

GETTING TO
**ZERO FEMALE
GENITAL MUTILATION**
IN AFRICA:

Strengthening Human Rights,
Accelerating Efforts and
Galvanizing Accountability



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Report

GETTING TO ZERO FEMALE GENITAL MUTILATION IN AFRICA:

Strengthening Human Rights, Accelerating Efforts
and Galvanizing Accountability



**Spotlight
Initiative**



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ACRONYMS AND ABBREVIATIONS

ACHPR	The African Charter on Human and People's Rights
ACRWC	African Charter on the Rights and Welfare of the Child
ARP	Alternative Rites of Passage
AU	African Union
AUC	African Union Commission
CEDAW	Convention on the Elimination of Discrimination Against Women
COTLA	Council of Traditional Leaders of Africa
CRC	Convention on the Rights of the Child
CSOs	Civil Society Organisations
FGM	Female Genital Mutilation
FGM/C	Female genital mutilation or cutting
GBV	Gender Based Violence
HHSD	Health, Humanitarian Affairs and Social Development Department
IAC	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
ICCP	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
NGO	Non-Governmental
SDGs	Sustainable Development Goals
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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GETTING TO ZERO FEMALE GENITAL MUTILATION IN AFRICA

FOREWORD

H.E. Minana Cessouma Samate,
Commissioner for Health, Humanitarian Affairs and Social Development



I am delighted to share this first of its kind African Union Commission Report on **“Getting to Zero Female Genital Mutilation in Africa: Strengthening Human Rights, Accelerating Efforts and Galvanizing Accountability”**.

The report comes amidst two years of the COVID 19 pandemic, where despite the challenges to execute our mandate and impact it has had our girls and women across the continent, we continue to see promising results across the continent.

In 2020 and 2021, estimates have suggested an increase in inequalities and vulnerabilities as a result of the pandemic containment

measures, with adolescent and young girls, and women most disproportionately affected. Global estimates are suggesting an increase in female genital mutilation cases of over 2 million by 2030 as a result of COVID 19. Despite this, the Commission is encouraged by the responsiveness and efforts of Member States to challenge national responses in ensuring the issues of adolescent and young girls, and women are a priority, and are integrated.



OVER 2 MILLION BY 2030

GLOBAL ESTIMATED INCREASE IN FGM CASES DUE TO COVID 19

The report's analysis and discussions are underpinned by human rights. It seeks to highlight good practices on the ground, whilst emphasizing the need for accountability at all levels if Africa is to get to Zero Female Genital Mutilation within this generation. The Commission takes note of Member States who are increasingly committing to a national deadline to completely eliminate this harmful practice, which is generating the right political momentum across the continent. The Commission calls on all Member States follow and invest in the same path.

The Commission has also commenced implementation of the African Union Saleema Initiative on Eliminating Female Genital Mutilation. The initiative seeks to catalyze action at all levels, and generating technical and financial support from Member States and partners to drive this agenda forward. In particular, I take this opportunity to thank the Spotlight Initiative Africa Regional Programme (SIARP) for its generous support in the drafting of this report. Particularly, the Department of Health, Humanitarian Affairs and Social Development of the Commission conveys its gratitude to UNFPA – leading the Female Genital Mutilation component of SIARP's Stream II in its shared commitment and hands-on support in this report and our overall portfolio. Results achieved at the level of the continent are a shared outcome and confirm the need for convergence of our mandates to protect adolescent and young girls, and women from all forms of gender-based violence and harmful practices – including female genital mutilation.

This is an important step in achieving Agenda 2063 aspirations to deliver the "Africa We Want" for girls and women. I welcome you to utilize the report in your programmes and advocacy efforts towards elimination of female genital mutilation, and continue to dialogue on more efforts we can co-lead towards better outcomes for all Africans.

H.E. MINATA SAMATE CESSOUMA

Commissioner for Health, Humanitarian Affairs and Social Development
African Union Commission



GETTING TO ZERO
FEMALE GENITAL
MUTILATION IN AFRICA

EXECUTIVE SUMMARY

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BACKGROUND

Female genital mutilation (FGM) is defined as
“All procedures involving partial or total removal of the
external female genitalia or other injury to the female
genital organs for non-medical reasons.”¹

The harmful practice of female genital mutilation contributes to adverse health outcomes including excessive bleeding, severe pain, infection and even death (short term), and obstetrics, gynaecological, sexual and reproductive health, and psychological problems, among other negative outcomes.

Across key indicators, including the 0 to 14 years and 15 to 49 years age-brackets – prevalence is from 1% to 97%. If trends continue, more than 50

million girls in Africa could be mutilated by 2030; while the Corona Virus (COVID 19) pandemic will further add an estimated two million additional cases of female genital mutilation.²

Within the broader scope of efforts to eliminate gender-based violence, addressing gender inequalities and empowering women and girls, ending FGM is an urgent priority for the African Union’s Saleema Initiative.



MORE THAN 50 MILLION
GIRLS IN AFRICA COULD BE MUTILATED BY 2030

THE ORIGIN AND IMPACT OF FGM

The origin and evolution of FGM remains unclear and unknown, with various competing explanations.

Generally, the incidence of FGM is a process of socialization into the value and belief systems about what it means to be a girl and a woman in practicing communities, where safeguarding virginity and increasing matrimonial opportunities is perceived as economically advantageous.

Reviews that document consequences of FGM on the wellbeing of girls and women illuminate adverse health outcomes inclusive of physical, social, sexual and economic consequences and the burden on health systems. Recently, the World Health Organization (WHO) launched an FGM Cost Calculator as a tool to identify the current cost of treating health conditions caused by and to take sustained action towards the complete elimination of FGM.³

PREVALENCE OF FGM IN AFRICA

Emerging lessons reveal that there are mixed trends in the prevalence of FGM in Africa, with varied generational changes between and within countries and regions that can be summarized as follows:



CONSISTENTLY VERY LOW FGM PREVALENCE: Throughout the years, the practice of FGM has been consistently lower in **Niger, Cameroon, Togo, Ghana, and Uganda.**

SLIGHT DECLINE IN FGM PREVALENCE: Côte d'Ivoire, Mauritania, and Sudan have experienced a slight decline in the prevalence of FGM across intergenerational age groups (45 - 49) and (15 - 19). This trend signifies limited success in convincing community members who practice FGM to abandon the practice en masse.



SIGNIFICANT DECLINE IN FGM PREVALENCE ACROSS INTERGENERATIONAL AGE GROUPS (45 - 49) AND (15 - 19):

In Benin, Nigeria, Liberia, Burkina Faso, Sierra Leone, United Republic of Tanzania, Kenya, Ethiopia, Eritrea, Central African Republic, and Egypt, evidence shows a generational shift where younger women are less likely to undergo FGM compared to older women. However, given the rapid growth of populations in these countries with huge proportion of young people, this intergenerational shift does not translate into the few numbers of girls at risk of FGM. In most cases, the number of girls facing FGM has significantly increased during the same period.



NO SIGNIFICANT CHANGE IN FGM PREVALENCE: For over three decades, there has been no significant change in FGM prevalence across intergenerational age groups (15 - 19) and (45 - 49) in Senegal, Guinea-Bissau, Gambia, Mali, Guinea, Djibouti, Somalia, and Chad. This trend signifies limited/lack of success by interventions designed to encourage communities to abandon FGM.

Knowledge and data gaps do however, continue to exist. Malawi, Mozambique, South Africa, Zambia are not listed among the countries with a prevalence of FGM. And it may be because the types of harmful female genital mutilation undertaken are not included in WHO's classification of Types.



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CHANGES IN FGM PRACTICE

There are current shifts happening in how FGM is practiced, especially in response to laws and policies against the practice, or as a result of its physical and psychosocial complications.

Changes in practice are also occurring with the migration to urban areas, “manifesting in varying degrees of behavioral change as a consequence of acculturation, length of residency, and/or the renegotiation and reinvention of FGM’s beliefs and practices.”⁴

Additionally, increased media exposure is altering the social underpinnings of FGM by questioning its value, especially in the face of its criminalization or awareness of the physical harm associated with the practice. Moreover, these changes are also leading to debates that interrogate the support for FGM or whether its practice should end.

FGM is also increasingly being performed by trained health care professionals as families are seeking to manage health risks, allowing families and health providers to conform to the social norms underpinning FGM. Families may also believe that using health care providers minimize the risks of FGM complications. Yet this is often not the case as immediate and long-term health problems can remain and even deaths can occur when performed by health care professionals. This is referred to as FGM Medicalization.

The need to be socially accepted by community members and the fear of the consequences of not conforming are strong motivations that can sustain FGM. An important change is that gender norms and expectations that underpin FGM practices are shifting.⁵ Shifts in the type of FGM are also occurring as a result of policy reforms to end the practice or as a result of increased awareness of its harm.



FACTORS CONTRIBUTING TO INCREASING RATES OF FGM

While progress has been made in ending FGM, **the COVID-19 outbreak has hampered previous efforts towards ending FGM** and even increasing rates across the continent.

The main drivers of FGM during the COVID-19 pandemic have been school closures, movement restrictions, confinement and lack of integration of services within COVID-19 responses.⁶

COVID-19 restrictions in mobility also constrained access to safe spaces for girls at risk, as well as survivors of FGM. Markedly, restricted access to communities by community-based organizations carrying out FGM programming may be resulting in increased rates of cutting and lack of accurate data, alongside reduced funding for FGM. UNFPA has further noted that “FGM and child marriage are also projected to increase, in

large part due to delays in the implementation of programmes to end these harmful practices. Programmes addressing these harmful practices are often communal, involving the exchange of information and perspectives.”⁷

Given the increased risks and vulnerabilities faced by women and girls in poor rural and urban communities in the face of the pandemic, multi-sectoral partnerships are required to document, disseminate, and sustain FGM initiatives beyond the crisis, including strengthening budgetary allocations, policy frameworks and legal responses.

INITIATIVES AND ACTIONS: ACCELERATING EFFORTS TO END FGM

AFRICAN UNION INITIATIVES

The continental legal frameworks, ACHPR, ACERWC, the Maputo Protocol and the Solemn Declaration, are complemented by an emerging array of AU policy instruments, declarations and resolutions.

The 32nd Ordinary Summit of the African Union in 2019 brought together Heads of State and Government, to spearhead the Continental International Conference held in Ouagadougou Oct 2018 under the theme, “Galvanizing Action to Accelerate the Elimination of Female Genital Mutilation by 2030”. This meeting led to the “Ouagadougou Call to Action on Eliminating Female Genital Mutilation” by Member States. It also led to the adoption of the AU Assembly Decision Assembly/AU/Dec.737 (XXXII), resulting in the launch of the Saleema Initiative on the Elimination of Female Genital Mutilation (FGM) on the continent.

Further, AUC is aligning its programme and work on ending harmful practices with the AU Agenda 2063 aspirations, prioritizing ending Violence and discrimination against women and girls, and clear targets to “End all harmful social norms and customary practices against women and girls and those that promote violence and discrimination against women and girls by 2025,” working with UN agencies and building on the current global momentum for ending FGM by 2030.

AFRICA-WIDE INITIATIVES

Efforts to abandon the practice of FGM in Africa have used several different approaches to inform interventions. The range of approaches have included provision of health information, conversion of excisors, training of health professionals, alternative rites to FGM, support for public declarations, empowerment of women and girls, and legal measures.

The efficacy of many interventions to end FGM are however, often reduced where the wider community is not involved or in the absence of sensitization where attitudinal change has occurred or is a prerequisite for change.

PROMISING INITIATIVES

There are promising interventions emerging that we can learn from to strengthen prevention and responses to ending FGM across five broad thematic areas:



POLICY AND LEGAL INTERVENTIONS

(creating an enabling environment)

- *In the context of laws, some form of legislation against FGM exists in most of the 29 African countries with FGM. However, there are serious challenges to the implementation and enforcement of those laws. Some of these challenges are systemic; limited knowledge or understanding of the law and or cultural challenges when leaders support the practice. Moreover, practicing communities may stop the practice or change the way they practice it by conducting it secretly because of fear of the law.*
- *Cross-border movements for the purposes of FGM is moreover, a persistent challenge along borders in the Africa region. For example, Member States of the African Union, Kenya, Uganda, Somalia, Ethiopia and Tanzania, are formulating and coordinating regional actions that will strengthen political will, programmes and stakeholders to reinforce Member State obligations to End Cross border FGM in the East Africa region.*



COMMUNITY LEVEL INTERVENTIONS

(challenging gender and social norms around FGM; and empowering women and girls).

At the community level, some of the best practices for combating FGM have been adopted including:

- *Leveraging cultural and religious leaders' efforts in Mali, where NGOs working in Mali like Plan International, Spotlight Initiative and the Association for Monitoring and Orientation on Traditional Practices (AMSOPT), have engaged cultural and religious leaders in their programming.*

- *Engaging boys and men in Nigeria, where men play a vital role in the realization of gender equality and abandonment of FGM.*
- *Alternative rites of passage in Kenya, where alternative initiation into womanhood without undergoing “the physical cut”, have been integrated as part of girl’s empowerment.*
- *Community conversations in Somalia, where community members and stakeholders discuss issues of FGM and formulate strategies to address it.*
- *Intergenerational dialogues in Senegal, where dialogues are based on strengthening dialogue between all generations, in order to involve the community in a collective process of change.*
- *Public declarations in Ethiopia, where members of a community openly or publicly announce their commitment to abandoning FGM.*
- *Rescue centers and safe houses in Tanzania, where girls who are at risk of FGM have sought help from Safe Houses that offer shelter and protection to girls escaping FGM, child marriage and other forms of gender-based violence.*
- *Around 1 in 4 girls and women who have undergone female genital mutilation (FGM), or 52 million FGM survivors worldwide, were cut by health personnel.⁸ There are interventions to help health care providers who are taking a public stand and advocating against FGM. In early 2020, a group of doctors in Egypt launched an anti-FGM campaign after the death of a 12-year-old girl.⁹ The campaign, called “White Coats”, raised awareness of the long term physical and mental complications of FGM.*



COMMUNICATION INTERVENTIONS

(creating awareness, knowledge and supporting activism to end FGM).

- *A range of communication tools have been explored such as social marketing that can promote communication among peers and communities and within families to support demand for ending the practice. For example: The Saleema Campaign was launched in 2008, in Sudan. It's a social marketing campaign that grew out of a need to have positive terms for women or girls who have not undergone FGM and change the language about it. The campaign uses different communication tools such as radio, television and billboards/ posters to mobilize communities to shift away from traditional practices and beliefs to new social norms by using positive language and messages thereby promoting long-term abandonment of FGM.*
- *The Saleema model has spread to countries like Egypt and Somalia. In February 2019, the African Union launched the Saleema Initiative to galvanize political action to enforce strong legislation, increase allocation of financial resources and strengthen partnerships to end female genital mutilation, particularly within communities most impacted by the harmful practice.¹⁰*



SUPPORT SERVICES

(providing services for FGM prevention, protection and care).

- *A holistic approach to addressing FGM includes a comprehensive child protection system that provides health-care, social welfare and legal services to girls and women who are at risk of or have undergone FGM.*
- *Beyond access to services, service providers (who are often respected members of the community) can also serve as community influencers and advocates for eliminating FGM*

- *Social protection programmes such as cash transfers have proven successful in addressing poverty and poor educational outcomes. Gender-responsive social protection can be an effective strategy for preventing families from resorting to negative coping mechanisms to alleviate household poverty, such as having girls undergo FGM.¹¹*



DATA AND EVIDENCE

(informing policy and programmatic decision making).

- *The increasing global, regional and national attention on FGM, has intensified efforts at understanding and addressing FGM as reflected in the increase in research and journal publications and improving data collection and analysis techniques that support a robust evidence base. This knowledge will help target interventions, and provide understanding why FGM persists in some areas and not others.*
- *It is also noteworthy that the African Union Gender Observatory and the Gender Scorecard has been playing a key role in strengthening the availability and use of quality and reliable data.¹²*

Critically, the COVID-19 outbreak has hampered efforts towards FGM and evidence shows increased rate across the continent.¹³ The main drivers of FGM during the COVID-19 pandemic seem to be school closures, movement restrictions, confinement and lack of integration of services within COVID-19 response.¹⁴ COVID-19 restrictions in mobility constrained access to safe spaces for girls at risk, as well as survivors of FGM. Markedly, restricted access to communities for community-based organizations carrying out FGM programming may be resulting in increased rates of cutting and lack of accurate data, alongside reduced funding for FGM given COVID-19.

SUSTAINING CHANGE AND GALVANIZING ACCOUNTABILITY: LESSONS LEARNT

Several lessons are emerging to inform the recommendations and improvements needed going forward. Highlights include;



FAILURE TO RECOGNIZE THE RIGHTS OF WOMEN AND GIRLS ALLOWS FOR PRACTICES THAT CAUSE HARM TO WOMEN AND GIRLS:

- *There is the strong continental recognition that FGM is a violation of the human rights of girls and women and a form of gender-based violence. FGM takes place in the context of harmful gender norms, gender inequalities, limited educational opportunities and poverty that intersect to disempower women and girls creating conditions of risks. The social change sought to support FGM abandonment requires that all strategies and interventions recognize that girls and women have equal rights and equal access opportunities. For these reasons the eradication of FGM must be informed by existing human rights frameworks.*



CHANGES IN THE PRACTICE OF FGM AND RATES OF PREVALENCE

- *Good progress has been made in ending FGM; for example, twice as many women in high-prevalence countries want the practice to end compared to 20 years ago; and Adolescent girls are more likely than older women to oppose the practice.¹⁵ However, the outbreak of COVID-19, as highlighted earlier, has witnessed increased rates of FGM across the continent. Additionally, the effects of climate change on women and girls in marginalized communities may also increase the risks of being subjected to harmful practices.*
- *The downward shift in age of cutting presents a new and critical challenge to ending FGM efforts. This change in age of cutting is frequently understood to be a consequence of anti-FGM campaigns, legal restriction on FGM and increasingly girls' resistance to FGM. It is, therefore, important to understand where and when girls will be at risk in order to have the relevant interventions.*



WHAT IS WORKING:

Programming and Implementation

- *Promising interventions that support efforts to end FGM have generally engaged and empowered local community actors inclusive of women and girls; men and boys; faith and community-based leaders as well as health care providers. Thus, transforming the social norms that underpin harmful attitudes and behaviours must be addressed at individual, interpersonal, community, and institutional levels to bring about the needed transformational change for women and girls. This approach is in recognition of the fact that individuals face multiple levels of influence that need to be addressed if programming to end FGM is to be effective.¹⁶*
- *Public health emergencies and humanitarian crises have heightened our understanding of the significant increases in risk of FGM; with disruptions to many services. Including prevention and response to these FGM risks within the humanitarian and health service responses is now recognized as critical components.*



CHALLENGES

- *Several countries in the Africa region now have laws banning FGM and a number are signatories to the human rights conventions and treaties. However, the practice does persist in certain communities, and health care providers are increasingly medicalising FGM. It is important to understand and monitor these changes in order to realize appropriate approaches towards addressing these issues.*
- *FGM practice is evolving. For example;*

Given laws that criminalize FGM, there is increasing secrecy of the practice through lowering of age of FGM, shifts in the decision-maker around the practice and changes in norms that underpin FGM.

In the context of climatic and/or economic insecurities families and daughters worry about their futures and FGM becomes their mechanism for entry into social support systems or into early/child marriages.



