

TAILORING STEPS TO END FEMALE GENITAL MUTILATION BASED ON AGE



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INTRODUCTION

Female genital mutilation, or FGM,¹ is internationally recognized as a violation of human rights. The practice has multiple negative consequences in the lives of girls and women, including medical, psychological, emotional and social problems, and even loss of life. Girls and women subjected to female genital mutilation are also at risk of early/child marriage, dropping out of school, and reduced opportunities for growth, development and sustainable incomes. Different reasons for practicing female genital mutilation encompass sociological, cultural, religious and socioeconomic factors, as well as perceptions related to hygiene and aesthetics. Above all, however, female genital mutilation is a social norm arising from deeply entrenched gender inequality and the desire to control women's sexuality.

Although female genital mutilation has common features across different countries and communities, there are important differences. These must be recognized to develop a critical, in-depth understanding of the practice in different countries and even communities within the same country. Female genital mutilation not only takes different forms but also has different meanings and drivers, depending on the context. Mapping the drivers helps to reveal the variations and shed light on the multi-level interventions required to address them comprehensively.

After years of anti-female genital mutilation programming, it is time to recognize that a "one-size-fits-all" approach will not work to achieve the globally agreed vision to eliminate the practice. The local context and circumstances need to inform suitable and effective programmes, with interventions tailored to distinct needs and objectives at the district and even community levels.

The age at which girls undergo female genital mutilation is one of the specific characteristics that shape the context for the practice. This brief paper focuses on this issue.

¹ **Female genital 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" (World Health Organization [WHO] 2008).

WHY IS THE AGE AT WHICH FEMALE GENITAL MUTILATION OCCURS SO IMPORTANT?

The age at which female genital mutilation occurs is crucial for programmatic interventions given the decision-making structures behind the practice. When girls are going through the practice at a young age, they will not have any role in influencing decisions made at the family and community levels.

When female genital mutilation is performed on adolescent girls, they will/can react in a different manner because of their age and interactions with family members, peers, a school community and the community at large. A few elements that distinguish this age cohort include the following:

- ✓ Adolescent girls often face peer pressure (mockery and stigma) for not undergoing female genital mutilation, which puts them in a situation where they will accept the request from families to undergo the practice.
- ✓ On a positive note, some girls are strong enough to resist the pressure from families/peers and decide not to undergo the practice. They may even report cases to the local administration or legal authorities, or seek protection.
- ✓ There are anecdotal reports that adolescent girls themselves request female genital mutilation even if they (or their parents) do not support the practice. This goes to the extent of paying a fee to the circumcisers out of their pocket or performing the practice themselves (cutting each other) to avoid peer pressure and fit into the “social norm”.
- ✓ Some girls run away from their homes to avoid the practice.
- ✓ In certain cases, female genital mutilation is a rite of passage preparing girls for marriage, with important implications for the future of the girls.
- ✓ Because of their age, adolescent girls can be directly targeted for female genital mutilation interventions.

WHAT THE DATA TELL US

Female genital mutilation prevalence measured at the national level masks important variations across different contexts linked to age, ethnicity, religion, educational status and other factors. A national perspective alone does not provide sufficient information to target and design interventions. Effective programmes require disaggregated data and in-depth analysis of the specific context and drivers of female genital mutilation. The following analysis demonstrates an attempt to better understand age structure as one context-specific characteristic.

To derive an age-specific risk structure of female genital mutilation, we use survival analysis. This method is appropriate as we are working with data on girls and women aged 0 to 49. Young girls and adolescents who have not experienced female genital mutilation at the time of data collection are still at risk. Survival analysis takes this risk into account and produces reliable estimates. The level of risk at any given age is determined by the overall age structure of female genital mutilation in a particular country. In some countries, girls are most at risk right after birth or in their early years; in others, risk commences with early adolescence (see [Figure 1](#)).

