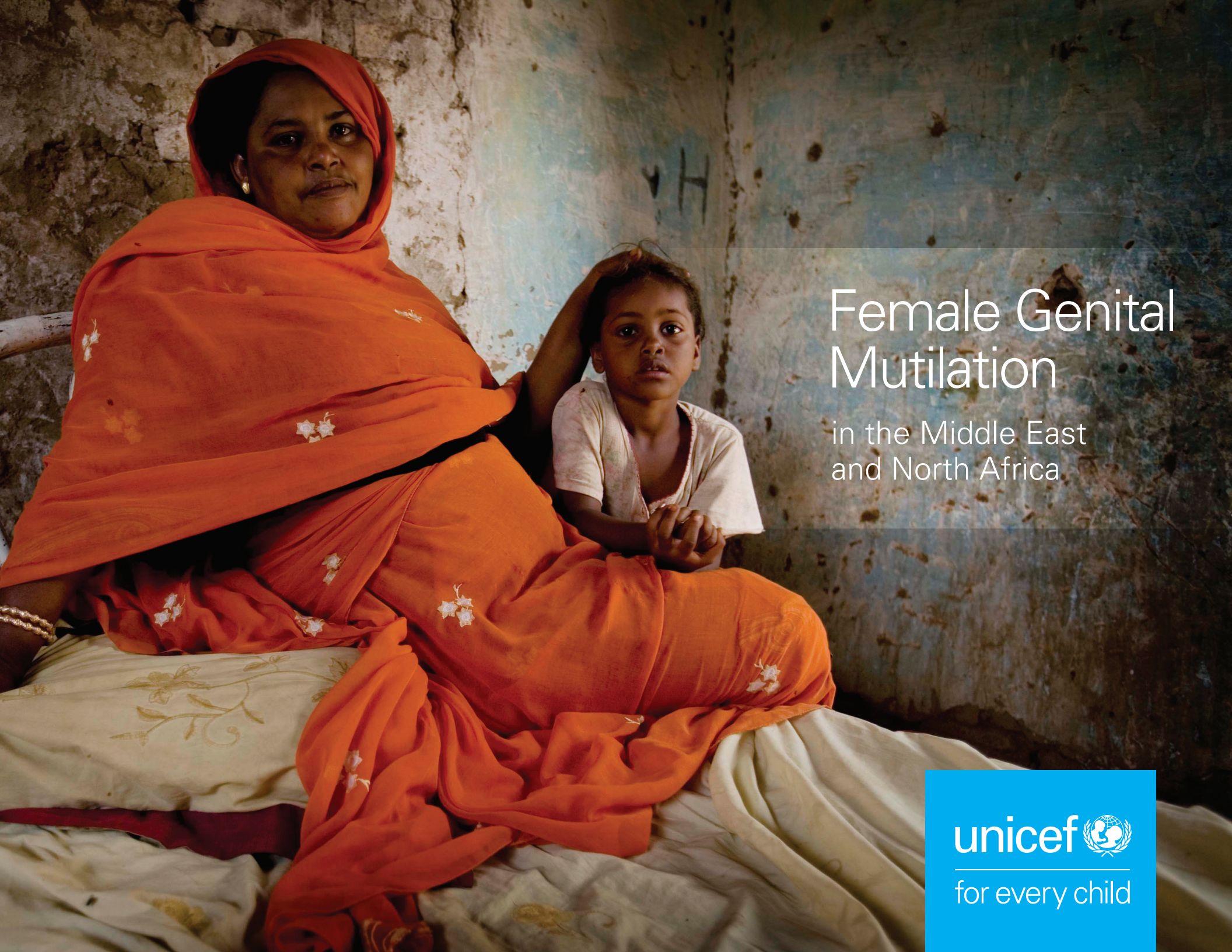


Female Genital Mutilation

in the Middle East and North Africa

unicef

for every child

Female genital mutilation in the global development agenda

Female genital mutilation (FGM) is a violation of human rights. Every girl and woman has the right to be protected from this harmful practice, a manifestation of entrenched gender inequality with devastating consequences. FGM is now firmly on the global development agenda, most prominently through its inclusion in Sustainable Development Goal (SDG) target 5.3, which aims to eliminate the practice by 2030.

SDG 5

Achieve gender equality and empower all women and girls

TARGET 5.3

Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation

INDICATOR 5.3.2

Proportion of girls and women aged 15 to 49 years who have undergone female genital mutilation

KEY FACTS

about FGM

Almost **50 million** girls and women have undergone female genital mutilation in five practising countries in the Middle East and North Africa, accounting for one quarter of the global total

The **prevalence of FGM varies** from 94 per cent in Djibouti to 7 per cent in Iraq

FGM is highly medicalized in Egypt and Sudan where **almost 8 in 10 girls** are cut by medical personnel, whereas traditional practitioners are responsible for most cutting in Djibouti, Iraq and Yemen

Age at cutting varies across countries in the region; in Yemen it most often occurs in the **first week of life**, while in Egypt it is most likely to occur in **adolescence**

Less than half
of women support the continuation of FGM in most countries in the region

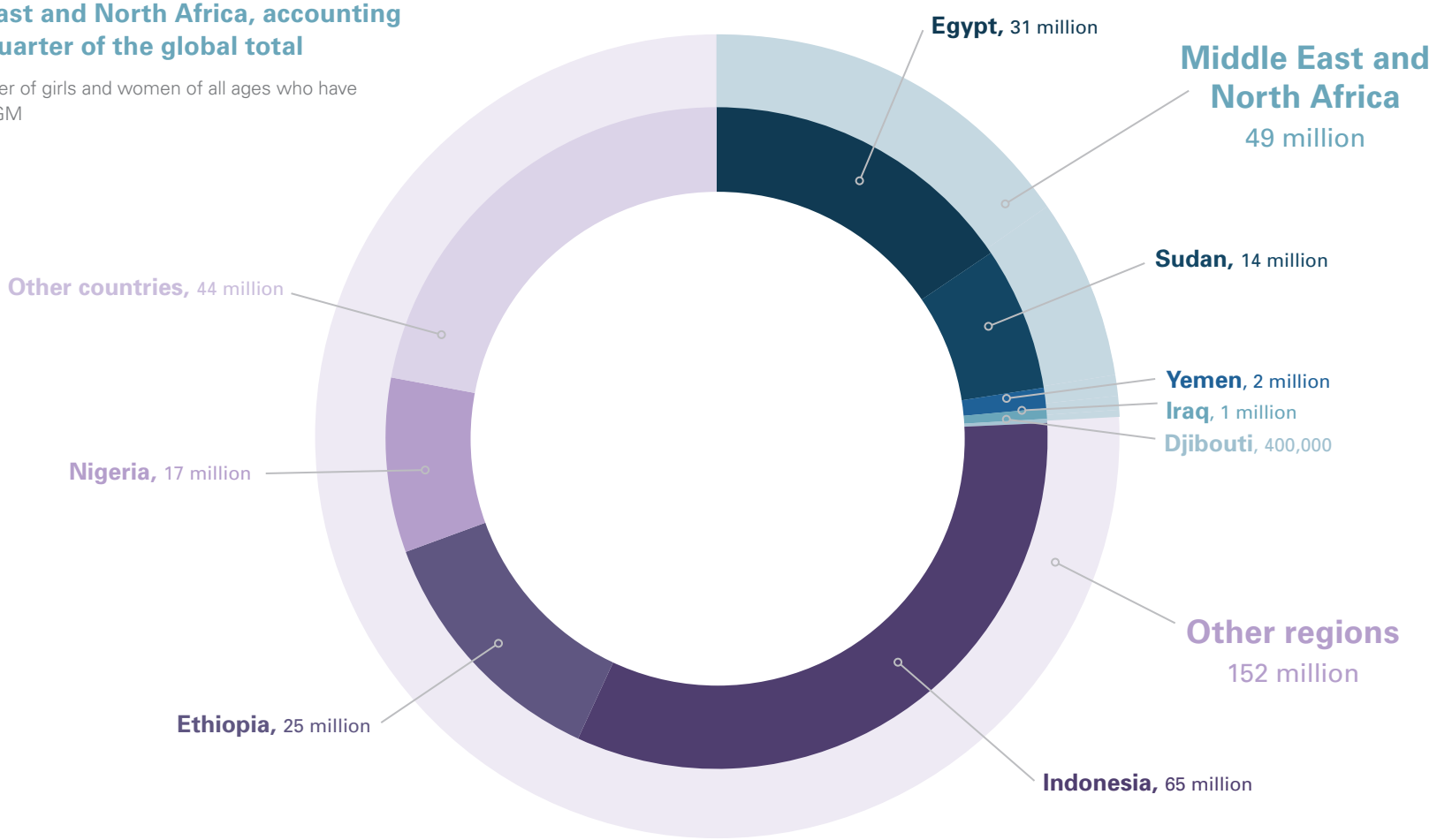
Countries in the Middle East and North Africa have made great strides in reducing FGM in the past generation, but the average prevalence remains among the **highest in the world**

