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Female genital mutilation around the world

Armelle Andro* and Marie Lesclingand**

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Where in the world is female genital cutting still practiced? Has female genital mutilation (FGM) become less common with continuing efforts to eradicate the practice, or has it persisted? Drawing on the most recent surveys, Armelle Andro and Marie Lesclingand offer an overview of the situation and trends in FGM around the world, and recall the consequences of genital mutilation for women's sexual and reproductive health.

Although female genital mutilation (FGM; see Box 1 for definition) was long considered a predominantly African phenomenon, such practices are present to various degrees on all continents [1, 2, 3]. Their prevalence has begun to decrease, albeit slowly and at different rates in different countries. In December 2012 the UN General Assembly adopted a resolution calling for their eradication, recognizing that they represent an abuse of women's human rights and a serious threat to their health.

A world-wide phenomenon

In 2016, UNICEF estimated that at least 200 million girls and women had been mutilated in 30 countries: 27 in Africa, along with Yemen, Iraq, and Indonesia. The geographical distribution of these girls and women is linked both to the prevalence of the practice (proportion of women who are mutilated) and to the demographic weight of each country. Thus, half of world's mutilated women and girls live in only three countries: Indonesia with a population of 256 million and an estimated prevalence of 51%, Ethiopia with 98 million and 74%, and Egypt with 89 million and 92% [3].

In Africa, FGM occurs in a set of countries forming a broad central band from the west of the continent to the east, and including Egypt, but with widely varying prevalence (Map). National prevalence figures can also hide regional variations: in Mali, for example, where national prevalence stood at around 90% in 2012, it was far lower (below 25%) in the country's three northern regions (Timbuktu, Kidal, and Gao) but nearly universal (above 90%) throughout the south.

Sociodemographic surveys conducted in the last two decades have revealed the presence of mutilated women and girls in a number of other regions around the world. This is due to improved measurement of these practices in countries where they were previously little known or even completely hidden (as in certain countries in the Middle East and Asia[1]).

In addition to these populations, there are girls and women from at-risk countries (or in families originating from these countries) living in countries of immigration, for which no overall estimates are yet available. Recent studies have estimated that over 500,000 girls and women have been mutilated or are at risk of mutilation in the United States [4], and that 500,000 female immigrants are in this situation in Europe.[2]

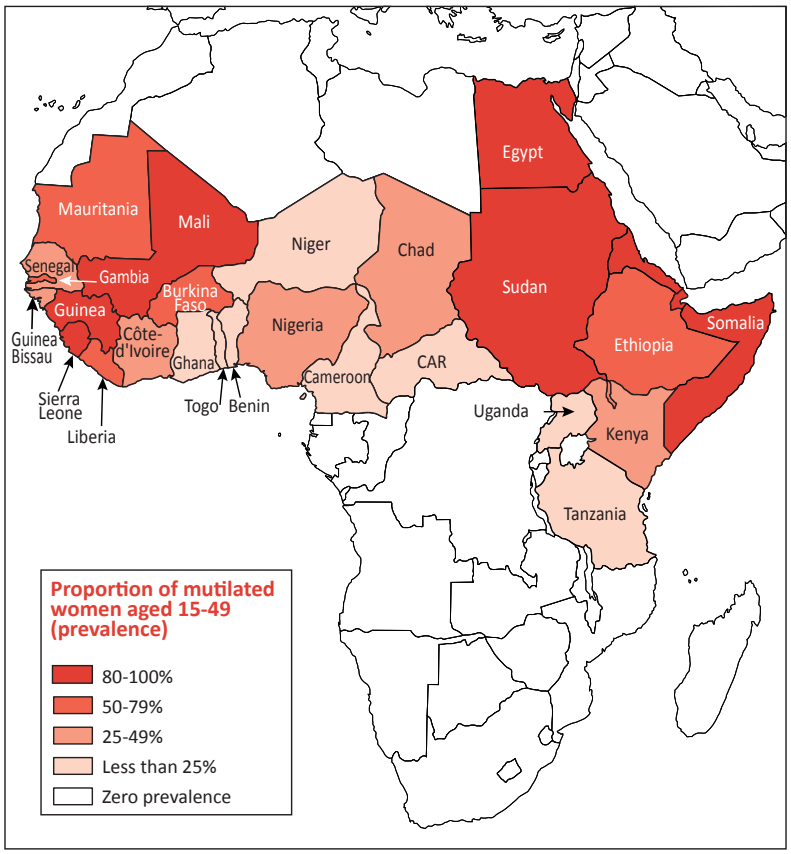
* Université Paris 1 Panthéon Sorbonne and French Institute for Demographic Studies (INED).

** Université Côte d'Azur, CNRS, IRD, URMIS.

(1) In addition to Iraq, Yemen, and Indonesia, where national surveys have revealed the practice of female genital mutilation, it has also been observed within minorities in Oman, Jordan, Syria, United Arab Emirates, Saudi Arabia, and Malaysia.