OPPORTUNITIES

- *UNICEF noted that in countries affected by FGM, 7 in 10 girls and women think the practice should end. Even among communities that practice FGM, there is a notable level of opposition. Among girls and women who themselves have been cut, 5 in 10 think the practice should end.¹⁷ These findings present openings for programming and identifying where and with whom to work.*
- *The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) convened its 34th Ordinary Session from 25th November to 5th December 2019 in Cairo, Egypt. Its recommendations on operationalizing accountability on harmful practices provides the ground work and support for Member States to strengthen action on ending FGM. The AUC has subsequently developed an Accountability Framework on Eliminating Harmful Practices, supporting Member States to deliver on collective commitments to end the practice of FGM as part of the sustainable development agenda and the continent's transformative Agenda 63.*

RECOMMENDATIONS



STRATEGIC

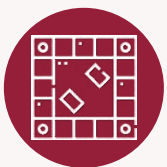
- *Utilizing comprehensive, collaborative, multisectoral approaches and partnerships to end FGM emerges out of evidence that no standalone measures are effective. Integrated and coordinated multisectoral approaches would ensure that programming builds strategic partnerships encompassing larger development goals, including health, justice, and education in responses to ending FGM.*

- *Most countries have developed laws to end FGM and there is consensus that such laws provide the framework for the implementation of abandonment interventions. Public support, knowledge about the intent of the law, and adequate resourcing of the justice system are required to enhance the claiming of rights and application of law in ways that are supportive of the well-being of women, girls and their families.*

- *Incorporate human rights and gender equality indicators in national responses to end FGM.*
- *Harmonize national laws with human rights standards for the promotion of FGM related health policies, programmes and services.*

- *Facilitate policy maker-researcher engagements to enhance the translation and effective use of data and evidence into policy making and programming.*

Will enable effective identification of some of the evidence gaps that limit a more complete understanding of the investments required for ending FGM, and how investments are translating into outcomes for women and girls.



PROGRAMMATIC

- *FGM prevention and responses must be population and context specific to be meaningful and in order to address the fundamental drivers of FGM. The resulting interventions must then be framed as addressing human rights and be grounded in theories of change for robust programming.*
- *Abandonment efforts must;*
 - *Recognize young girls and women as crucial partners in FGM interventions and agents in their own right, leading social change. This requires centering young girls and women in meaningful participation as well as building skills for leadership, and enhanced involvement in policy and programme formulation to end FGM.*

- *Incorporate comprehensive responses to support the safety, well-being and rights of girls and women. This will include the provision of legal, health and psychosocial services for FGM survivors.*
 - *Align with broader development efforts to ensure communities, women and girls can be more resilient in the face of risks, vulnerabilities and socio-economic factors that drive the continuation of FGM.*
- *Given different influencers that can shape opinion, perceptions and norms, inclusive of individuals, families, the community and the wider social institutions that sustain the social norms, behaviors and attitudes that reinforce FGM, it is critical to integrate families, communities and key stakeholders into programme design and implementation to end FGM:*

- *Faith based, opinion leaders, community leaders and Schools should continue to be engaged to:*

1. *Strengthen oversight and monitoring for prevention of FGM.*
2. *Challenge harmful social norms and modify social practices that arise from and perpetuate discriminatory practices against women and girls.*

- *Challenge harmful gender norms. This calls for involvement of men and boys to dismantle harmful social norms*

- *Communication and awareness raising materials and information must be in local languages to ensure accessibility and a wider reach.*

New technologies have become crucial tools for delivering broader gender based violence (GBV) interventions. They need to be discussed, tested and evaluated for the opportunities they provide for both the general public and for women and girls at risk for FGM.



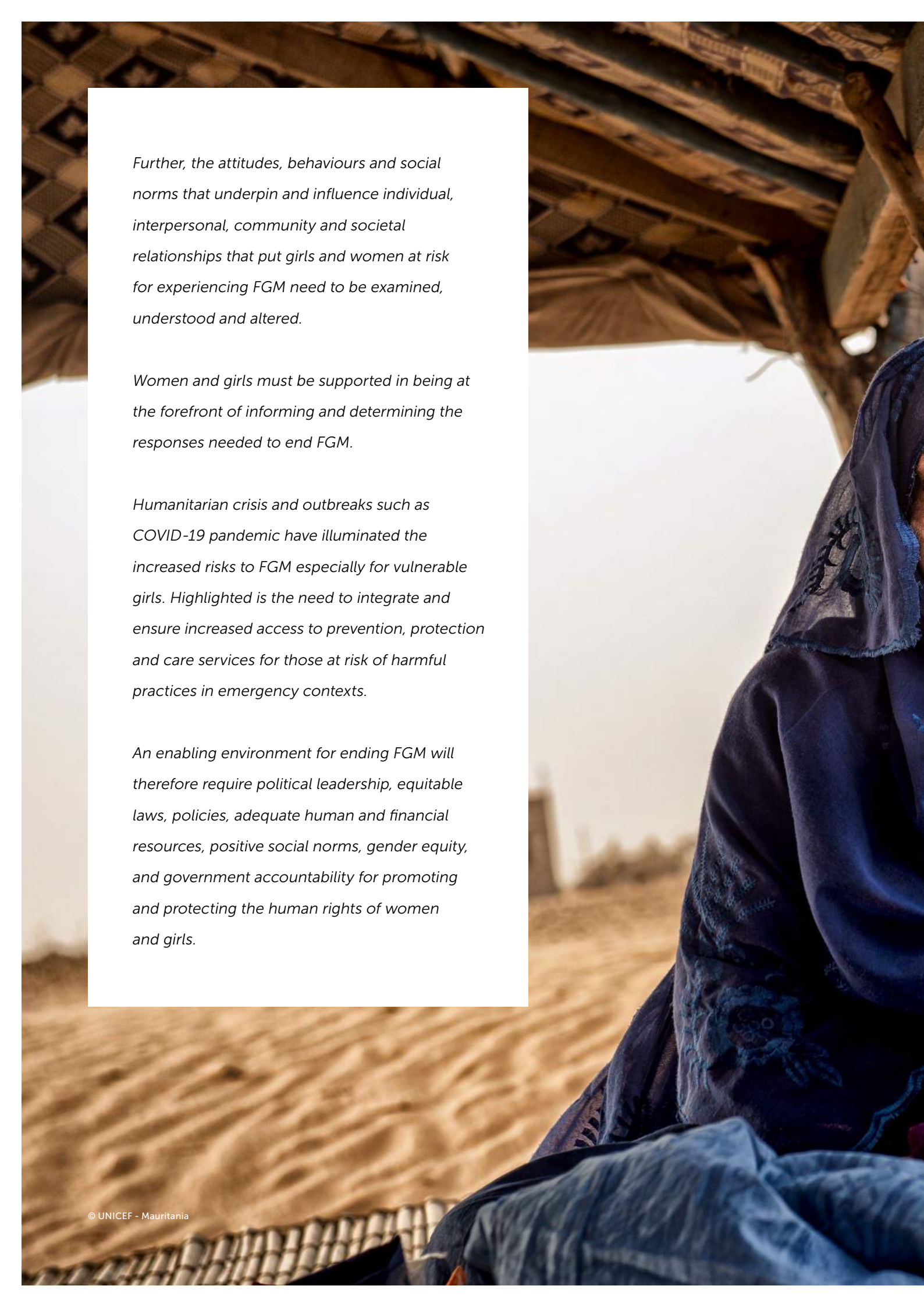
ACCOUNTABILITY

- *Greater examination and evaluation of interventions is needed to strengthen the evidence base to inform decision-making, demonstrate outcomes and lessons learnt to ensure accountability and for others to learn from, adapt, replicate, and scale up successful interventions.¹⁸*
- *Strengthen understanding of prevalence and risk factors for FGM especially at sub-national levels to strengthen policy decision making.*

CONCLUSION

FGM is a serious human rights violation with serious consequences for women and girls' physical, mental, sexual and reproductive health. Poverty, public health and humanitarian crises also drive FGM. Understanding the extent of FGM as a harmful practice is crucial in informing the actions and strategies needed to address it. A big win is that Member States are increasingly tracking progress in achieving international and regional obligations to combat FGM by measuring its occurrence. However, what remains to be prioritised is tracking the level of progress across diverse interventions. The influence of policies, as well as advances in developing legal and regulatory reforms, service availability, and budgetary allocations to address FGM, have been revealed by changes in the prevalence of FGM.

Current efforts by the African Union African Union's Saleema Initiative is to get to Zero FGM (with the guiding strategy including - within the context of agenda's 2030, 2063 and, within a generation). To do so needs increased mobilization and cooperation among Member States; and prevention and responses to end FGM must be coordinated across sectors. Good practices emerging across the African region highlight that social change in support of abandoning FGM requires multilevel and multisectoral approaches. This entails effectively coordinating all relevant stakeholders and ensuring they have the necessary material and technical support needed to work efficiently to strengthen sub-national and national responses to ending FGM.

A woman wearing a blue headscarf with intricate embroidery is seated under a traditional thatched roof. The background shows a vast, sandy desert landscape under a clear sky. The scene is captured in a warm, golden light, suggesting late afternoon or early morning.

Further, the attitudes, behaviours and social norms that underpin and influence individual, interpersonal, community and societal relationships that put girls and women at risk for experiencing FGM need to be examined, understood and altered.

Women and girls must be supported in being at the forefront of informing and determining the responses needed to end FGM.

Humanitarian crisis and outbreaks such as COVID-19 pandemic have illuminated the increased risks to FGM especially for vulnerable girls. Highlighted is the need to integrate and ensure increased access to prevention, protection and care services for those at risk of harmful practices in emergency contexts.

An enabling environment for ending FGM will therefore require political leadership, equitable laws, policies, adequate human and financial resources, positive social norms, gender equity, and government accountability for promoting and protecting the human rights of women and girls.



1. INTRODUCTION

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BACKGROUND

Female genital mutilation (FGM) is defined as **“All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.”**¹⁹

Complications resulting from FGM can include excessive bleeding, severe pain and infection. The harmful practice of female genital mutilation also contributes to negative maternal health outcomes, including obstetric fistula, as well as negatively impacting child health and contributing to child mortality.²⁰ FGM is prevalent in at least 29 African Union (AU) Member States on the continent. Across key indicators, including the 0 to 14 years and 15 to 49 years age-brackets –prevalence is from 1% to 97%. The practice

can also take different forms – from a slight cut or nip, to extensive mutilation that is injurious, causing life-long physiological, traumatic and psychological complications. Within the broader scope of efforts to eliminate gender-based violence and addressing gender inequalities and empowering girls and women, ending the practice of female genital mutilation and other harmful practices is an urgent priority for the African Union.



FGM IS PREVALENT IN AT LEAST
29 AU MEMBER STATES

The continent has an increasingly young population and anticipates reaping the economic growth associated with demographic dividends. However, with millions of young girls at risk of being subjected to this harmful practice, these opportunities are limited. Estimates suggest that more than 50 million girls could undergo female genital mutilation by 2030 in Africa if current trends are not reversed. Recent studies also suggest that globally, the ongoing Corona Virus (COVID 19) pandemic will further add an estimated two million additional cases of female genital mutilation²¹ widely impacting ongoing efforts; with a 1/3 reduction anticipated in the progress towards ending FGM by 2030.”²²

This report by the African Union Commission, under the Saleema Initiative on Eliminating Female Genital Mutilation, is drafted against this background.

SCOPE OF THE REPORT

This report, titled *Getting to Zero Female Genital Mutilation in Africa: Strengthening Human Rights, Accelerating Efforts and Galvanizing Accountability*

will be the first of its kind on the subject by the African Union Commission’s Department of Health, Humanitarian Affairs and Social Development. Emerging lessons and recommendations will inform, strengthen and support the African Union Saleema Initiative on Eliminating Female Genital Mutilation.

SECTION ONE

The Introduction, provides background to the purpose of the report outlining the roles, commitments and actions taken to date by the African Union to eliminate harmful practices that limit the full realization of girls’ and women’s rights. This section further draws attention to the global and regional human rights normative frameworks that recognize FGM as a violation of the rights of women, and girls; specifically, freedom from gender discrimination and violence, and the rights to health. Further foregrounding how FGM is a form of gender violence that sustains inequalities and discrimination.

SECTION **TWO**

Examines the nature of FGM defining the types and factors that contribute to FGM. It summarizes the immediate, medium and long-term consequences of FGM, including its root causes and other contributing factors and the risks and costs associated with FGM. The aim here is to understand the extent of FGM as a harmful practice to inform the actions and strategies needed to address FGM.

SECTION **THREE**

Looks in-depth at prevalence of FGM and highlights the diverse and varied regional and country by country prevalence and changes in prevalence across the Africa region. It sets out the broad context of FGM and outlines the extent and prevalence of FGM on the Africa continent, in order to better evaluate the scale of change and more critically illuminate the overall decline in prevalence, where good progress has been made and where efforts to accelerate action remain needed given persistent high prevalence rates.

SECTION **FOUR**

Brings further attention to changes in the actual practices of FGM outlining the factors that are contributing to these modifications in FGM.

SECTION **FIVE**

Reviews the critical concerns of the COVID-19 pandemic on ongoing efforts to eliminate FGM, especially the rising cases exacerbated by the disruptions of the pandemic. Current proposals to integrate FGM prevention within COVID-19 national responses are also outlined.

SECTION **SIX**

Summarises the continent-wide actions and initiatives that reflect good practices for learning and scaling efforts to end FGM.

SECTION SEVEN

Provides final reflections, from consultations, on lessons that are emerging to better inform Member States. It highlights AUC efforts addressing FGM, constraints to be addressed and identifies promising efforts underway such as strengthening accountability for ending FGM across the African continent.

SECTION EIGHT

The report concludes by translating the findings and learnings of the into actionable recommendations at different levels, guided by continental efforts led by the African Union Commission that can be adapted by Members States in support of efforts to accelerate the elimination of FGM.

The report has been developed drawing primarily on available-secondary data; and correlating this with information obtained from consultations with various stakeholders-primary data. Consultations with relevant stakeholders included the African Union, African regional bodies, UN agencies, researchers, non-governmental organisations, and independent experts working in this area. While documents reviewed included policy documents, strategies and action plans; official documents of national and regional institutions, journal articles, research studies, reports of non-governmental and civil society organizations, and the media.

STRENGTHENING HUMAN RIGHTS: ADDRESSING FGM AS A HUMAN RIGHTS CONCERN

“To regard [FGM] as a violation of the human rights of women and girls is to view this practice as an infringement by governments and societies upon the moral and political claims of women and children”²³

There have been great strides in efforts to address FGM and other harmful practices against women and girls. Prevention and response interventions are evident across Africa, with the human rights perspective and focus fast becoming an anchor and guiding principle to actions on the ground.

WOMEN, GIRLS AND CHILDREN: THE HUMAN RIGHTS APPROACH

States have an obligation and a duty to prevent and address violence against women and girls as well as provide services and relief to survivors of harmful practices. Female genital mutilation is recognized as a violation of human rights – namely freedom from gender discrimination and the right to life, health and physical integrity.

Consequently, there have been extensive efforts to promote the abandonment of the practice. The recognition of FGM as a human rights violation, provides an entry point for understanding the context from which it emerges and its related harmful and risk factors. Understanding FGM within the human rights framework has helped illuminate how the causes of FGM and factors that increase or sustain the practice are linked to wider systematic gender-based discrimination against women and girls or violations of women and girls' rights.

The African Union (AU) has identified the gaps to be addressed and steered attention to include FGM considerations in relevant policy instruments. The AU, guided by Agenda 2063's priority 6.1.2, is working to deliver on the commitment to eradicate within this generation **"...all harmful social norms and customary practices against women and girls and those that promote violence."** This is underpinned by a strong human rights framework guided by progressive continental legal instruments, including;²⁴

- *African Charter on Human and People's Rights (ACHPR 1987) and its Protocol on Women's Rights (the Maputo Protocol);*
- *African Charter on the Rights and Welfare of the Child (ACERWC 1990);*
- *Solemn Declaration on Gender Equality in Africa (2004);*
- *African Court of Justice and Human Rights (ACJHR 2004) a merging of the former Court on Human and People's Rights, and the African Court of Justice of the African Union);*
- *Pan African Parliament (PAP 2004), and*
- *Assembly Decisions and Declarations on Eliminating Harmful Practices, including Female Genital Mutilation and Child Marriage*



THE AFRICAN UNION HUMAN RIGHTS FRAMEWORKS

Article 4 of ACHPR states that Human beings are inviolable. Every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right. **Article 18** asserts that The State shall ensure the elimination of every discrimination against women and also ensure the protection of the rights of the woman and the child as stipulated in international declarations and conventions.

The Protocol on Women's Rights (the Maputo Protocol) in **Article 5** on Elimination of Harmful Practices calls on State Parties to prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised international standards. States Parties shall take all necessary legislative and other measures to eliminate such practices.

Article 21 of the ACRWC on Protection Against Harmful Social and Cultural Practices obliges States Parties to the present Charter shall take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development.

The African Charter on Human and People's Rights (ACHPR)²⁵ and its Protocol on Women's Rights (the Maputo Protocol)²⁶ and the African Charter on the Rights and Welfare of the Child (ACRWC)²⁷ serve as important expressions of the goal of equal rights for women, girls and children. They detail wide-ranging human rights provisions and cover the entire spectrum of political, economic, social rights inclusive of the rights of women, the rights of children and the rights to good health.

There is a human and ethical imperative to respond to girls and women's human rights given the harms and violations to their bodies that is at the centre of FGM practices. This demands understanding of the specific gender and social norms and contexts that hamper the realization of the human rights of girls and women. It further demands our understanding that women and girls are equally deserving of human rights and its protections.

The conventions and treaties provide the language of human rights that are the prerequisites of human well-being; inclusive of rights to health and rights to bodily integrity. Human rights language also establishes the State's obligations to prevent and respond to rights violations and to be held accountable for the fulfilment of those obligations. Moreover, human rights provide the tools and supportive environments, (for individuals, communities and governments), needed for concrete interventions to end FGM and to challenge the systemic inequalities that sustain this injurious practice. Conversely, gender which structures our human relationships gives shape to our life affirming experiences. As such the African Union approach "aims to accelerate actions that ensure every African girl can grow to maturity in her natural and original form: complete, unharmed, saleema."²⁸

As of 2021, 22 of the 29 countries with data have enacted national laws banning FGM.²⁹



INTERNATIONAL AND CONTINENTAL LEGAL COMMITMENTS RELEVANT TO ADDRESSING FGM

Although "there have been significant improvements in the adoption of Human Rights (HR) instruments and policies both at the continental and regional level by African Union Member States, progress remains limited due to the lack of capacities and resources needed to translate legislation and policies into action and tangible benefits for women/girls."³⁰

- *To date, the African Women's Rights Protocol has not secured universal ratification. Only 36 countries have signed and ratified, 15 have signed but not ratified and 3 have not signed or ratified.*
- *By 2017, more than 80% of AU Member states had ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (the Maputo Protocol), which guarantees comprehensive rights to women including the right to partake in political processes, social and political equality with men, reproductive health and an end to FGM.³¹*

African Union Member States, including those with high FGM prevalence have further signed and ratified international treaties and conventions that prioritize protection of human rights for women and girls through elimination of FGM (Table 1).³² Ratification of international treaties and regional legal instruments relevant for elimination of FGM will need to be accompanied by commitment to their implementation and accountability.

TREATY	RIGHTS PROTECTED
International Covenant on Civil and Political Rights (ICCPR)	Life, liberty, freedom from torture & slavery
International Covenant on Economic, Social and Cultural Rights (ICESCR)	Economic, social and cultural rights
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)	Fundamental and human rights for women
Convention on the Rights of the Child (CRC)	Fundamental and human rights for children

Table 1: **International Treaties and Conventions**

The African Union can reinforce and strengthen these standards and declarations, including legal frameworks; and can communicate and enforce expectations in relation to zero tolerance to all forms of harmful norms and practices that promote violence against women in alignment with its Agenda 2063.



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...HE IS ACCOUNTAB...

