EVID RESEARCH

Full REPORT

FEMALE GENITAL MUTILATION FGM IN HUMANITARIAN SETTINGS

Prepared for IPPF by:

EVID Research

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AWRO IPPF

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This report represents a collaborative effort to address the critical issue of Female Genital Mutilation (FGM) within the context of humanitarian crises. The study was led by **Dr. Khalifa Elmusharaf**, Associate Professor and Director of the Public Health Program at the University of Birmingham Dubai, and **Dr. Louran Ali**, Health System Management and Policy Consultant at EVID Research.

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TABLE OF ABBREVIATIONS

Abbreviation	Full Form
ACRWC	African Charter on the Rights and Welfare of the Child
ALIMA	Alliance for International Medical Action
ACHPR	African Charter on Human and Peoples' Rights
BEFEN	Well-being of Women and Children in Niger
BNPB	National Disaster Mitigation Agency
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CEFM	Child Early and Forced Marriage
CELIAF	Cellule de Liaison des Associations Féminines
CFA	Chartered Financial Analyst
CTOCIDTP	Convention Against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment
CAT	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CONIPRAT	National Committee on Harmful Traditional Practices
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Surveys
ECOWAS	Economic Community of West African States
ERSIP	Regional Survey on Social Indicators and Poverty
FGM/C	Female Genital Mutilation/ Cutting
FSL	Food security and livelihoods
GAGE	Gender and Adolescence: Global Evidence
GBVS	Gender-Based Violence Strategy
GDP	Gross Domestic Product
HDI	Human Development Index
HTP’s	Harmful Traditional Practices
IDP’s	Internally displaced persons
ILO	International Labor Organization
IHRRM	Implementation of the Human Rights Roadmap
IHRDA	Institute for Human Rights and Development in Africa
ICESCR	International Covenant on Economic, Social, and Cultural Rights
ICCPR	International Covenant on Civil & Political Rights
KPPPA	The Ministry of Women's Empowerment and Child Protection
KRG	Kurdistan Regional Government
KRI	Kurdistan Region of Iraq
MoWCY	Ethiopian Ministry of Women, Children and Youth

MOWHRD	Federal Ministry of Women and Human Rights Development
MOWDAFA	Ministry of Women's Development and Family Affairs
MOH	Ministry of Health (MOH)
MFRAE	Ministry for Religious Affairs and Endowment
MICS	Multiple Indication Cluster Survey
MIS	Malaria Indicator Survey
MSF	Médecins Sans Frontières
M&E	Budget and monitoring and evaluation
NGHSS	National Girls Education Sector Strategy
NGO	Non-Governmental Organization
NHSS	National Health Sector Strategy
NSPS	National Social Protection Strategy
NCCW	National Council for Child Welfare
NPLE	National Program for the Fight against Excision
NAPC	National Action Plan for Children
ODI	Open Data Institute
PNLE	National Program for the Fight Against Excision
RSF	Rapid Support Forces
SBC	Social and Behavior Change
SDR	Sustainable Development Report
SDGs	Sustainable Development Goals
SHHS	Sudan Household Health Survey
SNNP	Southern Nations, Nationalities, and Peoples
SWOT	Strength, Weaknesses, Opportunities, and Threats
SPA	Service Provision Assessment
SHDS	Somali Health and Demographic Survey
SAF	Sudanese Armed Forces
SLHDS	Somaliland Health and Demographic Survey
UN	United Nations
UNHRC	UN Human Rights Committee
UNFPA	United Nations Population Fund
UNGA	UN General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
UNJP	United Nations Joint Programme
UNCRC	United Nations Convention on the Rights of the Child
WADI	Association for Crises Assistance and Development Cooperation
WHO	World Health Organization
WAEMU	West African Economic and Monetary Union

WFP	World Food Programme
WaSH	Water, sanitation, hygiene
Y-PEER	Somaliland Youth Peer Education Network

EXECUTIVE SUMMARY

This report provides an in-depth examination of Female Genital Mutilation (FGM) within the context of complex humanitarian crises. Spanning 12 countries, the analysis explores the prevalence of FGM, its socio-economic and cultural determinants, the adaptation of practices in fragile settings, and the persistent structural barriers hindering elimination efforts. Despite decades of interventions, the global pace of decline needs to accelerate by up to 27 times to meet the 2030 Sustainable Development Goal (SDG) target, underscoring the urgency of the challenge.

The Evolving Crisis Landscape

Humanitarian crises have become increasingly complex and protracted, with more than 50% of the world's displaced people now coming from countries that practice FGM. Conflict, forced migration, and climate shocks have weakened governance systems, disrupted health services, and eroded community protection mechanisms—creating conditions that exacerbate gender-based violence (GBV) and reinforce harmful social norms. Within these fragile environments, FGM has evolved beyond a cultural ritual to become a coping mechanism for insecurity, economic hardship, and social control. Evidence from Sudan, Yemen, Chad, and Somalia highlights that displacement and loss of livelihoods have intensified community pressures to perform FGM as a perceived means of preserving marriageability and family honor. At the same time, emerging research indicates that migration—particularly among Sudanese refugees in Egypt and Chad—can also create opportunities for abandonment, as displaced mothers make independent choices away from extended family and traditional enforcers of the practice.

Prevalence of FGM and Socio-Cultural Determinants

The prevalence of FGM varies significantly across the 12 countries analyzed:

- **High-Prevalence Core (85%+):** Countries including Somalia, Mali, Egypt, and Sudan report rates exceeding 85%. While countries like Egypt have achieved a breakthrough in reducing prevalence among adolescent girls (down to 37% in 2021), this progress is threatened by the country's 74% medicalization rate and the ongoing conflict in the region.
- **Moderate/Declining Prevalence (30%–65%):** Ethiopia, Mauritania, and Chad demonstrate prevalence rates ranging from 30% to 65%. In Chad, FGM efforts are paralyzed by the lack of legal enforceability (missing

implementation decree), while Ethiopia is showing positive decline in younger generations.
- **Localized/Low Prevalence:** Iraq, Niger, Pakistan, and Indonesia report localized FGM within specific ethnic or cultural groups. For instance, in Pakistan, FGM is confined to the Dawoodi Bohra community, while in Iraq, it is primarily concentrated in the Kurdistan Region.

The findings confirm that FGM is sustained by socio-economic factors, including poverty, illiteracy, and deeply rooted gender-based violence (GBV), demonstrating the intersectionality of these issues across all settings.

FGM in Humanitarian Contexts and Structural Barriers

Humanitarian crises, driven by conflict, climate change, or prolonged emergencies, exacerbate FGM by eroding protection mechanisms and causing social chaos.

Findings from this report underscore the urgent need to reframe FGM as both a human rights violation and a humanitarian protection issue. Integrating FGM prevention into humanitarian response plans remains inconsistent and underfunded. FGM is still too often categorized as a "non-life-saving" issue, resulting in fragmented interventions and missed opportunities for cross-sectoral action.

Applying the Humanitarian–Development–Peace (HDP) Nexus offers a critical pathway forward. By linking immediate protection with long-term resilience building, the nexus approach enables continuity between emergency response, community recovery, and sustainable development. This integrated strategy ensures that anti-FGM measures remain active throughout all phases of crisis response and recovery.

Key findings:

- **Crisis Acceleration and Protection Failure:** The conflict in Sudan (since April 2023) has transformed FGM into an acute protection crisis. Displacement fuels FGM as a survival strategy (linking girls to child marriage) or as a desperate, falsely perceived protection measure against heightened Conflict-Related Sexual Violence (CRSV). The lack of state security leads to a collapse of protection across IDP and refugee settings.
- **Cross-Border Spread and Compounded Harm:** Cross-border FGM is rife in displacement environments (e.g., Sudanese refugees in Chad), where the practice occurs covertly and often involves procedures like

re-infibulation (*adal*). The resulting physical and psychosocial harm is compounded by the unsanitary conditions and absence of medical care in camps.

- **Structural and Legal Impunity:** A critical barrier across all 12 countries is fragmented leadership and pervasive legal impunity. This results from the absence of a national criminal ban (Mali, Yemen) or chronic weak enforcement due to missing implementing decrees (Chad) or wholesale legal collapse during conflict (Sudan).
- **Intervention Challenges:** Interventions are often undermined by short-term, inflexible funding that fails to address long-term behavioral change. National programs frequently suffer from fragmented structures and insufficient integration into broader health and emergency response plans.
- **Community Agency and Women's Leadership:** Women and girls are emerging as key actors in resisting FGM, particularly in displacement contexts where they exercise new forms of autonomy. Supporting local women's networks and refugee-led organizations can accelerate change.
- **Funding Deficits:** FGM programming remains underfunded within humanitarian appeals. Multi-year, flexible funding is necessary to align with the long-term nature of social norm change.

Recommendations and Way Forward

To accelerate elimination, strategies must pivot to the Humanitarian-Development-Peace (HDP) Nexus approach, ensuring immediate protection while dismantling FGM's deep structural roots.

1. **Strengthen Legal and Systemic Enforcement:** Rigorously enforce existing laws, particularly against medicalization, and enact binding national legislation in countries currently lacking a specific criminal ban. Local enforcement mechanisms must be strengthened with targeted training for judicial authorities and law enforcement personnel.
2. **Integrated Humanitarian Response:** FGM interventions must be prioritized and integrated into all humanitarian response plans (HRPs) to mitigate immediate risks among refugees and IDPs. Specific strategies must be funded to address cross-border FGM dynamics (e.g., between Sudan, Chad, and Egypt).
3. **Establish Comprehensive National FGM Programs:** Develop cohesive national policies and strategic plans with fully structured and accountable governing bodies from national to local levels. Allocate dedicated budgets to ensure sustained implementation.

4. **Community and Behavioral Change:** Leverage community-led advocacy and empowerment by engaging male community members, religious leaders, and influential figures to promote alternative rites of passage and challenge harmful norms, especially the misconception that FGM is religiously mandated.
5. **Enhancing Data and Accountability:** Include FGM indicators in national surveys (DHS/MICS) to track progress accurately. Establish strong accountability mechanisms to ensure governments and international partners uphold commitments to FGM elimination.
6. **Sustainable Financing and Resource Mobilization**: Mobilize and dedicate substantially increased, long-term, and flexible funding for FGM elimination programs, moving away from short-term emergency grants. Governments and international partners must ensure dedicated budget lines are established for FGM/GBV interventions within national planning.

Conclusion

The persistence of FGM in humanitarian settings underscores the urgency of addressing this harmful practice as part of broader efforts to protect women and girls in crises-affected regions. A definitive shift in strategy, focusing on the integrated HDP Nexus approach, is critical to accelerating progress. By aligning humanitarian, development, and peacebuilding efforts with comprehensive national systems, stakeholders can create sustainable and impactful solutions to eradicate FGM and safeguard the rights and health of vulnerable populations.

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INTRODUCTION

Female genital mutilation (FGM) refers to all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-medical, it interferes with the natural functioning of the body and has no known health benefits(1). FGM is widely recognized as a procedure that violates a person's human rights, as well as increasing their risk for health complications. literature reported the association between FGM and maternal morbidity and birth outcomes. Studies have shown maternal prolonged maternal hospitalization, low birthweight, prolonged labour, obstructed labour, and increased frequency of caesarean sections. In addition to the obstetrical, gynaecological, and neonatal impacts of FGM, other long-term health consequences include psychological and psychosexual disorders(2).

FGM is practiced for many different socio-cultural reasons. Often, those who practice it point out that it is rooted in local culture and has been passed from one generation to another. Indeed, research suggests that ethnicity and the practice of FGM are closely linked(3). It can serve as a marker of cultural identity, which has the effect of creating a powerful impetus to continue the practice, especially if a society feels under pressure or threat(4). Other cultural factors contributing to female genital mutilation (FGM) often stem from gender inequality, where women are seen as the custodians of family honour. In these societies, there is a belief that girls' sexual desires must be controlled from an early age to preserve their virginity and prevent immorality.

In some communities, FGM is considered essential for ensuring marital fidelity and preventing "deviant" sexual behaviour, while in others it is performed for hygiene and aesthetic reasons, with uncircumcised girls perceived as unclean or undesirable for marriage. In certain regions, such as northern Sudan, infibulation is thought to enhance beauty by creating smoothness(4), further reinforcing its cultural value. Additionally, FGM is practiced across various religious communities, including Muslim, Christian, Jewish, and those following traditional faiths, suggesting a complex connection between the practice and religious identity, even though it is not tied to any single religious tradition. While the majority of these religion do not practice FGM.

There are four types of FGM as classified by the World Health Organization and other UN agencies: Type I includes the partial or total removal of the clitoris and/or prepuce. Known as clitoridectomy. It is divided into two sub-divisions. Type I.a. involves the removal of the clitoral hood or prepuce and

Type I.b. involves the removal of the clitoris along with the prepuce. Type II, a more invasive procedure than Type I, includes the partial or total removal of the clitoris and the labia minora. This form can be performed with or without excision of the labia majora and is known as excision. Type III is the most severe type of FGM. It is known as infibulation, or in Yemen and other countries as pharaonic mutilation. Infibulation involves the narrowing of the vaginal orifice with the creation of a seal that is formed by cutting and then stitching the labia minora and/or the labia majora with or without excision of the clitoris. Type IV of FGM includes all other harmful procedures to female genitalia including pricking, piercing, incising, scraping, and cauterization. Types I and II account for nearly 85 per cent of all procedures globally.

In addition to these types, some forms of female genital mutilation have also been reported in other countries, including among certain ethnic groups in Central and South America. FGM is typically carried out on young girls, from infants to adolescents as old as 15 years of age. Occasionally it is carried out on adult women(5), when they are about to be married, or after marriage, during pregnancy and after childbirth, or when their daughters undergo the procedure(6).

FGM is a deeply rooted tradition in many communities in 28 countries in Africa and some countries in Asia and the Middle East(7). Nearly half of them are in just two countries: Egypt and Ethiopia. Countries in which FGM has been documented include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen(4).

In the world today, there are an estimated 130–140 million girls and women who have been subjected to the operation and 3 million girls are at risk of undergoing the practice every year (8). Studies indicate that the practice of FGM has changed in a number of ways. Most encouragingly, the practice is declining. This can be observed when looking at data from countries in which at least two surveys are available, showing advanced prevalence in a number of countries. This can also be observed by comparing the youngest and oldest age-group in one survey, showing that women aged 15–19 years are less likely to have been subjected to FGM than are women in older age groups(9)

Efforts to eliminate Female Genital Mutilation (FGM) have been ongoing for decades, with significant progress at the international level, including the inclusion of FGM in the Sustainable Development Goals (SDGs) under Target 5.3, which aims to eliminate all harmful practices by 2030. The UNICEF-

UNFPA Joint Program has been crucial in advancing these efforts, but FGM remains widespread and progress to end it remains is slow. Global efforts need to be 27 time faster to eliminate the problem. If the current trends continue, an estimated 68 million girls could undergo FGM between 2015 and 2030 in the 25 countries where it is most prevalent. In 2023, Globally, more than 230 million girls and women are estimated to have undergone FGM. Every year, over 2 million girls are subjected to it before their fifth birthday.[2] The global pace of decline would need to be 27 times faster to eliminate the practice by 2030[3].

Numerous statements and resolutions from international conferences, United Nations agencies, treaty monitoring bodies, and other human rights institutions have recognized female genital mutilation (FGM) as a violation of human rights, including the rights of women and girls to health, freedom from violence, life and physical integrity, non-discrimination, and freedom from cruel, inhuman, and degrading treatment. These organizations have condemned the practice and outlined specific responsibilities for governments to take action towards its eradication(10).

The 1995 Fourth World Conference on Women (Beijing Conference) called on governments to enact and enforce legislation against female genital mutilation (FGM)(11). Similarly, the 2002 Cairo Declaration for the Elimination of FGM emphasized that governments, in consultation with civil society, should adopt specific legislation to demonstrate their commitment to ending the practice and ensuring the human rights of women and girls(12).

In 2001, the UN General Assembly passed resolution 56/128 on Traditional or Customary Practices Affecting the Health of Women and Girls, urging states to implement measures to eliminate FGM, including enacting and enforcing national laws, policies, and programs aimed at abolishing the practice and prosecuting perpetrators(13). Also, he UN Resolution to Ending FGM (2020) A/HRC/RES/44/16 urges states to condemn particularly FGM, including medical procedures carried out both within and outside of medical institutions. It calls on governments to take all necessary measures to prohibit FGM and protect women and girls from this form of violence.

Convention on the Elimination of All Forms of Discrimination against Women. This convention urged states to take all appropriate measures, including the enactment of legislation, to modify or abolish existing laws, regulations, customs, and practices that discriminate against women. This includes repealing any national penal provisions that perpetuate discrimination against women.

Tackling female genital mutilation (FGM) requires a comprehensive and multi-faceted approach. The Joint Program on the Elimination of Female Genital Mutilation: Accelerating Change outlines essential elements for effective intervention. First, establishing good governance structures is crucial for overseeing FGM elimination efforts, ensuring accountability, and coordinating among stakeholders. Strengthening existing programs by building capacity and integrating best practices is also vital, as is utilizing evidence-informed planning, which involves leveraging data from desk reviews and community assessments to develop context-specific strategies. Result-based management should be a focus, prioritizing outcomes over activities to measure the impact of interventions and make necessary adjustments.

Promoting gender equality is another critical aspect, addressing the broader social norms and attitudes that perpetuate harmful practices. Outreach programming plays a key role in engaging communities through awareness campaigns, education, and dialogue aimed at changing perceptions and behaviors related to FGM.

Moreover, operational planning and resource allocation are essential to ensure effective implementation of strategies. Systematic monitoring and evaluation must be conducted regularly to assess the progress and impact of interventions, allowing for continuous improvement. Finally, supportive policies at local, national, and international levels are needed to endorse FGM elimination and protect the rights of affected individuals. By integrating these components, stakeholders can create a robust framework for combating FGM, ultimately fostering healthier communities and promoting human rights.

Humanitarian settings, such as those affected by conflict or displacement, present challenges, as FGM can be exacerbated by social pressures, patriarchal structures, and the perceived necessity of the practice for marriageability or protection. FGM is often deprioritized in humanitarian crises because prevention and response interventions are not considered lifesaving or essential to girls' resilience.

During the outbreak of COVID-19, most national humanitarian response plans did not initially include FGM prevention and response interventions. The COVID-19 pandemic disrupted prevention programs, potentially leading to an additional 2 million cases of FGM over the next decade. In these contexts, girls and women are even more vulnerable, as disrupted social services and instability can increase the likelihood of FGM. With the wide spreading of human crises globally, a comprehensive approach is required to end this

harmful practice, —one that addresses both the immediate and long-term social and cultural FGM factors, especially in humanitarian settings. Furthermore, there is a need for increased direct investments and a stronger commitment to ensuring the integration of FGM in humanitarian preparedness and response plans.

The Joint Programme is shifting towards an approach that spans the humanitarian-development-peace nexus, addressing female genital mutilation (FGM) across the full spectrum from emergency preparedness, response, and early recovery, to ongoing social and structural development. This approach is grounded in a paradigm that seeks to mitigate risk and fragility.

Many lessons from 2019 are being applied in the response to the COVID-19 pandemic, including adapting community outreach, leveraging new communication channels, providing psychosocial support through digital technology, and identifying new partners with experience in community-based interventions in hard-to-reach areas. Rather than continuing with a "business as usual" approach, the Joint Programme is reworking its strategies around gender and resilience within the nexus framework. This includes strengthening prevention measures, enhancing program responses, and creating greater opportunities for girls and women to engage with decision-makers in the design and implementation of humanitarian preparedness and response plans.

Key priorities involve addressing gender inequalities that limit access to information, promoting meaningful participation in decision-making at both local and national levels, and ensuring equitable access to resources that help girls and women adapt to shocks, reduce their vulnerability to FGM, and build resilience(14).

STUDY OBJECTIVES

This study aims to provide a comprehensive understanding of the prevalence and scope of FGM in humanitarian settings by analyzing data from 12 countries where this practice remains a significant challenge. The countries examined include Egypt, Iraq, Mauritania, Pakistan, Mali, Chad, Somalia, Indonesia, Ethiopia, Sudan, Yemen, and Niger.

The study identifies and summarizes contextual challenges and opportunities for the elimination of FGM, proposing strategies to address these challenges or leverage opportunities. Additionally, it evaluates international efforts towards FGM elimination, identifying key intervention elements or packages that have proven effective in strengthening national actions against FGM. The interconnections between these successful interventions and their broader implications for related issues are also explored.

A detailed analysis of FGM elimination program performance in the 12 focus countries is undertaken, highlighting both successes and limitations. These findings are used to inform recommendations for policy and programmatic reforms, aiming to enhance the effectiveness and sustainability of efforts to eliminate FGM in humanitarian contexts.

The objectives of this study are:

- **Identify Contributing Factors:** Examine the key factors driving the practice of FGM in humanitarian settings.
- **Map FGM Practices and Locations:** Document the types of FGM performed and their geographical distribution across affected areas.
- **Assess Consequences:** Evaluate the physical, psychological, and social impacts of FGM in humanitarian contexts.
- **Incorporate FGM Prevention in Emergency Response:** Explore strategies for integrating FGM prevention and response into broader emergency and humanitarian efforts.
- **Analyze Associated Sociocultural Factors:** Investigate the role of identity, social belonging, and marriageability in perpetuating FGM practices.
- **Support Evidence-Based Interventions and Policy Reforms:** Provide actionable recommendations to stakeholders involved in combating FGM in humanitarian settings, aimed at scaling up successful interventions and addressing existing gaps.

METHODOLOGY

Study Design

This scoping review systematically analyzed both quantitative and qualitative data to explore Female Genital Mutilation/Cutting (FGM/C) in humanitarian settings. The review included a synthesis of numerical data and thematic analysis of textual information to examine FGM/C practices, humanitarian responses, and economic impacts comprehensively.

Defining Humanitarian Settings

For the purposes of this study, a humanitarian setting is operationally defined as a country that satisfies one or more of the following inclusion criteria:

1. **Presence of a Complex Emergency or Protracted Crisis:** The country is experiencing ongoing or recurrent armed conflict, significant political instability, or widespread violence that has led to a breakdown in authority and basic services. This condition is evidenced by large-scale internal displacement, profound threats to the well-being of the population (e.g., high levels of food insecurity and epidemics), or widespread damage to societies and economies.

2. **Recurrent or Severe Natural Disasters:** The country exhibits high vulnerability to frequent, large-scale natural disasters (e.g., floods, earthquakes, tsunamis) that overwhelm the national capacity to respond without significant international humanitarian assistance.

3. **Significant Role as a Refugee Host Country:** The country hosts a substantial number of refugees and asylum-seekers fleeing regional conflicts, placing a significant strain on local resources and requiring a dedicated humanitarian response.

This operational definition is aligned with the core concepts and working definitions used by major international humanitarian actors, focusing on the fundamental principles of humanity and needs-based response. The multi-faceted criteria used in this study reflect the diverse scenarios in which these agencies operate.

- **Alignment with OCHA and IASC:** The first criterion, covering complex emergencies and protracted crises, mirrors the Inter-Agency Standing Committee (IASC) and Office for the Coordination of Humanitarian Affairs (OCHA) definition of a situation where a "considerable breakdown of authority" requires an international response based on

need alone. This definition ensures that the study addresses contexts where the local capacity has been overwhelmed.

- **Alignment with UNHCR:** The third criterion, concerning host countries and displaced populations, directly relates to the mandate of the UN High Commissioner for Refugees (UNHCR). UNHCR's primary purpose is to safeguard the rights and well-being of those forced to flee conflict or persecution, defining these situations as settings that require specific protection and assistance.

- **Alignment with General Principles:** The focus on "critical threat to the health, safety, security, and well-being of a community" within the definition is consistent with the basic description of a humanitarian setting used across the sector, including by organizations such as the World Health Organization (WHO) and the International Committee of the Red Cross (ICRC), which emphasize addressing human suffering wherever it is found.

Below is a table with different descriptions of humanitarian settings and links to the relevant source pages from the agent that provided the description.

Table 1. Descriptions of humanitarian settings

Agent/Source	Definition or Primary Focus	Source Link
Inter-Agency Standing Committee (IASC)	A "complex emergency" is a humanitarian crisis with a considerable breakdown of authority due to internal or external conflict, necessitating an international response beyond any single agency's capacity.	ICVA - The IASC and the global humanitarian coordination architecture
World Health Organization (WHO) / Global Health Cluster	Describes a humanitarian setting as one requiring specific approaches to provide quality, people-centered, safe, and equitable healthcare during public health emergencies and crises.	GHC - Quality of Care in Humanitarian Settings
United Nations High Commissioner for Refugees (UNHCR)	A humanitarian setting is any crisis, whether from conflict, violence, or natural disasters, that threatens affected populations. Adherence to humanitarian principles is crucial for gaining and maintaining access to these populations.	UNHCR Emergency Handbook - Humanitarian principles
Office for the Coordination of Humanitarian Affairs (OCHA)	Defines humanitarian settings in the context of the operational environment, emphasizing that a needs-based response relies on strict adherence to the core humanitarian principles of humanity, impartiality, neutrality, and independence.	OCHA on Message: Humanitarian Principles
Concern Worldwide	A humanitarian crisis is an event or series of events that poses a critical threat to the health, safety, security, or well-being of a large group of people over a wide area.	Concern Worldwide

International Committee of the Red Cross (ICRC)	The ICRC's work in conflict emphasizes protecting the rights and dignity of individuals based on international humanitarian law. It views humanitarian work as focused on "the condition of man" without other considerations.	OCHA - Humanitarian action - the compassion of peoples and states

Table 2. Classification of Countries included in this report by Humanitarian Typology

Country	Classification by Humanitarian Typology	Key Humanitarian Factors	Crisis Phase (IAWG Nexus Model)
Sudan	Complex Emergency; Protracted Crisis	Active armed conflict, severe political instability, the world's largest internal displacement crisis, profound threats to well-being including famine conditions, and a massive refugee outflow.	Emergency/Protracted Crisis: The ongoing civil war places Sudan in a severe emergency phase, with elements of protracted crisis due to long-term conflict.
Yemen	Complex Emergency; Protracted Crisis	Decades-long conflict, political fragmentation, economic collapse, high levels of food insecurity (risk of famine), large-scale displacement, and major damage to basic services.	Emergency/Protracted Crisis: A deep-seated conflict and complex political landscape keep Yemen in a protracted emergency, where development gains have been lost.
Somalia	Complex Emergency; Protracted Crisis	Ongoing conflict/insecurity, climate shocks (droughts/floods), and severe threats to well-being (food insecurity, health crises).	Emergency/Protracted Crisis: Long-running instability and recurrent environmental shocks mean Somalia cycles between emergency and protracted crisis phases.
Mali	Complex Emergency; Protracted Crisis	Persistent insecurity and conflict, political instability (coups), large-scale internal displacement, and climate-related events exacerbating vulnerabilities.	Protracted Crisis: Decades of conflict and recent political upheaval have resulted in a protracted, complex humanitarian situation.
Niger	Complex Emergency (Regional Instability)	Insecurity, political instability (recent coups), and food insecurity exacerbated by regional conflicts.	Emergency/Protracted Crisis: Instability and displacement from regional conflicts and internal factors lead to emergency conditions in certain regions, with a protracted overall context.
Chad	Complex Emergency	Significant refugee influx from the Sudan war,	Emergency/Protracted Crisis:

	(Refugee Crisis & Host Country)	straining local capacity, with concurrent internal issues like disease outbreaks.	A sudden refugee influx has created an emergency in the eastern regions, while internal vulnerabilities reflect a protracted situation.
Ethiopia	Protracted Crisis (Regional & Internal Drivers)	Internal conflicts and climate impacts cause displacement and food insecurity; the context involves balancing humanitarian and long-term development efforts.	Protracted Crisis/Transition: While still facing humanitarian needs, Ethiopia often operates in a protracted phase, with the aim of moving toward a development-oriented approach.
Iraq	Post-Conflict Transition; Protracted Displacement	Managing humanitarian needs related to ongoing displacement, returns, and climate migration after a major conflict.	Transition/Recovery: Largely focused on recovery and long-term development, but still managing protracted displacement and needs from the prior conflict.
Pakistan	Recurrent Natural Disaster; Refugee Host	Prone to climate-induced disasters like floods, and hosts a large refugee population from Afghanistan .	Preparedness/Recovery (Periodic Emergency): Primarily a preparedness and recovery phase, punctuated by periodic emergency phases following natural disasters.
Egypt	Refugee Host Country; Regional Spillover	Hosts refugees and asylum-seekers from regional conflicts (e.g., Sudan, Syria), creating humanitarian needs despite the country not being in a crisis.	Response (Localized): The humanitarian response is localized to assist refugee populations and mitigate impact on host communities, rather than addressing a nationwide crisis.
Mauritania	Refugee Host Country; Localized Needs	Hosts a significant number of refugees from the Mali conflict, leading to localized pressure on resources.	Response (Localized): The crisis phase is localized to refugee camps and host communities and involves a response based on specific needs.
Indonesia	Recurrent Natural Disaster	A high-risk country for natural disasters (tsunamis, volcanoes, earthquakes), which trigger localized humanitarian settings.	Preparedness/Recovery (Periodic Emergency): The country focuses on preparedness and recovery, with localized emergency responses during specific events.

Figure 1. Countries by Humanitarian Typology

Quantitative Data Review

Quantitative data were systematically reviewed by two independent reviewers from key sources, including the Demographic and Health Surveys (DHS), UNICEF datasets, UNFPA datasets, and reports from the World Bank Group. The analysis focused on:

- Documenting the prevalence and demographic patterns of FGM/C.
- Understanding the drivers and consequences of FGM/C, especially in crises contexts.

Key Sources:

- **Global and National Databases:** Data from WHO, UNICEF, UNFPA, World Bank, and the Global Burden of Disease (GBD) were examined to identify prevalence trends and regional variations, with a focus on how humanitarian crises—such as displacement, migration, and conflict—impact FGM/C.
- **Demographic and Health Surveys (DHS):** DHS data provided insights into the types and geographical distribution of FGM/C practices.
- **National and Humanitarian Reports:** Reports from governments and humanitarian organizations were analyzed for specific data on displaced populations, conflict zones, and climate-affected areas.

Qualitative Data Review

A comprehensive search of the literature was conducted using Google Scholar and PubMed, without restrictions on publication date or language. Relevant information was also retrieved from databases of six international

organizations actively engaged in FGM/C-related work, including WHO and UNFPA.

Key Sources:

- **National Reports:** Reports provided insights into the prevalence of FGM/C and its complications, as well as its connections to culture, education, socioeconomic factors, and women's empowerment.
- **Peer-Reviewed Articles:** Studies exploring the sociocultural, economic, and institutional drivers of FGM/C were included, focusing on how factors like social norms and marriageability sustain the practice in displaced and migrant populations.
- **Gray Literature:** Policy briefs, unpublished reports, and organizational documents provided additional perspectives on the challenges of addressing FGM/C in unstable regions.

Search Strategy

- **Keywords:** Search terms included "Female Genital Cutting," "FGM," "FGM/C eradication," "FGM humanitarian crises," and country-specific combinations such as "FGM Sudan" and "FGC Chad."
- **Supplementary Searches:** Reference lists of relevant reviews were scanned, and consultations with experts ensured comprehensive inclusion of data.

Eligibility Criteria

Studies were included if they:

- Focused on FGM/C practices or associated factors, particularly in humanitarian contexts.
- Investigated outcomes in crises, refugee settings, or socio-economic dimensions of FGM/C.
- Employed cross-sectional, cohort, randomized trial, qualitative, or other recognized study designs.
- Included gray literature, policy documents, and both published and unpublished reports.
- Were published in any language, with translations provided as necessary.

Screening and Study Selection

Three reviewers independently screened and selected studies relevant to specific countries, including Indonesia, Somalia, Ethiopia, Chad, Mali, Egypt, Sudan, Pakistan, Yemen, Niger, and Iraq-Kurdistan.

1. **Title and Abstract Screening:** Studies were initially identified based on titles and abstracts.

2. **Full-Text Review:** Inclusion was guided by pre-designed criteria focused on FGM/C practices, humanitarian contexts, and economic dimensions.
3. **Consensus:** Discrepancies between reviewers were resolved collaboratively.

Data Extraction and Analysis
Data were extracted using a structured Excel form to capture study characteristics, participant demographics, and key findings related to FGM/C practices, drivers, and responses.

- **Quantitative Data:** Trends and regional variations were identified, with a focus on the impact of crises on FGM/C prevalence. Visual summaries, such as charts, were developed using Microsoft Excel to present findings.
- **Qualitative Data:** Key themes were synthesized into categories such as FGM/C practices, humanitarian responses, and economic implications.

Addressing Data Gaps
For countries with limited data, supplementary searches were conducted to include additional studies, reports, and qualitative insights from peer-reviewed articles and gray literature.

Limitations

- **Variability in Data Quality:** Differences in methodology and context across studies may affect the comparability of findings.
- **Translation Challenges:** Translation of non-English studies could introduce errors affecting interpretation.
- **Gray Literature:** Inclusion of unpublished reports may result in variability in data quality.

Ethical Considerations
This review relied solely on publicly available secondary data from literature and organizational reports, so ethical approval was not required.

FGM IN HUMANITARIAN CRISES

The Crisis Context and Universal Dynamics

Humanitarian crises driven by protracted conflict, displacement, political instability, or climate shocks are becoming more frequent, complex, and prolonged, with the average duration now exceeding ten years (15). Across the twelve countries analyzed in this report (Sudan, Chad, Egypt, Somalia, Ethiopia, Yemen, Mauritania, Nigeria, Mali, Niger, Pakistan, and Indonesia) these overlapping crises have triggered profound social disruption, undermining governance, gender equality, and public health systems.

In these fragile environments, Female Genital Mutilation (FGM) is not merely a lingering cultural issue but a systemic form of Gender-Based Violence (GBV) that intensifies when legal, health, and social protection frameworks collapse. Displaced populations—particularly women and girls—face compounded vulnerabilities, with crisis conditions reversing hard-won gains toward FGM elimination (16).

Internationally, FGM is recognized as a humanitarian protection concern. The Inter-Agency Standing Committee (IASC), Inter-Agency Working Group on Reproductive Health in Crises (IAWG), and Sphere Humanitarian Standards all affirm that protection from harmful practices is a core humanitarian obligation. Crises reshape not only service delivery systems but also social contracts and gender hierarchies, often amplifying precarity while temporarily altering women's agency. Recent evidence (17) shows that crisis impacts on FGM are heterogeneous: drivers may be exacerbated, attenuated, or unchanged, and—critically—types of FGM may shift (e.g., from Type III to less extensive forms) rather than prevalence moving in a single direction. This chapter provides the conceptual foundation for the twelve country profiles that follow, examining how crisis dynamics sustain, modify, or weaken FGM practices across diverse humanitarian settings.

Crisis Dynamics and Heightened FGM Risk

Humanitarian emergencies produce distinct, recurring dynamics that heighten the risk of FGM, though the specific manifestations vary across regions.

1. **FGM as a Survival Mechanism**

In crisis settings such as Sudan, Somalia, Yemen, and northern Nigeria, economic collapse, displacement, and food insecurity push families to adopt coping strategies that reinforce harmful gendered practices. FGM becomes

intertwined with child, early, and forced marriage, perceived as a means to secure social and financial stability. Evidence from UNFPA and UNICEF (18) indicates that rates of CEFM and FGM rise during crises especially in communities where marriageability is linked to cutting. Thus, FGM transitions from a cultural rite to an economic survival mechanism. Multiple studies (17) in crisis and migration contexts link FGM to marriageability and household coping strategies amid financial hardship.

