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Female Genital Mutilation. Overview and Current Knowledge

Although the United Nations General Assembly adopted a resolution to ban female genital mutilation (FGM) in December 2012, efforts to stop this form of discrimination against women are still far from universal, and the number of women and girls concerned is still rising. In 2016, UNICEF estimates that at least 200 million women and girls alive today have been subjected to the practice worldwide (UNICEF, 2016). Most of them live in Africa (in 27 countries spanning the middle of the continent from east to west, including Egypt, Appendix Table A.1), in parts of the Middle East and Southeast Asia (Iraq, Yemen, Indonesia and Malaysia), and in countries of the North where there is African immigration, mainly Europe, North America and Australia (UNICEF, 2013).

Female genital mutilation, sometimes also called female sexual mutilation, comprises “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” (WHO, 1997). They have harmful consequences for sexual and reproductive health. By the 1990s, female genital mutilation (FGM) had become the standard term used by international organizations and by national institutions in the countries concerned by this issue. Changes in the terminology over time and debates surrounding these changes have signalled paradigm shifts in the perception of the practice. They have occurred in parallel with the growing international campaign to eradicate FGM. The earliest studies, conducted from an anthropological perspective, focused on the ritual aspects of FGM, which was called “female circumcision” at the time.⁽¹⁾ When the United Nations first investigated these procedures, in 1958, they were described as “customs involving ritual practices”, an expression

(1) In reference to rites of passage to adulthood, which in many African societies included practices of male and female circumcision (Sindzingre, 1977).

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adopted by the World Health Organization a year later (WHO, 1959). In the mid-1970s, under the influence of feminist movements, FGM was cast in a new light; the parallel with male circumcision was rejected and emphasis was placed on its harmful effects on women and girls' health (Hosken, 1979). The practice was subsequently addressed from a health and human-rights perspective, and described as "mutilation" (Shell-Duncan and Hernlund, 2001). Since 2013, UNICEF has used the expression "female genital mutilation/cutting" (FGM/C) in English and *mutilations génitales féminines/excision* (MGF/E) in French.⁽²⁾

FGM raises issues of discrimination, of human rights and the right to health, of public health in terms of risk prevention for girl children, and of sexual, reproductive and maternal health for women who have undergone the procedure. Consequently, international organizations dealing with these issues have become closely involved since the 1990s. But FGM also raises questions about the relations between Northern and Southern countries in the definition of an international doctrine, about the place of minorities in multicultural societies, and about the pertinence of hegemonic explanations. FGM remains a debated, controversial issue.

For all of these reasons, there is now an abundant scientific literature on FGM spanning most disciplines of the social sciences – anthropology, sociology, demography, history, law, political science, psychology, gender studies, social work, public health – as well as numerous articles in medical journals (Shell-Duncan and Hernlund, 2001). Despite that output, we still lack data and therefore accurate knowledge of some dimensions of FGM, be it medical data or information about the associated dynamics of social change. This article seeks to review the state of current knowledge on FGM.

Section I investigates the social and cultural aspects of the practice and the gradual construction of FGM as a human rights and right-to-health issue. Section II, more methodological in approach, examines the available data sources that now enable us to address this form of violence, which has long remained invisible. Section III describes the prevalence of the practice around the world and discusses the indicators used to measure it. Section IV analyses the dynamics of social change in a context of strong mobilization to eradicate FGM. Section V presents an overview of the consequences for the health and sexuality of women and girls who have undergone FGM and Section VI looks at the various medical responses. In its conclusion, the article raises several points for discussion with a view to filling in the knowledge gaps about this form of discrimination against women.

(2) "Cutting" is generally considered more neutral than "mutilation" and may also be a more literal translation of the expression used in the languages in the countries where the practice exists.

I. From female circumcision to female genital mutilation

1. An anthropological approach: understanding the social and cultural aspects

Origins and development

The exact historical and geographical origin of female genital mutilation is unknown. The hypothesis that the practice originated in the Middle East and the Arabian peninsula and was then carried across the African continent by Arab traders is not shared by all specialists (Erlach, 1986; Hosken, 1982). What does seem to be accepted is that FGM is an age-old practice, possibly dating as far back as Ancient Egypt,⁽³⁾ which may have originated in what is now Sudan and Egypt. The archaeological community is divided over whether marks found on Egyptian mummies are evidence of excision (Knight, 2001). The first reference to excision, recorded on papyrus, dates from the second century BCE in Egypt (Couchard, 2003). Later sources include accounts of travellers like the Ancient Greek geographer Strabo, who, after travelling to Egypt (around 25 BCE), described the operation as a customary practice (Hosken, 1982).

According to Mackie (1996), female genital mutilation spread from the western shore of the Red Sea (in what is now Egypt) to neighbouring regions of Africa to the south and west. He also establishes a link between infibulation,⁽⁴⁾ the most invasive form of FGM, which is mainly practised in eastern Africa (Eritrea, Djibouti, Somalia, Egypt and Sudan), and the slave trade, particularly during the period of Islamic expansion in Africa. This extreme form of FGM, whose name is derived from the Latin *fibula* (a brooch or pin), may also have been practised on female slaves in Ancient Rome to prevent sexual intercourse and avoid pregnancies, which would have rendered slaves unfit for work (Hosken, 1982). Despite the uncertainty about its origin, the evidence suggests that FGM existed long before the emergence and expansion of Islam in Africa, even if religious justifications were subsequently used to legitimize it. This is supported by the fact that FGM is practised in communities of Christians (Copts, Catholics and Protestants), Jews and animists. Unlike male circumcision, which, in Judaism and Islam, is the sign of a covenant between God, Abraham and his descendants, there is no commandment on excision in the books of the main monotheistic religions⁽⁵⁾ (Couchard, 2003; Thiam, 1978).

(3) Female genital mutilation is believed to have appeared later than male circumcision, which is attested in Egypt as early as the third millennium BCE (Erlach, 1986).

(4) Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (Table 1).

(5) According to Awa Thiam (1978), the association generally made between Islam and excision may originate in popular beliefs about the story of the prophet Ibrahim and his two co-wives Sarata and Haidara. The conflict between the two women led Sarata to excise Haidara. These three characters are known in the Bible as Abraham, Sarah and the servant Hagar.

Female genital mutilation (clitoridectomy⁽⁶⁾ and infibulation) has also been historically practised in the Western world, even if not imposed on whole communities. Chastity belts,⁽⁷⁾ a form of mechanical infibulation as opposed to the scarring practised on female slaves in Ancient Rome, were used in the Middle Ages (Hosken, 1982). In the nineteenth century, the pathologization of certain sexual practices, particularly female masturbation (Laqueur, 2005), led to the practice of surgical clitoridectomy, believed to cure the ills and deviant behaviour of women who lacked sexual restraint. This type of surgery, mainly practised in Europe in a context of repressive medicalization of sexuality, was first performed by a British doctor, Isaac Baker Brown, who believed it to be an effective cure for female masturbation and hysteria⁽⁸⁾ (Sindzingre, 1979). Although Baker Brown was expelled from the medical profession in 1867, in the United States the practice persisted into the 1960s (Cutner, 1985).

More recently, gender reassignment surgery performed on intersex newborn babies has been called genital mutilation by campaigners for the rights of those concerned (Löwy, 2003). This type of surgery, first performed in the 1950s,⁽⁹⁾ is still practised in some countries, including France (Lee et al., 2006).

A rite of passage or a marker of unequal gender relations?

Excision was first described in the anthropological literature, giving rise to functionalist and culturalist analyses linked to a psychoanalytical approach (Sindzingre, 1979). Female genital mutilation was mainly seen as a rite of passage, according to the three-phase interpretive model (separation of the individual from the group, marginalization then reintegration) established in the early twentieth century by the ethnographer Arnold Van Gennep (1909). Under this type of approach, which has been applied to various regions of Africa, excision is considered equivalent to male circumcision and is often referred to as “female circumcision” to emphasize the analogy between the two practices, which are described as markers of gender, age and sometimes ethnicity (Cartry, 1968; Chéron, 1933; Colleyn, 1975; Droz, 2000; Muller, 1993). These studies provide detailed documentation of initiation ceremonies, and a degree of justification, by emphasizing the mythical aspects of the rituals.⁽¹⁰⁾

These approaches were challenged in the 1970s, when the feminist campaign against excision was at its most vigorous. The equivalence between circumcision and excision was strongly contested, along with their common theoretical

(6) Excision of the prepuce with or without excision of part or the entire clitoris (Table 1).

(7) Elizabeth Gould Davis describes chastity belts in *The First Sex*, published in 1972. One method (which is a mechanical form of infibulation) involved passing rings through the labia majora and fastening them with wire or a padlock (Hosken, 1982).

(8) Female hysteria was believed to stem from uncontrolled sexual desire.

(9) The first surgical response in the scientific literature was reported by Hamburger et al. in 1953.

(10) The example of the Dogon myth of original androgyny, described by Griaule (1948), is particularly well known.

framework, and female genital mutilation was reframed within the broader issue of gender relations. Nicole Sindzingre was the first in the 1970s to argue against the idea of excision as a rite of initiation. She highlighted the asymmetry in practice between male circumcision and female excision ceremonies described in the anthropological literature. Firstly, in terms of its impact on physical integrity, female genital mutilation is not the equivalent of male circumcision. Furthermore, while male circumcision ceremonies are described as collective rituals with high social value, excision is usually presented as a “shortened” rite,⁽¹¹⁾ conducted within the family circle and centred on the individual (Sindzingre, 1977, 1979). However, it is primarily through the justifications for the practice – a concern to eliminate sexual ambiguity or original androgyny, a requirement of “purification” as a pre-requisite for marriage and childbirth, and a wish to curb sexual urges in order to ensure a girl’s virginity and a wife’s fidelity – that excision ties in with the question of the representation of femininity and gender relations more broadly.

Within the variety of discourses on female genital mutilation, it is possible to identify a common logic that not only links the practice to a concern for biological reproduction (through marriage and procreation) but also to a concern for social reproduction, since this sexual marking also marks the social roles of each gender. In many societies, the clitoris represents the “male part” with which the female sex is endowed at birth, a representation that is also found in myths of original androgyny or bisexuality⁽¹²⁾ (Couchard, 2003). Removing the clitoris thus provides a necessary means to make women’s bodies completely feminine (and exclusively devoted to procreation), but also to place them in a subordinate position within the male order by conferring on men the exclusive exercise of male authority, symbolized by the clitoris, the equivalent of the penis⁽¹³⁾ (Fainzang, 1985). Taking up Pierre Bourdieu’s analysis (1982) of rites of institution, a term he preferred to rites of passage, excision can be seen as a ritual practice to legitimize the difference between the sexes that underpins unequal power relations: excision is designed to “de-virilize” the woman in order to reduce her power, whereas circumcision “re-virilizes” the man in order to increase his authority (Fainzang, 1985). This paradigm, which denounces FGM as violence against women and incorporates the practice into the construction of unequal gender relations, has not been totally effective in deculturalizing the practice⁽¹⁴⁾ (Boni, 2009). FGM has since been analysed not only in terms of the imposition of patriarchal

(11) The excision ritual is shorter, has a simpler structure and fewer symbolic elements than the male circumcision ritual (Sindzingre, 1977).

(12) The foreskin of the penis represents the female part of the male genitalia.

(13) Recent studies have shown that, anatomically, the clitoris is equivalent to the penis (Foldes and Buisson, 2009).

(14) In France, the first book published on the issue by Awa Thiam in 1978 (*La parole aux négresses*), with a preface by Benoite Groult, sparked widespread debate and was not well received by African feminists, who felt that some of her arguments amounted to racist interference (Boni, 2009).

social norms but also from the perspective of the right to physical integrity and sexual freedom (Mbow, 1999).

2. The elaboration of an international doctrine against FGM: human rights and the right to health

On 20 December 2012, the United Nations General Assembly adopted a series of resolutions to eliminate practices and violations that present a grave danger to the health of women and girls. One of the five resolutions on the promotion of women's rights focuses specifically on intensifying global efforts for the elimination of female genital mutilations (A/RES/67/146). It urges the countries concerned to condemn all harmful practices that affect women and girls, in particular female genital mutilations, and to take all necessary measures, including enacting and enforcing legislation, raising awareness and allocating sufficient resources to protect women and girls against this specific form of violence. It calls for protection and support for women and girls who are at risk of or who have undergone female genital mutilation. The resolution is addressed to the countries where FGM is traditionally practised and to the countries of settlement of women who have migrated from those regions.

This international policy, which has now been ratified by the 194 member states of the United Nations, was elaborated slowly and in several stages. It is based on the triptych of human rights, the right to health, and women's rights, principles that themselves gained official recognition through the international treaties adopted in the latter half of the twentieth century.

The stages in the international campaign

The United Nations Commission on Human Rights first discussed the traditional practice of FGM in 1952. In 1958 the UN Economic and Social Council explicitly raised the issue of FGM and the harm it causes as a problem for the international community (Resolution 680 B II (XXVI) of the Economic and Social Council: Ritual Operations, 1958). At that time, the practice was approached primarily from a culturalist viewpoint. The World Health Organization refused to become involved, at the time considering FGM as a social and cultural practice rather than a health issue and therefore outside its competence (United Nations, 1959).

In 1977 the NGO Working Group on Traditional Practices was set up, opening up a discussion of the consequences of FGM on the health of women and girls. The previous anthropological approach to the practice had effectively rendered the harmful effects of FGM invisible (Thiam, 1978). In 1979, the WHO took a stance on the issue for the first time by inventorying the medical consequences of FGM. The WHO's Regional Office for the Eastern Mediterranean in Khartoum convened a seminar on "traditional practices affecting the health

of women and children”, attended by NGOs and doctors, at which Fran Hosken presented her report on genital and sexual mutilation of women (WHO, 1979).

At the World Conference for the United Nations Decade for Women, held in Copenhagen in 1980, there was a tense confrontation between the European and African delegations. The majority of the latter were still calling for the practice to be recognized as a rite of passage to adulthood on a par with the circumcision of boys (Sow, 1997). However, by the global conference on women in Nairobi in 1985, positions had changed and a broader consensus began to emerge, with recognition that the practice was harmful. International agencies became increasingly involved from that date onwards. The Working Group on Traditional Practices Affecting the Health of Women and Children submitted its first report to the UN Commission on Human Rights in 1986 (E/CN.4/1986/42). In the 1990s efforts to ban FGM became more structured. In 1990, the Inter-African Committee on Traditional Practices, set up by feminist organizations, adopted the term “mutilation”, following UNICEF’s lead.

The UN General Assembly adopted the Declaration on the Elimination of Violence against Women in 1993, which refers explicitly to female genital mutilation. In 1994, the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities adopted the first Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children. The United Nations’ abolitionist stance was reiterated at the International Conference on Population and Development in Cairo in 1994 and Fourth World Conference on Women in Beijing in 1995.

Under the new policy framework, the World Health Organization sponsored the first joint statement with UNICEF and UNFPA in 1997, officializing their support for programmes to prevent and eliminate the practice of FGM and undertaking to support the action of governments in that direction (WHO, 1997). Knowledge of and mobilization on the issue prompted the WHO to draft the first typology of FGM in 1997, jointly with UNICEF and UNFPA (WHO, 1997) (see Section I.3).

International legal instruments could not have been developed and adopted without the campaigns in the countries concerned. Since 1984, the role of the Inter-African Committee on Traditional Practices has been fundamental. The 1981 Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa, known as the “Maputo Protocol”, is a legal instrument, adopted by consensus in 2003 by the heads of state of the African Union. Article 5 of the protocol explicitly prohibits and condemns FGM and other harmful practices. It calls on the signatory states to take measures to develop public awareness, to pass legislation backed by sanctions to prohibit FGM, to support victims of harmful practices and to protect women who are at risk (zero tolerance to FGM). In 2008, an inter-agency statement led by the WHO, UNICEF and UNFPA set forth the international position on eradicating female genital mutilation (WHO, 2008).

From controversy to globalization of the issue

The gradual emergence of a consensus around an international policy on FGM has been hampered by the competing discourses of various international bodies. Elizabeth Boyle (2005) pointed out that, within the United Nations itself, the recognition of the universal rights of women and the right to bodily integrity has long competed with the principles of sovereign autonomy and respect for traditions and family transmission. In the end, the former principles took precedence in the elaboration of the international doctrine on FGM.

The doctrine is underpinned by two legal principles: the right to health and human rights. Some authors have described the “uneasy alliance” between human rights and the right to health in discussions of FGM (Gruenbaum, 2001; Hernlund and Shell-Duncan, 2007). It was through emphasis on the health effects of FGM that the practice came to be seen not in terms of a ritual of socialization but as a grave violation of the physical integrity of the women subjected to it, thus providing grounds for analysis from a human-rights perspective (Abusharaf, 2006). However, the health approach has also proved counter-productive, because opponents cite a lack of medical evidence (Obermeyer, 1999) and because of the medicalization of FGM procedures (Section VI).

Moreover, the motives behind the efforts of international feminist movements to ban the practice have long come under suspicion. The international campaign has too often portrayed African women as enduring the custom without resisting it, even though it endangers the lives of their daughters. This reductionist representation has led to the international campaign being perceived as racist and post-colonial, taking the form of a crusade by feminists from the North that has overshadowed the initiatives emanating from the societies concerned (Boddy, 2007; La Barbera, 2009).

Perceptions of the practice have nonetheless changed considerably since the turn of the twenty-first century. FGM, perceived as an exclusively African problem in the twentieth century, has now become a global issue, for two main reasons. Firstly, recent studies show that FGM is also traditionally practised in other regions of the world, where the prevalence of the phenomenon was previously unknown, and in some countries of the Middle East⁽¹⁵⁾ and Asia,⁽¹⁶⁾ particularly Indonesia (UNICEF, 2015). Secondly, the globalization of migration flows and the settlement in Northern countries of families from regions where FGM is traditionally practised have led destination countries to consider the practice as a domestic public health issue (Bell, 2005; Johnsdotter and Essen,

(15) With the exception of Iraq and Yemen, where national survey data were collected (Appendix Table A.1), studies mention the existence of the practice in minority communities in other Middle Eastern countries (Oman, Jordan, Syria, United Arab Emirates, Saudi Arabia), but there is insufficient data to evaluate prevalence (Alsibiani and Rouzi, 2010; UNICEF, 2013, 2016; WADI, 2010).

(16) Recently published survey reports mention the existence of the practice in Indonesia (UNICEF, 2015; Budiharsana et al., 2003) and Malaysia (Isa et al., 1999; Rashid et al., 2009).

2010). This new dimension of FGM has raised questions about the possible existence of the practice in yet more countries and about the implications of perpetuating or abandoning the practice in the context of migration.

Legislative developments

In the countries of origin and of destination, legislation on FGM has gradually moved in line with the intensified international and regional efforts to ban the practice since the 1990s (Toubia, 1993). In Dakar, in 2005, the African Parliamentary Conference adopted a resolution calling on states to enact laws to ban FGM.⁽¹⁷⁾

Of the 30 countries with the highest prevalence of FGM, 25 have passed decrees or laws on the practice in recent decades. In the vast majority of countries, laws have been passed since the late 1990s;⁽¹⁸⁾ in 15 countries, they were introduced in the 2000s and 2010s (Appendix Table A.2). The scope of this legislation varies considerably across countries⁽¹⁹⁾ and the divergence between international standards and local social norms makes it difficult to enforce (Boyle et al., 2002).

The introduction of a legislative framework in the countries of origin has been simultaneous with similar developments in the countries of immigration. The first destination countries to criminalize FGM, in the late 1970s and early 1980s, were France (1979), Sweden (1982) and the United Kingdom (1985). The United States, Canada, Australia and Norway passed legislation in the 1990s, and the other European countries in the 2000s (Boyle, 2005). Some European countries have specific laws on FGM, while others (such as France) have included FGM in their legislation on child abuse and mutilation (European Institute for Gender Equality, 2013). Almost all of the laws include a principle of extra-territoriality, which makes it possible to protect girls who habitually reside outside their country of origin; young girls are often at higher risk of undergoing FGM during temporary stays in their parents' home country. These legislative provisions have led to prosecutions in six European countries, although for many years France was the only country to have taken cases of FGM⁽²⁰⁾ to court (Boyle, 2005; Leye et al., 2007). In France, FGM has been a criminal offence since 1979 (Articles 222.08, 222.09 and 222.10 of the Criminal Code); in 2006, the statute of limitations was extended to allow victims to file a complaint up to 20 years after their majority at age 18.

(17) <http://www.ipu.org/splz-e/dakar05/declaration.htm>

(18) Except for two countries, Guinea and the Central African Republic, where laws were introduced in the mid-1960s (Appendix Table A.2).

(19) In Mauritania, the practice is only prohibited in public medical facilities and only on minors (likewise in Tanzania). At the other end of the spectrum, in Kenya, an amendment passed in 2001 added an extra-territorial clause, providing for prosecution of acts committed outside Kenya (UNICEF, 2010).

(20) By 2012, 42 cases had been tried in six EU countries, of which 29 in France. The first trial in France took place in 1979 (Leye et al., 2007).

