0 to 14 who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. For further details on the estimates presented in this figure, see endnote 79. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 1997–2011.

5. When and how is FGM/C performed?

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A large body of literature has documented the variations on when and what type of FGM/C is practised in different countries and population groups. Surveys have collected information on the type of FGM/C performed, the practitioner who carried it out and the age at which it occurred. What do the data tell us about the circumstances surrounding the practice?

FGM/C practitioners

Nearly all surveys with FGM/C modules have collected information on who performed the procedure.[91] In the surveys, cutters are classified as either traditional practitioners (traditional circumcisers, traditional birth attendants and, generally, older women) or health personnel (doctors, nurses, trained midwives or other trained health workers). The involvement of medical personnel in FGM/C is obviously more likely in countries or areas within countries with health-care coverage. One can also probably assume that families that rely on medical personnel to perform the

Box 5.1 Measuring the health consequences of FGM/C

A large body of literature has documented the adverse health consequences of FGM/C over both the short and long term. Immediate complications include bleeding, delayed or incomplete healing, and infections.[92] Long-term consequences are more difficult to attribute, but may include damage to adjacent organs, sterility, recurring urinary tract infections, the formation of dermoid cysts and even death.[93] Birth complications may also arise, leading to increased need for Caesarean sections and excessive bleeding during delivery.

For a number of years, the best available information on the frequency of health consequences attributable to FGM/C came from large-scale population-based surveys. Following in this vein, a number of early DHS asked women to report on health complications related to FGM/C. However, the ability to make inferences from women's self-reports is limited by a number of factors. First, self-reported retrospective data suffer from selection bias since they include only women who survived FGM/C. Additionally, since a number of women may have undergone the procedure in early childhood or infancy, it may be impossible to remember any details regarding the experience, including adverse health outcomes.[94] For this reason, a larger number of surveys added questions on the health consequences of FGM/C among daughters. Women were asked to report whether their daughters had experienced various consequences of FGM/C, including excessive bleeding, difficult urination, swelling or pain. Even though recall error and selection bias are minimized, interpretation of these data are still problematic: Women are asked to determine whether FGM/C is the cause of certain conditions, some of which may arise from other factors,[95] or women may not associate those conditions with FGM/C and attribute them to other causes.

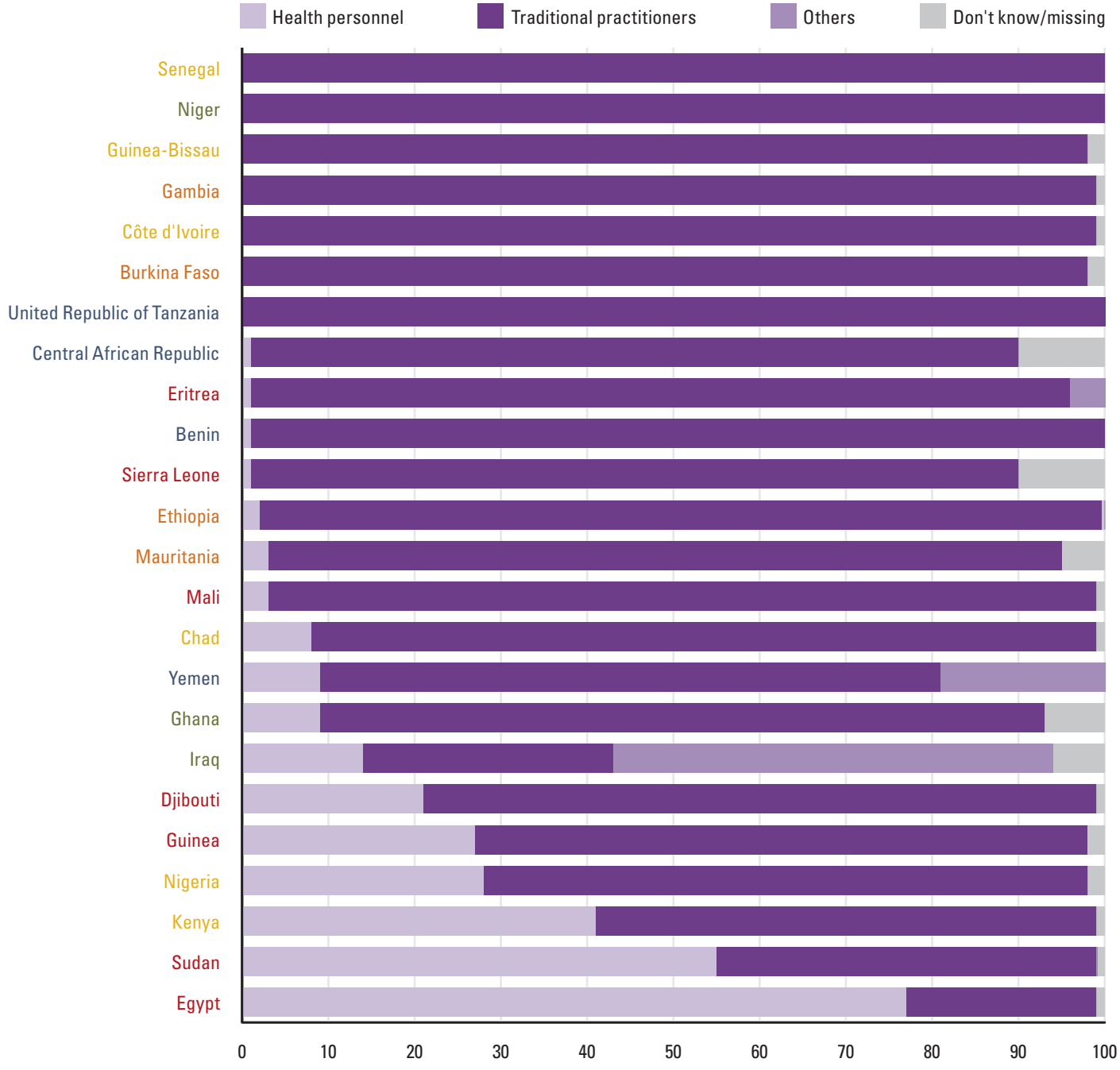
In groups where FGM/C prevalence is high, certain consequences that are common may be considered 'normal' and not associated with the practice. Additionally, ambiguity is introduced when women are asked to determine which conditions are abnormal or excessive.[96] For instance, Hanny Lightfoot-Klein interviewed a woman who reported that it took up to 15 minutes to empty her bladder and considered this condition normal.[97] In a community where everyone is infibulated, this may not be perceived and reported as 'difficult urination'. For all of these reasons, it has become increasingly accepted that women's reports are not a good method for obtaining reliable data on all the health risks attributable to FGM/C. A number of hospital-based[98] and epidemiological studies[99] have been developed to provide a clearer picture of the health dimensions of this harmful practice.

procedure do so in the belief that some of the health risks associated with the practice can be avoided *(see Box 5.1)*.

Figure 5.1 shows the percentage of girls who have undergone FGM/C by the person who carried it out, according to the most recent surveys. In the majority of countries, FGM/C is usually performed by traditional practitioners and, more specifically, by traditional circumcisers. In some countries, such as Egypt, Sudan and Kenya, however, a substantial number of health-care providers perform the procedure. This phenomenon is most acute in Egypt, where mothers report that in three out of four cases (77 per cent), FGM/C was performed on their daughters by a trained medical professional. In Egypt, this is most often a doctor, the only country where this holds true. In most countries where medical personnel play a significant role in performing FGM/C, nurses, midwives or other trained health personnel carry out the procedure *(see Figure 5.2)*.

Figure 5.1 In nearly all countries surveyed, traditional practitioners perform most cases of FGM/C

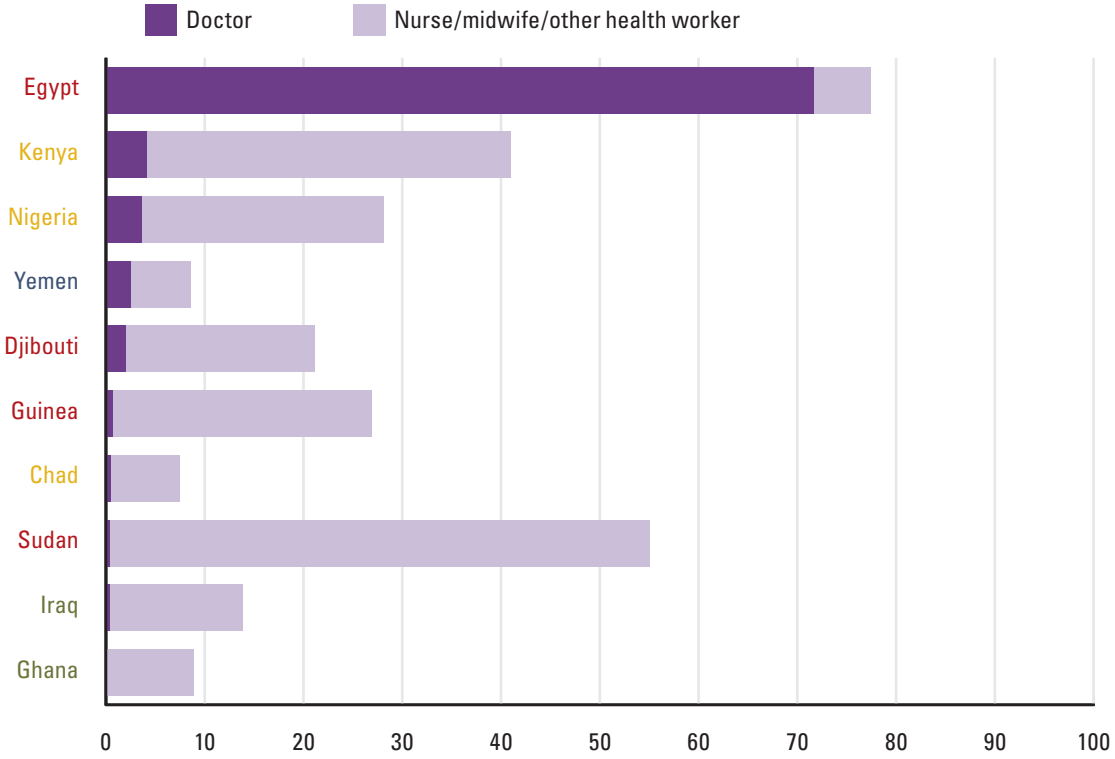
Percentage distribution of girls who have undergone FGM/C (as reported by their mothers), according to the type of person/practitioner performing the procedure



Notes: 'Health personnel' include doctors, nurses, midwives and other health workers. 'Traditional practitioners' include traditional circumcisers, traditional birth attendants, traditional midwives and other types of traditional practitioners. In Egypt, traditional practitioners also include *dayas, ghagarias* and *barbers*. In Yemen, traditional practitioners also include *dayas* and *barbers*, and 'others' reflects the combined categories of 'other' and 'grandmother/relative'. Data for Egypt refer to all daughters aged 0 to 17 who have undergone FGM/C. For Iraq, 'other traditional practitioners' reflects the category 'traditional (unlicensed) birth attendant/grandmother' and 'others' reflects the combined categories of 'other' and 'relative/friend'. Data for Senegal refer to all daughters aged 0 to 9 who have undergone FGM/C. Data for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone and Sudan refer to all daughters aged 0 to 14 who have undergone the procedure. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Cameroon and Togo are not presented since they are based on less than 25 unweighted cases. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997–2011.

Figure 5.2 In Egypt, doctors, as opposed to other health personnel, undertake most FGM/C procedures

Among girls who have undergone FGM/C (as reported by their mothers), percentage who have been cut, by the type of health personnel performing the procedure



Notes: This figure includes only countries where at least 5 per cent of daughters are cut by a health professional. Data for Egypt refer to all girls aged 0 to 17 who have undergone FGM/C. Data for Nigeria and Sudan refer to all girls aged 0 to 14 who have undergone FGM/C. Data for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Due to rounding, the data presented in this graph are slightly different from the numbers that appear in Figure 5.1. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997-2011.

Settings for the procedure and materials used

A few older surveys asked mothers about other aspects of the procedure performed on their daughters, such as the site where the cutting took place, the instrument used and whether some sort of anaesthetic was administered. With regard to the site, most mothers reported that their daughters were cut at home *(see Table 5.1)*. In Egypt, about a third of the procedures took place at a doctor's office, hospital or clinic. However, a comparison of this figure with the proportion of daughters cut by medical personnel (61 per cent in 2000) indicates that around half of the procedures for which medical personnel were responsible took place outside a clinical setting, more specifically in the home. In most cases, a blade or razor was used for cutting in Egypt, and one in four daughters underwent the procedure without an anaesthetic of any kind. It is plausible to expect this proportion to be much higher in countries where the practice is mostly performed by traditional circumcisers rather than medical personnel.

Type of FGM/C performed

Table 5.2 shows the different types of FGM/C performed among daughters.[100] Across a majority of countries for which data are available, mothers report that most daughters have had their genitalia cut, with some flesh removed. More than one in five daughters have undergone the most invasive form of FGM/C (involving the sewing of genitalia) in Somalia, Eritrea, Niger, Djibouti and Senegal. In at least 10 per cent of cases in Sierra Leone, Mauritania and Mali, the type of

Table 5.1 Most cases of FGM/C are performed at home using a blade or razor

Percentage distribution of girls who have undergone FGM/C (as reported by their mothers), according to the site where the procedure was performed, the tools used and the anaesthetic administered, if any

	Egypt	Kenya	Yemen
Site of procedure			
At home	65	46	97
Private doctor's office/clinic	28	N/A	3
Government hospital/clinic	5	N/A	N/A
Relative's house/neighbour's house	2	18	N/A
Barber's kiosk	0	N/A	N/A
Practitioner's home	N/A	26	N/A
Other	N/A	9	N/A
Don't know/missing	0	2	0.1
Instrument used			
Blade/razor	40	74	75
Scalpel	39	7	1
Scissors	5	N/A	21
Don't know/missing	16	9	3
Other	N/A	3	0.3
Knife	N/A	8	N/A
Anaesthetic used			
Local	60	N/A	N/A
General	13	N/A	N/A
Without	25	N/A	N/A
Don't know/missing	2	N/A	N/A

Notes: N/A = not available. Data for Egypt refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C; data on site of procedure are from the 2000 DHS; data on instrument and anaesthetic used are from the 1995 DHS. Data for Kenya refer to the eldest daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, 1995-2000.

FGM/C experienced by daughters could not be identified, which may be explained by the existence of forms not captured by the response categories used in the questionnaire *(see Box 5.2)*.

Data for daughters also show that the type of procedure performed is linked to ethnicity. In Eritrea, for instance, all Hedarib daughters were sewn closed, compared to 2 per cent of Tigrigna daughters *(see Table 5.3)*.

Age at cutting

Data on the age at which FGM/C is performed are helpful in understanding when girls are most at risk of being cut. The DHS and MICS routinely collect information on age at cutting for girls and women being interviewed, as well as for their daughters.[101] As is the case with all questions regarding the circumstances surrounding FGM/C, recall

Table 5.2 Most girls who have undergone FGM/C have had their genitalia cut, with some flesh removed

Percentage distribution of girls who have undergone FGM/C (as reported by their mothers), by type

Country	Type of FGM/C			
	Cut, no flesh removed/nicked	Cut, flesh removed	Sewn closed	Type not determined/ not sure/doesn't know
Benin	2	95	2	1
Burkina Faso	N/A	N/A	1	N/A
Central African Republic	24	61	6	9
Chad	9	81	8	2
Côte d'Ivoire	7	82	6	5
Djibouti	15	53	30	3
Egypt	N/A	N/A	2	1
Eritrea	52	6	38	4
Ethiopia	N/A	N/A	4	N/A
Gambia	0	86	12	1
Ghana	8	68	17	7
Guinea	2	85	10	2
Guinea-Bissau	0	88	10	2
Kenya	3	79	17	1
Mali	16	71	3	11
Mauritania	6	80	N/A	14
Niger	0	63	35	2
Nigeria	16	69	6	9
Senegal	N/A	N/A	21	N/A
Sierra Leone	1	70	12	17
Somalia	5	25	63	7
United Republic of Tanzania	1	98	2	N/A

Notes: N/A = not available. Data for Senegal refer to all daughters aged 0 to 9 who have undergone FGM/C. Data for Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria and Sierra Leone refer to all daughters aged 0 to 14 who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. In surveys in Burkina Faso, Egypt, Ethiopia and Senegal, questions only differentiated infibulation from non-infibulating forms of FGM/C. Information on type was not asked in more recent surveys in Egypt (2000, 2003, 2005 and 2008). Data for Cameroon and Togo are not presented since they are based on less than 25 unweighted cases. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 1995-2011.

bias as well as accurate reporting of age is a potential problem *(see Box 5.3)*.

Figure 5.3 shows the percentage distribution of cut daughters grouped according to the age at cutting. The ages at which large proportions of girls experience FGM/C vary substantially across countries. At least 80 per cent of cut girls in Somalia, Egypt, Chad and the Central African Republic had the procedure performed when they were between the ages of 5 and 14, while in countries such as Nigeria, Mali, Eritrea, Ghana and Mauritania, more than 80 per cent of cut girls experienced FGM/C before their fifth birthday. In Guinea-Bissau, about 18 per cent of cut girls underwent FGM/C after age 15, while in Kenya, 46 per cent were not cut until after age 9. Overall, similar age patterns can be observed among girls aged 15 to 19 *(see Statistical tables)*.

Box 5.2 Survey tactics used to collect information on the type of FGM/C performed

Questions in MICS and DHS regarding the type of cutting performed have been asked in various ways. Many DHS from several years ago classified FGM/C using the categories of *clitoridectomy, excision* and *infibulation*. However, these categories did not always correspond to local terminology used to describe types of cutting, and made it difficult for respondents to make a clear distinction among them. In light of this problem, the 1998 DHS for Niger asked respondents to name the practice in their own language, and used a local specialist to regroup them into the commonly used categories of *clitoridectomy, excision, infibulation* and *other*. The validity of this approach is not clear, however, and its use resulted in more than 50 different terms mentioned by respondents to describe the practice. Other challenges in data collection result from difficulties in establishing how clearly survey respondents understood the questions referring to the main types of FGM/C. Studies of the correspondence between self-reported types of FGM/C and clinically observed types also find varying levels of disagreement, with more frequent under-reporting than over-reporting on the extent of cutting.[102]

In the most recent MICS and DHS, types of FGM/C are classified into four main categories: 1) *cut, no flesh removed*, 2) *cut, some flesh removed*, 3) *sewn closed*, and 4) *type not determined/not sure/doesn't know*. These categories do not fully match the WHO typology. *Cut, no flesh removed* describes a practice known as nicking or pricking, which currently is categorized as Type IV. *Cut, some flesh removed* corresponds to Type I (clitoridectomy) and Type II (excision) combined. And *sewn closed* corresponds to Type III, infibulation.

Table 5.3 The type of FGM/C performed is linked to ethnicity

Percentage distribution of girls who have undergone FGM/C (as reported by their mothers) in Eritrea, by type and ethnicity

Ethnic group	Cut, no flesh removed/nicked	Cut, flesh removed	Sewn closed	Type not determined/ not sure/doesn't know
Afar	3	0.3	96	0.4
Bilen	10	2	88	1
Hedarib	0	0	100	0
Kunama	63	6	31	0
Nara	2	5	92	1
Saho	11	3	83	2
Tigre	20	5	75	1
Tigrigna	83	8	2	7

Notes: Only ethnic groups with a total of 25 or more unweighted cases of cut girls are presented in this table. Due to rounding, the data presented in this figure may not add up to 100 per cent.
Source: DHS 2002.

Box 5.3 Challenges in accurately reporting on age at cutting

In most surveys, girls and women are asked about their own age at cutting and that of their daughters (if any). While the responses help us better understand the practice, caution must be taken in their interpretation.

Among women, data on age at cutting are likely to be imprecise, since recall bias can be presumed to affect responses from girls and women who underwent FGM/C when they were very young. This is particularly true among women in the oldest age cohort (45-49), due to the length of time between the event itself and the survey interview.

Accuracy is also a challenge: Ages ending in zero or five (for example, 5, 10, 15) have been found to be overrepresented. Data on daughters (as reported by their mothers) are likely to be more accurate than self-reporting, although the risk of recall bias and difficulties related to age determination are still relevant. Moreover, while girls and women aged 15 to 49 are presumed to be past the age of cutting, data on daughters are, to varying degrees, censored – meaning that some girls who are currently uncut will be cut in the future. Censoring introduces a bias towards earlier ages in the distribution of age at cutting, type of procedure and practitioner, since girls who are cut at a younger age tend to be overrepresented in the sample of daughters who have undergone the practice. This is particularly true when data on girls aged 0 to 14 are used to look at the circumstances surrounding the practice.

To mitigate the effects of recall bias and censoring, it is preferable to use data on women in the youngest age cohort (15-19) or data on the proportion of girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Compared to data collected only on daughters aged 0 to 14, information obtained by asking mothers about the FGM/C status of the last daughter cut is based on a wider sample of girls of all ages and is therefore less likely to be affected by censoring.

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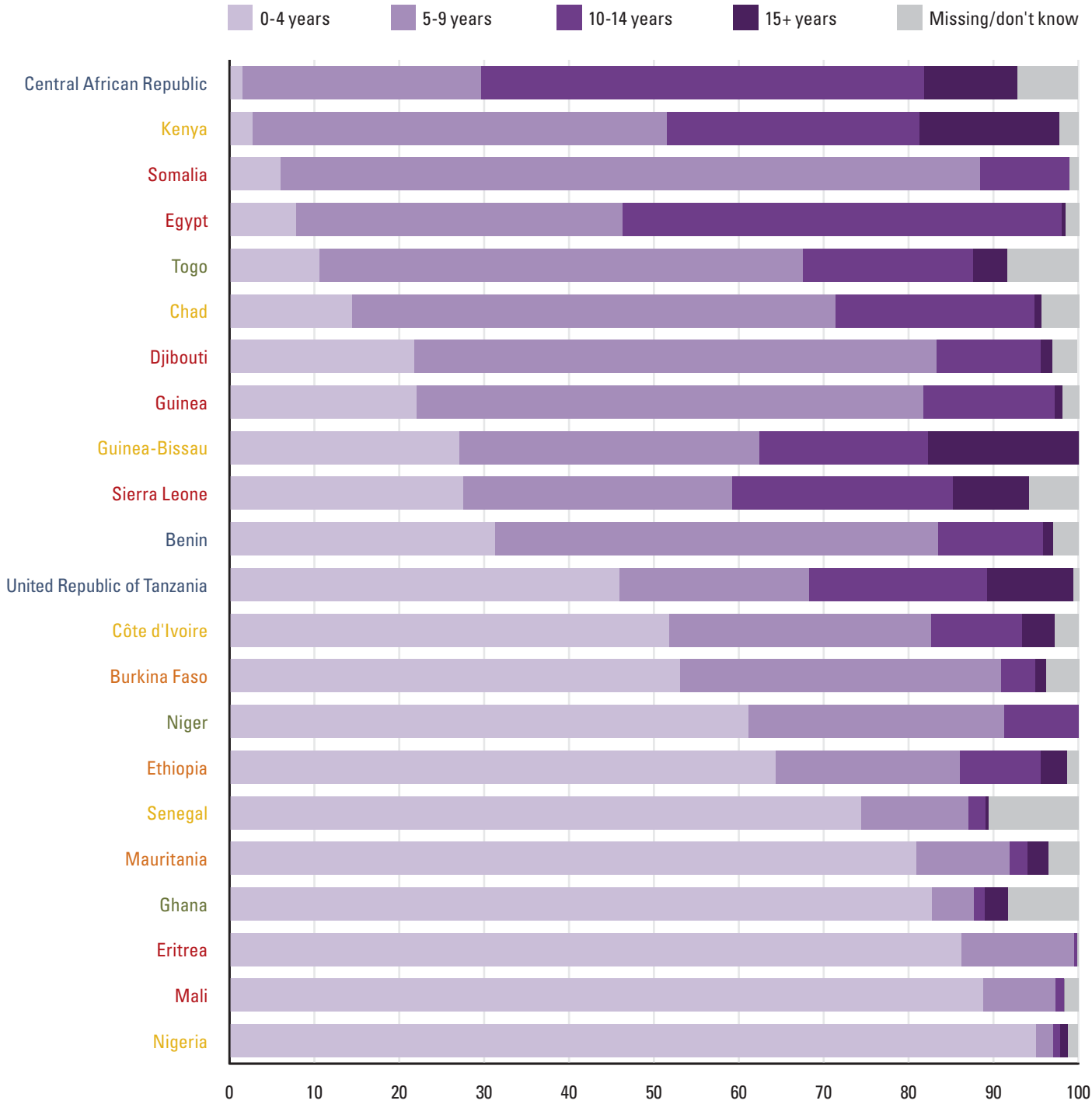
Mona Omar, a social worker, holds an FGM/C-awareness poster at a meeting of the UNICEF-assisted Better Life Association for Comprehensive Development in the village of Al Shorafa in Minya Governorate in Upper Egypt. The drawing depicts a girl crying as her mother forces her into a medical clinic to have the procedure performed, although the doctor also appears opposed to the practice. The text above reads, "From a medical perspective… cutting girls is most harmful." The poster was created by the National Campaign for Combating FGM, in collaboration with United Nations agencies. UNICEF supports advocacy on the dangers of FGM/C at health-care facilities and among local NGOs and other civil society groups across the country.

Figure 5.3 In half of the countries with available data, the majority of girls were cut before age 5

Percentage distribution of girls who have undergone FGM/C (as reported by their mothers), by age at which cutting occurred



Notes: Data for Cameroon are not presented since they are based on less than 25 unweighted cases. Data for Ghana and Togo are based on 25-49 unweighted cases. Data for Egypt refer to girls aged 0 to 17. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Burkina Faso, Central African Republic, Ghana, Mauritania, Nigeria, Senegal, Sierra Leone and Togo are from earlier surveys which collected data on the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C (for additional details on the choice of this indicator, see Box 5.3 on page 49). Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2000-2010.

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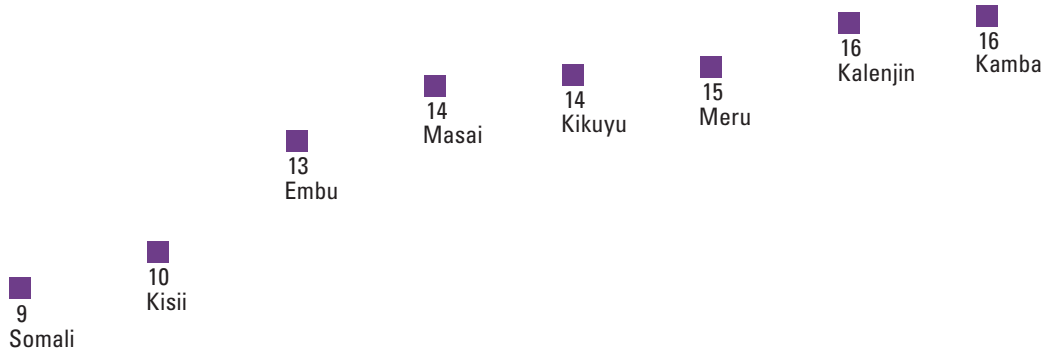
Asiya Abud, 22 years old and pregnant with her fifth child, poses for a photograph in the home she lives in with 20 other people in Amibara district, Afar region, Ethiopia. UNICEF and partners have been working throughout the district to educate communities and encourage dialogue to end FGM/C, which can often lead to dangerous health conditions during pregnancy.

Important differences in age at cutting are also found among ethnic groups living in the same country. For instance, data from Kenya show that the mean age at cutting among girls and women aged 15 to 49 ranges from 9 years among the Somali to 16 years among the Kamba and Kalenjin *(see Figure 5.4)*. In Guinea, 6 per cent of daughters from the Toma population were cut before age 5, compared to 39 per cent of daughters of Malinke background *(results not shown)*.

Figure 5.4 In Kenya, mean age at cutting ranges from about 9 to 16 years among various ethnic groups

Mean age at cutting among girls and women aged 15 to 49 years in Kenya, by ethnicity



Note: Only ethnic groups with a total of 25 or more unweighted cases of cut girls and women whose age at FGM/C is known are presented in this chart.
Source: DHS 2008-2009.

6. What are the prevailing attitudes towards FGM/C?

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In countries where FGM/C is concentrated, the attitudes of practising and non-practising populations can be leveraged to promote its elimination. To do so, it is essential to explore what people think about the practice. Does support vary across groups with different social and economic backgrounds? Do women and men share the same opinions? What are the perceived benefits of FGM/C and the reasons why women and men believe it should continue?

What girls and women think

Girls' and women's attitudes about FGM/C vary widely across countries (*see Figure 6.1*). The highest levels of support can be found in Mali, Guinea, Sierra Leone, Somalia,[103] Gambia and Egypt, where more than half the female population think the practice should continue. However, in most countries where FGM/C is concentrated (19 out of 29), the majority of girls and women think it should end. The data also show that between 1 per cent and 26 per cent of girls and women surveyed have mixed feelings on the subject, do not have a strong opinion or prefer not to express what they think. It bears repeating that information on FGM/C re-

Box 6.1 Measuring support for FGM/C

Since 1989, MICS and DHS modules on FGM/C have included questions on whether or not the practice should continue. The most recent surveys posed questions such as *Do you think this practice should continue?* or *Should it be discontinued?*, followed by pre-coded responses, including *continued, discontinued* and ambivalent responses, such as *it depends* or *not sure.* As in other survey topics, the way in which the questions have been asked has evolved over time. Earlier surveys included a larger set of attitudinal questions, inquiring not only whether the practice should continue but also the reasons behind a respondent's stated opinion, whether that opinion had changed, and views on perceived benefits or inconveniences of the practice.

Answers to questions capture a respondent's opinion at one point in time and in the context of responding to a formal survey. Among those who say they favour the discontinuation of FGM/C, it is possible that, with intense exposure to campaign messages against the practice, they may be reporting what they perceive to be the 'correct' answer, rather than their true opinion. Moreover, even a truthful response at one point in time fails to take into account that a person's opinion may shift as he or she is exposed to new information about the practice, or to the opinions of others. For instance, in writing about Senegal and the Gambia, Hernlund and Shell-Duncan emphasize that "there is a broad range of realities inhabited by those who participate in FGC in this region – ranging from strong support to strong opposition, but with the potential movement over time by an individual or even community from one category to another, and potentially back again."[104] They add that "the construction of a person's 'opinion' about the practice is more correctly an ongoing positioning vis-à-vis fluctuating needs and realities, representing contingencies that affect decision-making."[105]

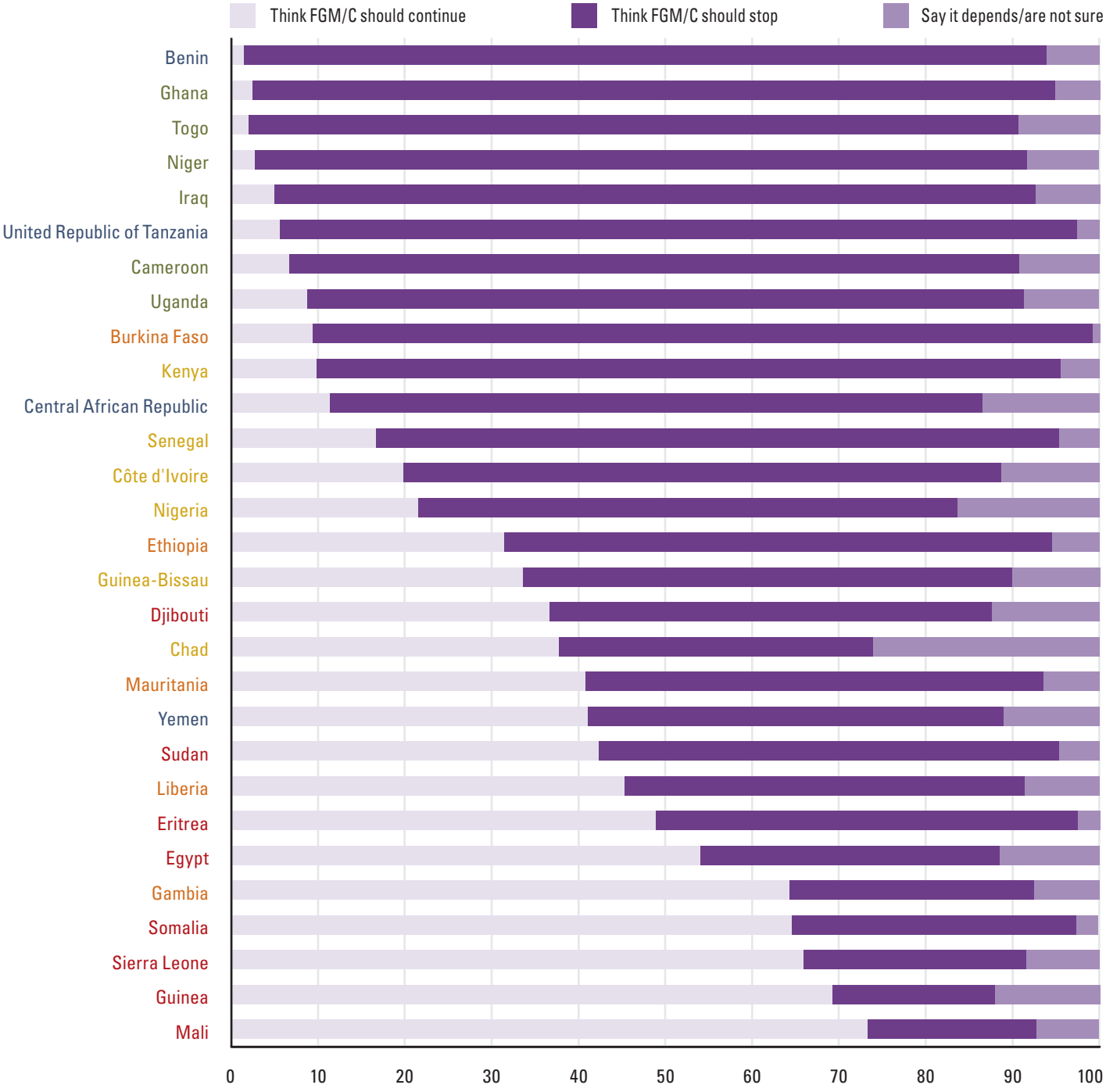
flects the reality at the time of data collection *(see Box 6.1)*. This is particularly relevant when data on attitudes are presented, as opinions may have changed since respondents stated their views.

Figure 6.2 contrasts national FGM/C prevalence among girls and women aged 15 to 49 with the percentage who favour the continuation of the practice. This comparison is meant to shed light on whether attitudes vary depending on how common FGM/C is in a particular society. As might be expected, a majority of girls and women think the practice should continue in a number of countries with high FGM/C prevalence, including Mali, Guinea, Sierra Leone, Somalia, Gambia and Egypt. However, in almost all countries, the percentage of girls and women who support the practice is substantially lower than the percentage of girls and women who have been cut, even in countries where FGM/C is universal. This discrepancy is most extreme in Burkina Faso, where 76 per cent of girls and women have been cut, but only 9 per cent favour the continuation of FGM/C. Large differences in prevalence and support are also found in Djibouti, Sudan, Ethiopia, Eritrea, Egypt and Somalia. On the other hand, in countries such as Yemen, Uganda and Cameroon, support for the continuation of FGM/C is actually higher than the prevalence, suggesting a tolerance for FGM/C among practising as well as non-practising women.

When comparing data by age groups (girls aged 15 to 19 versus women aged 45 to 49), stated opinions towards FGM/C are similar in almost half the countries with available data. However, when a difference is observed, a clear pattern emerges: With a few exceptions, more women in the older age cohort report that they want FGM/C to continue (*see Figure 6.3*). Strikingly large differences across cohorts are found in countries such as Egypt and Eritrea.

Figure 6.1 In most countries where FGM/C is practised, the majority of girls and women think it should end

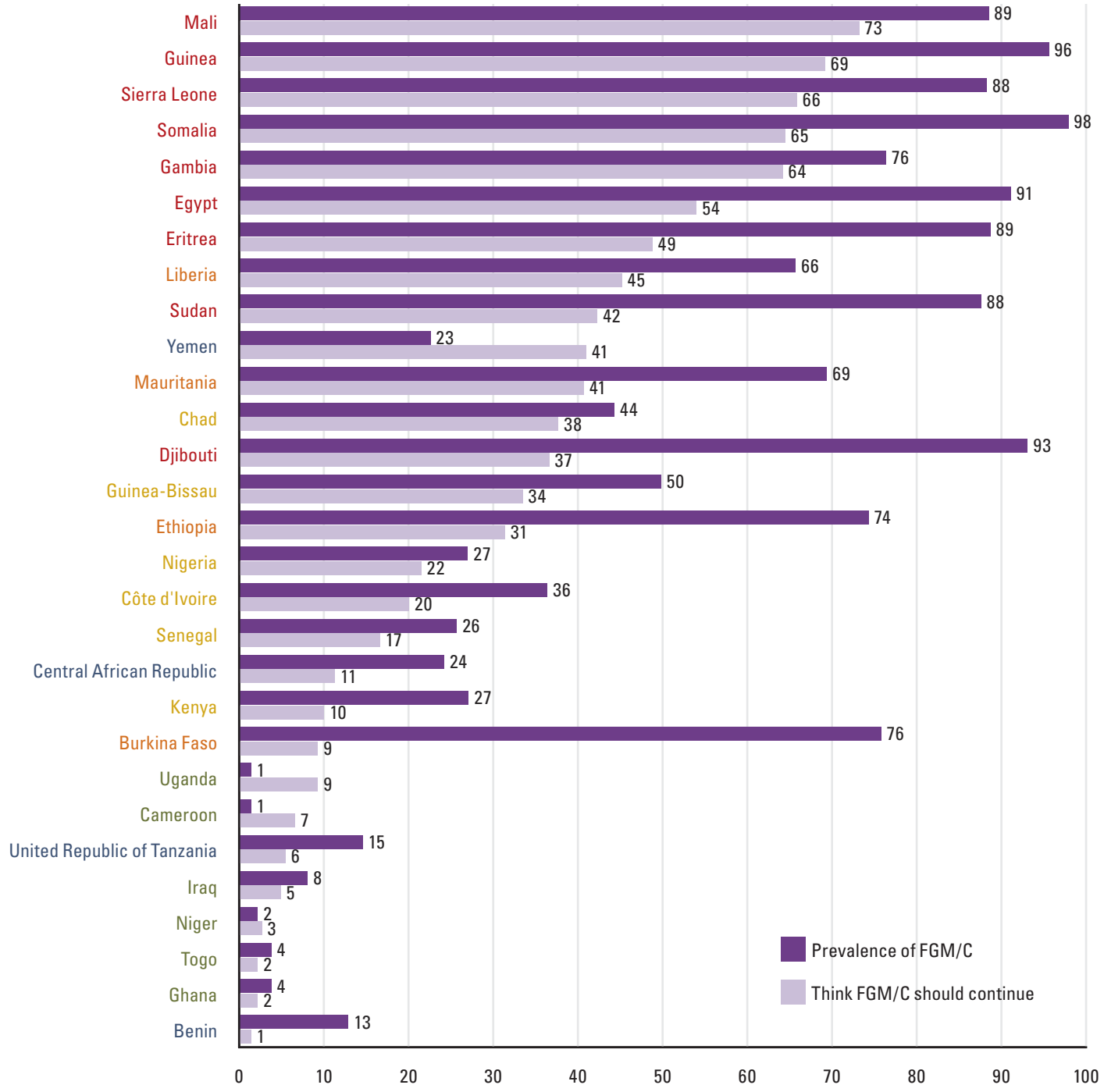
Percentage distribution of girls and women aged 15 to 49 years who have heard about FGM/C, by their attitudes about whether the practice should continue



Notes: The category of girls and women who are unsure or responded that 'it depends' also includes those for whom data are missing. In Liberia, only cut girls and women were asked about their attitudes towards FGM/C; since girls and women from practising communities are more likely to support the practice, the level of support in this country as captured by the 2007 DHS is higher than would be anticipated had all girls and women been asked their opinion. MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997-2011.

Figure 6.2 Even in countries where FGM/C is almost universal, the level of support among girls and women is lower than the prevalence level

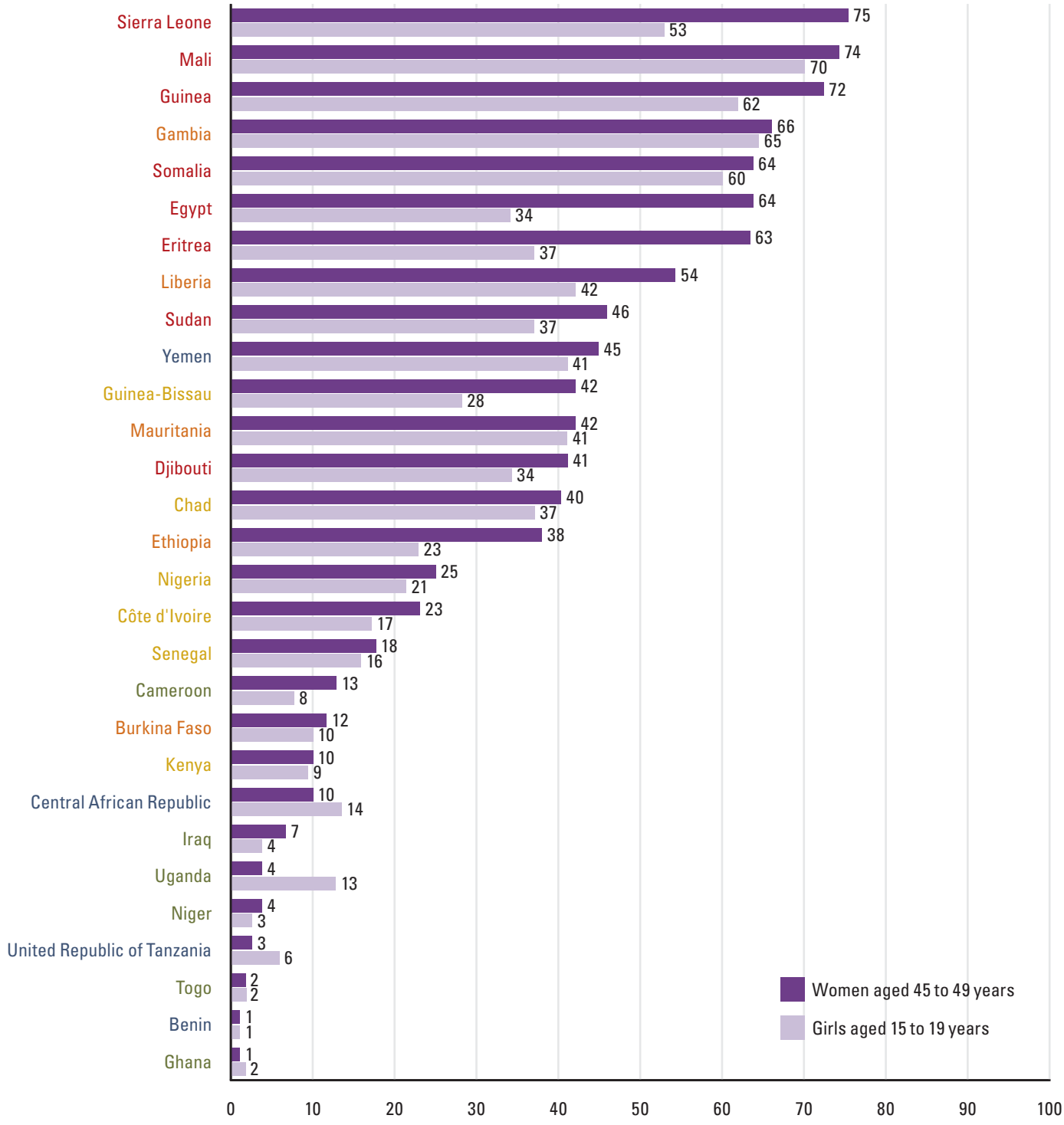
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C and percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue



Notes: In Liberia, only cut girls and women were asked about their attitudes towards FGM/C; since girls and women from practising communities are more likely to support the practice, the level of support in this country as captured by the 2007 DHS is higher than would be anticipated had all girls and women been asked their opinion. MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997-2011.

Figure 6.3 In Egypt and Eritrea, young girls are far less likely than older women to support the continuation of FGM/C

Percentage of girls aged 15 to 19 years and women aged 45 to 49 years who have heard about FGM/C and think the practice should continue



Notes: MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 1997-2011.

What boys and men think

Information on the attitudes of boys and men towards FGM/C is only available for 16 of the 29 countries where FGM/C is concentrated.[106] Moreover, this information has not always been collected in the latest surveys for which data on women's attitudes are available. This means that data on boys' and men's opinions of the practice are generally less up to date than data on girls and women, and may not reflect recent attitudinal changes.

The most recent data show that the level of support for the continuation of FGM/C among boys and men varies widely across countries (*see Figure 6.4*), as is the case for girls and women. In four countries with high FGM/C prevalence (Mauritania, Mali, Egypt and Guinea), the majority of boys and men report that they want FGM/C to continue. By contrast, in nine countries, the majority of them favour stopping the practice. While in most of these countries FGM/C prevalence is relatively low, the list also includes Burkina Faso and Sudan, where the practice is widespread.

When comparing data by age, strikingly large differences across cohorts are found in Egypt and Eritrea: In those countries, almost twice as many older men (aged 45 to 49) think the practice should continue compared to adolescent boys (aged 15 to 19) (*results not shown*). This is similar to the findings for girls and women in those countries, as shown in Figure 6.3. Large discrepancies between age groups are also found in Côte d'Ivoire, where 33 per cent of men aged 45 to 49 favour the continuation of the practice, compared to 14 per cent of boys aged 15 to 19.

The data also show that in the majority of countries, young boys are more likely to report that they don't know, are uncertain or it depends, when asked whether FGM/C should continue. The gap is particularly wide in Egypt, where 37 per cent of boys aged 15 to 19 are uncertain or say it depends, compared to 7 per cent of men aged 45 to 49, a pattern also observed among girls and women in that country (*results not shown*).

Variations by ethnicity and other socio-demographic characteristics

Given that FGM/C prevalence varies significantly along ethnic lines and to some degree according to other socio-demographic characteristics (as described in Chapter 4), it is reasonable to also expect a strong relationship between these variables and stated support for the continuation of the practice.

Ethnicity

Figure 6.5 shows the percentage of girls and women who support the continuation of FGM/C in ethnic groups with the lowest and highest degrees of support.[107] This comparison clearly illustrates that girls' and women's stated support for FGM/C varies widely among different ethnic groups in many countries, although the differences in support levels are not as large as the differences in prevalence levels.