2. FGM as Perceived Protection

In active conflict zones such as Sudan, Chad, Somalia, and Yemen, pervasive Conflict-Related Sexual Violence (CRSV) has led some families to view FGM, particularly Type III (infibulation), as a defensive measure to "protect" girls from rape and preserve honor. This tragic rationale underscores the collapse of protective institutions. UN Security Council Resolution 2467 recognizes CRSV as a driver of secondary gendered harms—including FGM—highlighting the continuum of violence in crisis. Humanitarian field reports from Sudan and Chad show mothers supporting FGM as a way of transferring trauma, reflecting how gendered pain becomes normalized under extreme stress. Displacement studies report families explicitly citing FGM (especially Type III) as perceived protection from rape and to maintain "honor" during instability (19). However, crises can also weaken social norms supporting FGM—underscoring a complex push-and-pull dynamic rather than a uniform increase (17).

3. Breakdown of Social Structures

Mass displacement and school closures across Sudan, Ethiopia, Niger, Mali, and Mauritania fracture traditional community control and dissolve protective networks. Girls' education—a key protective factor—is often interrupted for years, heightening isolation and exposure to misinformation. In these conditions, families advance "cutting seasons" to avoid detection, conducting procedures in secrecy. UNFPA and UNICEF (16)notes that post-displacement communities frequently experience temporary spikes in cutting before humanitarian surveillance systems stabilize. In refugee-camp and settlement studies, prevalence among crisis-affected girls can be substantial (e.g., 42% among Somali refugee girls 1–12 in Eastern Ethiopia; high proportions cut by age 12), but other sites show lower point estimates—again reflecting context variability (17).

4) Health-system collapse and compounded obstetric risk.

Overcrowded camps, weak infection control, and limited emergency obstetric capacity amplify immediate and long-term complications of FGM, including obstructed labour and haemorrhage. The literature is overly concentrated on medical sequelae; there remains a dearth of evidence on

social, economic and life-course consequences of FGM in humanitarian contexts, an important gap for programming.

The Cross-Border Challenge and Evasion

Displacement in regions such as the Horn of Africa, Sahel, and Red Sea corridor has transnationalized FGM, undermining legal sovereignty and complicating enforcement.

1. **Chad–Sudan Corridor:**
The influx of Sudanese refugees into Chad has created a high-risk humanitarian setting. Despite FGM bans in both countries, the practice remains prevalent and covert, often celebrated with henna rituals or reinforced through post-partum reinfibulation (adal). Weak judicial reach and limited humanitarian oversight sustain this continuity.

2. **Egypt–Sudan Migration:**
Among Sudanese refugees in Egypt, displacement has exposed communities to new influences. Reduced elder pressure and Egypt's stricter legal penalties provide opportunities for abandonment. Yet informal "Small Sudan" networks perpetuate traditional norms, and medicalized FGM creates new forms of normalization under the guise of safety.

3. **Mali–Niger and Sahel Transboundary Practices:**
In Mali and Niger, porous borders and nomadic migration sustain FGM's continuity. Families cross borders to evade national bans or to perform cutting during seasonal migration. This dynamic mirrors similar mobility between Ethiopia, Somalia, and Kenya, where border communities share ethnic ties and cultural norms.
These examples illustrate the urgent need for regional coordination mechanisms such as the IGAD Regional Action Plan on Ending FGM and the African Union Horn of Africa Initiative, as well as digital engagement to counter online reinforcement of FGM norms across diaspora and displaced communities.

Structural Barriers to Intervention

Across all twelve contexts, FGM programming in humanitarian settings is constrained by structural and institutional barriers that weaken prevention, response, and accountability.

1. **Under-Prioritization and Funding Gaps**
FGM elimination efforts remain underfunded in emergency response plans. Often misclassified as "non-life-saving," they fall outside immediate protection budgets. OCHA (15) estimates that less than 0.5% of GBV humanitarian funds target harmful practices. Short-term (6–12 month) project cycles prevent the sustained engagement required for social norm change or multi-year education initiatives. In countries like Sudan, Somalia, and Yemen, programmatic disruptions have erased years of progress made before crises erupted.

2. **Fragmented National Leadership**
Most national FGM coordination bodies across Sudan, Nigeria, Mauritania, and Ethiopia lack the authority, staff, or budgetary autonomy to compel sectoral integration. Ongoing conflicts displace civil servants, leaving UN agencies and NGOs to operate in ad hoc capacities without long-term institutional anchors. The absence of strong governance perpetuates fragmentation—between humanitarian clusters, national ministries, and community organizations—diluting accountability and sustainability.

3. **Compromised Legal Frameworks**
In Sudan, Chad, Egypt, and Nigeria, laws prohibiting FGM exist but enforcement collapses under insecurity, corruption, or weak judicial oversight. Communities are reluctant to report violations for fear of stigma or reprisal. Moreover, FGM remains largely invisible in humanitarian data systems.

Programmatic Implications: What Works

1. **Participatory, integrated, multi-level approaches:** Studies suggest promise in fully integrated services that link education, health, case management and community mobilisation, adopting bottom-up design and including both host and displaced populations, with men, religious and community leaders actively engaged (17).

2. **Measurement and joint situational analysis:** Routine use of standardised indicators on prevalence and consequences, joint humanitarian–development situational analyses, and enhanced emergency monitoring are recommended to build shared outcomes and track progress

3. **Digital tools and data systems:** Innovations like U-Report for community alerts and platforms such as Primero/GBVIMS+ for case management can support timely identification and response (17).

4. **Targeted capacity development:** Training frontline actors—including traditional birth attendants—to identify complications and refer, strengthen infection prevention for de-infibulation, and bolster government/health-system responders, are highlighted priorities

5. **Legal and policy frameworks with displacement lenses:** Strengthen anti-FGM laws and establish frameworks suited to displaced populations; complement with SRH/rights education to shift norms.

The Strategic Imperative: Adopting the HDP Nexus

To achieve the global target of eliminating FGM by 2030 (SDG 5.3), crisis-affected countries must move from fragmented short-term interventions to a Humanitarian–Development–Peace (HDP) Nexus approach, as suggested in the table below. This is particularly critical for the twelve countries covered in this report, where fragility, displacement, and gender inequality intersect.

Nexus Dimension	Strategic Focus for FGM Elimination
Humanitarian Response	• Integrate FGM prevention and survivor care into GBV and Sexual & Reproductive Health (SRH) services through the *Minimum Initial Service Package (MISP)* • Train frontline responders in FGM case management and psychosocial support
Development & Recovery	• Strengthen national health and education systems • Build long-term livelihood opportunities and social protection; • Align with the UNFPA–UNICEF Joint Programme on the Elimination of FGM (Phase IV, 2022–2025).
Peacebuilding & Norm Transformation	• Facilitate inter-community dialogue and cross-border women's networks in the Sahel, Horn of Africa, and South Asia • Engage men, faith leaders, and youth to redefine honor and identity around dignity and rights.

Applying the HDP Nexus across these twelve contexts demonstrates that, despite variations in crisis drivers—from conflict in Sudan to climate stress in Mauritania and Niger to fragility in Yemen and Somalia—the underlying enablers of FGM are consistent: inequality, poverty, and institutional weakness. Only through integrated, multi-sectoral engagement can humanitarian and development systems prevent regression and accelerate progress toward elimination.

Conclusion

Humanitarian crises amplify gender inequality and reshape how families navigate survival, protection, and belonging. FGM persists as both a symbol of continuity and a manifestation of structural violence. Ending FGM in these contexts requires recognizing it not as a cultural anomaly but as a predictable protection failure in humanitarian response. Integrating FGM prevention within the Humanitarian–Development–Peace Nexus will ensure that every crisis becomes a catalyst for transformation, not regression—building societies where resilience is measured by the safety, autonomy, and dignity of women and girls.

Countries profile

EGYPT

Background

Egypt, situated at the crossroads of Africa and Asia, plays a significant geopolitical and cultural role in the Middle East and North Africa (MENA) region. It is bordered by the Mediterranean Sea to the north, the Red Sea to the east, Sudan to the south, and Libya to the west. The Nile River, central to Egypt’s geography and economy, supports a population of over 104 million people as of 2024, primarily concentrated along its banks and delta.

As the most populous country in the Arab world and the third most populous in Africa, Egypt faces considerable development challenges. Despite progress in areas such as education and healthcare, significant disparities persist, particularly in rural regions. Gender inequality remains a critical issue, reflected in deeply rooted cultural practices, including FGM, which affects large portions of the female population.

Egypt's strategic location and relatively stable infrastructure make it a key destination for refugees and migrants fleeing conflict and instability in neighboring countries such as Sudan, Syria, Eritrea, and Somalia. These dynamics, combined with the country’s ongoing economic challenges, including high debt levels and underfunded public services, contribute to a complex humanitarian landscape.

Religious and cultural traditions also shape social practices in Egypt, with Islam being the predominant religion (90%) and Christianity, primarily Coptic Orthodox, representing about 10% of the population. These traditions influence public attitudes and responses to critical issues like FGM, gender-based violence, and the integration of refugee populations.

Humanitarian challenges

Egypt faces significant humanitarian challenges stemming from a combination of internal socio-economic issues and external pressures from regional conflicts. Urban poverty, high youth unemployment, and underfunded rural health and education services continue to strain the country's development efforts. Despite these obstacles, Egypt has made progress in improving certain public services; however, disparities remain, particularly in rural and marginalized areas.

The ongoing conflict in Sudan has led to a sharp increase in the number of refugees arriving in Egypt. Since April 2023, over 1.2 million Sudanese have sought international protection in the country, creating immense pressure on Egypt's already stretched resources and infrastructure.(20) Sudan is among the countries where FGM is highly prevalent, meaning many of the incoming refugees come from communities where FGM is practiced. This influx highlights the intersection of humanitarian and cultural challenges, as Egypt must address both immediate humanitarian needs and long-term efforts to eliminate harmful practices like FGM.

In addition to Sudanese refugees, Egypt hosts one of the largest Syrian refugee populations in the region. Many of these refugees have been living in Egypt since the onset of the Syrian crises in 2011. Syrians, unlike other refugee groups, have achieved some degree of economic integration, particularly in urban centers where they have established small businesses and contributed to the local economy. However, they continue to face challenges related to access to affordable housing, legal documentation, and education.

Refugees from Eritrea, Ethiopia, and Somalia, who have fled conflict, political instability, and economic hardship, also form a significant portion of Egypt's refugee population. These groups, often arriving through irregular migration routes, are particularly vulnerable to exploitation, trafficking, and abuse. For women and girls, the risks are compounded by harmful traditional practices, including FGM, which remain prevalent in their countries of origin.
The growing refugee population coincides with a severe economic crises in Egypt. Nearly half of the 2023/2024 national budget is allocated to debt repayment, leaving essential services like health and education significantly underfunded.(20) This economic strain has deepened poverty and food insecurity for both host communities and refugees. The combination of a surging refugee population and economic hardship has intensified the humanitarian situation, creating a complex environment requiring both immediate interventions and systemic reforms.(21)

The influx of refugees from countries with high FGM prevalence, such as Sudan, Somalia, and Eritrea, presents unique challenges. Many refugee women and girls are at risk of undergoing FGM, either as part of cultural traditions carried from their home countries or due to vulnerabilities exacerbated by displacement. Addressing this issue requires integrating culturally sensitive interventions into broader humanitarian efforts. Efforts to combat FGM in refugee populations include health education campaigns, access to prevention and treatment services, and community engagement to challenge harmful social norms. These interventions are crucial for ensuring

that displaced women and girls are protected from further harm and can access the support they need to recover.

Egypt's response to the growing humanitarian crises involves coordinated efforts between the government, international organizations, and non-governmental organizations (NGOs). These efforts aim to address immediate needs while promoting long-term resilience and integration.(21)

- **Government and International Cooperation:** The Egyptian government, in partnership with agencies such as UNHCR and UNICEF, oversees the delivery of humanitarian aid and services. For example, the Egypt Refugee Response Plan, led by UNHCR, focuses on addressing the needs of refugees while supporting host communities by providing education, healthcare, and livelihood opportunities.

- **Support for Refugee Children and Families:** UNICEF collaborates with the Egyptian Red Crescent and government entities to prioritize child protection, clean water, sanitation, and education services. These efforts are essential for mitigating the long-term impact of displacement on children and families.

- **NGO Contributions:** NGOs complement government and international initiatives by offering healthcare, education, and psychosocial support. Their work is crucial for addressing gaps in service delivery, particularly for refugees who are not officially registered or face legal and social barriers.

FGM prevalence

FGM has historically been near-universal in Egypt, with national surveys in the early 1990s reporting prevalence as high as 97% among women. Over the subsequent decades, legislative efforts and awareness campaigns led to a slow, steady decline in the lifetime prevalence among the adult female population. This prevalence dropped modestly to 95.5% by 2005, fell further to 92.3% by 2010, and reached 87.2% by 2015 among women aged 15–49. According to the most recent 2021 Egypt Family Health Survey (EFHS)(22), the overall prevalence of FGM among all women aged 15–49 is 86%, confirming that the practice remains deeply entrenched despite a marginal 1.2 percentage point drop since 2015.

The most compelling finding, however, is the generational shift observed in the age-cohort analysis. While FGM remains near-universal (over 96.8%)

among the oldest cohorts (45–49 years), the rate of FGM among girls aged 15–17 has plummeted to 37% in 2021, marking a dramatic achievement. This sharp decline represents a considerable acceleration in abandonment, down from 61% recorded for the same age group in 2014, underscoring the tangible impact of intensified legal and social interventions. This progress is reinforced by changing parental attitudes, as the percentage of mothers intending to have their daughters cut also fell significantly, from 35% in 2014 to just 13% in 2021. The age of cutting remains primarily in late childhood, with approximately 86% of women who underwent FGM reporting being cut before the age of 12.

Despite these positive national trends in younger cohorts (15-29 years), deep disparities persist, confirming that FGM prevalence in younger cohorts is fundamentally shaped by socioeconomic status and geographic location. The practice is significantly higher in rural areas (51.5%) than in urban areas (26.9%), a gap that highlights the influence of local norms. The Upper Egypt region remains the epicenter of FGM, with prevalence rates exceeding 60% among younger cohorts. Moreover, the practice disproportionately affects the marginalized: female youth in the lowest wealth quintile (61.6%) and those with no formal education (65.9%) face the highest risk, compared to those in the wealthiest quintile (19%), and those with at least secondery aducation (38.8%).

FGM in Egypt is typically performed on girls aged 9–12, often symbolizing their transition into "womanhood." In rural areas, the age of cutting tends to be slightly younger. Families often justify performing FGM early to avoid social stigma and to ensure the girl is perceived as ready for future marriage. This underscores the interplay of cultural norms, economic pressures, and societal expectations in sustaining the practice.

Cultural and socio-economic factors continue to drive FGM in Egypt, where it is often regarded as essential for marriageability and tied to notions of family honour, purity, and social acceptance. Poverty exacerbates the practice, as economically disadvantaged households view FGM as a way to secure a girl’s future and maintain social status.(23, 24) In rural areas with limited economic opportunities, adherence to these norms is even more pronounced.

Patriarchal social structures further perpetuate FGM. Families often fear ostracization if they deviate from the practice, while mothers who have undergone FGM are likely to pass it on to their daughters due to societal pressure and fear of exclusion. Urban areas generally exhibit lower FGM rates due to better education and healthcare access, but the practice persists even in cities among marginalized communities. (23, 24)

In Egypt, FGM predominantly involves Type I and Type II procedures, with Type II accounting for approximately 70% of cases and Type I for 25%. (23-25) Type III is rare, with a prevalence of around 5%. Rural areas show a preference for the more invasive Type II, reflecting deeply entrenched cultural norms, while urban centers report more cases of Type I, influenced by the growing trend of medicalization.

Medicalization remains a significant barrier to the eradication of FGM in Egypt, a prevalent trend where the procedure is largely performed by medical personnel. (23, 26) The rate of FGM carried out by doctors or nurses remains alarmingly high (78.5% in young girls as of 2021), a situation that creates a false perception of safety and legitimacy, thereby undermining abolition efforts and posing a complex obstacle to total eradication.

FGM and the Humanitarian Nexus

The mass migration of over 1.2 million Sudanese migrants to Egypt since the April 2023 war has created a complex challenge, as this represents forced displacement from one high-prevalence FGM country (Sudan, 86.6%) to another (Egypt, 86%). This dynamic is unique, as it involves communities navigating their cultural identity and FGM practices in a host environment that simultaneously practices and punishes FGM.

The rupture of traditional social structures due to displacement has introduced several factors that may unintentionally accelerate the abandonment of FGM among Sudanese migrant families (19):

- **Reduced Familial and Generational Pressure:** Migrant families often arrive without the full extended family unit, especially the influential elder members, such as grandmothers, who traditionally pressure younger generations to comply. The absence of these "key influencers" reduces social pressure, empowering younger mothers to become the primary decision-makers and assert their ability to reject the practice for their daughters. Women who experienced FGM harm or have higher education levels are particularly strong in their opposition.

- **Legal and Financial Deterrents in Exile:** The severity of Egyptian law—which includes sentences of up to 20 years for medical staff—acts as a powerful deterrent. This legal fear, coupled with the instability of their legal status and fear of deportation, motivates many to avoid the practice. Furthermore, economic hardship forces families to prioritize

survival needs like food, rent, and education over cultural traditions, pushing FGM lower on the family's agenda.

- **The Unintentional Barrier of Host Community Tension:** Due to perceived racism and fragile social relationships, many Sudanese migrants maintain limited interactions with the Egyptian host community. This tension makes them less likely to seek FGM advice from Egyptian sources or ask Egyptian doctors to perform the procedure. This avoidance of the host country's high-medicalization system creates an unintended safety barrier against new FGM procedures.

Despite the opportunities presented by displacement, several factors threaten the continuation of the practice:

- **"Small Sudan" Networks:** The close-knit social networks formed in areas with high migrant concentration (e.g., Nasr City, Faisal) risk perpetuating the practice by helping families covertly locate Sudanese midwives who adhere to traditional customs. These midwives, who may rely on FGM income, can become influential figures in maintaining the practice.

- **Misconceptions of Type I FGM:** Many participants still view Type I (Sunna type) as less harmful and believe it should continue. This misconception allows families to adhere to a modified version of the tradition while avoiding the severe Type III, which is associated with negative health consequences.

- **Conflicting Perceptions:** Sudanese communities generally perceive FGM primarily through a medical lens (focusing on Type III health harm) rather than a human rights lens (focusing on bodily autonomy). This limited understanding risks reinforcing the idea that a "less severe" or medicalized cut is acceptable.

- **Cross-Community Mislabeling & "Blame Shifting"**: Community narratives show mutual "othering" of cutting types: Sudanese respondents call Type III "Pharaonic," assuming Egyptians practice it; Egyptians, in turn, refer to it as "Sudanese." This reciprocal labeling obscures risk perception and can mislead families about what is practiced locally. Mislabeling creates false reassurance (e.g., that "Sunna/Type I" is minor/acceptable) and hinders targeted messaging that all FGM types are harmful and illegal.

The context of Sudanese migrants highlights the urgency of integrating FGM prevention directly into humanitarian response plans, capitalizing on the transient nature of displacement to effect long-term behavioral change.

National Policies and Laws

The Egyptian Constitution emphasizes the protection of children and women from all forms of violence. Articles 51 and 52 protect human dignity and prohibit all forms of torture, respectively, and are significant to the practice of FGM. Article 60 states, 'The human body is inviolable. Any assault, defilement or mutilation thereof is a crime punishable by law. Article 80 mandates the state to care for and protect children, while Article 11 focuses on protecting women from violence and empowering them. The Egyptian government has committed to combating this practice, as reflected in the Egyptian Constitution of 2014. Although the Constitution explicitly prohibits violence against women, it doesn't mention or prohibit harmful practices and FGM.

Egypt ratified and signed all regional and international legal frameworks, conventions and treaties that call upon states to take action to eliminate FGM. FGM banned in Egypt in 1997 by a ministerial decision, but the ban was not fully enforced until 2007, when the Ministry of Health issued a directive preventing these procedures in all healthcare facilities. Then, in 2008, the first criminal texts were introduced to criminalize FGM through an amendment to the Penal Code. Article 242 stipulates penalties ranging from imprisonment to fines (27) , meaning they may not fully understand what they are experiencing. Even if they do, it remains difficult for them to know how to resist or refuse the circumcision.

Before the legal criminalization of circumcision in 2008, families were quick to report the deaths of their daughters in the hope of punishing negligent doctors. However, the introduction of the new penal provision led to an unintended consequence: families became hesitant to report even in cases of death, as the new article imposes penalties on everyone involved—doctors, parents, and accomplices (such as nursing staff and medical personnel)—equally. This drives all parties to cover up the crime, as families feel they are in the same predicament as the doctors and nurses.

The crime of circumcision is committed daily and on a large scale, yet there is almost no reporting of it and no investigations take place except in cases resulting in the victim's death or permanent disability. This is largely because most people who are aware of the crime are often accomplices in it. Therefore, it is essential to think of ways to encourage anyone who knows

about the crime—even if they are complicit, like parents or relatives, or those who assisted, like nurses—to report it to the relevant authorities.

Nevertheless, punishing families not only leads to hesitance in reporting but also instills fear of seeking urgent medical assistance from equipped hospitals in cases of severe medical complications, which may include acute pain, infections, shock, and bleeding which might lead to female death. Despite the existence of Minister of Health Decision No. 271 of 2007, which prohibits doctors, nursing staff, and others from performing FGM within or outside medical facilities, this decision does not impose criminal responsibility on those in charge of medical institutions where circumcision is conducted. Violating this decision does not lead to criminal accountability for the director of the medical facility.

Since these penalties were deemed insufficient, the article was amended again in 2016 to toughen the penalties and add a new article reflecting the legislator's seriousness in confronting this harmful practice. These legal efforts reflect the evolving social awareness regarding the dangers of female circumcision and its negative impact on women's health and rights. The 2016 amendments redefined FGM as a felony rather than a misdemeanour and increased the penalty for performing it to imprisonment of not less than five years and not exceeding seven years. If the act of FGM resulted in the death of the victim or permanent disability, the penalty can escalate to hard labour for up to 15 years. Additionally, the amendments stipulated a prison sentence ranging from one to three years for anyone who requests female circumcision and for whom the procedure is carried out based on their request. However, the reference to Article 61 of the Penal Code at the beginning of the FGM article undermines the criminalization of this practice, as it suggests that there may be cases in which a doctor is compelled to perform circumcision to protect a girl from serious harm, which contradicts reality. Such a reference provides a strong argument for doctors, allowing them to claim that they were doing a medical procedure. Evidence of the misuse of this reference is evident in the few FGM incidents. Additionally, Article 61 is frequently used by judges who are not convinced of the need to criminalize FGM. This confusing statement reflects the high rate of medical doctors and nursing staff practising FGM of 67% and 12% respectively.(28)

The Egyptian Cabinet in 2021 approved an improved FGM law. The amendments were reflected in Articles 242 bis and 242 bis (a). The reference to Article 61 has been erased from the beginning of the text of the article. The law stated clearly that anyone who performs FGM will be punished with imprisonment for a period of not less than five years. If the act results in permanent disability, the penalty shall be hard labor for a period of not less

than seven years. If the act leads to death, the penalty shall be hard labor for a period of not less than ten years. And if the person who performed FGM is a doctor or nurse the penalty shall be hard labor for a period of not less than five years. If the crime results in permanent disability, the penalty shall be hard labor for not less than ten years. If the act leads to death, the penalty shall be hard labor for a period of not less than fifteen years and not exceeding twenty years. Also, the article stated prohibition of doctors and nursing professionals, from practicing their profession for a period of no less than three years and no more than five years, starting after the completion of their sentence. Furthermore, the court may order the closure of the private facility where the circumcision took place. Article 242 (a) stated that anyone who requests female circumcision and for whom the procedure is carried out based on that request shall be punished with imprisonment as stipulated in Article 242 bis of this law. Furthermore, anyone who promotes, encourages, or incites the commission of the crime of FGM shall also be punished with imprisonment, even if their actions do not result in any consequences. This law amendment responded to most of the concerns about FGM law and shows growing government commitment to end this harmful practice.

Some Penal Code articles, like Article 84 (a), Article 108 and Article 118 bis (b), exempt cooperating accomplices who report crimes if they proactively inform authorities or provide useful information. In this context, the legislator does not remove the criminality of the act but seeks to encourage accomplices to assist investigative authorities in uncovering the crime and its perpetrators. this amendment could help save the lives of many girls who undergo FGM. Families would feel more empowered to seek medical help in a timely manner, potentially preventing tragic outcomes.(29) It has not been possible to find any recent cases where the laws are listed in any published report. There is no evidence that cases were prosecuted by the authorities. There is no information on whether any Egyptian girls are being taken across borders to be cut in other countries or whether families from neighbouring countries cross into Egypt for FGM. Existing national FGM laws do not directly address cross-border FGM. More generally, Egyptian law prohibits cross-border crimes under Article 3 of Law No. 58. This can support efforts to ban cross-border FGM.

National legislation in Egypt against FGM is improving to be more effective in FGM elimination. The law criminalizes and punishes the performance of female genital mutilation (FGM) and anyone requesting the practice under Article 242-bis and Article 242-bis(A). However, the law does not explicitly specify penalties for those who aid or abet the practice, nor does it address the failure to report FGM, whether it is planned or has already occurred.

The country's laws still do not explicitly cover medical malpractice or the involvement of health professionals in performing FGM, whether in government or private hospitals, clinics, or private homes. Additionally, there is no mention of cross-border FGM. Despite these strict laws, the main challenge remains in strict enforcement and overcoming the reluctance of families and communities to report cases, as well as addressing the subtle legal ambiguity surrounding those who aid or abet the practice.

Community and National Efforts to Eliminate FGM

Efforts to eliminate Female Genital Mutilation/Cutting (FGM/C) in Egypt have involved both community-driven initiatives and national programs. Community engagement is a cornerstone of these efforts, as societal norms and traditions play a critical role in perpetuating the practice. Open dialogue programs involving men, women, and religious leaders have proven effective in dispelling misconceptions, with religious leaders clarifying that FGM/C is not a religious obligation. Engaging male community members has shown particular impact, as studies indicate women are less likely to support FGM/C if men disapprove.(24) These inclusive initiatives address broader community dynamics, fostering sustainable change.

Awareness campaigns targeting families, schools, and community centers have reshaped attitudes by educating communities about the health risks and human rights violations associated with FGM/C. Schools have played a vital role in reaching younger generations, fostering a cultural shift toward prioritizing the health and dignity of girls and women. Promoting alternative rites of passage has provided culturally sensitive solutions that protect girls' physical and mental well-being.(24, 26)

FGM elimination in Egypt took shape in 2003 after the development of the national program for FGM elimination affiliated with the National Council for Motherhood and Childhood, then it became the national program for family empowerment and elimination of FGM in 2009 under the responsibility of the Ministry of Family and Population. Currently, the program is affiliated with the National Council for Population. Egypt is a member of the UN joint program and works closely with UNICEF and UNFPA.

The National Strategy for Combatting Violence Against Women (2015–2020) was developed through a systematic and participatory process involving multiple sectors, including the Ministries of Interior, Justice, Social Solidarity, Youth, Education, Health, Endowments, and Labor, alongside NGOs and the Council for Women and Children.(30) This document categorized FGM as a form of family violence and emphasized its criminalization through legal

frameworks, including Ministerial Decision No. 271 of 2007, which prohibits healthcare professionals from performing FGM.

To enforce this decision, a 24-hour hotline (227922107) was established within the Ministry of Health's Preventive Department to facilitate reporting of violations and enable inspections of clinics and non-governmental hospitals. Health awareness campaigns were implemented to educate doctors and nurses on the harmful effects of FGM, complemented by the distribution of informational posters in healthcare facilities.

The National Council for Childhood and Motherhood later developed a comprehensive national strategy to combat FGM. This culminated in the National Strategy for the Elimination of FGM (2016–2020), which adopted a multisectoral approach. The strategy involved in-depth analysis of the country's context, a gap analysis of implemented activities, and progress in legislation. It focused on the coordination of interventions across sectors, engagement with communities to end FGM practices, mass media campaigns, and enforcing laws to combat the medicalization of FGM.(31)

Despite these efforts, significant challenges persisted. Although progress had been made in implementing legislation banning the practice and penalizing its medicalization, medicalized FGM remained prevalent, accounting for 78% of cases in 2015 for women aged 15–49 and 79% for girls aged 0–17. Weak enforcement of penalties, limited supervision of health facilities, and the lack of integration of FGM into medical education posed additional challenges. Advocacy and awareness campaigns were unsustainable, and community and youth programs were intermittent. Furthermore, decision-makers and religious leaders were not sufficiently mobilized, and messaging about FGM was not integrated with other health and social programs.

The strategy identified major objectives, including the enforcement of laws, promoting community behavior change to support women's rights, and improving monitoring and information systems. It concluded with an action matrix outlining planned activities and the roles of implementing actors.
In 2017, Egypt developed the National Women's Strategy (2017–2030) following a deep and inclusive consultation process involving actors from governmental and non-governmental sectors. FGM elimination was included under the "protection" objective, addressing harmful traditional practices.(32)

Interventions focused on strengthening law enforcement to halt the medicalization of FGM, increasing community awareness that the practice has no religious basis, and improving the supervision of health facilities.

That same year, the Supreme Council of Universities approved the integration of FGM into university curricula. This led to the launch of the University Pioneer Initiative in 12 national universities across 15 governorates, as well as the implementation of school-based programs in Upper Egypt and Greater Cairo. The "Doctors Against FGM" initiative was officially launched(33), and the Azhar Supreme Council issued a statement affirming that FGM has no foundation in Islamic law.(34)

In 2019, the National Councils for Women and for Motherhood and Childhood established a National Committee for FGM Elimination to improve coordination and ensure the implementation of strategies for FGM elimination and women's empowerment.(23) However, implementation efforts continue to face challenges due to political instability, extreme weather events, armed conflict, threats to human security, and refugee situations.(14)

Conclusion and Recommendations

Egypt has made notable progress in addressing FGM through public discourse, education, and community-driven initiatives.(24, 26) However, significant challenges remain, particularly in rural and underserved areas where deeply entrenched cultural norms and socio-economic barriers persist. The medicalization of FGM, weak enforcement of legal frameworks, and limited access to education and resources in these regions hinder the elimination of the practice. (23, 25, 26)

The ongoing humanitarian challenges in Egypt, including the influx of refugees from neighboring countries with high FGM prevalence, exacerbate these issues. Refugees and displaced populations, often settling in vulnerable rural areas, face heightened risks of FGM due to limited access to healthcare, education, and legal protection. This intersection of cultural practices and humanitarian crises underscores the need for a dual approach: addressing immediate needs while implementing long-term interventions to eliminate FGM.

Recommendations

Strengthening Legal and Systemic Enforcement

1. **Strengthen Legal Frameworks and Enforcement:** Rigorously implement and enforce the 2021 Penal Code amendments, which impose severe penalties on practitioners, especially medical staff. Legal measures must be rigorously enforced to eliminate FGM, particularly its medicalization.

2. **Combat Medicalization:** Enhance oversight of public and private health facilities. Enforce mandatory reporting requirements and integrate comprehensive anti-FGM training into all medical and nursing curricula, emphasizing the severe penalties and ethical violations associated with performing the procedure.

3. **Address Legal Gaps:** Reinforce local enforcement mechanisms with targeted training for judicial authorities and law enforcement personnel. Review the Penal Code to explicitly include criminal sanctions for those who aid or abet the practice, as well as mandatory failure-to-report provisions, eliminating ambiguities that impede prosecution.

4. **Resource the National Action Plan:** Ensure the 2022 National Action Plan for FGM Abandonment is adequately funded and implemented at the decentralized governorate level, targeting high-prevalence areas like Upper Egypt. Collaborative monitoring systems involving government agencies, NGOs, and community organizations can enhance accountability and deter violations.

Integrated Humanitarian Response and Migration Dynamics

1. **Integrate FGM Elimination into Humanitarian Responses:** Given the increasing number of refugees, FGM interventions should be integrated into broader humanitarian efforts. This includes incorporating FGM prevention and treatment into health services provided to refugees and displaced populations, as well as aligning FGM-related messaging with other gender-based violence (GBV) interventions.

2. **Targeted Legal Awareness Campaigns for Migrants:** Launch culturally sensitive campaigns specifically within Sudanese migrant communities (e.g., "Small Sudan" areas) to clearly communicate Egypt’s severe legal consequences (including penalties of up to 20 years for medical staff) and the risk of deportation linked to performing FGM.

3. **Capitalize on Hostile Tension:** Utilize the reluctance of Sudanese migrants to engage with the Egyptian health system for FGM by ensuring that humanitarian and migrant-serving medical facilities are FGM-free zones and trusted sources of alternative information. This capitalizes on the unintentional safety barrier against medicalization within the host system.

4. **Foster International Collaboration:** Egypt should continue partnering with international organizations like UNICEF, UNFPA, and UNHCR to enhance resource allocation and technical expertise. Global partnerships can provide funding, support research, and share best practices to accelerate progress toward eliminating FGM.

Community and Behavioral Change

1. **Leverage Community-Led Advocacy and Empowerment:** Community-driven initiatives remain vital for challenging cultural norms and reducing resistance to change.
    - **Empower Mothers and Youth in Exile:** Develop programs that provide psychosocial support and legal resources to empower younger mothers who are newly liberated from the pressure of influential elderly relatives to reinforce their decision to abandon FGM.
    - **Engage Influencers:** Programs involving male community members, religious leaders, and influential local figures can address misconceptions and shift attitudes.

2. **Scale-Up Awareness Campaigns:** Sustained, culturally sensitive awareness campaigns using mass media, social media, and community-based platforms are essential to challenge the normalization of FGM.
    - **Address Misconceptions of Type I:** Messaging should explicitly debunk the myth that Type I ("Sunna type") is harmless or religiously sanctioned, challenging the tendency to shift to less severe forms instead of complete abandonment.
    - **Promote Alternatives:** Promoting alternative rites of passage that respect cultural traditions while protecting girls' rights should be a core focus.

3. **Address Socio-Economic Barriers:** Economic empowerment programs targeting vulnerable communities can help reduce dependence on traditional practices like FGM, which are often linked to marriageability and social status. Providing livelihood opportunities,

especially for women, can encourage a shift away from harmful cultural norms.

Achieving the global target of eliminating FGM by 2030 will require a fivefold increase in the scale and impact of current initiatives. By integrating FGM elimination into the broader humanitarian response, strengthening legal and healthcare systems, and fostering community-driven change, Egypt can make substantial progress in eradicating this harmful practice and protecting future generations.

SUDAN

Background

Sudan, located in northeastern Africa, is the third-largest country on the continent, spanning an area of approximately 1.86 million square kilometers. It is bordered by Egypt to the north, Eritrea and Ethiopia to the east, South Sudan to the south, the Central African Republic to the southwest, Chad to the west, and Libya to the northwest. The Nile River, along with its two major tributaries, the Blue and White Nile, flows through Sudan, playing a critical role in the country's agriculture and sustaining its population.

