THE TIME IS NOW:

END FEMALE GENITAL MUTILATION/CUTTING (FGM/C)

An Urgent Need for Global Response

Five Year Update - 2025

End FGM EUROPEAN NETWORK

END FGM/C U.S. NETWORK

Equality Now
A just world for women and girls.

ABOUT EQUALITY NOW

Equality Now is an international human rights organization founded in 1992 to protect and advance the rights of all women and girls around the world. Its campaigns focus on four programmatic areas: achieving legal equality, ending sexual violence, ending harmful practices, and ending sexual exploitation, with a cross-cutting focus on the unique needs of adolescent girls and other vulnerable groups.

Equality Now is a global organization with partners all around the world. You'll find our 80+ team across the world in places such as Beirut, Johannesburg, London, Geneva, San José, New York, Nairobi, Tbilisi, and Washington DC, among many others.

ABOUT THE END FGM EUROPEAN NETWORK

The End FGM European Network is an umbrella of 39 organizations in 16 European countries working to ensure sustainable European action to end female genital mutilation (FGM). We are the central platform connecting grassroots communities and European decision-makers. The Network facilitates cooperation between all relevant actors in the field of FGM both in Europe and globally. Our mission is to be the driving force of the European movement to end all forms of FGM.

ABOUT THE U.S. END FGM/C NETWORK

The U.S. End FGM/C Network is a collaborative group of survivors, civil society organizations, foundations, activists, policymakers, researchers, healthcare providers and others committed to promoting the abandonment of female genital mutilation/cutting (FGM/C) in the U.S. and around the world. Our mission is to eliminate FGM/C by connecting, supporting, elevating and advocating on behalf of and with diverse U.S. stakeholders engaged in prevention, education, and care.

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FOREWORD

Mam Lisa Camara (The Gambia)

Domtila Chesang (Kenya)

Founding Members African Women Rights Advocates (AWRA)

The fight against female genital mutilation/cutting (FGM/C) is not confined by borders. It is a global struggle rooted in the pursuit of dignity, equality, and justice for women and girls everywhere. As activists from The Gambia and Kenya, our experiences have shown us both the devastating impact of this practice and the power of collective action to bring about change.

For me, Mam Lisa, growing up in The Gambia, the normalization of FGM/C was a harsh reality. Yet, witnessing the courage of survivors and the resilience of grassroots movements inspired me to advocate for systemic change. In recent years, The Gambia's legal reforms and advocacy efforts have faced significant backlash, underscoring the urgency of protecting hard-won progress.

For me, Domtila, the fight against FGM/C began in my pastoralist community of Kenya (West Pokot), where cultural traditions often overshadow the voices of women and girls. I decided to lend my voice to the many girls in my community who don't have the avenue to amplify their voices. I believe that education is the greatest way to end FGM In communities

"WITNESSING THE COURAGE OF SURVIVORS AND THE RESILIENCE OF GRASSROOTS MOVEMENTS INSPIRED ME TO ADVOCATE FOR SYSTEMIC CHANGE."

This report sheds light on the global nature of FGM/C, emphasizing its prevalence across continents and cultures. By framing FGM/C as a universal issue, it strengthens the case for coordinated global action. This updated evidence base is critical for dispelling myths, guiding policy, and mobilizing resources in regions often overlooked. It also amplifies the voices of survivors and activists who are at the heart of this movement.

The significance of this report cannot be overstated. It reaffirms that the eradication of FGM/C is achievable, but only if we act together. By combining evidence-based strategies with survivor-centered approaches, we can ensure that future generations of girls grow up free from this harmful practice.

Let this report serve as a rallying cry for governments, organizations, and individuals worldwide. Together, we can end FGM/C and build a world where all women and girls live with dignity, equality, and freedom.

ACKNOWLEDGMENTS

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We also appreciate the valuable input on available data, activist and survivor stories, and the situation in specific countries received from Anne-Marie Morin and Sean Callaghan (Orchid Project), Mariya Taher (Sahiyo), Masooma Ranalvi (WeSpeakOut), Claudia Cappa and Colleen Murray (UNICEF), Warda Warsame and Alisa Tukkimaki (End FGM Canada Network), Saza Faradilla (End FGC Singapore), Zaain Ahmed (Rise Up Maldives), Mamlisa Camara (African Women Rights Advocates), Leandra Becerra (Colombian activist), Isis Elgibali (WADI Foundation), Irene Kuzemko, Jana Hugo and Maddalena Bianchi (OII Europe), Zahra Naleie (FSAN), Aminata Sidibe (GAMS Belgium), Isabelle Gilette-Faye (Federation Nationale GAMS France), Angela Dawson (Associate Dean Research, University of Technology Sydney).

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Finally, we are extremely thankful to the survivors and activists who generously contributed their voices to the stories in this report, as well as to the foreword.

LIST OF ACRONYMS & ABBREVIATIONS

CDC	Centers for Disease Control and Prevention
CEDAW	Committee on the Elimination of Discrimination Against Women
DHS	Demographic and Health Surveys
EU	European Union
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting
IHSN	International Household Survey Network
MICS	Multiple Indicator Cluster Surveys
OHCHR	Office of the United Nations High Commissioner for Human Rights
SDGs	Sustainable Development Goals
UN	United Nations
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization
ZSBS	Zambia Sexual Behaviour Survey

WHAT IS FEMALE GENITAL MUTILATION/CUTTING?

Female genital mutilation/cutting (FGM/C) refers to all procedures involving partial or total removal of the female external genitalia or other injuries to the female genital organs for non-medical reasons. There are many terms used to describe this practice, including 'female circumcision,' 'female genital cutting,' 'khatna,' 'sunat,' 'sunat perempuan,' and many other terms or acronyms depending on the specific local context involved. The term FGM/C, as used in this report, is intended to be inclusive of all such terms.

The World Health Organization (WHO) classifies FGM/C into four types:

TYPE I:

*Partial or total removal of the clitoris and/or the prepuce (**clitoridectomy**).*

TYPE II:

*Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (**excision**).*

TYPE III:

*Narrowing of the vaginal orifice with creation of a covering seal by cutting and re-positioning the labia minora and/or the labia majora, with or without excision of the clitoris (**infibulation**).*

TYPE IV:

All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping, and cauterization.

***Note:** While the main focus of this report is the four types of FGM/C as defined by the WHO, it is important to highlight other similar practices that are still not recognized as forms of mutilation. Interventions like the husband stitch, intersex genital mutilation (IGM), or vaginoplasty, often practiced in what is known as the Western world, despite being interventions performed for non-medical reasons to comply with gendered social norms and leading to complications, are not addressed as FGM/C is. Many of them are accessible to minors and, for practices like IGM, do not necessarily require the consent of the person undergoing it. Therefore, considering the purpose of this report, other forms of FGM/C will be discussed, but the data shared will focus on the above definition.*

EXECUTIVE SUMMARY

FGM/C affects 230 million women and girls across the world

According to official UNICEF figures (2024), female genital mutilation/cutting (FGM/C) affects at least 230 million women and girls across the world. This increase of 15% compared to the previously available data (which estimated that FGM/C impacted 200 million girls) is a result of population growth in the communities that practice FGM/C as well as newly available data from countries that were not earlier included in the data. For the first time ever, UNICEF data includes specific estimates of **FGM/C prevalence across Asia (80 million), the Middle East (6 million),** and **countries where FGM/C is practiced by small communities or diaspora populations (1-2 million)**. While the overall figure is now a comprehensive global estimate, detailed data on the national prevalence of FGM/C is still available only for 31 countries worldwide.

FGM/C is present on every continent except Antarctica

This report updates data from the 2020 report, *Female Genital Mutilation/Cutting: A Call for a Global Response*, presenting detailed and comprehensive evidence of FGM/C taking place across the world, in numerous countries in Africa, Asia, the Middle East, Latin America, Europe, and North America, amongst indigenous and/or diaspora communities. Indirect estimates, small-scale research surveys, and anecdotal evidence documenting the practice have been produced by survivors of FGM/C,[1] activists, and grassroots organizations who are courageously working to end FGM/C across the globe. With this evidence, they have provided support to affected women and girls and advocated with policymakers, courts, and local authorities to introduce and enforce legal and policy frameworks against FGM/C.

Since the last report was published in 2020, newly available evidence and data demonstrate that FGM/C is occurring in at least 3 additional countries:

- Azerbaijan, where research investigations in 2020 found that FGM/C is being practiced in a few villages by North Caucasian communities;
- Vietnam and Cambodia, where preliminary findings from ongoing research demonstrate that FGM/C is being practiced by the Cham community.

In other countries, new reports and data have been published in the last five years, strengthening evidence about the prevalence and practice of FGM/C in various countries, including **Saudi Arabia**, **Malaysia**, **Sri Lanka**, the **United Arab Emirates**, the **Philippines**, and **Colombia**.

1 Survivors of FGM/C references women and girls who have experienced FGM/C. For the purposes of this report, the phrase 'survivor of FGM/C', 'survivor', or 'women and girls who have undergone FGM/C' will be used to refer to these brave women and girls.

FGM/C is present in at least 94 countries, all of which need to be under the international spotlight

As this report will show, there are 31 countries where nationally representative data on FGM/C is available. In addition, there are at least 63 other countries where the practice of FGM/C has been documented either through indirect estimates (usually used in countries where FGM/C is mainly practiced by diaspora communities), small-scale studies, or anecdotal evidence and media reports. This report, while not aiming to be an exhaustive review of all data on FGM/C, clearly shows that FGM/C is a global practice that requires a global response. If we want to achieve the worldwide eradication of FGM/C by 2030, we must measure its prevalence in every country and accelerate global efforts to end this harmful practice.

Lack of global awareness results in a lack of global action and investments

Despite the strong and continuously developing evidence base on the global presence of FGM/C, levels of awareness amongst the public and government officials regarding the global nature of the practice of FGM/C remain low. Activists and groups working to end FGM/C face monumental challenges in their work, compounded in many cases by the lack of reliable data, insufficient support and funding from the international community, and the reluctance of national governments to take action on the issue, particularly in countries which are not traditionally known for practicing FGM/C. The growing backlash against women's and girls' rights, which has led to legal challenges to existing anti-FGM/C laws such as in Kenya and The Gambia, also threatens to reverse hard-fought progress and gains made through decades of efforts by survivors and grassroots activists.

It is widely acknowledged that efforts to end FGM/C are severely underresourced and require urgent investment. While the majority of the current funding is concentrated in a limited number of countries in the African region, the responses are still extremely under-resourced in these countries. Asia, the Middle East, and Latin America receive only a small share of the investment. In these regions, several governments do not yet acknowledge (and in some cases even openly deny) the presence of FGM/C in their countries, thus undermining and sometimes openly discrediting the work of local survivors and activists.

The lack of political will and awareness of the existence of FGM/C worldwide impacts the availability of protective measures for women and girls who are at risk. Of the 94 countries with available data on FGM/C, only 59 have specifically addressed FGM/C within their national legal framework. There has been progress since 2020, with Sudan, Indonesia, Finland, Poland, and the United States passing new federal laws against FGM/C, while other countries strengthened their laws (such as France requiring education or awareness-raising on FGM/C in schools), passed laws at the state level (such as Galmudug state in Somalia), or adopting new legislation at the regional level as seen in the European Union. Officially recognizing FGM/C as a violation (whether in a standalone anti-FGM/C law or through specific provisions in existing laws) is arguably the first step to implementing national interventions to eradicate it and protect women and girls.

Laws against FGM/C are most common in the African continent as well as countries where FGM/C is largely known to be practiced by diaspora communities, including in Europe and North America. Asia and the Middle East lag behind in enacting legal prohibitions against FGM/C. In 2024, Indonesia became the first Asian country to pass a law against FGM/C through Government Regulation No.28/2024, which prohibits female circumcisions for infants, toddlers, and preschool children (likely only covering children under the age of 5).

Ending FGM/C requires a global yet nuanced approach

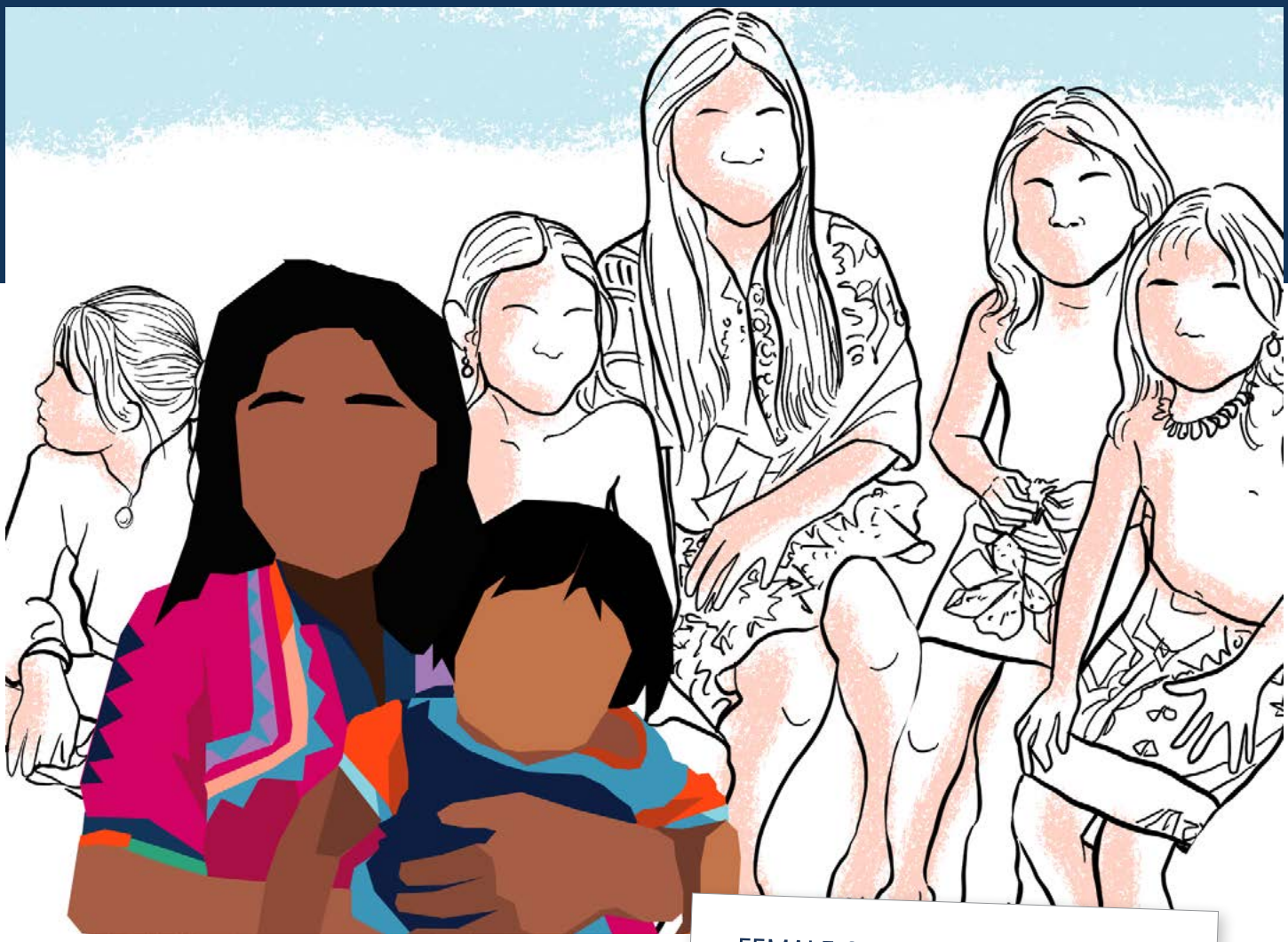
The globalized nature of FGM/C requires not only a global response but a nuanced one tailored to meet the particular contours of FGM/C as it is practiced in different regions, countries, or communities. As this report demonstrates, better and growing data on the existence and prevalence of FGM/C, increased investment in efforts to end FGM/C, effective implementation of laws banning the practice of FGM/C, and tailored and comprehensive policies and services for survivors are needed in every country where the practice is now known to be present.

Through the Sustainable Development Goals (SDGs), activists and countries have made strong public commitments to ending FGM/C throughout the world by 2030. To achieve this goal, political commitments must now be put into action fully by accelerating and globalizing efforts, collecting and circulating reliable data, and providing the proper funding needed to put effective laws, policies, and interventions in place to eradicate FGM/C once and for all.

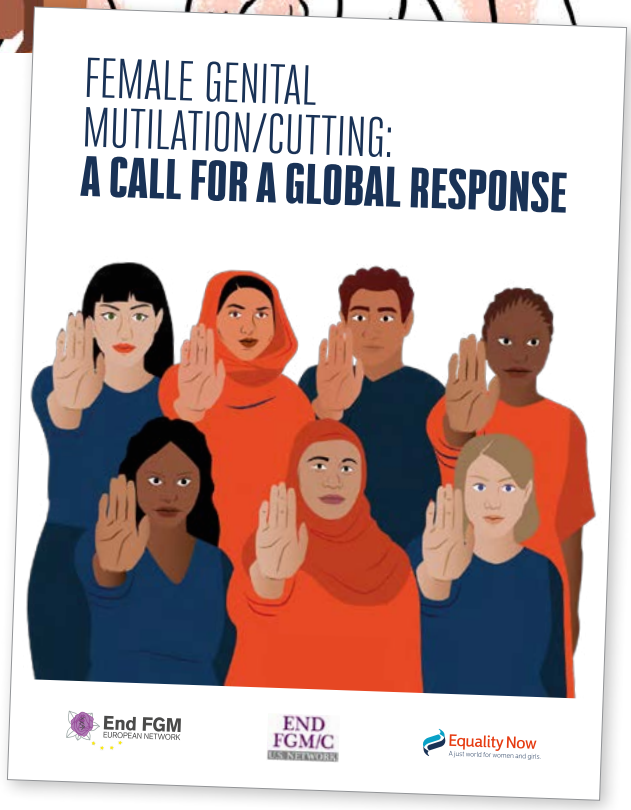
KEY RECOMMENDATIONS

To this aim, the key recommendations put forward in this report call on governments, the international community, and donors to:

- Strengthen the global political commitment and prioritization of FGM/C;
- Strengthen the evidence base through critical research;
- Increase resources to achieve the Global Goal (SDG 5.3);
- Enact and enforce comprehensive laws and national policies;
- Improve wellbeing via support and services for survivors.



INTRODUCTION



Female Genital Mutilation/Cutting: A Call for a Global Response (2020 Global Report) was released in March 2020. Led by Equality Now, the U.S. End FGM/C Network, and the End FGM European Network, with indispensable contributions from survivors of female genital mutilation or cutting (FGM/C) and civil society organizations, the report provided a global overview of the prevalence and protections regarding FGM/C. For the first time, the 2020 Global Report estimated that FGM/C was occurring in at least 92 countries across the world and found that only 51 countries (55%) of the countries practicing had specific laws prohibiting FGM/C. The report, above all, made an urgent and critical call for action from multiple sectors of society at a truly global scale to eradicate FGM/C.

UPDATE TO THE GLOBAL REPORT

Since 2020, UNICEF has refreshed its previous estimates of people who have undergone FGM/C in 2024 and found that there are at least 230 million people in the world who have undergone FGM/C. This increase of 15% compared to the previously available data (which estimated that 200 million girls were impacted by FGM/C) is a result of population growth in the communities that practice FGM/C as well as newly available data from countries that were not earlier included in the data. For the first time ever, UNICEF data includes specific estimates of **FGM/C prevalence across Asia (80 million), the Middle East (6 million),** and **countries where FGM/C is practiced by small communities or diaspora populations (1-2 million)**. Earlier data covered only specific countries from these regions, such as Iraq and Yemen in the Middle East, and Indonesia and the Maldives from Asia. This new data is a critical step in supporting advocacy toward ending FGM/C in Asia and the Middle East, where we have data estimating the scale of the issue across these regions for the first time.

Although not exhaustive, the findings in the 2020 Global Report have been utilized by civil society, survivors, and community members to highlight the global nature of the practice and instrumentalize it to advocate for an evidence-based and multi-faceted approach to ending FGM/C. Along with the efforts of multiple stakeholders, the report has contributed to the global shift in perceptions and language around FGM/C with a growing acknowledgment that FGM/C happens in over 90 countries.[2] Despite this progress, there is still a need for reliable and comprehensive data collection that can lead to increased awareness, understanding, and action on the human rights violations due to FGM/C in every part of the world. For many years, civil society, survivors, and human rights advocates have been relying on insufficient data collected through community-led efforts and have raised a consistent demand for governments to lead data collection, considering that government bodies have the most access to information and the most administrative reach. Further, the need for financial and material investments from the government also remains largely unchanged. The sector needs substantial, earmarked funding that can address the complex nature of FGM/C.