2. THE PRACTICE of FGM

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DEFINING FEMALE GENITAL MUTILATION (FGM)

Female genital mutilation (FGM) is the term given to different practices that involve cutting or nicking of female **genitalia**. In some parts of the continent, FGM is referred to as excision, while in others, the term circumcision is also used.

In 1990 the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) formally adopted the term Female Genital Mutilation. The World Health Organization (WHO), United Nations Children's Emergency Fund (UNICEF), United Nations Population Fund (UNFPA), jointly stated in 1997 that **"Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital**

organs whether for cultural or other non-therapeutic reasons", with the WHO adopting FGM as the standard terminology. Several variations on the terms are found in the literature and include Female Genital Cutting (FGC), Female Genital Circumcision (FGC) and Female Genital Surgeries (FCS). **The accepted terminology for the African Union is Female Genital Mutilation or FGM** and this is what is used in this report.



INTER-AFRICAN COMMITTEE FORMALLY ADOPTED
THE TERM FGM IN 1990

TYPES OF FGM

Female Genital Mutilation has been grouped into four distinct types³³, including:

TYPE ONE

This is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans);

TYPE TWO

This is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva);

TYPE THREE

Also known as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans (Type I FGM) and

TYPE FOUR

This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

- The type of procedures, the age at which it is carried out and the way in which it is done vary according to a variety of reasons.³⁴ These include; the girl or woman's ethnic group, the country and whether living in an urban or rural setting and their socio-economic background.³⁵
- Globally, Type I and II are the most common FGM procedures, but there is variation in how it is undertaken among countries. Type III is most commonly practiced in north-eastern Africa, particularly Djibouti, Eritrea, Somalia, and northern Sudan.³⁶ Type III is similarly prevalent in Niger and Senegal³⁷ with some limited practice in Nigeria.³⁸



FACTORS CONTRIBUTING TO FGM

The elimination of female genital mutilation requires **knowing and engaging with beliefs and social norms within the communities** where it is practiced.

The origins and growth of FGM remains unclear and unknown with numerous and aetiological explanations. Overall, FGM is believed to be a process of socialization into the value and belief systems of what it means to be a girl and a woman for particular communities and societies. It reflects the control of female bodies and sexuality and is therefore an expression of power. Where FGM is a social norm, the social pressure to conform to what others do and have been doing³⁹, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice.⁴⁰ There is "marked variations in type of FGM performed, and in the rituals associated with it. Even within the same geographic locality, the nature of the practice, its justifications, and the age at which it is performed differ vastly by ethnicity and class."⁴¹ Reflective of these differences is the fact that local communities will determine when the practice is performed, from as early as a few days after birth; anywhere between infancy and fifteen years of age; at puberty immediately, prior to entering a marital relationship, or in the case of adult women who had not been previously cut - then it may be undertaken prior to marriage or after a first pregnancy.^{42 43}

A variety of reasons, depending on the community, on why FGM is practiced. These must be understood in the context of societal pressures for women and girls to conform to female codes of behaviours and the discriminatory and unequal conditions of women's existence. The different reasons for FGM can be characterized into five groups as outlined broadly below:

MORALITY, SEXUALITY AND VIRGINITY

Frequently the intention of the procedure is to control women's sexuality and depending on the community, by either diminishing a woman's desire, restraining women's sexuality or ensuring marital fidelity. Where virginity is a prerequisite for marriage it can be a marker of premarital chastity and family honour. FGM therefore becomes a means for safeguarding the virginity of young girls, and increasing matrimonial opportunities especially where FGM is prevalent it continues to be perceived as economically advantageous⁴⁴ for increasing marriageability;

HYGIENE, AESTHETICS AND PURIFICATION

Female genitalia are considered dirty, ugly, or unhygienic and the aim of FGM is to ensure cleanliness and attain beauty. For example, the terms for FGM in Egypt (Tahare), Mali (Sili-ji) and Sudan (Tahur) are synonymous with purification;⁴⁵

FEMININITY

The clitoris threatens the male organ (Mali, Kenya, Sudan, and Nigeria), while among some communities the clitoris is identified as representing the male sex and must be excised;

INITIATION INTO WOMANHOOD AND COMMUNITY SOCIAL NORMS

FGM prepares girls for marriage and motherhood, for socialization into cultural identity, community membership, inclusion in older women's social networks and for maintenance of customs and traditions and thus providing a sense of belonging to a group;

RELIGIOUS REQUIREMENT

Although FGM is practiced by diverse religious groups it has been strongly identified with Islam in many African countries with the assertion that it is "sunna", meaning tradition in Islam. Yet there is no basis for FGM in any existing religious text, teaching or tradition; and

FERTILITY, PREGNANCY AND MATERNITY:

To ensure the safe delivery of a baby. Enhance fertility given belief that without FGM it can be challenging for a woman to conceive.



"FGM is a deeply entrenched social convention among some ethnic groups and as such carries consequences both when it is and when it is not practised. When girls and families conform to the practice they acquire social status and respect. For girls, undergoing FGM promotes honour and her full acceptance in the community, as well as imparts a sense of pride and of coming of age. In some societies, the link between FGM and value is explicit: girls who undergo FGM often receive rewards in the form of celebrations and gifts and the bride price(dowry) for a girl who has been cut is much higher than that for one who has not (25). For families, fulfilling the cultural expectation that girls should be cut assigns status and community membership. Conversely, failure to conform leads to difficulty in finding a husband for the girl, shame, stigmatization, as well as loss of social status, honour and protection, resulting in the family's social exclusion in the community"⁴⁶

RISKS, CONSEQUENCES AND COSTS OF FGM

FGM can result in acute, intermediate and late complications. FGM has been associated with numerous types of harmful consequences, inclusive of physical, psychological, social, sexual and economic consequences. These harmful effects of FGM can have negative impacts for individuals, their households, communities and countries' economies.

PHYSICAL CONSEQUENCES

FGM is usually done with crude unsterile instruments and without anaesthesia, by traditional practitioners. FGM can result in immediate harm. For example, girls can die as a direct consequence of FGM caused by complications such as haemorrhage, "pain and trauma, severe and overwhelming infection, or a combination of these complications."⁴⁷ FGM may also be associated with chronic problems affecting the genital and/or urinary systems of women and girls.⁴⁸

PSYCHOLOGICAL CONSEQUENCES

FGM or its delayed complications may trigger the onset of one or a combination of the following complications: acute anxieties, depression, neuroses, psychoses, and post-traumatic stress disorder.⁴⁹ However, there is also evidence that not undergoing FGM in certain communities has a greater psychological impact than the trauma caused by FGM itself, as a woman without FGM may 'become a social pariah'.⁵⁰ More rigorous evidence, particularly on the correlation between FGM type and severity of adverse mental health outcomes is needed.

EARLY CHILD MARRIAGE

Female genital mutilation is frequently linked to marriageability and is thought to be related to the marriage of girls younger than age 18, known as early/child marriage. These practices threaten the rights, health, development, and quality of life of girls and women. FGM and early/child marriage both are wrongfully perceived to protect girls from social and economic risks; they are driven by poverty and lack of economic opportunity for girls in the areas where they are practised. Rural, uneducated, poor women and girls face the highest risks of early/child marriage. Interventions directly targeting both FGM and early/child marriage may need to be paired with activities that promote education and socioeconomic empowerment to be effective.⁵¹ Not all child brides undergo FGM and not all girls who experience FGM are child brides. However, where FGM happens as a rite of passage into womanhood, it often leads to child marriage. Countries that have a high FGM practice rate also have a high rate of ECM.⁵²

SOCIAL AND ECONOMIC CONSEQUENCES

FGM increases the likelihood that a girl will leave school at a young age. The health problems resulting from FGM can cause girls to miss school. The resulting effects may include school dropout, reduced earnings, and less control and agency over life choices including marriage and family planning. FGM is also often a precursor to child marriage.⁵³ These economic and social impacts may go well beyond the individual girl in having consequences for her family or community. According to UNFPA,⁵⁴ 22 of 30 countries where FGM is practised have the lowest indicators of socioeconomic development.

GYNAECOLOGICAL COMPLICATIONS OR CONSEQUENCES

Emerging evidence reveals that FGM is associated with sexual complications. Women who had undergone FGM were more likely to report painful intercourse, no sexual desire, less sexual satisfaction, and less experience of orgasm compared to their uncut peers. Other sexual outcomes reported include women not initiating sex and lack of knowledge of the most sexually sensitive part of their bodies.⁵⁵ Moreover, women and girls who have undergone FGM Type III will often have to be de-infibulated to have sexual intercourse otherwise they may experience sexual pain from forced penetration.⁵⁶ A WHO study further notes that women with FGM are significantly more likely than those without FGM to have adverse obstetric outcomes. Risks seem to be greater with more extensive FGM. Additionally, deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum haemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death, than deliveries to women who have not had FGM.⁵⁷

FGM AND HIV RISK TRANSMISSION

Currently there are no studies providing strong evidence of this association. FGM and HIV risk transmission remains anecdotal even though the risk seems real. Sharing the same surgical instrument without sterilization could increase the risk for transmission of HIV between girls who undergo female genital mutilation together. However, the available evidence did not conclusively demonstrate the anticipated association between FGM and HIV.⁵⁸

WHAT WE ARE LEARNING ABOUT THE RISKS AND COSTS OF FGM

FGM procedures have been predominantly performed by traditional circumcisers and traditional birth attendants. In recent times, the practice is also increasingly performed by medically trained midwives, doctors and nurses who argue they reduce health risks and pain. This has threatened to legitimize FGM. Those who perform FGM, therefore, play an important role in the continuation of what is perceived as a highly valued service, while in some contexts such as Sierra Leone, circumcisers are highly respected women leaders who politically wield a lot of power given their control of traditional secret societies.

The health impacts resulting from FGM place a burden on health systems. However, little is known of the financial costs associated with FGM. In 2020, on Zero Tolerance Day, WHO launched FGM Cost Calculator.⁵⁹ The calculator tool, covers 27 countries, in Africa. They include Benin, Burkina Faso, Central African Republic, Côte d'Ivoire, Cameroon, Chad, Djibouti, Egypt, Eritrea, Ethiopia, Ghana,

Guinea, Gambia, Guinea-Bissau, Iraq, Kenya, Mali, Mauritania, Niger, Nigeria, Soudan, Senegal, Sierra Leone, Somalia, Togo, and United Republic of Tanzania. The tool enables the identification of current costs of treating health conditions caused by FGM showing the potential amount of money saved if FGM is prevented.⁶⁰ This will complement the now well documented research and evidence on the economic burden resulting from the management and treatment of the complications related to FGM.⁶¹

In view of the complexities of FGM, diversity of drivers and factors that perpetuate FGM as outlined in this section, ending female genital mutilation requires multisectoral and coordinated strategies involving almost all sectors of Government, the wider community, community leaders, women's rights groups, civil society organisations, health care providers, and even teachers, girls and boys. Further, programmes for health and sexual and reproductive health services must link with violence against women and girls and FGM programmes, as part of the comprehensive response needed to support the human rights, safety, and well-being of women and girls.



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GETTING TO ZERO
FEMALE GENITAL
MUTILATION IN AFRICA

3. PREVALENCE OF FGM

WHERE AND TO WHAT EXTENT IS FGM PRACTICED?

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DEFINING FEMALE GENITAL MUTILATION (FGM)

Female Genital Mutilation is practiced among particular communities in 29 African countries: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Democratic Republic of Congo, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda and Zambia.



Figure 1: **FGM Prevalence Among Women Aged 15-49 Years in Africa**⁶²

There has been increased momentum in the generation of evidence on FGM through work carried out by governments, international organizations, academic and research institutions, women's rights organizations, and CSOs.

However, knowledge and data gaps still do exist. Malawi, Mozambique, South Africa are not listed among the countries with a prevalence of FGM. For example, World Health Organisation does not list South Africa as a country where FGM is practised, except for migrant communities.⁶³ And it may be because the types of female genital mutilation undertaken⁶⁴ are not included in WHO's classification of Types. However, anecdotal reports and some early studies⁶⁵ do point to the practice as present among particular communities in the Southern Africa region. For example, Traditional chiefs in parts of Malawi have confirmed that the practice of female genital mutilation is prevalent in the country's southern region with the practice going almost unnoticed because of the secrecy surrounding it.⁶⁶ But there are no national statistics available on FGM in Malawi. Further, other reports suggest that FGM is practiced in Zimbabwe, but estimates on prevalence among girls and women are unknown and data unrecorded. More specific and detailed studies and data on FGM for the Southern Africa Region remains needed.

SIGNIFICANT GEOGRAPHIC VARIATIONS



A key lesson⁶⁷

FGM prevalence greatly varies between and within countries, thus understanding the local context of where and when FGM is practiced is essential for tailoring investments supporting abandonment efforts.

The prevalence of FGM varies almost as much within countries as it does between them. The practice tends to be concentrated in certain sub-regions and locations due to clustering of practicing ethnic groups; therefore, national data may mask important local variations. Subnational analyses can help programs identify "hot spots"—high prevalence areas that would benefit from tailored interventions.

First, prevalence varies significantly across the African region and second, more than 140 million girls and women have been subjected to FGM in African countries where data on FGM is available⁶⁸ (See Annex 1). Recent UNFPA data estimates that for Africa about 50 million girls will be at risk of FGM by 2030, if current levels of intervention remain in place.⁶⁹

Overall, FGM prevalence among women aged 15-49 years shows the lowest prevalence in Uganda (0.3%) and the highest in Somalia (98%) (See Annex 2). With regards to FGM prevalence among girls aged 0-14 years the percentage of girls who have undergone FGM in Africa also varies significantly across the African region. The lowest prevalence at the time of this study is in Benin (0.1%) while the highest is in Mali (83%).⁷⁰ Generally, apart from Mali, there is a significant reduction in FGM prevalence among girls aged 0-14 years as compared to women aged 15-49 years (See Annex 2). This trend perhaps signifies a generational shift in Africa with a reduction in the proportion of families likely to cut their daughters. It is nonetheless important to be cautious when interpreting data related to the FGM status of daughters as younger girls are still at risk of being cut especially in communities that do not cut their daughters at birth.

Generally, there is evidence that the practice of FGM is decreasing because prevalence is lower in the 15-19 age group compared to those who are much older (See Annex 2). FGM prevalence has declined faster (in relative terms) in countries with lower initial prevalence, and more slowly in countries with higher initial prevalence.⁷¹ Although better-educated women and those living in urban areas tend to have lower prevalence, in some countries the opposite pattern is observed.⁷² (Further) in settings with higher initial prevalence, FGM practice is likely to be more entrenched and to change more slowly.⁷³

It is also important to understand whether there have been changes in FGM prevalence in Africa.⁷⁴ And to do so requires examining prevalence rates across different age groups. There is strong evidence that there has been generational changes in FGM prevalence with varying levels across the regions.⁷⁵



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PREVALENCE: EMERGING LESSONS

Availability of national representative data on FGM is unequal across countries and the continent. Accurate, current and representative data on prevalence as well as data on which factors are sustaining FGM in specific contexts are key to tailoring responses to ending FGM. There are mixed trends in FGM prevalence with varied generational changes between countries and regions and also within communities in countries (See Annex 2 and 3) that can be summarized as follows:

CONSISTENTLY VERY LOW FGM PREVALENCE ACROSS ALL AGE GROUPS

Throughout the years, the practice of FGM has been consistently very low in Niger, Cameroon, Togo, Ghana, and Uganda. **What this signifies is that there are consistently fewer communities in these countries that practice FGM and a possibility of reduction in FGM prevalence.**

Nonetheless, it is important to narrow down to community specific evidence to establish changes or shifts, if any, among the practicing communities;

SLIGHT DECLINE IN FGM INTERGENERATIONAL PREVALENCE

Côte d'Ivoire, Mauritania, and Sudan have experienced a slight decline in the prevalence of FGM.

This trend signifies limited success in convincing community members who practice FGM to abandon the practice en masse;

SIGNIFICANT DECLINE IN FGM INTERGENERATIONAL PREVALENCE

In Benin, Nigeria, Liberia, Burkina Faso, Sierra Leone, United Republic of Tanzania, Kenya, Ethiopia, Eritrea, Central African Republic, and Egypt, evidence shows a significant decline in FGM prevalence across age groups with a possible generational shift where younger women are less likely to undergo FGM compared to older women. **The trend further signifies success of FGM interventions that have been carried out in these countries over the years to encourage communities to abandon the practice. There is a need to build on this momentum to accelerate total abandonment in the shortest period. However, this decline does not translate into the few girls at risk of FGM, given demographic growth in the concerned countries;**

NO SIGNIFICANT CHANGE IN FGM PREVALENCE

For over three decades (from the time data on FGM were first collected in the various countries), there has been no significant change in FGM prevalence in Senegal, Guinea-Bissau, Gambia, Mali, Guinea, Djibouti, Somalia, and Chad. This trend signifies limited/lack of success of interventions designed to encourage communities to abandon FGM in these countries. **There is a need to re-evaluate policies and programmes that have been implemented in these countries over the years to find out the best set of interventions that are likely to bring the desired change.**

The incidence of FGM will be very varied within a country because of how embedded negative gender and social norms are, the nature of the beliefs and the ethnic mix of communities that have abandoned the harmful practice, while for others it will become hidden and others will persist. For example, a study of the association between parental attitudes and the practice of female genital mutilation highlights that in most countries, the highest prevalence of FGM is among girls whose parents both wanted FGM to continue.⁷⁶

Additionally, UNICEF notes that recent major declines in FGM-risk are reported in urban areas. This suggests that further reductions in FGM-risk will only be possible if program interventions can successfully target and reach sub-populations of girls in hard-to-reach, remote and marginalized communities—and raises additional questions on the nature, feasibility and scale of FGM prevention programs needed for further reductions.⁷⁷

Measuring the occurrence of FGM enables States to monitor progress in meeting their international and regional obligations to end this harmful practice and other forms of gender-based violence. Changes in intergenerational prevalence of FGM is a pointer of the impact of interventions, progress in the establishment of legal and policy reforms, availability of services and budgetary allocations to address FGM.

Furthermore, tracking changes through regular data collection is extremely useful because “locating those at greatest risk of FGM requires a careful review of global and national age-specific trends over the last few decades, and likely future trajectories.”⁷⁸ However, not all countries are collecting data on a regular basis (due to the lack of financial and technical capacity), to allow for changes over time to be measured. There, consequently, remains a need for several countries to strengthen or implement regular collection of data on FGM to support planning of evidence-based interventions and to inform policy and strategy development. The African Union Commission is rolling out the Gender Observatory, which is expected to contribute towards addressing this challenge. However, more action is needed, beginning at the country level.