3. Classifying the different types of mutilation

With the help of data from the first Demographic and Health Surveys (DHS) to comprise a specific module on FGM, the WHO developed the first classification of female genital mutilation in 1995 (WHO, 1996). Included in the first inter-agency statement (WHO, 1997), the typology offers a common framework for identifying and classifying different types of mutilation (Table 1). The purpose of the international typology is (1) to propose a tool for studying the consequences of mutilation, (2) to enable more accurate estimates of the trends in prevalence

Table 1. WHO classification of FGM (1997 and 2007 revision)

Modified WHO typology of FGM, 2007	WHO typology, 1997
<p>Type I: Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).</p> <p>When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed:</p> <p>Type Ia: Removal of the clitoral hood or prepuce only;</p> <p>Type Ib: Removal of the clitoris with the prepuce.</p>	<p>Type I: Excision of the prepuce, with or without excision of part or the entire clitoris.</p>
<p>Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).</p> <p>When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:</p> <p>Type IIa: Removal of the labia minora only;</p> <p>Type IIb: Partial or total removal of the clitoris and the labia minora;</p> <p>Type IIc: Partial or total removal of the clitoris, the labia minora and the labia majora.</p>	<p>Type II: Excision of the clitoris with partial or total excision of the labia minora.</p>
<p>Type III: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).</p> <p>When it is important to distinguish between variations in infibulations, the following subdivisions are proposed:</p> <p>Type IIIa: Removal and apposition of the labia minora;</p> <p>Type IIIb: Removal and apposition of the labia majora.</p>	<p>Type III: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).</p>
<p>Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.</p>	<p>Type IV: Unclassified: pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cut) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedure that falls under the definition given above.</p>
<p>Source: WHO, 2008.</p>	

and practices, (3) to facilitate diagnosis by healthcare practitioners during medical examinations, and (4) to provide a framework of reference for the legal treatment of the issue.

The current WHO classification

In 1997, the WHO proposed its first classification based on four types of practice according to the anatomical extent of the cutting (Table 1) (WHO, 1996, 2008). After the typology was released in 1997, experts pointed out some limitations, namely that the proposed categories over-simplified the diversity of actual practices. The classification was revised in 2007, based on the conclusions of a group of experts commissioned by the WHO. The categories in the 1997 classification were amended slightly and subdivisions were created to cover the wide range of procedures more fully. The inter-agency statement, published jointly by eight UN agencies in 2008, indicates that FGM encompasses a range of practices that, while they all violate the integrity of the female genitalia, are nonetheless extremely varied (WHO, 2008).

Since 2008, the WHO has therefore recommended that female genital mutilation be classified into four main types, defined on the basis of the procedure performed at the time of the mutilation: Type I, often described as clitoridectomy (partial or total removal of the clitoral hood and clitoral glands); Type II, often called excision (removal of the inner labia and the clitoris); Type III, often called infibulation (narrowing of the vaginal orifice by stitching the outer labia over the opening, with or without removal of the clitoris); and Type IV which includes the other less common types (incising, cauterization, scarring). Types I, II and III can be further divided into sub-types (Table 1). The most common forms of mutilation are Types I and II. In West Africa, the most common form of FGM is Type II, whereas the rarer Type III is mainly found in eastern Africa (UNICEF, 2013) (Section III.2).

The limitations of the classification

Until the 2000s, specific modules on FGM in socio-demographic surveys (Section II.1) explicitly asked women about the type of FGM they had undergone by inviting them to choose from one of the three main types defined by the WHO (excision, clitoridectomy and infibulation).⁽²¹⁾ The quality of the information gathered was questionable, however. Several studies comparing the data collected from respondents with the data from clinical examinations revealed considerable discrepancies, particularly in the regions where Type III FGM (infibulation) is traditionally practised, and where the women often reported having undergone Type I or II (Elmusharaf et al., 2006b). In practice,

(21) In most of the surveys conducted in the 1990s, the female respondents were asked to indicate which of the three main types of FGM had been performed on them. In the late 1990s, two surveys (Côte d'Ivoire in 1998-1999 and Niger in 1998) modified their approach by asking the respondents to describe what had been done to them; their answers were subsequently classified under one of the three types defined by the WHO (Yoder, Abderrahim and Zhuzhuni, 2004).

the women do not always know which procedure they have undergone and are unable to give a precise answer. Moreover, the terms used by respondents to describe the types of mutilation performed on them vary across contexts and do not always conform to the WHO's physiological descriptions (Yoder et al., 2004). Starting in the 2000s, the question on FGM was reworded in the Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS), primarily in order to map prevalence of the most invasive procedure, i.e. Type III.⁽²²⁾ The first clinical studies performed in the 1990s showed that Type III FGM was associated with more serious health risks, particularly obstetric complications (Obermeyer, 1999, 2003; WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006). Although the WHO classification appears to be unsuitable for surveys based on self-reporting (Section II.3), it is still useful for clinical studies (Yoder et al., 2004).

The classification developed by the WHO in 1997 was revised in 2007 because the categories initially proposed were too reductionist and failed to capture the diversity of procedures (Table 1). The typology is constructed on the basis of two factors: the extent of tissue removal and the type of procedure performed at the time of the mutilation (cutting and/or stitching). It involves assessing the amount of tissue removed by the FGM practitioner, which varies by region, ethnic group or age when the FGM was performed; and reporting whether the vulva was stitched or not. The hypothesis of a causal link between the extent of tissue removal and the severity of consequences is central to the WHO typology. It is not always verified,⁽²³⁾ however, and the severity of consequences (particularly psychological and sexual) can vary with socio-demographic characteristics (age and marital status). Moreover, the typology does not consider the social and health environment in which the women concerned are now living. Among migrant women, the quality of obstetric healthcare at the time of childbirth in the country of immigration can minimize the consequences of FGM; the situation is very different in countries where little perinatal care is available (Andro et al., 2014; Essén et al., 2005; Zenner et al., 2013).

II. Data sources

The first quantitative medical data on FGM appeared in the report presented by Fran Hosken at the WHO's first international seminar on FGM in Khartoum in 1979 (Hosken, 1978, 1979). That was the first attempt to measure the prevalence of the practice in Africa. Quantitative data on FGM was collected regularly in the countries of origin from the 1990s, so that there is now a

(22) The question introduced into the DHS-MICS questionnaire was: "Was your genital area sewn closed?" (Appendix document A).

(23) In some types of infibulation, the clitoris is left intact, unlike in Types I or II, which are thought to have a greater impact on sexual sensitivity (Nour et al., 2006).

substantial body of reliable statistics. The first large-scale surveys were conducted at national level in the countries historically concerned by the practice (27 countries in Africa and two countries in the Middle East)⁽²⁴⁾ as part of various international demographic survey programmes (DHS and MICS) (Appendix Table A.1). Several other studies attest to the practice of FGM among minority groups in other parts of the world, for example in parts of Malaysia (Isa et al., 1999; Rashid et al., 2009) and Colombia (UNFPA, 2011), but there is insufficient data from representative surveys to reliably assess prevalence at this stage. Prevalence in Indonesia has been estimated for the first time using data from a health survey conducted in 2013 on a representative sample of households (UNICEF, 2015).

Lastly, FGM persists among migrant populations, particularly in Europe, North America and Australia and in some Middle Eastern countries.⁽²⁵⁾ Data collection on FGM in countries of immigration is much more recent (2000s) and is neither standardized nor generalized, as it is in the countries of origin. Socio-demographic surveys were conducted in two European countries (France and Italy) in the late 2000s. Despite the lack of survey data, prevalence can be estimated indirectly (Section III.1).

Clinical studies, conducted in countries of origin and countries of immigration, can be used to assess the consequences of FGM on health, in particular on women's reproductive health.

1. Socio-demographic surveys

In the countries of origin

Data in the countries of origin come from two main sources: Demographic and Health Surveys (DHS)⁽²⁶⁾ and Multiple Indicator Cluster Surveys (MICS) organized by UNICEF.⁽²⁷⁾ The first module specifically on FGM was introduced in the individual questionnaire for women in the DHS conducted in North Sudan in 1989-1990, then extended to the DHS conducted in all of the African countries concerned by the practice (Côte d'Ivoire, 1994; Egypt, 1995; Eritrea, 1995; Mali, 1995-1996; Central African Republic, 1994-1995). The FGM module is now included in the DHS in 25 countries (Yoder and Wang, 2013). Since the 2000s, the MICS have also been used to gather data on FGM in 17 countries, including seven⁽²⁸⁾ for which no data had previously existed (UNICEF, 2013).

(24) Yemen and Iraq.

(25) That appears to be the case in Saudi Arabia, where the practice is observed in population groups that originate from Yemen and neighbouring countries in the Horn of Africa (Alsibiani and Rouzi, 2010).

(26) The Demographic and Health Survey programme was started in 1984 (<http://dhsprogram.com/What-We-Do/Survey-Types/DHS.cfm>).

(27) The Multiple Indicator Cluster Survey programme was introduced in the mid-1990s to monitor the situation of women and children: http://www.unicef.org/statistics/index_24302.html

(28) Djibouti, 2006; The Gambia, 2005-2006; Guinea-Bissau, 2006; Sierra Leone, 2005-2006; Somalia, 2006; Chad, 2000; Togo, 2006.

The Indonesian survey conducted on 30,000 households in 2013 was not a DHS- or MICS-type survey, and the questions on FGM only concerned girls aged under 12 (UNICEF, 2015). In the 30 countries where FGM is concentrated (all in Africa, except for Iraq, Yemen and Indonesia), 89 nationally representative surveys are available, covering a 25-year period (1989–2014). For almost seven in ten of these countries, the data from at least three surveys are available (Appendix Table A.1).

The module on FGM in the DHS questionnaires is standardized, although there are some variants in different countries and some changes since the first version in the 1990s (Yoder et al., 2004; Yoder and Wang, 2013). The module, administered to female survey respondents aged 15–49, is introduced by a filter question on knowledge of FGM. The module consists of three sets of questions (Appendix Table A.1):

- The respondent's own FGM status: cut or not, type of cutting, circumstances of cutting (age when cut and person who performed the procedure);
- The FGM status of the respondent's daughter(s) (aged under 15):⁽²⁹⁾ cut or not, type of cutting, circumstances of cutting (same questions as for the mother) and intention for the future (asked of women who had at least one daughter aged under 15 who had not been cut at the time of the survey);
- Perceptions and attitudes: benefits of cutting/not cutting, reasons for the practice, attitude to continuing or abandoning the practice and perception of its impact on health.

In the 2000s, the questions on perceptions and attitudes were also included in the individual questionnaire administered to male survey respondents. Since 2010, the DHS and MICS have used a similar questionnaire. Some questions were removed (the health impact of FGM, respondents' intentions for their daughters), while other questions (cut or not, type and circumstances of cutting) were extended to include all daughters aged under 15 living with their mother (Yoder and Wang, 2013).

The data were analysed to measure the extent of the practice by calculating the percentages of women and girls who have undergone FGM in each country. These indicators are considered to be prevalence rates in the epidemiological sense. The prevalence of a condition at a point in time t is the number of cases (individuals) with the condition (here, having undergone FGM) relative to the total population (here, the total number of women). This measure, based on representative samples, is then extrapolated to estimate the total number of women and girls who have undergone FGM (Yoder and Khan, 2008; Yoder et al., 2013). Furthermore, matching the data on FGM against the women's socio-

(29) Before 1999, the questions about the respondent's daughters were only asked about the eldest daughter. Between 2000 and 2010, if the woman reported that at least one of her daughters had been cut, the questions were only asked about the daughter most recently cut. Since 2010, the questions have been asked about all daughters.

demographic characteristics gives an indication of the characteristics and determinants of the practice, which vary from one country to another, or within the same country, by ethnicity, educational level, income, etc. The variations in prevalence by age group and the existence of data collected at different dates⁽³⁰⁾ make it possible to assess trends in the phenomenon over time. Lastly, information about perceptions and attitudes (collected from men and women) gives an idea of the rationales underpinning the abandonment or perpetuation of FGM in these countries. Since the late 1990s, the results of the DHS and MICS have been presented in several reports that give a detailed overview of the practice in the most affected countries (Carr, 1997; UNICEF, 2005, 2013; Yoder et al., 2004, 2013; Yoder and Khan, 2008; Yoder and Wang, 2013).

In countries of immigration

In Europe and North America, FGM concerns only a specific part of the population, namely women who originate from at-risk countries. FGM is not a social norm in these regions; on the contrary, it is a deviant, clandestine practice, which is prohibited and has been against the law for several decades. In countries of immigration, there are no nationally representative surveys with a DHS-type module on FGM. In the 2010s, two socio-demographic surveys explicitly on FGM were conducted in two European countries: Italy (Farina and Ortensi, 2014b; Ortensi et al., 2015) and France (Andro et al., 2009). The target populations were migrant women (and daughters of migrants in the French survey) and the surveys were conducted in a sexual and reproductive health framework. The Italian survey was performed in a single region, Lombardy, on a representative sample of 2,011 migrant women and girls aged 15-49; the French survey was conducted in five regions⁽³¹⁾ on a sample of 2,882 migrant women aged 18 and over. The target population of both surveys (women having undergone or at risk of undergoing FGM) is small and hard to reach. Applying survey protocols designed to overcome these problems (Marpsat and Razafindratsima, 2012), the women were surveyed at health centres (family planning centres, mother-and-baby centres, gynaecological appointments in hospitals, etc.). They were selected using time-location sampling (TLS),⁽³²⁾ combined with respondent-driven sampling for the Italian survey.⁽³³⁾ In both surveys, questions about the FGM status of the women surveyed and their daughters were asked using the module on FGM from the DHS. The French survey was also designed as a case-

(30) Six countries have surveys that can be used to monitor the trend in prevalence over a period of at least 15 years: Côte d'Ivoire, Egypt, Mali, Central African Republic, Sudan and Yemen.

(31) These were five of the nine French regions identified as having the largest populations of women from countries where FGM is practised: Île-de-France, Provence-Alpes-Côte d'Azur, Nord-Pas-de-Calais, Pays de la Loire and Haute-Normandie (Andro et al., 2009).

(32) First, the locations attended by the population of interest and the times at which they attend are inventoried to create a survey base. A random sample of times of day at each location (location × time) is then taken, followed by a sample of the individuals who attend the locations at the sample times (Marpsat and Razafindratsima, 2013).

(33) Snowball sampling.

control study to measure the effects of FGM on the health of the women concerned (in the same way as clinical surveys). It also contained a module on reconstructive surgery,⁽³⁴⁾ which is available in France; a reconstructive surgery programme was set up by a French urologist in the 1990s, covered by French public health insurance since 2004 (Section VI.3).

2. Clinical surveys: measuring the medical consequences of FGM

There have been many clinical surveys of the medical consequences of FGM, but quality is variable. While the oldest ones date from the 1960s, the number of studies increased sharply in the 2000s. In a recent review, Rigmor Berg and colleagues (2014) inventoried more than 180 studies of the consequences of FGM in English-language bibliographical databases. The review probably underestimates the total number of studies, some of which may not be included in those databases. That nevertheless leaves a body of almost 140 quantitative studies,⁽³⁵⁾ covering around ten women for the smallest to several thousand for the largest (Fillo and Leone, 2007). Most of the surveys examine differences in health risk between women who have undergone FGM and other women living in the same environment, or differences in health risk by type of FGM performed (Almroth, Elmusharaf et al., 2005; Brewer et al., 2007; Elmusharaf, Elhadi and Almroth, 2006; Kaplan et al., 2011; Larsen and Okonofua, 2002; Morison et al., 2001). The other clinical studies focus either on series of women who attend medical consultations,⁽³⁶⁾ or take the form of cross-sectional health surveys, describing the state of health (assessed by medical diagnosis or self-reporting) at a time t of a sample of women having undergone FGM. There are also some case-control studies, which offer a more reliable and statistically accurate assessment of the additional health risk (Alsibiani and Rouzi, 2010; Andro et al., 2014).

The quality of the studies varies with the methodology used, the sample size and the precision of the questionnaires or forms used to diagnose the medical consequences of FGM. However, according to a recent evaluation, more than half of them produce reliable or relatively reliable results (Berg et al., 2014; Berg and Underland, 2013). Most of the studies were conducted in the countries of origin, in particular in countries in the Horn of Africa. Since 2010, several clinical studies have been conducted in countries of immigration (Abdulcadir et al., 2011; Andro et al., 2014; Vloeberghs et al., 2012; Wuest et al., 2009). Lastly, given the over-representation of countries from eastern Africa

(34) This module was divided into two sections: the first section was administered to all women who reported having undergone FGM and focused on awareness of reconstructive surgery and interest in it; the second section was only administered to women who had undergone reconstructive surgery (or who had requested it) (Andro et al., 2009).

(35) The others are individual case studies offering a detailed analysis of the condition of one person.

(36) Inventories of conditions or disorders diagnosed in a sample of women having undergone FGM, most of whom were interviewed at the time of medical consultations, but without comparison with a control group (Aktiononga et al., 2001; Al-Hussaini, 2003)

in clinical research, most of the surveys are of women who have undergone infibulation. The clinical surveys, which have enabled the WHO to define policy positions and recommendations, mostly investigate the consequences of FGM on sexual and reproductive health: they consider both the immediate and long-term impact, focusing on obstetric, gynaecological, sexual and psychological consequences (Section V).

3. Limitations and biases of self-reported data

Uncertainty linked to self-reporting

FGM status recorded by socio-demographic surveys is based on self-reporting by the women surveyed. It is assumed that the women are aware of their condition, and are able to answer the questions without fear. The first assumption, that cut women have an accurate awareness of their status, is not always verified. Several studies, which compare women's self-reports with the findings of clinical examinations by healthcare practitioners, reveal discrepancies between the two: while one study, conducted in the Gambia, found a difference of only 3% between the two types of data (Morison et al., 2001), studies conducted in Tanzania and Nigeria found a larger divergence (Klouman et al., 2005; Snow et al., 2002). Researchers attribute these differences to two main factors: firstly, some women, who underwent FGM at very young ages, are not fully aware of their status, and secondly, some more superficial types of FGM do not necessarily cause a visible alteration of the external genitalia and are not diagnosed by clinical examination.

The same observations have been made in migrant populations, particularly in the French survey, which included respondents' self-reports and diagnoses by healthcare practitioners (with the women's prior consent): among the respondents for whom both types of data are available (60% of the sample), the match was around 90%. More than half of the difference could be attributed to the clinician's failure to establish a diagnosis (the clinician answered, "Don't know"). In countries of immigration, such diagnostic failures are linked to a lack of medical training in identifying FGM (Andro et al., 2009). Interviews have also revealed that it is fairly common for women to discover their FGM status only when they become sexually active, and in some cases only when they give birth (Andro et al., 2010).

Under-reporting linked to the legislative context

Another under-reporting bias may be linked to legislative changes in certain countries (Section I.2). A longitudinal study conducted in northern Ghana in 1995 and 2000 assessed the consistency of women's self-reports over time: 15% of the women surveyed on both dates gave different answers, with the majority of that group reporting having undergone FGM in the first survey in 1995, and of not having undergone FGM in the second survey in 2000. The

researchers attributed the difference to a legislative effect: the first law criminalizing FGM in Ghana was introduced in 1994 and was followed by awareness-raising campaigns (Jackson et al., 2003).⁽³⁷⁾ A reluctance to report having undergone FGM in an environment where the practice has been banned has also been observed in other African countries where data have been collected on different dates.⁽³⁸⁾ From the mid-2000s, when international and African bodies intensified their campaign against FGM,⁽³⁹⁾ several DHS surveys recorded unexplained decreases in the prevalence of FGM in some age groups, which did not seem to reflect real declines but were probably the result of under-reporting by the women surveyed (UNICEF, 2013).

Such under-reporting is even more likely in migration contexts, particularly in surveys of migrants' descendants with origins in an at-risk country. In France, for example, where the practice of FGM has no social legitimacy in the mainstream population and where the legislation is particularly strict (Section I.2), it is difficult for women born or raised in France to report having undergone FGM and even more difficult for them to report FGM performed on their daughters. It is therefore important to consider the contexts in which the questions on FGM are asked, in order to adapt the survey protocols accordingly and to increase the number of data sources (Askew, 2005).

III. Genital mutilation around the world

1. Measuring the scale of the phenomenon

In 1979, the Hosken report presented the first measures of the total number of girls and women with FGM on the African continent. In the absence of national survey data, the country prevalence rates were estimated on the basis of case studies⁽⁴⁰⁾ and then directly applied to the number of women⁽⁴¹⁾ in each country. Although this first attempt at estimating prevalence was relatively crude and its methodology open to criticism, its context was a growing movement against FGM and nascent international awareness of the magnitude of the phenomenon and its health impacts. When the report was published in 1979, Fran Hosken estimated that there were around 80 million women with FGM

(37) According to the study authors, the first convictions of circumcisers in 1996 raised awareness of the 1994 law.

(38) The interval between two DHS surveys is usually five years. We would therefore expect the prevalence observed in the 20-24 age group on date t to be similar to that observed in the 25-29 age group on date $t+5$.

(39) The Maputo Protocol (Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa), which calls on African countries to take steps to eliminate FGM and other harmful traditional practices against women, came into force in 2005 (Section I.2).

(40) The data from the 26 countries included in the report were not drawn from representative surveys, and were highly disparate (Hosken, 1982).