Sudan has an estimated population of over 48 million as of 2023 (35), characterized by significant ethnic, linguistic, and cultural diversity. The population includes more than 500 ethnic groups, speaking a variety of languages and dialects. While Arabic is the official language, English is also widely used, especially in higher education and official communications. Islam is the predominant religion, shaping much of the country's social and cultural practices.(36)

Economically, Sudan has traditionally relied on agriculture and pastoralism, with many Sudanese communities dependent on subsistence farming and livestock rearing. Cash crops such as cotton, sesame, and gum arabic are central to the country's exports, although economic challenges, including inflation and currency devaluation, have impacted productivity. Urbanization is increasing, with cities like Khartoum and Port Sudan emerging as economic and administrative hubs, but the majority of the population still resides in rural areas.

Sudan’s history and cultural fabric are shaped by its diverse population and strategic location, which have contributed to its resilience but also present challenges in navigating socio-economic and gender-related issues.

Humanitarian challenges

Since April 2023, Sudan has been engulfed in a severe humanitarian crises, driven by escalating conflict between the Sudanese Armed Forces (SAF) and the Rapid Support Forces (RSF). This conflict has displaced over 11 million people, forcing many to flee across borders to neighboring countries. The war has also disrupted agricultural production, resulting in critical food shortages. By June 2024, over half of Sudan’s population—approximately 25.6 million

people—were facing acute food insecurity, with famine conditions confirmed in parts of North Darfur.(37)

Healthcare services have largely collapsed under the strain of conflict, leading to outbreaks of diseases such as cholera, with nearly 6,000 cases and 185 deaths reported by September 2024. An estimated 80% of hospitals in conflict areas are non-operational, compounding the health crises.(38)
The conflict that erupted on April 15th, 2023, was the culmination of long-standing historical, political, and socio-economic tensions. This complex war, marked by a rapid escalation and a multitude of humanitarian crises, has become a source of grave international concern when it triggered a mass displacement of 11.5 million people, 8.5 million internally within Sudan and 3 million who have sought refuge in neighboring countries, and critical shortages of essential resources such as food, water, medicine, and fuel (37) making the country one of the top four hunger hotspots of highest concern globally(39). Gender-based violence has surged since the outbreak of the conflict, exacerbated by limited humanitarian access to conflict-affected areas, shortages of essential supplies, and a lack of specialized services. These challenges heighten the risks faced by vulnerable populations and exacerbate the complications experienced by survivors, further deepening their plight(40).

Currently, a staggering 25.6 million people, over half of the population, are grappling with acute food insecurity, with 8.5 million facing emergency levels of hunger. This comes in addition to reports of widespread sexual violence, ethnic cleansing, and attacks on civilians.(41)
The fighting has also caused extensive damage to critical infrastructure, including water and healthcare, the collapse of banking and financial services, frequent interruptions to electricity supply and telecommunication services and widespread looting. Even before the conflict, Sudan's healthcare system faced significant challenges such as underfunding, unequal access, shortage of skilled personnel and high out of pocket costs.(42) The ongoing conflict has significantly intensified pre-existing challenges within the region's healthcare system. The World Health Organization (WHO) estimates a staggering 70-80% of health facilities in the most severely impacted areas are either barely functioning or completely closed. This devastating disruption is further compounded by over 100 verified attacks on healthcare infrastructure, including hospitals, ambulances, and medical personnel, as documented by the WHO. The resulting collapse of the healthcare system is fueling a large-scale humanitarian crises, leaving millions in dire need of urgent medical attention.(38)

The humanitarian response plan for Sudan(43) faces significant operational challenges, with limited access due to insecurity, bureaucratic hurdles, and damaged infrastructure. These constraints, coupled with reduced operational capacity, have severely hampered the ability to provide aid, as evidenced by only 5 million of the targeted population receiving assistance in 2023. Despite these difficulties, the plan emphasizes protection-centered programming, prioritizing the safety of vulnerable populations, particularly women and girls, through integrated measures that proactively address risks.

A critical component of the response is the expansion of multipurpose cash assistance, which provides a flexible and efficient way to meet the immediate needs of affected households. The plan also highlights the importance of inclusive programming, ensuring that gender equality, disability inclusion, and community participation are central to its implementation. Engaging local partners and community-driven approaches will strengthen accountability and ensure that assistance reaches those who need it most. To maintain effectiveness in a rapidly changing environment, the response plan incorporates a robust monitoring framework. This includes remote monitoring for inaccessible areas and regular assessments to adapt to evolving needs and access conditions.

Prevalence of FGM

FGM remains a prevalent issue in Sudan, posing a significant public health concern. Data from the 2014 Multiple Indicator Cluster Survey (MICS)(44) reveals an alarming national prevalence rate of 87% among women aged 15-49 which only decreased by 1% when compared to the 2010 Sudan Household Health Survey (SHHS)(45) with an estimated prevalence of 88%.
The practice is widespread across the country, with prevalence exceeding 85% in most states.(46) The humanitarian crises in Sudan reinforces the ongoing practice of FGM by strengthening traditional beliefs and hindering comprehensive reform, effectively negating any progress. Furthermore, within displaced populations, FGM is often employed as a mechanism to uphold cultural identity in the face of external pressures, thereby complicating abandonment efforts.(47)

The integration of FGM-related interventions within broader child protection and gender equality frameworks, as outlined by UNICEF(48), offers a pathway for sustainable change in these contexts. These efforts emphasize the importance of addressing humanitarian vulnerabilities while promoting protective behaviors within affected communities.

FGM remains a deeply concerning practice in certain regions. Type III, or infibulation, constitutes the most severe form and accounts for a significant majority (77%) of cases. The procedure is predominantly carried out by trained midwives (63.6%) or traditional cutters (28.7%).

Furthermore, reinfibulation (adal), which involves the re-suturing of the genitalia after childbirth, can occur multiple times throughout a woman's life. Although less prevalent than the initial FGM procedure, data indicates that approximately 23.9% of ever-married women aged 15-49 who have given birth have undergone reinfibulation.
While a definitive correlation between socioeconomic status and the prevalence of specific types of FGM in Sudan remains elusive due to limited research and data availability, ethnicity appears to be a significant contributing factor. Further investigation is needed to establish a clearer understanding of the complex interplay of socioeconomic factors and cultural practices that influence the prevalence of FGM in Sudan. The correlation between a woman's educational attainment and the likelihood of her having undergone FGM is multifaceted, echoing the complexities observed in the relationship between socioeconomic status and FGM prevalence. FGM remains a culturally ingrained practice, often mistakenly regarded as an Islamic requirement despite lacking any foundation in religious texts. Many communities associate FGM with ideals of modesty and purity; however, religious leaders are increasingly clarifying that the practice is cultural rather than religious. Efforts to reduce FGM are therefore focused on educational initiatives to dispel these misconceptions.

Attitudes toward FGM have shifted in recent years, with the 2014 Multiple Indicator Cluster Survey (MICS)(44) reporting that, among women aged 15–49 who had heard of FGM, 40.9% believed the practice should continue, while 52.8% supported its abandonment. This shift reflects the influence of ongoing awareness campaigns and education initiatives that highlight both the health risks and human rights implications of FGM.

FGM is deeply rooted in socio-cultural norms, with strong ties to traditions of family honor, purity, and social acceptance. The risk of practice performance to girls starts at the age of five.(14) Gender dynamics play a significant role in perpetuating the practice, with men often influencing decisions to abandon or maintain FGM. However, even within families that have rejected the practice, the potential for relapse remains significant, underscoring the complexity of the abandonment process.(49)

Economic and educational factors also contribute to the persistence of FGM. Limited awareness of its health implications perpetuates its prevalence.

Incorporating health education into secondary school curricula, as suggested by Mahgoub et al.(50), has proven effective in improving knowledge and attitudes among female students in Sudan, showcasing the transformative potential of school-based interventions.

The medicalization of FGM, where health professionals perform the procedure under the guise of safety, poses a significant challenge to eradication efforts is extremely common in Sudan, almost 8 in 10 girls are cut by health-care providers(51). Ahmed et al.(47) identified the need for interventions that address supportive attitudes among healthcare workers and strengthen health system functionality. The criminalization of FGM primarily targeted pharaonic circumcision. However, this inadvertently legitimized less severe forms such as Sunna circumcision.(52) This highlights the need for comprehensive legislation addressing all forms of FGM, accompanied by strict enforcement penalties for violators.

FGM and the Humanitarian Nexus

The current war in Sudan has severely disrupted national efforts against FGM and dangerously exacerbated the risk of the practice for women and girls. The conflict has transformed FGM from a slow-moving developmental challenge into an acute protection crisis.

Increased Vulnerability and Protection Risk in Displacement
The chaos of displacement, particularly in camps across the border in Chad, has created conditions where FGM risks spiking. (53)

- **Heightened Sexual Violence Risk:** The war has led to a massive spike in GBV, with Conflict-Related Sexual Violence (CRSV) being used as a weapon of war by armed groups.
- **FGM as a Secret Practice:** Women's rights campaigners fear FGM is rife among Sudanese refugees in camps in Chad. The cutting is taking place in secret to contravene Chadian laws, with families using henna tattoos on young girls as a traditional way of "celebrating" the procedure.
- **Re-infibulation ("Adal"):** Married women are also being subjected to another form of FGM after giving birth, known as *adal* (which means "fixing it"). This procedure, common in Sudan, continues in the camps.
- **Economic Drivers:** In situations of destitution, families face intense financial pressure, pushing some to give or sell young daughters into child marriage, which often entails FGM.
- **Transfer of Trauma:** Aid workers suggest that when mothers support cutting their children, it is "in part a transferring of the trauma and violence that they went through in Sudan".

- **Loss of Protection:** The conflict has caused the near-total collapse of health and social services, meaning protective spaces no longer exist for vulnerable girls.

Collapse of Legal Enforcement and Support
The war has rendered the landmark anti-FGM law largely ineffective, fostering a culture of impunity.

- **Impunity for Perpetrators:** The collapse of governance and security in conflict zones has severely undermined any enforcement of the 2020 law banning FGM, preventing accountability for FGM and other forms of GBV.
- **Cross-Border Evasion:** Before the 2020 FGM ban, Sudanese refugees in Chad would return to Sudan to cut their daughters and then head back across the border. Now, the practice continues covertly across borders, often carried out with "inadequate equipment, in inappropriate places, by people with no medical qualifications".
- **Interrupted Campaigns:** Awareness-raising programs like the Saleema initiative, which worked to change social dialogue, have been severely hampered by the chaotic and unpredictable conflict environment.

The level of violence against Sudanese women and girls in general is reportedly "very high," with the current crisis exacerbating harmful practices both internally and in refugee settings

National Policies and Laws

Human, women and child rights were core issues within the 2019 constitution and legislation reforms following it. The constitution(54) included chapters on women and child rights (chapters 49 and 50) and state commitment of the country to the signed international human rights protection conventions. By now, the country had signed the Convention Against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment (1984) (CTOCIDTP) and the Convention on the Rights of the Child (1989) (CRC). The country acceded to the International Covenant on Civil & Political Rights (1966) (ICCPR) and the International Covenant on Economic, Social & Cultural Rights (1966) (ICESCR). In 2021, Sudan ratified the Convention on the Elimination of All Forms of Discrimination Against Women (1979) (CEDAW). The Council of Ministers amended all laws that contradict the international conventions and laws that support human, women and child rights either updated or developed.

While Sudan has made progress in ratifying international conventions such as CEDAW and the CRC, the implementation of these commitments remains incomplete. The Committee on the Rights of the Child has explicitly urged

Sudan to adopt a comprehensive regulatory and policy framework, including the necessary legislation, to fully implement the 2010 Child Act. It has also recommended the establishment of a national, multi-sectoral monitoring mechanism to oversee implementation and the development of a national action plan for children's rights. Furthermore, the Committee emphasized the need for prioritizing children's rights through specific budget allocations to ensure the maximum possible realization of these rights. Strengthening these frameworks and mechanisms is critical to aligning Sudan's national policies with its international obligations and effectively addressing issues like FGM and broader child protection.

This reform includes FGM criminalization in Article 141 in the 2020 update of the national civil law. In 2020, the criminal law was updated, and the article on criminalizes FGM has been included in compliance with recommendations of the African Commission on Human & Peoples' Rights (recommendation 52)(55) and Committee on Rights of Childs but no further steps taken to Step up educational and awareness-raising programs on the harmful effects of FGM following the law pass (recommendation 57 a & b)(56). Sudan was among the leading countries that started the strategic planning to control FGM. The government formulated the National Council for Child Welfare (NCCW) in 1991 to coordinate and plan for child protection and development issues. NCCW is responsible for the follow-up of the country ratification and implementation of child-related international and regional conventions(57). The policy and strategic plans addressing FGM and Child, Early, and Forced Marriage (CEFM) between 1991 and 2018 faced significant obstacles, often hindered or entirely blocked by the previous government's conservative stance. Despite the NCCW being an autonomous body and the national authority on child-related issues, its recommendations were frequently disregarded by the national government. One clear example of this disconnect was the NCCW's inability to secure the passage of legislation criminalizing FGM.

Before 2019, although the constitution mandated the state to protect women and children, empower them, and shield them from harmful practices, the government's conservative and authoritarian policies made translating these provisions into actionable laws, regulations, and programs exceedingly difficult. For instance, Article 13 of the 2010 Child Act, which explicitly sought to ban and criminalize all forms of FGM, was removed during the approval process in the Council of Ministers.

Until 2020, there was no national legislation explicitly criminalizing FGM. Judges relied on their interpretation of Article 141 of the criminal law to address FGM cases, leading to inconsistent enforcement and accountability.

The absence of clear legal provisions during this period allowed harmful practices like FGM to persist largely unchecked, further underscoring the challenges posed by the previous government's approach.(57) Some incorporate FGM under this article while some don't have this approach. The 2019 constitution explicitly addresses harmful practices, with Article 49.4 stating that the state is committed to combating customs and traditions that undermine the dignity and status of women. Additionally, Article 50 mandates the protection of children's rights as outlined in international and regional agreements ratified by Sudan. These constitutional provisions provide a strong foundation for the development of specific laws aimed at eradicating FGM.

Recognizing the need for targeted legislation, Sudan updated its national civil law in 2020, amending Article 141 to explicitly ban FGM. The updated article imposes penalties of up to three years imprisonment and a fine, along with the option to close the premises where the practice was performed. While this represents a significant step forward, the law still falls short compared to the most comprehensive FGM acts in the region.

For instance, Article 141 does not address critical issues such as attempts to perform FGM or the obligation to report intended or completed cases. Additionally, it fails to include measures to protect women and families who refuse to comply with FGM practices, leaving them vulnerable to social and familial pressures. Cross-border FGM, another critical gap, is not criminalized under Article 141. However, Article 141A of the 1991 Criminal Act penalizes individuals who travel into Sudan to perform FGM, partially addressing this issue.

To strengthen the legal framework, amendments are needed to incorporate provisions for attempted FGM, mandatory reporting of cases, protective measures for individuals resisting the practice, and comprehensive cross-border regulations. These enhancements would align Sudan's legislation with global best practices and further its commitment to eliminating FGM in all its forms.

In addition to laws specifically targeting FGM, Sudan has broader legal provisions that prohibit causing harm to others, including children. For example, the 1990 Criminal Act (58) (Articles 138–142) criminalizes inflicting wounds that result in the loss of an organ, with penalties for perpetrators. Similarly, the 2010 Child Act (59) includes Article 5 in Section II, which mandates the protection of children from "all types and forms of violence, injury, inhuman treatment, or bodily, ethical, or sexual abuse, neglect, or exploitation." Although this act was initially intended to include an explicit

article criminalizing FGM, resistance from religious leaders led to its exclusion at the time of passage. (60)

A review of state-level FGM laws indicates that some states have enacted robust measures to prevent FGM and punish those involved. These laws often extend punishment to executors, participants, instigators, and promoters of the practice, with penalties reaching up to 15 years of imprisonment. Medicalized FGM remains a significant issue in Sudan. A secondary analysis of 2014 data revealed that 77.9% of women in urban areas and 56.7% of women in rural areas (aged 15–49) had undergone FGM performed by "trained midwives." The prevalence of medicalized FGM varies by state and has increased over time. However, an appraisal of health council and public health laws reveals no explicit penalties for healthcare practitioners who inflict harm on patients, including performing FGM.

The Medical Council's Decree No. 366 prohibits doctors from undertaking any actions that cause harm to individuals, including performing all forms of FGM. (61). While this is an important step, the penalties under this decree are administrative rather than criminal. They are enforced at the discretion of the medical council and can include the annulment of medical licenses and dismissal from the profession. (57) However, with the 2020 amendment to the Criminal Act, performing FGM in health facilities is now explicitly illegal. Despite these legislative advancements, enforcement of FGM bans at both national and state levels remains weak. There is no evidence of reported cases being prosecuted or reaching the courts since the enactment of national and state-level laws prohibiting FGM. This lack of enforcement underscores the need for comprehensive advocacy and awareness campaigns to ensure these laws are implemented effectively.

These campaigns should target decision-makers, law enforcement agencies, healthcare professionals, community leaders, and grassroots organizations. A bottom-up approach, combined with national-level top-down initiatives, can help align state-level efforts with national strategies. By building on existing state-level actions and fostering local engagement, these measures can accelerate progress toward eradicating FGM in Sudan.

Community and National Efforts to Eliminate FGM

Community-driven initiatives played a significant role in challenging social norms and fostering dialogue about FGM. Programs like Entishar and Rapid Operational Care and Scientific Services (ROCSS) employ participatory human rights education to promote awareness, encouraging communities to adopt alternative rites of passage.(48) Sessions held in schools, camps, and

youth centers emphasize collective commitment to human rights, engaging men, women, boys, and girls.

The Saleema campaign, launched in 2008, leverages traditional language, music, and cultural practices to foster positive values and aspirations for change. By reframing FGM abandonment as a gain rather than a loss, the campaign builds parental pride and supports broader child protection efforts. Male engagement, as promoted by Plan International, further strengthens these initiatives by involving male facilitators, religious leaders and community influencers in advocacy efforts by addressing gender norms and fostering intergenerational dialogue to drive change.(62)

Sudan has made significant progress in its efforts to eliminate FGM over the past decade through legislative reforms, community engagement, and educational initiatives. The July 2020 legal milestone reflects a strong commitment to addressing the practice. Recent studies suggest a gradual decline, particularly among younger women. Data from the 2021 Simple Spatial Survey Method (S3M II) (63) showed that 27.2% of girls under 14 had undergone FGM, with lower prevalence among younger girls, indicating a positive downward trend.

At the national level, the National Council for Child Welfare (NCCW) is responsible for coordinating FGM elimination efforts. Operating autonomously under the Ministry of Social Welfare, the NCCW has established a national coordination committee to end FGM/C, a structure replicated at the state level. This committee facilitates collaboration between line ministries, such as Health, Education, and Finance, as well as civil society organizations, universities, UN agencies, and NGOs. However, assessments have revealed gaps in the representation of non-governmental institutions and limited collaboration with key sectors such as higher education and media. Making FGM a standalone national priority across all sectors remains a challenge, as some ministries, such as Health, align donor support with broader health priorities, sidelining FGM interventions.

Sudan’s five-year Plan for Childhood (2007–2011) incorporated FGM elimination interventions. (64) In 2008, Sudan launched its first National Strategy for FGM Control (2008–2018)(65), aiming to eradicate the practice within a generation. While the strategy included a comprehensive context analysis, specific objectives, and costed activities, it lacked a monitoring and evaluation (M&E) framework. The absence of indicators, data collection processes, and defined responsibilities hindered its implementation. Similarly, the strategy did not detail the roles and expected contributions of stakeholders, making it difficult to track progress and ensure accountability.

Attitudes toward FGM in Sudan are also shifting. According to the 2014 MICS (44), among women aged 15–49 who had heard of FGM, 40.9% believed the practice should continue, while 52.8% supported its abandonment. This data indicates a growing inclination toward ending FGM, reflecting the impact of ongoing awareness campaigns and educational initiatives aimed at highlighting the health risks and human rights concerns associated with the practice.

The current National Plan to end FGM (48) differs significantly from the previous strategy in both content and structure. While it includes a lengthy introduction and mentions legislative updates, such as the 2020 amendment to Article 141 criminalizing FGM, the plan lacks clarity on specific interventions, implementation timelines, and responsibilities. It also omits an M&E framework and does not address the need for research, such as community Knowledge, Attitudes, and Practices (KAP) studies, or research priorities for policy updates and planning. Furthermore, while the plan emphasizes community behaviour change, it fails to outline actionable steps for achieving this goal or the mechanisms for enforcing updated laws.
The NCCW has developed a roadmap for training community leaders and health providers on law enforcement, aligned with national strategies such as the National Health Sector Strategy, the National Girls' Education Strategy, the National Social Protection Strategy, and the Gender-Based Violence Strategy. Additionally, a Memorandum of Understanding with the media has been proposed to support awareness campaigns about the law against FGM.(66)

The Saleema campaign (67) remains active, leveraging broadcast media, promotional materials, and cultural ambassadors such as singers, community leaders, and religious scholars to promote the abandonment of FGM as part of gender-based violence prevention. (68)
However, despite these advances, the practice remains prevalent in certain regions, necessitating continued efforts to address entrenched cultural norms. Sustained education, community dialogue, and the promotion of alternative rites of passage are essential to achieving the complete eradication of FGM in Sudan.

Support from international partners, including the UNFPA-UNICEF Joint Program, has been critical. These organizations have trained judges, prosecutors, and social workers, facilitating the enactment of Article 141 and supporting its enforcement. Sudan has also implemented a nexus approach to address FGM, integrating FGM interventions into broader systems for health, education, and social protection to ensure continuity of services

during crises. Budgeted emergency preparedness and disaster risk reduction plans developed in 2022 further incorporate FGM interventions(69).
The most recent MICS conducted in Sudan was in 2014, detailing prevalence, regional variations, and societal attitudes. There have been no subsequent DHS or MICS conducted in Sudan. It is unknown when the next survey will be conducted.

Sudan's progress in eliminating FGM highlights the importance of sustained advocacy, community-driven efforts, and robust legal frameworks. By addressing implementation gaps, fostering local engagement, and integrating FGM interventions into broader health and education strategies, Sudan can accelerate progress and achieve the complete eradication of FGM.

Conclusions and recommendation

Sudan has made commendable progress in addressing FGM through legislative reforms, public discourse, education, and community-driven initiatives. However, the ongoing conflict has severely disrupted systems critical to advancing FGM elimination programs. The collapse of governance, mass displacement of over 7.4 million people, and the prioritization of urgent humanitarian needs, such as food security, have significantly hindered progress.

The breakdown of law and order, coupled with the documented spike in GBV and sexual violence, creates an environment where FGM is increasingly likely to occur as both a harmful traditional practice and a perceived defense mechanism in displacement. Displacement has heightened the risk of FGM as families, seeking to preserve cultural practices, may resort to FGM in refugee settings or during migration. Weak enforcement of anti-FGM laws, medicalization of the practice, socio-economic barriers, and gaps in monitoring and evaluation frameworks further complicate efforts to eradicate FGM. Despite these challenges, opportunities remain to integrate FGM elimination into humanitarian responses, leveraging the nexus approach to align interventions with broader health, education, and social protection efforts.

To address the challenges and ensure sustained progress toward eliminating FGM, the following targeted actions are recommended:

1. **Integrate FGM Interventions into Humanitarian Responses**
    - Ensure FGM elimination programs are included in humanitarian action plans, with interventions tailored to the needs of displaced and refugee populations.

- Collaborate with host countries, such as Egypt, to protect Sudanese refugees from FGM and provide culturally sensitive awareness campaigns in refugee camps and host communities.
- Establish mobile teams in displacement settings to deliver integrated services, including health, legal aid, and psychosocial support, while disseminating anti-FGM messages.

2. **Strengthen Legislative Enforcement and Legal Protections**
   - Reinforce enforcement of existing anti-FGM laws, including Article 141, by training law enforcement and judicial officers to handle cases effectively, even amid conflict.
   - Address legislative gaps by criminalizing cross-border FGM, attempts to perform FGM, and failure to report intended or completed cases.
   - Introduce measures to protect women and families resisting FGM from social or familial pressures in displacement settings.

3. **Expand Community-Led Advocacy and Awareness**
   - Leverage successful campaigns like Saleema to engage displaced communities in dialogue about the harmful effects of FGM.
   - Train displaced community leaders, religious figures, and health professionals as advocates to amplify anti-FGM messages and foster trust.
   - Use culturally relevant alternative rites of passage to encourage abandonment of FGM in refugee and displacement settings.

4. **Address Medicalization of FGM**
   - Strengthen penalties for healthcare professionals performing FGM and provide alternative livelihood opportunities for midwives and other practitioners involved in the practice.
   - Conduct targeted campaigns to educate health workers on the ethical and legal ramifications of FGM, particularly in areas of displacement.
   - Incorporate FGM awareness and prevention into medical and nursing curricula to create a workforce committed to ending the practice.

5. **Develop and Implement Context-Specific Plans**
   - Create structured, costed plans for FGM elimination in stable regions, focusing on law enforcement, community engagement, and advocacy.
   - Include a robust monitoring and evaluation (M&E) framework to track progress, identify gaps, and ensure accountability.
   - Invest in research to update prevalence data, understand the impact of displacement on FGM practices, and inform evidence-based policy and programming.

6. **Foster Collaboration and Coordination Among Stakeholders**
   - Strengthen partnerships between government agencies, international organizations, NGOs, and community leaders to align efforts and share resources.
   - Encourage international donors to prioritize FGM interventions as part of humanitarian and development aid packages.
   - Facilitate regional and cross-border initiatives to address FGM among displaced populations and foster collaboration between neighboring countries hosting refugees.

7. **Leverage the Nexus Approach for Holistic Interventions**
   - Align FGM elimination efforts with broader gender-based violence (GBV) strategies, integrating them into food security, health, and education programs.
   - Build resilience in local governments and service providers to ensure continuity of FGM programs during crises.
   - Ensure emergency preparedness and disaster response plans explicitly include FGM elimination interventions.

While the conflict in Sudan poses significant challenges to eliminating FGM, integrating FGM interventions into humanitarian response efforts presents an opportunity to sustain progress. By building on previous achievements, strengthening legislative frameworks, engaging displaced communities, and fostering collaboration among stakeholders, Sudan can continue its journey toward eradicating FGM, ensuring the protection and empowerment of women and girls even in the face of adversity.

CHAD

Background

Chad is a landlocked country in north-central Africa, sharing borders with Libya to the north, Sudan to the east, the Central African Republic to the south, and Cameroon, Nigeria, and Niger to the west. Its geography is diverse, ranging from the arid Sahara Desert in the north to fertile savannahs in the south, with Lake Chad serving as a vital ecological and economic resource. Chad gained independence from France on August 11, 1960, and is home to over 200 ethnic groups, reflecting a rich cultural and linguistic diversity. French and Arabic are the official languages, but numerous indigenous languages are spoken across the country. As of 2023, Chad's population is approximately 18.28 million,(35) with about 52% identifying as Muslim, 44% as Christian, and the remainder adhering to indigenous or other beliefs.(36)

Economically, Chad's GDP (purchasing power parity) was estimated at $32.4 billion in 2023, with a per capita GDP of $1,800.(35) The economy primarily depends on agriculture, livestock, and oil. However, challenges such as widespread poverty, political instability, weak infrastructure, and the adverse effects of climate change continue to hinder sustainable development. Chad is an active member of international organizations, including the African Union and the United Nations, playing a strategic role in regional security and development efforts. Despite its challenges, the country has untapped potential for growth and stability, particularly in its natural resources and agricultural sector.

Humanitarian challenges

Chad is confronting a multifaceted and prolonged humanitarian crises that has been exacerbated by decades of conflict, forced displacement, widespread food insecurity, and the intensifying effects of climate change. Since gaining independence in 1960, the country has experienced recurring instability, with major conflicts erupting in the 1960s, 1970s, and 1980s. More recently, the Chadian Civil War (2005–2010) and ongoing clashes with Boko Haram have further destabilized the nation, leaving behind a legacy of fragility and displacement.

Chad hosts refugees predominantly from neighbouring conflict-affected countries such as Sudan, the Central African Republic, and Nigeria. These refugees, combined with a significant number of internally displaced persons (IDPs), have overwhelmed Chad's already limited resources and fragile

infrastructure. Overcrowded camps lack adequate shelter, clean water, sanitation, healthcare, and education, creating a cycle of deprivation and vulnerability.

Food insecurity is a pressing concern, affecting large number of the population who require urgent assistance. Climate change has further aggravated the situation, with prolonged droughts, erratic rainfall, and desertification contributing to poor agricultural yields and livestock losses. The scarcity of resources has increased competition among communities, fueling local conflicts and further destabilizing affected regions.

Women and children are among the most vulnerable groups in Chad's humanitarian crises. Gender-based violence, including sexual exploitation and abuse, is widespread, especially in displacement settings where protection mechanisms are weak. Limited access to education and economic opportunities compounds these vulnerabilities, leaving women and girls with few avenues for empowerment and protection.
The humanitarian response in Chad faces significant challenges, including chronic underfunding and security concerns that restrict access to vulnerable populations. Violent incidents and logistical barriers make it difficult for aid organizations to deliver life-saving assistance, further exacerbating the plight of those in need. International efforts, while ongoing, often struggle to keep pace with the scale and complexity of Chad's crises, leaving critical gaps in service delivery and support.
The convergence of these factors has entrenched Chad's humanitarian challenges, creating a protracted crises that demands sustained attention and intervention. Without addressing these issues, the country remains at risk of further instability and deteriorating living conditions for millions of its residents and refugees.

Prevalence of FGM

In Chad, FGM remains a deeply rooted cultural practice.(57) The societal consequences of FGM in Chad are profound. Women and girls who have not undergone FGM are often ostracized and ridiculed, with derogatory labels such as "koye," meaning "uncut girl," used to demean them. These women face exclusion from critical social and cultural activities. They are perceived as immature, unreliable, or unsuitable for marriage, driving families to subject their daughters to FGM to ensure social respectability and secure marital prospects (70). Despite these societal pressures, the physical and psychological consequences of FGM are devastating. Women endure chronic pain, recurrent infections, complications during menstruation, and severe childbirth risks, including maternal and neonatal mortality. The psychological

toll is equally severe, with survivors often experiencing anxiety, depression, and post-traumatic stress disorder, highlighting the urgent need for comprehensive interventions to address this harmful practice (70, 71)

Between 2004 and 2014, the overall prevalence for women aged 15-49 fell from 44.9% to 38.4%, even more to 34.1% in 2019.(27, 44) FGM prevalence varies widely across Chad. The prevalence rates were higher in the south-east regions: Salamat, Sila while the prevalence rates were lower in the north-west regions Lac and Bourkou/Tibesti (1.8%).

The most practiced form of FGM in Chad is type I (72%). The procedure is predominantly performed on girls aged 5 to 14, though some may undergo it earlier due to familial or community pressures(71). Traditional excisors carry out the practice using rudimentary tools such as razors or knives, often under unhygienic conditions and without anaesthesia, which increases the risks of excessive bleeding, infections, and severe pain.(72)
Although medicalisation is not yet widespread, it is emerging in urban areas where healthcare providers perform FGM in clinical settings, ostensibly to reduce immediate health risks such as infection. However, this shift risks legitimizing the practice and complicates efforts for its complete elimination.(71)

While limited research and data availability preclude a definitive correlation between socioeconomic status and specific FGM types in Chad, socioeconomic factors are likely significant contributors to the practice. Further research is necessary to gain a deeper understanding of the complex interplay between socioeconomic factors and cultural practices that contribute to the prevalence of FGM in Chad. For instance, the Sara-Madjingaye community, located in southern Chad, particularly in the Mandoul and Moyen-Chari provinces, stands out for its deeply entrenched practice of FGM. Despite being in a region where Christian and traditional practices dominate, the Sara-Madjingaye community extensively practices FGM, often seen as a conventional rite linked to Islamic values, even though these justifications are more economic and sociocultural than religious.(70)

Additionally, economic dependency on FGM sustains the practice, as excisors rely on it as a primary source of income, creating resistance to its eradication.(73) Women aged 15-49 who live in rural areas are slightly more likely to undergo FGM (32.2%) than those who live in rural areas (34.6%).(44) Higher education generally correlates with lower FGM prevalence, but there is an unexpected rise in prevalence among women with higher education. This highlights the need for targeted studies to understand the sociocultural dynamics affecting this subgroup.(44)

The most recent MICS(44) conducted in Chad was in 2019 detailing prevalence, regional variations, and societal attitudes. There have been no subsequent DHS(27) or MICS(44) conducted in Chad. It is unknown when the next survey will be conducted.

FGM and the Humanitarian Nexus

The persistence of FGM in Chad cannot be understood without recognizing the country's position within a volatile regional humanitarian landscape. Over the past two decades, Chad has absorbed successive waves of displacement from Sudan, the Central African Republic, Nigeria, and Cameroon while facing its own internal instability and environmental stress.
Such conditions have reconfigured gender relations, household authority, and social identity. In these fragile environments, practices like FGM become mechanisms of continuity and control—preserving community cohesion and cultural legitimacy when other structures collapse. Displacement, loss, and trauma have therefore not diminished FGM; rather, they have reshaped its social function and reinforced it in some localities as a symbol of belonging.

Inside Chad's borders, refugee settlements in Ouaddaï, Wadi Fira, and the Lake Chad Basin illustrate how humanitarian response frameworks can inadvertently overlook or even reinforce harmful practices. In these camps, FGM persists beneath the radar of protection systems because emergency priorities centre on survival: food, water, shelter, and security.

Recent field observations (53) from Adré, near the Sudanese border, show that cutting continues in secrecy among newly arrived Sudanese refugees and occasionally among host families living in similar economic hardship. The resurgence of re-infibulation ("adal") after childbirth, as reported by social workers, highlights how displacement can revive deeply internalized rituals of purity and repair within disrupted communities. These are not isolated events but expressions of the broader social anxiety that accompanies protracted humanitarian existence—where preserving a recognizable moral order becomes a coping strategy.

Chad's humanitarian experience is deeply intertwined with the crises of its neighbours. The civil war in Sudan, renewed instability in the Central African Republic, and the enduring insecurity of the Lake Chad Basin have collectively produced a cross-border humanitarian corridor where people, norms, and survival strategies circulate freely. In this environment, FGM travels with displacement flows. Refugees bring diverse cutting traditions

that interact with existing Chadian customs—sometimes intensifying local practices through social imitation, sometimes softening them through dialogue and exposure. For instance, the arrival of Darfuri communities practising more severe forms of FGM has created new hybrid patterns along the eastern frontier(53). Conversely, exposure to humanitarian messaging and alternative rites promoted by aid agencies has encouraged some mixed communities to question long-held beliefs. This dynamic underscores that FGM in Chad today is regionally co-produced, sustained by overlapping humanitarian ecosystems rather than by any single cultural group.

While crises often reinforce FGM, they can also open transitional spaces for change. Displacement disrupts traditional power hierarchies and exposes communities to new legal, medical, and rights-based discourses. Younger women, health volunteers, and faith leaders engaged in humanitarian programming frequently become norm challengers, introducing alternatives within aid-supported social structures.

However, these opportunities remain fragile and uneven. Without deliberate integration of FGM prevention into protection, education, and reproductive-health services, humanitarian operations risk defaulting to cultural neutrality—implicitly allowing harmful norms to persist. Aligning action with the Humanitarian–Development–Peace (HDP) nexus can convert these fragile spaces into pathways for transformation: humanitarian assistance that protects, development interventions that empower, and peacebuilding that rebuilds trust and identity beyond gendered violence.