Figure 1: Grouping of countries by the age at which female genital mutilation occurs

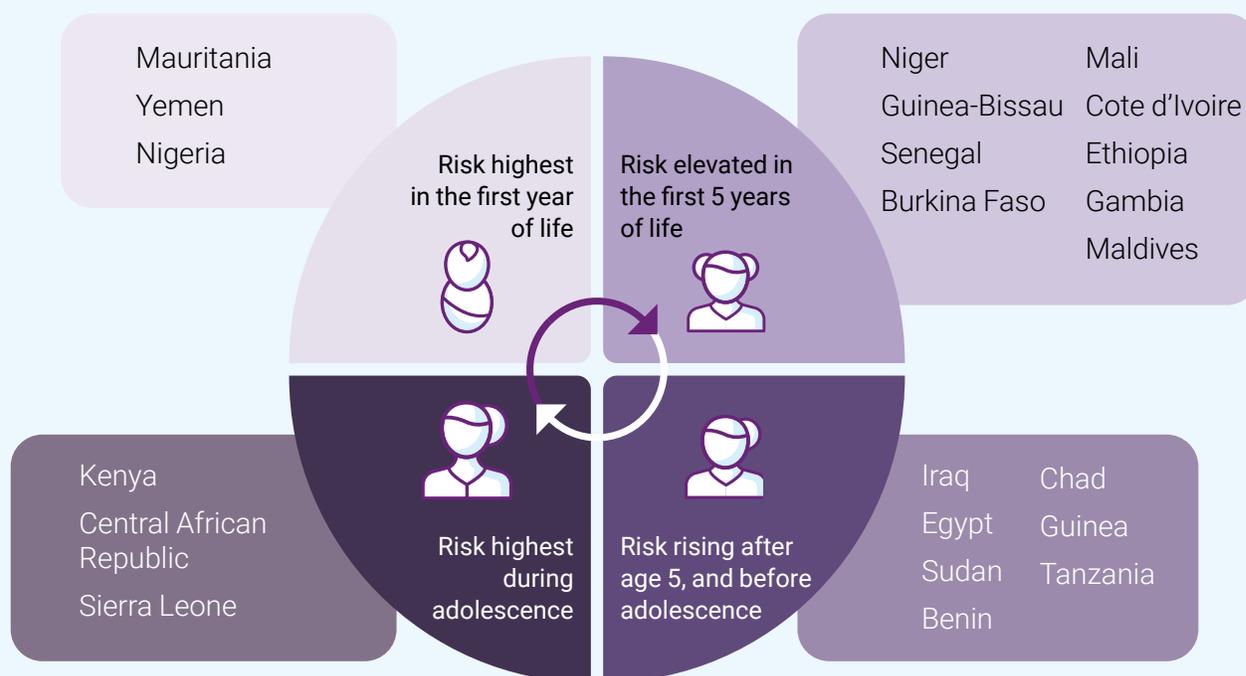
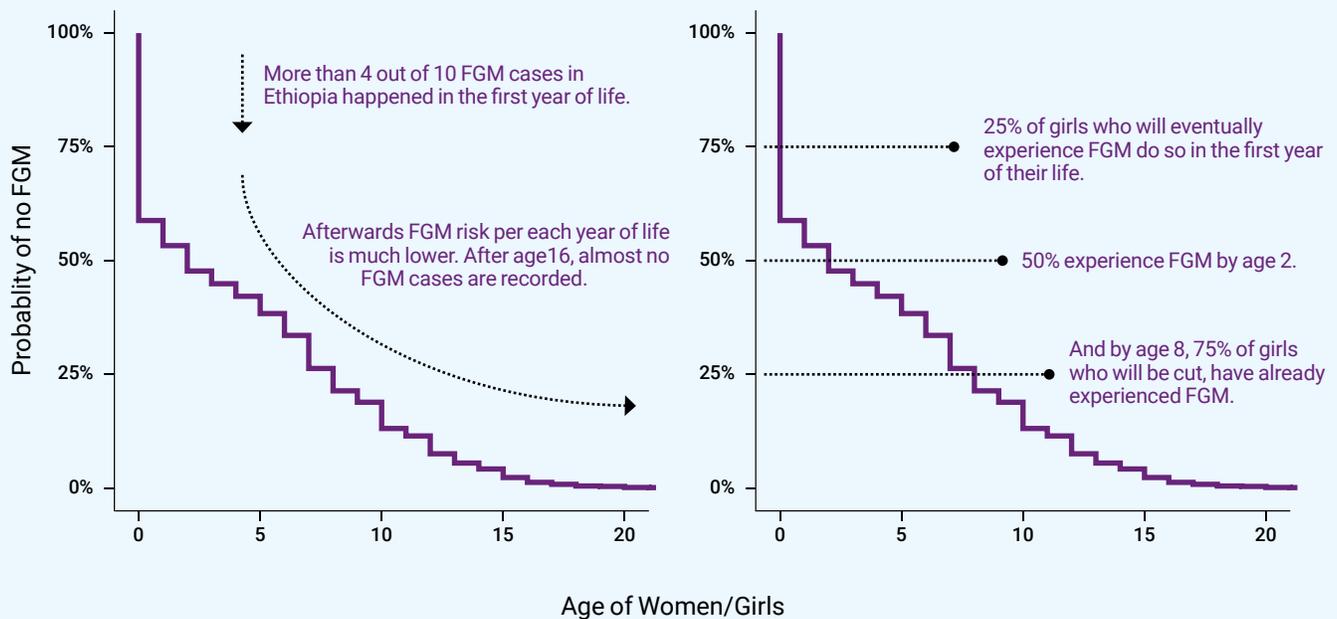


