

# Demographic Perspectives on Female Genital Mutilation





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# Foreword

Female genital mutilation (FGM) is the practice of partially or totally removing the external genital organs for non-medical reasons. It violates the human rights of girls and women, and causes serious and, in some cases, life-threatening health complications.

In 2012, the United Nations General Assembly passed resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations, reaffirmed by resolution 69/150 in 2014. The Human Rights Council in 2014 passed resolution 27/22 on intensifying global efforts and sharing good practices to effectively eliminate female genital mutilations. These commitments by United Nations Member States reflect an unprecedented awareness of the practice and growing efforts to stop it. Global consensus is clear; FGM must end.

Accurate and current data are essential for policy makers and advocates to build on current momentum, develop successful interventions and achieve commitments made by UN Member States.

Data on current prevalence levels and projections of FGM trends are imperative, as is accurate and up-to-date information on population changes, including urbanization and resulting shifts in practising populations. Tracking rates of reduction and progress of change is necessary to inform ongoing and future interventions, and to identify what has been successful and where.

This report, the first such published by the United Nations Population Fund (UNFPA), looks at FGM through the lens of population dynamics and the demographic dividend, based on current evidence and data. It offers quantitative information that both supports evidence-based programming, and frames financial implications for Member States and international donors. Evidence to define the size of the target population and orient actions around areas of greatest impact is of high value in developing interventions and formulating policies.

UNFPA remains strongly committed to engaging with Member States, civil society, UN agencies and all other stakeholders to accelerate the elimination of FGM worldwide. Protecting girls upholds their sexual and reproductive health and rights, and enables them to realize their full potential.



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# 1

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## Introduction

FGM has been internationally recognized as an extreme form of violation of the rights, health and integrity of women and girls. In 2012, the United Nations General Assembly adopted the first-ever resolution against FGM (67/146), calling for intensified global efforts to eliminate it.

The resolution reaffirms that FGM is “a harmful practice that constitutes a serious threat to the health of women and girls, including their psychological, sexual and reproductive health, which can increase their vulnerability to HIV and may have adverse obstetric and prenatal outcomes as well as fatal consequences for the mother and the newborn, and that the abandonment of this harmful practice can be achieved as a result of a comprehensive movement that involves all public and private stakeholders in society, including girls and boys, women and men.”<sup>1</sup>

The resolution demonstrates deep concerns about the persistence of FGM, indicating increasing international commitment to abandonment of the practice. But so far, a funding shortfall has limited the scope and pace of programmes to achieve elimination.

FGM is a deeply ingrained cultural practice with devastating medical, social, emotional, legal and economic repercussions for young girls and women. It refers to all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-medical reasons.<sup>2</sup> Although primarily concentrated in 29 countries in Africa and the Middle East, FGM is a universal problem. It is practiced in some countries in Asia, including India, Indonesia, Iraq and Pakistan,<sup>3</sup> as well as in Latin America, and among immigrant populations in Western Europe, North America, Australia and New Zealand. The European Parliament estimated that, in 2009, about 500,000 women lived with the consequences of FGM in the European Union, and approximately 180,000 additional women and girls are at risk of undergoing it each year.<sup>4</sup>

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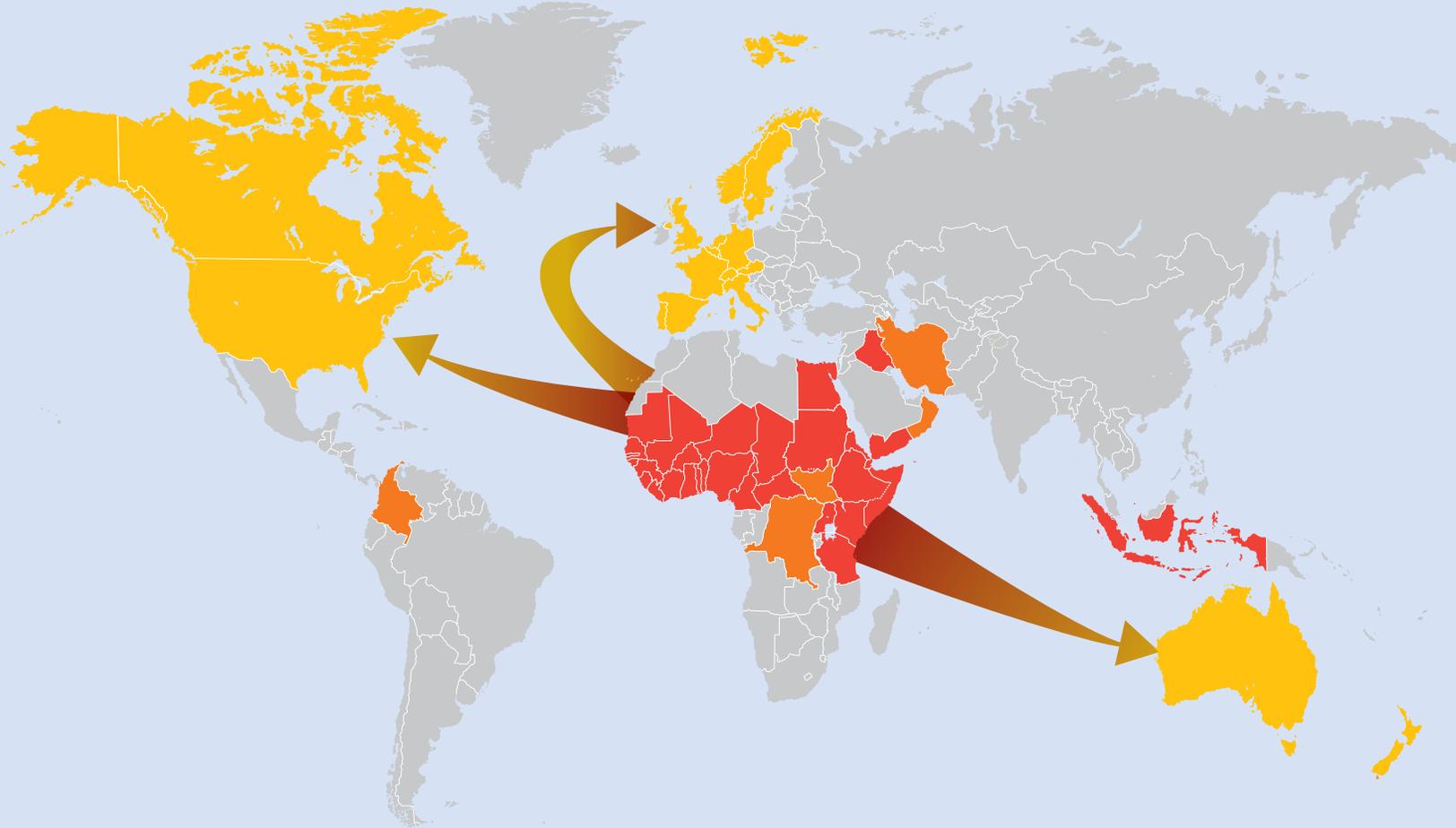
<sup>1</sup> UN General Assembly resolution 67/146 on intensifying global efforts for the elimination of female genital mutilations. 5 March 2013. See: [www.un.org/ga/search/view\\_doc.asp?symbol=A/RES/67/146](http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/67/146) (accessed 24 April 2014).

<sup>2</sup> “Female Genital Mutilation: A joint WHO/UNICEF/UNFPA statement.” 1997, reiterated in 2008. Geneva: World Health Organization (WHO).

<sup>3</sup> “Ending Female Genital Mutilation/Cutting: Lessons from a decade of progress.” 2013. Washington, DC: Population Reference Bureau.

<sup>4</sup> European Parliament resolution of 24 March 2009 on combating female genital mutilation in the European Union.

# FGM can be found around the world



- Countries with FGM data collected by household surveys
- Countries in which FGM has been reported
- Countries in which FGM has been reported among some immigrant communities

Source: UNFPA analysis based on DHS and MICS, 2002-2014, and WHO, "Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Statement," 1997.

This publication documents the most relevant features of the practice of FGM in 27 African, 2 Arab, and 1 Asia countries. The main objective is to provide a simple presentation of current levels; the main differences, according to background characteristics; and observed trends in the last 10-15 years. Considering past, current and future demographic dynamics helps identify possible scenarios for elimination.

Data on FGM have been collected through Demographic Health Surveys (DHS)<sup>5</sup> since 1990, with about 50 surveys conducted in 25 countries with prevalent FGM, and through Multiple Indicator Cluster Surveys (MICS)<sup>6</sup> since 2000, with more than 30 surveys conducted in 18 countries with prevalent FGM. Reliable data on the practice are now available for all African countries where the practice is concentrated, plus Iraq and Yemen. Statistical information is currently not available for countries where FGM has been newly identified, such as Colombia and India.

The first section of this paper presents background information and a description of efforts to eliminate FGM. The second section introduces key demographic characteristics of countries with FGM concentrations. The third section features current levels, trends and disparities based on the latest FGM statistics, focusing on gaps in existing analyses. The fourth section presents current projections of efforts required to eliminate FGM, providing a new perspective by factoring in demographic dynamics analysis.

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<sup>5</sup> ICF International implements DHS surveys, funded by the United States Agency for International Development, with contributions from other donors such as UNICEF, UNFPA, WHO and UNAIDS. These household surveys provide data on a wide range of indicators on population, health and nutrition.

<sup>6</sup> The MICS are household surveys run under a UNICEF programme to provide internationally comparable, statistically rigorous data on the situation of children and women.



# 2

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## A Demographic Overview of FGM Prevalent Countries

Several demographic characteristics are common to countries where FGM is prevalent. They all have young populations, high fertility levels, and high child and maternal mortality rates. These characteristics define the complexity and consequences of the practice, and make its elimination more challenging.

## 2.1. Young Populations

The total number of girls affected by FGM is ultimately determined by its prevalence/intensity and by the total number of girls at risk during their life span—referring, in other words, to the age structure of the population. As FGM mostly happens to girls before they reach age 15,<sup>7</sup> age structure is important. Population size and structure vary due to past and present patterns of fertility, mortality and migration. The majority of FGM affected countries, 22 out of 30, are least developed countries,<sup>8</sup> exceptions being Cameroon, Côte d'Ivoire, Egypt, Ghana, Indonesia, Iraq, Kenya and Nigeria. These countries grew at a fast pace between 1950 and 2010, and will continue doing so given their population momentum and high levels of fertility. The population of the least developed countries is expected to reach over 1.8 billion by 2050.<sup>9</sup>

Most countries with prevalent FGM have large proportions of young adolescents and children (0-14 years of age). All 30 FGM prevalent countries with available data, besides Indonesia, are experiencing high population growth and a young age structure, with 30 per cent or more of their female populations under age 15. In comparison, Viet Nam, a non-FGM prevalent country, has only 22 per cent of females under age 15. In Chad, Niger and Uganda, the percentage was almost half the female population in 2015 (see Table 2.1 and Figure 2.1).

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<sup>7</sup> "Female Genital Mutilation Factsheet No. 241." 2014. Geneva: WHO. See [www.who.int/mediacentre/factsheets/fs241/en/](http://www.who.int/mediacentre/factsheets/fs241/en/) (accessed April 25, 2014).

<sup>8</sup> The least developed countries are classified by the United Nations based on their low gross national income, weak human assets and high degree of economic vulnerability.

<sup>9</sup> United Nations Department of Economic and Social Affairs, Population Division. 2013. *World Population Prospects: The 2012 Revision*.

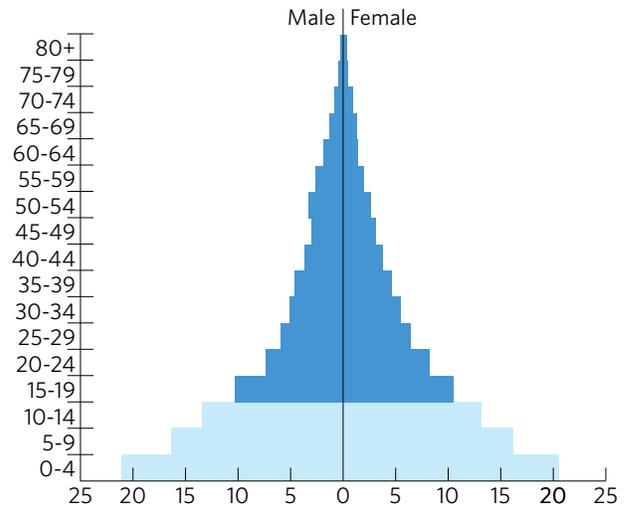
**Table 2.1. Number and percentage of girls under age 15 in FGM prevalent countries, 2015**

FGM PREVALENT COUNTRIES	NUMBER OF GIRLS UNDER AGE 15 in thousands	PERCENTAGE OF GIRLS UNDER AGE 15 as of total female population
<b>VERY YOUNG AGE STRUCTURE (MORE THAN 45% OF WOMEN UNDER AGE 15)</b>		
Niger	4,723	49.5
Uganda	9,557	47.7
Chad	3,230	47.6
Mali	3,790	47
Somalia	2,581	46.2
<b>YOUNG AGE STRUCTURE (BETWEEN 35% AND 45% OF WOMEN UNDER AGE 15)</b>		
Gambia	446	44.8
United Republic of Tanzania	11,593	44.4
Nigeria	39,730	44.1
Burkina Faso	3,961	44
Cameroon	4,939	42.2
Eritrea	1,419	42.1
Senegal	3,202	42
Liberia	933	41.8
Benin	2,270	41.6
Côte d'Ivoire	4,338	41.5
Guinea	2,560	41.5
Kenya	9,714	41.5
Ethiopia	20,259	41
Togo	1,489	41
Guinea-Bissau	367	40.8
Sierra Leone	1,292	40.6
Sudan	7,905	40
Mauritania	796	39.3
Central African Republic	945	38.7
Yemen	4,891	38.6
Iraq	6,819	38.5
Ghana	5,022	37
<b>RELATIVELY YOUNG AGE STRUCTURE (LESS THAN 35% OF WOMEN UNDER AGE 15)</b>		
Djibouti	149	33.3
Egypt	12,770	30.3
Indonesia	34,935	27.5

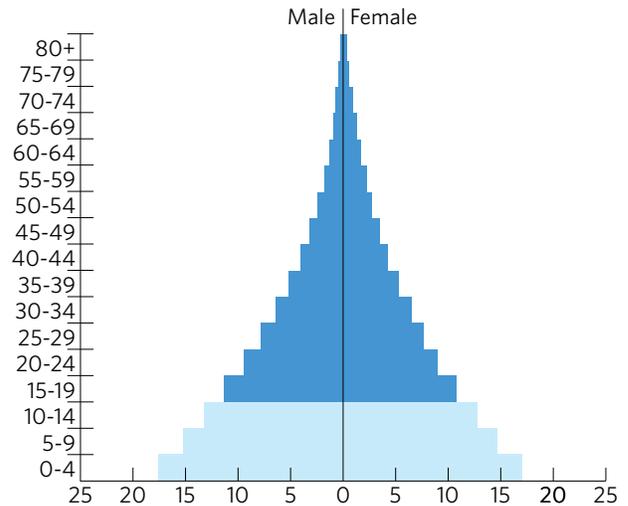
Source: United Nations Department of Economic and Social Affairs, Population Division. 2013. *World Population Prospects: The 2012 Revision*.