To reach the SDG target of eliminating FGM by 2030, the rate of progress in the region would need to be **15 times faster**

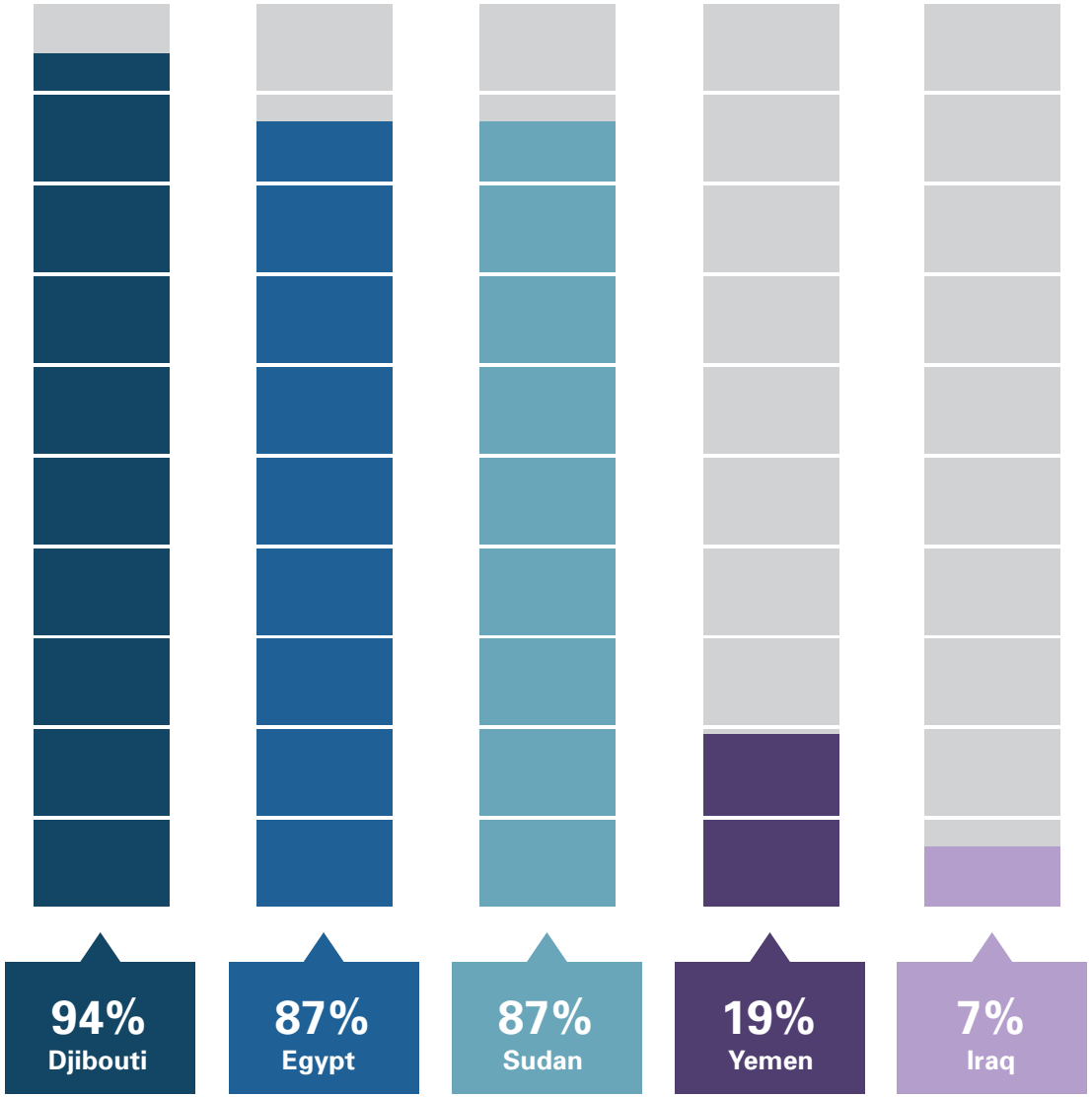
CURRENT LEVELS OF FGM

Almost 50 million girls and women have undergone FGM in five countries in the Middle East and North Africa, accounting for one quarter of the global total

FIG. 1 Number of girls and women of all ages who have undergone FGM



Notes: Due to rounding, displayed values may not add up to the total. Countries included in the analysis are those with nationally representative prevalence data on FGM.



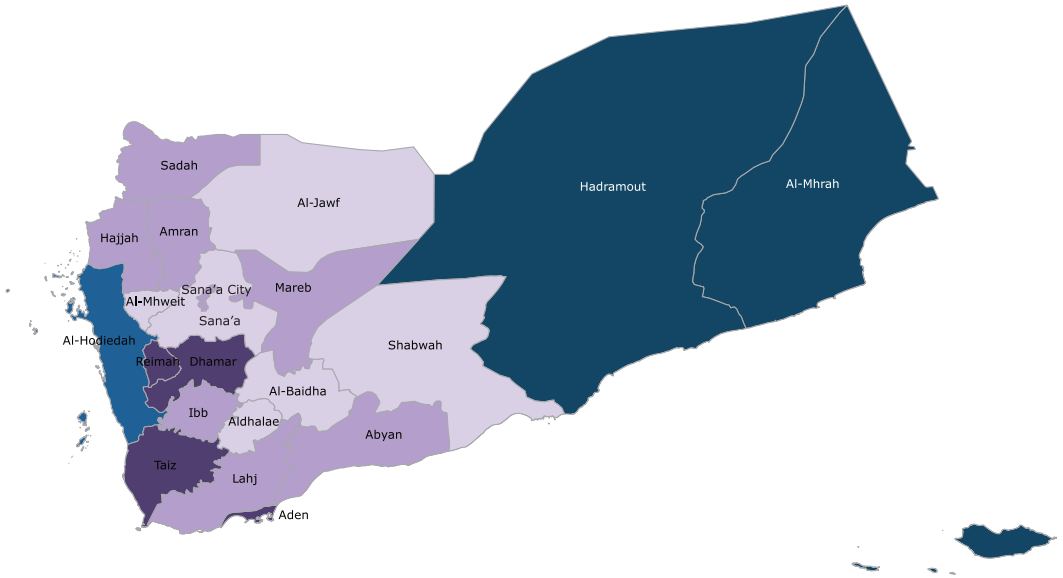
The prevalence of FGM varies in the Middle East and North Africa from 94 per cent in Djibouti to 7 per cent in Iraq

FIG. 2 Percentage of girls and women aged 15 to 49 years who have undergone FGM

Available data from large-scale representative surveys show that the practice of FGM is highly concentrated in a small number of countries. FGM is a human rights issue that affects girls and women worldwide however, including in additional countries in the Middle East and North Africa.

Prevalence data on FGM are not available for these additional countries, but local and small-scale research studies provide an indication of the existence of the practice, including in Oman, Saudi Arabia and the United Arab Emirates.

For more detail, see: Cappa, Claudia, Luk Van Baelen and Els Leye, 'The Practice of Female Genital Mutilation Across the World: Data availability and approaches to measurement', *Global Public Health*, vol. 14, no. 8, 2019, pp. 1139–1152.



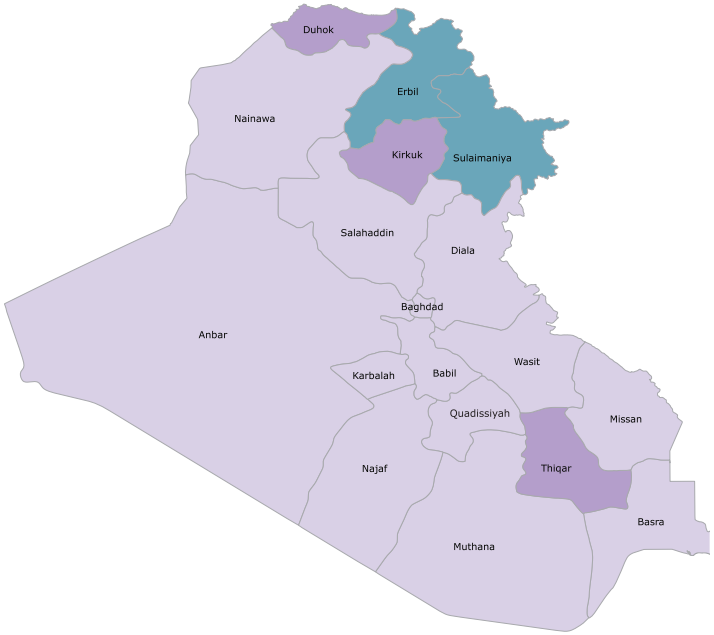
In Yemen, the prevalence of FGM varies from 85 per cent in Al-Mhrah to almost zero per cent in Al-Baidha