National Policies and Laws

One of the most important observations about Chad is that the country for years centered around the weakness of the legislative frame. This status prevented it from playing an effective role in protecting women's rights in Chadian local communities. FGM as a practice is still considered one of the deepest shapes of gender-based violence that is widely spread in Chadian society. The Constitution of Chad (1996)(74) does not expressly refer to harmful practices or FGM, but Article 14 assures equality 'without distinction of origin, of race, of sex, of religion, of political opinion or of social position.' It also places a duty on the state to eliminate all forms of discrimination against women and to assure the protection of their rights in all domains of private and public life. Article 17 addresses an individual's right to life and personal integrity, and Article 18 prohibits cruelty, degrading and humiliating treatment, and torture.

National Chad Legislation doesn't provide a clear definition of FGM or criminalizes its performance, procurement, arrangement or assistance of its acts. The legislation also doesn't ban the participation of medical professionals in acts of FGM or prohibit the practice of cross-border FGM. The main law relating to FGM in Chad is Law 006/PR/2002, The Reproductive Health Law, dated 15 April 2002 (The Reproductive Health Law). However, this law still requires an implementation decree from the president to be passed before it becomes effective and enforceable(75). Chad's Penal Code of 1967 (Penal Code)(76) makes it a criminal offence to commit an act of violence or assault, including mutilation, upon another person. A new Penal Code was passed by the parliament in Chad at the end of 2016, but this has not yet come into force, and details of its relevance to FGM are not available.

The Reproductive Health Law has some articles that focus on the protection of human right issues. For instance, article 1 defines health as the 'state of complete physical, mental and social well-being of the human person in all aspects concerning the reproductive system, its functions and functioning, not only in the absence of disease or infirmity.' while Article 3 also states that 'all individuals are equal in rights and dignity in matters of reproductive health without discrimination', including in regards to age or sex. Article 9 expressly prohibits all forms of violence, including FGM, early marriage, domestic violence and sexual abuse. It stipulates that every person has the right not to be subjected to torture and cruel, inhuman or degrading treatment of his/her body in general and of reproductive organs in particular. However, Article 9 does not provide a definition of FGM. Article 18 makes it a criminal offence to violate the provisions of The Reproductive Health Law, whether by practice or in writing, speech, advertising or propaganda. It also has a state penalty of imprisonment from five months to five years and/or a fine of 100,000 to 500,000 francs CFA (approximately US$184–9206). Also, there is Article 18, with the wide nature of it is wideness, it is likely that aiding and abetting FGM would fall within the scope of the law, although this is not explicitly stated. The Reproductive Health Law does not oblige any person to report awareness of FGM and does not criminalize the failure to report the practice, whether it has taken place or is planned(77).

In addition, the Penal Code contains provisions relating to the prohibition of violence in general, which may apply to FGM. Article 252 makes it a criminal offence to 'intentionally hurt, wound or commit any other act of violence or assault upon another person will be punished by imprisonment for a period of six days to one year, plus a fine ranging from 500 to 50,000 francs CFA (approximately US$1–627)'. Article 254 also criminalizes inflicting wounds on a child (under 13 years of age) with doubled penalty. The Chad 2012 Human Rights Report notes, 'FGM/C could be prosecuted as a form of assault under

the penal code, and charges could be brought against the parents of victims, medical practitioners, or others involved in the action.' However, it also noted that prosecution is hindered by the lack of specific penalty provisions in the Penal Code.

The Ministry of Social Action and the Family has indicated that the existence of The Reproductive Health Law is leading to FGM being increasingly practiced 'underground' and on girls at a younger age. It was reported that, in 2016, certain villages and schools were found to be deserted and that the Ministry of Social Action and the Family presumes girls were taken into the bush to undergo FGM. Currently, the medicalization of FGM has not appeared to be significant in Chad, according to available data; 0.9% of women were reported to be cut by a health professional in 2015.5 The Reproductive Health Law does not explicitly refer to the practice of FGM carried out by a health professional or in a medical setting. However, given the broad nature of Article 18, The Reproductive Health Law appears to apply universally, which would likely include health professionals.(78)

Although The Reproductive Health Law does not explicitly oblige a person to report awareness of FGM, nor makes failure to report FGM a criminal offence, it is understood that there are several organizations in the country that are able to file a complaint directly with the courts or tribunals of Chad against persons involved in the practice. Such organizations include the NGO coalition CELIAF; the Association of Women Lawyers of Chad, an NGO focused on improving socio-legal conditions for, and defending the rights of, women and children in Chad; and the Ministry of Social Action and the Family itself.

Overall, Chad's commitment to promoting and protecting women's rights is undermined by an inadequate legal framework that fails to explicitly address FGM. The combination of a lack of clear definitions, penalties, and mandatory reporting requirements creates an environment where the practice can continue unchallenged. To effectively combat FGM, Chad must enact comprehensive reforms that strengthen its legal provisions, enhance enforcement mechanisms, and engage communities in changing societal attitudes towards harmful practices. Only through such measures can the rights and well-being of women and girls in Chad be safeguarded.

Community and National Efforts to Eliminate FGM

Ministry of Women, Early Childhood Protection and National Solidarity are coordinating the FGM elimination interventions. However, there is no evidence or details of any formal program structure, strategies or national

action plans currently for Chad. Interventions are mainly directed towards awareness raising campaigns with a focus on parents, and traditional and religious leaders who lead the resistance to any action to stop the practice.

The government of Chad took steps to stop FGM as part of its intervention to stop all forms of violence against women. It started with the formulation of a working group for the elimination of FGM. Training for police, judiciary, and gendarmerie on child rights and protection took place to improve these sectors' work. In 2021, a toll-free hotline was created to receive compliance about all forms of violence, including FGM. On 14 May 2019, the Ministry of Women, Family and Child Protection created an interministerial coordination framework for child protection.

Furthermore, the government Established child protection committees at provincial, departmental, and cantonal levels for the implementation of a referral mechanism for victims of violence. Also, the government improved the child care services to improve psychosocial, medical, and legal care to victims or girls at risk. Also, different types of social/behavioral change activities in the areas affected by this practice were implemented to raise community awareness of the risks and consequences of FGM. In 2022, Chad joined the UN joint program, and following that, it started to get support to promote its interventions to eliminate FGM. Several NGOs and women's associations, like ASTBEF and the National Association for the Prevention of Practices Harmful to Women and Children, are leading the struggle against female circumcision in the country. Also, there is CELIAF, a network of over 450 NGOs dedicated to promoting women's rights in Chad, and the Association Tchadienne pour la Promotion et la Défense des Droits de l'Homme. CELIAF focused on improving socio-legal conditions for and defending the rights of, women and children in Chad. It plays a role in filing complaints directly with the courts or tribunals of Chad against persons involved in the practice.

The efforts of Chad to eliminate the practice of FGM have been effective. The prevalence of FGM among women aged 15–49 has decreased from 38.4% in 2014–2015 (DHS)(27) to 34.1% in 2019 (MICS)(44), signaling a decline. Among girls aged 0–14, 19% reported being cut between the ages of 10 and 14, reflecting efforts to limit the continuation of the practice among younger generations. Attitudes toward FGM are also changing, with support for the practice dropping from 29.1% in 2014–2015 (DHS)(27) to 22% in 2019 (MICS)(44). Additionally, Chad has established a legal framework to combat FGM, including the Reproductive Health Law of 2002, which prohibits the practice. However, the enforcement of these laws remains weak, as the law's

implementation decree has yet to be signed by the President. Similarly, while the Penal Code criminalizes acts of violence, including mutilation, no FGM-related prosecutions have been recorded in recent years.(78)

Efforts to eliminate FGM face significant cultural resistance, particularly in southeastern regions, where traditional and religious leaders often uphold the practice. FGM is increasingly being performed in secret and on younger girls to evade detection. There are also unconfirmed reports of cross-border FGM, with girls brought into Chad from countries with stricter anti-FGM laws.(75)

Despite these challenges, advocacy and awareness campaigns are making an impact. Government ministries, NGOs, and organizations like Cellule de Liaison des Associations Féminines (CELIAF) are raising awareness through public campaigns and community programs, often promoting alternative rites of passage to replace FGM. These efforts focus on shifting parental attitudes, as parents play a crucial role in deciding whether their daughters undergo the practice.

Conclusions and recommendations

Chad has made notable progress in its efforts to eliminate FGM through advocacy campaigns, community engagement, and legislative initiatives. The prevalence of FGM has decreased in recent years, signaling a positive shift in societal attitudes and practices. However, deeply entrenched cultural norms, weak enforcement of existing laws, and gaps in the legal framework continue to hinder progress. Challenges such as secret practices, younger age at cutting, and reports of cross-border FGM exacerbate the situation, particularly in southeastern regions where resistance remains strong.
The country's fragile political and economic landscape, compounded by widespread poverty and limited access to education and healthcare, further complicates efforts to address FGM. Although Chad has established child protection mechanisms and joined international programs such as the UN Joint Program on FGM, substantial gaps remain in legal enforcement, coordination, and sustainable community interventions.

To accelerate the elimination of FGM, Chad must adopt a comprehensive and multi-sectoral approach, integrating legal, community-based, and institutional reforms:

1. **Strengthen Legislative and Enforcement Mechanisms**

- Finalize and implement the presidential decree to enforce the Reproductive Health Law of 2002, ensuring its provisions on FGM are actionable and widely disseminated.
- Amend existing laws to explicitly define and criminalize all forms of FGM, including medicalized and cross-border practices, and mandate the reporting of known or suspected cases.
- Establish specialized training programs for law enforcement, judiciary, and healthcare workers to ensure the effective application of laws and protection of victims.
- Create a monitoring system to track and report FGM cases, with clear penalties for non-compliance by perpetrators and enablers.

2. **Expand Community-Based Advocacy and Awareness Programs**
   - Scale up social and behavioral change campaigns, particularly in high-prevalence areas, to address cultural and religious misconceptions about FGM.
   - Engage traditional and religious leaders as advocates for change, leveraging their influence to challenge societal norms that perpetuate FGM.
   - Promote alternative rites of passage through community-led initiatives that preserve cultural identity without harming girls.
   - Target parents with education campaigns emphasizing the health risks and legal consequences of FGM.

3. **Integrate FGM Elimination Efforts with Broader Development Goals**
   - Embed anti-FGM messaging in health, education, and social protection programs to reach diverse populations, especially in rural and underserved areas.
   - Strengthen child protection mechanisms at the local level by empowering child protection committees and enhancing their capacity to respond to FGM cases.
   - Address economic dependency on FGM by providing alternative income-generating opportunities for excisors and empowering women economically through vocational training and access to credit.

4. **Improve Coordination and Collaboration**
   - Strengthen coordination between government ministries, NGOs, and international organizations to avoid duplication and ensure resource optimization.
   - Enhance the role of networks like CELIAF and other women's organizations in advocating for policy changes and community engagement.

- Develop partnerships with neighboring countries to address cross-border FGM and harmonize anti-FGM laws and practices.

5. **Enhance Data Collection and Research**
   - Conduct updated surveys such as DHS and MICS to monitor FGM prevalence, trends, and societal attitudes.
   - Invest in qualitative and quantitative research to understand the socio-economic factors driving FGM and identify effective intervention strategies.
   - Use research findings to tailor programs and policies that address regional disparities and target high-prevalence communities.

The fight against FGM in Chad requires sustained and coordinated efforts across legal, social, and institutional domains. By strengthening laws, engaging communities, and integrating FGM elimination into broader development frameworks, Chad can accelerate progress toward the eradication of FGM and the protection of the rights and well-being of women and girls. These efforts will not only contribute to ending FGM but also enhance gender equality, public health, and socio-economic development in the country.

THE FEDERAL REPUBLIC OF SOMALIA

Background

Somalia, located on the Horn of Africa, is bordered by Ethiopia to the west, Djibouti to the northwest, and Kenya to the southwest. To its east lies the Indian Ocean, giving the country a strategic geographic position with one of the longest coastlines in Africa, spanning over 3,000 kilometres. Somalia's unique geography is marked by arid plains, semi-arid landscapes, and fertile river valleys, with the Shebelle and Juba rivers being vital water sources for agriculture and pastoralism. The country's economy largely depends on these activities, along with remittances from the Somali diaspora.

The population of Somalia is estimated at approximately 12.7 million as of 2023 (35), with ethnic Somalis comprising around 85% of the population. Other minority groups include the Bantu, Arabs, and various indigenous communities, particularly in southern regions. Over 99% of the population adheres to Sunni Islam, which profoundly influences Somali culture, societal structures, and daily life (36). Somali and Arabic are the official languages, although English and Italian are also spoken in some urban centres. Somalia is divided into three primary regions: Somaliland, Puntland, and South-Central Somalia. Somaliland, in the northwest, declared independence in 1991 but remains unrecognized internationally. Puntland, in the northeast, functions as an autonomous region. South-Central Somalia is home to the internationally recognized Federal Government, based in Mogadishu. This federal structure aims to decentralize governance and promote regional stability.

The country has one of the highest fertility rates globally, averaging 6.2 births per woman. This rapid population growth exerts pressure on limited resources and public services, particularly in healthcare and education. Somalia's GDP is estimated at $11.68 billion (35), making it one of the world's poorest nations. The economy is primarily informal, relying on livestock, agriculture, and remittances. Livestock exports, particularly camels, goats, and sheep, are a critical revenue source, alongside the cultivation of bananas, sorghum, and maize in fertile areas.

However, Somalia faces significant development challenges. Access to education remains limited, with literacy rates among the lowest in the world. Only about 30% of Somali children complete primary school, and the education system suffers from a lack of infrastructure, resources, and qualified teachers. Similarly, healthcare services are inadequate, with many

rural communities relying on traditional healers due to the lack of medical facilities and trained personnel.

Despite these challenges, Somalia has a rich cultural heritage and a vibrant oral tradition of poetry, storytelling, and music. Somali cuisine, arts, and customs reflect the country's diverse history, influenced by Arab, Persian, Indian, and European interactions through centuries of trade.
With its strategic location and untapped potential in sectors like fisheries, renewable energy, and trade, Somalia has opportunities for growth and development. Efforts to rebuild infrastructure, strengthen institutions, and promote regional integration have the potential to transform the country's prospects, provided these initiatives are sustained and adequately supported.

Humanitarian Challenges

Somalia faces a complex and multifaceted humanitarian crises, largely driven by a combination of natural and man-made factors (79). These challenges have created a protracted situation that leaves millions of people vulnerable and reliant on humanitarian aid.

Conflict and Displacement: Decades of instability and violence, primarily involving clan militias and extremist groups, have displaced millions of people. As of 2023, Somalia has over 3 million internally displaced persons (IDPs), many of whom live in overcrowded camps with inadequate access to basic services. Refugees returning from neighbouring countries also strain limited resources.
Food Insecurity and Malnutrition: Somalia frequently experiences extreme weather events, including recurrent droughts and periodic flooding. The 2022 drought, the worst in 40 years, left over 7 million people in need of urgent food assistance. The resulting crop failures and livestock losses have pushed families into acute food insecurity, with malnutrition rates, particularly among children, reaching alarming levels (80).

Healthcare System Strain: The healthcare system in Somalia is severely underdeveloped, with less than 20% of the population having access to basic health services. Outbreaks of preventable diseases such as cholera, measles, and malaria are common, exacerbated by poor sanitation and limited access to clean water. Maternal and child health services are particularly inadequate, contributing to high maternal and neonatal mortality rates.

Impact of Climate Change: Somalia is among the most climate-vulnerable countries globally. Recurrent droughts, desertification, and floods not only displace communities but also exacerbate resource competition, often

fueling inter-clan conflicts. The effects of climate change also disrupt livelihoods, particularly in agricultural and pastoralist communities.

Chronic Underfunding of Humanitarian Efforts: Despite international attention, Somalia's humanitarian needs remain significantly underfunded. Insecurity, logistical challenges, and limited access to conflict-affected areas further hamper the delivery of aid. Many vulnerable populations remain unreached, and essential services, including education and healthcare, struggle to meet demand.

These humanitarian challenges have a disproportionate impact on Somalia's most vulnerable populations, particularly women, children, and the displaced. Addressing these issues requires sustained international assistance, stronger local governance, and innovative strategies to build resilience and provide long-term solutions.

Prevalence of FGM

FGM is nearly universal in Somalia,(81, 82) the most recent estimates place prevalence at 99.2% of women aged 15-49 years (2020).(27) Deeply rooted in cultural and religious traditions, FGM is often perceived as a rite of passage marking a girl's transition to womanhood, ensuring marriageability, and symbolizing purity and morality.(83, 84) The prevalence rate in Somalia has not changed since 2006 when it was 97.9%.(27) It should be noted there is no geographical breakdown available for the prevalence in 2020.(85)

The most severe form, Type III (infibulation), is the most common, affecting about 64% of women in this region. Most girls undergo FGM between the ages of 5-9 (70.9%) and 10-14 (27.7%), typically performed by traditional practitioners in unsanitary conditions using rudimentary tools without anaesthesia.(46) A rare minority (0.2%) underwent FGM at the age of less than five according to the 2020 SHDS survey.(85) Despite growing trends toward medicalisation, where families seek healthcare providers to perform FGM under sanitised conditions, this shift merely reduces immediate risks such as infection but legitimises and perpetuates the practice.(84, 86)

The prevalence of FGM in Somalia is consistently high across all socioeconomic strata. Analysis reveals no significant correlation between socioeconomic status and FGM prevalence rates. Furthermore, the practice is widespread in both urban (97%) and rural (98%) areas, indicating its pervasiveness across geographic contexts. However, the prevalence of FGM is inversely correlated with the level of education.

Religion has significantly influenced the high prevalence of FGM in Somalia, with 72% of Somali women believing it to be a religious requirement. In 2012, religious leaders in Somaliland opposed initial anti-FGM policies calling for zero tolerance, only revisiting their stance years later. In February 2018, Somaliland's Ministry of Religious Affairs issued a *fatwa* banning the most severe form of FGM, known as pharaonic (sewn closed).

A growing movement advocates for ending FGM due to its severe health risks and human rights implications. However, support for FGM remains strong among women aged 15–49 in both Somalia and Somaliland, with 76.4% favouring its continuation—an increase from the 64.5% recorded in the 2006 Multiple Indicator Cluster Survey (MICS).(87) Women who have undergone FGM are more likely to support it (76.5%) compared to uncut women (63.8%), though the sample of uncut women surveyed is notably small. Additionally, advocacy campaigns often clash with societal and religious sentiments, particularly in rural areas where traditional norms dominate.(84, 88)

National Policies and Laws

The Constitution of Somalia (2012)1 protects human dignity and equality under Articles 10 and 11 respectively. With regards to FGM, it states under Article 15(4) that: Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited. Article 29(2) further provides, ‘Every child2 has the right to be protected from mistreatment, neglect, abuse or degradation. However, there is no legislation caramelizes FGM or punishes its practice. While for Somaliland’s legal system is a mixture of civil law, Islamic (Sharia) law, and customary law. This mixed system can lead to conflict and is not generally supportive of women’s rights.(89) the Constitution of the Republic of Somaliland (2001) confirmed compliance with all international agreements and treaties formerly signed and ratified by Somalia in Article 10(1), ‘provided that these do not conflict with the interests and concerns of the Republic of Somaliland’.(90) Although Somaliland is an unrecognized state and not member of the United Nations but, Somaliland signed and ratified the Convention on Rights of the Child in May 2002.(91)

The Constitution of Somaliland does not specifically mention female genital mutilation (FGM). However, Article 8 addresses the equality of citizens and states in paragraph (2) that "programs aimed at eradicating long-lasting harmful practices shall be a national obligation." Additionally, Article 24 affirms that everyone has the right to personal security, prohibits injury to individuals, and specifies that crimes "against human rights," including torture and "mutilation," are not subject to limitation periods.

The Penal Code, Law No. 05/19623 (the Penal Code), which came into force on 2 April 1964, is applicable to all jurisdictions in Somalia including Somaliland, it makes it a criminal offence to cause hurt to another that results in physical or mental illness. In article 440(3), hurt is deemed 'very grievous' if it results in (b) 'loss of a sense' or (c) 'loss of a limb, or a mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate.' In 2015, it was reported that work had begun to initiate a bill that would criminalize FGM across all of Somalia, and the Ministry of Women Affairs and Human Rights has declared its willingness to introduce FGM-eradication laws in Somalia; however, no specific bill has yet been proposed. in Puntland FGM legislation passed to parliament for approval. in 2016 the Sexual Offences Act was enacted to address harmful practices.

Currently, there is no national policies nor legislation in Somaliland that explicitly criminalizes or punishes the practice of female genital mutilation (FGM), which has continued to encourage the practice. In February 2018, the Ministry of Religious Affairs in Somaliland issued a fatwa (an Islamic legal ruling) prohibiting the most severe form of FGM, known as Type III (Infibulation). The fatwa stated that individuals who perform this type of FGM would face punishment, and victims would be entitled to compensation.

However, it did not specify the details regarding the nature of the punishments, the amount to be compensated or who would be responsible for paying it.(92) There is no clear definition of FGM in the constitution of both Somalia and Somaliland, and it is not mentioned whether the banishment for practicing FGM extended to those who procure, encourage or assist in its performance. both constitutions don't criminalize failure to report FGM, FGM performance by health professionals or the practice of cross border FGM. On the other hand, there is an increase in medicalized FGM in Somalia and Somaliland. A recent study indicates that an increasing number of nurses and midwives are now performing FGM in Somaliland, particularly the types referred to as sunna, in healthcare facilities or private homes.(93) no data about FGM medicalization in Somalia, but studies reflect the increase in the practice medicalization is due to rich and educated families reducing harm to their children. Currently, national legislation does not criminalize FGM when it is conducted by a healthcare professional or in a medical setting. Efforts are in the process of developing a national policy to ban performance FGM by health professionals and propose revoke of the license of any health professional who violates the policy. In Puntland, an inter-ministerial decree against FGM developed by the Ministry of Health and signed in 2014 states that there will be no medicalization of FGM.

As there is no legislation for FGM there are no penalties set out for its practice. Also, there are no reported cases of arrests or court proceedings in Somaliland. There is also no evidence of the Penal Code being used to prosecute perpetrators of FGM. Furthermore, no cases of malpractice have been identified against health professionals for performing FGM in Somaliland. Even in cases where females face complications that lead to death, it appears that such cases were settled privately between the medical practitioners and the families.

There is a lack of up-to-date and accurate data on the practice of FGM, which hinders effective policy and program development. The Somaliland Constitution does not explicitly prohibit FGM, and the ongoing absence of a national law to criminalize and punish all forms of the practice undermines the efforts of those working to eliminate it in the region. Addressing FGM in Somaliland will remain a complex challenge, but enacting national legislation is a crucial element of the strategy, as it would demonstrate the government's commitment to protecting women and girls and eradicating this harmful practice. The law should be comprehensive with the engagement of all stakeholders involved in its drafting, execution and enforcement. In addition, the law needs to criminalized and punish all perpetrators of the practice

However, recently, Somaliland passed a landmark law protecting children from all forms of abuse and neglect after the country’s first Children’s Act was approved by Parliament in 2022. The act addresses children’s fundamental rights and places a duty on parents, caregivers, the State and others to protect them. This act is a significant and vital step forward towards eliminating Female Genital Mutilation/Cutting (FGM/C), which is an extreme form of discrimination against girls and women.

Community and National Efforts to Eliminate FGM

The leading government departments responsible for work to end FGM in Somalia are the Federal Ministry of Women and Human Rights Development (MOWHRD) in Central South and the Ministry of Women’s Development and Family Affairs (MOWDAFA) in Puntland. In addition, across all zones, the Ministry for Religious Affairs and Endowment, Ministry of Health (MOH) and Ministry of Youth all contribute to the work to end FGM. In Somaliland Ministry of Labour and Social Affairs is the leading government entity responsible for FGM elimination activities with the participation of the Ministries of Health, Justice and Religion. Nevertheless, there is a federal mechanism for coordination of FGM intervention in Somalia regions.(94)

Since 2015, the federal MOWHRD and the MOH have co-chaired an FGM taskforce meeting to coordinate anti-FGM work. Despite this, Somalia lacks a comprehensive national strategy or policy for addressing FGM. The 2011 Health Policy highlighted the need for a national policy for FGM.(95) In 2015, the Action Plan for the Implementation of the Human Rights Roadmap (HRRM) of Federal Government of Somalia 2015 – 2016, identified FGM as a key issue under Thematic Area 4: Rights of Children and Women, Gender Equality, and other Vulnerable Groups. The plan recommended several critical actions, including developing a penal code to criminalize FGM, strengthening coordination mechanisms for FGM campaigns and activities, conducting advocacy campaigns targeting community and religious leaders, and finalizing an anti-FGM policy and bill. (96) In 2017, a draft policy on FGM was reportedly under development (34). By 2021, national action plans with defined targets, budgets, and monitoring and evaluation frameworks for ending FGM had been established (69). These interventions are integrated into the broader gender-based violence (GBV) program (97). However, despite these efforts and progress, Somalia still lacks a finalized and comprehensive national policy or strategy specifically dedicated to FGM elimination. This gap underscores the need for sustained coordination and the formalization of policies to address FGM effectively.

Somalia is a member of the East African Community Prohibition of Female Genital Mutilation Act (EAC Act). As part of this initiative, a comprehensive Action Plan (2019–2024) was developed to address cross-border FGM/C through a multisectoral and strategic approach. This plan aims to enhance collaboration among East African countries to combat FGM/C effectively. However, the implementation of the action plan, adopted in 2019, faced significant delays due to the disruptions caused by the COVID-19 pandemic.(94)

In 2009, Somalia joined the UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting (UNJP), with Somaliland also actively participating in the program. The UNJP collaborates with government agencies and partners to engage communities, develop communication strategies, and provide support services for women and girls affected by FGM. A core focus of the program is supporting Somali efforts to formulate policies and draft anti-FGM legislation (98).

In Somaliland, UNJP interventions include community engagement initiatives, such as the Somaliland Youth Peer Education Network (Y-PEER), and the establishment of religious leaders' networks across the country to advocate against FGM. The program also provides protection and support

services for women and girls and develops communication strategies to raise awareness about the harmful effects of FGM (98).

In Puntland, progress was marked by the approval of an official government policy in March 2014 outlawing all forms of FGM. However, while the policy was disseminated, no implementation plan or supportive legislation has been developed to enforce it. In July 2014, both the Somalia and Puntland governments signed the Girl Summit Charter on Ending FGM, Child Early, and Forced Marriage, signaling their commitment to addressing these harmful practices (98).

In Somaliland, the Ministry of Health developed national management protocols and training materials in 2016 to address complications arising from FGM, focusing on the Somali and Afar regions (98).
Despite these efforts, several barriers remain. The lack of accurate data on FGM prevalence, the absence of national legislation criminalizing the practice, funding shortages, and limited sustainability of programs pose significant challenges. NGOs working to eliminate FGM in Somalia often struggle with these obstacles. However, a network of NGOs collaborates with the government and the UNJP to mobilize local communities and implement strategies aimed at eradicating FGM (98).

Projections by the UNJP indicate that Somalia must dramatically accelerate its efforts—by at least 20 times—to meet the global target of FGM elimination by 2030. This underscores the urgency of overcoming existing challenges and achieving coordinated, sustained action across all regions of the country (99). Despite these efforts, Somalia's policies remain fragmented, with limited enforcement of international human rights commitments, such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Maputo Protocol (99). Community-driven approaches, including engaging religious leaders to challenge misconceptions and promote alternative rites of passage, are recognized as critical for long-term change but remain underdeveloped in many regions (100).

Somalia has also initiated the process of issuing a Child Rights Bill, aligning with the United Nations Convention on the Rights of the Child (UNCRC). This bill prohibits harmful practices, including child marriage and FGM, but it is currently pending parliamentary approval. While specific data on FGM elimination progress is limited, available statistics reveal a significant divide in attitudes toward the practice. Approximately 65% of women aged 15–49 believe FGM should continue, while 33% think it should end. Education plays a critical role in shaping these views; 60% of women with secondary or higher education oppose FGM, compared to just 30% of those with no formal

education. Similarly, location influences attitudes, with 40% of urban women opposing the practice, compared to 25% in rural areas. Although FGM remains prevalent, opposition is growing, particularly among younger, educated, and urban populations, driven by ongoing awareness campaigns and educational initiatives (85, 87)

NGOs working in Somalia, despite facing significant challenges such as funding shortages and weak legislative enforcement, collaborate with the government and the UNJP to mobilize local communities and implement strategies aimed at ending FGM. However, projections by the UNJP suggest that Somalia must accelerate its efforts by at least 20 times to meet the global target of eliminating FGM by 2030 (99).

While there has been progress in Somalia, the lack of cohesive policies, limited enforcement, and fragmented community engagement highlight the need for a more consolidated and coordinated approach. Strengthening legislative frameworks, ensuring sustainable funding, and scaling up community-driven advocacy and education efforts are critical to eliminating FGM entirely in the country.

Conclusion and recommendations:

Somalia has made some progress in its efforts to eliminate FGM, with initiatives from government entities, NGOs, and international organizations such as UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting (UNJP). Community engagement, educational campaigns, and regional collaborations, such as the East African Community Prohibition of FGM Act, are contributing to shifts in societal attitudes, especially among younger, urban, and educated populations. However, the persistence of deeply rooted cultural and religious norms, a lack of national legislation criminalizing FGM, fragmented policies, and limited enforcement mechanisms hinder the effectiveness of these efforts.
Projections indicate that Somalia needs to accelerate its interventions by at least 20 times to achieve the global target of eliminating FGM by 2030. Challenges such as funding shortages, weak institutional capacity, and the absence of reliable data exacerbate the complexity of the situation. Despite these obstacles, growing awareness and shifting attitudes among certain segments of the population offer a foundation for building a more cohesive and sustainable strategy.

By implementing the following recommendations, Somalia can build on existing progress and work towards the complete elimination of FGM,

ensuring the health, dignity, and rights of women and girls across the country:

1. **Strengthen Legislative Frameworks**
   - Finalize and enact comprehensive national legislation that criminalizes all forms of FGM, including medicalized and cross-border practices.
   - Ensure legislation includes clear definitions, penalties, mandatory reporting requirements, and protections for victims and whistleblowers.
   - Integrate FGM-related policies into broader gender-based violence and child protection frameworks to ensure a holistic approach.

2. **Enhance Policy Coordination and Implementation**
   - Develop a national action plan for FGM elimination that aligns with Somalia's commitments under international human rights conventions such as CEDAW and the Maputo Protocol.
   - Strengthen the federal coordination mechanism to ensure effective implementation of FGM-related policies across all regions, including Puntland and Somaliland.
   - Provide adequate training and resources for law enforcement, healthcare providers, and social workers to enforce legislation and support victims effectively.

3. **Scale Up Community Engagement**
   - Expand grassroots advocacy programs, focusing on engaging religious leaders, traditional practitioners, and community influencers to challenge misconceptions and promote alternative rites of passage.
   - Strengthen youth engagement initiatives, such as the Somaliland Youth Peer Education Network (Y-PEER), to create a generational shift in attitudes toward FGM.
   - Leverage community-driven approaches to integrate FGM elimination into existing development programs, including health, education, and livelihood initiatives.

4. **Increase Funding and Sustainability**
   - Secure sustainable funding for FGM elimination programs through partnerships with international donors, private sector stakeholders, and diaspora communities.
   - Allocate resources to support NGOs and community-based organizations working to eradicate FGM, ensuring their interventions are scalable and long-term.
   - Establish monitoring and evaluation frameworks to track progress and adjust strategies as needed.

5. **Improve Data Collection and Research**
   - Conduct regular surveys, such as DHS or MICS, to provide updated and reliable data on FGM prevalence, attitudes, and medicalization trends.
   - Undertake targeted research to explore the socio-economic, geographic, and cultural dynamics of FGM in Somalia, identifying specific barriers to eradication.
   - Use evidence-based insights to inform policy-making and program development.

6. **Integrate FGM Elimination into Broader Development Efforts**
   - Link FGM interventions with broader health and education initiatives, such as maternal and child health services and school-based awareness programs.
   - Promote gender equality and women's empowerment through livelihood programs, vocational training, and educational opportunities for girls and women.
   - Address structural barriers, such as poverty and lack of access to services, that perpetuate the practice of FGM.

ETHIOPIA

Background

Ethiopia, situated in the Horn of Africa, is one of the oldest nations in the world, with a rich history that dates back millennia. The country is a cultural and ethnic mosaic, home to more than 80 ethnic groups, each with its distinct languages, traditions, and customs. With a population of approximately 126.5 million as of 2023, (35)Ethiopia is the second-most populous country in Africa after Nigeria. Its official language is Amharic, although other languages such as Oromo, Tigrinya, and Somali are widely spoken.

The Ethiopian economy is predominantly agrarian, with agriculture accounting for a significant share of the GDP, which stood at $163.7 billion in 2023. (35) Coffee, a vital export commodity, plays a central role in the economy, alongside other crops such as cereals, pulses, and oilseeds. Livestock farming is also integral to the livelihoods of many Ethiopians. Despite recent efforts to diversify the economy, Ethiopia faces persistent challenges such as poverty, inflation, and limited industrial development. Ethiopia is religiously diverse, with Christianity and Islam being the predominant faiths. Ethiopian Orthodoxy is practiced by 43.8% of the population, Protestantism by 22.8%, and Catholicism by 0.7%, while Muslims make up 31.3%. (36) This diversity reflects the country's deep historical ties to both Abrahamic religions and indigenous beliefs.

Addis Ababa, Ethiopia's capital and largest city, serves as the political and diplomatic hub of the continent. It hosts the African Union's headquarters and numerous international organizations, cementing Ethiopia's strategic role in regional and global affairs. Ethiopia’s geography is equally diverse, encompassing the highlands of the Ethiopian Plateau, the Great Rift Valley, and arid lowlands. This geographical variety supports a wide range of ecosystems and biodiversity but also poses challenges such as soil erosion, deforestation, and vulnerability to climate change.

Despite its rich history and economic potential, Ethiopia faces significant development challenges, including limited access to education and healthcare, high unemployment rates, and persistent gender inequality. Addressing these issues, alongside ongoing humanitarian crises, is vital for the country's long-term stability and growth.

Humanitarian Challenges

Ethiopia is grappling with a series of interlinked humanitarian crises that have escalated in recent years, driven by conflict, climate change, and public health emergencies. These crises have left millions of Ethiopians vulnerable and dependent on international aid for survival.

Conflict and Displacement: The Tigray conflict, which began in late 2020, has expanded into the Amhara and Oromia regions, leading to widespread violence, destruction, and displacement. Over 4 million people have been displaced internally, while thousands have fled to neighboring countries as refugees. These conflicts have disrupted communities, destroyed infrastructure, and led to severe shortages of food, water, and essential services.

Food Insecurity and Drought: Ethiopia has faced severe drought conditions since 2021, particularly in the Afar, Somali, and southern Oromia regions. These droughts have devastated agricultural yields and livestock, leaving over 20 million people facing food insecurity and pushing some areas toward famine. Compounded by rising global food prices and economic challenges, many families are unable to meet basic nutritional needs, leading to alarming levels of malnutrition, especially among children.

Public Health Crises: Outbreaks of preventable diseases, such as cholera, measles, and malaria, have surged, exacerbated by limited access to healthcare and poor sanitation. The collapse of healthcare infrastructure in conflict-affected areas has worsened maternal and child health outcomes. Internally displaced populations, living in overcrowded and unsanitary conditions, are particularly vulnerable to these outbreaks.