**Figure 2.1. Population pyramids for FGM countries compared to a non-FGM prevalent country, 2015**

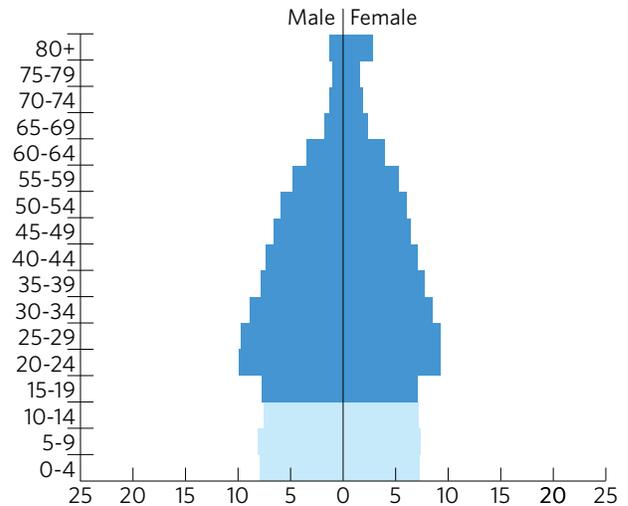
**A. Very young age structure example, Niger**



**B. Young/relatively young age structure example, Burkina Faso**



**C. Non-FGM prevalent developing country example, Viet Nam**



Source: United Nations Department of Economic and Social Affairs, Population Division, 2013, *World Population Prospects: The 2012 Revision*.

## 2.2. High Levels of Fertility

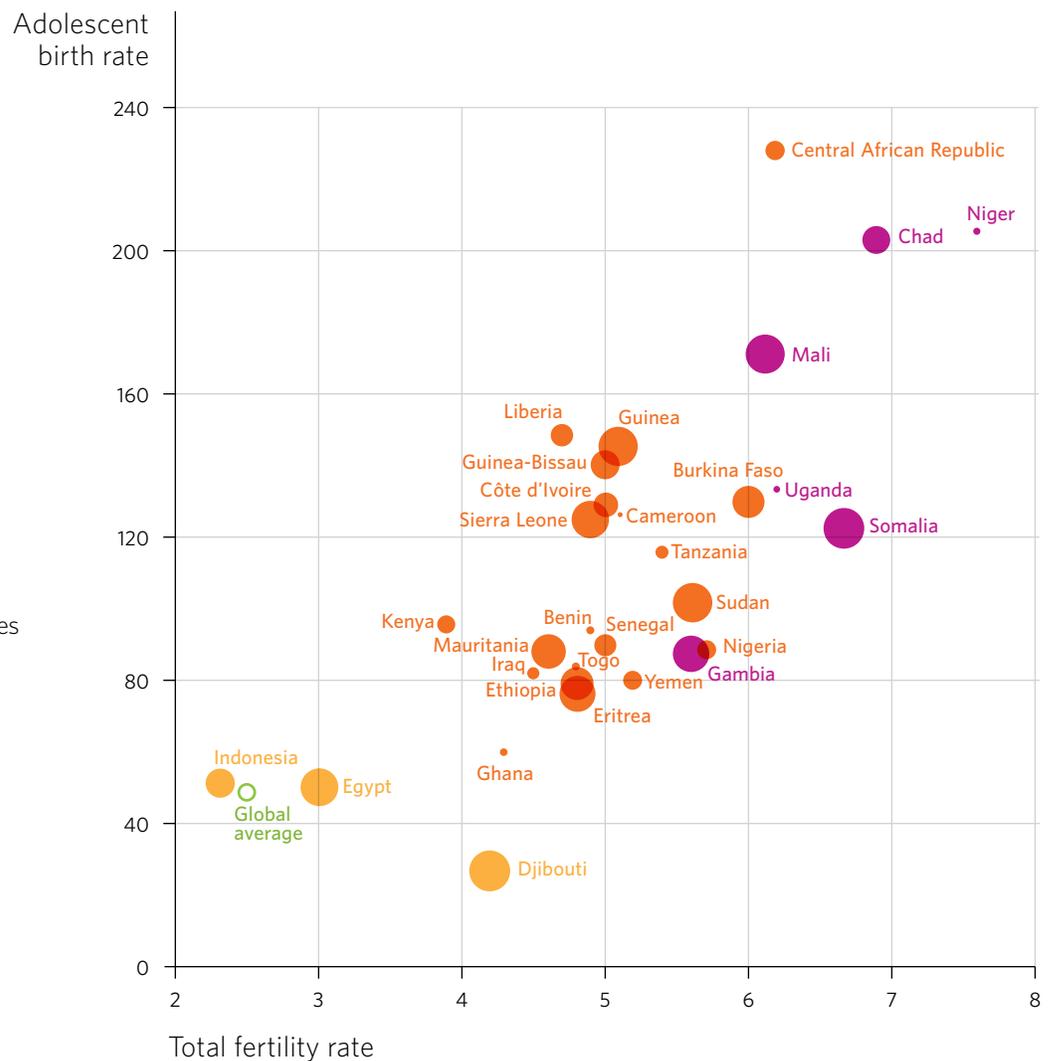
In addition to having young populations, FGM prevalent countries have high fertility. Globally, the total fertility rate from 2010 to 2015 was 2.5 children per woman 15-49 years of age, and the adolescent birth rate was 49 live births per 1,000 women 15-19 years of age.<sup>10</sup> Among the 30 FGM prevalent countries, all have total fertility rates greater than 4 children per woman aged 15-49 (except for Egypt

with 3 and Indonesia with 2.3), and adolescent birth rates that exceed 70 per 1,000 women aged 15-19 (except for Djibouti, Egypt, Ghana and Indonesia). Niger presents the highest total fertility rate at 7.6 children per women aged 15-49, while the Central African Republic has the highest adolescent birth rate at 229 live births per 1,000 women aged 15-19.

**Figure 2.2.**  
Prevalence of FGM among girls aged 15-19 according to adolescent birth rate and total fertility rate, 2002-2014

- Global average
- Slow growth countries
- Rapid growth countries
- Very rapid growth countries

**Bubble size:** prevalence of FGM/C among girls aged 15-19, besides global average



Source: DHS, MICS and other national surveys

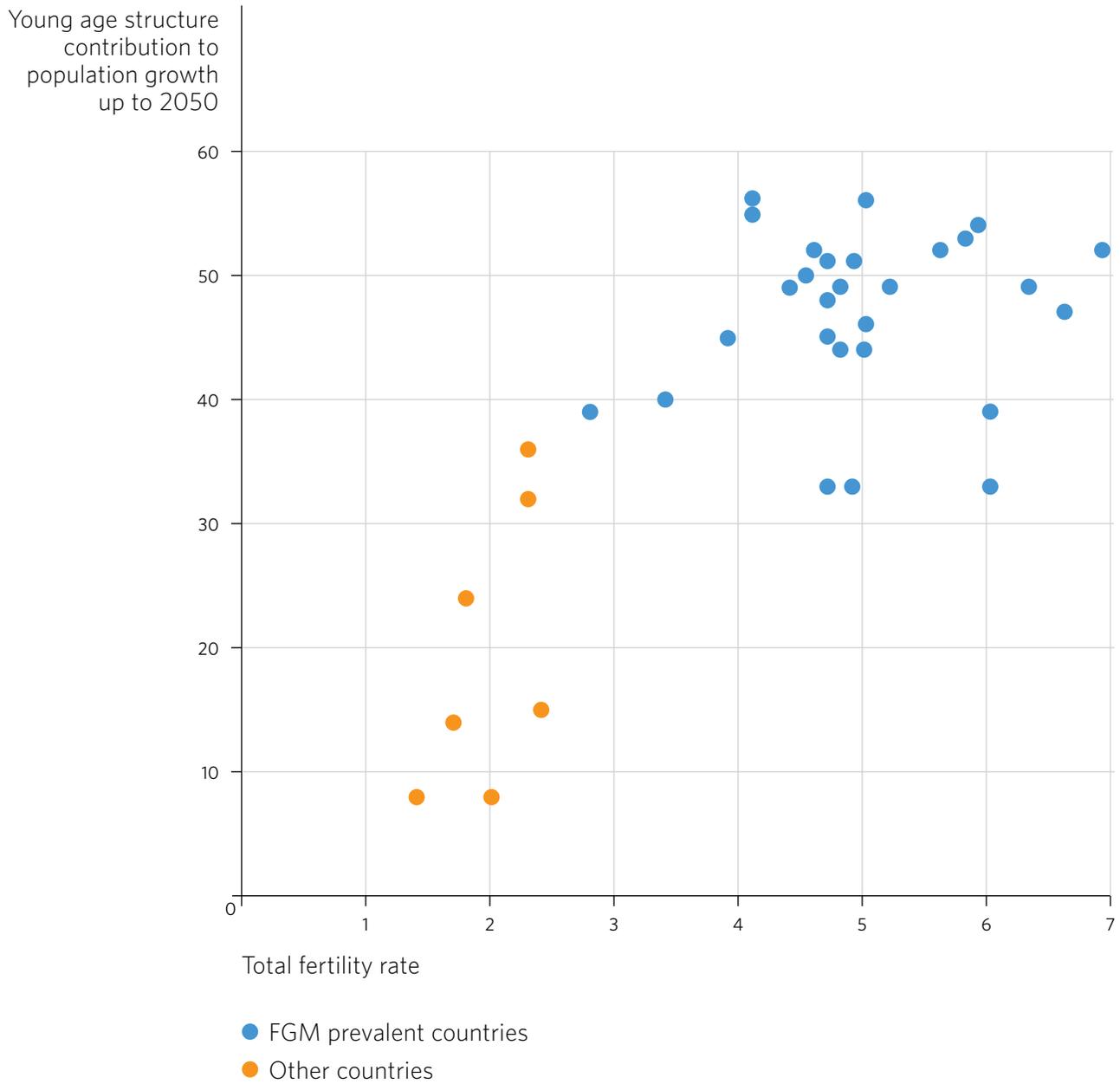
<sup>10</sup> United Nations Department of Economic and Social Affairs, Population Division. 2013. *World Fertility Patterns 2013*.

Variations in the prevalence of FGM among girls aged 15-19 are shown according to the corresponding levels of fertility in the country (adolescent birth rate and total fertility rate, Figure 2.2). It also reveals that countries with very rapid growth generally have a very high total fertility rate (approximately 5.6-7.6 children per woman aged 15-49) and very high adolescent birth rates (88-206 per 1,000 women aged 15-19). Although the FGM prevalent countries have significantly higher total fertility rates and adolescent birth rates than the global average, there is no significant positive correlation between levels of FGM and total fertility rates/adolescent birth rates. This finding indicates that the practice is not linked directly to these rates, but to other factors.

Among FGM affected countries, high levels of fertility are associated with relatively young populations (population momentum, Figure 2.3). These countries have greater population growth given their very young age structure. In Senegal, for example, a young age structure contributes to 56 per cent of future population growth, and together with the effect of high fertility, 67 per cent. These two features account for nearly all future growth. In contrast, in Thailand and the United States, where fertility levels are at or below replacement level, age structures will only contribute to 8 per cent of future population growth.

It is possible to counteract the impact of population momentum caused by a young age structure. For example, additional reduction in population growth can be achieved by raising the average age at which women begin bearing children, and by lengthening the interval between births. Most women affected by FGM, however, do not have the option to decide on whether or not to have sexual relations, when to have sexual relations, when or whom to marry, and whether to defer childbearing. Similarly, these women tend to have short intervals between births as a result of social pressure and as a means of obtaining social acceptance and economic security. Since delaying the start of childbearing contributes to fertility reduction and population growth, and to the improvement of women's well-being and quality of family life, it is important to develop comprehensive policies and interventions that address not only the practice of FGM, but also child and early marriage, early childbearing and birth spacing.

**Figure 2.3.** Distribution of countries according to current levels of fertility (2010-2015) and the contribution of a young age structure to population growth up to 2050



Source: UNFPA Decomposition of Future Population Growth Tool.  
 See: [www.dataforall.org/dashboard/unfpa/decomposition](http://www.dataforall.org/dashboard/unfpa/decomposition).



## 2.3. High Levels of Mortality

High levels of mortality are the third demographic characteristic observed among FGM prevalent countries. According to 2013 United Nations estimates,<sup>11</sup> the average global maternal mortality ratio<sup>12</sup> is 210 maternal deaths per 100,000 live births; the ratio in 27 of the 30 FGM prevalent countries is higher than this.<sup>13</sup> Infant mortality rates<sup>14</sup> follow a similar pattern. According to 2013 estimates produced by the United Nations Inter-agency Group for Child Mortality Estimation,<sup>15</sup> the infant mortality rate in FGM prevalent countries considerably exceeded the global average, except in Egypt, Indonesia and Iraq. Figure 2.4 shows the distribution of FGM prevalent countries according to their prevailing levels of both maternal and infant mortality, underlining that the majority of FGM affected countries are affected by rapid population growth and high mortality.

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<sup>11</sup> Produced by the Inter-agency Group on Maternal Mortality Estimation, comprising WHO, UNFPA, UNICEF, World Bank and United Nations Population Division.

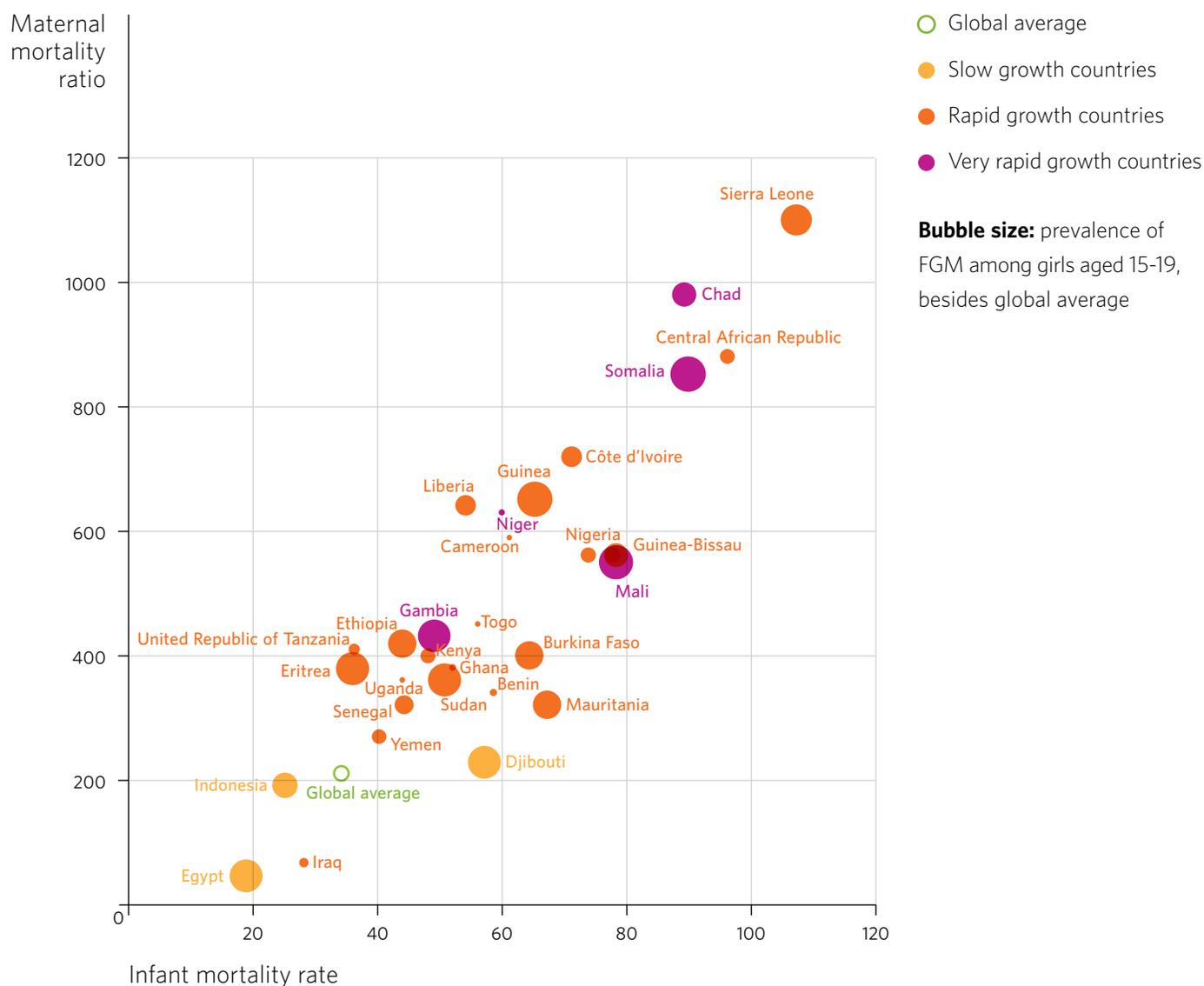
<sup>12</sup> The maternal mortality ratio is the number of women who die during pregnancy and childbirth per 100,000 live births.