THERE ARE AT LEAST 230 MILLION PEOPLE IN THE WORLD WHO HAVE UNDERGONE FGM/C

At this juncture, five years since the 2020 Global Report was released, an update to the report was much needed, including to ensure inclusion of the latest data and research on FGM/C from across the world, as well as to reflect changes in laws in countries.

2 The 2020 Global Report has been cited in various high-profile publications, including by the UN Secretary-General, in the Phase IV Strategy of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, and used by the OECD as a supplemental base for identifying countries which have evidence of FGM in its Social Institutions and Gender Index (SIGI).

PROGRESS IN THE LAST FIVE YEARS

Since the last report, there have been instances of global and coordinated efforts to bring attention to the practice of FGM/C and policies to address it at every level - international, regional, national, and state level. New prevalence data also shows that a number of countries have made significant progress toward reducing FGM/C prevalence, including in Burkina Faso (from 75% to 56%), Liberia (from 44% to 32%), and Kenya (from 21% to 15%), amongst others.

The UN General Assembly adopted the Pact of the Future in 2024 and explicitly encouraged member states to "*Address the challenges faced by all young women and girls, including by combating gender stereotypes and negative social norms and eliminating discrimination, harassment, all forms of violence against young women and girls, including sexual and gender-based violence,* ***and harmful practices, including female genital mutilation and child, early and forced marriage.***"

International human rights mechanisms, including UN Treaty Body expert committees and the Universal Periodic Review mechanism of the Human Rights Council, have issued an increased number of recommendations on FGM/C to various governments, including, crucially, to countries that have never before received recommendations on this issue. Since 2020, for the first time ever, the following countries received recommendations from international human rights mechanisms on ending FGM/C: India, Jordan, Kuwait, Singapore, Sri Lanka, The Russian Federation, The United Arab Emirates, and the United States of America (U.S.). The past ten years have also seen an uptick in recommendations to countries where FGM/C is largely practiced by diaspora communities, including in Europe and North America, with treaty bodies recommending that these governments invest in developing national action plans and increasing resourcing towards ending FGM/C domestically. International human rights mechanisms have also been leveraged to call for further research on the practice of FGM/C in countries where there is insufficient data, such as a recommendation to Panama to investigate the possible existence of FGM/C amongst indigenous communities in areas bordering Colombia.

In Portugal, the United Kingdom, and The Gambia, the first-ever successful prosecutions took place for either conspiring, performing, or transporting a girl for FGM/C. There has also been a push globally for the adoption of more holistic laws on FGM/C that also address prevention and response measures. For instance, in the U.S., the *STOP FGM Act 2020* requires an annual report by the Department of Justice on data and efforts to end FGM/C. At the state level, the State of Washington passed a state-level law that prohibits FGM/C and 'vacation-cutting' but also made provisions for education, prevention, and outreach. In Colombia, a bill to address FGM/C introduced in 2024 and pending before Congress focuses mainly on awareness-raising and prevention efforts. In the European Union, the newly adopted directive on combating violence against women and domestic violence criminalizes FGM/C as a form of gender-based violence, ensuring uniform punishment across the Union while establishing minimum rights for survivors, including access to specialist support services, the obligation for member states to implement preventive measures and professional training.

These successes are no doubt positive steps towards eradicating FGM/C, facilitated and made possible through consistent and determined grassroots and international advocacy of survivors, people at risk, community members, human rights advocates, faith-based leaders, and civil society.

CHALLENGES AND THE ANTI-RIGHTS BACKLASH

However, despite progress, most of the recommendations of the *2020 Global Report* remain relevant today as they have not been fully implemented. The latest data from UNICEF also shows that in many countries, despite significant efforts, the prevalence rate of FGM/C has remained stagnant. **The pace at which FGM/C is declining is not even matching the rate of population growth, and the pace will need to be 27 times faster to meet the Sustainable Development Goal (SDG) target of eradicating FGM/C from the lives of women and girls by 2030.** In fact, the number of girls expected to be subjected to FGM/C annually in 2030 is expected to be 4.6 million, as compared to 4.4 million in 2024 and 4.1 million in 2019. Despite having critical data crucial for developing strategies and opposing harmful norms, the global pandemic, increasing humanitarian and environmental crises, lack of political will, low levels of funding, and low education and awareness have impeded efforts to eradicate FGM/C.

An example of the egregious gaps in adequate response to the practice is the deaths due to FGM/C that continue to be reported, including the death of three girls in Sierra Leone in January 2024 due to bleeding related to FGM/C and the death of a woman in Kenya in November 2024. Sierra Leone and Kenya are not alone, with a 2023 study by researchers from the University of Birmingham estimating that there were over 44,000 additional deaths due to FGM/C every year across 28 countries in Africa, making it one of the leading causes of death for girls and young women in these countries.

At the same time, women and girls are also facing a pushback on hard-won rights and legal protections from FGM/C. The Gambia, which adopted a law prohibiting FGM/C in 2015 - *the Women's Amendment Act, 2015* - came dangerously close to becoming the first country that would repeal an anti-FGM law in 2024 when select Members of Parliament initiated public discussions and introduced a bill proposing to repeal the *Women's Amendment Act, 2015*. The motion to repeal the law against FGM/C was defeated in the National Assembly through a vote in March 2024. The pushback was unsuccessful only due to the resistance from a strong feminist and CSO movement developed over time in the country and the collective efforts of the women's and girls' rights groups, media, and international actors, both in The Gambia and globally. After the proposed repeal bill failed, the constitutionality of the *Women's Amendment Act, 2015* was immediately challenged before the Gambian Supreme Court, where the petition remains pending, mirroring a similar unsuccessful challenge in Kenya which was dismissed by the High Court in 2021. Another example of such pushback is the issuance of a fatwa by the Ethiopian Islamic Affairs Supreme Council in 2024, supporting medicalized FGM/C.

There is also a significant gap in funding required to end FGM/C. According to a report by UNFPA, an investment of USD 3.3 billion is required to end FGM/C by 2030 in 31 priority countries (not even including the 63 other countries where FGM/C is known to take place). Yet, only USD 275 million is currently available for development assistance to end FGM/C. This huge shortfall was recognized by over 200 organizations and activists who signed on to the 2023 Kigali Declaration to Close the Funding Gap and Unite for Action to end FGM/C to highlight the urgent resourcing need for the end FGM/C sector. Among key areas, the Declaration

highlights that the funding to grassroots organizations remains patchy, short-term, hard to access, and unsustainable.

Additionally, to meaningfully address FGM/C, we must take an intersectional and human-rights-based approach. It is well established that FGM/C is a form of patriarchy, which, compounded with other forms of discrimination and systemic inequality, can have devastating and life-long impacts on women and girls. FGM/C-affected communities and survivors are diverse, including people from different socio-economic backgrounds, nationalities, ethnicities, and cultures. These lived experiences, identities, and local realities should be taken into consideration when developing strategies, laws, and programs against FGM/C. Combatting FGM/C as a form of gender-based violence, laws, and policies must also address systemic and deep-rooted racism, Islamophobia, sexism, homophobia, religious persecution, and lack of meaningful access to healthcare and critical social programs, which are all inter-related and are a part of ensuring access to an indivisible set of fundamental human rights. In practice, however, there is still a lack of a truly intersectional approach to addressing FGM/C in many parts of the world. In many countries, FGM/C is treated as a practice that is only present as a religious norm or is exclusive to the diaspora communities, deepening the stigma and myths attached to the practice. As a result, the laws and policies too specifically target immigrant or specific religious communities, leading to further marginalization of the communities.

A SURVIVOR'S JOURNEY TOWARD HEALING AND ADVOCACY

RENEE'S STORY

My name is Dr. A. Renee Bergstrom. I am 80 years old, a mother of three, grandmother of ten, and great-grandmother of one. I grew up in South Dakota, United States, surrounded by the plains and a tight-knit family of five children. My brother was just thirteen months older than me, and I had twin sisters who were 18 months younger. My parents had another daughter ten years later. We were a busy household, and life was not without its challenges.

My husband and I have lived in Minnesota for over 60 years, and we currently live in Lanesboro, a small town in Southeast Minnesota. It's a beautiful place, known for its art and theater scene, and it suits my passions well. I'm an artist, a photographer, a weaver, and a watercolor painter, and I find peace in creative expression. My life is rich with friends, reading, and discussions. I've retired from my career as a patient educator at the Mayo Clinic, but I remain active in advocacy and education, especially on a deeply personal issue that shaped my life: female genital mutilation (FGM).

"When I was three years old, a doctor cut my body. My mother had taken me to the clinic after noticing I was touching my genital area while playing. Concerned, she sought advice from a doctor who was a member of the Seventh-day Adventist church. At the time, their teachings were strict about masturbation, viewing it as sinful. The doctor told my mother, "I can fix that," and performed what I now know was FGM, removing my outer clitoris.

I remember the pain. I remember lying on the table, seeing my mother at the foot of it, and feeling betrayed. When we got home, she told me, "Never talk about this." From that moment, I carried a secret that wasn't mine to bear, protecting her from shame.

The physical consequences were immediate and lasting. Some sensitive tissue fused with my inner labia, causing a constant tugging sensation that I endured for decades. At 15, I drove myself to the family clinic, not realizing it was the same place where I'd been cut. I told the doctor, "Some stupid doctor cut me, and now I have this problem. Can you fix it?" Instead of helping me, he handed me a brochure on the "sin of self-pleasuring."

The emotional toll was just as profound. In my late teens, as I grieved the loss of my brother, I also began to grieve for the loss of my body. When I gave birth years later, the scar tissue didn't stretch, causing significant complications. The medical team didn't inform me of what was happening; they anesthetized me and performed an extensive episiotomy. Recovery was painful, and intercourse afterward was excruciating. A doctor told me, "You don't look like other women," and explained how the cutting had altered my anatomy. I lived with discomfort until menopause when the scar tissue finally began to separate.

For years, I didn't share my story, not with friends, not with my siblings, and not even with my children. The silence was isolating. When I became a mother, I couldn't talk about my birth experiences as other women did. It wasn't until my thirties, after moving to a new town, that I found the strength to confront what had happened. Looking out my window one morning, I saw a nearby church and broke down in tears. The realization that a religious institution had played a role in my cutting overwhelmed me. I spoke to my pastor, who referred me to a social worker. That was the beginning of my healing.

Speaking out wasn't easy, but it was necessary. I began sharing my story publicly, first with organizations in Geneva working to end FGM. Over time, I connected with other survivors from diverse backgrounds, and we formed a unique bond. Despite our differences, we all understood the shame and stigma forced upon us.

One of the most challenging parts of my advocacy has been the impact on my family. When I finally told my children about my experience, my daughter, who was very close to my mother, struggled to reconcile the truth. My grandchildren learned about my story through an article published in *The Guardian*. While the timing was unexpected, I was relieved that the conversation had started. I've been fortunate to receive overwhelming support from my family and friends, but I understand why others might stay silent.

FGM is shrouded in secrecy, often perpetuated by shame. I know that in the small North Dakota community where I was cut, other girls must have experienced the same, yet I've never connected with them. Silence is powerful; it isolates us and protects the systems that harm us. Breaking that silence takes courage but is the only way to create change.

"BREAKING THAT SILENCE TAKES COURAGE BUT IS THE ONLY WAY TO CREATE CHANGE."

Today, I work to raise awareness and support survivors. I've collaborated with a Somali woman to create brochures for infibulated women, helping them plan labor and delivery to avoid unnecessary cesarean sections. I speak to medical students annually, emphasizing the importance of cultural sensitivity and trust-building with patients who've experienced trauma. I also write op-eds and participate in programs like the *Public Voices Fellowship on Advancing the Rights of Women and Girls.*

Education is key to ending FGM. Healthcare providers must be trained to recognize and support survivors. Communities need to challenge the cultural and religious norms that perpetuate these practices. And we must create spaces where women can share their stories without fear or shame.

Though I'll never know what my life might have been like without FGM, I find purpose in sharing my experience. I want other survivors to know they're not alone and that their voices matter. Together, we can break the silence and ensure no child endures what we have."

INTERNATIONAL AND REGIONAL HUMAN RIGHTS OBLIGATIONS

FGM/C has long been recognized as an extreme and serious form of gender-based violence that can amount to torture. Women and girls have a fundamental right to be protected from FGM/C under the core international and regional human rights treaties as a form of sex- and gender-based discrimination. In addition to the general protections, there is explicit recognition of FGM/C by international human rights mechanisms and UN agencies binding State parties to legal obligations to address FGM/C effectively. Internationally, the UN has continued to advocate for the implementation of international legal obligations, including urging member states to take concrete measures to fully realize Sustainable Development Goal 5.3, which explicitly states that achieving gender equality will require an end to FGM/C.

ACHIEVING GENDER EQUALITY WILL REQUIRE AN END TO FGM/C

These international laws have helped set the standards of human rights that are essential to protect, promote, and fulfill the cultural, social, political, civil, and economic rights of everyone - all of which are deeply impacted by the harmful practice of FGM/C. Developments in recent years have also strengthened and clarified the framework for regional human rights obligations toward ending FGM/C, such as the launch of the Joint General Comment on Female Genital Mutilation by the African Commission on Human and Peoples' Rights and the African Committee of Experts on the Rights and Welfare of the Child in 2023; and the adoption of the EU Directive to Combat Violence against Women in 2024 which requires all member states of the European Union to criminalize FGM/C.

The year 2025 marks the 30th year since the landmark Beijing Declaration and Platform for Action (Beijing Platform) was adopted in 1995 at the UN Fourth World Conference on Women.

The Beijing Platform continues to be a significant document that provides a roadmap for progress with regard to women's and girls' human rights. FGM/C was addressed in the Beijing Platform explicitly and within the framework of ending gender-based violence as a part of the 12 areas of concern, particularly, as a part of women and health, violence against women, human rights of women, and the girl child. Countries have committed to ending FGM/C globally - acknowledging its unique nature, deep patriarchal roots, social norms, related myths and taboos, its different forms and methods, and the monumental yet necessary action needed at the highest levels.

We hope that this report will be utilized to guide efforts to end FGM/C at every level, by governments or to hold governments accountable, and to protect women and girls from violations against their fundamental and most basic human rights of living free from violence and harm.

In 2025, FGM/C remains a global practice occurring beyond borders and it continues to require a united global response.

METHODOLOGY

This updated report is intended to serve as a reference and advocacy tool in the fight to end FGM/C globally. Though an effort was made to include as much information as possible relating to both available data on FGM/C and national legal frameworks against FGM/C, this report does not purport to constitute a comprehensive or exhaustive authority on this issue. This report is based on publicly available information online, updated up to December 2024.

DATA

The data sources used in this report were collected using different research criteria based on the information already included in the 2020 Global Report, with research covering any new data published after January 2020 or changes in laws since then.

1 **Countries with available data on FGM/C from nationally representative surveys:** For this category, the data is largely derived from the UNICEF Global Database on Female Genital Mutilation, 2024. Also, searches were performed on the websites of the Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Surveys (MICS), and the International Household Survey Network (IHSN) to cover the most recent surveys as well as surveys that may not have been included in the UNICEF global database.

2 **Countries with available data on FGM/C from indirect estimates**: This category includes published articles with national and regional indirect prevalence estimates of FGM/C in countries where there is a significant population of women and girls originating from countries where FGM/C is known to be common. This includes countries where FGM/C is largely known to be practiced by diaspora communities, for example, countries such as the U.S., Canada, many European countries, Australia, and New Zealand (although in some countries like the U.S., recent anecdotal evidence shows that the practice of FGM/C may be more widespread, with incidences reported from members of white Christian communities for example, as highlighted in Renee's Story in page 16). Only studies published between 2000 - 2024 were included.

3 **Countries with available data on FGM/C from small-scale studies:** Published reports and studies that document the existence of FGM/C by direct interviews with survivors, cutters, or members of the community where FGM/C is taking place were included. Studies were only included in this category if they either (i) had a minimum sample size of at least 25 survivors from the country concerned **or** (ii) were qualitative studies documenting the existence of FGM/C within a community or country published in peer-reviewed journals. Only countries that have reports of FGM/C taking place between 2000 and 2024 have been included.

4 **Countries with available data on FGM/C from media reports and anecdotal evidence**: An effort was made to be as inclusive as possible. Data available from published media reports, as well as reports of UN agencies, concluding observations of and submissions made to UN human rights bodies and reports of human rights or international organizations that mention the existence of FGM/C within a country without specifically referring to the underlying primary data, have been included in this category. Small-scale studies and surveys that do not meet the criteria for Category 3 were also included in this category. Only countries that have reports of FGM/C taking place between 2000 and 2024 have been included.

The data for the second, third, and fourth categories was collected from numerous sources. This included existing databases, sources, and reports on FGM/C, including the websites of Orchid Project (and the FGM/C Research Initiative) and Stop FGM Middle East, End FGM European Network's online interactive map on data, laws and policies, and the article titled 'The practice of female genital mutilation across the world: Data availability and approaches to measurement' by Cappa, Van Baelan and Leye published in Global Public Health in February 2019. Further, general internet searches in non-academic search engines using the search terms female genital mutilation (FGM), female genital cutting (FGC), and female circumcision/female genital circumcision, combined with potential countries, were used to track down additional studies. Data was also identified in some countries through individual communications and snowball attempts to connect with activists and organizations working on FGM/C in-country. Through these conversations, an attempt was made to verify and supplement the data sources wherever possible.

LAWS ON FGM/C

The data included on laws to end FGM/C relies partially on the Laws and FGM/C resource of the FGM/C Research Initiative and was also largely derived from the World Bank's 'Compendium of International and National Frameworks on Female Genital Mutilation' (Eighth Edition, 2024). Similar to the World Bank Compendium, this report only includes references to national laws of countries where there is evidence of FGM/C being practiced.

It is pertinent to note that the World Bank's Compendium includes all countries with a specific law/legal provision relating to FGM/C, as well as those where FGM/C can potentially be prosecuted under general criminal provisions. However, this report only highlights countries with either a specific law against FGM/C or a specific provision relating to FGM/C in any of its laws. The conscious decision to exclude countries with general criminal provisions that can be used to prosecute FGM/C offenses (such as those that prohibit violence, acts against bodily integrity, assault, harm, and the like) from the scope of this report was taken for the following reasons:

First, specific laws or legal provisions against FGM/C often operate as a declaration of political will and demonstrate government commitment towards ending FGM/C. They lay down a norm that FGM/C is a harmful practice that violates human rights, sending a strong message that the practice is socially and legally unacceptable in the country. Having a specific provision addressing FGM/C as an official acknowledgment of the issue is arguably the first step in putting in place comprehensive policies and the provision of adequate services at a national level to tackle this harmful practice.

Second, having FGM/C openly labeled as a criminal offense can act as a deterrent to the practice and can be used as an educational and awareness-raising tool to sensitize affected communities and contribute to behavioral change.

Third, specific laws against FGM/C may help introduce positive state measures, such as social programs and specific FGM/C-related funding sources for prevention, education, and community outreach that are rooted in the law. The specific measures embedded in the law help ensure measures are being taken to address FGM/C in the country.

In the absence of a clear legal framework criminalizing FGM/C, the lack of political will, social pressure to maintain its practice of FGM/C, low levels of awareness relating to the practice and its harms, and myriad other reasons results in little or no likelihood of FGM/C being tackled under general criminal provisions unless there is a specific government policy or directive requiring law enforcement officials to undertake such prosecutions (e.g., in the case of France).

OTHER FORMS OF GENITAL MUTILATION

A comprehensive approach towards addressing FGM/C requires using an intersectional approach that addresses all forms of genital mutilation. There is a growing recognition globally that FGM/C has existed in similar or additional forms and manners, such as labia pulling and the 'husband stitch' in various regions of the world. It is important to address FGM/C in all its forms to tackle the root causes behind the harm they cause in all parts of our globalized world. It is also important to highlight other similar practices that are still not recognized as forms of mutilation, such as intersex genital mutilation (IGM) or vaginoplasty. Often, these practices take place in what is known as the Western world despite being interventions performed for non-medical reasons to comply with gendered social norms and leading to complications that are not addressed as FGM/C is.