4. CHANGES IN FGM PRACTICES

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Together with decreases in FGM prevalence there are corresponding shifts happening in how FGM is practiced especially in response to laws banning FGM⁷⁹ or as a result of physical and psychosocial complications of FGM.⁸⁰

Changes in practice are also occurring with movements to urban areas,⁸¹ or migration “manifesting in varying degrees of behavioural change as a consequence of acculturation, length of residency, and/or the renegotiation and reinvention of FGM’s beliefs and practices.⁸² Some of these changes raise concerns primarily if they are responses by individuals and communities to sustain the practice in the face of criminalization or awareness of the physical harm of FGM. At the same time these changes are also leading to debates that challenge the support for FGM continuation or whether the practice should end.⁸³



THE PRACTICE OF
FGM AND ITS
SOCIAL AND
CULTURAL
UNDERPINNINGS
**ARE
CHANGING.⁸⁴**

DECREASING AGE FOR FGM

The age at which FGM is carried out is decreasing in some countries. One of the reasons for this shift in cutting at younger ages is the presence of legislation against FGM which has driven the practice underground and cutting of younger girls as families seek to avoid legal repercussions.⁸⁵

MEDICALIZATION OF FGM

Medicalization has increased in several FGM prevalent countries undermining abandonment efforts for the practice. Medicalization refers to any act of female genital mutilation that is performed in both public and private hospitals and in some cases, domestic settings, by trained medical personnel. This includes the performance of excisions by health workers and the use of modern medication to relieve pain and fight infection. Trained health professionals who perform female genital mutilation violate the human rights of women and girls. They also violate the fundamental medical ethic to do no harm.⁸⁶



"THERE ARE **FOUR MAIN REASONS** WHY HEALTH CARE PROVIDERS PERFORM FGM—

- They are members of practicing communities and subject to the same social norms and may therefore be supportive of the practice;
- They are satisfying a demand, which may seem inevitable, and they see themselves as supplying a service to families;
- Many claim that they are reducing harm by performing FGM because they can do it in a safer way; and
- Many report carrying out the practice for financial reasons to supplement income or to receive in kind payments from community members".⁸⁷

FGM is increasingly being performed by trained health care professionals as families are seeking to manage health risks, enabling families and health providers to conform to social norms underpinning FGM while addressing risks of complications and legal prohibitions.

Medicalized FGM is perceived to have few health complications, shorter healing, and enables families to hide from law.⁸⁸ UNFPA estimates that one-in-five girls subjected to FGM are cut by trained health workers, with the majority occurring in Egypt (38%), Sudan (67%), Kenya 15%, Nigeria 13% and Guinea (15%).⁸⁹ This change has occurred in response to awareness-raising campaigns focused on the health risks of FGM. Yet medicalized FGM carries risks and trained health professionals who perform FGM are violating the medical ethic to “do no harm”. There is no medical justification for FGM from a public health and human rights perspective.⁹⁰ Medicalization of all forms of FGM violates human rights, ethical principles of justice, beneficence and non-maleficence and the medical code of ethics. It creates tacit approval that only propels this harmful practice, rather than tacit disapproval and encouragement⁹¹ of social norm change.

However, according to a new UNICEF analysis⁹², increased prevalence in medicalized FGM obscures global progress on eliminating support for the practice. The same analysis⁹³ also highlights positively that:

- *Twice as many women in high-prevalence countries want the practice to end compared to 20 years ago; and*
- *Adolescent girls are more likely than older women to oppose the practice. In Egypt, Sierra Leone and Guinea, adolescent girls are at least 50 per cent more likely than older women to oppose FGM.*

Art. 5 (b) of the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol) prohibits, through legislative measures backed by sanctions, all forms of female genital mutilation, scarification, medicalization and para-medicalization of female genital mutilation and all other practices, in order to eradicate them.⁹⁴

CHANGING SOCIAL AND GENDER NORMS

At the heart of interventions, implemented at the community level, is the appreciation that FGM is driven by negative gender and social norms that involve social pressure on community members to conform. **The need to be socially accepted by community members and the fear of the consequences of not conforming are strong motivations that can sustain FGM.**⁹⁵

An important change is that gendered social norms and expectations that underpin FGM practices are shifting. Societies are dynamic and some of these changes to FGM practices are a consequence of community wide changes through the various interventions implemented such as women's empowerment, increasing awareness and knowledge. It is increasingly acceptable for men from these practicing communities to marry an uncut woman especially in cultures where a woman with FGM is considered more marriageable.⁹⁶ While there is evidence that more girls and women are opposed to FGM, and increasingly less supportive of continuing the practice. An encouraging trend, is that women aged 15–19 years are less likely to have been subjected to FGM than women in older age groups, showing signs of a possible generational shifts in the practice. For example, in Senegal, "rather than resisting change, we find that some older women express an openness to reassessing norms and practices as they seek solutions to maintaining the physical well-being, moral integrity and cultural identity of girls in their families."⁹⁷

SHIFTS IN FGM PROCEDURES

Shifts in the type of FGM are further occurring as a result of policy reforms to end the practice or as a result of increased awareness of the harm especially of type III FGM. For example, there are shifts away from the most severe form of FGM in Somaliland, Somali region of Ethiopia and Sudan from the widely practiced, Type III FGM (pharaonic cut or infibulation), to the perceived less severe Type I called "Sunna" with many people, believing it is religiously required and approved.⁹⁸ The nature of the shift in the type of FGM does, however, remain anecdotal in the absence of rigorous evidence.





5. COVID-19 IMPACT ON FGM

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Disease outbreaks affect women and men differently.

Pandemics make inequalities, for women and girls and discrimination of other marginalized groups such as persons with disabilities and those in extreme poverty, worse and can impact how they receive treatment and care.⁹⁹

The COVID-19 pandemic constitutes a major issue of concern. As a pandemic its consequences are gendered as has been evidenced by the increasing gender-based violence, impacting negatively on the basic rights of women and girls inclusive of security and bodily integrity and therefore health and wellbeing.

FACTORS CONTRIBUTING TO INCREASING RATES OF FGM

Good progress has been made in ending FGM but the outbreak has COVID-19 has witnessed increased rates of FGM across the continent.

UNFPA and UNICEF projected that “a further 2 million girls globally have been put at risk of FGM due to lockdowns and school closures – bringing the total number of at-risk girls globally to 70 million in this decade”. The main drivers of FGM during the COVID-19 pandemic seem to be school closures, movement restrictions, confinement and lack of integration of services within COVID-19 response given disruptions to FGM prevention programmes.¹⁰⁰ Moreover, economic hardships arising out loss of jobs and incomes in the pandemic environment increases vulnerability with girls being cut as a prerequisite for marriage in exchange of bride price received by her family.

Additionally, “lockdowns and social-distancing measures provide less chance of detection by those who typically report on suspected FGM cases: teachers, social workers and healthcare services.”¹⁰¹ FGM prevalence is further likely to increase in the context of the COVID-19 pandemic because girls may not have access to the protective services, prevention messages, and care networks that usually offer a degree of protection from the practice, which is illegal in most settings.¹⁰²

Researching the impact of COVID-19 on FGM across West Africa and East Africa the Orchid Project (2020)¹⁰³ noted the following severe disruptions to FGM services and the increased risk of female genital mutilation due to the COVID-19 pandemic:

- *Lockdowns and quarantine have placed girls and women at risk of female genital mutilation. For example, the closure of schools and other educational institutions as well as restrictions in mobility due to COVID-19, increased vulnerability as girls staying home increased their risk of being subjected to FGM and early marriage as families sought ways to cope given economic hardships, reduction in household income and loss of incomes;*
- *Health care providers burdened with COVID-19 patients and the lack of FGM integration within COVID-19 response have been unable to provide quality and appropriate prevention, protection and care service provision related to FGM in highly affected areas;*
- *COVID-19 restrictions in mobility also constrained access to safe spaces for girls at risk and survivors of FGM; and*
- *Restricted access to communities for community-based organisations (CBOs) carrying out FGM programming may be resulting in increased rates of cutting and lack of accurate data, alongside reduced funding for FGM.*

UNFPA, among other organizations, has further noted that “FGM and child marriage are also projected to increase, in large part due to delays in the implementation of programmes to end these harmful practices. Programmes addressing these harmful practices are often communal, involving the exchange of information and perspectives.”¹⁰⁴

PREVENTION AND RESPONSES TO FGM UNDER COVID-19

“the participation of girls and women in decision-making for COVID-19 preparedness and response is fundamental to ensure that their voices are heard and represented at all levels”.¹⁰⁵

Recognizing that COVID-19 has hampered FGM prevention and response efforts and learning from past epidemics will be critical to strengthening efforts going forward and future responses. In facing the pandemic, countries and international development agencies have looked to strengthen coordination and responses, and these have sought to ensure that women and girls have access to justice, information, education, healthcare and social services. For example, the UNFPA-UNICEF Joint Programme on the Elimination of FGM: Accelerating Change have developed technical guidelines to inform their “support preparedness and response plans for addressing the impact of COVID-19 pandemic on girls and women at risk of and affected by FGM.”¹⁰⁶ The guidance prioritizes actions that are reflective of overall approaches supported by diverse stakeholders:

- *Understand the impact of COVID-19 on girls and women at risk of or affected by FGM to identify challenges, gaps and opportunities;*
- *Advocate for the integration of FGM in COVID-19 plans across all sectors with a special call for support to Ministries responsible for gender, families and child protection to play an active role in ensuring integration of GBV and FGM in all COVID-19 preparedness and response plans.*
- *Protection of girls and women at risk of FGM with the use of law enforcement;*
- *Documentation of policies and programmes; including good practices and lessons related to FGM during the pandemic in preparation for post-COVID-19 response;*
- *Work with government and civil society to ensure continued access to prevention, protection and care services as well as expanding use of mass and social media to support actions during COVID-19; and*
- *Utilize adaptive M&E approaches to track vulnerable and marginalized girls and also inform programme response adaptations.*¹⁰⁷

Given the risks and vulnerabilities faced by women and girls in poor rural and urban communities, multisectoral partnerships are required to document, disseminate, and sustain FGM initiatives beyond the pandemic including strengthening budgetary allocations, policy frameworks and legal responses.

FGM IN CONFLICT, CRISIS AND HUMANITARIAN SETTINGS

Much still remains to be understood about FGM in humanitarian crises and public health emergencies. Conflicts and crises intensify gender inequalities. Furthermore, young girls in crisis and humanitarian contexts have often had their needs and rights neglected.¹⁰⁸ While FGM prevention and response during emergencies has generally not been perceived or understood as a life-saving issue,¹⁰⁹ recent efforts show a growing understanding and clarity of action. For example, UNICEF has developed technical guidance to facilitate the exchange of knowledge and the impact of humanitarian crises on FGM and approaches to ensure FGM is addressed.¹¹⁰



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A photograph of a man in a blue shirt holding a baby in an orange shirt. They are standing in front of a brick wall. The image is overlaid with a dark red semi-transparent box containing white text.

GETTING TO ZERO
FEMALE GENITAL
MUTILATION IN AFRICA

6. INITIATIVES AND ACTIONS: ACCELERATING EFFORTS TO END FGM

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Successful initiatives to end FGM **provide an enabling environment that explicitly draws attention to the urgency of ending harmful gender and social norms, and practices that sustain violence against women.** Such initiatives also paint a clear picture of the FGM environment to not only inform programming and strategies, but to also encourage investment to support efforts to end FGM.

AFRICAN UNION INITIATIVES

Continental legal frameworks including ACHPR, ACERWC, the Maputo Protocol and the Solemn Declaration, are complemented by an emerging array of AU policy instruments, declarations and resolutions.

At the 32nd Ordinary Summit of the African Union in 2019, Heads of State and Government taking note of the AU led Continental International Conference held in Ouagadougou October 2018, under the theme “Galvanizing Action to Accelerate the Elimination of Female Genital Mutilation by 2030 and the “Ouagadougou Call to Action on Eliminating Female Genital Mutilation”, adopted Assembly Decision Assembly/AU/Dec.737(XXXII) endorsed and launched the implementation of the Saleema Initiative on the Elimination of Female Genital Mutilation (FGM) on the continent. The President of Burkina Faso was also designated as the African Champion on the Elimination of FGM to bring visibility on the agenda to end the harmful practice and advocate for the implementation of the Saleema Initiative at the highest political levels. The initiative has aimed to amplify Member States’ efforts, programmes, best practices and experiences, whilst galvanizing political action to accelerate an elimination of FGM.

In addition, the decision called for regular reporting on actions, greater accountability, domestic resource allocation, strengthened legal frameworks, and engagement of communities and leaders in all facets of society to transform the social norms perpetuating the gender-based violence and human rights violation that this harmful practice represents.¹¹¹



REMARKABLE PROGRESS IN REDUCING THE LEVELS OF SEXUAL AND PHYSICAL VIOLENCE AGAINST WOMEN AND GIRLS

the continental score stood at **67%** of the 2019 target. However, performance on reducing female genital mutilation was relatively weak, recorded at **20%**. In both domains of curbing violence against women and reducing genital mutilation, Member States made substantial gains. Source: NEPAD's Agenda 2063 Dashboard: <https://www.nepad.org/agenda-2063>

In the follow up 33rd Ordinary Session of the Assembly of the Union in 2020, Heads of State and Government reaffirmed commitment to implementing recommendations from the report of the African Union Champion on the Eliminating Female Genital Mutilation, including; (a) Political and community level action; (b) Strengthening of legislative frameworks that seek to encourage community engagement and ownership; (c) Allocation of sufficient domestic resources to drive national and local action to eliminate the harmful practice; (d) Strengthening partnership, information and knowledge sharing between Member States; and (e) Member States to “report regularly to the African Union Commission” on action to eliminate harmful practices. Further, there was a request for the AUC to put in place an accountability framework for the AU continental initiative Saleema to assist Member States to account and monitor progress at the regional and national level in line with commitments made and to report periodically on female genital mutilation in Africa, through existing African Union instruments and platforms, including the African Committee of Experts on the Rights and Welfare.

In this view, the AUC is aligning its Agenda 2063 aspirations of prioritizing end Violence and discrimination against women and girls with clear targets to “End all harmful social norms and customary practices against women and girls and those that promote violence and discrimination against women and girls by 2025”¹¹² working in collaboration with UN agencies and building on the current global momentum on ending FGM by 2030.

SALEEMA YOUTH VICTORIOUS AMBASSADORS:

Youth spokespersons and advocates for the Saleema Initiative and Accountability to End Harmful Practices

The SYVA is composed of 6 young women. SYVAs were selected in each of the six African Union regions including the Diaspora to represent youth, women and FGM Survivors at institutional level based on their commitment and experience advocating for Girls and Women’s Rights.

The Saleema Youth Victorious Ambassadors are the voices of young women and the bridge between the African Union and the grassroots actors involved in the process for the elimination of Female Genital Mutilation in Africa.

The UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation with the support of the European Union (EU) through the Spotlight Initiative has been the main partners of the AUC Saleema Initiative since its inception.

Reaffirming and aligning with the above regional efforts are international actions. In July 2020 at its 44th Session, the Human Rights Council adopted Resolution 44/16 on elimination of female genital mutilation. The resolution among other things calls upon States to take comprehensive, multisectoral and rights-based measures to prevent and eliminate female genital mutilation; and to pay attention to the specific needs of women and girls, especially those in vulnerable situations, in the context of the COVID-19 pandemic.¹¹³

In 2020, recognizing that young African women are at the heart of efforts to end FGM, the African Union Commission, through the Department of Health, Humanitarian Affairs and Social Development in partnership with the African Union Youth Envoy Office, launched the Saleema Youth Victorious Ambassadors (SYVA) programme. Members of SYVA are also young women living FGM. They have become a crucial link to policy makers, advocating on behalf of all survivors across six regions (North Africa, Central Africa, West Africa, East Africa, Southern Africa and the Diaspora).

OBJECTIVES:

The objectives of the SYVA includes; Popularizing the Saleema Initiative among African youth by creating interactive communication channels, as well as online and offline platform; Fostering Intergenerational co-Leadership and dialogues with leaders in public, private, civil society and community levels; Amplifying the voice of FGM survivors in the political and institutional spaces; Enabling young African women and especially African FGM survivors to speak up and take action; Ensuring regional representation and outreach of the Saleema Initiative.

AFRICA WIDE INITIATIVES

Efforts to abandon the practice of FGM in Africa have used several approaches. **They particularly emphasize human rights frameworks, legal mechanisms, health risks, alternative rites, positive deviance, training health workers as change agents, training and converting circumcisers, and the use of comprehensive social development processes.** Interventions based on these approaches have targeted stakeholders at individual, interpersonal, community, and national levels.¹¹⁴

Efforts to abandon the practice of FGM in Africa have used several approaches to inform interventions. There are now several efforts to capture and document interventions or strategies that support the elimination of FGM. Drawing on *“What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation,”*¹¹⁵ this section highlights some of the most common approaches as well as their challenges and constraints. The section then concludes with highlights of promising and good practices that may inform and accelerate efforts in other contexts.

APPROACHES FOR THE ABANDONMENT OF FEMALE GENITAL MUTILATION	CHALLENGES AND CONSTRAINTS
<p>Health Risk Approach: Providing information about the health risks associated with FGM has been the most popular approach. It builds on the premise that if people are informed about the negative health effects of FGM, they will abandon the practice. The negative health effects of FGM presented by a health authority such as a medical professional have also been a key motivational factor for religious leaders to take a clear and strong stance against the practice. Health information has also influenced policy makers to promote laws and regulations.</p>	<p>In communities where FGM is common, and is upheld as a social norm and enforced through social sanctions of individuals or families that do not conform; the risk of being socially ostracized, excluded from community activities, denied financial and practical support, as well as marriage possibilities, can outweigh the health risks associated with the practice. Health information has also led to changes other than abandonment, most commonly an increase in the extent to which health providers are performing FGM.</p>
<p>Conversion of Excisers: The vast majority of FGM in Africa, around 80%, is carried out by traditional practitioners. A popular approach has been to target these excisers to convince them to stop performing FGM. Using education and encouragement to stop performing FGM. In some cases, training and financial support is provided for excisers to help them find sources of income other than performing FGM. The expected outcome is a reduction in the numbers of excisers performing FGM subsequently leading to a reduction in the number of FGM performed.</p>	<p>Excisers share their often-precarious living situations with the majority of the community. Some evidence suggests that singling out excisers for financial support and training in such precarious settings could contribute to internal conflicts and can boost the role of the excisers in the community or contribute to the recruitment of new excisers.</p>
<p>Training of Health Professionals as Change Agents: Several interventions have targeted health professionals, with the aim of preventing them from performing FGM, building their capacities to identify and treat complications and recruiting them as change agents.</p>	<p>The ability of health professionals to translate training into action both requires structural support, that is, in the form of resources and time allocated, and techniques, encouragement and empowerment strategies</p>
<p>Alternative Rites Programmes: In some of these communities, interventions have been developed to replace the rite of passage with FGM, by an alternative rite without FGM. Such alternative rites programmes are expected to fulfil the cultural tradition of a coming of age ritual, so that girls can be socially accepted without having to go through FGM.</p>	<p>The efficacy of such interventions are reduced where the wider community is not involved or in the absence of sensitization in which an attitudinal change has to have occurred. Further, given that role and meaning of traditional rites of passage and of FGM vary considerably between ethnic groups alternative rites of passage have been hindered where there has been insufficient consultation, co-creation and adaptation of a communities traditions.</p>
<p>Community-led Approaches: Community-led programmes have been identified as a necessary factor to tackle the social convention of FGM and create sustainable change. Community-led interventions to abandon FGM aim at promoting the empowerment of women and girls and the community at large to enable them to critically examine their own tradition and to gain the power to abandon FGM for their own benefit.</p>	<p>Success of community-led approaches varies between communities with evidence suggesting that differences in social and religious factors may be key to variation. Another challenge with community-led approaches is the absence of participatory approaches to involve others to empower themselves.</p>
<p>Public statements: An important element in the process of mobilizing communities is a public statement (often referred to as public declarations) of a decision to abandon FGM by a larger group, usually a significant part of a community. A public statement can create a sense of collective change, which can help to empower families to abandon FGM and encourage others to follow.</p>	<p>Interventions ensuring public statements from sub-groups rather than whole communities rarely result in abandonment.</p>
<p>Legal Measures: Laws against FGM are an important policy commitment and create an enabling environment. When preceded and complemented by education campaigns and advocacy and the sensitization of leaders, as well as adequate implementation, their effect is expected to be higher.</p>	<p>One challenge of enacting and enforcing legal measures is that the practice may go underground as a way to avoid legal implications. There can be resistance and protest. The existence of a law may also scare people with immediate health complications after FGM from seeking health care.</p>

A number of programmes have been effective in addressing FGM, especially where they have been community-led, changing social norms at community level, and empowerment of girls and women.¹¹⁶ The above diverse and numerous efforts speak of the diversity and context specific dimensions of FGM. There is need to understand these initiatives in order to better develop measures or strategies for renewed efforts towards meeting human rights and continental commitments. This report consequently showcases promising strategies across the African region in the following section.