<sup>13</sup> Egypt and Djibouti have values below the global average. WHO, UNICEF, UNFPA, World Bank and United Nations Population Division. 2014. *Trends in maternal mortality: 1990 to 2013*. Geneva: WHO.

<sup>14</sup> The infant mortality rate is the number of infants dying before reaching one year of age, per 1,000 live births in a given year.

<sup>15</sup> UNICEF, WHO, World Bank and United Nations Population Division. 2013. *Levels and Trends in Child Mortality Report 2013*. New York: UNICEF.

**Figure 2.4. Maternal mortality ratio, infant mortality ratio and prevalence of FGM among girls aged 15-19 in FGM prevalent countries**



Notes: Maternal mortality ratio and infant mortality rates are for 2013; FGM prevalence rates are from 2002 to 2013.

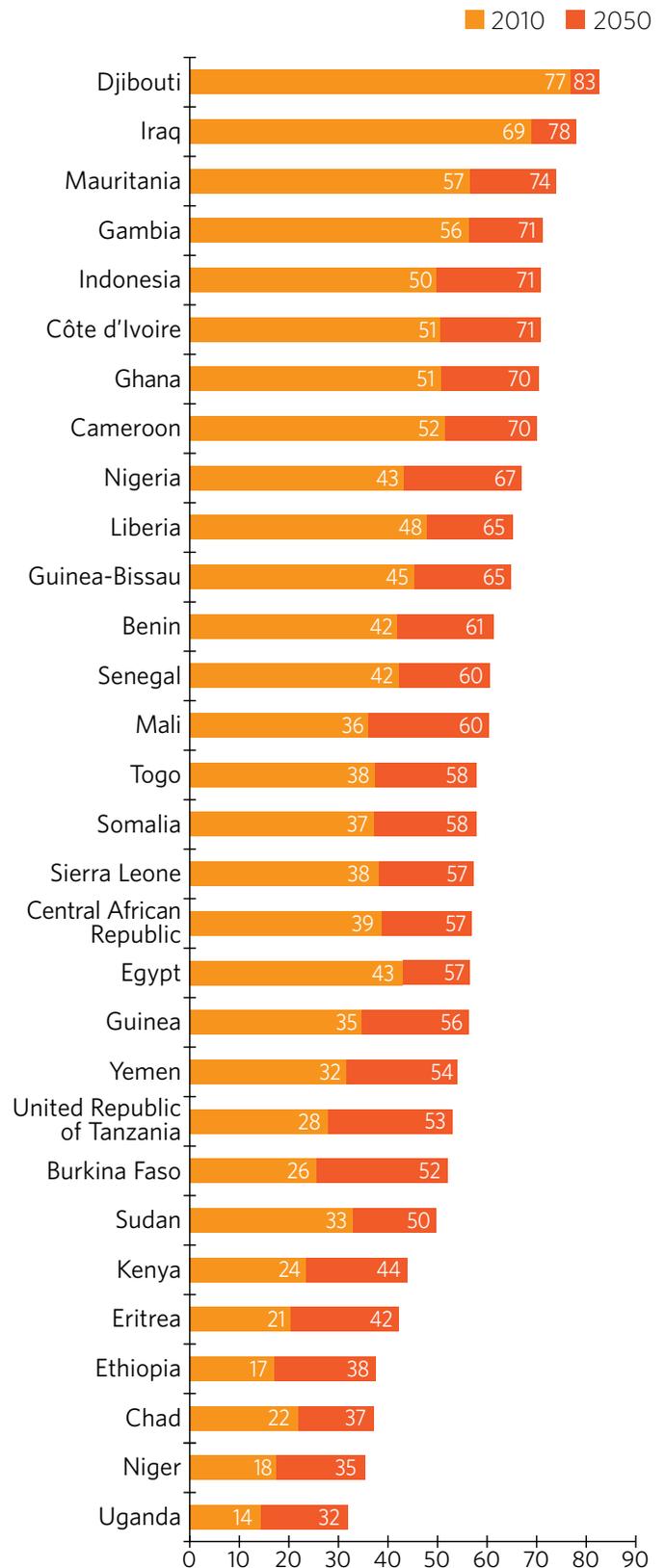
Source: DHS, MICS and other national surveys; WHO, UNICEF, UNFPA, World Bank and United Nations Population Division, 2014, *Trends in maternal mortality: 1990 to 2013*, Geneva: WHO; UNICEF, WHO, World Bank and United Nations Population Division. 2014. *Levels and Trends in Child Mortality Report*. New York: UNICEF.

## 2.4. Urbanization and Migration

In 2015, more than half of the world's population lives in urban areas. By 2050, the United Nations Population Division projects that this figure will reach 66 per cent of the world's population.<sup>16</sup> Although urbanization is a universal phenomenon, it has regional differences, with Latin America being highly urbanized, Asia almost half urban and sub-Saharan Africa about one-third urban. Among countries with low urbanization levels, the rate of urban growth can still be very high; low current levels can change into fast-paced urbanization in the future.

Most FGM affected countries are less urbanized than others in their regions; 22 of the 30 FGM affected countries have less than half of their populations in urban areas (see Figure 2.5). This feature is important as FGM is more prevalent in rural areas. One exception is Nigeria, where FGM occurs at high rates among urban residents. This may be explained by ethnicity.<sup>17</sup>

Figure 2.5. Percentage of people living in urban areas in FGM prevalent countries, 2010 and 2050



Source: United Nations Department of Economic and Social Affairs, Population Division. 2014. *World Urbanization Prospects: The 2014 Revision*.

Urbanization worldwide but particularly in Africa is fuelled by a constant flow of rural to urban migrants. Greater and better opportunities are the main reasons, as people seek expanded access to basic services such as water and sanitation, education, health, employment and income. The positive effects of urbanization include the abandonment of FGM, as families and women in particular benefit from better education and access to services that encourage changes in norms and behaviours that previously supported FGM. The challenge becomes how to reap the benefits of urbanization in advancing the elimination of FGM. Within the specific context of urban and rural dynamics, policies and interventions to eliminate FGM can acquire maximum relevance, effectiveness, efficiency and impact.

Between 2010 and 2050, the percentage of people in urban areas in FGM affected countries will increase by almost 60 per cent. In eight countries, the increase is expected to be 70 per cent or higher: Yemen (70 per cent), Kenya (86 per cent), the United Republic of Tanzania (89 per cent), Niger (101 per cent), Burkina Faso (103 per cent), Eritrea (104 per cent), Ethiopia (117 per cent) and Uganda (121 per cent). Some changes from rural to urban migration could include increased prevalence in urban areas due to the movements of ethnic groups who practice FGM, as has been noted in Senegal.

There is growing recognition of the precarious situation faced by the world's 232 million migrants,<sup>18</sup> and the imperative of fulfilling and protecting their human rights. International migration has increased the number of girls and women in Western countries who have undergone FGM or who may be at risk. It is through migration that this once remote practice and its harmful consequences have become a reality in Europe, Northern America, Australia and New Zealand. Often, there is continuing support for the practice among communities originating from FGM countries, suggesting that this social convention is strongly rooted. Because FGM is closely tied to culture, it becomes an integration issue, in addition to being a health and human rights issue. Data on FGM prevalence among migrants in destination countries are rare, however. Most of the time, extrapolations from known cases are used to measure the extent of the practice. Strategies addressing FGM must be adapted to the specificities of migration.<sup>19</sup>

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<sup>16</sup> United Nations Department of Economic and Social Affairs, Population Division. 2014. *World Urbanization Prospects: The 2014 Revision*.

<sup>17</sup> A. A. Abiodun, B. A. Oyejola and O. Job. 2011. "Female Circumcision in Nigeria, Prevalence and Attitudes." CENTREPOINT JOURNAL (science edition) 17(2).

<sup>18</sup> Statement by the United Nations Secretary-General on 15 December 2014.

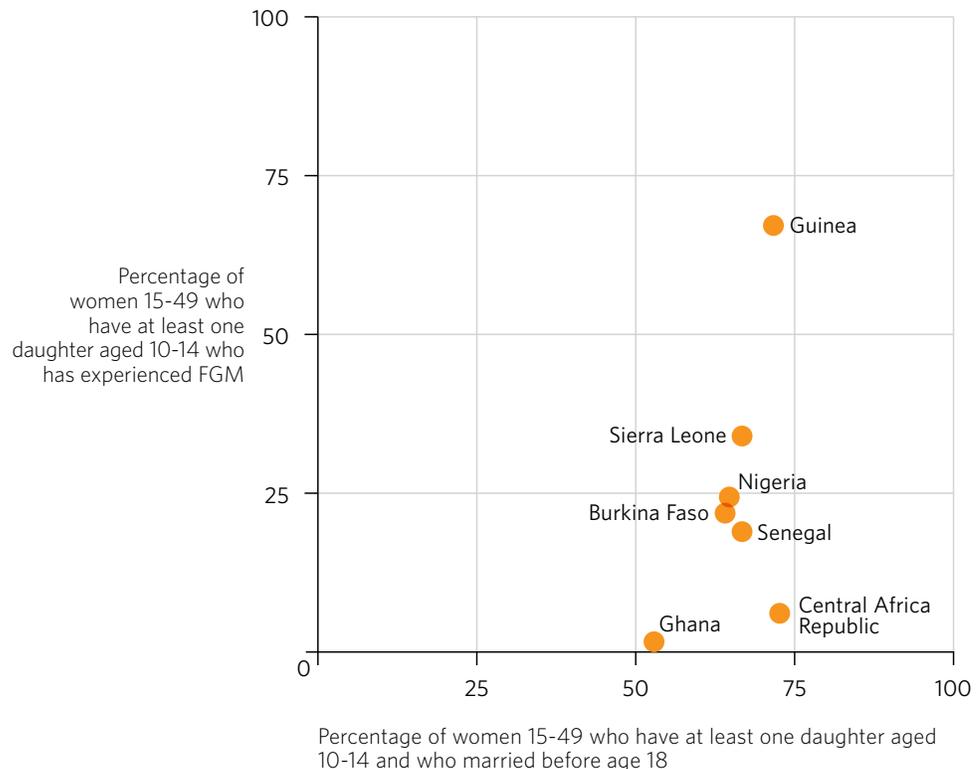
<sup>19</sup> International Organization for Migration "Supporting the Abandonment of Female Genital Mutilation in the Context of Migration."

## 2.5. FGM and Other Forms of Violence against Girls and Women

FGM and child marriage are forms of violence that cause negative consequences for girls and women, including through the perpetuation of gender inequality. These practices happen to girls and women at different times of their lives, exposing them to various levels of vulnerabilities and multiple human rights violations. This section explores the evidence to determine if women who have experienced other forms of violence are more likely to subject their daughters to FGM. This is done with data on women with daughters aged 10-14 in nine countries where the majority of FGM takes place before age 10.

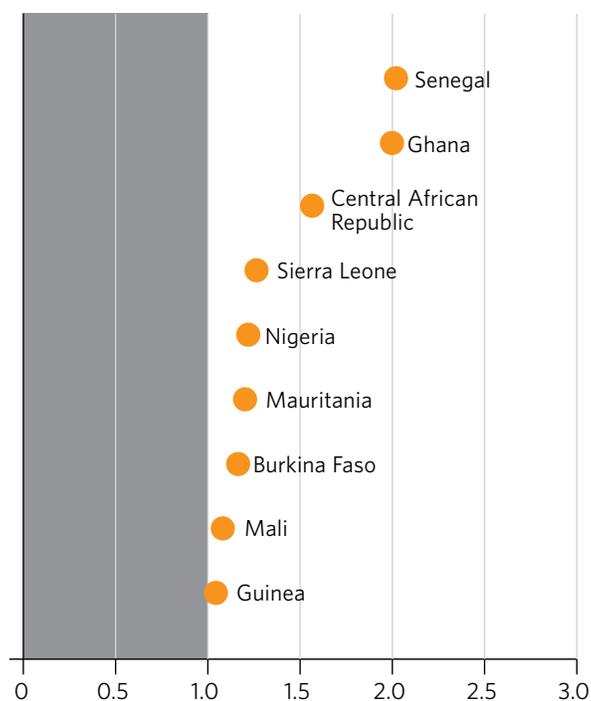
By analysing data for women aged 15-49 who have at least one daughter aged 10-14, Figure 2.6 shows a positive relationship between child marriage and the probability of cutting the daughters for selected countries. In other words, women married as children tend to practice FGM on their daughters. This is more evident when comparing Ghana with Senegal, or Ghana or Togo with Nigeria. In Guinea and Nigeria, we observe that a higher percentage of mothers married before age 18 resulted in a higher prevalence of mothers cutting at least one of their daughters.

**Figure 2.6.** Among mothers who have at least one daughter aged 10-14, the percentage of whom have at least one daughter who has experienced FGM, and the percentage of whom married before age 18



This hypothesis becomes more apparent from data in Figure 2.7, which shows FGM ratios<sup>20</sup> among women married before, and at or after age 18. In all nine countries mothers who experienced child marriage are more likely to cut at least one of their daughters, compared to the mothers who married at or after age 18 (a ratio greater than one).

**Figure 2.7. Ratio of the percentage of mothers who have at least one daughter who has experienced FGM, by mothers married before age 18 over mothers married at age 18 or later**



Mothers who married before age 18 are more likely to cut their girls.

Source: UNFPA analysis based on DHS and MICS.