Intersex genital mutilation

Intersex genital mutilation (IGM) is a medical (surgical or hormonal) intervention performed on children without their expressed wish and fully informed consent, not for health reasons but to align their sex characteristics with cultural expectations of what a woman or man's body should look like. These 'sex-normalising' procedures perpetuate harmful gender norms, implying that to be socially acceptable, one's body needs to fit into specific norms.

People who have undergone IGM have faced multiple health consequences, including but not only trauma and physical pain, similar to those who have undergone FGM. The two practices share other commonalities: both are considered child rights violations by the UN Child Rights Committee, but both are still perpetuated across the world and are present on all continents.
For more information on the impact of IGM on the lives of survivors, please read Adeline's story on page 39.

Husband Stitch

The husband stitch is the term given for the medical practice of placing an extra stitch during vaginal repair after childbirth, with the purpose of tightening the vaginal opening to increase sexual pleasure for a male partner. It is often done without the consent of the woman involved. Recent research has found that the husband stitch has been documented by various women, including in the United States, Europe, and Japan, with survivors experiencing health complications and comparing the practice to FGM/C.

In 2024, more than 60 women in California filed a civil lawsuit alleging Dr. Barry Brock and the hospital where he worked had subjected them to various forms of sexual abuse and gender-based violence, including FGM/C in the form of the husband stitch. A further 107 women filed an additional suit in early 2025. References to the husband stitch often occur in speculation, denoting the practice as a myth. Lending to this, there have been no scientific studies conducted to date to show how many people have been affected, nor is there a clear method for evaluating its prevalence. This lawsuit is the first time the husband stitch has been explicitly identified and challenged as a form of gender-based violence and FGM/C in a U.S. court.

INDONESIA

A JOURNEY OF RESILIENCE, ADVOCACY, AND INTERSECTIONALITY

"BY FRAMING FGM/C AS A GLOBAL ISSUE, WE CAN CHALLENGE THE SYSTEMS THAT ALLOW IT TO PERSIST."

DENA'S STORY

"My name is Dena. I'm 27 years old, an Indonesian Muslim writer, poet, and playwright born and raised in Queens, New York. My work explores the histories of migration, queerness, anticipated grief, and the archives of Indonesian communities in the U.S. My writing often serves as both an expression of identity and a means of advocacy. It is through this lens that I have chosen to publicly share my experience as a survivor of female genital cutting (FGC).

I was nine years old when I underwent FGC during a family visit to Indonesia. This was my first trip to the country, a significant moment connecting with my heritage and relatives. Yet, this journey also marked a profound and painful event in my life.

I didn't know what was happening when my aunt took me to a different area far from my grandmother's house. The trip felt unusually long, and I remember feeling a growing heaviness in my chest. When we arrived, I was taken into a back room that looked clinical. There was a metal table and medical supplies, but it wasn't a hospital. My aunt pushed me onto the table, held me down, and instructed me to keep my legs open. I was scared, confused, and crying but felt compelled to obey.

The woman performing the procedure used a scalpel. I vividly remember the coldness of the blade and the sharp sensation of being cut. The pain was immediate and overwhelming, and the feeling of gauze being pressed into the wound was agonizing. When it was over, I couldn't walk properly for days. My aunt's reassurances did little to ease the physical or emotional trauma I was experiencing.

At the time, I didn't fully understand what had happened to me. My family explained it as "*Sunat Perempuan*," a cultural practice rooted in the belief that cutting a girl's genitalia reduces her sexual desires and ensures her purity. For my aunt, this was a preventative measure to protect me from premarital sex, abuse, or being perceived as promiscuous, issues she believed were especially prevalent in the United States where I was being raised. It was not until years later that I realized the full extent of what I had undergone and its implications.

The long-term impact of FGC has been multifaceted: physical, emotional, and social. Physically, I experienced discomfort and challenges in navigating intimacy and body awareness. Emotionally, the procedure instilled a complex relationship with my identity as a non-binary person and a survivor. I grappled with feelings of shame, confusion, and distrust of my own body, particularly during my teenage years and early adulthood.

My journey toward healing and advocacy began with writing. Sharing my story publicly was both cathartic and terrifying. It gave me a platform to connect with other survivors and shed light on a practice often hidden in silence and stigma. Yet, being open about my experience has also come with challenges. As a writer, I've had to navigate the lack of agency often afforded to survivors in how their stories are told and shared. I've seen my work misquoted, reframed, and used without consent in ways that perpetuate Islamophobia or pity-driven narratives.

Despite these difficulties, I continue to speak out because I believe in the power of survivor-centered storytelling. I advocate for approaches that respect intersectionality, acknowledging how socioeconomic disparities, racial prejudice, and systemic gender-based violence intersect with FGC. Survivors face barriers to accessing healthcare, mental health resources, and safe housing, and these factors must be addressed as part of the larger conversation.

In my advocacy, I emphasize the importance of shifting the narrative around FGC. This practice is not an isolated cultural issue; it is part of a broader web of gender-based violence and patriarchal control. By framing FGC as a global issue, we can challenge the systems that allow it to persist while ensuring that efforts to end it do not vilify the communities where it occurs.

Education, survivor agency, and intersectional approaches are key to addressing FGC. We need survivor-led initiatives that inform policy without increasing surveillance of marginalized communities. We must also provide healthcare professionals with trauma-informed training to ensure survivors receive compassionate and culturally responsive care.

Today, I remain committed to raising awareness and supporting survivors. Through my writing and advocacy, I hope to create a world where survivors are heard, their stories are honored, and no child has to endure the pain I did. My journey is far from over, but every step forward is a step toward justice and healing for myself, my community, and the generations to come."

THE GLOBAL PICTURE OF FGM/C

THE DATA

We are aware of at least 94 countries across the globe where there is currently available evidence of women and girls living with FGM/C or who are at risk of having FGM/C performed on them.

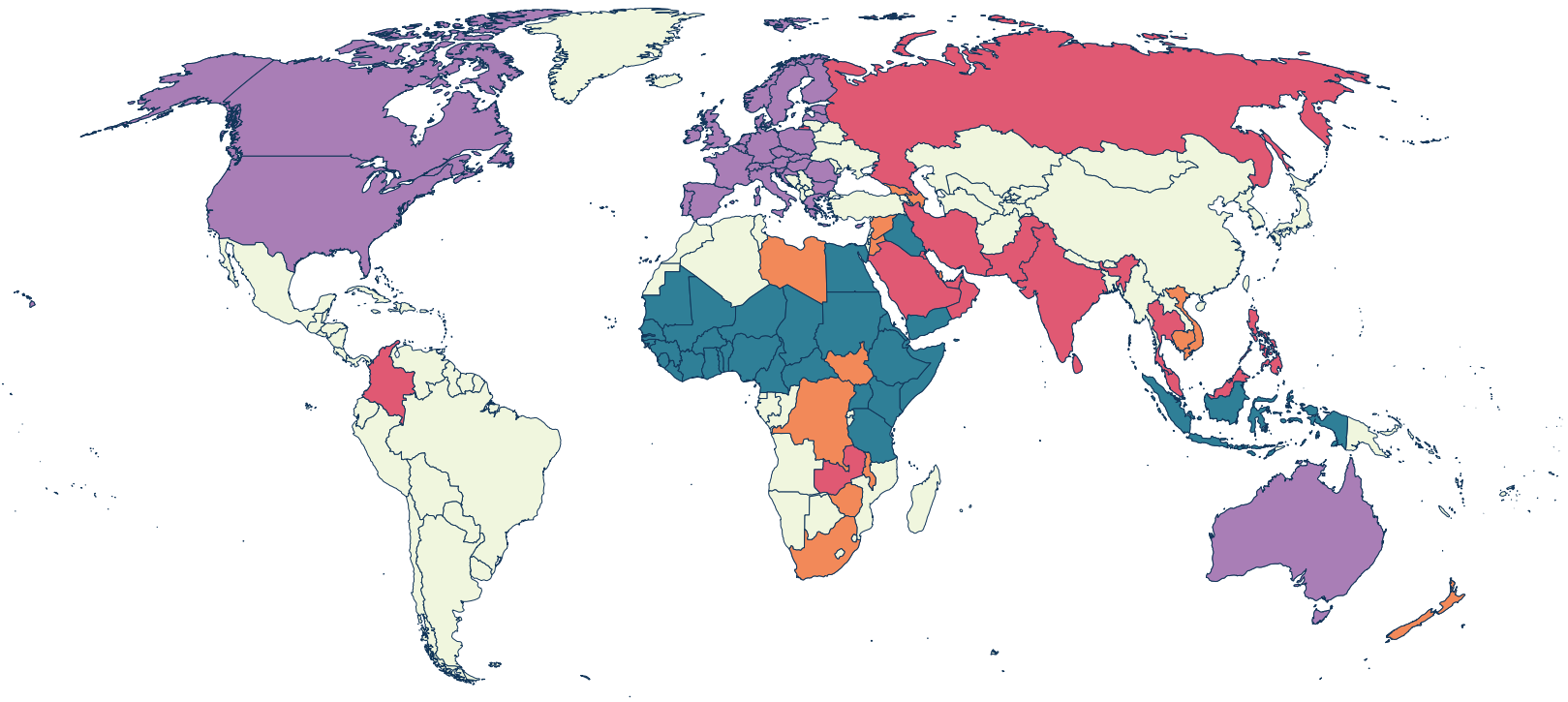
Of these, only **31 countries** have nationally representative prevalence data on FGM/C, most of which are concentrated in the African continent but also include Iraq, Yemen, Indonesia, and the Maldives.

In an additional **32 countries**, including a number of European countries, Canada, the United States, and Australia, FGM/C is largely known to be practiced by diaspora communities living in these countries. In some countries like the U.S., recent anecdotal evidence suggests that the practice of FGM/C may be more widespread, with incidences reported from members of white Christian communities, for example. These countries have available data indirectly estimating the prevalence of FGM/C based on the number of women and girls living within the country who originated from a country where FGM/C is known to be practiced, multiplied by the FGM/C prevalence rate in the country of origin.

Activists and researchers in **15 other countries** have conducted small-scale primary research studies that document the existence of FGM/C within a country or community through direct interviews with survivors, community members, cutters, and religious leaders. Most of these studies have a small sample size, although the largest study surveyed 4,800 respondents. Some of these studies have indicated a likely prevalence of FGM/C within the sample surveyed, which often covers only a particular region or community within a country.

In an additional **16 countries**, media reports, UN documents, government reports, and reports of civil society organizations have made references that point to or establish the practice of FGM/C within the country. However, no further information on prevalence or data from research studies is available for these countries.

MAP & KEY DATA



Countries with nationally representative surveys on FGM/C

Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Indonesia, Iraq, Kenya, Liberia, The Maldives, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, Yemen

Countries with indirect estimates on FGM/C

Australia, Austria, Belgium, Bulgaria, Canada, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, Switzerland, United Kingdom, United States of America

Countries with small-scale studies on FGM/C

Colombia, India, Iran, Kuwait, Malaysia, Oman, Pakistan, Philippines, Russia, Saudi Arabia, Singapore, Sri Lanka, Thailand, United Arab Emirates, Zambia

Countries where media reports and anecdotal evidence refer to occurrence of FGM/C

Azerbaijan, Bahrain, Brunei Darussalam, Cambodia, Democratic Republic of Congo, Georgia, Jordan, Libya, Malawi, New Zealand, Qatar, South Africa, South Sudan, Syria, Vietnam, Zimbabwe.

LAWS AGAINST FGM/C

Since 2020, there has been progress with new legislations being introduced in various countries that specifically prohibit FGM/C at different jurisdictional levels. For instance, since 2020, Sudan, Indonesia, Finland, Poland, and the United States have all passed federal laws or amended existing criminal laws to prohibit FGM/C explicitly. Additionally, in 2024, Galmudug became the first state in Somalia to pass a specific law against FGM/C. The U.S., which outlawed FGM/C in 1996, passed the *Stop FGM Act of 2020*, followed by seven additional states/districts outlawing FGM/C since then, increasing the total number of states that have criminalized FGM to 41 out of the 50 U.S. states, as well as the District of Columbia (Washington D.C.) which passed a law prohibiting FGM/C at the end of 2024 and is expected to be signed into law in early 2025. France, too, strengthened its laws in 2021 to require education and awareness-raising of students and communities on FGM/C.

The developments in the last five years have brought the number of countries with specific national laws against FGM/C to 59 out of the 94 countries (62%), where FGM/C is known to be practiced across all data categories. These include either specific anti-FGM/C laws or laws that prohibit FGM/C under a criminal provision in other domestic laws such as the criminal or penal code, child protection laws, violence against women laws, or domestic violence laws.

Laws against FGM/C remain most common in Africa, with at least 50% of total laws globally coming from the 28 countries that have enacted specific laws or specific legal provisions against FGM/C.

Apart from the African continent, 44% of total laws against FGM/C are of countries where FGM/C is most commonly practiced by diaspora communities, with 21 European countries, the U.S., Canada, Australia, and New Zealand all having specific laws or legal provisions relating to FGM/C. Georgia has also passed a law against FGM/C.[3]

In contrast, in the Middle East, only Iraq (Kurdistan), Iran, and Oman have specific laws or legal provisions banning FGM/C.[4] In Asia, only Indonesia has enacted a specific legal prohibition against FGM/C.[5] There are also no specific laws or legal provisions against FGM/C in Latin America, though bills to address FGM/C are currently pending before the Colombian Congress.

The information presented in this report indicates that 81% of countries with data on FGM/C from nationally representative surveys have specifically prohibited FGM/C under their laws (refer to table, graph, or both).

3 In Georgia, FGM/C is commonly practised by non-diaspora communities.

4 Laws in Egypt and Sudan also specifically prohibits FGM/C. However, Egypt and Sudan have been included as part of Africa as opposed to the Middle East for the purposes of this report.

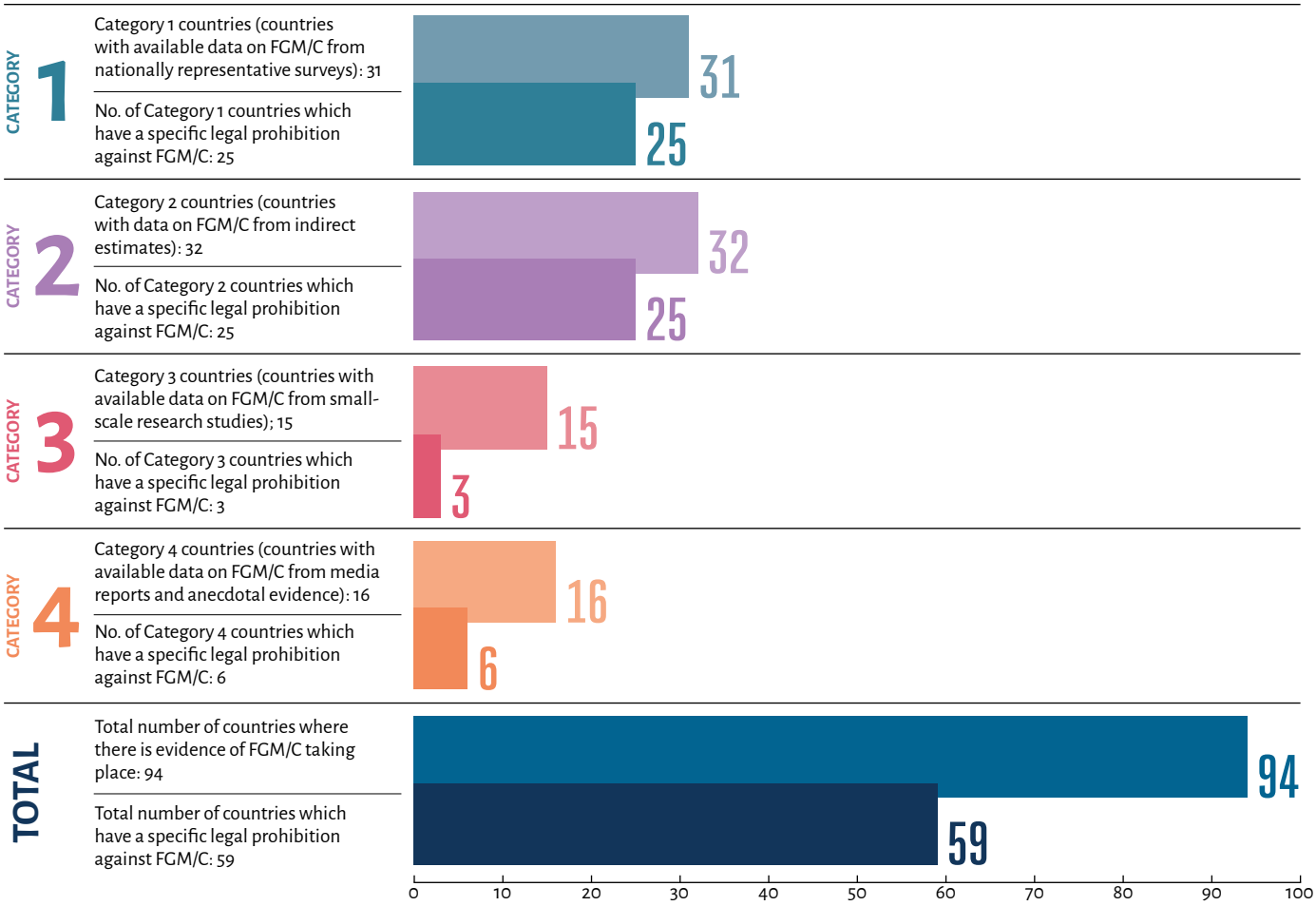
5 Cyprus and Georgia have passed specific prohibitions against FGM/C. Though Cyprus and Georgia are sometimes considered part of Asia, they are included within the European continent for the purposes of this report as Cyprus is a member of the EU and Georgia is a State Party to the Council.

On the other hand, 78% of countries with data on FGM/C from indirect estimates have specifically addressed FGM/C in their laws. However, it is relevant to note here that a handful of countries in Europe, whilst not having specific criminal prohibitions against FGM/C, do include FGM/C under general criminal provisions that prohibit violence, acts against bodily integrity, assault, harm, and the like.

Among countries with available data on FGM/C from small-scale research studies, three have specific legal provisions against FGM/C, bringing this category to a 20% adoption level.

In contrast, 38% of countries with available data on FGM/C from media reports and anecdotal evidence have passed laws against FGM/C. Of the six countries that have passed laws, four are African countries (where there is generally greater awareness about FGM/C), and one is a country with significant diaspora communities (New Zealand).

While the availability of data provides tools for civil society organizations, survivors, and people at risk to advocate to their governments for specific and robust laws, further research beyond this report is still needed to understand the relationship between the availability of clear data on FGM/C within a country and the adoption of FGM/C laws, along with the impact of other various contextual factors (i.e., geographic location, measures of awareness) on this relationship, if any.



JOURNEY TOWARD ENDING FGM/C FROM SOMALIA TO THE NETHERLANDS

SOMALIA AND THE NETHERLANDS

ISTAHIL ABDULAHI'S STORY

"I was born and raised in Mogadishu, Somalia, in a large family with one brother and 5 sisters. We grew up with strong family ties, but war tore us apart. When I was nearly 20, I left Somalia to play basketball nationally thinking I will come back 14 days later but I never came back.. When the war erupted, I ended up as a refugee, traveling through Kenya, and eventually found myself alone in the Netherlands. That's been my life, a journey of survival, adaptation, and resilience.

In the Netherlands, I started a new life. I met my husband in a refugee camp, and against all odds, we fell in love. We married and had three children; one son and two daughters they are young adults now. When I had my first child, no one in the medical system understood my experience. I went through my pregnancies without any doctor acknowledging the scars of FGM or asking me about my past. It was as if my story, my trauma, didn't exist. Here I was, thinking every woman in the world had gone through it, until I spoke to my husband, a Dutchman. I realized FGM was not universal. I asked him if his mother and his sisters had been cut. He looked at me with confusion, and only then did I begin to understand the extent of my isolation.

When I was six, I was taken to a small village far from Mogadishu. My mother didn't tell us what would happen. She gave us candies and nice dresses, and we traveled, happy and innocent. When we arrived, they separated me from my sister. My mother led me into a room where a woman was sitting, holding a razor blade. No one said anything. They didn't explain; they didn't warn me. Suddenly, I was on the ground. They held my hands and legs, and then I felt the pain, the unimaginable pain. I screamed and cried, but they stuffed my mouth with cloth, and then they stitched me up. After I was cut, I couldn't urinate because they had sealed everything. When my mother discovered this, she brought someone who heated a metal object and used it to reopen my stitches so I could urinate.