(41) The numbers of women were not drawn from census data, but corresponded to half the total population in each country, assuming that this is the proportion of women in the population.

on the African continent (Hosken, 1979). In 1995 the data were updated on the basis of population growth rates, bringing the estimated number of women and girls with FGM to 150 million (Hosken, 1995; Table 2). Until 2015, all the publications of international organizations (UNFPA, WHO, UNICEF) and all published research on FGM referred to total numbers of between 100 and 140 million women and girls with FGM in the world, without clearly specifying the methodology used to arrive at these figures (Yoder et al., 2013). A very recent UNICEF publication (early 2016), which adds Indonesia, evaluates the number at 200 million.

As more DHS and MICS surveys are conducted in the countries of origin and new data are obtained on the prevalence of this practice in both women aged 15-49 years and their daughters aged below 15 years, estimates will be increasingly reliable and well documented. In the absence of documented prevalence rates, estimates have also been produced in countries of immigration using indirect methods.

Direct estimates on the basis of socio-demographic surveys

In 1997, an initial estimate (Table 2) established on the basis of Demographic and Health Surveys suggested that there were 30 million women and girls with FGM in seven countries (Carr, 1997). Ten years later, aggregated data from 27 African countries led to an estimate of 92 million (Yoder and Khan, 2008). In 2013, the estimated number in Africa and the Middle East was 125 million (UNICEF, 2013; Table 2). In February 2016, UNICEF published a new estimate

Table 2. Some estimates of the number of women with FGM in countries where survey data are available

Reference	Number of women and girls (million)	Region	Type of data used
Hosken, 1979	80	26 African countries	Case studies
Hosken, 1982	84	26 African countries	Case studies
Hosken, 1995	150	26 African countries	Case studies
Carr, 1997	30	6 African countries (Côte d'Ivoire, Egypt, Eritrea, Mali, Central African Republic, Sudan) and Yemen	DHS surveys
Yoder and Khan, 2008	92	27 African countries	DHS and MICS surveys and US Census Bureau data
Yoder et al., 2013	100	27 African countries and Yemen	DHS and MICS surveys and US Census Bureau data
UNICEF, 2013 ^(a)	125	27 African countries, Yemen and Iraq	DHS and MICS surveys and US Census Bureau data
UNICEF, 2016	200	27 African countries, Yemen, Iraq, and Indonesia	DHS and MICS surveys and US Census Bureau data

(a) This estimate, which features in the 2013 UNICEF report (p. 22), is based on the methodology developed by Yoder and colleagues (also published in 2013), with the addition of data from Iraq and using the most recent survey data. These notably include DHS surveys carried out in the early 2010s (the estimate of Yoder and colleagues had drawn on data from the the 2000s only).

of the affected population of women and girls around the world, updating estimates established in 2013 (on the basis of population growth rates) and adding the population of women and girls with FGM in Indonesia on the basis of data collected in 2013 from girls below age 12. The UNICEF estimate increased from 125 million to 200 million. This large difference is linked notably to the demographic weight of Indonesia (255 million inhabitants in 2015), where an estimated one in two girls or women have undergone FGM (UNICEF, 2016).

The calculation method used in the most recent and precisely documented estimates (2008 and 2013) is based, first, on the proportion of women with FGM in each country⁽⁴²⁾ as calculated on the basis of DHS and MICS survey data, and second, on the numbers of women in each country as indicated by the US Census Bureau.

The sample populations of the DHS and MICS surveys include only women aged 15-49. An initial direct estimate can be established by applying the prevalence rates provided by demographic surveys to total numbers of women aged 15-49, breaking down the rates into five-year age groups as prevalence can vary across age groups (Section IV.2). For women aged 50 or above and for girls aged 10-14 (for whom prevalence data are lacking), the rates for the closest known age group (respectively, 45-49 years and 15-19 years) are applied (Appendix figure A.1).

Indirect estimates in the absence of survey data

In countries of immigration, direct estimates are impossible for two reasons: the first is the lack of representative surveys at the national level comparable to the Demographic and Health Surveys (DHS) which include a module on FGM for the whole female population residing in these countries (Section II.1).⁽⁴³⁾ The second resides in the difficulty of identifying the relevant population, notably in countries with no population register. This population consists of immigrant women (born abroad) from countries where FGM is traditionally practiced, and women born in countries of immigration to at least one parent from one of these countries. For the first group, depending on the country, public statistical data by country of origin is not always available (notably due to the small numbers of relevant individuals), and some may also have a residency status that makes identification very difficult (undocumented individuals, refugees, asylum seekers). Women in the second category can only be identified using knowledge of their parents' country of birth, a question that is rarely asked in large national surveys (Simon, 2012).

There is thus no clearly defined, homogeneous methodology for estimating prevalence in the various countries of immigration. The European Parliament

(42) Called the prevalence or prevalence rate of the practice.

(43) The Virage survey on gender violence currently underway in France is the first to ask the question of FGM status in a general population survey.

resolution of 24 March 2009 on Combating Female Genital Mutilation in the EU (European Parliament, 2009) estimated that there were around 500,000 women with FGM living in the EU, and that 180,000 girls were at risk of FGM each year. The methodology used to arrive at these figures was not specified (Leye et al., 2014). While there is currently no way to calculate an overall estimate (like those established for the countries of origin), estimates produced using indirect methods – based on the extrapolation of observed prevalence in countries of origin – are available for a number of countries (Table 3).⁽⁴⁴⁾

Table 3. Estimates of the total number of women with FGM in countries of immigration

Reference	Number of women and girls with FGM	Country	Types of data used
Andro and Lesclingand, 2007	53,000 ^(a)	France	Survey combined with census (Étude de l'histoire familiale [family history survey]) and DHS-MICS
Ministero delle Pari Opportunita, 2009	35,000	Italy	Population register, residence permit data, and DHS-MICS
Hänselmann et al., 2011	24,000	Germany	Population census and DHS-MICS
Dubourg and Richard, 2011	13,000	Belgium	National population register, register on refugees and asylum seekers, birth records, and DHS-MICS
PRB, 2013	507,000	United States	Census and DHS-MICS
Exterkate, 2013	29,000	Netherlands	Census, register of female asylum seekers, DHS-MICS
Macfarlane and Dorkenoo, 2014	137,000	England and Wales	Population census, birth register, and DHS-MICS

(a) The estimate was for adult women only.
Note: For complete country-by-country documentation on European countries, see the website of the European Institute for Gender Equality (EIGE): <http://eige.europa.eu/gender-based-violence/literature-and-legislation>
Sources: Andro and Lesclingand, 2007; Dubourg et al., 2011; Exterkate, 2013; Leye et al., 2014; Macfarlane and Dorkenoo, 2014; Ortensi et al., 2015; PRB, 2013.

This indirect estimation method consists of applying the observed prevalence in countries of origin to the populations of women and girls from at-risk countries (Appendix figure A.2). Its details vary depending on the public statistical data that are available for each country (Leye et al., 2014). In Europe, estimates were established beginning in 2005, notably in the western European countries with the largest populations of immigrants and descendants of immigrants from at-risk countries (Belgium, France, Germany, Italy, and the United Kingdom). In the late 2000s, on the initiative of the European Institute

(44) These estimates are available for 13 countries in the European Union (Leye et al., 2014) and for the United States (Jones et al., 1997; PRB, 2013). To our knowledge, indirect estimates are not available for other possibly affected countries such as Canada and Australia.

for Gender Equality (EIGE), a group of European experts undertook a major review of existing work on FGM in Europe, and notably of estimates produced in individual countries (European Institute for Gender Equality, 2013). Generally, the first step consists in identifying the reference population, defined as all women and girls who come from the 30 countries where the practice of FGM exists and is documented, or with at least one parent from one of those countries (Section II.1), by means of different sources (population census, population registers, general population surveys, registers of refugees or asylum seekers, etc.). The prevalence rates provided by the DHS/MICS surveys are then applied to this reference population (Appendix figure A.2). Depending on the variables available in a given country of immigration, these rates may be broken down by age, level of education, and age at arrival in the country (Leye et al., 2014).

These indirect estimates are subject to a number of limitations and biases. The identification of the relevant population depends on the data available from censuses, the existence of a population register, and ease of access to registers of asylum seekers and births. The heterogeneity of sources makes it difficult to use a common methodology in different countries. Moreover, depending on the history of migration flows to each country, the presence of a second, or even a third generation also implies locally specific definitions of the “at-risk population”. For migrant women, the definition is largely shared, namely all women born in one of the 30 countries where the practice is identified and prevalence has been measured using DHS and MICS surveys. For subsequent generations, the definition of women with “origins” in at-risk countries (those born in countries of immigration, but with parentage in an at-risk country) can vary: for example, having one or both parents born in an at-risk country. However, as mentioned above, information on parents’ country of birth is rarely available (Simon, 2012).

Other limitations or biases of these indirect estimates are linked to the method of extrapolation, i.e. the application of prevalences measured in these countries of origin to the population identified as at-risk in countries of immigration. As we will see in Section III.2, the practice of FGM varies with ethnicity (or geographic origin), level of education, place of residence (urban/rural), income, and age (in the countries where the practice is decreasing over the generations), among other factors. While it is generally possible, when calculating estimates in countries of immigration, to apply observed prevalence rates from countries of origin by age and level of education (variables that are also available from surveys in countries of immigration), it is rarely possible to do so on the basis of ethnic origin using public statistical data in the North. And yet prevalence can vary widely by ethnic group within a given country of origin: in Senegal, while the national prevalence of FGM is 26%, it is practically non-existent among the Wolof (1%) and Serer (2%), but very widespread among the Poular (55%), Diola (52%), Soninke (65%), and Mandingo (82%) ethnic groups (DHS-MICS Senegal, 2010-2011). The application of a mean national

prevalence by country of origin can thus lead to substantial under- or over-estimation, depending on the migrants' ethnic origin.⁽⁴⁵⁾

Moreover, it is difficult for these indirect estimates to factor in the effects of migration itself. Other studies have demonstrated that the migrant population is not socio-demographically representative of the population that remains in the country of origin (Massey, 1998), and also that migration can have an effect on the actual practice of FGM, notably among girls who migrated in early childhood and who had not undergone FGM at the time. Furthermore, protection against FGM has become an admissible reason for seeking asylum in several European countries. Since 2009, the United Nations High Commission for Refugees has recognized that a woman's or girl's fear of being subjected to FGM constitutes one of the five grounds for recognition as a refugee ("membership in a particular social group").⁽⁴⁶⁾ However, according to a recent UNHCR study, the number of women claiming asylum on the basis of a risk of mutilation remains quite low (UNHCR, 2013).⁽⁴⁷⁾

Other recent studies have refined the methodology for estimating numbers of women with FGM by taking into account the largest possible set of sociodemographic variables in order to better characterize the migrant population (Ortensi et al., 2015). They also apply different hypotheses depending on age at arrival in the country of immigration, assuming, for example, that girls who arrive before the age of 15 years are not subject to the same risks as those who arrive after this age, who were more exposed to these risks in their country of origin (Andro and Lesclingand, 2007; Exterkate, 2013).

And finally, the method of extrapolation is particularly difficult to apply to the first-generation (and even second-generation) descendants of immigrants. In addition to selection effects, it may be assumed that immersion and socialization in the destination society lead to the progressive abandonment of FGM (Section IV.1). But quantitative data on the abandonment or perpetuation of this practice in the context of migration are generally lacking, aside from Italian and French sociodemographic surveys (Andro and Lesclingand, 2008; Farina and Ortensi, 2014b). In the absence of such data, the application of prevalence rates observed in countries of origin to the daughters of migrants is a highly approximate solution at best.

(45) However, ethnic origin alone does not suffice to explain differences in prevalence. The results of the DHS and MICS surveys also show that prevalence can vary within a single ethnic group depending on the individuals' nationality (UNICEF, 2013).

(46) This reason is invoked more and more frequently when determining refugee status, as states have recognized women, families, tribes, members of particular professions, and homosexuals as constituting "a certain social group" in the sense of the 1951 Convention. The social group in our case can be defined broadly as "women and girls", or more narrowly as "women belonging to an ethnic group that practices FGM" (UNHCR, 2009).

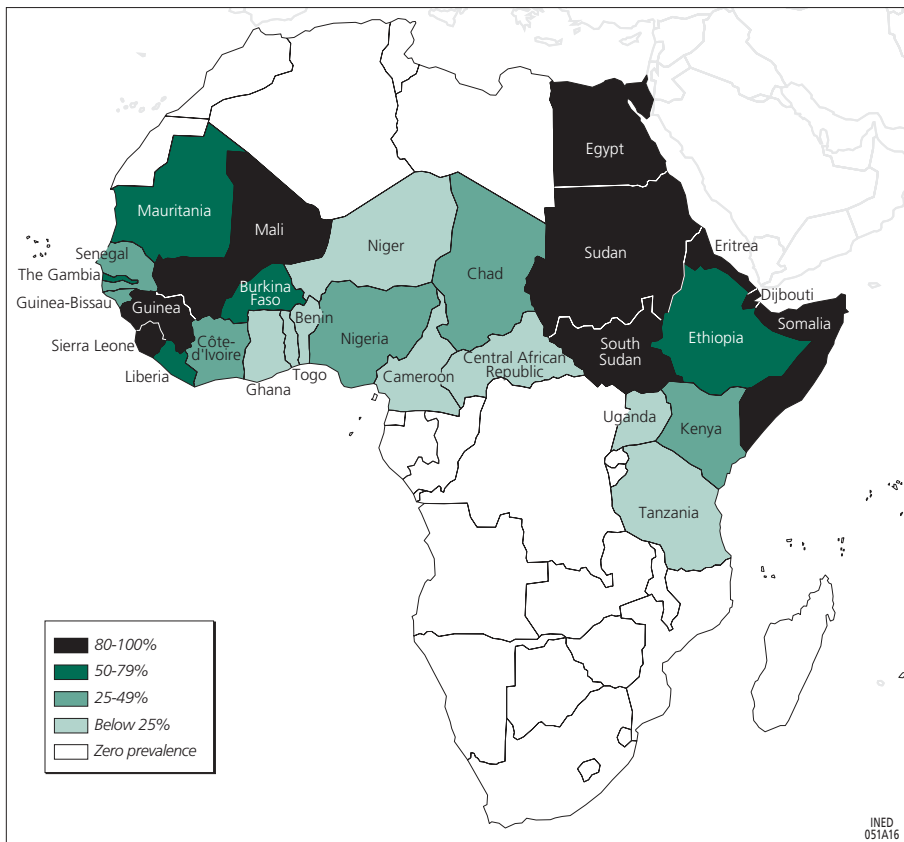
(47) In France, for example, the UNHCR estimates that in 2011, among the 2,735 asylum applications filed by women from countries where FGM is practiced, 670 were directly grounded upon a risk of mutilation (UNHCR, 2013).

2. Current situation in the countries of origin

Prevalence rates by country and region

The prevalence of FGM varies widely across the 30 countries (almost all in Africa and the Middle East) where it is most common (Figure 1). They can be grouped into four broad categories by prevalence rate: (1) countries where the practice is nearly universal, with prevalence of 80% or higher; (2) countries where the majority of women undergo genital mutilation, but prevalence is more moderate (50-79%); (3) countries where only a portion of the population (25-49%) is concerned by this practice; and (4) countries where FGM is a minority practice, with prevalence below 25%. In Africa, the practice extends through a wide central band running across the continent from west to east, with prevalence particularly high in a large portion of west Africa (Mali, Guinea, Sierra Leone, Burkina Faso, and Mauritania) and the easternmost part of east Africa (Somalia, Djibouti, Eritrea, Egypt, and Sudan). FGM is not practiced in the Maghreb, southern Africa, or a large portion of central Africa (Figure 1).

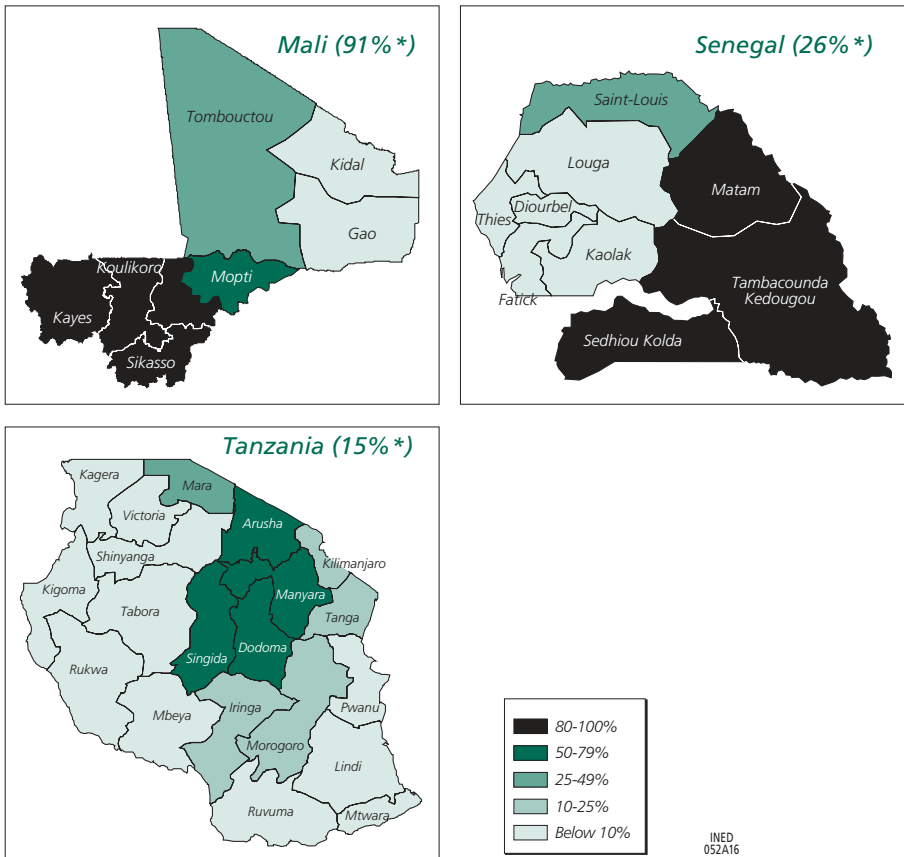
Figure 1. Prevalence of FGM in Africa



Sources: Most recent DHS and MICS surveys (Appendix table A.1).

These national prevalence rates are not the best way to approach this very long-standing practice, historically more common in some societies than in others. Even in countries with very high national prevalence, FGM is absent or rare in certain populations.⁽⁴⁸⁾ Within-country contrasts by region of residence and ethnicity, two variables that are often correlated, are particularly striking. Large geographical differences exist in all cases, including in countries with very high national prevalence (Figure 2).

Figure 2. Regional variations in the prevalence of FGM in Mali, Senegal, and Tanzania



(*) National prevalence.

Note: There is a more recent DHS for Mali (conducted in 2012-2013), but whose sample did not cover all the regions of northern Mali (Tombouctou, Kidal and Gao) because of political unrest in 2012 (Mali DHS-V, 2012-2013).

Sources: DHS Mali, 2006; DHS-MICS Senegal, 2010-2011; DHS Republic of Tanzania, 2010.

(48) Populations with a low demographic weight that have little effect on national prevalence. In The Gambia, for example, where national prevalence is 76%, the prevalence among certain ethnic groups (such as the Mandjak and the Wolof, who represent less than 20% of the total population) is below 15% (MICS-Gambia, 2012).

This is the case, for example, in Mali, where FGM is virtually non-existent in the (sparsely inhabited) north of the country, home notably to Songhai and Tamasheq populations, among whom genital mutilation is rare or not practiced (Mali DHS-IV, 2006). In Senegal, levels are highest in the east and the south, in regions neighbouring Mali and Guinea, where 9 in 10 women are mutilated. In Tanzania, national prevalence (15%) is relatively low, but the practice is common in a few regions in the northeast (Figure 2).

As mentioned above (Section II.3), as women do not know precisely what form of FGM they were subjected to, the questions in the most recent DHS and MICS surveys attempt to distinguish just two types of mutilation: excision with or without removal of tissue, and infibulation (Figure 3).

Self-reported data on the type of mutilation are available in survey data from 22 countries.⁽⁴⁹⁾ In six countries,⁽⁵⁰⁾ above 5% of women reported not knowing what type of mutilation they had undergone, with the proportion reaching 19% in Mauritania and 26% in Mali.

In most countries, the form of mutilation most often reported is cutting with or without removal of tissue: in 15 countries, more than two thirds of women surveyed reported this type of mutilation (Figure 3A). The most invasive type of mutilation, infibulation, is localized in eastern Africa, in Somalia, Djibouti, and Eritrea, where 77%, 62% and 35% of women, respectively, reported having undergone this type of FGM. It is much rarer in other regions, where it generally represents less than 10% of cases (Figure 3B). Women's responses in these surveys indicate that, overall, the distribution of types of FGM practiced is stable over the generations.⁽⁵¹⁾ In certain countries where the most invasive form of FGM is predominant, as in Djibouti, results suggest that the practice of infibulation on girls is decreasing. Note, however, that this proportion is not definitive, as some girls may undergo it at a later age (Carillon and Petit, 2009). Finally, several studies show that in regions where mutilation is more often carried out by health professionals, as in Nigeria and Kenya, the least invasive forms seem to be favoured (Orubuloye et al., 2001; Njue and Askew, 2004).