<sup>20</sup> A ratio greater than one indicates that being in the selected/exposed group increases the odds or risk of experiencing the outcome.

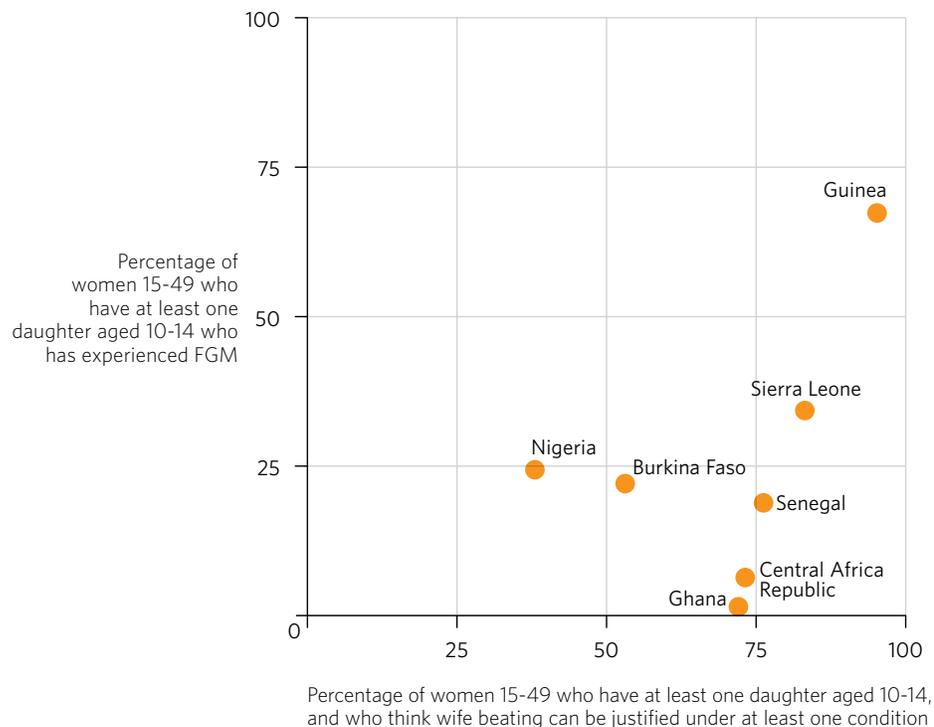
Domestic violence is prevalent across all societies and all levels within them, a manifestation of gender inequality and a grave human rights violation. Figures 2.8 and 2.9 show the relationship between women's attitudes towards domestic violence (wife beating acceptance) and the percentage of them with at least one daughter who has experienced FGM.

Figure 2.8 indicates a positive relationship, with women who believe that domestic violence is justified under at least one circumstance more likely to subject their daughters to FGM than those who consider it not acceptable at all. This is particularly evident when comparing, for instance, Burkina Faso with Guinea, or comparing Ghana with Senegal, where higher percentages of mothers who think domestic violence can be justified under at least one condition resulted in higher percentages of mothers who have at least one daughter who has experienced FGM, as reported by the mothers.

Figure 2.9 presents the ratios of FGM prevalence to women justifying domestic violence versus those who reject the notion completely. Women in Burkina Faso, Mauritania, Nigeria, Senegal and Sierra Leone who tend to justify domestic violence are more likely to subject their daughters to FGM by a ratio exceeding one compared to those who reject it.<sup>21</sup> Central African Republic has a ratio of less than one, and Ghana has a high ratio, but calculations were influenced by uncertainty around FGM estimates. Ghana has a relatively low level of FGM, below 2 per cent, as shown in the next section.

Girls who marry before age 18 are less likely to complete their education, and more likely to experience domestic violence and complications in childbirth, inequalities that stand in the way of development. Empowered women, by contrast, contribute to the health and productivity of whole families and communities, and improve prospects for the next generation.

**Figure 2.8.** Among mothers who have at least one daughter aged 10-14, the percentage of whom have at least one daughter who has experienced FGM, and the percentage of whom think domestic violence can be justified under at least one condition



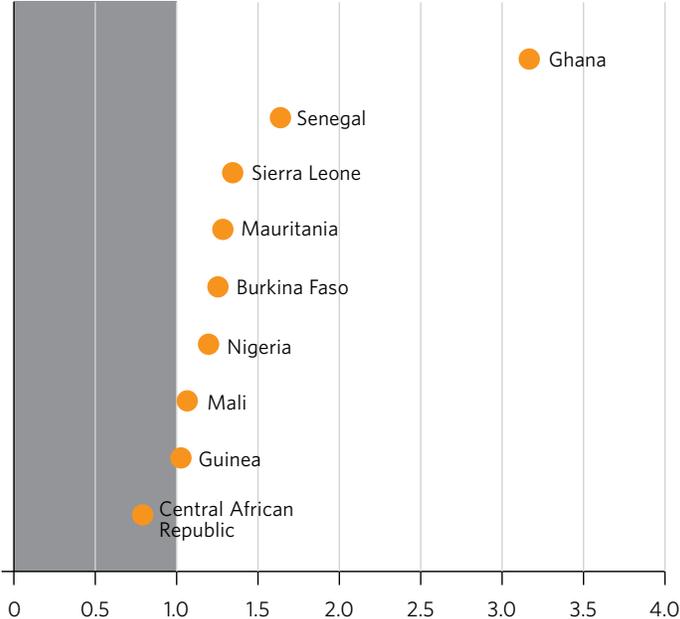
Development policies must address persistent discrimination and inequalities to be effective. Efforts to address FGM must occur within a wider framework of policies and interventions that holistically address all harmful practices and forms of violence against girls and women.

This overview of several socio-demographic characteristics—fertility, mortality, migration and gender-based violence—implies that any attempt to further conceptualize and contextualize the practice of FGM needs to be done in light of these, taking on board the specific patterns in any given country. Girls and women subjected to FGM find themselves having many children, having a higher risk of dying in childbirth along with their children also dying, and being victims of domestic abuse—all factors with important implications, directly or indirectly, for work

to address FGM. Understanding the demographic background of a country is useful in developing a holistic comprehension of the context in which FGM occurs and drawing relevant conclusions to guide programming.

For advocacy and programmatic purposes, it can be important to stress that interventions targeting FGM abandonment could help improve demographic characteristics. For example, effectively addressing FGM entails the better overall well-being and status of girls and women at the family and community levels. It can help redress gender inequality and encourage a strong, holistic, sustainable social change process. Programmes primarily designed around other types of violence and gender inequality, such as child marriage, also need to systematically incorporate FGM as a way of broadening opportunities to advance change.

**Figure 2.9.** Ratio of the percentage of mothers who have at least one daughter who has experienced FGM, by mothers who think domestic violence can be justified under at least one condition over mothers who think it cannot be justified under any condition



Mothers who think domestic violence can be justified under at least one condition are more likely to cut their girls.

Source: UNFPA analysis based on DHS and MICS.

<sup>21</sup> A ratio greater than one indicates that being in the selected/exposed group increases the odds or risk of experiencing the outcome.

# 3



## Levels and Trends

## 3.1. Global Estimates and Country Prevalence

Today, by some estimates, 130 million girls and women have undergone FGM in the 29 countries with FGM data collected by household surveys.<sup>22</sup> Other estimates indicate that almost 87 million women and girls aged 15 years and older have been subjected to it in 27 African countries and Yemen,<sup>23</sup> or about 100 million to 140 million girls and women worldwide.<sup>24</sup> The actual number remains unknown, mainly due to a lack of reliable data on girls younger than age 15, on women and girls in the Arab States, Asia and Latin America, and on immigrant communities continuing the practice in Europe, North America and Australia.

The main indicator to measure FGM prevalence is the percentage of girls aged 15-19 experiencing any form of FGM, as self reported. This indicator is used for three reasons. First, it is likely to reflect more complete FGM status, since almost all girls are cut before age 15. After that age, their risk of FGM is much lower. Indicators that measure girls younger than age 15 only reflect the current FGM status of these girls. This, therefore, can result in under-reporting of the actual prevalence of FGM because the girls are still at risk of undergoing this practice. Second, this indicator is the closest to FGM incidence (new FGM cases), and it focuses on girls most recently cut.

The widely used indicator on the percentage of girls and women of reproductive age (15-49) who have experienced any form of FGM, although showing a bigger picture, does not capture recent changes. That is because women ages 20-24 years have already undergone FGM at least five years prior to the survey, depending on the age of cutting. The practice may have happened much earlier for women aged 25 and beyond. Therefore the programmes targeting the abandonment of this practice will not have any influence on the older women. A third reason is data availability. All household surveys allow the calculation of FGM prevalence among the group aged 15-19.

There is wide variation in FGM prevalence across countries, as indicated by the most recent data (see Table 3.1 and Map 3.1). The highest prevalence was in Somalia at 97 per cent, followed by Guinea at 94 per cent and Mali at 90 per cent. The lowest prevalence was in Cameroon at 0.4 per cent, after which come Niger and Uganda at 1 per cent. Countries are divided into three groups based on FGM prevalence: high, medium and low. Subnational variation differs, being less in high-prevalence countries and greater in low-prevalence countries.

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<sup>22</sup> UNICEF. 2014. "Female Genital Mutilation/Cutting: What might the future hold?" New York.

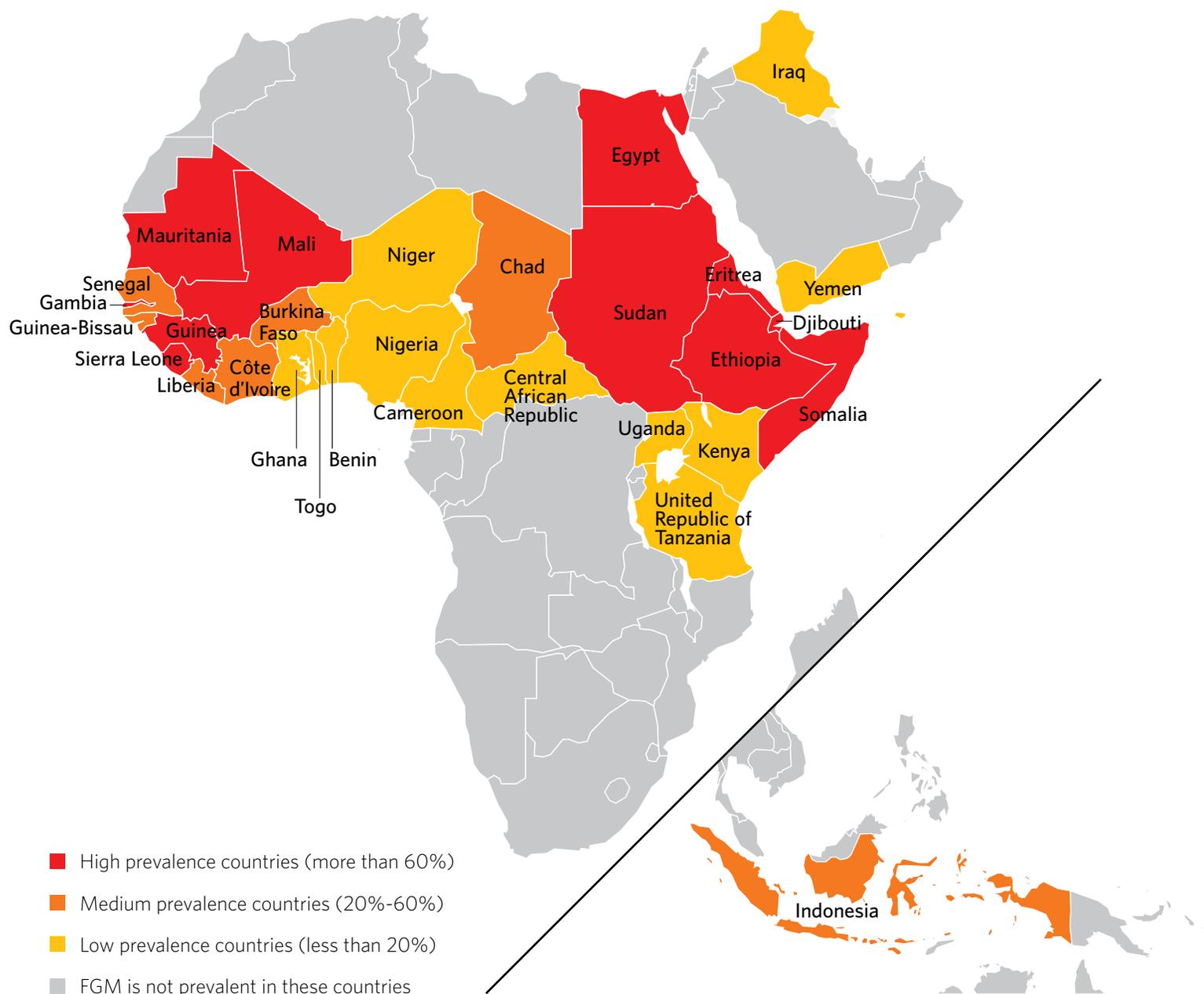
<sup>23</sup> P. S. Yoder, S. Wang and E. Johansen. 2013. "Estimates of Female Genital Mutilation/Cutting in 27 African Countries and Yemen." *Studies in Family Planning* 44(2): 189-204.

<sup>24</sup> Population Reference Bureau. 2014. "Female Genital Mutilation/Cutting: Data and Trends."

**Table 3.1. Percentage of girls aged 15-19 experiencing any form of FGM, by country, most recent data, 2002-2014**

FGM PREVALENT COUNTRIES	PERCENTAGE OF GIRLS AGED 15-19 EXPERIENCING ANY FORM OF FGM	DATA SOURCE
<b>HIGH PREVALENCE COUNTRIES (MORE THAN 60%)</b>		
Somalia	96.7	2006 MICS
Guinea	94	2012 DHS
Mali	90.3	2013 DHS
Djibouti	89.5	2006 MICS
Sudan	84	2010 SHHS
Egypt	81	2008 DHS
Eritrea	78.3	2002 DHS
Gambia	76.3	2013 DHS
Sierra Leone	74.3	2013 DHS
Mauritania	65.9	2011 MICS
Ethiopia	62.1	2005 DHS
<b>MEDIUM PREVALENCE COUNTRIES (20-60%)</b>		
Burkina Faso	58	2010 DHS
Indonesia*	51	2013 RISKESDAS
Guinea-Bissau	48.4	2010 MICS
Chad	41	2010 MICS
Cote d'Ivoire	31	2011-12 DHS
Liberia**	26.4	2013 DHS
Senegal	21.1	2014 DHS
<b>LOW PREVALENCE COUNTRIES (LESS THAN 20%)</b>		
Central African Republic	18	2010 MICS
Yemen	16.4	2013 DHS
Nigeria	15.3	2013 DHS
Kenya	11.4	2014 DHS
United Republic of Tanzania	7	2010 DHS
Iraq	4.9	2011 MICS
Benin	2	2011-12 DHS
Togo	1.8	2014 DHS
Ghana	1.5	2011 MICS
Niger	1.4	2012 DHS
Uganda	1	2011 DHS
Cameroon	0.4	2004 DHS

Map 3.1. FGM prevalent countries where data are available, latest data



It is evident that the prevalence of FGM varies from less than 1 per cent in certain countries to being almost universal in others. The pattern of subnational variation in FGM prevalent countries differs.

