

Female Genital Mutilation: Slow Progress?

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INTRODUCTION

This paper gives an overview of Female Genital Mutilation (FGM) prevalence rates [1], following impressive research by Koski and Heyman [2]. Rawat [3], Shell-Duncan and Hernlund [4] and Simister [5] claimed estimates of FGM prevalence “are tentative, since nationally representative data do not exist for many countries”. UNICEF [6] wrote “Together, DHS and MICS allow a comprehensive picture to be constructed of the current global prevalence rates among women and daughters. They provide valid data on the occurrence of FGM/C practice”. Yoder and Wang [7] wrote “National level prevalence data on FGC from population-based surveys are now available for 27 countries in Africa as well as Yemen and Iraq”. Koski and Heyman [2] analyzed DHS data from 22 countries; this paper adds Guyana and Sudan, using all DHS FGM data available in October 2018 (DHS restrict data access in some surveys: Eritrea, Ghana, Mauritania and Yemen).

FGM is associated with African cultures; there are many versions, practiced in different countries [4]. Each ethnic group which practices FGM does so in their own way: some groups impose FGM on babies or very young children, whereas other ethnic groups implement FGM when the girl/woman is a teenager or adult – usually before marriage [5]. FGM is typically carried out by women rather than men.

FGM is a “manifestation of structural inequality and violates universally recognized human-rights principles of equality and non-discrimination” [6]. “Used as a way to control women’s sexuality, FGM/C is a main manifestation of gender inequality and discrimination” [6]. FGM might be intended to limit women’s freedom (perhaps a woman is less likely to be unfaithful to her husband, if she finds sex less enjoyable due to clitoridectomy).

RESULTS

Table 1 reports FGM prevalence and number of women who answered FGM questions, for all DHS surveys with FGM data available to the public.

Shell-Duncan and Hernlund [4] claimed FGM is seen as “entrenched”, having been “practiced for thousands of years in parts of Africa”. “Despite global prevention programs and laws operating for several decades and some hopeful signs of abandonment, one in eight or nine girls from practicing countries is currently at risk of being circumcised” [1]. For this paper, the author divides countries subjectively into countries where FGM prevalence fell (**Chart 1**) and countries not improving (**Chart 2**).

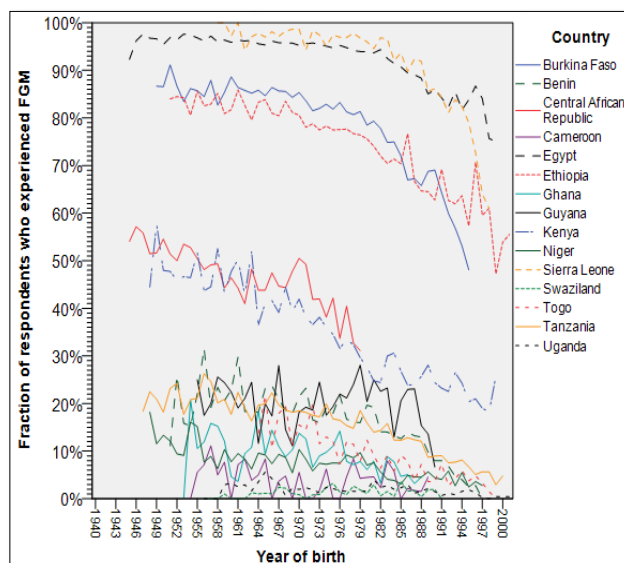


Chart 1. FGM prevalence among countries making progress.

Source: Author’s analysis of DHS survey data

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Table 1. DHS surveys with FGM prevalence data.

Country	Year	FGM prevalence	Sample-size
Burkina Faso	1998	84%	5,606
	2003	77%	12,049
	2010	76%	17,031
Benin	2001	17%	6,214
	2006	21%	11,877
	2011	12%	11,212
Central African Republic	1994	44%	5,877
Cote D'Ivoire	1998	45%	2,883
	2005	49%	5,165
	2011	44%	9,441
Cameroon	2004	4%	1,662
Egypt	1995	95%	14,768
	2000	96%	15,572
	2003	97%	9,142
	2005	96%	19,465
	2008	94%	16,523
	2014	90%	21,754
Ethiopia	2000	78%	15,367
	2005	74%	13,628
	2016	70%	7,163
Ghana	2003	9%	5,681
Gambia	2013	74%	10,127
Guinea	1999	99%	6,741
	2005	97%	7,944
	2012	98%	9,130
Guyana	2005	20%	1,867
Kenya	1998	35%	7,873
	2003	33%	8,174
	2008	32%	8,038
	2014	31%	14,289
Mali	1995	86%	9,704
	2001	91%	12,440
	2006	89%	13,251

