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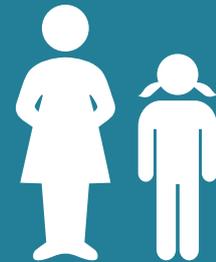
# Towards estimating the prevalence of female genital mutilation/cutting in Australia

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The World Health Organization estimates that female genital mutilation/cutting (FGM/C) affects over 200 million women and girls across the world.

This report indicates the potential number of women and girls living in Australia who may have undergone FGM/C. These numbers are modelled estimates only, calculated by combining international survey data with Australian population estimates.

While rudimentary, these estimates can provide insight into the potential extent of FGM/C in Australia. This can help health-care providers, community service providers and policymakers to ensure that appropriate services are available for girls and women who need support as a result of FGM/C. Increasing awareness of this complex global issue may also help to reduce the number of girls who undergo FGM/C in the future.



The United Nations estimates that at least **200 million** girls and women alive today have undergone FGM/C.



FGM/C has **no health benefits**, and there is no medical justification for it.



It is estimated that **53,000** girls and women born elsewhere but now living in Australia have undergone FGM/C.

AIHW

# Understanding FGM/C around the world and in Australia

## What is FGM/C?

FGM/C refers to all procedures involving partial or total removal of the external female genitalia, or other injury to female genital organs (such as stitching of the labia majora or pricking of the clitoris) for non-medical reasons (WHO 2018a).

FGM/C is classified into four major types by the World Health Organization (WHO):

**Type 1**—clitoridectomy: partial or total removal of the clitoris and/or the prepuce (fold of skin surrounding the clitoris)

**Type 2**—excision: partial or total removal of the clitoris and the labia minora (inner folds of the vulva), with or without excision of the labia majora (outer folds)

**Type 3**—infibulation: 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

**Type 4**—other: all other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterisation (WHO 2018a).

## Terminology

A range of terms can be used when discussing FGM/C. In some contexts, the word 'cutting' is preferred to reflect the importance of using non-judgemental terminology, especially within practising communities. In other situations, the term 'mutilation' is preferred so as not to diminish the impacts of the practice and to emphasise its human rights aspect. In this report, the term 'female genital mutilation/cutting' is used, acknowledging both perspectives. The term '(female) circumcision' has not been used because it is a term more commonly associated with males and may be associated with only the less invasive forms of FGM/C.

For further guidance on terminology, see the publication *Respectful dialogue: a guide for responsible reporting on female genital cutting* (AMWCHR 2014).

## Reasons that FGM/C is practised

The reasons FGM/C is performed are complex and involve a mix of social and cultural factors that can vary across time, ethnicity and region. Some reasons commonly cited include to prepare for marriage and adulthood, to preserve socially accepted values related to femininity and modesty, and to ensure a woman's premarital and marital fidelity (WHO 2018b). It is important to recognise that FGM/C has no basis in religion (AMWCHR 2014; WHO 2018a) and is practised by ethnic groups of many faiths.

## Age at which FGM/C is performed

The age at which girls are typically cut differs between practising communities, ranging from 0–1 to 8–18; however, for the vast majority of girls, FGM/C is performed by the age of 15, and for many before the age of 9 (DHS 2018; UNICEF 2018).

## Health consequences of FGM/C

FGM/C has no health benefits, and there is no medical justification for it (WHO 2018a). It can interfere with normal body functions and may result in lifelong physical and sexual health complications. Psychological effects, such as anxiety and depression and post-traumatic stress disorder, can also be serious and long term.

### Some potential short-term and long-term health consequences of FGM/C

Short-term consequences	Long-term consequences
Pain	Menstrual problems (for example, difficulty passing blood or painful periods)
Bleeding	Increased risk of childbirth complications
Shock	scar tissue complications (e.g. keloids and epidermal inclusion cysts)
Urination problems	Chronic pain
Infection and septicaemia	Reproductive tract infections
Genital tissue swelling	Urinary tract infections
Death	Sexual health complications
Psychological problems	Psychological problems

Sources: WHO 2016, 2018a.

