6-1-2018

# A Reference Guide: Six Practical Tips for Understanding Data on Female Genital Mutilation/Cutting (FGM/C)

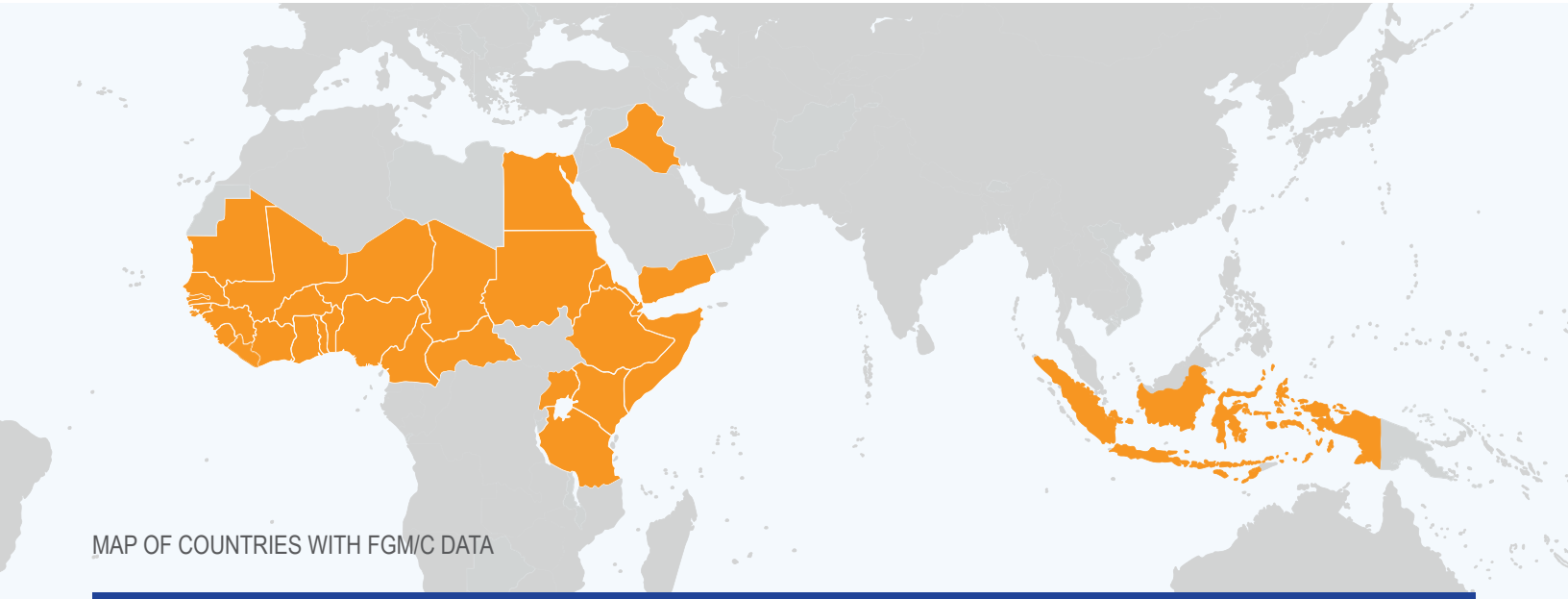
Charlotte Greenbaum

Reshma Naik

# A REFERENCE GUIDE

Six Practical Tips for Understanding Data on Female Genital Mutilation/Cutting

Evidence to End FGM/C
Research to Help Girls and Women Thrive



MAP OF COUNTRIES WITH FGM/C DATA

This reference guide provides practical tips for understanding survey data on female genital mutilation/cutting (FGM/C). Up-to-date data, correctly interpreted, are critical to ending this harmful practice. Whether you are a researcher, advocate, program manager, or policymaker, you must know where the data come from, what the data tell you, and how to draw appropriate implications and conclusions.

## 1 USE THE FGM/C MODULE REGULARLY

The Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Surveys (MICS)—the two main sources of nationally representative FGM/C data—include an FGM/C module with standardized questions for women and men. All countries with FGM/C should use the module every five years to monitor changes over time and compare data across countries to assess the effectiveness of campaigns or interventions and inform future actions.