FIG. 3 Percentage of girls and women aged 15 to 49 years who have undergone FGM, by governorate

70% or more | 50–69% | 30–49% | 10–29% | 1–9% | Less than 1%

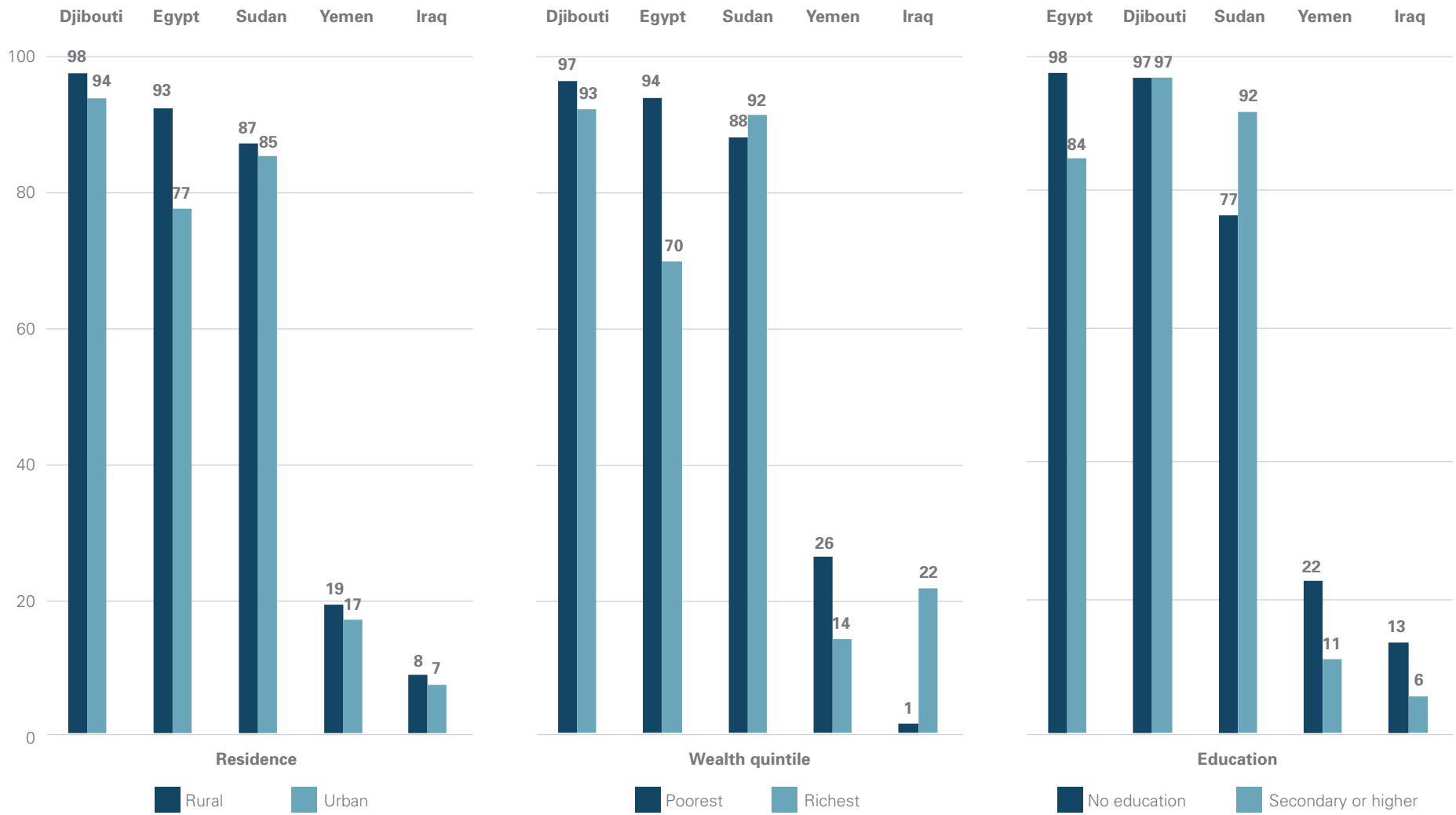
In Iraq, the practice is concentrated in the north-east, particularly Erbil and Sulaimaniya

FIG. 4 Percentage of girls and women aged 15 to 49 years who have undergone FGM, by governorate



FGM is found more often among those living in rural areas, the poorest households and populations with less education; however, in Iraq, FGM is most common among the richest wealth quintile, and in Sudan, those with more education have a higher prevalence

FIG. 5 Percentage of girls and women aged 15 to 49 years who have undergone FGM, by place of residence, wealth quintile and education



Note: The prevalence by education in Djibouti is calculated among ever-married women only; data were not collected on the education level of never-married women.

Levels of FGM among girls under age 15 vary across countries in the region

FIG. 6a Percentage of girls aged 0 to 14 years who have undergone FGM

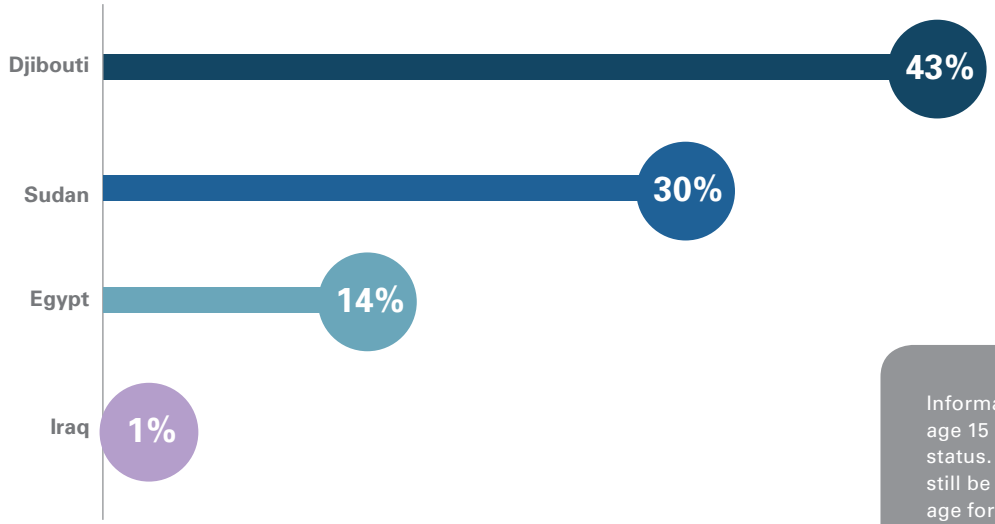


FIG. 6b Percentage of ever-married girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM

Information collected on FGM about girls under age 15 reflects their current, but not final, FGM status. Some girls who have not been cut may still be at risk once they reach the customary age for cutting.

Therefore, the data on prevalence for girls under age 15 is an underestimation of the true extent of the practice.

Since age at cutting varies among settings, the amount of underestimation also varies. This should be kept in mind when interpreting all FGM prevalence data for this age group.

Note: In Egypt, data refer to girls aged 6 months to 14 years.