Figure 2 shows an analysis of the age structure of female genital mutilation using Ethiopia's Demographic and Health Survey (DHS) 2016. The left of the figure depicts all girls and women who have experienced female genital mutilation. The y-axis measures the proportion of girls who have not undergone the practice, and the x-axis indicates age. Each year, the purple line drops by the proportion of girls who experience female genital mutilation at a given age. The result is a step function.

Figure 2: Survival analysis with FGM – Ethiopia DHS2 2016

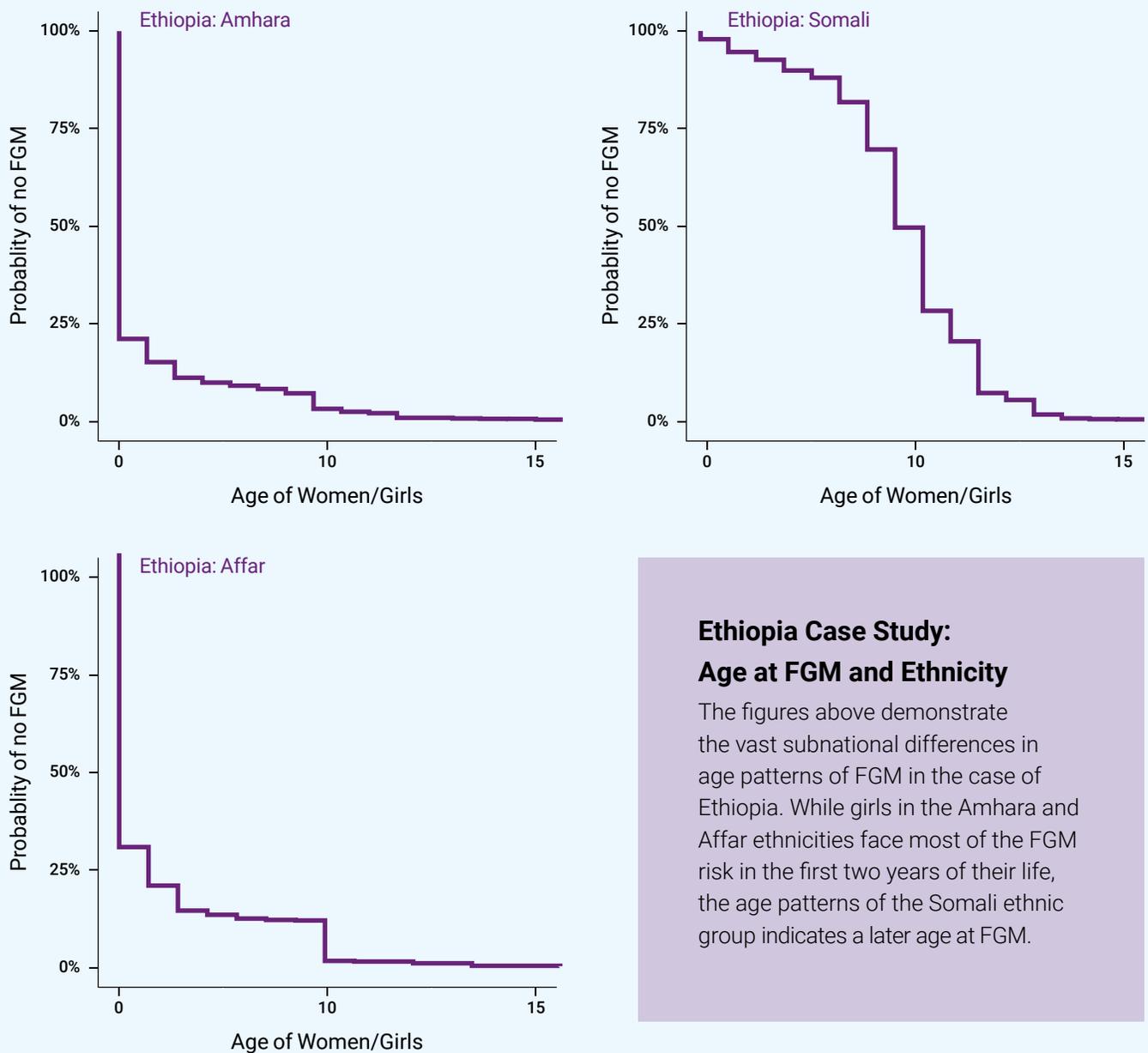


Source: 2016 Ethiopia Demographic and Health Survey.

WHAT THE DATA TELL US

Within Ethiopia, there are variations in the age structure of female genital mutilation depending on specific ethnicities. **Figure 3** illustrates different patterns among the Amhara, Somali and Affar ethnic groups in Ethiopia.

Figure 3: Subnational variations in the age-specific risk of FGM



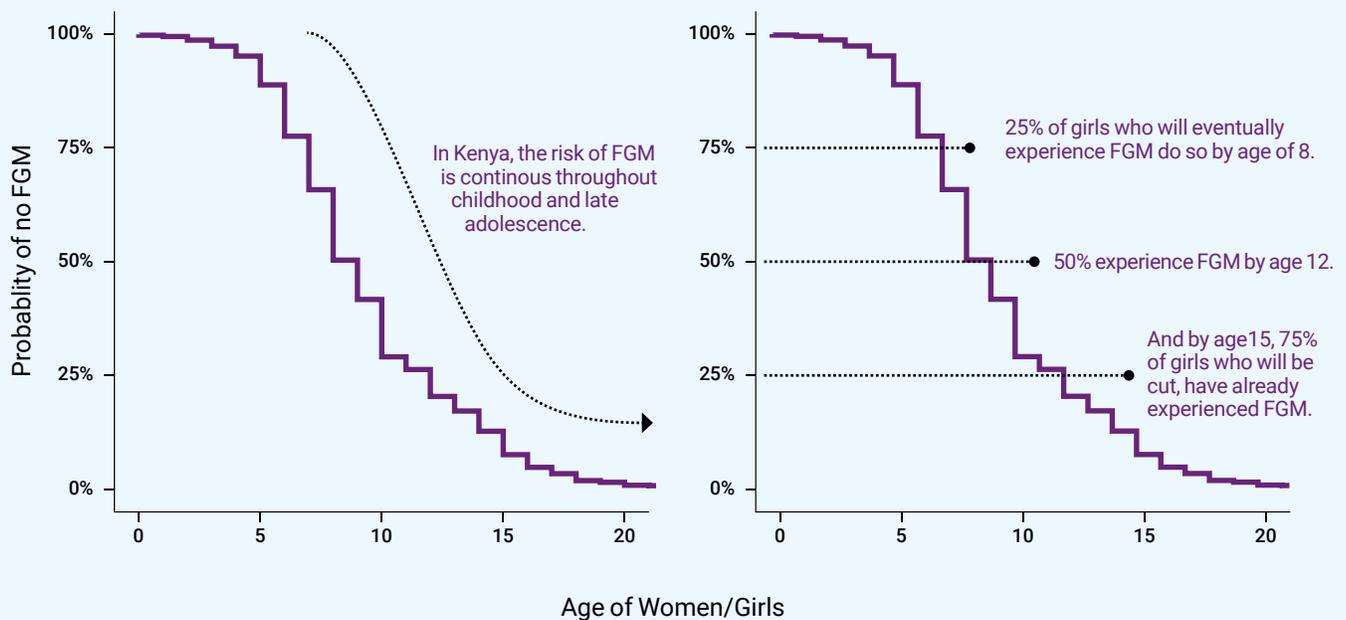
**Ethiopia Case Study:
Age at FGM and Ethnicity**