I didn't understand what had happened to me. Back in Mogadishu, there was a celebration. People were happy, but inside, I was broken. For years, we didn't talk about it. It was a hidden pain, a silent trauma that lived inside me. Even as I grew older, I still didn't know why it had been done or even what exactly had happened to me. When I finally found the courage to speak out in 2019, it was like a weight had lifted. I had carried this silence for too long. I forgave the people who did this to me but couldn't let it continue. I began sharing my story in Dutch and Somalia, and I was determined to break the taboo and make people understand. I am not afraid anymore. Storytelling changes the world, and if my story can bring awareness, it has served a purpose.

FGM is deeply rooted in cultural and religious beliefs. Growing up, I was told it was necessary, that it was a part of being a Muslim woman. But I've since learned that's not true. Religion was used to justify this harmful practice, to manipulate and control. In my community, girls are told they will be unclean and unworthy of marriage if they are not cut. They believe they have no choice. I want to show them there is another way.

"I SPEAK UP BECAUSE I DON'T WANT MY GIRLS AND ANY OTHER GIRL TO GO THROUGH WHAT I WENT THROUGH."

There are times when people in my community challenge me, saying FGM is an old tradition and an essential part of our culture. But I don't care what people say. I know my truth, and I know the pain I endured. I speak up because I don't want my girls and any other girl to go through what I went through. I have two daughters and I didn't circumcise them. Today, I advocate for education and awareness. I want healthcare professionals to recognize the signs, ask about them, and address FGM with sensitivity and understanding. Now, things are changing, but we have a long way to go.

I dream of a world where we don't have to talk about FGM because it no longer exists. I know the United Nations aims to end FGM by 2030, but we need the support of men in positions of power, both in Africa and in Europe. Women's voices must be heard, and our stories must be valued. It's a difficult journey, but I believe that by sharing my story and speaking openly, we can challenge the silence and end this practice once and for all."

COUNTRIES WITH AVAILABLE DATA ON FGM/C FROM NATIONALLY REPRESENTATIVE SURVEYS

UNICEF estimates include **31 countries** with nationally representative data on prevalence. These countries are largely concentrated on the African continent plus a few in the Middle East (Yemen and Iraq) and Indonesia. Additionally, the Demographic and Health Surveys for the Maldives in 2016-17 collected information on FGM/C prevalence within the Maldives for the first time.

Nationally representative data on FGM/C is collected through household surveys and is mainly available from two sources:

- the Demographic and Health Surveys (DHS) funded by the United States Agency for International Development (USAID)
- Multiple Indicator Cluster Surveys (MICS) supported by UNICEF

The DHS and MICS have developed FGM/C modules with standardized questions on FGM/C, with results fully aligned and comparable across the two survey programs. In some countries, data is available through other nationally representative household surveys, normally conducted by the national government.

There are some challenges to obtaining these direct estimates, including difficulties in capturing a representative sample of the female population who have undergone FGM/C or those who are at risk of FGM/C, particularly in countries where FGM/C is practiced only by certain communities, as well as the time and costs associated with such surveys (Cappa, Van Baelen & Leye, 2019).

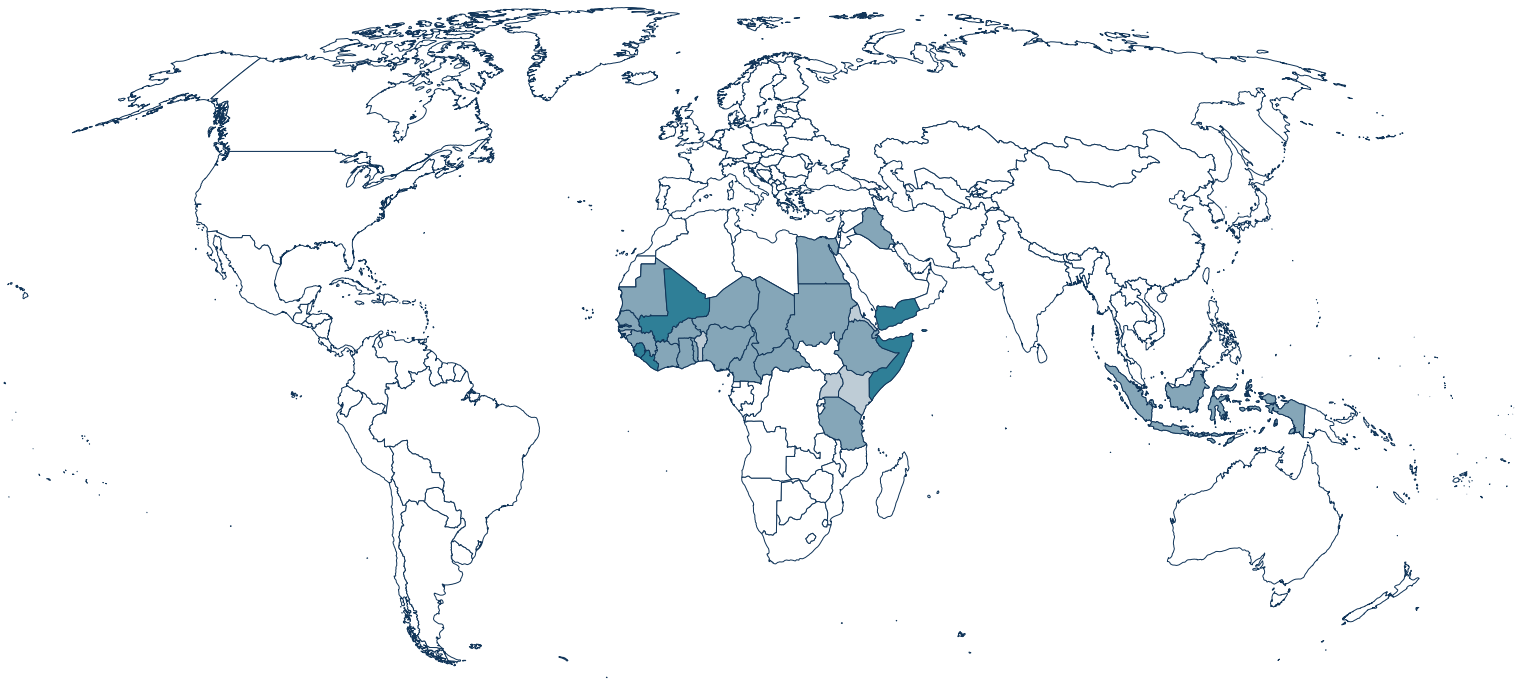
Since the 2020 global report was published, new data reflect that certain countries have made significant progress in reducing FGM/C prevalence, particularly Burkina Faso (from 76% to 56%), Liberia (from 44% to 32%), and Kenya (from 21% to 15%). Meanwhile, prevalence rates in other countries such as Somalia, Mali, Guinea-Bissau, The Gambia, and Senegal have remained stagnant with no progress. Additionally, 14 of the 31 countries have not had updated prevalence data since 2020.

Figure: Percentage of Women and Girls aged 15-49 who have undergone FGM/C in Countries with Data from Nationally Representative Surveys

Figure: Percentage of Women and Girls aged 15-49 who have undergone FGM/C in Countries with Data from Nationally Representative Surveys

Countries	Percentage of women and girls aged 15-49 who have undergone FGM/C
Benin	9.2%*
Burkina Faso	56.1%
Cameroon	1.4%*
Central African Republic	21.6%
Chad	34.1%
Côte d'Ivoire	36.7%*
Djibouti	90.1%
Egypt	87.2%*
Eritrea	83%*
Ethiopia	65.2%*
Gambia	72.6%
Ghana	2.4%
Guinea	94.5%*
Guinea-Bissau	52.1%
Indonesia	51.2%
Iraq	7.4%*
Kenya	15%
Liberia	31.8%
Maldives	12.9%*
Mali	88.6%*
Mauritania	63.9%
Niger	2%*
Nigeria	15.1%
Senegal	25.2%
Sierra Leone	83%
Somalia	99.2%
Sudan	86.6%*
Tanzania	8.2%
Togo	3.1%*
Uganda	0.3%*
Yemen	18.5%*

Source: UNICEF Global Database, 2024. In Indonesia, FGM/C prevalence was only measured among girls aged 0-11.
*No updated data available since 2020 as of December 2024.



LEGAL STATUS OF FGM/C IN COUNTRIES WITH NATIONAL PREVALENCE ESTIMATES:

Countries which have enacted a specific national anti-FGM/C law	Countries where FGM/C is specifically mentioned/ covered within other laws	Countries which do not specifically address FGM/C within their laws
1. Benin	1. Burkina Faso	1. Mali
2. Eritrea	2. Cameroon	2. Liberia
3. Guinea-Bissau	3. Central African Republic	3. Sierra Leone
4. Kenya	4. Chad+	4. Somalia**
5. Uganda	5. Côte D'Ivoire	5. The Maldives
	6. Djibouti	6. Yemen
	7. Egypt	
	8. Ethiopia	
	9. The Gambia	
	10. Ghana	
	11. Guinea	
	12. Indonesia++	
	13. Iraq (Kurdistan)#	
	14. Mauritania	
	15. Niger	
	16. Nigeria	
	17. Senegal	
	18. Sudan*	
	19. Tanzania	
	20. Togo	

**Sudan passed a law in July 2020 amending the Criminal Code to include a specific offense relating to FGM/C.*

***Somalia's Constitution expressly states that the "circumcision of girls is prohibited." However, there is no national legislation that expressly implements this Constitutional provision, and there are no known instances where FGM/C offenses have been prosecuted under general criminal provisions. In 2024, Galmudug state in Somalia passed a specific law against FGM/C.*

+ Though FGM/C was outlawed in Chad by the Reproductive Health Law passed in 2002, the implementation decree required to bring the law into force only became effective in 2020 through the implementation decree No. 2121/PR/2020.

++The Government Regulation No.28/2024 prohibits female circumcisions for infants, toddlers, and preschool children (likely only covering children under the age of 5), though the National Commission of Violence against Women has recommended that the regulation needs to be expanded to cover all women and girls.

 # The criminal provision on FGM/C in Iraq applies only in the Kurdistan region, a semi-autonomous region, which accounts for most cases of FGM/C in the country. FGM/C prevalence in Iraqi Kurdistan is 37.5% amongst women and girls aged 15-49.

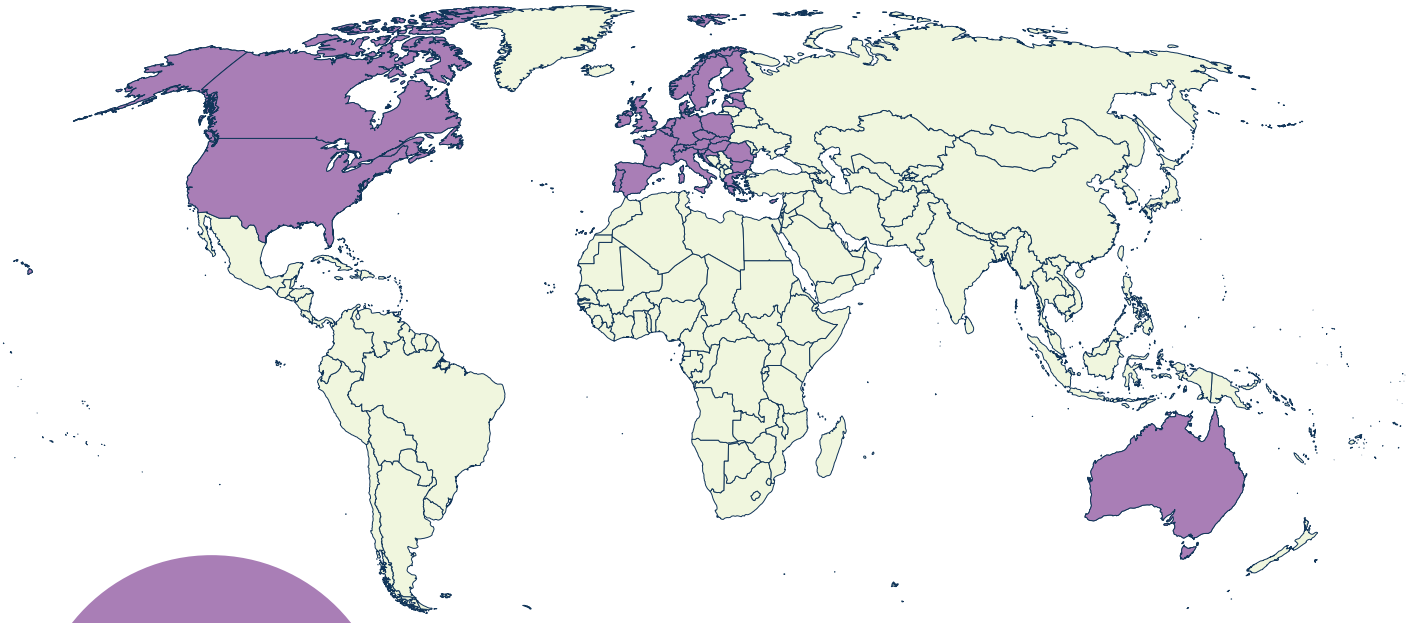
THE IMPORTANCE OF COMPREHENSIVE, ACCURATE AND UPDATED DATA ON FGM/C

As highlighted above, though UNICEF's new global estimates have been updated to present a more comprehensive global picture, nationally representative prevalence data on FGM/C is still only available for 31 countries. National prevalence data is critical because it is often used as a base for other measurements, such as the funding needed globally to end FGM/C by 2030, the calculation of the costs of FGM/C, and even as the base for the indirect estimates in destination countries of migration. However, such datasets based only on countries with national prevalence data present an incomplete picture as they do not take into account all the countries where we know that FGM/C is happening globally.

Therefore, continued research on FGM/C globally is critical in providing comprehensive, accurate, and updated data on the practice, including through primary research studies and other means of data collection. For instance, in the UK, all health professionals treating patients through the National Health Service (NHS) are required to collect data on FGM/C. The NHS data from 2023-2024 surprisingly records small numbers of patients reporting that they were subjected to FGM/C in countries that are not traditionally to have FGM/C occur (and which are not included in this report due to lack of available data), including **Algeria, Turkey, Libya, Afghanistan, Bangladesh, and Papua New Guinea** amongst others. This data shows us that:

First, there could still be pockets of communities practicing FGM/C in various countries for which we have anecdotal evidence but no available data, such as the Kurdish community in Turkey or the Bohra community in Bangladesh.

Second, increasing global migration patterns means that FGM/C is now being performed in every part of an increasingly globalized world (though migration also provides a strong entry point for abandoning the practice). We also need to update our traditional understanding of "destination countries of migration" and conduct more research in the Global South on the practice of FGM/C by diaspora communities originating from other countries. UN Treaty Bodies have already begun to address FGM/C as a more global concern, issuing recommendations to African countries like Congo-Brazaville (CRC, 2024) and Gabon (CRPD, 2015 and CRC, 2016) where FGM/C is not traditionally known to take place, expressing concern about FGM/C being performed amongst migrant communities, as well as of being carried over into the local population through marriage.



COUNTRIES WITH INDIRECT ESTIMATES OF FGM/C PREVALENCE

Many countries where FGM/C is practiced mainly by diaspora communities estimate its prevalence within their population by using indirect methodologies. Such data provides an indirect estimate of women and girls from diaspora communities living in the country who have undergone FGM/C and/or who are at risk of having FGM/C performed on them using an extrapolation method. The prevalence rate of FGM/C in the countries of origin (as found by nationally representative surveys such as DHS and MICS) is multiplied by the total number of girls and women in the country of destination who have come from an FGM/C country of origin and/or were born to a mother who came from an FGM/C country of origin. The number of women from countries of origin where FGM/C is practiced is based on data retrieved from a variety of sources, including a population register, birth register, register of asylum seekers, results from a national census, or a combination of some of these data sources.

The available data from these indirect estimates indicates that:

In Europe, it is estimated that around **600,000 women and girls are living with the consequences of FGM/C and that a further 190,000 girls and women are at risk** of undergoing the harmful practice in 17 European countries alone (Updated Map 2024 End FGM European Network).

There are between **421,000-577,000 women and girls living in the United States** who have either undergone FGM/C or are at risk,

There are an estimated **53,088 survivors of FGM/C living in Australia**.

There are between **95,000 and 161,000 women and girls in Canada** living with the consequences of FGM/C or are at risk of undergoing the practice.

The breakdown of the available data on FGM/C from indirect estimates by country is set out below:

S.No	Country	No. of women and girls who have undergone FGM/C	No. of girls at risk (including high-risk scenarios)*	Source	Legal status
1	**Australia**	53,088	N/A	Australian Institute of Health and Welfare (2019)	Specific criminal provision prohibiting FGM/C.
2	**Austria**	7,036	1083	Van Baelan, Ortensi, Leye (2016); EIGE (2020)	Specific criminal provision prohibiting FGM/C.
3	**Belgium**	23,395	12,064	GAMS (2022)	Specific criminal provision prohibiting FGM/C.
4	**Bulgaria**	31	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C.
5	**Canada**	Between 95,000 - 161,000 women and girls living in Canada have either undergone FGM/C or are at risk.		Statistics Canada (2023)	Specific criminal provision prohibiting FGM/C.
6	**Croatia**	112	N/A	Van Baelan, Ortensi, Leye (2016)	Specific criminal provision prohibiting FGM/C.
7	**Cyprus**	1301	132 (high risk scenario)	Van Baelan, Ortensi, Leye (2016); EIGE (2018)	Specific criminal provision prohibiting FGM/C.
8	**Czech Republic**	312	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C.
9	**Denmark**	7,910	2,568	EIGE (2021)	Specific criminal provision prohibiting FGM/C.
10	**Estonia**	8	N/A	Van Baelan, Ortensi, Leye (2016)	Specific criminal provision prohibiting FGM/C.
11	**Finland**	10,254	3,075	Finland Ministry of Social Affairs and Health (2019)	Specific criminal provision prohibiting FGM/C.

12	**France**	125,000	44,106 (high risk scenario)	Lesclingand et. al. (2019); EIGE (2018)	Specific references to FGM/C under general law,including requiring education on FGM/C and incitement of FGM/C. General criminal provisions have been successfully used to prosecute offenses of FGM/C.
13	**Germany**	103,947	17,721	Terre des Femmes (2022)	Specific criminal provision prohibiting FGM/C.
14	**Greece**	15,249	748 (high risk scenario)	Van Baelan, Ortensi, Leye (2016); EIGE (2018)	Specific criminal provision prohibiting FGM/C.
15	**Hungary**	396	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C
16	**Ireland**	5,790	1,632 (high risk scenario)	Akina Dada wa Africa based on 2016 data collected by Ireland's Central Statistics Office (2017); EIGE (2015)	Specific criminal provision prohibiting FGM/C.
17	**Italy**	87,600	4600 (high risk scenario)	Farina et. al. (2020)	Specific national anti-FGM/C law which prohibits FGM/C.
18	**Latvia**	5	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C.
19	**Luxembourg**	379	136	Van Baelan, Ortensi, Leye (2016); EIGE (2021)	Specific criminal provision prohibiting FGM/C
20	**Malta**	565	279 (high risk scenario)	Van Baelan, Ortensi, Leye (2016); EIGE (2018)	Specific criminal provision prohibiting FGM/C.
21	**Netherlands**	41,000	4,200	Pharos (2019)	No specific law against FGM/C. General criminal provisions have been used to prosecute offenses of FGM/C.
22	**Norway**	17,058	N/A	Van Baelan, Ortensi, Leye (2016)	Specific criminal provision prohibiting FGM/C.