Education Disruption: The humanitarian crises have significantly impacted education, particularly in the Afar and Somali regions. Drought and conflict have forced the closure of schools as families migrate in search of water and pasture, and teachers return to their home communities. This has deprived children, especially girls, of educational opportunities, increasing their vulnerability to early marriage and other forms of exploitation. (101)

Gender-Based Violence and Harmful Practices: The breakdown of community protection structures due to conflict and displacement has heightened the risk of gender-based violence, including child marriage and FGM. (17) Economic insecurity and the loss of livelihoods have exacerbated these practices, as families resort to them as survival strategies. In some cases, displaced communities have altered traditional FGM practices to evade

detection in areas where it is criminalized, further complicating eradication efforts.

Impact of Climate Change: Ethiopia's vulnerability to climate change is evident in its recurrent droughts, erratic rainfall, and desertification. These environmental challenges not only exacerbate food insecurity but also fuel local conflicts over scarce resources such as water and grazing land. Flooding, another consequence of climate change, frequently displaces communities and destroys critical infrastructure.

Access and Funding Constraints: Delivering humanitarian aid in Ethiopia remains challenging due to ongoing conflicts, bureaucratic hurdles, and logistical constraints. Security risks in conflict zones hinder the movement of aid workers and supplies, leaving many vulnerable populations unreached. Moreover, international funding for Ethiopia's humanitarian response continues to fall short of needs, leaving critical gaps in food, healthcare, and shelter provision.
These humanitarian challenges have far-reaching implications for Ethiopia's population, particularly for women, children, and marginalized communities. Addressing these crises requires coordinated international and domestic efforts, focusing on immediate relief and long-term resilience-building strategies.

Prevalence of FGM

FGM in Ethiopia is predominately rooted in traditional beliefs, with ethnicity and cultural practices being significant drivers.(102) Poverty, limited education, and adherence to longstanding norms maintain its prevalence, particularly in communities where FGM is tied to girls' moral standing, marriageability, and control over sexuality.(102, 103) Over the past two decades, Ethiopia has experienced a decrease in the prevalence of FGM going from 79.9% in 2000 to 65.2% in 2016.(46) However, significant regional variations persist. The eastern regions of Somali and Affar report considerably higher prevalence rates, while the northern region of Tigray shows the lowest. FGM is a deeply entrenched practice in certain communities, driven by complex socio-cultural factors rather than specific religious mandates. While prevalent across various groups, the procedure is particularly concentrated among Somali and Affar populations, with 75.6% and 71% of women aged 15-49 respectively having undergone the procedure. Among Ethiopian women aged 15–49 who have undergone FGM, 73% report having had flesh removed, 3% report being cut without flesh removed, and 6.5% report undergoing infibulation, or being "sewn closed" 17.9% do not know what type of FGM/C they have undergone.(27) The shift toward less severe forms of FGM, such as

"Sunna" cuts, highlights the medicalization trend, particularly in regions like Fafan. While medicalized FGM may appear less harmful, it perpetuates the practice and its underlying norms. Education and outreach among healthcare workers are essential to combat this trend and reinforce zero-tolerance policies.(104, 105)

In Ethiopia, 23.6% of women and 16.8% of men aged 15–49 believe that FGM is a requirement of their religion. The practice is more common in Muslim communities, although it is important to emphasize that the driving force is cultural tradition rather than Islamic doctrine.(27) However, it should be noted that Infibulation is practiced the most amongst Muslim communities. Orthodox Christian communities also exhibit significant prevalence rates, albeit slightly lower than their Muslim counterparts, again highlighting the role of tradition. Conversely, Protestant and other religious groups and specifically the Harari ethnic group demonstrate lower FGM/C prevalence, with some actively opposing the practice due to health and human rights concerns. (105, 106)

Between 2000 and 2016, a trend of increasing disparity in prevalence across wealth quintiles has emerged. While the middle three quintiles experienced relatively stable prevalence rates, a notable decline was observed in both the lowest and highest quintiles. This suggests a complex relationship between socioeconomic status and prevalence, with factors beyond simple wealth contributing to the observed changes. Additionally, the decline in the prevalence of FGM between 2000 and 2016 was more pronounced in urban areas compared to rural areas. By 2016, the prevalence of FGM in urban areas had decreased to 53.9%, while in rural areas it remained higher at 68.4%. Women from rural areas, with less education and who identify as Muslim are more likely to have undergone FGM.(27) A correlation has been observed between educational attainment and the prevalence of FGM.(107) Data suggests that women aged 15-49 with secondary or higher education levels exhibit a lower likelihood of undergoing FGM compared to those with no formal education.

FGM among girls aged 0-14 is primarily performed by traditional circumcisers, accounting for 95.3% of procedures. A small percentage of procedures are carried out by traditional birth attendants (2.2%) and, in rare instances, by medical professionals (1.9%). The most recent DHS(44) conducted in Ethiopia is the 2021–22 Service Provision Assessment (SPA). However, it does not include data on FGM prevalence or attitudes. The most recent comprehensive data on FGM in Ethiopia is from the 2016 DHS, detailing prevalence, regional variations, and societal attitudes. A new DHS planned for 2024 is expected to provide updated insights.

National Policies and Laws

The Constitution of the Federal Democratic Republic of Ethiopia (1995) does not directly address FGM/C but contains several statements relevant to the practice in Articles; 16, 18, 25, 35, 36.(108) In particular Articles 35 – Rights to Women. Article 16 protects all citizens against 'bodily harm'. Article 18(1) states, "Everyone has the right to protection against cruel, inhuman or degrading treatment or punishment." while Article 25 addresses the 'Right to Equality' and Article 35 addresses the 'Rights of Women'. In addition, Article 35(4) asserts, 'The State shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited.' Article 36 sets out the 'Rights of Children' and states that all actions 'shall be in the best interest of the child'. Although Ethiopia is divided into federal states, each with its constitution, these state constitutions often mirror or align closely with the federal constitution, particularly regarding fundamental rights and protections.(109)

The main law governing FGM/C in Ethiopia is Proclamation No. 414/2004, also known as The Criminal Code of the Federal Democratic Republic of Ethiopia 2004 (the Criminal Code).(110) This is a federal act that makes it a criminal offence to perform or procure FGM/C in Ethiopia. In addition, as well as being a criminal offence, performing any action that causes bodily harm is a civil offence under the Ethiopian Civil Code (1960).(111) Articles 561 –570 deal with life, persons and harmful practices. These articles criminalize FGM performance under part III titled (crimes committed against life, person and health through harmful traditional practice). Article 561 states whoever causes the death of a pregnant or delivering mother or a newly born child as a result of the application of harmful traditional practice such as through the exercise of other traditional practices known by the medical profession to be harmful, is punishable with fine or simple imprisonment from three months to one year.

Article 562 refer to endangering life or causing bodily injury or impairment of a pregnant woman or new-born child as a result of the application of harmful traditional practices known by the medical profession to be harmful. Article 564 applies to a person who, by doing violence to a marriage partner or a person cohabiting in an irregular union injures to his/her physical or mental health. Articles 565 and 566 respectively set out punishments for the performance of FGM/C on 'a woman of any age' simple imprisonment for not less than three months, or a fine not less than five hundred Birr while, for infibulation of 'the genitalia of a woman' the punishment is with rigorous imprisonment from three years to five years and, if injury resulted provides for

a more severe penalty the punishment shall be rigorous imprisonment from five years to ten years.

Article 568 mentions that anyone participates in the transmission of communicable diseases through harmful traditional practices will be subjected to penalties. Article 569 put the performance of, and aiding and abetting of FGM/C by parents or any person, as a criminal offence with a penalty of imprisonment for not more than three months or a fine of not more than 500 Birr. The code also through article 570 criminalizes organization or participation in any action for promotion of FGM/C as well as encouragement of anyone to disregard the legislation prohibiting harmful traditional practices. Article 570 penalty is similar to Article 568.

Complementing this situation, the Ethiopian Ministry of Health issued a circular in January 2017 that banned the medicalization of FGM in all public and private medical facilities across the country (112) According to the circular, medical personnel who engage in any form of FGM within medical settings are subject to legal action. However, as noted by UNICEF(113) there is no national legislation that explicitly criminalizes health professionals who condone, perform, attempt to perform, or assist in the practice of FGM. FGM in Ethiopia is mostly performed by traditional practitioners, accounting for 86% of cases. However, in certain regions such as the Southern Nations, Nationalities, and Peoples' Region (SNNPR), health personnel are increasingly involved. In this region, 1 in 10 women who underwent FGM were cut by a doctor, nurse, midwife, or other health professional.(114)

The Criminal Code of Ethiopia includes provisions aimed at addressing FGM/C, including cross-border practices. Article 18, titled "Other Crimes Committed Outside Ethiopia," applies the Code to any person who has committed a crime outside Ethiopia against an Ethiopian national or any Ethiopian national who commits a crime outside the country. This provision prohibits performing FGM outside Ethiopia and ensures accountability for acts committed beyond the country’s borders.

Despite these measures, the legal framework for FGM in Ethiopia has faced criticism of inconsistent FGM legislation under the law. (109) Under the 1957 Penal Code, FGM is criminalized as a crime against persons and health, whereas the 2004 Criminal Code categorizes it as one of the crimes of harmful traditional practices (HTPs). This distinction results in significant differences in penalties: under the 2004 Criminal Code, FGM is punishable by up to five years of rigorous imprisonment, whereas under the earlier Penal Code, crimes against person and health could warrant punishments of up to 15 years of rigorous imprisonment. Critics argue that this lesser penalty for

FGM under the 2004 Code diminishes its seriousness and perpetuates the fallacy that FGM is not a violation of bodily integrity akin to other crimes against person and health (46).

Ethiopia is bound by several international conventions that address FGM and harmful practices. The country has ratified key treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (1979), the African Charter on Human and Peoples' Rights (ACHPR, Banjul Charter), and the African Charter on the Rights and Welfare of the Child (ACRWC). Ethiopia has also acceded to global agreements like the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), and the Convention on the Rights of the Child (CRC). In July 2018, Ethiopia ratified the Maputo Protocol, further reinforcing its commitment to eliminating harmful traditional practices, including FGM. These instruments obligate Ethiopia to prohibit and condemn practices such as FGM that negatively impact the rights and well-being of women and girls (46).

Despite the presence of legal provisions, implementation and enforcement remain weak. Data from UNICEF and UNFPA reports (*Accelerating Change*, 2008–2018) show limited progress in prosecuting FGM cases. For instance, in 2018, Ethiopia recorded 13 arrests, 9 cases brought to court, and 4 convictions. During the 2015–2017 period, there were 280 arrests, 77 court cases, and only 2 convictions related to FGM (34, 115).

Barriers to enforcement include the lack of explicit mention of FGM in other sections of the Criminal Code, creating inconsistencies in legal proceedings. This ambiguity allows for discretionary interpretation, leaving women more vulnerable to harm. Stigma and fear of social isolation also discourage victims and their families from reporting FGM cases. Additionally, the requirement for concrete evidence and the secrecy surrounding FGM practices, often conducted in remote areas, further hinder legal action (116).

However, it has been reported that laws are rarely enforced, as many local officials prioritize the social norms surrounding FGM over the legal prohibitions.(117) Arrests, prosecutions, and convictions remain exceptionally rare. Awareness of the law is poor even among law enforcement agencies, and reluctance by local officials to enforce anti-FGM laws persists. Many rural communities rely on traditional justice systems, such as elder-run councils, rather than formal legal mechanisms, allowing perpetrators to evade accountability. In some areas, community leaders continue to support

traditional practitioners, undermining efforts to enforce the law (117). Moreover, because FGM/C is frequently carried out in secrecy, often in remote or isolated areas, there are rarely witnesses who can testify in court, making it even more challenging to pursue legal action.(118)

The lack of a robust enforcement mechanism, combined with cultural and systemic barriers, underscores the need for targeted legal reforms, increased awareness, and stronger institutional commitment to effectively combat FGM in Ethiopia(46, 109, 118).

Community and National Efforts to Eliminate FGM

In 2013, Ethiopia endorsed the National Strategy and Action Plan on Harmful Traditional Practices, introducing a dedicated budget line to support interventions aimed at eliminating FGM. The National Implementation and Monitoring Platform was tasked with coordinating and implementing the 2013 strategy, which focused on key areas such as raising awareness, developing support networks, creating safe spaces for girls, ensuring access to quality education and health services, and involving leaders from various faiths in the movement to end FGM. In 2014, the government articulated a national vision to end child marriage and FGM by 2025 and established the National Alliance to End Child Marriage and FGM within the Ministry of Women, Children, and Youth (MoWCY).

In 2015, the Committee on the Rights of the Child (CRC) recommended Ethiopia intensify programs targeting FGM through sensitization campaigns in high-prevalence regions and enforce existing legislation prohibiting FGM, ensuring that perpetrators are prosecuted and convicted.(119) These recommendations were reflected in the Second Growth and Transformation Plan (2015–2020), which included clear FGM targets and indicators. In 2016, the government launched the Adolescent and Youth Strategy (2016–2020), which also emphasized the elimination of FGM. In 2019, the Committee on the Elimination of Discrimination Against Women (CEDAW) called on Ethiopia to implement the revised penalties for FGM under the 2005 Criminal Code and to effectively execute the 2013 National Strategy and Action Plan on Harmful Traditional Practices .(120)

In response, the MoWCY reviewed the National Policy on Women (introduced in 1993) with the aim of adopting a comprehensive gender-equality policy. The same year, Ethiopia launched the National Costed Roadmap to End Child Marriage and FGM (2020–2024), which is budgeted against five core outcomes at both the regional and federal levels.(95) The roadmap adopts a multi-sectoral collaboration approach, engaging sectors such as education,

health, and justice. However, the Charities and Societies Proclamation No. 621/2009 restricted civil society contributions, posing challenges to the roadmap's implementation.(121) The roadmap emphasized enhancing systems, accountability, and services across sectors to meet the needs of girls at risk of or affected by FGM and child marriage. Services were designed to be more girl-friendly and responsive, including legal aid, school-based support, psychosocial counseling, and guidance.

In 2021, Ethiopia, in collaboration with UNICEF, developed the Gender Equality Strategy, which provides overall guidance for program interventions, monitoring, reporting, and capacity-building to achieve gender-equality outcomes.(122) This strategy encourages collaboration with women's organizations and community-based groups for greater localization and ownership. It highlights the involvement of gender-equality experts and the integration of women's perspectives throughout programs to foster empowerment.

Ethiopia has implemented Social Behavior Change (SBC) interventions targeting FGM elimination. These interventions focus on tailored messaging for pregnant women, new parents, or parents-to-be to discourage them from cutting their newborns. Health extension workers play a pivotal role in these programs. In the SNNPR, where FGM medicalization is prevalent, health professionals and workers are engaged in SBC strategies, not only to raise awareness about the legal and health consequences of FGM but also to promote gender-sensitive services. Community conversations with decision-makers and gatekeepers have been used to develop action plans to end FGM. These dialogues proved effective in 2017–2018, though challenges such as limited involvement of adolescents, inconsistent follow-up, and a focus on raising awareness rather than challenging social and gender norms persist.(33, 34)

Activities involve engagement with religious leaders through their training and awareness raising of religious leaders. Religious leaders will play a key role in de-linking FGM from religion, promoting women's empowerment, equality, reproductive rights and wellbeing and positive familial relationships. FGM practiced in diverse ways even within a single zone. Therefore, it is important to assess progress through regular community-based monitoring exercises aimed at tracking both its incidence and type(s), and how practices might be shifting to make them less visible.(117) Efforts have been made to address these challenges by enhancing the capacity of community members delivering messages and ensuring service sustainability.

Engagement with religious leaders has also been prioritized. Through training and awareness campaigns, religious leaders play a vital role in de-linking FGM from religion, promoting women's empowerment, reproductive rights, and well-being, and fostering positive familial relationships.

FGM practices in Ethiopia vary significantly, even within a single zone. Regular community-based monitoring is crucial to track its incidence, types, and potential shifts in practices aimed at evading detection (111). Ethiopian attitudes toward FGM are gradually shifting toward opposition. Greater awareness of FGM's harmful effects, legal bans, and advocacy campaigns have contributed to declining support for the practice. Younger generations and urban populations are more likely to oppose FGM, while support persists in rural and conservative areas. However, consistent national and local efforts continue to challenge traditional norms, fostering a broader consensus against the practice.

Despite Ethiopia's robust legal framework to combat FGM, several persistent barriers hinder the effective enforcement of laws and implementation of interventions. One of the most significant challenges is the limited awareness of FGM-related legislation among law enforcement agencies and local communities. This lack of knowledge contributes to inconsistent application and weak enforcement of laws, particularly in rural and remote areas.

Community resistance also undermines progress, as traditional norms and practices often hold greater influence than legal prohibitions. Many local officials and community leaders continue to support FGM, prioritizing cultural acceptance over legal accountability. This dynamic is exacerbated by the reliance on informal justice systems in rural areas, where disputes are typically resolved through traditional mechanisms that often condone or ignore harmful practices like FGM.

Stigma and fear further complicate efforts to combat FGM. Survivors and witnesses are often reluctant to report cases due to the fear of social ostracism and the stigma attached to speaking out against entrenched cultural norms. This silence perpetuates the practice and limits the ability of authorities to take legal action.

Additionally, the clandestine nature of FGM presents a significant barrier. In many cases, the practice is carried out in secrecy, particularly in remote or isolated locations, making it difficult to gather evidence or secure witnesses for prosecution. This secrecy is compounded by the lack of up-to-date and accurate data on FGM prevalence, which hinders the development of targeted and effective policies and programs.

Addressing these barriers requires a multifaceted approach that includes raising awareness about FGM legislation, engaging local communities to shift cultural attitudes, strengthening law enforcement, and improving data collection and monitoring systems. Without addressing these persistent challenges, Ethiopia's efforts to eradicate FGM will remain constrained.

Conclusion and recommendations:

Ethiopia has made commendable progress in addressing FGM through a robust legal framework, national strategies, and community-based interventions. The decline in FGM prevalence from 79.9% in 2000 to 65.2% in 2016 underscores the impact of these efforts, particularly in urban areas and among younger and more educated populations. However, persistent challenges, including weak enforcement of laws, cultural resistance, limited awareness of legislation, and reliance on informal justice systems, hinder the complete eradication of the practice. The medicalization of FGM, particularly in the SNNPR, adds complexity, perpetuating the practice under the guise of harm reduction. Ethiopia must address these barriers through targeted, multisectoral approaches to achieve its vision of eliminating FGM by 2025. By addressing the following recommendations, Ethiopia can build on its progress and accelerate efforts to eliminate FGM, fostering a safer and more equitable environment for women and girls across the country:

1. **Strengthen Legal Enforcement and Awareness:**
    - Enhance the capacity of law enforcement agencies through training programs focused on FGM legislation, investigative methods, and the importance of prosecuting perpetrators.
    - Raise awareness of FGM laws among local communities, particularly in rural and high-prevalence areas, to improve compliance and reporting.
    - Promote community-based monitoring to identify and report FGM practices, ensuring confidentiality and protection for whistleblowers.

2. **Combat Cultural Resistance:**
    - Collaborate with religious and community leaders to de-link FGM from cultural and religious justifications, fostering broader support for its elimination.
    - Engage influential figures such as elders, traditional leaders, and healthcare providers in advocacy campaigns to challenge entrenched norms.

- Develop tailored, region-specific messaging that resonates with diverse cultural and ethnic groups, emphasizing the health risks and human rights implications of FGM.

3. **Address Medicalization of FGM:**
   - Enforce the 2017 directive banning FGM in medical facilities, with clear penalties for non-compliance.
   - Train healthcare professionals on gender-sensitive practices and the health and legal consequences of performing FGM.
   - Develop a certification program for healthcare workers that includes zero-tolerance training on FGM, ensuring accountability.

4. **Enhance Access to Education and Services:**
   - Expand access to quality education for girls, particularly in rural and underserved areas, to reduce vulnerabilities to FGM and early marriage.
   - Strengthen psychosocial support, legal aid, and school-based services for survivors and at-risk girls, ensuring these services are accessible and girl-friendly.
   - Integrate FGM prevention messages into broader health and education programs using platforms such as maternal and child health services.

5. **Promote Data Collection and Research:**
   - Conduct regular, nationwide surveys to update data on FGM prevalence, regional variations, and emerging trends, including shifts toward less severe forms or medicalization.
   - Monitor and evaluate the impact of community-based interventions, using findings to refine and scale up effective practices.
   - Invest in qualitative research to understand the socio-cultural drivers of FGM and identify region-specific barriers to its eradication.

6. **Ensure Sustained Funding and Multisectoral Coordination:**
   - Increase national and international funding for FGM elimination programs, ensuring budget allocation aligns with the National Costed Roadmap (2020–2024).
   - Foster collaboration across sectors, including health, education, and justice, to create integrated and holistic solutions.
   - Involve civil society organisations and community-based groups in program implementation, advocacy, and monitoring to enhance localization and sustainability.

MALI

Background

The Republic of Mali is a landlocked country in West Africa, covering approximately 1,241,238 square kilometres, making it the eighth-largest nation on the African continent. Mali's geographic location places it at the intersection of the Sahel and West Africa, bordered by Algeria to the north, Niger to the east, Burkina Faso and Côte d'Ivoire to the south, Guinea to the southwest, and Senegal and Mauritania to the west. This positioning has historically facilitated trade, cultural exchange, and political interactions, shaping Mali's rich and diverse society.

As of 2024, Mali's population stands at an estimated 21.9 million people, growing at an annual rate of 2.9%. The country's demographic structure is youthful, with 67% of the population under the age of 25, presenting both opportunities for development and challenges in terms of education, employment, and social services. Mali's cultural diversity is reflected in its numerous ethnic groups, the largest of which is the Bambara (33.3%), followed by the Fulani (13.3%), Sarakole/Soninke/Marka (9.8%), Senufo/Manianka (9.6%), and Malinke (8.8%). Other significant groups include the Dogon (8.7%), Sonrai (5.9%), Bobo (2.1%), and Tuareg/Bella (1.7%). Smaller ethnic groups and individuals from neighboring regions, including ECOWAS states, also contribute to Mali's societal fabric. (123)

Mali's economy is predominantly reliant on agriculture and mining, particularly gold production, which drives much of its export revenue. In 2023, the country's GDP was valued at $20.9 billion, reflecting its position as a low-income economy with limited industrial diversification. Despite economic challenges, including extreme poverty, food insecurity, and vulnerabilities to climate change, Mali has demonstrated resilience, with a projected 3.7% GDP growth in 2024 driven by agriculture and the service sector. (124)

However, Mali remains deeply affected by structural challenges such as rapid population growth, high fertility rates (5.88 children per woman in 2018), electricity shortages, and ongoing insecurity. The extreme poverty rate, which worsened to 19.1% in 2022, remains a pressing issue, particularly in rural areas of the south, where 90% of the population resides. (124) These socio-economic challenges are compounded by political instability and environmental stressors, making Mali's path to sustainable development particularly challenging. (125)

Humanitarian Challenges

Mali faces a complex and multifaceted humanitarian crisis driven by conflict, political instability, climate change, and poverty. These challenges have severely impacted vulnerable populations, leading to widespread displacement, food insecurity, and the deterioration of basic services.

1. **Conflict and Displacement:** Mali has experienced persistent instability since the Tuareg rebellion in 2012, which triggered conflicts involving armed groups, extremist organizations, and intercommunal violence. The security situation remains volatile in the northern and central regions, where armed attacks and communal tensions continue to displace civilians. As of 2023, Mali hosts approximately 375,539 internally displaced persons (IDPs) alongside refugees fleeing violence in neighboring countries, including 29,138 from Burkina Faso, 20,617 from Niger, and 14,956 from Mauritania. (123)These displacement dynamics place immense strain on Mali's already limited resources and infrastructure.

2. **Food Insecurity and Malnutrition:** Mali's reliance on rain-fed agriculture makes it highly vulnerable to climate shocks such as droughts, desertification, and erratic rainfall. Severe food insecurity affects millions of Malians, particularly in the conflict-affected regions of the north and central areas. Rising global food prices, disrupted agricultural activities, and limited access to markets exacerbate food shortages. Malnutrition is widespread, especially among children, with acute malnutrition rates rising in IDP camps and rural areas. (126)

3. **Climate Change and Environmental Stress:** Climate change has exacerbated environmental challenges, including desertification, land degradation, and water scarcity. These conditions not only threaten agricultural livelihoods but also fuel competition over resources, leading to intercommunal violence. The Sahelian climate makes Mali highly susceptible to prolonged droughts, which undermine food production and force communities to migrate in search of better living conditions.

4. **Education Disruption:** Ongoing conflict and displacement have severely impacted access to education in Mali. Schools in conflict-affected areas are frequently closed due to insecurity, with teachers fleeing and families prioritizing survival over education. In regions experiencing severe drought, migration in search of water and pasture

further disrupts children's schooling, disproportionately affecting girls who are at increased risk of child marriage and exploitation.

5. **Gender-Based Violence and Harmful Practices:** The breakdown of community protection structures in conflict zones has heightened the risk of **gender-**based violence (GBV), including sexual violence, exploitation, and trafficking. Harmful traditional practices, such as Female Genital Mutilation (FGM) and child marriage, remain prevalent, driven by cultural norms and exacerbated by poverty. Economic hardship often compels families to marry off daughters early as a survival strategy.

6. **Healthcare and Disease Outbreaks:** Mali's healthcare infrastructure remains fragile, particularly in conflict-affected and rural regions. Displacement and poor sanitation conditions have led to recurring outbreaks of preventable diseases, including cholera, measles, and malaria. Limited access to clean water, healthcare facilities, and essential medicines further compounds health challenges, particularly for women, children, and the elderly.

7. **Humanitarian Access and Funding Constraints:** Delivering humanitarian assistance in Mali is fraught with challenges due to insecurity, restricted access, and logistical difficulties. Armed conflict, road blockages, and attacks on aid workers hinder the delivery of life-saving support. Moreover, humanitarian funding remains insufficient to meet the growing needs of displaced populations, food-insecure households, and vulnerable communities.

Prevalence of FGM

Female Genital Mutilation (FGM) remains a significant cultural and health issue in Mali, where it is deeply ingrained in various ethnic and social groups. The practice is often justified by traditional beliefs regarding purity, marriageability, and social norms. FGM is most commonly performed on girls between infancy and adolescence, with the prevalence varying across regions and ethnic communities. Despite growing awareness and efforts to eradicate the practice, FGM continues to be widespread in Mali, with a large proportion of women and girls having undergone the procedure. The government, along with international organizations, is actively working to raise awareness, implement legal measures, and provide support to those affected by FGM, but challenges remain due to cultural traditions and resistance to change.

The data from the two surveys, MLI MICS 2010 and MLI DHS 2012-2013, show the prevalence of female genital mutilation (FGM) in Mali across different age groups. In both surveys, the overall prevalence of FGM is quite high. According to the MLI MICS 2010, the total prevalence was 88.5%, while the MLI DHS 2012-2013 survey showed a slight increase to 91.4%. This reflects an increase of 4% in FGM prevalence between 2006 and 2010, indicating that the practice has become more widespread in recent years.

When broken down by age groups, the prevalence of FGM among women aged 15-19 was 87.7% in the MICS 2010 survey and rose to 90.3% in the DHS 2012-2013 survey. Although this shows a slight increase over the three-year period, FGM remains less common among girls aged 15-19 than among women aged 45-49, who show higher prevalence rates. For the 45-49 age group, the prevalence increased from 88.5% in the MICS 2010 survey to 92.1% in the DHS 2012-2013 survey, reflecting the enduring cultural practice of FGM in Mali, especially among older generations.

These trends highlight that, while the overall prevalence of FGM remains high in Mali, the practice continues to affect women across all age groups, with only marginal changes over the years. Despite ongoing efforts to reduce FGM, the data suggests that the practice remains deeply entrenched in Mali's cultural and social fabric.(124)

The majority of FGM cases, accounting for 48.9%, involve the removal of part of the flesh, which is the most common form of FGM in the region. A smaller percentage, 25.9%, represents cases where the genitalia are "nicked, with no flesh removed." This type of FGM typically involves a less invasive procedure but still poses significant health risks. Additionally, 14.6% of the cases involve the procedure known as "sewn closed," which is more severe and often leads

to long-term complications for the women and girls affected. The remaining 10.6% falls under "don't know/missing," indicating cases where the type of FGM performed is not clearly identified or recorded.

This distribution reflects the varying severity and types of FGM practiced, with the majority of cases still involving significant bodily harm. The high percentage of "partly flesh removed" cases points to the ongoing prevalence of FGM practices that cause serious physical and psychological consequences, highlighting the urgent need for(124) continued efforts to eradicate this harmful tradition. In some cases, involuntary infibulation occurs when a girl’s legs are tightly bound post-procedure to ensure the healing of the closed vaginal opening.(127)

The practice is rooted in complex traditional and symbolic systems. Among the Mandingo ethnic groups, FGM is justified through the belief in "wanzo," an evil force thought to reside in the clitoris, which must be removed to ensure fertility and the survival of offspring. For the Dogon, FGM aligns with a symbolic view of humans as dual-gendered entities; removing the clitoris is seen as eliminating a girl's masculinity and fulfilling a spiritual debt to the earth through blood sacrifice. Other groups associate FGM with purification and hygiene, believing the external genitalia to be dirty or aesthetically displeasing. Social pressures also play a significant role, as non-circumcised women risk ridicule, exclusion, or repudiation by their husbands. Psychosexual motivations further reinforce the practice, with FGC being viewed as a means to diminish libido and ensure marital fidelity.(127)

FGM in Mali has significant health consequences, with complications varying by type. Type III presents the most severe risks, with 14% of women experiencing complications compared to 4% and 3% for Type II and Type I, respectively. Immediate risks include excessive bleeding, infections, and severe pain, while long-term issues include vaginal stenosis, keloid formation, and complications during childbirth. Among circumcised women, 29% face delivery complications such as tissue tearing, episiotomy, and haemorrhage, compared to only 7% of non-circumcised women. Multivariate analysis indicates that the likelihood of a problematic delivery increases significantly with FGC severity.(127)

The age of cutting for Female Genital Cutting (FGC) in Mali typically ranges between 5 and 14 years. However, depending on cultural norms and family decisions, it may be performed earlier or later. This aligns with the practice being considered a preparation for adulthood and marriage and a cultural rite of passage. Some ethnic groups may adhere to specific age ranges, but

the practice generally occurs during childhood or early adolescence across the regions where it is prevalent.(127)
Based on the Multiple Indicator Cluster Survey (MICS) 2010.(27) The data reveals that the vast majority of FGM procedures (91%) are carried out by traditional excisors, underscoring the deeply entrenched cultural practices surrounding FGM in the country. A small percentage, 1%, of the procedures are performed by other traditional practitioners, while 1% are performed by nurses, midwives, or other health workers, and only 0.3% by doctors. Additionally, 7% of cases have missing or unknown data regarding the performer.

This distribution illustrates the limited role of medical professionals in performing FGM in Mali, with the practice predominantly handled by traditional excisors. Despite growing awareness and legal efforts to end FGM, the data indicates that traditional methods remain prevalent, which presents significant challenges to reducing the practice. The involvement of healthcare workers in FGM, although small, raises concerns about medicalization, which can make the practice appear more legitimate and safer, further entrenching its harmful impact.(128) Medicalization is emerging as a growing trend, particularly in urban areas, where healthcare providers are increasingly seeking to perform FGM under safer conditions, reducing immediate health risks such as infections but inadvertently legitimizing the practice and delaying its total eradication. (127, 129, 130) Despite international advocacy, FGM stop faces opposition from influential cultural and religious groups, including the High Islamic Council.(127, 130)

The distribution of FGM by education level in Mali shows minimal variation in prevalence across different education categories. Among women and girls with no education, 69.1% have undergone FGM, while the prevalence is slightly higher for those with primary education at 70.5%. For those with secondary or higher education, the prevalence is 67.8%. This suggests that education level has a limited effect on reducing the practice of FGM, with prevalence remaining relatively consistent across all education levels. Despite the slight differences, the overall high prevalence indicates that cultural and social factors related to FGM are more influential than education alone in shaping these practices.(128)

The distribution of FGM by wealth quantile in Mali shows a notable trend where the prevalence of FGM increases with wealth. Among the poorest 20%, the prevalence is the lowest at 64.3%, while in the wealthier groups, the rates increase significantly. The second wealth quantile has a prevalence of 68.2%, the middle quantile at 67.7%, and the fourth quantile at 71.3%. The richest 20% exhibit the highest prevalence at 74.8%. This pattern suggests that FGM is

more prevalent among wealthier households, which may be linked to social and cultural factors where wealthier families are more likely to adhere to traditional practices, including FGM, as a way to maintain social status and cultural identity. Wealthier families may also have greater access to healthcare professionals who perform FGM, thus medicalizing the practice. This highlights that, while wealthier groups may have more resources, they are not necessarily more likely to abandon harmful traditional practices like FGM, indicating the need for interventions that also address cultural norms alongside economic development.

The prevalence of FGM is highest in the western regions, with Kayes showing the most severe rate at 95%, followed by Koulikoro at 94%. Sikasso and Bamako also report high prevalence rates of 91% and 90%, respectively. Segou and Mopti follow closely at 89% and 88%, indicating that FGM is widely practiced in these areas as well.

The southern regions represent areas with prevalence rates of 55% or higher. The high prevalence in these regions suggests that FGM remains a deeply rooted cultural practice, particularly in the southern parts of Mali. The map also highlights that the northern regions of Mali, which are not depicted in red, likely experience lower rates of FGM, though detailed figures for these areas are not provided. The data underscores the need for targeted interventions, particularly in the southern regions, to reduce the practice of FGM and address the underlying cultural norms that perpetuate it.(128)

Based on the Demographic and Health Surveys conducted in 2012-2013. The data shows that FGM is most prevalent among the Sarakole/Soninke/Marka ethnic group, with a striking 81.8% of women and girls affected. Other groups, such as the Malinke (76.3%) and Peulh (72.3%), also show high prevalence rates, indicating that FGM is widely practiced among these communities as well.

The prevalence decreases slightly among the Bambara (67.8%) and Dogon (67.6%) ethnic groups but still remains significant. The Senoufo/Manianka group has a prevalence rate of 65%, further demonstrating the widespread nature of FGM in various ethnic communities across Mali. In contrast, the Sonrai ethnic group shows a significantly lower rate of 42.2%, and the Bobo group has the lowest prevalence of FGM at 32.3%. These lower rates suggest that there may be regional, cultural, or social factors influencing the practice of FGM, with some ethnic groups exhibiting a more entrenched cultural norm than others.(128)

Based on the MLI DHS 2006 and MLI MICS 2010 surveys. The overall percentage of women and girls who support the discontinuation of FGM increased slightly from 16% in 2006 to 20% in 2010. This suggests a modest shift in public opinion towards ending FGM, though the numbers remain low, reflecting the cultural entrenchment of the practice.

The data highlights a clear correlation between education and the attitude towards FGM. Among women with secondary or higher education, 34% in 2006 and 36% in 2010 expressed support for ending FGM, the highest percentage across all education levels. This contrasts with those with no education (14% in 2006 and 16% in 2010) and those with primary education (18% in 2006 and 20% in 2010). This indicates that education plays a significant role in raising awareness about the harmful effects of FGM and in changing attitudes towards the practice.