CIRCUMSTANCES AROUND FGM

Practitioners, types of FGM and age at cutting

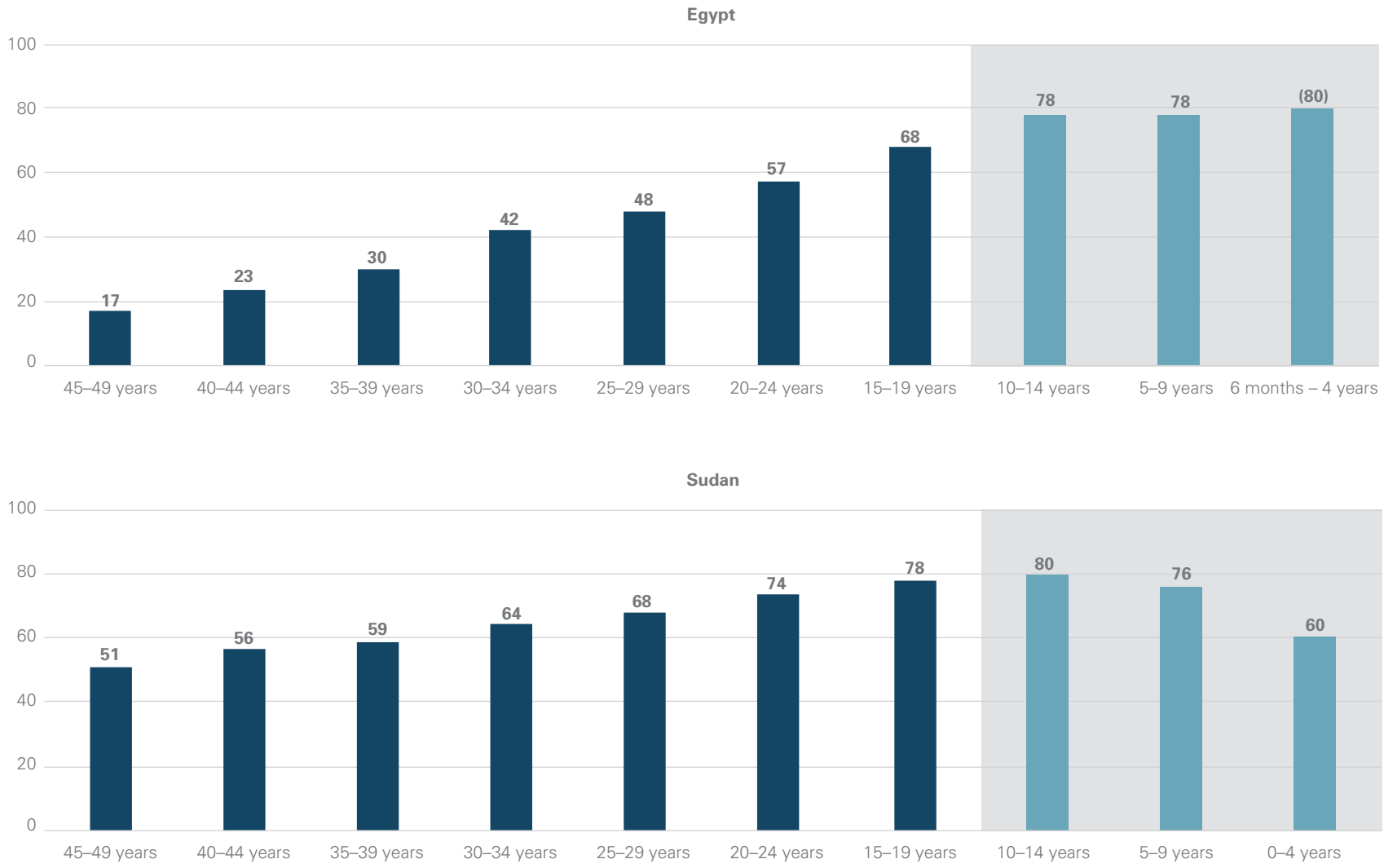
FGM is highly medicalized in Egypt and Sudan, where almost 8 in 10 girls are cut by medical personnel, whereas traditional practitioners are responsible for most cutting in Djibouti, Iraq and Yemen

FIG. 7 Percentage distribution of girls aged 0 to 14 years who have undergone FGM, by practitioner

Notes: Data for Yemen refer to the percentage distribution of practitioners among ever-married girls and women with at least one living daughter who has undergone FGM. Data for Egypt refer to girls aged 6 months to 14 years. Due to rounding, individual figures may not add up to 100.

FGM is increasingly occurring at the hands of medical personnel in Egypt and Sudan

FIG. 8 Percentage of cut girls and women aged 0 to 49 years who underwent FGM by a medical practitioner, by age



Notes: Values presented here are based on at least 25 unweighted cases. Those based on 25 to 49 unweighted cases are shown in parentheses. Information collected on FGM about girls aged 0 to 14 years reflects their current, but not final, FGM status, since some girls who have not been cut may still be at risk of experiencing the practice once they reach the customary age for cutting. Therefore, the results among girls under age 15 should not be read as a complete assessment of the degree of medicalization among this age group.

Among cut girls, 9 in 10 experienced flesh removal in Iraq and Yemen

FIG. 9 Percentage distribution of girls aged 0 to 14 years who have undergone FGM, by type of FGM

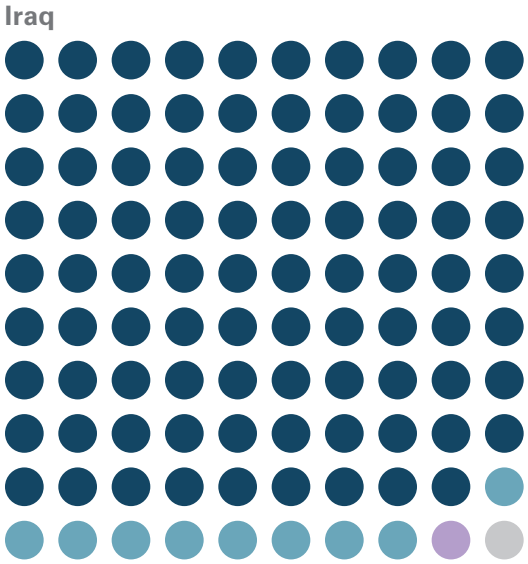
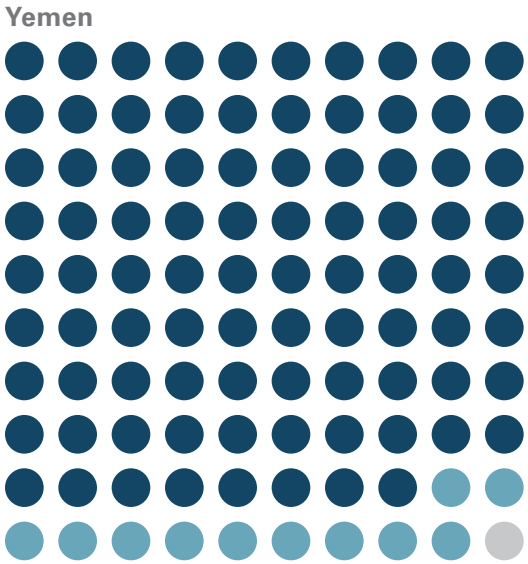


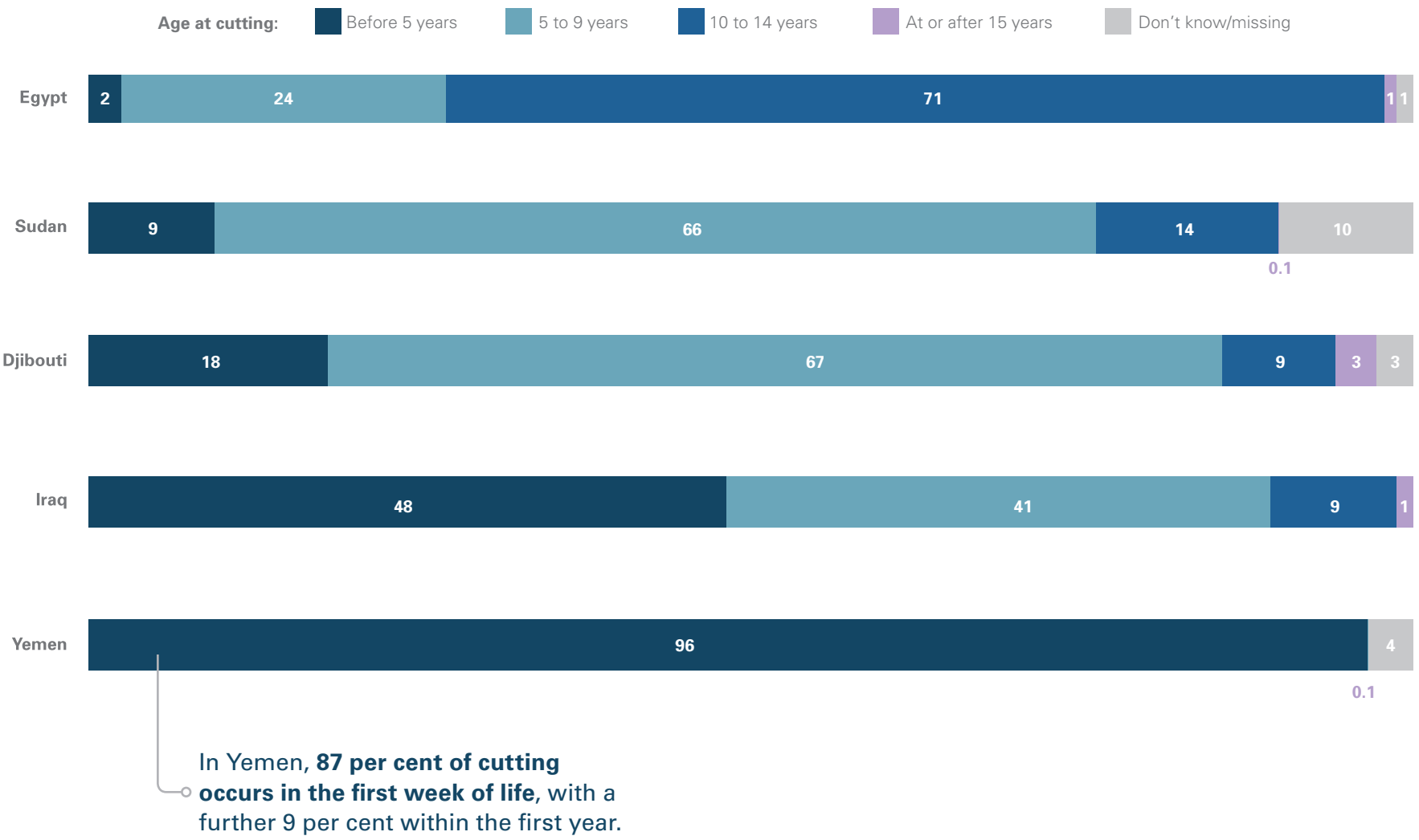
FIG. 10 Percentage distribution of ever-married girls and women aged 15 to 49 years with at least one living daughter who has undergone FGM, by type of FGM



Note: Data on type of FGM among girls under age 15 were not available in the most recent surveys for the other countries in the region.