PROMISING PRACTICES

There have been and continues to be numerous promising efforts by the AU, Government, Non-governmental bodies, UN Agencies, community based organizations, advocates and activists in designing and implementing responses that are effectively supporting the drive to end FGM.

The section below highlights promising interventions that can be implemented to strengthen prevention and responses to ending FGM across six broad thematic areas:

- *Policy and Legal Interventions (creating an enabling environment);*
- *Community level Interventions (challenging gender and social norms around FGM; and empowering women and girls);*
- *Engaging traditional, religious, local and national and opinion leaders (transforming norms, instilling new conventions and traditions and promoting male involvement);*
- *Communication Interventions (creating awareness, knowledge and supporting activism to end FGM);*
- *Support Services (providing services for FGM prevention, protection and care); and*
- *Data and Evidence (informing policy and programmatic decision making).*



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POLICY AND LEGAL INTERVENTIONS: CREATING AN ENABLING ENVIRONMENT

22 out of 29 FGM practicing African countries have national laws in place banning FGM. **Additionally, several States have implemented action plans against female genital mutilation.**

Laws and national plans improve the promotion and protection of girls and women's human rights and are reflective of compliance to African Unions' regional and international human rights standards. Ending FGM requires an enabling environment of equitable policies, adequate resources, accountability, gender equity and supportive social norms. The use of law and policy has been a fundamental strategy for enhancing and supporting efforts to end FGM in the region. This is because state legal frameworks that address FGM and other harmful practices have emerged out of the standards and discourses of human rights.



LEGISLATION CAN SUCCESSFULLY LEAD TO REDUCTION IN THE PROBABILITY OF A GIRL'S BEING CUT AS ILLUSTRATED BY BURKINA FASO'S EXAMPLE OF GOOD PRACTICES ONCE LAWS ARE IN PLACE.

Over a ten-year period from 1996 when the law was enacted, it averted the genital mutilation of approximately 237,591 women and girls. They highlight that "this success was attributed to the sustained awareness campaigns and community education initiatives that started in 1975, creating fertile ground for sensitization about the law banning FGM as well as political goodwill supporting implementation of the law".¹¹⁷

Additionally, when comparing four border and inland communities of Benin, Cote d' Ivoire, Mali, and Togo- all bordering Burkina Faso -before and after the country's anti-FGM political efforts, one finds that populations residing on the borderlands show declines not only in proportion but also the type of FGM.¹¹⁸ It has been suggested that it is Burkina Faso's political efforts resulting in knowledge spillovers that have had this external influence.¹¹⁹ All these countries do have laws against FGM, although enforcement varies widely.

The complexities that emerge with legislation are also illustrated in Burkina Faso. For example, it is possible that given the strong law in Burkina Faso daughters may have been taken to countries without laws or weak law enforcement. Or it is "ethnic ties across frontiers [that] underpin social and cultural networks that help cross-border excision."¹²⁰ The Peul move between the borders of Burkina Faso and Niger, the Gourmantche between Burkina and Niger, the Dagara and Lobi between Burkina and Ghana, while Burkinabe workers in Cote d' Ivoire go home to subject the girls to FGM and return".¹²¹ Thus the presence of legislation banning the practice has resulted in cross-border movement from a country where the practice is illegal to another country with weaker FGM laws, where it is allowed, or border police can do little to stop crossing borders to perform or undergo the procedure without regional legislation.¹²²

In the East African region there are similar cross-border challenges in response to policy interventions. For example, "cross-border movement for the purposes of FGM has remained a challenge in Kenya (in particular among the Pokot, Borana, Abakuria, Rendille, Somali and Maasai ethnic groups). This problem is especially pervasive along the border with Uganda, Somalia, Ethiopia and Tanzania, where people from the same ethnic groups cross the border in both directions to perform FGM".¹²³ As a result of an increase in cross-border FGM, the Member States of the African Union are formulating and coordinating regional actions that strengthen political will, programmes and stakeholders to strengthen Member State obligations to treaties and conventions.¹²⁴ An important example of such an initiative is the Declaration and Action Plan to End cross-border FGM by Kenya, Tanzania, Uganda, Ethiopia, Somalia that will need to be enacted and implemented to enable a supportive environment for interventions to end cross-border FGM.

THE DECLARATION AND ACTION PLAN TO END CROSS-BORDER FGM

by Kenya, Tanzania, Uganda, Ethiopia, and Somalia.

In October 2018 at the International Conference on Ending Female Genital Mutilation in Ouagadougou, Burkina Faso, representatives of Gender Ministries from Kenya, Uganda and Tanzania, together with UNFPA and UNICEF agreed to set up a tripartite initiative to End Cross border FGM in the East Africa region. The Government of Kenya went on to invite the governments of Ethiopia, Somalia, Tanzania and Uganda to join this effort as part of the commitment laid down out in its National Policy on Elimination of FGM to End Cross Border FGM. The Declaration and Action Plan to End Cross-border FGM were adopted at an inaugural regional inter-ministerial meeting held in 2019 with all five countries in attendance. The meeting, which was the first of its kind in the history of global efforts to eradicate FGM, reaffirmed the need for strong partnerships at all levels to end this harmful practice.¹²⁵

Participating governments put forward recommendations that reaffirmed the need for strong partnerships at all levels in order to end cross-border FGM.

There is a Plan of Action with 4 priority areas:

- *Improvement of the legislative and policy frameworks as well as the environment to end cross-border FGM;*
- *Effective and efficient coordination and collaboration amongst the 5 national governments to end FGM within their borders;*
- *Communication and advocacy on cross-border FGM prevention and response;*
- *National governments, academia and statistical offices have a better capacity to generate and use evidence and data for addressing cross-border FGM.¹²⁶*

In the context of laws, a review of FGM laws by *28 Too Many*, highlights that “while some form of legislation against FGM exists in at least all the 29 African countries of focus, there are serious challenges to their implementation and enforcement. Some of these challenges are systemic as there may be limited knowledge or understanding of the law and or cultural challenges when leaders believe in the practice.”¹²⁷ Moreover, practicing communities may change their FGM practices to conducting it secretly because of fear of the law.¹²⁸ Furthermore, with criminalization of FGM girls and women could be deterred from seeking healthcare services for fear of prosecution.



A key lesson

LAWS ARE IMPORTANT BUT REQUIRE SOCIAL LEGITIMACY TO BE EFFECTIVE.¹²⁹

Laws banning FGM have existed for decades, but the public may be unaware of them or choose to ignore them, and they may not be enforced. Legal prohibitions of FGM may promote abandonment of the practice or may drive it underground. It is critical to address inherent conflicts between formal laws prohibiting FGM and religion and customs, which are also recognized as sources of law.

An expert group meeting organized by the Office of the United Nations High Commissioner for Human Rights in Addis Ababa in 2019 concluded that the following actions are pivotal:

- *Developing comprehensive and rights-based policy frameworks;*
- *Enforcing laws including across borders and in the context of population movements;*
- *Scaling up innovative interventions that address social norms and strengthen social accountability; and*
- *Collecting more reliable and accurate data including through the use of new technologies.*

The expert group also found that leadership, political commitment and a long-term vision are major factors of success.¹³⁰ Some countries have now established mechanisms to monitor progress in elimination efforts and have allocated resources for implementation, including equipping relevant officials with the requisite personnel, financial, technical and other resources. For instance, Kenya's law prohibiting the practice mandates the establishment of an anti-female genital mutilation board, which has both an operational and advisory role, including the mandate for securing adequate resources for combatting female genital mutilations.



POLICY INITIATIVES CAN ALSO BE ENABLING OF STATE ACTIONS TO SUPPORT NATIONAL LEVEL EFFORTS ON ENDING FGM.

The establishment of the FGM Board in Kenya is an example of an important step in formally operationalizing government efforts to eradicate the practice and to provide oversight and coordination of non-state actors engaging in FGM programmes. The work of the Board has included development of anti-FGM materials such as guidelines on how to conduct community dialogues and alternative rites of passage (ARP), information and communication materials and simplified versions of the Prohibition of FGM Act in both Kiswahili and English. The Board has also organized awareness-raising initiatives, such as road shows to demonstrate the negative effects of FGM, and exchange programmes between elders of different counties (Narok, Samburu and Kajiado).¹³¹

COMMUNITY LEVEL INTERVENTIONS

FGM is a social norm. “Community factors above and beyond individual factors, play a crucial role in the perpetuation, spread or decline of the practice of FGM.”¹³² It is therefore critical to create an enabling community environment to transform and change negative gender and social norms, practices and institutions that sustain FGM. Thus, community interventions have been the critical approach in driving the social changes that can create consensus on adopting new social norms.

Families cut their daughters because they believe doing otherwise could lead to the loss of status, stigma, or risk of other social sanctions. It is believed that large-scale transformation of social norms related to FGM requires a collective, coordinated decision at the community level so that no girl or family suffers retribution by a decision not to perform the practice.¹³³⁻¹³⁴

ALTERNATIVE RITES OF PASSAGE (ARPS) IN KENYA

Where female genital mutilation is performed on girls in their early adolescence or later, giving girls the information and means to stand up for themselves through empowerment measures and safe spaces can be highly effective in addition to taking steps to target parents and community members.¹³⁵

For numerous practicing communities in Kenya, FGM is traditionally seen as a rite of passage from girlhood into womanhood, preparing the girl for marriage. ARPs were a new approach developed by NGOs and some communities as an alternative initiation to womanhood without undergoing “the physical cut” and have been integrated as part of girl’s empowerment and community awareness programmes.¹³⁶ The first ARP was developed in 1996 by Maendeleo ya Wanawake (a women’s development movement) in collaboration with PATH (Programme for Alternative Technology in Health), in the Tharaka Nithi County in Eastern Kenya. Over time this approach has become popularized in Kenya and Tanzania and has been well funded by international donors with about 10 NGOs still implementing ARP programmes in Kenya.

In addition, ARP guidelines have been developed by the Anti-FGM board in Kenya which is a semi-autonomous government agency established in December 2013.¹³⁷ There is no standard approach, however ARPs usually consists of two parts: a training session or sessions, for girls and sometimes boys, followed by a public graduation ceremony where the participants and sometimes parents declare that they have renounced FGM. Girls would attend one-two week training sessions in secluded areas or boarding schools. The training sessions consisted of modules on sexual and reproductive health, human rights, tradition, and culture among other topics.

ARPs were considered most appropriate for communities where FGM involves a public declaration where over time, ARP graduation ceremonies would replace FGM however still maintain the principles of socialization (such as educating girls on family life and women’s roles, exchange of gifts) and traditional celebration for community recognition.¹³⁸ Previous research has shown that for ARPs to be successful they need to be understood and accepted locally, particularly by decision-makers (parents, churches and local community leaders).¹³⁹ Organisations like AMREF in Kenya who have been

implementing ARPs since 2009 have documented impacts of their program with reductions in FGM prevalence and increases in years of schooling for girls over time.¹⁴⁰ There is still a lot of variability in implementation such as the quality of training that girls and community members receive and multi-pronged approaches that have made it challenging to determine the long-term impacts of ARP.

COMMUNITY CONVERSATIONS /DIALOGUES IN SOMALIA

A community dialogue is an opportunity for members of the community and stakeholders to get together to discuss a particular issue and work together to address and solve the issue of FGM moving forward¹⁴¹ Most organisations who have implemented this approach have sought to use the community conversations to break the silence on FGM, challenge negative social and gender norms that have contributed to FGM, provide a space for community members to be heard and increase community commitment to ending the practice.

Community dialogues are not meant for people to be lectured on the harms of FGM. Rather it's a space to facilitate conversations for community members to discuss the implications of the practice and their options for change among themselves. This intervention requires a number of steps such as a team of diverse experts that will develop the agenda and dialogue guides (ending FGM may not be the main issue however the facilitators need to ensure it fits in the broader aspect of the discussions).¹⁴² Community mobilization and involvement of community leaders to get buy-in and ownership is also a key step in selecting participants and a neutral location in the community to meet.

Implementers using this method have conducted community conversations where about 20-50 people attend including groups of women, men, local community leaders, religious leaders, police and or traditional cutters. In some instances, the participants are a mixture of all groups and they may meet once or twice a month and at the end of each dialogue session there is a plan of action. Different modes of communication have been used to spur dialogue on difficult decisions faced by individuals relating to FGM such as theatre, drama, dance and song. International, Non-Governmental (NGO) and Local Organisations like UNICEF, Action Aid, Save the Children, Norwegian Church Aid, The Girl Generation, Somaliland Women Development Association, and others have used this approach in Somalia and Somaliland to empower communities to challenge and abandon FGM.

Community conversations have also been widely used in Ethiopia and usually result in Public Declarations among community members to end the practice. One limitation of this approach is that although it may increase knowledge and change attitudes towards FGM, changing behaviours for future generations requires longer time and commitment and a more holistic multisectoral approach.

EMPOWERING GIRLS TO BECOME CHANGE AGENTS

Targeting girls with information about FGM and building their agency is one approach that has been used by many development partners including the UNFPA- UNICEF Joint Programme on the elimination of Female Genital Mutilation.¹⁴³

Girls' clubs or safe space programmes offer information on comprehensive sexual education, human rights, financial literacy and building life and leadership skills. These young adults or adolescent girls are then introduced to new concepts, social relations and exchange of ideas that foster critical thinking and empower them to become change agents in their community and engage in intergenerational dialogue. Both formal and informal education of girls have been offered to reduce FGM, in Burkina Faso and Gambia, FGM is part of the school curriculum¹⁴⁴ while in Mauritania, a pilot project was implemented by the government that included training teachers on reproductive health including FGM in secondary schools.

Organizations like Plan International have implemented girl centered programming against FGM in Egypt, Ethiopia, Mali, and Tanzania.¹⁴⁵ Football clubs have also been incorporated to bring girls together, protect them against FGM, build their confidence and use the sporting platform as way to raise awareness on FGM in the community. In addition, the Grandmother Project in Senegal utilizes an inclusive and intergenerational approach to promote girl's education and development so as to adopt anti-FGM attitudes and behaviours.

A recent report by UNICEF demonstrated that empowering women and girls through formal education is effective in reducing FGM prevalence, can spur women and girls to demand their rights and challenge gender and social norms for FGM.¹⁴⁶ Although evidence emerging and shows promising results, the dearth of projects that have been rigorously evaluated means it is difficult to conclude that this the most effective approach and perhaps there are other factors that should be considered such as access to formal education.

INTERGENERATIONAL DIALOGUE IN SENEGAL

"A participatory method for ending FGM with the aim of establishing a change in attitude towards FGM. These dialogues are based on strengthening dialogue between all generations, so that the entire community engages in a collective process of change."

Previous research in the Senegambia area/region has shown that FGM is “women’s business” to the extent that it is arranged and carried out by older women on younger women. Those that have undergone FGM had access to the resources and support of older women. At the same time, older women often assess whether or how excision practices should be altered or ended in light of shifting social circumstances.¹⁴⁷

Since 2008, The Grandmother Project has implemented a Girls Holistic Development Program where it emphasizes the inclusion of elders, especially grandmothers; strengthening communication between generations; and methods that promote dialogue and consensus building to encourage community-wide support for positive change. A study in 2019 identified 3 main factors that contributed to grandmothers strong commitment to abandon FGM in their own communities:¹⁴⁸

<p>Increased awareness of the harmful effects of FGM and realization that Islam doesn’t require the practice</p>	<p>Increased confidence, due to the grandmother leadership training, that empowered them to participate in public events and express their ideas in public</p>	<p>Creation of safe spaces for open and intergenerational discussion on previously taboo issues dealing with girls’ development, including FGM</p>
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PUBLIC DECLARATIONS IN ETHIOPIA AND EGYPT

Collective abandonment, in which a whole community chooses to abandon FGM, is an effective way to end the practice.

It ensures that no single girl or family will be disadvantaged by the decision. Many experts hold that FGM will only end through collective abandonment. The decision to collectively abandon FGM requires a process in which communities are educated about FGM, and then discuss, reflect and reach consensus on changing the norm. The health and human rights aspects of FGM should feature prominently in these dialogues, and local and grassroots organizations should play an important role in raising awareness and educating communities. When communities choose to abandon the practice, they often participate in a collective public declaration to keep their girls uncut, such as signing and circulating a public statement or hosting festivities to celebrate the decision. Neighbouring communities are often invited to these events so they can see the successful process of abandonment, helping to build momentum for collective abandonment elsewhere.¹⁴⁹

Public Declarations occur when members of a community openly or publicly announce their commitment to abandoning FGM in their communities. This declaration usually is preceded by community sensitizations and awareness campaigns that focus on the rights of girls and or the health risks associated with the harmful practice as well as mobilization of community elders, local leaders and decision makers. It's a popular approach that is used today by the UNFPA- UNICEF Joint Programme on the elimination of Female Genital Mutilation, where one of their significant achievements are that more than 2.8 million people have participated in public declarations of FGM elimination.¹⁵⁰

In Ethiopia, a local NGO, Kembatti Mentti-Gezimma (KMG) founded in 1997 is credited with changing attitudes towards FGM and drastically reducing the practice in the Kembatta Region of Ethiopia. This was mainly done through building trust of the community by introducing a wide range of community development projects, they also implemented community conversations, raising awareness and use of youth advocates to change behaviours.¹⁵¹ In 2000, KMG organised a series of public weddings for couples who abandoned the practice recruiting uncut girls as bridesmaids and were widely attended. These events were followed by annual "whole body" festivities starting in 2004 that celebrated girls not subjected to FGM. KMG has also led numerous community declarations where even religious leaders have also publicly declared to end the practice.¹⁵²

In Egypt, the FGM Free village model that was launched in 2003 by National Council for Childhood and Motherhood has sought to break the silence of FGM and shift public opinions of the practice.¹⁵³ It was developed from earlier work on FGM abandonment in the country and involves empowering families to publicly speak out against FGM. The project also utilized a multi-pronged approach that engaged with NGOs/ civil society, media, community and religious leaders, policy makers, youth groups, and professionals in the health, legal and communication sectors.

Available evidence shows that public declarations are a first step in changing attitudes and practices towards total abandonment of FGM.

RESCUE CENTERS / SAFE HOUSES IN TANZANIA

Despite the practice of FGM being criminalized in 1998, it persists in the Central and Northern Regions of Tanzania.¹⁵⁴ Due to an increase in community outreach and girls' education, in areas like the Mara Region in Northern Tanzania, girls who are at risk of FGM have sought help from Safe Houses. These safe houses also known as rescue centres offer shelter and protection to girls escaping FGM, child marriage and other forms of gender-based violence and harmful practices.

Most girls who seek refuge at these safe houses are escaping a 6 week-long “cutting season” that traditionally occurs every two years in the Serengeti Region.¹⁵⁵ Girls between the ages of 10-13 years usually escape their homes in the middle of the night and seek help from local volunteers in surrounding villages, the Police Gender Desk (PGD) and or Social Welfare Officers (SWO) who link them to the safe houses. They are mostly run by local churches and community-based organisations (CBOs) with support from international funds. Hope for Girls and Women is a CBO founded by Tanzanian FGM activist and survivor Ms. Rhobi Samwelly in 2017, it operates two safe houses in the Serengeti Districts of the Mara region in Northern Tanzania.¹⁵⁶

Safe houses usually offer girls access to education, vocational training courses such as farming, agri-business, computer skills and tailoring. Alternative Rites of Passage (ARPs) have also been closely linked with safe houses; most girls who reside in safe houses undergo ARPs before efforts are made to reunite them with their families. Re-unification with families is usually a challenge given the girls may face hostility at home and it is difficult to enforce that parents will not subject their daughters to FGM in the future. Rescue centres are also popular in Kenya among Maasai communities where the founder of Tasaru Ntomonok Girls Rescue Center in Narok County, Ms Agnes Pareiyo is the National Chairperson of the Anti-FGM board in Kenya.