Associated factors: education, place of residence, economic status, and religion

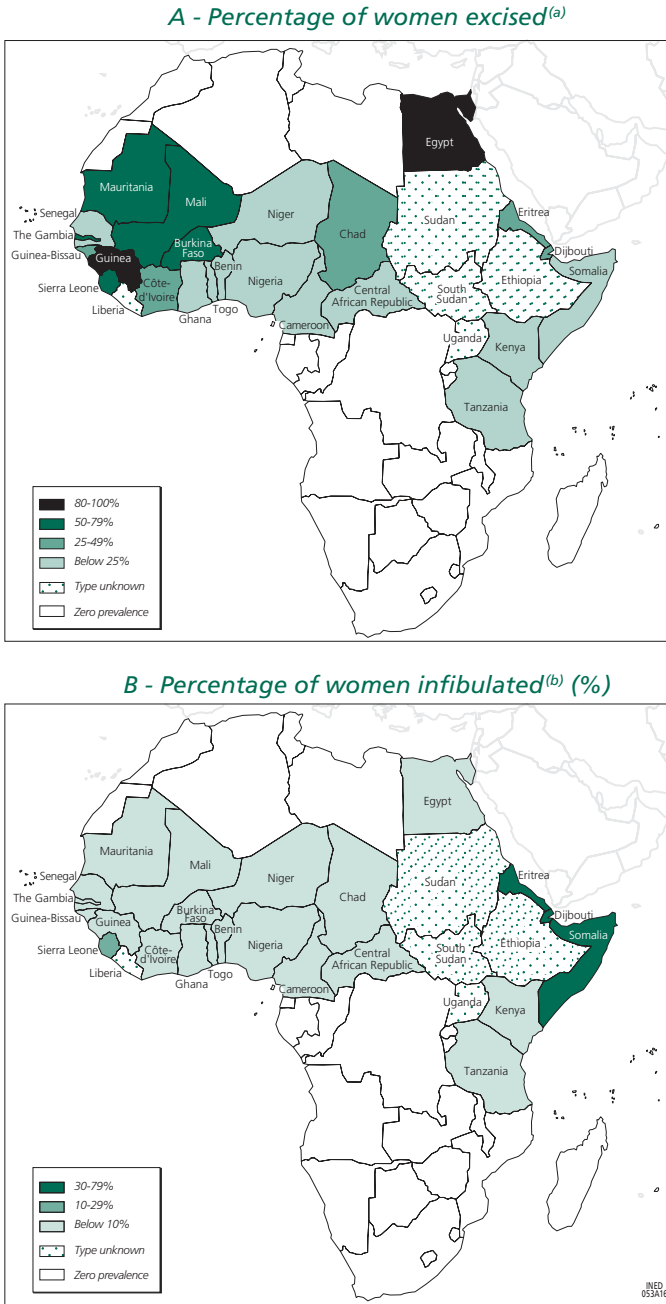
DHS and MICS survey data can be used to examine and highlight possible relationships between FGM status and a number of individual sociodemographic variables, such as level of education, place of residence, economic status, and religion.

(49) In 5 countries (Iraq, Liberia, Uganda, Sudan, Yemen), this question was not included.

(50) Eritrea, Mali, Mauritania, Nigeria, Senegal, Sierra Leone.

(51) An examination of the different types of FGM by group of women surveyed based on a comparison of the forms of FGM reported by the oldest women (45-49 years) and those reported by the youngest women (15-19 years) yields the same result (UNICEF, 2013).

Figure 3. Geographical distribution of different forms of FGM in Africa circa 2010



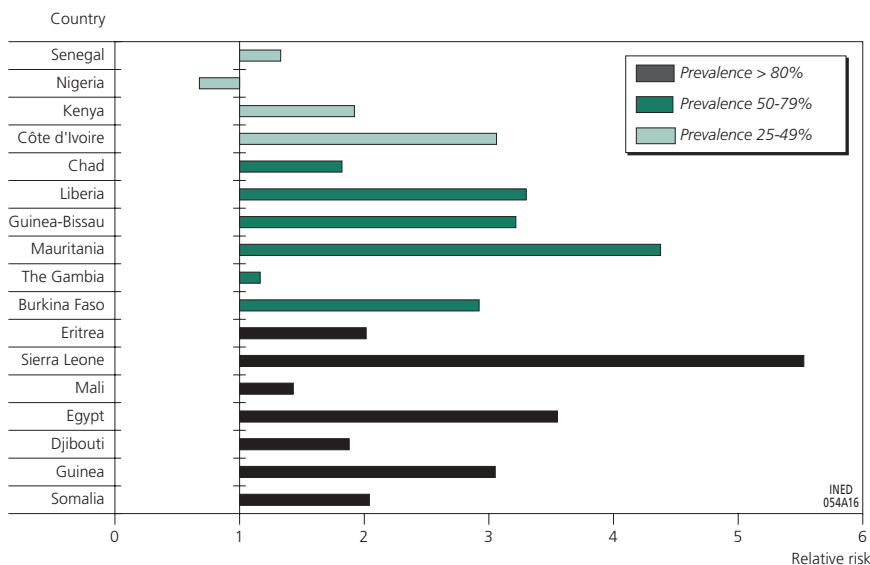
(a) With or without removal of tissue (types I and II).

(b) Type III mutilation.

Sources: Most recent DHS and MICS surveys for which data on the type of FGM are available.

Women’s schooling is associated with a decline in FGM⁽⁵²⁾ in practically all countries (albeit to varying degrees): the risk for the most educated women is lower than that for women with no formal education. In some countries, the risk of FGM is three to five times greater for the least educated women than for women with higher levels of education, notably in Egypt, Sierra Leone, Mauritania, and Liberia (Figure 4).

Figure 4. Relative risk of FGM by level of education



Note: Relative risk of FGM for women with primary education or less versus women with secondary education or more, by national prevalence. Relative risk is the ratio of the probabilities of these two groups. A relative risk of 1 indicates that the risk of FGM is identical in both cases. A value greater than 1 indicates that the least educated women have a greater risk of FGM than the most educated women.

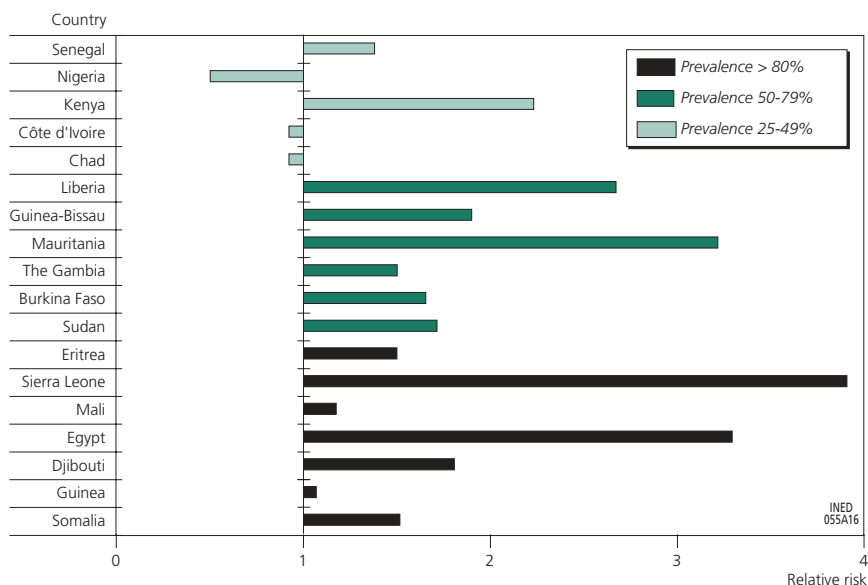
Sources: Most recent DHS and MICS surveys of countries where national prevalence is above 25% (Appendix Table A.1).

Level of education cannot be interpreted as a directly causal explanatory factor, as women do not control genital cutting (as we will see, it occurs before schooling), but it can serve as a proxy to measure the influence of family background. Investment in schooling, and notably girls’ schooling, may correlate with greater openness to arguments against this practice and an understanding of its negative consequences. The influence of education is confirmed by the proportion of girls with FGM by mother’s level of education: in countries with high, medium, and low prevalence, the proportion of girls who undergo FGM decreases as their mother’s level of education increases (UNICEF, 2013).

(52) With the exception of Nigeria, where educated women more frequently undergo FGM than uneducated women. This apparently inconsistent finding arises from the fact that only the Yoruba and Igbo ethnic groups practice FGM in Nigeria. They live in the south of the country, which is much more urbanized than the north, and has higher school attendance levels (Andro and Lesclingand, 2007).

While education seems to be an important factor in trends over time, survey results also indicate that other factors, such as place of residence and economic status, also play a role. The risk of mutilation is almost always higher in rural than in urban areas⁽⁵³⁾ (Figure 5).

Figure 5. Relative risks of FGM in Africa by place of residence



Note: Relative risk of FGM among women residing in rural versus urban areas, by national prevalence. Relative risk is the ratio of the probabilities for women in these two groups of being (rather than not being) mutilated. A relative risk of 1 indicates that the risk of FGM is identical in both cases. A value greater than 1 indicates that women in rural areas have a greater risk of mutilation than women in urban areas.

Sources: Most recent DHS and MICS surveys of countries where national prevalence is above 25% (Appendix Table A.1).

While relative risk is lower overall for this factor than for level of education, the countries where differentials in levels of education are highest⁽⁵⁴⁾ are also those where women in rural areas are most disproportionately at risk of mutilation (Figure 5).⁽⁵⁵⁾ Note, however, that women's place of residence at the time of the survey is not a truly accurate indicator of women's geographical origin. Because levels of rural-urban migration in Africa are high (Temin et al., 2013),⁽⁵⁶⁾ a non-negligible proportion of women who were living in an urban area at the time of the surveys were originally from rural areas. In spite of this limitation, which is inherent to this variable, it is also possible that the greater ethnic and social diversity found in cities, and thus the opportunity to have

(53) With the exception of Nigeria (cf. previous note).

(54) Egypt, Sierra Leone, Mauritania, and Liberia.

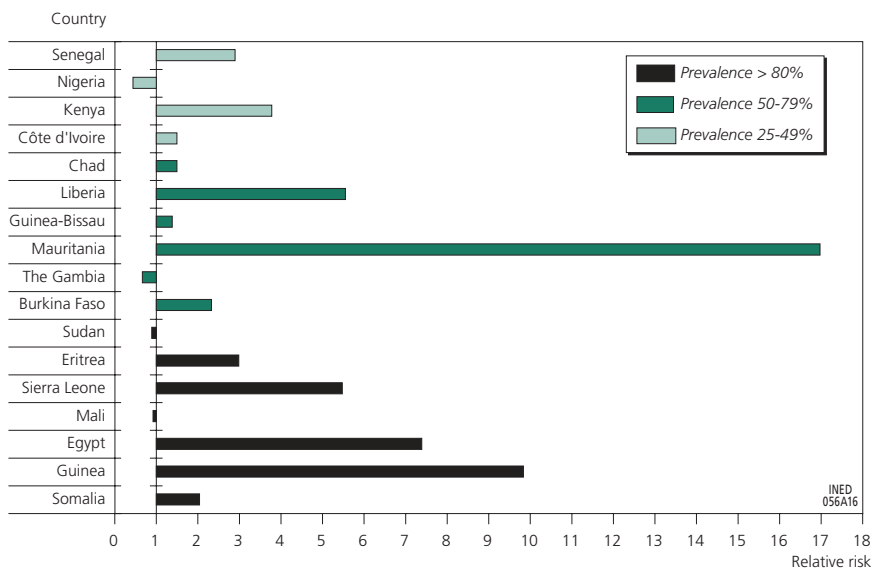
(55) This doubtless reflects a fairly strong correlation in these countries between level of education and rural/urban status.

(56) Notably during adolescence (Temin et al., 2013) and thus during periods following the time when the risk of mutilation is highest, i.e. before the age of 10 years (Section III.2).

contact with communities that do not practice FGM, may affect individual expectations and practices over time. This hypothesis is supported by data from certain countries on the relationship between women respondents' place of residence and their daughters' risk of mutilation.⁽⁵⁷⁾ In Kenya, for example, the daughters of women surveyed in rural areas are four times more likely to have undergone FGM than those of women living in urban areas. In Burkina Faso, Mauritania, and Senegal, the relative risk is 2, while elsewhere it is close to 1 (UNICEF, 2013).

Data on socioeconomic status and FGM (Figure 6) show that the risk is most often higher in very poor households than in rich households, except in the cases of Nigeria, Mali, and the Gambia, where inequality is low and regional (and ethnic) differences are greater. In contrast, relative risk is particularly high in Mauritania, Guinea, and Egypt.

Figure 6. Relative risk of FGM by household economic status



Note: Relative risk of FGM among women living in the poorest households (lowest quintile) versus women living in the richest households (highest quintile). Relative risk is the ratio of the probabilities for the women in these two groups of having undergone FGM. A relative risk of 1 indicates that the risk of FGM is identical in both cases. A value greater than 1 indicates that poorer women have a greater risk of mutilation than wealthier women.

Sources: Most recent DHS and MICS surveys in countries where national prevalence is above 25% (Appendix Table A.1).

While wealth is linked to other social characteristics (in particular, place of residence and/or household level of education), it remains clearly associated with decreased risk of FGM in certain countries.

(57) Girls' place of residence is more stable than that of their mothers, although mobility in childhood is relatively widespread in Africa, notably for young girls, due to fostering.

Regarding religion, data from the DHS and MICS surveys show that FGM occurs among populations that describe themselves as animist as well as in populations of adherents to the three great monotheistic faiths, Islam, Christianity and Judaism (UNICEF, 2013). Because populations that describe themselves as Muslim make up a majority of the population in most countries where FGM occurs, the practice has long been thought of as linked to Islam (Boddy, 1991). In 2007, Al-Azhar University published a religious edict (*fatwa*) condemning FGM and recalling that the practice is not mentioned in the Koran. This position was echoed by many religious leaders at the national and local levels in a number of countries (UNFPA and UNICEF, 2009). Nevertheless, in certain countries (Eritrea, Guinea, Egypt, Mali, Mauritania, Sierra Leone, and Chad), large proportions of both men and women⁽⁵⁸⁾ consider the practice to be a religious obligation (UNICEF, 2013). Several recent studies have shown that the relationship between Islam and the practice of FGM is not systematic, and varies greatly with context. These ethnographic studies show that religious beliefs coexist with other social norms on FGM (Boddy, 1991; Johnson, 2001). A study carried out in Burkina Faso (Hayford and Trinitapoli, 2011), a country with animist (10%), Muslim (60%), and Christian (30%) populations,⁽⁵⁹⁾ showed that the impact of religion on this practice (both at individual and collective levels) differs by level of prevalence: in communities where prevalence is high, Muslim religious affiliation is not correlated with the practice of FGM, while the opposite is true in those with low prevalence. The authors explained this in terms of the dominance of group social norms in the first case, independently of religious affiliation, arguing that in the second case, religious beliefs are the dominant influence. Ultimately, the links between religion and FGM are complex and multiform, and ethnographic approaches are needed to arrive at a more precise understanding of them (Boyle, 2005; Johnsdotter, 2007; Johnson, 2007).

The conditions in which FGM is practiced

FGM has long been described in the anthropological literature in the context of rites of passage, notably for the transition to adulthood (Section I.1). Findings from the DHS and MICS surveys on the conditions in which this practice is carried out⁽⁶⁰⁾ reveal that it is now most often disconnected from this ritual dimension. In all countries, virtually all of the women surveyed

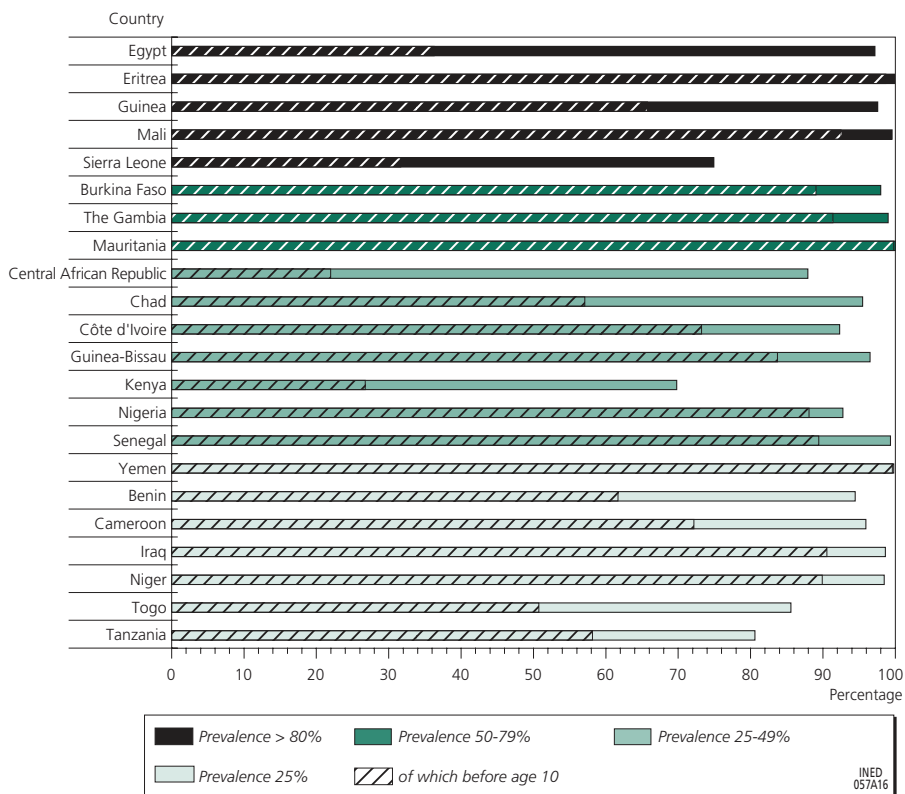
(58) Between 30% and 60%. In these countries, more women than men consider FGM to be a religiously required practice, with the exception of Mauritania and Egypt where the reverse is true (UNICEF, 2013).

(59) In Burkina Faso, the correlation between ethnic group and specific religious affiliation is quite low. Religious diversity is found in most ethnic groups in Burkina Faso, apart from the nomadic, majority-Muslim Peul and Touareg peoples (Hayford and Trinitapoli, 2011).

(60) The collected data are affected by recall biases, as women (and particularly the oldest women) are often reporting distant events. Additionally, some women who underwent FGM at a very young age do not clearly remember the circumstances of the event.

reported having undergone FGM before the age of 15; in 18 out of 22 countries where data on age at FGM are available, the majority of women were mutilated before age 10 (Figure 7).

Figure 7. Percentage of women aged 15-49 years reporting having undergone FGM before age 15 or age 10, by national prevalence



Sources: Most recent DHS and MICS surveys from the 22 countries for which data on age at FGM are available.

In Egypt and the Central African Republic, more than half of women (58% and 60%, respectively) underwent FGM between the ages of 10 and 14 years. In only two countries – Sierra Leone and Kenya – were a relatively substantial proportion mutilated at later ages, with 23% and 29%, respectively, undergoing FGM after age 15 (Figure 7). In most countries, age at mutilation also varies by ethnicity. This is the case for example of Kenya,⁽⁶¹⁾ where mean age at FGM among women aged 15-49 ranged from 9 years among the Somali to 16 years among the Kamba and Kalenjin (UNICEF, 2013).

While FGM continues to be associated with collective initiation rites in certain ethnic groups, in Kenya and Chad for example (Ahmadu, 2001;

(61) According to the results of the 2008-2009 DHS.

Droz, 2000; Leonard, 1996), in other regions, such as the Gambia, this is no longer the case: in these regions, FGM is practiced individually rather than in a group, is disconnected from any group celebrations, and may progressively lose its social signification (Hernlund, 2001). Moreover, in half of the countries where mothers' reports on their daughters' age at FGM are available,⁽⁶²⁾ the majority were cut before age 5, suggesting that age at FGM may be decreasing (UNICEF, 2013). These findings must be interpreted with caution, however: this effect could be at least partly due to the fact that certain girls who had not yet undergone FGM at the time of the survey will undergo it at a later age.

In all of the countries surveyed, mutilation is mainly performed by "traditional" practitioners (women circumcisers or *exciseuses*, village matrons). There are exceptions, however, as in Egypt⁽⁶³⁾ and Sudan, where a third of women report having been cut by a health professional: physicians in Egypt, and nurses or midwives in Sudan (UNICEF, 2013). In Egypt, the proportion of girls cut by a health professional has considerably increased over time, from 55% in 1995 to 77% in 2008. This trend towards medicalization⁽⁶⁴⁾ of the practice has also occurred in Kenya, where around 40% of procedures were performed by health professionals in the late 2000s, versus a third in the late 1990s (Shell-Duncan et al., 2001; UNICEF, 2013). This recent trend, which in some cases has accompanied a decline in the practice, as in Kenya (Section IV.2), seems to be explained by a counter-productive effect of the first campaigns against mutilation in the 1990s (Section VI.1). These early campaigns focused on the health risks of FGM, notably short-term risks such as haemorrhage and infections, suggesting that they would be decreased if mutilation was performed by health professionals and under more hygienic conditions (Shell-Duncan, 2001).

IV. The social dynamics of abandonment or perpetuation of FGM

The fight against FGM has been shaped by the debate that surrounds this practice, which intensified in the 1990s under the impetus of major international organizations (Toubia and Sharief, 2003; Boyle, 2005). The first to speak out were feminist researchers in both North and South, who generally saw the practice as a manifestation of women's oppression in a patriarchal system. But

(62) Namely Nigeria, Mali, Eritrea, Ghana, Mauritania, Senegal, Ethiopia, Niger, Burkina Faso, and Côte d'Ivoire (UNICEF, 2013).