As well, women may also face later surgery, such as deinfibulation (a procedure to reverse some types of FGM/C) and reinfibulation (resewing following deinfibulation). Deinfibulation can be required to give birth or to relieve symptoms of the health consequences of FGM/C. In Australia, deinfibulation is often performed during antenatal care or by specialist outpatient clinics, such as that at The Royal Women's Hospital in Melbourne (RWH 2018). Reinfibulation is not legal in Australia.

## FGM/C across the world

The United Nations estimates that at least 200 million girls and women alive today have undergone FGM/C. This figure is based on prevalence data from surveys in around 30 countries (UNICEF 2016). The total number of girls and women who have undergone FGM/C worldwide is likely to be higher, as there is evidence that FGM/C also occurs in other countries for which national prevalence data are not available.

A list of countries in which FGM/C is generally accepted as being practised is provided in this report; however, this list is not exhaustive. The FGM/C prevalence rates for these countries vary considerably by factors such as region of birth within a country, ethnicity, religion, educational status and socioeconomic status. It is therefore important to appreciate that FGM/C is an issue affecting individuals within specific communities and ethnic groups rather than all girls and women from these countries (AMWCHR 2014).

FGM/C is a global issue. It affects not only women living in regions where FGM/C is commonly practised but also, due to migration, women in other parts of the world, including Australia. In an Australian context, a link with FGM/C for individuals whose country of origin is listed in this report should not be automatically assumed; conversely, it should be understood that individuals with FGM/C may have been born in countries other than those listed.

## FGM/C prevalence rates for 15–49 year olds for countries with practising communities<sup>(a)</sup>

Country with practising communities	Prevalence rate (%) <sup>(b)</sup>	Year data collected	Source
Benin	9	2014	UNICEF 2018
Burkina Faso	76	2010	DHS 2018
Cameroon	2	2004	DHS 2018
Central African Republic	24	2010	UNICEF 2018
Chad	38	2014–15	DHS 2018
Colombia	n.a.	..	Ross et al. 2015
Côte d'Ivoire	37	2016	UNICEF 2018
Djibouti	93	2006	UNICEF 2018
Egypt	87	2015	DHS 2018
Eritrea	83	2010	DHS 2018
Ethiopia	65	2016	DHS 2018
(The) Gambia	75	2013	DHS 2018
Ghana	4	2011	UNICEF 2018
Guinea	97	2016	UNICEF 2018
Guinea-Bissau	45	2014	UNICEF 2018
India	n.a.	..	Anantnarayan et al. 2018
Indonesia <sup>(b)</sup>	49	2013	UNICEF 2018
Iraq	8	2011	UNICEF 2018
Kenya	21	2014	DHS 2018
Liberia	50	2013	DHS 2018
Malaysia	n.a.	..	Rashid et al. 2009
Mali	83	2015	UNICEF 2018
Mauritania	67	2015	UNICEF 2018
Niger	2	2012	DHS 2018
Nigeria	18	2016–17	UNICEF 2018
Philippines	n.a.	..	Manalocon-Basher 2014
Saudi Arabia	n.a.	..	Alsibiani & Rouzi 2010
Senegal	24	2017	DHS 2018
Sierra Leone	90	2013	DHS 2018
Somalia	98	2006	UNICEF 2018
South Sudan	n.a.	..	MHNBS 2010
Sudan (north)	87	2014	UNICEF 2018
Tanzania	10	2015–16	DHS 2018
Togo	5	2013–14	DHS 2018
Uganda	<1	2016	DHS 2018
Yemen	19	2013	DHS 2018

n.a. prevalence data not available

.. not applicable

< less than

(a) This list of countries is not exhaustive—FGM/C is also practised by communities in countries not included in this table.

(b) Prevalence estimates for each country are for girls and women aged 15–49, except for Indonesia, where estimates are for girls aged 0–11.

## Changing attitudes

Over the past three decades, the prevalence of FGM/C has declined, even in some high-prevalence countries, because of changing attitudes (Koski & Heymann 2017). In some countries, criminalising FGM/C has played a role in reducing FGM/C (UNICEF 2018). By 2013, 24 of the 29 countries where FGM/C is concentrated had enacted decrees or legislation aimed at preventing FGM/C, including high-prevalence countries, such as Egypt, Eritrea, Ethiopia, Iraq, Somalia and Sudan (some states) (UNICEF 2013).