## 2 ESTABLISH TRENDS THROUGH COMPARABLE DATA

When comparing data from two or more surveys over time, check that the survey location and interviewees are comparable. Common changes across surveys might include the addition or removal of certain regions or provinces; shifts in borders and boundaries; adjustments to sample sizes used in different subnational geographic areas; and changes in eligibility criteria for the sample. The following examples show how such changes can affect data comparability and interpretation:

- Before 2008, DHS surveys in Egypt sampled ever-married women ages 15 to 49, but in 2008, the DHS added never-married women ages 15 to 49 to the sample. The estimated decline of FGM/C prevalence (from 95.8 percent in 2005 to 91.1 percent in 2008) was due largely to the change in sample because FGM/C rates are lower among never-married women. Prevalence among ever-married women in 2008 was 95.2 percent, a decrease of only 0.6 percentage points from 2005.[1]
- Kenya's North Eastern Province was added to the DHS sample in 2003 and has been included in the 2008-09 and 2014 DHS. Direct comparisons of national FGM/C prevalence from years prior to and after 2003, therefore, would not be accurate. For an accurate comparison, the North Eastern Province would need to be excluded from the prevalence calculation from 2003 or later.[2]

## 3 BE REALISTIC ABOUT SELF-REPORTED DATA

Most data on the FGM/C status of girls or women rely on self-reported information, raising questions about its reliability. Some older studies in the Gambia, Tanzania, and Nigeria found varying degrees of disagreement between self-reported status and clinical examination, ranging from 3 percent to 20 percent.[3] Clinical examination of all girls and women in a nationally representative survey is not practical or ethical, and DHS and MICS professionals agree that women's self-reports are reliable enough to produce reasonable estimates of FGM/C prevalence.[4]

When interpreting self-reported data, consider timing and circumstances, as factors such as active campaigns or interventions, shifts in social norms, and FGM/C's legal status could influence participants' responses. For example, a longitudinal study in Ghana showed that exposure to anti-FGM/C campaigns and the passage of a law banning it may have influenced a sizeable proportion of adolescent girls who had reported undergoing FGM/C to later deny being cut.[5]

Self-reported information on the type and severity of FGM/C should be interpreted with caution. Studies show that women frequently underreport the severity of cutting.[6] Many factors could explain this: Girls and women may have undergone the procedure when they were young and may not be aware of the details of their own genital modification; they may lack a good reference point, since what they know of themselves or their peers may appear to be the norm; and they likely do not have a clear understanding of the official FGM/C classifications to accurately categorize their own procedures. Data on the FGM/C status of daughters reported by mothers may be somewhat more reliable but is subject to many of the same limitations.

## 4 RECOGNIZE THAT DATA ON DAUGHTERS HAVE CHANGED

When analyzing daughter data—information on the FGM/C status of daughters ages 0 to 14 given by their mothers—assess how the data were collected and which daughters were included in the sample. Prior to 1999, DHS surveys asked mothers about the FGM/C status of only the eldest daughter. Beginning in 1999, the DHS asked whether any daughter had undergone FGM/C. In 2010, the DHS and MICS FGM/C modules were standardized to ask mothers about the FGM/C status of all daughters under age 15. This change means daughter data is not comparable across these time periods. Data on the cutting status of the eldest daughter or any daughter can only be used to calculate the percent of women with at least one daughter cut. Only the newer, more complete data that includes the cutting status of all daughters allows for a calculation of FGM/C's overall prevalence among girls under age 15.

### UNDERSTAND THE DIFFERENCE BETWEEN CURRENT AND FINAL FGM/C STATUS

Another important consideration when interpreting daughter data is the difference between current and final status. Girls are presumed to have reached their final cutting status by age 15. Uncut girls younger than age 15 are still considered to be at risk, and thus their reported status may not be final. This is especially the case if they are within the typical age range for cutting in their communities. These cases are described as censored observations, meaning the girl's final cutting status is not yet known.

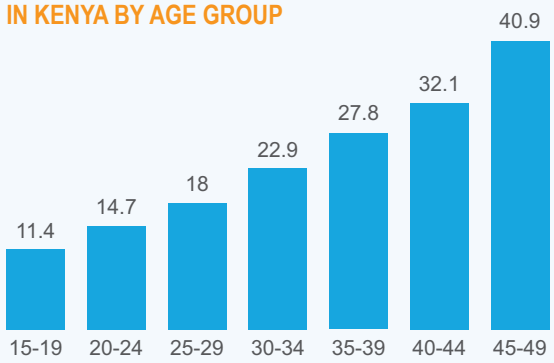
Because of censored cases, direct comparisons of FGM/C prevalence between girls within an at-risk age group and girls or women in an older age group whose cutting status is final are not possible. You can instead use this type of data to compare age-specific cutting rates. For example, compare current DHS data on the share of girls at a certain age who have been cut to the share of women ages 15 to 49 years who report being cut by that same age. In Ethiopia, around 30 percent of 11-year-old girls have been cut compared to about 50 percent of women ages 15 to 49 who report having been cut by age 11. Such analysis can identify shifts in norms around the practice.