23	**Poland**	207	N/A	Van Baelan, Ortensi, Leye (2016)	Specific criminal provision prohibiting FGM/C.
24	**Portugal**	6,576	1,365 (high risk scenario)	Lisboa et. al. (2015); EIGE (2015)	Specific criminal provision prohibiting FGM/C.
25	**Romania**	79	N/A	Van Baelan, Ortensi, Leye (2016)	FGM/C included within scope of GBV law.
26	**Slovakia**	57	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C.
27	**Slovenia**	69	N/A	Van Baelan, Ortensi, Leye (2016)	No specific law against FGM/C**.**
28	**Spain**	15,907	3,652	Van Baelan, Ortensi, Leye (2016); EIGE (2021)	Specific criminal provision prohibiting FGM/C.
29	**Sweden**	38,939	11,287 (high risk scenario)	Van Baelan, Ortensi, Leye (2016); Socialstyrelsen 2023	Specific national anti-FGM/C law which prohibits FGM/C.
30	**Switzerland**	22,410		Abdulcadir et. al. (2023)	Specific criminal provision prohibiting FGM/C.
31	**United Kingdom**	137,000	67,300	Macfarlane & Dorkenoo (2015) [*new study by University of Birmingham underway*]	Specific national anti-FGM/C law which prohibits FGM/C.
32	**United States of America**	513,000 women and girls who have either undergone FGM/C or are at risk, as per data from the Centers for Disease Control (CDC). A 2023 study found that an estimated 577,000 women and girls were potentially impacted by FGM/C in 2019, though this figure is reduced to 421,000 if the estimate takes into account the impact of migration on the practice.		Goldberg et al. (2016); Callaghan (2023)	Specific national anti-FGM/C law that prohibits FGM/C.

**For those countries where the number of girls at risk is based on a high-risk scenario:* *A high-risk scenario, as defined by the European Institute for Gender Equality (EIGE), is based on the premise that there is no influence of migration whatsoever and that the number of girls (originating from an FGM/C risk country) at risk of FGM/C would be the same as if they had never migrated.*

Note on sources: Some studies only contain indirect estimates of the number of women and girls living in a particular country who have undergone FGM/C, some only estimate the number of girls at risk of undergoing FGM/C, and some studies have both indirect estimates of women and girls who have undergone FGM/C and the number of girls at risk of undergoing FGM/C. For this reason, some countries in the above table have two sources listed while others have only one.

CHALLENGES OF COLLECTING DATA THROUGH INDIRECT ESTIMATES

The lack of adequate funding for developing these indirect estimates of FGM/C, non-systematic data collection, and lack of harmonization result in wide differences in methodology and delivery in the studies conducted in various countries.

There are several challenges affecting the reliability of indirect estimates:

First, there is a lack of disaggregated data (including on the basis of sex, community, ethnicity, and religion) on diaspora communities. Hence, for example, the indirect estimates would not take into account practicing communities with high FGM/C prevalence who are from 'low prevalence' countries or the families that have rejected the practice.

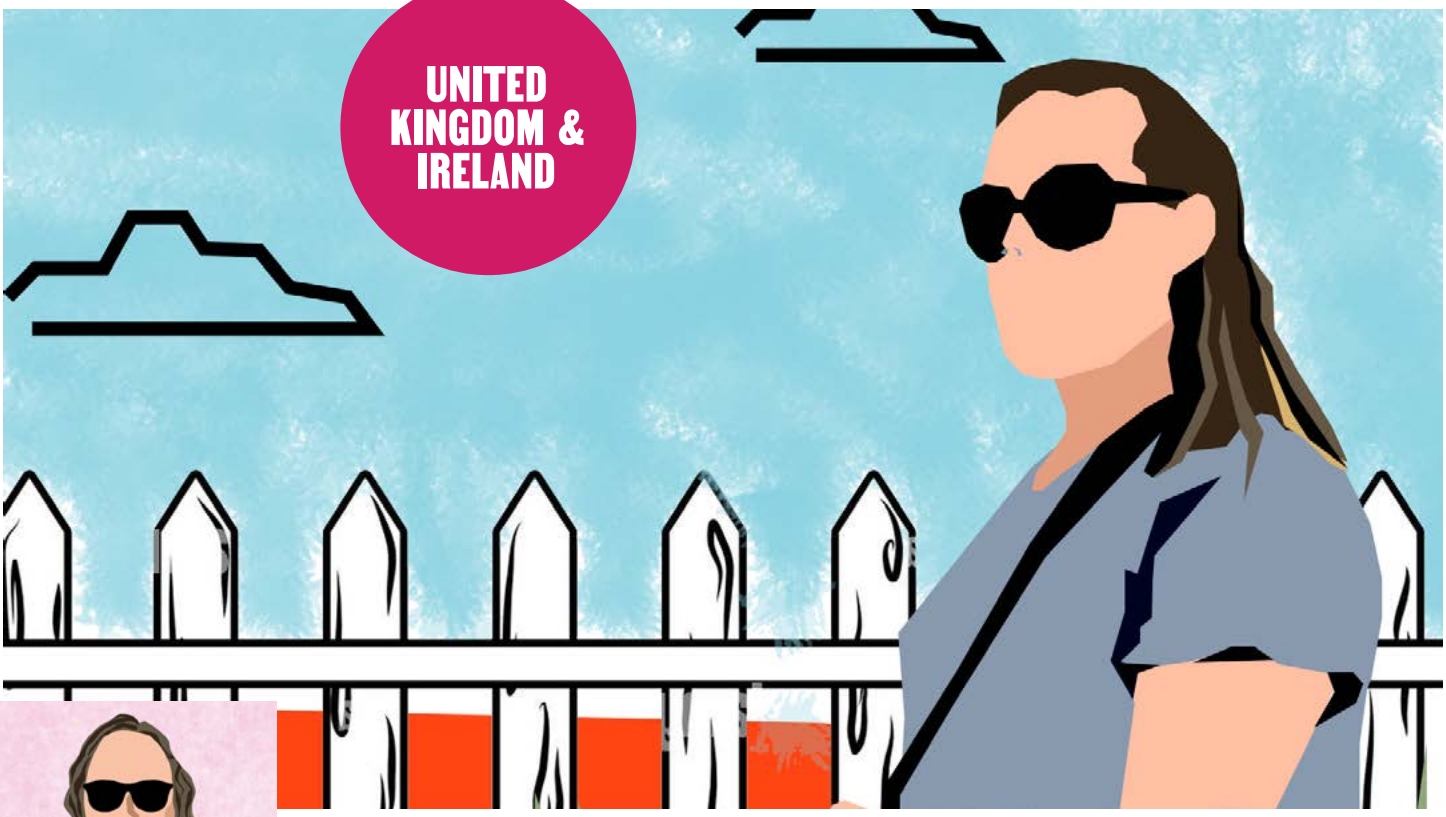
Second, in many cases, asylum seekers, refugees, and undocumented immigrants are not included in the estimates due to the absence of systematic data collection at all stages of the asylum process in many countries. (Leye et al., 2014)

Third, such studies also often base the likelihood of FGM/C in countries of birth rather than considering how the practice of and attitudes towards FGM/C may have developed due to migration.

Fourth, such indirect estimates only take into account FGM/C prevalence amongst diaspora communities from countries where data on FGM/C prevalence is available from nationally representative surveys (i.e., Category 1 countries). For instance, indirect estimates of FGM/C prevalence in the U.S. and Europe do not take into account survivors of FGM/C from most Asian and Middle-Eastern countries, including countries like Malaysia and Oman, which are known to have a high prevalence of FGM/C. Additionally, studies within the Bohra community have surveyed survivors from the community who had been subjected to FGM/C in the U.S. and the UK, though they are not included in the estimates. Hopefully, the recently adopted European Union Directive on Combatting Violence against Women and Domestic Violence will help fill the data gap in Europe as States are now under the obligation to provide up-to-date data on gender-based violence prevalence, including FGM/C.

Further, continued historical misconceptions and lack of awareness surrounding FGM/C, wherein it is treated strictly as a practice occurring in Africa and carried over through migration to North America and Europe, means that there is resistance to fully accepting and introducing social programs that reflect it. These myths have harmful implications for the diaspora community as well as other groups of people that are affected by FGM/C since it leaves the women and girls in those communities under-protected, and they continue to experience the harm without any outreach, education, and resources dedicated to supporting them.

SURVIVING INTERSEX GENITAL MUTILATION: FINDING IDENTITY AND ADVOCACY AMIDST INJUSTICE



DR. ADELINE BERRY'S STORY

"My name is Addy, short for Adeline. That name has been with me my whole life, though not always openly. It's a name with history, a name given to me by my mother, who thought I'd be born a girl after taking a drug called diethylstilbestrol (DES), which doctors guaranteed would ensure a healthy pregnancy. My mother believed I'd be named after my aunt Adeline, who had died tragically in the 1920s. But I was assigned male at birth, and my name was taken from me. For years, my parents hid the reality of my body, a reality they were ashamed of, a reality they didn't understand. Eventually, I took back the name that was always mine, Adeline.

I was born in England to Irish parents: my father, a construction worker, and my mother, a nurse. They both carried their own heavy histories, especially my mother, who had survived an abusive upbringing. When I was born, I was assigned male at birth. With a body that didn't fit the medical norms, the doctors told my parents to keep it a secret. They said to move away, to avoid talking about it. My mother resented this and carried a bitterness she never quite let go of. We moved back to Ireland, where my childhood was a mix of shame, confusion, and constant punishment for being 'different.'

Growing up, I didn't understand why I was treated as I was. I was effeminate, and in a world where masculinity was rigidly defined, I was constantly told I didn't measure up. My father believed that forcing me into manual labor in his construction business would 'toughen me up.' It didn't work. I wasn't a 'proper boy,' and that was treated like a failure. I spent my childhood isolated, reading and drawing, hiding away in libraries. I was bullied and relentlessly beaten both at home and at school. By fourteen, I had broken nearly every bone in my body. I survived, but at what cost?

I moved to the United States to study and, for the first time, encountered people who were like me, people who didn't fit neatly into the male or female boxes. It was eye-opening and deeply validating. I had spent years struggling with my identity, not even knowing the word 'intersex' until I was an adult. Growing up, I had no language for what I was, only shame. When I finally learned the words intersex and transgender, I found a way to define myself, a way to understand my own existence.

Despite the challenges, I went on to earn a PhD. My research focuses on the experiences of older intersex people across Europe, people who, like me, have lived in silence and shame, their medical histories hidden from them. I conducted interviews with people who had lived through the same kinds of secrecy and the same dismissive treatment by doctors, regardless of wealth or status. It's astonishing how similar our stories are. Whether our families were wealthy or not, our bodies were altered without consent, and we were left to navigate the fallout alone.

"MEDICAL PROFESSIONALS STILL PERFORM UNNECESSARY SURGERIES ON INTERSEX INFANTS, JUSTIFYING IT WITH THE SAME SOCIAL REASONS THAT FUEL FEMALE GENITAL MUTILATION (FGM)."

I live with the physical and emotional scars of surgeries performed on me without my consent. When I seek help for the medical issues that these surgeries caused, I'm often dismissed or told that my experiences are 'impossible.' The medical community rarely understands, and worse, they often don't want to understand. They are trapped in a system that maintains a strict binary view of bodies, a system that values conformity over the well-being of people like me.

As I've grown, so has my activism. I am vocal about the harm done to intersex people, whether it's in medical settings, in research, or in casual conversations. I wrote letters to politicians, met with human rights officials, and even sat down with Queen Máxima of the Netherlands to talk about mental health for intersex children. People often don't know what intersex means until they have an intersex child. By then, they're left grappling with fear and confusion because society hasn't prepared them for the existence of bodies that don't fit the norms.

In my advocacy, I've seen how people who don't fit into the binary are dismissed, devalued, and silenced. Medical professionals still perform unnecessary surgeries on intersex infants, justifying it with the same social reasons that fuel female genital mutilation (FGM) in certain communities. These surgeries, like FGM, are about control, about forcing people into narrow categories. The United Nations classifies these surgeries as torture, yet they persist, cloaked in the authority of medicine.

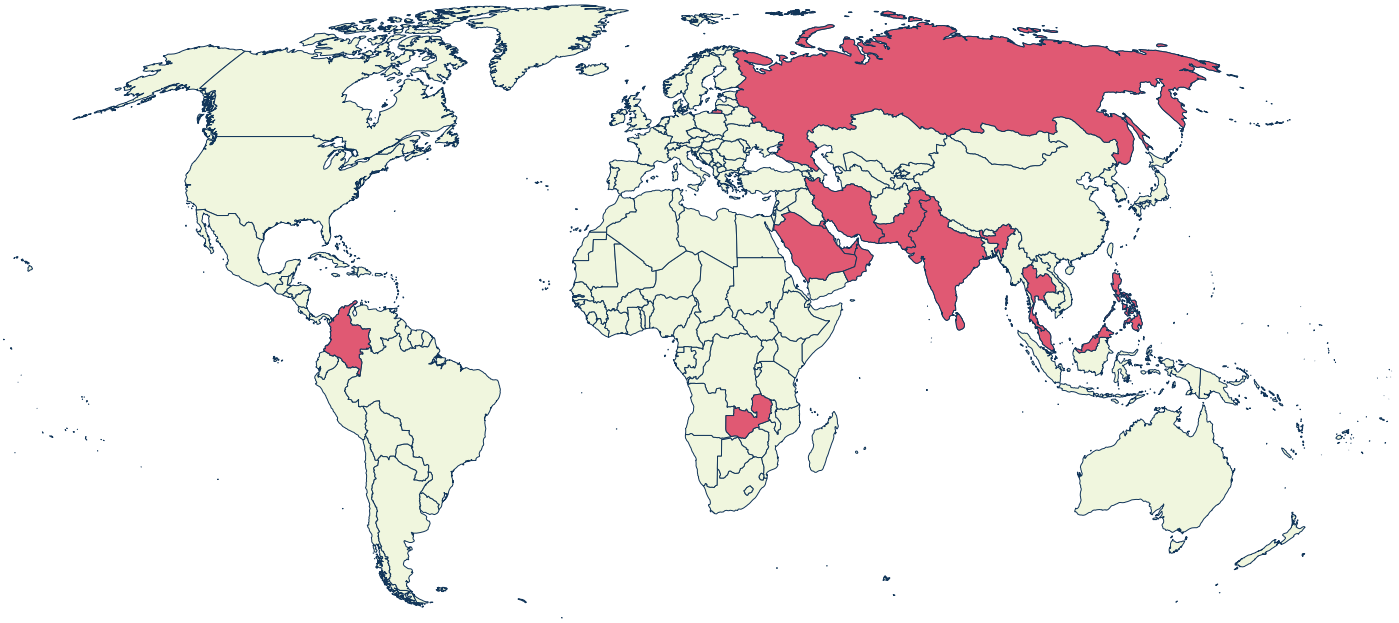
Living as an intersex person means living with constant stigma and isolation, compounded by a healthcare system that fails to see us. I've had to learn to find my own strength. Art has been one of my survival tools. Drawing gave me an outlet, a way to process the pain and turn it into something tangible. Without art, I'm not sure I would have survived. Many intersex people I know turn to creative expression as a lifeline, a way to tell their stories when words fall short.

I'm not hopeful about the future. The rise of fascism and regressive ideologies makes it hard to believe that acceptance is on the horizon. But I keep fighting, not because I believe I'll see the world change in my lifetime, but because I owe it to the people who come after me. I want them to know that there were those of us who fought for them, who spoke out, who refused to be erased.

My story is not unique. It's the story of countless intersex people who were born into a world that didn't know how to love or accept them. I hope that by sharing my story by pushing for change, I can make even a small difference. Because, in the end, it's not just about intersex rights. It's about humanity, dignity, and the right to exist as we are."

COUNTRIES WITH AVAILABLE DATA ON FGM/C FROM SMALL-SCALE STUDIES

The small-scale research studies that are relied on in this category are often very useful in providing concrete evidence that FGM/C is taking place in a particular country or community. They also provide invaluable data on numerous issues such as medicalization, the impact of FGM/C, how to best support survivors in a particular context, reasons for practice in a particular community, and the like. However, such studies usually have a fairly small sample size and are, thus, not representative of the whole community or the country where FGM/C is taking place. Based on these studies, it is not possible to derive a reliable estimate of FGM/C prevalence in a particular community or country. Also, these studies are normally one-off surveys since the organizations and researchers conducting the study are often underfunded and lack the capacity and support to regularly follow up on the research they have previously conducted. (Cappa, Van Baelen & Leye, 2019).



S.No	Country	Details of Study	Legal Status
1	**Colombia**	A 2011 study documented the existence of **clitoridectomy amongst the Embera indigenous community in Colombia** (Henao). The procedure is normally performed on newborn babies. The existence of FGM/C amongst the Embera community has also been confirmed by UNFPA (UNFPA, 2011). The Colombian Ministry of Health and Social Protection has recorded 54 cases of FGM/C in 2024 and 91 cases in 2023 through its integrated information system (SISPRO). The Integrated Information System on Gender Violence (SIVIGE) of the Colombian government recorded 122 cases of FGM/C between 2020 and mid-2024 (though this is likely to be an under-reporting). While most reported cases were from Indigenous communities, there were also 1.1% of cases of FGM/C reported from Afro-Colombian, Raizales, and Palenqueras communities and 1.1% from migrant communities, demonstrating that the practice is more widespread than just the Embera community. (Colombia Ministry of Foreign Affairs, 2024). According to the Colombian National Indigenous Organization, it is estimated that **two out of every three Emberá women have suffered FGM/C**. (ONIC, 2012)	No specific law against FGM/C.[6]

6 However, three bills against FGM/C were introduced in the Colombian Congress in 2024, which remain pending.

2	**India**	A qualitative report from 2018 by Anantnarayan, Diler & Menon surveyed 94 participants across five Indian states (Gujarat, Madhya Pradesh, Maharashtra, Rajasthan, and Kerala). **Prevalence of FGM/C within the Bohra community was estimated to be 75% of daughters** (aged seven years and above) of all respondents in the sample. It also found that FGM/C was practiced by some Sunni Muslim communities in Kerala. A 2017 study by Taher surveyed 385 participants from the Bohra community across the world. Out of these, 217 of the participants reported that they had undergone FGM/C in India. A 2021 study by Mumkin, which included 221 respondents from the Bohra community, of which 159 were from India, found that 81% of respondents opposed the practice of FGM/C. A 2022 survey conducted in New Delhi found low awareness of the existence of FGM/C amongst the public (Nanda & Ramani, 2022)	No specific law against FGM/C.
3	**Iran**	A 2015 study by Ahmady, which surveyed 4,000 participants (3,000 women and 1,000 men), found the existence of FGM/C in the **Western and Southern provinces of Iran**. **The estimated prevalence of FGM/C within the sampled population from these regions ranged from 16 - 60 %** (60% in Hormozgan province, 21% in West Azerbaijan province, 18% in Kermanshah, and 16% in Kurdistan). A recent study on FGM/C found evidence of the continuing practice in Lorestan province in Western Iran (through interviews with 26 survivors) when it was previously thought that the practice had died out in that region (Mohamadeh, Seddighi & Rozafarian, 2022). Earlier studies reported an FGM/C prevalence of 83.2% amongst 400 participants in Qeshm island (Mozafarian, 2014), 68.5% amongst 780 participants in Hormozgan province (Dehgankhalili et al., 2015), 69.7% in Minab, a city in Hormozgan Province in 2002 based on a survey of 400 women (Khadivzadeh et al., 2009); and 55% amongst a survey sample of 348 women referred to five health centers in Ravansar city in Kermanshah province (Pashaei et al., 2012). Qualitative studies in Iran have also recently focused on the impacts and drivers of the practice, including highlighting harmful myths and misconceptions that drive the practice (Bokaie et al., 2020) and the impact of FGM/C on sexual quality of life (Laleh, Soltani & Roshanaei, 2022), psycho-sexual difficulties (Mahmoudi & Hosseini, 2017) and mental health (Abdollahzadeh, M., Nourizadeh, R. & Jahdi, 2023)	Art. 663 of the Penal Code imposes a fine for mutilation of female genital organs.
4	**Kuwait**	A 2011 study (Chibber et al.) examined 4,800 pregnant women over four years from 2001 to 2004 and reported a **38% prevalence of FGM/C** amongst the sample. The study also found that FGM/C was associated with adverse materno–fetal outcomes and psychiatric issues, including flashbacks, anxiety, and post-traumatic stress disorder.	No specific law against FGM/C.

