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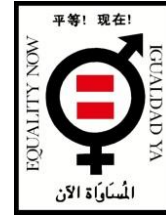
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**Female Genital Mutilation in England and Wales:
Updated statistical estimates of the numbers of affected women living
in England and Wales and girls at risk
Interim report on provisional estimates**

Alison Macfarlane BA Dip Stat C Stat FFPH
Professor of Perinatal Health, City University London

Efua Dorkenoo BSc MSc RGN RSCN OBE
Programme Director, End FGM/C Social Change Campaign
Senior Advisor, Equality Now
Honorary Visiting Senior Fellow, City University London

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Executive summary

Background

This report contains provisional estimates of the numbers of women with female genital mutilation (FGM) living in England and Wales, the numbers of women with FGM giving birth and the numbers of girls born to women with FGM. These are headline figures for England and Wales as a whole. Further work is under way to provide estimates at a local authority level and to refine these national analyses. These will be published later in the full project report.

Sources of data

To derive these estimates, data about the prevalence of FGM were derived from reports of household interview surveys in the countries in which it is practised. Demographic data about women born in these countries and girls born to them were derived from the 2011 census and from birth registration. In the census analysis, women who had been born in countries where FGM is practised, but were members of South Asian and other populations which do not practise FGM were, as far as possible excluded from the analyses. For analyses of birth data, it was not possible to do this directly, so multiplying factors derived from the census analyses were used to estimate the relevant numbers.

Migration to England and Wales from countries where FGM is practised

The overall numbers of women aged 15-49, who were permanently resident in England and Wales but born in FGM practising countries increased from 182,000 in 2001 to 283,000 in 2011. Numbers of women born in the countries in the Horn of Africa, where FGM is almost universal and where the most severe Type III form, infibulation, is commonly practised, increased by 34,000 from 22,000 in 2001 to 56,000 in 2011. The numbers of women from countries in East and West Africa, where FGM Types I and II, clitoridectomy with or without excision of the labia minora, are very common, also increased by 10,000 over the same period.

Estimated numbers of women and girls with FGM

An estimated 103,000 women aged 15-49 with FGM born in countries in which it is practised were living in England and Wales in 2011, compared with the estimated 66,000 in 2001. In addition there were an estimated 24,000 women aged 50 and over with FGM born in FGM practising countries and nearly 10,000 girls aged 0-14 born in FGM practising countries who have undergone or are likely to undergo FGM. Combining the figures for the three age groups, an estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011.

Over half of the women aged 15-49 with FGM, 53,000, were born in countries with almost universal Type III FGM, and a further 20,500 were born in countries with very high rates of Type I and II FGM. Women aged 50 and over with FGM are likely to continue to experience gynaecological and psychosomatic problems. These older women who have had FGM themselves are also likely to create pressure to continue the practice among their younger family members. Three fifths of these women were born in countries where FGM is almost universal.

Estimated numbers of women with FGM giving birth

It was estimated that, since 2008, women with FGM have made up about 1.5 per cent of all women delivering in England and Wales each year. About three fifths of them were born in the group of countries in the Horn of Africa where FGM is almost universal and Type III is commonly practised.

Girls born in England and Wales to mothers with FGM

From 1996 to 2010, 144,000 girls were born in England and Wales to mothers from FGM practising countries. It was estimated that 60,000 of these girls aged 0-14 in 2011 were born to mothers with

FGM. In both cases, well over half of the mothers came from the countries in the Horn of Africa where FGM is almost universal and Type III is practised and slightly under a fifth came from the countries in West and East Africa where Types I and II are highly prevalent.

Comments

These figures may be slight underestimates as they do not take account of migration since 2011. Further analytical work will incorporate this. It will also look at the extent to which the women who migrate, especially from countries with lower prevalences of FGM, are typical of their populations in general, or whether they may come from groups with lower or higher estimates of FGM. In addition, as there is some under-enumeration of Black African women in general in the Census compared with the population of England and Wales as a whole, there may be some under-enumeration of the sub-group of Black African women who migrated from countries where FGM is practised.

The size of these provisional figures underlines the urgent need for a robust plan for services to support women who have undergone FGM and to safeguard their daughters from undergoing it.

1 Background

The term female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.¹ The World Health Organisation (WHO) has classified FGM into the types shown in Table 1.

Table 1 WHO Classification of FGM by Type¹

Type	Description
I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). Type Ia , removal of the clitoral hood or prepuce only Type Ib , removal of the clitoris with the prepuce.
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Type IIa , removal of the labia minora only; Type IIb , partial or total removal of the clitoris and the labia minora; Type IIc , partial or total removal of the clitoris, the labia minora and the labia majora.
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). Type IIIa : removal and apposition of the labia minora; Type IIIb : removal and apposition of the labia majora.
IV	Unclassified: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterisation.

UNICEF has estimated that more than 125 million girls and women globally have undergone FGM and that 3 million girls in Africa are at risk each year.² FGM has been documented in 28 countries in Africa, Prevalence rates vary significantly between countries, as Table 2 shows. In Somalia, Guinea, Djibouti and Egypt, for example, more than 90 per cent of the female population aged 15-49, whereas in Cameroon and Uganda, this has happened to fewer than two per cent.² There are also differences in the types of FGM practised. In this report, countries have been grouped into the categories shown in Table 3.

The extent of FGM can also vary widely between regions of the same country. Differences between regions with the highest and lowest rate are shown in Figure 1.

FGM is found in parts of the Middle East and Asia, although there are no data about its extent. It is also found amongst migrant communities worldwide. In Europe, It has been suggested that 500,000 women living in the EU have undergone FGM and 180,000 girls are at risk of undergoing FGM every year although it is unclear how this estimate was derived.³

Female genital mutilation is mostly carried out on girls between the ages of 0 and 15 years. In half of countries girls were cut before the age of five. Occasionally, adult and married women are also subjected to the procedure, for example re-infibulation following childbirth, or where a woman is forced to undergo the procedure by husband and his family after marriage. It is commonly

Table 2, National FGM/C prevalence data by age cohort for the most recent DHS / MICS survey by country

Country	Source	Year	Age of women							Overall	Group
			15-19	20-24	25-29	30-34	35-39	40-44	45-49		
Djibouti	MICS	2006	89.5	93.7	93.3	95.9	94.7	93.1	94.4	93.1	1.1
Eritrea	DHS	2002	78.4	87.9	90.9	93.4	92.7	94.1	95.2	88.7	1.1
Somalia	MICS	2008	96.7	97.9	97.9	98.8	98.9	97.9	99.1	97.9	1.1
Sudan*	SHHS	2010	83.7	86.8	89.5	88.3	89.7	89.8	89.1	87.6	1.1
Burkina Faso	DHS	2010	57.7	69.8	77.5	82.8	85.2	88.2	89.3	75.8	1.2
Egypt	DHS	2008	80.7	87.4	94.3	95.2	96.4	96.2	96.0	91.1	1.2
Ethiopia	DHS	2005	62.1	73.0	77.6	78.0	81.2	81.6	80.8	74.3	1.2
Gambia, The	MICS	2010	77.1	76.8	77.5	74.7	73.2	75.3	79.0	76.4	1.2
Guinea	DHS	2005	89.3	94.6	96.6	97.4	98.6	98.1	99.5	95.6	1.2
Mali	MICS	2010	87.7	88.2	87.9	89.1	90.2	89.4	88.5	88.5	1.2
Sierra Leone	MICS	2010	79.8	86.9	92.2	93.2	95.8	95.3	96.4	88.3	1.2
Central African Republic	MICS	2010	17.9	22.1	24.5	25.5	28.4	29.9	33.8	24.2	2
Chad	MICS	2010	41.1	43.0	46.1	45.4	45.7	44.6	47.2	44.3	2
Guinea-Bissau	MICS/ RHS	2010	48.4	49.2	51.0	49.8	49.0	54.1	50.3	49.8	2
Iraq	MICS	2011	4.9	7.5	9.1	9.1	9.7	9.4	10.3	8.1	2
Ivory Coast	DHS	2012	31.3	35.1	36.8	40.3	45.4	44.6	46.9	38.2	2
Kenya	DHS	2008-09	14.6	21.1	25.3	30.0	35.1	39.8	48.8	27.1	2
Liberia**	DHS	2007	35.9	51.1	61.3	63.4	66.7	71.2	79	58.3	2
Mauritania	MICS	2011	65.9	66.2	67.4	71.3	72.0	76.2	75.2	69.4	2
Nigeria	MICS	2011	18.7	21.5	26.1	29.7	31.5	34.9	38.0	27.0	2
Senegal	DHS	2010-11	24.0	24.3	26.1	24.9	29.0	26.9	28.5	25.7	2
Yemen*	DHS	1997	19.3	22.2	21.3	22.9	23.6	25.1	25	22.6	2
Benin	DHS	2006	7.9	9.9	13.6	14.3	16.3	17.0	15.8	12.9	3
Cameroon	DHS	2004	0.4	2.5	1.6	1.1	1.2	1.8	2.4	1.4	3
Democratic Republic of the Congo			0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3
Ghana	MICS	2010/11	1.5	1.8	3.0	4.4	5.5	6.6	6.4	3.8	3
Niger	DHS	2006	1.9	1.6	2.4	2.1	2.9	2.9	2.8	2.2	3
Tanzania	DHS	2010	7.1	11.0	11.7	19.1	21.6	22.2	21.5	14.6	3
Togo	MICS	2010	1.0	2.4	3.6	4.6	6.3	5.2	6.5	3.8	3
Uganda	DHS	2011	1.0	0.8	1.9	2.1	1.3	1.7	1.9	1.4	3