(2) Estimates established in the European Union member countries, as well as in Norway and Switzerland; women in the second or third generation following migration are not included [5].

Map. Frequency of female genital mutilation in Africa



A. Andro and M. Lesclingand, *Population & Societies* n° 543, INED, April 2017.

Sources: Most recent DHS and MICS surveys.

FGM is less common in the younger generations

In all the countries where data on FGM are available for multiple dates, observations show declining rates over the generations. Rates seem to be decreasing more rapidly in countries where the practice is less common. In countries where prevalence is high, FGM remains a very strong social norm, despite government mobilization and the strengthening of the arsenal of legal tools against it.[3] In Burkina Faso and Liberia, two countries where FGM still affects a majority of women (between 50% and 79%), rates have been steadily decreasing over the generations: in Liberia, only a third of women aged 15-19 years are mutilated, versus three quarters of those aged 45-49. In countries where only a minority of women are affected, such as Côte d'Ivoire, Kenya, Nigeria, and Central African Republic, decreases have been considerable. In these countries, the practice is becoming less valued, and a large majority of the population no longer recognizes it as a social obligation. Finally, in countries of immigration where FGM is strongly stigmatized and the practice is outlawed, families with origins in at-risk countries face contradictory social norms, and the risk of mutilation is thus much lower [2].

Women's and men's opinions on FGM are changing everywhere. In most of the countries studied, including those where prevalence remains high, the proportion of people supporting the continuation of these practices is decreasing (Figure). In Egypt, for example, whereas in 1995 eight out of 10 women aged 15-49 years said they supported the continuation of the practice, in 2008 this figure had dropped to six in 10. In Guinea and Mali, however – two countries where no change in practices over the generations has yet been observed – opinions have also remained stable. In almost all of these countries, FGM is now illegal,[4] but it remains difficult to speak out against the practice.

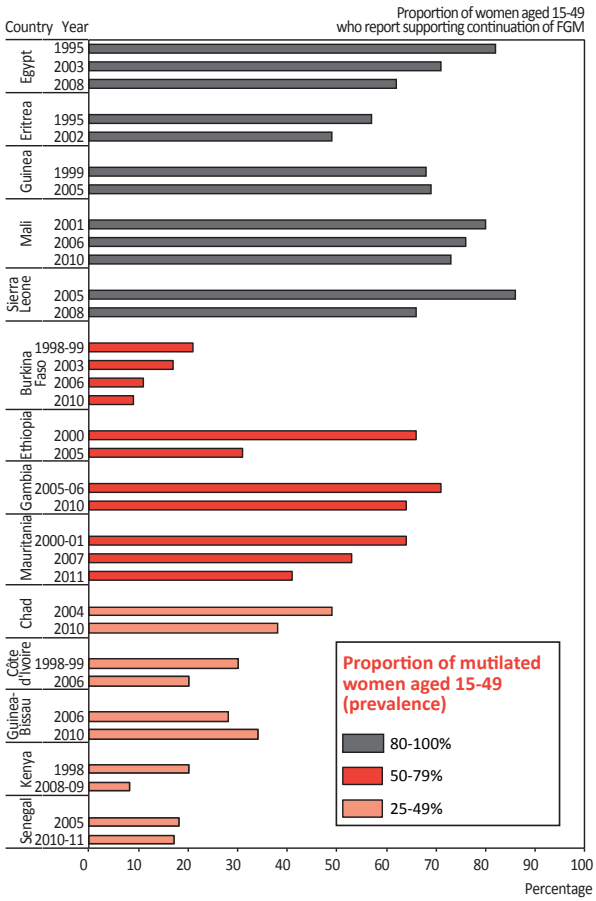
Risk of mutilation is linked to family region of origin and social factors

The principal factor in the risk of mutilation is ethnic origin, as FGM is historically associated to traditional rites marking the transition to adulthood. Level of education, living standards, and place of residence are also determinants: women who went to school are less often mutilated than those who did not, and this is also true of their daughters. The risk of mutilation is lower in cities, where greater social mixing accelerates changes in family norms and behaviours. There are no clear links, however, between FGM and religion, although most countries where FGM is widely

(3)With the exception of Mali, all other countries where prevalence is above 80% have adopted laws prohibiting the practice of FGM, most of them in the 2000s [2].

(4) Among the 30 countries with the highest rates of FGM, only 5 have not yet adopted a law prohibiting the practice: Cameroon, the Gambia, Indonesia, Liberia, and Mali [2].

Figure. Attitudes towards FGM



A. Andro and M. Lesclingand, *Population & Societies* n° 543, INED, April 2017.

Sources: DHS surveys in countries where prevalence is above 25% and where opinions on continuation or abandonment of FGM were recorded on multiple dates.

practiced have majority-Muslim populations. In most of the affected countries, communities with Christian, Jewish, and animist traditions also practice FGM. Religious convictions coexist with other value systems in the legitimation of FGM. Although the origins of these practices are not clearly known, they seem to date back to ancient Egypt – that is, long before the expansion of Islam. Moreover, in many Muslim-majority countries (on the African continent and elsewhere), FGM is not practiced (this is true, for example, throughout the Maghreb).