MEDIA AND SOCIAL MARKETING CAMPAIGN IN SUDAN

Interventions to end FGM have recognized the need to advance not just the knowledge and capacities of individuals, families and communities but to also address the gender and social norms, myths, beliefs and attitudes that sustain FGM.

A range of communication tools have been explored such as social marketing that can promote communication among peers and communities and within families to support demand for ending the practice. For example:

The Saleema Campaign was launched in 2008, by the National Council of Child Welfare (NCCW) and UNICEF Sudan, the program supports the protection of girls from FGM, particularly in the context of efforts to promote collective community abandonment of the practice.¹⁵⁷ It's a social marketing campaign that grew out of a need to have positive terms for women or girls who have not undergone FGM and change the way people talk about the harmful practice. Saleema also aims to stimulate new discussions about FGM at family and community levels looking at who talks to whom and what specific issues are discussed. The campaign uses different communication tools such as radio, television and billboards/ posters to mobilize communities to shift away from traditional practices and beliefs to new

social norms by using positive language and messages thereby promoting long-term abandonment of FGM. UNICEF, NCCW and other local partners have conducted evaluations of the campaigns and they found that people responded positively to the Saleema Campaign and suggested continuing advocacy targeting older women in rural villages and youth for support of the campaign.¹⁵⁸ In addition, during the implementation period findings suggest that social norms are changing in Sudan over time, specifically in reduction of pro-FGM social norms.¹⁵⁹ The Saleema model of positive communication and keeping girls whole, healthy in body and mind and intact has spread to neighbouring countries like Egypt and Somalia.

In February 2019, the African Union launched the Saleema Initiative to galvanize political action to enforce strong legislation, increase allocation of financial resources and strengthen partnerships to end female genital mutilation, particularly within communities most impacted by the harmful practice.¹⁶⁰ The AU Initiative addresses one of the gaps of the original campaign where behaviour change was focused on individuals and communities, however not much was done to target policy makers.

ENGAGING BOYS AND MEN IN NIGERIA

In a 2015 review, a number of men consulted wished to abandon FGM because of the physical and psychosexual complications to both women and men. While the social obligation and silent culture between the sexes were presented as major obstacles for change, the strongest influence of support for abandonment was education.

UNICEF in Nigeria has been working with Men Engage Alliance and by 2020, they had established 81 new coalitions for men and boys. These coalitions target peer public spaces advocating against FGM.

IN 2019, THE MEN ENGAGE NETWORKS REACHED

14511 PEOPLE

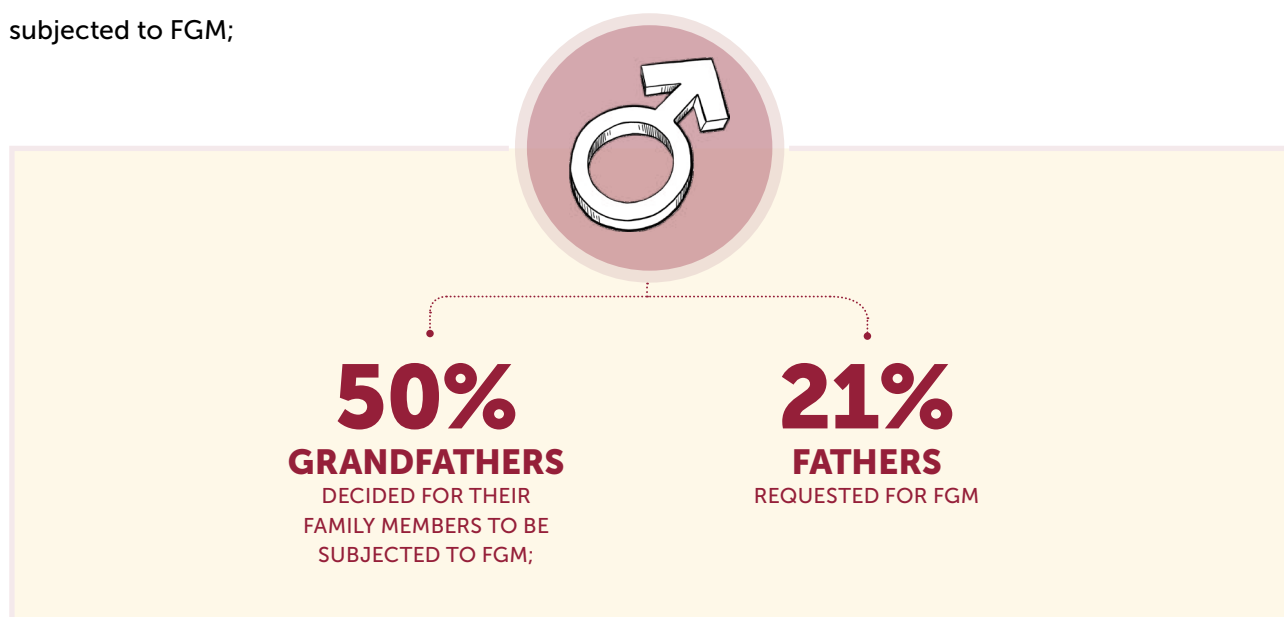


13,918
MEN



593
WOMEN

Men play an important role in the realisation of gender equality and abandonment of FGM. For select communities in Western Nigeria, men are predominantly the decision makers on girls and women being subjected to FGM;



LEVERAGING CULTURAL AND RELIGIOUS LEADERS IN MALI

Community based interventions need to have integrated ways for participants to spark public dialogue and have people share information and knowledge to change their perceptions of FGM.¹⁶¹

Research has established that one of the best practices in implementing social marketing campaigns against FGM is to train community leaders to deliver messages.¹⁶² Cultural and religious leaders are often influential and trusted members of their community and they play important roles in program buy-in and community mobilization. NGOs working in Mali like Plan International, Spotlight Initiative and the Association for Monitoring and Orientation on Traditional Practices (AMSOPT) have engaged cultural and religious leaders in their programming. Plan International connects community members with an Imam who talks to parents about the Koran and counsels them that FGM is not part of Islam.¹⁶³

The Spotlight Initiative, a global, multi-year partnership between the European Union and the United Nations uses targeted and large-scale investments to eliminate all forms of violence against women and girls by 2030. They have recruited more than 300 religious leaders across Mali from both Islam and Christianity to spread messages on violence against women using television and radio mediums.¹⁶⁴ While AMSOPT have trained and utilized village chiefs in the Kayes Region to hold public assemblies

where women, youth and village leaders agree to abandon FGM, this is followed by a committee who ensure accountability.¹⁶⁵ Cultural and religious leaders can be influential in challenging the reasons for FGM and may increase knowledge and attitudes towards anti-FGM norms, there still needs to be concerted efforts to change behaviours at individual, relational and household level.



A PAN AFRICAN CONTINENTAL MOVEMENT OF PROGRESSIVE TRADITIONAL AND CULTURAL LEADERS -

the Council of Traditional Leaders of Africa (COTLA)/ Conseil des Autorites Traditionnelles D'Afrique (CONATA) was created¹⁶⁶ in 2018 COTLA works closely with UN Women and AU where they are building a movement to drive the transformation and eradication of negative cultural practices, customs, and traditions to end child marriage, FGM, and other harmful practices.¹⁶⁷

TARGETING TRADITIONAL PRACTITIONERS / INITIATORS IN LIBERIA

Community based interventions seeking to convert traditional practitioners and provide alternative sources of income have been an approach used to reduce the practice FGM in Liberia.

In Liberia, The Spotlight Initiative was launched in 2019 where UN Women in collaboration with Plan International trained about 300 former traditional practitioners in an Alternative Economic Livelihood programme.¹⁶⁸ Although traditional practitioners are key stakeholders in reducing and preventing FGM, current evidence shows this is not an effective strategy. Converting traditional initiators/cutters may not address the issues of community recognition where traditional practitioners/cutters are seen as influential members of the society. In some instances, the alternative sources of income are not comparable to the lucrative pay they would have received during initiation seasons. A report from UNICEF also highlights that these efforts may have contributed to the shift towards medicalization of FGM and conducting the practice in secret.¹⁶⁹

HEALTH CARE PROVIDERS ADVOCATING AGAINST FGM IN EGYPT

Around 1 in 4 girls and women who have undergone female genital mutilation (FGM), or 52 million FGM survivors worldwide, were cut by health personnel, according to a new analysis by UNICEF. This proportion is twice as high among adolescents: 34 per cent of FGM victims 15-19 years of age have undergone medicalized FGM, compared to 16 per cent of victims 45-49 years of age, indicating growth in the medicalization of the practice.¹⁷⁰

Lessons from Egypt show that the practice of FGM is deemed acceptable when it's performed by a medical professional. For some hesitant mothers who were debating on abandoning the practice they would consult with the doctors, hence leaving the doctor to make the decision if their daughter needed to undergo the cut or not.¹⁷¹ The language of FGM is also being reframed as "cosmetic surgery" by health professionals to escape blame and convince families to cut their daughters.¹⁷² There are health care providers who are taking a public stand and advocating against FGM.

In early 2020, a group of doctors in Egypt launched an anti-FGM campaign after the death of a 12-year-old girl.¹⁷³ The campaign, called "White Coats", was spearheaded by Randa Fakhri El Deen, who leads the NGOs' Union Against Harmful Practices on Women. The campaign was staged at the Cairo metro station, where posters with the slogans "No to FGM" and "FGM is a Crime" were displayed, and doctors in white coats also gave out leaflets about the dangers of the practice. It raised awareness of the long term physical and mental complications of FGM and had a message that they (doctors) didn't want their "white coats" to be stained with blood.

The National Council for Childhood and Motherhood offers training to doctors on how to address FGM prevention, working with partners such as UNFPA. The main challenges with engaging health care professionals include that there is still low levels of awareness and knowledge about the negative consequences of FGM especially amongst medical professionals.¹⁷⁴ Hence community-based interventions need to educate and raise awareness on the changing nature of the practice and on the integrity of female genitalia, and sexuality amongst parents, medical professionals and community members.¹⁷⁵

SUPPORT SERVICE INTERVENTIONS



MAINSTREAMING FGM INTERVENTIONS ACROSS LEGAL, SOCIAL AND ECONOMIC PROGRAMS AND SERVICES

STRENGTHEN CHILD PROTECTION SYSTEMS TO ENSURE ACCESS TO ESSENTIAL SERVICES

A holistic approach to addressing FGM includes a comprehensive child protection system that provides health-care, social welfare and legal services to girls and women who are at risk of or have undergone FGM. Provision of services contributes to promoting positive social norms that keep girls healthy and intact, as service providers share information and provide counselling to girls, women and other community members about the consequences of FGM. Given that FGM is performed to increase a girl's marriageability as a way to secure economic security and alleviate household poverty, UNICEF is increasingly using gender-responsive social protection, such as cash transfers, to prevent harmful practices including FGM.

Beyond access to services, service providers (who are often respected members of the community) can also serve as community influencers and advocates for eliminating FGM, including the end of medicalization.

GENDER-RESPONSIVE SOCIAL PROTECTION

Social protection programmes such as cash transfers have proved successful in addressing poverty and poor educational outcomes. Gender-responsive social protection can be an effective strategy for preventing families from resorting to negative coping mechanisms to alleviate household poverty, such as having girls undergo FGM as a precursor to child marriage, which is linked to economic security and social inclusion.

SOURCE: UNICEF, A Decade of Action to Achieve Gender Equality: The UNICEF Approach to the Elimination of Female Genital Mutilation



LEVERAGING THE HEALTH SYSTEMS AND HEALTH CARE PROVIDERS

THE HOSPITAL AND FGM¹⁷⁶

The Edna Adan Hospital (Somaliland) deals with the management of complications caused by FGM almost on a daily basis. Cases include children who have undergone the procedure hours and sometimes days before being brought to the hospital and who are still bleeding heavily or unable to pass urine. One of the most severe cases in recent years was one in which the child had been so badly cut that there was virtually no skin to suture together to stop the blood gushing from her body. Common cases include newly married girls and women requiring defibulation and management of bleeding, infection, or extreme pain. Others may be in labour for protracted periods due to FGM scarring, preventing the birth canal from dilating properly. Some of these women fall victim to third degree lacerations and other postnatal complications. Edna has been dealing with cases of this nature for more than 50 years as a midwife and has been engaged in a life-long struggle to bring this practice to an end. Not surprisingly, therefore, the Edna Adan Hospital is spearheading the campaign to abolish FGM in Somaliland. The hospital has become a repository of all information relating to FGM in the country and throughout the region. An auditing process began in 2002 for the purpose of acquiring baseline data about the prevalence of FGM in Somaliland. As part of its efforts to accelerate FGM abandonment, the hospital holds educational seminars for special interest groups. At a patient level, counselling services are provided to women with FGM and their families.

DATA AND EVIDENCE

The increasing global, regional and national attention on FGM brought by the International Day of Zero Tolerance for Female Genital Mutilation, marked globally every year on 6th February has led to intensified efforts to support a robust evidence base through understanding and addressing the harmful practice as reflected in the increased research and journal publications and improving of data collection and analysis techniques.

These efforts have provided insights of when, where and how FGM is practiced; the geographic patterns for the burden of FGM, emerging trends, where and how progress is being made. This evidence informs the development of target interventions, and provide understanding what works in some areas and not others. The African-led [Evidence to End FGM Research Programme](#) is a recent example of such efforts.



UTILIZING CONTEXTUAL EVIDENCE AND LOCAL EXPERTISE TO INFORM ACTIONS

In 2017, Population Council collaborated with partners including Orchid Project and Somaliland Family Health Association (SOFHA) to pilot a new approach to disseminating research findings in order to increase the impact of evidence-based decision making in programme, policy, and investments in FGM. The three day knowledge sharing workshop was held in Hargeisa Somaliland with over 40 policy makers and programme implementers who are part of the National FGM Task Force. The workshop utilized an open space approach to encourage review of recent key evidence on FGM in Somaliland; explore UNICEF's six elements of abandonment and their relevance to the Somaliland context; link research with decision making; and develop action plans.

The open space approach allowed for participants to delve deeper into the research and the six elements of abandonment and use it to stimulate conversation, identifying six key themes for further reflection: behavioural/ social change, medicalization, policy, child rights, further research, and the role of NGOs and CBOs. After the discussions on the last day of the workshop, participants developed draft action plans to link the research to their current work on policy and programming for FGM. "We have to work collectively and come up with action plans using robust evidence to design and implement FGM interventions in the community, the research is showing that trends are changing hence the need to remodel advocacy programs to better respond to the needs of the people." Remarks on the way forward from Mustafe Ahmed, Nagaad Network.¹⁷⁷

It is also noteworthy that the African Union Gender Observatory and the Gender Scorecard has been playing a key role in strengthening the availability and use of quality and reliable data.¹⁷⁸







GETTING TO ZERO
FEMALE GENITAL
MUTILATION IN AFRICA

7. SUSTAINING CHANGE AND GALVANIZING ACCOUNTABILITY: LESSONS LEARNT

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The Saleema Initiative advances Africa's Agenda 2063 and is aligned to the 2030 Agenda in its commitment to advocate for the elimination of all forms of gender-based violence and harmful practices, including female genital mutilation. **This report provides a baseline review of FGM in the Africa region and reports on changes, trends, good practices, challenges and opportunities towards realization of ending FGM.** Several lessons are highlighted to inform the recommendations and improvements needed going forward.

FAILURE TO RECOGNIZE THE RIGHTS OF WOMEN AND GIRLS ALLOWS FOR PRACTICES THAT CAUSE HARM TO WOMEN AND GIRLS:

There is the strong continental recognition that FGM is a violation of the human rights of girls and women. FGM takes place in the context of harmful gender norms, gender inequalities, limited educational opportunities and poverty that intersect to disempower women and girls, creating conditions of risks. The social change sought to support FGM abandonment requires that all strategies and interventions recognize that girls and women have equal rights and equal access to opportunities. For these reasons the abandonment of FGM must be informed by existing human rights frameworks.

CHANGES IN THE PRACTICE OF FGM AND RATES OF PREVALENCE

- Good progress has been made in ending FGM; for example, twice as many women in high-prevalence countries want the practice to end compared to 20 years ago; and Adolescent girls are more likely than older women to oppose the practice.¹⁷⁹ However, the outbreak of COVID-19, as highlighted earlier, has resulted in increased rates of FGM across the continent.
- The recent major declines in FGM risk are concentrated in urban areas. This suggests that further reductions in FGM risk will only be possible if program interventions can successfully target and reach vulnerable girls in hard-to-reach, remote communities—and raises additional questions on the nature, feasibility and scale of FGM prevention programs needed for further reductions.¹⁸⁰
- While prevalence is indeed falling, there is clear evidence that FGM remains universal in Djibouti, Egypt, Guinea, Sierra Leone, and Somalia. On the other hand FGM is reportedly occurring among certain communities in the Southern Africa region yet there is no data on FGM. There is continuing need for data and evidence. Data helps inform and thus support Government commitments.
- The downward shift in age of cutting presents a new and critical challenge to ending FGM efforts. This change in age of cutting is frequently understood to be a consequence of anti-FGM campaigns, legal restriction on FGM and increasingly girls' resistance to FGM. It is, therefore, important to understand where and when girls will be at risk in order to have the relevant interventions.
- There is increasing recognition that men and boys are more open to support end FGM agenda. This presents an important opportunity to involve and include men in current FGM abandonment efforts.
- Increasing migration has meant that FGM is an issue of global concern. Diaspora communities continue to have close links to their countries of origin that sustain the practice of FGM in the Africa region. Cross border FGM takes place as girls are sometimes sent to their families' in countries of origin for FGM and especially to those African countries or communities where it remains universal.
- There remains a need to better understand what intervention(s) work and produce social change. The measurement of progress and regression remains key as it also helps ensure that accountability can take place.

WHAT IS WORKING: PROGRAMMING AND IMPLEMENTATION

- Promising interventions that support efforts to end FGM have generally engaged and empowered local community actors inclusive of women and girls; men and boys; faith and community-based leaders as well as health care providers. Thus, transforming the social norms that underpin harmful practices must be addressed at individual, interpersonal, community, and institutional levels to bring about the needed transformational change for women and girls. This approach is in recognition of the fact that individuals face multiple levels of influence that need to be leveraged if programming to end FGM is to be effective.¹⁸¹
- Moreover, interventions are not equally or similarly implemented across communities or even within a country thus the results will vary. The diversity of approaches recognizes that there are varied and complex reasons for FGM practices and its continuation. Not all approaches will work in all contexts. For example, ARPs would not be appropriate in countries like Somalia or Mauritania given FGM is not practiced as a rite of passage nor is it done in secrecy. Thus responses for ending FGM must be contextualized, target multiple sectors at the local level and also encompass multiple measures inclusive of awareness-rising, behavior change initiatives, skills, health services, social protection, partnerships with faith and community leaders to facilitate attitude change, the education of girls, community dialogues; empowering women and girls; ensuring laws and policies are implemented and support of networks and advocates working to prevent FGM.

A key learning of the work in the area of FGM is that interventions should not be simply replicated because the political, social and economic contexts vary dramatically. Plus the underpinning norms and age of practice are also varied. And given the presence of laws banning FGM, there are significant changes happening that are across the African continent. What this implies is that our interventions must be based on research and understanding of the context.