*Sample consisted of ever-married women

** Women were asked if they had been initiated into a secret society.

Source: UNICEF and DHS

Table 3 FGM practising country groups

1.1	Almost universal FGM, over 30% FGM Type III	Sudan (north), Somalia, Eritrea, Djibouti
1.2	High national prevalence of FGM, WHO Type I and II	Egypt, Ethiopia, Mali, Burkina Faso, Gambia, Guinea, Sierra Leone
2	Moderate national prevalence of FGM, WHO Type I and II	Central African Republic, Chad, Cote D'Ivoire, Guinea Bissau, Iraq (Kurdistan), Kenya, Liberia, Mauritania, Nigeria, Senegal, Togo
3	Low national prevalence of FGM WHO, Type FGM I and II	Benin, Cameroon, Ghana, Niger, (Democratic Republic of Congo), United Republic of Tanzania, Togo, Uganda, Yemen

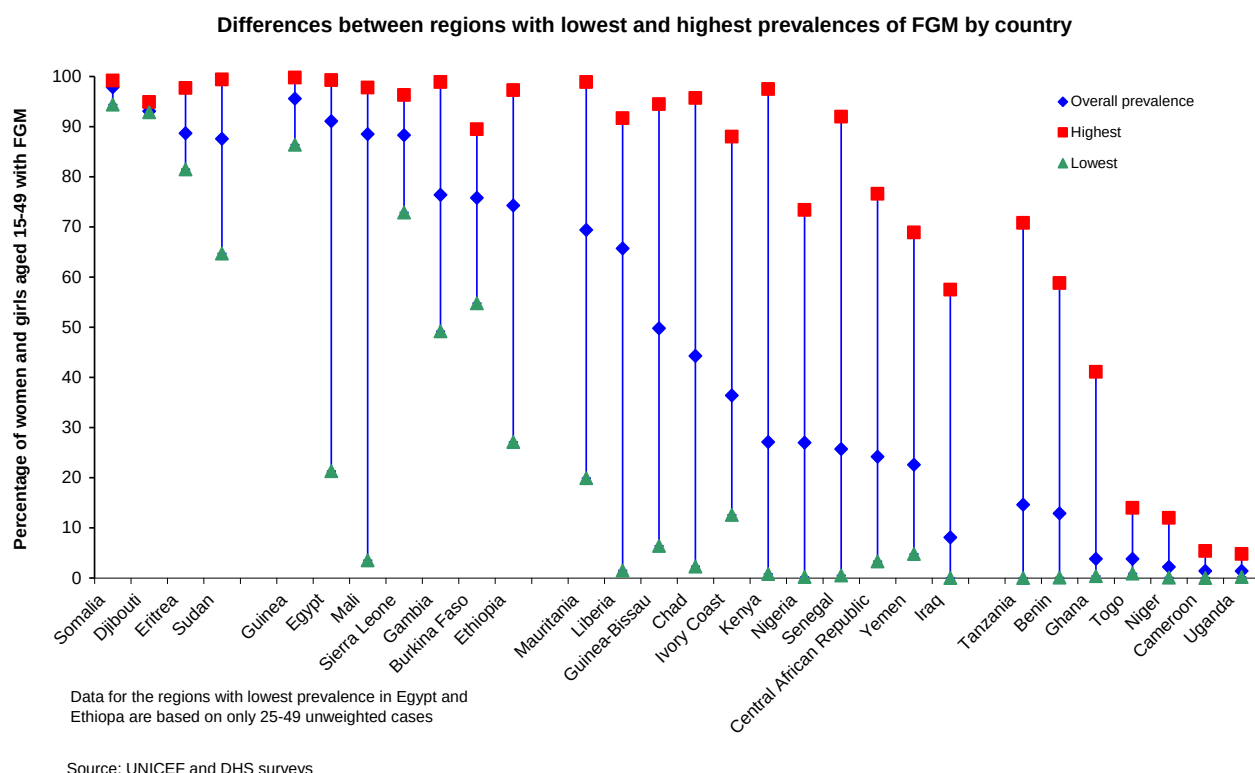
performed by traditional practitioners with no formal medical training, without anaesthetics using crude instruments such as knives, scissors, razor blades and in some instances shards of glass, although in some instances it is carried out by health professionals. Often the girl is pinned down by a number of adults. In other instances, girls are expected to bear the pain stoically by not moving or crying during the procedure.

FGM is practised by specific ethnic groups and the rationale for the practice differs from one group to the other. It is also constantly changing.

In some societies, the practice is embedded in coming-of-age rituals which are considered necessary for girls to become adult and responsible members of the society. It is believed to be a religious requirement by some Muslim populations who practise FGM although FGM is not mentioned in the Koran and most Muslims in the world do not know about FGM. Moreover, in communities where FGM is a social norm, it is practised by Muslims, Christians and followers of indigenous religions which suggest that the practice is more cultural than a religious practice.

A recurring theme for the justification of FGM in practising communities is to attenuate the sexual desire of females in order to conform to prescribed social norms relating to girls and women moral conduct. FGM is often linked to marriageability of girls and family “honour”. A common held belief in FGM practising communities is that girls and women who have not undergone FGM have insatiable sexual appetite which has to be restrained to prevent bringing dishonour and shame to families. Infibulation is the extreme caution taken by some groups to enforce virginity before marriage. In the Sudan where infibulation is near universal, the tight opening left following infibulation is believed to increase the sexual enjoyment of men. This is often an underlying motive behind repeat infibulation following each delivery. In a number of communities, young women who do not undergo FGM may face stigma, discrimination and threats from family and community members.

Figure 1



The practice is medically unnecessary and poses serious health risks to girls and women who undergo it both at the time when the mutilation occurs and in later life. The immediate health complications include severe pain, injury to adjacent organs, urine retention, shock, haemorrhage, infections sometimes leading to death. The long term health risks consist of chronic pain, infections, keloids formation and primary infertility. FGM increases the risks of obstetric complications such as prolonged labour, lacerations and obstetric hemorrhage.⁴ Women with FGM are more likely than women without FGM to experience pain during intercourse and have reduced sexual satisfaction as well as reduced sexual desire.⁵ The psychological trauma that girls go through during mutilation often stays with them for the rest of their lives. In the modern sector and amongst younger women, this may lead to post traumatic stress, feelings of incompleteness, confusion, betrayal and depression.^{6, 7}

FGM violates a number of human rights principles, including the principles of equality and non-discrimination on the basis of sex. It is considered as a form of violence against girls and women and a form of child abuse.⁸ It carries a strong message about the subordinate role of women and girls in society.⁹ Moreover, it perpetuates the perception that women may play only the roles of mother and spouse, reinforcing women's subordination in political, economic, social and cultural realms.⁹

Mainly due to migration, women who have experienced FGM are increasingly found in the United Kingdom. Little is known about the reasons why practising groups continue with FGM even when they have migrated to the UK. Some members from affected communities continue to support FGM, linking it to their cultural heritage and/or control of female sexuality.^{10, 11} The younger generation is most likely to be against FGM but may give in to pressures from their extended family. There is a call by some women in affected community for greater intervention by the state.¹⁰ Amongst groups who practise FGM Type III, increasing support for less severe forms of FGM is reported. Better knowledge about differences in attitudes and rationale in migrant communities is crucial for sharpening our approaches to prevention as well as monitoring trends in attitudes.