The analysis also shows a relationship between wealth and the attitude towards FGM. The poorest 20% showed the lowest support for ending FGM (9% in 2006 and 18% in 2010), while the wealthiest 20% had a higher level of support (22% in 2006 and 25% in 2010). However, these changes are relatively modest, suggesting that while wealthier groups may have more access to information and resources, other cultural and social factors continue to influence attitudes towards FGM.(128)

National Policies and Laws

The Constitution of Mali (1992)(131) is limited in its commitment to protection for women and girls. It does not explicitly reference violence against women and girls, harmful practices or FGM. Article 1& 2 provide general base for human rights protection. For instance, article 1states that 'the human person shall be sacred and inviolable' and that '[e]very individual shall have the right to life, liberty, security and integrity of his person.' while article 3 further states that 'no one shall be submitted to torture, nor to inhuman, cruel, degrading or humiliating treatment or brutality.' however, up to date there is no national legislation in Mali that specifically criminalizes and punishes its planning, facilitation or assistance or its practice. There are numerous attempts over the years 2002, 2009 and most recently in 2018. But Mali has struggled to pass a comprehensive ban on Female Genital Mutilation (FGM). Various draft laws proposed by both government departments and non-governmental organizations (NGOs) but, failed to gain the necessary support in parliament to stop the practice of FGM. This situation put Mali among the only remaining 5 countries in Africa without a law specifically panning FGM/C.(132)

Historically, In July 2017, a new draft law aimed at addressing gender-based violence, including the prohibition of Female Genital Mutilation (FGM), was prepared by the National Program for the Fight Against Excision (PNLE) and presented to the Ministry for the Advancement of Women, Children, and the Family, with support from technical and financial partners. However, once again, the law faced significant obstacles, primarily due to strong opposition from influential religious leaders who continue to support the practice. Article 116 of the Constitution states, 'Treaties or agreements regularly approved or ratified shall have, from their publication, an authority superior to that of laws'. Mali, having ratified key international treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the African Charter on Human and Peoples' Rights (Maputo Protocol), is legally obligated to take measures to eliminate practices like Female Genital Mutilation (FGM). Both treaties impose binding commitments on signatories to adopt laws and policies that protect women and girls from harmful traditional practices, including FGM. The Maputo Protocol, in particular, explicitly requires African Union member states to prohibit FGM and other harmful practices, providing a clear legal framework for addressing gender-based violence.

Mali's civil law system, based on the French model, means that international treaties like CEDAW and the Maputo Protocol should be incorporated into domestic law, making their provisions enforceable in the country's legal system. However, despite these international commitments, the challenge remains in translating these legal obligations into concrete action, as seen in the repeated failures to pass a domestic law banning FGM. This ongoing struggle reflects the tension between international human rights norms and local cultural practices, as well as the political and social resistance to change within certain sectors of Mali's society, particularly from religious and traditional leaders. In April 2021, the NGO Equality Now and the Institute for Human Rights and Development in Africa (IHRDA), together with two other local organizations, filed a case against the Government of Mali in the Economic Community of West African States' (ECOWAS) court of justice in Abuja, Nigeria, to challenge Mali's failure to prohibit FGM by adopting a legal and policy framework that would criminalize the practice.(133)

In the absence of a specific national law prohibiting Female Genital Mutilation (FGM), Mali's Criminal Code (2001)(134) contains provisions that could be applied to the practice, though they have not been used successfully to prosecute perpetrators to date. These include:

- Articles 202 and 207, which criminalize and punish anyone who inflicts "blows, wounds, or commits voluntary violence" on another person. These provisions could theoretically be applied to FGM, as the

procedure involves inflicting bodily harm. However, the lack of clear legal language directly addressing FGM has likely contributed to challenges in enforcement.
- Article 220, which punishes anyone who fails to provide assistance to a person in danger, without risk to themselves or others, either by taking personal action or contacting emergency services. This could be relevant in cases where individuals are complicit in allowing FGM to occur without intervening, although this provision has also not been widely used in FGM-related cases.

Despite these provisions, there is little evidence that they have been effectively applied to combat FGM, suggesting a gap between existing legal frameworks and their practical application in addressing such harmful practices. This highlights the need for clearer, specific legislation against FGM in Mali, which could provide more effective legal tools for prosecution and deterrence.

Mali's Code of Persons and the Family (2011)(135) includes provisions that could potentially address Female Genital Mutilation (FGM). Article 4 asserts that "everyone has the right to respect for his body" and declares the human body to be "inviolable." **Article 5** further states that the integrity of the human person may only be impaired in the event of "medical necessity," though it does not define what constitutes "medical necessity." Importantly, it also notes that "acts of a religious or customary nature, provided they are not harmful to health, are not covered by this provision." Given the well-documented harmful effects of FGM on health, the practice could be considered as falling under this provision, suggesting that it violates the principle of bodily integrity outlined in the Code. However, the lack of a clear legal framework specifically prohibiting FGM means that these provisions have not been actively used to prosecute or prevent the practice.

In Mali, medicalized FGM is not widespread, with almost all cases still being carried out by traditional practitioners rather than medical professionals. In the absence of national legislation specifically criminalizing FGM, Circular No. 99-00197 was issued in 1999 by the Minister of Health, the Elderly, and Solidarity. This administrative instruction prohibited FGM in health facilities, stating that "the practice of FGM cannot be tolerated" and urging hospital directors to take steps to prevent its occurrence within their institutions. While this Circular remains in force, it lacks legal enforcement power, as it does not prescribe sanctions for non-compliance and does not carry the weight of a law passed through parliament. As a result, while it provides guidance for healthcare professionals, it has not been effective in eradicating

FGM, especially given the cultural and societal factors that support its continued practice outside medical settings.

Currently, no penalties set out in the laws of Mali for practicing FGM. The under-consideration draft law against gender-based violence sets out punishments including a range of fines and prison sentences. Penalties for inflicting 'blows, wounds or committing voluntary violence' under the Criminal Code include five to twenty years' imprisonment in the event of unintentional death (under Article 202) or imprisonment of one to five years and a fine of between 20,000- and 500,000-francs CFA(US$35–8849) if causing illness or personal inability to work for more than 20 days (under Article 207). Anyone who fails to provide assistance to a person in danger (under Article 220) is liable to imprisonment for between one month and three years and/or a fine of between 24,000 and 1 million francs CFA (US$42–1,76910)(136)

Under Article 207 of Mali's Criminal Code, medical professionals who engage in FGM could be penalized for inflicting wounds or committing voluntary violence. The penalties for such offenses include suspension from their profession for between five and ten years, imprisonment ranging from five to 20 years depending on the severity of the crime, and, in some cases, a ban from the country for one to ten years. However, despite these provisions, there is a lack of evidence that they have been successfully applied in cases related to FGM in Mali rather than only one reported case in 2013. This indicates a gap between the legal framework and its enforcement, suggesting that the legal tools available are not being effectively used to prosecute medical professionals involved in the practice of FGM.

The lack of a legal framework banning FGM/C in Mali not only hinder the country efforts to eliminate FGM practice but, it has increased cross-border FGM/C. Families in neighbouring countries are crossing into Mali to have girls cut because it is illegal in their home.(137) This further highlights the need for a more integrated approach, combining legal reforms with wide advocacy campaign to mobilize the decision makers and confronting religious leaders, educational campaigns to shift public attitudes and ensure pass of legislation to stop FGM/C practice for protection of women and girls from such harmful practices.

Community and National Efforts to Eliminate FGM

The leading government department in Mali responsible for gender issues, including the elimination of FGM, is the Ministry for the Advancement of Women, Children and the Family. The coordination of work to end FGM is the

responsibility of both the National Action Committee for the Abandonment of Practices Harmful to the Health of Women and Children, established in 1999, and the National Program for the Fight against Excision, established in 2002 (NPLE). The Malian government conducted community awareness campaigns as part of the UNFPA–UNICEF joint program to stop FGM. In collaboration with the Ministry of Health and NGOs, an FGM/C curriculum was developed, tested, and used to train reproductive healthcare providers and medical social workers to help them understand, identify, and treat complications from FGM/C in some districts. Treatment of FGM/C complications is now included in health professionals' (doctors, nurses, midwives) curricula The PNLE is divided into committees with specific responsibilities. The PNLE coordinate the national policy to end FGM in Mali and its evaluation, and it has been closely involved in the recent drafting and consultation phase of the proposed bill against gender-based violence. It leads the public-awareness-raising activities, education and support services for FGM elimination. However, over the last 15 years, Mali has been criticized by many international treaty monitoring committees(138) for not passing legislation to stop FGM practice due to pressure from religious leaders. with UNICEF support, a new country program for FGM Elimination (2020-2024) was developed for Mali. The program includes, as one of its objectives, a change in social norms and gender norms surrounding FGM. The success of this approach will be measured by whether there is an increase in the proportion of women and men who believe that FGM should be eliminated.

The Ministry of Promotion of Women, Children and Family leads the initiative, with contributions from line ministries, community-based, civil society and non-governmental organizations, and other UN agencies. The program has six evidence-based strategies; the first strategy is to design context relevant approach for FGM Stop. This is to respond to the variation of the practice prevalence across the different country regions and the differences in the factors driving the communities practice of FGM. The second strategy is the promotion of leadership and coordination between national, regional and local levels of the government. The program also coordinates stakeholders, provides leadership and holds partners accountable. Advocacy efforts are targeting the adoption of a law on gender-based violence, drafted in 2017, to criminalize FGM and other types of violence. The third strategy is active community engagement, dialogues with girls, women, boys and men to reflect upon the practice, and discuss solutions and challenges. Such dialogues are carried out through a participatory and gender-sensitive process, reinforced by communication campaigns through the media, local radio stations, and local and religious leaders and social networks. The fourth strategy is girl's empowerment, helping them build their capacity to promote changes in behaviour and social norms. Activities aim to develop life skills

such as self-esteem and empathy, teaching young people to communicate constructively and effectively and to express their potential for change. In addition, both girls and boys are encouraged to play an active role in social mobilization and intergenerational dialogues. the fifth strategy is Communication for development and gender transformative approaches This goal is directed to stem traditional beliefs about the need to control girls and women and to put an end to social impunity in the face of violence against them. The sixth strategy is Quality services: FGM-related services must effectively meet the needs of girls and be located in close proximity to those they are intended to serve. Girls and their families are encouraged to report incidents of FGM and to seek quality professional support to better cope with and resolve resulting physical or emotional trauma.(139) The most recent National Action Plan adopted by the Malian Government to address FGM covers the period 2015–2019.

Efforts to address FGM in Mali are largely led by NGOs, international organizations, and grassroots initiatives, including the Tostan Village Empowerment Program, which focuses on raising awareness about the health risks and human rights violations associated with FGM. Public declarations of abandonment have been achieved in some communities; however, these initiatives often lack follow-up mechanisms, limiting their long-term impact. Advocacy campaigns involving religious leaders have aimed to dispel misconceptions that FGM is a religious obligation but continue to encounter significant resistance.

Conclusion and recommendations

Mali continues to face substantial challenges in addressing Female Genital Mutilation (FGM) despite numerous national and international efforts. The practice remains deeply entrenched within cultural and social norms, particularly among specific ethnic groups and in southern regions, where prevalence rates are among the highest in Africa. Mali lacks comprehensive legislation to explicitly criminalize and punish FGM, putting it among the few African nations yet to enact such laws. Existing legal provisions, while applicable in theory, are neither clear nor effectively enforced. Strong resistance from religious leaders and cultural gatekeepers has further hindered legislative progress.

International commitments, such as the ratification of the CEDAW and Maputo Protocol, provide a framework for Mali to address harmful practices. However, the gap between these commitments and domestic legal enforcement highlights the need for urgent action. While community-based programs, advocacy, and awareness campaigns have shown some success in

shifting attitudes, the slow decline in support for FGM underscores the need for multi-sectoral, sustainable, and culturally sensitive interventions. By implementing the following recommendations, Mali can bridge the gap between its international commitments and domestic action, ensuring stronger protections for women and girls. A holistic, culturally sensitive approach—centered on legal reform, community engagement, and improved services—will be critical to eradicating FGM and promoting gender equality in Mali .(127, 130, 140).

1. **Enact and Enforce Comprehensive Anti-FGM Legislation**
    - Finalize and pass a law explicitly prohibiting all forms of FGM, with clear penalties for perpetrators, facilitators, and those complicit in its practice.
    - Align domestic laws with international commitments, particularly the CEDAW and Maputo Protocol, to ensure the legal protection of women and girls.
    - Establish mechanisms for enforcing anti-FGM laws, including training law enforcement, healthcare workers, and judicial personnel on their roles in implementing the legislation.

2. **Engage Religious and Traditional Leaders**
    - Implement targeted outreach programs to engage religious and traditional leaders as advocates for ending FGM. Religious leaders should be supported to dispel misconceptions linking FGM to religious obligations.
    - Encourage public declarations of abandonment by communities, with follow-up monitoring to ensure sustained behavioral change.

3. **Strengthen Community-Based Interventions**
    - Expand participatory community dialogues involving women, men, girls, and boys to challenge social norms and build consensus around the abandonment of FGM.
    - Empower young girls and women with life skills, leadership training, and platforms to advocate for their rights and influence community decisions.
    - Promote communication campaigns tailored to regional and cultural contexts, utilizing local radio, social media, and grassroots networks to amplify anti-FGM messaging.

4. **Address Cross-Border FGM**
    - Strengthen regional cooperation with neighboring countries to address cross-border FGM through joint surveillance mechanisms, data sharing, and enforcement of anti-FGM laws.
    - Collaborate with regional bodies such as ECOWAS to harmonize legal frameworks and ensure that families cannot exploit legal gaps to have girls cut across borders.

5. **Improve Health and Support Services**
    - Integrate FGM-related services into existing health systems, ensuring survivors receive accessible and quality medical, psychosocial, and legal support.
    - Develop and implement protocols for healthcare workers to identify, treat, and report FGM cases without fear of reprisals.
    - Increase training for healthcare providers to address the physical and psychological consequences of FGM, while discouraging the medicalization of the practice.

6. **Scale Up Education and Awareness Programs**
    - Promote education as a critical tool for FGM abandonment, with an emphasis on increasing girls' school enrollment and retention rates, particularly in rural and conflict-affected areas.
    - Include FGM education in school curricula and youth programs to challenge harmful practices and foster intergenerational change.
    - Educate parents and families on the health risks and human rights implications of FGM, emphasizing alternatives to traditional rites of passage.

7. **Enhance Data Collection and Monitoring**
    - Conduct regular and comprehensive surveys to update data on FGM prevalence, attitudes, and trends, disaggregated by region, ethnicity, education, and socioeconomic status.
    - Implement community-based monitoring systems to track the incidence of FGM and evaluate the impact of interventions over time.

8. **Ensure Adequate Funding and Multi-Sectoral Coordination**
    - Increase government investment in FGM prevention and response programs, ensuring resources are allocated to education, health, legal enforcement, and advocacy efforts.

- Strengthen coordination among government ministries, civil society organizations, and international partners to create a unified and effective response.
- Support NGOs and grassroots initiatives, ensuring they have the resources and capacity to sustain community engagement and program implementation.

MAURITANIA

Background

Mauritania, officially known as the Islamic Republic of Mauritania, is a sovereign country located in Northwest Africa. The Atlantic Ocean borders it to the west, Western Sahara to the north and northwest, Algeria to the northeast, Mali to the east and southeast, and Senegal to the southwest. Mauritania is the 11th-largest country in Africa and ranks 28th globally, covering an area of approximately 1 million square kilometres. The country is largely dominated by the Sahara Desert, with about 90% of its landmass being desert terrain. The majority of Mauritania's population, around 4.9 million people as of 2023, resides in the more temperate southern region, with approximately one-third of the population living in the capital, Nouakchott, located along the Atlantic coastline.

The population of Mauritania is estimated at 4.9 million people (2023)(35), with a diverse ethnic composition comprised of various ethnic groups: 40% Black Moors (Haratines), Arabic-speaking descendants of African origin; 30% White Moors (Beydane), of Arab and Amazigh descent; and 30% Sub-Saharan Mauritanians, including ethnic minorities like the Halpulaar, Fulani, Soninke, Wolof, and Bambara, mostly from the Senegal River Valley. Mauritania also hosts a significant refugee population, including around 26,000 Sahrawi refugees from Western Sahara as of 2021 and over 104,000 refugees from Mali as of 2023, fleeing ongoing conflicts in the region.

Mauritania's economy is primarily driven by extractive industries such as mining, oil, and fisheries, with agriculture also playing a key role. Despite a rich endowment of natural resources, including iron ore, gold, and copper, Mauritania faces challenges related to overexploitation, fluctuating global commodity prices, and environmental stress. The country's fisheries are among the most productive in the world, contributing significantly to exports. In 2023, the country's GDP was $10.45 billion, with an annual growth rate of 6.5%. (35)Mauritania's economy is expected to continue growing, driven by sectors such as gas production and foreign investment, though risks related to regional instability and external factors persist.

Humanitarian Challenges

Mauritania faces a range of humanitarian challenges exacerbated by climate change, regional instability, and socio-economic factors. These issues have

deeply impacted vulnerable populations, resulting in food insecurity, displacement, and strained resources.

1. **Food Insecurity and Climate Change**: Prolonged droughts and desertification have made Mauritania highly susceptible to food insecurity, affecting approximately 470,000 people, including women and children. The country's dependence on rain-fed agriculture makes it vulnerable to climate shocks, with rural communities, particularly in the south, being the hardest hit. As a result, many people are struggling to access sufficient food, and malnutrition rates are rising, particularly in conflict-affected regions.

2. **Displacement and Refugees**: Mauritania has become a host country for large numbers of refugees fleeing conflicts in neighbouring countries. As of 2023, over 104,000 people from Mali have sought refuge in Mauritania, escaping violence from the ongoing conflict in the Sahel region. The country also hosts refugees from Western Sahara, adding to the strain on local resources and services. The influx of refugees, coupled with internal displacement due to environmental and political instability, has placed significant pressure on Mauritania's already limited infrastructure.

3. **Healthcare and Water Access**: The humanitarian situation is compounded by inadequate healthcare services, especially in remote areas, and the lack of access to clean water. The country's healthcare system faces capacity and resource constraints, limiting the provision of essential medical services. Diseases like cholera, malaria, and respiratory infections remain a significant public health challenge. Moreover, clean water access is limited in rural areas, with many communities relying on unsafe water sources, contributing to the spread of waterborne diseases.

4. **Education Disruption**: The ongoing conflict in neighbouring countries and environmental challenges in Mauritania have disrupted education, particularly in the south, where resources are limited. The lack of infrastructure, compounded by the displacement of families, has severely impacted school attendance, especially for girls. With limited access to education, the country faces long-term challenges in human capital development, which will further exacerbate its socio-economic issues.

5. **Gender-Based Violence and Harmful Practices**: Gender-based violence (GBV) remains a significant concern in Mauritania, where harmful practices such as Female Genital Mutilation (FGM) are still

prevalent, especially among rural and marginalized communities. GBV is exacerbated by the breakdown of community protection mechanisms in the face of displacement and poverty. Women and girls are particularly vulnerable to exploitation, trafficking, and early marriage, with little access to legal protections or support services.

6. **Economic Vulnerabilities**: The majority of Mauritania's population relies on agriculture and pastoralism for livelihoods. However, recurring droughts and land degradation have led to reduced agricultural yields, affecting food security and economic stability. The pressure on natural resources, particularly water and arable land, has intensified competition among local communities, contributing to inter-communal tensions and sporadic violence.

7. **Humanitarian Access and Funding Constraints**: Delivering aid to vulnerable populations in Mauritania has become increasingly difficult due to logistical constraints, political instability in neighboring regions, and limited funding. Insecurity in the Sahel region complicates the movement of humanitarian aid, and access to some areas remains restricted due to conflict or environmental factors. International aid organizations face challenges in securing sufficient resources to meet the growing needs of displaced populations, food-insecure communities, and those affected by health crises.

Prevalence of FGM

FGM in Mauritania is a culturally entrenched practice that affects women and girls across the country, though prevalence and type vary by region and ethnicity. In Mauritania, the prevalence of FGM among women and girls aged 15-49 is 68.9%, according to the MICS 2011 data. Among girls aged 15-19, the prevalence is 54.4%. The FGM prevalence rate is particularly high in the most affected ethnic groups, although specific data for these groups is not provided.(44)

The graph illustrates the prevalence of FGM in Mauritania by age group, comparing data from 2007 and 2011. Overall, there is a noticeable decrease in FGM prevalence between 2007 and 2011 across all age groups. In 2007, the total prevalence was 72.2%, which decreased to 69.4% in 2011. For the 15-19 age group, the prevalence of FGM fell from 68% in 2007 to 65.9% in 2011, suggesting a slight reduction in the practice among younger women and girls. The 45-49 age group, which historically experiences higher rates of FGM, showed a decrease from 77.8% in 2007 to 75.2% in 2011, indicating that older women are also experiencing a marginal reduction in the practice.(44)

These trends suggest that while FGM remains widespread in Mauritania, there is some progress in reducing its prevalence, especially among younger age groups. The slight decline could reflect the growing awareness and efforts to eliminate the practice, although further interventions are needed to see a more substantial reduction in future years.

The distribution of FGM by type in Mauritania, as shown in the graph, indicates that the majority of cases involve the removal of flesh, accounting for 68.6% of reported cases. A smaller percentage, 3.5%, corresponds to instances where the genitalia are nicked, with no flesh removed. The remaining 28% of cases are categorized as "Not Determined," indicating that the specific type of FGM is not specified or recorded.

The distribution of FGM by performer in Mauritania shows that the practice is predominantly carried out by traditional excisors, accounting for 57% of cases. Other traditional performers, who are not necessarily trained medical professionals, contribute to 33% of the cases so 90% of the procedures is done by traditional practitioners, often in unhygienic conditions. Only a small percentage of FGM procedures are performed by medical professionals, with nurses, midwives, or other health workers responsible for 1%, and doctors also involved in 1%. The remaining 8% is either unknown or missing data. This highlights the continued reliance on traditional methods of FGM in Mauritania, despite efforts to curb the practice through medical and legal means. Women with higher levels of education are less likely to support or undergo FGM, reflecting the role of education in reducing prevalence. The practice is predominantly performed on girls aged 5 to 12, with traditions and cultural beliefs driving the age range.

The geographical distribution FGM in Mauritania reveals significant regional variation, with the highest prevalence rates concentrated in the southern and central parts of the country. Regions like Hodh El Gharbi, Guidimakha, and Assaba have exceptionally high FGM rates, ranging from 97% to 99%, indicating that FGM is almost universal in these areas. Other regions, such as Brakna, Gorgol, and Hodh El Charghi, also report high prevalence rates between 84% and 98%. On the other hand, regions like Nouakchott and Trarza have lower but still concerning rates of 51% and 20%, respectively. The map shows a clear division, with the red and orange zones representing areas with high FGM prevalence (35% and above), while the light blue areas indicate lower prevalence, particularly in the northern and western parts of the country. This geographical distribution underscores the regional disparities in the practice, with certain areas facing more entrenched cultural practices of FGM, highlighting the need for targeted interventions based on specific regional contexts.

There is geographical variation of FGM types practiced in Mauritania that Type II being the most commonly practiced form, accounting for approximately 85% of reported cases. Other types of FGM, though less prevalent, account for about 15% combined, primarily in urban areas where there is a higher awareness of health risks.

The data show a significant increase in the percentage of women and girls, aged 15-49, who believe that female genital mutilation (FGM) should be discontinued in Mauritania between 2007 (38%) and 2011 (53%). This shift in opinion is notably influenced by factors such as education, urban vs rural location, and economic status.

In rural areas, there was a marked increase from 21% in 2007 to 41% in 2011, whereas urban areas showed a stronger shift, with 56% in 2007 rising to 66% in 2011. Regarding education, opposition to FGM was more prevalent among those with higher levels of education. Among women with no education, 22% opposed FGM in 2007, rising to 40% by 2011. In contrast, 67% of those with secondary or higher education in 2007 supported discontinuing FGM, which rose to 73% by 2011.

Economic status also played a role, with the wealthiest 20% of women showing the strongest opposition, with 69% opposing FGM in 2007, rising to 75% by 2011. The poorest 20% showed the lowest opposition, but even within this group, there was a notable increase from 10% in 2007 to 24% in 2011. These findings demonstrate that increasing education and urbanization, along with improving economic conditions, have contributed to greater opposition to FGM in Mauritania over time. However, significant regional, educational, and economic disparities still exist.(44)

National Policies and Laws

Mauritania has indeed made significant strides in enhancing its legal framework to promote and protect the rights of women and girls. By ratifying key UN and African Union human rights instruments, as well as various ILO Conventions, the country has laid a solid foundation for advancing gender equality and women's rights. The government’s proactive engagement with UN human rights mechanisms, including its collaboration with Treaty Bodies and invitations extended to Special Procedures, reflects a commitment to accountability and continuous improvement in human rights practices. These efforts are vital for creating a more equitable society and ensuring that the rights of women and girls are respected and upheld. (141) There is a prohibition for FGM under the law of female genital mutilation, as well as

several preventive actions led by the Government including through the socio-economic rehabilitation of traditional cutters.

The Constitution of Mauritania does not specifically refer to violence against women and girls, harmful traditional practices or FGM/C. Article 13 states, 'No one shall be submitted to torture and other cruel, inhuman or degrading treatments. These practices constitute crimes against humanity and are punished as such by the law.(142)

Article 12 of the Child Criminal Protection Code criminalizes and punishes any causing of injury to the genital organs of a girl through infibulation, anaesthetization or any other means that results in harm to the child. Heavier penalties apply when the perpetrator of the act is a medical or paramedical professional. Under article 79 of Act No. 2018-024 of 21 June 2018 on the General Child Protection Code, female genital mutilation is punished and classified as cruel, inhuman or degrading treatment, as follows: "Cruel, inhuman or degrading treatment includes harmful excision and all other similar practices performed on girls, and negative customary, cultural and social practices affecting the physical integrity, health or dignity of the child." This removes any ambiguity with respect to the understanding of genital mutilation and of negative customary, cultural and social practices affecting the physical integrity, health or dignity of the child. The bill on combating violence against women and girls, which has been approved by the Council of Ministers, punishes female genital mutilation and all other practices harmful to the health of women and girls.

In 2016, the Council of Ministers of the Government of Mauritania approved the texts of two new bills on Gender Based Violence and Reproductive Health. The bills reportedly include a ban on FGM/C and penalties for perpetrators in accordance with the Penal Code. The GBV law was subsequently withdrawn from parliament by Government in January 2019 and reportedly still awaits further amendments. The Reproductive Health Act was adopted by parliament in October 2017, in which FGM/C is mentioned, among other acts of sexual violence, in Article 22, which states that 'they are prohibited and punished in accordance with legal provisions.(143) Act No. 2017-025 of 15 November 2017 on reproductive health, which criminalizes female genital mutilation, has been promulgated and is being broadly disseminated among health-care personnel.

The government established the National Committee against Gender-based Violence, including Female Genital Mutilation. Following that a regional committee against gender-based violence, including female genital mutilation developed. In addition to, that a network of non-governmental

organizations which specialize in combating female genital mutilation formulated. Also, there had been implementation of standard operating procedures for combating and responding to violence against women, and for ensuring comprehensive support for survivors of gender-based violence. Furthermore, Mauritania developed and approve the framework bill on violence against women and girls (including female genital mutilation, sexual, domestic and psychological violence), which is being considered by parliament for adoption(144), in 2020, a draft law on GBV were adopted, including specific FGM provisions. Also, the Ministry of Social Affairs and Family and its partners prompted doctors to adopt a national declaration condemning the adverse effects of FGM.

On the other hand, Islamic scholars issued a "fatwa" (a religious edict that provides a non-binding legal interpretation of Sharia), declaring that the practice lacked a religious basis. However, gaps in legal enforcement against FGM and a lack of public awareness of its harms remain.55 There are no records of any prosecutions for cases of FGM performed in recent years. Freedom House in 2020 reported the law against FGM is "rarely enforced." That Since the adoption of the law, no information about reported cases. Therefore, it is essential to encourage the reporting of the practice and to severely sanction those responsible of its performance, in particular the perpetrator of it. Moreover, according to the 2020 ERSIP survey, only about half of women and girls aged 15 to 49 years who have heard of FGM think the practice should stop.(18)

Community and National Efforts to Eliminate FGM

The Ministry of Social Affairs, Childhood and the Family is the leading government entity with regard to FGM elimination. The national strategy to abandon FGM developed in 2008, updated in 2015 and validated in 2017.(145) The strategy led to institutional capacity improvement and development of integrated a five-year plan for communication. in 2008 by a ministerial decree issued for setting up national and regional Committees to tackle gender-based violence, including FGM/C and a network of non-governmental organizations which specialize in this practice elimination. However, up to date, there is no evidence of a coordination mechanism engaging all FGM elimination actors in the country.(34) In 2011, Mauritania join the UNFPA-UNICEF Joint Program to Eliminate FGM. Strategies to end FGM/C included education and community support, public declarations of abandonment, and policy and law reinforcement. A government budget-line for work to end FGM/C was introduced in 2016, and the practice is also included as a public-health concern in the National Strategy on Reproductive Health (2016–2020) and the National Strategy on Accelerated Growth and Prosperity (2016–

2030).(143) also, reports from civil societies reflect decline in the practice in some parts of the country. But the law enforcement is weak and had no contribution in the stopping of the practice. The National Strategy against GBV was updated for the period 2016–2019. The strategy included interventions to promote the abandonment FGM. Most recently, the country again updated The National Strategy against GBV and had been approved by the Council of Ministers for 2020–2024.(143)

Between 2014-2018 government state that increasing declaration of FGM practice abandon from communities in villages and active committees' formulation by these communities to these villages' actions against FGM. Also, standard operating procedures and materials such as booklets, brochures, films, modules, etc. for ensuring comprehensive support for survivors of gender-based violence had been implemented. The framework bill on violence against women and girls including FGM developed and approved and passed for consideration by the parliament for adoption. as part of the prevention of FGM, training to 180 imams in wilayahs where the practice is very widespread implemented. Also, an action plan to encourage the voluntary discontinuation of female genital mutilation in regions implemented where the practice is very widespread. Implementation of awareness-raising campaigns against harmful practices, including female genital mutilation and child marriage. Furthermore, harmonized training modules on combating female genital mutilation including cultural arguments had been prepared. victims of female genital mutilation are cared for in public health facilities, including the mother and Child Hospital Centre and in shelters opened by certain non-governmental organizations.(144)

Furthermore, in 2019 UN Human Rights Committee (HRC) for Mauritania expressed concern that FGM/C persists ’on a major scale in some regions and among some ethnic groups’. The committee recommended Amendment of the legislation to prohibit FGM practice against all women and girls; to ensure that all cases of female genital mutilation are promptly investigated and prosecuted, that perpetrators and accomplices are appropriately punished and that victims have access to social and medical services, to strengthen awareness-raising and education programs with a view to eradicating the practice.(146) Also, the Working Group on discrimination against women and girls on its report may 2024 was concerned that” since the adoption of the laws prohibiting female genital mutilation, no cases were reported to authorities” the committee consider this as” highlighting a serious monitoring gap”.(147)

Conclusion and Recommendations

Mauritania has demonstrated a commitment to addressing Female Genital Mutilation (FGM) and other gender-based violence through legislative efforts, international partnerships, and national strategies. However, the persistence of FGM remains a critical concern, deeply entrenched in cultural, social, and regional practices. While prevalence rates have shown modest declines, particularly among younger age groups, FGM continues to be practiced in its most severe forms, disproportionately affecting women and girls in rural and marginalized communities. Weak enforcement of existing laws, limited public awareness, and cultural resistance have hindered more significant progress. Additionally, gender-based violence and harmful practices remain exacerbated by broader humanitarian challenges, including food insecurity, displacement, and inadequate healthcare infrastructure.

Despite the development of national strategies, regional committees, and awareness campaigns, the lack of comprehensive coordination mechanisms and limited legal enforcement has undermined the effectiveness of efforts to eliminate FGM. While positive trends, such as growing opposition to the practice among educated and urban populations, offer hope, significant regional and economic disparities persist. Mauritania must bridge these gaps to ensure sustained progress toward eradicating FGM and protecting the rights of women and girls.

By addressing the following recommendations through a multi-sectoral and evidence-based approach, Mauritania can make substantial progress toward eliminating FGM, protecting women and girls, and fostering a society that upholds gender equality and human rights.

1. **Strengthen Legal Frameworks and Enforcement:**
    - Finalize and adopt the draft gender-based violence (GBV) law with explicit provisions criminalizing FGM and ensure strict penalties for perpetrators, accomplices, and enablers.
    - Address gaps in enforcement by implementing mechanisms to encourage reporting, investigation, and prosecution of FGM cases. This includes capacity-building for law enforcement officials, judiciary, and healthcare professionals to identify and act against FGM.
    - Promote public awareness of existing laws and penalties, ensuring communities understand that FGM is illegal and harmful.

2. **Enhance Community Engagement and Awareness:**
    - Expand community-led initiatives, particularly in high-prevalence regions, to address the cultural and social norms that perpetuate

FGM. Utilize religious leaders, imams, and traditional leaders to challenge misconceptions and promote the religious edicts ("fatwa") that declare FGM unnecessary.
    - Support public declarations of FGM abandonment at the village and community levels and ensure follow-up monitoring mechanisms to sustain progress.
    - Implement targeted awareness campaigns using culturally sensitive communication tools, such as radio broadcasts, social media, and local dialogues, tailored to rural and marginalized communities.

3. **Improve Education and Empowerment of Girls and Women:**
    - Increase access to education, particularly in rural areas, as education correlates with reduced FGM prevalence. Focus on gender-sensitive curricula that address harmful practices and promote gender equality.
    - Empower women and girls through life skills training, economic opportunities, and leadership programs to challenge gender-based norms and encourage reporting of FGM cases.

4. **Integrate Health and Social Support Services:**
    - Strengthen health services to address the physical and psychological consequences of FGM, including specialized care and counseling for survivors. Public health facilities, such as the Mother and Child Hospital Centre, should expand services for FGM survivors.
    - Train healthcare professionals on identifying, treating, and preventing FGM and ensure their active role in community education and advocacy.
    - Develop survivor support mechanisms, such as shelters, legal aid, and psychosocial counseling, to encourage victims to come forward.

5. **Address Regional Disparities and Humanitarian Challenges:**
    - Prioritize targeted interventions in high-prevalence regions such as Hodh El Gharbi, Guidimakha, and Assaba, where FGM remains nearly universal. Design region-specific action plans to address drivers of the practice.
    - Integrate FGM prevention strategies into broader humanitarian responses addressing food insecurity, displacement, and healthcare challenges to provide comprehensive support for vulnerable populations.

6. **Improve Monitoring, Data Collection, and Coordination:**
    - Establish a national coordination mechanism to align the efforts of government agencies, NGOs, and international partners in the fight against FGM.
    - Develop a robust monitoring and evaluation system to track FGM prevalence, trends, and the impact of interventions, ensuring accurate and timely reporting.
    - Encourage collaboration with international organizations, such as UNICEF and UNFPA, to strengthen technical and financial support for FGM elimination efforts.

