THERE HAS BEEN AN OVERALL DECLINE IN THE PREVALENCE OF FGM/C OVER THE LAST THREE DECADES. YET, NOT ALL COUNTRIES HAVE MADE PROGRESS AND THE PACE OF DECLINE HAS BEEN UNEVEN.

Current progress is insufficient to keep up with increasing population growth. If trends continue, the number of girls and women undergoing FGM/C will rise significantly over the next 15 years.

<table>
<thead>
<tr>
<th>Country</th>
<th>1980 (%)</th>
<th>2010 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>89%</td>
<td>58%</td>
</tr>
<tr>
<td>Egypt</td>
<td>97%</td>
<td>70%</td>
</tr>
<tr>
<td>Kenya</td>
<td>41%</td>
<td>11%</td>
</tr>
<tr>
<td>Liberia</td>
<td>72%</td>
<td>31%</td>
</tr>
<tr>
<td>Togo</td>
<td>10%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Note: This is a weighted average based on comparable data.

Fast decline among girls aged 15 to 19 has occurred across countries with varying levels of FGM/C prevalence.
Female genital mutilation/cutting (FGM/C) is a human rights issue that affects girls and women worldwide. As such, its elimination is a global concern. In 2012, the United Nations General Assembly adopted a milestone resolution calling on the international community to intensify efforts to end the practice. More recently, in September 2015, the global community agreed to a new set of development goals – the Sustainable Development Goals (SDGs) – which includes a target under Goal 5 to eliminate all harmful practices, such as child, early and forced marriage and FGM/C, by the year 2030. Both the resolution and the SDG framework signify the political will of the international community and national partners to work together to accelerate action towards a total, and final, end to the practice in all continents of the world. More and better data are needed to measure progress towards this common goal.


References:

Language: English
FEMALE GENITAL MUTILATION/CUTTING:
A GLOBAL CONCERN
The prevalence of FGM/C varies greatly across countries as the availability of representative data on the extent of FGM/C increases, so does the number of girls and women known to have undergone the practice.

In most of the countries, the majority of girls were cut before age 5. In Yemen, 85 per cent of girls experienced the practice within their first week of life.

While in nearly all countries FGM/C is usually performed by traditional practitioners, more than half of girls in Indonesia underwent the procedure by a trained medical professional.

Notes: The latest available data for each country are presented in the charts above. An older source had to be used to report on the prevalence of FGM/C among girls and women aged 15 to 49 years for Somalia (MICS 2006) since the 2011 MICS was conducted separately in the two parts of the country: the Northeast Zone (also referred to as Puntland) and Somaliland. Prevalence data on FGM/C for girls and women aged 15 to 49 are not available for Indonesia. Data on girls for Egypt refer to ages 1 to 14 years and for Indonesia to ages 0 to 11 years. Older sources had to be used to report on the prevalence of FGM/C among girls aged 0 to 14 years for Gambia (MICS 2010), Sierra Leone (MICS 2010) and Yemen (National Social Protection Monitoring Survey 2012) since the latest source for each of these countries did not collect these data. Prevalence data on FGM/C among girls under age 15 are not available for the remaining nine countries. Prevalence data on FGM/C for girls and women aged 15 to 49 years for Ethiopia are from a different source than data on FGM/C for girls aged 0 to 14 years.
Available data from large-scale representative surveys show that the practice of FGM/C is highly concentrated in a swath of countries from the Atlantic coast to the Horn of Africa, in areas of the Middle East such as Iraq and Yemen and in some countries in Asia like Indonesia. However, FGM/C is a human rights issue that affects girls and women worldwide. Evidence suggests that FGM/C exists in some places in South America such as Colombia and elsewhere in the world including in India, Malaysia, Oman, Saudi Arabia, and the United Arab Emirates, with large variations in terms of the type performed, circumstances surrounding the practice and size of the affected population groups. In these contexts, however, the available evidence comes from (sometimes outdated) small-scale studies or anecdotal accounts, and there are no representative data as yet on prevalence. The practice is also found in pockets of Europe and in Australia and North America which, for the last several decades, have been destinations for migrants from countries where the practice still occurs. Some studies, conducted mainly in Europe, have attempted to quantify the number of immigrant girls and women who have undergone the practice or are at risk of undergoing it, but such efforts have not been systematic in all affected countries.

To date, the primary sources of nationally representative data on FGM/C have been household surveys. As understanding of the practice has grown, so have efforts to undertake data collection in countries where there has been widespread recognition that it is taking place. For instance, it was widely acknowledged for some time that FGM/C was being practised in the Kurdish region of Iraq and, in 2011, the first-ever national household survey that collected data on the practice in the country was conducted. Similarly, in 2013, the Ministry of Health in Indonesia included questions on the prevalence of FGM/C among the youngest girls in one of its household surveys, thus producing national prevalence data on the issue for the first time.

More data collection in countries where no such data currently exist is needed in order to present a more reliable and complete picture of the practice.
The majority of people in countries with data think the practice should end.

In Guinea and Sierra Leone, boys and men are more likely to oppose the practice than girls and women.

Notes: The latest available data for each country are presented in the charts above. The 2011 MICS data for Ghana could not be used to report on attitudes towards FGM/C due to the fact that information is missing for girls and women with no living daughters; data from the 2006 MICS are used instead. In Liberia, only cut girls and women were asked about their attitudes towards FGM/C; since girls and women from practising communities are more likely to support the practice, the level of opposition in this country as captured by the 2013 DHS is lower than would be expected had all girls and women been asked their opinion. Data on attitudes towards FGM/C among girls and women are not available for Indonesia. Data on boys and men for Cameroon, Chad, Mali and Mauritania refer to ages 15 to 59 years. Data on boys and men for Benin, Chad, Mali, Mauritania, Sudan and the United Republic of Tanzania cannot be directly compared with data on girls and women since data sources for the latter are more recent for these countries. Data on attitudes towards FGM/C among boys and men are limited since these data have not been systematically collected in all surveys.