Age at cutting varies across countries in the region; FGM occurs earliest in Yemen, while in Egypt it is most likely to occur in adolescence

FIG. 11 Percentage distribution of adolescent girls aged 15 to 19 years who have undergone FGM, by age at cutting



Note: Due to rounding, individual figures may not add up to 100.

OPINIONS ON FGM

Less than half of girls and women support the continuation of FGM in most countries in the region

FIG. 12 Percentage of girls and women aged 15 to 49 years who think the practice should continue

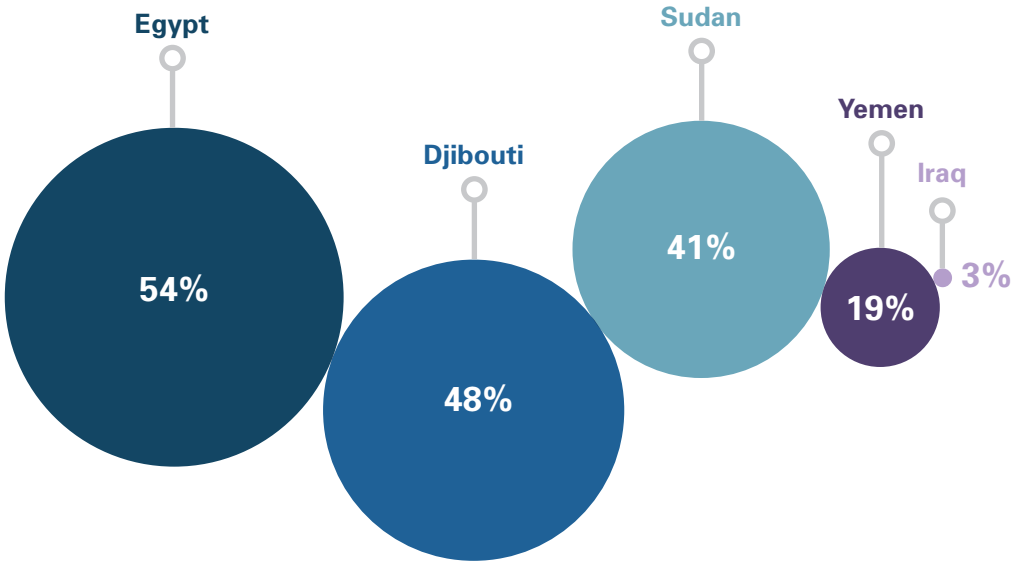
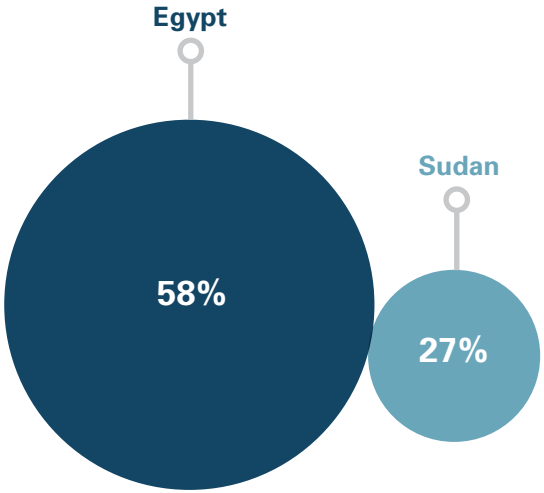


FIG. 13 Percentage of boys and men aged 15 to 49 years who think the practice should continue



Notes: Support for the practice in Djibouti is measured among ever-married women. The question posed to respondents in Djibouti is slightly different than the standard: "Do you think the practice is necessary and important to daughters (girls)?" For Djibouti and Egypt, percentages are calculated among all women or men regardless of their knowledge of FGM. For Sudan, data for men are based on an older source as men's attitudes were not measured in the latest survey.

Around 5 in 10 Egyptians believe the practice is required by religion, while 2 in 10 girls and women in Yemen believe so

FIG. 14 Percentage of boys and men aged 15 to 49 years who think the practice is required by religion

Egypt, 50%

Egypt, 46%

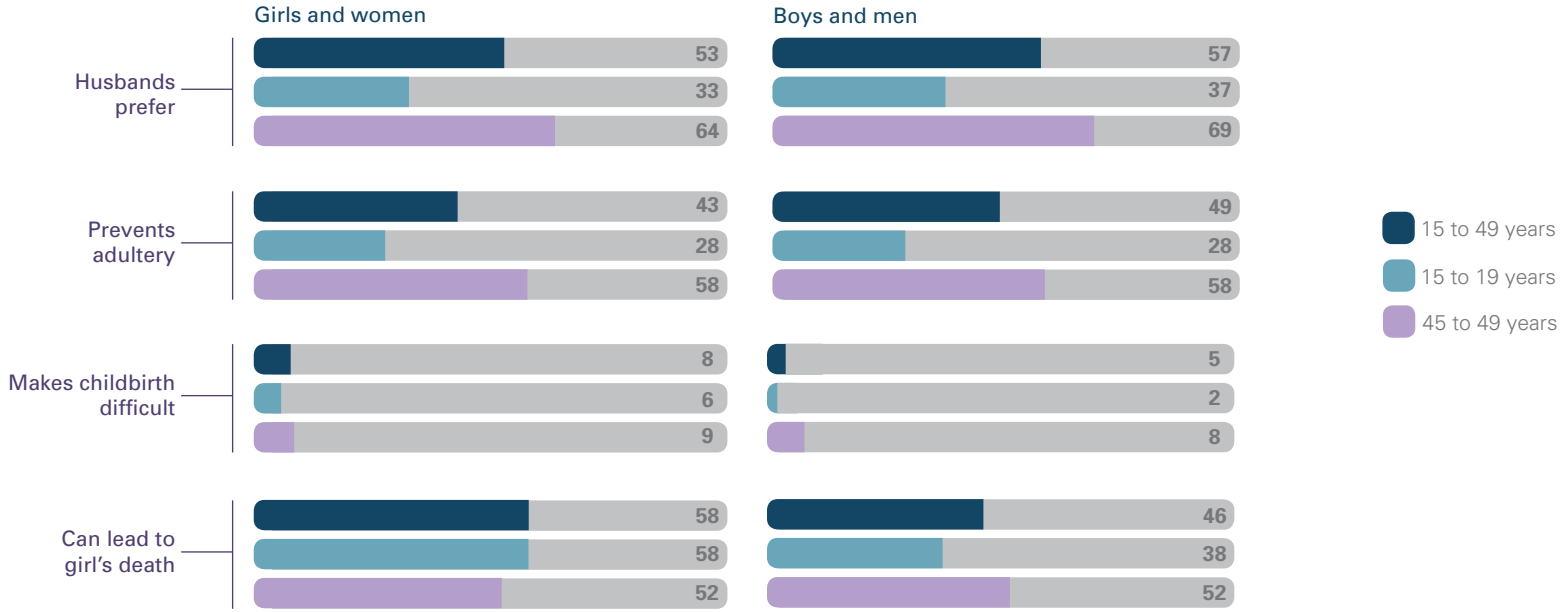
Yemen, 21%

FIG. 15 Percentage of girls and women aged 15 to 49 years who think the practice is required by religion

Notes: For Egypt, percentages are calculated among all women or men regardless of their knowledge of FGM. Data on whether FGM is considered a religious requirement were not available in the most recent surveys for the other countries in the region.