5	**Malaysia**	There are several quantitative studies documenting the existence of FGM/C within Malaysia. Pillai et al. conducted an online survey in 2021 with 107 participants, of which 79.4% had been circumcised. The main reasons cited by participants who supported the practice included religious obligations, hygiene and cleanliness, and reducing or controlling sexual lust or desire. A 2012 study by Dahlui et al. surveyed 1196 Muslim women, of which **93% had been 'circumcised'**. A 2019 study by Rashid & Iguchi of 605 participants from Northern Malaysia documented the rising medicalization of FGM/C and found that 87.6% of participants viewed FGM/C as compulsory in Islam, and **over 99% wanted the practice to continue**. A 2009 study by Rashid et al. found that the majority of participants believed that FGM/C was required for religious reasons and wanted the practice to continue. Based on the quantitative data provided by these studies, Orchid Project and ARROW (2024) estimate an FGM/C prevalence rate of 93% amongst the female ethnic Malay population and that an estimated 7.5 million women and girls are impacted by the practice in Malaysia. The ethnic Malays make up around 57% of Malaysia's total population - this means that an estimated 53% of all female citizens in Malaysia are affected by FGM/C (Orchid Project and ARROW, 2024).	No specific law against FGM/C.
6	**Oman**	A 2018 survey (Thabet & Al-Kharousi) of 200 women in the **Ad-Dakhiliya province found that 95.5% of the women surveyed had undergone FGM/C**. 85% of participants expressed support for the practice. A 2014 study by Al-Hinai in the **capital of Muscat** surveyed 100 women from various regions across Oman and found an FGM/C prevalence of 78% among the survey sample. The survey also found that the **practice continued to take place in 64% of families**.	Specific criminal provision prohibiting FGM/C.

7	**Pakistan**	A 2017 study by Taher surveyed 385 participants from the Bohra community across the world. Of these, 44 women reported that they had been subjected to FGM/C in Pakistan. All the women had undergone FGM/C at a private residence (as opposed to a medical clinic). A 2018 study (Syyed) included the results of two semi-structured interviews with survivors of FGM/C from the Bohra community in Pakistan and documented their views on FGM/C and their experiences in undergoing the procedure. In 2021, Habibi interviewed two survivors of FGM/C from Pakistan as well as a man from the Bohra community to analyze the impact of FGM/C on sexual desire and the psycho-sexual trauma caused as a result of FGM/C. There is anecdotal evidence that FGM/C may also be taking place among the Sheedi community in Pakistan (Orchid Project and ARROW, 2024). There are no prevalence estimates available.	No specific law against FGM/C.
8	**Philippines**	A study of 458 individuals from 5 provinces in the Bangsamoro region of the Philippines found that Type IV FGM/C, known locally as 'pag-islam' is widely acceptable, commonly practiced, and highly likely to continue in the Bangsamoro region (Limpao et al., 2021). The study also highlighted the link between FGM/C and child marriage, as girls who have undergone FGM/C are considered ready for marriage. Previous studies have documented the existence of FGM/C within the same region amongst the Meranaos people in Lanao del Sur (Basher, 2014) and Muslim women in Zamboanga City (Belisario, 2009). There are no prevalence estimates available. The type of FGM/C could take the following forms: "1) bathing of the genital area; 2) swabbing the clitoris with cotton; 3) rubbing a knife gently over the anterior portion of the labia majora or stroking the clitoris two or three times; 4) scraping of the labia majora with an unpointed knife until it is erythematous; assuring that there is no bleeding, or 5) pricking and removing some tissue from the clitoris." (UNICEF Philippines, 2016).	No specific law against FGM/C.*
9	**Russia**	A 2016 study by Antonova & Siradzhudinova documented the continued practice of FGM/C by the Avars in East Dagestan. The report included interviews with 25 survivors and 17 experts with knowledge of the practice. The report estimates that the prevalence of FGM/C varies in different districts, ranging from 90-100% in the Botlikhsky and Tsuntinsky regions to 50% in the Tlyaratinsky region, to an estimated 25% of girls and women who have been subjected to FGM/C or are at risk in the Tsyumadinsky and Kizlyarsky regions. Based on birth statistics, a total of **1,240 girls every year** were estimated to be at risk of being subjected to FGM/C (Antonova & Siradzhudinova, 2018).	No specific law against FGM/C.

10	**Saudi Arabia**	FGM/C can be found in Saudi Arabia, both among Saudi women and girls and those from diaspora/immigrant communities, based on information from over 13 research studies (Almeer et al., 2021). A study surveyed **963 women in Jeddah** between December 2016 and August 2017 (Rouzi et al., 2019) and found that **18.2% of women had undergone FGM/C**. The sample included both Saudi and immigrant women, and 62.8% of the women who had undergone FGM/C were either Saudi or naturalized Saudi women. The majority (68%) of women wanted FGM/C to stop. A 2018 household survey in the **region of Hali** on the western coast of Saudi Arabia surveyed a cross-sectional sample of 365 households across the region (Milaat, Ibrahim & Albar). Data on FGM/C was only collected for girls under the age of 18. Out of 285 girls in the sample, 175 had undergone FGM/C, indicating a **prevalence of 80.3% within the survey sample**. In 91.4% of the cases, the cutting was carried out by doctors. An earlier study from 2008 (Alsibiani & Rouzi) found a link between FGM/C and sexual dysfunction among women.	No specific law against FGM/C.
11	**Singapore**	FGM/C is documented mainly amongst the **Malay community in Singapore** (which makes up 15% of the total population). A pilot survey of 360 Muslim women in Singapore conducted in 2020 by End FGC Singapore found that 75% of Muslim women in the study sample had been cut in their early childhood. Of the 360 respondents from the survey, 57% were from the Malay community, while the rest identified as belonging to Javanese, Indian, Boyanese, Arab, and other communities. A 2015 article by Marranci documents a qualitative study from 2011 that gathered evidence on the existence and practice of FGM/C within the Malay community from around 30 participants, including survivors, Malay men, circumcisers, and religious leaders.	No specific law against FGM/C.
12	**Sri Lanka**	A study of 998 women conducted in 2024 found that 465 Muslim women had either personally experienced FGM/C or knew someone who had undergone it. The study also found an increasing trend of the medicalisation of FGM/C, with procedures being performed in private medical clinics by Muslim doctors. A study published in December 2019 by Ibrahim & Tegal surveyed 26 women, of which 20 women self-identified as having undergone FGM/C, while an additional four 'assumed' that they had undergone the practice since everyone in their family had. These women were from the **Moor, Malay, and Bohra ethnic communities**. A 2021 qualitative study with 221 participants reported that FGM/C is an enduring yet clandestine practice within Muslim communities in Sri Lanka, with older women known as *osthi mamis* being the main practitioners of FGM/C (Dawson & Wijewardene). Earlier studies, including a 2012 UNESCAP Study, also document FGM/C taking place on babies soon after birth. There are no prevalence estimates available.	No specific law against FGM/C.

13	**Thailand**	A 2008 study by Merli documents the practice of 'Sunat' amongst the **Muslim community in Southern Thailand** through interviews with *bidan* (local midwives/circumcisers) and by directly witnessing one case of FGM/C. Orchid Project and ARROW (2024) estimate that the prevalence of FGM/C in Southern Thailand's Muslim community is similar to that of the Kelantan community in Malaysia (where prevalence is 88.5%) due to cultural and religious similarities between the communities. In submissions to the CEDAW Committee (2024), the Thai government noted that FGM/C/Khitan was promoted by Islamic principles as a practice performed in return for virtue, though it was not mandatory.	No specific law against FGM/C.
14	**United Arab Emirates**	A 2020 study (Awar & Al-Jefout et al.) revealed insights from an interview of 1035 participants from across the UAE, **with 41.4% of the female participants having undergone FGM/C**. The study found that Type I (62.8%) was the most prevalent, followed by Type II (16.6%) and Type III (5%). In an earlier from 2011 (Al Marzouqi) of 100 Emirati women, **34% of female respondents were found to have undergone FGM/C**. The study does not specify the type of FGM/C performed, merely noting that the common type practiced is one where "only a small portion of the female genitalia is removed." In its 2022 Concluding Observations, the CEDAW Committee to the UAE noted with concern the lack of comprehensive data on the prevalence of FGM/C within the country and issued recommendations relating to laws, awareness-raising and education.	No specific law against FGM/C.
15	**Zambia****	The Zambia Sexual Behaviour Survey (ZSBS, 2009), based on a random sampling of 2500 households, found that 0.7% of female respondents had been circumcised, demonstrating a decrease from the 4% prevalence recorded in the first ZSBS from 2000. Based on the ZSBS results, many of the respondents who reported being circumcised are from diaspora communities originating from other countries. The survey results also highlighted that some of the women who reported being 'circumcised' could have been subjected to labia pulling/ elongation.	Specific criminal provision prohibiting FGM/C.

**The Philippines has a criminal provision on mutilation of reproductive organs, which could potentially be used to apply to cases of FGM/C.*
*** Zambia has been included in Category III, instead of Category I, despite having conducted several nationally representative household surveys in the past which collected data on FGM/C. However, such data collection on FGM/C through household surveys was stopped in recent years, given the small share of the population performing FGM/C; hence, Zambia has been removed from Category I.*

MEDICALIZATION OF FGM/C

"Medicalization" is defined by the WHO as the instance where FGM/C is practiced by a healthcare provider, whether in a public or a private clinic, at home, or elsewhere. The medicalization of FGM/C is motivated by multiple factors, such as healthcare professionals also belonging to practicing communities and so supporting the same beliefs and the practice, financial compensation, or the belief that medicalized FGM/C results have little to no negative physical and psychological consequences. Where practiced, medicalized FGM/C is often wrongly considered a safe alternative because it is performed in a sterilized environment with access to anesthesia products. However, even when practiced by healthcare professionals, FGM/C remains a human rights violation, a form of gender-based violence with both short and long-term consequences, and contributes to the perpetuation of the practice. The health sector plays an important part in not only supporting survivors but also preventing the further perpetration of FGM/C, and its practice by professionals represents a serious breach of the medical ethics principle of 'Do no harm.'

The latest data from UNICEF in 2024 indicates that 66 percent of girls who recently experienced female genital mutilation did so at the hands of a health worker. Medicalized FGM/C has been increasingly mainstreamed in all parts of the world, from Russia, where clinics advertised for medicalized FGM/C, to high-prevalence countries such as Indonesia, Kenya, and Egypt, where medicalized FGM/C is seen as a legitimate alternative. In Indonesia, only 62% of those who underwent the practice were cut by a medical practitioner, and most of the time, FGM/C is provided as part of the child delivery package or by specialized clinics. Another concerning development is the publication in 2024 by the Ethiopian Islamic Affairs Supreme Council of a fatwa supporting medicalized FGM/C as a safer option to perform FGM/C. This shows how medicalization continues to justify perpetrating the practice, which hinders progress in eliminating it. In fact, the evidence indicates that health workers may be performing FGM/C more severely than traditional practitioners, as demonstrated by research in Indonesia.

This question is increasingly being discussed at the global level as it represents an obstacle to ending FGM. For instance, in recognition of the continuing problem that the medicalization of FGM is posing for its elimination, the 2024 UN Secretary General's Report reminds States not to facilitate or engage in medicalization.

FINDING HOPE IN THE FACE OF BACKLASH

THE GAMBIA

**The name of the individual in this story has been changed to protect their privacy and identity.*

BINTA'S STORY

"Back then, it was a big ceremony in my town because female genital mutilation (FGM) wasn't banned yet. It felt like a celebration, and I remember being with my friends and cousins. They took us to the cutter, who we called *Ngansimba*. My grandmother or maybe my aunt carried me on her back early in the morning, and there was a lot of drumming and singing. They blindfolded me, but I could still sense all the people around me: women holding my hands and others gripping my legs. They told me it wouldn't hurt, that I shouldn't scream. But I did, I screamed once.

Afterwards, we stayed in that *kota* for three months, all of us kids together. It wasn't the most comfortable place, and now, when I look back, I realize it wasn't hygienic either. When it was finally time to leave, there was another big ceremony. They took us to the river, made us bathe, and gave us new clothes to wear. That was my experience with FGM.

Growing up, I didn't think there was anything wrong with it. Among us kids, we would actually tease those who hadn't been through FGM, calling them names like they were different. I believed in it because that's what we were taught. But things started shifting as I got older, especially when I became a mother. When I had my first child, it was a difficult delivery; I had 33 stitches. I remember a Gambian midwife telling the doctor about my condition. It didn't make sense at the time, but now I realize it was because of the FGM I had gone through.

Later, when I joined the campaign against FGM, I started getting flashbacks. Passing by the street where the *kota* was, I would feel a strange smell that brought back memories I didn't fully understand. People talk about Post Traumatic Stress Disorder (PTSD); maybe it was that. Those memories are part of me; even as an adult, they sometimes trigger me.

When I began speaking out against FGM, I faced a lot of resistance, especially from my family. I come from a practicing community, and my siblings had even taken their daughters to undergo the same procedure. Religious leaders in the community accused me of going against Islam, claiming I was being paid by the West to betray our culture. I would leave those community meetings questioning myself, feeling exhausted from the accusations.

One day, after I had my second child, I was speaking at a school assembly about FGM. A teacher stood up and called me a liar, accusing me of spreading false information for money. That was the day I finally broke down in front of people. I cried as I told them about my experience and how difficult my life has been because of FGM. It was one of the hardest moments for me, but it was also a turning point. I realized that sharing my story could help others understand the reality of FGM.

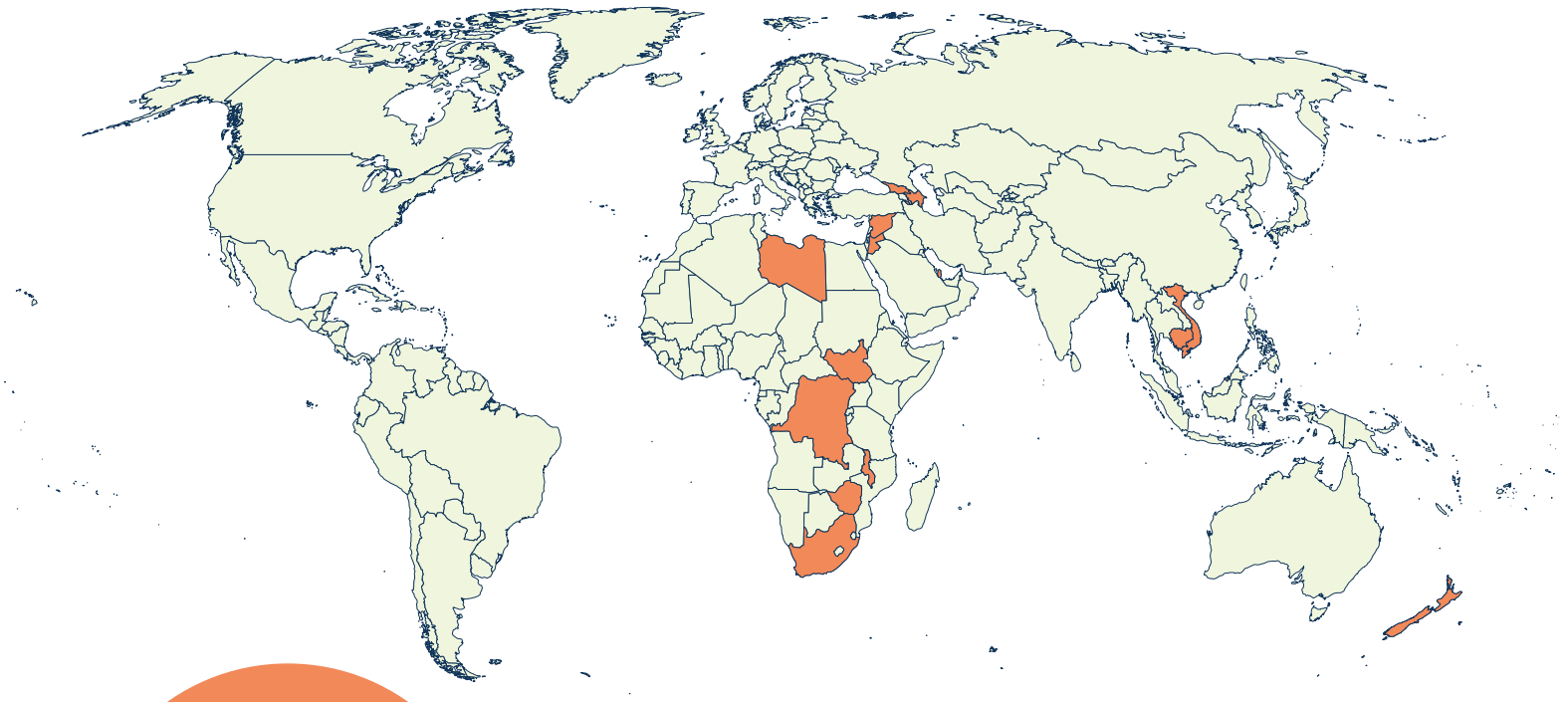
The proposal to repeal the FGM ban in The Gambia was a major setback, exposing deep divisions and forcing activists to reconsider their approach. The lack of preparedness revealed the need for immediate re-strategizing, not just by grassroots organizations but across all sectors, including donors and international partners. As public support for FGM grows without accountability, the movement must adapt to prevent similar challenges from spreading to other countries in the region.

"WHEN I BEGAN SPEAKING OUT AGAINST FGM, I FACED A LOT OF RESISTANCE."

I have been a strong advocate of fighting FGM respectfully, recognizing it as an age-old tradition tied to religious and cultural beliefs. FGM cannot be eradicated alone – it intersects with community issues like sexual and gender-based violence, women's economic empowerment, financial independence, girls' education, and teenage pregnancy. When engaging communities, these issues must be addressed together.

We need to return to our people, sit with them, and have honest conversations led by us, respecting traditions, culture, and religion. Progress has been made, but we must evaluate the work and investments in the fight against FGM to understand what needs to change.

Honest conversations with communities, policymakers, and activists are essential, and men must be part of these discussions as they lead households and religious spaces. Education about religion and financial independence empower women and protect our daughters, and I continue to emphasize this in my work to help end FGM in The Gambia."



COUNTRIES WITH AVAILABLE DATA ON FGM/C FROM MEDIA REPORTS AND ANECDOTAL EVIDENCE

This category includes data on the existence of FGM/C available from published media reports as well as reports of UN agencies, concluding observations of and submissions made to UN human rights bodies, reports of human rights organizations, and other forms of anecdotal evidence. It is often difficult to assess the quality and reliability of the evidence in this category as information may be based on media reports or other sources that mention the existence of the practice in the country without providing details of the methods used and underlying materials on which the information is based. Governments and international institutions often do not give sufficient weight to such evidence.

S.No	Country	Available Data	Legal Status
1	**Azerbaijan**	In 2020, activist Nurlana Jalil conducted preliminary research that demonstrated the existence of FGM/C in the North and North West regions of the country and isolated villages of Zagatala and Balakan (Jalil, 2020). An investigation by Current Time media outlet in 2020 also confirmed that FGM/C is practiced in some remote areas to girls aged 2 to 3 by a traditional cutter in secret ceremonies organized by mothers or grand-mothers by North Caucasian peoples (Avars and Akhvakhs). However, as of now, there is no official or consistent data, and the topic remains taboo in suspected practicing communities (Media Az, 2020; Kavkazskii Ouzel, 2018).	No specific law against FGM/C.

2	**Bahrain**	The 2005 U.S. State Department report refers to "several cases" of FGM/C being received by the Bahrain Human Rights Society in 2004. An online survey conducted in 2013 (Shaeer & Shaeer) with 992 participants from 11 countries across the Middle East revealed that 8.3% of female survey participants from Bahrain reported having undergone FGM/C. However, the exact number of women from Bahrain who took part in the survey is unclear.	No specific law against FGM/C.
3	**Brunei Darussalam**	The Ministry of Religious Affairs has stated that the practice of "female circumcision" or "excision of the prepuce only" takes place in Brunei and that it is considered *wajib* (compulsory) in Islam. (Response to List of Issues to Child Rights Committee, 2015; USCIRF, 2021). The UN CEDAW Committee (2014) and the Committee on the Rights of the Child (2016) have expressed concern over the high prevalence of FGM/C and denial of the grave nature of the practice. 73.8% of Brunei's population are Malay Muslims, who are known to practice FGM/C in neighboring Malaysia (Orchid Project and ARROW, 2024).	No specific law against FGM/C.
4	**Cambodia**	The Cham community in Cambodia is known to practice FGM/C (Asia Network to end FGM/C), though research into the practice is still ongoing (Zahari, Rashid, and Iguchi), and there is no published data or research available yet.	No specific law against FGM/C.
5	**The Democratic Republic of the Congo**	UNICEF estimated in 2007 that there was less than a 5% prevalence of FGM/C in the Democratic Republic of the Congo, though no survey data was available. A 2014 Gender Country Profile report notes (based on interviews with local organizations) that "Female Genital Mutilation in Equateur [province], where it has been practiced in the past, is in sharp decline." The Child Rights Committee in 2017 had expressed concern about the persistence of FGM in some parts of the country, particularly in Mweso, North Kivu, where the practice went unreported.	Specific criminal provision prohibiting FGM/C.
6	**Georgia**	Media reports indicate the practice of FGM/C by the ethnic community of Avars, who are largely found in Eastern Georgia. (IWPR, 2016). A 2018 study by Gupta et al. surveyed 330 men and women across Georgia, including 14 members of the Avar ethnic community. Participants indicated that other ethnic communities in Georgia did not practice FGM/C, though older women from the Avar community all reported undergoing Type Ia FGM/C (removal of the clitoral hood/prepuce). While participants indicated that the practice of FGM/C had reduced amongst the current generation of Avars, experts who were interviewed noted that the perceived reduction of FGM/C could be due to legal penalties, which may have driven the practice underground.	Specific criminal provision prohibiting FGM/C.