In general, subnational variations in prevalence in high FGM countries tend to be minor, while low FGM prevalence countries tend to show more significant variations.

Source: DHS and MICS, 2002-2014.

## 3.2. Trends: Is the Practice Changing?

An increasing number of countries have conducted one or more household surveys with an FGM module, thereby making trend analysis more feasible. Trend analysis can be conducted from multiple perspectives. One of the most common methods is to take more than one survey for the same country, and compare the prevalence of FGM for one age group. It is also possible to compare the prevalence of FGM across five-year age cohorts from the same survey. For example, a comparison of prevalence among girls aged 15-19 and among women aged 45-49 may indicate a decreasing or increasing trend. Depending on the age at cutting, the trend may also be analysed by comparing the prevalence among girls aged 15-19 years and among girls under age 15 (aged 0-4, aged 5-9 and aged 10-14) from the same survey. When making this type of comparison, it is important to adjust the prevalence among girls under 15. Since they are still subjected to FGM, prevalence is likely to be underestimated.

This report analyses trends by comparing the prevalence among girls aged 15-19 from two points in time for the same country (around 2007 and around 2012). Figure 3.1 shows that of the 23 countries with two consecutive household surveys, 16 have

seen a decline in prevalence among girls aged 15-19. Among the high prevalence countries, the fastest reduction has taken place in Egypt, from 96 per cent in 2005 to 81 per cent in 2008, a 16 per cent decline. Surprisingly, two high prevalence countries showed an increase, Guinea and Mali. In Guinea, prevalence climbed from 89 per cent in 2005 to 94 per cent in 2012.

The change in FGM in medium prevalence countries and in low prevalence countries varied. The largest decline was in Liberia, dropping from 36 per cent in 2007 to 26 per cent in 2013, a 26 per cent decline, followed by Senegal, with a 12 per cent decrease from 24 per cent in 2010 to 21 per cent in 2014. In Côte d'Ivoire, the reported prevalence rose slightly between 2006 and 2012, from 28 per cent to 31 per cent. In Guinea-Bissau, the prevalence went from 44 per cent to 48 per cent, an 11 per cent increase.

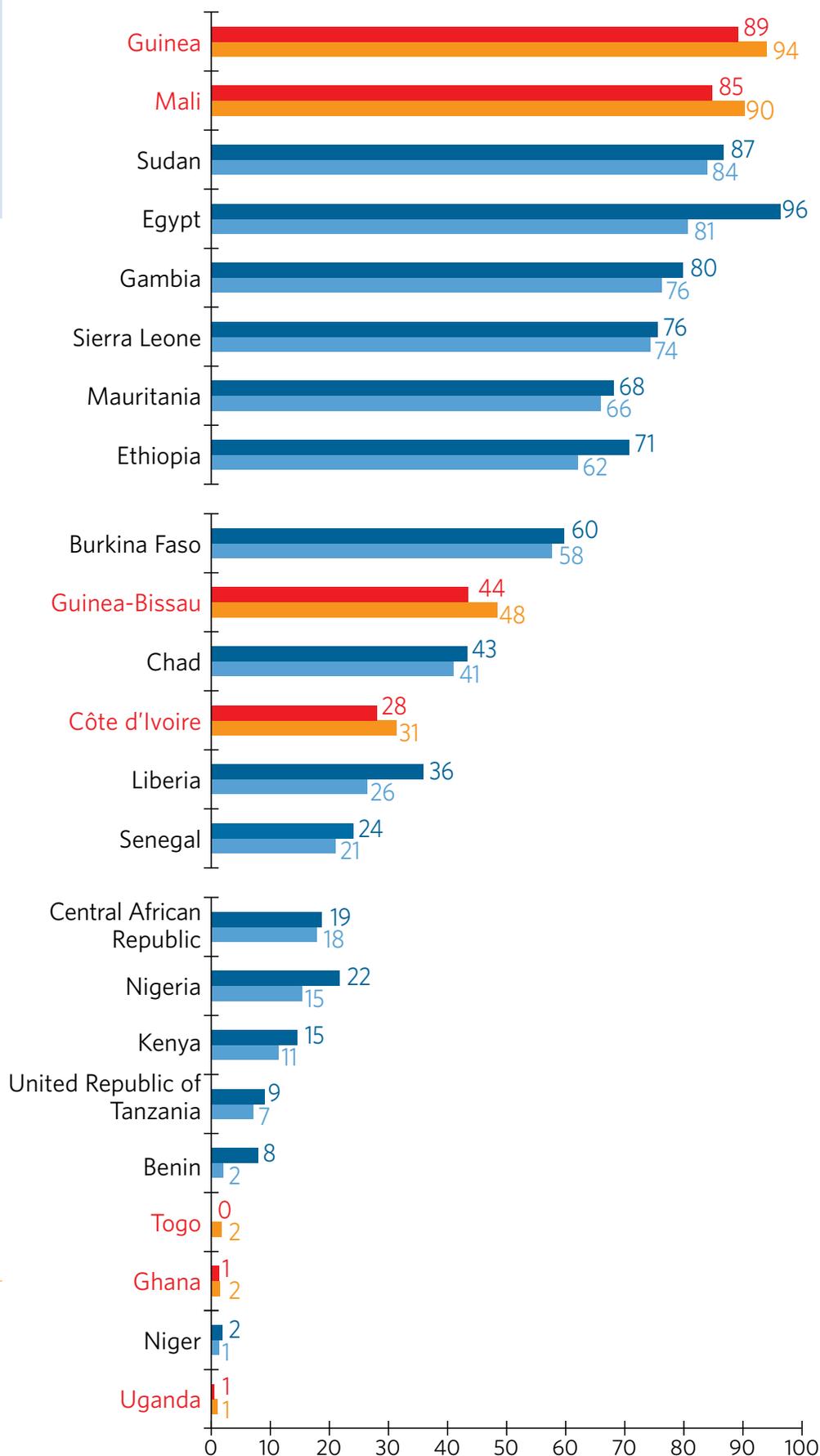
The most dramatic decline in low prevalence countries was in Benin, from 8 per cent in 2006 to 2 per cent in 2012, a reduction of 75 per cent. In Kenya, prevalence fell by 28 per cent, from 20 per cent in 2003 to 15 per cent in 2008.

**Table 3.2. Data on FGM are available for 30 FGM prevalent countries, after 2000**

Egypt	2014 DHS	2008 DHS	2005 DHS	2003 DHS	2000 DHS
Nigeria	2013 DHS	2011 MICS	2008 DHS	2007 MICS	2003 DHS
Mali	2013 DHS	2010 MICS	2006 DHS	2001 DHS	
Senegal	2014 DHS	2012 DHS	2010 DHS	2005 DHS	
Sierra Leone	2013 DHS	2010 MICS	2008 DHS	2005 MICS	
Benin	2012 DHS	2006 DHS	2001 DHS		
Burkina Faso	2010 DHS	2006 MICS	2003 DHS		
Central African Republic	2010 MICS	2006 MICS	2000 MICS		
Chad	2010 MICS	2004 DHS	2000 MICS		
Gambia	2013 DHS	2010 MICS	2005 MICS		
Ghana	2011 MICS	2006 MICS	2003 DHS		
Kenya	2014 DHS	2008 DHS	2003 DHS		
Mauritania	2011 MICS	2007 MICS	2000 DHS		
Sudan	2010 SHHS	2006 SHHS	2000 MICS		
Togo	2014 DHS	2010 MICS	2006 MICS		
Côte d'Ivoire	2012 DHS	2006 MICS			
Ethiopia	2005 DHS	2000 DHS			
Guinea	2012 DHS	2005 DHS			
Guinea-Bissau	2010 MICS	2006 MICS			
Liberia	2013 DHS	2007 DHS			
Niger	2012 DHS	2006 DHS			
United Republic of Tanzania	2010 DHS	2004 DHS			
Uganda	2011 DHS	2006 DHS			
Cameroon	2004 DHS				
Djibouti	2006 MICS				
Eritrea	2002 DHS				
Indonesia	2013 RISKESDAS				
Iraq	2011 MICS				
Somalia	2006 MICS				
Yemen	2013 DHS				

Source: UNFPA analysis based on DHS and MICS.

**Figure 3.1. Reductions and increases in FGM according to the percentage of girls aged 15-19 who have experienced any form, 2007-2012**



■ Around year 2007  
 ■ Around year 2012

Notes: Data for Ethiopia are taken from DHS 2000 and 2005 as DHS 2010 did not collect data on FGM.

Source: DHS, MICS and other national surveys.

### 3.3. Case Studies: Trends and Disparities in Burkina Faso and Guinea

This section looks at specific trends in Burkina Faso and Guinea.

To capture the most recent changes in Guinea, the prevalence of FGM among young girls under age 15, as reported by their mothers, was analysed, adjusting for the fact that girls under age 15 are still at risk of being cut. The group of girls aged 10-14 was selected because estimates for them are less sensitive to censoring, compared to estimates for younger girls, and because their status is more likely to be their final one.

Calculating the adjusted prevalence requires examining patterns of age at the time FGM was performed and related trend. In Guinea, no significant trend was found for age at cutting. Table 3.2 presents the prevalence of FGM among girls and women aged 5-49 by five-year

age groups, according to age at time of cutting. Among girls aged 15-19, 23 per cent were cut under age 5, 44 per cent between ages 5-9, 27 per cent between ages 10-14, and 1 per cent at age 15 years or later, adding up to a total prevalence of 94 per cent. This comparison is made with girls aged 10-14, where 12 per cent were cut before age 5, 54 per cent between ages 5-9, and 14 per cent between ages 10-14. By taking the ratios of girls cut at ages 0-4 corresponding to girls aged 15-19 and 10-14, and those cut at ages 5-9 corresponding to girls aged 15-19 and 10-14, it can be estimated that approximately 6 per cent of girls aged 10 to 14 are expected to be cut before age 15. According to Table 3.2, once girls reach age 15, approximately 1 per cent who have not yet undergone FGM are still at risk of being cut. This adds up to an adjusted prevalence of 86 per cent among girls aged 10-14.

**Table 3.2. Percentage of girls and women in Guinea who have undergone FGM by five-year age group, by age at cutting**

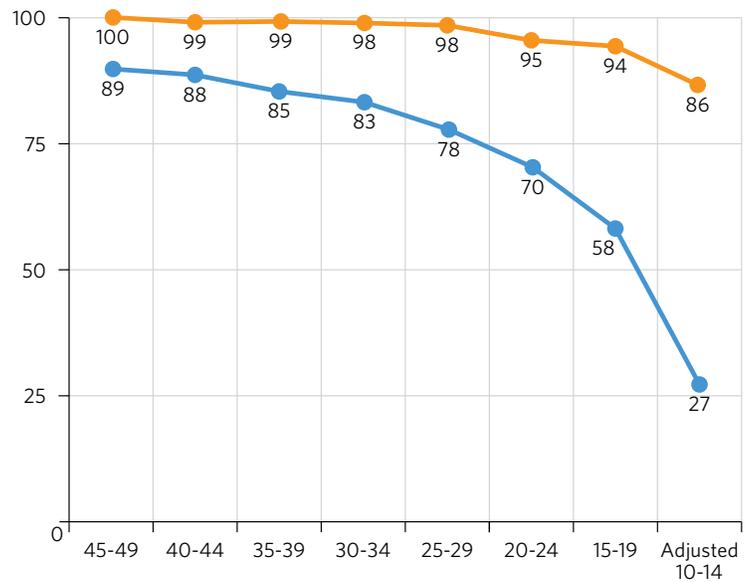
AGE GROUP	CUT AT 0-4	CUT AT 5-9	CUT AT 10-14	CUT AT 15+	PREVALENCE OF GIRLS AND WOMEN WHO HAVE NOT UNDERGONE FGM	PREVALENCE OF FGM
5-9	17.9	32.6			49.4	50.6
10-14	11.6	54.3	14.1		19.9	80.1
10-14 adjusted prevalence*	11.6	54.3	19.6	0.8	13.7	86.3
15-19	22.5	43.5	26.8	1.1	6	94
20-24	24.2	41.8	26.5	2.4	5.1	94.9
25-29	25.9	40.3	29.4	2.4	2.1	97.9
30-34	25.3	36.5	34.6	1.9	1.7	98.3
35-39	23.0	35.4	38.0	2.4	1.2	98.8
40-44	22.4	38.7	34.7	3.0	1.2	98.8
45-49	23.8	37.3	33.6	4.9	0.4	99.6

Source: DHS, MICS and other national surveys.

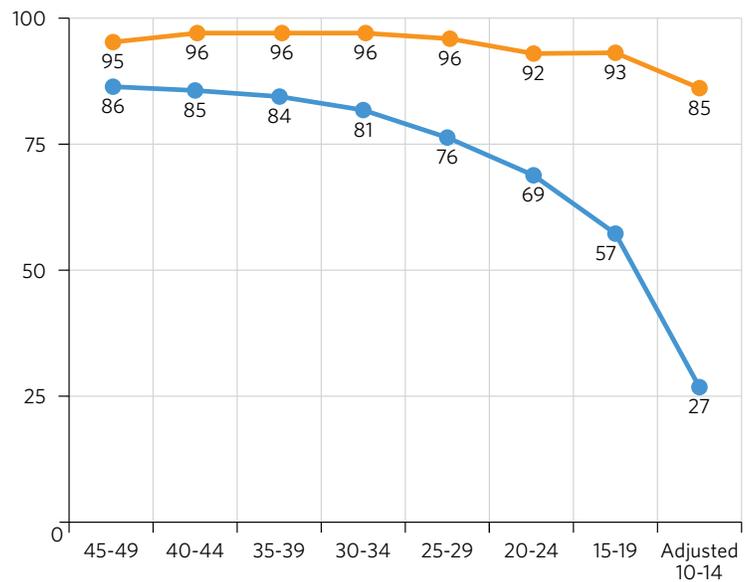
\* Prevalence rates among girls aged 10-14 need to be adjusted because they are still at risk of being cut before they reach age 15 (value for being cut at 10-14 is underestimated), and even after they reach age 15 (value for being cut at 15 and beyond is missing).

**Figure 3.2. Percentage of girls and women who have undergone FGM, by age group, cut at any age, cut before age 15 only and cut before age 10 only**

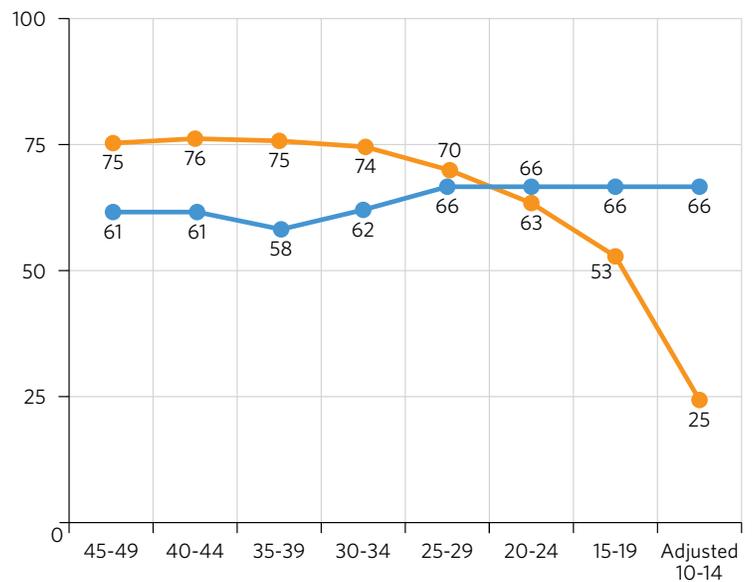
**A.**  
Cut at any age



**B.**  
Cut before age 15 only



**C.**  
Cut before age 10 only



- Guinea
- Burkina Faso

Source: UNFPA analysis based on DHS. Burkina Faso DHS 2010 and Guinea DHS 2012.