The extent and pace of the decline have varied across countries, but current progress is insufficient to keep pace with population growth. The United Nations International Children's Emergency Fund (UNICEF) predicts that, based on this trend, the number of girls and women undergoing FGM/C will rise substantially over the coming decade (UNICEF 2016).

## International policy context

FGM/C is recognised by the United Nations as a form of violence against women (UN Women et al. 2017). The practice violates the United Nations Charter of Human Rights (UN1948) and the United Nations Charter of Women's Rights (UN 1979) and, when carried out on children, the Charter of the Rights of the Child (UNICEF 1989) and the Charter of Rights of the African Child (ACHPR 1990).

In December 2012, the United Nations General Assembly unanimously passed a resolution, co-sponsored by Australia, banning the practice of FGM/C, and encouraging member states to focus on its elimination (AGD 2013). Achieving total abandonment of the practice by 2030 is a priority within the United Nations' sustainable development goals (UN 2019).

## FGM/C in Australia

At a national level, the evidence on the prevalence of FGM/C in Australia is limited. Population-level prevalence estimates have not previously been published, although a report by Family Planning Victoria/ Royal Melbourne Institute of Technology provided estimates of the number of people living in Australia who were born in countries where communities practise FGM/C (Costello et al. 2014).

Two studies have examined the prevalence of FGM/C among women giving birth at particular hospitals.

- A study of births at a metropolitan health service found the prevalence of FGM/C among women born in selected African countries was 3.6% (Gibson-Helm et al. 2014). Women from refugee migrant backgrounds were more likely to have FGM/C than non-refugee migrants.
- Another study by Varol et al. (2016) of births at a metropolitan hospital found 2.2% of women who gave birth across a six-year period had FGM/C. Obstetric outcomes for women with FGM/C who had care from clinicians with FGM/C expertise were similar to those for other women.

Other literature published on FGM/C in Australia focuses on health professionals' knowledge and/or experience with FGM/C among midwives, obstetricians, gynaecologists and paediatricians.

- A survey of Australian midwives' knowledge, experience and training needs in relation to FGM/C found that, of 198 midwives, 53% knew the correct classification of FGM/C; 48% reported not receiving FGM/C training during their midwifery education; and 8% had been asked, or knew of others who had been asked, to perform FGM/C in Australia. Many midwives were not clear about the law or health data related to FGM/C and were not aware of referral paths for affected women (Turkmani et al. 2018a).
- Another study of Australian midwives found that many midwives lacked confidence and experience when caring for women with FGM/C. Associated problems included developing rapport with women, working with interpreters, misunderstanding the culture of the women, being inexperienced with associated clinical procedures and lacking knowledge about FGM/C types and data collection (Dawson et al. 2015a).
- Similar issues were explored by Ogunsiyi (2016) in a qualitative study of Australian midwives' experiences of caring for women with FGM/C. The paper recommends that holistic, culturally competent and sensitive care be delivered, with appropriate organisational support, clinical knowledge and adequate follow-up of women.
- A survey of Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) fellows, trainees, diplomates and other FGM/C program workers found that 82 (21%) respondents had been asked to re-suture after delivery, and two (0.5%) had been asked to perform FGM/C (Moed & Grover 2012).
- Murray et al. (2010) conducted semi-structured interviews with 10 refugee women who had given birth in Queensland, citing issues with the experience and training of midwives in the clinical management of FGM/C.
- A survey of paediatricians found that 23 clinicians (2.3%) had seen 59 children with FGM/C in the previous 5 years in their practice in Australia (Zurynski et al. 2017). Most (90%) were identified via refugee screening, and were born overseas; however, three (10%) were born in Australia, two of whom had had FGM/C done in Australia, and one in Indonesia.
- A survey of paediatricians' knowledge, attitudes and clinical experiences found that 10% of the 497 who responded had seen FGM/C in girls aged younger than 18 throughout their career, and 22% were aware of the WHO classification of FGM/C (Sureshkumar et al. 2016).
- Several systematic reviews of FGM/C have been published by Australian authors on:
  - maternity care experiences and needs of migrant women with FGM/C (Turkmani et al. 2018b)
  - evidence to inform midwifery practice (Dawson et al. 2015b)
  - doctors' experience and needs to support care of women with FGM/C (Dawson et al. 2015c)
  - health professionals' knowledge, attitudes and clinical practice (Zurynski et al. 2015).