(63) In 1994, the Egyptian Ministry of Health issued a decree strictly regulating the practice of FGM, authorizing it only in a limited set of public hospitals. This decree was repealed under pressure from women's rights organizations (who saw it as a legitimization of the practice). In 1997 a new decree was issued prohibiting the practice throughout the healthcare system.

(64) Defined as the tendency to call on a health professional to perform FGM rather than a traditional practitioner (Section VI.1).

this perspective, partly instrumentalized by Northern hegemonic discourse, was strongly criticized, notably in postcolonial studies,⁽⁶⁵⁾ where certain feminist approaches were condemned as “imperialist”, “neo-colonial”, and even “racist” (Wade, 2012).⁽⁶⁶⁾ This contrast in approaches harks back to an older debate between relativism and universalism, here in the context of a globalized, transnational world, where questions of sex and race are strongly intertwined in countries of immigration (Dorlin, 2009; Hernlund and Shell-Duncan, 2007, Watson, 2005).

1. The dynamics of social change

Independently of particular conditions and justifications, individuals experience FGM as a rule or norm that is interiorized by everyone in the group, with transgression leading to social sanctions: uncut women are seen as “dirty” or “obscene”. But beyond impurity, what is at stake is non-recognition as a woman, and thus as a future wife and mother, as designated for example by the term *bilakoro*⁽⁶⁷⁾ among the Malinke of Mali. Different theoretical approaches to the abandonment (or perpetuation) of FGM, in both its countries of origin and in the context of migration, have thus focused on its status as a social norm.

A first approach, inspired by modernization theory, considers the determinants of the practice as documented in sociodemographic surveys. Its proponents argue that macro-social factors such as economic development, urbanization, increases in school enrolment, and paid employment – accompanied by a weakening of the role of families and a privatization and individualization of behaviour – will lead to a decline in “traditional” practices such as FGM (Boyle et al., 2002; Farina and Ortensi, 2014a). Other approaches focus on factors linked to gender inequality, arguing that the practice will only decrease when women achieve greater autonomy and independence, and hence more room for manoeuvre in decision-making in the marital and family spheres (Yount, 2002). The most recent approaches have provided the framework for the programmes of international organizations in recent years (Lewnes et al., 2005; UNFPA and UNICEF, 2014; UNICEF and Innocenti Research Centre, 2010). They still treat FGM as a question of gender inequality, but argue that the practice can only be abandoned individually when there is a critical mass of uncut women within a given group. Applying the theory

(65) Postcolonial approaches, generally traced back to Edward Saïd and his book *Orientalism*, published in 1978, aim to highlight how Western, imperialist discourse, based upon a colonial history, “has constructed and continues to construct a vision of the colonized or racialized Other” (Benelli et al., 2006).

(66) According to Wade, beginning in the 1990s, postcolonial studies challenged the Manichean perception of FGM as a symptom of cultural inferiority. From their point of view, Western feminist engagement against FGM is part of an “imperialist” project.

(67) In Malinke culture, a pejorative term for an “uncircumcized” or “uncut” person (Bellas Cabane, 2008).

of social conventions⁽⁶⁸⁾ to the practice of FGM, Mackie and LeJeune (2009) propose an analytical framework that considers the effects of social, moral, and legal norms. For these authors, even in a context of moral sanctions (guilt about subjecting one's daughters to violence) and legal sanctions (fear of fines or imprisonment), sanctions for non-compliance with social norms may prove stronger, since in addition to the social stigma of non-conformity, they often result in exclusion from the marriage market (Lewnes et al., 2005; Mackie, 1996; Mackie and LeJeune, 2009).⁽⁶⁹⁾ Under this view, the practice can only be abandoned when, following a collective discussion (and a public declaration), a "critical mass" of men and women decide to give it up, and are able to convince a large portion of the community that doing so is necessary. NGO programmes supported by international organizations in the countries where FGM is practiced have pursued this approach, which is centred on dialogue with the community. These campaigns, often local in scale, have had contrasting effects in different contexts (UNICEF and Innocenti Research Centre, 2010), and methodological limitations make it difficult to assess their efficacy (Askew, 2005). More generally, while available data, notably from DHS and MICS surveys, can be used to track trends in this phenomenon, they must be interpreted with caution on the explanatory level.

2. The effect of anti-FGM policies

What is being measured?

A first approach to measuring trends in the practice is obviously to track how it changes over time. However, as respondents to the DHS and MICS surveys are mainly women aged 15-49, and the procedure in most countries is carried out at early ages (below 15 years), the impact of the campaigns of the last two decades is not immediately visible. Among the 30 countries where surveys have been performed, data covering a period of more than 15 years are available for only five: Côte d'Ivoire, Egypt, Mali, the Central African Republic, and Sudan (Appendix Table A.1). In addition to the limitations inherent to comparing the results of cross-sectional surveys performed at different times on different samples,⁽⁷⁰⁾ the main bias is possible under-estimation of the phenomenon, given that the data are drawn entirely from women's self-reports. In the context of increasing penalization (Section 1.2), apparent declines

(68) The theory of social conventions looks at how individuals behave in the face of uncertainty. In the case of FGM, families have their daughters cut in order to adapt their behaviour to the dominant social norm. Conversely, if a certain number of families decide not to have their daughters cut, their individual behaviours may lead to change in the social convention or norm.

(69) The connection between the practice of FGM and access to the marriage market is at the heart of Mackie and LeJeune's model. Mackie (1996) drew a parallel between the cessation of the ancient practice of footbinding (itself tied to marriage) in the early twentieth century in China and the possible future pattern of abandonment of FGM.

(70) These limitations are not specifically connected to the measurement of FGM, but relate to possible changes in sampling between surveys: inclusion/exclusion of certain regions, selection criteria for respondents (married women or all women, etc.).

in the practice may simply reflect under-reporting, and not an actual decrease. In Burkina Faso, for example, the prevalence found in the 2010 survey was 4 percentage points higher than in 1998-1999 (72%). The first law making FGM a criminal offense was adopted in 1996, and there were around a hundred convictions between 1997 and 2005. The outlawing of FGM seems to have led to under-reporting of the practice by women respondents in the 1998-1999 survey (Diop et al., 2008).

For countries where survey data are more recent, it is still possible to carry out a generational analysis by comparing observed prevalence in the youngest and oldest age groups, or by comparing observed prevalence among women respondents (mothers) and their daughters. However, not only is reported prevalence in girls liable to be affected by mothers under-reporting of their daughters' and their own mutilation (for fear of prosecution); but it is also a poor final measure of prevalence. Depending on the age at which FGM is practiced, some of the daughters of surveyed women (aged 0-14 years) have not yet been cut at the time of the survey, but are still at risk.

Finally, questions introduced more recently into the DHS and MICS surveys offer information on women's and men's attitudes to FGM, uncovering possible ongoing or future changes.

Mixed trends, with contrasts between countries

As the legal framework on FGM is very recent in most countries (Section I.2), it is difficult to draw any conclusions on the impact of new laws on changes in the practice over time. While legislation seems necessary, it is not sufficient, and programmes to combat FGM also include awareness campaigns (Rahman et al., 2000; Shell-Duncan et al., 2013). These programmes often target local populations at a relatively small scale: in some contexts, at the local level, decreases have been observed following the implementation of programmes based on winning over the community (shifting the norm). The first NGO to implement the theoretical framework developed by Gerry Mackie in its programmes to combat FGM is the association Tostan⁽⁷¹⁾ which has been working in Senegal since 1991, and whose "community empowerment programme" has been deployed since 2007 in a number of other African countries. Actions carried out in Senegalese villages since the late 1990s have yielded positive results, according to numerous field evaluations (UNICEF and Innocenti Research Centre, 2010). However, on a broader scale, trends are uncertain.

In the 11 countries where multiple surveys have been carried out, the total period covered is more than 10 years. The general trend in all of these countries⁽⁷²⁾ is a decrease in the practice, but the pace of change differs between countries (Figure 8). In seven cases, decreases were small (less than 5 percentage points).

(71) <http://fr.tostan.org/>

(72) With the exception of Burkina Faso (Section IV.2).

This is notably the case in countries where the practice is nearly universal: in Egypt, over the course of 19 years (1995-2014), prevalence fell from 97% to 92%; in Mali, in 17 years (1995-2012), it fell from 94% to 89%. In contrast, relatively large declines were observed in the Central African Republic and Kenya. In the Central African Republic, the proportion of women aged 15-49 with FGM dropped from 43% in 1994 to 36% in 2000, 26% in 2006, and 24% in 2010. In Kenya, the proportion fell from 38% in 1998 to 27% ten years later (Figure 8).

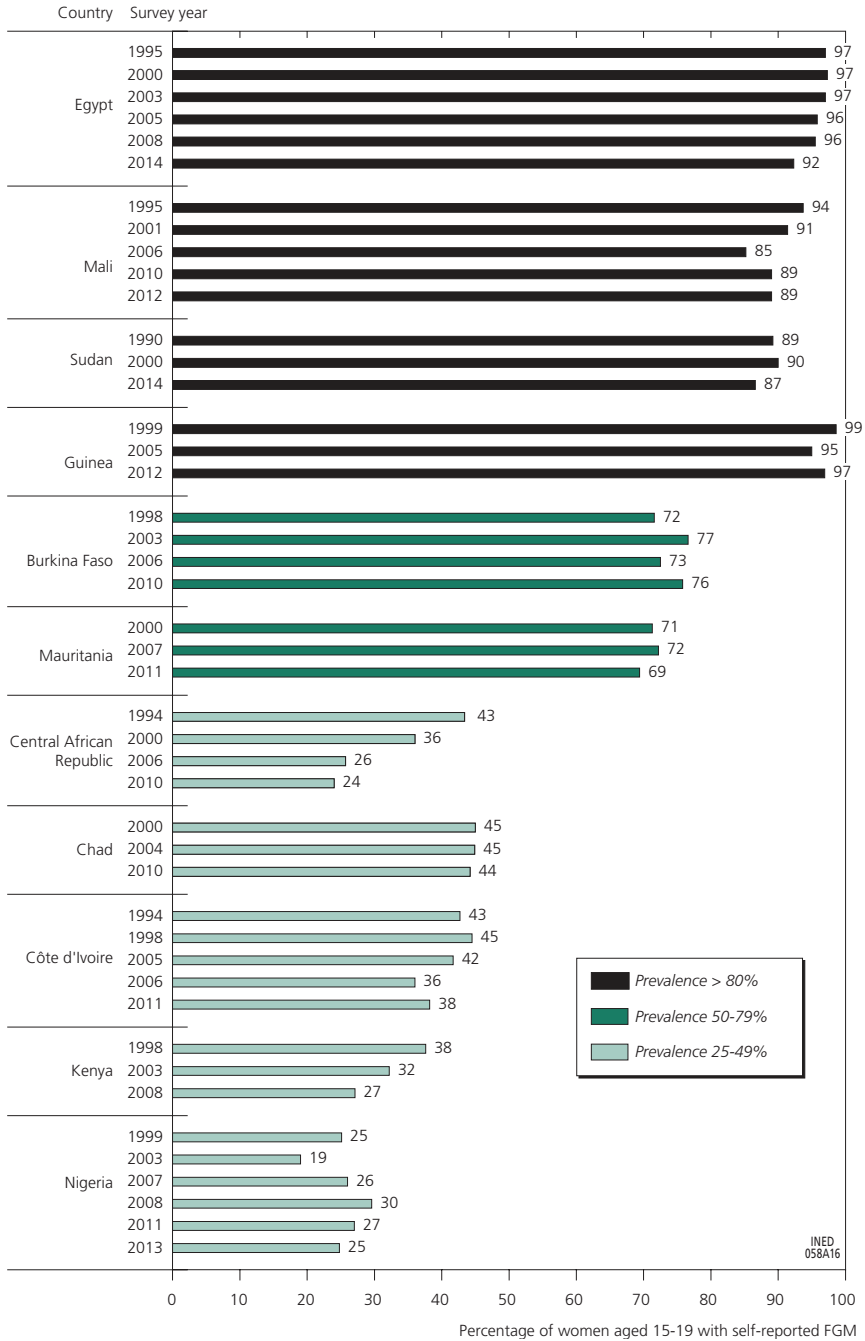
These trends are confirmed by comparing prevalence in different cohorts of women: in all countries, there is a general downward trend over the generations (Figure 9). In the countries where the practice is nearly universal, however, differences remain relatively small, with the exception of Sierra Leone and Egypt, where the prevalence levels observed in the youngest groups (15-19 and 20-24 years) are around 10 percentage points lower than those in older groups. Among countries where prevalence is between 50% and 79%, Burkina Faso and Liberia stand out, showing relatively linear decline with decreasing age, a sign of genuine change in the practice over time. Finally, among countries where FGM is a minority practice, the countries that have shown the most progress over the generations are Kenya, the Central African Republic, and Nigeria (Figure 9).

Another way to capture the social dynamics of the abandonment of this practice is to examine the opinions of women (and men) who express support for its continuation. Questions added to the FGM modules of the DHS and MICS surveys provide a means to assess overall support for FGM amongst all respondents who reported, independently of their own FGM status, being aware of the practice (Figure 10).

In all countries, women with FGM are far more likely to favour the continuation of the practice than others: differences by FGM status are often considerable, notably in Mali and the Gambia, where more than 8 in 10 women with FGM favour the continuation of FGM, versus a very low proportion (7% and 3% respectively) of non-FGM women. In two countries, Guinea and Sierra Leone, the opinions of FGM and non-FGM women diverge less markedly (70% versus 49% in Guinea, 69% versus 25% in Sierra Leone), doubtless reflecting greater tolerance for traditional practices among non-FGM women. And finally, in countries where intermediate national prevalence reflects distinct populations with widely varying prevalence, opinions also differ widely, with FGM women much more likely to support the practice than the average (Figure 10). These results reflect the current opinion of adult women, a large majority of whom are no longer in the age group at risk of mutilation. Among women who had undergone FGM, the question was asked well after the actual procedure – that the women themselves had not chosen to undergo.

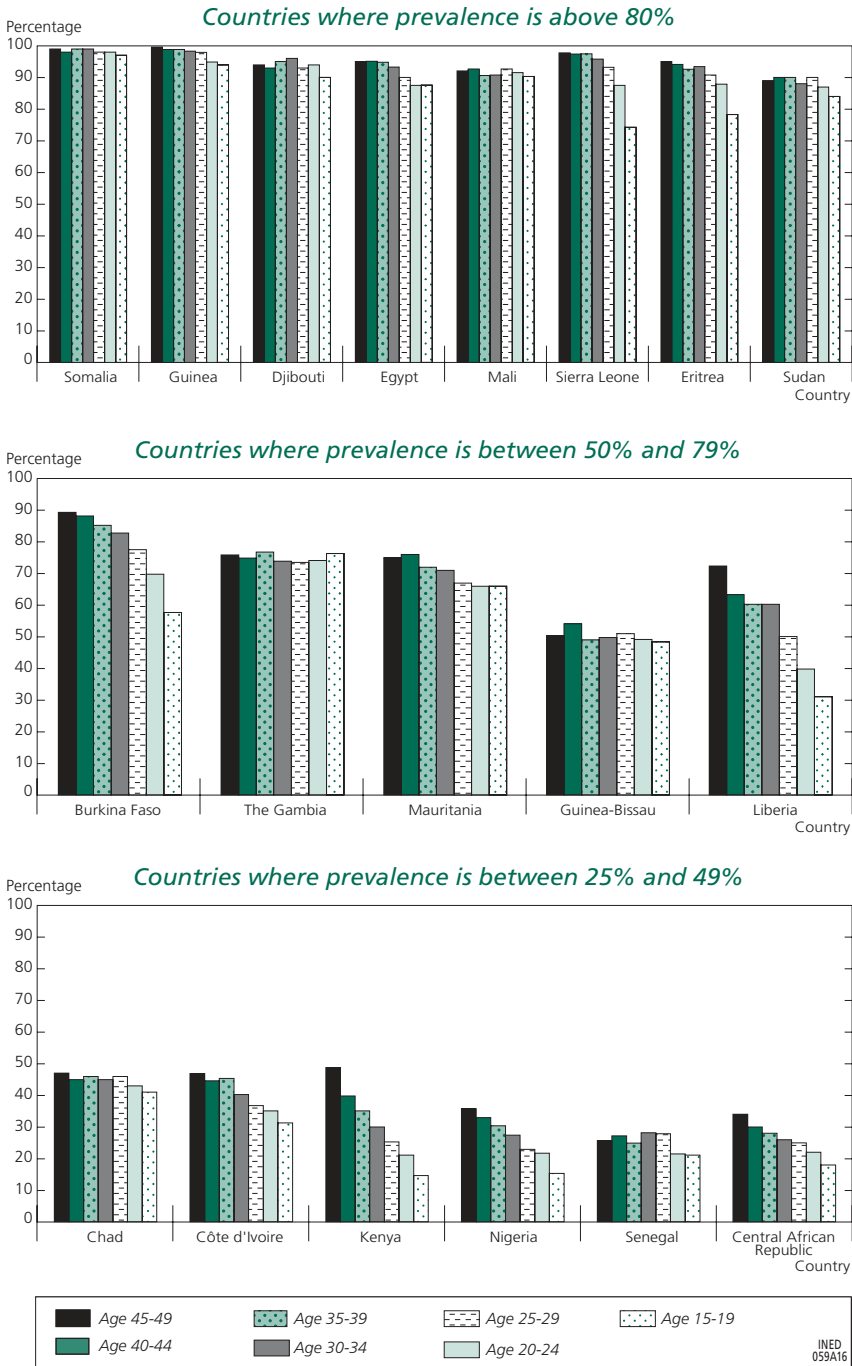
Another way to address the question is to look at changes in opinion over time (Figure 11). Overall, the proportion of women who favour continuation

Figure 8. Changes in the proportion of women with FGM aged 15-49 by national prevalence in 11 African countries



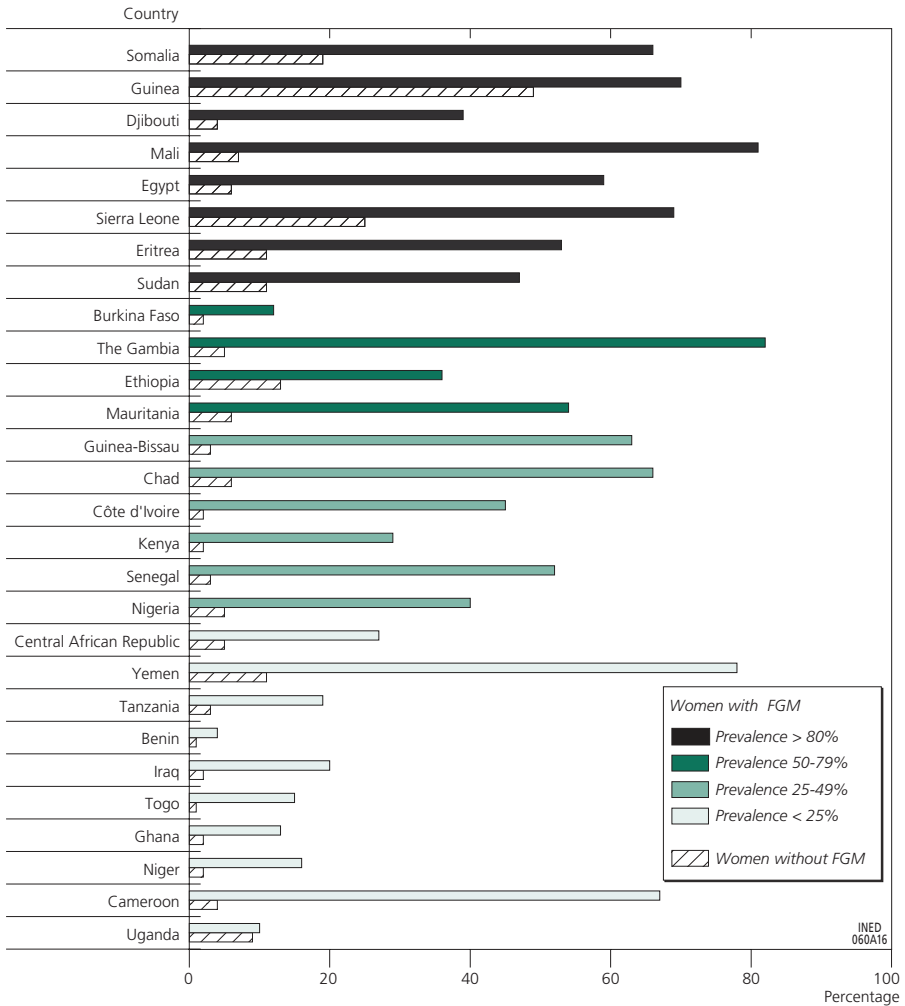
Sources: DHS and MICS data from the 11 countries where surveys have been performed in different years, covering a total period of at least 10 years (Appendix Table A.1).

Figure 9. Percentage of women with FGM in each age group, by national prevalence



Sources: Most recent DHS and MICS surveys in countries where national prevalence is above 25% (Appendix Table A.1).