- Effectiveness will depend on the content of the strategies and how strategies are implemented, which in turn will be influenced by the individuals, organizations and the networks implementing them.
- Public health emergencies and humanitarian crises have heightened our understanding of the significant increases in risk of FGM; with disruptions to many services. Integrating prevention and response to these FGM risks within the humanitarian and health service responses is now recognized as a critical strategy.



EFFECTIVENESS OF INTERVENTIONS

Law and legal enforcement take a long time to produce results.

At the community level, health education and community dialogues with parents and religious leaders can change attitudes towards FGM, an important step in the continuum of change towards the abandonment of the practice.

Media and social marketing efforts are effective in changing social norms and attitudes towards abandoning and, in some cases, reducing FGM.

Notably, efforts to convert and/or provide traditional practitioners with alternative sources of income are not effective in eliminating FGM.

At the individual level, formal education (educating mothers) can reduce the number of girls being subjected to FGM, while educating girls leads to improved knowledge on the consequences of FGM and changing attitudes towards the need for the practice. However, the returns of formal education in ending FGM may take many years to be realized.

At the service level, available evidence, though limited, shows that health-care provider training can improve the capacity for prevention and treatment of FGM. More research is needed at the service level, especially into how the health system can effectively prevent and respond to FGM.¹⁸²

CHALLENGES

- Several countries in the Africa region now have laws banning FGM and several are signatories to the human rights conventions and treaties. However, the practice does persist in certain communities, and health care providers are increasingly medicalising FGM. It is important to understand and monitor these changes in order to realize appropriate approaches towards addressing these issues.
- Countries do not have policies that regulate and consistently penalize health professionals for violating the laws and policies. This remains a key problem.

There is no medical justification for FGM. Trained health professionals who perform the practice violate girls' rights to life, physical integrity and health. Medicalizing the practice does not make it safer, as it still removes and damages healthy, normal tissue, and interferes with the natural functions of girls' bodies. Further, if medical professionals are seen to perform and uphold the practice, this may strengthen its legitimacy and the social expectation that it will and should continue.¹⁸³

- A limitation of current evidence regarding interventions is it is not robust enough to speak to attribution. Additionally,

There is limited evidence on the impact of many of the efforts in part because many interventions are implemented by small organisations with inadequate resources to document and evaluate their activities.¹⁸⁴ The complex nature of FGM interventions, as with other interventions aimed at addressing violence against women and girls,¹⁸⁵ also makes it difficult to adequately document what is done, how, when, and with what results.¹⁸⁶

- How FGM is practiced is evolving for example;

1. *Where there are laws that criminalize FGM there is increasing secrecy of the practice through lowering of age of FGM, shifts in decision-making around the practice and changes in norms that underpin FGM.*
2. *In the context of climatic and/or economic insecurities families and daughters worry about their futures and FGM becomes their mechanism for entry into a perceived social support system or into early/ child marriages.*

OPPORTUNITIES

- UNICEF noted that in countries affected by FGM, 7 in 10 girls and women think the practice should end. Even among communities that practice FGM, there is a notable level of opposition. Among girls and women who have undergone FGM, 5 in 10 think the practice should end.¹⁸⁷ These findings present openings for programming and identifying where and with whom to work with.
- Lessons from across programmes at ending harmful social practices point to giving women and girls a voice in all aspects of interventions, inclusive of decision making and as agents of change. Thus, an essential part of abandonment efforts is to create lasting social change through the empowerment of young girls and young women through the provision of skills and the opportunities needed to advocate for themselves. The African Union's Saleema Youth Victorious Ambassadors programme is one such successful platform helping to reduce pro-FGM social norms.
- Given the influence of urbanization, education and economic development in helping bring about social changes in support of FGM abandonment; it is increasingly crucial to understand how responses to end FGM need to be focused on holistic and multisectoral approaches since stand-alone approaches will not deliver the social change needed to end FGM.
- There are good practices that can be borrowed from the crisis caused by COVID-19. For example, during COVID-19 designing digital interventions for sexual and reproductive health programming to reduce crisis induced risks were implemented in some programmes. Awareness raising, messages about risks, prevention, sensitization and support and even training for care providers were delivered digitally using phones, laptops or portable speakers to sustain project delivery. However, this highlighted the digital divide whereby the use of digital methods in poorer or very rural communities may be constrained with unreliable services, and cost or lack of technology infrastructure. In addition, programmes are yet to monitor or measure the success of the new technological innovations/ interventions during COVID-19. So further evaluations will need to be conducted on them to support their scale up into efforts to end harmful practices.

- The African Committee of Experts on the Rights and Welfare of the Child (ACERWC) convened its 34th Ordinary Session from 25th November to 5th December 2019 in Cairo, Egypt. Its recommendations on operationalizing accountability on harmful practices provides the ground work and support for Member States to undertake the necessary steps for advancing accountability on their efforts to end FGM. The ACERWC recommendations were inclusive of the following:¹⁸⁸

1. *Commit to strengthening Member States reporting on fulfilment of obligations under the African Charter on the Rights and Welfare of the Child (ACRWC); (a) Review the reporting guidelines – noticeable gaps on what to report on ending FGM, (b) Develop General Comment on Female Genital Mutilation;*
2. *At 30 years of ACRWC, undertake targeted follow-up country missions based concluding observations in this period and produce a special report to be submitted to AU Heads of State and Government;*
3. *Make action on ending harmful practices (child marriage, female genital mutilation) a key index in state party reports going forward and;*
4. *Build close collaboration on advancing the “ending harmful practices” agenda with other AU treaty bodies.*

- The AUC has subsequently initiated efforts developing accountability mechanism for FGM so that Member States can focus their efforts on achieving the collective outcomes and impact that brings harmful practices to an end.



8. RECOMMENDATIONS FOR ACTION

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STRATEGIC

- Utilizing comprehensive, collaborative, multisectoral approaches and partnerships to end FGM emerges out of evidence that no standalone measures are effective. Integrated and coordinated multisectoral approaches would ensure that FGM programming builds strategic partnerships encompassing larger development goals, including health, justice, and education in response to ending FGM.
- Most countries have developed laws to end FGM and there is consensus that such laws provide the framework for the implementation of abandonment interventions. Public support, knowledge about the intent of the law, and adequate resourcing of the justice system are required to enhance implementation of laws in ways that are supportive of the well-being of women, girls and their families.

1. *Incorporate human rights and gender equality indicators in national responses to end FGM.*
2. *Harmonize national laws with human rights standards for the promotion of FGM related health policies, programmes and services.*

- Facilitate policy maker-researcher-programmer engagements to enhance the translation and effective use of data and evidence into policy making and programming.

1. *Will enable effective identification of some of the evidence gaps that limit a more complete understanding of the investments required for ending FGM, and how investments are translating into outcomes for women and girls.*

PROGRAMMATIC

- FGM prevention and responses must be population and context specific to be meaningful, through understanding the fundamental drivers of FGM. The resulting interventions must then be framed as addressing human rights and be grounded in theories of change and evidence for robust programming.

ABANDONMENT EFFORTS MUST;

1. *Recognize young girls and women as crucial partners in FGM interventions and agents in their own right leading social change. This requires meaningful participation as well as building skills for leadership, and enhanced involvement in policy and programme formulation to end FGM.*
2. *Incorporate comprehensive responses to support the safety, well-being and rights of girls and women. This will include the provision of legal, health and psychosocial services for FGM survivors.*
3. *Align with broader development efforts to ensure communities, women and girls are more resilient in the face of increased risks, vulnerabilities and socio-economic factors that drive the continuation of FGM.*

- Given the various and diverse influencers, inclusive of individuals, families, the community and the wider social institutions that sustain negative gender and social norms, behaviours and attitudes that reinforce FGM, it is critical to integrate families, communities and key stakeholders into programme design and implementation to end FGM:

1. *Faith based, opinion leaders, community leaders and schools should continue to be engaged to:*
 - *Strengthen oversight, surveillance and monitoring for prevention of FGM and specifically cross-border practices.*
 - *Challenge harmful social norms and modify social practices that arise from and perpetuate discriminatory practices against women and girls.*
2. *Challenge harmful gender norms. This calls for involvement of men and boys to dismantle harmful social norms.*





9. CONCLUSION

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FGM is a form of Gender-based violence and a human rights violation with serious consequences for women and girls' physical, mental and, sexual and reproductive health.

Poverty, humanitarian crises and public health emergencies have been shown to increase vulnerabilities to women and girls hence perpetuating FGM.

Understanding the extent of FGM as a harmful practice is crucial in informing the actions and strategies needed to address it. A big win is that Member States have increasingly been able to track their progress in achieving their international and regional duties to combat FGM by measuring its occurrence. However, what remains missing is tracking the level of progress being made across with the diverse interventions. The influence of policies, as well as advances in developing legal and regulatory reforms, service availability, and budgetary allocations to address FGM, have been revealed by changes in the prevalence of FGM.

Current efforts by the African Union African Union's Saleema Initiative is to get to Zero FGM by 2030. To do so needs increased mobilization and cooperation among Member States; and prevention and responses to end FGM must be coordinated across sectors. Good practices emerging across the African region highlight that social change in support of abandoning FGM requires multilevel and multisectoral approaches. This entails effectively coordinating all relevant stakeholders and ensuring they have the necessary material and technical support needed to work efficiently to strengthen sub-national and national responses to ending FGM.

Further, the attitudes, behaviours and social norms that underpin and influence individual, interpersonal, community and societal relationships putting women and girls at risk for experiencing FGM need to be examined, understood and altered.

Women and girls must be supported to be at the forefront of informing and determining the responses needed to end FGM.

Humanitarian crisis and outbreaks such as COVID-19 pandemic have illuminated the increased risks to FGM especially for vulnerable girls. Highlighted is need to integrate and ensure increased access to prevention, protection and care services for those at risk of harmful practices in emergencies contexts.

An enabling environment for ending FGM will therefore require political leadership, equitable laws, policies, adequate human and financial resources, supportive social norms, gender equity, and government accountability for promoting and protecting the human rights of women and girls.



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ANNEXES

ANNEX: 1 – FGM DATA SOURCES

Nationally representative data on FGM for women aged 15-49 years and their daughters aged 0-14 years have been collected in 27 countries in Africa (Table 1). The main sources of data are the **Demographic and Health Survey (DHS)** and **Multiple Indicator Cluster Survey (MICS)**. The most recent available data on FGM in Africa is shown in Table 1 with oldest data source being the Cameroon DHS that were conducted in 2004 while the latest data were collected in 2019 in Chad, Central African Republic, and Guinea-Bissau. It is important to note that while this report has used the most recently available nationally representative data, there are significant differences across countries regarding the year when data were collected. It is possible that FGM prevalence derived from data sources that were recently collected are likely to give the most recent status of FGM as compared to datasets that were collected many years back.

COUNTRY	REFERENCE YEAR	DATA SOURCE
Benin	2014	MICS
Burkina Faso	2010	DHS/MICS
Cameroon	2004	DHS
Central African Republic	2018-19	MICS
Chad	2019	MICS
Côte d'Ivoire	2016	MICS
Djibouti	2012	PAPFAM
Egypt	2015	Health Issues Survey (DHS)
Eritrea	2010	Population and Health Survey
Ethiopia	2016	DHS
Gambia	2018	MICS
Ghana	2017-18	MICS
Guinea	2018	DHS

Guinea-Bissau	2018-19	MICS
Kenya	2014	DHS
Liberia	2013	DHS
Mali	2018	DHS
Mauritania	2015	MICS
Niger	2012	DHS
Nigeria	2018	DHS
Senegal	2017	DHS
Sierra Leone	2017	MICS
Somalia	2006	MICS
Sudan	2014	MICS
Togo	2017	MICS
Uganda	2016	DHS
United Republic of Tanzania	2015-16	DHS

Table 1: **Most recent available FGM data sources in Africa**



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Table 2 details the most recently available nationally representative data on FGM for women aged 15-49 years in Africa.

Table 2: **Most recent available FGM data sources in Africa**

COUNTRY	REFERENCE YEAR	DATA SOURCE
Benin	2014	MICS
Burkina Faso	2010	DHS/MICS
Cameroon	2004	DHS
Central African Republic	2018-19	MICS
Chad	2019	MICS
Côte d'Ivoire	2016	MICS
Djibouti	2012	PAPFAM
Egypt	2015	Health Issues Survey (DHS)
Eritrea	2010	Population and Health Survey
Ethiopia	2016	DHS
Gambia	2018	MICS
Ghana	2017-18	MICS
Guinea	2018	DHS
Guinea-Bissau	2018-19	MICS
Kenya	2014	DHS
Liberia	2013	DHS
Mali	2018	DHS
Mauritania	2015	MICS
Niger	2012	DHS
Nigeria	2018	DHS
Senegal	2017	DHS
Sierra Leone	2017	MICS
Somalia	2006	MICS
Sudan	2014	MICS
Togo	2017	MICS
Uganda	2016	DHS
United Republic of Tanzania	2015-16	DHS

ANNEX: 2 – FGM NATIONAL PREVALENCE

National percentages of women aged 15-49 years who have undergone FGM in Africa are presented in a bar graph (Figure 1).¹⁹⁰

Figure 1: FGM Prevalence Among Women Aged 15-49 Years In Africa

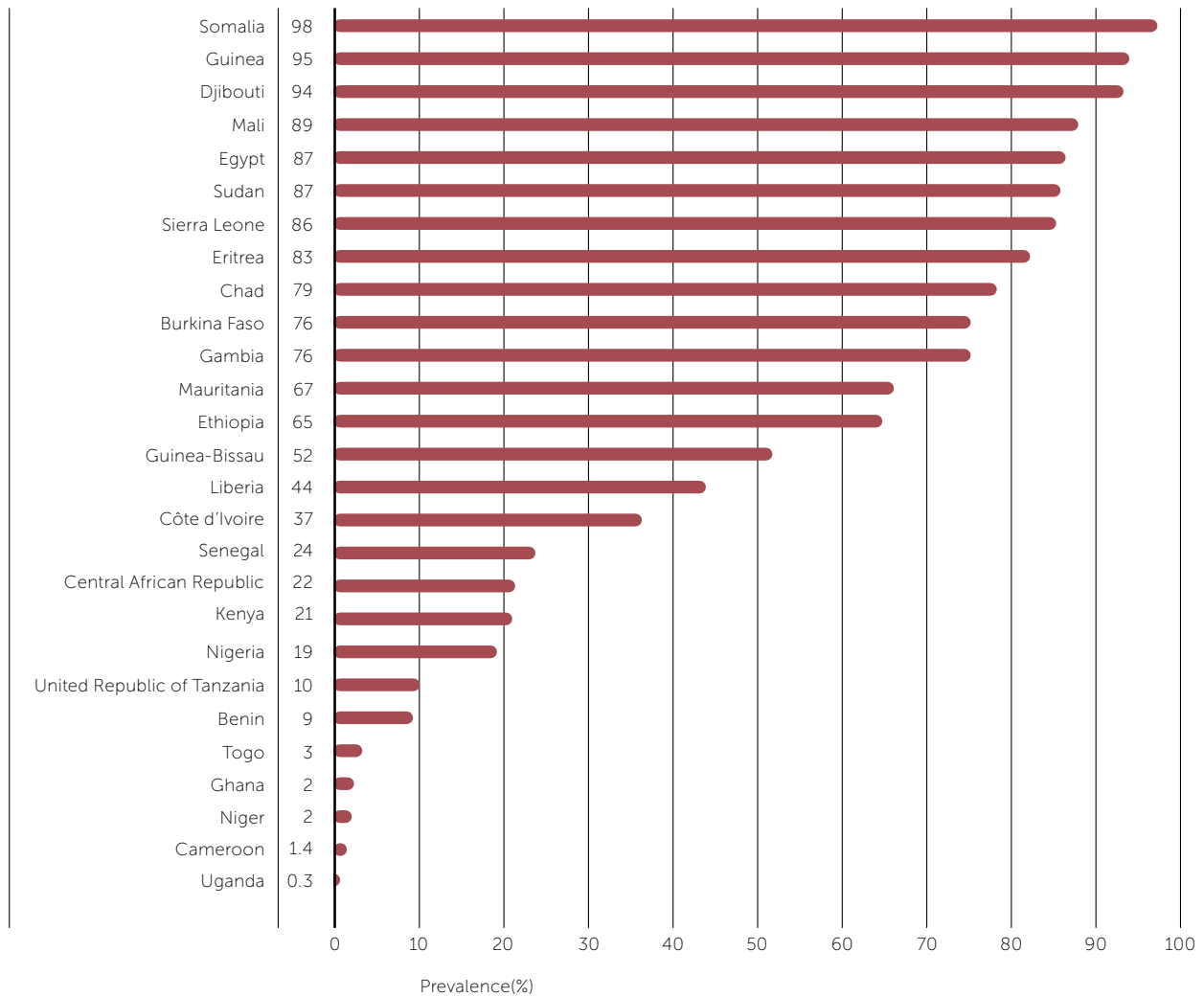
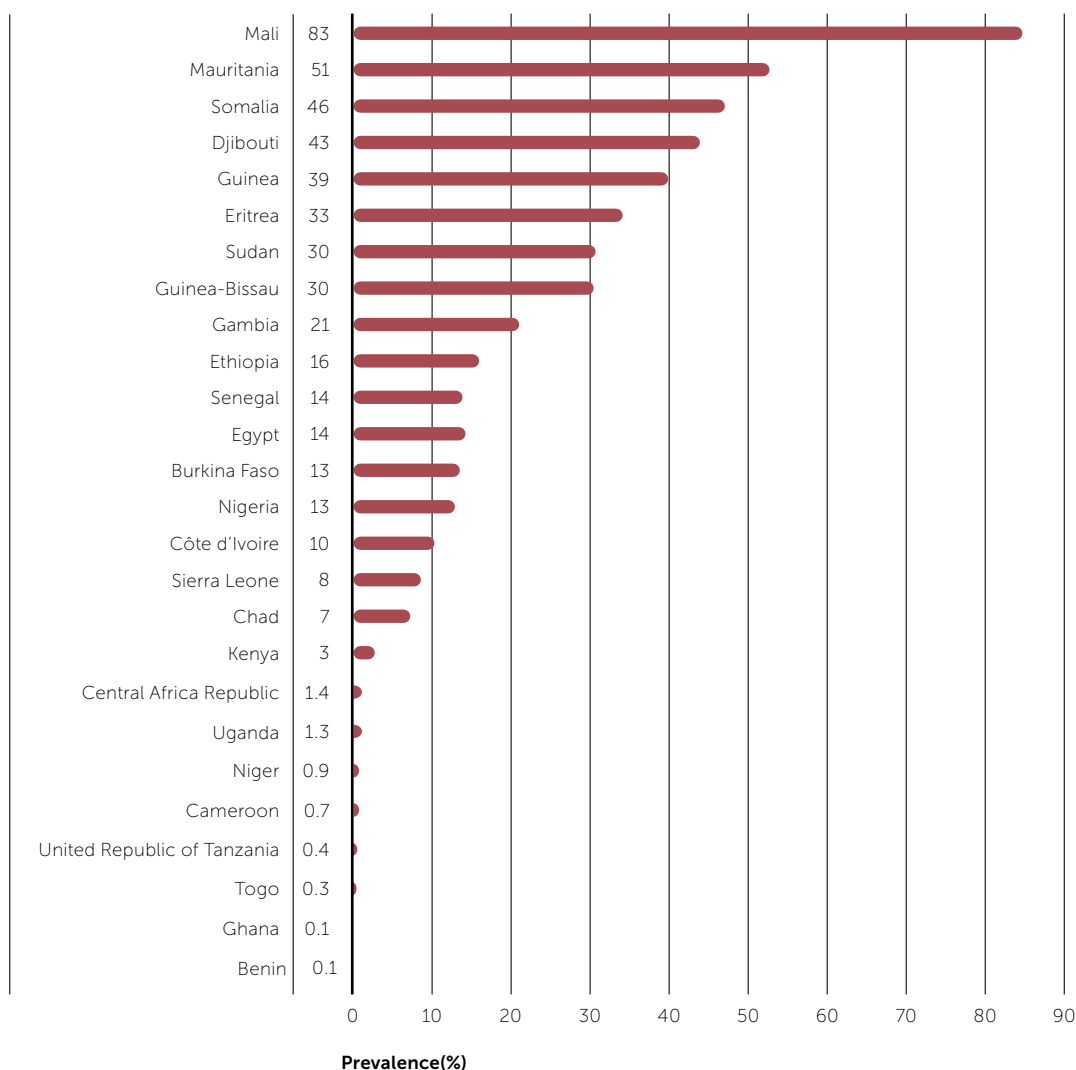