The range of variation in support for FGM/C among boys and men in different ethnic groups is also quite large in a number of countries (*results not shown*). These findings suggest that, for both men and women, ethnicity serves as an important marker of groups who share normative expectations regarding the continuation of the practice.

Household wealth

Figure 6.6 shows support for the continuation of FGM/C among girls and women in the lowest and highest wealth quintiles.[108] The data show that in all countries, wealth is associated with relatively lower levels of support for the continuation of FGM/C, as predicted by modernization theory.

Support for the continuation of FGM/C among boys and men shows a similar pattern to that found among girls and women, although differentials in support between relatively wealthy and poorer males are much less pronounced than those found among females (*results not shown*).

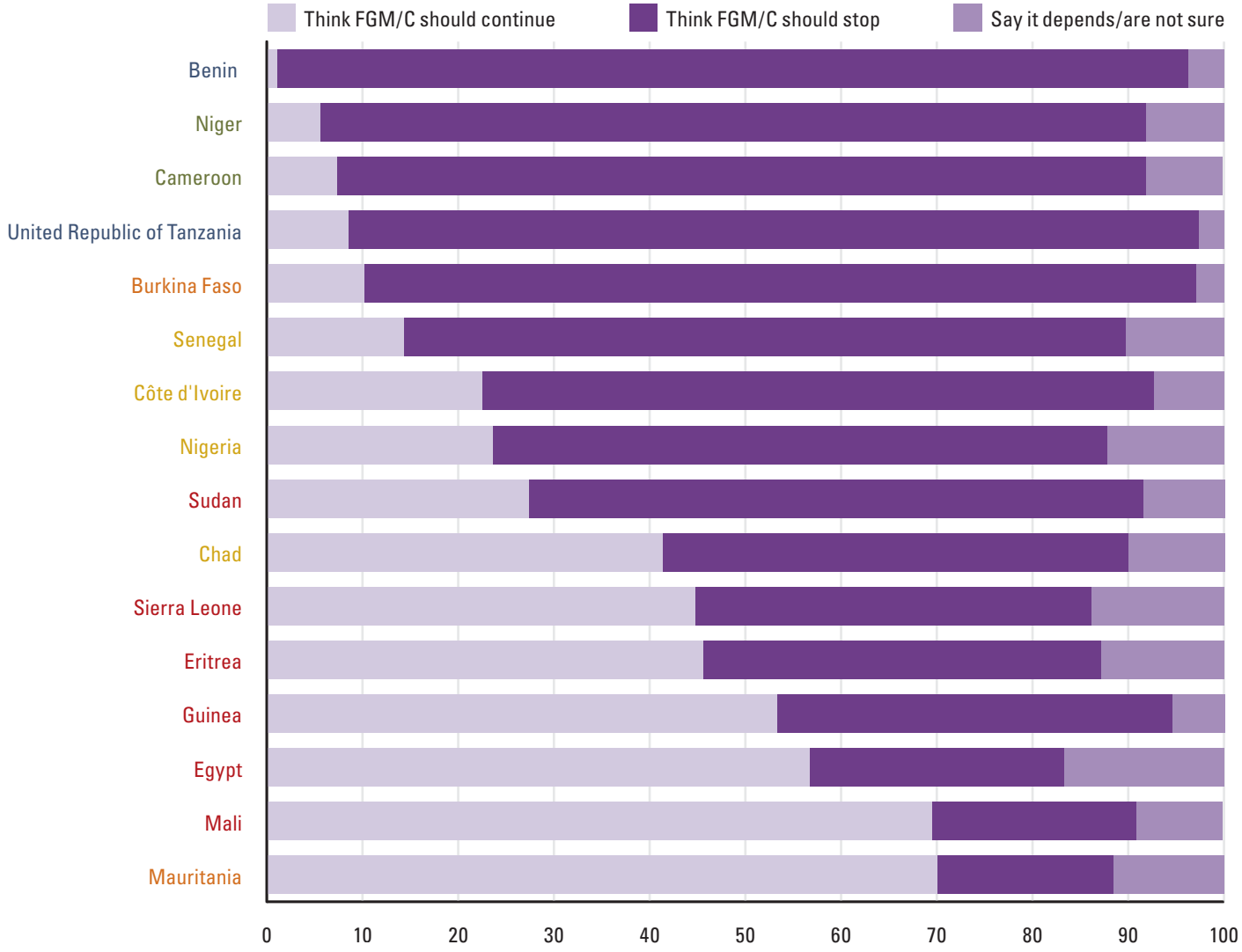
Education

In Figure 6.7, women's support for the continuation of FGM/C is disaggregated by their level of education. Support for the practice declines progressively with increased levels of education. Differences in support for FGM/C among women with no education versus women with secondary education were above 30 percentage points in eight countries: Eritrea, Sudan, Guinea-Bissau, Sierra Leone, Ethiopia, Kenya, Guinea and Mauritania.

Support for FGM/C among boys and men with varying degrees of education shows patterns similar to those found among girls and women (*results not shown*). Compared to men with secondary or higher education, men with no education are more likely to support the continuation of FGM/C, except in Niger and Nigeria. Moreover, because women and men who are more highly

Figure 6.4 In most countries, the majority of boys and men think FGM/C should end

Percentage distribution of boys and men aged 15 to 49 (or 59, see note) years who have heard about FGM/C, by their attitudes about whether the practice should continue



Notes: The category of boys and men who are unsure or responded that 'it depends' also includes those for whom data are missing. Data from Benin, Burkina Faso, Cameroon, Egypt, Sierra Leone, Sudan and the United Republic of Tanzania refer to boys and men aged 15 to 49. Data from all other countries refer to boys and men aged 15 to 59. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1995-2010.

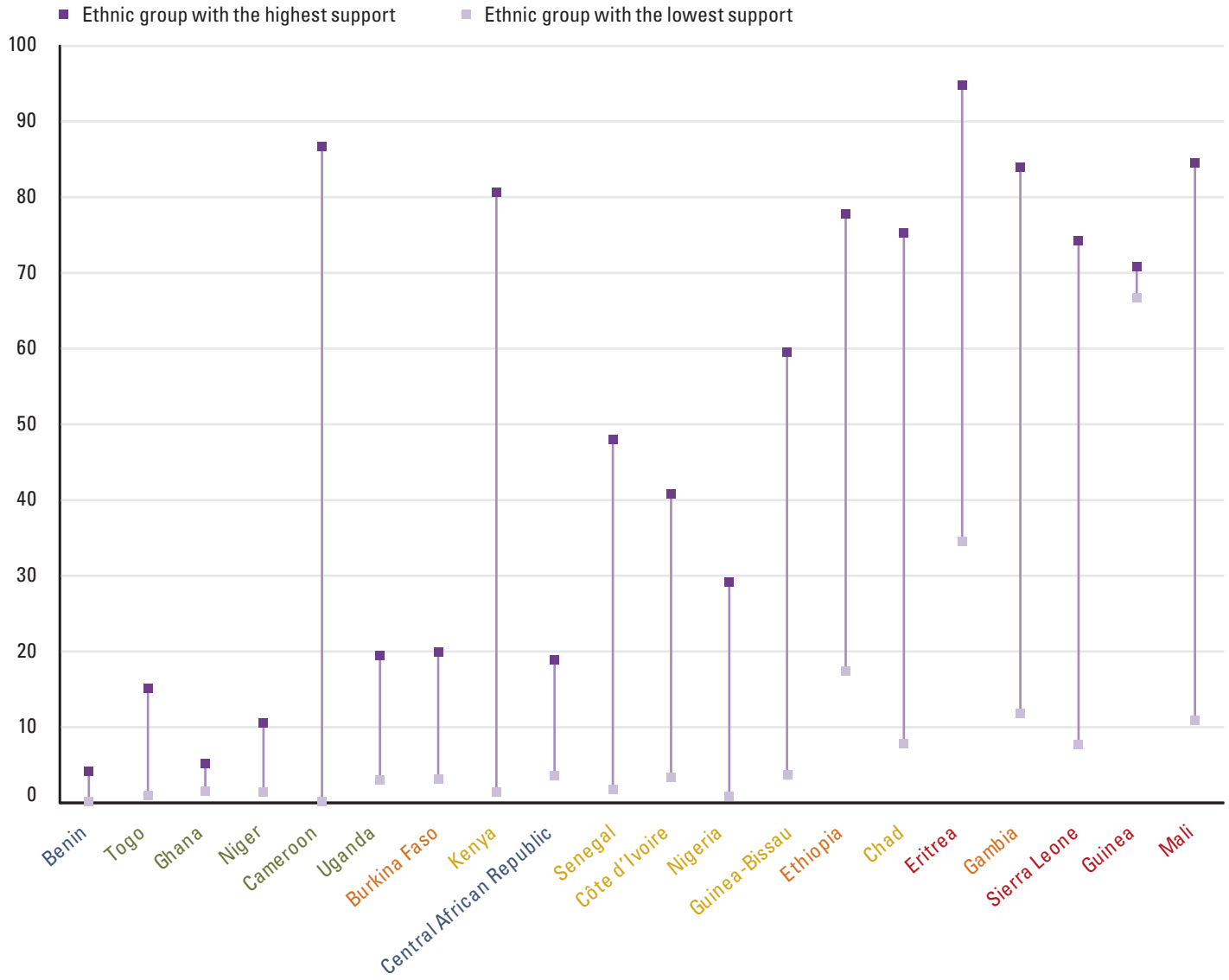
educated are likely to be younger, wealthier and live in urban areas, multivariate analyses can provide an enhanced understanding of the association between support for FGM/C and education.

Comparing attitudes between the sexes

Over the decades, some have viewed FGM/C as a manifestation of patriarchal oppression of women, which would suggest that men are ardent supporters of the practice. This appears not to be the case. Figure 6.8 compares the attitudes of males and females towards FGM/C, using data from the same surveys. In most countries analysed, a similar level of support for FGM/C is found among both women and men. In Guinea, Sierra Leone and Chad, substantially more

Figure 6.5 Support for FGM/C among girls and women varies widely among ethnic groups within the same country

Among girls and women aged 15 to 49 years who have heard of FGM/C, percentage who support the continuation of the practice in the two ethnic groups with the lowest and highest levels of support

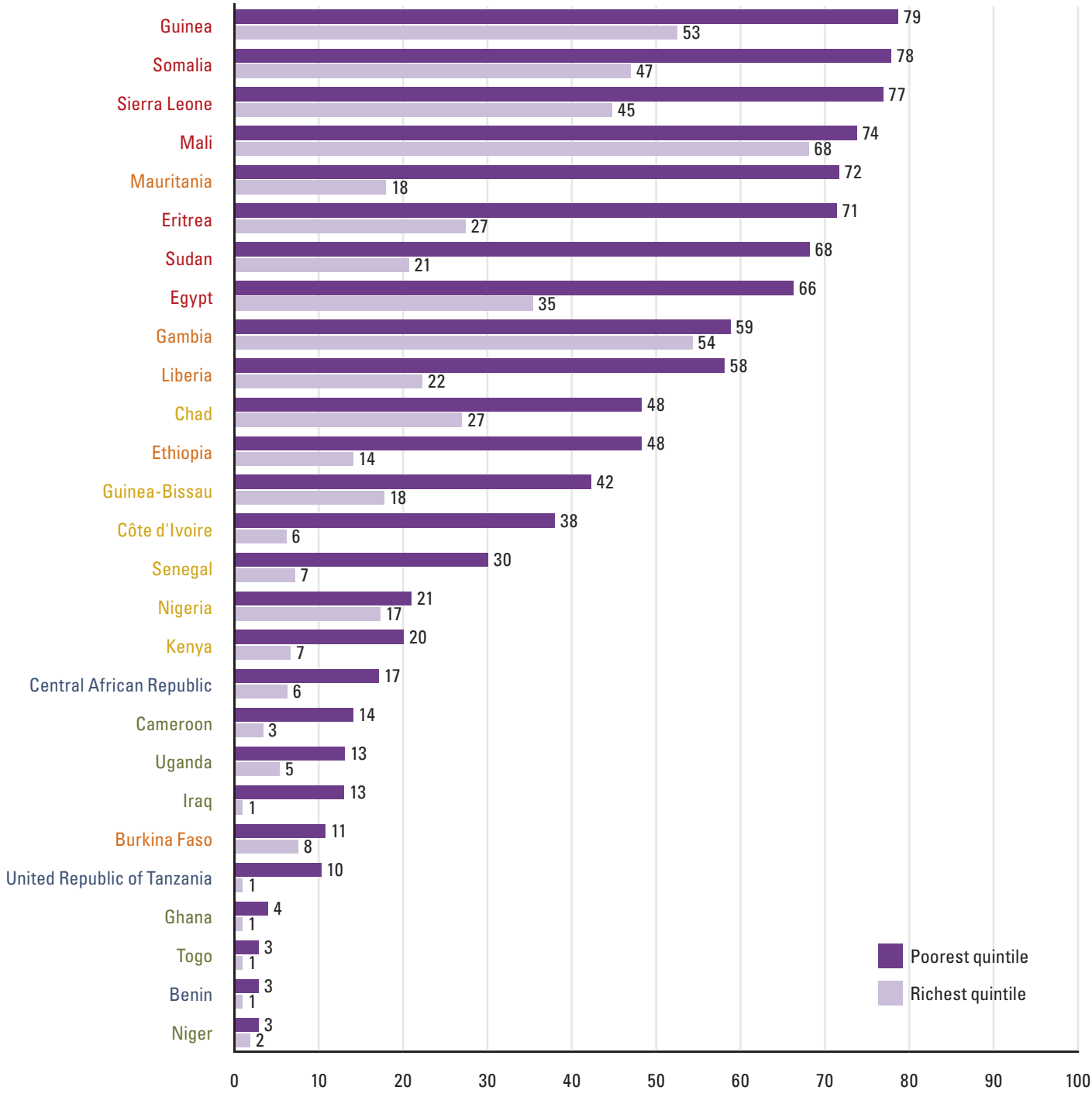


Notes: Only categories with 25 or more unweighted cases are presented. Data for Cameroon (ethnic group with the lowest support) are based on 25-49 unweighted cases. Data for Guinea-Bissau are from MICS 2006 since more recent ethnicity data are unavailable. MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2002-2011.

men than women want FGM/C to end, while in Egypt and Mauritania, more women than men report they would like the practice to stop. In Eritrea, important differences are found between the proportions of men and women who are uncertain about the continuation of FGM/C, with men being nearly three times less likely to express a firm opinion than their female counterparts. These findings point to the conclusion that men may, in certain contexts, be important agents of change. This suggests that discussions about FGM/C should involve not only women, but also entire communities, including men, particularly in settings where men participate in the decision-making process.

Figure 6.6 Support for FGM/C is stronger among girls and women in the poorest households than in the richest households

Among girls and women aged 15 to 49 years who have heard of FGM/C, percentage who support the continuation of the practice, by poorest and richest wealth quintiles

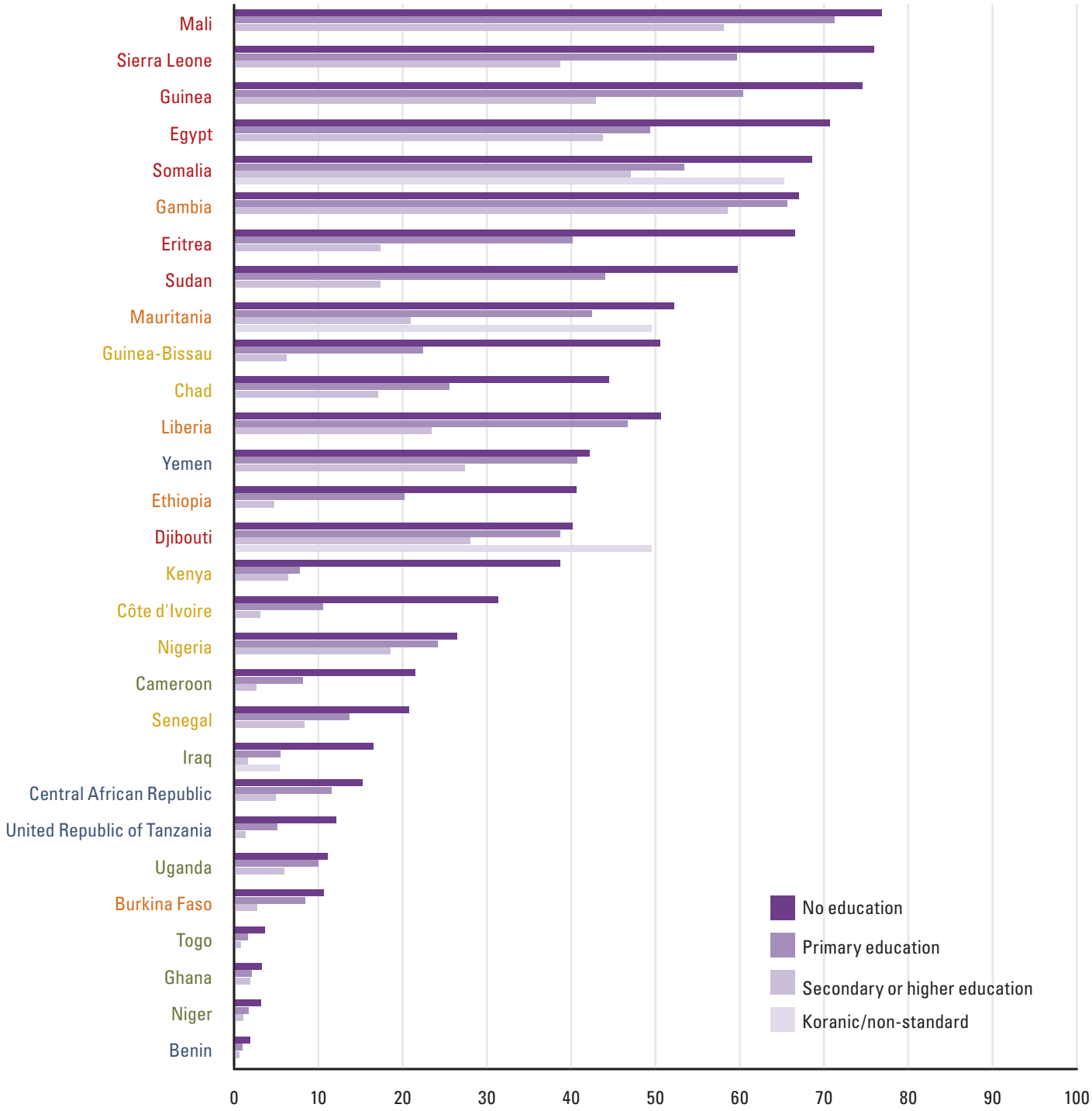


Notes: MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 2002-2011.

Figure 6.7 Girls and women with no education are substantially more likely to support the practice of FGM/C

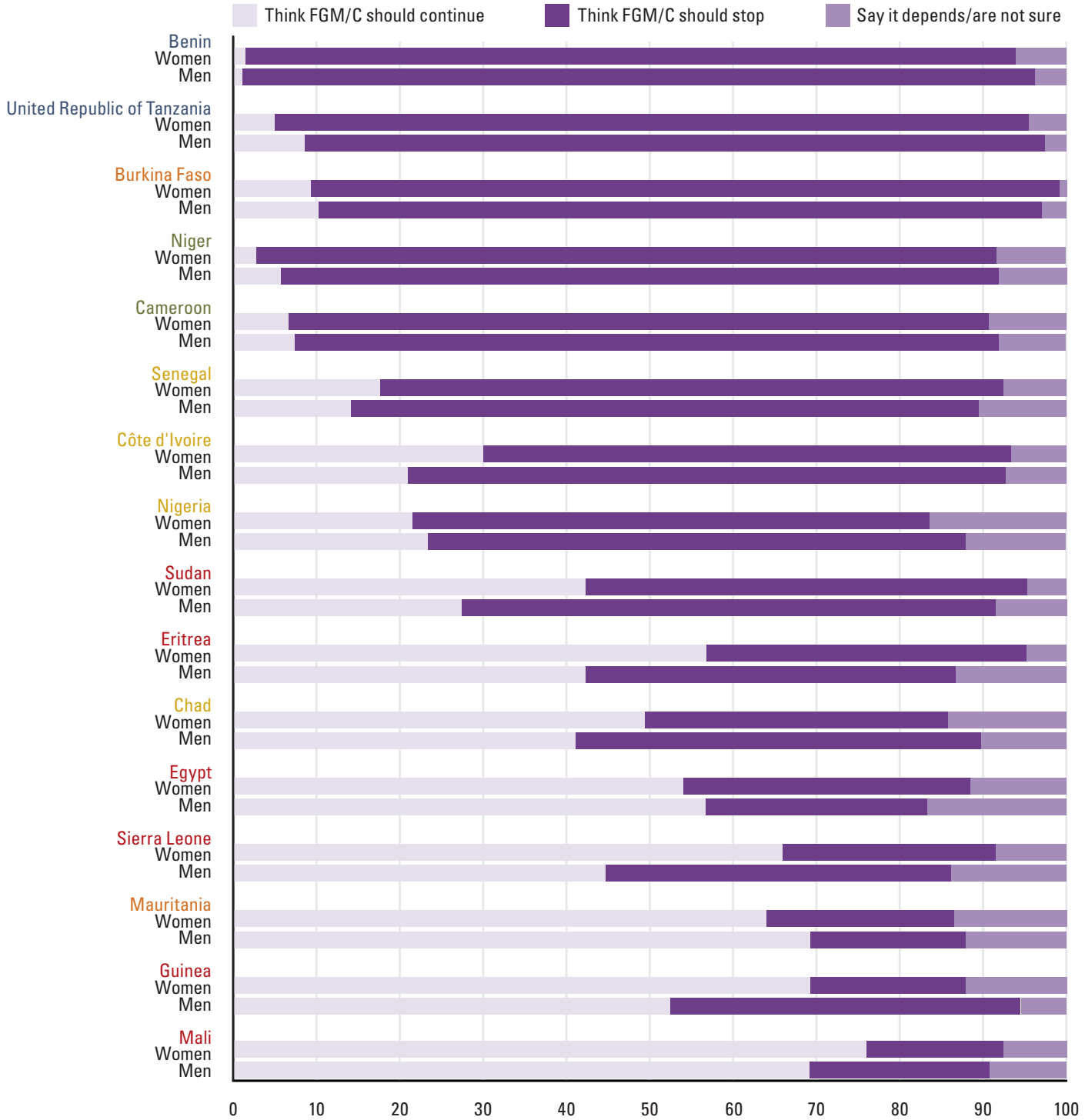
Among girls and women aged 15 to 49 years who have heard of FGM/C, percentage who support the continuation of the practice, by level of education



Notes: MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997-2011.

Figure 6.8 In countries such as Guinea, Sierra Leone and Chad, substantially more men than women want to see FGM/C end

Percentage distribution of girls and women aged 15 to 49 years and boys and men aged 15 to 49 years who have heard about FGM/C, according to their attitudes about whether the practice should continue



Notes: The category of girls and women and boys and men who are unsure or responded that 'it depends' also includes those for whom data are missing. The data for girls and women included in this figure are different from those shown in Figure 6.1 for Chad, Côte d'Ivoire, Eritrea, Mali, Mauritania, Senegal and the United Republic of Tanzania due to the lack of comparable data for boys and men from the most recent surveys. To maintain comparability with women, the data for men have been recalculated to reflect levels of support among boys and men aged 15 to 49 and may therefore be different from the from those shown in Figure 6.4. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 1998-2010.

Some surveys have asked women whether they thought men wanted the practice to continue or end. A similar question was asked of men about the attitudes of women. Answers to these questions show whether women and men have an accurate understanding of the attitudes of the opposite sex towards FGM/C. The data suggest this is not the case. Across all countries with available data, girls and women consistently underestimate the share of boys and men who want FGM/C to end (*see Figure 6.9*).

In some surveys, women and men were also asked whether they knew the opinion of the opposite sex regarding the continuation of the practice. Large proportions of respondents, especially women, admitted they did not know what they opposite sex thought, particularly in Egypt and Nigeria (*see Figure 6.10*). These findings are significant for programmes. Activities to inform girls and women of the true opinions of boys and men regarding the continuation of FGM/C may result in greater overall support for ending the practice.

Attitudes among couples

In a behaviour change study in Senegal and the Gambia, Bettina Shell-Duncan and colleagues also found that more men than women favoured stopping FGM/C.[109] In addition, they found that when men were involved in deciding whether their daughters should undergo FGM/C, their daughters were more likely to remain uncut. This is additional evidence that men can play an important role in the decision-making process resulting in the abandonment of FGM/C. Because of the important role played by men, it is interesting to examine the degree of agreement or discordance among couples regarding the continuation of the practice *(see Table 6.1)*. The data show that, in several countries, a substantial number of couples do not agree on whether FGM/C should stop or be continued, while in Mali and Mauritania, the majority of couples favour the continuation of FGM/C.[110]

In considering these findings, it is interesting to explore whether wives and husbands even talk about FGM/C, or know what their partners think about the practice. Surveys conducted in Eritrea (DHS 1995, DHS 2002), Nigeria (DHS 1999), Sudan (MICS 2000) and Yemen (DHS 1997) tried to answer such questions by asking married women if they had talked to their husbands about the practice (Sudan, Yemen) and if they knew their husband's opinion (Eritrea, Nigeria, Sudan, Yemen).

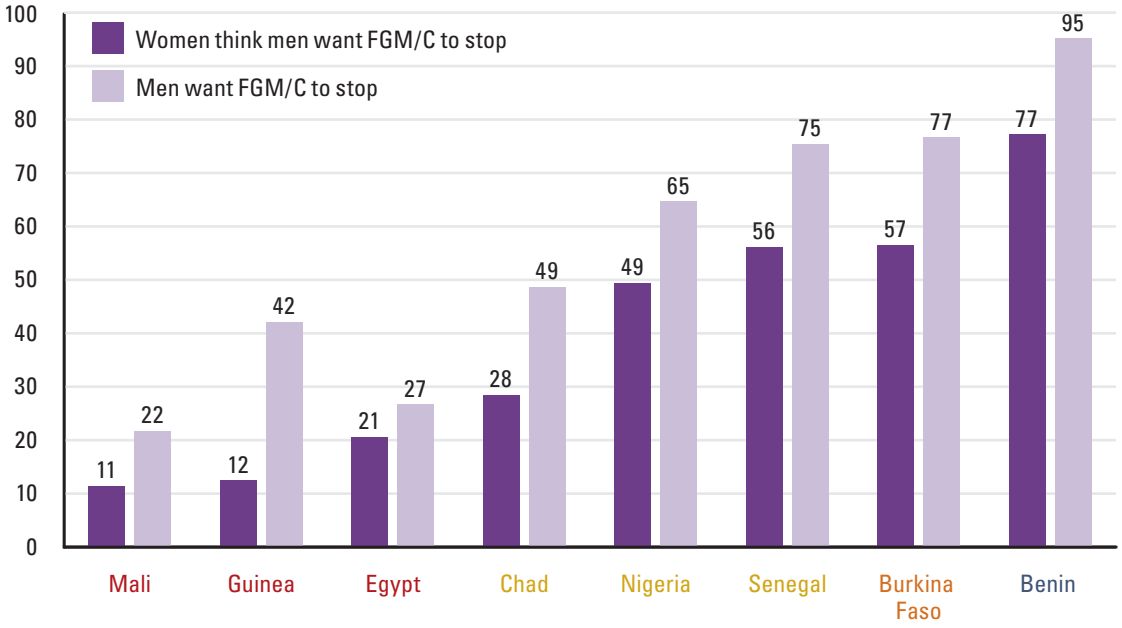
The results show that a large proportion of wives do not know their husbands' views on FGM/C. In Eritrea (DHS 2002), for instance, 22 per cent of married women said that they were unaware of what their partners thought. Even among women with at least one daughter who had been cut, almost one in five do not know their husband's attitudes towards the practice. In Yemen, this lack of knowledge is even more pervasive, with 45 per cent of wives reporting that they are unaware of their partners' opinions on FGM/C. These data suggest that many couples do not consider FGM/C an appropriate topic for discussion between husband and wife. Men may hesitate to broach the topic because it is largely considered a 'women's issue'. Data for Sudan (MICS 2000), for instance, indicate that two thirds of ever-married girls and women never talked about FGM/C with their husbands. Open dialogue about it may, therefore, serve to reduce ignorance and communicate that prevailing social expectations around FGM/C are being challenged.

Justifications for supporting the practice

In a number of countries, women and men were asked what they perceived to be the benefits or advantages for a girl to undergo FGM/C. This information essentially captures the commonly held beliefs about why the practice of FGM/C should continue. Responses were pre-coded in a variety of ways, with the most common list of possible reasons including: *cleanliness/hygiene*, *social acceptance*, *better marriage prospects*, *to preserve virginity*, *more sex-*

Figure 6.9 Girls and women underestimate the proportion of boys and men who want FGM/C to end

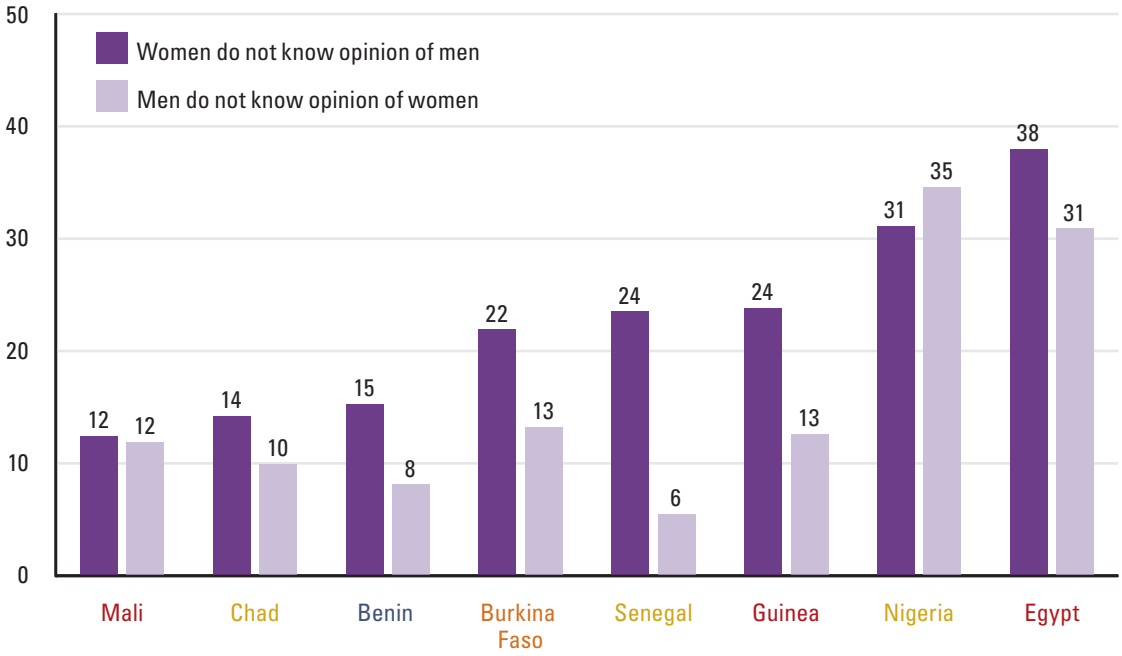
Percentage of girls and women aged 15 to 49 years who think that men want FGM/C to stop, and the percentage of boys and men aged 15 to 49 years who have heard about FGM/C and think the practice should stop



Notes: The data for boys and men included in this figure are different from those shown in Figure 6.4 for Burkina Faso, Nigeria, Guinea and Mali. To maintain comparability with women, the data for men have been recalculated to reflect levels of support among boys and men aged 15 to 49. Additionally, the data for men presented here are from older surveys that also collected data on the percentage of girls and women aged 15 to 49 according to whether they believe men want FGM/C to continue or end. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and DHS/MICS, 2003-2008.

Figure 6.10 Large percentages of women and men are unaware of what the opposite sex thinks about FGM/C

Percentage of girls and women aged 15 to 49 years and percentage of boys and men aged 15 to 49 (or 59, see note) years who say they do not know the attitudes of the opposite sex towards the continuation of FGM/C



Notes: Data for Burkina Faso, Chad, Guinea, Mali, Nigeria and Senegal refer to boys and men aged 15 to 59. Data for Benin and Egypt refer to boys and men aged 15 to 49. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and DHS/MICS, 2003-2008.

Table 6.1 In several countries, a substantial share of couples disagree about whether FGM/C should continue

Among cohabiting couples, percentage of girls and women aged 15 to 49 years and percentage of boys and men aged 15 to 49 (or 59, see note) years who have heard about FGM/C, according to their agreement/disagreement on whether FGM/C should continue or be discontinued

Country	Both want FGM/C to continue	Both want FGM/C to stop	Both are undecided	Discordant
Benin	0	88	1	11
Burkina Faso	2	77	0	21
Cameroon	4	64	2	30
Chad	32	23	1	42
Côte d'Ivoire	20	43	1	36
Guinea	46	7	1	46
Mali	60	5	1	34
Mauritania	56	8	1	35
Niger	1	76	0	21
Nigeria	10	40	2	46
Senegal	10	58	1	30
Sierra Leone	37	10	1	51
United Republic of Tanzania	1	81	0	18

Notes: Data for Benin, Burkina Faso, Cameroon, Sierra Leone and the United Republic of Tanzania refer to boys and men aged 15 to 49. Data for all other countries refer to boys and men aged 15 to 59. Due to rounding, the data presented in this figure may not add up to 100 per cent. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and DHS/MICS, 1998-2010.

ual pleasure for the man and *religious necessity/approval*. Variations on the wording of these categories have been used in some countries, and some surveys have included their own additional categories (in the Gambia [MICS 2010], for instance, self-esteem was included as a response category). Respondents were allowed to select more than one reason. In the most recent surveys, questions about the benefits of FGM/C are often not included. This means that for a few countries, data on reasons for support are less current than other information about the practice.

What can be learned from the responses? Ethnographic accounts tell us that the practice of FGM/C typically takes on different meanings that are interconnected in complex and varied ways, and are often mutually reinforcing (*see Box 6.2*). These meanings may vary among individuals and shift over time. It is important to understand how such meanings influence opinions and delib-

erations, and to note whether messages delivered in campaigns are at odds with commonly accepted rationales for continuing the practice. These views are better understood using methods such as rapid ethnographic assessment than responses to survey questions with pre-coded responses.

For all these reasons, questions on why FGM/C should continue and the perceived benefits of the practice have been omitted from the most recent standard DHS module on FGM/C, which now includes only a question on whether the practice is required by religion. Still, an examination of available survey responses provides clues to some of the factors behind support for the practice.

The most common responses from women and men on their reasons for continuing FGM/C are summarized in Tables 6.2 and 6.3, respectively. Among women, the most common reason selected from the pre-formulated list is to gain social acceptance. This is consistent with the understanding that decisions about FGM/C among individuals are motivated by empirical expectations derived from observing how others in their reference group behave *(see Box 6.3)*, as well as normative expectations that the practice will be enforced through positive and negative sanctions. For instance, in many lineages in Senegal and the Gambia, FGM/C is considered a crucial element in training girls to display respect for their elders and to behave in a morally virtuous manner, making them worthy of inclusion in elders' social networks.[111] Within extended families, mothers, aunts and grandmothers are widely expected to conform to prevailing ideas about proper parenting.[112]

Under Mackie's formulation, marriageability is posited as the key factor behind the origin and spread of FGM/C.[113] Once in place, FGM/C becomes embedded within the broader cultural context and is linked to other practices and cultural values that may shift over time. If links to marriageability weaken over time, the practice

Box 6.2 The constellation of beliefs and meanings surrounding FGM/C

Many observers have noted that FGM/C is usually embedded in a broader cultural context of practices and meanings, and that the constellation of associated beliefs varies across settings. These beliefs are often inextricably linked to the perpetuation of the practice and, many would argue, must be taken into account to create locally attuned policies and effective programmes.[114] It is widely understood that "justifications offered for the practice of FGM/C are numerous and in their specific context, compelling. While these justifications may vary across communities, they follow a number of common themes: FGM/C ensures a girl's or woman's status, marriageability, chastity, health, beauty and family honour."[115]

Mackie and LeJeune explain that the conditions in which FGM/C originated and associated beliefs need not remain static.[116] Michelle Johnson, writing about the Mandinga ethnic group in Guinea-Bissau, cites an ethnographic account from the 1940s that suggests that FGM/C in previous generations was linked to marriageability.[117] Decades later she finds that no longer holds true, and that the practice is most strongly tied to concepts of personhood and religious identity.[118] Mackie and LeJeune emphasize the need to identify the range of beliefs that hold the practice of FGM/C in place, and to provide credible information from trusted sources that is tailored to the local context and local meanings of the practice.[119]

Box 6.3 Inferring support for FGM/C

Individuals may infer that others support the practice of FGM/C if they see that families continue to cut their daughters and there is no objection to it. In surveys from seven countries (Burkina Faso, Côte d'Ivoire, Eritrea, Mali, Niger, Nigeria and the United Republic of Tanzania), mothers with at least one daughter who had undergone FGM/C were asked if anyone had objected to the procedure. Data from Eritrea (DHS 2002, the latest survey that included this question) show that 95 per cent of women said 'no', suggesting general acceptance of the practice. However, it is important to acknowledge that not actively opposing FGM/C does not necessarily imply support for the practice.

Table 6.2 Among girls and women, the most commonly reported benefit of FGM/C is gaining social acceptance

Among girls and women aged 15 to 49 years who have heard of FGM/C, the percentage who cite specific benefits or advantages for a girl to undergo the procedure

Country	No benefits	Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	More sexual pleasure for the man	Required by religion	Other	Don't know
Benin	55	0	8	1	2	1	1	1	34
Burkina Faso	52	6	24	3	4	0.4	3	2	N/A
Cameroon	50	0	1	1	4	0.4	2	2	40
Chad	37	5	31	8	7	2	23	4	N/A
Eritrea	29	13	42	25	4	N/A	18	3	N/A
Gambia	28	N/A	N/A	N/A	19	N/A	N/A	6	14
Guinea	10	13	64	5	6	3	32	3	N/A
Kenya	81	3	8	3	5	1	2	51	N/A
Mali	17	22	37	10	12	7	24	16	N/A
Mauritania	21	19	35	4	31	2	29	9	N/A
Niger	76	1	9	2	4	2	1	8	N/A
Nigeria	58	6	8	8	11	5	2	3	8
Senegal	49	6	19	3	14	1	7	19	N/A
Sierra Leone	25	22	55	19	9	1	5	13	N/A

Notes: N/A = not asked. Multiple responses were allowed. Only the most common response categories are included in the table. Preservation of virginity also includes categories called *Preserves virginity/prevents premarital sex*, *Preservation of virginity/prevention of immorality*, and *Reduces sexual desire*. Required by religion also includes categories called *Religious demand*, *Religious approval* and *Gain religious approval*. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2000-2010.

may still be upheld by other social meanings ascribed to it. Consequently, marriageability need not be the only or even the primary reason for performing FGM/C.[120] With the exception of Eritrea, relatively few women reported concern over marriage prospects as a reason for a girl to be cut. Preserving virginity, which may be indirectly related to marriage prospects in some settings, was among the more common responses of women in Mauritania, Gambia, Senegal and Nigeria.

Among boys and men, the reasons for a girl to undergo FGM/C largely mirrored those given by girls and women, with social acceptance and preservation of virginity being the most commonly cited reasons in most countries (*see Table 6.3*).

Data on the perceived benefits of FGM/C can also be disaggregated by women's FGM/C status for a select number of countries. However, it is inappropriate to compare the opinions of cut and uncut girls and women since those who have not been cut are more likely to say there are no benefits to the practice. Nevertheless, an examination of the perceived benefits of FGM/C among cut girls and women alone reveals some surprising findings: An unexpectedly high proportion do not think there

Table 6.3 Boys and men cite similar benefits from the practice as girls and women

Among boys and men aged 15 to 49 (or 59, see note) years who have heard of FGM/C, the percentage who cite specific benefits or advantages for a girl to undergo the procedure

Country	No benefits	Cleanliness/ hygiene	Social acceptance	Better marriage prospects	Preservation of virginity	More sexual pleasure for the man	Required by religion	Other	Don't know
Benin	72	0.4	3	1	2	1	0.4	2	21
Burkina Faso	69	4	10	2	5	1	5	1	N/A
Cameroon	70	0.3	4	2	6	2	2	4	9
Chad	42	8	19	5	15	3	12	7	N/A
Guinea	40	8	39	7	12	2	25	2	N/A
Mali	23	14	19	5	22	5	24	19	N/A
Mauritania	21	13	29	9	25	2	41	10	N/A
Niger	69	3	7	1	7	4	1	12	N/A
Nigeria	52	4	6	6	17	7	3	4	N/A
Senegal	58	4	10	2	8	2	5	21	N/A
Sierra Leone	36	24	42	18	8	4	3	13	N/A

Notes: N/A = not asked. Multiple responses were allowed. Only the most common response categories are included in the table. Preservation of virginity also includes categories called *Preserves virginity/prevents premarital sex* and *Reduces sexual desire*. Required by religion also includes categories called *Religious demand*, *Religious approval* and *Gain religious approval*. Data for Benin and Cameroon refers to boys and men aged 15 to 49. Data for all other countries refer to boys and men aged 15 to 59. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and DHS/MICS, 2000-2008.

are any benefits for a girl to undergo the procedure (*see Figure 6.11*). This figure is particularly striking in Kenya, where more than half of girls and women who have been cut do not see any benefits.

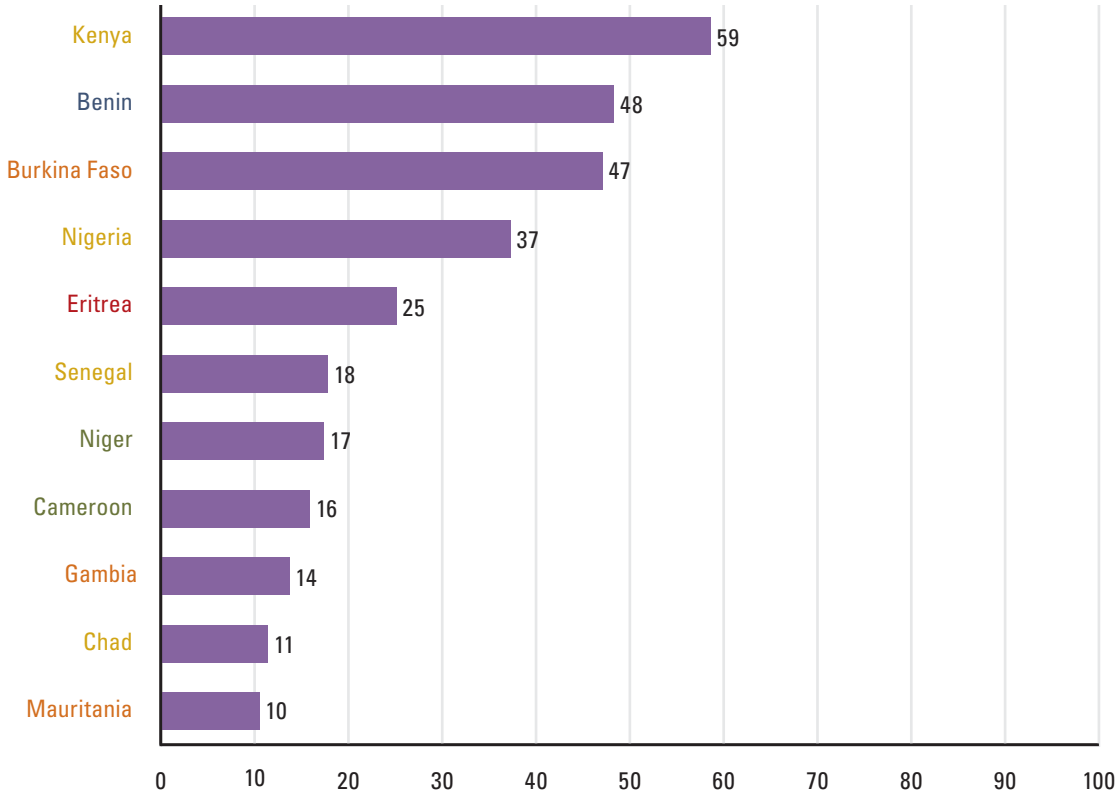
Role of religion in the continuation of FGM/C

FGM/C is often seen to be somehow connected to Islam, a view that is perhaps unsurprising given the frequency with which it is practised by many Muslim African groups. However, not all Islamic groups practise FGM/C, and many non-Islamic groups do. Gruenbaum has emphasized that followers of all three monotheistic religions – Christianity, Judaism and Islam – "have at times practised female circumcision and consider their practices sanctioned, or at least not prohibited, by God."[121]

Despite the fact that FGM/C predates the birth of Islam and Christianity and is not mandated by religious scriptures, the belief that it is a religious requirement contributes to the continuation of the practice in a number of settings. As illustrated in the previous section and confirmed by ethnographic studies, in certain settings FGM/C is widely held to be a religious obligation.[122] Tables 6.2 and 6.3 show that in countries such as Guinea, Mali and Mauritania, significant proportions of women and men reported that FGM/C is required by their religion. This is often closely linked to the response of *cleanliness/hygiene*, since FGM/C has become understood in some Muslim communities to be a cleansing rite that enables women to pray in a proper manner.[123] The

Figure 6.11 In Kenya, Benin, Burkina Faso and Nigeria, more than one in three women who have undergone FGM/C do not see any benefits to the practice

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C and say there are no benefits for a girl to undergo the procedure



Note: Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2000-2010.

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Sadjo 'Kobaie' Nyabaly renounces the practice of FGM/C during an event in Darsilameh village celebrating the end of FGM/C and early marriage in 24 communities in eastern Upper River region in the Gambia. Ms. Nyabaly, a traditional cutter in her village, inherited the role from her grandmother. She came to renounce it while participating in the Community Development and Empowerment Programme, supported by the government, the NGO Tostan and UNICEF. While testifying to the suffering and death of girls subjected to the practice, Ms. Nyabaly said, "The only thing I can do to make up for my past deeds is to become an advocate, and call upon all women to come together and collectively bring an end to this practice."