Under the Female Genital Mutilation Act 2003, it is a criminal offence for a United Kingdom national or a permanent United Kingdom resident to excise, infibulate or otherwise mutilate the whole or any part of a girl's labia minora or clitoris, whether in the United Kingdom or overseas but there has been no prosecution on the issue although there are currently two charges pending – a doctor and a husband of a victim waiting decision on court charges. The Government document, Multi-Agency Practice Guidelines: Female Genital Mutilation,⁸ suggests that many British girls living in minority ethnic communities in the United Kingdom are taken abroad to their family's country of origin during the school summer holidays to be subjected to FGM, but there are no data on their numbers.

2 Statement of the problem

2.1 Previous estimates of the prevalence of FGM in England and Wales

Previous research, published in 2007, estimated the prevalence of FGM in the population of women of childbearing age in England and Wales, the numbers of girls aged under 15 with or at risk of FGM and the prevalence of FGM among women giving birth in England and Wales from 2001 to 2004.¹² Estimates were not derived for Scotland or Northern Ireland, where well under 10 per cent of births in 2004 were to women born outside the UK.

Data from the 2001 census were used to estimate numbers of women aged 15-49 and numbers of girls aged under 15 who were born in FGM practising countries and resident in England and Wales in 2001.¹² Migration statistics were used to attempt to estimate numbers of women migrating from FGM practising countries to England and Wales each year from 2001 to 2004.

Data from birth registration were used to derive numbers of women from FGM practising countries giving birth in England and Wales each year from 2001 to 2004. Data from the same source were used to derive numbers of girls aged under 15 born in England and Wales from 1993 to 2004 to women from FGM practising countries

No data were available about the prevalence of FGM among women from FGM practising countries who migrated to England and Wales, or about the prevalence of FGM among their daughters born in England and Wales. In their absence, age specific country specific prevalence rates, derived from surveys in countries of origin, were used. Most of these came from the USAID Demographic and Health Surveys (DHS)¹³ or the UNICEF Multiple Indicator Cluster Surveys (MICS)¹⁴ implemented by national governments' health ministries with technical assistance from Macro International based in USA, UNICEF or other agencies. In the small numbers of countries where these were not available, estimates were derived from one-off research studies.

These proxy prevalence rates were applied to data about women living in England and Wales who were either enumerated in the 2001 census or were resident and gave birth in England and Wales. The only data items used from the census were the woman's age and her country of birth, as in some countries, notably those in which FGM was most extensively practised, prevalence rates were lower among younger women. Analyses of data from birth registration also used the babies' sex and the mother's local authority of residence. Migration data provided by ONS were very broad estimates of numbers of migrants from FGM practising countries.

Although a useful step forward, these estimates had known limitations. They could not include women who were born in countries other than their parents' countries of origin, or take account of the extent to which migrant women living in inner city areas may have been under-enumerated in the 2001 census. In addition, only countries of birth are recorded UK censuses, but in some countries, there are regional and social variations in FGM practices, as Figure 1 shows, and women who migrate may not be typical of the country as a whole. Finally, attitudes to FGM may change with migration.

This means that ideally, data on prevalence should be collected in the UK, but this is a challenging task as there are a number of barriers to collecting such data and which have to be overcome. The Department of Health has initiated data collection from women using health services in England, on a trial basis, but results are not yet available at the time of writing.

2.2 The need for new estimates of the prevalence of FGM

Much has changed since the original estimates of the prevalence of FGM in England and Wales were produced. More recent population data are available from the 2011 census and improvements have been made to national migration statistics. These have shown that since 2001, the numbers of women from some FGM practising countries, notably countries in the Horn of Africa and Nigeria, Ghana and other countries in West Africa living in England and Wales have increased considerably,¹⁶ as Table 4 shows. In addition, further surveys have been undertaken in the FGM practising countries in which women were born and have shown decreases in prevalence in some countries, although not in others, as can be seen in Appendix 1.

The estimates for England and Wales as a whole provided very little information about the origins of the women and hence the type of FGM they were likely to have undergone. There was no indication at all of this in estimates produced at local authority level. More detailed local authority level data are urgently needed for planning and commissioning of services, to inform maternity, gynaecological and psycho-sexual care provision and for targeted advocacy with affected communities.

In particular, the Local Government and Public Involvement in Health Act 2007 requires that all local authorities and local public health departments produce a Joint Strategic Needs Assessment (JSNA) of the health and wellbeing of the local community. Without data on FGM, these needs assessments will have no foundation on which to build a picture of the local need for FGM-related services and the funds needed to provide them.

Although the percentage of births to women born outside the United Kingdom has increased in Scotland and Northern Ireland, the rise has largely been in migrants from Eastern Europe and

numbers of women from FGM practising countries are small, especially in Northern Ireland. We understand that a study is under way in Scotland. As a consequence, as in the earlier project, we are restricting our scope to England and Wales.

Table 4 Comparison of numbers of women aged 15-49 born in FGM practising countries, England and Wales Censuses, 2001 and 2011

Country	Enumerated number of women aged 15-49, 2001	Enumerated number of women aged 15-49, 2011	Difference 2011 - 2001	Group
Djibouti	93	204	111	1.1
Eritrea	2,804	7,071	4,267	1.1
Somalia	15,744	43,558	27,814	1.1
Sudan	3,200	5,412	2,212	1.1
1.1	21,841	56,245	34,404	
Burkina Faso	33	81	48	1.2
Egypt	3,698	4,463	765	1.2
Ethiopia	3,421	6,930	3,509	1.2
Gambia	1,387	4,236	2,849	1.2
Guinea	101	911	810	1.2
Mali	41	140	99	1.2
Sierra Leone	6,625	8,903	2,278	1.2
1.2	15,306	25,664	10,358	
Central African Republic	163	75	-88	2
Chad	44	121	77	2
Guinea Bissau	155	970	815	2
Iraq	7,546	18,344	10,798	2
Ivory Coast	1,082	3,625	2,543	2
Kenya	45,396	31,740	-13,656	2
Liberia	555	1,234	679	2
Mauritania	13	64	51	2
Nigeria	33,485	68,727	35,242	2
Senegal	264	701	437	2
Yemen	1,092	5,062	3,970	2
2	89,795	130,663	40,868	
Benin	99	242	143	3
Cameroon	1,353	4,227	2,874	3
Democratic Republic of the Congo	1,199	8,783	7,584	3
Ghana	22,116	33,059	10,943	3
Niger	39	76	37	3
Tanzania	10,512	7,729	-2,783	3
Togo	174	586	412	3
Uganda	19,640	15,715	-3,925	3
3	55,132	70,417	15,285	
Africa - East (not otherwise stated)	3,626			
Africa - North (not otherwise stated)	276			
Africa - West (not otherwise stated)	896			
Africa (not otherwise stated)	4,232	4,028		
Total, ignoring not otherwise stated	182,074	282,989	100,915	

Source: ONS

3 Objectives

The objectives of this project are:

- (i) To use data from surveys in FGM practising countries and from other sources to derive updated proxy estimates of the prevalence of FGM among women born in the FGM practising countries and among their daughters.
- (ii) To apply these to data collected at birth registration in England and Wales to produce updated and more reliable estimates of:
 - a. Numbers of women with FGM living in England and Wales and in each local authority area giving birth each year from 2000 to 2011.
 - b. Numbers of daughters born to women born in FGM-practising countries resident in England and Wales and in each local authority area and numbers at risk of FGM.
- (iii) To produce updated and more reliable estimates of numbers of women born in FGM practising countries and numbers of women with FGM living in England and Wales as a whole and in each local authority area in 2011.
- (iv) To disseminate estimated numbers of women with FGM and girls at risk of FGM in their area to local authorities to enable them to produce guidance to support their community safety role in the reduction of FGM and also to other relevant organisations.

Contents of this interim report

This interim report contains provisional national estimates for England and Wales combined of

- a) Numbers of women and girls with FGM living in England and Wales in 2011
- b) Numbers of daughters born to women with FGM living in England and Wales

Further analyses of data at a national level along with estimates for local authority areas will be published later in the final report.