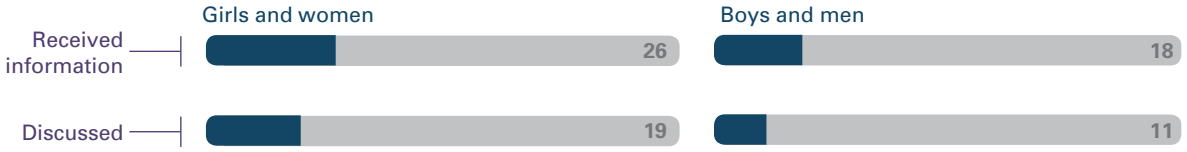
The majority of Egyptians believe that husbands prefer women who have undergone FGM, and nearly half believe the practice prevents adultery; these beliefs are much less common among adolescents than the older generation

FIG. 16 Percentage of girls and women and boys and men aged 15 to 49 years who agree with various statements about FGM



One in four girls and women have received information about FGM recently in Egypt, and one in five girls and women have discussed FGM with their relatives, friends or neighbours. Fewer boys and men are exposed to such information and discussions

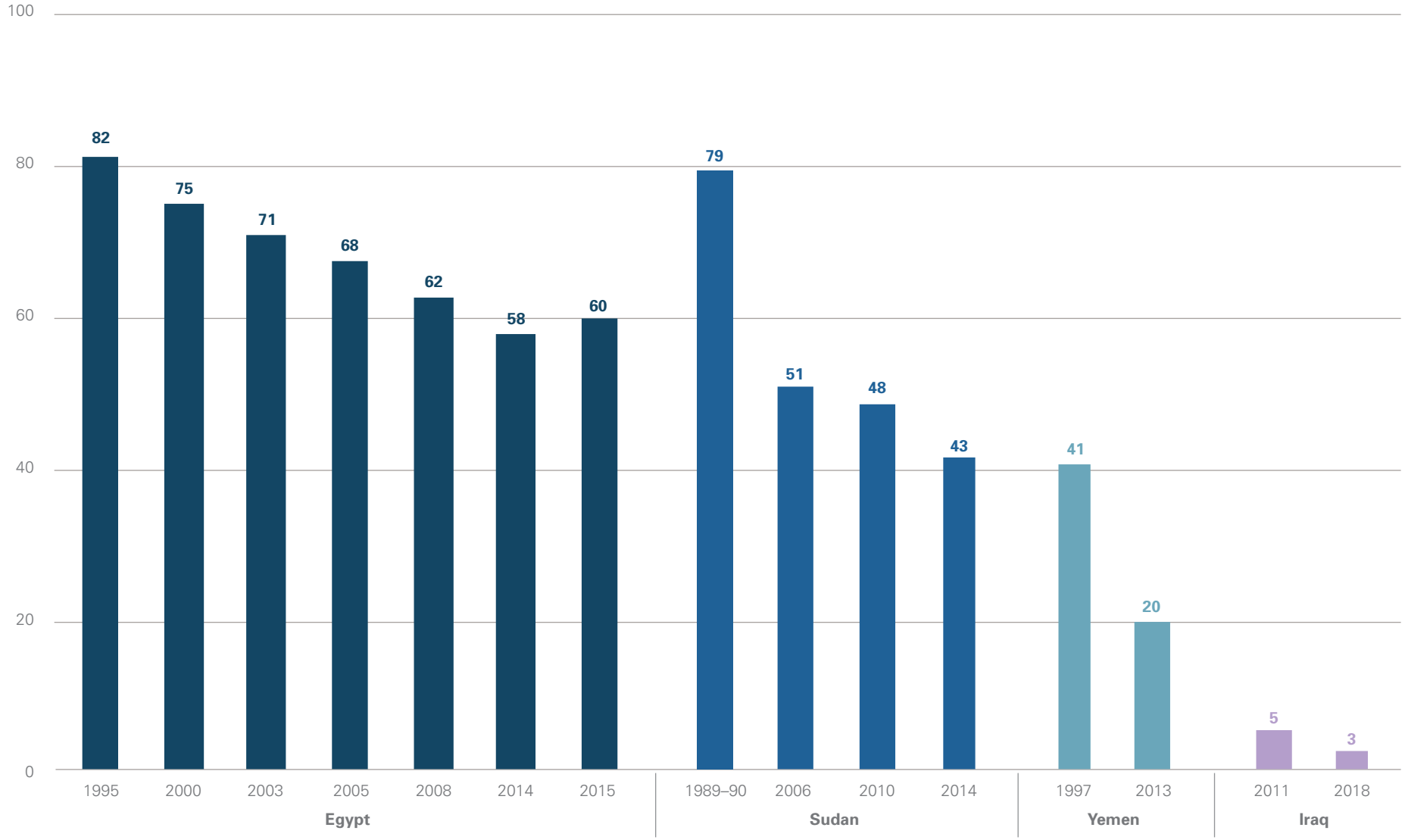
FIG. 17 Percentage of girls and women and boys and men aged 15 to 49 years who have received information recently about FGM, and who have discussed FGM with relatives, friends or neighbours



The main source of information about FGM was television, named as the source of information among 80 per cent of girls and women and 91 per cent of boys and men.

Support for FGM has declined in Egypt, Sudan and Yemen, with a slowing of progress in Egypt in recent years. Support remains low in Iraq

FIG. 18 Percentage of girls and women aged 15 to 49 years who think the practice should continue

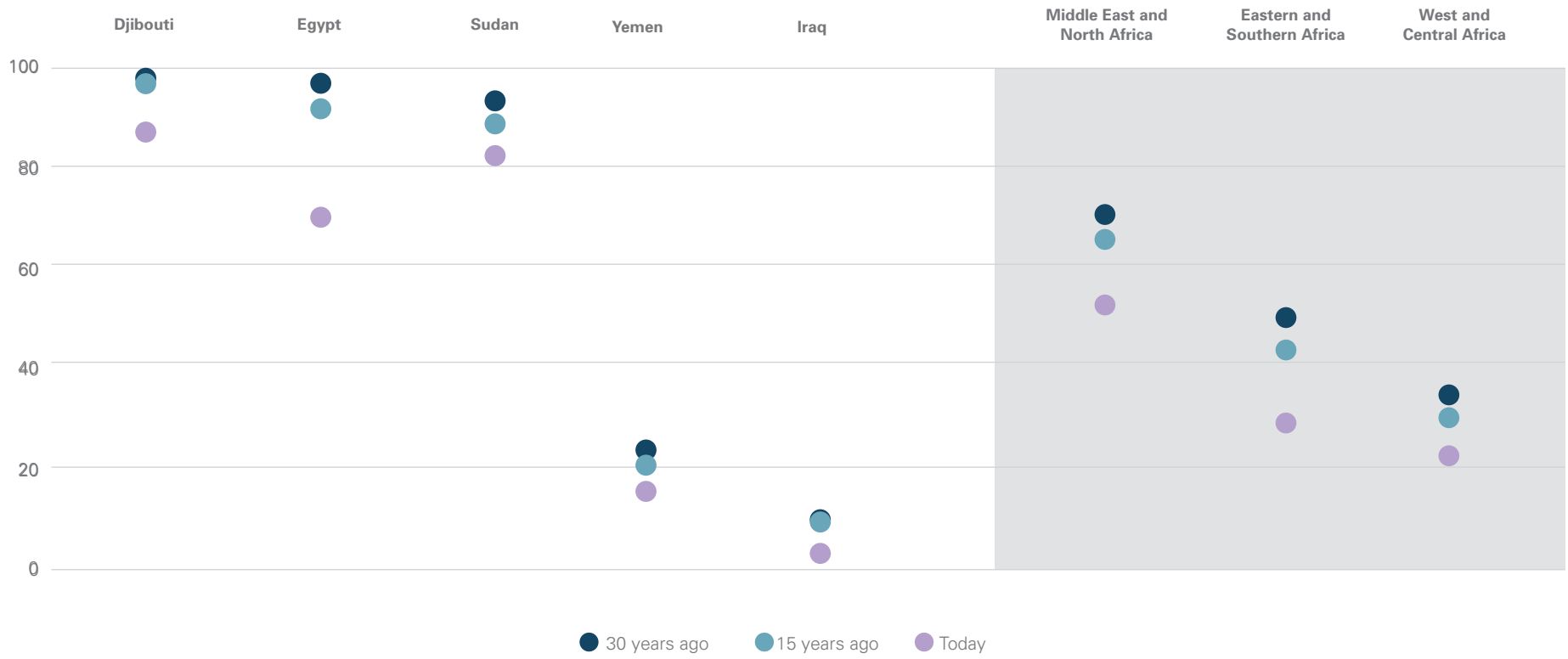


Notes: For Egypt, Sudan and Yemen, data were recalculated for comparability over time within each country; therefore, values may differ from those presented in Figure 12. Values in Egypt and Sudan are based on ever-married women regardless of knowledge of FGM; those in Yemen are based on ever-married women who have heard of FGM; those in Iraq are based on all women who have heard of FGM.

GENERATIONAL TRENDS IN REDUCING FGM

The Middle East and North Africa has made great strides in reducing FGM in the past generation, but the average prevalence remains among the highest in the world

FIG. 19 Percentage of adolescent girls aged 15 to 19 years who have undergone FGM



Notes: Regional values represent population-weighted aggregates of the data from practising countries. Regions shown in this chart include those with at least two countries with nationally representative data on the prevalence of FGM. See technical notes for additional details.