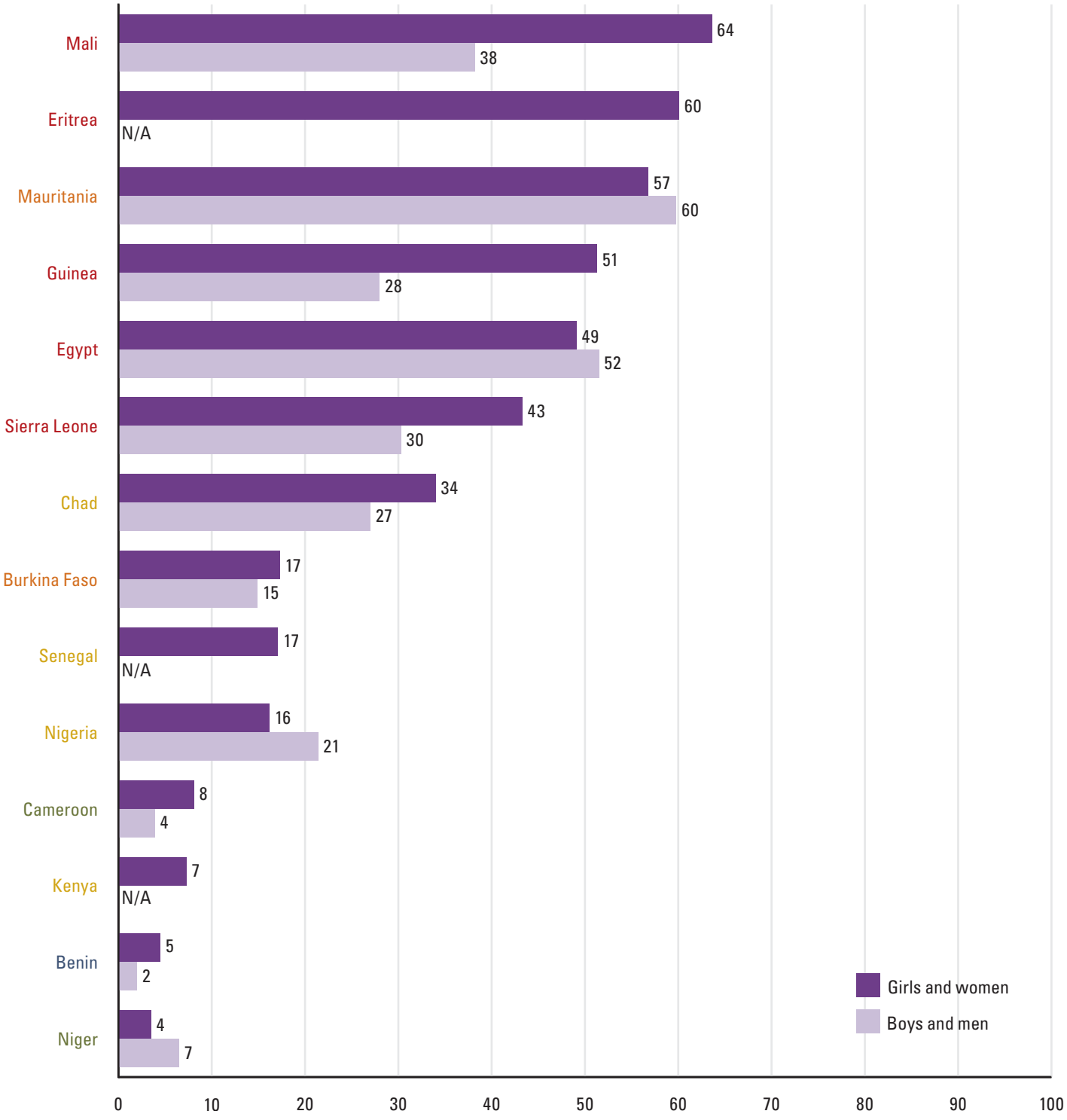
importance of religion is further confirmed by other MICS and DHS data. In some surveys, interviewees were asked specifically whether FGM/C was required by religion. Results, shown in Figure 6.12, indicate that even larger percentages of respondents answered affirmatively. In Mali, for example, nearly two thirds of girls and women and 38 per cent of boys and men regard FGM/C as a religious duty.

A great deal of effort by scholars and activists has concentrated on demonstrating a lack of scriptural support for the practice. In Egypt, for example, the most authoritative condemnation of FGM/C in Islam to date is the 2007 fatwa (religious edict) issued by the Al-Azhar Supreme Council of Islamic Research, explaining that FGM/C has no basis in Sharia (Islamic law) or any of its partial provisions, and that it is a sinful action that should be avoided. Several regional and national fatwas have followed in the years since, with the original statement as their basis.[124] In Sudan, a national campaign is working to promote the positive association of Islam to *saleema*, a term identified and widely promoted to describe a happy, healthy girl who is uncut, as God made her.[125] In Senegal, religious leaders have played an important role in publicly addressing the practice, confirming that FGM/C is not sanctioned anywhere in Islam or the Koran and violates a woman's dignity.[126] However, because religious beliefs often exist alongside other social norms surrounding FGM/C, the lack of clear scriptural dictates does not automatically cause religious motivation for the practice to diminish. For instance, Janice Boddy, writing on Sudan, found that "religion and tradition are not merely intertwined, they are one and the same."[127] Similarly, Michelle Johnson, writing about the Mandingas in Guinea-Bissau, describes a total correspondence between FGM/C, ethnic identity and Islamic identity; she also says the practice is widely considered a prerequisite for ritual purity necessary for prayer, and a marker of belonging to an Islamic community.[128]

Studies among Mandinga and Somali immigrants in Europe have shown that exposure to a broader Islamic community in which FGM/C is not often practised caused many to question the link between tradition and religion, and to become ambivalent or opposed to the continuation of FGM/C.[129] Members of migrant Mandinga communities in Portugal, among whom FGM/C is not widely practised, apparently do not subscribe to the beliefs linking the practice to Islamic requirements. Presumably, this is because they are exposed to 'modern' Islam, as understood and practised by those outside Africa. Johnson describes how this has led many to make the distinc-

Figure 6.12 In 4 out of 14 countries, more than 50 per cent of girls and women regard FGM/C as a religious requirement

Percentage of girls and women aged 15 to 49 years and boys and men aged 15 to 49 (or 59, see note) years who have heard of FGM/C, by their opinion on whether the practice is required by religion



Notes: N/A= not available. Data for Benin, Burkina Faso, Cameroon, Egypt, Nigeria and Sierra Leone refer to boys and men aged 15 to 49. Data for all other countries refer to boys and men aged 15 to 59. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2000-2011.

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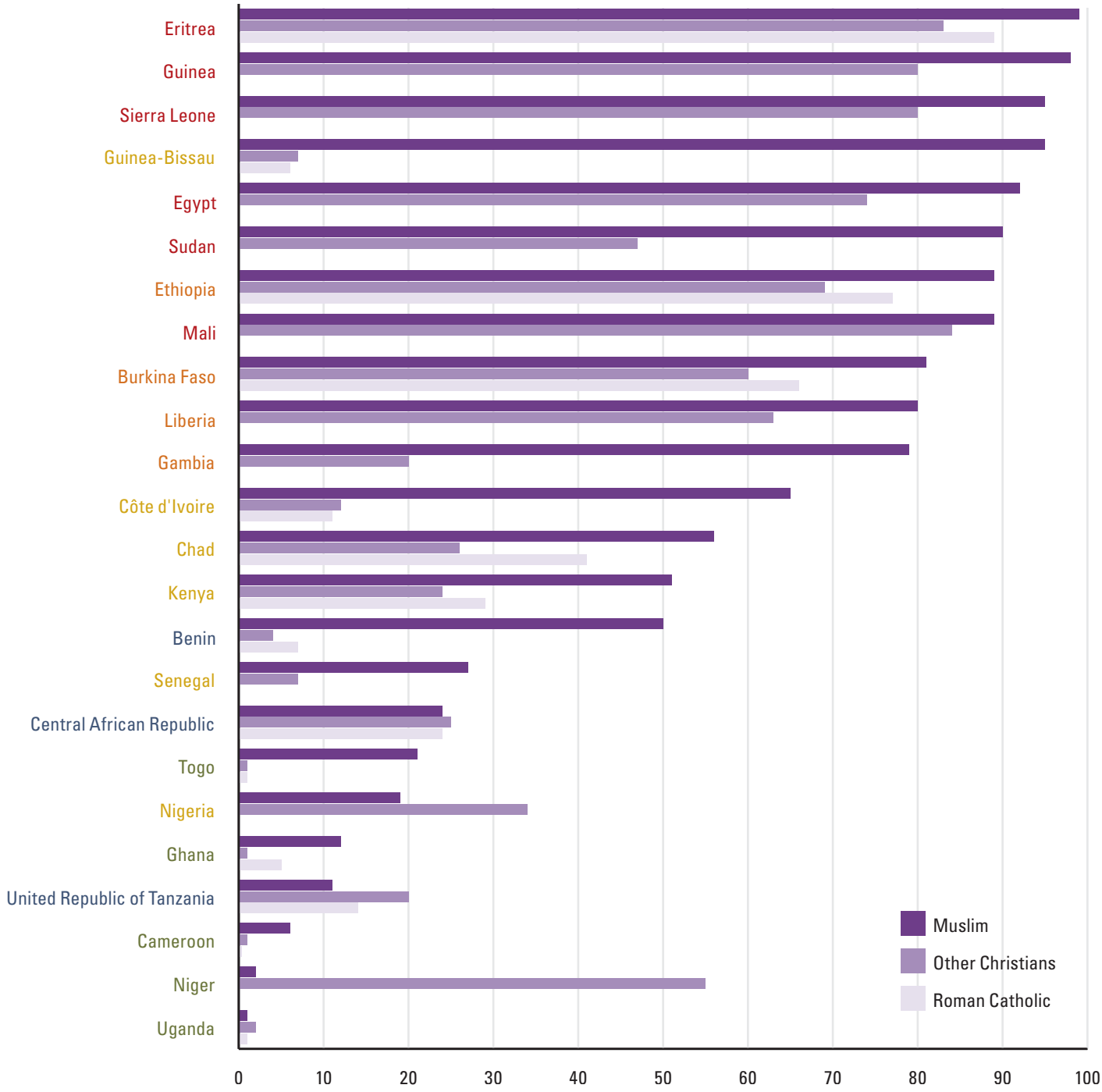
Girls sing at a community meeting welcoming UNICEF visitors to Sufi Al Bashir village, Kassala State, Sudan. FGM/C is still widely practised in the village.

tion between religion and culture, which in some cases has helped call the practice of FGM/C into question.[130] This example illustrates the process by which re-examination of practices and social norms attributed to religion can result in changes in understanding. While religious leaders have at various times and places actively campaigned against the practice, facilitating dialogue with the larger religious communities is likely to contribute to the process of abandonment, particularly when religious leaders are able to speak effectively about the lack of theological support for FGM/C.

Available survey data show that, predictably, the association between religion and FGM/C varies widely across countries.[131] Figure 6.13 presents data on prevalence among girls and women aged 15 to 49 according to their faith. Religious categories differ across surveys to reflect the faiths present within each country, making comparisons across surveys somewhat challenging. This analysis considered differences and similarities among girls and women of three main religious groups: Muslims, Roman Catholics and other Christians, including Protestants and Orthodox Christians. In many countries, FGM/C prevalence is highest among Muslim girls and women. The practice, however, is also found among Catholic and other Christian communities. In some countries where a particular religion is almost universal, as is the case with Islam in Sudan, the extent to which people of other religions practise FGM/C has little influence on overall prevalence. Clearly, variations in prevalence among people of different faiths demonstrate that FGM/C is a challenge for all religious groups in affected countries. Religious leadership may have to further engage in understanding FGM/C in their communities to promote a change in the practice.

Figure 6.13 While the majority of cut girls and women are Muslim, other religious groups also practise FGM/C

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by religion



Notes: For several surveys, the data were re-analysed to disaggregate prevalence data by three main religious groups. FGM/C prevalence data broken down by other religions, such as 'Traditional' or 'Animist', are not presented here because they are only reported in a small number of countries. In Ethiopia, the category for 'Other Christians' includes 'Orthodox', which represents the majority of the population (49 per cent of surveyed women and men); FGM/C prevalence among Orthodox girls and women alone is 68 per cent. Data for Sierra Leone are from the 2008 DHS and data for the United Republic of Tanzania are from the 2004-2005 DHS, since more recent data on religion were unavailable. Data for Sudan are from the 1989-1990 DHS, since more recent data on religion are unavailable. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 1989-2011.

7. What is the relationship between the experience of FGM/C,

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In many countries, including those where FGM/C is universal, a large share of women and men do not support the practice but are reluctant to defy social norms. What is the relationship between the experience of FGM/C and attitudes towards the practice? In particular, what do girls and women from practising communities say about FGM/C? To what extent do their decisions about their daughters reflect their stated opinions of the practice?

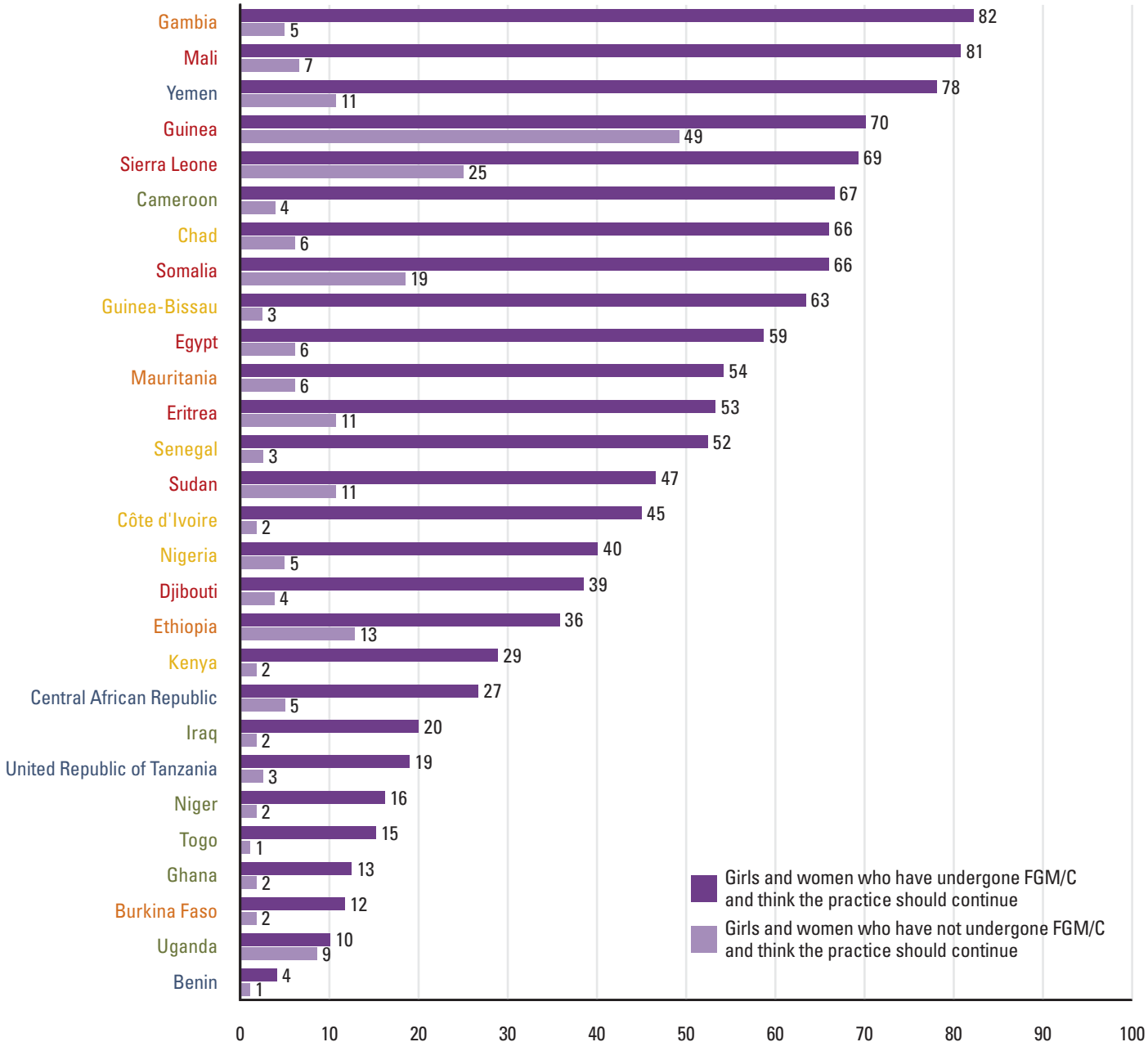
Attitudes of girls and women from practising communities

The findings presented in Chapter 6 reflect the views of girls and women about FGM/C regardless of whether they have been cut or live in a community that practises FGM/C. Given the social expectations to perform FGM/C in many areas, it is reasonable to expect that the strongest support for the continuation of the practice would come from girls and women who have been cut. In other words, women who are part of a community that practises FGM/C would be expected to support it to a greater extent than those who are not.

This assumption is confirmed by the data: Girls and women who have been cut are more likely to favour maintaining the practice than their peers who have not been subjected to it *(see Figure 7.1)*. In the Gambia, for instance, 82 per cent of girls and women who have undergone the procedure think the practice should continue, compared to 5 per cent of girls and women

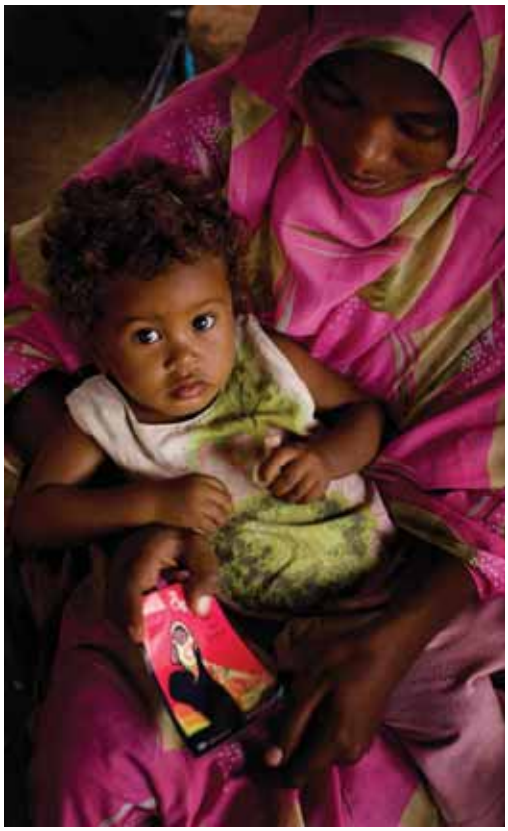
Figure 7.1 Girls and women who have been cut are more likely to favour maintaining the practice

Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue, by FGM/C status



Notes: In Liberia, only cut girls and women were asked questions about their attitudes towards FGM/C; therefore data for Liberia could not be included in this chart. MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS, MICS and SHHS, 1997-2011.



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A woman and her daughter attend a community meeting to discuss collective abandonment of FGM/C, in Ardel Al Hajar village, Kassala State, Sudan. Women in the community meet regularly to discuss women's health matters.

who are uncut. It is not entirely clear how responses indicating support for the continuation of FGM/C by uncut women should be interpreted. One possibility is that they reflect tolerance for traditions upheld by others. Further research is needed to confirm this hypothesis.

Data from a number of countries indicate that a large proportion of girls and women who have undergone FGM/C want the practice to end (*see Figure 7.2*). In 11 out of 29 countries, the majority of girls and women who have been cut favour stopping the practice. However, these include mostly countries in which FGM/C prevalence is moderately low to very low (such as Kenya, Iraq, United Republic of Tanzania, Togo and Ghana). One possible explanation for this finding is that cut girls and women who live in low to moderately low prevalence countries may have more opportunity to interact with people who do not practise FGM/C and have experienced no negative consequences as a result. An exception is Burkina Faso, a moderately high prevalence country where 87 per cent of girls and women who have been cut think the practice should end.

Comparing the FGM/C status of girls and women to their stated opinions about the practice gives an indication of the overall degree of support for FGM/C among practising communities. In interpreting the findings, it should be kept in mind that most cut girls and women aged 15 to 49 experienced the procedure many years ago, while their responses to survey questions reflect their current opinion. In addition, it is likely that they had little influence in the decision about whether or not they should be cut. Finally, the views they express may not necessarily reflect their capacity to act upon their beliefs. For all these reasons, it is far more relevant to compare girls' and women's opinions of the practice and the FGM/C status of their daughters. This provides a better indication of the extent to which attitudes are aligned with behaviour.

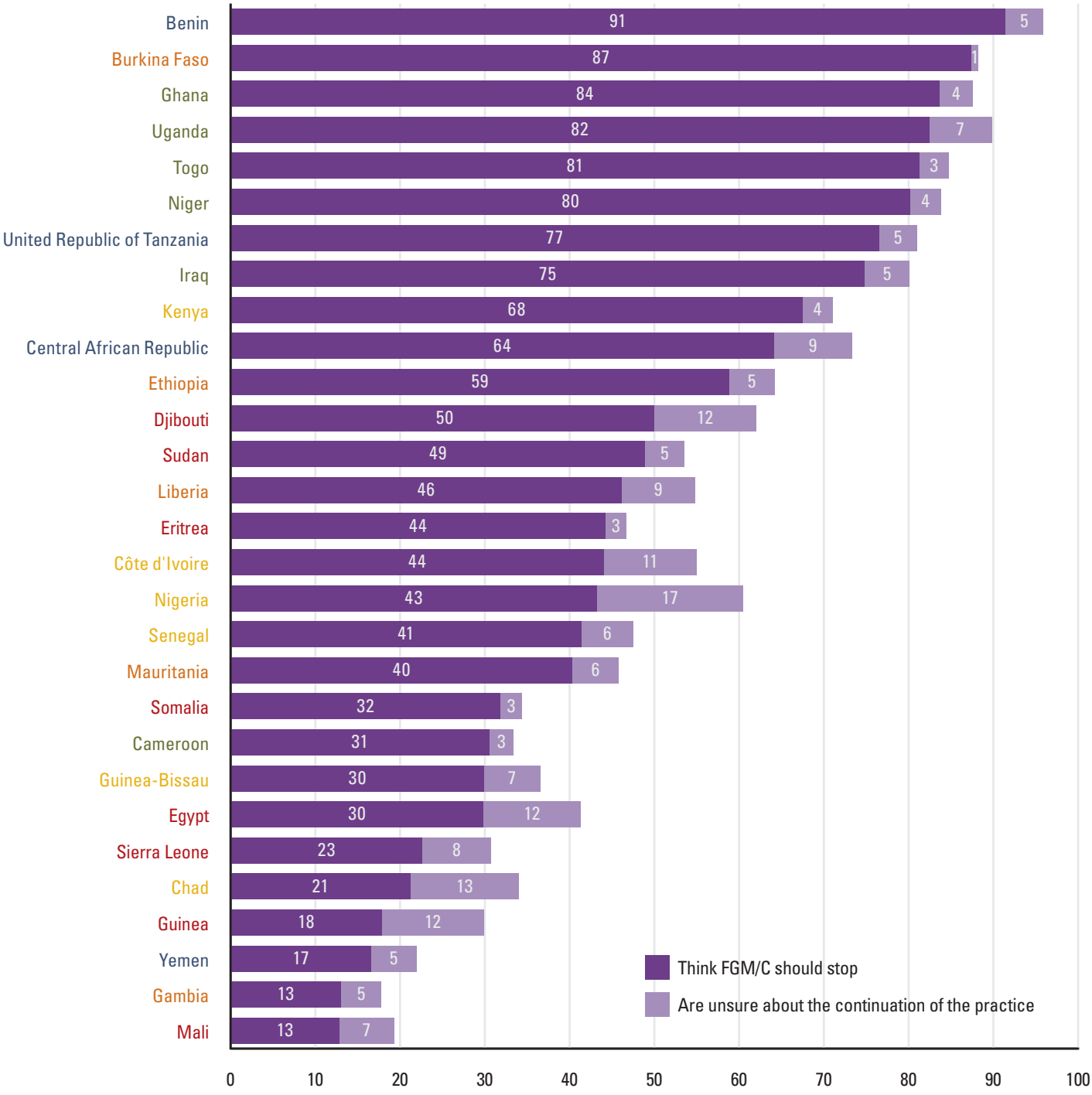
How attitudes relate to behaviour

Evidence that FGM/C is held in place by social norms can be generated by examining the correspondences or discrepancies between individual support for the practice and actual behaviour. Individuals who are convinced that FGM/C should end may be reluctant to act on their beliefs if there is an expectation of rewards for adhering to the practice or sanctions for non-conformance. Individuals or single families who opt to stop cutting their daughters risk the social acceptance of these girls as well as the social status of the family. In addition, the preferences of any individual may be trumped by others, often members of their family, who are motivated to follow social expectations and avert negative sanctions and social costs.

Mothers' attitudes towards FGM/C and their daughters' FGM/C status can be used to compare the prevalence of cutting among daughters of cut girls and women who support the continuation of the practice, on one hand, and of cut girls and women who want it to stop, on the other. This analysis is helpful in understanding the extent to

Figure 7.2 Many girls and women who have undergone FGM/C want the practice to end

Among girls and women aged 15 to 49 years who have undergone FGM/C, the percentage who think the practice should stop or are unsure/say it depends



Notes: The category of girls and women who are unsure also includes those who responded that 'it depends', as well as girls and women for whom data are missing. MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 1997-2011.

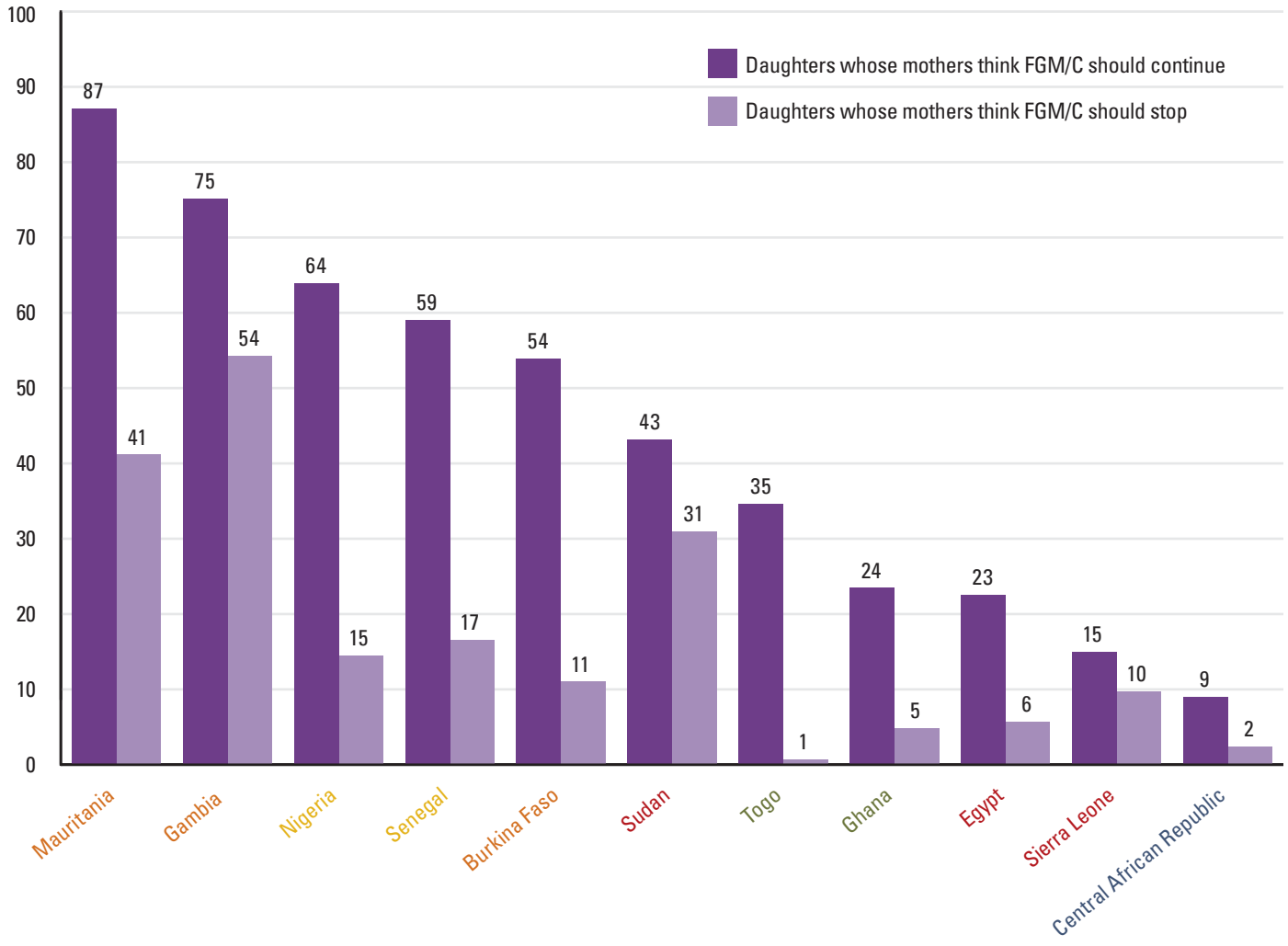
which attitudes translate into behaviour. Figures 7.3A and 7.3B present the results, based on two different (and non-comparable) methods of data collection, as explained in Box 4.3.[132] Not surprisingly, a daughter's likelihood of being cut is much higher when her mother thinks the practice should continue. It is important to note, however, that many cut girls have mothers who oppose the practice.

How might this gap between attitudes and behaviour be interpreted? It is possible that some mothers may have changed their opinion of the practice after their daughters were cut. Or, despite their personal feelings, they may have proceeded to have their daughters cut because of pressure from others and concerns about social rewards and sanctions. The existence of such

Many girls who are cut are daughters of women who oppose the practice

Figure 7.3A

Among daughters of cut girls and women, the percentage of girls aged 0 to 14 years who have undergone FGM/C (as reported by their mothers), by mothers' attitudes about whether the practice should continue



Notes: Data for Egypt have been recalculated for girls aged 0 to 14. Data for Senegal refer to girls aged 0 to 9. Data for Uganda are not presented since they are based on less than 25 unweighted cases. Data for daughters whose mothers think FGM/C should continue for Ghana and Togo were based on 25-49 unweighted cases. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 2008-2011.

pressure has been confirmed by the finding in Chapter 6 that social acceptance is the most commonly reported justification for the practice. It is also possible that women who want FGM/C to stop are unaware that others also want the practice to end. This results in a phenomenon known as pluralistic ignorance, as discussed in Chapter 3, where individuals erroneously believe that their opinion is not shared by others (*see Box 7.1*).

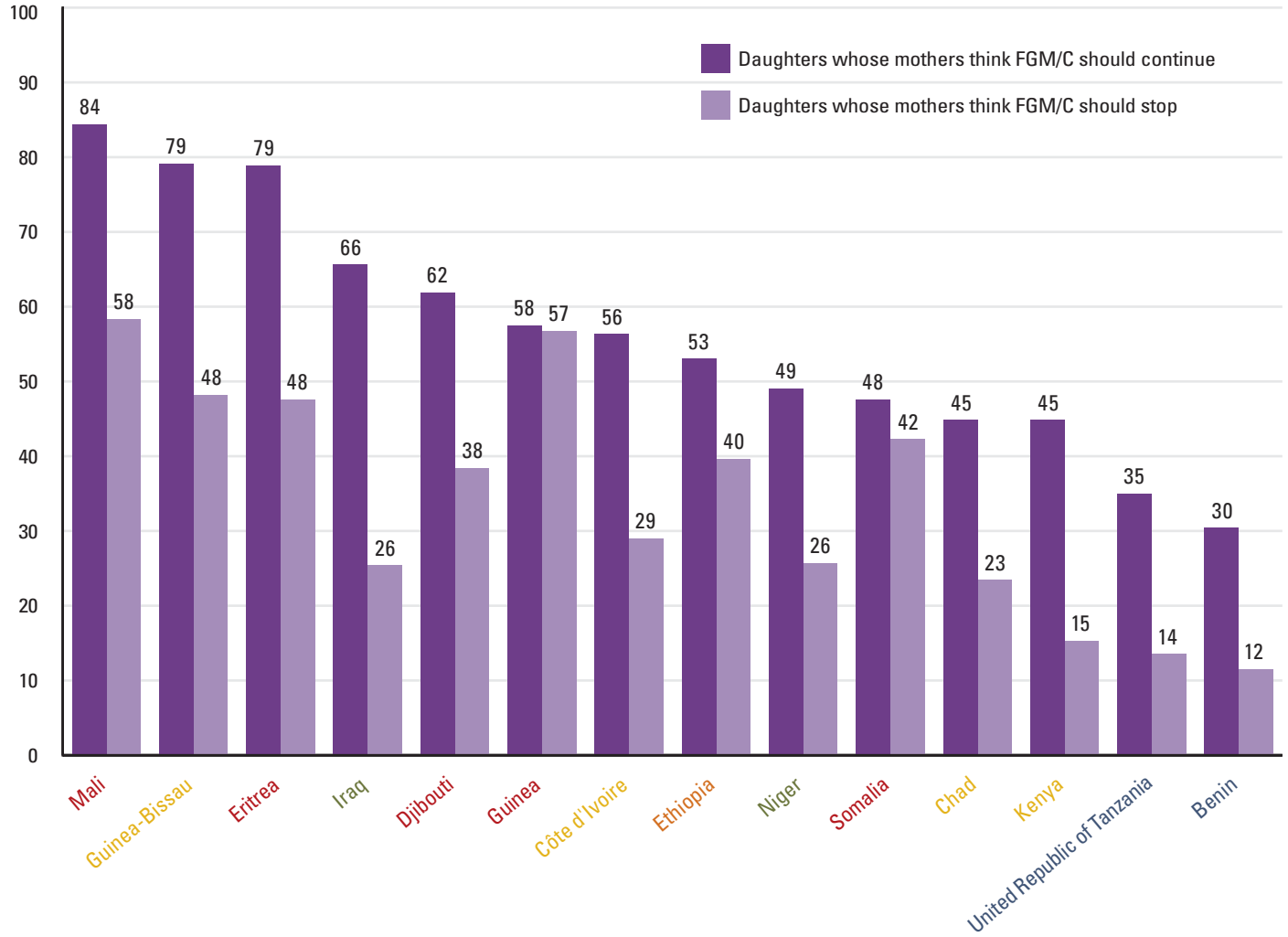
In such a situation, facilitating discussion among members of a practising group may serve to support and accelerate the abandonment process.

Models of behaviour change

Many 'readiness to change' models have been developed to better understand behaviour change and are based on the assumption that

Figure 7.3B

Percentage of cut girls and women aged 15 to 49 years who have at least one daughter who has undergone FGM/C, by mothers' attitudes about whether the practice should continue



Notes: Data in Figure 7.3A reflect the latest method of collecting information on FGM/C prevalence among all girls aged 0 to 14, while data in Figure 7.3B refer to cut girls and women with at least one daughter who has been cut, as explained in Box 4.3. The prevalence of FGM/C across the two graphs cannot be directly compared due to differences in the methods used to collect the data. Data for Cameroon are not presented since they are based on less than 25 unweighted cases. Data for daughters whose mothers think FGM/C should continue for Niger were based on 25-49 unweighted cases. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2002-2011.

Box 7.1 Discrepancies between attitudes and behaviour: How can they be explained?

A number of scholars have pointed to the flaw of assuming a direct link between information, intention and behaviour change. Rather, they stress the importance of understanding the influence of social interactions and the social context in which decisions are made.[133] When individuals are given new information about a normative practice, they may begin to question its value. However, a mere preference for change may not be sufficient to alter behaviour when the practice is held in place by reciprocal social expectations. This is one possible explanation for the finding that FGM/C prevalence is often significantly higher than stated support for the practice.

Assumptions about reciprocal social expectations are not always accurate. Psychologists point out that people draw inferences about others' likes and dislikes from the behaviour they observe; [134] rarely do they have access to other people's private thoughts or feelings. And even when attitudes change privately, others might not be aware of that fact, resulting in inferences that are seriously in error. As described in Chapter 3, this phenomenon is known as pluralistic ignorance. When individuals erroneously believe their changed preferences are not shared by others, it can produce a 'conservative lag', where change in preference is not accompanied by behaviour change, thus leaving a practice in place long after private support has dwindled.

The degree of pluralistic ignorance in a particular community is an important consideration in programme design. Typically, when a social norm has long been in place, people tend to overestimate the support it receives by others. High levels of pluralistic ignorance result from a lack of open dialogue about a norm assumed to have wide support. While knowledge and experience may change individual preferences, this information must be communicated in safe spaces where people feel comfortable sharing their views. In addition, survey data on preferences can raise awareness about shifting expectations in a community. By opening channels of communication and sharing information, it becomes possible to create common knowledge and alter reciprocal social expectations. Indeed, experiments on dispelling pluralistic ignorance show that it can produce rapid changes in behaviour.[135]

Another factor that can contribute to discrepancies between personal attitudes and behaviour is that decisions about FGM/C are often made by a group.[136] The size and composition of the group may change over time, and not all members may have equal powers of persuasion. Consequently, power relations become an important consideration. The opinions of various decision-makers may also be influenced by people in their social networks, and these networks and their members may change over time. Hernlund and Shell-Duncan have emphasized that the construction of a person's opinion about FGM/C is attuned to shifting relationships, contexts and experiences, a concept they describe as 'contingencies'.[137] Analyses of the dynamics of the practice must, therefore, be sensitive to shifting local conditions as well as power relations among decision-makers.

individuals are able to act upon their intentions. For instance, the 'Stages of Change' model developed in the field of health psychology to help people stop smoking has been applied to a wide range of behaviours, such as substance abuse, dietary change, exercise promotion and safer sex.[138] The model asserts that individuals go through a common sequence of stages in the behaviour change process: 1) *pre-contemplation* – or not intending to make behaviour changes in the foreseeable future, 2) *contemplation* – considering behaviour change but not yet making a firm commitment to change, 3) *preparation* – commitment to behaviour change in the next 30 days but not yet changing behaviour, 4) *action* – successfully changing behaviour, and 5) *maintenance* – behaviour change sustained over six months.[139] The terminology used in this model, as well as another closely related staging model by Everett Rogers,[140] has been applied to FGM/C.[141] Shell-Duncan and Hernlund have adopted this model to take into account the fact that decisions regarding FGM/C are influenced by social norms.[142] They consider that an individual's actual or intended behaviour is not independent, but is conditioned by others, and identify five categories of readiness to change with respect to FGM/C: 1) *willing adherents* – individuals who support the continuation of FGM/C and have or will cut their daughters, 2) *reluctant adherents* – those who oppose the continuation of the practice but have or will perform FGM/C on their daughters, 3) *contemplators* – those who are undecided about their preferences and plans regarding FGM/C and question the practice, 4) *reluctant abandoners* – those who prefer to continue FGM/C but will not perform FGM/C on their daughters, and 5) *willing abandoners* – those who favour stopping FGM/C and will not perform FGM/C on their daughters (*see Figure 7.4*).[143]

Survey questions on support for the practice and daughters' FGM/C status can be used to categorize mothers into one of these five categories. The attitude categories are determined by mothers' responses to whether they favour the continuation or discontinuation of FGM/C (*thinks FGM/C should continue, are unsure or say it depends, thinks FGM/C should stop*). The behaviour categories are determined by whether any living daughter is cut or if the mother intends to cut her daughter(s). Specifically, 'adherents' of FGM/C are women who have had their daughters cut or report that they intend to have their daughter cut. Those who respond *don't know* to the question on intent to have FGM/C performed are considered 'undecided'. Those who have a daughter who is not cut and report that they do not intend to have her cut are categorized as 'abandoners'.

Figure 7.4 Five categories can be used to describe readiness to change

Dimensions of readiness to change, as they relate to FGM/C

Behaviour	Attitudes towards the practice		
	Thinks FGM/C should continue	Undecided	Thinks FGM/C should stop
Adherent of FGM/C	**Willing adherent**		**Reluctant adherent**
Undecided		**Contemplator**	
Abandons FGM/C	**Reluctant abandoner**		**Willing abandoner**

Source: Adapted from Shell-Duncan, B. and Y. Hernlund, 'Are there "Stages of Change" in the Practice of Female Genital Cutting? Qualitative research findings from Senegal and the Gambia', *African Journal of Reproductive Health*, vol. 10, no. 2, 2006, pp. 57-71.

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Hela Bakri, 31, sits with her 15-year-old daughter, Neshwa Sa'ad, in their home in the Abu Si'id neighbourhood of Omdurman, a city in Khartoum State, Sudan. Hela dropped out of school at age 10, shortly after she was subjected to FGM/C. She has sent all three of her daughters to primary school, and is saving money to send Neshwa to secondary school. "I want Neshwa to have all of the education that she can because I missed out on that," said Hela. Years ago, Neshwa was cut even though Hela opposes the procedure. "I didn't have any choice…. I boycotted the celebrations afterwards because I wasn't in agreement." She hopes to keep her two younger daughters from experiencing FGM/C.

As explained in Chapter 4, a portion of daughters who have not undergone the practice may still be cut once they reach the age at which FGM/C is traditionally performed. In a subset of surveys, a negative response to the question of whether a daughter has been cut is followed by a question on whether the mother intends to have her daughter cut. The reliability of this method is affected by the fact that mothers are often not the sole decision-makers and may not be able to act upon intent. Moreover, as their daughters approach the usual age at cutting, mothers may succumb to social pressure and conform to what they believe others expect of them. Finally, as laws criminalizing FGM/C become more widely known, respondents may be less willing to disclose their intention to cut their daughters. For these reasons, information on intention to cut is not a good proxy for future prevalence. However, when data on intention are not added to figures on the FGM/C status of daughters, the risk is to misclassify a large proportion of mothers as abandoners only because their daughters have not yet reached the usual age at cutting.

Data on intention to cut has been collected in 33 surveys in 16 of the 29 countries in which FGM/C is concentrated. In countries where the majority of girls are cut before age 1, the question of a mother's intention to cut was not asked, since

FGM/C had, in most instances, already been performed. In countries such as Egypt, where cutting usually takes place in adolescence, information on intention to cut is essential to understanding the percentage of girls at risk. Table 7.1 shows, for selected countries, the percentage of girls and women aged 15 to 49 who have themselves undergone FGM/C in each of the assigned stages of readiness to change, based on their daughters' FGM/C status and their stated intention to cut. The data show that, in Mali, Guinea, Sierra Leone, Egypt, Mauritania and Sudan, the majority of mothers are willing adherents of FGM/C. In contrast, the majority of mothers in the United Republic of Tanzania and Kenya have willingly abandoned FGM/C, suggesting that stable change has taken place. In the United Republic of Tanzania, 12 per cent of women are reluctant adherents of FGM/C, suggesting that for a number of women, abandonment of FGM/C is impeded by a lack of change in social norms. The proportion of girls and women classified as 'contemplators' is small in all countries. This suggests that the period of ambivalence is short-lived and therefore not frequently detected in a cross-sectional survey. The only exception is Nigeria, where 13 per cent of women are contemplating change. Again, when interpreting these figures, it is important to bear in mind the limitations of self-reported data on intention to cut.

Table 7.1 The distribution of women in various stages of readiness to change provides clues on the stability of the practice

Among girls and women aged 15 to 49 years who have undergone FGM/C, the percentage of them in assigned stages of readiness to change (based on the FGM/C status of their daughters and their intention to cut), in selected countries with available data

Country	Willing adherent	Reluctant adherent	Contemplator	Reluctant abandoner	Willing abandoner
Egypt	64	3	8	3	22
Guinea	74	11	11	*	3
Kenya	21	13	*	5	58
Mali	83	7	6	1	3
Mauritania	55	40	5	*	*
Nigeria	37	14	13	5	30
Sierra Leone	73	11	7	1	8
Sudan	55	18	5	0	22
United Republic of Tanzania	16	12	(4)	(2)	66

Notes: An asterisk indicates that a figure is based on fewer than 25-49 unweighted cases and has been suppressed. Figures in parentheses are based on 25-49 unweighted cases. Data from Mauritania and Sudan refer to all girls aged 0 to 14 who have undergone FGM/C. Data for Egypt refer to all girls aged 0 to 17 who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS, MICS and SHHS, 2005-2011.

8. Is the practice of FGM/C changing?

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As efforts to eliminate FGM/C intensify at local, national and international levels, there is growing interest in knowing if they are resulting in measurable change. The central questions are: Have attitudes towards FGM/C shifted? Is the practice becoming less common? Are there signs of change in how and when FGM/C is performed?

Tracking change

When examining trends in the practice of FGM/C, four important factors should be considered:

Variations in the number of years between consecutive surveys. These range from 1 to 20, depending on the country. Data on Sudan, for instance, have been collected regularly from 1989-1990 to 2010, allowing for a long time period in which to assess change.

The number of data points available for each country. These can also vary and affect the way trends are analysed. The patterns of change are more evident when several surveys are available for a country, as opposed to only two data sources.

The time lag when interpreting trends (*see Box 8.1*). In Mauritania, for example, most girls are cut during their first month of life. Thus, a survey conducted in 2011 documents changes in the practice that occurred roughly between 1962 and 1996.

The magnitude of change. Change can be gauged in two ways: by looking at the absolute difference (change in percentage points) between estimates and by looking at the percentage change between estimates. For example, prevalence may drop from 90 per cent to 80 per cent in five years in a given country and from 20 per cent to 10 per cent in another. The 10-percentage-point decrease that occurred in both countries corresponds to an 11 per cent drop in the first instance and a 50 per cent drop in the second. In this chapter, conclusions are drawn on the basis of both measures.

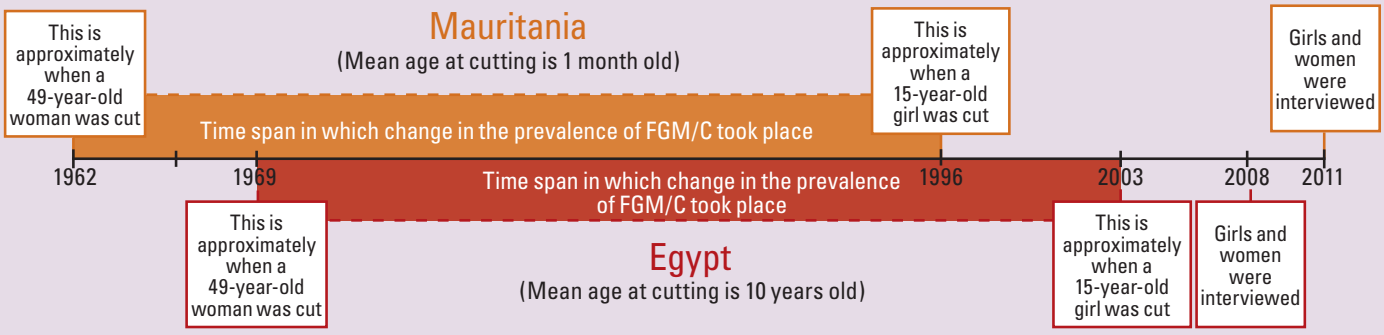
In addition to these factors, one should also consider how survey design and implementation can affect findings across consecutive data collection rounds (*see Box 8.2*). This could include, for example, changes in sampling frames, questionnaire content and structure, and the language used to refer to the practice. As noted previously, the way in which surveys have

Box 8.1 The effect of time lags in interpreting trends in FGM/C prevalence among girls and women aged 15 to 49

When tracking changes in FGM/C prevalence among girls and women of reproductive age, it is important to remember that respondents are usually reporting on an event that occurred many years previously. This time lag will vary, depending on the woman's current age and the age at which she was cut, and any attempt to understand the impact of efforts to reduce FGM/C must take this into account. Data on age at cutting is routinely collected in DHS and MICS and provides adequate information for determining the approximate timing of behaviour changes.