Figure 10. Proportion (%) of women aged 15-49 years who reported supporting the continued practice of FGM, by respondent's FGM status



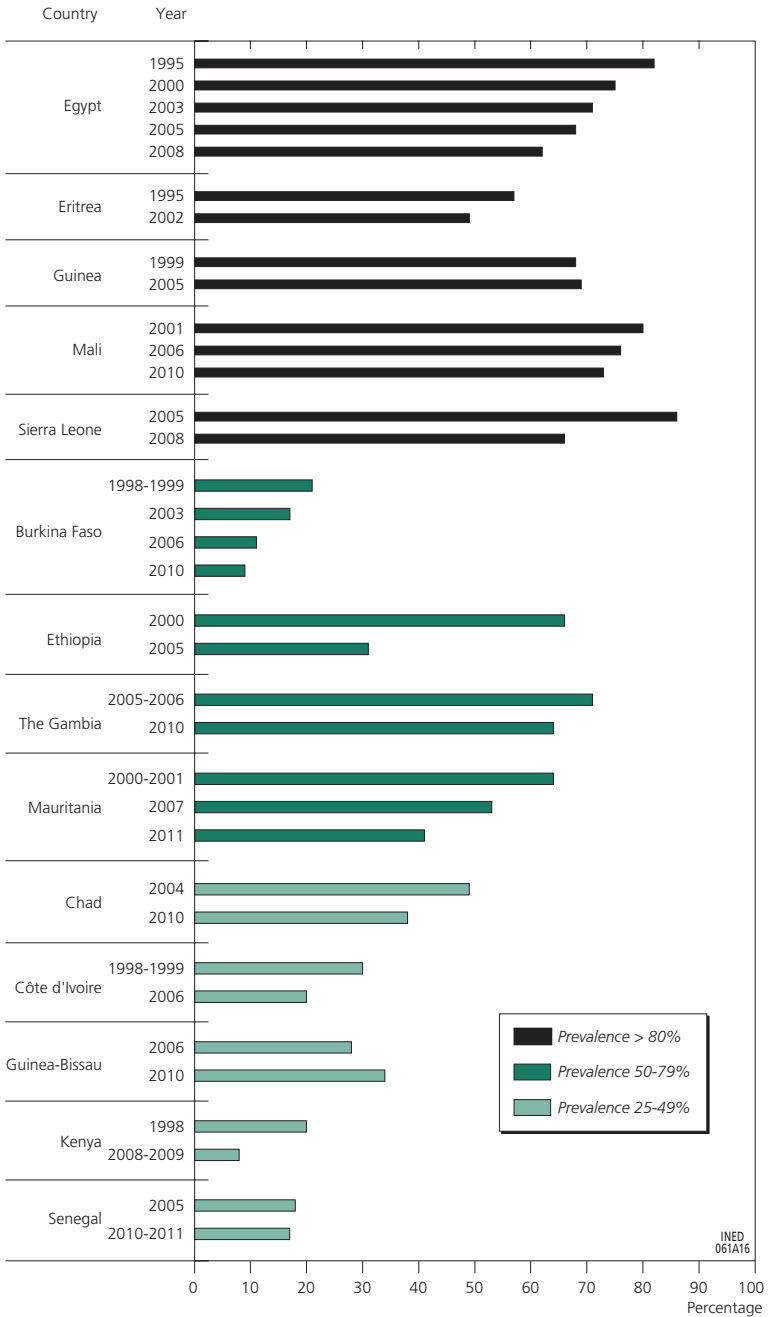
Sources: Most recent DHS and MICS surveys.

of the practice has been decreasing, including in countries where the practice is nearly universal, as in Egypt, where the level of support fell from 82% to 62% in 13 years, and in Sierra Leone, where it fell from 86% to 66% in less than 5 years (Sierra Leone) (Figure 11).

These results partly confirm changes in the prevalence of the practice over the generations (Figure 9). In the countries⁽⁷³⁾ where results on this question are also available for men on several dates (data not shown), changes

(73) Benin (2001, 2006); Burkina Faso (1998-1999, 2003, 2010); Guinea (1999, 2005); Mali (2001, 2006, 2010); Niger (1988, 2006) (UNICEF, 2013).

Figure 11. Change in percentage of women aged 15-49 years who reported supporting the continuation of FGM



Sources: DHS surveys in countries where prevalence is above 25% and where opinions on the abandonment or continuation of FGM have been recorded on several occasions.

of opinion among men over time are fairly similar to those among women. For example, in Guinea and Mali both women's and men's opinions have changed little, as support for the practice has remained high. This reflects the persistence of strong social norms in favour of FGM in these societies (UNICEF, 2013).

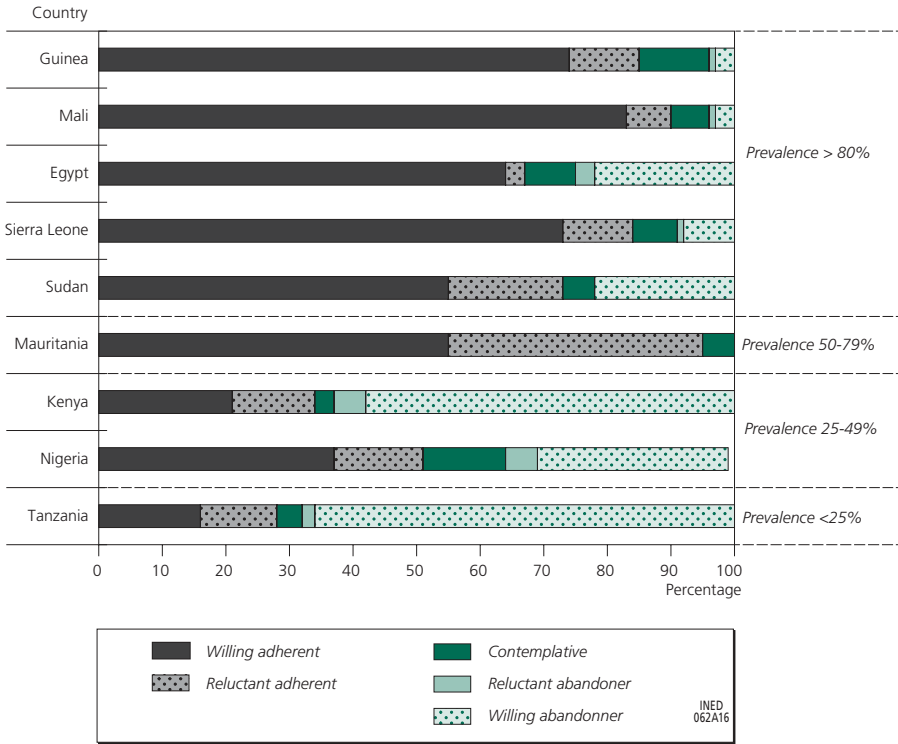
Differences between prevalence and percentage of opinion in favour of the continuation of the practice do not completely predict future changes. In contexts where FGM is now condemned, it is more difficult to express support for the practice. To better account for differences between intentions and actual behaviours, the “stages of change” model, originally developed in health psychology to capture changes in behaviour over time, has been applied to FGM (Shell-Duncan and Hernlund, 2006).⁽⁷⁴⁾ Starting from the hypothesis that a person's actual or desired behaviour is influenced by others, the authors identified five categories of readiness for change in the practice of FGM, comparing the opinions of women (with or without FGM) on the continuation or abandonment of the practice and their intentions for their daughters. Women who reported that they supported the practice and that they had had their daughters cut or intended to do so were classified as “willing adherents”; at the opposite extreme, women who supported abandonment of the practice and who said they would not have their daughters cut were considered “willing abandoners” (Appendix table A.3). Applying this model in a qualitative study in three regions in the Gambia and Senegal, Shell-Duncan and Hernlund (2006) showed that this categorization can shed light on trends in FGM, which is not a matter of purely individual decision-making. The most recent UNICEF report presents the distribution of women across these five categories for a number of countries (Figure 12).

Unsurprisingly, the proportion of women identified as “willing adherents” is highest in countries where prevalence is above 80%, and conversely, in countries with low prevalence, the majority of women are “willing abandoners”. This indicator is consistent with changes in prevalence and opinions over time: in countries where prevalence is high, when support for abandonment increases, prevalence decreases among the youngest women (Figures 9 and 11), with increasing numbers of women classified as “willing abandoners” or “reluctant abandoners” (Figure 12). This is true, for example, of Egypt and Sierra Leone, whereas in Guinea and Mali little change has been observed.⁽⁷⁵⁾ Similarly, in Kenya where both FGM and support for its continuation have substantially declined over 10 years (Figures 9 and 11), nearly 6 in 10 women (Figure 12) are now willing abandoners.

(74) This model, initially developed in the context of support for tobacco cessation, was then applied to addictive behaviours in other areas (drug addiction, diet, promotion of physical exercise, risky sexual behaviour) (Prochaska et al., 1994).

(75) In Egypt and Sierra Leone, the two categories of women who favour abandonment of the practice (willing and reluctant) make up 25% and 9% of all women, versus 4% in Mali and Guinea (Figure 12).

Figure 12. Distribution of women aged 15-49 years among the five categories of readiness to change FGM practice, in 9 countries



Sources: Most recent DHS-MICS surveys from a selection of countries (UNICEF, 2013).

This categorization could be refined, for example, with data on spouses' opinions, but it nevertheless provides a relatively clear image of the dynamics of ongoing change. The analysis should be extended to all countries where data on these variables is available from different surveys, with a view to measuring a possible continuum in these stages of change.

3. The effect of migration

The question of the abandonment of FGM is also posed in countries of immigration, but under very different conditions. In these societies, the practice has no historical foundations and is strongly condemned by the law. It is widely seen as violation of the rights of children, and is a factor in the stigmatization of families from “visible minorities” who are considered at risk of engaging in the practice. In Europe, this question has been examined in qualitative studies carried out in the 2000s (Behrendt, 2011; Berg and Denison, 2013; Dieleman, 2010; Johndotter, 2007; Johndotter et al., 2009; Johnson, 2007), and more recently in two quantitative surveys performed in Italy (2010) and France (2007-2009).

The first effect directly linked to migration – the selection effect – was shown in both the French and Italian surveys, notably in terms of level of education and geographic origin (Andro and Lesclingand, 2008; Farina and Ortensi, 2014b). Another effect is expected in the longer term, namely a decrease in the practice among the children of immigrants, under the assumption that the influence of other reference groups will override that of origin country communities, leading to progressive change in norms and behaviours (Farina and Ortensi, 2014b). Some researchers have also hypothesized a correlation between poverty, discrimination, and the continuation of traditional practices from the country of origin (Barth, 1969). Under this hypothesis, FGM in France should decline as the social status of the relevant groups increases. Similarly, the practice of FGM may decrease in families which use the resources of the host country (education, salaried employment, etc.) to improve their social and family status; in contrast, it may persist in families where the conditions of migration reinforce gender inequalities, regardless of social status. Nevertheless, minorities' experiences of discrimination and their disadvantaged positions in society may give rise to “reactive culturalism”, whereby traditions allowing them to affirm their identity as members of the group are rekindled (Coene, 2007). Generally speaking, migrant populations are confronted with two competing systems of representations: in countries of immigration, FGM is seen as a grave violation of human rights, while in the countries of origin where the practice is widespread, it is a social norm. Migrants must thus reconcile two contradictory pressures. This can lead to parental strategies such as having only one of their daughters cut, most often the eldest (Andro and Lesclingand, 2008).

Finally, as mentioned above (Section I.2), in addition to the social stigma associated with FGM, the practice is illegal, and practitioners can be prosecuted in the country of immigration even if the procedure was performed elsewhere (principle of extraterritoriality). This likely makes women all the more reticent to report that of any of their daughter(s) have undergone FGM. In the French and Italian surveys, to limit this bias, the prevalence of the practice among the daughters of immigrants was measured both through the mother's reports on their daughters' FGM status and through responses to questions on the mother's and/or the father's intentions.⁽⁷⁶⁾ The risk of FGM was considerably lower for daughters born in France or Italy than for those born abroad, confirming the direct effect of migration on this practice.⁽⁷⁷⁾ Moreover, all other things being equal, the risk of mutilation is lower in the youngest

(76) The Italian survey only featured one question on mothers' intentions with regard to the possible cutting of their daughters. In the French survey, further questions were added on the intentions of the father and of the family residing in the country of origin.

(77) In France, all other things being equal (daughter's age and mother's year of birth, level of education, and country of childhood socialization), a daughter born in France is three times less likely to undergo FGM than one born abroad (Andro and Lesclingand, 2008).

cohorts, doubtless reflecting effects of anti-FGM campaigns and criminal prosecutions in both countries of immigration⁽⁷⁸⁾ and countries of origin (Andro and Lesclingand, 2008; Farina and Ortensi, 2014b). Finally, analysis of data on the intentions of parents and of family members in the country of origin suggests that levels of risk among daughters who had not undergone FGM at the time of the survey vary: while in seven out of ten cases the risk is virtually nil (neither the girl's parents nor family members who did not migrate intend to have her cut), in a third of cases a risk remains, either because her parents' intentions are uncertain, or because of the expectations of family in the country of origin in the case of return – a risk that mothers are aware of. In the latter case, mothers can apply two strategies to prevent the cutting of their daughters: communication about the law (notably the principle of extraterritoriality) and refusal to send their daughters temporarily (for holidays) to their country of origin (Andro et al., 2009).

V. The effects of FGM on women's health and sexuality

In the first decades of mobilization against FGM, the existence of systematic and lasting consequences of sexual mutilation was hotly debated (Obermeyer, 1999, 2003, 2005). While genital mutilation was recognized to be harmful and a human rights violation, a lack of specific clinical studies meant that knowledge of the practical effects of sexual mutilation on women's health was limited, and the very existence of those effects was sometimes questioned.

While the most important issue in the fight against the sexual mutilation of women is to demonstrate the massive scale and wide geographical distribution of these practices through regular measures of their prevalence, the second is to provide medical evidence of their harmful consequences. The key is to provide objective findings that can contribute to the historical debate between relativist and abolitionist discourses.

Proponents of the former, inspired by culturalist approaches, have tended to minimize the violence inflicted on women who undergo FGM, describing it simply as a “cultural” practice, whereas those in the latter group have often generalized the most dramatic clinical cases in order to advance their case. An article published in 1999 in *Medical Anthropology Quarterly* surveying the literature available at the time highlighted the lack of statistically valid empirical findings on the nature and scope of the consequences of these practices (Obermeyer, 1999). Obermeyer criticized the international agenda of anti-FGM policy for its emphasis on condemning the practice on grounds of principle

(78) In France, while the first prosecutions for FGM took place in the early 1980s, sanctions against the practice became more severe in the 1990s, notably with the highly publicized trial early in the decade of Hawa Gréou, a Malian *exciseuse* who was sentenced to several years in prison. There is a very clear gap, in terms of the prevalence of FGM, between girls born in France in the 1980s and those born in the 1990s (Andro et al., 2009).

rather than offering documented descriptions of women's situations. He recognized, however, that the consequences of FGM had rarely been studied, and thus could be both minimized and/or exaggerated. Gerry Mackie (2003) questioned Obermeyer's conclusions, highlighting the reductive choice of sources (the few existing clinical surveys dating from the 1990s) that he used to discredit arguments against these practices largely supported by public opinion, the non-academic knowledge of actors on the ground, and the observations of health professionals mobilized on these issues. According to Mackie, lack of knowledge on the consequences of FGM was due more to taboos around the issue than to their supposed innocuity.

The medical consequences of FGM were first investigated in the 1980s in the framework of clinical studies, but it was not until the early 2000s that the research literature became broad enough to begin characterizing the health risks associated with FGM. Most studies were performed in countries where the practice is historically widespread, and examined both the physical and psychological consequences of FGM. Their findings revealed both direct consequences of FGM and consequences related to inadequate healthcare provision – a problem in many of these countries, notably in maternal and infant care. This made it difficult to distinguish between direct and indirect health risks. In recent years, a number of publications have reviewed these studies, highlighting their sometimes equivocal results, and notably the difficulty of precisely quantifying the prevalence of different pathologies (Obermeyer, 2005), but confirming the systematic association between FGM and an increase in certain health risks (Berg et al., 2014; Berg and Denison, 2012). The WHO summarized the results of these clinical studies, developing a typology of the different consequences of FGM (WHO, 2000, 2008), which today serves as a reference for the development of public policies on healthcare for women.

The WHO distinguishes three types of health complications linked to FGM: immediate risks that apply at the time of the act itself, long-term risks of problems that can arise at any time in life, and risks that are specific to type III mutilations – that is, to FGM involving the stitching of the labia majora (Table 1).

The immediate risks are those resulting directly from the trauma of mutilation. They include severe pain (at the time of FGM and during the healing process), bleeding (including in some cases severe haemorrhaging), a state of shock (related to the violence of the act and the resulting trauma), infections (linked to the conditions in which the mutilation is carried out and to the healing process), and finally the potential transmission of HIV (linked, again, to the conditions in which the act is performed). In some cases, these immediate risks can lead to death.⁽⁷⁹⁾

(79) Infant and childhood mortality linked to FGM is poorly measured and is invisible in mortality statistics for the affected countries.

There are many long-term risks, and while the associated problems do not occur in all cases, they are extremely frequent. Girls and women can suffer from chronic pain and keloids.⁽⁸⁰⁾ Genital, pelvic, and urinary infections, as well as urinary pathologies, can arise from childhood onward. Infections of the reproductive system, genital herpes, sexually transmitted infections, and the risk of HIV transmission are added when women become sexually active. Overall, the risks of sexual dysfunction are high, ranging from lack of sexual desire to systematic pain during intercourse. Last, obstetric complications (Caesarean delivery, post-partum haemorrhaging, tearing, and even obstetrical fistulae) are widespread. Risks of lifelong psychological effects have also been documented.

Finally, risks specific to infibulation include major urinary and menstrual problems, forced deinfibulation during sexual intercourse or childbirth, and chronic sexual pain and dysfunction.

The WHO developed this overall clinical picture based on a review of various studies performed over the last two decades. It has strongly supported the campaign to end FGM in regions where arguments based on women's and children's rights carry little weight. While the WHO was able to create a detailed overview of the harmful effects of FGM, not all of these health risks are sufficiently documented and studied to measure their relative importance. However, some recent studies on large samples of women or girls offer evidence beyond that provided by clinical case studies.

1. Immediate complications

Immediate risks and complications are difficult to analyse on a large scale given the conditions in which FGM is generally practiced. The few available studies suggest that complications are under-reported (El Dareer, 1983). In all cases, the consequences can only be studied some time after the event, and the type of information collected is substantially biased by memory effects, among both girls asked about their own experience and parents asked about their daughters. In a recent review, Berg and colleagues (2014) estimated, on the basis of available reliable surveys,⁽⁸¹⁾ that the most commonly reported consequences are excessive bleeding and urine retention (different studies found that between 5% and 62% of women suffer these complications), followed by genital tissue swelling and healing problems (2% to 27% of women).

2. Other physical and psychological complications

Several studies have confirmed the existence of statistically significant relationships between FGM and the prevalence of infections and urogenital

(80) An overgrowth of scar tissue that can develop in the location of the cutting and create chronic problems.

(81) That is, representative surveys on large samples, such as the few DHS surveys that have included a module on this question (Central African Republic in 1995, Chad in 2004).

problems at all ages (Almroth, Bedri et al., 2005; Andro et al., 2014). Urinary infections and pain or difficulty with urination are particularly common. In their 2014 meta-analysis, Rigmor Berg and colleagues estimated that these urinary problems are three times more common among women who have undergone FGM than in other women (Elmusharaf, 2006a; Okonofua et al., 2002). Similarly, mycoses/fungal infections and the associated symptoms (vaginal discharge and itching) are more common among women with FGM, and particularly those who have been infibulated. They are also present in women who undergo a medicalized FGM (Almroth, Bedri et al., 2005). Other physical sequelae are rarer, and extant studies have not demonstrated a statistically significant relationship between FGM and cysts, abscesses, fistulae, or vaginal obstruction (Berg et al., 2014).

The link between FGM and the transmission of STIs and HIV is also not yet clearly established. The case-control study by Elmusharaf and colleagues (2006a) in Sudan concluded that the differences between the cases (infected women) and controls (non-infected women) were small and that FGM status has neither a negative nor a positive effect on the risks of infection. Other studies on the topic have yielded similar results (Berg et al., 2014).

With regard to psychological consequences, many studies have been carried out but they have not yielded robust results. They are predominantly based on case studies, and cannot be used to assess the prevalence of psychological disorders among women with FGM or to establish a link between such disorders and FGM itself. There is an exception, however, with regard to women who have migrated to Europe: Vloeberghs and colleagues (2012) in a quantitative study on psychological disorders in 66 migrant women who had undergone FGM, showed that one in six suffered from post-traumatic stress disorder, and that a third suffered symptoms of depression and anxiety. A survey of migrant women in France also showed an increased risk of symptoms of “ill-being”, with fatigue and anxiety reported by more than a quarter of women with FGM (Andro et al., 2014).

3. Obstetric complications

Since the 2000s, the WHO has placed particular emphasis on the issue of obstetric complications in its efforts to combat FGM, and this is the most widely studied aspect of the practice. The survey carried out between 2001 and 2003 by Banks and colleagues in 28 maternity units in six African countries,⁽⁸²⁾ covering a sample of 28,393 mothers, produced solid results on the obstetric consequences of FGM in countries where it has historically been practiced (WHO Study Group on Female Genital Mutilation and Obstetric Outcome, 2006). The women were examined before delivery and followed up until their return home. This major, large-scale study showed that women with

(82) Burkina Faso, Ghana, Kenya, Nigeria, Senegal, and Sudan.