The figures above demonstrate the vast subnational differences in age patterns of FGM in the case of Ethiopia. While girls in the Amhara and Affar ethnicities face most of the FGM risk in the first two years of their life, the age patterns of the Somali ethnic group indicates a later age at FGM.

Source: 2016 Ethiopia Demographic and Health Survey.

Performing a similar analysis for Kenya shows a very different age structure of female genital mutilation. The risk in the first years of life is low. Women and girls are most at risk throughout their adolescence (Figure 4).

Figure 4: Survival analysis with FGM – Kenya



Source: 2014 Kenya Demographic and Health Survey.

We performed this type of analysis for all countries that collect data on female genital mutilation and the age at which it is performed in nationally representative household surveys. Figure 1 summarizes when the risk is highest for each country (refer to Annex for further details and for some data quality issues).

PROGRAMMATIC IMPLICATIONS

Programmes need to factor in the age of female genital mutilation as this has important implications for the measures to take and whom to target. Although community-level engagement should be considered in all contexts, interventions should speak to the localized drivers behind the practice. When girls go through female genital mutilation at a young age, interventions have to primarily target their parents/guardians, community leaders and community members. However, where female genital mutilation is performed on girls in their early adolescence or later, giving girls the information and means to stand up for themselves through empowerment measures and safe spaces can be highly effective in addition to taking steps to target parents and community members.

To elaborate potential sets of interventions based on the four categories introduced in [Figure 1](#).

Target groups iconography



Community



Girls



Health Services



Families



Education



General Population

Risk highest in the first year of life



- ✓ Mobilize communities by engaging **influential persons** (religious leaders, community elders and others based on the local context) and wider **community representatives**. Community network analysis needs to be conducted by community agents.

- ✓ Set up **community surveillance systems** to monitor a public commitment/declaration to abandon the practice of female genital mutilation. It can also serve as a link to health facilities and the justice system, monitor newborns to ensure they are uncut, and report cases of female genital mutilation for legal action.

- ✓ Identify and train female genital mutilation champions among **traditional birth attendants**.



- ✓ Target **women** accessing antenatal, delivery and postnatal care and immunization services (have minimum prevention strategies and culturally sensitive videos or dramas).

- ✓ Use **women's groups** for education, dialogue and support.

- ✓ Encourage **women** delivering at health facilities to sign a commitment card.



- ✓ Create a referral pathway between **health facilities** or **midwives** at community levels and **women's support groups** and **community-based organizations**.



- ✓ Engage **fathers** (whenever the opportunity exists).

- ✓ Engage **grandmothers**.



- ✓ Conduct **mass media** campaigns.