To take a specific example: According to the 2011 MICS in Mauritania, the mean age at cutting is 1 month old. This implies that most girls in the youngest cohort, 15 to 19 years of age, are generally reporting on an event that took place almost 15 to 19 years before the survey – between 1992 and 1996. Similarly, older women aged 45 to 49 are referring to an event that occurred between 1962 and 1966. Hence, the data collected from these girls and women will not reflect the impact of recent campaigns aimed at ending FGM/C, but describe events and changes that occurred over about three decades – between 1962 and 1996.

By contrast, in Egypt (DHS 2008), the mean age at cutting is around 10 years. Hence, the oldest women in the survey (age 49) are reporting on an event that took place, on average, some 39 years previously. The youngest women in the survey (age 15) are reporting on an event that occurred about 5 years previously. Data from the youngest cohort, 15 to 19 years of age, are, in this case, sensitive to change resulting from more recent efforts to discourage FGM/C, since the survey captures events that occurred as recently as 1999 to 2003.



Box 8.2 Measuring changes in FGM/C: The influence of survey design and implementation

Factors relating to survey design and implementation can influence estimates in a particular country, and should be taken into account when looking at findings across all available surveys. Such factors can compromise the comparability of data and include variations in sampling frames, questionnaire content and structure, and language used to refer to the practice.

Changes in sampling frames may include the exclusion of a geographic area from the survey, altering eligibility criteria, or changing the sample fraction in particular regions. In such instances, the data may need to be adjusted to assure comparability. In the 1998 DHS for Kenya, for example, the North Eastern Province was not included. This area is primarily inhabited by Somali communities, where FGM/C is almost universal. It was added in the 2003 and 2008-2009 DHS. This change in the sampling frame makes it inappropriate to directly compare estimates from more recent surveys with those from 1998. If data from the North Eastern Province are excluded from the 2003 and 2008-2009 surveys, data from all three surveys can be compared. Under this scenario, FGM/C prevalence dropped from 38 per cent in 1998 to 31 per cent in 2003 to 26 per cent in 2008-2009 in portions of the country excluding the North Eastern Province. Levels of support for the practice declined from 20 per cent in 1998 to 8 per cent in 2008-2009.

In Mali, the sample used in the 1995-1996 DHS did not cover the district of Kidal (an area of very low prevalence) and under-represented the districts of Tombouctou (an area of higher prevalence) and Gao (an area of very low prevalence). The support for FGM/C was 6 per cent in 1995-1996 in the districts of Tombouctou/Gao and 35 per cent in 2001 in Tombouctou/Gao/Kidal. Therefore, the overall prevalence and levels of support for the practice were likely to be slightly higher in 1995-1996 than recorded by the survey. However, the size of that increase cannot be calculated with precision and the 1995-1996 data cannot be directly compared with later surveys.

In Egypt, changes in eligibility criteria affected the sampling frame across repeat surveys. The DHS conducted between 1995 and 2005 only sampled girls and women between the ages of 15 and 49 who had ever been married, while the 2008 DHS sampled girls and women in the same age group who had ever been married and never been married.[144] The apparent decline in prevalence

asked girls and women about the practice, including questions about their own FGM/C status, has evolved dramatically over the years. It is plausible to expect that such changes have influenced responses. While data sources have been reviewed to verify the comparability of data over time, caution is still warranted when comparing findings from repeat surveys.

Differences in FGM/C prevalence and in attitudes towards the practice may also arise from under-reporting due to the adoption of laws that criminalize FGM/C (*see Boxes 8.3 and 8.4*). As described in Chapter 2, most of the countries in which FGM/C is concentrated have adopted laws against the practice. At the same time, campaigns and other interventions aimed at eliminating it have intensified. It is difficult to evaluate the extent to which such initiatives have introduced reporting biases in surveys.

Finally, it is important to identify differences in estimates that are larger than one would expect from sampling errors alone.[145] All of these factors need to be taken into account when analysing trends, since observed differences may be the result of differences in data collection methods or bias rather than actual changes in the practice.

Change in attitudes

A number of programming efforts have included educational campaigns aimed at raising awareness of the risks of FGM/C and stimulating public discussion and debate on the practice (*see Box 8.5*). Individuals who want FGM/C to stop may be called upon to convince others in their social networks to think likewise, thereby altering reciprocal expectations. Their effectiveness in doing so would presumably be enhanced if they had a leadership role in the community or strong powers of persuasion. After decades of campaigns against the practice, one would expect to see an increasing

from 96 per cent in 2005 to 91 per cent in 2008 is largely due to the fact that FGM/C prevalence is lower among never-married women. When the 2008 data are used to recalculate prevalence among ever-married respondents only, the percentage of girls and women cut is 95 per cent.

In Nigeria, estimates of national FGM/C prevalence have varied over the years. They were recorded as 25 per cent in 1999 (DHS), 19 per cent in 2003 (DHS), 26 per cent in 2007 (MICS), 30 per cent in 2008 (DHS), and 27 per cent in 2011 (MICS). On closer inspection, it appears that three issues pertaining to questionnaire design, sampling and questionnaire content affected the data and compromised the comparability of survey findings over time.

The first issue, in the 1999 DHS, was a skip introduced erroneously into the questionnaire, so that questions on FGM/C were not asked of girls and women who had never had sexual intercourse. This resulted in a large proportion of women (16 per cent) for whom data on FGM/C were missing, including more than half (52 per cent) of girls aged 15 to 19.

The second issue concerns under-representation in the sample of respondents from a region with relatively high levels of prevalence. Nigeria is divided into six geopolitical zones, with major differences in FGM/C prevalence. Data from the last MICS, in 2011, indicate that only 4 per cent of girls and women aged 15 to 49 are cut in the North East region, compared to 48 per cent in the South West region. A comparison of the sampling frames used across available surveys indicates that, in 2003, the sample of girls and women aged 15 to 49 in the South West region was significantly under-represented. This may explain a lower overall prevalence figure in the 2003 DHS (19 per cent).

The third issue relates to changes in questionnaire content. The 2008 DHS in Nigeria expanded the definition of 'circumcision' to include *angurya* (scraping of the vaginal orifice) and *gishiri* cuts (cuts on the wall of the vagina), two procedures that are considered lesser forms of FGM/C and are quite common in Kano State, which is part of the North West Zone. This change in the questionnaire raised the overall prevalence in the North West Zone that year, which was recorded as 20 per cent in 2008, compared with 3 per cent in 2007 and 12 per cent in 2011. It also boosted overall prevalence in the country as a whole, which was reported as 30 per cent in the 2008 DHS. Assuming that FGM/C prevalence in the North West Zone in 2008 was close to 3 per cent, as found in the 2007 MICS, rather than 20 per cent, then the FGM/C prevalence for 2008 would be lower, and closer to the prevalence observed in 2007 and 2011.

number of individuals say that they would like the practice to end. Has this happened?

Of all 29 countries where FGM/C is concentrated, 20 have collected comparable data on attitudes among girls and women more than once, permitting a comparison of levels of support for FGM/C at two or more points in time following interventions to raise awareness of the practice.[146] In six countries, repeat surveys asked boys and men about their opinions regarding the continuation of FGM/C, but in only five countries are available data comparable.[147]

Attitude change among girls and women

Figures 8.1A through 8.1E present trends in support for FGM/C among girls and women aged 15 to 49 in five groups of countries categorized by current prevalence levels (as explained in Box 4.4 on page 27).

As noted earlier, people in high prevalence countries are likely to have little contact with uncut girls and women. As a result, it may be challenging to deliver credible information about the benefits of remaining uncut, making it more difficult to convince women that FGM/C should end. However, the data show that even in countries where FGM/C is almost universal (**Group 1**), such as Egypt and Sudan, a substantially lower proportion of girls and women report that they want FGM/C to continue (*see Figure 8.1A*). Guinea is a notable exception: Over time, the proportion of girls and women who support FGM/C in this country has remained unchanged.

One can expect that in settings with lower prevalence, women are likely to have more interaction with uncut women, providing the opportunity to observe that they do not suffer adverse social sanctions. Presumably, it would then be easier to convince these women that FGM/C should end. In such settings,

Box 8.3 Measuring change in FGM/C prevalence: The effects of under-reporting

As the case of Mali illustrates, changes in FGM/C prevalence may result from under-reporting rather than actual changes in the practice. Among Malian girls and women aged 15 to 49, FGM/C prevalence dropped from 92 per cent in 2001 to 85 per cent in 2006. This finding is hard to explain, since prevalence levels in that country tend to be steady across age cohorts, suggesting no change over time. How might this inconsistency be interpreted?

A comparison of age cohorts in repeat surveys provides some insights. The estimated prevalence in five-year age cohorts is steady in all four surveys conducted in Mali. Women who were 20 to 24 in 1995-1996 were 25 to 29 in 2001, 30 to 34 in 2006 and approximately 35 to 39 in 2010. Therefore, the prevalence among women within each of these age cohorts would be expected to be about the same across surveys. However, the prevalence of FGM/C among these age groups was 94 per cent in 1995-1996; it was roughly the same (92 per cent) in 2001, dropped to 84 per cent in 2006 and went up to 90 per cent in 2010. This pattern is found across all age cohorts, indicating that the apparent decline is likely due to under-reporting of FGM/C in the 2006 survey.

Data from Burkina Faso are a reminder that legal bans on FGM/C may influence the willingness of respondents to honestly disclose their FGM/C status, and the status of their daughters. Four surveys were conducted in Burkina Faso between 1998 and 2010. In those surveys, the reported prevalence of FGM/C among girls and women aged 15 to 49 fluctuates between 72 per cent and 77 per cent. Rather than detecting a genuine change in the practice, it is likely that these findings reflect under-reporting in the 1998-1999 and 2006 surveys due to the enactment and enforcement of a law criminalizing FGM/C (passed in 1996), and a reproductive health law outlawing harmful practices (passed in 2005).

An in-depth study by Nafissatou J. Diop and colleagues reports that, unlike most other African countries, the Government of Burkina Faso has systematically enforced the law on FGM/C, making 97 convictions between 1997 and 2005.[148] Their study found widespread knowledge of the law as well as fear of prosecution. This was supported by the available survey data: In the 1998-1999 modules on FGM/C, 78 per cent of women reported that they were aware of the law criminalizing the practice, rising to 92 per cent in 2006.

A toll-free hotline, SOS Excision, allows people to anonymously report planned or completed acts of cutting. Security teams are mobilized to dissuade people from performing FGM/C and enforce the law. These efforts have been accompanied by numerous other interventions, including media messaging, outreach to youth and women's groups, and information and education campaigns. Diop and colleagues report that responses to the national campaigns have been mixed, in some cases motivating abandonment and, in others, driving the practice underground.[149]

Again, the comparison of age cohorts across available surveys in Burkina Faso provides important insights. The estimated prevalence among women aged 30 to 34 in the 1998-1999 survey is 74 per cent. A similar prevalence should be found among women who were 35 to 39 in 2003; however, the reported prevalence that year among women in that age group was 82 per cent – that is, 8 percentage points higher. Similarly, the prevalence among women who were 20 to 24 in 2006 should be similar to that of women who were 25 to 29 in 2010. However, the prevalence of FGM/C among these age groups was 70 per cent in 2006 and 78 per cent in 2010. This pattern is found across all age cohorts, suggesting that the apparent increases seen in 2003 and 2010 could, in reality, be under-reporting of FGM/C in previous surveys (1998-1999 and 2006).

women may participate in non-kinship-based reference groups – through school, work or religious institutions – whose members may not share expectations about performing FGM/C. Women's opinions may thus be influenced by the opinions of others in these social networks.

Data show that in almost all countries with moderately high or moderately low prevalence (**Group 2** and **Group 3**), the percentage of girls and women who report wanting the practice to continue has steadily decreased (*see Figures 8.1B and 8.1C*). Guinea-Bissau and Senegal are two exceptions to this pattern.

Box 8.4 Measuring support for FGM/C before and after the passage of a law

In areas where legislative measures prohibiting FGM/C have been adopted, it is reasonable to wonder whether people are reporting their true opinions about the practice or providing an interviewer with what they perceive to be the correct response.

As mentioned in Chapter 2, legislative measures that prohibit FGM/C have been put in place in many countries. Deterrence theory suggests that where widespread knowledge of a law and belief in its enforceability exists, the fear of prosecution should reduce support for FGM/C and contribute to a decline in the practice. However, when legal norms run counter to social norms, moral values or religious beliefs, legislative reform may have a limited effect on changing attitudes and practices. Conflicts between legal norms and social norms may be expected to be strongest in countries with high FGM/C prevalence, such as Burkina Faso,[150] but they have been reported in lower prevalence countries as well, including Ghana[151] and Senegal.[152] Where this occurs, additional measures are needed to harmonize social and legal norms.

Data on the level of support among girls and women aged 15 to 49 before and after laws criminalizing FGM/C are available for countries including Benin, Guinea, Kenya, Mauritania and Niger. Laws banning FGM/C were passed in 2003 in Benin,[153] in 2000 in Guinea (following an initial law in 1965), in 2001 in Kenya (extended in 2011), in 2003 in Niger and in 2005 in Mauritania. All of these countries, with the exception of Guinea, saw a decrease in the percentage of girls and women who said they wanted FGM/C to continue. The degree to which this was driven by fear of prosecution or a courtesy bias cannot, however, be determined from the data.

Box 8.5 Public debate and exposure to information about FGM/C

One of the widespread effects of campaigns aimed at ending FGM/C has been to spark debate over the continuation of the practice. Writing about the Gambia, Hernlund illustrates this point:[154]

The way that 'circumcision' is talked about in the Gambia is changing rapidly and dramatically. Prior to the 1980s, the topic was seldom publically addressed; it was considered kulloo *(secret). Recent years, however, have seen intense media coverage of FGM in newspapers, on the radio, and in the past few years, on television. Gambians are not only consumers of this international media…but have become subjects of such reports, and there is widespread awareness that this 'local practice' has become part of a global debate. In the 1980s and 1990s, an increasingly intense dialogue has emerged between those Gambians who perceive a need to eradicate 'female genital mutilation' and those who seek to preserve female 'circumcision' as an integral part of culture.*

A few DHS surveys have asked respondents whether they had discussed the practice of FGM/C with anyone, or had heard or seen anything about the practice. In Egypt, such questions were asked in all DHS conducted between 2000 and 2008. Data show that, in 2008, around three quarters of women reported having heard information of FGM/C, mainly through television, compared to 52 per cent of men. Additionally, around half of women aged 15 to 49 reported that they had discussed the practice with relatives, friends or neighbours, up from 33 per cent in 2000.

Among low and very low prevalence countries (**Group 4** and **Group 5**), a particularly sharp decrease in support for FGM/C can be observed in the Central African Republic and Niger (*see Figures 8.1D and 8.1E*). In the Central African Republic, the proportion of girls and women who think the practice should continue fell from 30 per cent to 11 per cent in about 15 years. In Niger, it dropped from 32 per cent to 3 per cent between 1998 and 2006. In Togo and the United Republic of Tanzania, no significant change over time was observed.

Overall, fewer girls and women want FGM/C to continue, even in some countries where the practice is almost universal

Figure 8.1A

Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue, in countries with **very high** FGM/C prevalence (above 80 per cent)

Notes: Data for Egypt and Sudan refer to ever-married girls and women. Confidence intervals for Eritrea (DHS 1995) and for Sudan (SHHS 2006) could not be calculated since the datasets were unavailable. For Mali, see Box 8.2.
Sources: DHS, MICS and SHHS, 1989-2010.

Figure 8.1B

Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue, in countries with **moderately high** FGM/C prevalence (between 51 per cent and 80 per cent)

Sources: DHS and MICS, 1998-2011.

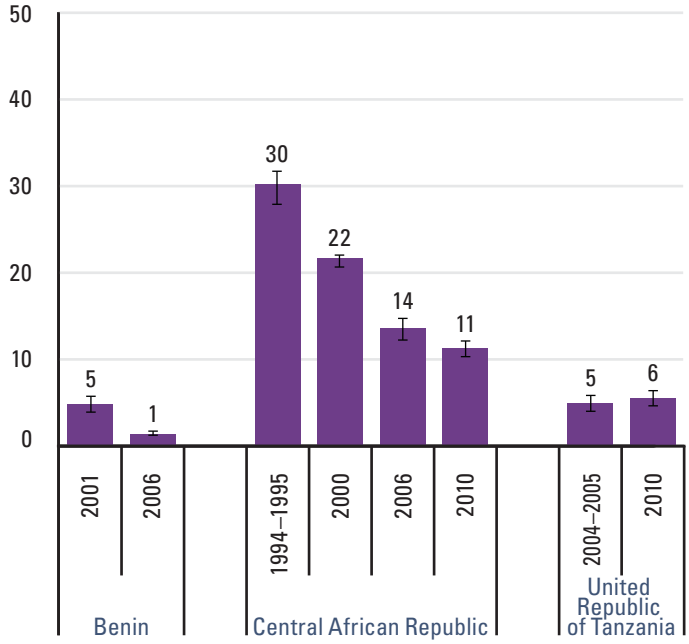
Figure 8.1C

Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue, in countries with **moderately low** FGM/C prevalence (between 26 per cent and 50 per cent)

Note: For Kenya, see Box 8.2.
Sources: DHS and MICS, 1998-2011.

Figure 8.1D

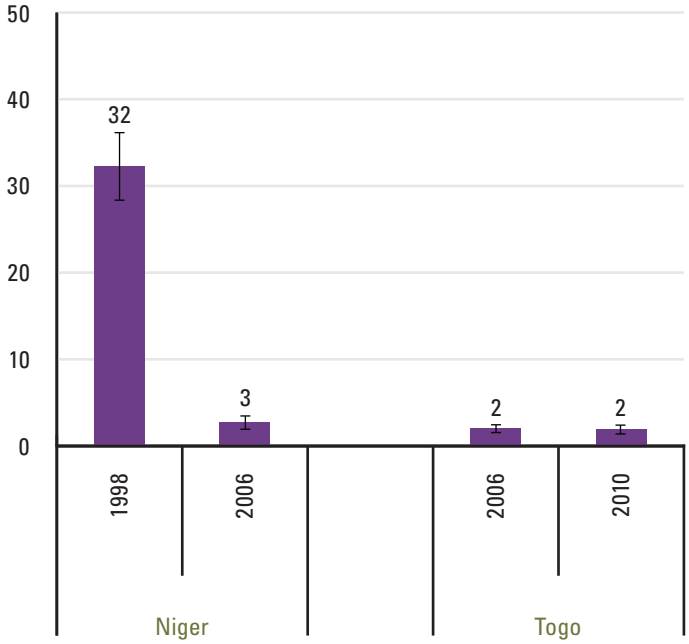
Percentage of girls and women age 15 to 49 years who have heard about FGM/C and think the practice should continue, in countries with **low** FGM/C prevalence (between 10 per cent and 25 per cent)



Sources: DHS and MICS, 1994-2010.

Figure 8.1E

Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue, in countries with **very low** FGM/C prevalence (less than 10 per cent)



Sources: DHS and MICS, 1998-2010.

Attitude change by ethnicity

Different rates of decline in support for FGM/C can be observed across various ethnic groups. Figures 8.2 and 8.3 disaggregate data on attitudes among girls and women aged 15 to 49 by ethnicity using data from the Central African Republic and Burkina Faso. These charts reveal that reductions in the level of support have occurred at different speeds in populations of varying ethnicity.

Attitude change among boys and men

Figure 8.4 shows that in three of the countries with available data (Niger, Burkina Faso and Benin), the proportion of boys and men who report that they want FGM/C to continue has decreased.

Comparing attitude change between the sexes

When comparing attitudes over time between the sexes, data show that patterns of change are similar when change did occur, but also when no decline in support is indicated. When changes did take place, they are always in a downward direction for both sexes. Change also occurred at similar rates, except in Niger. There, the decline in support has been significantly sharper among girls and women than boys and men. In Guinea, no major changes can be observed in either group (*see Figure 8.5*).

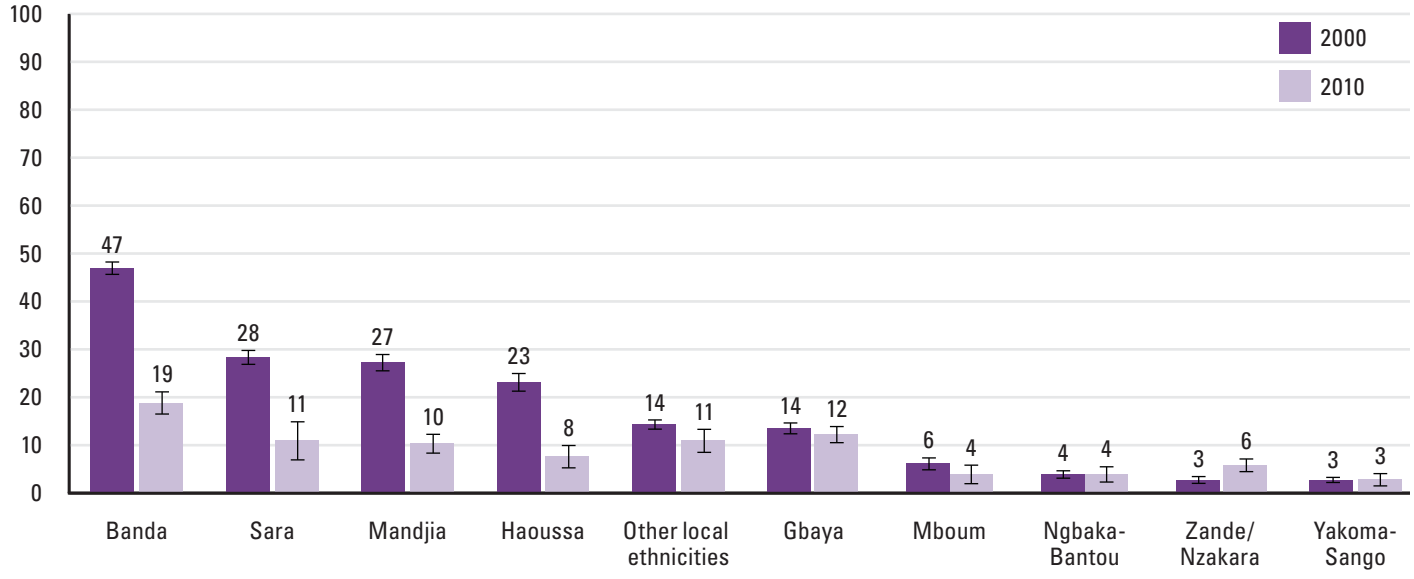
Change in justifications for the practice

Overall, the reasons for supporting the continuation of FGM/C among both sexes have not changed dramatically over time. However, there has been an increased understanding of some of the more serious health implications of the practice.

In Egypt, all DHS conducted in the country between 1995 and 2008 included several statements with which girls and women were asked to agree or disagree. Two of the statements ad-

Figure 8.2 In the Central African Republic, a sharp decline in female support for the practice has occurred among the Banda, Sara, Mandjia and Haoussa ethnic groups

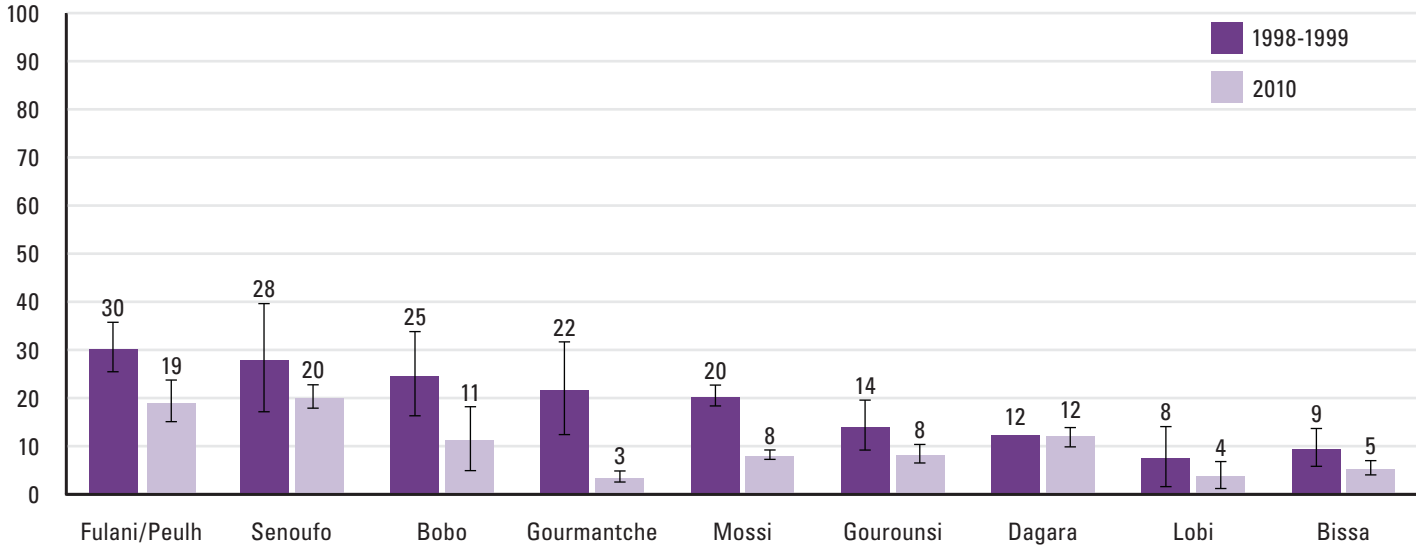
Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue in the Central African Republic, by selected ethnic groups with comparable data, in 2000 and 2010



Sources: MICS, 2000 and 2010.

Figure 8.3 In Burkina Faso, a sharp decline in female support for the practice has occurred among the Gourmantche and Mossi ethnic groups

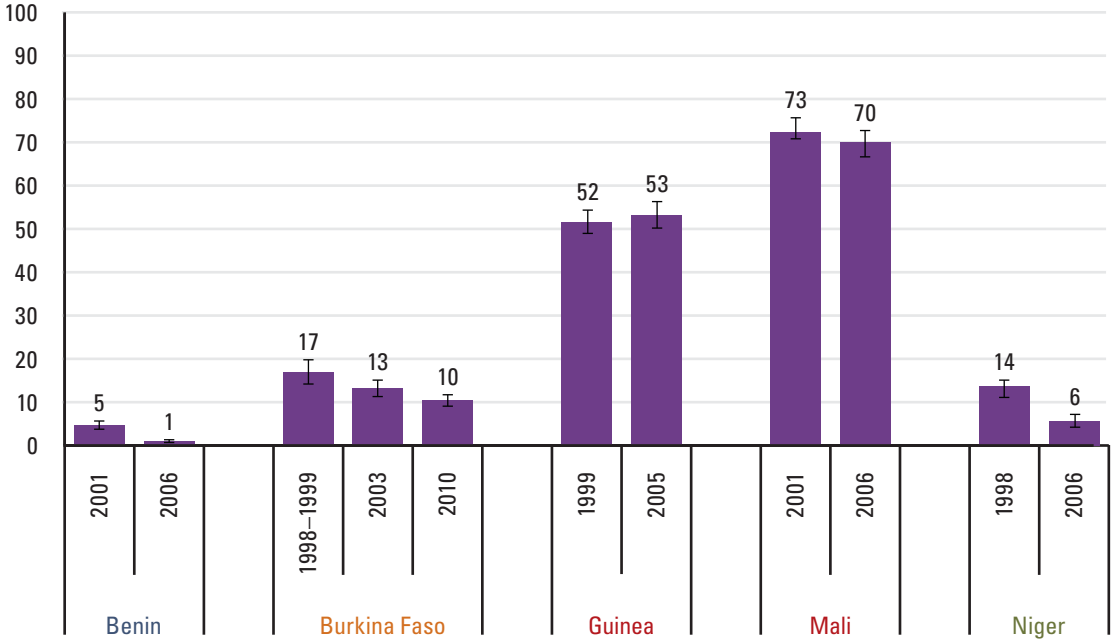
Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue in Burkina Faso, by selected ethnic groups with comparable data, in 1998-1999 and 2010



Sources: DHS 1998-1999 and DHS/MICS 2010.

Figure 8.4 In Niger, Burkina Faso and Benin, male support for FGM/C has declined

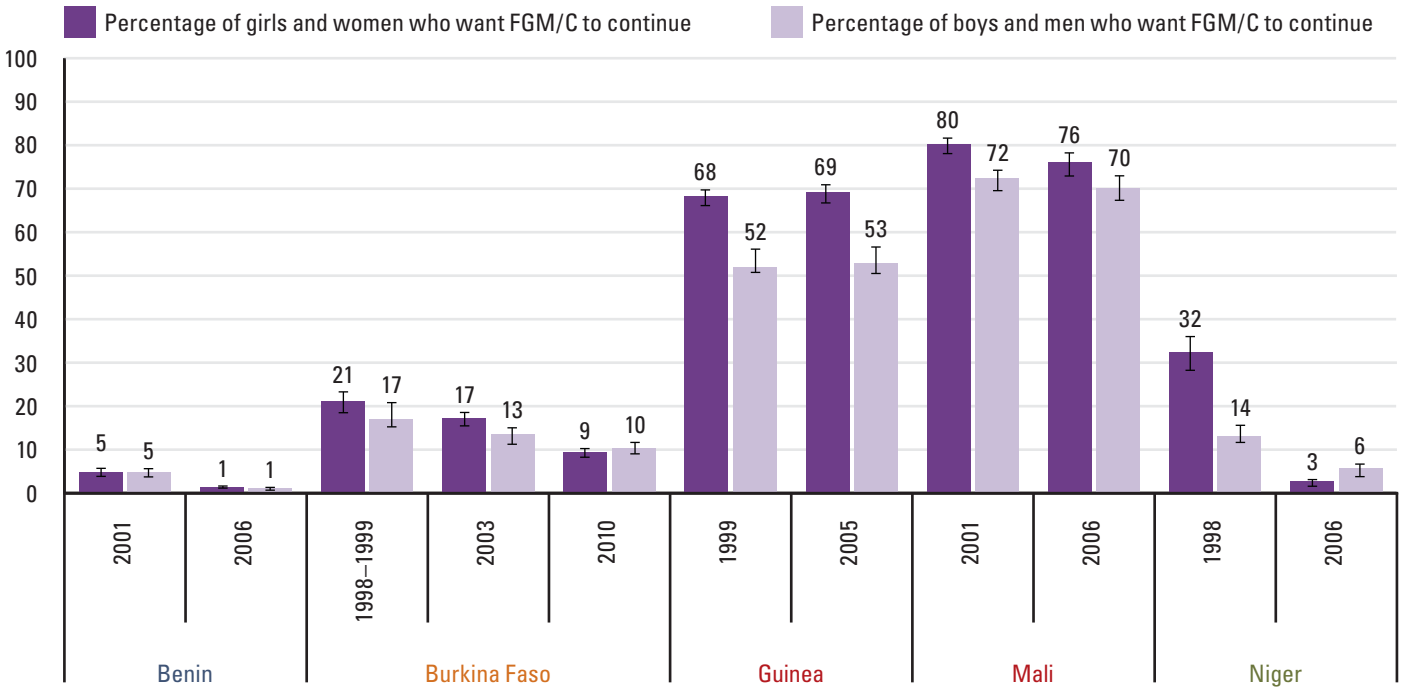
Percentage of boys and men aged 15 to 59 (or 64, see note) years who have heard about FGM/C and think the practice should continue



Notes: Data for Benin refer to boys and men aged 15 to 64. Data for Burkina Faso, Guinea, Mali and Niger refer to boys and men aged 15 to 59. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 1998-2010.

Figure 8.5 Patterns of attitude change in men and women are similar

Percentage of girls and women aged 15 to 49 years and percentage of boys and men aged 15 to 59 (or 64, see note) years who have heard about FGM/C and think the practice should continue



Notes: Data for Benin refer to boys and men aged 15 to 64. Data for Burkina Faso, Guinea, Mali and Niger refer to boys and men aged 15 to 59. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 1998-2010.

dressed factors that are often cited as primary rationales for the practice: *A husband will prefer his wife to be circumcised* and *Circumcision prevents adultery*. The other statements were related to health concerns associated with the practice: *Childbirth is more difficult for a woman who has been circumcised* and *Circumcision can cause serious consequences that can lead to a girl's death*. Earlier surveys in Egypt asked women to agree or disagree with additional statements related to some other adverse consequences of FGM/C, including reduced sexual satisfaction and infertility. The results show that 44 per cent of women in 2008 agreed that FGM/C can cause severe complications that may lead to a girl's death – up from 24 per cent in 1995 (*see Table 8.1*). The proportion of girls and women who agreed that husbands prefer cut women declined from 74 per cent to 55 per cent over the same period.

Change in prevalence

With increased availability of nationally representative data on FGM/C, including repeat surveys in several countries, trends in prevalence can be analysed from a number of perspectives. First, prevalence can be compared from surveys in the same country from two (or more) points in time. Second, a trend analysis can examine FGM/C prevalence at one point in time across five-year age cohorts for girls and women aged 15 to 49. Finally, current prevalence among girls aged 15 to 19 and 'adjusted' prevalence among girls aged 10 to 14 can be analysed, as explained later in this chapter. These three methods offer different insights into whether and when change has occurred and are best used in combination to draw a comprehensive picture of what is happening.

Table 8.1 In Egypt, many more women now understand the serious, potentially fatal, consequences of FGM/C

Percentage of ever-married girls and women aged 15 to 49 years in Egypt who agree with various statements about FGM/C

	Lessens sexual satisfaction	Causes infertility	(Important) religious tradition	Husbands prefer	Prevents adultery	Can lead to a girl's death	Makes childbirth difficult
1995	29	7	72	74	41	24	5
2000	37	8	73	67	51	29	8
2003	32	8	72	64	47	28	6
2005	N/A	N/A	N/A	61	54	32	13
2008	N/A	N/A	N/A	55	41	44	6

Note: N/A = not asked.
Sources: DHS, 1995-2008.

Prevalence at two or more points in time among girls and women aged 15 to 49

Of all 29 countries where FGM/C is concentrated, 23 have been surveyed more than once, permitting a comparison of FGM/C prevalence at two or more points in time.[155] What sort of changes can be expected in countries with low or high FGM/C prevalence? As with attitudes, it is likely that declines in prevalence would be smaller in high prevalence countries because of limited exposure to non-practising groups. In addition, if FGM/C is strongly associated with group identity in minority populations, one might presume that the practice is strongly guarded and resistant to change. Finally, where the practising population is small, migration in or out of that group will tend to have significant effects on prevalence.

Figures 8.6A through 8.6E present FGM/C prevalence estimates among girls and women aged 15 to 49, based on consecutive surveys in 23 countries with available trend data. The countries have been divided by current prevalence levels (as explained in Box 4.4 on page 27).

The most dramatic reduction in prevalence has taken place in the Central African Republic, dropping from 43 per cent in 1994-1995 to 24 per cent in 2010. This reflects a 44 per cent decline from the late-1970s to the mid-1990s. In Kenya, the reported prevalence shows a 28 per cent decrease between 1998 and 2008-2009, dropping from 38 per cent to 26 per cent. On the other hand, the prevalence of FGM/C among girls and women has remained constant in countries such as Egypt, Gambia, Senegal and Sudan.

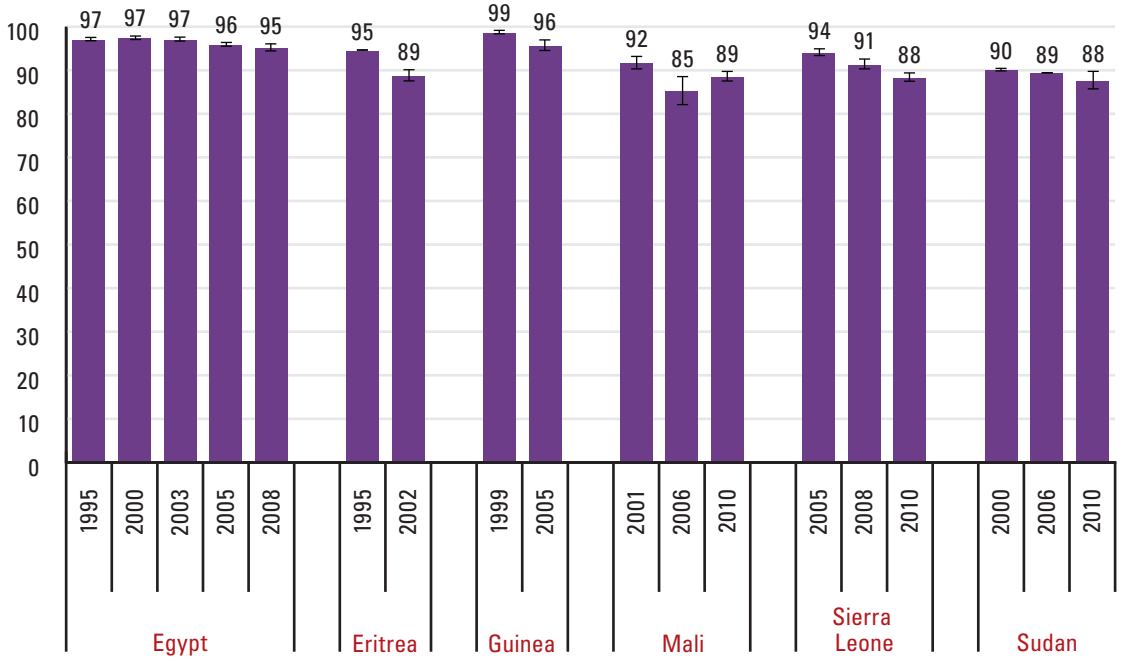
Prevalence at two or more points in time among girls

Prevalence levels among the youngest cohorts are important statistics for evaluating recent progress towards ending FGM/C in a particular country. Comparing prevalence in girls aged 15 to 19 across various surveys, instead of looking at the entire group of girls and women of reproductive age, narrows the window of time in which the practice is observed. It places the focus on girls most recently cut, rather than aggregating them with women who may have been cut decades ago and is a good way to gain insights into how the practice has changed in recent years.

When data from consecutive surveys are compared, the most dramatic reductions in FGM/C prevalence are seen in the Central African Republic and Kenya

Figure 8.6A

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, in countries with **very high** FGM/C prevalence (above 80 per cent)



Notes: Data for Egypt refer to ever-married girls and women. For Egypt and Mali, see Boxes 8.2 and 8.3. For Sudan, see endnote 144. Confidence intervals for Eritrea (DHS 1995) and Sudan (SHHS 2006) could not be calculated since the datasets were unavailable.
Sources: DHS, MICS and SHHS, 1995-2010

Figure 8.6B

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, in countries with **moderately high** FGM/C prevalence (between 51 per cent and 80 per cent)

Sources: DHS and MICS, 1998-2011.

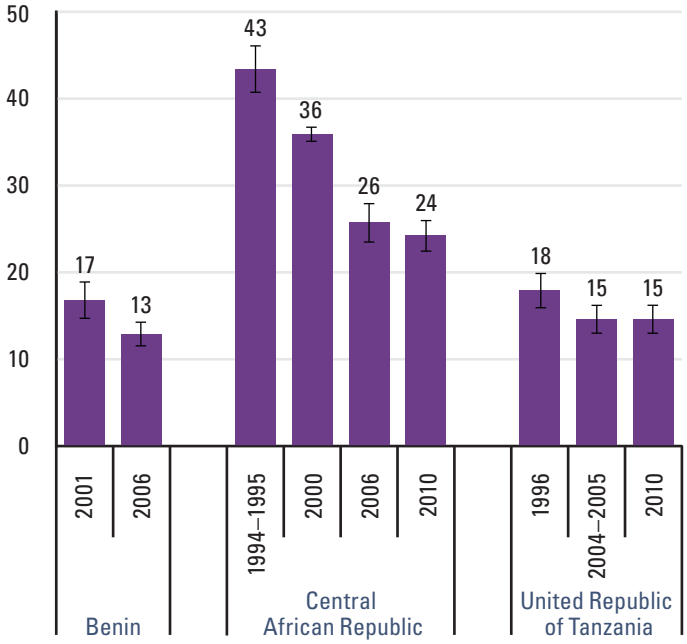
Figure 8.6C

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, in countries with **moderately low** FGM/C prevalence (between 26 per cent and 50 per cent)

Notes: For Kenya and Nigeria, see Box 8.2. Confidence intervals for Côte d'Ivoire (DHS 2012) could not be calculated since the dataset is not yet available.
Sources: DHS and MICS, 1994-2012.

Figure 8.6D

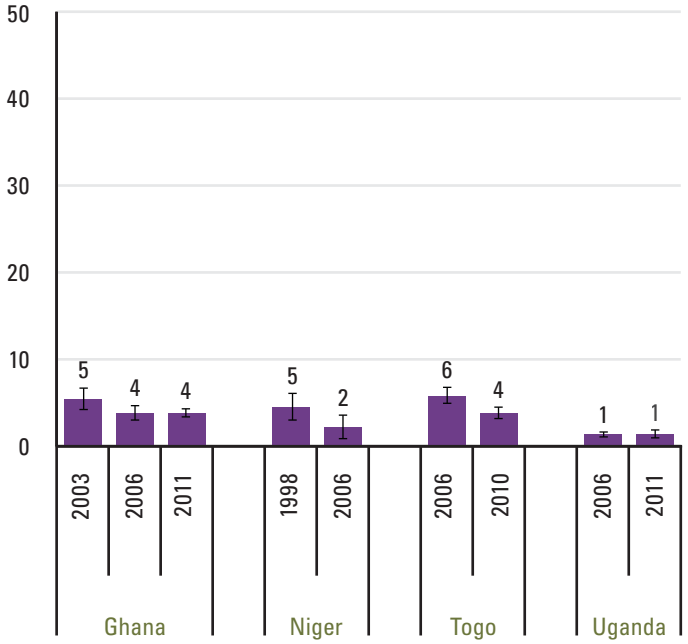
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, in countries with **low** FGM/C prevalence (between 10 per cent and 25 per cent)



Sources: DHS and MICS, 1994-2010.

Figure 8.6E

Percentage of girls and women age 15 to 49 years who have undergone FGM/C, in countries with **very low** FGM/C prevalence (less than 10 per cent)



Sources: DHS and MICS, 1998-2011.

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Sabina stands in a friend's house in Rebu, a village in Tarime district, Mara region, United Republic of Tanzania. Sabina was subjected to FGM/C at age 11 and was married at age 12. "I would refuse to let my child get circumcised," she said, "but my husband would have to agree with me."

When looking at the prevalence levels of girls aged 15 to 19 across various surveys, one finds that in Eritrea and Sierra Leone, where a small decline in prevalence was noted among girls and women of reproductive age (15 to 49), an even stronger reduction is observed in the youngest age cohort. Moreover, some evidence of change, although slight, starts to emerge in younger cohorts in countries like Guinea *(results not shown)* where no change is observed among all girls and women of reproductive age.

Prevalence levels among girls aged 0 to 14 can also be compared in repeat surveys. Such data are currently available for two countries only, Egypt and Sudan, and do not show major changes (*results not shown*). Here, however, an important factor needs to be taken into account: The age at cutting may change over time and influence the proportion of girls who are currently uncut but who are likely to be cut in the future.

Generational trends

A useful method to assess trends in FGM/C prevalence is to subdivide respondents from a single survey into five-year age cohorts and examine changes across generations. A decline in FGM/C prevalence between women aged 45 to 49 and those aged 15 to 19 suggests a reduction in the practice over the course of about three decades.[156]

Comparing FGM/C prevalence across cohorts can also be used to assess change in countries that have not had repeat surveys, as is the case for Cameroon, Djibouti, Iraq, Liberia, Somalia and Yemen. An analysis of generational trends may highlight changes in the practice of FGM/C that

may not be apparent when looking at estimated prevalence in the entire 15 to 49 year age group in successive surveys. For instance, large differences in prevalence among girls and women aged 15 to 49 in surveys conducted five years apart are not to be expected when comparing estimates from two points in time; in these cases, overall prevalence levels are only affected by how widespread the practice is among girls who 'age into' the youngest cohort (15-19) and women who 'age out' of the oldest cohort (45-49).

Comparing FGM/C prevalence among various age groups can also suggest whether the decline in prevalence is a recent phenomenon or a more steady and consistent trend. Interpretation of these trends, however, requires consideration of the age at which FGM/C is typically performed, as illustrated in Box 8.1. In settings where cutting occurs at early ages, this method will not capture recent changes due to the length of retrospective periods. In other words, in settings where most girls are cut before age 1, the youngest female respondents (in the 15-19 age cohort) would report on an event that occurred approximately 14 to 18 years prior to the survey, while the older ones (in the 45-49 age cohort) would refer to an event that took place 44 to 48 years earlier. Any change that occurred more recently will not be reflected in these data, but will have to be assessed by looking at the adjusted prevalence among daughters aged 10 to 14, as explained in Box 8.6.

Figure 8.7 shows that in more than half of the 29 countries analysed, significantly lower prevalence levels can be found in the youngest age group (15-19) compared to the oldest age group (45-49). This includes Egypt, where no change was detected when looking at FGM/C prevalence among girls and women aged 15 to 49 in repeat surveys. In a number of countries, FGM/C prevalence is dramatically lower among adolescents aged 15 to 19, as compared to women aged 45 to 49. The decline is particularly sharp in some countries: In Kenya and the United Republic of Tanzania, for example, women aged 45 to 49 are approximately three times more likely to have been cut than girls aged 15 to 19. In Benin, Central African Republic, Iraq, Liberia and Nigeria, prevalence has dropped by about half among adolescent girls. On the contrary, no significant changes in FGM/C prevalence can be observed in Chad, Djibouti, Gambia, Guinea-Bissau, Mali, Senegal, Somalia, Sudan and Yemen.

Figures 8.8A through 8.8F show the prevalence of FGM/C for each age cohort in the 29 practising countries, according to the most recent survey data. As with previous figures, they are divided into five groups by current prevalence levels (both Figures 8.8A and 8.8B show high prevalence countries, but are divided into groups showing no or significant changes among age cohorts). In examining the figures, it appears that changes began at different times in different countries. In Egypt, for instance, a reduction in FGM/C prevalence is first noted in the 20-24 year age cohort. With a mean age at cutting of approximately 10 years (among girls and women aged 15 to 49), and a survey undertaken in 2008, this suggests that the trend in reduced cutting began in the mid-1990s. By contrast, in Kenya,

Box 8.6 Adjusting FGM/C prevalence estimates for girls under age 15

To account for the fact that girls aged 0 to 14 who have not undergone FGM/C may still be at risk once they reach the customary age for cutting, adjustments can be made to data on FGM/C prevalence. This is done by combining figures on the proportion of girls who are already cut with those at risk of being cut.