7. **Promote Economic Empowerment and Alternative Livelihoods:**
    - Provide economic incentives and alternative livelihood programs for traditional cutters to dissuade them from practicing FGM. Support skill development and microfinance initiatives to transition them into new roles.
    - Invest in poverty alleviation strategies, as economic insecurity often reinforces harmful practices such as FGM and child marriage.

8. **Mobilize Political and Religious Will:**
    - Encourage stronger political leadership and advocacy for FGM elimination, including prioritization in national policies and strategies.
    - Strengthen partnerships with religious leaders to reinforce messages that FGM is not a religious requirement, leveraging existing "fatwas" and religious declarations to dispel myths.

YEMEN

Background

Yemen, located at the southern tip of the Arabian Peninsula, is strategically positioned between the Red Sea and the Arabian Sea, with Saudi Arabia to the north and Oman to the east. Its location near the Bab al-Mandab Strait, a critical maritime trade route, gives it immense geopolitical importance. Covering an area of approximately 527,968 square kilometers, Yemen is home to a population of around 34 million people (2023), making it one of the most densely populated countries in the region.

Yemen boasts a rich and ancient history. Due to its historically fertile land and prosperity, it is often referred to as Arabia Felix ("Fortunate Arabia"). Yemen is home to some of the oldest cities in the world, including Sana'a and Shibam, both UNESCO World Heritage Sites. Yemen's cultural heritage reflects its deep historical roots, with unique traditions in architecture, poetry, music, and cuisine.

Yemen's population is predominantly Muslim, with Sunni Islam (primarily Shafi'i) constituting the majority and Zaidi Shi'ism practiced in the northern regions. Yemen's ethnic and tribal diversity has contributed to its cultural richness but has also played a role in the nation's complex political landscape. Economically, Yemen is among the poorest countries in the Middle East, with a GDP of approximately $20 billion (2023). The economy is heavily dependent on agriculture, small-scale trade, and remittances, while oil exports, once a significant source of revenue, have sharply declined due to conflict. Economic collapse, governance failures, and widespread poverty have exacerbated Yemen's fragile development trajectory, leaving over 80% of the population in dire need of assistance. Despite these challenges, Yemen's cultural and social resilience remains a hallmark of its identity.

Humanitarian Challenges

Yemen faces one of the most severe humanitarian crises globally, driven by prolonged armed conflict, economic collapse, and natural disasters. The situation has been described by the United Nations as the "worst humanitarian catastrophe in history," with millions of lives at risk. (148, 149)

1. **Widespread Food Insecurity and Famine**: Yemen is on the brink of famine, with 50% of the population at risk of starvation. According to the World Food Programme (WFP), more than 17 million people are food insecure, and approximately 2.2 million children suffer from acute

malnutrition. The destruction of agricultural infrastructure, blockade-related restrictions, and the economic crises have severely impacted food availability and affordability. Rural communities dependent on agriculture and fishing are particularly vulnerable.

2. **Displacement and Refugee Crises**: The conflict has resulted in the displacement of 4.5 million people, of whom 80% are women and children. Many internally displaced persons (IDPs) live in overcrowded, unsanitary camps with limited access to basic services, including clean water, food, and healthcare. Women-headed households, constituting 26% of displaced families, face additional challenges, including social exclusion, economic hardship, and increased vulnerability to exploitation and violence.
3. **Healthcare Collapse and Disease Outbreaks**: Yemen's healthcare system has been decimated by years of conflict, with only 50% of healthcare facilities fully operational. Limited access to medical care has left millions vulnerable to preventable diseases such as cholera, measles, and malaria. Since 2017, Yemen has faced one of the largest cholera outbreaks in history, with over 2.5 million suspected cases reported. The COVID-19 pandemic further strained an already overwhelmed system, exacerbating mortality rates, especially among women, children, and the elderly.
4. **Water Scarcity and Sanitation Crises**: Yemen is one of the most water-scarce countries in the world, with over 15 million people lacking access to clean drinking water and basic sanitation. Damage to water infrastructure from conflict, coupled with prolonged droughts, has led to severe water shortages. Communities are often forced to rely on unsafe water sources, contributing to the spread of waterborne diseases and further worsening public health conditions.
5. **Education Disruption**: Conflict and displacement have severely disrupted education, affecting over 2.7 million children who are out of school. Schools have been destroyed, repurposed for military use, or used as shelters for displaced families. Girls are disproportionately affected, with many forced into early marriage as a coping mechanism. The lack of access to education perpetuates poverty, limits opportunities, and poses long-term development challenges for Yemen.
6. **Gender-Based Violence and Harmful Practices**: Gender-based violence (GBV) has surged amid the ongoing crises, exacerbating the already entrenched gender inequalities in Yemen. (148) Women and girls face heightened risks of sexual violence, exploitation, and trafficking. Harmful practices, including Female Genital Mutilation (FGM) and child marriage, remain prevalent, particularly in rural areas and among displaced populations. Societal discrimination restricts

women's mobility, economic participation, and access to healthcare and legal protections.

7. **Economic Collapse and Poverty**: Years of conflict have crippled Yemen's economy, leading to widespread unemployment, poverty, and soaring inflation. Over 80% of Yemenis live below the poverty line, struggling to afford basic necessities. The collapse of public services, non-payment of salaries, and reliance on humanitarian aid have created unsustainable conditions for millions. Remittances, once a lifeline for many households, have also declined due to the global economic downturn.
8. **Impact of Climate Change**: Yemen's vulnerability to climate change exacerbates its humanitarian crises. Prolonged droughts, unpredictable rainfall, and flash floods have destroyed homes, agricultural land, and infrastructure, displacing thousands. Rising temperatures and desertification threaten Yemen's food security and water resources, compounding the country's already dire challenges.
9. **Humanitarian Access and Funding Gaps**: Delivering humanitarian aid in Yemen remains fraught with challenges due to ongoing conflict, restricted access to certain regions, and attacks on aid workers. Bureaucratic hurdles and security risks further limit aid delivery. Despite efforts by international organizations, funding remains insufficient, with the UN Humanitarian Response Plan for Yemen consistently underfunded, leaving critical gaps in food, healthcare, and shelter provision.

Prevalence of FGM

FGM/C remains deeply rooted in Yemen, particularly in coastal regions, where it is sustained by cultural traditions and misconceptions about health and morality.(148) Key predictors of the practice include older maternal age (40+years), rural residency, and maternal history of FGM/C, underscoring its intergenerational perpetuation. The overall prevalence of FGM/C in Yemen is 19% among women aged 15-49. Efforts to reduce FGM/C, such as women's protection programs in Al-Hodeidah over the past decade, may have contributed to its declining prevalence in some regions. However, variations remain significant, often shaped by internal displacement due to war, with displaced families from northern Yemen less likely to practice FGM/C. In the recent national survey, Al-Mahrah recorded the highest prevalence of FGM/C in Yemen, that most of those who had not undergone FGM/C were families displaced from the conflict areas in northern Yemen where the practice is less common.(150)

Most FGM/C was performed at home by a traditional birth attendant and not a trained health provider. The practice depends on the community or individual family and girls are not aware that they have been circumcised until they get married or have been examined.(151) FGM/C is performed in early age of a girl's life. The analysis of the DHS revealed that most of the practice of FGM/C in Yemen was performed within the first month after birth. This could be due to tradition, and it could be to avoid pain.(151) Women who have undergone FGM/C are more likely to have the procedure performed on their daughters. However, there is evidence of a generational shift, with increasing awareness and non-supportive attitudes from both women and their husbands influencing decisions to abstain from performing FGM/C on daughters.(151) Among women, having a mother aged 40 years or older was statistically associated with FGM/C in their youngest daughters, suggesting that the practice may be declining among younger generations.(152)

Compared to mothers, the prevalence of FGM/C in the youngest daughters was approximately 9% lower, reflecting a potential positive shift due to efforts by the Yemeni government and international partners to combat the practice. Nevertheless, additional awareness programs remain necessary to further decrease its prevalence.(152) A 2008 UNICEF report highlighted that 30% of Yemeni women had undergone FGM/C, with type II being the most common, accounting for 88% of cases, while type I comprised 11%.(153, 154) In Yemen's coastal areas, a local custom known as *al-takmeed* involves placing a heated compress made of sand, oil, or herbs on a female's genitalia for several weeks to deaden nerve endings in that region.(153) This tradition, considered less invasive, falls under Type IV, which includes harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping, and cauterization.(154, 155)

The Minister of Public Health has strongly condemned the practice of FGM/C and issued a ministerial decree on January 9, 2001, banning the procedure in both public and private institutions. However, enforcement of this law remains weak. In 2009, a draft law proposing the prohibition of FGC was introduced to parliament, but it has yet to be approved.(149) This delay is believed to stem from significant social and religious pressures, which caused many parliament members to reluctantly abandon the proposal. Additionally, the Yemeni socioeconomic context surrounding this issue remains unclear, with limited research conducted.(149) The Yemeni government has also stated that insufficient studies have been conducted to justify passing a law prohibiting FGC, asserting that the prevalence of the practice must first be confirmed. Consequently, there is a lack of evidence on the factors influencing FGC across different geographic regions, which hinders the development of effective community-based interventions tailored to varying

prevalence levels and contexts. Addressing this evidence gap is crucial for designing effective strategies to combat FGC and for understanding how socioeconomic changes influence attitudes towards the practice.

The ongoing conflict in Yemen has exacerbated poverty, disrupted education, and strained healthcare systems, contributing to the persistence of FGM/C. Addressing these issues requires coordinated international efforts, community-based interventions, influencers and religious leaders to address misconceptions and advocate against the practice(153). As a collaboration network, the Global Protection Cluster (GPC) links together non-governmental organizations (NGOs), international organizations, and United Nations (UN) agencies that take part in humanitarian crises, such as armed conflicts and natural disasters. The GPC is mandated by the Inter-Agency Standing Committee (IASC) and functions under the direction of the UN High Commissioner for Refugees (UNHCR). A multi-partner Operations Cell supports the Strategic Advisory Group, which is directed by the GPC Coordinator and a functioning NGO and is responsible for accountability.(149) Education has emerged as a pivotal factor in this decline. Women with higher education levels and their spouses are less likely to support the practice. Educational initiatives targeting women and men, including rural societies, have contributed to increased awareness and a gradual shift in attitudes.(155)

Medicalisation, where healthcare providers perform FGM/C to reduce perceived harm, has gained traction in Yemen, undermining efforts to eliminate the practice. While Yemen's Ministry of Health issued a declaration in 2019 prohibiting FGM/C in healthcare facilities, enforcement has been inconsistent. Strengthening health sector policies, providing training to health workers, and unequivocally opposing medicalised FGM/C are critical to reducing its prevalence.(156) Yemen which lacks national FGM/C legislation, have decrees against medicalization. Medicalization or the practice of FGM/C by professionals, which is outlawed in several countries and is a violation of their code of ethics, is on the rise in Yemen.(156)

The shift in attitudes among women and their husbands regarding FGM/C may be linked to the ministerial decree that prohibits health providers in Yemen from performing the practice. This decree stemmed from the 1999 Clinical-Based Investigation of FGM/C in Selected Areas of Yemen, conducted by various government entities. However, health officials acknowledged the difficulty of monitoring the decree's enforcement across all medical facilities.(157) Additionally, increased exposure to information through health providers, media, and awareness initiatives on health issues, including FGM/C, may have influenced the changing perceptions in Yemen. Educated women were found to be less likely to perform FGM/C on their daughters compared

to their illiterate counterparts, highlighting a significant correlation between education and the discontinuation of FGM/C. Illiterate women showed stronger support for FGM/C, whereas more educated mothers were less inclined to have their daughters circumcised. Education is seen as a tool for empowering women, enabling them to access and process information effectively.(158) This finding aligns with other studies indicating that women's attitudes towards FGM/C evolve with increased education and awareness.

The International Conference on Population and Development (ICPD) urged governments to ban FGM/C and prevent infanticide.(159) In response, Yemen’s Ministry of Public Health and Population (MoPHP) drafted a law in 2008 to prohibit FGM/C by anyone, including health providers. However, the law was not passed due to resistance, including concerns raised by religious leaders in the Ministry of Endowment about the health consequences of FGM/C. In 2012, the MoPHP drafted another law to prohibit FGM/C, supported by educational and awareness programs targeting affected populations since 1999.

The ICPD also addressed broader sexual and reproductive health issues in chapter VII (Reproductive Rights and Reproductive Health).(159) Studies emphasize the importance of sexual and reproductive health education for both men and women.(160, 161) To effectively address FGM/C, community, school, and university-level initiatives should focus on the health risks associated with the practice. Including men and boys in these efforts is crucial, as they play a significant role in decision-making.(151)

Community engagement is essential to addressing the socio-cultural drivers of FGM/C. Religious leaders play a pivotal role in challenging cultural norms by aligning opposition to FGM/C with Islamic teachings. Collaborative initiatives involving religious figures, community leaders, and educational institutions have shown promise in reshaping societal attitudes and fostering collective opposition to FGM/C.(152) A decline in FGM/C rates has been attributed to changing attitudes among women and their husbands. Non-supportive perspectives towards the practice significantly correlate with the decision to forgo FGM/C for daughters, regardless of maternal age or educational attainment.(151) Yemen has yet to enact nationwide legislation banning FGM/C. While the 2019 Ministry of Health declaration was a step forward, comprehensive legal frameworks are necessary to reinforce these measures. However, evidence suggests that legislation alone is insufficient and must be complemented by initiatives addressing underlying socio-cultural causes.(156) Various Policy Recommendations include Enact National Legislation: Pass and enforce laws criminalizing FGM/C at the national level; Community Engagement: Strengthen collaborations with religious leaders,

community influencers, and educators to reshape cultural norms; Invest in Education: Focus on improving women's access to education, as it has a transformative impact on reducing FGM/C; Ban Medicalisation: Enforce strict policies against medicalised FGM/C in healthcare facilities and educate health workers about its harms and Promote Awareness: Implement culturally sensitive campaigns to raise awareness and promote behavioral change.(156)

The prevalence of FGM/C among women and girls aged 15-49 across governorates in Yemen, reveals significant regional disparities. Al Mahrah, Hadramout, and Al Hudayda report the highest prevalence rates of FGM/C at 85%, 80%, and 62%, respectively. These areas are predominantly coastal and have strong cultural ties to the practice, suggesting deep-rooted traditional norms as key drivers of the high prevalence. In contrast, governorates like Al Bayda, Al Jawf, and Al Mahwit show zero prevalence, indicating either a complete absence of the practice in these regions or a cultural context where FGM/C is not traditionally practiced.

Intermediate prevalence rates are observed in Raimh (22%), Aden (15%), Dhamar (14%), and Ta'izz (13%). These regions may be transitioning culturally, where traditional practices are being challenged by increased education, urbanization, or anti-FGM/C interventions. Governorates like Hajjah (8%), Ma'rib (7%), Ibb (6%), Abyan (5%), and Sana'a City (5%) exhibit relatively low prevalence rates, indicating a reduced but not entirely eradicated practice. The lowest prevalence rates, at 1% or below, are recorded in Sana'a, Shabwah, Amran, and Al Dala, suggesting that FGM/C is largely marginalized in these areas. This could reflect the impact of legal frameworks, education campaigns, or shifting cultural norms that prioritize women's rights and health.

Overall, the data underscores the regional variation in FGM/C prevalence in Yemen, highlighting the need for tailored interventions that address specific cultural, social, and geographical contexts. High-prevalence regions require intensified efforts, including community engagement and education, while areas with low prevalence should continue efforts to prevent a resurgence of the practice.

The predominant form of FGM/C is Type II, often referred to as excision. Notably, the most severe form, Type III (infibulation), is not practiced in the country. The majority of FGM procedures in Yemen are performed on infants, with approximately 83.8% occurring within the first week of life. These procedures are primarily carried out by traditional practitioners, who are responsible for an estimated 92.8% of cases. The prevalence of FGM/C in

Yemen reveals a complex socioeconomic pattern. While the poorest women face the highest risk (26.5%), the relationship between socioeconomic status and FGM prevalence isn't straightforward. Interestingly, the middle (13.3%) and richest (14.0%) quintiles show the lowest prevalence, suggesting that economic factors may play a role in perpetuating FGM, but other factors likely contribute to its persistence as well. Educational attainment also played a role, with lower levels of education correlating to higher rates of FGM. Conversely, higher levels of education were associated with lower prevalence rates (Figure 5). Interestingly, the disparity between urban (17.1%) and rural (19.2%) areas was minimal.

FGM is not exclusive to any single religious group in Yemen, though it is more prevalent in certain regions, often tied to cultural rather than strictly religious practices. FGM is practiced among both Sunni and Zaidi Shia communities. While some individuals and communities may justify FGM on religious grounds, many religious leaders in Yemen and elsewhere have clarified that it is not a religious obligation. Efforts to reduce FGM in Yemen increasingly emphasize education and community engagement to challenge the cultural beliefs associated with the practice.

The most recent DHS conducted in Yemen was the 2013 Yemen National Health and Demographic Survey (YNHDS).(150) It remains the most comprehensive source of data on FGM detailing prevalence, regional variations, and societal attitudes. There have been no subsequent DHS or MICS conducted in Yemen. It is unknown when the next survey will be conducted.

National Policies and Laws

Yemen ranked at the bottom in the World Economic Forum’s Global Gender Gap index, it was found at 155 out of 156, followed only by Afghanistan. Gender inequality in Yemen is deeply rooted in a patriarchal society that prevents girls and women from accessing education, health services and labour markets, increasing their vulnerability to different violent and harmful practices, including FGM.(162)

There is no law that prohibits FGM/C.(18) Only a 2001 ministerial decree prohibits carrying out FGM/C procedures in public and private health settings. But it does not impose penalties for violations. According to health officials, the decree has not been effective in stopping FGM/C due to the difficulty of monitoring its implementation in medical facilities. This indicates the occurrence of practice medicalization in the recent data. That there is rising in number of daughters aged 0–14 years cut by a health professional

from 8% to 12.8%.(27) A 2011 report by UNFPA and the Ministry of Health showed that, despite efforts against the medicalization of FGM, 12% of all health facilities still performed the procedure.(163)

A child rights bill that proposed to criminalize FGM/C and stipulated prison sentences and fines for offenders was submitted for ministerial review in 2014.26 The Safe Motherhood Bill proposed to introduce a provision that prohibited FGM. However, the Parliament didn't pass it, and some members opposed it due to concerns that it contradicted Sharia. As a result, the Safe Motherhood Law 2014 didn't include the prohibition on FGM/C.(164)

The debate on passing FGM law continued during the National Dialogue Conference 2013-2014. In its final report, the Conference's Sustainable Development group recommended that the government: Accelerate efforts to adopt provisions that criminalize performing harmful medical procedures on children, especially FGM. Monitor doctors and medical practitioners who further perpetuate such practices. And raise awareness regarding the negative consequences of these practices by implementing effective awareness programs in collaboration with communities and religious leaders. The Conference's Rights and Freedom group also recommended criminal prohibitions in its recommendation No. 94: "Criminalize assault on physical integrity (FGM)."(165)

In response to these recommendations, in April 2014 the ministers of social affairs and labour, and legal affairs, submitted a draft of a new Child Rights Law to Prime Minister. The bill also seeks to prohibit FGM, stating that a child has the right to "enjoy health" and should be protected from all forms of violence, including FGM. The bill would impose criminal penalties of one to three years in prison or a fine of between 300,000 and 1 million Yemeni Riyal (US$1,400-4,700) for violating the provision. At the time of writing, the cabinet had yet to approve the bill and forward it to parliament for debate and adoption.(5, 166)

A draft law entitled "Protection of Women Act": The draft law, currently pending before parliament, is the effort of the national advocacy committee established on violence against women, including FGM. There was also an endorsement of the National Reproductive Maternal Newborn Health and Advocacy Strategy. The National Strategy focuses on the rights of children to protection from violence including GBV and promotes quality access to services for children at risk during emergencies.(167)

In 2019, Yemen developed a national action plan, which provides a policy framework to implement United Nations Security Council Resolution 1325 on

Women, Peace and Security over the period 2020–2023.59 Goal three of the plan mentions FGM as a form of violence toward women and girls and the government emphasizes the need to strengthen the protection of women from all forms of violence. However, little has been done to enforce this goal and ensure its implementation at the government level.(168)

Community and National Efforts to Eliminate FGM

The Yemen Government started to tackle FGM before the conflict. In 2001 the Ministry of Health brought for the first time a range of stakeholders to publicly discuss female health and FGM. A country plan including a ministerial decree to ban the medicalization of the practice was the outcome of this meeting. The second national plan was launched in 2008 to reduce FGM, but campaigns were only small scale. However, all efforts to end FGM have been severely disrupted by the conflict since 2015. FGM has been included in more recent government strategies addressing reproductive and maternal health, but detail of actions arising is not publicly available.

Actions to eliminate FGM is challenged by the serious humanitarian context and the conflict in the country. In 2019, Yemen developed a national action plan, which provides a policy framework to implement United Nations Security Council Resolution 1325 on Women, Peace and Security over the period 2020–2023. Goal three of the plan mentions FGM as a form of violence toward women and girls, and the government emphasizes the need to strengthen the protection of women from all forms of violence. However, little has been done to enforce this goal and ensure its implementation at the government level.(168) Development of a national policy or strategy has been delayed for years, to date, no FGM elimination policy or strategy includes a plan of action with targets, a budget and a monitoring and evaluation (M&E) framework for FGM elimination. The FGM program is fragmented: each organization had its own one-off activities, without coordination with other actors. The lack of coordination among organizations working on FGM elimination affects overall country intervention outcomes. Likewise, data were fragmented and went unused as it is collected by different organizations. Moreover, data collected were on Gender Based Violence (GBV) in general and did not distinguish FGM from other types of GBV. However, it was revealed that a GBV information management system is not in place. it is noted that if M&E funds are made available, it is hard to prioritize M&E and data collection in a state of war. (168) With the current country’s performance, UNICEF stated that there is a need to accelerate efforts at least 10 times to eliminate FGM by 2030.(168)

FGM is not included in medical school curricula. There used to be a brief mention of FGM calling it a bad habit practiced in some rural areas without providing details. This reference was removed in 2008, due to fear of the impact of this topic on practice encouragement. Some progress has already been made in Yemeni schools. The Hodaida branch of the Yemeni Women's Union has launched projects that aim to engage with students in high school and their teachers around increasing awareness of the negative health consequences of FGM. Following their projects, the Union has seen spontaneous initiatives by some students to address the topic through art and theatre. According to the women's union more can be done to make the activity systematic and sustained.

The limited resources available and competing priorities make it difficult to fund FGM interventions. Although Yemen joined the UNJP program, UNICEF failed to mobilize resources to support the country's FGM elimination interventions. Also, the practice continuation and medicalization are challenging. It is more challenging with the support of religious leaders to practice provision and community recognition to the community practitioners who keep practicing FGM. On the other hand, there is a critical role for health professionals to play in raising awareness about the harmful impact of the FGM, and mobilization of families and communities to abandon the practice. This can be through the introduction of anti-FGM messages by medical professionals during antenatal and prenatal health visits. Dissemination of messages about FGM using different channels through which the public can be made aware of the harms of FGM and the dangers of circumcision and explaining the health problems resulting from it. In addition to that, working with religious leaders, instilling, disseminating and reinforcing the idea that FGM is not a religious requirement helps in changing the community's perception of FGM as a religious obligation.(162)

Yemen has demonstrated commendable progress in its efforts to eradicate FGM, even amidst persistent challenges. Interactive community theatre programs in areas with high FGM prevalence have fostered open dialogue, leading to public declarations of abandonment of the practice. Digital campaigns, such as "No More Cutting," have effectively leveraged social media to raise awareness and challenge deeply ingrained cultural norms. Furthermore, exceeding initial targets, healthcare providers in at least 16 facilities have received training in FGM prevention.

While Yemen currently lacks specific legislation prohibiting FGM, discussions regarding legal reforms are ongoing among religious leaders and advocates. Continued international support remains vital to sustain and expand these promising initiatives.

Additionally, a growing national consensus against FGM is evident in the country, with approximately 75% of women aged 15-49 expressing support for its discontinuation in the 2013 DHS. However, regional variations persist, highlighting the enduring influence of cultural traditions. In areas like Al-Mahrah and Hadramout, where FGM prevalence remains high, a significant segment of the population continues to support the practice. Future action plans need to prioritize these areas and focus on community-based interventions, education, and awareness campaigns to address the deep-rooted cultural beliefs and social norms that perpetuate FGM.

Conclusion and recommendations

Yemen faces an entrenched humanitarian crises, compounded by prolonged conflict, economic collapse, climate shocks, and gender inequalities. Widespread food insecurity, displacement, a near-total collapse of public services, and significant healthcare and education disruptions have devastated the population. Women and girls are disproportionately affected, facing heightened vulnerabilities to gender-based violence (GBV), early marriage, and harmful practices such as Female Genital Mutilation (FGM). Although Yemen has seen some positive shifts, such as increased awareness of FGM's harms and changing attitudes, the lack of legal enforcement, weak health infrastructure, and socio-cultural resistance continue to hinder progress.

The prevalence of FGM remains regionally concentrated, with coastal areas like Al-Mahrah and Hadramout reporting the highest rates. While ministerial decrees have banned medicalized FGM, enforcement gaps and resistance from certain community segments have slowed progress. Yemen's socioeconomic challenges, coupled with the absence of coordinated, large-scale programs and legal frameworks, highlight the need for urgent action to address the root causes and consequences of FGM and its persistence.

Yemen's path to eradicating FGM requires a multi-faceted approach that includes legislative reforms, education, community engagement, and health sector interventions. Addressing the humanitarian crises, empowering women and girls, and fostering cultural change through collaboration with religious leaders and influencers are critical to eliminating FGM. Enhanced international support, combined with national accountability and targeted action in high-prevalence regions, can significantly accelerate progress toward ending this harmful practice:

1. **Enact National Legislation**
    - Urgently pass comprehensive anti-FGM legislation to criminalize the practice in all its forms, including medicalized FGM.
    - Ensure enforcement mechanisms are clear, with penalties for violators and accountability for healthcare providers engaging in the practice.

2. **Strengthen Healthcare Systems**
    - Train healthcare professionals to advocate against FGM, incorporate anti-FGM messages during prenatal and antenatal care visits, and refuse medicalized FGM procedures.
    - Include FGM prevention in medical and nursing curricula, emphasizing its health impacts and the ethical obligations of health providers.

3. **Community Engagement and Awareness**
    - Engage religious and community leaders to challenge misconceptions, align opposition to FGM with Islamic teachings, and foster local declarations of abandonment.
    - Use culturally sensitive communication strategies, including theatre programs, social media campaigns, and grassroots initiatives, to raise awareness about the harms of FGM.
    - Target high-prevalence areas such as Al-Mahrah, Hadramout, and Al Hudayda with intensive community-based interventions.

4. **Invest in Education and Empowerment**
    - Expand access to education for girls and women, recognizing its transformative impact on reducing FGM and improving gender equality.
    - Integrate anti-FGM education into school curricula to promote early awareness of its health consequences and cultural alternatives.
    - Empower women and girls through economic initiatives to address poverty-driven motivations for perpetuating harmful practices.

5. **Strengthen Monitoring and Coordination**
    - Develop a national action plan with clear targets, budgets, and a monitoring and evaluation framework to eliminate FGM.
    - Establish a centralized coordination mechanism among government agencies, NGOs, and international partners to improve collaboration and resource allocation.

- Collect disaggregated data on FGM prevalence, regional disparities, and the role of socioeconomic factors to inform tailored interventions.

6. **Address Humanitarian Needs and Funding Gaps**
   - Prioritize humanitarian assistance for conflict-affected populations, ensuring access to clean water, food, healthcare, and protection services for vulnerable women and girls.
   - Mobilize international resources to support FGM prevention programs, particularly in conflict-affected and displaced communities.

7. **Combat Medicalization of FGM**
   - Enforce the ban on medicalized FGM, strengthening health sector policies and ensuring providers adhere to ethical guidelines.
   - Raise awareness among healthcare workers about the harmful impact of FGM and the importance of rejecting its medicalization.

8. **Leverage International Support**
   - Strengthen collaboration with UN agencies, the Global Protection Cluster (GPC), and international partners to integrate FGM prevention into broader humanitarian and development efforts.
   - Utilize platforms such as UN Security Council Resolution 1325 to prioritize the protection of women and girls, including addressing FGM.

IRAQ

Background

Iraq is located in the Middle East, bordered by Turkey to the north, Iran to the east, Kuwait to the southeast, Saudi Arabia to the south, Jordan to the southwest, and Syria to the west. The country's geography ranges from fertile plains in the central region to desert areas in the west and mountainous terrain in the north.(36)

Iraq is a diverse country with Arabs forming the majority of the population. Other significant ethnic groups include Kurds, Turkmen, , and Yazidis, with many of these minorities residing in the northern regions, particularly in the Kurdistan Region.(169)

Iraq has a total population exceeding 44 million people, with the Kurdistan Region—the primary area where FGM is practiced—hosting approximately six million people.(44) Infant Mortality in the country is 23 deaths per 1,000 live births (2019) while Maternal Mortality is 79 deaths per 100,000 live births (2017). Iraq ranked 122 out of 144 countries, with a score of 51.2% (2022), reflecting significant disparities in gender equality and the need for continued improvement.(36)

The majority of Iraq's population is Muslim. Minority religious groups include Christians, Yazidis, and Mandaeans, who primarily reside in the northern regions.(44)

Humanitarian Challenges

Iraq continues to face challenges stemming from decades of conflict, which have led to widespread displacement, infrastructure damage, and limited access to essential services (36). These challenges are compounded by economic instability, political disputes, and climate-related stress, leaving millions of people vulnerable.

1. **Internal Displacement and Refugee Crises**: Years of armed conflict, including the 2003 invasion, sectarian violence, and the rise of ISIS between 2014 and 2017, have displaced over 6 million Iraqis internally. As of 2023, 1.2 million people remain internally displaced (IDPs), primarily in camps or informal settlements, while over 260,000 refugees—mainly from Syria—reside in northern Iraq (36, 169).

2. **The Kurdish Population and Regional Challenges**: The Kurdistan Region of Iraq (KRI), home to approximately 6 million Kurds, faces unique humanitarian challenges stemming from its autonomous status, political tensions with Baghdad, and economic instability. The region hosts over 1 million IDPs, further straining limited resources. Kurdish women and children are particularly vulnerable to gender-based violence and early marriages, while climate change impacts, such as water scarcity, compound existing hardships. (169-173)

3. **Economic Instability and Poverty**: Iraq's heavy reliance on oil revenues makes its economy highly vulnerable to fluctuations in global oil prices. Prolonged instability, corruption, and inadequate public services have left 27% of Iraqis living below the poverty line. Youth unemployment exceeds 35%, contributing to social unrest and mass emigration. Economic hardships in the Kurdistan Region are exacerbated by strained public services and ongoing political tensions with the central government in Baghdad. Fluctuating oil revenues further undermine the region's capacity to meet the needs of both its population and displaced communities (169)

4. **Gender Inequality and Gender-Based Violence**: Women and girls in Iraq face significant gender inequalities, worsened by conflict, cultural norms, and economic hardship. Gender-based violence (GBV), including domestic violence, child marriage, and harmful practices such as Female Genital Mutilation/Cutting (FGM/C), remains prevalent, particularly in rural and marginalized communities (169, 174). Iraq has ratified international frameworks such as the Convention on the Rights of the Child (CRC) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). However, cultural resistance and weak enforcement capacities hinder progress in eliminating harmful practices like FGM/C (171, 174).

5. **Healthcare Collapse and Disease Outbreaks:** Iraq's healthcare system remains fragile, with over 30% of health facilities damaged or destroyed during years of conflict. Limited access to medical care has left millions vulnerable to preventable diseases such as cholera, measles, and respiratory infections. The KRI faces similar challenges, with displaced populations in camps experiencing inadequate healthcare services, exacerbating the spread of communicable diseases (169, 171).

6. **Education Disruption**: Years of conflict and displacement have significantly disrupted education, affecting over 3.2 million children who are out of school. Girls are disproportionately impacted, often

forced into child marriage or domestic labor. In the KRI, the influx of IDPs has further strained educational resources, leading to overcrowded classrooms and insufficient support for teachers. (169)

7. **Climate Change and Water Scarcity**: Iraq's vulnerability to climate change has exacerbated water scarcity, particularly in the Tigris and Euphrates basins. Reduced water flow, desertification, and prolonged droughts have impacted agriculture and displaced rural families, intensifying urban migration and resource competition. The KRI is similarly affected, with climate change aggravating economic and humanitarian pressures (169, 173).

8. **Humanitarian Response and Funding Gaps**: The humanitarian response in Iraq, including the KRI, has involved collaboration between the Iraqi government, UN agencies, and international organizations. Agencies such as UNICEF and WHO have provided clean water, healthcare, and education to vulnerable populations, particularly in IDP camps (169, 171). Despite these efforts, the scale of the crises continues to exceed available resources, with critical funding gaps undermining long-term recovery and resilience-building initiatives.

Prevalence of FGM

FGM remains a significant concern in the Kurdistan Region of Iraq. The prevalence varies by region and community, with studies highlighting higher rates in Erbil (62.9%) and Sulaimaniyah (55.8%) governorates. Within specific districts, such as Pishdar and Rania, prevalence rates exceed 95%, making them the areas with the highest rates.(175, 176)

FGM in Kurdistan has traditionally been practiced due to a combination of cultural, social, and perceived religious factors deeply embedded in community norms. FGM is often seen as a rite of passage for girls, symbolizing their transition into womanhood. It is linked to maintaining purity, ensuring marriageability, and upholding family honour.(175-177) Many families believe that FGM curbs female sexual desire, which is perceived as necessary for maintaining a girl's chastity before marriage and fidelity after marriage. Despite no explicit mandate in Islamic teachings, many communities view FGM as a religious obligation influenced by local interpretations and societal pressure from religious leaders and older generations. Social conform ostracism further compels families to subject their daughters to FGM, ensuring they align with community expectations and avoid being stigmatized as "unclean" or unworthy of marriage.(169, 177)

Additionally, patriarchal norms frame women's bodies as objects to be controlled for societal acceptance. Efforts to abandon FGM in Kurdistan face challenges due to its deep-rooted cultural and social justifications, compounded by limited legal enforcement and educational outreach.(175, 177)

Female Genital Mutilation (FGM) is concentrated in the Kurdistan Region of Iraq, where 37% of women aged 15–49 have undergone the practice. In other parts of Iraq, FGM is rare and has negligible prevalence, particularly in Arab-majority areas.(178) Female Genital Mutilation (FGM) in Iraq is predominantly practiced among Kurdish communities in the northern regions, particularly in the Kurdistan Region. The practice typically occurs among girls aged 5 to 14, with traditional practitioners performing the procedures in almost all cases. Education plays a significant role in reducing FGM prevalence, as women and girls with higher levels of education are less likely to undergo the practice. Encouragingly, attitudes toward FGM are shifting, with 94% of women expressing the belief that the practice should end. This change reflects a growing awareness of the harmful effects of FGM and ongoing advocacy efforts.(178)

There is a unique trend in FGM prevalence among girls and women aged 15 to 49 years in Iraq when categorized by wealth quintile. Contrary to global patterns, the highest prevalence is observed among the wealthiest households, with 21.7% of women having undergone FGM. This contrasts sharply with the poorest quintile, where the prevalence is minimal, at only 1.4%. The second and middle quintiles show similarly low rates of 2.6% and 2.8%, respectively, while the fourth quintile presents a moderate prevalence of 6.3%. These findings suggest that FGM in Iraq is influenced more by cultural or regional factors, particularly within the Kurdistan Region, than by economic status. The disproportionately high prevalence among the wealthiest groups indicates that traditional and social norms may play a stronger role in driving the practice, emphasizing the need for targeted awareness and intervention programs within these communities.