Risk elevated in the first 5 years of life



- ✓ Mobilize communities by engaging **influential persons** (religious leaders, community elders and others based on the local context) and wider **community representatives**. Community network analysis needs to be conducted by community agents.



- ✓ Target **mothers** during antenatal, delivery and postnatal care. Use **women's groups** for education, dialogue and support.
- ✓ Use women's groups for education, dialogue and support.



- ✓ Use **child survival programmes** (particularly immunization) for outreach.



- ✓ Create a referral pathway between **health facilities** or **midwives** at community levels and **women's support groups** and **community-based organizations**.



- ✓ Engage **fathers** (whenever the opportunity exists).
- ✓ Engage **grandmothers**.

Risk rising after age 5, and before adolescence



- ✓ **School** based interventions:
 - ✓ Design curricula for children and youth.
 - ✓ Use various events organized at school level.
 - ✓ Engage with parents associations.



- ✓ Mobilize communities by engaging **influential persons** (religious leaders, community elders and others based on the local context) and wider **community representatives**. Community network analysis needs to be conducted by community agents.



- ✓ Educate and engage **older siblings**.
- ✓ Engage **mothers** and **fathers**.

Risk highest during adolescence



- ✓ Girls' empowerment initiatives targeting both **in- and out-of-school girls** (clubs, peer group approach, life skills, alternative rites of passage programmes, etc.).
- ✓ Protection and service provision (to protect girls who stand up against the practice and/or run away from their homes).
 - ✓ Provision of shelters – sustainable protection mechanisms.
 - ✓ Facilitate access to justice.
 - ✓ Have helpline (for accessing information and reporting cases).
 - ✓ Creating safe spaces.



- ✓ **School** interventions (including integration of female genital mutilation topics into secondary school curriculum, establishment of guidance and counselling units in schools etc.).



- ✓ Mobilize communities by engaging **influential persons** (religious leaders, community elders and others based on the local context) and wider **community representatives**. Community network analysis needs to be conducted by community agents.



- ✓ Engage **mothers** and **fathers**.



- ✓ Establish **referrals pathways**.

RECOMMENDATIONS TO MOVE FORWARD

This brief analysis leads to the following recommendations for moving forward:

- ✓ **Standardized and nationally representative surveys and data on female genital mutilation need to:**
 - Generate evidence that is representative at lower geographic disaggregation, including the local level. Currently, the lowest disaggregation feasible with DHS and Multiple Indicator Cluster Survey (MICS) data is the regional level (administrative level 1), which is not granular enough for programmes critical to addressing the problem.
 - Include questions not only on whether or not female genital mutilation status, but also on the age at which it happened to allow incidence estimates.
 - Strong data analysis should take into account contextual variables, such as ethnicity, age when female genital mutilation occurs, etc., that shape and drive the practice and provide sufficient information to design effective programmes.
- ✓ Use cross-border and subnational data as well as data disaggregated by ethnicity for advocacy to create awareness and drive action accordingly.
- ✓ Ensure programme interventions reflect and are informed by the local context instead of adopting generic interventions that are not context-sensitive.
- ✓ Establish a monitoring system and operational research at community level that will encourage learning and adaptation of interventions as the FGM age structure changing.