4 Study design

4.1 Countries of birth included

The estimates focus mainly on countries which are known to practise FGM and for which there are data for the country of origin. An addition to the list in 2011 is Iraq. FGM is practised in Kurdistan, which is split between Iraq, Iran, Syria and Turkey, but there are no data for Iran, Syria and Turkey. The Democratic Republic of the Congo was included in the previous study, with an assumed prevalence of 5 per cent, but it is now believed that this should be zero. FGM is also reported to be practised in parts of Indonesia and Malaysia, but no data are available about the extent.

4.2 Methods

4.2.1 Deriving updated proxy estimates of prevalence

The focus was particularly on countries which make a substantial contribution to numbers of women with FGM, either because their rates of prevalence are high or because their numbers are large, even though prevalence is lower, so they also make a major contribution to the numbers of women with FGM giving birth. In many of these countries, more recent surveys have been undertaken, so data from these have been used to update those in the earlier study and to examine

changes over time. Data were derived from Demographic and Health Surveys (DHS) undertaken by USAID¹³ and the UNICEF MICS¹⁴ surveys. Both sets of surveys are household interview surveys using a common design to collect data about population, health, HIV, and nutrition. In countries where this is relevant they have a sheet of questions which have been reviewed to analyse prevalence of FGM in women and their daughters, starting with data reported in UNICEF² and DHS¹⁵ summary reports and then going to the DHS and MICS web sites to look for any surveys which were not included.

UNICEF reports showed that in some countries, prevalence rates in both the women interviewed and their daughters differed by level of education, religion and socio-economic status.^{2,17} For countries in which more than one survey has been done, the data were compared to assess trends and variations in prevalence in relation to age, educational level, religion and socio-economic status.

This also drew on work already done by WHO, UNICEF and in recent literature reviews, notably those included in reports by the European Institute for Gender Equality to map the situation of FGM in the European Union and Croatia.¹⁸ and in a study of prevalence of FGM in the Netherlands, undertaken by PHAROS with the Erasmus University Medical Centre.¹⁹

Age-specific rates prevalence of FGM in countries of origin shown in Table 1 were extracted either from reports published by UNICEF² and DHS¹⁵ or directly from survey reports. These are the most recent published data for each country. Where there are earlier reports, they are shown in the full list in Appendix 1, which shows the extent of changes over time in countries with more than one survey.

These data along with data from Table 6 of the UNICEF report² which summarised the types of FGM practised in each country were used to group the countries as shown in Table 3. The groups were almost the same as in our previous report, with three exceptions. Previously overall prevalence in Togo had been estimated using data for 1993 from an unpublished report which suggested that it was 50 per cent, but an MICS survey undertaken in 2010 showed the prevalence to be under four per cent so it was moved from group 2 to group 3. Nigeria was moved from group 3 to group 2. Iraq was categorised as group 2 as, although prevalence was minimal in the country as a whole, it was high in Iraqi Kurdistan.

4.2.2 Estimates derived from census data

Analysis of the 2011 census was under way at the time the project was being planned and standard tables were being produced and published on the web site of the Office for National Statistics. Initially it was planned to request specially commissioned tables for this project, but after discussion with the Office for National Statistics, it was decided to request an extract of anonymised census records for people born in FGM practising countries and analyse them in the secure environment of the Office for National Statistics' Virtual Microdata Laboratory (VML). These data were used to derive estimates at a national and local authority level. The tabulations are being examined in the VML as only aggregated disclosure controlled data can be released, where numbers are small, in line with ONS' disclosure control policies.

The data items requested were sex, age in years, country of birth, ethnicity, local authority of residence, age on arrival in the UK, year of arrival in the UK, passport held, main language spoken, proficiency in English, religion, highest educational qualification, National Statistics Socio-economic Class, address one year ago, whether they were usually resident in the UK and size of household. The reason for choosing these additional variables was to see what information they yielded about the extent to which migrants to the UK differed from residents of their country of birth in general. Data were requested for people born in the countries of birth shown in Table 1.

Data were also requested for people born elsewhere but who had characteristics associated with FGM practising countries, including those who had passports from one of these countries or stated

that languages spoken in these countries were their first language. In addition to tabulations using standard tabulations by ethnic group, we also looked at a table giving data about ethnicities which respondents write into the 'other' boxes on the census form and identified ethnicities relevant to FGM. These were Somali, Possible mixed Somali, Somalilander, Nigerian, possible mixed Nigerian and Kurdish. Data were requested for anyone who described themselves as having any of these ethnicities. This information was used to attempt to assess the extent of second generation migrants with family origins in FGM practising countries.

In addition, a table produced by ONS for its own work on childbearing of UK and non-UK born women²⁰ giving total numbers of residents in England and Wales tabulated by country of birth, sex and five year age groups, was made available for use in the VML. This is the table structure used to produce the previous headline estimates of numbers of women aged 15-49 with FGM and the proxy estimates of prevalence and enabled us to make immediate comparisons with the corresponding table for 2001.

In our previous project, all that was available to us was a table in this format, so age specific prevalence rates for each country were multiplied by the total numbers of women born in that country. Although we were aware that migrants to the UK from some African countries included substantial numbers of people of South Asian origin, we were unable to adjust for this. In the current project, having individual records meant that we could exclude women from ethnic and religious groups which do not practice FGM from the analysis. We excluded people whose religion was stated to be Jew, Sikh, Hindu or Buddhist or whose ethnic origin, using the census classification was stated to be White/ Asian, Asian British, Black Caribbean, Other Black, unless they had stated that their ethnicity was wholly or partially Kurdish, Somali, Somalilander or Nigerian.

4.2.3 Estimates derived from birth registration data

For each year from 2005 to 2012, an extract of anonymised data about women born in each FGM practising country who gave birth in England and Wales was provided by the Office for National Statistics for analysis in the secure environment of its Virtual Microdata Laboratory. The data items included were mother's country of birth, father's country of birth, mother's age in years at birth of child, Government Office Region, County code and County district code for mother's usual place residence of mother, place of birth and multiplicity. Country and age specific prevalence rates are being applied to the tabulated numbers of women to estimate the numbers of births to women with FGM from each country living in each local authority in each year, as data about ethnicity and religion are not recorded at birth registration in England and Wales.

A second anonymised extract of records of births of girls has also been supplied. This contains the same data items, except that it does not include place of birth and it includes fuller details of multiple births. This is being used to estimate the likely numbers of girls born to mothers with FGM. The data on maternities and live births of girls for the years 2005 onwards have been combined with data from the earlier project to produce estimates of numbers of women delivering and of girls aged under 15 born to women with FGM by country group. It was not possible to directly, so proportions of women in each country and age group were derived from the census analysis and applied to the numbers of births and maternities to estimate the numbers of women to be excluded from estimates of prevalence,

Many of these analyses have small numbers in some cells so because of disclosure control rules, they cannot be published in their raw form. The tables are being examined in the secure environment of the Office for National Statistics' VML and countries are being grouped within the country groups shown in Table 3. Decisions will be made about the level of detail which can be used for publishing data for each local authority. Where estimated numbers are low, numerical data will not be released.

4.2.4 Ethics approval

The project uses fully anonymised individual records analysed in the secure environment of the Office for National Statistics' Virtual Microdata Laboratory so ethics approval was not required. Alison Macfarlane and Efua Dorkenoo made successful applications to ONS for Approved Researcher status and the project was submitted to ONS Microdata Release Panel for approval. All outputs have been examined by ONS staff to ensure that no disclosive data are released, in line with ONS' disclosure control policies. Data derived from DHS and MICS surveys were used in aggregated or anonymised form and no individuals were interviewed.