## Australian policy context

All states and territories in Australia have passed criminal legislation prohibiting FGM/C. These laws apply extraterritorially, prohibiting an Australian resident from travelling overseas to undergo the procedure, or to perform the procedure on an Australian overseas (AGD 2013).

All Australian states and territories have mandatory reporting laws that require selected groups of people (for example, medical practitioners, nurses, teachers and police) to report suspected cases of child abuse (which includes FGM/C) and neglect to government authorities (AIFS 2017).

Australia's National Plan to Reduce Violence against Women and their Children 2010–2022 (COAG 2011) is consistent with international policy and the legislative context on FGM/C.

As well, the health and community sector is strongly committed to better understanding and managing FGM/C. For example, the Australian Medical Association and the RANZCOG have issued position statements about FGM/C, and the Australian College of Nursing and Australian College of Midwives have established an FGM/C online learning hub (ACM 2014; AMA 2017; RANZCOG 2017).

The Multicultural Centre for Women's Health published the National Education Toolkit for FGM/C Awareness (NETFA), a best-practice guide providing a nationally accepted benchmark for culturally appropriate FGM/C health promotion programs (MCWH 2014).

## Changing attitudes among communities in Australia

There is some evidence that attitudes towards FGM/C are changing among migrant communities in Australia. A study conducted in North Yarra, Melbourne reported that FGM/C had decreasing relevance in migrant communities, reducing over time after resettlement in Australia (Vaughan et al. 2014). Community members emphasised the vast generational change occurring in these communities, with younger women usually strongly opposing FGM/C for their daughters. Factors supporting this change include education about the physical and mental health consequences of FGM/C, increasing awareness that FGM/C is illegal in Australia and the role of male and female community leaders in opposing FGM/C.

Costello et al. (2014) called FGM/C in Australia a 'tradition in transition', citing education programs and community initiatives in New South Wales (NSW Health 2018) and in Victoria. Nationwide, there are several non-profit organisations whose work is to support communities to transition away from FGM/C—for example, the Family and Reproductive Rights Education Program (FARREP) in Victoria (MCWH 2018a) and No FGM Australia. The NETFA provides information about initiatives in other states and territories (MCWH 2018b).

## Method to calculate prevalence estimates

The method used in this report to calculate prevalence estimates applies country- and age-specific prevalence rates—sourced from population health surveys in 29 countries where FGM/C is concentrated and data are available—to the estimated number of girls and women living in Australia who were born in these countries (DHS 2018; UNICEF 2018). Estimates of the number of girls and women living in Australia are based on Australian Bureau of Statistics (ABS) Census data and data on births, deaths and net migration.

The method broadly replicates the extrapolation method used in various European studies to estimate national prevalence of FGM/C in countries outside those where FGM/C is most practised—for example, in Belgium (Dubourg et al. 2011), Norway (Ziyada et al. 2016), Portugal (Teixeira & Lisboa 2016) and in a study that covered several European Union countries (Van Baelen et al. 2016). Family Planning NSW (2014) used this same method in its work to investigate the feasibility of a national female genital mutilation data collection. These studies applied the basic methodology in several ways. The method used in this report most closely resembles that used in the studies conducted in Belgium and Portugal, particularly in relation to the method used to estimate the prevalence for 0–14 year olds.

## Steps in the method to estimate prevalence

1. Obtain five-year age-specific prevalence estimates of FGM/C for 29 countries for age groups between 15–19 and 45–49. The latest age-specific prevalence estimates for relevant countries were from population health surveys accessible online from either the Demographic and Health Surveys (DHS) Program (DHS 2018) or the UNICEF Multiple Indicator Cluster Surveys (MICS) (UNICEF 2018).
2. Obtain five-year age-specific Australian female population estimates by country of birth for each year between 2011 and 2017 from the ABS. The ABS compiles Australian population estimates by country of birth annually, as at 30 June. These estimates, produced by single year of age and sex, classify the population according to country of birth, based on data about births, deaths, net overseas migration and the Census. For the purpose of estimating net overseas migration, a person is regarded as a usual resident if they have been (or expect to be) residing in Australia for a period of 12 months or more over a 16-month period. As such, these estimates include all people, regardless of nationality, citizenship or legal status, who usually live in Australia, except foreign diplomatic personnel and their families. For more information on population estimates by country of birth, see Migration, Australia, 2016–17 (ABS 2018).
3. Multiply the prevalence of FGM/C in each country by five-year age groups (step 1) by the number of girls and women living in Australia for the corresponding country of birth and five-year age groups (step 2) to estimate the number of girls and women with FGM/C for each country of birth. The prevalence of FGM/C for the age group 15–19 was applied to girls aged 14 and under, and the prevalence of FGM/C for the age group 45–49 to women aged 50 and over.
4. Sum the figures across all age groups and countries to estimate the total number of girls and women with FGM/C living in Australia.
5. Repeat calculations for each year (from 2011 to 2017).