	2012	93%	10,240
Niger	1998	14%	2,424
	2006	5%	3,803
	2012	4%	4,993
Nigeria	1999	47%	9,810
	2003	23%	7,321
	2008	46%	18,487
	2013	39%	24,473
Sudan	1989	89%	5,855
Sierra Leone	2008	91%	7,279
	2013	90%	16,614
Senegal	2005	38%	13,732
	2010	40%	14,228
	2012	37%	7,744
	2015	40%	15,717
Swaziland	2006	1%	4,978
Chad	2004	57%	5,402
	2014	49%	9,130
Togo	2013	9%	7,018
Tanzania	1996	17%	8,117
	2004	19%	7,866
	2010	16%	8,504
	2015	10%	11,200
Uganda	2006	2%	2,809
	2011	3%	4,918
	2016	1%	10,247
Yemen	2013	23%	31,784

Source: DHS data (author's analysis)

Chart 1 shows FGM prevalence falling in 15 countries; but **Chart 2** shows less change – each line is approximately horizontal. UNICEF [6] reports “Governments have sometimes been reluctant to address FGM/C”; but many countries where it occurs passed legislation against FGM. Current laws seem insufficient: “Community norms are often seen to be more important than the legal restrictions or laws against FGM, thus stalling the progress of the various national and international agencies working to improve women and girls’ health and rights” [3].

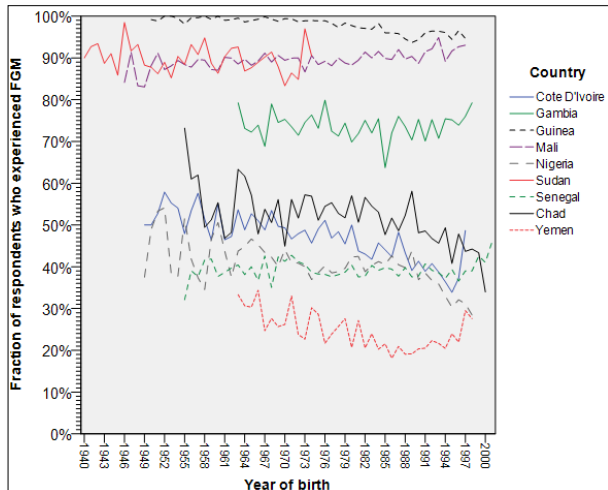


Chart 2. FGM prevalence among countries not making progress.

Source: Author's analysis of DHS survey data

CONCLUSION

UNICEF, UNFPA and WHO released a joint statement in 1997, intended to bring about substantial decline in FGM in 10 years and end FGM within 3 generations. Koski and Heyman [2] report "Slow progress is being made toward reducing the prevalence of FGM but the practice remains nearly universal in some countries"; this paper confirms their findings. This paper divides countries into two groups: **Chart 1** countries made progress, whereas **Chart 2** countries apparently made little or no improvement. Many activists and campaigners work to eliminate FGM in their community; this paper may encourage them. There is a lot more work to be done.

REFERENCES

1. Costello S (2015) Female genital mutilation/cutting: Risk management and strategies for social workers and health care professionals. *Risk Manag Healthc Policy* 8: 225-233.
2. Koski A, Heyman J (2017) Thirty-year trends in the prevalence and severity of female genital mutilation: A comparison of 22 countries. *BMJ Glob Health* 2: 1-8.
3. Rawat R (2017) The association between economic development, education and FGM in six selected African countries. *Afr J Midwifery Womens Health* 11: 137-146.
4. Shell-Duncan B, Hernlund Y (2000) *Female circumcision in Africa: Culture, controversy and change*. USA: Lynne Rienner.
5. Simister J (2018) Impact of age on harm risks of female genital mutilation: Analysis of demographic and health surveys. *MOJ Womens Health* 7: 31-40.

6. UNICEF (2005) *Female genital mutilation/cutting: A statistical exploration*. Available at: https://www.unicef.org/publications/files/FGM-C_final_10_October.pdf
7. Yoder PS, Wang S (2013) *Female genital cutting: The interpretation of recent DHS data*. DHS Comparative Report 33. Calverton, Maryland, USA: ICF International. Available at: <https://www.dhsprogram.com/pubs/pdf/CR33/CR33.pdf>