Figures 3.2a-c show the percentages of girls and women who have undergone FGM by five-year age groups in Burkina Faso and Guinea. Figure 3.2a summarizes the prevalence of FGM at any time in the girls' lives. Figure 3.2b includes cuts done before age 15, and Figure 3.2c only cuts before age 10. Together, the figures provide an alternative overview of the latest trends in FGM prevalence in the two countries. While the trend in Guinea remains almost constant, and although FGM is almost universal among women aged 45-49 years, a small percentage of girls aged 15-19 remain uncut. In Burkina Faso, the prevalence of FGM has declined in the past decade.

Although the adjusted prevalence helps minimize the risk of underestimation due to censoring, there are still uncertainties due to risks that include misreporting on age at cutting, and unwillingness among mothers to disclose their or their daughters' real FGM status because of their knowledge of campaigns on FGM abandonment and legal bans on the practice.

The prevalence of FGM can vary significantly across different ethnic and religious groups, even if trends in overall prevalence are constant for some countries. Figure 3.3 shows trends among girls aged 15-19 by ethnicity and religion, in Burkina Faso and Guinea, based on three consecutive DHS surveys.<sup>25</sup>

In Guinea, although the prevalence of FGM among Peulh, Soussou, Kissi, and Malinke women remained over 90 per cent between 2000 and 2012, the prevalence among Guerze women declined in the same period from 70 per cent to 38 per cent. In Burkina Faso, prevalence among three ethnic groups (Bobo/Dioula/Sénoufo, Mossi, and other) out of five groups declined between 1999 and 2010. Reduction among Bobo/Dioula/Sénoufo women was the fastest, from 78 per cent to 58 per cent. Fulfuldé/Peul women have experienced a continuous increase in prevalence, from 60 per cent in 1999, to 64 per cent in 2003, to 78 per cent in 2010. Groups like this deserve particular attention from programme managers and policy makers, as prevalence is higher than among other groups and has increased over time.

Prevalence in both countries is much higher among Muslim women compared to other religious groups (Christian, Catholic, animist and no religion). Almost no changes have been observed in prevalence among Muslim women in the past decade. In contrast, prevalence in Christian/Catholic women has declined.

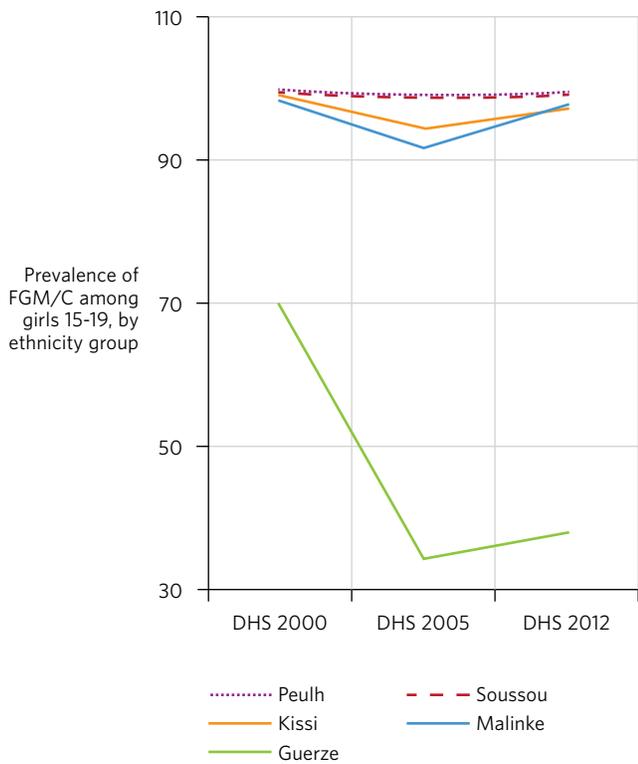
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<sup>25</sup> Some of these estimates are based on a reduced number of observations and therefore may be affected by sampling errors that, together with non-sampling errors, may compromise the significance of described differences between groups. Differences should be used carefully to further identify underlying cultural practices.

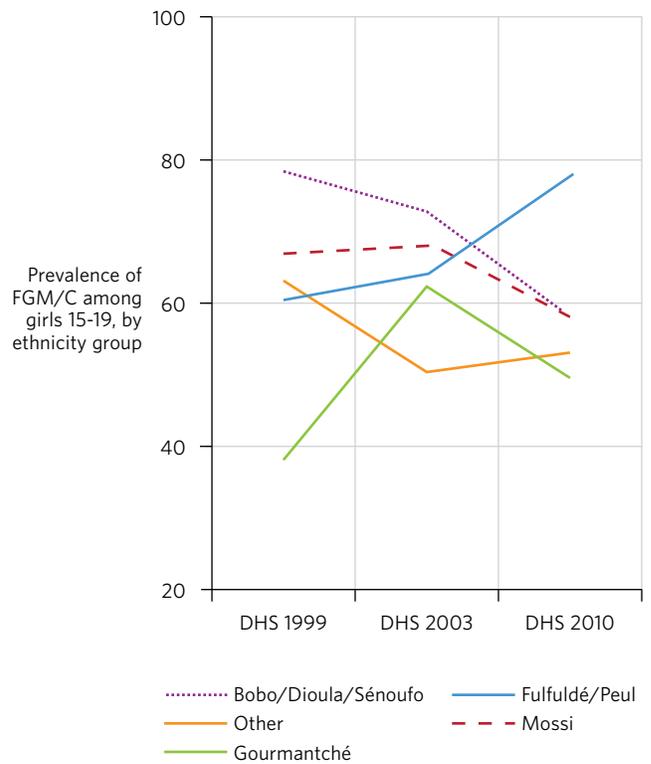


Figure 3.3. Trends in prevalence of FGM among girls aged 15-19, by ethnic group and religion

A. Guinea, by ethnic group

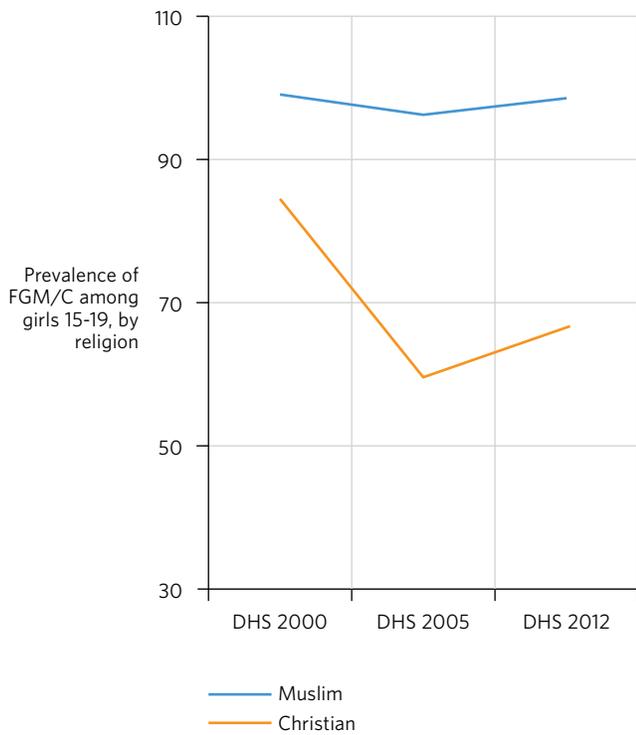


B. Burkina Faso, by ethnic group

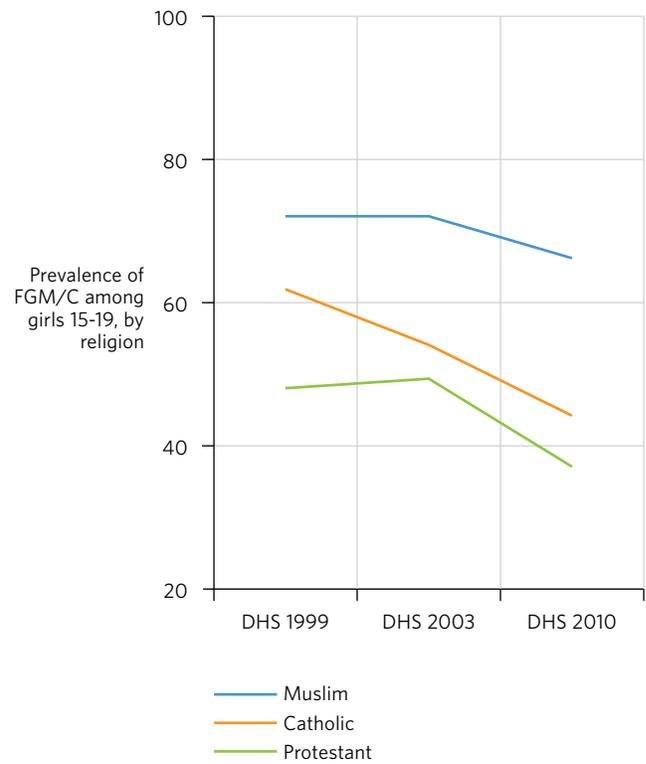




C. Guinea, by religion



D. Burkina Faso, by religion



Notes: Traditional, animist and no religion categories were excluded due to limited number of cases.

Source: UNFPA analysis based on DHS.

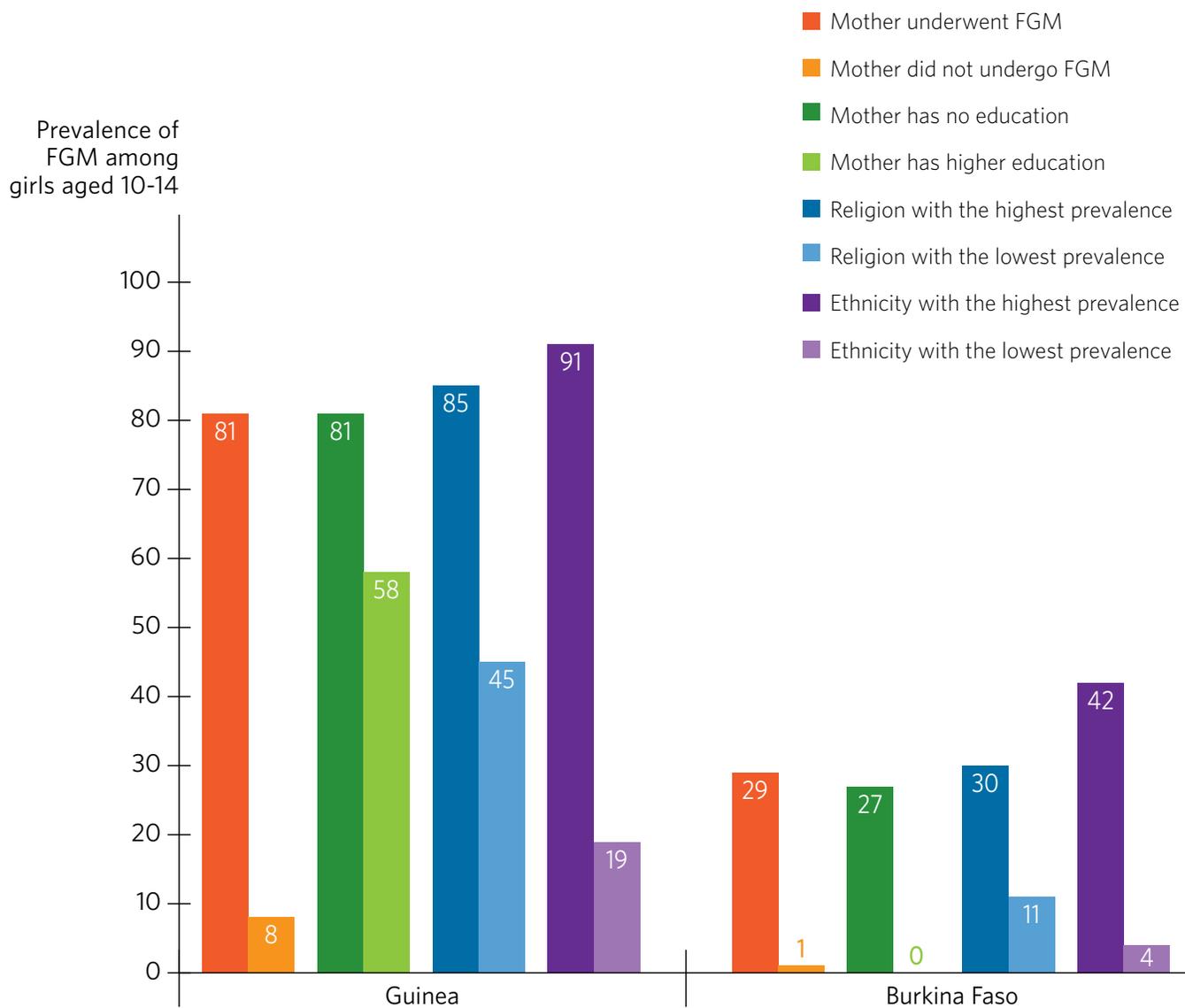
A more comprehensive picture of disparities across different socio-demographic characteristics comes from analysing FGM prevalence among young girls aged 10-14, based on data disaggregated by 13 socio-demographic characteristics of their mothers or households. These include: 1) whether mother underwent FGM, 2) wealth index, 3) highest educational level of mother, 4) husband/partner's education level, 5) mother works for family, others or self, 6) place of residence, 7) religion, 8) ethnicity, 9) literacy, 10) mother ever heard of fistula, 11) adolescent pregnancy, 12) belief that FGM required by religion, and 13) opinion that FGM should be continued or be stopped. After comparing the levels across groups for each characteristic, the most relevant characteristics were identified (see Figure 3.4):

- 1) Whether mother underwent FGM
- 2) Highest educational level of mother
- 3) Religion
- 4) Ethnicity

The FGM status of mothers has high influence on the status of the daughters. In Guinea, mothers who underwent FGM are 10 times more likely to subject their daughters to the practice, a pattern also found in Burkina Faso. A mother's education is also a key factor. In Burkina Faso, 27 per cent of girls whose mothers have no education have experienced FGM, compared to 0 per cent of girls whose mothers have a higher educational level.

The two case studies provide further evidence that a practice such as FGM occurs within very defined socio-cultural parameters. These disparities within and among countries highlight the need to pay attention to different factors that may cause FGM and could be the basis of more targeted interventions.

Figure 3.4. Prevalence of FGM among girls aged 10-14, by selected socio-demographic characteristics



Source: UNFPA analysis based on DHS. Guinea DHS 2012 and Burkina Faso DHS 2010.