5 Results

5.1 Estimated numbers of women and girls with FGM

Table 5 Women aged 15-49, permanently resident in England and Wales, Census 2011

Country of birth	All born in FGM practising countries		Excluding non-practising ethnicities and religions		Group
	Enumerated in	Estimated	Enumerated in	Estimated number	
	census	number with FGM	census	with FGM	
Djibouti	204	191	179	168	1.1
Eritrea	7,071	6,457	6,884	6,286	1.1
Somalia	43,558	42,766	42,618	41,842	1.1
Sudan	5,412	4,796	4,990	4,421	1.1
Group 1.1, all	56,245	54,209	54,671	52,717	
Burkina	81	65	71	57	1.2
Egypt	4,463	4,181	3,740	3,505	1.2
Ethiopia	6,930	5,379	6,577	5,101	1.2
Gambia, The	4,236	3,208	4,074	3,085	1.2
Guinea	911	874	878	843	1.2
Mali	140	124	132	117	1.2
Sierra Leone	8,903	8,265	8,457	7,848	1.2
Group 1.2, all	25,664	22,097	23,929	20,556	
Central African Republic	75	20	50	13	2
Chad	121	54	106	48	2
Guinea-Bissau	970	490	930	469	2
Iraq	18,344	1,612	14,308	1,256	2
Ivory Coast	3,625	1,484	3,442	1,410	2
Kenya	31,740	11,523	10,472	3,270	2
Liberia	1,234	780	1,102	692	2
Mauritania	64	45	34	24	2
Nigeria	68,727	20,344	65,878	19,451	2
Senegal	701	185	632	166	2
Yemen	5,062	1,161	3,573	801	2
Benin	242	34	204	29	3
Group 2, all	130,905	37,732	100,731	27,629	
Cameroon	4,227	64	4,084	62	3
Democratic Republic of the Congo	8,783	NA	8,459	NA	3
Ghana	33,059	1,583	31,964	1,527	3
Niger	76	2	65	2	3
Tanzania	7,729	1,465	2,919	505	3
Togo	586	27	559	25	3
Uganda	15,715	260	9,730	155	3
Group 3, all	70,175	3,401	57,780	2,276	
Total	282,989	117,440	237,111	103,177	

Source: ONS

Estimated numbers of women aged 15-49 with FGM living in England and Wales in 2011 are shown in Table 5. For comparative purposes estimates based on overall numbers of women shown. There was an estimated number of 103,000 women aged 15-49. Over half of these, nearly 53,000 came from countries in the Horn of Africa where FGM is virtually universal and Type III is commonly practised.

Estimates of numbers of women aged 50 or more with FGM were made, based on prevalence in the 45-49 age group and are shown in Table 6. They suggest that there were nearly 24,000 women with FGM in this age group, of whom 9400 came from countries where FGM is almost universal with Type 3 being commonly practised and a further 5600 coming from countries with almost universal FGM, usually Types I and II.

Table 6 Women aged 50 and over, permanently resident in England and Wales, Census 2011

Country of birth	All born in FGM practising countries		Excluding non-practising ethnicities and religions		Group
	Enumerated in census	Estimated number with FGM	Enumerated in census	Estimated number with	
Djibouti	40	38	28	26	1.1
Eritrea	1195	1,138	1,080	1,028	1.1
Somalia	7853	7,782	7,557	7,489	1.1
Sudan	1437	1,280	949	846	1.1
Group 1.1, all	10525	10238	9614	9389	
Egypt	7070	6,787	1,764	1,693	1.2
Ethiopia	912	737	747	604	1.2
Gambia, The	428	338	390	308	1.2
Guinea	46	46	26	26	1.2
Sierra Leone	3285	3,167	3,046	2,936	1.2
Burkina and Mali	17	15	13	12	
Group 1.2, all	11758	11090	5986	5579	
Guinea-Bissau	140	70	133	67	2
Iraq	6418	661	4,453	459	2
Ivory Coast	156	73	143	67	2
Kenya	37026	18,069	1,985	969	2
Liberia	195	154	181	143	2
Nigeria	17380	6,604	15,697	5,965	2
Senegal	63	18	34	10	2
Yemen	2342	586	1,123	281	2
Central African Republic, Chad and Mauritania	37	19	13	8	2
Group 2, all	63757	26254	23762	7968	
Cameroon	416	10	340	8	3
Congo (Democratic Republic)	839	NA	631	NA	3
Ghana	13766	881	12,832	821	3
Tanzania	9860	2,120	513	110	3
Togo	46	3	41	3	3
Uganda	14626	278	1,902	36	3
Benin and Niger	37	5	27	4	3
Group 3, all	39590	3297	16286	982	
Total	125630	50,879	55,648	23,918	

Source: ONS

Table 7 shows estimated numbers of girls aged 0-14 born in FGM practising countries. Just under 24,000 girls aged 0-14 born in FGM practising countries were living in England Wales in 2011. It

was estimated that if they experience FGM at the same rate as girls aged 15-19 in their countries of birth, then nearly 10,000 of them have undergone or will undergo FGM.

Table 7 Girls aged 0-14, permanently resident in England and Wales, Census 2011

Country	All born in FGM practising countries		Excluding non-practising ethnicities and religions		Group
	Enumerated in census	Estimated number likely to undergo FGM	Enumerated in census	Estimated number likely to undergo FGM	
Djibouti	15	13	14	13	1.1
Eritrea	589	462	581	456	1.1
Somalia	5631	5,445	5497	5,316	1.1
Sudan	547	458	521	436	1.1
Group 1.1, all	6782	6378	6613	6220	
Egypt	964	778	821	663	1.2
Ethiopia	546	339	534	332	1.2
Gambia, The	383	295	369	284	1.2
Guinea	92	82	88	79	1.2
Sierra Leone	405	323	390	311	1.2
Burkina and Mali	17	12	14	10	1.2
Group 1.2, all	2407	1830	2216	1679	
Guinea-Bissau	64	31	61	30	2
Iraq	2227	109	1751	86	2
Ivory Coast	232	73	225	70	2
Kenya	1659	242	1240	181	2
Liberia	58	21	56	20	2
Nigeria	6941	1,298	6831	1,277	2
Senegal	61	15	60	14	2
Yemen	745	144	655	126	2
Central African Republic, Chad and Mauritania	23	10	21	9	2
Group 2, all	12010	1942	10900	1814	
Cameroon	347	1	340	1	3
Congo (Democratic Republic)	969	NA	957	NA	3
Ghana	1904	29	1841	28	3
Tanzania	290	21	205	15	3
Togo	66	1	62	1	3
Uganda	537	5	515	5	3
Benin and Niger	17	1	14	1	3
Group 3, all	4130	58	3934	50	
Total	25329	10,208	23663	9,763	

Source: ONS

Temporary residents

In addition to permanent residents, nearly 4200 temporary residents born in FGM practising countries were enumerated, of whom just over 900 came from countries where FGM is almost universal.

5.2 Estimated numbers of women with FGM giving birth

Maternities are defined as pregnancies ending with one or more registrable live or still birth and thus are counts of women rather than babies. After increasing steeply over the years 2001 to 2004, as documented in our earlier report, the estimated numbers of maternities to women with FGM increased from just over 9,000 in 2005 to nearly 11,000 in 2008, since when the numbers have