The adjusted prevalence is calculated as the sum of the current FGM/C prevalence among girls aged 10 to 14 and the percentage of girls aged 10 to 14 who are expected to be cut before they reach age 15, based on data on age at cutting. The use of prevalence data for girls aged 10 to 14 is preferred since figures for younger girls aged 0 to 9 are more sensitive to censoring.

For instance, data from the 2010 DHS in Burkina Faso show that, among girls aged 15 to 19 who underwent FGM/C, 91 per cent of them were cut by age 10; 7 per cent were cut between 10 and 14 years of age; 1 per cent were cut at age 15 or later; and the age at cutting was unknown for 1 per cent. The data also indicate that 25 per cent of girls aged 10 to 14 have already experienced FGM/C. An analysis of trends confirms that, in most countries including Burkina Faso, the age at cutting has remained fairly stable over time. One can therefore expect to see a similar pattern in age at cutting between girls aged 15 to 19 and girls aged 10 to 14. On the basis of this assumption, it can be estimated that, in the case of Burkina Faso, approximately 7 per cent of the girls aged 10 to 14 who have not yet undergone FGM/C will be cut before they turn 15. This gives us the proportion of girls aged 10 to 14 who are still at risk of being cut – that is, around 2 per cent.

While this method is helpful in diminishing the risk of underestimation, a key point should be considered. As explained earlier, information on age at cutting may be inaccurate, due to difficulties among respondents in recalling the exact age at which the cutting occurred. As a result, adjusted prevalence figures among girls aged 10 to 14 need to be considered approximations rather than precise estimates.

steady declines in prevalence are seen across all age cohorts. Since the mean age at cutting in that country is around 12 years and data on FGM/C were last collected in 2008-2009, this suggests that the practice of FGM/C has been steadily declining since the 1970s.

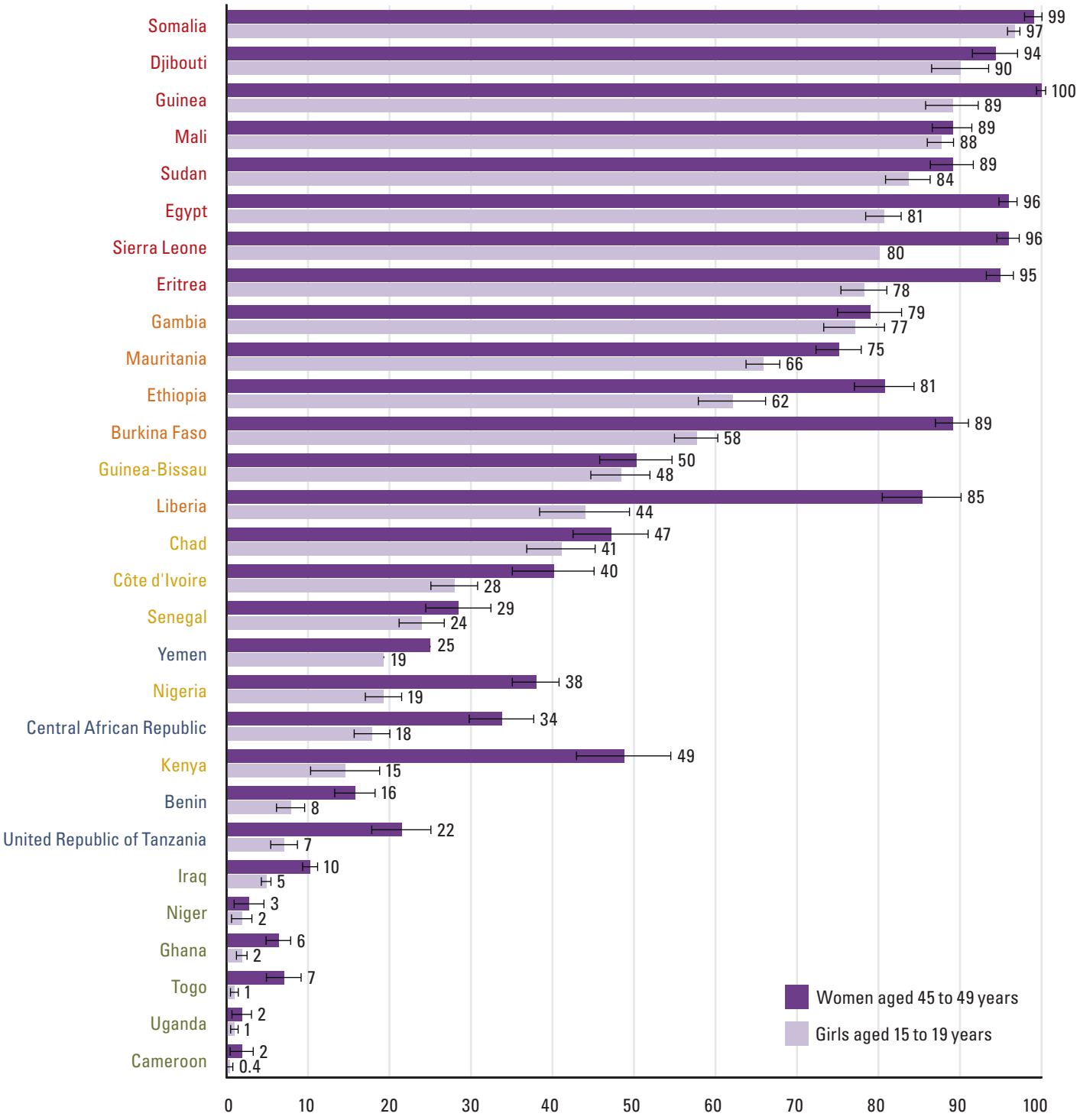
A tempting way to assess trends in the practice of FGM/C is to compare prevalence levels of women aged 15 to 49 to those of their daughters (aged 0 to 14), using data from a single survey. However, prevalence data for the two groups are not comparable, since a certain proportion of girls are simply too young to have been cut, and may undergo the practice once they reach the customary age. Therefore, prevalence among girls aged 0 to 14 will always include a certain level of underestimation, particularly in the case of countries where most of the girls are cut in early adolescence.

A possible comparison is one that looks at adjusted prevalence among girls aged 10 to 14 and prevalence among girls aged 15 to 19. An adjustment is made for the younger age group, since they may still be subjected to cutting before age 15 (*see Box 8.6*).

Figure 8.9 shows current FGM/C prevalence among girls aged 15 to 19 and adjusted prevalence among girls aged 10 to 14 for nine countries with available data.[157] In Burkina Faso, the adjusted prevalence for girls aged 10 to 14 is expected to be around 26 per cent. This proportion is about half the share of girls cut among those aged 15 to 19 (58 per cent). This finding seems to suggest an important and accelerating trend towards the elimination of the practice in recent years. However, as noted in Box 8.3, the enforcement of the laws against FGM/C resulted in several prosecutions, including against parents for cutting their daughters. The degree to which the observed trend is the result of under-reporting due to fear of prosecution rather than an actual decline cannot, however, be determined from the data. A similar decreasing trend is observed in the Central African Republic, Egypt and Sierra Leone, but not in countries such as the Gambia or Nigeria, where adjusted prevalence figures among girls aged 10 to 14 are practically the same as those among girls aged 15 to 19.

Figure 8.7 In most of the 29 countries, FGM/C is less common among adolescent girls than middle-aged women

Percentage of girls aged 15 to 19 years and women aged 45 to 49 years who have undergone FGM/C



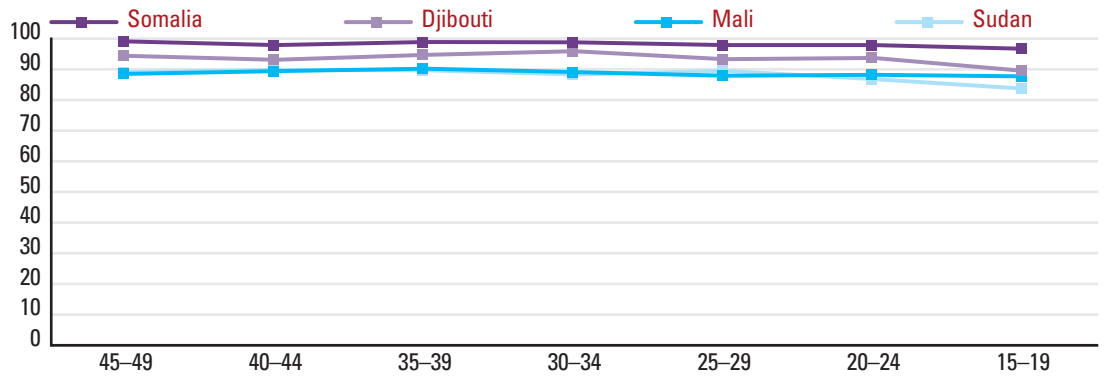
Notes: Confidence intervals for Sierra Leone could not be calculated since the prevalence among girls aged 15 to 19 has been adjusted, as explained in endnote 156. Confidence intervals for Yemen could not be calculated since access to the dataset is restricted. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.

Sources: DHS and MICS, 1997-2011.

Declines in the practice of FGM/C seem to have occurred at different rates and at different times

Figure 8.8A

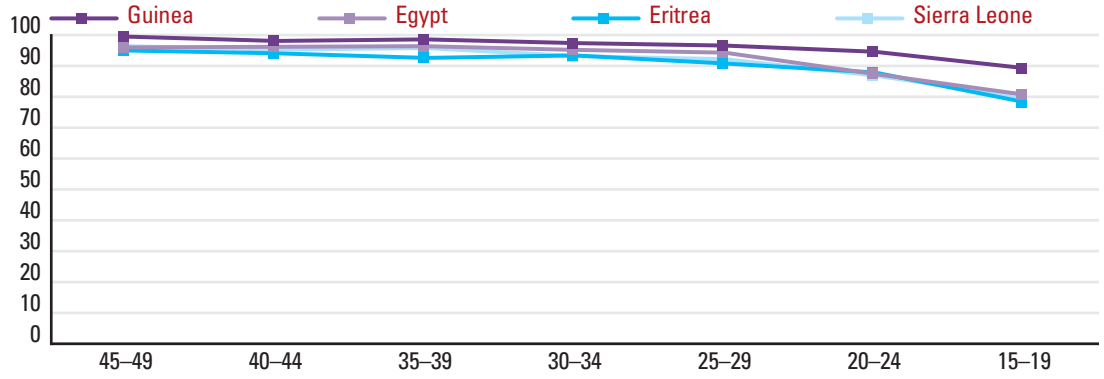
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **very high** FGM/C prevalence (above 80 per cent) and **no significant change** in prevalence across age cohorts



Sources: MICS and SHHS, 2006-2010.

Figure 8.8B

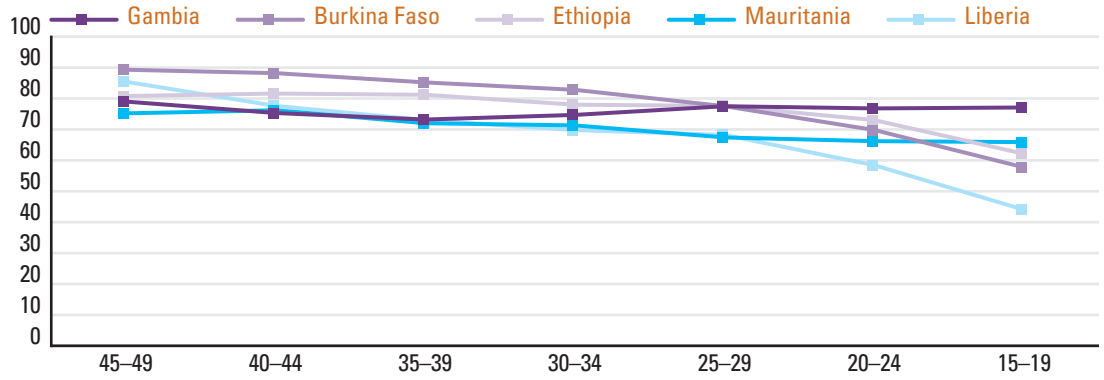
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **very high** FGM/C prevalence (above 80 per cent) and **changes** in prevalence across age cohorts



Note: For further details on the prevalence among girls aged 15 to 19 in Sierra Leone, see endnote 156.
Sources: DHS and MICS, 2002-2010.

Figure 8.8C

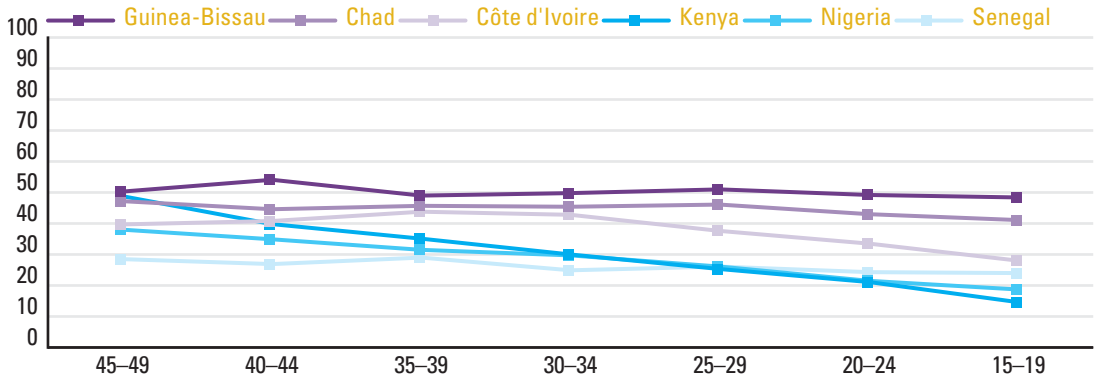
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **moderately high** FGM/C prevalence (between 51 per cent and 80 per cent)



Sources: DHS and MICS, 2005-2011.

Figure 8.8D

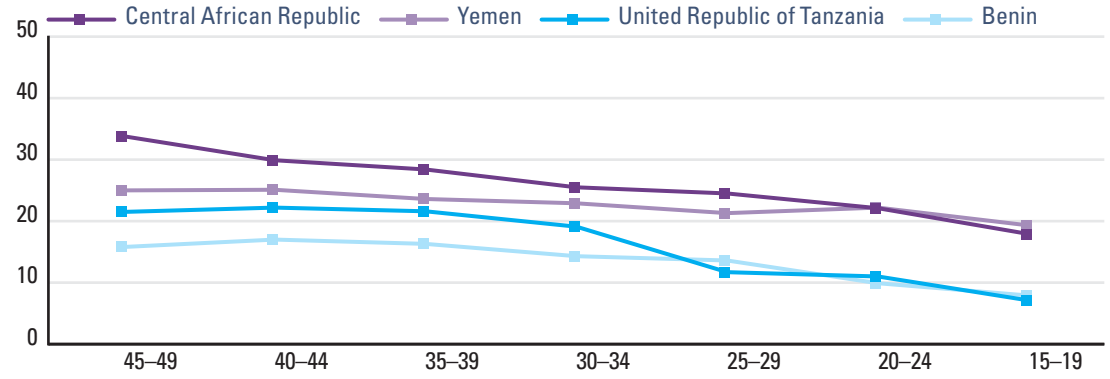
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **moderately low** FGM/C prevalence (between 26 per cent and 50 per cent)



Sources: DHS and MICS, 2006-2011.

Figure 8.8E

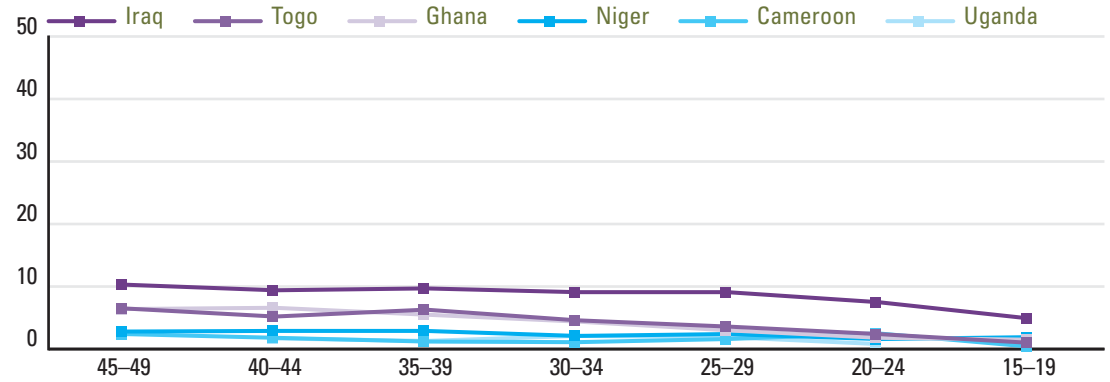
Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **low** FGM/C prevalence (between 10 per cent and 25 per cent)



Sources: DHS and MICS, 1997-2010.

Figure 8.8F

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C, by age cohort, in countries with **very low** FGM/C prevalence (less than 10 per cent)



Sources: DHS and MICS, 2004-2011.

Trends by region and ethnicity

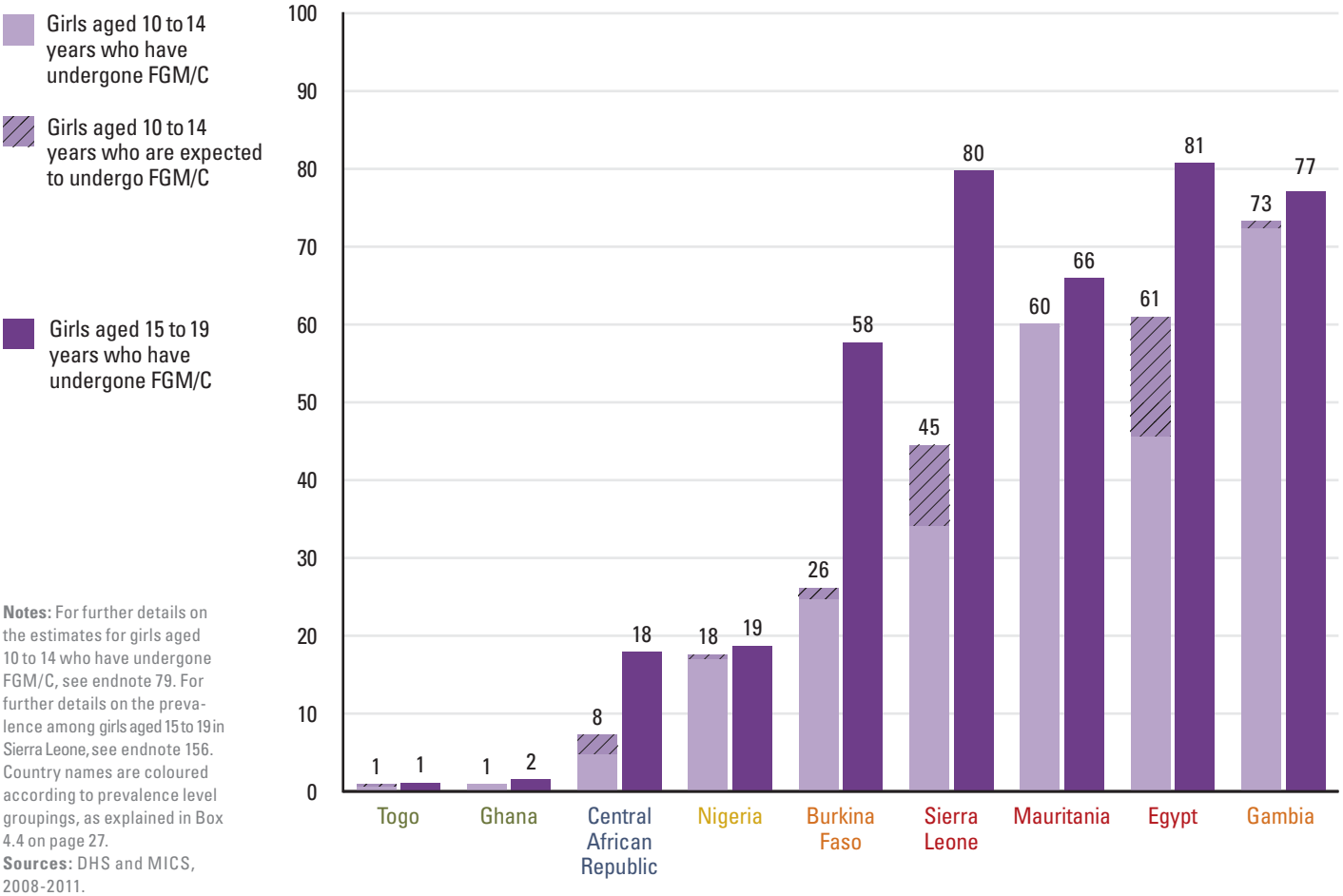
The disaggregation of data by regions within a country allows for the identification of areas that have experienced the fastest declines in FGM/C prevalence. In the Central African Republic, for instance, FGM/C prevalence overall has declined over time in most geographic areas. However, the rate of change is not uniform, with certain regions experiencing a faster decline. When comparing prevalence data by region in 2000 and 2010, it is apparent that dramatic changes have occurred both in high prevalence areas, such as Nana-Grebizi, as well as in low prevalence areas such as Sangha-Mbaere (*see Figure 8.10*).

Different rates of decline by region can be observed in other countries as well. As explained earlier, when and where change has occurred is best understood by examining prevalence by age cohorts. If the abandonment of FGM/C involves coordinated change among members of a social network, one might expect to see periods of moderate or low change, followed by steeper drops in prevalence. If the decision to abandon FGM/C is not relational, and can be decided upon by individual families, one might anticipate steady declines in the practice.

Data from Liberia show that FGM/C prevalence among older women (aged 45 to 49) is around 93 per cent to 99 per cent in the South Central, North Western and North Central regions. However, different rates of decline can be observed in these three areas. The percentage of girls aged 15 to 19 who experienced some form of FGM/C ranges from 77 per cent in North Central to 42 per cent in South Central, indicating a much faster and sud-

Figure 8.9 Data from Burkina Faso and the Central African Republic suggest major progress in reducing FGM/C in girls under age 15

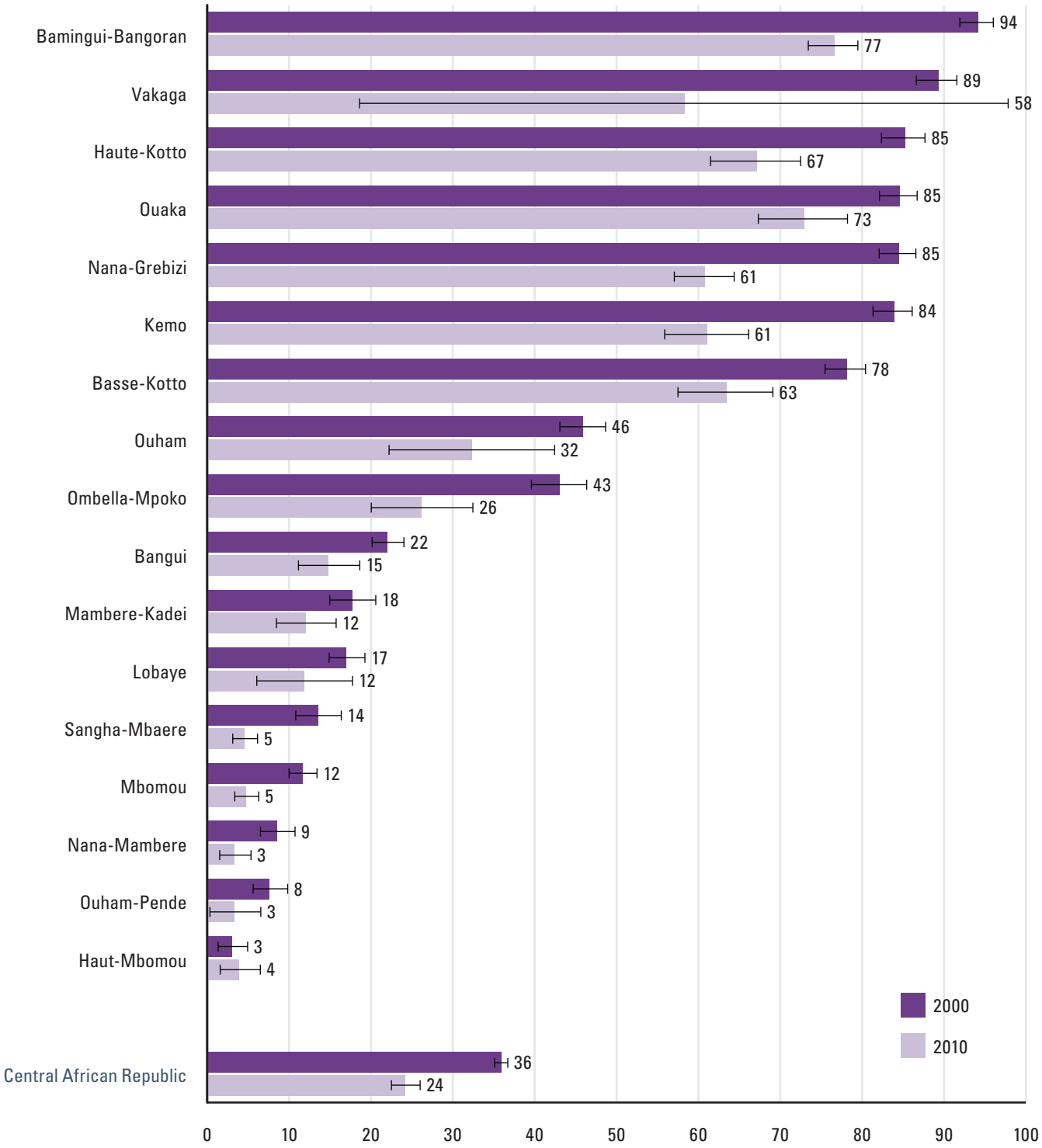
Percentage of girls aged 10 to 14 years who have undergone FGM/C, percentage of girls aged 10 to 14 years who are expected to undergo FGM/C, and percentage of girls aged 15 to 19 years who have undergone FGM/C



Notes: For further details on the estimates for girls aged 10 to 14 who have undergone FGM/C, see endnote 79. For further details on the prevalence among girls aged 15 to 19 in Sierra Leone, see endnote 156. Country names are coloured according to prevalence level groupings, as explained in Box 4.4 on page 27.
Sources: DHS and MICS, 2008-2011.

Figure 8.10 In the Central African Republic, the rate of decline in the practice of FGM/C varies by region

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in the Central African Republic, by region, in 2000 and 2010



Note: Data for the Vakaga region from MICS 2010 are based on 25-49 unweighted cases.
Sources: MICS, 2000 and 2010.

den rate of decline in the latter region, particularly among women between 15 and 29 years of age (*see Figure 8.11*). This is consistent with the hypothesis that FGM/C is relational and coordination with others is required to bring about change.

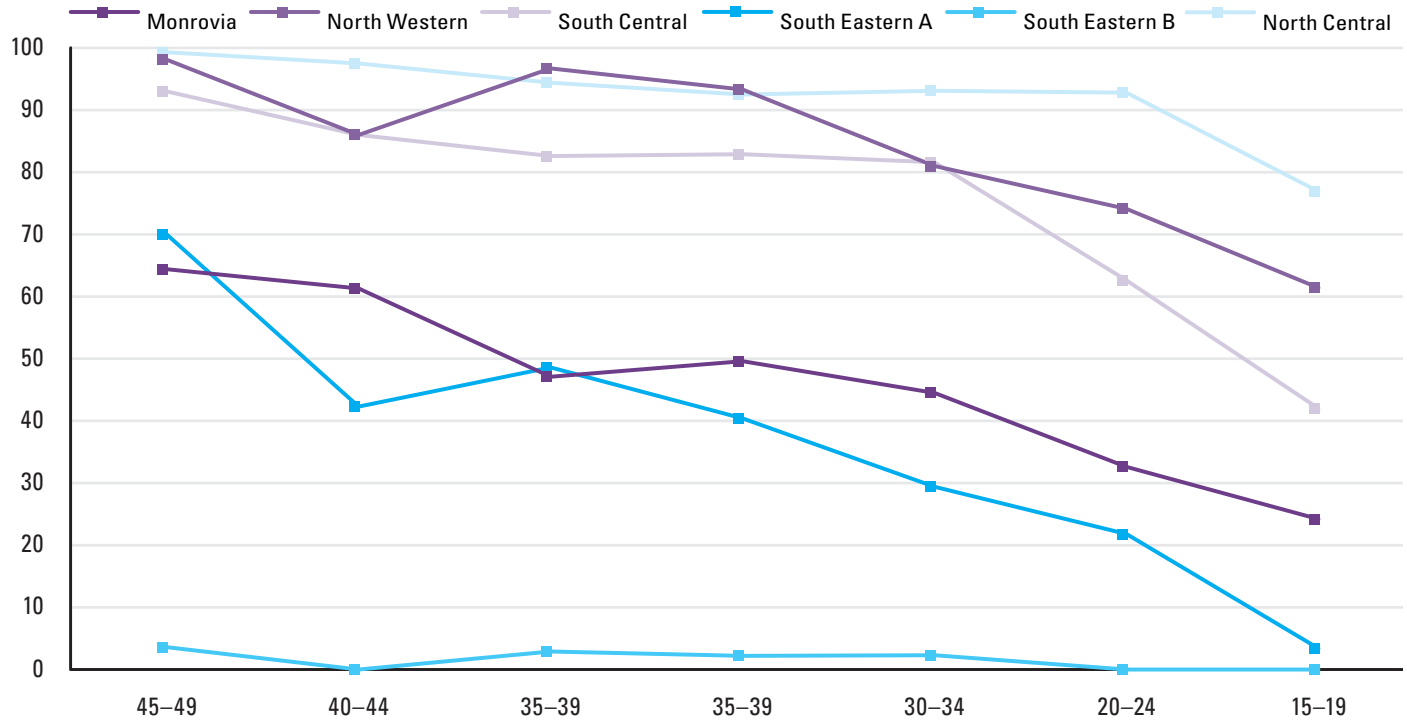
As mentioned in Chapter 4, in countries with a very low national FGM/C prevalence, the practice tends to be concentrated in select areas. Therefore, change is best assessed by looking at regions where the practice is most prevalent. In Ghana, Iraq and Togo, the region with the highest level of FGM/C in each country registered significant drops in prevalence between women aged 45 to 49 and girls aged 15 to 19 (*see Figure 8.12*). In the remaining countries with very low national prevalence (Cameroon, Niger and Uganda), clear patterns of change across age cohorts in the regions of highest prevalence are not evident. Rather, they display fluctuations in prevalence that are difficult to interpret (*results not shown*). Data from these countries are based on a limited number of observations and yield very large confidence intervals. For these reasons, it is difficult to draw clear conclusions on the changes that may have occurred in the levels of the practice.

Different rates of decline in FGM/C prevalence can also be observed across ethnic groups, supporting the current understanding that the practice is relational. Data from Kenya illustrate this point. FGM/C has declined substantially in some ethnic groups, such as the Kikuyu and Kalenjin, whereas in others, such as the Kisii and Somali, it remains nearly universal. Figure 8.13 shows that in ethnic groups that have experienced a drop in FGM/C prevalence, the decline has been fairly steady across age cohorts. In the 15-19 year age cohort,

Figure 8.11 Over about three decades in Liberia, FGM/C prevalence has declined at a much faster rate in South Central than in North Central region, with recent acceleration in the pace of change

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Liberia, by age cohort and region

Note: Data for South Eastern A and South Eastern B regions are based on 25-49 unweighted cases.
Source: DHS 2007.



the practice of FGM/C is now quite rare among the Kamba (10 per cent), Kalenjin (8 per cent) and Kikuyu (4 per cent), and has almost disappeared entirely among the Meru (less than 2 per cent).

Change in circumstances

Numerous studies have described recent changes in how and when the practice is performed, including a tendency for FGM/C to be carried out at younger ages, in the absence of ritual celebration, and by medical personnel.[158] What do survey data tell us about these trends? What might be driving these changes, and what are the practical implications?

One possible effect of movements to end FGM/C, including campaigns highlighting potential dangers, might be parental strategies to reduce harm, such as carrying out the procedure in environments deemed 'safer', such as health facilities, where these are accessible. Similarly, with the establishment of legislation and declining acceptability, parents may handle the practice in a less visible and more private manner or perform FGM/C at younger ages and in less radical forms. With repeat survey data, it is possible to look at trends over time regarding the way in which FGM/C is being carried out, to see if these hypotheses hold true.

A growing trend towards the medicalization of FGM/C

With the availability of repeat survey data, it is possible to examine the trend in the use of medically trained personnel to perform FGM/C. The 'medicalization' of FGM/C refers to the shift from traditional practitioners to health-care professionals

Figure 8.12 In Ghana, Iraq and Togo, the region with the highest level of FGM/C in each country registered significant drops in prevalence

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Ghana, Iraq and Togo, by age cohort and region with highest FGM/C prevalence

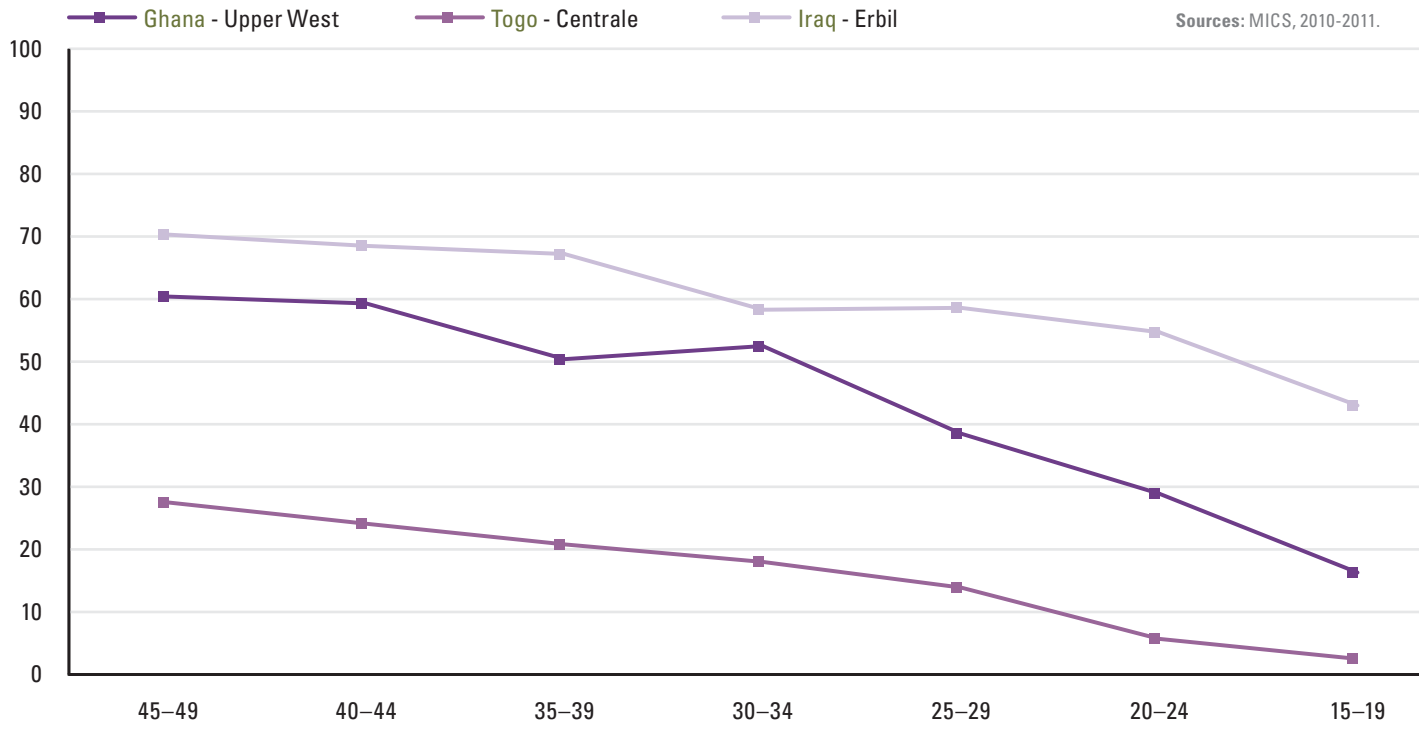
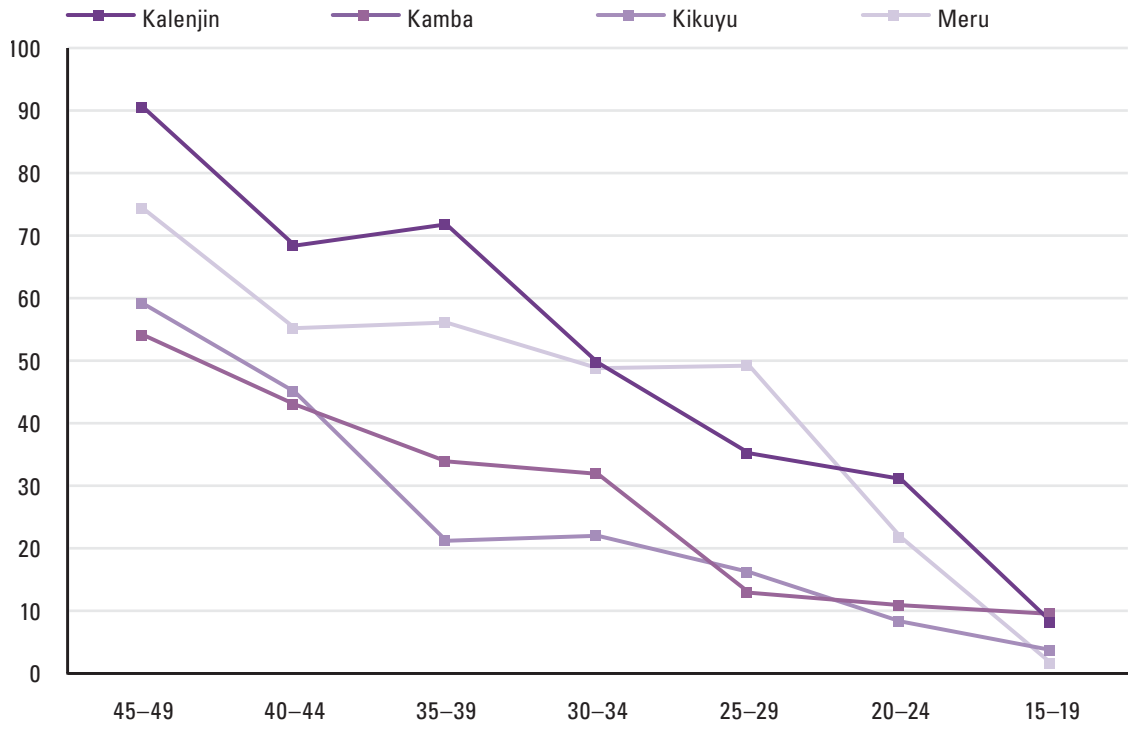


Figure 8.13 In Kenya, over three generations, the practice of FGM/C has almost disappeared among some ethnic groups

Percentage of girls and women aged 15 to 49 years who have undergone FGM/C in Kenya, by age cohort and selected ethnic groups



Notes: Data for Meru women aged 40 to 44 and 45 to 49 are based on 25-49 unweighted cases.
Source: DHS 2008-2009.

(*see Box 8.7*).[159] It sometimes also refers to the use of medical instruments, antibiotics and/or anaesthetics by traditional practitioners.[160] When performed in a health-care facility, this trend is also referred to as 'clinicalization'.[161] While DHS and MICS have collected information on the types of practitioners who performed FGM/C in all countries where the practice is concentrated, only a few older surveys asked questions about where the practice was performed (Egypt 1995 and 2000, Kenya 1998 and Yemen 1997), the tools used (Egypt 1995, Kenya 1998, Sudan 2000 and Yemen 1997) and whether the procedure was carried out under an anaesthetic (Egypt 1995).

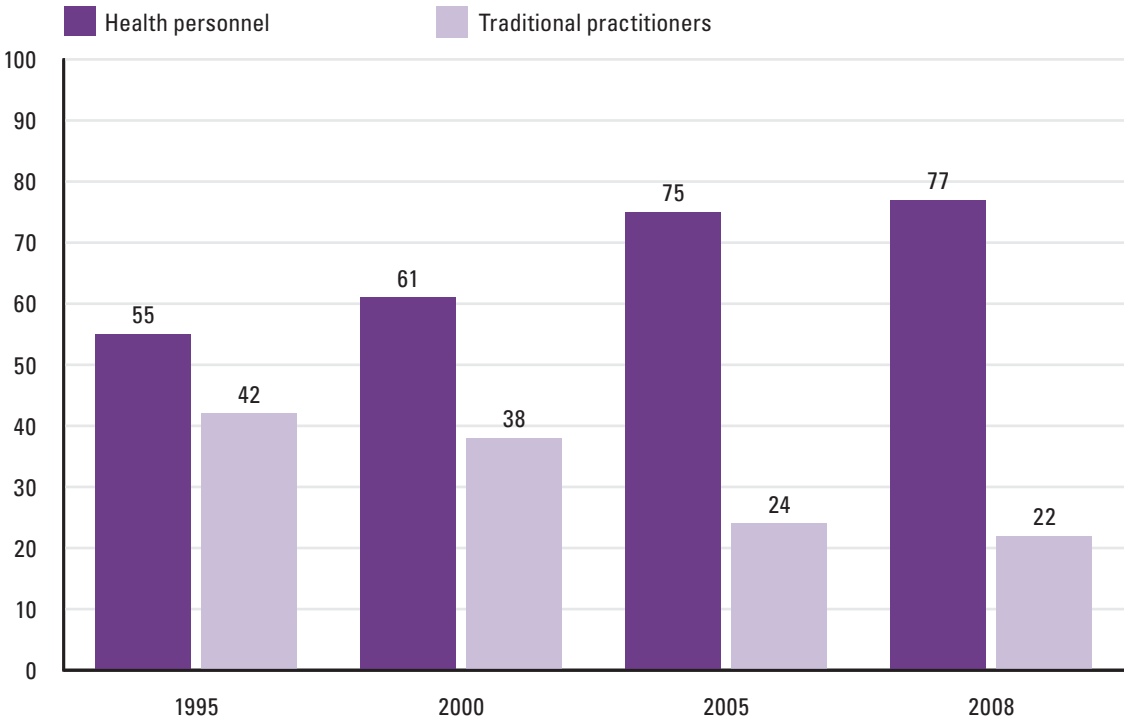
Available trend data on practitioners show that in Egypt, where the level of medicalization is highest, the percentage of daughters cut by traditional practitioners has decreased steadily – from 42 per cent in 1995 to 22 per cent in 2008. At the same time, the percentage of daughters cut by health personnel in that country increased from 55 per cent in 1995 to 77 per cent in 2008 (*see Figure 8.14*). This steady trend occurred over a period of intense scrutiny and public debate about Egypt's official policy on the medicalization of the practice. "In an effort to improve the safety of what was viewed as an 'inevitable practice', Egypt's Ministry of Health issued in 1994 a decree permitting only doctors in government hospitals to perform female genital cutting. However, this policy was reversed in October 1995 after women's rights and health advocates criticized it as government endorsement of 'female genital mutilation', and instead state hospitals were banned from performing the procedure."[162] Yet even then, the ban was not total and permitted the procedure when it was deemed medically necessary, thereby creating, de facto, an important loophole. In 2007, following the highly publicized death of an 11-year-old girl who was cut in a clinic, further restrictions banned all state-licensed health workers in either

Box 8.7 The medicalization of FGM/C

The trend towards increased medicalization of FGM/C has been attributed to decades of advocacy centred on delivering a message about the health risks of the practice.[163] While these campaigns are acknowledged to have raised awareness of such risks, they may have inadvertently promoted the perception that these harmful effects could be largely avoided if performed by medical personnel.[164] Since the early 1990s, efforts have been made to move beyond the narrow health focus and to contextualize FGM/C as a human rights violation.[165] United Nations agencies first condemned the medicalization of FGM/C in 1979 and reiterated this position in two recent interagency statements: *Eliminating Female Genital Mutilation: An interagency statement* [166] and the *Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation*.[167] The former statement specifies that any procedure conducted by a trained professional "is not necessarily less severe, or conditions sanitary. Moreover, there is no evidence that medicalization reduces the documented obstetric or other long-term complications associated with female genital mutilation."[168] Additionally, given that medical personnel often hold positions of authority and respect, medicalization may institutionalize the practice in the medical system and legitimize the practice as medically sanctioned. Numerous medical associations have condemned the medicalization of FGM/C, including the International Federation of Gynecology and Obstetrics (FIGO), which passed a resolution in 1994 at its General Assembly opposing the performance of FGM/C under any circumstances, in health establishments or by health professionals.[169]

Figure 8.14 In Egypt, the percentage of girls cut by health personnel has increased dramatically

Percentage of girls who have undergone FGM/C (as reported by their mothers) in Egypt, according to the type of person/practitioner performing the procedure



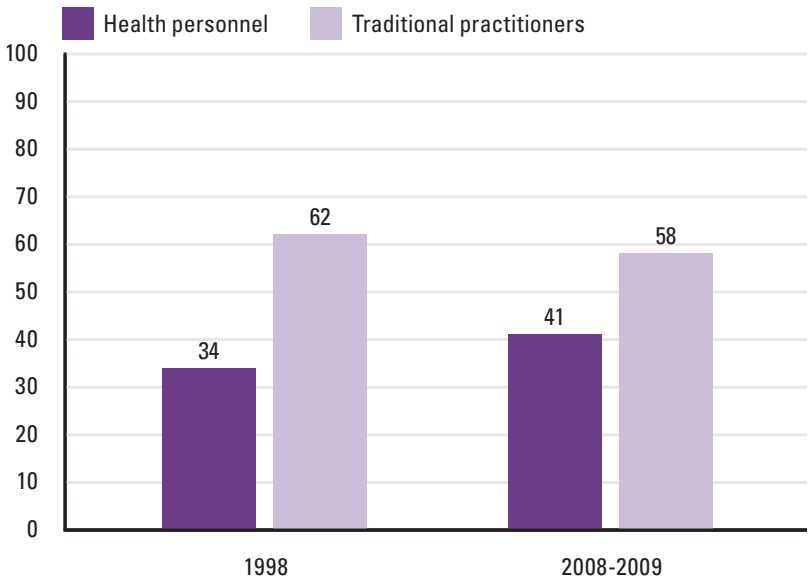
Notes: 'Health personnel' include doctors, nurses, midwives and other health workers. 'Traditional practitioners' include *dayas, ghagarias* and *barbers*. Data from 1995 and 2000 refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data from 2005 and 2008 refer to all daughters aged 0 to 17 who have undergone the procedure.
Sources: DHS, 1995-2008.

government or private clinics from performing FGM/C.[170] In June 2008, the Egyptian Parliament adopted a law imposing a sentence of a maximum of two years and a fine of up to $1,000 as a penalty for performing FGM/C. A recent hospital-based study suggests that, despite this ban, health-care providers have continued to perform FGM/C.[171]

Egypt is unique in having had a period in which the government gave its consent for FGM/C when performed by health personnel. In other countries, government policies have either been absent or actively opposed to health-care providers performing the procedure. In Kenya, for instance, the Ministry of Health issued a policy directive in 2001 making it illegal to perform FGM/C in health-care facilities.[172] Kenya's 2001 Children's Act criminalizes the cutting of girls under age 18, and sets a penalty of 12 months' imprisonment and/or a fine of about $600. However, survey data from before and after the adoption of these measures in Kenya show that the percentage of girls who had the procedure performed by health-care personnel increased nonetheless (*see Figure 8.15*), rising from 34 per cent in 1998 to 41 per cent in 2008-2009. Data for Egypt and Kenya suggest that as long as there is social support for the continuation of FGM/C, parents will look for ways to decrease harm to their daughters by having FGM/C carried out by medical personnel.