## Limitations and assumptions

The following key limitations and assumptions should be borne in mind when interpreting the estimated prevalence data in this report. They relate to both the method and the underlying data sources, particularly the country-specific surveys.

### Representativeness issues

The method used for the analysis presented in this report assumes that the prevalence of FGM/C reported from each country-specific survey provides a reliable estimate of the prevalence of FGM/C among girls and women born in those countries and living in Australia. However, the validity of this assumption depends on the girls and women living in Australia being representative of girls and women living in the country of birth across various factors for which FGM/C is known to vary. These factors include region of birth within a country, ethnicity, religion, educational status and socioeconomic status.

### Migration status as a factor for which FGM/C rates may vary

Available evidence suggests that migration itself is a factor that may correlate with FGM/C rates: those who migrate are less likely to have undergone FGM/C, particularly if they are from countries with moderate or low prevalence (UNICEF 2013). This is less true for countries with high FGM/C prevalence, where it would be more likely that the rate of FGM/C in the migrating populations is similar to the overall country rate.

The reason for migration may also be a factor. A study examining women receiving obstetric care in an area of Melbourne found that FGM/C was more common among women from a refugee background than among women from non-refugee backgrounds (Gibson-Helm et al. 2014). Without further comparisons, it is not possible to assess whether this would be valid for women born in other regions or for women living in other areas of Australia.

### Timing of surveys

The country-specific surveys used were conducted at different times: the earliest in 2004 and the latest in 2017. The majority were done during the period 2010–2016, but three surveys were done more than 10 years ago (for Cameroon, Djibouti and Somalia), and may not reflect current practices in these countries, especially for younger age groups.

### Exclusion of some countries known to practise FGM/C

Prevalence rates by country were available for only 29 countries although FGM/C is known to be practised in other countries. Excluding these other countries might contribute to an underestimate of FGM/C in Australia in this report.

One notable exclusion in the prevalence estimates in this report is Indonesia. In 2017, almost 47,000 Indonesian-born girls and women were living in Australia (ABS 2018). Although some Indonesian FGM/C prevalence data have been published—in 2013, 49% of Indonesian girls aged 0–11 had undergone FGM/C (UNICEF 2018)—the scope of these data was insufficient to estimate prevalence for all ages of girls and women born in Indonesia.

### Exclusion of ‘second generation’ girls and women

The method used in this report does not include ‘second generation’ girls and women—those born outside the countries used in our analysis but whose parents *were* born in those countries. This study assumes that these ‘second generation’ girls and women have not undergone FGM/C; however, they may have, or may potentially be at risk of FGM/C in the future.

Evidence from other countries suggests that some families have FGM/C done while girls are visiting the country of their parents’ birth (NHS England 2018). Although there is no evidence to suggest that FGM/C is routinely conducted in Australia, Zurynski et al. (2017) and Moeed & Grover (2012) both report instances of its being performed in Australia. There have also been a couple of legal cases in Australia involving people accused of performing FGM/C or arranging for FGM/C to be conducted.

### Age and year of arrival in Australia

Because (in general) FGM/C is done before a girl turns 15 (UNICEF 2013), assumptions about the likelihood of having undergone FGM/C could be made based on the age girls and women are when they arrive in Australia. For example, an older woman who arrives in Australia may be more likely to have undergone FGM/C than a girl aged under 10.