In Iraq, both governorates in which FGM is concentrated have seen a decline in the last 30 years. In Yemen, among the governorates where the prevalence of FGM is more than 10 per cent, only Al-Mhrah presents statistically significant progress in the last 30 years

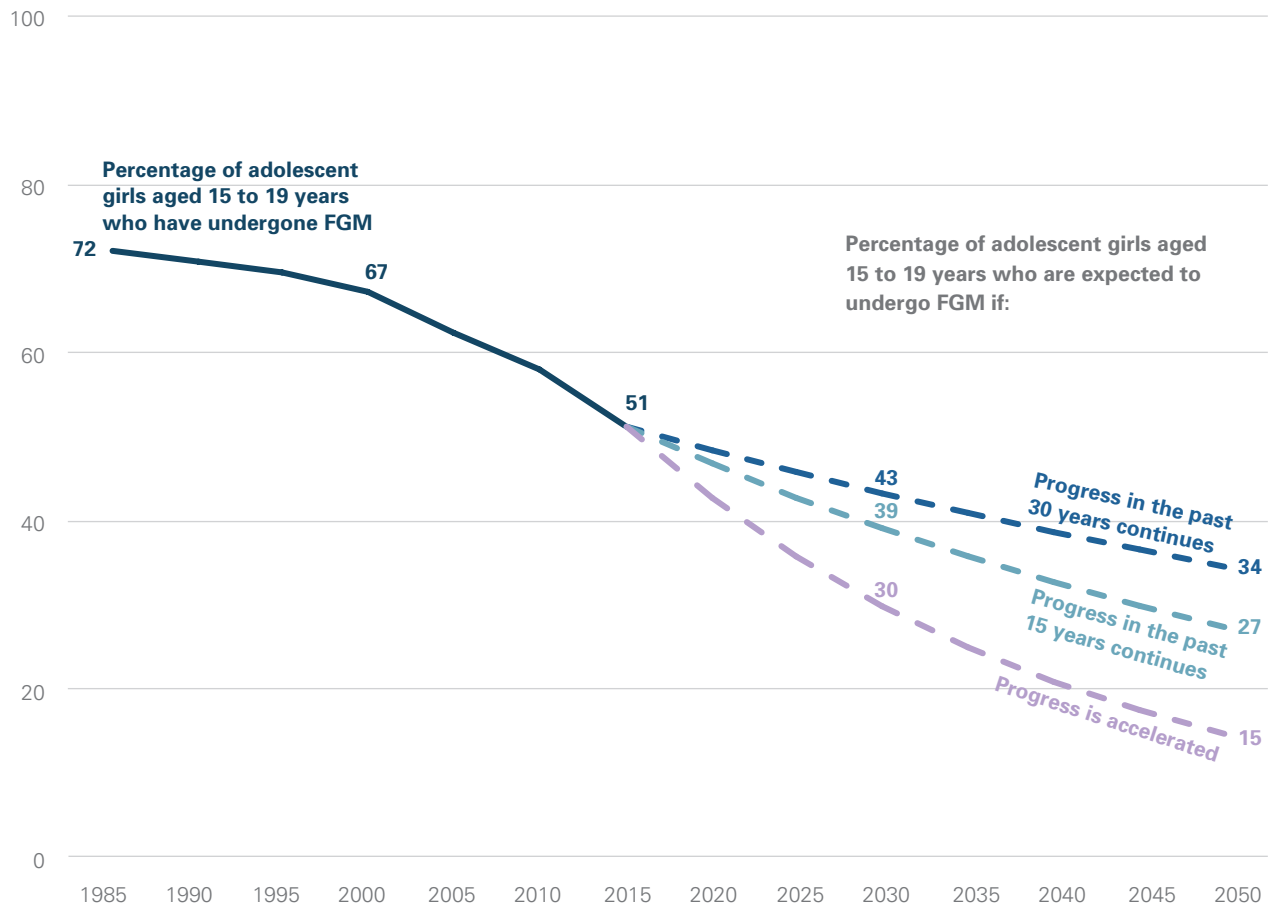
FIG. 20 Percentage of adolescent girls aged 15 to 19 years who have undergone FGM, selected governorates in Iraq and Yemen

Note: The figure presents only those governorates where 10 percent or more of girls and women aged 15 to 49 years have undergone FGM.

LOOKING AHEAD TOWARDS ELIMINATION OF FGM

Even if the progress is accelerated, about one in three adolescent girls will still experience FGM in 2030

FIG. 21 Observed and projected percentage of adolescent girls aged 15 to 19 years who have undergone FGM



Note: The trend line represents a population-weighted aggregate of the data from the five countries in the region in which the practice is concentrated.

How to read the projections

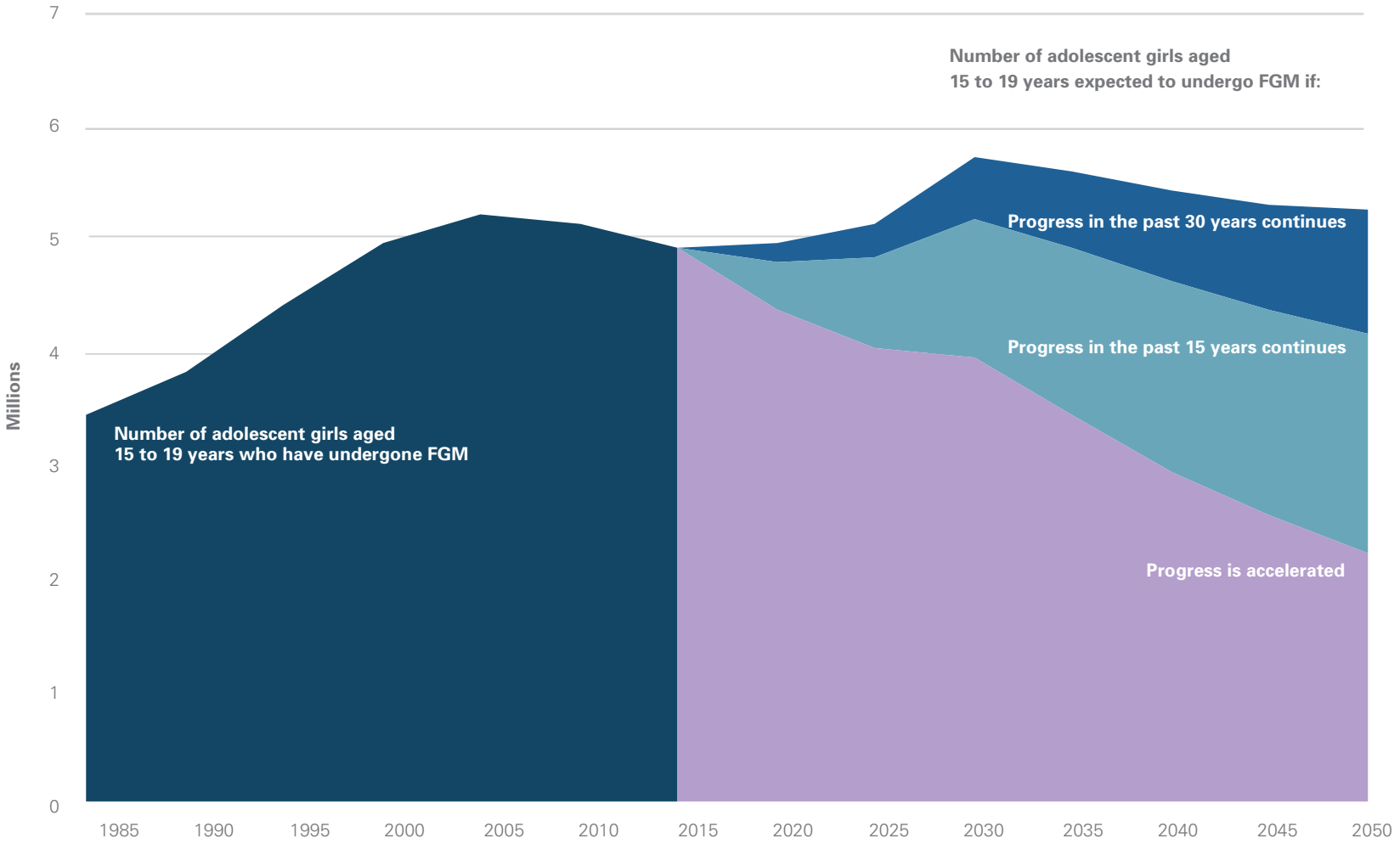
Figures 21 to 23 show how the scale of the practice has changed since 1985, as well as a selection of scenarios that could occur in the future. Figure 21 illustrates how the percentage of adolescent girls who have undergone FGM has changed and could continue to change through 2050. Figure 22 indicates the numbers of girls affected, taking into account both the prevalence of FGM, and the observed and expected changes in population. Figure 23 shows progress in observed rates of reduction and rates required to meet the elimination target by 2030.

In Figures 21 and 22, the projections build on the existing trends to show the expected values if progress from the past 30 years were to continue (in dark blue), or if progress from the past 15 years were to continue (in light blue). It is clear that there has been slower progress in the past 30 years, making this the less ambitious of the two scenarios. There is also a more ambitious scenario shown (in purple), which projects an acceleration of progress, namely twice the progress observed over the past 15 years.