# 4

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## Projections

Over the last 20 years, significant efforts have been made at the local, regional and international levels to eliminate FGM. Nonetheless, in 2012, in 17 countries<sup>26</sup> implementing intensive FGM programmes, it was performed on about 12 million girls aged 15-19.<sup>27</sup> If prevalence remains unchanged in these countries, by 2020, 15 million girls born between 2000 and 2005 will undergo FGM.

Figure 4.1 presents prevalence estimates among girls aged 15-19 based on the most recent data, and the annual rate of reduction based on consecutive surveys in 24 countries with available trend data. In reviewing historical trends, it is possible to generate the annual rate of reduction (ARR)<sup>28</sup> for 2007 to 2012. The countries with the highest ARR are Benin with 23 per cent, Nigeria with 7 per cent and Egypt with 6 per cent. On the other extreme are negative rates indicating an increase in prevalence. These include Guinea-Bissau at -2.1 per cent, Mali at -0.9 per cent, and Guinea at -0.7 per cent. Confirmation of an increase, however, would require further examination of methodological matters such as sampling.<sup>29</sup>

Countries like Niger, with an ARR of 5 per cent, Kenya with 4 per cent, Senegal with 3 per cent, and Burkina Faso with 1 per cent, have implemented specific programmatic interventions that may have had an impact on behaviour change and reduction of FGM. These include a community empowerment programme highlighting FGM as a human rights violation in Senegal, political will and enforcement of legislation banning FGM in Burkina Faso, and education on the negative aspects of FGM by churches in Kenya. Civil society organizations and the media have been active in all three countries in ensuring that the harmful effects of FGM are widely known.

<sup>26</sup> The 17 countries are covered by the second phase of the UNFPA-UNICEF Joint Programme on FGM/C.

<sup>27</sup> The second phase is from 2014-2017. These 17 countries were selected because more information on policy and programmatic interventions was available.

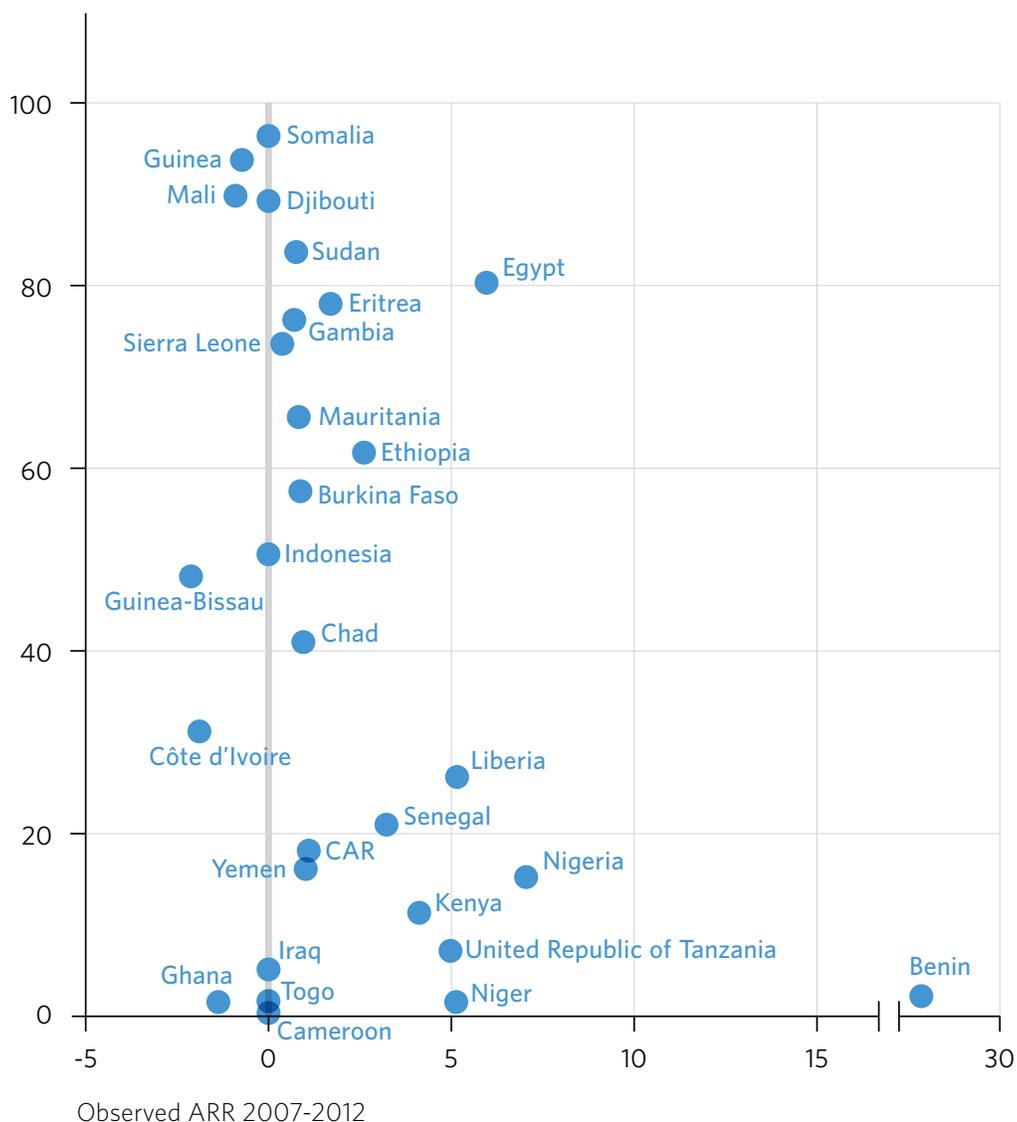
<sup>28</sup> Change in prevalence is assumed to take an exponential function similar to the one calculated as "compound interest rate" in financial terms. For any given year  $t$ , if the prevalence is known

to be  $X_t$ , and the annual rate of reduction is constantly  $r\%$ , then the prevalence of the next year, denoted as  $X_{t+1}$ , can be calculated as:  $X_{t+1} = X_t \cdot (1-r\%)$ .

<sup>29</sup> Possible methodological matters may also include the placement of the question about the FGM status of the respondent. P. S. Yoder, N. Abderrahim and A. Zhuzhuni. 2004. *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*. DHS Comparative Reports No 7. Calverton, Maryland: ORC Macro.

**Figure 4.1.** Percentage of girls aged 15-19 who have experienced any form of FGM, according to the most recent data, and observed annual rate of reduction in prevalence between 2007 and 2012

Prevalence of FGM/C  
among girls 15-19,  
2012 (per cent)



Notes: ARR for countries that have not had repeat surveys (Cameroon, Djibouti, Iraq, Liberia and Somalia) were assigned a value of 0. The rates for Togo and Uganda were also assigned a value of 0 as prevalence in the two countries is extremely low, and changes may be insignificant. The rate for Eritrea was assigned by using the average of the rate in neighbouring countries (Ethiopia and Sudan). As the prevalence in Uganda is extremely low and the change may be insignificant, data for it are not presented.

Source: UNFPA analysis based on DHS, MICS and other national surveys.

Several countries started to address the elimination of FGM more than a decade ago. Over the years, they have been able to create a favourable political environment, an institutional response, a coordinated multisectoral approach and legislation banning FGM, while civil society organizations have implemented well-structured community interventions. These elements are key factors to achieve FGM abandonment fairly rapidly.<sup>30</sup>

Among the 17 countries, about seven countries may accelerate elimination, with sufficient resources. Five of the seven countries—Burkina Faso, Ethiopia, Kenya, Senegal and Sudan—show a positive annual rate of reduction, ranging from 4.1 per cent to 0.8 per cent. For all 17 countries, projections based on the most recent prevalence estimates in each were used as baselines to calculate country-specific targets by 2020. A reduction of 40 per cent is envisaged for seven countries with capacities to accelerate the elimination of FGM between 2012 and 2020; a reduction of 15 per cent in Djibouti, Egypt, Guinea-Bissau, Mauritania and Mali; a reduction of 10 per cent in Gambia, Guinea, Nigeria and Somalia; and a reduction of 5 per cent in Yemen (Table 4.1).<sup>31</sup> In Nigeria and Yemen, efforts targeting FGM have mostly come from civil society organizations, although elimination needs to be addressed in a comprehensive and organized manner.<sup>32</sup>

**Table 4.1. FGM abandonment targets in specific countries by 2020**

CLUSTER OF COUNTRY	TARGET REDUCTION BETWEEN AROUND 2010 <sup>33</sup> AND 2020, %
<b>GROUP 1</b>	
Burkina Faso	40
Eritrea	40
Ethiopia	40
Kenya	40
Senegal	40
Sudan	40
Uganda	40
<b>GROUP 2</b>	
Djibouti	15
Egypt	15
Gambia	10
Guinea	10
Guinea-Bissau	15
Mali	15
Mauritania	15
Somalia	10
<b>GROUP 3</b>	
Nigeria	10
Yemen	5

<sup>30</sup>“UNFPA-UNICEF Joint Programme on FGM/C Summary Report of Phase I 2008-2013,” 2014.

<sup>31</sup>The second phase of the UNFPA-UNICEF Joint Programme on FGM/C (2014-2017) uses a cluster approach based on a few criteria and possible scenarios. One scenario is that FGM abandonment will accelerate at different paces in these clusters. “UNFPA-UNICEF Joint Programme on the Abandonment of Female Genital Mutilation/Cutting: Accelerating Change, Funding Proposal for a Phase II, 2014.”

<sup>32</sup>WHO, OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA and others. “Eliminating Female Genital Mutilation. An interagency statement.” 2008.

<sup>33</sup>Baseline surveys are the latest DHS and MICS conducted around 2012.

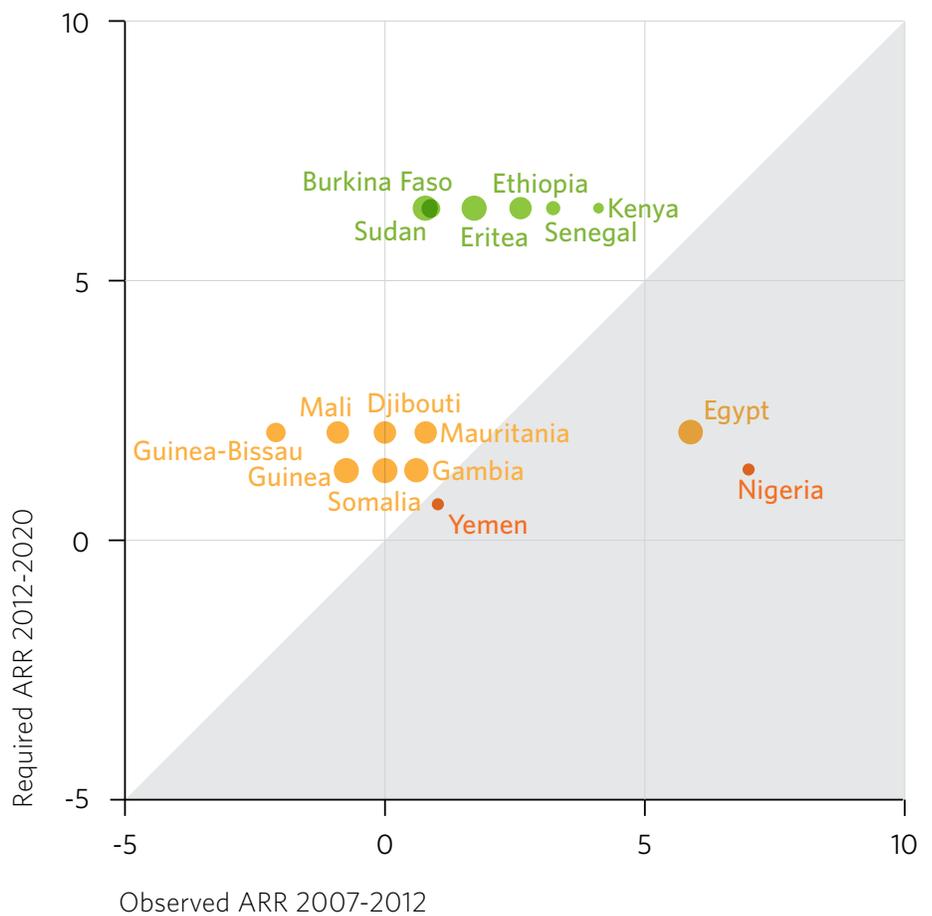
One of the unique aspects of the analysis presented here is the calculation of the historical ARR for the 17 target countries and its comparison with the ARR required if these countries are to meet the reduction targets by 2020. Figure 4.2 compares the historical ARR between 2007 and 2012 and the required ARR between 2012 and 2020 for each country. Countries in the shaded area are in a better position to achieve the targets, as historical rates in these countries show a faster reduction compared to the required rates.

These countries include Egypt (Group 2), Nigeria (Group 3) and Yemen (Group 3). Most countries classified under Group 1 have a historical rate much lower than the required rate. As such, they need to accelerate efforts. This requires, in part, carrying out an analysis of current strategies and interventions, and determining which areas should be given more focus. It may also require balancing the focus of programmatic interventions, particularly between national advocacy with more emphasis on policy and legal aspects, and community level outreach focused on changing social norms.

**Figure 4.2. Observed ARR 2007-2012, and required ARR 2012-2020, based on country targets**

- Group 1 countries
- Group 2 countries
- Group 3 countries

**Bubble size:** prevalence of FGM/C among girls aged 15-19



Notes: As the prevalence in Uganda is extremely low and the change may be insignificant, data for it are not presented.

Based on population size, current level of FGM and country targets, the projected number of girls aged 15-19 who will experience FGM in 2020 if current trends continue, and the projected number if countries reach their targets were calculated. The two projections show the number of girls who could potentially be protected from FGM (Table 4.2). More than 70 per cent would be in three countries: Ethiopia with 1.6 million, Sudan with 0.8 million and Egypt with 0.5 million.