Figure 2

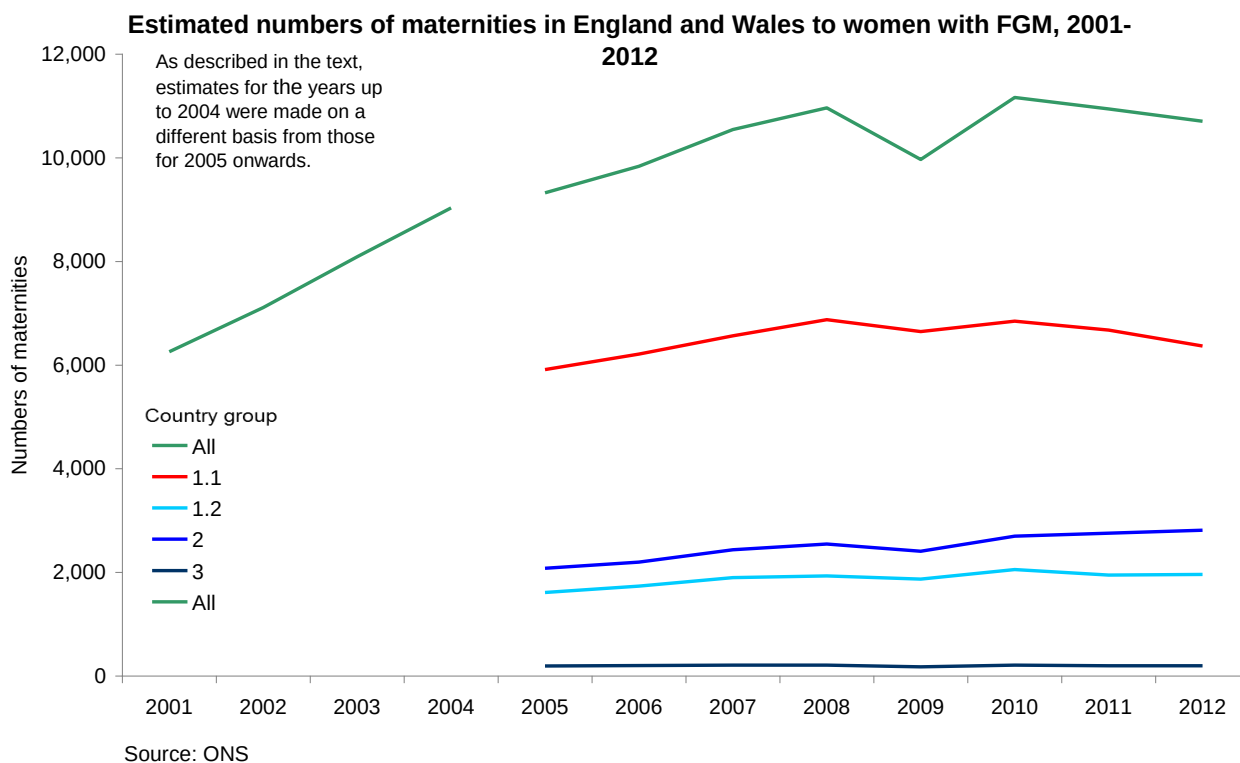
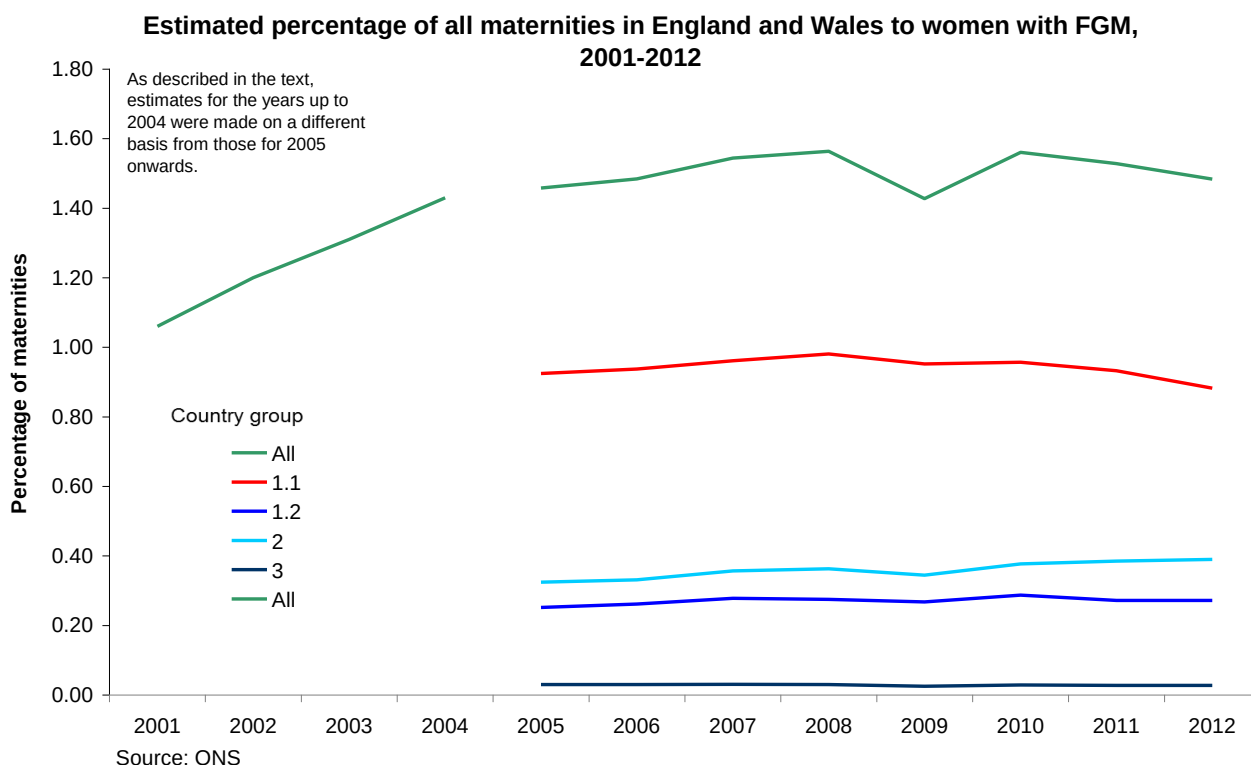


Figure 3



levelled off, as Figure 2 shows. About three fifths of these women were from countries where FGM is almost universal and Type III is commonly practised. As Figure 2 shows, the estimated percentage of women with FGM fluctuated around 1.5 per cent of all maternities.

5.3 Girls born to mothers with FGM

Estimated numbers of girls born in England and Wales to mothers with FGM and to all mothers from FGM practising countries are shown in Table 8. From 1996 to 2010, 144,000 girls were born in England and Wales to mothers born FGM practising countries and a further 29,000 were born in 2011 and 2012, as Table 8 shows. It was estimated that 60,000 of the girls aged 0-14 born before 2011 and 11,700 of those born in 2011 and 2012 were born to mothers with FGM. In both cases, well over half of the mothers came from the countries in the Horn of Africa where FGM is almost universal and Type III is practised and slightly under a fifth came from the countries in West and East Africa where Types I and II are highly prevalent.

Table 8 Estimated numbers of girls born in England and Wales to mothers born in FGM practising countries

Practising countries		Country of birth group				
Year of birth	Age in 2011	1.1	1.2	2	3	Total
Estimated numbers of girls born to mothers with FGM						
1993-1995	15-17	1,885	1,166	2,225	331	5,607
1996-2000	10-14	5,800	2,259	3,268	491	11,818
2001-2005	5-9	11,953	3,490	3,770	529	19,741
2006-2010	0-4	16,859	4,937	6,391	527	28,714
1996-2010	0-14	34,612	10,686	13,429	1,547	60,273
2011-2012		6,651	1,984	2,859	201	11,695
Estimated numbers of girls born to mothers born in countries where FGM is practised						
1993-1995	15-17	1963	1304	8701	5593	17561
1996-2000	10-14	6015	2543	12896	8589	30043
2001-2005	5-9	12421	4096	15546	12060	44123
2006-2010	0-4	17918	6200	28559	17219	69896
1996-2010	0-14	36,354	12,839	57,001	37,868	144,062
2011-2012		7086	2479	12770	6419	28754

Source: ONS

Figures 4 and 5 show trends over the years 1993 to 2012 in numbers of girls born to women from FGM practising countries and in estimated numbers born to women with FGM.. While in overall terms, the increase was in numbers of girls born to women born in countries in Group 2, where prevalence is in the medium range, the increase in numbers of girls born to mothers with FGM related particularly to those from countries where FGM is nearly universal and Type III is commonly practised.