7	**Jordan**	A single news report from 2003 reports the existence of FGM/C in the town of Rahmah, which has a population of 500 (Daily Star, 2003). An online survey conducted in 2013 (Shaeer & Shaeer) with 992 participants from 11 countries across the Middle East revealed that 7.4% of female participants from Jordan reported having undergone FGM/C. However, the exact number of women from Jordan who took part in the survey is unclear. A 2022 study by UNFPA also found that FGM/C is still being practiced by Sudanese and Somali migrants/refugees in Jordan.	No specific law against FGM/C.
8	**Libya**	An online survey conducted in 2013 (Shaeer & Shaeer) with 992 participants from 11 countries across the Middle East revealed that 8.1% of female participants from Libya had reported having undergone FGM/C. However, the exact number of women from Libya who took part in the survey is unclear. The U.S. State Department Human Rights Country Report from 2007 reports FGM/C taking place in "remote areas of the country within African migrant communities," and its 2018 report similarly notes that while "FGM/C was not a socially acceptable practice among Libyans," some of the migrant populations in Libya came from sub-Saharan African countries where it was a practice.	No specific law against FGM/C.
9	**Malawi**	The UN Human Rights Committee in 2014 expressed concern about "reports on the prevalence of the practice of female genital mutilation in some regions," echoed by the CEDAW Committee in 2023. Media reports (The Nation, 2013; The Chronicle, 2006) and reports by the U.S. State Department (2017) indicate that FGM/C takes place amongst some small ethnic communities in Southern Malawi. Most girls are cut between the ages of 10 and 15, and the type of FGM/C that takes place is reportedly cutting of the tip of the clitoris (Type I).	No specific law against FGM/C.
10	**New Zealand**	Diaspora communities living in New Zealand include some that are known to practice FGM/C, particularly communities from Egypt, Eritrea, Ethiopia, Indonesia, Iraq, and Somalia. Census figures from 2013 indicate an estimated population of adult women over 15 years from these communities is around 4,400. (Said et al., 2018) However, there is no accurate data or statistics on the number of women living with FGM/C in New Zealand or evidence to show that FGM/C is practiced within New Zealand.	Specific criminal provision prohibiting FGM/C.
11	**Qatar**	A 2021 survey of obstetricians in Qatar found that 88 of them reported treating patients with experience of FGM/C, largely women from countries such as Sudan, Egypt, Ethiopia, and Somalia who reside in Qatar. Crucially, 19% of obstetricians said they would perform reinfibulation on request after delivery. (Naz & Lindow) There is no other available data or evidence on the practice in Qatar. A medical case report from 2007 (Ahmed & Abushama) also documents the medical complications faced by a survivor of Type III FGM/C living in Qatar (the woman appears to be from a diaspora community).	No specific law against FGM/C.

12	**South Africa**	There is evidence of FGM/C taking place amongst a few ethnic groups, including the Venda people in Limpopo Province (Manabe, 2010; Kitui, 2012) and some ethnic communities in the Eastern Cape region (SABC, 2019), and also diaspora communities in South Africa. (Mswela, 2009). A study of 51 gynecologists in South Africa found that 70% of them had treated patients who had undergone FGM/C, demonstrating increasing exposure to FGM/C due to migration (Subrayan, 2019). Doctors have called for further research on FGM/C in South Africa (Smillie, 2022)	Specific criminal provision prohibiting FGM/C.
13	**South Sudan**	In 2015, a UNICEF study estimated that the prevalence rate of FGM/C in South Sudan was 1%. It also noted that 80% of the South Sudanese population disapproved of the practice. FGM/C has been noted to take place in the Northern regions of the country bordering Sudan (Orchid Project, 2020; Committee on the Rights of the Child, 2022), including in refugee camps (Danish Refugee Council, 2014).	Specific criminal provision prohibiting FGM/C.
14	**Syria**	An online survey conducted in 2013 (Shaeer & Shaeer) with 992 participants from 11 countries across the Middle East found that 8.3% of female participants from Syria reported having undergone FGM/C. However, the exact number of women from Syria who took part in the survey is unclear. In contrast, a 2016 study by Pharos, which included desk research and conversations with some experts (no direct interviews with Syrian women), concluded that "[t]he research activities did not lead to substantiated information that FGM is a traditional practice in Syria."	No specific law against FGM/C.
15	**Vietnam**	The Cham community in Vietnam is known to practice FGM/C (Iguchi, 2022), though research into the practice is still ongoing, and there is no published data or research available.	No specific law against FGM/C.
16	**Zimbabwe**	News reports from 2016 (The Herald) document "circumcision" amongst the Tonga community in Binga, where it was used to facilitate conception in women who had trouble getting pregnant, though there are also reports of a wider existence of the practice within the community (Amakhosikazi Media, 2019). In the past, infibulation (Type III FGM/C) has been documented within the small Remba ethnic group in the Midlands province. (UN SR on VAW, 2003)	Specific criminal provision prohibiting FGM/C.

COUNTRIES WITH HISTORICAL EVIDENCE OF THE PRACTICE OF FGM/C

In a number of countries, including Israel, Peru, Mexico, and Brazil, there is historical evidence of FGM/C having taken place amongst the native population within the last generation. However, there is little or no evidence to confirm whether the practice has died out or is still being continued. Further research is needed in these countries to confirm whether FGM/C is still taking place or not.

Israel: FGM/C had been documented in Israel amongst Bedouin tribes by earlier studies (Belmaker, 2012; Halila et al., 2009; Asali et al., 2009). However, the Israeli government, in a submission to the UN Secretary-General in May 2024, has reported that the practice has been completely eradicated in Israel and that there have been no instances of FGM/C being performed in Israel over the last decade. This is confirmed by the previously mentioned academic studies, which had not found evidence of the practice of FGM/C amongst younger generations.

Peru: The practice of introcision has been reported in the past amongst the Conibos, a division of Pano Indians from Peru. (OHCHR, 1995). Introcision has been described as a practice where an elderly woman using a bamboo knife "cuts around the hymen from the vaginal entrance and severs the hymen from the labia, at the same time exposing the clitoris. Medicinal herbs are applied." A documentary film from 2017 (Chua) documents the existence of FGM/C amongst the Shipibo people in Peru in the form of clitoridectomies (Type I FGM/C). Community members, however, reported that the practice was last known to take place around forty years ago and had been abandoned by the community (Tomazoni & Garbini Both, 2018). There is no recent evidence from Peru that documents the continued existence of FGM/C within the country. In its submission to the UN Secretary-General in 2024, the Peruvian government confirmed that there was no current evidence available of FGM/C occurring within the country.

Brazil and Mexico: A report from the UN Office of the High Commissioner of Human Rights from 1995 reports the practice of "introcision" in Brazil and eastern Mexico (OHCHR, 1995). Introcision is usually defined as the enlarging or tearing of the vaginal opening and, in some cases, the perineum as well. Clitoridectomies (Type I FGM/C) have been reported in the past in Western Brazil and Mexico until the late 1970s (Rushwan, 2013), though there is insufficient evidence to determine current practice.

Introcision has also been historically documented amongst the Pitta-Patta indigenous people of Australia (OHCHR, 1995). It is not known whether the practice continues to take place.

In addition, there is evidence of white communities in the U.S. and the U.K. being subjected to FGM/C, as doctors used to prescribe clitoridectomies (Type I FGM/C) as a cure for hysteria, mental illness, and masturbation in the nineteenth and twentieth centuries There are some recent anecdotal reports regarding the practice of FGM/C within conservative Christian communities in the U.S. Please see Renee's Story on page 16 for more details, However, there is no further data available.

A MOTHER, A LEADER, AND A VOICE FOR CHANGE

COLOMBIA

**The name of the individual in this story has been changed to protect their privacy and identity.*

ANA'S STORY

"My name is Ana.' I'm a wife, a mother of ten, and a proud Embera Katio woman. My life is rooted in a small Embera settlement in Pueblo Rico, Risaralda. I grew up here, surrounded by our traditions, but my path hasn't been straightforward. It's been shaped by challenges and decisions that brought me here to a point where I feel strong enough to speak out against practices that hurt our women and girls.

In our community, women have often been told to stay silent, to obey, and to accept life as it is. Decisions are usually in the hands of our husbands, and for a long time, I thought this was simply the way of things. My husband, unlike many men, has supported me in pursuing work and education. He's a good man, different from others who dominate or mistreat their wives. I count myself fortunate for that, but I still feel that women's voices are undervalued. As I grew older, I began to question why things are the way they are, especially when it comes to our daughters.

One of the secrets kept by the women in our community is something I can only describe as a hidden wound, a practice we call 'the cure.' This practice, which others call female genital mutilation (FGM), is done to newborn girls, often without the mother's knowledge or permission. My first encounter with it came when my first daughter was born. After the birth, my mother-in-law, a midwife, took her, saying she would care for her while I rested. When they brought her back, she looked hurt, and she cried inconsolably. My questions were met with silence or dismissed as things I 'wouldn't understand.'

"I BELIEVE WE CAN CREATE A FUTURE WHERE GIRLS ARE SAFE AND WHERE THEY GROW UP WHOLE AND UNSCARRED."

Over time, I came to understand what "the ablation" really was. The idea behind it is that girls who aren't 'cured' will grow up to be promiscuous or undesirable for marriage. In our community, a girl who is different, who hasn't undergone this ritual, faces judgment and even violence. The fear of this violence drives many families to carry on with the practice, even if they feel uncomfortable about it. But I can't ignore the pain it causes, the harm that lasts a lifetime. This is not part of our true Embera culture; our culture is in our dances, our language, our weaving. This practice is something else, a dark inheritance from colonial times.

I am a survivor of FGM, though I didn't know it until I was much older. My body bears the evidence of it, though I didn't fully understand until I began to learn more. I'm one of the lucky ones. In 2007, the issue gained national attention after several newborn girls died in the hospital following 'the cure.' Government representatives visited our communities to talk about it, and that's when I realized how widespread and dangerous this was. I started speaking out, first to my family and then to my community.

It was with my fourth daughter that I could finally make a decision. I told the midwife, 'No. You will not do this.' That moment marked a turning point, and since then, I have worked tirelessly to protect my daughters and granddaughters from the same fate. It hasn't been easy. In my community, FGM is shrouded in secrecy. Midwives don't speak openly about it, and men often claim they know nothing of it. Even bringing up the topic was met with resistance. I was warned that I could be punished and threatened with being put in the stocks for daring to question our customs. But I couldn't stay silent, not when I knew the pain this practice caused.

My daughters now understand the dangers of FGM. I've spoken to them, to my daughters-in-law, and even to my nephews and their wives. I tell them that this tradition is not ours to keep and that no one has the right to harm a girl's body. I have found support among other women who, inspired by my actions, have started to say, 'If Ana can do it, so can we.' Together, we are building a quiet resistance, one conversation at a time.

As a teacher, I have a platform to reach more people. But I want to do more than just talk. I'm training to become a midwife so I can prevent this from happening to other girls. I attend meetings organized by the Colombian Congress, where a bill is pending to address FGM. I believe change is possible. Our community needs education about women's rights, body autonomy, and the consequences of FGM. We need safe spaces to talk openly, with fire and food, where elders and young people alike can share their perspectives.

The journey is not easy. Our people face many challenges: displacement, malnutrition, forced marriages of girls as young as twelve, and a lack of education. All of these issues create a cycle of poverty and violence that keeps practices like FGM alive. If we can address these root causes, I believe we can create a future where girls are safe and where they grow up whole and unscarred.

For now, I remain a voice in the darkness, speaking out against a harmful practice that others wish would stay hidden. I am not afraid of what they might say or do because I believe that if men are right, women are too. And we have every right to be heard, to protect our daughters, and to keep them safe from harm. This is my mission, my promise to the next generation, and I will not give up."

CONCLUSION

As highlighted in this report, there is evidence that FGM/C is present in over 94 countries. The aim of this report is to use the existing evidence to highlight the global nature of FGM/C and to advocate for the need for a global and comprehensive response. We hope this report serves as a resource to inform efforts to end FGM/C at all levels, aiding governments in their initiatives and holding them accountable while also safeguarding women and girls from violations of their fundamental human rights to live free from violence and harm.

Through SDG 5.3, the global community has pledged to eliminate FGM/C by 2030, but with just five years remaining, we are significantly off course. According to UNFPA, nearly 4.4 million girls, more than 12,000 a day, are at risk around the world. Unless efforts to end this practice intensify, the number of girls at risk is projected to rise to 4.6 million in 2030. Specifically, progress would need to be 27 times faster than the rate seen in the past decade to end FGM/C by 2030. Even these alarming figures are inadequate as they do not take into account, as outlined in this report, countries with no national-level prevalence data available.

Since the publication of the last report, there have been unified global efforts to raise awareness about the practice of FGM/C and to implement policies targeting it across all levels—international, regional, national, and state. Several countries, such as Burkina Faso, Liberia, and Kenya, have made noteworthy advancements in reducing the prevalence of FGM/C. In 2024, the UN General Assembly adopted the Pact of the Future, urging member states to combat FGM/C. International human rights mechanisms, such as UN Treaty Body expert committees and the Human Rights Council's Universal Periodic Review, have increased their recommendations on FGM/C, including for countries that have not previously received such guidance.

ONLY 59 (62%) OF COUNTRIES HAVE SPECIFIC LAWS PROHIBITING FGM/C.

Yet, only 59 (62%) of countries have specific laws prohibiting FGM/C, and women and girls are increasingly facing pushback on the hard-fought rights and legal protections against FGM/C.

In 2025, the need for financial and material investments from the government will remain largely unchanged. The sector needs substantial, earmarked funding that can address the complex nature of FGM/C, as noted in the 2023 Kigali Declaration to Close the Funding Gap and United for Action to end FGM/C. According to UNFPA, an investment of USD 3.3 billion is required to end FGM/C by 2030 in 31 priority countries, a gross underestimation given that it does not cover funding needed in the other 60+ countries where FGM/C is known to take place. Yet, currently, only USD 275 million is available for development assistance to end FGM/C, leaving a funding gap of over USD 3 billion.

FGM/C, a human rights violation shrouded in secrecy and deeply embedded in communities, can end. Historically, transformative social change has required a collaborative, collective, and multi-pronged approach, which included social reforms, strong legal protections, positive rights, and systemic changes. Eradicating FGM/C, too, requires that approach. No doubt, legal protections to guarantee justiciable human rights are an essential and foundational step.

The recommendations from the *2020 Global Report* remain urgent and applicable to the current programs, commitments, and obligations to end FGM/C. The implementation of these recommendations remains the responsibility of multiple actors, particularly governments, which possess substantial power, resources, and influence over societies they are bound to govern. However, FGM/C is a practice deeply rooted in gendered social norms that requires the collaboration and meaningful participation of family members, parents, medical professionals, educators, caregivers, spouses, law enforcement, judges, lawyers, social workers, policymakers, religious and traditional leaders, and other members of our communities to be aware, and ready to take action to eradicate the practice sustainably.

To this aim, we urgently call upon governments, the international community, and donors to take action in the following areas:

- Strengthen the global political commitment to eliminating FGM/C;
- Urgently increase resources and investment to end FGM/C and support survivors;
- Strengthen the evidence base of the global extent of the practice through critical research
- Enact and enforce comprehensive laws and national policies;
- Improve the well-being of survivors by providing necessary and critical support and service.

BREAKING TABOOS, INITIATING CONVERSATIONS ON FGM/C

THE MALDIVES

**The name of the individual in this story has been changed to protect their privacy and identity.*

FATIMA'S STORY

"I am a 28-year-old woman from Hithadhoo in the Maldives. My childhood was shaped by an overprotective yet supportive upbringing, with parents who were both conservative and doting, leaving me both sheltered and spoiled. Today, I work in the hospitality industry and live in staff accommodations at a resort where I've been for the past eight months.

Although I did not attend college, my 15 years of schooling were formative in shaping my perspective.

In my free time, I enjoy arts and crafts. My creativity provides solace and an outlet for self-expression, especially as I reflect on my journey and my experience with *'anhenun hithaanu kurun'* (female genital mutilation/cutting - FGM/C), a practice I have come to understand and oppose deeply.

As a toddler, I underwent a procedure that was later revealed to me as FGM/C. I have no memory of the event itself, only what was described to me. When I was around 16 or 17, I learned that I had undergone a "procedure" as a child. However, it wasn't until 2023 that I understood the true nature of what had been done.

I was subjected to the procedure by a doctor, and I now understand that the intent was to remove a thin layer from my body. My family was unaware of the details of the procedure or its actual implications. It was something I didn't know about, something that happened to me without my consent or understanding. When I finally discovered the truth, I felt deeply hurt. I feel it is an unfair practice with consequences that are overlooked.

The physical effects of FGM/C have lingered, but I've been fortunate to not experience significant emotional distress beyond the initial hurt upon learning the truth.

I've always believed FGM/C is unnecessary, and my stance against it is unwavering. There is no medical or anatomical justification for the practice. This belief fuels my quiet resistance and my hope for a future free from its shadow.

In the Maldives, FGM/C is not a widely discussed topic. It's considered taboo, making open conversations about it challenging. While I have been able to discuss my experience with some close connections, it is not a subject that is openly acknowledged or debated within families or communities.

The practice has often been linked to religion, which complicates efforts to challenge it. There are cultural and political sensitivities tied to the issue, particularly when religion is used as justification. I worry that if FGM/C is ever reintroduced under the guise of religious necessity, it could cause cultural and political clashes in a society already navigating complex dynamics.

"FGM/C IS NOT A WIDELY DISCUSSED TOPIC. IT'S CONSIDERED TABOO, MAKING OPEN CONVERSATIONS ABOUT IT CHALLENGING."

While I haven't extended my advocacy beyond personal conversations, I am determined not to let anyone in my vicinity undergo the same procedure. My hope is that awareness campaigns can break the taboo surrounding FGM/C, encouraging open discussions and education.

I believe that Maldivians are educated and empowered enough to take a stand against this practice. However, as with many issues, there is a risk of FGM/C being politicized, which could hinder progress.

I envision a future where FGM/C is not only eradicated but where conversations about it can happen without fear or stigma. Awareness campaigns and education must take precedence, and the narrative around the practice must shift.

The journey to end FGM/C will be long and difficult, but I hope the practice does not return and is totally wiped out."

RECOMMENDATIONS

1. STRENGTHEN THE GLOBAL POLITICAL COMMITMENT TO ELIMINATING FGM/C

Political commitment is key to ending FGM/C. This report urges governments, the international community, and donors to:

- Renew their commitment towards the elimination of FGM/C worldwide.
- Recognize FGM/C as a gross violation of human rights, a form of violence against women and girls, and a manifestation of gender inequality.
- Recognize that FGM/C is occurring across continents, cultures, socio-economic classes, educational status, religions, and ethnicities; make efforts to end FGM/C a global priority.
- Refrain from stigmatizing a single affected community, culture, or religion, and ensure that all interventions take into consideration gender inequality as the root cause of FGM/C.
- Enforce and implement a zero-tolerance policy for FGM/C, irrespective of the type or form of FGM/C practiced or the perceived severity of the cutting, as all forms of FGM/C are deeply rooted in gender inequality and, regardless of their physical consequences, have a psychological impact on women and girls.
- Ensure country-level reporting of FGM/C prevalence and action taken to end the practice in every country to comply with indicator 5.3.2 of the SDGs.
- Ensure that the implementation of these recommendations is monitored and that clear accountability mechanisms are in place to track progress and resource allocation.