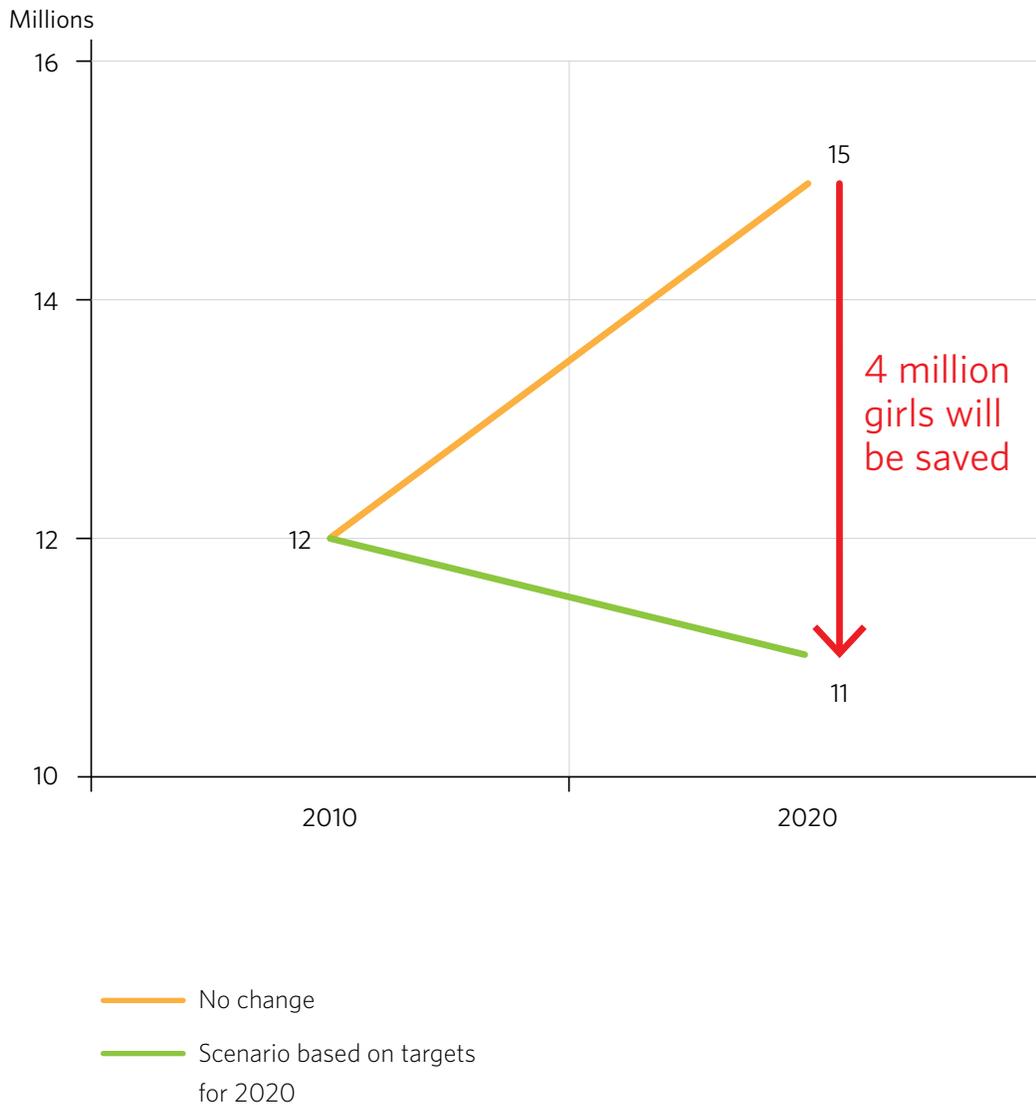
In highly populated countries such as Egypt, Ethiopia and Nigeria, FGM prevalence among girls aged 15-19 is 80.7 per cent, 62.1 per cent and 15.3 per cent, respectively. The historical ARR are 5.9 per cent for Egypt, 2.6 per cent for Ethiopia and a high of 7 per cent for Nigeria. If these countries attain the targets of a 40 per cent reduction for Ethiopia, 15 per cent for Egypt and 5 per cent for Nigeria—calculated through the annual reduction rate of 6.4 per cent for Ethiopia, 2 per cent for Egypt and 1.3 per cent for Nigeria—then the number of girls protected from FGM would be 1.6 million girls in Ethiopia, 0.5 million in Egypt and 165,000 in Nigeria. In less populated countries such as Guinea-Bissau, the same type of analysis reveals an FGM prevalence among girls aged 15-19 of 48.4 per cent. The historical ARR is -2.1 per cent, indicating increased prevalence in recent years. Guinea-Bissau has a goal of 15 per cent, which corresponds to an annual rate of reduction of 2 per cent for the country. If Guinea-Bissau reaches this target, then 8,000 girls would be protected from FGM by 2020.

Data limitations required using estimates in the projection. As such, the number of girls undergoing FGM between 2010 and 2020 was determined by estimating the total number of girls aged 15-19 in 2020 who would have undergone FGM. This cohort of girls, born between 2000 and 2005, and aged 15-19 in 2020, will experience FGM at different ages according to the rates observed in the most recent household surveys. An assumption was made that the current FGM prevalence rate will remain at the same level at year 2020. The number of girls protected from FGM could be overestimated in the “no change” scenario in 2020 (Figure 4.3) if prevalence at that time is different from the current rate observed in the household surveys.

Assuming all countries reach the targets by 2020, the number of girls born between 2000 and 2005 subjected to FGM would fall to 11 million. That means protecting a total of 4 million girls from FGM (Figure 4.3).

The projections provide strong, compelling evidence for the continued intensive effort to accelerate the elimination of FGM, and offer a quantitative basis for current and future programmatic and financial investments. For example, Ethiopia, with a potential for protecting 1.6 million girls, may need more intensive support than a country like Djibouti, with a target of 6,000 girls.

Figure 4.3. Projected numbers of girls aged 15-19 who will experience FGM, under a scenario of no change and a scenario based on country targets, year 2020



**Table 4.2. Projected prevalence of FGM among girls aged 15-19 and number of girls protected, and country targets, 2020**

COUNTRY/FGM JOINT PROGRAMME CLUSTER	YEAR/SOURCE	PREVALENCE AMONG GIRLS AGED 15-19, MOST RECENT DATA (per cent)	HISTORICAL ARR 2007-2012
<b>GROUP 1</b>			
Burkina Faso	2010 DHS	58	0.9
Ethiopia	2005 DHS	62	2.6
Kenya	2014 DHS	11	4.1
Senegal	2014 DHS	21	3.2
Sudan*	2010 SHHS	84	0.8
Uganda	2011 DHS	1	-
Eritrea	2002 DHS	78	1.7
<b>GROUP 2</b>			
Egypt	2008 DHS	81	5.9
Gambia	2013 DHS	76	0.6
Guinea	2012 DHS	94	-0.7
Guinea-Bissau	2010 MICS	48	-2.1
Mali	2013 DHS	90	-0.9
Mauritania	2011 MICS	66	0.8
Djibouti	2006 MICS	90	0
Somalia	2006 MICS	97	0
<b>GROUP 3</b>			
Nigeria	2013 DHS	15	7.0
Yemen	2013 DHS	16	1.0
<b>TOTAL</b>			

**Scenario:** a reduction of 40 per cent in acceleration countries; a reduction of 15 per cent in Djibouti, Egypt, Guinea-Bissau, Mauritania, Mali; a reduction of 10 per cent in other emergent countries plus Nigeria; no change in other new countries (Yemen), by year 2020

NUMBER OF GIRLS 15-19 EXPERIENCING FGM, 2012 (000)	PROJECTED NUMBER OF GIRLS 15-19 EXPERIENCING FGM IF CURRENT TREND CONTINUES, 2020 (000)	PROJECTED PREVALENCE AMONG GIRLS 15-19, 2020 (per cent)	PROJECTED NUMBER OF GIRLS 15-19 EXPERIENCING FGM, 2020 (000)	PROJECTED NUMBER OF GIRLS 15-19 PROTECTED, 2020 (000)
480	645	35	387	258
3019	3930	37	2358	1572
245	323	7	194	129
149	191	13	115	76
1573	1993	50	1196	797
19	26	1	16	11
238	314	47	188	125
2974	3141	69	2670	471
68	94	69	85	9
543	693	85	624	69
41	51	41	43	8
642	906	77	770	136
122	154	56	131	23
42	39	76	33	6
488	676	87	608	68
1222	1645	14	1481	165
231	252	16	240	13
<b>12,096</b>	<b>15,073</b>		<b>11,138</b>	<b>3,935</b>

Notes: Djibouti, Eritrea, Somalia and Yemen have only one data point, thus the AAR cannot be calculated. The ARR for Ethiopia was assigned by using the average of the ARR in neighbouring countries (Ethiopia and Sudan); ARRs for Djibouti, Somalia and Yemen were assumed to be 0.

Source: UNFPA analysis based on DHS and MICS.



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## Conclusion and the Way Forward

Gender equality, women's empowerment and the realization of women's rights are fundamental to their well-being, and that of their families and communities, and to achieving sustainable development.

Human rights violations against women and girls include harmful practices, such as child, early and forced marriage, and FGM; lack of reproductive rights and reproductive health care; and women's and girls' unequal access to education, employment, leadership and decision-making. The post-2015 international sustainable development agenda recognizes the key importance of gender equality, both in its own right and in achieving all sustainable development goals.<sup>34</sup> A major barrier to equality is women's and girls' lack of control over their bodies, and violations of sexual and reproductive health and rights.

There is compelling information for the need to continue accelerating and scaling up the abandonment of harmful practices such as FGM. If programmatic interventions and financial resources remain the same or decline, over 15.2 million girls will be subject to FGM by 2020. This number is staggering. However if the 17 target countries achieve their targets, 4 million girls will be protected from FGM.

The data provided in this report offer reliable quantitative information to define programmatic and financial support, and can guide individual governments and international donors. Formulating interventions to prevent and eventually eliminate FGM will benefit from having the evidence to define the size of the target population, and to orient action around areas of greatest impact.

An added benefit of quantitative targets is being able to determine the cost-effectiveness of interventions.

FGM cannot be addressed in isolation. When societal pressures prevent women from making decisions about their reproductive health and rights, they will also feel compelled to subject their daughters to a deeply ingrained practice with strong cultural and ritual relevance. Demographic analysis of FGM demonstrates that it is a practice that occurs within specific socio-cultural parameters, such as place of residence, and reproductive health and status. Interventions focusing on abandonment have to take into consideration existing gender inequalities and how these manifest, including in exacerbating high fertility and perpetuating very young populations.

The case studies focusing on Burkina Faso and Guinea show that characteristics such as the mother's educational level and whether or not she experienced FGM, religious background and ethnicity provide valuable information in determining who is subject to FGM and defining the milieu in which they live. This information corroborates other studies finding that ethnic and religious background are strong determinants.

Analysis presented here also strongly highlights the importance of data in understanding the context within which FGM programmes operate, especially those that target local communities.

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<sup>34</sup> "Sustainable Development Knowledge Platform—Technical Support Team Issues Brief: Gender Equality and Women's Empowerment." See: [http://sustainabledevelopment.un.org/content/documents/2396TST%20Issues%20Brief%20GEWE\\_FINAL.pdf](http://sustainabledevelopment.un.org/content/documents/2396TST%20Issues%20Brief%20GEWE_FINAL.pdf).

For example, Djibouti, with a rapidly growing urban population, should focus on prevention programmes in cities. A highly rural country such as Guinea-Bissau will take a different approach, as only a few ethnic groups practice FGM. Efforts there could focus more on promoting the law against FGM and community education.

Approximately 130 million girls and women have undergone FGM in countries where we have data. Over the past five years, prevalence has decreased due to targeted efforts, encompassing strengthened national ownership, capacity and leadership for abandonment; partnerships and coordination among national and community level actors; and the integration of programmatic approaches, strategies and initiatives into national interventions. These efforts are rooted in a comprehensive, human rights based, culturally sensitive approach, with consistent focus on changing value attributed to girls and women affected by FGM.

They build on many core elements of achieving gender equality. Reproductive health programmes contribute to improvements in the status of women. Increased schooling for girls produces many benefits, including reduced fertility later in life. Legal protections for women uphold their rights, backed by advocacy at the community level. Community initiatives on reproductive health and gender have increased knowledge and generated solutions to reduce violence against women, including FGM.

Gender equality has a catalytic effect on the achievement of inclusive and progressive human development, good governance, sustained peace, and harmonious dynamics between environments and human populations—all of which are at the centre of sustainable development and human rights.<sup>35</sup>

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<sup>35</sup> Ibid.

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Delivering a world where  
every pregnancy is wanted  
every childbirth is safe and  
every young person's  
potential is fulfilled

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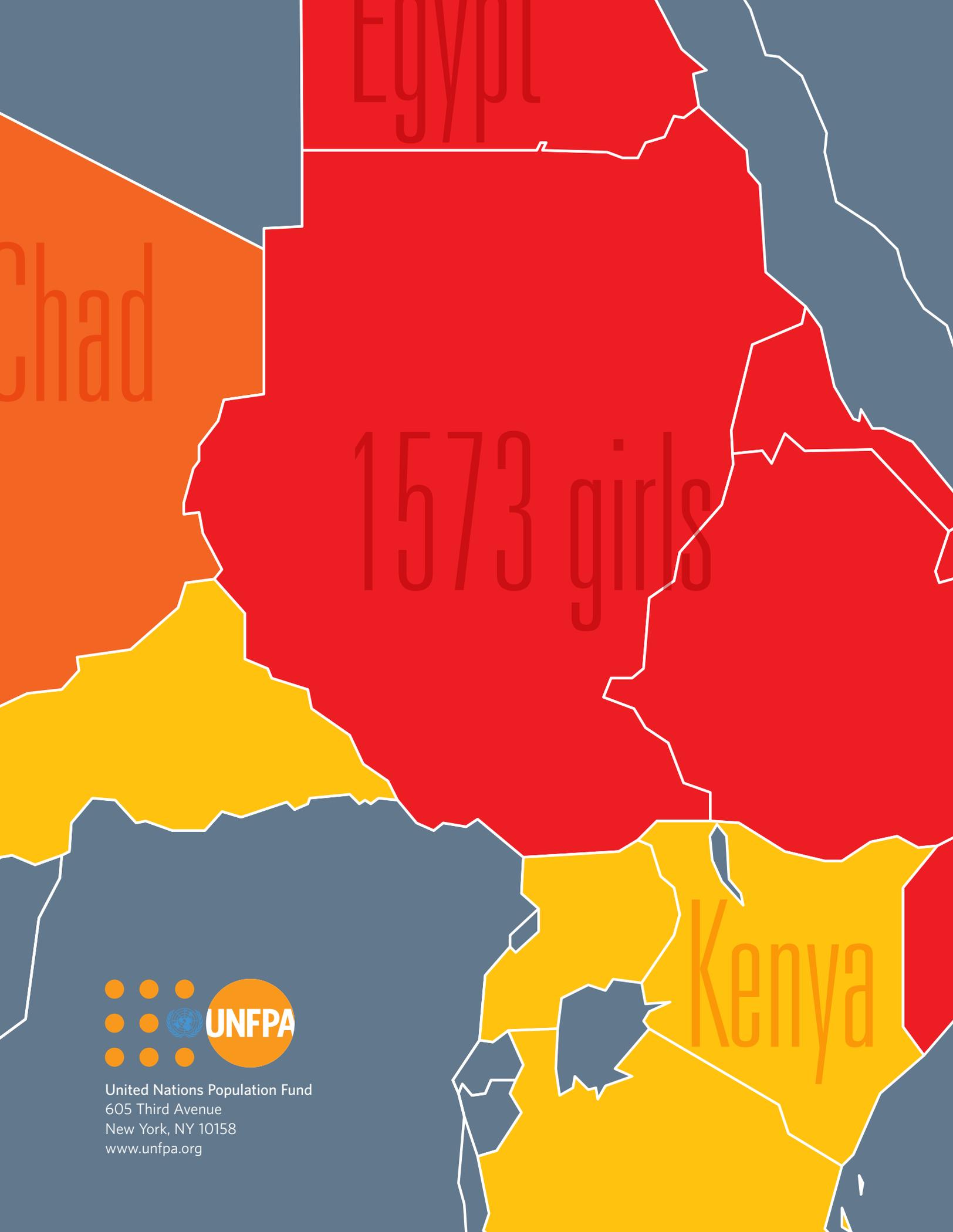
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Egypt

Chad

1573 girls

Kenya



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