FGM are at greater risk than other women of Caesarean section, postpartum haemorrhage, respiratory distress in the newborn, neonatal death (which is twice as frequent in women with FGM), low birth weight, and an extended hospital stay. These risks are highest among women who have undergone type III mutilation.

These findings reflect not only the greater health risks surrounding childbirth in women with FGM, but also, more generally, the often poor conditions of hygiene and safety in which these women gave birth (Ndiaye et al., 2010). However, a study of women with FGM who gave birth in a high-quality healthcare environment in Switzerland found that some health risks remain, notably the risks of emergency Caesarean section and deep tears (Wuest et al., 2009). Risks of tearing during delivery are also significant in France (Andro et al., 2014). A very recent study in a Swiss clinic specialized in care of women with FGM showed, however, that these risks are lower when the medical team has specialized know-how (Abdulcadir et al., 2015).

4. Impact on sexual life

Academic interest in the consequences of FGM for women's sexuality is recent and, as yet, few solid results are available, as research on the sexual function⁽⁸³⁾ of women in general, and women with FGM in particular, is very heterogeneous (Berg and Denison, 2012). The scientific approaches to women's sexuality are heavily influenced by social norms and representations (Gagnon et al., 2008), and there is no general consensus on the choice of tools for measuring quality of sexual function and sexual life. This makes it difficult to study the sexual consequences of FGM. The first studies by Catania and colleagues (Catania et al., 2007), in which several groups of women were compared, showed that measuring differences in degree of sexual satisfaction is a complex exercise.

A few results have now been validated, and links between certain sexual dysfunctions and FGM have been highlighted in several studies (Berg and Denison, 2012). Both sexual desire and sexual satisfaction are lower in women with FGM, and pain during intercourse is significantly more common. A case-control study with migrant women in Saudi Arabia gave evidence of difficulties with orgasm, lubrication, and sexual satisfaction among women with FGM (Alsibiani and Rouzi, 2010). A case-control study in France also highlighted clear negative effects on the sexual life of women with FGM compared to other women with comparable social characteristics (migrants or daughters of migrants): they were more likely to report pain or burning sensations during intercourse, chronic lack of sexual desire, and lack of satisfaction with their sexual life more generally (Andro et al., 2014).

(83) The notion of sexual function encompasses the bio-physiological functioning of the genital organs as part of the "human sexual response cycle" (Giami, 2007).

These studies show that sexual mutilations create risks for women's health that persist throughout their lives, both in childhood and later during sexual and reproductive life. Most studies focus on adult women, and little is known (and then only retrospectively) about the problems that girls experience during childhood and puberty due to FGM (Aboyeji and Ijaiya, 2003; Ekenze et al., 2007). Research has thus far concentrated on pathologies linked to sexual and reproductive life, leaving aside health risks in childhood.

VI. The role of the medical sector

The medical sector has taken on diametrically opposed roles with regard to FGM in different regions over the last two decades. On the one hand, in order to minimize health risks, health professionals have been increasingly involved in performing genital mutilation on children in accordance with family traditions. Physicians and other health professionals are in growing demand for such operations on both boys and girls. Indeed, social transformations have placed health professionals in the spotlight with regard to FGM, not only in the countries of origin where they are gradually replacing traditional circumcisers (*exciseuses*), but also in countries of immigration where they have discovered the reality of this phenomenon. Moreover, the medical sphere has begun to offer treatment to girls and women for the sequelae of FGM (Momoh et al., 2001). These medical services, generally referred to as rehabilitation or reconstruction, aim to treat women in cases where the adverse effects of FGM on their quality of life have been recognized and denounced (Abdulcadir et al., 2011).

1. The medicalization of FGM and mobilization against its spread

Following the Technical Consultation on the Medicalization of Female Genital Mutilation/Cutting organized by the UNFPA in 2009 in Nairobi, all international organizations have condemned the involvement of health professionals in FGM, in any context, whether in hospitals, other healthcare institutions, or elsewhere (UNFPA et al., 2010). This international position statement was needed to counter the expanding medicalization of FGM (Serour, 2013).

Medicalized FGM has substantially increased in recent years, particularly in Egypt, Kenya, Guinea, Nigeria, and South Sudan (in Africa), as well as in Yemen and Indonesia. In these countries, between 30% and 80% of FGM procedures are carried out by health professionals (UNICEF, 2013, 2015). This issue is particularly acute in the youngest cohorts, where the trend is recent and worrying, as it may have the potential to fundamentally undermine the discourse against these harmful practices.

These new forms of FGM involving health professionals have expanded since the early 2000s (Shell-Duncan, 2001), weakening the case for its eradication (Shell-Duncan, 2008).

In some countries, health professionals have started to practice genital cutting, and even infibulation, on grounds that it reduces the incidence of complications. These medicalized acts have also, in many cases, become non-negligible sources of income for practitioners, at the expense of traditional circumcisers. In some countries, such as Egypt and Malaysia, governments and certain associations have unfortunately considered that performing FGM in this way offers an acceptable solution. As Serour (2013) recalls, in the late 1990s some healthcare personnel began to more or less explicitly recognize and accept the medicalization of FGM.⁽⁸⁴⁾ It was only following the mobilization of the International Federation of Gynecology and Obstetrics (FIGO) that this medicalization was gradually outlawed in most countries, with the notable exception of Indonesia.⁽⁸⁵⁾

This new situation led to major discussion within the anti-FGM movements. The main question at issue was whether or not to recognize this medicalization as an acceptable strategy, notably in regions where social resistance to the complete abandonment of the practice is strong (Shell-Duncan, 2001). While this could be seen as an intermediate path that limits health risks to women, the majority of movements involved in the fight against FGM opposed this proposal, arguing that recognizing the medicalization of practices that violate the physical integrity of girls and women, and thus their rights, could legitimate them and contribute to their persistence.

However, beyond these clearly established positions of principle, there is little research into the role of health professionals in the abandonment or perpetuation of FGM. A few studies performed in Egypt (Abdelshahid and Campbell, 2015; Modrek and Liu, 2013; Modrek and Sieverding, 2015; Rasheed et al., 2011) have shown that while families are increasingly likely to rely on doctors' opinions when making a decision about a medicalized FGM procedure, physicians tend not to refuse what they consider to be a legitimate parental request. They also highlight the economic aspect of this practice, which is a complementary source of income for the medical sector. These studies conclude that in countries where medicalization is already very advanced, the training of professionals will be a central element in the abandonment of these practices.

(84) The Egyptian Ministry of Health recognized the legality of these practices for health professionals in 1994, Médecins Sans Frontières held an ambiguous position for a short time, and the American Association of Pediatricians took a highly controversial standpoint, promoting medically executed FGM on American soil as a way to reduce health risks for girls who would otherwise undergo FGM during a visit to their families' country of origin.

(85) After an unsuccessful attempt to prohibit medicalized FGM in 2006, in 2010 the Indonesian Ministry of Health issued a decree authorizing health professionals (physicians, midwives, and trained nurses) to practice FGM in a medical environment (public and private). Following a campaign against this decree by the Women's Commission and the Committee on the Rights of the Child, the decree was repealed in 2014. However, in the absence of sanctions, the practice continues (UNICEF, 2015).

2. The particular case of reinfibulation

The term “reinfibulation” refers to cases where stitching is re-applied after childbirth in women who have previously undergone type III FGM. This customary practice is still common in a number of countries. While the reliability of data on this issue is poor, the number of women reinfibulated following childbirth is estimated at between 6.5 and 10.4 million (Serour, 2010). In the countries where these procedures are most commonly practiced, they have also become increasingly medicalized, and are often presented as requests made by the women themselves at the time of childbirth. Here again, a discourse has developed that aims to justify the medicalization of reinfibulation in terms of risk reduction, notably in the short term (infections, haemorrhage, etc.). But the few studies on the question have confirmed that it is of no benefit, and is associated with major medical complications for women (Serour, 2010). As with the medicalization of FGM, this practice is difficult to challenge, given the strength of social norms, but also the associated financial interests.

Reinfibulation constitutes an ethical issue, both in countries of origin and countries of immigration; it has been the object of major debate in medicine, and notably in obstetric gynaecology, in recent years. These procedures raise complex ethical questions, as health professionals are subjected to contradictory injunctions, between the demands of health policy and professional responsibility on the hand, and questions of consent and free will on the other: a request made by an adult woman able to give informed consent cannot be considered in the same way as the case of a little girl subjected to FGM. However, practitioners must also take into account the social pressure that undoubtedly weighs on these women, whose freedom of consent may be limited (Cook and Dickens, 2010). Cook and Dickens argue that a physician’s refusal to perform reinfibulation can never be considered equivalent to cases where a doctor declines to perform a procedure on grounds of professional conscience, as seen in some countries with regard to sterilization and abortion, given that clinical analyses clearly demonstrate the adverse effects of reinfibulation (Serour, 2010).

3. Rehabilitation operations and their slow recognition

Different forms of surgical intervention to improve the situation of women affected by the sequelae of FGM have been developed since the 1990s. Some have been evaluated in clinical studies and are now medically recommended, and validated by the WHO. This is the case for deinfibulation and vulvar reconstruction to treat the effects of type III FGM, which includes stitching of the labia majora. Treatments for the effects of clitoridectomy, which have been developed in parallel, are still being evaluated by national and international health authorities, and there are few clinical studies as yet. France has taken a leading role in this domain. It is the only country to have developed techniques

of surgical repair that are recognized and reimbursed by the national health insurance system, and that are available in many public hospitals.

Vulvar reconstruction and deinfibulation

Deinfibulation is a reconstructive surgical procedure performed on the scar tissue caused by the stitching of the labia majora during infibulation. The opening of this scar tissue frees the vagina, the urethral meatus, and the (often intact) clitoral glans, allowing substantial improvements in the patient's urogenital and sexual health (Nour et al., 2006).⁽⁸⁶⁾ Both the surgical act in itself and postoperative management are generally straightforward. These operations can take place at different times in women's lives. In some cases, the request is made by women who have not yet initiated adult sexual life and who wish to limit or prevent possible complications. In others, deinfibulation is performed during pregnancy or at the time of childbirth. In both cases, multidisciplinary care for women who choose deinfibulation is crucial, as their choice often reflects a desire to distance themselves from or even challenge family practices and community social norms (Abdulcadir et al., 2011).

Clitoral repair

While the WHO recommends deinfibulation operations for women who have undergone type III mutilations, the current situation with regard to clitoral repair surgery is different. This type of operation remains rare and its clinical evaluation is ongoing (Abdulcadir et al., 2015). It is practiced in a handful of countries, including Senegal, Burkina Faso, and notably Côte d'Ivoire (Ouedraogo et al., 2013; Thabet and Thabet, 2003), as well as in France where it is available in about 20 hospitals and has been covered by the national health insurance system since 2004 (Andro et al., 2010; Antonetti Ndiaye et al., 2015; Foldès et al., 2012; Foldès and Louis-Sylvestre, 2006; Villani, 2009; Villani and Andro, 2010).

Clitoral surgery following FGM was developed in the late 1990s by Pierre Foldès, a French urologist, as a humanitarian medical intervention for mutilated women with painful complications. The operation consists in freeing the clitoral stump and repositioning it in its anatomical position (Foldès and Louis-Sylvestre, 2006). This operation is carried out in response to a wider range of needs: painful sequelae, but also demands for improved quality of sexual life and/or expectations and demands for physical integrity ("to be a complete woman"). The surgical technique and initial results have been described in various publications, mainly from France (Antonetti Ndiaye et al., 2015; Foldès et al., 2012; Foldès and Louis-Sylvestre, 2006). They show that clitoral surgery

(86) The study, carried out by Nawal Nour and colleagues in two Boston hospitals with 40 deinfibulated women who were followed up by telephone 6 months and 2 years later, showed that they did not experience any postoperative complications, that they would recommend the operation to other women with FGM, that they are satisfied with the results of the operation, and that they have satisfying sexual relations with their spouses (Nour et al., 2006).

significantly improves patients' quality of life but that it is probably not an appropriate solution for all women.

The 2,938 patients operated on by Pierre Foldès between 1998 and 2009 represent the largest analysed and published series of "repairs" (Foldès et al., 2012). Patients' requests are generally part of a multi-factorial process and are sometimes formulated with difficulty. The three main expectations are linked to treatment for pain, improvement of sexual function, and a more complex dimension of "becoming a complete woman". In the study cohort, the overwhelming majority of patients (821 out of 840) followed up one year after surgery reported that these expectations were satisfied.⁽⁸⁷⁾

The other studies examine smaller series. Two adopt a wider perspective, analysing the results not only of the surgical intervention, but also of the accompanying multidisciplinary care system (Antonetti Ndiaye et al., 2015; Merckelbagh et al., 2015). One covers 270 women who received care between 2007 and 2012, and the other a separate sample of 169 women treated between 2006 and 2011, in two hospitals in the Paris region. Less than half of the patients ultimately had the surgery. These two studies showed that a large proportion of women requesting surgery have experienced sexual trauma other than genital mutilation (sexual assault and violence). They confirm that "repair" following FGM is not a matter of surgery alone, but that surgery does improve the quality of sexual life.

In France, the Excision et Handicap (FGM and disability) survey, a general population survey carried out in 2007-2009, also showed that a third of female respondents with FGM reported being interested in surgical reconstruction and that the few who had undergone the surgery (21 out of 685 women) were satisfied with the results (Andro et al., 2009, 2010).

VII. Conclusion: the importance of further research

Research on FGM has been expanding since the early 1990s. Studies have shed light on the scale of this phenomenon and its effects on women's sexual and reproductive health. Recognition of the adverse effects of genital mutilation on obstetric health is the main factor behind world-wide efforts to eradicate these practices and to place them on the international agenda of women's and children's rights (UNFPA, 2014). The most recent studies have focused more specifically on the consequences of these practices for women's health and on the social dynamics at work around their persistence or abandonment, and have examined changes over time in social and family practices in a context of continuous reinforcement of anti-FGM policies. Among ongoing research priorities, four themes can be identified. Two concern the analysis and production

(87) In physiological terms, 99% of women experienced a noticeable transformation of their clitoris; 4% required a second operation.

of data on the topic: first, further exploration of the determinants of the practice and of resistance to its abandonment, and second, a better understanding of the globalization of the phenomenon through more accurate measures in countries where it is not widely recognized and in countries with migrant populations. The third, more medical theme is the advancement of knowledge on the health consequences of FGM. The fourth and final theme concerns public action, and the appropriation and definition of international policies by the women concerned.

1. Improving analysis of available data

A large body of factual statistical data on female genital mutilation has been produced in recent decades, under the aegis of international organizations. These efforts have yielded sound knowledge of the prevalence and characteristics of these practices in 30 countries, of their determinants and consequences, and of changes in perceptions over time. However, most analyses aimed at understanding the mechanisms of reproduction are still largely descriptive. More sophisticated statistical approaches are now needed, notably in countries where comparable data are available, using multivariate and multilevel analyses to better understand the weight and particular roles of the various determinants, which may vary across different contexts. Social norms act through the family environment, the neighbourhood or village, the region, and the country (of origin and/or destination), and the interrelationships between these different levels must be studied. Once these contextual analyses have been carried out, it will become possible to explore the factors that contribute to social transformation, such as those classically used to measure women's autonomy (polygamy, modern contraceptive practices, etc.). Better integration of men's behaviours and opinions into models and analyses could shed light on their role, which is too often neglected. The specific impact of migration, both rural-to-urban and transnational, must also be studied in more detail.

2. Developing data collection

The situation in countries of immigration, where the relevant populations are recent, particularly vulnerable and have low social visibility, and where FGM remains a marginal phenomenon, remains largely unknown. For example, little is known about the prevalence of female sexual mutilation in Europe. There is currently no standardized method for estimating the scale of the phenomenon in the various member states or for producing comparable data. Developing common definitions and methodologies for estimating the number of women affected by FGM in each country is one of the recommendations in the final report of the project on Female Genital Mutilation in the European Union and Croatia published by the European Institute for Gender Equality (EIGE, 2013). The situation in countries of immigration seems to be relatively similar to that of African countries with low levels of FGM (prevalence under 5%, as in Cameroon,

Uganda, Niger, Ghana, and Togo). The development of a common methodology to produce comparable data for all countries in the world is a fundamental element in the fight to eliminate these practices, and to implement policies on care and support for women with FGM. These data are needed by public authorities (health, education, justice) and civil society actors. Such improvements in the tools for guiding public policy would help to improve the situation of women and girls who have been subjected to this harmful traditional practice.

3. Greater focus on the health effects of FGM

The typology developed by the WHO has made it possible to survey and quantitatively document the medical effects of FGM. Despite notable advances in the last two decades, as Berg and colleagues have shown, many pathologies remain poorly studied. While their existence has been documented in case studies, knowledge of their incidence and their connection to FGM remains limited. This typology is the outcome of clinical studies carried out over several decades under the aegis of the WHO, and of often heated debates within a multidisciplinary research community that combines anthropological, medical, political, and moral approaches. The qualification of FGM as a “harmful practice” by international organizations (WHO, UNICEF, UN, UNFPA, UNHCR, UNAIDS) has had a contentious history, generating much international debate. Today, political discourse against these practices focuses mainly on their perinatal effects. These effects are indeed dramatic in the countries where FGM is a traditional practice, much less so in countries of immigration where the medicalization of childbirth considerably reduces the risks. In these countries, the greatest health effect for women with FGM is the poor quality of their sexual life. The results of medical research on the pathophysiology of FGM suggest that a new system for categorizing types of sexual mutilation is needed. But in the countries where this practice is traditional, there are major barriers to explicit discourse on improving women’s sexual health, and health professionals are reluctant to take the lead. Medical studies show that sexual mutilation leads to health risks that persist throughout life, with effects sometimes appearing long after the act itself. Most clinical surveys are carried out in adult women and focus mainly on pathologies in sexual and reproductive life, thus neglecting risks in childhood. Little is currently known about the health problems suffered by girls in childhood and puberty following genital mutilation.

Health professionals will have a fundamental role in the eradication of FGM in the coming decades, both as key actors in prevention and as experts in the care and treatment of affected women. Their training will be central to the eradication of these mutilations.

4. Implications for women’s rights

The fight to eradicate FGM has been built around theories of social conventions and social change. After 30 years of mobilization, it is still difficult

to determine whether this approach is appropriate. The pace of social change is relatively slow, and measuring changes will take time. The increasingly global scale of the phenomenon, linked to the circulation of persons and ideas, is now becoming clear, along with a new awareness of the extent of these practices in regions where they were previously underestimated. The fight against FGM will be multifaceted: it must be adaptable to diverse situations, both in the countries of origin and in countries of immigration. But we must not forget that efforts to eradicate the practice may backfire if they lead to the imposition of hegemonic social norms (Vissandjée et al., 2014). The two positions consisting of dismissing cultural practices as “barbaric” on the one hand, or dismissing engagement in favour of women’s rights as “imperialist” on the other, are ultimately counterproductive. The former disregards opposition to FGM within the affected populations, while the latter neglects the power asymmetry between North and South in international efforts to combat the practice. While international organizations continually stress that the priority is to eradicate FGM, and the globalization of migratory flows has transformed the practice into a world-wide public health issue, developing a shared international discourse remains a major challenge. Although there is consensus on defending children’s rights and protecting mothers, women’s right to a fulfilling sexuality is still subject to debate. A lack of knowledge on women’s sexuality often limits the reach of discourse against FGM based on arguments about its harmful effects on sexual life. It is thus clear that a critical analysis of the construction of international arguments in the historical fight against FGM is needed. This is doubtless a necessary step on the way to adopting a new perspective on this form of gender violence: one that is based on the perceptions and felt experiences of the women concerned, and notably their capacity for resilience, and that ceases to rely exclusively on forms of medical and anthropological discourse that too systematically ignore women’s own points of view on their situation. We must therefore continue, in the light of recent research, to deconstruct the stereotypical figure of the “cut woman” understood as a homogeneous and objective category, and seek instead to grasp the diversity of situations and harmful effects that this act can have on the life trajectories of these women, and thereby move towards its eradication.