Figure 8.15 An increasing trend towards the medicalization of FGM/C is also observed in Kenya

Percentage of girls who have undergone FGM/C (as reported by their mothers) in Kenya, according to the type of person/practitioner performing the procedure



Notes: 'Health personnel' include doctors, nurses, midwives, and other health workers. 'Traditional practitioners' include traditional circumcisers and other traditional practitioners. Data refer to the most recently cut daughter among mothers aged 15 to 49 with at least one living daughter who has undergone FGM/C.
Sources: DHS, 1998 and 2008-2009.

Trends in the type of FGM/C performed

Survey data on the type of FGM/C performed make it possible to examine whether the severity of cutting has changed over time. In interpreting the results, it is important to note that various forces may be influencing the extent of cutting. For example, when cutting first began in a particular area, conditions of extreme resource inequality may have been present, and competition for the wealthiest husbands may have made the practice prone to exaggeration.[173] As these conditions improved, it might be expected that the prevalence of more severe forms of FGM/C would decrease. Parallel to the medicalization of FGM/C, decades of educational campaigns focusing on health risks may have motivated individuals to seek less severe forms of cutting. Additionally, in some settings, advocacy for less severe forms of cutting may have been under way. I. O. Orubuloye and colleagues have reported that health professionals who performed FGM/C in Nigeria promoted nicking instead of clitoridectomy to reduce the risk of complications and attention to the practice.[174] The same phenomenon has been reported in southwest Kenya.[175] United Nations agencies have generated evidence showing that it is possible to move directly to abandonment among practising communities and caution against the promotion of interim strategies, since they may serve to legitimize and hence prolong the practice.[176] As with medicalization, such strategies focus narrowly on health risks, and fail to fully address the human rights violated by FGM/C.

Changes over time in the type of FGM/C performed can be examined in different ways. One can compare: 1) results of multiple surveys for

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Women hold up signs during a ceremony renouncing FGM/C in the village of Cambadju in Bafatá region, Guinea-Bissau. The village is the first in the country to renounce the practice. The event, organized with support from the international NGO Tostan, a UNICEF partner, was attended by girls and young women, former traditional cutters, delegates from youth and women's groups, government officials and others.

girls and women aged 15 to 49 or their daughters, 2) differences in types of cutting among various age groups within one survey, and 3) types of cutting across generations by looking at FGM/C in girls and women aged 15 to 49 and their daughters. All these approaches have limitations, and findings from the different methods should be viewed together to provide a more reliable picture. Young girls are more likely to have a better recollection of what happened than older women, since they are closer in years to the event. At the same time, however, neither girls nor women are likely to recall what happened if the practice was performed on them at a very young age, though mothers may provide a more accurate account of what was done to their daughters.

The comparison of types of cutting performed on girls and women aged 15 to 49 and on their daughters confirms that in most countries, a large number of responses were in the category *not determined/not sure/doesn't know*, particularly among mothers and older women (*see Statistical tables*), which makes it difficult to draw conclusions. In countries where levels of ambiguous answers are low and are similar across comparison groups, no substantial difference was found in the type of cutting performed (*results not shown*). A trend towards less severe cutting across generations is discernible in Djibouti, where 83 per cent of women aged 45 to 49 reported being sewn closed compared to 42 per cent of girls aged 15 to 19. The comparison of types of FGM/C among girls and women of reproductive age and their daughters was consistent with this finding: 67 per cent of girls and women aged 15 to 49 reported that the opening of their vagina was sewn closed, compared to 30 per cent of daughters. Overall, it can be tentatively concluded that there is a good deal of stability in the type of FGM/C performed across generations, and that where change has occurred, the most common trend is towards less severe cutting.

Trends in age at cutting

Accounts from a number of settings describe a trend in which FGM/C is being performed at younger ages. Occasionally, as the timing of FGM/C shifts from adolescence to early childhood or infancy, it is performed individually rather than in groups, and where it was coupled with training and celebration performed in the course of coming-of-age rituals, it is no longer linked to these.[177]

One commonly cited reason for cutting girls at earlier ages is being able to do so more discretely, particularly when people are aware of campaigns aimed at ending the custom or where the practice has become criminalized.[178] It is also commonly reported that young girls heal more quickly than older girls or

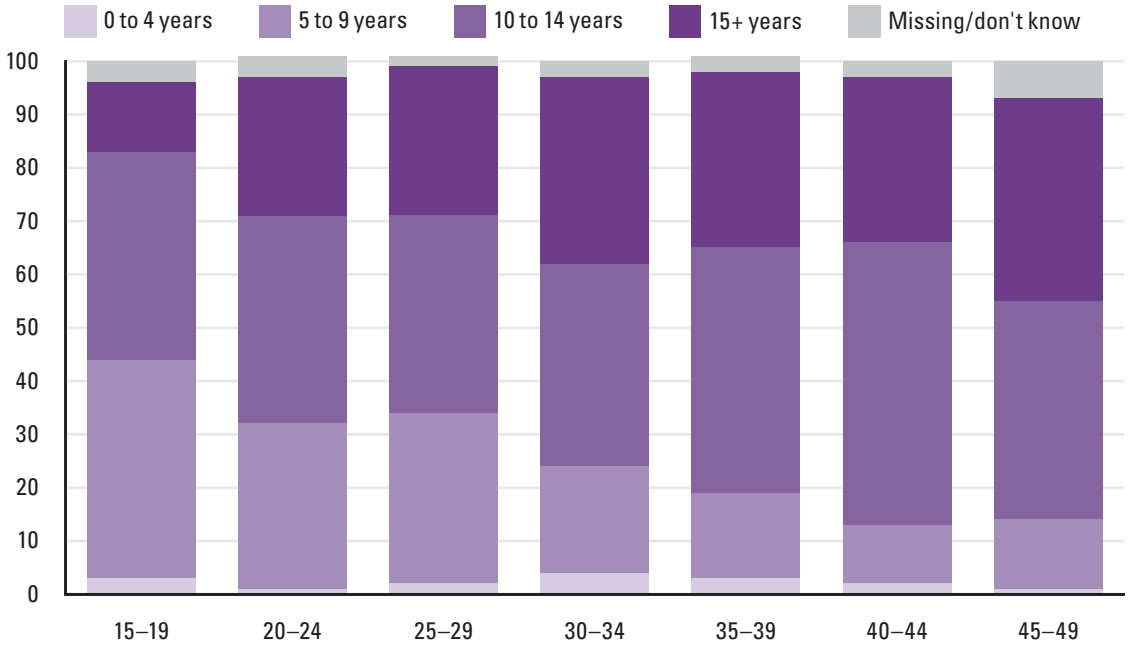
women, and put up less resistance. As FGM/C is performed at younger ages, the practice tends to become a purely physical procedure, and it is possible that, for some, it loses its broader social meaning.[179] It should be noted, however, that a number of groups have long performed FGM/C at very early ages and that, for many of them, the practice continues to have strong cultural significance. Do survey data support the impression that, in many settings, girls are being cut at increasingly younger ages?

MICS and DHS provide data on age at cutting at two points or more in time for girls and women aged 15 to 49 and for their daughters for 16 and 20 countries, respectively. In many surveys, particularly the early ones, a high percentage of girls and women reported not knowing their age when FGM/C took place, making it difficult to draw definitive conclusions on trends. The comparison of age at cutting between girls and women on the one hand, and daughters on the other, is also to be avoided. Recall biases are more likely to affect self-reported data for girls and women of reproductive age, while more accurate information tends to be provided by mothers on their daughters. Additionally, as explained in Chapters 4 and 5, data on daughters are affected by censoring due to age. Censoring introduces a bias in the distribution of age at cutting towards earlier ages. A better way to assess change in the age at cutting is through comparisons across age cohorts among girls and women aged 15 to 49 in countries where the proportion of missing or uncertain information on age is similar across cohorts.

Overall, the data suggest that the age at cutting has remained fairly stable in most countries (*results not shown*). Where change has occurred, the most common trend is towards younger ages. In Kenya, the proportion of girls and women who were cut before age 10 has increased from 14 per cent among women aged 45 to 49 to 44 per cent among girls aged 15 to 19, as shown in Figure 8.16. The same pattern can be observed in other countries, such as the United Republic of Tanzania and in Mali (*results not shown*).

Figure 8.16 In Kenya, age at cutting is declining

Among cut girls and women aged 15 to 49 years, percentage distribution by age at which cutting occurred in Kenya, according to current age groups



Note: Due to rounding, the data presented in this figure may not add up to 100 per cent.
Source: DHS 2008-2009.

9. Moving forward

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Obtaining timely, comparable and reliable information on FGM/C is a key aspect of efforts aimed at promoting its elimination. The wealth of information available in this report can be used by governments, international agencies, civil society and other development partners to fine-tune strategies seeking to encourage the abandonment of the practice.

The practice of FGM/C has proven remarkably tenacious, despite attempts spanning nearly a century to eliminate it. Nevertheless, the data in this report show that the practice has declined in a number of countries, and other changes are also under way. These changes, which include shifts in attitudes and in the way the procedure is carried out, are taking place at different speeds across population groups. The data also indicate that, in other countries, FGM/C remains virtually unchanged.

Due to time lags inherent in the practice itself and in monitoring it, the results of intensified efforts to address FGM/C over the last decade cannot yet be fully assessed. That said, an analysis of

the current data reveals patterns that allow us to draw some general conclusions about the changing nature of the practice. These patterns also confirm the understanding of the social dynamics that underlie FGM/C and help to explain its persistence. These findings can be used to further strengthen and refine programmes and policies aimed at eliminating this harmful practice.

Key findings

More than 125 million girls and women alive today have undergone some form of FGM/C in a swath of 29 countries across Africa and the Middle East. Another 30 million girls are at risk of being cut in the next decade. The practice is found to a far lesser degree in other parts of the world, though the exact number of girls and women affected is unknown.

While FGM/C is nearly universal in Somalia, Guinea, Djibouti and Egypt, it affects only 1 per cent of girls and women in Cameroon and Uganda. In countries where FGM/C is not widespread, it tends to be concentrated in specific regions of a country and is not constrained by national borders. FGM/C is closely associated with certain ethnic groups, suggesting that social norms and expectations within communities of like-minded individuals play a strong role in the perpetuation of the practice. In many countries, prevalence is highest among Muslim girls and women. However, the practice is also found among other religious communities. In 4 out of 14 countries with available data, more than 50 per cent of girls and women regard FGM/C as a religious requirement.

FGM/C is usually performed by traditional practitioners. In countries including Egypt, Kenya and Sudan, a substantial proportion of health-care providers carry out the procedure. Available trend data show that, in Egypt, where the medicalization of FGM/C is most acute, the percentage of girls cut by health personnel increased from 55 per cent in 1995 to 77 per cent in 2008.

In half of the countries with available data, the majority of girls are cut before the age of five. In Somalia, Egypt, Chad and the Central African Republic, at least 80 per cent of girls are cut between the ages of 5 and 14, sometimes in connection with coming-of-age rituals marking the passage to adulthood.

Most mothers whose daughters have undergone FGM/C report that the procedure entailed the cutting and removal of some flesh from the genitalia. In Somalia, Eritrea, Niger, Djibouti and Senegal, more than one in five girls have undergone the most radical form of the practice known as infibulation, which involves the cutting and sewing of the genitalia. Overall, little change is seen in the type of FGM/C performed across generations. A trend towards less severe cutting is discernible in some countries, including Djibouti, where 83 per cent of women aged 45 to 49 reported being sewn closed, versus 42 per cent of girls aged 15 to 19.

Trend data show that the practice is becoming less common in more than half of the 29 countries. The decline is particularly striking in some moderately low to very low prevalence countries. In Kenya and the United Republic of Tanzania, for example, women aged 45 to 49 are approximately three times more likely to have been cut than girls aged 15 to 19. In Benin, Central African Republic, Iraq, Liberia and Nigeria, prevalence has dropped by about half among adolescent girls. In the highest prevalence regions of Ghana and Togo, respectively, 60 per cent and 28 per cent of women aged 45 to 49 have undergone FGM/C compared to 16 per cent and 3 per cent of girls aged 15 to 19.

Some evidence of decline can also be found in certain high prevalence countries. In Burkina Faso and Ethiopia, the prevalence among girls aged 15 to 19 compared to women aged 45 to 49 has dropped by 31 and 19 percentage points, respectively. Egypt, Eritrea, Guinea, Mauritania and Sierra Leone have registered smaller declines. In a few countries, new data on girls under 15 years of

age seem to confirm an important trend towards the elimination of the practice in recent years. In countries such as the Central African Republic and Kenya, the drop in prevalence has been constant over at least three generations of women and appears to have started four to five decades ago. In other countries, including Burkina Faso, the decline appears to have started or accelerated over about the last 20 years. No significant changes in FGM/C prevalence can be observed in Chad, Djibouti, Gambia, Guinea-Bissau, Mali, Senegal, Somalia, Sudan and Yemen.

The data reveal that FGM/C often persists in spite of individual preferences to stop it. In most countries where FGM/C is practised, the majority of girls and women think it should end. Moreover, the percentage of females who support the practice is substantially lower than the share of girls and women who have been cut, even in countries where FGM/C prevalence is very high. The largest differences in prevalence and support are found in Burkina Faso, Djibouti, Sudan, Ethiopia, Eritrea, Egypt and Somalia.

In 11 countries with available data, at least 10 per cent of girls and women who have been cut say they see no benefits to the practice. The proportion reaches nearly 50 per cent in Benin and Burkina Faso, and 59 per cent in Kenya. Not surprisingly, the chances that a girl will be cut are considerably higher when her mother favours the continuation of the practice.

The attitudes of men and women towards FGM/C are more similar than conventional wisdom would suggest. Genital cutting is often assumed to be a manifestation of patriarchal control over women, suggesting that men would be strong supporters of the practice. In fact, a similar level of support for FGM/C is found among both women and men. In Guinea, Sierra Leone and Chad, substantially more men than women want FGM/C to end.

Marriageability is often posited as a motivating factor in FGM/C. This may have been true at one time. However, with the exception of Eritrea and Sierra Leone, relatively few women report concern over marriage prospects as a justification for FGM/C. Preserving virginity, which may be indirectly related to marriageability, was among the more common responses in women in Mauritania, Gambia, Senegal, Mali and Nigeria. The responses of boys and men to questions regarding the possible benefits of the practice largely mirrored those given by girls and women, with social acceptance and preservation of virginity being the most commonly cited reasons in most countries.

When attitudes are tracked over time, it appears that overall support for the practice is declining, even in countries where FGM/C is almost universal, such as Egypt and Sudan. Data show that in nearly all countries with moderately high to very low prevalence, the percentage of girls and women who report that they want the practice to continue has steadily declined. In the Central African Republic, for instance, the proportion of girls and women who support the practice has continued to fall – from 30 per cent to 11 per cent in about 15 years. In Niger, the share dropped from 32 per cent to 3 per cent between 1998 and 2006. There are, however, exceptions: The proportion of girls and women who reportedly want FGM/C to continue has remained constant in countries including Guinea, Guinea-Bissau, Senegal and the United Republic of Tanzania.

Implications for programming

Take into account differences among population groups within and across national borders.

When national data on FGM/C are disaggregated by region and by ethnicity, it becomes clear that changes in the practice vary according to population groups. This is consistent with the notion that specific social dynamics are at play within different communities. In Kenya, for instance, FGM/C has declined steadily among certain ethnic groups where it was once almost universal and has persisted among others. In

the space of three generations, the practice has become rare among the Kalenjin and Kikuyu, and has almost disappeared among the Meru. At the same time, more than 95 per cent of Somali and Kisii girls are still being cut.

These findings suggest that national plans to eliminate FGM/C should not apply uniform strategies in all parts of a country. Rather, they need to consider the specificity of various groups that share ethnicity or other characteristics. These groups may be concentrated in certain geographic regions of a country or extend across national borders. In the latter case, collaboration with neighbouring countries and with members of the diaspora may be required.

In particular, strategies need to consider both the degree of and trends in support for FGM/C and prevalence among different population groups. Where positive transformation is occurring rapidly, it can potentially be leveraged to encourage change elsewhere, as explained below. Strategies may also need to be adjusted over time to reflect changes in the practice within specific groups. Focused attention may be needed among communities where little or no change in the practice is evident.

Seek change in individual attitudes about FGM/C, but also address expectations surrounding the practice within the larger social group.

A review of trends in attitudes towards FGM/C and prevalence suggests that diminishing support tends to precede an actual decline in the practice. To influence individual attitudes, it is important to continue to raise awareness that ending FGM/C will improve the health and well-being of girls and women and safeguard their human rights. At the same time, legislative action is critical, especially as an instrument to decrease support for FGM/C, including by highlighting the legal consequences of engaging in the practice. Also essential are efforts to correct the misconception that FGM/C is required by religion. In numerous countries, religious leaders and scholars are attempting to 'delink' FGM/C from religion. In Sudan, a national campaign portrays the uncut girl as whole, intact, unharmed, pristine – in other words, in perfect, God-given condition.

While shifts in individual attitudes are important, the data also show that they do not automatically lead to behaviour change. Across countries, many cut girls have mothers who oppose the

Women, several of whom are accompanied by children, hold up their hands in the universally popular 'peace' sign, during a session on the dangers of FGM/C at the UNICEF-supported Kabbary Youth Centre for working children in the port city of Alexandria, Egypt. The centre offers community education and outreach programmes, educational activities, vocational training, psychosocial support and medical care for working children.

practice. This indicates that other factors, which may include expectations within the larger social group, prevent women from acting in accordance with their personal preferences. Data also reveal that the most commonly reported reason for carrying out FGM/C is a sense of social obligation. This provides further evidence that the practice is relational and that the behaviour of individuals is conditioned by what others they care about expect them to do.

All of these findings suggest that efforts to end the practice need to go beyond a shift in individual attitudes and address entire communities in ways that can decrease social expectations to perform FGM/C. Such a collective approach may be necessary to generate the shift in social norms required to catalyse changes in the practice of FGM/C and could help bring down prevalence levels more rapidly.

Find ways to make hidden attitudes favouring the abandonment of the practice more visible.

Discrepancies between declining support for FGM/C and the continuation of the practice suggest that attitudes about genital cutting tend to be kept in the private sphere. Opening the practice up to public scrutiny in a respectful manner, as is being done in many programmes throughout Africa, can provide the spark for community-wide change.

For decades, programmatic efforts have actively promoted pronouncements by respected and influential personalities, including traditional and religious leaders, calling for the elimination of FGM/C. More can be done to bring the lack of support for FGM/C into the public sphere. Programme activities can stimulate discussion within practising groups so that individual views opposing the practice can be aired. Local and national media as well as other trusted communication channels can serve as a forum to disseminate information on decreasing support for FGM/C as well as to discuss the advantages of ending the practice. In West Africa, for example, traditional communicators, or *griots*, are passing along such information and stimulating debate about the practice through theatre and songs.

Collective pronouncements or declarations against FGM/C are effective ways to make evident the erosion in social support for the practice. They also send the message that non-conformance will no longer elicit negative social consequences. The efficacy of such an approach has been demonstrated in all 15 countries that are part of the Joint UNFPA-UNICEF Programme on FGM/C and in other countries, such as Niger.[180] One result of the pronouncements is that families experience less social pressure to perform FGM/C and have less fear of social exclusion for not cutting their daughters. Over time, as more and more families are able to act in a way that is consistent with their personal preferences to end FGM/C, actual cutting will decrease. And, as individuals witness this transformation, they will have even greater assurance that the practice is no longer necessary for social acceptance.

This type of chain reaction may explain the process under way in many countries and in population groups within countries. In Burkina Faso, for example, support for FGM/C has been very low for decades, likely as a result of nationwide activities raising awareness of the harms of the practice as well as legislation prohibiting FGM/C, which has been enforced. Over this period, prevalence fell moderately but consistently. In the last 15 years or so, programme activities also provided opportunities for groups to collectively take a stand against the practice. The data indicate that the decline in prevalence during this period has accelerated.

Increase engagement by boys and men in ending FGM/C and empower girls.

Discussion about FGM/C needs to take place at all levels of society, starting with the family, and include boys and men. This is especially important since the data indicate that girls and

women tend to consistently underestimate the share of boys and men who want FGM/C to end.

Data also reveal that a large proportion of wives do not even know their husbands' opinions of the practice. Facilitating discussion of the issue within couples and in forums that engage girls and boys and women and men may accelerate the process of abandonment by bringing to light lower levels of support than commonly believed, especially among men, who are likely to wield greater power in the community. In addition, the pattern indicating that girls and younger women tend to have less interest than their older counterparts in continuing the practice suggests that they can be important catalysts of change, including through intergenerational dialogues.

Increase exposure to groups that do not practise FGM/C.

Where prevalence and support for FGM/C are very high, increasing exposure to groups that do not practise it and awareness of the resulting benefits is crucial. Through such exposure, individuals are able to witness that girls who are not cut thrive and their families suffer no negative consequences. This can make the alternative of not cutting plausible. The more affinity practising groups have with the non-practising groups they are exposed to and interact with, the greater the likelihood that positive influence will be exerted.

The data show that FGM/C prevalence, as well as support for the practice, is generally lower among urban residents, educated individuals and those from wealthier households, indicating that exposure is important. Urban areas tend to have more heterogeneous populations than rural areas, and members of groups that practise FGM/C are likely to interact more regularly with individuals and groups that do not. Similarly, wealthier individuals and families tend to have more opportunities to learn about or engage with non-practising communities.

Data also show that prevalence levels are typically lower among individuals that have completed higher levels of education. This suggests that education is an important mechanism to increase awareness of the dangers of FGM/C and knowledge of groups that do not practise it. Education also fosters questioning and discussion, and provides opportunities for individuals to take on social roles that are not dependent on the practice of FGM/C for acceptance.

Promote abandonment of FGM/C along with improved status and opportunities for girls, rather than advocating for milder forms of the practice.

An important question for programming is whether advocating a shift to less severe forms of cutting is a path that is effective for eliminating FGM/C. The data on changes in the practice indicate a trend towards less severe forms of cutting in certain countries. However, overall, the type of cutting performed has changed little across generations. While the findings are not conclusive, the stability of the practice suggests that pursuing the elimination of FGM/C by moving towards a progressive reduction in the degree of cutting does not hold much promise. Moreover, the benefits of a marginal decrease in harm resulting from less severe forms of FGM/C need to be weighed against the opportunity cost of promoting the end of FGM/C as one of many harmful practices that jeopardize the well-being of girls and infringe upon their human rights. In countries including Ethiopia, Guinea-Bissau and the United Republic of Tanzania, programmes that aim to raise the status of girls and women in society are helping to discourage FGM/C as well as child marriage and forced marriage.

Next steps

Overall, the findings presented here confirm progress reported by programmatic initiatives aimed at ending FGM/C. They also contain some welcome surprises, such as a greater than expected decline in prevalence in the Central African Republic, which had not been previously documented. The report also raises new questions. For example, it is unclear why a discernible decline in FGM/C has not been found in Senegal, where concerted efforts to eliminate the practice have been under way for over a decade. Additional research and analyses are needed to provide a clearer picture of the reasons why data reflect greater or smaller than expected changes in the practice.

Measuring various aspects of FGM/C will need to continue, as it has for the last 20 years, in both high and low prevalence countries, along with stepped up efforts to encourage its full and irreversible elimination. As new rounds of household surveys are undertaken in the next few years, the outcome of these efforts will be more fully revealed. If commitment is sustained and programmes strengthened in light of increasing evidence, the data should show that the transformation currently under way has gained momentum, and that millions of girls have been spared the fate of their mothers and grandmothers.

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78. For the remaining countries, the available data, presented in the Statistical tables, refer to the percentage of girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 with at least one living daughter who has undergone FGM/C. Data for daughters were never collected in Liberia. Prevalence data among girls aged 0 to 14 are not comparable with estimates obtained by collecting information on the FGM/C status of any living daughter of girls and women aged 15 to 49.

79. Due to a skip in the questionnaire, information on the number of daughters of mothers who have not heard of FGM/C were not collected through the FGM/C modules in Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone and Togo. Adjustments to prevalence data for girls aged 0 to 14 were made to account for the proportions of daughters with missing information. In the case of Burkina Faso, Egypt and Senegal, prevalence data had to be recalculated due to an oversight in the algorithm used to produce the estimates. For these reasons, the figures presented in this publication may differ from those included in original DHS and MICS country reports.

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81. Mackie, 'Female Genital Cutting: The beginning of the end'.

82. Dorkenoo, E., *Cutting the Rose – Female Genital Mutilation: The practice and its prevention*, Minority Rights Group, London, 1994; Shell-Duncan, B., and Y. Hernlund, 'Female "Circumcision" in Africa: Dimensions of the practice and debates', *Female "Circumcision" in Africa: Culture, controversy, and change*, edited by B. Shell-Duncan and Y. Hernlund, Lynne Rienner Publishers, Boulder, CO, 2000, pp. 1-40.

83. Ahmadu, F., 'Rites and Wrongs: An insider/outsider reflects on power and excision', *Female "Circumcision" in Africa: Culture, controversy, and change*, edited by B. Shell-Duncan and Y. Hernlund, Lynne Rienner Publishers, Boulder, CO, 2000, pp. 283-312.

84. Hernlund, Y., 'Cutting Without Ritual and Ritual Without Cutting: Female "circumcision" and the re-ritualization of initiation in the Gambia', *Female "Circumcision" in Africa: Culture, controversy, and change*, edited by B. Shell-Duncan and Y. Hernlund, Lynne Rienner Publishers, Boulder, CO, 2000, pp. 235-252.

85. Gruenbaum, E., *The Female Circumcision Controversy: An anthropological perspective*, University of Pennsylvania Press, Philadelphia, PA, 2001.

86. In their study of communities in Senegal and the Gambia, Bettina Shell-Duncan and colleagues found that FGM/C is usually only indirectly related to marriageability via concerns over preserving virginity. The majority of their study participants reported that FGM/C is neither a prerequisite for marriage nor a strategy for securing a better marital partner. It is possible that, in the past, concerns over marriageability contributed to the origin

and spread of FGM/C. See: Shell-Duncan, B., et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia*, Summary report, 2010, <http://csde.washington.edu/bsd>, accessed 11 April 2013; Shell-Duncan, B., et al., 'Dynamics of Change in the Practice of Female Genital Cutting in Senegambia: Testing predictions of social convention theory', *Social Science & Medicine*, vol. 73, no. 8, 2011, pp. 1275-1283.

87. There are no ethnicity data for Djibouti, Egypt, Iraq, Liberia, Mauritania, Somalia, Sudan, United Republic of Tanzania and Yemen.

88. Kennedy, J. G., 'Circumcision and Excision in Egyptian Nubia', *Man*, vol. 5, 1970, pp. 175-191; Hayes, R. O., 'Female Genital Mutilation, Fertility Control, Women's Roles, and the Patrilineage in Modern Sudan: A functional analysis', *American Ethnologist*, vol. 2, no. 4, 1975, pp. 617-633; van der Kwaak, 'Female Circumcision and Gender Identity'; Yount, K., 'Like Mother, Like Daughter? Female genital cutting in Minia, Egypt', *Journal of Health and Social Behavior*, vol. 43, 2002, pp. 336-358; Hayford, S., 'Conformity and Change: Community effects on female genital cutting in Kenya', *Journal of Health and Social Behavior*, vol. 46, no. 2, 2005, pp. 121-140.

89. No wealth index data are available for Djibouti. Data by wealth for Yemen could not be calculated since access to the dataset is restricted.

90. While this is mostly true, it is not always the case. Until recently, it was common in parts of Kenya to end girls' schooling so that they could be cut in preparation for marriage; policies and campaign messages directed at these communities have linked ending early marriage and FGM/C with keeping girls in school. However, in Kenya, as elsewhere, girls are commonly not involved in the decision-making process regarding their own cutting. See: Shell-Duncan, B., and O. Olungah, 'Between Crime, Faith and Culture: Contesting female genital cutting and the "best interest" of the child', Paper presented at the annual meeting of the American Anthropological Association, 2009.

91. Data on type of practitioner among daughters are unavailable for Liberia, Somalia and Uganda.

92. Bjälkander, O., et al., 'Health Complications of Female Genital Mutilation in Sierra Leone', *International Journal of Women's Health*, vol. 4, 2012, pp. 321–331; WHO, *Eliminating Female Genital Mutilation: An interagency statement*.

93. Mgbako, C., et al., 'Penetrating the Silence in Sierra Leone: A blueprint for the eradication of female genital mutilation', *Harvard Human Rights Journal*, vol. 23, 2010, pp. 111-140.

94. Shell-Duncan, B., 'The Medicalization of Female "Circumcision": Harm reduction or promotion of a dangerous practice?' *Social Science and Medicine*, vol. 52, 2001, pp. 1013-1028.

95. Obermeyer, C. M., 'Female Genital Surgeries: The known, the unknown, and the unknowable', *Medical Anthropology Quarterly*, vol. 13, no. 1, 1999, pp. 79-105.

96. Shell-Duncan, 'The Medicalization of Female "Circumcision"'; Yoder, Abderrahim and Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys*.

97. Lightfoot-Klein, H., *Prisoners of Ritual: An odyssey into female genital circumcision in Africa*, Routledge, London, 1989, p. 54.

98. See, for example: WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 'Female Genital Mutilation and Obstetric Outcome: WHO collaborative prospective study in six African countries', *The Lancet*, vol. 367, 2006, pp. 1835-1841.

99. See, for example: Morison and Scherf, 'The Long-Term Reproductive Health Consequences of Female Genital Cutting in Rural Gambia'.

100. Data on type of cutting among daughters are unavailable for Iraq, Liberia, Uganda and Yemen. Data on type of cutting for Sudan are only available from MICS 2000, but are not included in Table 5.2 because of lack of comparability.

101. Data on age at cutting were collected for girls and women aged 15 to 49 in 22 countries and for daughters in 26 countries. Data on age at cutting for girls and women aged 15 to 49 are unavailable for Djibouti, Ethiopia, Liberia, Somalia, Sudan, Uganda and Yemen. Data on age at cutting for daughters were not collected in Iraq, Liberia and Uganda. Age at cutting among daughters could not be calculated for Yemen (DHS 1997) since access to the dataset is restricted. Data on age at cutting among daughters for the Gambia are not presented in Figure 5.3 since the earlier MICS (2006) did not have questions on age at cutting for most recently cut daughters; data for girls aged 15 to 19 indicate that most of the cutting occurs before age 5, as shown in the Statistical tables. Data on age at cutting for daughters are available for Sudan (MICS 2000). However, these data were excluded because they contradict to a large extent other evidence suggesting that cutting typically occurs in this country between the ages of 5 and 11 years. For example, see: UNICEF, *The Dynamics of Social Change*; the Sudan National Committee on Traditional Practices website, <http://www.snctp.org/>, accessed 2 July 2013; United Nations Population Fund (UNFPA), 'Ending female genital mutilation/cutting in Sudan', <http://countryoffice.unfpa.org/filemanager/files/sudan/facts/fgm.pdf>, accessed 2 July 2013.

102. Morison and Scherf, 'The Long-Term Reproductive Health Consequences of Female Genital Cutting in Rural Gambia'; Elmusharaf et al., 'Reliability of Self-Reported Forms of Female Genital Mutilation and WHO Classification'.

103. According to preliminary findings from the 2011 MICS, the percentage of girls and women aged 15 to 49 who think the practice should continue is 58 per cent in the Northeast Zone and 29 per cent in Somaliland.

104. Hernlund, Y., and B. Shell-Duncan, 'Contingency, Context and Change: Negotiating female genital cutting in the Gambia and Senegal', *Africa Today*, vol. 54, no. 4, 2007, p. 46.

105. Hernlund and Shell-Duncan, 'Contingency, Context and Change: Negotiating female genital cutting in the Gambia and Senegal', p. 44.

106. In addition to being administered to boys and men aged 15 to 49, men's questionnaires often cover men aged 50 and above.

107. There are no ethnicity data on girls and women for Djibouti, Egypt, Iraq, Liberia, Mauritania, Somalia, Sudan, United Republic of Tanzania and Yemen.

108. No wealth index data are available for Djibouti. Data for Yemen could not be calculated since access to the dataset is restricted.

109. Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia*.

110. The couple datasets are created by merging individual datasets for women and men who are either married or living together in the same household.

111. Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia*; Shell-Duncan et al., 'Dynamics of Change in the Practice of Female Genital Cutting in Senegambia'.

112. Hernlund, Y., 'Winnowing Culture: Negotiating female "circumcision" in the Gambia', Doctoral dissertation, University of Washington, Department of Anthropology, Seattle, 2003; Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia*; Shell-Duncan et al., 'Dynamics of Change in the Practice of Female Genital Cutting in Senegambia'.

113. Mackie and LeJeune, *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory.*

114. UNICEF, *Changing a Harmful Social Convention;* Mackie and LeJeune, *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory.*

115. UNICEF, *Changing a Harmful Social Convention*, p. 11.

116. Mackie and LeJeune, *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory.*

117. Carreira, 1947, cited in: Johnson, M., 'Becoming a Muslim, Becoming a Person: Female "circumcision," religious identity, and parenthood in Guinea-Bissau', *Female "Circumcision" in Africa: Culture, controversy, and change*, edited by B. Shell-Duncan and Y. Hernlund, Lynne Rienner Publishers, Boulder, CO, 2000, pp. 215-234.

118. Johnson, 'Becoming a Muslim, Becoming a Person'.

119. Mackie and LeJeune, *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory.*

120. Mackie and LeJeune, *Social Dynamics of Abandonment of Harmful Practices: A new look at the theory.*

121. Gruenbaum, *The Female Circumcision Controversy*, p. 60.

122. For examples from Sudan and Guinea-Bissau, respectively, see: Boddy, J., 'Body Politics: Continuing the anti-circumcision crusade', *Medical Anthropology Quarterly*, vol. 5, no. 1, 1991, pp. 15-17; Johnson, 'Becoming a Muslim, Becoming a Person'.

123. Johnson, 'Becoming a Muslim, Becoming a Person'.

124. UNFPA, *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/ Cutting: Accelerating Change, Annual report 2011*, p. iv.

125. UNICEF, *The Dynamics of Social Change: Towards the abandonment of female genital mutilation/cutting in five African countries*, pp. 43-44; van der Kwaak, 'Female Circumcision and Gender Identity'.

126. UNFPA, *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/ Cutting: Accelerating Change, Annual report 2011*, p. 25; van der Kwaak, 'Female Circumcision and Gender Identity'.

127. Boddy, 'Body Politics: Continuing the anti-circumcision crusade', p. 15.

128. Johnson, 'Becoming a Muslim, Becoming a Person'.

129. Johnson, 'Making Mandinga or Making Muslims?'; Johnsdotter, 'Persistence of Tradition or Reassessment of Cultural Practices in Exile?'.

130. Johnson, 'Making Mandinga or Making Muslims?'.

131. There are no data on religion for Djibouti, Iraq, Mauritania and Somalia. Data for Yemen could not be calculated since access to the dataset is restricted.

132. Data for daughters were never collected in Liberia. Data for Yemen could not be calculated since access to the dataset is restricted.

133. Davies, P., 'On Relapse: Recidivism or rational response?', *AIDS: Rights, risk and reason*, edited by P. Aggelton, P. Davies and G. Hart, The Falmer Press, Washington, D.C., 1992, pp. 133-141; Ingham, R., et al., 'The Limitations of Rational Decision-Making Models as Applied to Young People's Sexual Behaviour', *AIDS: Rights, risk and reason*, edited by P. Aggleton, P. Davies and G. Hart, The Falmer Press, Washington, D.C., 1992, pp. 163-173; Parker, W., *Rethinking Conceptual Approaches to Behaviour Change: The importance of context,* Centre for AIDS Development, Research and Evaluation (CADRE), Johannesburg, 2004; Yoder, P. S., 'Negotiating Relevance: Belief, knowledge, and practice in international health projects', *Medical Anthropology Quarterly*, vol. 11, no. 2, 1997, pp. 131-146; Yoder, P. S., and M. Mahy, *Female Genital Cutting in Guinea: Qualitative and quantitative research strategies*, DHS Analytical Studies No. 5., ORC Macro, Calverton, MD, 2001.

134. Miller, D., et al., 'Pluralistic Ignorance and Inconsistency Between Private Attitudes and Public Behaviours', *Attitudes, Behaviours and Social Context: The role of social norms and group membership*, edited by D. J. Terry and M. A. Hogg, Lawrence Erlbaum Associates, Inc., Mahwah, NJ, 2000.

135. Miller et al., 'Pluralistic Ignorance and Inconsistency between Private Attitudes and Public Behaviours'.

136. Davies, 'On Relapse: Recidivism or rational response?'; Shell-Duncan and Hernlund, 'Are there "Stages of Change" in the Practice of Female Genital Cutting?'.

137. Hernlund and Shell-Duncan, 'Contingency, Context and Change: Negotiating female genital cutting in the Gambia and Senegal', p. 44.

138. Prochaska, J. O., et al., 'Stage of Change and Decisional Balance for 12 Problem Behaviors', *Health Psychology*, vol. 13, 1994, pp. 39-46.

139. Prochaska, J. O., and C. C. DiClemente, 'Transtheoretical Therapy: Toward a more integrative model of change', *Psychotherapy Theory, Research and Practice*, vol. 19, no. 3, 1982, pp. 276-288; Prochaska, J. O., and C. C. DiClemente, 'In Search of How People Change: Applications to addictive behaviours', *American Psychologist*, vol. 47, 1992, pp. 1102-1114.

140. Rogers, E., *Diffusion of Innovation*, The Free Press, New York, 1995.

141. Diop, N. J., et al., *The Tostan Program: Evaluation of a community based education program in Senegal*, Population Council, New York, 2004; Izett, S. and N. Toubia, *A Research and Evaluation Guidebook Using Female Circumcision as a Case Study: Learning about social changes*, RAINBO, New York, 1999.

142. Shell-Duncan, B., and Y. Hernlund, 'Are there "Stages of Change" in the Practice of Female Genital Cutting? Qualitative research findings from Senegal and the Gambia', *African Journal of Reproductive Health*, vol. 10, no. 2, 2006, pp. 57-71.

143. Shell-Duncan and Hernlund, 'Are there "Stages of Change" in the Practice of Female Genital Cutting?'.

144. In Sudan, the DHS conducted in 1989-1990 also sampled only girls and women aged 15 to 49 who had ever been married, while later surveys collected data on all girls and women, regardless of their marital status. For this reason, data from the 1989-1990 survey were not used in the analysis of trends in prevalence among girls and women aged 15 to 49.

145. A sampling error is usually measured in terms of the *standard error* for a particular statistic (mean, percentage, etc.). The standard error can be used to calculate confidence intervals within which the true value for the population can reasonably be assumed to fall. For example, for any given statistic calculated from a sample survey, the value of that statistic will fall within a range of plus or minus two times the *standard error* of that statistic in 95 per cent of all possible samples of identical size and design (the 95 per cent confidence intervals). Narrower confidence intervals suggest more precision in the estimates. Where relevant, charts include error bars to show the 95 per cent confidence interval for each country estimate when datasets were available to allow for the calculation.

146. Data on female attitudes towards FGM/C are available from one survey only for Cameroon (DHS 2004), Djibouti (MICS 2006), Iraq (MICS 2011), Liberia (DHS 2007), Somalia (MICS 2006), Uganda (DHS 2011) and Yemen (DHS 1997). MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) are not used to report on attitudes due to the fact that information is missing for girls and women with no living daughters; data from older surveys (2006-2008) were used for these three countries. Data were collected for Mali in 1995-1996 (DHS) and Nigeria in 1999, 2003 and 2008 (DHS), but these data are not included in the trend analysis since findings are not fully comparable, as explained in Box 8.2. These comparability issues result in only one data source that can be used to report on attitudes in Ghana (MICS 2006) and Nigeria (MICS 2007). Data on female attitudes towards FGM/C were not collected in the following surveys: Chad (MICS 2000), Côte d'Ivoire (DHS 1994), Ghana (DHS 2003), Kenya (DHS 2003), Sudan (MICS 2000), United Republic of Tanzania (DHS 1996) and Uganda (DHS 2006).

147. Data on male attitudes were collected for Nigeria in 2003 and 2008 (DHS), but these data are not included in the trend analysis since findings are not fully comparable, as explained in Box 8.2.

148. Diop, N. J., et al., *Analysis of the Evolution of the Practice of Female Genital Mutilation/Cutting in Burkina Faso*, Frontiers in Reproductive Health, Population Council, Washington, D.C., 2008. According to Ministry of Justice estimates, the cumulative number of people sentenced for violating the law against FGM/C from 2005 to 2012 is 813, including both cutters and parents. *UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change*, Annual reports 2008-2012, <http://www.unfpa.org/topics/genderissues/fgm>, accessed 31 May 2013.

149. Diop et al., *Analysis of the Evolution of the Practice of Female Genital Mutilation/ Cutting in Burkina Faso.*

150. Diop et al., *Analysis of the Evolution of the Practice of Female Genital Mutilation/ Cutting in Burkina Faso.*

151. Ako, A. A., and P. Akweongo, 'The Limited Effectiveness of Legislation against Female Genital Mutilation and the Role of Community Beliefs in Upper East Region, Ghana', *Reproductive Health Matters*, vol. 17, no. 34, 2009, pp. 47-54.

152. Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia.*

153. In Benin, girls and women aged 15 to 49 were asked during the 2006 DHS whether they knew there was a law forbidding the practice of FGM/C and how they were informed about it *(national or local radio, non-governmental organization, local authority, family/friend, others)*. The results show that among girls and women who had heard of the practice, over 66 per cent knew about the existence of the legislation mainly through radio broadcasts. This corresponds to 44 per cent of all girls and women in the country.

154. Hernlund, 'Cutting Without Ritual and Ritual Without Cutting'.

155. Data on FGM/C prevalence among girls and women aged 15 to 49 are available from one survey only for Cameroon (DHS 2004), Djibouti (MICS 2006), Iraq (MICS 2011), Liberia (DHS 2007), Somalia (MICS 2006) and Yemen (DHS 1997). Data were also collected for Mali in 1995-1996 (DHS), Nigeria in 1999, 2003 and 2008 (DHS), and Sudan in 1989-1990 (DHS) but these data are not included in the trend analysis since findings are not fully comparable, as explained in Box 8.2 and endnote 144.

156. The comparison of prevalence levels across age cohorts is possible due to the fact that almost all girls are cut before the age of 15. However, as mentioned earlier, in a handful of countries including the Central African Republic, Kenya, Sierra Leone and the United Republic of Tanzania, between 8 per cent (Central African Republic) and 20 per cent (Sierra Leone) of cut girls aged 15 to 19 underwent the procedure after the age of 15 *(see Statistical tables)*. The influence of this factor was considered in the analysis of generational trends and was found to be minimal in all countries but Sierra Leone. To account for the fact that in this country a certain proportion of girls aged 15 to 19 who have not undergone FGM/C may still be at risk, adjustments were made to prevalence data for this age group. The adjusted prevalence was calculated as the sum of the current FGM/C prevalence among girls aged 15 to 19 and the percentage of girls aged 15 to 19 who are expected to be cut after age 15, based on data on age at cutting. The adjustment increases the prevalence among girls aged 15 to 19 from 70 to 80 per cent. For this reason, the figure presented in this publication differs from that included in the original MICS 2010 country report.

157. Data on age at cutting are not available for Uganda. For Sudan, see endnote 101. Prevalence data among girls aged 10 to 14 were not collected in Senegal. Adjustments can be made using prevalence data for girls aged 5 to 9. Data from the 2010-2011 DHS/MICS in Senegal indicate that 17 per cent of girls aged 5 to 9 have already experienced FGM/C. The data also indicate that, among girls aged 15 to 19 who have undergone FGM/C, 72 per cent of them were cut by age 5; 20 per cent were cut between 5 and 14 years of age; 0.3 per cent were cut at age 15 or later; and the age at cutting was unknown for 7 per cent. The adjusted prevalence for girls aged 5 to 9 is similar to the share of girls cut among those aged 15 to 19 (24 per cent, ranging from 21 to 28 per cent with confidence intervals).

158. Hernlund, 'Cutting Without Ritual and Ritual Without Cutting'; Johnson, 'Becoming a Muslim, Becoming a Person'; Satti, A., S. Elmusharaf, et al., 'Prevalence and Determinants of the Practice of Genital Mutilation of Girls in Khartoum, Sudan', *Annals of Tropical Paediatrics: International child health*, vol. 26, 2006, pp. 303-310; Christoffersen-Deb, A., 'Taming Tradition: Medicalized female genital practices in western Kenya', *Medical Anthropology Quarterly*, vol. 19, 2005, pp. 402-418.

159. World Health Organization, *Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation. UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, ICN, IOM, MWIA, WCPT, WMA,* WHO, Geneva, 2010.

160. Shell-Duncan, B., 'The Medicalization of Female "Circumcision"'.

161. Obiora, 'Bridges and Barricades'.

162. Shell-Duncan, 'The Medicalization of Female "Circumcision"', p. 1019.

163. UNICEF, *Changing a Harmful Social Convention.*

164. Shell-Duncan, 'The Medicalization of Female "Circumcision"'; Njue, C., and I. Askew, *Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya*, Frontiers in Reproductive Health Program, Population Council, 2004; Christoffersen-Deb, 'Taming Tradition'.

165. Boyle, E. H., *Female Genital Cutting: Cultural conflict in the global community*, Johns Hopkins University Press, Baltimore, MD, 2002; UNICEF, *Changing a Harmful Social Convention*; Shell-Duncan, 'From Health to Human Rights'.