Figure 4

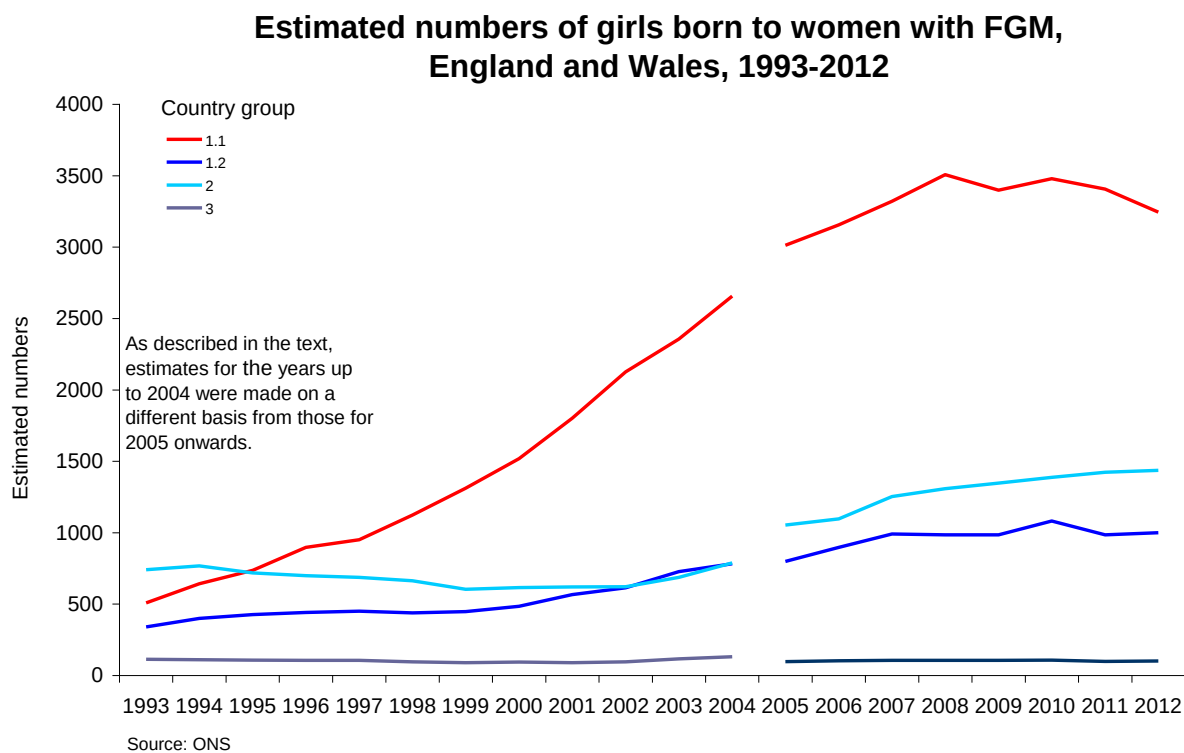
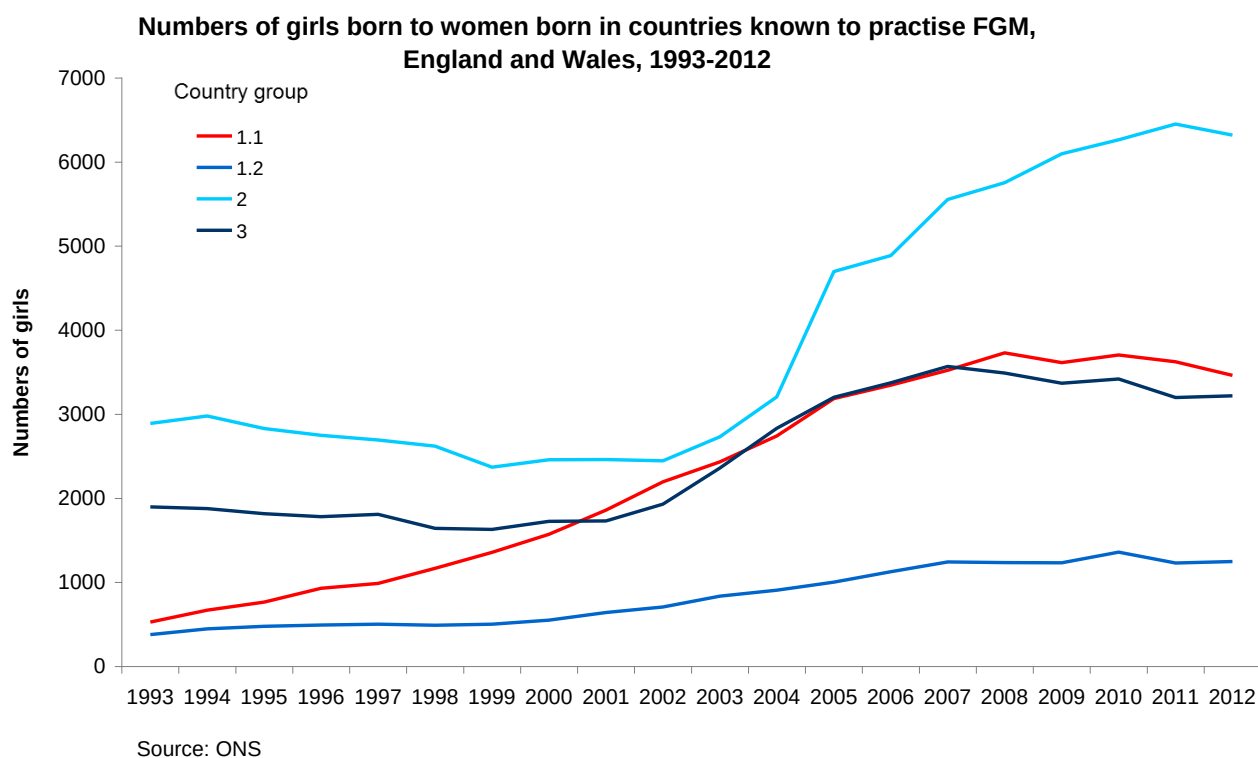


Figure 5



Discussion

These figures may be slight underestimates as they do not take account of migration since 2011, and further work will incorporate this as well as the extent to which the women who migrate, especially from countries with lower prevalences of FGM, are typical of their populations in general. In addition there is evidence that Black African women as a whole are slightly more likely to be under-enumerated in the Census than the population of England as a whole.²¹

The way the estimates have been made here are not directly comparable with our earlier report. Because we have been able to analyse individual anonymised census records, we have been able to exclude white and South Asian women born in FGM practising countries and produce more reliable estimates. Iraqi Kurdistan was not included in our earlier estimates, as no data were available and we still have no data to indicate whether FGM is practised in other parts of Kurdistan. Despite this, the estimated numbers have increased substantially, following migration both from countries in the Horn of Africa and west and East Africa with very high rates of FGM and migration from Nigeria, which has lower rates.

In addition, our earlier estimate was restricted to women aged 15-49. Adding estimates for women aged 50 and over gives a fuller picture of the growing numbers of women in this age group. They will experience gynaecological problems for which they need medical care and will also influence decisions about the practice of FGM among young girls in their families and communities.

A recent report based on 2011 census data and ONS' birth statistics concluded that there were 170,000 women aged 15 and over in England and Wales with FGM and that 63,000 girls aged 0-13 were at risk of FGM.²² This did not subdivide the women by age group and all women were included instead of excluding white and South Asian women, who make up a substantial proportion of women aged 50 and over born in FGM practising countries. All asylum seekers were added in, instead of just those from FGM practising countries. According to the Home Office's Asylum Statistics, the numbers of applications from women nationals from FGM practising countries were 2641 in 2011 and 2841 in 2012.²³ If the numbers in 2013 are at a similar level, the total would be well under 9,000, rather than the 52,500 the author assumed.

The author used overall prevalences taken from a voluntary organisation's web site rather than using age specific data directly from UNICEF and DHS reports. When estimating the numbers of girls at risk, she included all girls irrespective of the prevalence rates in their mothers' countries of birth. Her estimates relate to girls aged under 14, while our estimates of 72,000 girls born to mothers with FGM related to the 0-16 age group. Finally, she quoted data as if they related to the UK as a whole, although her source was the Office for National Statistics, whose census and birth statistics do not routinely include Scotland and Northern Ireland.

The estimates in our interim report take no account of secondary migration. This is potentially available only for women who wrote in their ethnicity as Somali, Somalilander, Kurd or Nigerian, but data for these groups will be included in our final report.

In the absence of regional data, we looked at the women's first languages reported in the census, but as these were predominantly English, this shed little light on regional patterns of migration. Analysis of educational qualifications showed that there were high proportions of graduates among women born in many FGM practising countries, apart from Somalia, Eritrea and the Yemen. Surveys show that prevalence varies by educational level in some countries but not others. Possible associations will be explored in the final report.

The problems in interpreting these proxy data underline the need for directly collected data and the Department of Health's attempt to pilot data collection are welcome, although there are many logistical and diagnostic problems to overcome. Linking data collection to hospital visits will necessarily result in under-reporting. Holding data on general practice records would seem a sensible approach, but recent problems with attempts at national collection of data from general practice systems mean that these are unlikely to become a source of population-based data.

Conclusions

This interim report shows that the numbers of women with FGM have increased since 2001, especially due to migration from countries in conflict. The substantial proportion of the increase which is among women from countries where FGM is nearly universal or prevalence is very high supports the need for action. Recommendations for urgent action have been set out in the recent report from the House of Commons Home Affairs Select Committee²⁴ and in the Intercollegiate recommendations for identifying, recording and reporting FGM, set out in the report Tackling FGM in the UK.²⁵

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This work contains statistical data from ONS which is Crown Copyright. The use of the ONS statistical data in this work does not imply the endorsement of the ONS in relation to the interpretation or analysis of the statistical data. This work uses research datasets which may not exactly reproduce National Statistics aggregates.