APPENDICES

Document A. Specific questionnaire on FGM
in the most recent Demographic and Health Surveys (DHS)

FEMALE GENITAL CUTTING/MUTILATION FOR WOMAN'S QUESTIONNAIRE (1)			
NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
GC1 (2)	Now I would like to ask some questions about a practice known as female circumcision. Have you ever heard of female circumcision?	YES 1 NO 2	→ GC3
GC2	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?	YES 1 NO 2	→ NEXT SEC.
GC3	Have you yourself ever been circumcised?	YES 1 NO 2	→ GC9
GC4	Now I would like to ask you what was done to you at that time. Was any flesh removed from the genital area?	YES 1 NO 2 DON'T KNOW 8	→ GC6
GC5	Was the genital area just nicked without removing any flesh?	YES 1 NO 2 DON'T KNOW 8	
GC6 (3)	Was your genital area sewn closed?	YES 1 NO 2 DON'T KNOW 8	
GC7	How old were you when you were circumcised? IF THE RESPONDENT DOES NOT KNOW THE EXACT AGE, PROBE TO GET AN ESTIMATE.	AGE IN COMPLETED YEARS <input type="text"/> <input type="text"/> AS A BABY/DURING INFANCY 95 DON'T KNOW 98	
GC8 (4)	Who performed the circumcision?	TRADITIONAL TRAD. CIRCUMCISER 11 TRAD. BIRTH ATTENDANT 12 OTHER TRAD. _____ 16 (SPECIFY) HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY) DON'T KNOW 98	
GC9 (5)	CHECK 213, 215 AND 216: HAS ONE OR MORE LIVING DAUGHTERS BORN IN 2000 OR LATER <input type="checkbox"/> ↓	HAS NO LIVING DAUGHTERS BORN IN 2000 OR LATER <input type="checkbox"/>	→ GC16

Document A (cont'd). Specific questionnaire on FGM
in the most recent Demographic and Health Surveys (DHS)

FEMALE GENITAL CUTTING/MUTILATION FOR WOMAN'S QUESTIONNAIRE (1)

GC09A (5)	CHECK 213, 215 AND 216: ENTER IN THE TABLE THE BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2000 OR LATER. ASK THE QUESTIONS ABOUT ALL OF THESE DAUGHTERS. BEGIN WITH THE YOUNGEST DAUGHTER. (IF THERE ARE MORE THAN 3 DAUGHTERS, USE ADDITIONAL QUESTIONNAIRES). Now I would like to ask you some questions about your (daughter/daughters).												
GC10 (5)	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2000 OR LATER.</th> <th style="width:25%;">YOUNGEST LIVING DAUGHTER</th> <th style="width:25%;">NEXT-TO-YOUNGEST LIVING DAUGHTER</th> <th style="width:25%;">SECOND-TO-YOUNGEST LIVING DAUGHTER</th> </tr> </thead> <tbody> <tr> <td></td> <td>BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/></td> <td>BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/></td> <td>BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/></td> </tr> <tr> <td></td> <td>NAME _____</td> <td>NAME _____</td> <td>NAME _____</td> </tr> </tbody> </table>	BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2000 OR LATER.	YOUNGEST LIVING DAUGHTER	NEXT-TO-YOUNGEST LIVING DAUGHTER	SECOND-TO-YOUNGEST LIVING DAUGHTER		BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>	BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>	BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>		NAME _____	NAME _____	NAME _____
BIRTH HISTORY NUMBER AND NAME OF EACH LIVING DAUGHTER BORN IN 2000 OR LATER.	YOUNGEST LIVING DAUGHTER	NEXT-TO-YOUNGEST LIVING DAUGHTER	SECOND-TO-YOUNGEST LIVING DAUGHTER										
	BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>	BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>	BIRTH HISTORY NUMBER .. <input style="width:40px;" type="text"/>										
	NAME _____	NAME _____	NAME _____										
GC11	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Is (NAME OF DAUGHTER) circumcised?</th> <th style="width:25%;">YES 1 NO 2</th> <th style="width:25%;">YES 1 NO 2</th> <th style="width:25%;">YES 1 NO 2</th> </tr> </thead> <tbody> <tr> <td></td> <td style="text-align:center;">(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)</td> <td style="text-align:center;">(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)</td> <td style="text-align:center;">(GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16)</td> </tr> </tbody> </table>	Is (NAME OF DAUGHTER) circumcised?	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2		(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)	(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)	(GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16)				
Is (NAME OF DAUGHTER) circumcised?	YES 1 NO 2	YES 1 NO 2	YES 1 NO 2										
	(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)	(GO TO GC11 IN NEXT COLUMN; OR IF NO MORE DAUGHTERS, GO TO GC16)	(GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16)										
GC12	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">How old was (NAME OF DAUGHTER) when she was circumcised? IF THE RESPONDENT DOES NOT KNOW THE AGE, PROBE TO GET AN ESTIMATE.</th> <th style="width:25%;">AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/></th> <th style="width:25%;">AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/></th> <th style="width:25%;">AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/></th> </tr> </thead> <tbody> <tr> <td></td> <td>DON'T KNOW 98</td> <td>DON'T KNOW 98</td> <td>DON'T KNOW 98</td> </tr> </tbody> </table>	How old was (NAME OF DAUGHTER) when she was circumcised? IF THE RESPONDENT DOES NOT KNOW THE AGE, PROBE TO GET AN ESTIMATE.	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>		DON'T KNOW 98	DON'T KNOW 98	DON'T KNOW 98				
How old was (NAME OF DAUGHTER) when she was circumcised? IF THE RESPONDENT DOES NOT KNOW THE AGE, PROBE TO GET AN ESTIMATE.	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>	AGE IN COMPLETED YRS .. <input style="width:40px;" type="text"/>										
	DON'T KNOW 98	DON'T KNOW 98	DON'T KNOW 98										
GC13 (3)	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Was her genital area sewn closed?</th> <th style="width:25%;">YES 1 NO 2 DON'T KNOW 8</th> <th style="width:25%;">YES 1 NO 2 DON'T KNOW 8</th> <th style="width:25%;">YES 1 NO 2 DON'T KNOW 8</th> </tr> </thead> <tbody> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>	Was her genital area sewn closed?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8								
Was her genital area sewn closed?	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8	YES 1 NO 2 DON'T KNOW 8										
GC14 (4)	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:33%;">Who performed the circumcision?</th> <th style="width:25%;">TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)</th> <th style="width:25%;">TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)</th> <th style="width:25%;">TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)</th> </tr> </thead> <tbody> <tr> <td></td> <td>HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)</td> <td>HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)</td> <td>HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)</td> </tr> <tr> <td></td> <td>DON'T KNOW 98</td> <td>DON'T KNOW 98</td> <td>DON'T KNOW 98</td> </tr> </tbody> </table>	Who performed the circumcision?	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)		HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)	HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)	HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)		DON'T KNOW 98	DON'T KNOW 98	DON'T KNOW 98
Who performed the circumcision?	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)	TRADITIONAL TRADITIONAL CIRCUMCISER .. 11 TRAD. BIRTH ATTENDANT .. 12 OTHER TRAD. _____ 16 (SPECIFY)										
	HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)	HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)	HEALTH PROFESSIONAL DOCTOR 21 NURSE/MIDWIFE .. 22 OTHER HEALTH PROFESSIONAL _____ 26 (SPECIFY)										
	DON'T KNOW 98	DON'T KNOW 98	DON'T KNOW 98										
GC15	<table border="1" style="width:100%; border-collapse: collapse;"> <tbody> <tr> <td style="width:33%;"></td> <td style="width:25%;">GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.</td> <td style="width:25%;">GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.</td> <td style="width:25%;">GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16.</td> </tr> </tbody> </table>		GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.	GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.	GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16.								
	GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.	GO BACK TO GC11 IN NEXT COLUMN; OR, IF NO MORE DAUGHTERS, GO TO GC16.	GO TO GC11 IN FIRST COLUMN OF NEW QUESTIONNAIRE; OR IF NO MORE DAUGHTERS, GO TO GC16.										

Document A (cont'd). Specific questionnaire on FGM
in the most recent Demographic and Health Surveys (DHS)

FEMALE GENITAL CUTTING/MUTILATION FOR WOMAN'S QUESTIONNAIRE (1)

NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP
GC16 (2)	Do you believe that female circumcision is required by your religion?	YES 1 NO 2 NO RELIGION 3 DON'T KNOW 8	
GC17	Do you think that female circumcision should be continued, or should it be stopped?	CONTINUED 1 STOPPED 2 DEPENDS 3 DON'T KNOW 8	

Table A.1. DHS^(a) and MICS^(b) surveys with a module on FGM^(c) and prevalence of FGM measured in each survey (%)

Country	Number of surveys	Survey year	Type of survey	% of women aged 15-49 with FGM
Benin	4	2014	MICS	9.2
		2011-2012	DHS	7.3
		2006	DHS	12.9
		2001	DHS	16.8
Burkina Faso	4	2010	DHS	75.8
		2006	MICS	72.5
		2003	DHS	76.6
		1998-1999	DHS	71.6
Cameroon	1	2004	DHS	1.4
Côte d'Ivoire	5	2011-2012	DHS	38.2
		2006	MICS	36.0
		2005	DHS	41.7
		1998-1999	DHS	44.5
		1994	DHS	42.7
Djibouti	1	2006	MICS	93.1
Egypt	6	2014	DHS	92.3
		2008	DHS	95.5
		2005	DHS	95.8
		2003	DHS	97.0
		2000	DHS	97.3
		1995	DHS	97.0
Eritrea	2	2002	DHS	88.7
		1995	DHS	94.5
Ethiopia	2	2005	DHS	74.3
		2000	DHS	79.9
The Gambia	3	2013	DHS	74.9
		2010	MICS	76.3
		2005-2006	MICS	78.3
Ghana	3	2011	MICS	4.0
		2006	MICS	3.8
		2003	DHS	5.4
Guinea	3	2012	DHS	96.9
		2005	DHS	95.0
		1999	DHS	98.6
Guinea-Bissau	3	2014	MICS	44.9
		2010	MICS	49.8
		2006	MICS	44.5
Iraq	1	2011	MICS	8.1
Indonesia	1	2013	RISKESDAS	51.0 ^(d)
Kenya	3	2008-2009	DHS	27.1
		2003	DHS	32.2
		1998	DHS	37.6
Liberia	2	2013	DHS	49.8
		2007	DHS	65.7
Mali	5	2012-2013	DHS	91.4
		2010	MICS	89.0
		2006	DHS	85.2
		2001	DHS	91.4
		1995-1996	DHS	93.7

Table A.1 (cont'd). DHS^(a) and MICS^(b) surveys with a module on FGM^(c) and prevalence of FGM measured in each survey (%)

Country	Number of surveys	Survey year	Type of survey	% of women aged 15-49 with FGM
Mauritania	3	2011	MICS	69.4
		2007	MICS	72.2
		2000-2001	DHS	71.3
Niger	3	2012	DHS	2.0
		2006	DHS	2.2
		1998	DHS	4.5
Nigeria	6	2013	DHS	24.8
		2011	MICS	27.0
		2008	DHS	29.6
		2007	MICS	26.0
		2003	DHS	19.0
		1999	DHS	25.1
Uganda	2	2011	DHS	1.4
		2006	DHS	0.6
Central African Republic	4	2010	MICS	24.0
		2006	MICS	25.7
		2000	MICS	36.0
		1994-1995	DHS	43.4
Tanzania	3	2010	DHS	14.6
		2004-2005	DHS	14.6
		1996	DHS	17.7
Senegal	3	2014	DHS	24.7
		2010-2011	DHS	25.7
		2005	DHS	28.2
Sierra Leone	4	2013	DHS	89.6
		2010	MICS	88.0
		2008	DHS	91.3
		2005-2006	MICS	94.0
Somalia	1	2006	MICS	98.0
Sudan ^(e)	3	2014	MICS	86.6
		2000	MICS	90.0
		1989-1990	DHS	89.2
Chad	3	2010	MICS	44.2
		2004	DHS	44.9
		2000	MICS	44.9
Togo	3	2013-2014	DHS	4.7
		2010	MICS	4.0
		2006	MICS	5.8
Yemen	2	2013	DHS	18.5
		1997	DHS	22.6
TOTAL	89			

(a) Demographic and Health Surveys.

(b) Multiple Indicator Cluster Surveys.

(c) With the exception of Indonesia, where the 2013 survey was not a DHS- or MICS-type survey but a representative national survey of 300,000 households carried out on the initiative of the Ministry of Health (RISKESDAS).

(d) Prevalence for girls aged 0-11 years only (UNICEF, 2015).

(e) In Sudan, data on FGM were collected only in the north of the country (UNICEF, 2013).

Table A.2. Year of adoption of anti-FGM laws in the 30 countries with the highest prevalence of FGM

Country	Year
Guinea	1965
Central African Republic	1966
Ghana	1994
Djibouti	1995
Burkina Faso	1996
Côte d'Ivoire	1998
Tanzanie	1998
Togo	1998
Nigeria	1999
Senegal	1999
Kenya	2001
Yemen	2001
Benin	2003
Niger	2003
Chad	2003
Ethiopia	2004
Mauritania	2005
Eritrea	2007
Egypt	2008
Sudan	2008
Uganda	2010
Guinea-Bissau	2011
Iraq	2011
Somalia	2012
Sierra Leone	2015
Cameroon	(a)
Gambia	(a)
Indonesia	(a)
Liberia	(a)
Mali	(a)

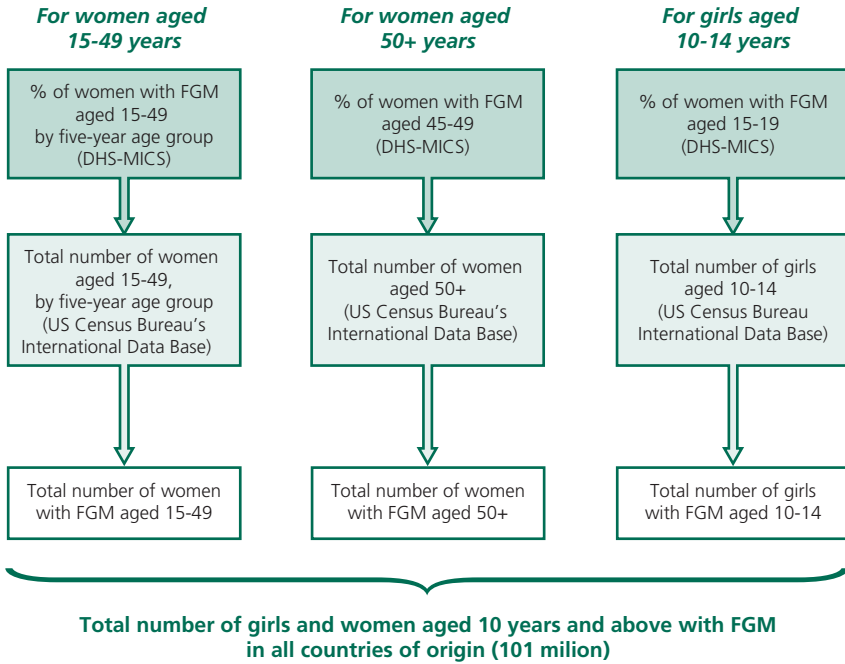
(a) No law has been passed.
Source: UNICEF, 2013.

Table A.3. The five categories for describing readiness for change

Reported behaviour (real or planned)	Reported opinion		
	Supports continuation of the practice	Undecided	Supports abandonment of the practice
Has or will have daughter (s) cut	Willing adherent		Reluctant adherent
Not sure whether she will have daughter (s) cut		Contemplative	
Will not have daughter (s) cut	Reluctant abandoner		Willing abandoner

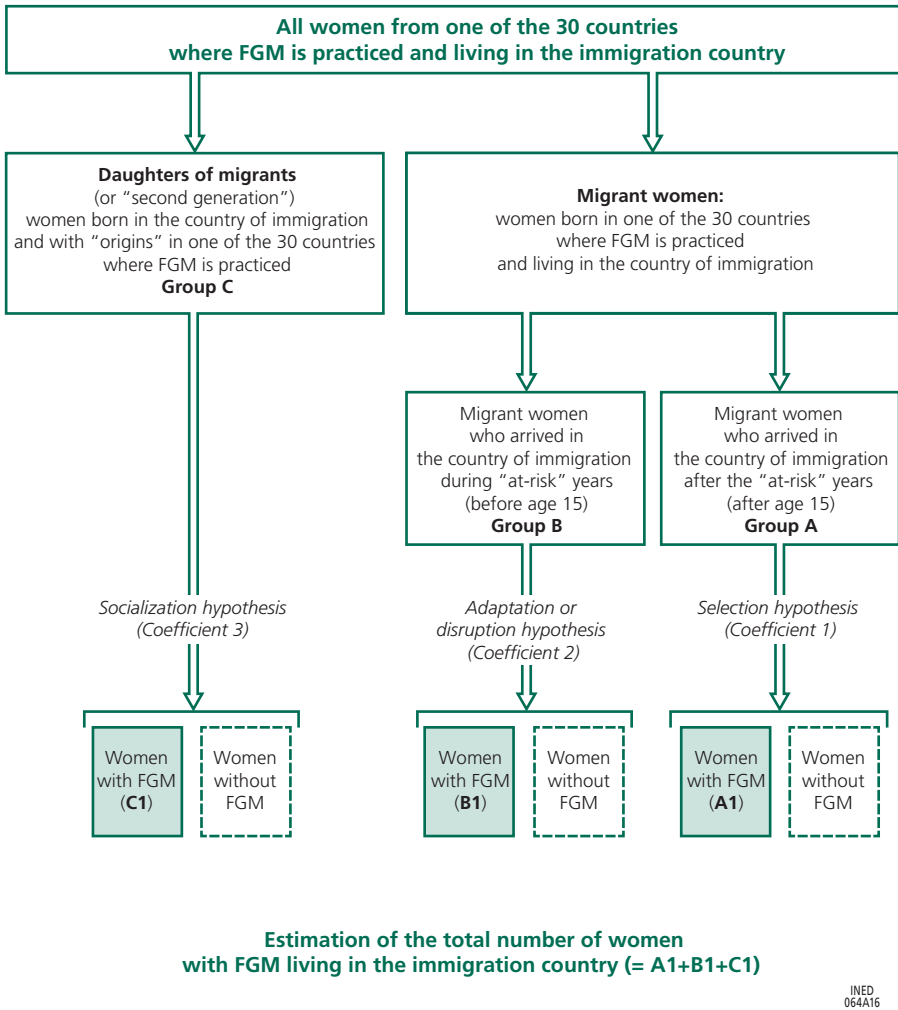
Source: Shell-Duncan and Hernlund (2006).

Figure A.1. Method for estimating the number of women and girls with FGM (aged 10 years and over) on the basis of data from the DHS/MICS surveys



Source: Yoder et al., 2013.

Figure A.2. Method for estimating the number of women with FGM in countries of immigration using the indirect method



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Armelle ANDRO, Marie LESCLINGAND • FEMALE GENITAL MUTILATION. OVERVIEW AND CURRENT KNOWLEDGE

Female genital mutilation (FGM), which is any form of non-therapeutic intervention leading to the ablation or alteration of the female genital organs, has adverse health consequences. According to UNICEF, in 2016, more than 200 million women in the world have undergone FGM. This article examines the prevalence of FGM and its variation over time in the different regions of the world, and presents current knowledge of the determinants of the practice and its effects on health and sexuality. Recent public health studies have demonstrated the scale and diversity of the consequences of FGM, and specific medical services have been developed for the women concerned. Available data show that while FGM is well studied in Africa, it remains poorly documented in certain regions of the world. This is notably the case in countries where the practice is clandestine, and in those with immigrant populations from countries where women undergo FGM.

Armelle ANDRO, Marie LESCLINGAND • LES MUTILATIONS GÉNITALES FÉMININES. ÉTAT DES LIEUX ET DES CONNAISSANCES

Les mutilations génitales féminines (MGF), qui désignent toutes les formes d'interventions non thérapeutiques aboutissant à une ablation ou une altération des organes génitaux féminins, ont des conséquences délétères sur la santé. En 2016, elles concernent plus de 200 millions de femmes et filles dans le monde selon l'Unicef. Cet article fait le point sur l'état des connaissances récentes en matière de prévalence de ces pratiques et sur l'état de la recherche concernant leurs déterminants, leurs conséquences et les enjeux à venir pour favoriser leur éradication. Les chiffres disponibles montrent que si les MGF sont bien étudiées sur le continent africain, elles restent mal connues dans certaines régions où elles sont encore des pratiques cachées et dans des pays où elles sont liées à la mobilité internationale. La typologie des MGF élaborée par l'OMS a permis de recenser et d'objectiver les formes et les conséquences médicales de ces pratiques. Les déterminants de leur perpétuation ou de leur l'abandon varient selon les régions concernées, et les évolutions restent lentes même si elles sont avérées. Les études menées récemment en santé publique ont montré l'ampleur et la diversité des séquelles liées à ces pratiques et elles ont permis le développement de dispositifs de prise en charge médicale des MGF.

Armelle ANDRO, Marie LESCLINGAND • LAS MUTILACIONES GENITALES FEMENINAS. ESTADO DE LA CUESTIÓN Y DE LOS CONOCIMIENTOS

Las mutilaciones genitales femeninas (MGF), que designan todas las formas de intervención no terapéuticas que conducen a una ablación o una alteración de los órganos genitales femeninos, tienen consecuencias perniciosas para la salud. Según la Unicef, en 2016 este tipo de mutilaciones concernían más de 200 millones de mujeres y niñas. Este artículo recapitula la prevalencia de dichas prácticas y su evolución en diferentes regiones del mundo, y da cuenta de las investigaciones sobre sus determinantes y consecuencias médicas y sexuales. Los estudios recientes de salud pública han mostrado la importancia y la variedad de las secuelas ligadas a estas prácticas y han permitido el desarrollo de dispositivos para la atención y el tratamiento médicos de las MGF. Las cifras disponibles muestran que si las MGF están bien estudiadas en el continente africano, son poco conocidas en ciertas regiones donde estas mutilaciones son clandestinas y en países con una migración internacional proveniente de los países expuestos a las MGF.

Keywords: Female genital mutilation, female genital cutting, gender, violence, sexuality, health, prevalence, demographic survey.

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