ANNEX

DETAILED RESULTS FOR SELECTED COUNTRIES

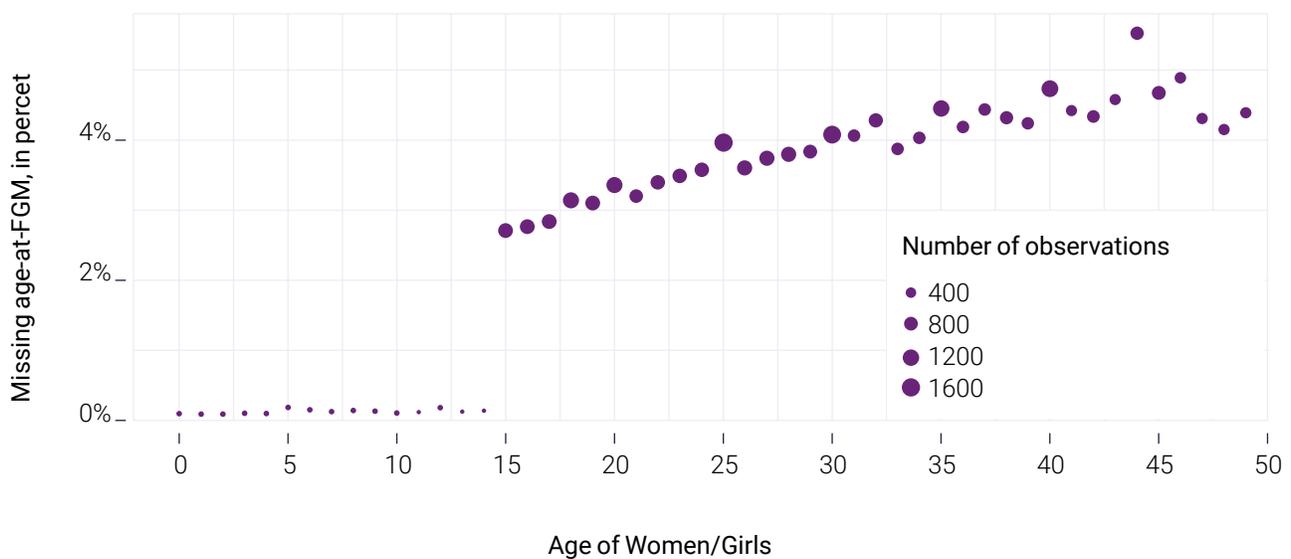
Age at which 25%, 50%, and 75% of women and girls have experienced FGM.

Country	25%	50%	75%	Description	Source	
Mauritania	0	0	0	Risk highest in the first year of life	MICS 2015	
Nigeria	0	0	0		MICS 2016-2017	
Yemen	0	0	0		DHS 2013	
Maldives	0	0	2	Risk elevated in the first 5 years of life	DHS 2016-2017	
Niger	0	2	4		DHS 2012	
Senegal	0	2	4		DHS 2017	
Mali	0	2	5		DHS 2015	
Ethiopia	0	2	8		DHS 2016	
Gambia	1	3	6		DHS 2013	
Guinea-Bissau	2	3	5		MICS 2014	
Burkina Faso	3	5	6		DHS 2010	
Côte d'Ivoire	3	5	8		MICS 2016	
Iraq	4	5	7		Risk rising after age 5 but before adolescence	MICS 2018
Tanzania	5	8	13			DHS 2015-2016
Sudan	5	7	8	MICS 2014		
Chad	6	8	10	DHS 2014-2015		
Guinea	5	7	10	DHS 2016		
Egypt	9	10	11	DHS 2015		
Benin	8	10	12	DHS 2011-2012		
Kenya	8	11	14	Risk highest during adolescence	DHS 2014	
Central African Republic	10	11	13		MICS 2010	
Sierra Leone	10	12	15		MICS 2017	
Togo	5	8	12	Continuous risk	DHS 2013-2014	
Ghana	4	9	12		MICS 2011	

DATA QUALITY ISSUES

Our analysis relies on micro datasets collected through DHS and MICS surveys, which are subject to a number of data availability and quality constraints. The age at which female genital mutilation occurs, for example, is self-reported by women aged 15 to 49, and reported by mothers for their daughters aged 0 to 14. Consequently, the data suffer from recall bias. Women often do not remember when they experienced the practice. This issue is more problematic the older a woman is (see [Figure 5](#)).

Figure 5: Missing information on the age at which FGM occurred, by age.



Source: Based on 66 surveys with age at FGM data.

This figure demonstrates that with increasing age, the percentage of missing information on age at FGM increases. It also depicts differences in data quality between self-reported information (age 15-49) and proxy reporting (age 0-14).



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United Nations Population Fund
605 Third Avenue
New York, NY 10158
1-212-297-5000

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