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Appendix 1 National FGM prevalence data by age cohort from DHS and MICS surveys by country

Country	Source	Year	Age of women							
			15-19	20-24	25-29	30-34	35-39	40-44	45-49	15-49
Benin	DHS	2001	12.1	13.4	16.9	18.4	18.3	25.1	23.7	16.8
Benin	DHS	2006	7.9	9.9	13.6	14.3	16.3	17.0	15.8	12.9
Burkina Faso	DHS	1998-99	64.2	70.7	75.0	73.7	74.1	76.7	74.1	71.6
Burkina Faso	DHS	2003	65.0	76.2	79.2	79.4	81.6	83.1	83.6	76.6
Burkina Faso	DHS	2010	57.7	69.8	77.5	82.8	85.2	88.2	89.3	75.8
Cameroon	DHS	2004	0.4	2.5	1.6	1.1	1.2	1.8	2.4	1.4
Central African Republic	DHS	1994-95	34.6	42.7	44.3	44.1	47.5	51.4	53.1	43.4
Central African Republic	DHS	2000	27.2	33.8	35.6	39.9	43.3	41.5	41.9	35.9
Central African Republic	MICS	2010	17.9	22.1	24.5	25.5	28.4	29.9	33.8	24.2
Chad	DHS	2000	41.6	43.9	44.4	46.5	45.0	45.2	51.5	44.9
Chad	DHS	2004	43.4	45.8	45.2	43.5	46.2	46.1	45.9	44.9
Chad	MICS	2010	41.1	43.0	46.1	45.4	45.7	44.6	47.2	44.3
Cote d'Ivoire	DHS	1994	35.3	42.2	47.7	47.1	43.7	44.8	44.3	42.7
Cote d'Ivoire	DHS	1998-99	41.2	42.7	42.4	49.0	44.5	51.4	51.0	44.5
Cote d'Ivoire	MICS	2006	28.0	33.5	37.6	42.8	43.8	40.8	39.7	36.4
Cote d'Ivoire	DHS	2012	31.3	35.1	36.8	40.3	45.4	44.6	46.9	38.2
Democratic Republic of the Congo	WHO	1998								5.0
Djibouti	Union Nation	1991								98.0
Djibouti	MICS	2006	89.5	93.7	93.3	95.9	94.7	93.1	94.4	93.1
Egypt*	DHS	1995	98.1	98.3	97.0	95.8	96.7	97.2	96.8	97.0
Egypt*	DHS	2000	99.1	97.4	97.2	96.7	97.4	96.9	97.9	97.3
Egypt	DHS	2003	96.8	97.4	97.3	96.5	96.4	96.5	98.0	97.0
Egypt*	DHS	2005	96.6	95.9	95.1	95.9	95.9	96.0	96.3	95.8
Egypt	DHS	2008	80.7	87.4	94.3	95.2	96.4	96.2	96.0	91.1
Eritrea	DHS	1995	90.4	94.4	94.9	95.6	97.0	95.9	97.1	94.5
Eritrea	DHS	2002	78.4	87.9	90.9	93.4	92.7	94.1	95.2	88.7
Ethiopia	DHS	2000	70.7	78.3	81.4	86.1	83.6	85.8	86.8	79.9
Ethiopia	DHS	2005	62.1	73.0	77.6	78.0	81.2	81.6	80.8	74.3
Gambia, The	Singhateh S	1985								79.0
Gambia, The	MICS	2010	77.1	76.8	77.5	74.7	73.2	75.3	79.0	76.4
Ghana	DHS	2003	3.3	3.8	6.4	6.3	6.7	5.5	7.9	5.4
Ghana	MICS	2010/11?	1.5	1.8	3.0	4.4	5.5	6.6	6.4	3.8
Guinea	DHS	1999	96.6	98.5	99.1	99.1	99.1	99.3	99.5	98.6
Guinea	DHS	2005	89.3	94.6	96.6	97.4	98.6	98.1	99.5	95.6
Guinea-Bissau	WHO	1998								50.0
Guinea-Bissau	MICS/ RHS	2010	48.4	49.2	51.0	49.8	49.0	54.1	50.3	49.8
Iraq	MICS	2011	4.9	7.5	9.1	9.1	9.7	9.4	10.3	8.1
Kenya	DHS	1998	26.0	32.2	40.4	40.9	49.3	47.4	47.5	37.6
Kenya	DHS	2003	20.3	24.8	33.0	38.1	39.7	47.5	47.7	32.2
Kenya	DHS	2008-09	14.6	21.1	25.3	30.0	35.1	39.8	48.8	27.1
Liberia	Marshall R	1984								60.0
Liberia**	DHS	2007	35.9	51.1	61.3	63.4	66.7	71.2	79	58.3
Mali	DHS	1995-96	92.5	94.2	93.9	94.8	93.9	94.2	92.4	93.7
Mali	DHS	2001	91.2	91.3	91.9	92.1	92.3	91.2	91.0	91.6
Mali	DHS	2006	84.7	84.5	86.7	84.2	84.9	86.2	85.8	85.2
Mali	MICS	2010	87.7	88.2	87.9	89.1	90.2	89.4	88.5	88.5
Mauritania	DHS	2000-01	65.9	71.1	73.4	74.2	71.7	76.5	68.6	71.3
Mauritania	MICS	2011	65.9	66.2	67.4	71.3	72.0	76.2	75.2	69.4
Niger	DHS	1998	5.0	4.8	4.3	5.3	3.8	3.3	3.3	4.5
Niger	DHS	2006	1.9	1.6	2.4	2.1	2.9	2.9	2.8	2.2
Nigeria	DHS	1999	8.8	19.6	26.4	31.3	31.0	37.9	48.3	25.1
Nigeria	DHS	2003	12.9	17.0	20.8	19.4	22.2	22.2	28.4	19.0
Nigeria	DHS	2008	21.7	26.4	28.9	32.8	33.9	36.4	38.1	29.6
Nigeria	MICS	2011	18.7	21.5	26.1	29.7	31.5	34.9	38.0	27.0
Senegal	DHS	2005	24.8	28.0	28.4	30.1	30.5	30.3	30.6	28.2
Senegal	DHS	2010-11	24.0	24.3	26.1	24.9	29.0	26.9	28.5	25.7
Sierra Leone	Koso - Thom	1987								90.0
Sierra Leone	DHS	2008	75.5	89.4	95.2	94.9	96.4	96.1	95.9	91.3
Sierra Leone	MICS	2010	79.8	86.9	92.2	93.2	95.8	95.3	96.4	88.3
Somalia										97.0
Somalia	MICS	2006	96.7	97.9	97.9	98.8	98.9	97.9	99.1	97.9

Country	Source	Year	Age of women							
			15-19	20-24	25-29	30-34	35-39	40-44	45-49	15-49
Sudan*	DHS	1989-90	86.8	89.7	88.6	89.7	89	89	90.9	89.2
Sudan (north)	DHS Survey	2000	85.5	88.6	89.3	89.8	91.5	91.6	92.9	90.0
Sudan*	SHHS	2010	83.7	86.8	89.5	88.3	89.7	89.8	89.1	87.6
Togo	National Con	1993								50.0
Togo	MICS	2010	1.0	2.4	3.6	4.6	6.3	5.2	6.5	3.8
Uganda	WHO	1998								5.0
Uganda	DHS	2006	0.5	0.8	0.3	0.8	0.8	1.0	0.4	0.6
Uganda	DHS	2011	1.0	0.8	1.9	2.1	1.3	1.7	1.9	1.4
United Republic of Tanzania	DHS	1996	15.7	17.7	20.9	19.9	18.3	19.3	20.1	18.5
United Republic of Tanzania	DHS	2004-05	9.1	13.7	15.2	16.0	16.0	18.8	22.9	14.6
United Republic of Tanzania	DHS	2010	7.1	11.0	11.7	19.1	21.6	22.2	21.5	14.6
Yemen*	DHS	1997	19.3	22.2	21.3	22.9	23.6	25.1	25	22.6

*Sample consisted of ever-married women

** Women were asked if they had been initiated into a secret society.