## 5 ASSESS CHANGES IN FGM/C RATES OVER TIME BY COMPARING YOUNGEST AND OLDEST COHORTS

When using national DHS data, the best way to determine a change in a country's FGM/C rate over time is to compare the prevalence of the oldest age group (ages 45 to 49) to the youngest age group (ages 15 to 19) within a single survey. This comparison highlights the magnitude of change and provides a more accurate picture than comparing the overall prevalence of FGM/C among those ages 15 to 49 across different survey years. Many of the same women in this broader age range who were already cut (and whose status won't change) remain in the sample until they age out, and their rates of FGM/C may mask more recent changes among the youngest age group. For an even fuller picture of the timing and pace of change, compare prevalence across five-year age groups.

To illustrate, FGM/C prevalence among women ages 15 to 49 in the 2008-09 Kenya DHS was 27 percent, while in 2014 it was 21 percent. This decline appears to be relatively small. However, the extent of change is more notable when you examine the difference between the youngest and oldest cohorts in 2014: FGM/C prevalence among women ages 45 to 49 is nearly 41 percent, more than three times greater than the prevalence among women ages 15 to 19 (11 percent). Looking at the data this way shows that there has been a significant and recent decline in the practice.[7] The figure shows how expanding the analysis to look at each five-year age group reveals how change occurred steadily over time.

### PREVALENCE OF FGM/C IN KENYA BY AGE GROUP




Source: Kenya Demographic and Health Survey 2014.

Similarly, data from Egypt's 2015 Health Issues Survey shows that FGM/C prevalence is 27 percentage points lower among girls ages 15 to 19 (70 percent) than women ages 45 to 49 (97 percent), indicating a sizeable decline in the practice over time.[8]

## 6 UNDERSTAND HOW THE BEST ESTIMATES OF GIRLS AND WOMEN AFFECTED BY AND AT RISK OF FGM/C ARE DERIVED

The exact number of women and girls who have experienced FGM/C—within a country or globally—is unknown. However, reliable estimates from the 30 countries that collect data can be used to determine a global number. This calculation starts by multiplying the number of women ages 15 to 49 in each country by the FGM/C prevalence for that age group.[9] Nationally representative prevalence data for women and girls ages 15 to 49 exists for 29 countries. For girls ages 0 to 14 and women 50+, prevalence is estimated and then multiplied by each age group's respective population size. Prevalence data in Indonesia is only available for girls ages 0 to 11; this rate is applied to all age groups to estimate Indonesia's total of women and girls cut.

Finally, country-level totals are added together to estimate the global number of girls and women who have been cut. Following this process, the United Nations Children's Fund (UNICEF) estimates that at least 200 million girls and women have experienced FGM/C.[10] While this number is the best available, the exact number is likely higher, as FGM/C reportedly occurs in many countries where nationally representative data do not exist.

**200 MILLION**

Women and girls in 30 countries are estimated to have been cut.

### BECOME FAMILIAR WITH NEW PROJECTIONS OF GIRLS AT RISK OF BEING CUT

In 2018, the United Nations Population Fund (UNFPA) issued a new methodology for calculating the number of girls currently at risk for FGM/C and projecting those expected to be cut each year from 2015 to 2030. The new estimates consider a girl's probability of being cut at each age between 0 and 14—the time in life when she is most at risk of being cut. Using this methodology, an estimated 68 million girls from 25 countries will be cut between 2015 and 2030. The number of girls cut per year increases from an estimated 3.9 million in 2015 to a projected 4.6 million in 2030.[11] Since FGM/C prevalence is kept constant in this analysis, UNFPA's estimation method will be most accurate if FGM/C rates remain steady over time. If rates decline, the method will overestimate the actual number of girls at risk; if rates increase, it will underestimate the number.

**68 MILLION**

Girls in 25 countries around the world may be cut between 2015 and 2030.

### CONSIDER FGM/C IN IMMIGRANT COMMUNITIES

FGM/C occurs among immigrant communities in the United States and elsewhere. To estimate FGM/C prevalence among these communities, prevalence from the home country is multiplied by the population size of the immigrant community in the host country. Such estimation has limitations, since migrants likely come from more urban, educated, and higher socioeconomic backgrounds, and may not be representative of their countries of origin.[12] Further, assimilation or other factors may influence immigrants' decisionmaking around cultural practices like FGM/C. Regardless, these estimates can still provide a sense of how many women and girls may be at risk of FGM/C in host countries. The U.S. Centers for Disease Control and Prevention (CDC) applied country-specific FGM/C prevalence rates for girls ages 15 to 19 to the number of girls from FGM/C-practicing countries under age 18 in the United States in 2012. They found that 169,000 U.S. girls may be at risk of undergoing FGM/C. The CDC also applied country and age-specific prevalence rates to the number of women ages 18+ who come from FGM/C-practicing countries and estimated that 344,000 U.S. women are living with FGM/C.[13]

This publication is based on the technical brief, *Considerations on the Use and Interpretation of Survey Data on FGM/C*, by Bettina Shell-Duncan (Population Council 2016), and includes new data from the UNFPA's "Bending the Curve: FGM Trends We Aim to Change" (2018).