In Figure 23, the observed average annual rates of reduction quantify the rate of progress over each period. A higher rate indicates faster progress. Required rates are calculated to illustrate what would be necessary to eliminate the practice by 2030, target 5.3 of the SDGs.

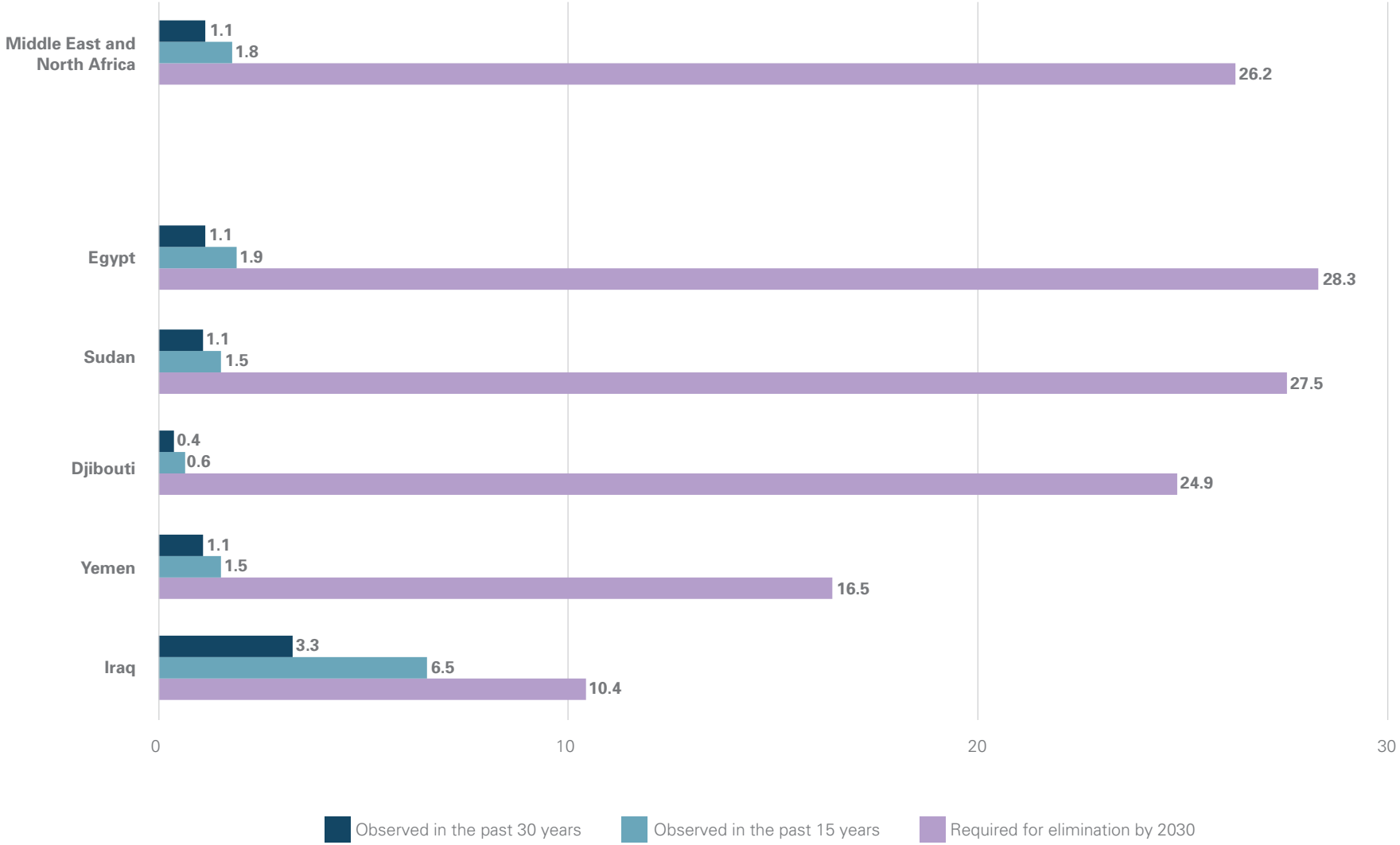
A growing population in the region could put additional girls at risk of FGM; however, if progress is accelerated, the number of girls undergoing FGM could decrease by 2030

FIG. 22 Observed and projected number of adolescent girls aged 15 to 19 years who have undergone FGM



In order to reach the SDG target of eliminating FGM by 2030, the rate of progress would need to be 15 times faster for the region overall

FIG. 23 Average annual rate of reduction (per cent) in the percentage of adolescent girls aged 15 to 19 years who have undergone FGM, observed and required for elimination



PROTECTING EVERY CHILD AND ADOLESCENT FROM FGM

To strengthen the response to FGM in the Middle East and North Africa, and to support countries to eliminate the practice, UNICEF and UNFPA are collaborating under the auspice of the Global Programme to End Female Genital Mutilation with the following strategies for action:

- **Support countries to establish an enabling environment for the elimination of FGM in line with human rights standards.** Work with regional and subregional political entities, national governments, civil society and communities to increase accountability and harness political will to ensure the implementation of laws and policies that prevent FGM. This includes closing legal loopholes and ensuring adequate monitoring of compliance.
- **Empower girls and women to exercise and express their rights.** Address FGM by engaging with parents and communities to transform social norms that promote the practice. This includes applying a cross-sectoral perspective where programme development is evidence-driven, taking into account contextualization at the subnational level. The approach uses strategies that target a range of barriers including, but not limited to, social, structural, service delivery, power dynamics, laws and governing entities.
- **Improve access to services for girls and women** for prevention, protection and care. Work with and train service providers to end the medicalization of FGM. Ensure access to quality and appropriate services that meet child protection and sexual and reproductive health rights and needs of girls and women in the region.
- **Support countries to generate evidence and data for policymaking and programme improvement.** Strengthen monitoring and evaluation of FGM interventions through providing training and guidance tools, and increasing the availability of national and subnational data on FGM. Collect data on social and behaviour change indicators on FGM to establish intermediate milestones on the way to the tipping point of shifting a norm. Track the effectiveness of interventions that seek to address FGM by measuring and demonstrating results, and continuously enhancing programmatic and policy responses.

TECHNICAL NOTES

To assess the prevalence of FGM, this analysis used SDG indicator 5.3.2 – the proportion of girls and women aged 15 to 49 years who have undergone female genital mutilation (FGM).

Aggregate regional estimates for the Middle East and North Africa are based on the five countries in the region where the practice is concentrated. Estimates for all practising countries are based on 31 countries with nationally representative data on the prevalence.

The estimates presented in this brochure reflect the set of countries outlined by the mandate of UNICEF's Middle East and North Africa Regional Office. For this reason, regional estimates may differ from those included in other UNICEF publications that are based on a geographical classification of countries in a particular region.

Confidence intervals are not shown in this publication. Caution is therefore warranted in interpreting the results since apparent differences among groups may not be significant. Key message titles for the figures were developed in light of the confidence intervals for these values. Thus, in cases where the title indicates that there is a difference among groups, it has been confirmed as statistically significant.

Data on age at cutting in the Middle East and North Africa are presented here as measured among adolescent girls aged 15 to 19 years. In this region, cutting mainly occurs before age 15. Girls aged 15 to 19 years have most recently surpassed the customary age at cutting, allowing for the most recent assessment of circumstances around FGM without the risk of censoring. Data on practitioner and type of FGM are represented as measured among girls aged 0 to 14 years as reported by their mothers. Since these measures are less sensitive to the age at which cutting occurs, reporting on the younger age group is preferable to give the most current assessment.

Projected values based on a continuation of observed progress apply the average annual rate of reduction in the prevalence of FGM, or the percentage of adolescent girls aged 15 to 19 years who have undergone FGM, over the past 30 years and over the past 15 years. The acceleration scenario assumes a doubling of the observed annual rate of reduction over the past 15 years. For statistical purposes, 'elimination' is defined here as a prevalence of less than 1 per cent.

DATA SOURCES

Djibouti data are from the Pan Arab Project for Family Health (PAPFAM) 2012; Egypt data are from the Health Issues Survey 2015; Sudan data are from the Multiple Indicator Cluster Survey 2014; Yemen data are from the Demographic and Health Survey 2013; and Iraq data are from the Multiple Indicator Cluster Survey 2018. Additionally, previous available surveys are used: the Egypt Demographic and Health Surveys 1995, 2000, 2003, 2005, 2008 and 2014; Sudan Demographic and Health Survey 1989-90, and the Household Health Surveys 2006 and 2010; the Yemen Demographic and Health Survey 1997 and the Iraq Multiple Indicator Cluster Survey 2011. All other data are from UNICEF global databases, 2019, based on Multiple Indicator Cluster Surveys, Demographic and Health Surveys and other nationally representative surveys. For detailed source information by country, see <data.unicef.org>. Population data are from United Nations, Department of Economic and Social Affairs, Population Division, *World Population Prospects 2019*, Online Edition, 2019.

ACKNOWLEDGEMENTS

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