2.

URGENTLY INCREASE RESOURCES AND INVESTMENT TO END FGM/C AND SUPPORT SURVIVORS

It is acknowledged that current efforts to end FGM/C are severely under-resourced. Current funding does not sufficiently take into consideration all countries where FGM/C is present, particularly some of the countries highlighted in this report. If we are to end FGM/C, we need to urgently scale up investments to protect and support all women and girls adequately.

We therefore urge governments, the international community, and donors to:

- Scale up global investment in efforts to end FGM/C.
- Ensure that resources are also invested in programs to end FGM/C in countries that have not traditionally been prioritized, including Asia and the Middle East.
- Ensure the availability of funding opportunities that overcome geographical barriers, enabling projects and initiatives that address the complexity of FGM/C through more comprehensive transnational and cross-border interventions.
- Prioritize resources towards grassroots and community-led interventions and support the sustainability of community engagement through adequate funding that takes into account the operational realities of community-based organizations and initiatives.
- Ensure scaled-up funding to train professionals in all relevant sectors (such as health, social work, asylum, education including sex education, law enforcement, justice, child protection, and media and communication) on how to effectively respond to cases of FGM/C and violence against women and girls and ensure adequate and holistic care and protection for survivors and women and girls at risk.
- Secure funding for youth-led initiatives and movements to ensure they can be full actors of change to end FGM/C within this generation.

3.

STRENGTHEN THE EVIDENCE BASE THROUGH CRITICAL RESEARCH

As highlighted in this report, significant data gaps exist in relation to the prevalence and practice of FGM/C globally. Having reliable data on FGM/C prevalence is extremely important since this data can be used to trigger and guide action to end FGM/C, assess progress on prevention, measure the effectiveness of anti-FGM/C interventions, and ensure accountability and influence global resource allocation toward ending FGM/C.

In this regard, we urge governments, the international community, and donors to:

- Increase and sustain funding for research on FGM/C, including by prioritizing countries where FGM/C is present, but that have not traditionally been associated with FGM/C.

We specifically urge governments and the international community (including UNICEF, which holds the mandate to ensure implementation of indicator 5.3.2 of the SDGs) to:

- Fill the data gaps outside the 31 countries that have nationally representative prevalence data on FGM/C and generate more reliable data on FGM/C prevalence globally.

- Generate nationally representative data on FGM/C in countries where there is evidence of widespread practice of FGM/C across the country, for instance, in Malaysia, Oman, Iran, and Brunei Darussalam, including through the use of the FGM/C modules as part of a country's DHS or MICS surveys. In countries where the practice of FGM/C is more localized, generate more robust data either through nationally representative surveys or through specific research surveys/studies, which produce accurate, reliable, and comprehensive data relating to the practice of FGM/C within a particular community/communities or region(s) within the country.

- Improve the available indirect estimates on FGM/C by ensuring the use of more rigorous methodologies, utilizing consistent methods across countries to enable comparison of the data, and systematically updating the indirect estimates at regular intervals.

- Enact laws and policies that integrate provisions for national health institutions to collect accurate and reliable data on the prevalence of FGM/C and monitor the implementation of programs to address the practice with regular reporting.

- Through a community-based and participatory approach, involve academics, health professionals, and practicing communities and survivors in data collection and research; work together to provide more accurate qualitative and quantitative information on FGM/C; and make it available and accessible to the wider public to ensure tailored interventions.

4.

ENACT AND ENFORCE COMPREHENSIVE LAWS AND NATIONAL POLICIES

A specific legal and policy framework tackling FGM/C demonstrates political will towards ending FGM/C and lays down a norm that FGM/C is a harmful practice. While not sufficient, its existence can play an important role in accelerating social change and contribute to ending the practice of FGM/C. However, the effectiveness of such anti-FGM/C frameworks depends largely on their correct implementation involving key actors, including law enforcement agencies, child protection professionals, educators, healthcare professionals, local, traditional, and religious leaders, government agencies, advocates, communities, and survivors.

To this aim, we urge governments to:

- Pass specific laws or legal provisions to prohibit FGM/C in every country where there is evidence of FGM/C being present. The law should recognize FGM/C as a human rights violation and a form of gender-based violence and should, therefore, include a strong gender analysis of the practice. It should prioritize prevention measures to protect girls and women from FGM/C.
- Enforce and implement existing anti-FGM/C laws and adopt comprehensive National Action Plans involving all relevant stakeholders in the elimination of FGM/C and provision of care and protection for survivors, including ensuring necessary budgetary allocation.
- Mainstream the prevention of FGM/C in all sectors, especially health, including sexual and reproductive health, social work, asylum, education including sex education, law enforcement, justice, child protection, and media and communication; establish multi-stakeholder platforms among the different sectors to better coordinate such cooperation.
- Ensure that appropriate and structured mechanisms are in place to meaningfully engage with FGM/C-affected community representatives and grassroots women's organizations, including survivor-led and youth-led organizations, in policy and decision-making.
- Engage local communities in law enforcement to improve compliance and ensure that laws are seen as tools for protection rather than punishment.
- Provide education and information on the existence and effects of FGM/C and its legal status within the country; issue appropriate policies, directives and guidelines to law enforcement officials to enforce anti-FGM/C laws; and sensitize and enhance the capacity of government officials to ensure that they do not stigmatize practicing communities in their work.
- Prevent and address the growing concern of medicalization of FGM/C, including by issuing guidelines and advisories to all health professionals prohibiting them from performing FGM/C that may lead to revocation of professional licenses and/or criminalization.
- Integrate youth voices at every level of decision-making, including through collaborations with existing global, regional, and grassroots youth organizations.
- Promote the use of the multi-sectoral approach and collaboration through establishing formalized frameworks for collaboration between sectors (health, education, law enforcement, civil society, etc.) will improve coordination and reduce overlap.

5.

IMPROVE THE WELL-BEING OF SURVIVORS BY PROVIDING NECESSARY AND CRITICAL SUPPORT AND SERVICES

230 million women and girls in over 90 countries in the world live with the lifelong consequences of FGM/C. All these women and girls are survivors of a harmful practice and must be able to access equal standards of tailored support and care from a physical, psychological, and sexological perspective, regardless of where they live. This is paramount to empower these women and girls and support them in their lives.

Therefore, we urge governments, the international community, and donors to:

- Invest in better research studies on the psychological, sexual, and health impacts of FGM/C, differentiated by type (including Types I and IV FGM/C, of which evidence is scant), and understand the healthcare needs of FGM/C survivors.

- Prioritize and significantly increase investments towards initiatives focusing on care and self-care for survivors and creating networks of survivors, including those who are active in ending the practice of FGM/C, to support them in their journey adequately.

Moreover, we specifically urge governments to:

- Ensure that all FGM/C survivors, regardless of where they live, have access to adequate, affordable, and quality general and specialized services of their choice that are gender, child, and culture-sensitive.

- Ensure a holistic healthcare accompaniment for FGM/C survivors that is women/girl-centered and which takes into consideration physical, psychological, and sexological consequences of the practice and addresses them comprehensively and sensitively.

- Given the cultural complexities around FGM/C, ensure that approaches are culturally sensitive and community-driven, focusing on education, awareness, and positive community-led change.

Equality Now, the End FGM European Network, and the U.S. End FGM/C Network are all part of the Global Platform for Action on Ending FGM/C, along with a number of other civil society organizations and activists. Within this platfor,m we have launched a global call to action to end FGM/C.

Please visit our website and sign here: actiontoendfgmc.com

FGM/C IN THE AFRICAN REGION

FGM/C IN THE ASIA-PACIFIC REGION

PAKISTAN
FGM/C is known to take place within the Bohra community in Pakistan, which is estimated to be around 100,000 people. There is anecdotal information that it may be practiced in the Sheedi community. There are no prevalence estimates available. Type I FGM/C is practiced (cutting of the clitoral hood and/or the clitoris).

INDIA
FGM/C is known to be practiced by the Bohra community as well as a Sunni Muslim sect in Kerala. The Bohra population in India is estimated to be around 1 million. A 2018 study estimated prevalence of FGM/C within the Bohra community to be 75% of daughters of all respondents in the sample. The Bohra community practices Type I FGM/C (cutting of the clitoral hood and/or the clitoris), known locally as "khatna" or "khafz".

SRI LANKA
FGM/C is known to occur among the Moor, Malay, and Bohra communities in Sri Lanka. No prevalence estimates are available. The type of FGM/C practiced is usually Type I/Type IV FGM/C (cutting/pricking of the clitoral hood and/or clitoris).

MALDIVES
National prevalence data shows FGM/C prevalence of 13% among women and girls aged 15-49, but a prevalence of only 1% among girls aged 0-14. Anecdotal evidence suggests that in the Maldives, Type IV FGM/C is mainly practiced, consisting mostly of small cuts to the genitals.

KEY:
- Countries with national-level prevalence estimates of FGM/C
- Other countries with evidence of FGM/C

CAMBODIA
The Cham community in Cambodia is known to practice FGM/C, though research into the practice is still ongoing and there is no published data or research available.

VIETNAM
The Cham community in Vietnam is known to practice FGM/C, though research into the practice is still ongoing and there is no published data or research available.

SINGAPORE
FGM/C is known to be practiced in Singapore in the Malay Muslim community (accounting for around 15% of the total population). A pilot survey found that 75% of Muslim women in the study sample had been cut in their early childhood. The Malays normally practice Type I/Type IV FGM/C (cutting/pricking of the clitoral hood and/or clitoris) in a procedure known as 'sunat perempuan'.

THAILAND
FGM/C in Thailand is known to be practiced by Muslim communities (which make up 5-8% of the total population), largely concentrated in the three southern provinces of Yala, Narathiwat and Pattani. Type I/Type IV FGM/C is known to be practiced (cutting/pricking of the clitoral hood and/or clitoris) in a procedure known as 'sunat' or 'sunat perempuan'.

BRUNEI DARUSSALAM
The Government of Brunei has confirmed that Type I FGM/C is practiced in the country. Though no specific prevalence rates are available, FGM/C is known to be widely practiced within the Malay community which makes up a majority of Brunei's population.

PHILIPPINES
FGM/C in the Philippines is practiced only in small pockets of the country, mainly by Muslim communities in the Mindanao region. Practicing communities refer to this type of mutilation as pag-sunnat or turi and largely falls under Type IV. In some cases, particularly the practice of turi by the Meranaos, Type I is practiced.

MALAYSIA
An estimated 53% of all female citizens in Malaysia are affected by FGM/C. Type I/Type IV FGM/C is known to be practiced (cutting/pricking of the clitoral hood and/or clitoris), most commonly on babies aged 1-2 months old.

INDONESIA
National data shows FGM/C prevalence of 51.2% among girls aged 0-11 across the country. The type of FGM/C practiced is usually Type I/Type IV FGM/C (cutting/pricking of the clitoral hood and/or clitoris).

AUSTRALIA
Indirect estimates indicate that there are 53,088 survivors of FGM/C living in Australia.

NEW ZEALAND
Anecdotal evidence indicates that there are survivors of FGM/C from diaspora communities living in New Zealand, though there is no reliable estimate available.

FGM/C IN THE MIDDLE EAST REGION

IRAQ
National data for Iraq estimates FGM/C prevalence of 7.3% among women and girls aged 15-49 in Iraq. The practice of FGM/C in Iraq is largely concentrated in the Kurdistan region. The most common type of FGM/C is Type I.

IRAN
FGM/C in Iran is known to be concentrated among the Kurdish community and the Sunni minority communities in Iran, largely in provinces located in the west and south of the country. Various studies across regions in Iran have found FGM/C prevalence ranging from 16 - 83% within the population sample. Type I FGM/C is the most common, although Type II has also been reported.

SYRIA
There is anecdotal evidence of FGM/C occurring in Syria, but the evidence available is scarce.

KUWAIT
There is one study of FGM/C in Kuwait which estimates FGM/C prevalence at 38% among the study sample.

JORDAN
There is anecdotal evidence of FGM/C occurring in Jordan, but the evidence available is scarce.

BAHRAIN
There is anecdotal evidence of FGM/C occurring in Bahrain, but the evidence available is scarce.

QATAR
There is anecdotal evidence of FGM/C occurring in Qatar, but the evidence available is scarce.

SAUDI ARABIA
FGM/C in Saudi Arabia is found to exist among women and girls from both indigenous and diaspora communities based on information from 13 research studies. A study from Jeddah found that 18% of women and girls surveyed had undergone FGM/C, while another study based in Hali estimated prevalence within that survey sample at 80%. The most commonly reported procedures of FGM/C are Types I and II, though some cases of Type III FGM/C were also reported.

UNITED ARAB EMIRATES
Two small-scale studies found that FGM/C is occuring in the United Arab Emirates, demonstrating prevalence of 41% and 34% amongst the survey samples.

KEY:
- Countries with national-level prevalence estimates of FGM/C
- Other countries with evidence of FGM/C

YEMEN
National prevalence data estimates FGM/C prevalence of 18.5% among women and girls aged 15-49 in Yemen. Type II FGM/C is most commonly practiced in Yemen and the practice is spread throughout the country.

OMAN
FGM/C is reportedly practiced throughout the country. A survey from the Ad-Dakliya province found that 95.5% of women from the sample had undergone FGM/C, while an earlier study of women living in the capital Muscat demonstrates a prevalence of 78% among women in that study. Type I and in some cases Type II FGM/C are reportedly practiced in Oman.

FGM/C IN THE EUROPEAN REGION

SURVIVORS OF FGM/C LIVING IN EUROPE

NORWAY 17,058

SWEDEN 38,939

FINLAND 10,254

ESTONIA 8

LATVIA 5

DENMARK 7,910

NETHERLANDS 41,000

IRELAND 5,790

UK 137,000

LUXEMBOURG 379

BELGIUM 23,395

GERMANY 103,947

POLAND 207

CZECH REPUBLIC 312

SLOVAKIA 57

AUSTRIA 7,036

HUNGARY 396

SWITZERLAND 22,410

FRANCE 125,000

SLOVENIA 69

CROATIA 112

ROMANIA 79

BULGARIA 31

ITALY 87,600

SPAIN 15,907

PORTUGAL 6,576

GREECE 15,249

MALTA 565

CYPRUS 1,301

RUSSIA

FGM/C is practiced in Russia by the Avar community in East Dagestan. Type I FGM/C was the most common, though among the Andi people, removal of the clitoris and the labia minora (Type II FGM/C) was also observed. 1240 girls are estimated to be at risk of undergoing FGM/C every year.

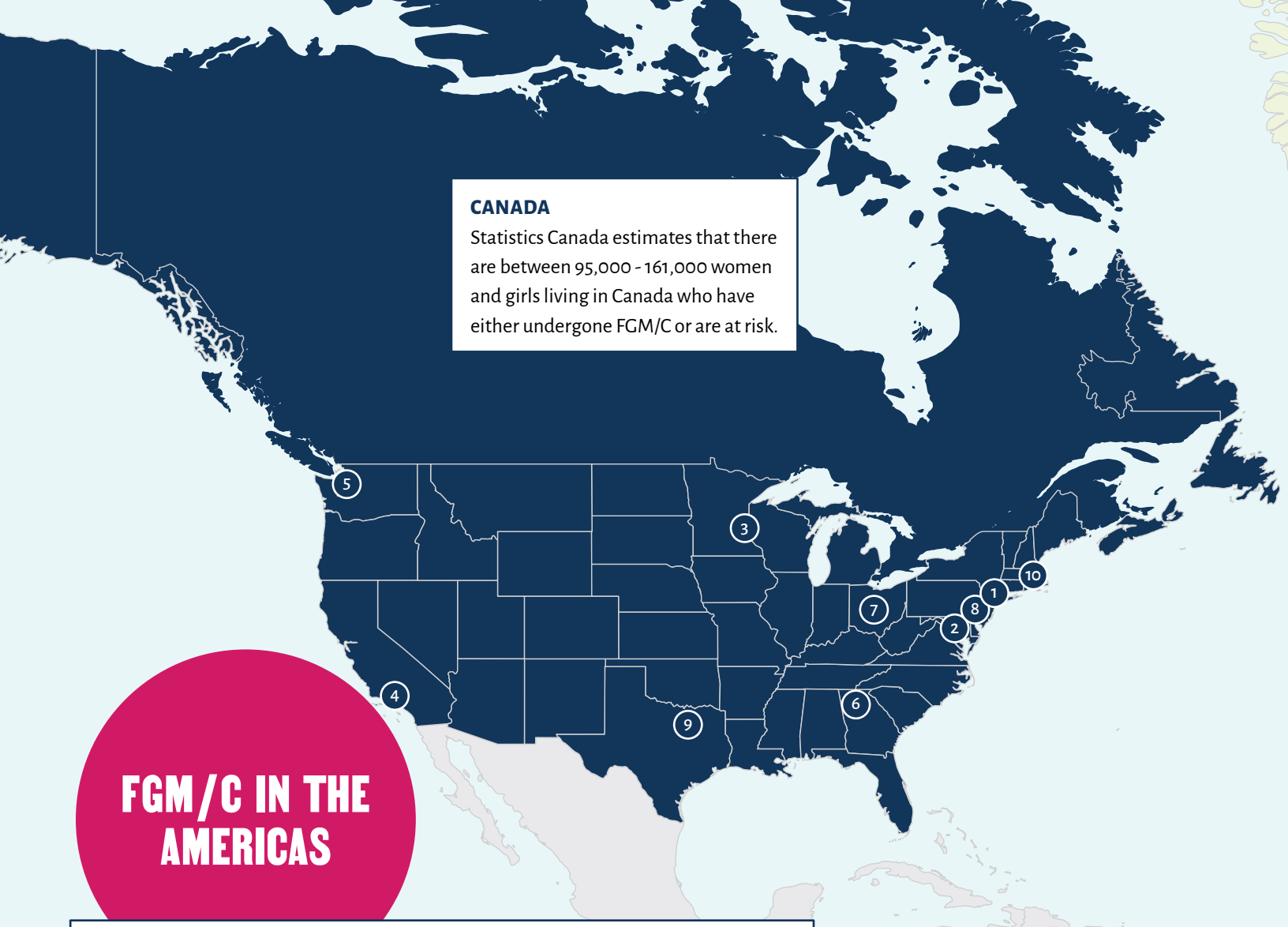
GEORGIA

Type I FGM/C is practiced by the Avar community (a small community in Georgia with a population of around 3000).

AZERBAIJAN

FGM/C has been found to be practiced in Azerbaijan by North Caucasian communities (Avars, Akhvakhs) in some villages in the North and North West region of the country.

This data has been internally gathered by the End FGM European Network using existing studies. It should be noted that methodologies used for the studies differ as well as the years of data collection. In the meantime, some countries have noted significant increases in the numbers. The collection of data continues to be a huge challenge.



FGM/C IN THE AMERICAS

CANADA

Statistics Canada estimates that there are between 95,000 - 161,000 women and girls living in Canada who have either undergone FGM/C or are at risk.

USA

513,000* women and girls nationwide are at risk of undergoing FGM/C. A 2023 study by AHA Foundation found that an estimated 577,000 women and girls were potentially impacted by FGM/C in 2019, though this figure is reduced to 421,000 if the estimate takes into account the impact of migration on the practice.

The highest numbers of at-risk women and girls live in these metropolitan** areas:

1. New York, Newark, Jersey City - New York State: **65,893**
2. Washington DC, Arlington, Alexandria - Virginia: **51,411**
3. Minneapolis, St. Paul, Bloomington - Minnesota: **37,417**
4. Los Angeles, Long Beach, Anaheim - California: **23,216**
5. Seattle, Tacoma, Bellevue - Washington: **22,923**
6. Atlanta, Sandy Springs, Roswell - Georgia: **19,075**
7. Columbus - Ohio: **18,154**
8. Philadelphia, Camden, Wilmington - Pennsylvania: **16,417**
9. Dallas, Fort Worth, Arlington - Texas: **15,854**
10. Boston, Cambridge, Newton - Massachusetts: **11,347**

*Statistic from The Centers for Disease Control and Prevention 2016
**Metropolitan area statistics from Population Reference Bureau study, 2015

COLOMBIA

Type I FGM/C is known to be practiced by the Embera indigenous people in Colombia, normally on newborn babies. It is estimated that **two out of every three Emberá women have suffered FGM/C**. Other indigenous communities and Black, Afro-Colombian, Raizales and Palenqueras communities may practice FGM/C.

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