## ACKNOWLEDGMENTS

This publication was prepared by Charlotte Greenbaum and Reshma Naik of Population Reference Bureau (PRB). Bettina Shell-Duncan, Jacinta Muteshi, Caroline Kabiru, and Charlotte Feldman-Jacobs provided technical review, and Heidi Worley and Nancy Matuszak contributed editorial feedback.


## REFERENCES


[1] Fatma El-Zanaty and Ann Way, Egypt Demographic and Health Survey 2005 (Cairo, Egypt: Ministry of Health and Population, National Population Council, El-Zanaty and Associates, and ORC Macro, 2006); and El-Zanaty and Way, Egypt Demographic and Health Survey 2008 (Cairo, Egypt: Ministry of Health and Population, El-Zanaty and Associates, and Macro International, 2009).

[2] Central Bureau of Statistics (CBS) [Kenya], Ministry of Health (MOH) [Kenya], and ORC Macro, Kenya Demographic and Health Survey 2003 (Calverton, MD: CBS, MOH, and ORC Macro, 2004); Kenya National Bureau of Statistics (KNBS) and ICF Macro, Kenya Demographic and Health Survey 2008-09 (Calverton, MD: KNBS and ICF Macro, 2010); and KNBS and ICF International, Kenya Demographic and Health Survey 2014 (Rockville, MD: KNBS and ICF International, 2015).

[3] Joseph Ifeanyi Adinma, "Current Status of Female Circumcision Among Nigerian Igbos, *West African Journal of Medicine* 16, no. 4 (1997): 227-31; Sia E. Msuya et al., "Female Genital Cutting in Kilimanjaro, Tanzania: Changing Attitudes?" *Tropical Medicine and International Health* 7, no. 2 (2002): 159-65; Elise Klouman, Rachel Manongi, and Knut-Inge Klepp, "Self-Reported and Observed Female Genital Cutting in Rural Tanzania: Associated Demographic Factors, HIV, and Sexually Transmitted Infections," *Tropical Medicine and International Health* 10, no. 1 (2005): 105-15; and Rachel C. Snow et al., "Female Genital Cutting in Southern Urban and Peri-Urban Nigeria: Self-Reported Validity, Social Determinants, and Secular Decline," *Tropical Medicine and International Health* 7, no. 1 (2002): 91-100.

[4] P. Stanley Yoder, Noureddine Abderrahim, and Arlinda Zhuzhani, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis* (Calverton, MD: ORC Macro, 2004).

[5] Elizabeth F. Jackson et al., "Inconsistent Reporting of Female Genital Cutting Status in Northern Ghana: Explanatory Factors and Analytical Consequences," *Studies in Family Planning* 34, no. 3 (2003): 200-210.

[6] Linda Morison et al., "The Long-Term Reproductive Health Consequences of Female Genital Cutting in Rural Gambia: A Community-Based Survey," *Tropical Medicine and International Health* 6, no. 8 (2001): 643-53; and Susan Elmusharaf, Nagla Elhadi, and Lars Almroth, "Reliability of Self-Reported Form of Female Genital Mutilation and WHO Classification: Cross-Sectional Study," *BMJ* 333, no. 7559 (2006): 124-28.

[7] KNBS and ICF Macro, Kenya Demographic and Health Survey 2008-09; KNBS and ICF International, Kenya Demographic and Health Survey 2014.

[8] Ministry of Health and Population [Egypt], El-Zanaty and Associates, and ICF International, *Egypt Health Issues Survey* 2015 (Cairo, Egypt, and Rockville, MD: Ministry of Health and Population and ICF International, 2015).

[9] The population of women by age group in a given country can be obtained from the U.S. Census Bureau's International Data Base.

[10] United Nations Children's Fund (UNICEF), *Female Genital Mutilation/Cutting: A Global Concern* (2015), accessed at www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf, on May 14, 2018.

[11] United Nations Population Fund (UNFPA), "Bending the Curve: FGM Trends We Aim to Change" (February 2018), accessed at www.unfpa.org/resources/bending-curve-fgm-trends-we-aim-change, on May 14, 2018.

[12] Livia Elisa Ortensi, Patrizia Farina, and Alessio Menonna, "Improving Estimates of the Prevalence of Female Genital Mutilation/Cutting Among Migrants in Western Countries," *Demographic Research* 32, no. 18 (2015), DOI 10.4054/DemRes.2015.4032.4018.

[13] Howard Goldberg et al., "Female Genital Mutilation/Cutting in the United States: Updated Estimates of Women and Girls at Risk, 2012," *Public Health Reports* 131, no. 2 (2016): 340-7.



UKaid from the British people

POPULATION COUNCIL Ideas. Evidence. Impact.

PRB INFORM EMPOWER ADVANCE