Long described as a rite of passage to adulthood, the trend has been for genital mutilation to occur increasingly early in life. In most countries, the majority of mutilated women underwent the procedure before the age of 10 years, and in the youngest generations, before the age of 5 years. In recent years, this tendency toward earlier genital mutilation has been accompanied by another worrying development: the medicalization of FGM (Box 2).

Box 1. Female genital mutilation: Definitions and consequences

"Female genital mutilation/cutting" includes "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" [1]. The international community has definitively recognized these practices as a human rights violation and a serious threat to the health of girls and women.

The forms of female genital mutilation

Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III: Narrowing of the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (infibulation).

Type IV: Not classified: all other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping and cauterizing the genital area.

Data on types of mutilation are available from surveys of women in 22 countries. In most countries, the most often reported form of mutilation is excision, with or without removal of tissue. The most invasive type of mutilation, infibulation, is practiced in eastern Africa, notably in Somalia, Djibouti, and Eritrea.

The health consequences of female genital mutilation

The World Health Organization groups the consequences of female genital mutilation into three categories:

- immediate risks of health complications from types I, II and III, such as pain, haemorrhage, the risk of urine retention, infections, and a state of shock following the operation;
- long-term health risks resulting from mutilation of types I, II, and II (which can arise at any time in life), such as pelvic infections, sterility, menstrual difficulties, and problems during pregnancy and childbirth (greater likelihood of perineal tears and fetal distress), vesico-vaginal or recto-vaginal fistulas leading to incontinence;
- additional risks of complications resulting from type III mutilation.

Sources: [1, 6]

Major consequences for sexual and reproductive health

It is now clearly established that genital mutilation has harmful effects on women's health and sexuality (Box 1, overall clinical picture established by the World Health Organization, WHO). The prevalence of urogenital problems is higher throughout life. Studies of mutilated women who have migrated to Europe show higher rates of post-traumatic stress and symptoms associated with depressive and anxious states than the general population. The situation with respect to obstetric complications is

Box 2. The medicalization of FGM

While in the majority of cases FGM is still performed by "traditional" practitioners, in a number of countries (Egypt, Guinea, Indonesia, Kenya, Nigeria, South Sudan, Yemen), increasing numbers of girls are undergoing FGM at the hands of health professionals in a medical context under the pretext of reducing the health risks of the procedure. On the initiative of the United Nations Population Fund (UNFPA), international organizations have condemned this trend, based on a misinterpretation of the first awareness campaigns, as it compromises the goal of eradicating FGM.

In this context, it should be remembered that certain population categories were also subjected to these practices in northern countries until very recently. Throughout the 19th century (and until the 1960s in the United States), clitoridectomies were practiced as a means to repress forms of female sexuality judged to be deviant by the medical profession – and are still performed today as part of sex reassignment surgery on intersex newborns. Moreover, new forms of genital plastic surgery such as nymphoplasty (partial or total removal of the labia minora, sometimes accompanied by reduction of the clitoral hood) are now developing in the United States, Latin America, Asia, and Europe.

more mixed. While these risks are particularly severe in many African countries, this is much less true in northern countries, where care for pregnant women is more medicalized, and obstetric risks are much lower as a consequence. Finally, various studies have demonstrated a link between mutilation and certain types of sexual dysfunction, both in countries of origin and countries of immigration. The sample population in most of these studies has consisted of adult women. The health problems affecting girls in puberty or childhood remain largely undocumented (or only retrospectively). Since the late 1990s, medical treatments for the consequences of FGM have become more widely available. A number of surgical protocols aimed at improving the situation of mutilated women have been evaluated and are recommended by the WHO.

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The globalization of migration, the discovery of FGM in regions where it remained hidden in the past, and the spread of medicalized forms of FGM make it a global public health and human rights issue. New knowledge on the social and family dynamics of the abandonment, perpetuation, or transformation of these practices, and on the experiences of those affected, is indispensable to enable women and girls to better express their perspective in the struggle against this form of gender violence. International organizations must ceaselessly fight for the eradication of FGM, and their arguments must be taken up by governments and NGOs.

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Abstract

In 2016, UNICEF estimated that at least 200 million girls and women had experienced genital mutilation in 30 countries: 27 in Africa, along with Yemen, Iraq, and Indonesia. Migration currents have carried these practices to other continents. While they are decreasing in the countries where they are least prevalent, no change has been observed in those where they are highly frequent, although the proportion of persons who support their continuation is falling. Under the pretext that it reduces the health risks of the procedure, some health professionals have begun to perform genital mutilation, although this is firmly condemned by the WHO and other international organizations.

Keywords

Female genital mutilation, female genital cutting, gender relations, reproductive health, sexuality, religion, Africa.

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INSTITUT NATIONAL D'ÉTUDES DÉMOGRAPHIQUES

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