166. WHO, *Eliminating Female Genital Mutilation: An interagency statement.*

167. WHO, *Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation.*

168. WHO, *Eliminating Female Genital Mutilation: An interagency statement*, p. 12.

169. *International Federation of Gynecology and Obstetrics General Assembly Resolution on Female Genital Mutilation*, 1994, <http://www.figo.org/projects/general_assembly_resolution_FGM>, accessed 26 March 2013.

170. Shell-Duncan, 'The Medicalization of Female "Circumcision"'.

171. Rasheed, S. M., A. H. Abd-Ellah and F. M. Yousef, 'Female Genital Mutilation in Upper Egypt in the New Millennium', *International Journal of Gynecology and Obstetrics*, vol. 114, no. 1, 2011, pp. 47-50.

172. Njue and Askew, *Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya*.

173. Mackie, 'Female Genital Cutting: The beginning of the end'.

174. Orubuloye, I. O., P. Caldwell and J. Caldwell, 'Female "Circumcision" Among the Yoruba of Southwest Nigeria: The beginning of change', *Female "Circumcision" in Africa: Culture, controversy and change*, edited by B. Shell-Duncan and Y. Hernlund, Lynne Rienner Publishers, Boulder, CO, 2000, pp. 73-94.

175. Njue and Askew, *Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya.*

176. WHO, *Global Strategy to Stop Health-Care Providers from Performing Female Genital Mutilation*, p. 9.

177. For examples from Gambia, Kenya and Guinea, respectively, see: Hernlund, 'Cutting Without Ritual and Ritual Without Cutting'; Njue and Askew, *Medicalization of Female Genital Cutting Among the Abagusii in Nyanza Province, Kenya*; Yoder and Mahy, *Female Genital Cutting in Guinea*.

178. Hernlund, 'Cutting Without Ritual and Ritual Without Cutting'; Shell-Duncan et al., *Contingency and Change in the Practice of Female Genital Cutting: Dynamics of decision making in Senegambia'*; Njue and Askew, *Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya*.

179. For example, see: Njue and Askew, *Medicalization of Female Genital Cutting among the Abagusii in Nyanza Province, Kenya.*

180. United Nations Children's Fund, 'Public Declaration for the Abandonment of Traditional Harmful Practices: 20 villages of Makalondi region commit to enforce children's and women's rights in Niger', Press release, UNICEF, Niamey, Niger, 15 May 2013.

Appendix

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on knowledge of FGM/C and related issues															
Have you ever heard about female circumcision?	901	901		1001	FG1	1101	1001			FG1	FG1		1001	FG1	
Have you ever heard about female circumcision? (a practice in which a girl may have part of her genitals cut)															
Have you heard of the Bondo/Sande/other secret societies/ female circumcision?															
Have you ever heard of the Bondo society?															
Now I would like to ask you about something else. As you know, some women belong to bush societies, like the Sande society. Have you heard of these societies?															
In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	902	902	901	1002	FG2	1102	1002			FG2	FG2		1002	FG2	
In many communities girls are introduced to womanhood by participating in some ceremonies and undergoing specific procedures. I want to discuss with you the circumcision of girls. In this community, is female circumcision practised?															
In many communities girls are also circumcised. In your community, is female circumcision practised?															
Are women circumcised in this area?															
Do you know any type of female circumcision?															
If yes, mention those types (multiple response allowed) (pharaonic, sunna, intermediate, others/identify)															
During the past six months, have you heard or seen anything about female circumcision? (radio,TV, magazine, etc.)			920a												
During the past year, have you heard or seen anything about female circumcision?															
Where did you hear or see this information? (TV, radio, newspaper/magazine, pamphlet/brochure, etc.)															
What is the main source of information on circumcision? (none, public health provider, relatives, friends, TV, etc.)			920b												
Do you ever hear about female genital mutilation campaigns?															
Have there been any activities against female circumcision arranged in this area?															
Please describe the activities.															
Have there been any activities against female circumcision in this community?															
Should you be able to choose, from which source would you like to receive information about circumcision? (clinic, radio, journal, TV, school, etc.)			920c												
Do you know that there is a law that forbids the practice of circumcision?		924A	920d		FG16A								1024A		
How were you informed about it?		924B											1024A		
Is circumcision authorized by the law?															
Do you think that there is a law that forbids the practice of circumcision?				1024A											

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
			FG1	1101	FG1	801		801				725	901	1001	FG1	FG1		FG1	FG1	1001	901	FG1	590
		901	FG2	1102	FG2							725A			FG2	FG2		FG2	FG2	1002	902	FG2	591
																	820						
							809	808	813	916													
									814	917													
											745	745											
											746	746											
				1118																			

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on knowledge of FGM/C and related issues																
Have you ever heard about female circumcision?	FG1			1301			901	901b	FG1	501	FG1	FG1		901		
Have you ever heard about female circumcision? (a practice in which a girl may have part of her genitals cut)																
Have you heard of the Bondo/Sande/other secret societies/ female circumcision?																
Have you ever heard of the Bondo society?																
Now I would like to ask you about something else. As you know, some women belong to bush societies, like the Sande society. Have you heard of these societies?					958											
In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	FG2			1302			902	902	FG2	502	FG2	FG2	551	902		
In many communities girls are introduced to womanhood by participating in some ceremonies and undergoing specific procedures. I want to discuss with you the circumcision of girls. In this community, is female circumcision practised?		1001	820													
In many communities girls are also circumcised. In your community, is female circumcision practised?																
Are women circumcised in this area?																
Do you know any type of female circumcision?																
If yes, mention those types (multiple response allowed) (pharaonic, sunna, intermediate, others/identify)																
During the past six months, have you heard or seen anything about female circumcision? (radio,TV, magazine, etc.)																
During the past year, have you heard or seen anything about female circumcision?																
Where did you hear or see this information? (TV, radio, newspaper/magazine, pamphlet/brochure, etc.)																
What is the main source of information on circumcision? (none, public health provider, relatives, friends, TV, etc.)																
Do you ever hear about female genital mutilation campaigns?																
Have there been any activities against female circumcision arranged in this area?																
Please describe the activities.																
Have there been any activities against female circumcision in this community?															536	
Should you be able to choose, from which source would you like to receive information about circumcision? (clinic, radio, journal, TV, school, etc.)																
Do you know that there is a law that forbids the practice of circumcision?																
How were you informed about it?																
Is circumcision authorized by the law?																
Do you think that there is a law that forbids the practice of circumcision?																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	901	FG1	FGC01	FG1	901	1101			FG1							499F	1210	FG1	FG1		631D	901	48
																				643A			1
								1101															1
							FG1																1
																							1
	902	FG2	FGC02	FG2	902	1102		1102	FG2							499G	1211	FG2	FG2		631E		47
																							2
																							1
															1001								1
												1											1
												2											1
																							1
																							4
																							2
																							1
												17											1
																							2
																							2
																							1
																							1
																							4
																							2
																							1
																							1

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on FGM/C status															
Are you circumcised?			902	1003	FG3	1103		1001	19			5A			
Are you circumcised, meaning, did they cut your external genital organs?							1003								
Are you circumcised, meaning, did they cut or nick something from your external genital organs?													1003		
Have you yourself ever been circumcised?										FG3	FG3			FG3	
Have you yourself ever been circumcised/had your genitals cut?															
Has (name) been circumcised/cut?															
Did you receive circumcision?															
Are you a member [of the Bondo society]?															
Have you yourself ever been initiated/circumcised?															
Are you a member of the Sande society or a woman's bush society?															
In this household, how many females have been circumcised?															

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on FGM/C status																
Are you circumcised?		1002	821			551									520	
Are you circumcised, meaning, did they cut your external genital organs?										503						
Are you circumcised, meaning, did they cut or nick something from your external genital organs?																
Have you yourself ever been circumcised?	FG3			1303			903		FG3		FG3	FG3	552			
Have you yourself ever been circumcised/had your genitals cut?																
Has (name) been circumcised/cut?																
Did you receive circumcision?																
Are you a member [of the Bondo society]?																
Have you yourself ever been initiated/circumcised?																
Are you a member of the Sande society or a woman's bush society?					959											
In this household, how many females have been circumcised?																

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
	229					802		802	801	901							821						
		902	FG3	1103	FG3						726		902	1002	FG3	FG3		FG3	FG3	1003		FG3	592
												725B											
															FG3AA								

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																							17
																							2
																							1
	903	FG3	FGC03	FG3		1103			FG3	FG3	227		FG1		1002	499H	1213	FG3	FG3	643B	631F	902	41
																							1
														FGM/C1									1
												3											1
							FG3																1
								1103															1
																							1
																							1

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on the type of FGM/C															
What type of circumcision did you experience (clitoris, clitoris/small labia, clitoris/big labia, other)?			903												
What type of circumcision did you have? Did you have clitoridectomy, excision or infibulation?															
What do you call this practice (that you had)?															
What type of circumcision did you have? Did you have pharaonic, intermediate or sunna circumcision?															
Which type did you receive? (pharaonic, sunna, intermediate, other/ identify, don't know)															
How would you call the type of practice that you experienced (total removal of the clitoris and inner labia, total removal of clitoris, partial removal, pinching or cut, other)?															
Did they cut your external genital organs?	903	903													
Did they cut something in the genital area?	904	904		1004	FG4					FG4					
Was any flesh (or something) removed from the genital area?						1104	1004				FG4		1004	FG4	
Was the genital area just nicked without removing any flesh?				1005		1105					FG5		1005	FG5	
Was the genital area just nicked without cutting any flesh?	905	905			FG5		1005			FG5					
Was the genital area just nicked/cut without removing any flesh?															
Did they cut/scratch your genital parts without really cutting them?															
Was the genital area cut on the surface without removing any flesh?															
Was your genital area sewn?															
Was your/the genital area sewn closed?	906	906			FG6	1106	1006			FG6	FG6			FG6	
Did they close the vaginal area in any form?															
Was the vaginal/genital area sewn closed or almost closed (during the circumcision)?			906										1006		
During the circumcision, did they close completely the genital area by sewing?				1006											
Did the vaginal area have to be cut open when you began menstruating or were first married?			907												
Did the vaginal area have to be cut open when you began menstruating or had your first sexual activity?													1006a		

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
											727												
		903																					
																				1005			
																					903		
			FG4		FG4																904	FG4	593a
				1104								726				FG4		FG4	FG4				
				1105								726A				FG5		FG5					
					FG5																905	FG5	593b
																			FG5				
			FG5																				
			FG6	1106	FG6							726B	903	1003		FG6		FG6	FG6			FG6	593c
																					906		
		906				808														1007			
		907				809														1008			

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on the type of FGM/C																
What type of circumcision did you experience (clitoris, clitoris/ small labia, clitoris/big labia, other)?																
What type of circumcision did you have? Did you have clitoridectomy, excision or infibulation?						552									521	
What do you call this practice (that you had)?													553			
What type of circumcision did you have? Did you have pharaonic, intermediate or sunna circumcision?																
Which type did you receive? (pharaonic, sunna, intermediate, other/identify, don't know)																
How would you call the type of practice that you experienced (total removal of the clitoris and inner labia, total removal of clitoris, partial removal, pinching or cut, other)?																
Did they cut your external genital organs?								903						903		
Did they cut something in the genital area?							904	904			FG4			904		
Was any flesh (or something) removed from the genital area?				1304					FG4	504		FG4				
Was the genital area just nicked without removing any flesh?				1305			905		FG5	505		FG5				
Was the genital area just nicked without cutting any flesh?								905			FG5			905		
Was the genital area just nicked/cut without removing any flesh?																
Did they cut/scratch your genital parts without really cutting them?																
Was the genital area cut on the surface without removing any flesh?																
Was your genital area sewn?																
Was your/the genital area sewn closed?				1306			906		FG6		FG6					
Did they close the vaginal area in any form?								906						906		
Was the vaginal/genital area sewn closed or almost closed (during the circumcision)?													556			
During the circumcision, did they close completely the genital area by sewing?																
Did the vaginal area have to be cut open when you began menstruating or were first married?																
Did the vaginal area have to be cut open when you began menstruating or had your first sexual activity?													557			

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																							1
															1003								4
																							2
											228												1
												4											1
																							1
					903																		6
					904													FG4					16
	904	FG4	FGC04	FG4		1104		1104	FG4	FG4						499I	1214		FG4				25
		FG5	FGC05	FG5		1105		1105	FG5	FG5						499J	1217						23
					905													FG5	FG5				15
																							1
																							1
	905																						1
																499K	1218						2
	906	FG6	FGC06	FG6	906	1106		1106	FG6	FG6								FG6	FG6				34
																							3
																							6
																							1
																							4
																							2

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on the circumstances surrounding the practice															
How old were you when you were circumcised?	907	907	904	1007		1107	1007	1002		FG7	FG7	5B	1007	FG7	
How old were you when you were initiated/circumcised?															
Who performed the circumcision?	908	908	905	1008	FG7	1108	1008			FG8	FG8		1008	FG8	
Who performed the initiation/circumcision?															
Who initiated you [to the Bondo society]?															
Who cut (or nicked) the genitals?															
Where was the circumcision performed?															
Do you know what tool was used in the circumcision? (sharp blade/ razor, scalpel, scissors, don't know)															
Was the circumcision carried out under an anaesthetic?															

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on the circumstances surrounding the practice																
How old were you when you were circumcised?	FG7	1003		1307		553	907	907	FG7	506		FG7	554	907	522	
How old were you when you were initiated/circumcised?																
Who performed the circumcision?	FG8			1308		554	908	908	FG8	507	FG7	FG8	555	908	523	
Who performed the initiation/circumcision?																
Who initiated you [to the Bondo society]?																
Who cut (or nicked) the genitals?																
Where was the circumcision performed?																
Do you know what tool was used in the circumcision? (sharp blade/razor, scalpel, scissors, don't know)																
Was the circumcision carried out under an anaesthetic?																

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
	231	904		1107		803			802	902	728	727				FG7			FG7	1004	907		594
	230	905	FG7	1108	FG7	804				903	729	728			FG7	FG8		FG7	FG8	1006	908	FG7	593d
						805																	
						806																	
						807																	

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	907		FGC07	FG7	907	1107			FG7						1004	499L	1219		FG7				47
								1107															1
	908	FG7	FGC08	FG8	908	1108			FG8		229		FG2	FGM/C2	1005			FG7	FG8				53
								1108															1
							FG7																1
																499M	1220						2
																							1
																							1
																							1

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on attitudes/opinions towards the practice															
Do you think female circumcision (or this practice) should be continued (or maintained) or should it be discontinued (or stopped or abandoned or disappear)?	923	923	923	1023	FG16	1117	1023	1005	22	FG16	FG22		1023	FG17	
Do you think the Bondo society should be continued or should it be discontinued?															
Do you think female circumcision should continue?															
What do you think about this practice?									20						
Are you in favour of FGM/C?									21						
Do you appreciate female circumcision?															
Why do you appreciate female circumcision? (preservation of virginity, demanded by men, custom, religion, other/identify, don't know)															
Why don't you accept female circumcision? (I know from orientation sessions it's a bad habit, not in the religion, I know from mass media, my husband didn't accept it, other/identify)															
Why do you think female circumcision (or this practice) should continue (or be continued or still be practised)?			917					1006	23						
What is your reason why it should be continued? (religious, traditional, other/specify)															
Why do you think female circumcision (or this practice) should be discontinued (or not continued or stopped)?			919					1007	24						
Why are you opposed to female circumcision? (religious prohibition, failure to achieve sexual satisfaction, medical complications, painful personal experience, against dignity of women, other/specify)															
What is your reason to discontinue? (religious, traditional, infertility, infection, difficulty in labour, other/specify)															
What type of circumcision should be continued? (pharaonic, intermediate, sunna, don't know)															
What type of female circumcision do you think should be continued: clitoridectomy, excision or infibulation?															
What do you mean by 'good tradition/custom'?			918												
What do you mean by 'bad tradition'?			920												
What type of circumcision would you prefer? (pharaonic, intermediate, sunna, other)															
Why do you think this practice continues? (ignorance of consequences, fear of social criticism, fear of initiating social change, influence of parents, etc.)															
What do you think is the best way to stop the practice of female circumcision? (practitioners should be stopped from doing the operation, sex education, educational campaign for parents, other)															
What, in your opinion, is the best way to abolish the practice? (enforced legislation, education campaigns for women, involvement of fathers, improvement of women's status, sex education, other/specify)															
Has your opinion about female circumcision changed during the past year? If yes, are you more likely or less likely to approve of circumcision now?															
What benefits do girls themselves get if they are initiated/circumcised? (cleanliness/hygiene, social acceptance, better marriage prospects, etc.)															

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
		916	FG16	1117	FG16	830	814	807	816	919	739	742A	910	1010	FG16	FG22		FG16	FG22	1023	923	FG16	598
		917	FG16A			831					741												
																		FG16A					
		920	FG16B			832					742												
																		FG16A					
											740												
		919																					
		922																					
						833																	
							811																

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on attitudes/opinions towards the practice																
Do you think female circumcision (or this practice) should be continued (or maintained) or should it be discontinued (or stopped or abandoned or disappear)?	FG22	1012		1321	960	560	923	923	FG17	523	FG16	FG22	566	923	530	
Do you think the Bondo society should be continued or should it be discontinued?																
Do you think female circumcision should continue?																
What do you think about this practice?																
Are you in favour of FGM/C?																
Do you appreciate female circumcision?																
Why do you appreciate female circumcision? (preservation of virginity, demanded by men, custom, religion, other/identify, don't know)																
Why don't you accept female circumcision? (I know from orientation sessions it's a bad habit, not in the religion, I know from mass media, my husband didn't accept it, other/identify)																
Why do you think female circumcision (or this practice) should continue (or be continued or still be practised)?	FG23	1013				562							567		532	
What is your reason why it should be continued? (religious, traditional, other/specify)																
Why do you think female circumcision (or this practice) should be discontinued (or not continued or stopped)?		1014				563							569		533	
Why are you opposed to female circumcision? (religious prohibition, failure to achieve sexual satisfaction, medical complications, painful personal experience, against dignity of women, other/specify)																
What is your reason to discontinue? (religious, traditional, infertility, infection, difficulty in labour, other/specify)																
What type of circumcision should be continued? (pharaonic, intermediate, sunna, don't know)																
What type of female circumcision do you think should be continued: clitoridectomy, excision or infibulation?						561									531	
What do you mean by 'good tradition/custom'?													568			
What do you mean by 'bad tradition'?													570			
What type of circumcision would you prefer? (pharaonic, intermediate, sunna, other)																
Why do you think this practice continues? (ignorance of consequences, fear of social criticism, fear of initiating social change, influence of parents, etc.)																
What do you think is the best way to stop the practice of female circumcision? (practitioners should be stopped from doing the operation, sex education, educational campaign for parents, other)																
What, in your opinion, is the best way to abolish the practice? (enforced legislation, education campaigns for women, involvement of fathers, improvement of women's status, sex education, other/specify)																
Has your opinion about female circumcision changed during the past year? If yes, are you more likely or less likely to approve of circumcision now?																
What benefits do girls themselves get if they are initiated/ circumcised? (cleanliness/hygiene, social acceptance, better marriage prospects, etc.)																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	923	FG16	FGC21	FG22	923	1117		1121	FG22	FG16			FC1	FG17		499W	1230	FG16	FG22		631G	912	65
							FG16																1
											232												1
																							1
																							1
												12											1
												13											1
												14											1
											234											913	14
																							1
																						914	12
											235												1
																							1
										FG16A													1
																							3
																							3
																							3
											233												1
											236												1
																							1
											237												1
																							1
								1119															1

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on attitudes/opinions towards the practice															
What benefits do girls themselves get if they are circumcised (or undergo genital cutting)? (cleanliness/hygiene, social acceptance, better marriage prospects, preserve virginity/prevent premarital sex, more sexual pleasure for man, religious approval, other, no benefits)															
What are the benefits of FGC? (keep virginity, to prevent fooling around, self-esteem, no benefit, other/specify, don't know)															
What benefits do girls themselves get if they do NOT undergo circumcision (or genital cutting)? (fewer medical problems, avoiding pain, more sexual pleasure for her, more sexual pleasure for the man, follows religion, other/specify, no benefits)															
What are the advantages for a girl to be circumcised?	919	919		1019			1019						1019		
What are the advantages for girls NOT to be circumcised?	920	920		1020			1020						1020		
Would you say that this practice is a way to prevent a girl from having premarital sex or sex before marriage, or does it have no effect on premarital sex?	921	921		1021			1021								
Does it increase the chance for marriage or does it have no effect?															
Do you think this practice decreases a woman's sexual desire, or does it have no effect?													1021		
Do you think that circumcision has any negative effects?					FG15A										
What type of negative effects do you know?					FG15B										
What are the dangers of FGC? (bleeding, spread of STDs, complications during pregnancy/delivery, sexual difficulty, no danger, other/specify, don't know)															
Agree or disagree with the following statements about circumcision: A husband will prefer his wife to be circumcised, circumcision can cause severe complications that might lead to a girl's death, circumcision prevents adultery, circumcision may cause a girl to have problems in becoming pregnant, circumcision lessens sexual satisfaction for a couple, childbirth is more difficult for a woman who has been circumcised															
In the last 12 months/past year, have you discussed the practice of female circumcision with relatives, friends, neighbours?															
In the last 12 months, have you discussed the practice of female circumcision with anyone?															
Do you ever talk about circumcision with your husband?															
What is your husband's opinion about circumcision?															
Does your husband/partner think (or is in favour) that female circumcision should be continued or discontinued?															
Do you think that men want this practice to be continued or discontinued?													1024		
Do you think men care that this practice is maintained or do you think they are in favour of its abandonment?	924	924		1024			1024								
What type of female circumcision does your husband favour? (pharaonic, intermediate, sunna, other, don't know)															
Do you believe (or think) that this practice (or female circumcision) is required by your religion (or religious precepts)?	922	922		1022		1116	1022						1022		
Is this practice accepted by the religion?															
Do you think this practice is required by your tradition or customs?		922A													

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
							812					739											
																FG23							
							813					740											
																				1018	919		
																				1019	920		
												741								1020	921		
																				1021			
																FG24							
						834 [1]	816 [2]	810 [3]	818 [4]	921 [5]													
							810	809	812	915													
											744	744											
							815		817	920		742B									924		
				1116					815	918		742									922		
																				1022			

1 Also includes the statement "Circumcision is an important part of religious tradition."
2 Also includes the statement "Circumcision is an important part of religious tradition."
3 Also includes the statement "Circumcision is an important part of religious tradition."
4 Does not include the statements "Circumcision lessens sexual satisfaction for a couple" and "Circumcision may cause a girl to have problems in becoming pregnant."
5 Does not include the statements "Circumcision lessens sexual satisfaction for a couple" and "Circumcision may cause a girl to have problems in becoming pregnant."

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on attitudes/opinions towards the practice																
What benefits do girls themselves get if they are circumcised (or undergo genital cutting)? (cleanliness/hygiene, social acceptance, better marriage prospects, preserve virginity/ prevent premarital sex, more sexual pleasure for man, religious approval, other, no benefits)				1319												
What are the benefits of FGC? (keep virginity, to prevent fooling around, self-esteem, no benefit, other/specify, don't know)																
What benefits do girls themselves get if they do NOT undergo circumcision (or genital cutting)? (fewer medical problems, avoiding pain, more sexual pleasure for her, more sexual pleasure for the man, follows religion, other/specify, no benefits)																
What are the advantages for a girl to be circumcised?							919	919		517				919		
What are the advantages for girls NOT to be circumcised?							920	920		518				920		
Would you say that this practice is a way to prevent a girl from having premarital sex or sex before marriage, or does it have no effect on premarital sex?							921	921						921		
Does it increase the chance for marriage or does it have no effect?																
Do you think this practice decreases a woman's sexual desire, or does it have no effect?										520						
Do you think that circumcision has any negative effects?																
What type of negative effects do you know?																
What are the dangers of FGC? (bleeding, spread of STDs, complications during pregnancy/delivery, sexual difficulty, no danger, other/specify, don't know)																
Agree or disagree with the following statements about circumcision: A husband will prefer his wife to be circumcised, circumcision can cause severe complications that might lead to a girl's death, circumcision prevents adultery, circumcision may cause a girl to have problems in becoming pregnant, circumcision lessens sexual satisfaction for a couple, childbirth is more difficult for a woman who has been circumcised																
In the last 12 months/past year, have you discussed the practice of female circumcision with relatives, friends, neighbours?																
In the last 12 months, have you discussed the practice of female circumcision with anyone?		1015														
Do you ever talk about circumcision with your husband?																
What is your husband's opinion about circumcision?																
Does your husband/partner think (or is in favour) that female circumcision should be continued or discontinued?															535	
Do you think that men want this practice to be continued or discontinued?																
Do you think men care that this practice is maintained or do you think they are in favour of its abandonment?							924	924		524				924		
What type of female circumcision does your husband favour? (pharaonic, intermediate, sunna, other, don't know)																
Do you believe (or think) that this practice (or female circumcision) is required by your religion (or religious precepts)?				1320			922	922		522				922		
Is this practice accepted by the religion?																
Do you think this practice is required by your tradition or customs?																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	919		FGC19																				5
																							1
	920																						3
					919																		12
					920																		12
	921				921																		12
																							1
																							2
																							1
																							1
																							1
																							5
																							4
																							1
												15										916	2
												16										917	2
											239												4
	924																						7
					924																		9
											240												1
	922		FGC20		922	1116		1120															21
																							1
					922a																		2

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on knowledge of, and experiences with, complications as a result of FGM/C															
Have you had problems after circumcision?								1003							
What kind of problems/complications?								1004							
Did you have any health problems or other complications during sexual relations or delivery because of your circumcision? If yes, complications during sexual relations or delivery? (yes, during delivery; yes, during sexual relations; yes, both; no)													1008A		
Did you have any health problems or other complications during delivery because of your circumcision?															
What did you do in case of health problems and complications during delivery? (went to health institution, went to traditional healer, nothing, other)															
Did you have any complications at the time of the circumcision or afterwards?															
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling/ failure to heal, shock, other/specify)															
Did you have any health problems or other complications during sexual relations because of your circumcision?															
What did you do in case of health problems and complications during sexual relations? (went to health institution, went to traditional healer, nothing, other)															
What did you do in case of health problems and complications during sexual relations and delivery? (went to health institution, went to traditional healer, nothing)															
Did you receive any health care for those complications?															
What kinds of health care did you receive? (hospitalized, suturing, blood transfusion, medicine/injection, other/specify)															

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
											737												
												737											
												737A											
						810																	
						811																	
												738											
												738A											
											738												
						812																	
						813																	

Questions posed to girls and women aged 15 to 49 years about their knowledge, experiences and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on knowledge of, and experiences with, complications as a result of FGM/C																
Have you had problems after circumcision?																
What kind of problems/complications?																
Did you have any health problems or other complications during sexual relations or delivery because of your circumcision? If yes, complications during sexual relations or delivery? (yes, during delivery; yes, during sexual relations; yes, both; no)																
Did you have any health problems or other complications during delivery because of your circumcision?																
What did you do in case of health problems and complications during delivery? (went to health institution, went to traditional healer, nothing, other)																
Did you have any complications at the time of the circumcision or afterwards?																
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling/failure to heal, shock, other/specify)																
Did you have any health problems or other complications during sexual relations because of your circumcision?																
What did you do in case of health problems and complications during sexual relations? (went to health institution, went to traditional healer, nothing, other)																
What did you do in case of health problems and complications during sexual relations and delivery? (went to health institution, went to traditional healer, nothing)																
Did you receive any health care for those complications?																
What kinds of health care did you receive? (hospitalized, suturing, blood transfusion, medicine/injection, other/specify)																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																							1
																							1
																							2
																							1
																							1
																							1
																							1
																							1
																							1
																							1
																							1
																							1

Questions posed to girls and women aged 15 to 49 about their daughters' experiences

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on daughters' FGM/C status															
Are all of your daughters circumcised?															
Has (name of eldest daughter) been circumcised?			909												
Have any of your daughters been circumcised?															
Have any of your daughters (or alive daughters) been circumcised (or experienced this practice)? If yes, how many?	910	910		1010	FG9		1010			FG9			1010	FG10	
Is she (name of the daughter) circumcised?						1111					FG15				
How many of your daughters between the ages of 0 and 14 have been circumcised?															
How many daughters do you have?															
How many were circumcised?															
Has your daughter/have any of your daughters been initiated/ circumcised?															
Are any of your daughters members of the Bondo society? If yes, how many?															
To which of your daughters did this happen most recently?	911	911		1011	FG10		1011			FG10			1011	FG11	
To which of your daughters did this happen most recently? How old is she?															
Which of your daughters was initiated most recently?															
Do you have any daughter who is not circumcised?															
Do you have any daughter who is not initiated/circumcised?															
Number of years since the most recent circumcision was done to any of your daughters.															

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
		909									731												
			FG9		FG9	815	802	804/ 804A				730	905	1005	FG9			FG9		1010	910	FG9	595a
				1111					807	909						FG15			FG15				
			FG10		FG10	816	803					730A	906	1006	FG10			FG10		1011	911	FG10	
																							595b

Questions posed to women aged 15 to 49 about their daughters' experiences

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on daughters' FGM/C status																
Are all of your daughters circumcised?																
Has (name of eldest daughter) been circumcised?		1005	823			556							559		525	
Have any of your daughters been circumcised?																
Have any of your daughters (or alive daughters) been circumcised (or experienced this practice)? If yes, how many?	FG10A			1310			910	910	FG10	509	FG9			910		
Is she (name of the daughter) circumcised?												FG15				
How many of your daughters between the ages of 0 and 14 have been circumcised?																
How many daughters do you have?																
How many were circumcised?																
Has your daughter/have any of your daughters been initiated/circumcised?																
Are any of your daughters members of the Bondo society? If yes, how many?																
To which of your daughters did this happen most recently?				1311			911	911	FG11	510	FG10			911		
To which of your daughters did this happen most recently? How old is she?																
Which of your daughters was initiated most recently?																
Do you have any daughter who is not circumcised?																
Do you have any daughter who is not initiated/circumcised?																
Number of years since the most recent circumcision was done to any of your daughters.	FG16A															

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
											230												1
															1007								9
																						904	1
	910	FG9	FGC10		910					FG9						499O	1222	FG9					38
				FG15		1111			FG15										FG15				12
																					631I		1
												5											1
												6											1
								1110															1
							FG9																1
	911	FG10	FGC11		911			1111		FG10						499P	1223	FG10					36
																							1
							FG10																1
			FGC 17																				1
								1117															1
																							1

Questions posed to women aged 15 to 49 about their daughters' experiences

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on the type of FGM/C															
What type of circumcision did your daughter undergo?															
Was any flesh (or something) removed from the genital area?	912	912		1012	FG11		1012			FG11	FG17		1012	FG12	
Was the genital area just nicked without removing any flesh?				1013	FG12		1013				FG18		1013	FG13	
Was the genital area just nicked without cutting any flesh?	913	913								FG12					
Was her genital area cut on the surface without removing any flesh?															
Was her or (name of daughter) genital area sewn closed?	914	914				1113	1014				FG19			FG14	
Was her genital area sewn?															
Was the vaginal area sewn closed or almost closed (during the circumcision)?															
During this practice, did they close completely or almost completely the part that was cut by sewing?													1014		
During circumcision, did they close completely (or totally) the vaginal area by sewing?				1014	FG13					FG13					
Did they close the vaginal area in any form?															
During the circumcision of (name of eldest daughter), which parts of the body were removed?															
What type of circumcision did (name of eldest daughter) experience? (clitoris, clitoris/small labia, clitoris/big labia, other)			910												
What do you call the type of practice that she experienced?															

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
			FG11		FG11							730B				FG17		FG11	FG17		912	FG11	595c
												730C				FG18		FG12	FG18		913		
			FG12		FG12																	FG12	595d
				1113	FG13							730D	907	1007		FG19		FG13	FG19				595e
						822																	
																				1015			
			FG13																			FG13	
																					914		
		910																		1013			

Questions posed to women aged 15 to 49 about their daughters' experiences

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on the type of FGM/C																
What type of circumcision did your daughter undergo?													560			
Was any flesh (or something) removed from the genital area?				1312			912	912	FG12	511	FG11	FG17		912		
Was the genital area just nicked without removing any flesh?				1313			913	913	FG13	512		FG18				
Was the genital area just nicked without cutting any flesh?											FG12			913		
Was her genital area cut on the surface without removing any flesh?																
Was her or (name of daughter) genital area sewn closed?				1314			914		FG14							
Was her genital area sewn?																
Was the vaginal area sewn closed or almost closed (during the circumcision)?																
During this practice, did they close completely or almost completely the part that was cut by sewing?																
During circumcision, did they close completely (or totally) the vaginal area by sewing?											FG13					
Did they close the vaginal area in any form?								914						914		
During the circumcision of (name of eldest daughter), which parts of the body were removed?		1010														
What type of circumcision did (name of eldest daughter) experience? (clitoris, clitoris/small labia, clitoris/big labia, other)																
What do you call the type of practice that she experienced?																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																							1
	912	FG11	FGC12	FG17	912			1112	FG17	FG11						499Q	1224	FG11	FG17				38
		FG12	FGC13	FG18	913			1113	FG18	FG12						499R	1225	FG12	FG18				28
																							9
	913																						1
	914	FG13	FGC14	FG19	914	1113		1114	FG19	FG13									FG19				28
																499S	1226						2
																							1
																							2
																		FG13					7
																							3
																							1
																							1
																							2

Questions posed to women aged 15 to 49 about their daughters' experiences

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on the circumstances surrounding the practice															
In which year was she circumcised?															
How old was she (or name) when she was circumcised (or when this occurred)?	915	915	911	1015	FG14	1112	1015			FG14	FG16		1015	FG15	
What age was she when she experienced this practice?															
Age of the girl when circumcised (less than 3 years, 3 to 7 years, above 7 years, don't know)															
Who performed the circumcision?	916	916	912	1016	FG15	1114	1016			FG15	FG20		1016	FG16	
Who cut (or nicked) the genitals?															
Who performed the initiation/circumcision?															
Where was the circumcision performed?															
Which instruments were used to perform the circumcision? (own blade/razor, shared blade/razor, scalpel, knife, other, don't know)															
Do you know what tool was used in the circumcision? (sharp blade/ razor, scalpel, scissors, don't know)															
Tools used in circumcision (blade, scissors, others/identify)															
Did anyone object to your (eldest) daughter being circumcised? (respondent, respondent's husband, respondent's mother, respondent's mother-in-law, respondent's father/father-in-law, other relative of respondent, other relative of the husband, other, nobody)			913												
Before (name of eldest daughter) was circumcised, was she informed about the details of the circumcision procedures?															
Was the circumcision carried out under an anaesthetic?															

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
		911	FG14	1112	FG14	817	804		809	911	732	731	908	1008		FG16		FG14	FG16	1012	915	FG14	596
		912	FG15	1114	FG15	818	805		808	910	733	732	909	1009	FG15	FG20		FG15	FG20	1014	916	FG15	597
						819	806																
						820																	
		913									734	733											
						821																	

Questions posed to women aged 15 to 49 about their daughters' experiences

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on the circumstances surrounding the practice																
In which year was she circumcised?																
How old was she (or name) when she was circumcised (or when this occurred)?		1007		1315		557	915	915	FG15	513	FG14	FG16			527	
What age was she when she experienced this practice?													561	915		
Age of the girl when circumcised (less than 3 years, 3 to 7 years, above 7 years, don't know)																
Who performed the circumcision?	FG20A	1008		1316		558	916	916	FG16	514	FG15	FG20	562	916	528	
Who cut (or nicked) the genitals?																
Who performed the initiation/circumcision?																
Where was the circumcision performed?		1009														
Which instruments were used to perform the circumcision? (own blade/razor, shared blade/razor, scalpel, knife, other, don't know)		1009a														
Do you know what tool was used in the circumcision? (sharp blade/razor, scalpel, scissors, don't know)																
Tools used in circumcision (blade, scissors, others/identify)																
Did anyone object to your (eldest) daughter being circumcised? (respondent, respondent's husband, respondent's mother, respondent's mother-in-law, respondent's father/father-in-law, other relative of respondent, other relative of the husband, other, nobody)						559							563		529	
Before (name of eldest daughter) was circumcised, was she informed about the details of the circumcision procedures?		1011														
Was the circumcision carried out under an anaesthetic?																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																		FG10a					1
	915	FG14	FGC15	FG16		1112	FG14	1115	FG16	FG14					1008	499T	1227	FG14	FG16			905	55
					915																		3
												8											1
	916	FG15	FGC16	FG20	916	1114			FG20			7			1009			FG15	FG20			907	56
																499U	1228						2
							FG15	1116															2
																						908	4
																							1
																						906	2
												9											1
															1010								8
																							1
																							1

Questions posed to women aged 15 to 49 about their daughters' experiences

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on women's intention to have their daughter(s) undergo FGM/C															
Do you plan (or intend) to have (name of eldest daughter) [or your daughters or all your daughters or any (other) daughters] circumcised in the future?	918	918	914	1018			1018						1018		
Would you like your daughter to be circumcised?															
Will you circumcise your next daughter?															
If yes, why?															
Do you intend to have any of your daughters initiated/circumcised in the future?															
Do you intend to have one of your daughters experience this type of ceremony?															
Do you intend to circumcise your daughters who have not yet been circumcised, if any?															
For married women or women who have ever been married: If you have uncircumcised daughters, do you intend to circumcise them?															
Why don't you intend to have your daughter(s) circumcised?															
Is (or was) there anyone who is encouraging (encouraged) you to have your daughter circumcised?															
Do you think that if you oppose the practice, somebody from your 'entourage' (family, friends) might have your daughter excised/ circumcised anyway?			915												
Who decides about the circumcision of the daughter?			916												

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
		914				827	807	805	811	914											918		
															FG7AA	FG25							
																				1017			
						828	808	806															
						829																	
		915																					

Questions posed to women aged 15 to 49 about their daughters' experiences

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on women's intention to have their daughter(s) undergo FGM/C																
Do you plan (or intend) to have (name of eldest daughter) [or your daughters or all your daughters or any (other) daughters] circumcised in the future?		1006	824	1318		559a	918	918		516			564	918	526	
Would you like your daughter to be circumcised?																
Will you circumcise your next daughter?												FG23				
If yes, why?												FG24				
Do you intend to have any of your daughters initiated/ circumcised in the future?																
Do you intend to have one of your daughters experience this type of ceremony?																
Do you intend to circumcise your daughters who have not yet been circumcised, if any?																
For married women or women who have ever been married: If you have uncircumcised daughters, do you intend to circumcise them?																
Why don't you intend to have your daughter(s) circumcised?																
Is (or was) there anyone who is encouraging (encouraged) you to have your daughter circumcised?																
Do you think that if you oppose the practice, somebody from your 'entourage' (family, friends) might have your daughter excised/ circumcised anyway?													565			
Who decides about the circumcision of the daughter?																

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	918		FGC18		918						231					499V	1229						29
																							2
																							1
																							1
								1118															1
																							1
														FG00									1
													FC2										1
																							3
																							1
																							3
																							1

Questions posed to women aged 15 to 49 about their daughters' experiences

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on daughters' experiences with complications as a result of FGM/C															
Did your daughter have any complications at the time of the circumcision or afterwards?															
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling, pus, other/specify)															
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling/ failure to heal, shock, other/specify)															
Did any of the following problems occur at the time or after they cut the genital parts of (name)? (excessive bleeding, difficulty keeping urine or urinating, swelling of the genital area, infection of the genital area/did not heal properly)	917	917		1017			1017						1017		
What kinds of complications was the girl exposed to when circumcised? (bleeding, infections, shock, all above, no complications, don't know)															
What kind of risks did the circumcised girl suffer during delivery? (fistula, obstructed labour, others/determine, no risks, don't know)															
Did she receive any health care (or medical attention) for the complications?															
What kinds of health care did she receive? (hospitalized, suturing, blood transfusion, medicine/injection, other/specify)															

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on daughters' experiences with complications as a result of FGM/C																
Did your daughter have any complications at the time of the circumcision or afterwards?																
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling, pus, other/specify)																
What were those complications? (severe pain at the wound, bleeding, infection/fever, difficulty in passing urine/urine retention, swelling/failure to heal, shock, other/specify)																
Did any of the following problems occur at the time or after they cut the genital parts of (name)? (excessive bleeding, difficulty keeping urine or urinating, swelling of the genital area, infection of the genital area/did not heal properly)							917	917		515				917		
What kinds of complications was the girl exposed to when circumcised? (bleeding, infections, shock, all above, no complications, don't know)																
What kind of risks did the circumcised girl suffer during delivery? (fistula, obstructed labour, others/determine, no risks, don't know)																
Did she receive any health care (or medical attention) for the complications?																
What kinds of health care did she receive? (hospitalized, suturing, blood transfusion, medicine/injection, other/specify)																

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
						823																	
						824														1016	917		
						825																	
						826																	

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
																						909	2
																						910	1
																							1
	917				917																		13
												10											1
												11											1
																						911	2
																							1

Questions posed to boys and men aged 15 to 49 (or 64) years about their knowledge and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on knowledge of FGM/C and partner's FGM/C status															
Have you ever heard about/of female circumcision?	701	701		701		814	501				MFG1		701		
In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?	702	702	701	702		815	502				MFG2		702		
During the past year have you discussed female circumcision with your relatives, friends or neighbours?															
During the past year have you heard, seen or received any information about female circumcision?															
Where did you hear or see this information? (TV, radio, newspaper/ magazine, pamphlet/brochure, etc.)															
Currently married or lives with a woman: Is your wife or one of your wives/partners circumcised?															
Was married or was living with a woman: Has your wife or have some of your wives/partners been circumcised?															
Did you know that your wife was circumcised when you got married?															
Who usually takes the decision for circumcising a female child? (mother, father, both, aunt, uncle, grandparents, other)			701a												

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 - 1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on knowledge of FGM/C and partner's FGM/C status																
Have you ever heard about/of female circumcision?							701	701		701				701		
In some countries, there is a practice in which a girl may have part of her genitals cut. Have you ever heard about this practice?							702	702		702			701	702		
During the past year have you discussed female circumcision with your relatives, friends or neighbours?																
During the past year have you heard, seen or received any information about female circumcision?																
Where did you hear or see this information? (TV, radio, newspaper/magazine, pamphlet/brochure, etc.)																
Currently married or lives with a woman: Is your wife or one of your wives/partners circumcised?																
Was married or was living with a woman: Has your wife or have some of your wives/partners been circumcised?																
Did you know that your wife was circumcised when you got married?																
Who usually takes the decision for circumcising a female child? (mother, father, both, aunt, uncle, grandparents, other)																

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
				814																701	701		
		701		815																702	702		
										206													
										207													
										208													
																				704a			
																				704b			
																				705			

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	901		FGC01		701			901						FG2		619A							20
	902		FGC02		702			902						FG3		619B							23
																							1
																							1
																							1
																							1
																							1
																							1
																							1

Questions posed to boys and men aged 15 to 49 (or 64) years about their knowledge and opinions of FGM/C

	Benin		Burkina Faso				Cameroon	Central African Republic				Chad			
	DHS 2001	DHS 2006	DHS 1998-1999	DHS 2003	MICS 2006	DHS/MICS 2010	DHS 2004	DHS 1994-1995	MICS 2000	MICS 2006	MICS 2010	MICS 2000	DHS 2004	MICS 2010	
Questions on attitudes/opinions towards the practice															
Do you think female circumcision (or this practice) should continue (or be maintained) or should it be discontinued (or stopped, abandoned or disappear)?	707	709	702	707		817	509				MFG3		709		
What type of circumcision do you think should be continued: clitoridectomy, excision, infibulation?															
Why do you think female circumcision should continue (or still be practised)?			703												
Why do you think female circumcision should be discontinued (or stopped)?			705												
What do you mean by 'good tradition/custom'?			704												
What do you mean by 'bad tradition'?			706												
Do you prefer marrying a circumcised women, a non-circumcised woman, or is this not important?															
Would you like to marry a woman who is not circumcised (her genitals are not cut)?															
What benefits (or advantages) do girls themselves get if they undergo circumcision (or this practice)? (cleanliness/hygiene, social acceptance, better marriage prospects, preserve virginity/prevent premarital relations, stop adultery, more sexual pleasure for the man, religious necessity, other, no advantage)	703	703		703			503						703		
In your opinion, what kind of inconveniences, if any, do girls encounter when they undergo this kind of practice?															
Would you think/say that this kind of practice prevents a girl's sexual relations before marriage (or sex before marriage), or does it have no effect on premarital relations/sex?	705	706		705			506								
Do you think this practice improves a girl's chances of marriage?															
What are the benefits (or advantages) for girls NOT to be circumcised? (fewer medical problems, avoiding pain, more sexual pleasure for her, more sexual pleasure for the man, follows religion, other/specify, no benefits, don't know)	704	704		704			504						704		
Do you think this practice decreases the woman's sexual desire, or does it have no effect?													706		
Do you think that women want (or wish) that this practice be kept (or continued) or, instead, do you think they are in favour of abandonment (or that it be stopped)?							510						710		
Do you think women care that this practice is maintained or do you think they are in favour of its abandonment?	708	710													
Does you wife/partner think female circumcision should be continued or discontinued?															
Do you think that men wish that this practice be kept or, instead, do you think they are in favour of abandonment?				708											
Agree or disagree with the following statements about female circumcision: A husband will prefer his wife to be circumcised, circumcision can cause severe complications that might lead to a girl's death, circumcision prevents adultery, childbirth is more difficult for a woman who has been circumcised															
Do you think/believe this practice is required by your religion (or religious precepts)?	706	708		706		816	508						708		
Do you think this practice is accepted by your religion?															
Do you think this practice is required by your tradition or customs?		708A													

	Côte d'Ivoire				Djibouti	Egypt					Eritrea		Ethiopia		Gambia		Ghana			Guinea		Guinea-Bissau	
	DHS 1994	DHS 1998-1999	MICS 2006	DHS 2012	MICS 2006	DHS 1995	DHS 2000	DHS 2003	DHS 2005	DHS 2008	DHS 1995	DHS 2002	DHS 2000	DHS 2005	MICS 2005-2006	MICS 2010	DHS 2003	MICS 2006	MICS 2011	DHS 1999	DHS 2005	MICS 2006	MICS/RHS 2010
		702		817						210	524									712	709		
											525												
		703									526												
		706									527												
		705																					
		708																					
																				706			
																				707	703		
																				708			
																				709	706		
																				710			
																					704		
										211											710		
											529												
										212													
				816						209											708		
																				711			

Questions posed to boys and men aged 15 to 49 (or 64) years about their knowledge and opinions of FGM/C

	Iraq	Kenya			Liberia	Mali				Mauritania			Niger		Nigeria	
	MICS 2011	DHS 1998	DHS 2003	DHS 2008-2009	DHS 2007	DHS 1995 -1996	DHS 2001	DHS 2006	MICS 2010	DHS 2000-2001	MICS 2007	MICS 2011	DHS 1998	DHS/MICS 2006	DHS 1999	
Questions on attitudes/opinions towards the practice																
Do you think female circumcision (or this practice) should continue (or be maintained) or should it be discontinued (or stopped, abandoned or disappear)?							707	709		709			702	709		
What type of circumcision do you think should be continued: clitoridectomy, excision, infibulation?																
Why do you think female circumcision should continue (or still be practised)?													703			
Why do you think female circumcision should be discontinued (or stopped)?													705			
What do you mean by 'good tradition/custom'?													704			
What do you mean by 'bad tradition'?													706			
Do you prefer marrying a circumcised women, a non-circumcised woman, or is this not important?																
Would you like to marry a woman who is not circumcised (her genitals are not cut)?																
What benefits (or advantages) do girls themselves get if they undergo circumcision (or this practice)? (cleanliness/hygiene, social acceptance, better marriage prospects, preserve virginity/ prevent premarital relations, stop adultery, more sexual pleasure for the man, religious necessity, other, no advantage)							703	703		703				703		
In your opinion, what kind of inconveniences, if any, do girls encounter when they undergo this kind of practice?																
Would you think/say that this kind of practice prevents a girl's sexual relations before marriage (or sex before marriage), or does it have no effect on premarital relations/sex?							705	706						706		
Do you think this practice improves a girl's chances of marriage?																
What are the benefits (or advantages) for girls NOT to be circumcised? (fewer medical problems, avoiding pain, more sexual pleasure for her, more sexual pleasure for the man, follows religion, other/specify, no benefits, don't know)							704	704		704				704		
Do you think this practice decreases the woman's sexual desire, or does it have no effect?										706						
Do you think that women want (or wish) that this practice be kept (or continued) or, instead, do you think they are in favour of abandonment (or that it be stopped)?							708	710		710						
Do you think women care that this practice is maintained or do you think they are in favour of its abandonment?														710		
Does you wife/partner think female circumcision should be continued or discontinued?																
Do you think that men wish that this practice be kept or, instead, do you think they are in favour of abandonment?																
Agree or disagree with the following statements about female circumcision: A husband will prefer his wife to be circumcised, circumcision can cause severe complications that might lead to a girl's death, circumcision prevents adultery, childbirth is more difficult for a woman who has been circumcised																
Do you think/believe this practice is required by your religion (or religious precepts)?							706	708		708				708		
Do you think this practice is accepted by your religion?																
Do you think this practice is required by your tradition or customs?																