Figure 3: FGM Prevalence Among Women Aged 15-49 Years In Africa



ANNEX: 3 – FGM REGIONAL PREVALENCE DATA

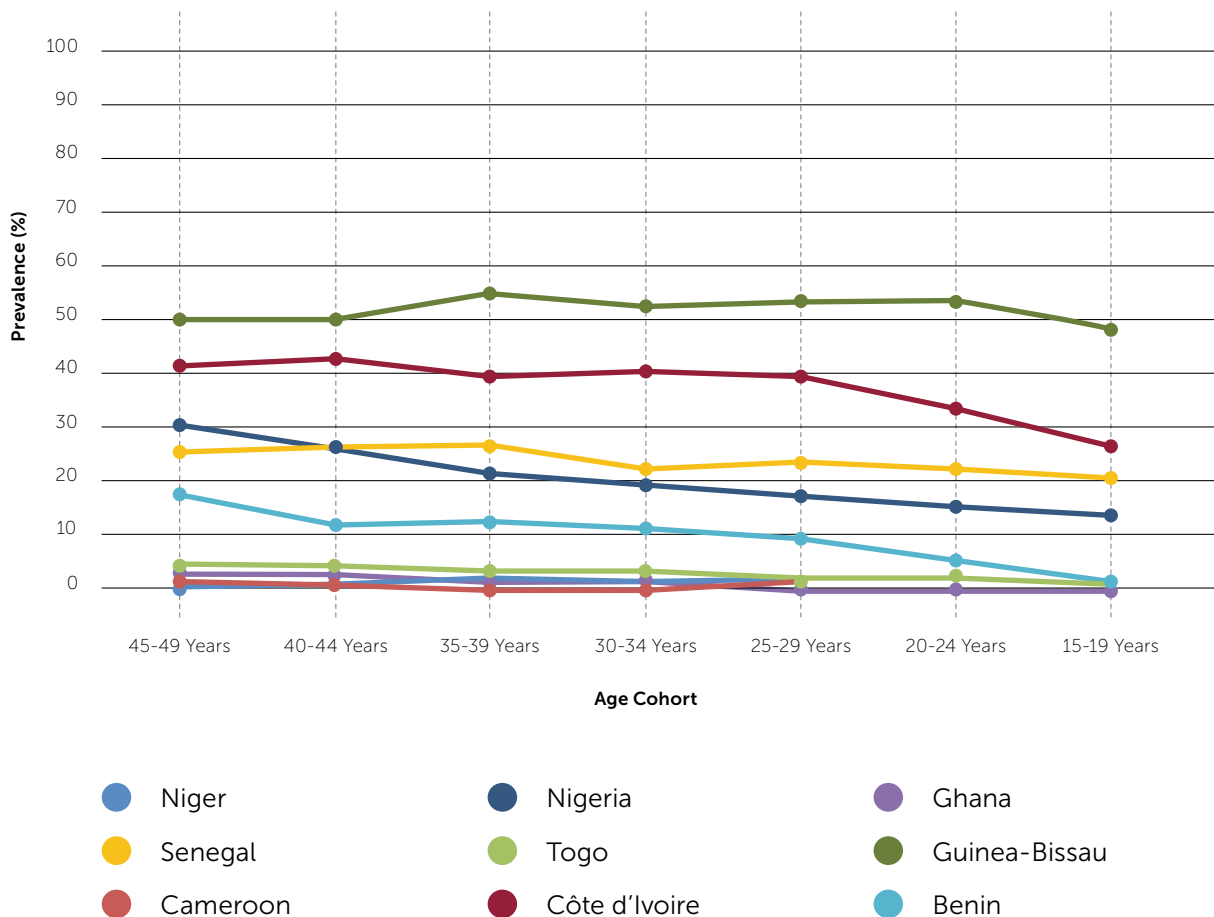
FGM PREVALENCE IN WEST AFRICA REGION

For ease of presentation, data for the 16 countries making up the West African region are presented in two graphs—Figure 5(a) and (b). Figure 5(a) presents data for nine countries that had an FGM prevalence rate of less than 50% among its oldest age cohort (45-49 years), while Figure 5(b) comprises six countries that had an FGM prevalence rate of more than 50% among its oldest age cohort (45-49 years).

AS SHOWN IN FIGURE 5(A):

- The practice of FGM has been consistently very low throughout the years in Niger, Cameroon, Togo, and Ghana;
- In Benin and Nigeria, the prevalence has significantly declined in three decades with a clear generational shift comparing the prevalence of FGM among the oldest cohort (18% in Benin and 31% in Nigeria for women aged 45-49) and the youngest cohort (2% in Benin and 14% in Nigeria for girls aged 15-19 years); and
- In Côte d'Ivoire, there has been a slight decline in the prevalence (from 42% to 27%), while in Senegal and Guinea-Bissau, data shows no significant change in the prevalence of FGM over time.

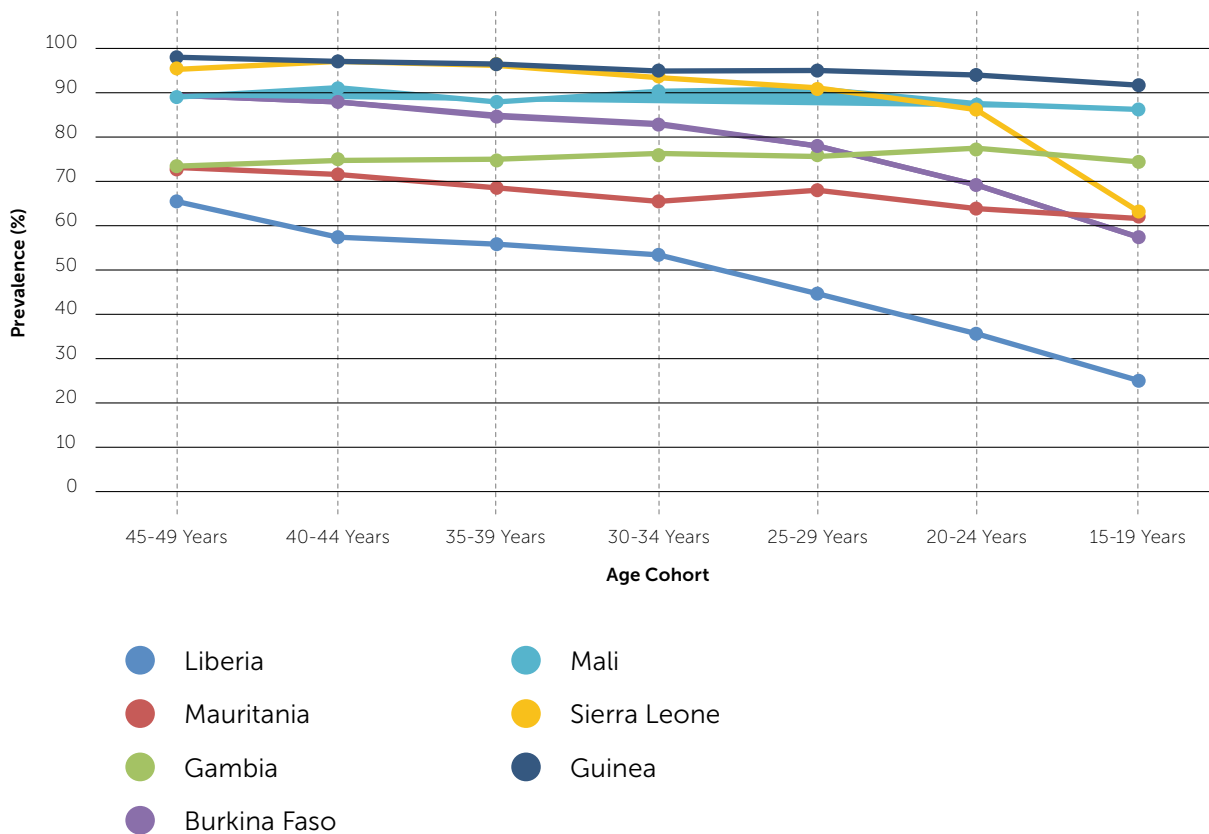
Figure 5(A): Percentage of women aged 15-49 years who have undergone FGM by age cohort in West Africa



AS SHOWN IN FIGURE 5(B):

- There were significant declines in the prevalence of FGM over time in Liberia (from 66% among those aged 45-49 years to 26% among those aged 15-19 years), Burkina Faso (from 89% among those aged 45-49 years to 58% among those aged 15-19 years), and Sierra Leone (from 98% among those aged 45-49 years to 64% among those aged 15-19 years);
- In Mauritania, there are signs of a small decline in the prevalence over time; and
- In Gambia, Mali and Guinea, there is no evidence of decline in the prevalence of FGM comparing the prevalence among the oldest and youngest age cohorts.

Figure 5(B): Percentage of women aged 15-49 years who have undergone FGM by age cohort in West Africa

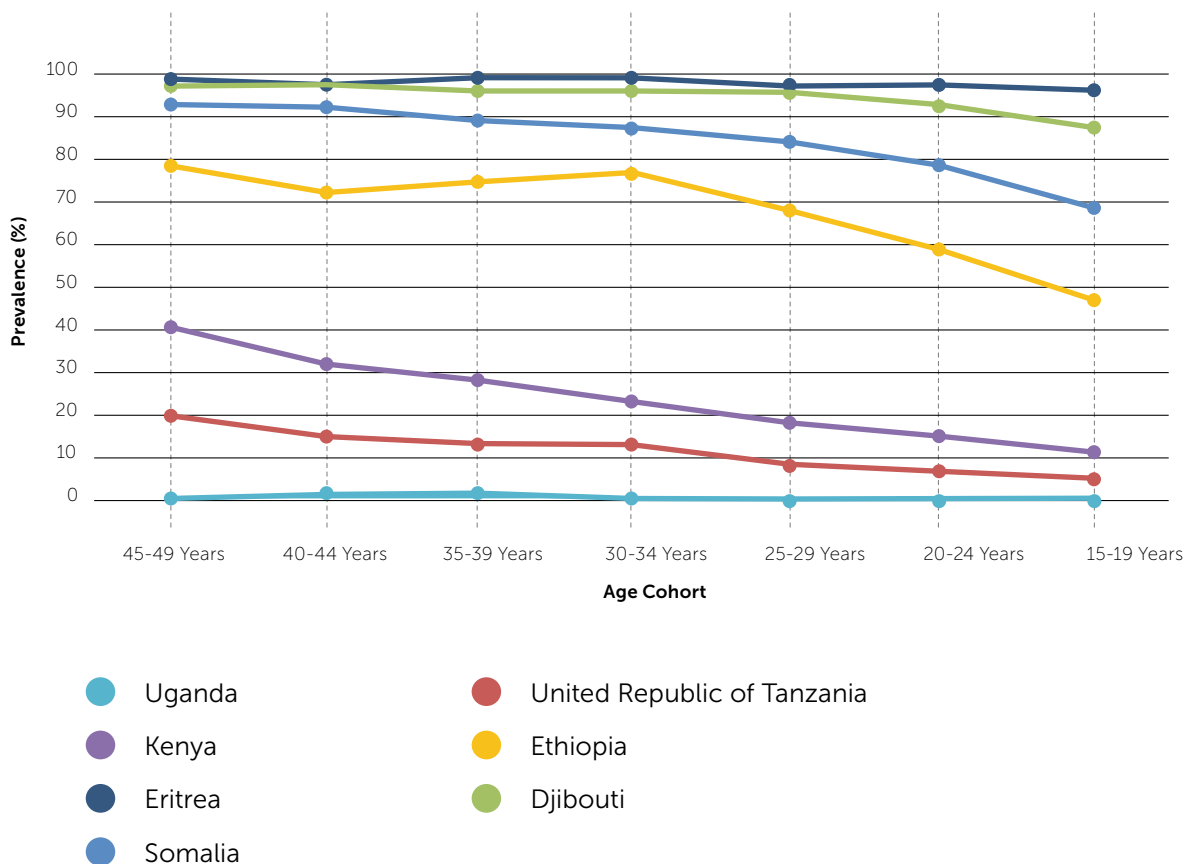


FGM PREVALENCE IN EAST AFRICA REGION

AS SHOWN IN FIGURE 6;

- The practice of FGM has been consistently very low throughout the years in Uganda;
- The United Republic of Tanzania and Kenya have experienced dramatic declines in the prevalence of FGM among women aged 15-19 years compared to those aged 45-49 years (from 19% to 5% in the United Republic of Tanzania, and 41% to 11% in Kenya);
- There have been equally some considerable declines in the prevalence of FGM in Ethiopia (from 80% to 47%) and Eritrea (from 93% to 69%) with a lesser proportion of women in the youngest age cohort having undergone the practice compared to the oldest age cohort ¹⁹¹; and
- There was no significant change in the prevalence of FGM across generations in Djibouti and Somalia.

Figure 6: Percentage of women aged 15-49 years who have undergone FGM by age cohort in East Africa

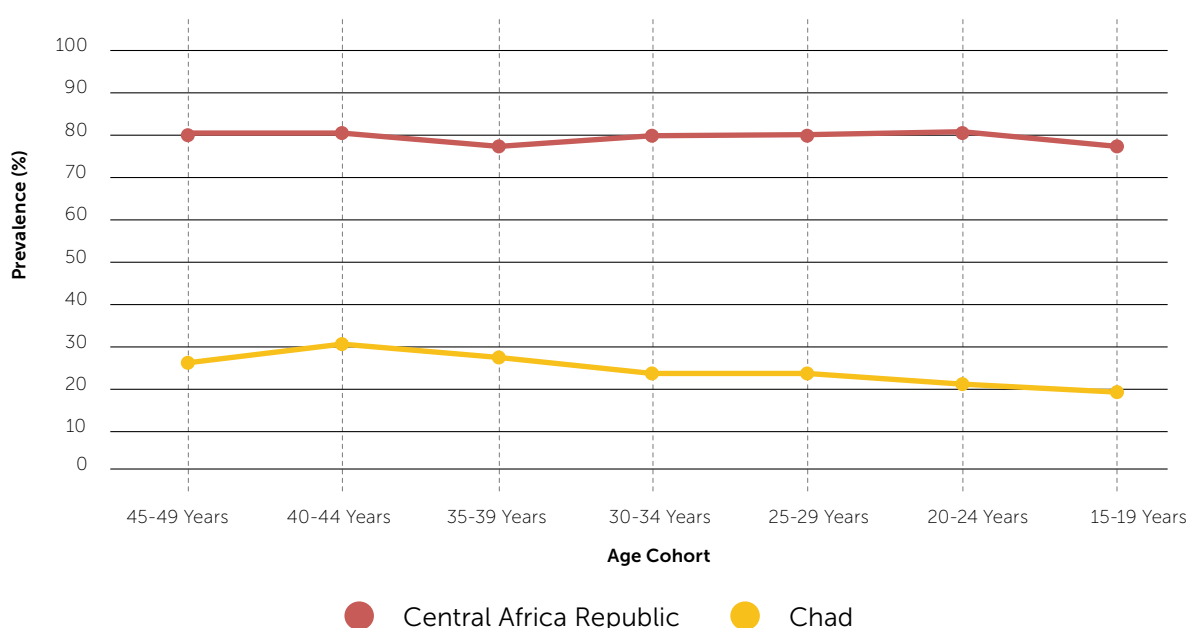


FGM PREVALENCE IN CENTRAL AFRICA REGION

AS SHOWN IN FIGURE 7;

- The practice of FGM has declined over time in Central African Republic (from 34% among those aged 45-49 years to 18% among those aged 15-19 years); and
- There has been no significant decline in the prevalence of FGM in Chad for all age groups.

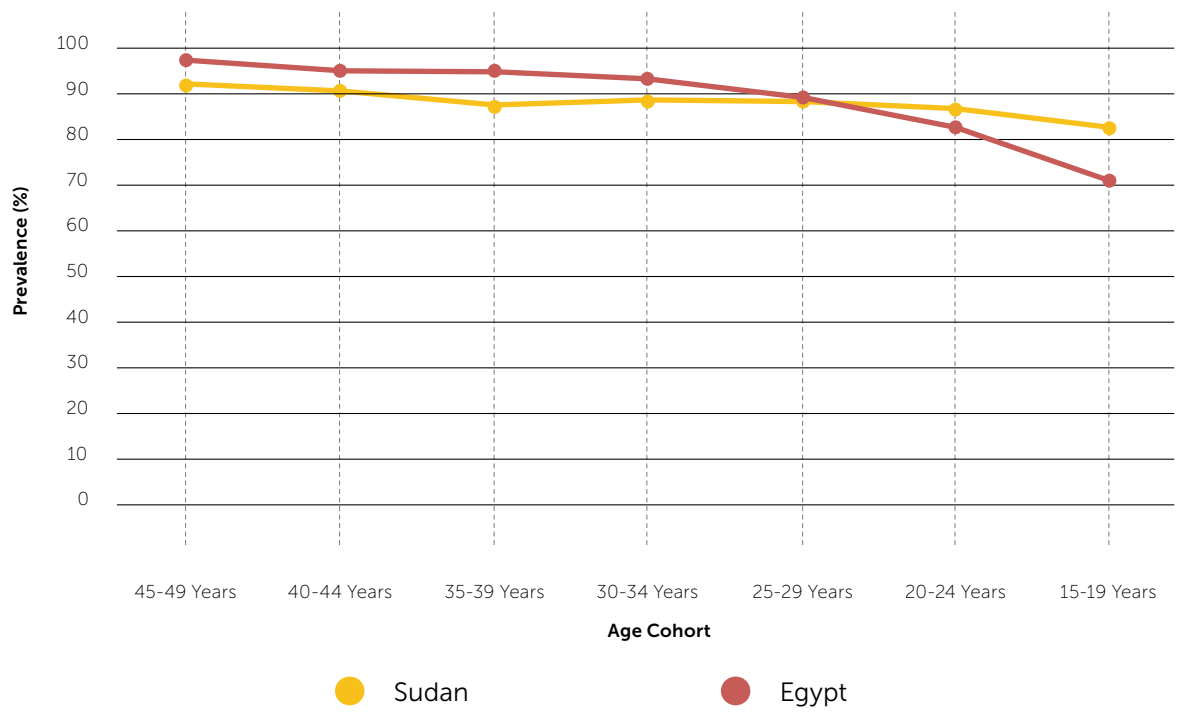
Figure 7: Percentage of women aged 15-49 years who have undergone FGM by age cohort in Central Africa



FGM PREVALENCE IN NORTH AFRICA REGION

AS SHOWN IN FIGURE 8;

- In Sudan, there has been a slight decline in the prevalence of FGM over the years from 92% among the oldest age cohort (45-49 years) to 82% among the youngest age cohort (15-19 years); and
- In Egypt, there is evidence that a significantly lesser proportion of girls aged 15-19 years (70%) have undergone FGM compared to the proportion of older women aged 45-49 years (97%).



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