It is possible, however, that families intending to migrate to Australia arrange for their child to undergo FGM/C before leaving their country, irrespective of the child’s age. Conversely, in some contexts, the opposite may occur. For example, within a refugee context, girls who would normally have been cut may not be, due to unplanned displacement from their country of birth. Data on the age of arrival are not available at a national level, and have not been taken into account in the method used in this study.

The year of arrival may also have an impact if rates of FGM/C have changed in a woman’s country of birth over time. For example, women migrating from a country where FGM/C rates have declined over time would statistically be more likely to have undergone FGM/C if she migrated several decades ago than if she migrated more recently. The effect of this may be amplified where there are waves of mass migration from certain regions at particular periods of time.

## Extrapolation of data for age groups under 15 and 50 and over

Prevalence data obtained from country-specific surveys were not generally available for girls aged under 15, and for women aged 50 and over. For this reason, the prevalence of FGM/C for adolescents aged 15–19 was applied to girls aged 14 and under, and the prevalence of FGM/C for women aged 45–49 was applied to women aged 50 and over. As a result, estimates of girls and women with FGM/C are considered more reliable for those aged 15–49 than for those in other age groups.

## Reliability of self-reported information

Country-specific FGM/C prevalence rates were based on self-reported information collected through population health surveys. Self-reported data should be treated with caution, as studies on the reliability and validity of self-reported information on FGM/C indicate a complex picture with mixed conclusions. *World health statistics 2017* notes that the reliability and validity of self-reporting of FGM/C are unknown (WHO 2017).

The evidence suggests that reliability and validity will vary depending on the region, and on the level of community acceptance. In regions where FGM/C is more commonly practised and socially accepted, self-reported data on FGM/C are likely to be more valid (Askew 2005; Jackson et al. 2003). Studies that considered changes in the prevalence of FGM/C over time also found that prevalence rates can be affected positively by comprehensive public health campaigns promoting FGM/C abandonment, and/or legislative changes relevant to FGM/C (Chikhungu & Madise 2015). As a result, the time when the survey was done should be considered in light of any related social and legislative changes in the community.

Women may also be unaware that they have been cut or of the extent of the cutting, especially if FGM/C was done at an early age, resulting in an underestimate of prevalence (UNICEF 2013).

## Type of female genital mutilation/cutting

The method used in this report does not take into account the type of FGM/C, as collecting this information through self-reported surveys has been shown to have low reliability (Elmusharaf et al. 2006). However, the prevalence of the different types of FGM/C does vary between practising communities.

## Modelled estimates of FGM/C in Australia

Based on the model described, it is estimated that 53,000 girls and women born elsewhere but living in Australia in 2017 had undergone FGM/C during their lifetime—a rate of 4.3 per 1,000 girls and women in Australia, or 0.4% of Australia's overall female population.

Among girls and women living in Australia but born in the countries used in the calculations in this report, the FGM/C rate was estimated to be 452 per 1,000 (or 45%). The estimated prevalence rates for the specific countries of birth ranged from less than 1% to 98%.

Girls and women aged 15–49 accounted for more than half (57%) of the estimated total of girls and women with FGM/C in Australia in 2017.

## Estimated prevalence of FGM/C in Australia, by country of birth, 2017

Country of birth	Estimated number of girls and women in Australia with FGM/C <sup>(a)</sup>
Côte d'Ivoire	102
Egypt	20,381
Eritrea	2,388
Ethiopia	5,206
Ghana	135
Guinea	525
Iraq	3,616
Kenya	2,996
Liberia	1,070
Nigeria	934
Sierra Leone	1,954
Somalia	4,831
Sudan (north)	8,364
Tanzania	273
Other <sup>(b)</sup>	312
<b>Total<sup>(c)(d)</sup></b>	<b>53,088</b>

n.a. not available

n.p. not published

.. not applicable

(a) Prevalence estimates are calculated using five-year age-specific prevalence estimates (for the age range 15–49) for each country.

(b) 'Other' includes Benin, Burkina Faso, Cameroon, Djibouti, The Gambia, Mali, Mauritania, Niger, Senegal, Togo, Uganda and Yemen. Data are not published separately for these countries due to small estimated numbers (less than 100) of girls and women in Australia with FGM/C from these countries.

(c) The sum of girls and women with FGM/C from each country may not equal the total due to rounding.

(d) Includes Central African Republic, Chad and Guinea-Bissau. There were no female residents from any of these countries.