Notes: Numbers in this table refer to the original question number used in the surveys. Questions with similar wording and meaning were merged in order to simplify and condense the presentation of the information. Words in parentheses are all the various synonyms that were used to convey the question or response categories. Some of the questions on FGM/C in Sudan (SHHS 2006 and 2010) were asked in the household questionnaire, while others were included in the questionnaire for girls and women aged 15 to 49 years.

	Nigeria				Senegal		Sierra Leone			Somalia	Sudan				United Republic of Tanzania			Togo		Uganda		Yemen	
	DHS 2003	MICS 2007	DHS 2008	MICS 2011	DHS 2005	DHS/MICS 2010-2011	MICS 2005	DHS 2008	MICS 2010	MICS 2006	DHS 1989-1990	MICS 2000	SHHS 2006	SHHS 2010	DHS 1996	DHS 2004-2005	DHS 2010	MICS 2006	MICS 2010	DHS 2006	DHS 2011	DHS 1997	Total
	907		FGC05		709			905						FG4		619C							25
																							1
																							4
																							4
																							3
																							3
																							1
								906															1
	903		FGC03		703			903															15
																							1
	905				706																		11
																							1
	904				704																		12
																							2
	908																						8
					710																		4
																							1
																							1
																							1
	906		FGC04		708			904															17
																							1
					708A																		2

In the case of Egypt (1995, 2000, 2003, 2005), Sudan (DHS 1989-1990) and Yemen (DHS 1997), questions on FGM/C were only asked to ever-married women. In the case of Egypt DHS 2008, questions on FGM/C were asked of both ever-married women and never-married women in the health issues survey.

Statistical tables

Table 1 FGM/C prevalence among girls and women aged 15 to 49 years

Country	FGM/C prevalence among girls and women (%)	FGM/C prevalence among girls and women, by selected background characteristics (%)															
		Current age							Residence		Household wealth quintile					Region	
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	Urban	Rural	Poorest	Second	Middle	Fourth	Richest	Region with the highest prevalence	Region with the lowest prevalence
Benin	13	8	10	14	14	16	17	16	9	15	15	19	17	10	5	59	0.1
Burkina Faso	76	58	70	78	83	85	88	89	69	78	77	78	78	80	69	90	55
Cameroon	1	0.4	3	2	1	1	2	2	1	2	1	4	1	1	1	5	0
Central African Republic	24	18	22	25	26	28	30	34	18	29	34	31	26	17	15	77	3
Chad	44	41	43	46	45	46	45	47	46	44	53	47	43	37	43	96	2
Côte d'Ivoire	36	28	34	38	43	44	41	40	34	39	55	34	37	38	23	88	13
Djibouti	93	90	94	93	96	95	93	94	93	96	–	–	–	–	–	95	93
Egypt	91	81	87	94	95	96	96	96	85	96	95	96	95	92	78	99	(21)
Eritrea	89	78	88	91	93	93	94	95	86	91	94	91	89	87	84	98	82
Ethiopia	74	62	73	78	78	81	82	81	69	76	73	76	75	78	71	97	(27)
Gambia	76	77	77	78	75	73	75	79	75	78	73	76	82	83	69	99	49
Ghana	4	2	2	3	4	6	7	6	3	5	13	4	3	1	1	41	0.4
Guinea	96	89	95	97	97	99	98	100	94	96	97	98	95	94	95	100	86
Guinea-Bissau	50	48	49	51	50	49	54	50	41	57	49	57	60	44	41	95	6
Iraq	8	5	8	9	9	10	9	10	9	6	10	12	10	6	4	58	0
Kenya	27	15	21	25	30	35	40	49	17	31	40	31	29	26	15	98	1
Liberia	66	44	58	68	70	73	78	85	45	81	84	80	75	58	40	92	2
Mali	89	88	88	88	89	90	89	89	89	88	84	84	88	93	92	98	4
Mauritania	69	66	66	67	71	72	76	75	57	81	94	88	71	57	48	99	20
Niger	2	2	2	2	2	3	3	3	2	2	1	2	1	5	2	12	0.1
Nigeria	27	19	22	26	30	32	35	38	33	24	12	21	29	39	31	73	0.2
Senegal	26	24	24	26	25	29	27	29	23	28	43	30	26	21	15	92	1
Sierra Leone	88	80	87	92	93	96	95	96	81	92	94	93	93	88	76	96	73
Somalia	98	97	98	98	99	99	98	99	97	98	98	99	98	98	96	99	94
Sudan	88	84	87	90	88	90	90	89	84	90	90	87	82	88	91	99	65
Togo	4	1	2	4	5	6	5	7	3	5	3	6	5	4	2	14	1
Uganda	1	1	1	2	2	1	2	2	1	1	2	1	1	1	2	5	0.2
United Republic of Tanzania	15	7	11	12	19	22	22	22	8	17	25	16	17	13	6	71	0
Yemen	23	19	22	21	23	24	25	25	26	22	–	–	–	–	–	69	5

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage of girls and women aged 15 to 49 years who have undergone FGM/C.

Notes: In Liberia, girls and women who have heard of the Sande society were asked whether they were members; this provides indirect information on FGM/C, since it is performed during initiation into the society. Data for Yemen refer to ever-married girls and women; some data could not be calculated since access to the dataset is restricted. Data for Côte d'Ivoire presented in this table are from MICS 2006 since the DHS 2012 data are preliminary and were used only to report on the prevalence among girls and women in the text. To account for the fact that in Sierra Leone about one in five girls aged 15 to 19 years who have not undergone FGM/C may still be at risk, adjustments were made to prevalence data for this age group, as explained in endnote 156. For this reason, the figure presented here differs from that included in the original MICS 2010 country report. For Burkina Faso and Togo, the categories 'Animist' and 'Traditional religion' are grouped together under 'Traditional religion'.

Country	FGM/C prevalence among girls and women, by selected background characteristics (%)													Reference year	Data source
	Education				Ethnicity		Religion								
	No education	Primary completed	Secondary or higher	Koranic/ non-standard	Ethnic group with the highest prevalence	Ethnic group with the lowest prevalence	Muslim	Roman Catholic	Other Christians	Animist	Traditional religion	Other religion	No religion		
Benin	18	4	2	–	74	0.2	50	7	4	–	7	2	23	2006	DHS
Burkina Faso	80	70	56	–	87	22	81	66	60	–	76	–	62	2010	DHS/MICS
Cameroon	5	1	0.4	–	13	0	6	0.3	1	0	–	1	0.3	2004	DHS
Central African Republic	30	25	12	–	53	3	24	24	25	–	–	21	23	2010	MICS
Chad	47	42	31	–	92	1	56	41	26	7	–	59	11	2010	MICS
Côte d'Ivoire	52	21	15	–	(77)	4	65	11	12	45	–	10	30	2006	MICS
Djibouti	94	96	91	93	–	–	–	–	–	–	–	–	–	2006	MICS
Egypt	97	89	87	–	–	–	92	–	74	–	–	–	–	2008	DHS
Eritrea	93	86	82	–	100	(79)	99	89	83	–	(100)	*	–	2002	DHS
Ethiopia	77	71	64	–	(100)	(0)	89	77	69	–	49	74	–	2005	DHS
Gambia	78	77	74	–	98	12	79	–	20	–	–	–	*	2010	MICS
Ghana	13	2	1	–	30	0	12	5	1	–	10	(1)	4	2011	MICS
Guinea	97	92	90	–	99	68	98	–	80	88	–	–	75	2005	DHS
Guinea-Bissau	65	39	28	–	–	–	95	6	7	5	–	7	8	2010	MICS/RHS
Iraq	16	7	6	2	–	–	–	–	–	–	–	–	–	2011	MICS
Kenya	38	26	19	–	98	0.1	51	29	24	–	–	–	38	2008-2009	DHS
Liberia	84	60	41	–	–	–	80	–	63	–	95	–	88	2007	DHS
Mali	89	88	88	–	98	13	89	–	84	86	–	*	88	2010	MICS
Mauritania	82	71	51	77	–	–	–	–	–	–	–	–	–	2011	MICS
Niger	2	2	1	–	66	0.2	2	–	55	*	–	*	20	2006	DHS/MICS
Nigeria	15	35	32	–	–	–	19	–	34	–	–	29	24	2011	MICS
Senegal	28	24	20	–	82	1	27	–	7	20	–	*	*	2010-2011	DHS/MICS
Sierra Leone	95	85	74	–	92	34	–	–	–	–	–	–	–	2010	MICS
Somalia	98	97	96	99	–	–	–	–	–	–	–	–	–	2006	MICS
Sudan	84	91	92	–	–	–	–	–	–	–	–	–	–	2010	SHHS
Togo	8	3	1	–	28	0.1	21	1	1	2	–	0	1	2010	MICS
Uganda	2	1	2	–	3	0	1	1	2	–	–	0.1	–	2011	DHS
United Republic of Tanzania	20	16	3	–	–	–	–	–	–	–	–	–	–	2010	DHS
Yemen	22	26	29	–	–	–	–	–	–	–	–	–	–	1997	DHS

Table 2A Girls aged 0 to 14 years who have undergone FGM/C

Country	FGM/C prevalence among girls (%)	Girls who have undergone FGM/C, by selected background characteristics (%)																
		Mother's current age							Residence		Mother's education				Mother's FGM/C status		Region	
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	Urban	Rural	No education	Primary completed	Secondary or higher	Koranic / non-standard	FGM/C	No FGM/C	Region with the highest prevalence	Region with the lowest prevalence
Burkina Faso	13	3	7	10	14	15	18	22	7	15	15	8	2	–	16	1	27	4
Central African Republic	1	0.1	0.1	1	1	2	3	3	1	2	2	1	0.2	–	4	0.1	6	0
Egypt	17	1	1	4	16	24	30	38	13	19	24	22	10	–	17	1	64	1
Gambia	56	33	42	54	58	60	63	70	51	60	59	51	42	–	72	2	89	33
Ghana	1	0	1	1	1	1	1	1	0.3	1	2	0.3	0	–	7	0.1	7	0
Mauritania	54	50	48	48	55	54	59	59	33	68	66	49	21	60	69	5	94	9
Nigeria	14	19	14	12	14	13	14	19	11	16	19	14	11	–	26	2	38	0
Senegal	12	14	13	11	12	11	12	18	8	15	14	7	3	–	41	0.2	50	0
Sierra Leone	13	0.3	3	8	12	18	23	26	13	13	15	8	9	–	14	2	21	8
Sudan	37	7	13	20	33	42	47	55	31	39	20	62	76	–	41	3	61	23
Togo	0.4	(5)	0	0.2	1	0.3	1	1	0.1	1	1	0.1	0	–	5	0.1	2	0
Uganda	1	2	2	1	1	2	2	1	1	1	1	2	0.4	–	1	1	6	0

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage of girls aged 0 to 14 years who have undergone FGM/C (as reported by their mothers).

Notes: For Senegal, data refer to all daughters aged 0 to 9 years who have undergone FGM/C. Due to a skip in the questionnaire, information on the number of daughters of

Table 2B Girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM/C

Country	Mothers with at least one daughter cut (%)	Girls and women with at least one living daughter who has undergone FGM/C, by selected background characteristics (%)																
		Mother's current age							Residence		Mother's education				Mother's FGM/C status		Region	
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	Urban	Rural	No education	Primary completed	Secondary or higher	Koranic / non-standard	FGM/C	No FGM/C	Region with the highest prevalence	Region with the lowest prevalence
Benin	2	0	0.1	0.4	2	3	5	6	2	2	3	1	0.1	–	13	0.2	8	0
Cameroon	1	0	1	1	1	0.3	1	2	1	1	2	1	0.1	–	34	0.1	2	0
Chad	18	2	3	10	21	27	33	38	19	18	21	11	6	–	39	1	46	1
Côte d'Ivoire	21	7	9	12	20	28	34	33	17	24	29	8	5	–	42	1	49	7
Djibouti	49	*	9	18	39	54	71	80	48	58	53	45	33	(27)	51	7	59	47
Eritrea	63	23	40	49	62	70	77	82	59	65	68	59	40	–	68	17	78	54
Ethiopia	38	15	14	21	32	45	59	67	30	39	41	25	19	–	45	8	85	24
Guinea	57	4	8	30	55	72	88	94	59	56	58	53	54	–	58	15	71	38
Guinea-Bissau	39	16	28	34	41	43	51	52	30	45	49	24	9	–	72	2	84	3
Iraq	3	0	0.2	1	3	4	6	6	4	2	10	2	1	0	35	0.1	28	0
Kenya	8	0	1	3	5	11	13	20	2	9	23	6	5	–	23	0.2	59	0
Liberia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Mali	74	42	59	70	79	84	85	87	74	75	76	71	68	–	81	6	91	2
Niger	1	0	0	1	1	1	2	2	1	1	1	0.4	1	–	33	0.4	5	0
Somalia	46	0	4	21	51	71	84	91	48	45	47	44	55	43	46	39	48	37
United Republic of Tanzania	3	1	1	1	2	4	10	7	1	4	5	3	0.2	–	18	0	18	0
Yemen	20	20	17	18	20	21	21	22	20	20	20	22	15	–	–	–	63	2

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage of girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM/C.

Country	Girls who have undergone FGM/C, by selected background characteristics (%)														Reference year	Data source
	Household wealth quintile					Ethnicity		Religion								
	Poorest	Second	Middle	Fourth	Richest	Ethnic group with the highest prevalence	Ethnic group with the lowest prevalence	Muslim	Roman Catholic	Other Christians	Animist	Traditional religion	Other religion	No religion		
Burkina Faso	16	16	13	12	8	26	3	16	7	6	–	14	–	12	2010	DHS/MICS
Central African Republic	2	1	2	0.4	0.4	3	0	2	1	1	–	–	3	2	2010	MICS
Egypt	22	21	17	12	10	–	–	17	–	12	–	–	–	–	2008	DHS
Gambia	51	55	62	66	45	93	5	57	–	9	–	–	–	–	2010	MICS
Ghana	2	0.2	0.1	0.2	0.3	6	0	1	1	0.2	–	3	*	1	2011	MICS
Mauritania	83	70	53	33	21	–	–	–	–	–	–	–	–	–	2011	MICS
Nigeria	18	17	15	15	7	–	–	19	–	10	–	–	24	11	2011	MICS
Senegal	21	14	11	7	2	32	0.3	12	–	2	6	–	*	*	2010-2011	DHS/MICS
Sierra Leone	13	14	14	13	13	19	4	–	–	–	–	–	–	–	2010	MICS
Sudan	36	41	35	38	36	–	–	–	–	–	–	–	–	–	2010	SHHS
Togo	1	1	1	0.1	0	8	0	2	0	0	1	–	(0)	0	2010	MICS
Uganda	2	2	0.4	2	1	4	0	1	2	1	–	–	1	–	2011	DHS

mothers who have not heard of FGM/C were not collected through the FGM/C modules in Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone and Togo. Adjustments to prevalence data for girls aged 0 to 14 years were made to account for the proportions of daughters with missing information. In the case of Burkina Faso, Egypt and Senegal, prevalence data had to be recalculated due to an oversight in the algorithm used to produce the estimates. For these reasons, the figures presented in this publication may differ from those included in original DHS and MICS country reports. For Burkina Faso and Togo, the categories 'Animist' and 'Traditional religion' are grouped together under 'Traditional religion'. For Senegal, the categories 'Other religion' and 'No religion' are grouped together under 'Other religion'.

Country	Girls and women with at least one living daughter who has undergone FGM/C, by selected background characteristics (%)														Reference year	Data source
	Household wealth quintile					Ethnicity		Religion								
	Poorest	Second	Middle	Fourth	Richest	Ethnic group with the highest prevalence	Ethnic group with the lowest prevalence	Muslim	Roman Catholic	Other Christians	Animist	Traditional religion	Other religion	No religion		
Benin	3	4	2	1	1	15	0	7	1	0.2	–	0.4	0	3	2006	DHS
Cameroon	0.2	2	1	1	1	(35)	0	3	0.2	0.2	0	–	4	0	2004	DHS
Chad	22	20	17	15	17	42	1	25	12	8	2	–	22	5	2010	MICS
Côte d'Ivoire	32	20	23	19	9	46	2	34	5	4	28	–	4	18	2006	MICS
Djibouti	–	–	–	–	–	–	–	–	–	–	–	–	–	–	2006	MICS
Eritrea	71	65	60	62	54	93	55	72	76	55	–	*	–	–	2002	DHS
Ethiopia	38	37	38	41	34	91	(0.2)	40	25	38	–	20	20	–	2005	DHS
Guinea	55	57	56	59	59	66	24	61	–	35	41	–	–	20	2005	DHS
Guinea-Bissau	41	44	44	32	28	–	–	72	4	4	1	–	(6)	11	2010	MICS/RHS
Iraq	4	4	4	2	1	–	–	–	–	–	–	–	–	–	2011	MICS
Kenya	14	10	9	5	2	52	0.1	24	8	6	–	–	*	5	2008-2009	DHS
Liberia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Mali	70	70	75	78	78	92	8	75	–	41	60	–	–	76	2010	MICS
Niger	1	1	0.4	2	1	(7)	0.2	1	–	(4)	–	–	*	(4)	2006	DHS/MICS
Somalia	49	44	44	46	48	–	–	–	–	–	–	–	–	–	2006	MICS
United Republic of Tanzania	5	5	4	2	0.4	–	–	–	–	–	–	–	–	–	2010	DHS
Yemen	–	–	–	–	–	–	–	–	–	–	–	–	–	–	1997	DHS

Notes: Data for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM/C. For Yemen, some data could not be calculated since access to the dataset is restricted. Data on daughters were not collected in Liberia. For Cameroon, the category 'Other religion' refers to 'New religions'. The prevalence of FGM/C across Tables 2A and 2B cannot be directly compared due to differences in the methods used to collect the data.

Table 3 Support for the continuation of FGM/C among girls and women aged 15 to 49 years

Country	Girls and women supporting the continuation of FGM/C (%)	Girls and women supporting the continuation of FGM/C, by selected background characteristics (%)																		
		Current age							Residence		Household wealth quintile					FGM/C status		Region	
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	Urban	Rural	Poorest	Second	Middle	Fourth	Richest	FGM/C	No FGM/C	Region with the highest support	Region with the lowest support
Benin	1	1	2	2	1	1	1	1	1	2	3	2	2	1	1	4	1	4	0
Burkina Faso	9	10	9	9	9	8	8	12	8	10	11	11	10	8	8	12	2	21	3
Cameroon	7	8	7	7	6	2	6	13	5	13	14	22	6	5	3	67	4	19	(1)
Central African Republic	11	14	13	10	9	12	8	10	7	15	17	16	12	7	6	27	5	(32)	4
Chad	38	37	38	38	38	37	35	40	29	41	48	45	39	33	27	66	6	90	5
Côte d'Ivoire	20	17	18	19	22	23	23	23	13	27	38	24	22	17	6	45	2	70	5
Djibouti	37	34	33	34	38	44	41	41	37	42	–	–	–	–	–	39	4	48	35
Egypt	54	34	47	57	60	65	69	64	43	62	66	63	58	50	35	59	6	74	(7)
Eritrea	49	37	45	46	54	55	60	63	34	60	71	63	56	37	27	53	11	73	28
Ethiopia	31	23	27	35	37	38	34	38	10	36	48	39	34	31	14	36	13	74	6
Gambia	64	65	67	64	63	61	61	66	64	65	59	65	72	71	54	82	5	79	46
Ghana	2	2	2	3	3	2	3	1	2	3	4	4	3	2	1	13	2	7	1
Guinea	69	62	66	71	73	72	73	72	54	76	79	75	75	66	53	70	49	89	49
Guinea-Bissau	34	28	31	35	34	38	39	42	21	44	42	44	41	24	18	63	3	69	4
Iraq	5	4	4	4	5	6	6	7	4	9	13	8	4	3	1	20	2	15	0
Kenya	10	9	10	10	9	10	10	10	8	11	20	10	10	7	7	29	2	90	2
Liberia	45	42	45	42	45	44	45	54	28	52	58	57	46	32	22	–	–	55	24
Mali	73	70	73	74	76	75	74	74	71	75	74	72	76	77	68	81	7	86	6
Mauritania	41	41	40	39	41	40	43	42	26	54	72	58	44	25	18	54	6	78	12
Niger	3	3	2	4	2	3	2	4	2	3	3	2	4	3	2	16	2	5	2
Nigeria	22	21	21	21	20	21	22	25	20	23	21	27	23	23	17	40	5	27	10
Senegal	17	16	17	16	16	18	17	18	13	21	30	25	18	11	7	52	3	65	2
Sierra Leone	66	53	60	68	68	73	73	75	50	75	77	77	73	64	45	69	25	76	44
Somalia	65	60	62	66	66	69	70	64	54	72	78	78	68	56	47	66	19	80	32
Sudan	42	37	40	45	43	47	43	46	27	50	68	59	43	30	21	47	11	67	22
Togo	2	2	3	2	2	2	1	2	1	3	3	3	2	1	1	15	1	4	1
Uganda	9	13	9	7	9	7	6	4	5	10	13	11	11	7	5	10	9	17	4
United Republic of Tanzania	6	6	6	4	6	6	7	3	2	7	10	8	8	4	1	19	3	16	(0)
Yemen	41	41	42	37	39	44	42	45	32	46	–	–	–	–	–	78	11	66	13

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage of girls and women aged 15 to 49 years who have heard about FGM/C and think the practice should continue.

Notes: MICS data for Ghana (2011), Nigeria (2011) and Sierra Leone (2010) were not used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from older surveys were used for these three countries. Data for Yemen refer to ever-married girls and women; some data could not be calculated since access to the dataset is restricted. In Liberia, only cut girls and women were asked about their attitudes towards FGM/C; since girls and women from practising communities are more likely to support the practice, the level of support in this country as captured by the 2007 DHS is higher than would be anticipated had all girls and women been asked their opinion. For Cameroon, the category 'Other religion' refers to 'New religions'. Data presented in Tables 3 and 4 cannot be directly compared for all countries since data sources for girls and women are more recent than those for boys and men for some countries.

Country	Girls and women supporting the continuation of FGM/C, by selected background characteristics (%)													Reference year	Data source
	Education				Ethnicity		Religion								
	No education	Primary completed	Secondary or higher	Koranic/ non-standard	Ethnic group with the highest support	Ethnic group with the lowest support	Muslim	Roman Catholic	Other Christians	Animist	Traditional religion	Other religion	No religion		
Benin	2	1	1	–	4	0	2	1	1	–	2	1	2	2006	DHS
Burkina Faso	11	8	3	–	20	3	12	5	2	–	10	–	16	2010	DHS/MICS
Cameroon	22	8	3	–	87	(0)	17	3	5	*	–	3	*	2004	DHS
Central African Republic	15	12	5	–	19	3	12	12	11	–	–	13	13	2010	MICS
Chad	45	26	17	–	75	8	52	19	15	18	–	(41)	14	2010	MICS
Côte d'Ivoire	31	11	3	–	41	3	32	6	4	33	–	5	19	2006	MICS
Djibouti	40	39	28	50	–	–	–	–	–	–	–	–	–	2006	MICS
Egypt	71	49	44	–	–	–	56	–	22	–	–	–	–	2008	DHS
Eritrea	67	40	17	–	95	34	73	38	34	–	(82)	*	–	2002	DHS
Ethiopia	41	20	5	–	78	17	42	34	27	–	36	38	–	2005	DHS
Gambia	67	66	59	–	84	12	66	–	15	–	–	–	*	2010	MICS
Ghana	3	2	2	–	5	1	3	2	2	–	3	*	3	2006	MICS
Guinea	75	60	43	–	71	67	69	–	61	91	–	–	84	2005	DHS
Guinea-Bissau	51	22	6	–	–	–	61	5	5	7	–	7	7	2010	MICS/RHS
Iraq	17	6	2	5	–	–	–	–	–	–	–	–	–	2011	MICS
Kenya	39	8	6	–	81	1	40	8	7	–	–	(5)	29	2008-2009	DHS
Liberia	51	47	23	–	–	–	44	–	43	–	(88)	–	75	2007	DHS
Mali	77	71	58	–	85	11	74	–	47	72	–	*	82	2010	MICS
Mauritania	52	42	21	50	–	–	–	–	–	–	–	–	–	2011	MICS
Niger	3	2	1	–	11	1	3	–	4	–	–	–	28	2006	DHS/MICS
Nigeria	26	24	19	–	29	1	29	17	17	–	37	(29)	–	2008	DHS
Senegal	21	14	8	–	48	2	17	–	4	–	–	19	–	2010-2011	DHS/MICS
Sierra Leone	76	60	39	–	74	8	72	–	46	–	*	*	(78)	2008	DHS
Somalia	69	53	47	65	–	–	–	–	–	–	–	–	–	2006	MICS
Sudan	60	44	17	–	–	–	–	–	–	–	–	–	–	2010	SHHS
Togo	4	2	1	–	15	1	6	1	1	2	–	0	4	2010	MICS
Uganda	11	10	6	–	19	3	3	9	8	–	–	(32)	–	2011	DHS
United Republic of Tanzania	12	5	1	–	–	–	–	–	–	–	–	–	–	2010	DHS
Yemen	42	41	27	–	–	–	–	–	–	–	–	–	–	1997	DHS

Table 4 Support for the continuation of FGM/C among boys and men aged 15 to 49 (or 64)

Country	Boys and men supporting the continuation of FGM/C (%)	Boys and men supporting the continuation of FGM/C, by selected background characteristics (%)																	Reference year	Data source
		Current age										Residence		Household wealth quintile						
		15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Urban	Rural	Poorest	Second	Middle	Fourth	Richest		
Benin	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	2006	DHS
Burkina Faso	10	12	10	9	10	10	9	11	11	12	–	9	11	13	10	11	10	9	2010	DHS/MICS
Cameroon	7	7	11	6	8	6	4	7	5	7	–	5	12	8	18	10	6	3	2004	DHS
Chad	41	51	32	27	43	40	44	56	44	42	–	31	46	78	49	27	26	29	2004	DHS
Côte d'Ivoire	23	14	31	17	20	19	20	29	38	31	–	15	28	39	20	30	23	6	1998-1999	DHS
Egypt	58	36	51	64	63	66	69	69	66	70	–	53	63	60	62	61	61	48	2008	DHS
Eritrea	46	24	30	48	44	53	63	55	73	60	–	28	54	–	–	–	–	–	1995	DHS
Guinea	53	56	44	48	51	57	54	59	59	57	–	44	59	61	62	56	49	45	2005	DHS
Mali	70	70	69	68	67	73	72	63	70	78	–	65	72	74	73	71	67	65	2006	DHS
Mauritania	70	68	68	63	69	74	72	77	73	84	–	61	82	–	–	–	–	–	2000-2001	DHS
Niger	6	7	11	7	3	5	3	3	5	5	–	4	6	5	6	6	8	4	2006	DHS/MICS
Nigeria	24	23	25	25	23	23	22	22	25	26	–	28	21	17	18	24	28	26	2008	DHS
Senegal	14	13	16	12	17	16	13	14	20	11	–	11	19	24	20	17	11	8	2005	DHS
Sierra Leone	46	44	38	45	47	44	47	52	57	52	–	37	51	54	55	49	41	35	2008	DHS
Sudan	27	31	28	25	25	28	24	26	–	–	–	21	32	45	37	25	22	17	2010	SHHS
United Republic of Tanzania	9	12	8	8	7	10	6	7	–	–	–	4	11	14	11	10	7	3	2004-2005	DHS

Table 4 (continued)

Countries	Boys and men supporting the continuation of FGM/C (%)	Boys and men supporting the continuation of FGM/C, by selected background characteristics (%)															Reference year	Data source
		Education				Region		Ethnicity		Religion								
		No education	Primary completed	Secondary or higher	Koranic/ non-standard	Region with the highest support	Region with the lowest support	Ethnic group with the highest support	Ethnic group with the lowest support	Muslim	Roman Catholic	Other Christians	Animist	Traditional religion	Other religion	No religion		
Benin	1	1	1	1	–	4	0	3	0.3	2	1	1	–	0.3	0	2	2006	DHS
Burkina Faso	10	12	10	5	–	16	3	21	(0)	13	5	5	–	14	*	*	2010	DHS/MICS
Cameroon	7	21	10	4	–	16	2	(75)	(0)	13	6	4	5	–	14	7	2004	DHS
Chad	41	59	33	16	–	88	5	76	(0)	58	29	17	*	–	*	(19)	2004	DHS
Côte d'Ivoire	23	37	21	7	–	28	14	–	–	34	9	9	–	27	–	–	1998-1999	DHS
Egypt	58	68	66	55	–	89	(21)	–	–	60	–	20	–	–	–	–	2008	DHS
Eritrea	46	58	30	13	–	71	24	–	–	–	–	–	–	–	–	–	1995	DHS
Guinea	53	64	54	39	–	78	30	64	32	56	–	35	52	–	–	(52)	2005	DHS
Mali	70	74	69	57	–	76	4	82	4	71	–	34	59	–	*	(72)	2006	DHS
Mauritania	70	79	67	62	79	90	49	–	–	–	–	–	–	–	–	–	2000-2001	DHS
Niger	6	5	7	5	–	13	2	7	2	5	–	*	*	–	–	*	2006	DHS/MICS
Nigeria	24	19	28	24	–	37	12	39	9	23	27	22	–	54	34	–	2008	DHS
Senegal	14	20	14	8	–	54	3	37	2	15	–	3	–	–	–	*	2005	DHS
Sierra Leone	46	51	47	37	–	52	34	52	19	48	–	37	–	*	*	*	2008	DHS
Sudan	27	47	29	16	–	60	11	–	–	–	–	–	–	–	–	–	2010	SHHS
United Republic of Tanzania	9	12	8	2	–	24	(1)	–	–	7	8	7	–	–	*	19	2004-2005	DHS

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage of boys and men who have heard about FGM/C and think the practice should continue.

Notes: Some data for Eritrea could not be calculated since access to the dataset is restricted. In Burkina Faso, the categories 'Animist' and 'Traditional religion' are grouped together under 'Traditional religion'. For Cameroon, the category 'Other religion' refers to 'New religions' and 'Buddhist/Hindu'. For Côte d'Ivoire, the category 'Traditional religion' includes 'Traditional religion', 'No religion' and 'Other/missing'. Data presented in Tables 3 and 4 cannot be directly compared for all countries since data sources for girls and women are more recent than those for boys and men for some countries.

Table 5 Practitioners of FGM/C

Country	Person performing FGM/C on girls and women aged 15-49 years (% distribution)							Person performing FGM/C on daughters (% distribution)							Reference year	Data source
	Doctor	Nurse/ midwife/ other health worker	Traditional circumciser	Other traditional practitioner	Other	Don't know/ missing	Total	Doctor	Nurse/ midwife/ other health worker	Traditional circumciser	Other traditional practitioner	Other	Don't know/ missing	Total		
Benin	0.2	1	96	2	–	2	100	0.4	1	97	1	–	0.2	100	2006	DHS
Burkina Faso	0.1	0.1	97	2	–	1	100	0	0.2	97	1	–	2	100	2010	DHS/MICS
Cameroon	2	2	81	12	–	3	100	–	*	*	*	–	–	*	2004	DHS
Central African Republic	0.3	2	86	9	–	3	100	0	1	78	11	–	10	100	2010	MICS
Chad	1	5	89	4	–	2	100	1	7	86	5	–	1	100	2010	MICS
Côte d'Ivoire	0.2	0.2	94	1	–	4	100	0	0.1	98	1	0	1	100	2006	MICS
Djibouti	1	5	92	2	–	1	100	2	19	76	1	–	2	100	2006	MICS
Egypt	24	8	–	66	0	2	100	72	6	–	22	–	1	100	2008	DHS
Eritrea	0.1	1	84	8	2	5	100	0.3	1	84	11	4	0.1	100	2002	DHS
Ethiopia	–	–	–	–	–	–	–	2	–	87	10	–	1	100	2005	DHS
Gambia	0	0.1	98	0.1	–	1	100	0	0.1	99	1	–	1	100	2010	MICS
Ghana	1	0.2	83	6	–	10	100	–	9	62	22	–	7	100	2011	MICS
Guinea	0.3	10	87	2	–	1	100	1	26	69	3	–	1	100	2005	DHS
Guinea-Bissau	0	0.2	98	2	–	1	100	0	0.1	96	2	–	2	100	2010	MICS/RHS
Iraq	0.3	6	–	35	45	14	100	0.4	13	–	29	51	6	100	2011	MICS
Kenya	6	14	75	4	–	2	100	4	37	56	3	–	1	100	2008-2009	DHS
Liberia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Mali	0.3	1	91	1	–	7	100	0.4	3	94	2	–	1	100	2010	MICS
Mauritania	1	1	57	33	–	8	100	1	2	59	34	–	4	100	2011	MICS
Niger	1	–	98	1	–	1	100	0	0	100	0	0	0	100	2006	DHS/MICS
Nigeria	3	14	66	4	–	13	100	4	25	66	4	–	2	100	2011	MICS
Senegal	–	–	91	9	–	–	100	–	–	97	3	–	0.2	100	2010-2011	DHS/MICS
Sierra Leone	0.1	1	95	1	–	3	100	0	1	87	2	–	10	100	2010	MICS
Somalia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Sudan	0.3	41	–	57	0.3	2	100	0.4	55	–	44	0.2	1	100	2010	SHHS
Togo	–	–	94	5	–	2	100	*	*	*	*	*	*	*	2010	MICS
Uganda	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
United Republic of Tanzania	0.3	2	70	19	–	10	100	–	0.4	73	26	–	0.4	100	2010	DHS
Yemen	–	–	–	–	–	–	–	3	6	5	68	19	0.1	100	1997	DHS

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage distribution of girls and women aged 15 to 49 years who have undergone FGM/C and percentage distribution of daughters who have undergone FGM/C, according to the type of person/practitioner performing the procedure.

Notes: Due to rounding, the data presented in these tables may not add up to 100 per cent. For Egypt, data on daughters refer to all daughters aged 0 to 17 years who have undergone FGM/C. For Senegal, data on daughters refer to all daughters aged 0 to 9 years who have undergone FGM/C. For Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone, Sudan, Togo and Uganda data on daughters refer to all daughters aged 0 to 14 years who have undergone FGM/C. For all other countries, data on daughters refer to the most recently cut daughter among mothers aged 15 to 49 years with at least one living daughter who has undergone FGM/C. Data on daughters for Iraq and Yemen refer to ever-married girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM/C. Some data for Yemen could not be calculated since access to the dataset is restricted. Data on daughters were not collected in Liberia. The category 'Other traditional practitioners' includes traditional birth attendants, traditional midwives and other types of traditional practitioners. For Egypt, traditional circumcisers also include *dayas, ghagarias* and *barbers*. For Iraq, 'other traditional practitioners' reflects the category 'traditional (unlicensed) birth attendant/ grandmother' and 'others' reflects the combined categories of 'other' and 'relative/ friend'. For Ethiopia, 'doctor' reflects the category 'doctor/nurse/trained midwife'. For Yemen, traditional practitioners also include *dayas* and *barbers*, and 'others' reflects the combined categories of 'other' and 'grandmother/relative'.

Table 6 Type of FGM/C

Country	Girls and women aged 15-49 years by type of FGM/C (% distribution)					Daughters by type of FGM/C (% distribution)					Reference year	Data source
	Cut, no flesh removed/ nicked	Cut, flesh removed	Genital area sewn closed	Type not determined/ not sure/ don't know	Total	Cut, no flesh removed/ nicked	Cut, flesh removed	Genital area sewn closed	Type not determined/ not sure/ don't know	Total		
Benin	1	98	0	2	100	2	95	2	1	100	2006	DHS
Burkina Faso	17	77	1	5	100	–	–	1	–	–	2010	DHS/MICS
Cameroon	4	85	5	7	100	*	*	*	*	*	2004	DHS
Central African Republic	20	70	7	3	100	24	61	6	9	100	2010	MICS
Chad	10	80	7	3	100	9	81	8	2	100	2010	MICS
Côte d'Ivoire	6	80	6	8	100	7	82	6	5	100	2006	MICS
Djibouti	6	25	67	2	100	15	53	30	3	100	2006	MICS
Egypt	–	–	1	1	–	–	–	2	1	–	1995	DHS
Eritrea	46	4	39	11	100	52	6	38	4	100	2002	DHS
Ethiopia	–	–	6	–	–	–	–	4	–	–	2005	DHS
Gambia	0.1	89	9	2	100	0	86	12	1	100	2010	MICS
Ghana	4	74	8	14	100	8	68	17	7	100	2011	MICS
Guinea	2	86	9	3	100	2	85	10	2	100	2005	DHS
Guinea-Bissau	0.2	84	12	4	100	0.4	88	10	2	100	2010	MICS/RHS
Iraq	–	–	–	–	–	–	–	–	–	–	–	–
Kenya	2	83	13	2	100	3	79	17	1	100	2008-2009	DHS
Liberia	–	–	–	–	–	–	–	–	–	–	–	–
Mali	14	55	2	28	100	16	71	3	11	100	2010	MICS
Mauritania	4	69	–	28	100	6	80	–	14	100	2011	MICS
Niger	1	78	13	8	100	0	63	35	2	100	2006	DHS/MICS
Nigeria	8	48	4	39	100	16	69	6	9	100	2011	MICS
Senegal	10	53	14	24	100	–	–	21	–	–	2010-2011	DHS/MICS
Sierra Leone	1	72	17	10	100	1	70	12	17	100	2010	MICS
Somalia	1	15	79	4	100	5	25	63	7	100	2006	MICS
Sudan	–	–	–	–	–	–	–	–	–	–	–	–
Togo	27	66	5	3	100	*	*	*	*	*	2010	MICS
Uganda	–	–	–	–	–	–	–	–	–	–	–	–
United Republic of Tanzania	2	91	1	6	100	1	98	2	0	100	2010	DHS
Yemen	–	–	–	–	–	–	–	–	–	–	–	–

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage distribution of girls and women aged 15 to 49 years who have undergone FGM/C and percentage distribution of daughters who have undergone FGM/C, by type of FGM/C performed.

Notes: Due to rounding, the data presented in these tables may not add up to 100 per cent. For Egypt, data on daughters refer to all daughters aged 0 to 17 years who have undergone FGM/C. For Senegal, data on daughters refer to all daughters aged 0 to 9 years who have undergone FGM/C. For Burkina Faso, Central African Republic, Gambia, Ghana, Mauritania, Nigeria, Sierra Leone, Sudan, Togo and Uganda data on daughters refer to all daughters aged 0 to 14 years who have undergone FGM/C. For all other countries, data on daughters refer to the most recently cut daughter among mothers aged 15 to 49 years with at least one living daughter who has undergone FGM/C. Data on daughters were not collected in Liberia. For Burkina Faso and Senegal, questions on type of cutting for daughters only differentiated infibulation from non-infibulating forms of FGM/C. For Egypt and Ethiopia, questions on type of cutting for both girls and women and daughters only differentiated infibulation from non-infibulating forms of FGM/C. Information on type of FGM/C was not asked in more recent surveys in Egypt (2000, 2003, 2005 and 2008). Data on type of cutting for Sudan are only available from MICS 2000, but were not included because of lack of comparability.

Table 7 Age at cutting

Country	Girls and women aged 15 to 49 years by age at cutting (% distribution)						Reference year	Data source	Daughters by age at cutting (% distribution)						Reference year	Data source
	0-4	5-9	10-14	15+	Missing/ don't know	Total			0-4	5-9	10-14	15+	Missing/ don't know	Total		
Benin	49	25	19	4	3	100	2006	DHS	31	52	12	1	3	100	2006	DHS
Burkina Faso	60	28	9	2	1	100	2010	DHS/MICS	53	38	4	1	4	100	2006	MICS
Cameroon	21	47	22	4	6	100	2004	DHS	*	*	*	*	*	*	–	–
Central African Republic	1	19	60	11	8	100	2010	MICS	2	28	52	11	7	100	2006	MICS
Chad	14	38	35	4	9	100	2010	MICS	14	57	23	1	5	100	2010	MICS
Côte d'Ivoire	55	17	18	8	1	100	2006	MICS	52	31	11	4	3	100	2006	MICS
Djibouti	–	–	–	–	–	–	2006	MICS	22	62	12	1	3	100	2006	MICS
Egypt	2	38	52	2	6	100	2008	DHS	8	39	52	1	2	100	2008	DHS
Eritrea	75	15	1	0.1	9	100	2002	DHS	86	13	0.3	0	0.2	100	2002	DHS
Ethiopia	–	–	–	–	–	–	2005	DHS	64	22	10	3	1	100	2005	DHS
Gambia	57	18	7	1	17	100	2010	MICS	–	–	–	–	–	–	–	–
Ghana	34	18	20	11	17	100	2011	MICS	(83)	(5)	(1)	(3)	(8)	(100)	2006	MICS
Guinea	36	32	27	3	3	100	2005	DHS	22	60	16	1	2	100	2005	DHS
Guinea-Bissau	43	29	11	3	14	100	2010	MICS/RHS	27	35	20	18	0.1	100	2010	MICS/RHS
Iraq	27	40	6	1	26	100	2011	MICS	–	–	–	–	–	–	–	–
Kenya	2	23	42	29	4	100	2008-2009	DHS	3	49	30	16	2	100	2008-2009	DHS
Liberia	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Mali	71	13	8	1	8	100	2010	MICS	89	9	1	0	2	100	2010	MICS
Mauritania	93	1	0.2	0	6	100	2011	MICS	81	11	2	2	4	100	2007	MICS
Niger	65	17	11	1	6	100	2006	DHS/MICS	61	30	9	0	0	100	2006	DHS/MICS
Nigeria	66	7	5	7	16	100	2011	MICS	95	2	1	1	1	100	2008	DHS
Senegal	71	14	6	1	8	100	2010-2011	DHS/MICS	74	13	2	0.3	11	100	2005	DHS
Sierra Leone	2	14	41	25	18	100	2010	MICS	28	32	26	9	6	100	2008	DHS
Somalia	–	–	–	–	–	–	2006	MICS	6	82	11	0	1	100	2006	MICS
Sudan	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Togo	17	15	39	23	7	100	2010	MICS	(11)	(57)	(20)	(4)	(8)	(100)	2006	MICS
Uganda	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–
United Republic of Tanzania	39	18	22	19	2	100	2010	DHS	46	22	21	10	1	100	2010	DHS
Yemen	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–	–

– Data not available.
() Figures are based on 25-49 unweighted cases.
* Figures are based on less than 25 unweighted cases and have been suppressed.

Indicator definition: Percentage distribution of girls and women aged 15 to 49 years who have undergone FGM/C and percentage distribution of daughters who have undergone FGM/C, by age when cutting occurred.

Notes: Due to rounding, the data presented in these tables may not add up to 100 per cent. For Egypt, data on daughters refer to all daughters aged 0 to 17 years who have undergone FGM/C. For all other countries, data refer to the most recently cut daughter among mothers aged 15 to 49 years with at least one living daughter who has undergone FGM/C. Data on daughters from Burkina Faso, Central African Republic, Ghana, Mauritania, Nigeria, Senegal, Sierra Leone and Togo are from earlier surveys that collected data on the most recently cut daughter among mothers aged 15 to 49 years with at least one living daughter who has undergone FGM/C. Data on daughters were not collected in Liberia. Data on age at cutting among daughters for the Gambia are not presented since the earlier MICS (2006) did not have questions on age at cutting for most recently cut daughters. Age at cutting could not be calculated for Yemen since access to the dataset is restricted. Data on age at cutting for daughters are available for Sudan (MICS 2000) but were not asked in more recent surveys. However, these data were excluded because they contradict to a large extent other evidence on the age at cutting in the country.

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Cover photos:

Top: Fatima, who underwent female genital mutilation/cutting (FGM/C) at the age of 1, sits on a bed in her home in the village of Karensa, in Amibara district, Afar region, Ethiopia.

Bottom: Photographs of girls who were not subjected to FGM/C adorn the walls of the Rohi-Weddu Pastoral Women Development Organization office in the town of Awash Sabat Kilo, in Amibara district, Afar region, Ethiopia. The girls were spared the procedure because of Rohi-Weddu's activities in the region, which include advocacy, training and the promotion of community dialogue. These kinds of holistic, human rights-based programmes are helping to change attitudes about harmful practices, with girls who are most affected playing an active role.

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