Sources: ABS population estimates (ABS 2018); AIHW estimates based on DHS (2018) and UNICEF (2018) age-specific prevalence estimates for specific countries.

## Estimated prevalence of FGM/C in Australia, by age group<sup>(a)</sup>, 2017

Age group (years)	Estimated number of girls and women in Australia with FGM/C	Estimated number of girls and women in Australia <sup>(b)</sup>	Age-specific prevalence per 1,000 girls and women in Australia <sup>(c)</sup>	Estimated proportion of all girls and women in Australia with FGM/C (%) <sup>(d)</sup>
0–4	410	764,887	0.5	0.8
5–9	988	773,385	1.3	1.9
10–14	1,737	715,467	2.4	3.3
15–19	2,604	724,218	3.6	4.9
20–24	3,511	842,755	4.2	6.6
25–29	4,820	921,491	5.2	9.1
30–34	5,634	924,243	6.1	10.6
35–39	5,029	830,943	6.1	9.5
40–44	4,602	805,939	5.7	8.7
45–49	4,162	840,186	5.0	7.8
50–54	3,555	782,812	4.5	6.7
55–59	3,152	767,759	4.1	5.9
60–64	3,068	682,895	4.5	5.8
65–69	2,955	607,738	4.9	5.6
70–74	2,479	487,400	5.1	4.7
75 and over	4,383	922,396	4.8	8.3
<b>Total<sup>(e)</sup></b>	<b>53,088</b>	<b>12,394,514</b>	<b>4.3</b>	<b>100.0</b>

(a) Because of the method used, estimates of girls and women with FGM/C are considered more reliable for those aged 15–49 than for other age groups.

(b) Information on the estimated number of girls and women living in Australia was sourced from ABS 2018.

(c) Estimated number of girls and women with FGM/C divided by the estimated total number of girls and women in Australia, expressed as a rate.

(d) Estimated number of girls and women in Australia with FGM/C divided by the estimated total number of girls and women with FGM/C in Australia, expressed as a percentage.

(e) The sum of girls and women with FGM/C may not equal the total due to rounding.

Sources: ABS population estimates (ABS 2018); AIHW estimates based on DHS (2018) and UNICEF (2018) age-specific prevalence estimates for specific countries.

From 2011 to 2017, the estimated number of girls and women with FGM/C in Australia rose by 21%—from about 44,000 to 53,000. This rise was due to an increase in the number of girls and women in Australia born in the countries included in the calculation—in particular, Egypt, Ethiopia, Somalia, Sudan and Iraq.

Overall, the estimated prevalence of FGM/C in Australia remained steady across the years between 2011 and 2017, at about 4 per 1,000 girls and women.

## Estimated prevalence of FGM/C in Australia, 2011–2017

Year	Estimated number of girls and women with FGM/C	Estimated number of girls and women in Australia	Prevalence per 1,000 girls and women <sup>(a)</sup>
2011	43,962	11,221,790	3.9
2012	45,261	11,426,100	4.0
2013	46,790	11,633,201	4.0
2014	48,344	11,824,746	4.1
2015	49,717	12,009,957	4.1
2016	51,219	12,198,963	4.2
2017	53,088	12,394,514	4.3

(a) Estimated number of girls and women with FGM/C divided by the estimated number of girls and women in Australia, expressed as a rate.

Sources: ABS population estimates (ABS 2018); AIHW estimates based on DHS (2018) and UNICEF (2018) age-specific prevalence estimates for specific countries.

## Improving the evidence on FGM/C

The rudimentary modelled prevalence estimates in this report are only a first step towards increasing our understanding of the extent of FGM/C in Australia. Future contributions to improving the evidence on FGM/C at a national level could include work to:

- establish national arrangements to collect information on FGM/C in a standard way—particularly within hospitals and health-care services
- develop a set of national metadata standards for FGM/C to support the collection of data in a range of settings in a consistent way
- improve the current hospital information by improving the classification codes used to capture FGM/C information during hospitalisations.

Such work could support more comprehensive reporting on:

- FGM/C prevalence—for example, by providing information on the age that FGM/C occurred, and sociodemographic characteristics
- the impact of FGM/C on girls and women in Australia over their lifetime
- the role that health and community services play in supporting these girls and women.

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