The data reveals that 34.7% of FGM cases are conducted by traditional practitioners, a group that often includes older women, community elders, or traditional birth attendants. These individuals typically rely on cultural and ritualistic knowledge rather than medical expertise. A smaller proportion, 6.5%, of FGM cases are medically performed, which involves healthcare professionals such as doctors or nurses. Although this is a relatively small fraction, the medicalization of FGM remains a concerning trend, as it may give the false impression that the practice is safer or more acceptable when performed in a medical setting. The largest share, 58.8%, falls under the

"other/unknown" category, indicating either a lack of detailed data on these cases or involving performers not traditionally or medically classified. This could point to gaps in data collection or awareness about the individuals conducting the procedures.

The significant reliance on traditional practitioners reflects FGM's deeply embedded cultural roots in Iraq. This highlights the need for community-based interventions that address these conventional norms and practices. Medicalization: Although only a tiny fraction of cases are medically performed, this trend is alarming. It risks legitimizing the practice under the guise of safety and underscores the importance of engaging healthcare professionals in advocacy efforts to reject FGM outright. Data Gaps: The high percentage of "other/unknown" performers suggests a critical gap in identifying and tracking FGM cases. Strengthening data collection mechanisms can provide a clearer picture and better inform policy and intervention strategies.

FGM in KRI is deeply rooted in cultural traditions and reinforced by social and religious norms. Despite its pre-Islamic origins, FGM is often justified using religious arguments, with specific interpretations of Islamic teachings cited as mandates for the practice. However, religious leaders have no consensus, and some vehemently oppose it. Customary traditions and the transmission of practices through familial lines also play a crucial role in sustaining FGM. Mothers and grandmothers often serve as critical decision-makers, perpetuating the practice of maintaining social conformity and securing marriage prospects.(170, 175)

Economic and educational disparities are strongly linked to the prevalence of FGM in KRI. Women from lower-income households and those with limited education exhibit higher rates of FGM. In rural areas, where poverty and traditional norms are more pronounced, FGM is practised more widely compared to urban centres like Erbil City. Furthermore, the practice is associated with housewives and women whose mothers have also undergone FGM, indicating the intergenerational transmission of this harmful tradition.(170, 175)

In the Kurdistan Region of Iraq (KRI), FGM predominantly involves Type I (clitoridectomy), accounting for approximately 76–99% of cases, depending on the region. This procedure typically occurs when girls are between the ages of 4 and 12, with the average age being around 7. The practice has not seen widespread medicalization; it is typically performed by traditional practitioners, often midwives or older women within the community. It is performed under unhygienic conditions, posing significant health risks. So,

addressing the practice requires targeted interventions focusing on community education and the engagement of healthcare professionals to discourage the continuation of this harmful tradition.(179)

National Policies and Laws

The legal framework for the elimination of FGM in the Kurdistan region of Iraq evolved over years. In the early 80th the, Constitution for Iraq provided basic provisions that could have protected women and girls from FGM. Article 11 promised the primacy of the family through State provision of maternal and child care 32, and Article 22 specifically protected individual dignity because "it is inadmissible to cause any physical or psychological harm"33. Even in areas where FGM was considered a religious mandate in Iraqi Kurdistan because Article 25 promised such freedom 34, it would have been inadmissible through Article 22. This was the head of the International Committee on the Convention of the Elimination of All Forms of Discrimination Against Women (CEDAW) declaration of FGM a global health issue to be eradicated, which took place in 1990.(180) However, FGM was considered taboo, so most in Iraqi Kurdistan were reluctant to discuss FGM.

The prevalence of FGM was hardly known at this stage from outside the region, and even Iraqis thought it to be an isolated occurrence. In 1992, The Kurdistan National Assembly was formulated, and the Kurdistan regional government was validated. which "decided to adopt and abide by all Iraqi laws except for those that violated human and universal rights"49. Despite this, throughout the 1990s, political instability and the lack of acknowledgement and assistance from the Kurdish political leadership added to the suffering of women. Following the new wave of transnational feminism to address women's rights as human rights during the 1995 United Nations Fourth World Conference on Women in Beijing, the growing Kurdistan National Assembly engaged in the global human rights conversations, particularly regarding women's rights and the Special Women's Committee established in 2001. The committee's performance was affected by the high illiteracy among women, cultural values that limited the women's voice and regional instability. Following the UNGA resolution declaring FGM a harmful traditional practice66, on June 23, 2002, The National Council of Childhood and Motherhood brought about the Cairo Declaration for the Elimination of FGM. Conversation on the role of FGM in society, its prevalence, and its eradication started in Kurdistan region with an international NGO called WADI. FGM remained as a culturally taboo topic until 2008. While "68 out of 111 parliamentarians supported the passing of the law" to abandon FGM during this year, the KNA "refused to publicly debate the draft law", thus pigeon-holing it to fail. Conduction of a big stop FGM

campaign that engage villages and government ministries led to the codification of the 2011 Family Violence Bill criminalizing FGM, Law No. 8.

Law No. (8) of 1022 is a law aimed at combating domestic violence in the Kurdistan Region of Iraq. This law focuses on protecting individuals, especially women and children, from all forms of domestic violence. It includes legal measures to safeguard victims and enhances the prosecution of offenders. The law explicitly prohibits FGM, recognizing it as a form of violence and a violation of human rights. Also, it gave the victim of FGM, or a legal representative on their behalf, to file a report to the court or initiate legal proceedings. It protects the confidentiality of the process and calls upon related institutions to provide reports. The law put measures to ensure its implementation and responsible parties and how they contribute to domestic violence as well as FGM. It stated that a specialized court for cases related to combating domestic violence –including FGM- is established according to the Judicial Authority Law of the Region No. (13) of the year.

The Ministry of Health, in coordination with the Ministry of Labor and Social Affairs, shall ensure healthcare and rehabilitation for victims of domestic violence. Also, the General Directorate for Combating Violence Against Women in the Ministry of Interior is responsible for monitoring cases of domestic violence. The Ministry of Interior shall establish a special department within the police force, primarily composed of female police officers, to handle cases of domestic violence. The relevant ministries and official bodies shall promote a culture against domestic violence. The law mentions specific penalties for FGM. Anyone who performs or participates in the circumcision of a female minor shall be punished with imprisonment for a period of no less than one year and no more than three years, and/or a fine of no less than six million (6,000,000) dinars and no more than ten million (10,000,000) dinars, or one of these penalties. If the perpetrator is a doctor, midwife, or someone who assists chemically or pharmaceutically, it is considered an aggravating circumstance. The court shall order the suspension of their practice or work for a period not exceeding 3 years.

Community and National Efforts to Eliminate FGM

Anti-FGM movement in Iraqi Kurdistan has been particularly successful with the key role of civil societies that contribute to state-building and capacity-building in both legal and cultural factors of FGM high prevalence. FGM in Kurdistan is taboo until the presence of German-Iraqi NGO WADI. This NGO worked with local community of the region and gain their trust. Learning from the community and understanding them they were able to bringing universal human rights within accessible reach. As commitment to global

human rights conversations, particularly regarding women's rights Kurdistan National Assembly established Women's Committee in 2001. The task of the committee is to raise awareness of women's rights through education, media, health, and religious institutions. It served as a governmental watchdog on behalf of Kurdish women, magnifying their voice in legislating policy. In 2003 a project led by WADI worked on FGM in remote areas through a mobile health workers team. In the next year, the women from the community were able to lead the talk about FGM and its consequences. This was followed by a greater conversation on the role of FGM in society, its prevalence, and its eradication.in 2006 the first conference about FGM was held in Iraq.

In 2007, the draft law was presented to the KRG and to the Kurdish women's parliamentary group. in the spring of the same year WADI began the first surveys awareness-raising initiatives in the region in 2007 through launching the Stop FGM in Kurdistan campaign.(181) the study result presented in 2010 shows the prevalence of FGM. It engaged villages and governmental ministries in catching the wave of the global agenda for women's rights. This led to the codification of the 2011 Family Violence Bill criminalizing FGM, Law No. 8. In October 2008, the KRG established the Directorate for Combating Violence Against Women within the Ministry of Interior.

The Kurdistan Regional Government sponsored a 2011 study about FGM in the three main regions of Iraqi Kurdistan. The researchers advocated for "strong, long-term, and committed multidisciplinary action" to work to abandon the practice. This is along with "awareness campaigns, legal actions, targeted community interventions, advocacy, and educational programs". Meanwhile, the FGM-Free Village Campaign and WADI's Stop FGM Mobile Team infrastructure and grassroots integrative efforts continue to address the psychological and physical effects of FGM through dialogue with empowerment programs and community development.(182)

In 2013, Iraq joined the stop FGM Middle East, and in 2014, WADI and Hivos held the second FGM conference. Countries' experiences were shared and emphased on the importance of Asian countries is reflected. In 2018, during a regional conference in Gario Kurdistan regional group announced a collaboration with UNFPA and a plan for FGM elimination in Kurdistan. As part of the program, the Ministry of Health planned to train staff in primary health care units to inform parents about FGM during the vaccination campaign, and the Ministry of Education planned to arrange training with teachers and parents.(183)

In 2019, a one and half year program for the elimination of FGM was developed in Iraq, targeting the Kurdistan region. The planning strategy

focused on community behaviour changes and law implementation enforcement. The regional government, through concerned ministries, issued a fatwa and announced publicly that FGM is not Islamic and continuously hammered on that through imam's speeches. in addition to that, awareness activities by local authorities about the law and the penalty were part of the plan. The Ministry of Education plays a critical role in message dissemination about FGM as a harmful practice. This is planned to be through kinder gardens, schools and all activities that engage schools with families and the community. Community intervention led by local authorities and key participation of village imams and health care providers in the village. Regular meetings for village committees are planned to ensure that the practice is not performed by health professionals. Imams keep giving speeches about the non-Islamic base of the practice. The planned project is multi-disciplinary in notion with wider stakeholders' participation from public, private and non-governmental sectors. The plan includes the use of media and IEC materials to speak about the problem and share the plan slogan.(184)

In 2020-2021, both Garmyan and Halabja were declared free of FGM. However, many challenges are faced to ensure the sustainability of the FGM elimination program. One of these challenges is the regularity of data collection about the problem. The government does not gather region-wide statistics on FGM, nor has it instructed public health facilities to monitor the prevalence or consequences of the practice. As described, the government did not include FGM in the 2006 UNICEF-supported MICS and in the WHO supported Iraq Family Health Survey (IFHS). This is despite the suggestive results of the Ministry of Human Rights' single survey of FGM in the district of Chamchamal. Also, Healthcare professionals in Iraqi Kurdistan do not have consistent perspectives and understandings of the consequences of FGM. It has been reported that they provide misleading information about the consequences of FGM and its complications or not orienting the communities about its harmful impact on women and the community.(180)

Conclusion and Recommendations

Iraq's humanitarian situation remains critical, with decades of conflict and instability leaving millions displaced, infrastructure weakened, and essential services under strain. Vulnerable populations, particularly women and children, face significant challenges, including gender-based violence, food insecurity, and inadequate access to healthcare and education. The Kurdistan Region of Iraq (KRI), while holding autonomous status, struggles with its own humanitarian crises, including the high prevalence of Female Genital Mutilation/Cutting (FGM/C) and climate-induced stressors such as water scarcity. Despite progress in enacting laws and fostering community-based

interventions, deeply rooted cultural norms and limited enforcement of policies continue to hinder efforts to eliminate harmful practices and promote societal resilience. A comprehensive and inclusive approach, supported by sustained international collaboration, is critical for addressing Iraq's multifaceted challenges and fostering long-term stability.
By addressing the following recomednations through a coordinated, inclusive, and sustained effort, Iraq can make meaningful progress in overcoming its humanitarian challenges and fostering a more equitable and resilient society.

1. **Strengthen Legal Frameworks and Enforcement**
    - Extend and enforce anti-FGM/C legislation beyond the Kurdistan Region to all of Iraq, ensuring consistent monitoring and accountability mechanisms.
    - Bolster the implementation of existing laws, such as Law No. 8 in the Kurdistan Region, with dedicated resources and coordination among government bodies, healthcare providers, and law enforcement agencies.
2. **Enhance Humanitarian Assistance and Service Delivery**
    - Increase funding for humanitarian programs targeting internally displaced persons (IDPs) and refugees, focusing on healthcare, education, and protection services in camps and vulnerable communities.
    - Expand access to clean water and sanitation through infrastructure development and climate-resilient solutions, particularly in rural and conflict-affected areas.
3. **Address Gender Inequality and Harmful Practices**
    - Implement nationwide public awareness campaigns to challenge cultural norms perpetuating FGM/C and other harmful practices, leveraging the influence of religious leaders and community elders.
    - Promote gender-sensitive programming to support survivors of gender-based violence (GBV) and strengthen referral systems to ensure access to healthcare and legal aid.
4. **Support Economic Recovery and Livelihoods**
    - Diversify the economy to reduce reliance on oil revenues and create sustainable employment opportunities, particularly for youth and marginalized groups.
    - Enhance social safety nets and vocational training programs to support economic empowerment and community resilience.
5. **Improve Education Access and Quality**
    - Prioritize rebuilding and equipping schools in conflict-affected areas, ensuring access to education for displaced and marginalized children, particularly girls.

- Develop targeted programs to address child marriage and engage families in valuing education as a pathway to long-term societal development.

6. **Invest in Climate Adaptation and Resource Management**
   - Develop integrated strategies to address water scarcity, desertification, and climate-induced migration, focusing on sustainable agriculture and urban planning.
   - Foster regional collaboration on water resource management to mitigate the impacts of reduced flows from the Tigris and Euphrates rivers.
7. **Support Community-Led Interventions**
   - Engage community-based organizations and civil society actors in program design and implementation to ensure culturally relevant solutions.
   - Expand initiatives such as the "Stop FGM in Kurdistan" campaign and grassroots education programs to sustain momentum against harmful practices.
8. **Strengthen Data Collection and Monitoring**
   - Establish systematic data collection mechanisms to track the prevalence and impact of FGM/C, GBV, and other humanitarian challenges, ensuring evidence-based policy and programming.
   - Include comprehensive metrics on FGM/C in national surveys and public health monitoring systems to inform and evaluate intervention efforts.

INDONESIA

Background

Indonesia, a Southeast Asian archipelago comprising over 17,000 islands, is the world's fourth most populous nation with approximately 277 million residents (2023).(35) Its robust economy boasts a GDP of $1.37 trillion (2023).(35) While predominantly Muslim (87%), Indonesia also hosts significant Christian (11%), Hindu, and Buddhist communities.(36)
Indonesia's demographic and cultural diversity is both a strength and a challenge. The country hosts hundreds of ethnic groups and languages. While this diversity enriches its culture, it also presents challenges in achieving equitable development and social cohesion.
In recent years, the country has made progress in improving its health indicators, but significant gaps remain, particularly in maternal and child health, non-communicable diseases (NCDs), and healthcare access in remote and rural regions.

Humanitarian Challenges

Indonesia faces a multifaceted humanitarian crises driven by natural disasters, environmental degradation, social inequality, and challenges in addressing public health and education needs.(185) An influx of Rohingya refugees arriving by boat in Aceh has encountered local resistance due to concerns over resource scarcity.

1. **Frequent Natural Disasters:** Frequent natural disasters such as earthquakes, tsunamis, floods, and volcanic eruptions exacerbate the vulnerabilities of millions of Indonesians. Furthermore, natural disasters, such as the recent eruption of Mount Lewotobi Laki-laki, have caused fatalities and widespread displacement. Situated along the Pacific Ring of Fire, the country experiences high seismic activity, with disasters often displacing families, destroying infrastructure, and straining government resources.

2. **Climate Change Impacts:** Climate change further intensifies these issues, leading to rising sea levels and unpredictable weather patterns that threaten agricultural livelihoods and food security, particularly for communities dependent on farming and fishing. Following the devastating 2004 tsunami and other recent calamities, Indonesia has improved early warning systems and disaster preparedness initiatives. However, these systems still face logistical and financial limitations, especially in remote and rural areas. (185-187) In addition, deforestation

and environmental exploitation contribute to biodiversity loss and displacement of indigenous communities, deepening socioeconomic disparities.(186, 188)

3. **Refugees and Displacement:** Indonesia is both a source and a transit point for displaced populations. Internal displacement due to disasters and development projects is a persistent challenge. Additionally, the country hosts refugees from neighbouring conflict-affected regions, including Myanmar, placing further strain on already limited resources in some areas. In Papua, a protracted conflict originating in 1969 persists, marred by reports of human rights violations including extrajudicial killings and forced displacement, prompting calls from the United Nations for unimpeded humanitarian access.

4. **Public Health Challenges:** Indonesia also grapples with public health challenges, including maternal and child health issues, malnutrition, and insufficient access to clean water and sanitation in remote areas. Outbreaks of infectious diseases like dengue fever and COVID-19 have underscored gaps in healthcare infrastructure, especially in rural and isolated regions. Moreover, social inequality and systemic poverty impact marginalized groups, including women, children, and indigenous populations. In addressing public health and social welfare, the government works closely with international bodies to improve maternal and child health outcomes, tackle malnutrition, and expand access to clean water and sanitation. Humanitarian responses often include emergency food aid, shelter provision, and long-term programs aimed at rebuilding livelihoods for displaced populations. For instance, UNICEF and other organizations have implemented community-level education and health programs targeting vulnerable groups, particularly women and children, who face higher risks during crises

5. **Gender Inequality and Violence:** Gender-based violence, child labor, and early marriage remain prevalent, with practices like Female Genital Mutilation/Cutting (FGM/C) persisting as culturally entrenched norms that affect over 50% of girls under 12 years old in some regions.(186, 188)

6. **Infrastructure and Service Delivery**: Remote and isolated islands pose logistical challenges for delivering humanitarian aid, healthcare, and other essential services. Weak infrastructure, including poor roads and unreliable electricity, hampers efforts to reach affected populations during emergencies.

7. **Indigenous and Vulnerable Populations:** Indigenous communities in Indonesia often live in remote areas with limited access to government support and services. These populations are particularly vulnerable to displacement caused by large-scale development projects, deforestation, and climate change.

Prevalence of FGM

Female Genital Mutilation (FGM), locally referred to as khitan perempuan, is deeply rooted in cultural and religious traditions in Indonesia. In the most recent national survey conducted by the Ministry of Women's Empowerment and Child Protection in 2021 across 160 districts, the national prevalence was found to be 50.5%,(189) with the highest prevalence recorded as 81% on the island of Sulawesi, one of the four Greater Sunda Islands in Indonesia, hosting a population of 20.6 million.(46) Indonesia ranks fourth globally in the percentage of girls aged 0–14 who have undergone FGM, following Mali, Gambia, and Mauritania. It leads Southeast Asia in the number of individuals affected, with over 50% of girls under 12 experiencing some form of FGC. (186)

The majority of FGM procedures in Indonesia were performed on infants, with an estimated 72% occurring before the age of 1 year and 26% within the first 10 days of life. Caretaker decisions regarding FGM are primarily influenced by religious and cultural beliefs, particularly within Muslim-majority communities.(185, 187, 190) It is often regarded as a symbolic ritual of purification and moral preparation for womanhood, frequently justified as an Islamic requirement despite the absence of explicit mandates in Islamic texts.(188) Generational dynamics, particularly the influence of mothers and grandmothers, sustain the practice by linking it to family honour and societal acceptance. Societal pressures and intergenerational influence are also significant drivers.(185)

While precise data on the prevalence of specific FGM types is unavailable, Types 1 (Clitoridectomy) and 4 (Unknown/Unclassified) appear to be the most common, according to the WHO's categorization.(191) The procedures are typically carried out by midwives, traditional birth attendants, or, in some instances, other health professionals. Medicalization presents a growing challenge in Indonesia's efforts to combat FGM. Increasingly, healthcare professionals, including midwives and nurses, conduct less invasive procedures under sanitized conditions which families perceive as safer. Additionally, many healthcare workers lack sufficient training to manage FGM-related complications or advocate for its abandonment, further complicating their roles in promoting women's health and rights. (192, 193)

The economic dimension further complicates eradication efforts, as traditional practitioners, such as midwives or local healers, depend on the practice as a source of income.(185, 187, 190) In Indonesia, the prevalence was higher among the richest quintile and in urban areas which differs from other countries. The prevalence of FGM appeared to inversely correlate with the level of education. Higher education equated with less prevalence of FGM.

A 2017 study conducted by the Center for Population and Policy Studies revealed that 97.8% of respondents supported female circumcision. The primary justifications cited were religious obligation (92.7%) and adherence to traditional practices (84.1%). These deeply held beliefs pose a considerable obstacle to efforts aimed at reducing and ultimately eliminating FGM in Indonesia.(46)

The most recent DHS(27) conducted in Indonesia was the 2022-23 Indonesia Demographic and Health Survey (IDHS). However, it does not include data on FGM prevalence or attitudes. The most recent nationally representative data on FGM in Indonesia were collected in the 2021 National Women's Life Experience Survey.(189) Since then, there have been no comprehensive national surveys providing updated statistics on FGM prevalence in Indonesia.

National Policies and Laws

After a long history of debate and efforts to strengthen actions to prevent Female Genital Mutilation (FGM), the Indonesian government officially signed Government Regulation No. 28/2024 on 26 July 2024, which includes Article 102(a) explicitly banning female circumcision (FGM) for infants and children under the age of five. Although no information about the content of the law is available to date, this regulation marks a significant step forward in addressing FGM. It reflects the government's commitment to protecting the health and rights of young girls while reinforcing its stance against the practice and its commitment to international Human Rights, Gender-Based Violence and Female Genital Mutilation Frameworks ratified by the government.(46)

Historically, before the above-mentioned law, the Indonesian government issued several laws to enhance gender equality and to combat discrimination against women in all its forms. This legislation includes Law No. 7/1984 on the ratification of the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW); Law No. 5/1998 on the ratification of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment; Presidential Decree No. 36/1990 concerning the ratification of the Convention on the Rights of the Child; Law No. 23/2002 on

Child Protection; Law No. 23/2004 on the Elimination of Domestic Violence; and Law No. 23/2009 on Health. Also, there is the 2006 government circular, No. HK.00.07.1.3. 1047a, signed by the Director General of Community Health,(194) which specifically prohibited all forms of FGM from being performed by health professionals and warned about the negative health effects of female genital mutilation on women.(195)

However, debate and discussions around the practice continued. In 2010, The Ministry of Health in the Republic of Indonesia issued a decree stating that FGC is permitted so long as health professionals carry it out and follow specific guidelines. Article no II of the ministry decree states that only medical doctors, midwives, and nurses who have obtained their practice license or work permit can perform this practice. Article no II states that "performance of female circumcision can only be approved upon request from the woman who is to be circumcised, her parents, and/or her guardian", and the medical professional is obliged to provide information about the expected complication from the practice before its performance. Article no III Also, there is "consent from the woman who is going to be circumcised, the parents, and/or her guardian(s) shall be obtained according to the laws and regulations".

Articles no IV, V & VI provide standards and guidelines on how health professionals can perform the practice. This issue was a complete reversal of the existing government plan for the practice in 2006. This ruling overturned an existing ban on the practice under pressure from Indonesia's largest Muslim cleric body, The Majelis Ulema, which produced a fatwa in 2008 arguing for the government to repeal the FGM banning. This 'compromise' by the government resulted in overturning the existing ban while also introducing legislation stipulating that FGM must only be performed under medical supervision and only in accordance with specific guidelines. The guidelines suggest performing Female Genital Cutting (FGC) in a way that "prevents harm to girls" by allowing only slight cutting or scraping of the skin and restricting the procedure to medical practitioners have been widely criticized. Proponents argue that medicalization of FGC would reduce physical harm, but many medical experts and human rights groups dispute this claim. They contend that medicalization does not mitigate the deeply traumatic psychological, cultural, and social consequences of FGC. Furthermore, these critics warn that the promotion of medicalized FGC may lead to an increase in the number of women and girls subjected to the procedure, as it normalizes and institutionalizes the practice, rather than eradicating it. Instead of protecting women's health, medicalizing FGC risks perpetuating its harmful effects, both physically and emotionally.

In early 2014, the Indonesian government revoked a 2010 law that had previously allowed Female Genital Cutting (FGC) to be performed in certain circumstances. The decision to revoke the law was based on the understanding that FGC does not have any medical justification or urgency.(196) The government stated that it would no longer condone the practice, signalling a shift away from any form of legal tolerance for FGC and reaffirming its commitment to protecting the health and rights of women and girls.(197) Critics have argued that the 2014 regulation is a step backwards rather than forward, as it still allows the practice of FGM to continue without direct state intervention or regulation and the practice will remain legally unaddressed.(198) The responsibility for taking further action lies with the Health Consultative Assembly, which has yet to establish a clear legal framework to regulate or prohibit FGC in the country.

The lack of concrete action at the time left the practice of Female Genital Mutilation (FGM) unregulated, potentially allowing it to continue despite the government's stated opposition. However, with the signing of Government Regulation No. 28/2024 in July 2024, there is now a real opportunity to protect young girls from this harmful practice. This regulation, which bans female circumcision for infants and children under the age of five, significantly increases the chances of reducing FGM's prevalence in Indonesia and ensuring better protection for future generations of girls. It marks a meaningful shift towards more effective action and stronger safeguards against the practice.

Community and National Efforts to Eliminate FGM

In its 2007 concluding observations, the CEDAW Committee recommended that Indonesia develop a plan of action to eliminate the practice of female genital mutilation, including implementing public awareness-raising campaigns to change the cultural perceptions connected with it and provide education regarding the practice to explain that it is a violation of the human rights of women and girls that has no basis in religion.(199) In 2008, the Committee Against Torture, in its examination of Indonesia called for the Government to “adopt all adequate measures to eradicate the persistent practice of female genital mutilation, including through awareness-raising campaigns in cooperation with civil society organizations. Also, in 2012 the CEDAW Committee expressed its deep concern about “the serious regression with regard to the practice” of FGM and particularly the Ministry of Health’s regulation authorizing certain medical practitioners to conduct FGM. It called on the Indonesian Government to “adopt robust legislation which will criminalize all forms of female genital mutilation, it went on to call for awareness raising and sensitization.

In 2013, The Ministry of Health's Research and Development Agency published the results of the Basic Health Research, which state that FGM is a high rate in the country, reaching up to 51.2% among girls aged 0 to 11 years. In 2015, UNFPA conducted an International Seminar and National Discussion on FGM (Social, Cultural, Religious, and Health Perspectives). The seminar was attended by religious leaders from different countries. They reflected the non-religious base of the practice and advocated for the practice elimination. Following that UNFPA and KPPPA developed a background paper for a policy brief on eradication of the practice of female circumcision (later called FGM/C) in Indonesia. In 2016 KPPPA implemented different activities to stop FGM practice. This included a qualitative study about the socio-cultural factor of the problem, with UFPA stakeholders mapping conducted. Also, guidelines for advocacy and an IEC pocket book for religious leaders concerning the prevention of FGM/C from the perspective of Islam developed.

In 2017 the joint UNFP/UNICEF initiative to eradicate FGM/C started. It was undertaken by many parties long before. led by many related government bodies; Bappenas, the Ministry of Women Empowerment and Child Protection, the Ministry of Health, the Ministry of Religious Affairs, the Ministry of Education and Culture, local governments, and Komnas Perempuan. A study about medicalization of FGM was conducted in 17 cities. following, guideline on advocacy about prevention for youth developed.

In 2018, a national meeting attended by religious leaders was held. training related to advocacy for prevention of GM/C for young facilitators conducted. Also, guidelines for advocacy strategy to communicate prevention of FGM/C for community organizations using a family approach. Medical guidelines, advocacy guidelines and IEC concerning prevention of FG M/C for healthcare personnel for Prevention of the Practice of FGM developed by Ministry of Health with other partners. In addition to that, the Policy Paper on Prevention of FGM/C in the educational environment was developed with the support of UNFPA.

In 2019, outreach programs were conducted in Pesantren and among youth, focusing on advocacy and awareness. Building on these activities, a nationwide outreach advocacy initiative targeted healthcare providers across ten provinces, utilizing advocacy guidelines and IEC brochures. Additionally, a pilot program addressing gender-based violence was implemented, employing a transformative gender approach. In 2020, the Ministry of Women Empowerment and Child Protection (KPPPA), with support from UNFPA, developed a Roadmap for the Prevention of FGM/C by 2030, along with an accompanying Action Plan. In 2021, a National Reference Group

Meeting on the Prevention of FGM/C was convened in Indonesia, engaging religious leaders to foster collaboration and support for the initiative.(200)

Community leadership and participation were the cornerstone of this initiative. The approach of this program is oriented toward building critical awareness about the dangers of FGM/C, through changes in perspectives about females' sex and sexuality, perspectives about religious interpretations and culture in connection with this issue, and changes in health behaviour.

FGM in Indonesia is deeply rooted in both cultural and religious beliefs, making it crucial to involve religious leaders in reshaping societal views on the practice. Religious leaders can play a key role by offering interpretations of religious texts that challenge the misconception that FGM is a religious obligation. By using their influence, they can help shift public understanding and promote the view that FGM is not mandated by religion.

After a prolonged struggle, Indonesia has taken the significant step of criminalizing the practice of FGM. While the strengths and limitations of the legislation remain unclear, its issuance marks a pivotal achievement. However, the country's plans and interventions lack a systematic and organized framework, which undermines progress. Despite concerted international and national efforts to eradicate FGM, deeply entrenched cultural and religious beliefs continue to sustain and perpetuate the practice. Moreover, challenges such as inadequate funding, corruption, and weak policy implementation further hinder the effectiveness of humanitarian and advocacy responses.(186, 187)

To address these challenges, Indonesia must strengthen enforcement mechanisms for existing laws, integrate FGM-related education into healthcare training, and support community-driven advocacy to dismantle cultural and economic drivers of the practice. Sustained efforts that align legal reforms with grassroots engagement are crucial to achieving lasting change and aligning with international human rights standards.(190, 201)

Conclusion and recommendations

Indonesia faces complex humanitarian and public health challenges, amplified by its geographic vulnerability to natural disasters, the impacts of climate change, and entrenched social inequalities. The persistence of Female Genital Mutilation (FGM), deeply rooted in cultural and religious beliefs, poses a significant challenge, with over 50% of girls under 12 years old undergoing the practice in some regions. Despite the recent signing of

Government Regulation No. 28/2024 banning FGM for children under five, enforcement mechanisms and societal norms continue to hinder progress.

Addressing these multifaceted challenges requires a comprehensive approach that combines legal reform, community engagement, and international collaboration to ensure long-term resilience and social transformation.

1. **Strengthen Legal Frameworks and Enforcement**
    - Implement robust mechanisms to enforce Government Regulation No. 28/2024, ensuring penalties for violators and consistent monitoring of FGM practices.
    - Develop a clear and comprehensive national strategy criminalizing all forms of FGM, supported by legislation that addresses both medicalized and traditional forms of the practice.
    - Provide training for law enforcement, healthcare providers, and judiciary personnel to ensure consistent application of the law.
2. **Expand Awareness and Education Campaigns**
    - Launch nationwide awareness campaigns targeting cultural and religious misconceptions about FGM, emphasizing its lack of basis in Islamic teachings and its harmful effects on health and well-being.
    - Integrate FGM education into school curricula, teacher training, and healthcare programs to foster a new generation informed about the practice's consequences.
    - Engage religious leaders to disseminate messages against FGM and promote culturally sensitive interpretations of religious texts.
3. **Enhance Healthcare Interventions**
    - Train healthcare providers to identify and manage FGM-related complications while equipping them with advocacy skills to discourage the practice.
    - Include FGM education as part of antenatal and postnatal care to inform parents and caregivers about its harmful impacts.
    - Expand access to healthcare in remote and rural areas to reduce reliance on traditional practitioners.
4. **Empower Communities and Women**
    - Support community-based initiatives, including peer education programs, to foster critical awareness about gender norms, sexuality, and the health risks of FGM.
    - Strengthen economic opportunities for traditional practitioners to provide alternative livelihoods, reducing their dependence on income from performing FGM.

- Promote women's leadership and participation in decision-making processes to challenge patriarchal norms and advocate for change.

5. **Enhance Data Collection and Research**
   - Establish regular, nationwide surveys to collect disaggregated data on FGM prevalence, practices, and attitudes to guide policy and interventions.
   - Conduct qualitative and quantitative studies to understand regional and cultural variations in FGM and evaluate the effectiveness of interventions.
6. **Address Broader Humanitarian Challenges**
   - Strengthen disaster preparedness and response systems, particularly in rural and vulnerable communities, to mitigate the impact of frequent natural disasters.
   - Tackle water scarcity and environmental degradation through sustainable resource management and community-led climate adaptation strategies.
   - Prioritize programs addressing maternal and child health, malnutrition, and gender-based violence to improve overall well-being.
7. **Foster International Collaboration**
   - Leverage partnerships with international organizations like UNFPA, UNICEF, and WHO to support capacity-building initiatives and resource mobilization for FGM eradication.
   - Align Indonesia's efforts with global human rights frameworks and commitments to the Sustainable Development Goals (SDGs), particularly Goal 5 on achieving gender equality.

NIGER

Background

Niger, a landlocked country in West Africa, shares borders with seven nations with much of its territory covered by the Sahara Desert. It has an estimated population of 27.2 million (2023 estimate), predominantly residing in the southern regions, with Niamey serving as the capital and largest city. The nation is ethnically diverse, comprising groups such as the Hausa (53.1%), Zarma/Songhai (21.2%), Tuareg (11%), and Fulani (6.5%).

Islam is the dominant religion, practiced by over 98% of the population, primarily Sunni Muslims. Christianity and indigenous beliefs constitute less than 2% of the populace.(36) Economically, Niger faces significant challenges, with a GDP of approximately $16.82 billion as of 2023.(35) The economy relies heavily on agriculture, livestock, and mining, particularly uranium. However, issues such as high poverty rates, limited access to education, and food insecurity persist.

Humanitarian Challenges

Niger is experiencing multiple humanitarian crises affecting millions. Armed conflict with extremist groups has caused widespread displacement, with over 370,000 people internally displaced and more than 320,000 refugees from neighboring countries. Food insecurity and malnutrition are at alarming levels, particularly among children, while climate-related disasters, including devastating floods, displaced more people and damaged the country’s infrastructure. Additionally, political instability following a 2023 coup has led to economic sanctions, worsening conditions. These factors combine to overwhelm Niger's resources, creating a critical need for international humanitarian aid.

Niger has witnessed a rise in sexual and psychological violence, particularly evident in cases of early marriage, which significantly affect physical integrity and health. The Constitution of Niger, adopted on 25 August 2010, underscores the nation's dedication to human rights as outlined in the Universal Declaration of Human Rights (1948), with particular attention to women's rights. It emphasizes the fight against violence targeting women and children, notably through Articles 14, 21, 22, 23, and 26. In line with this commitment, the Penal Code was amended in 2003, including specific provisions under Article 232 aimed at eradicating FGM.

In Niger, nearly 3 million people face food insecurity, and the number of displaced individuals has nearly doubled over the past year, with over 265,000 internally displaced. Thousands continue to cross the southeastern border, fleeing violence in Nigeria. Rising attacks on humanitarian workers and kidnappings have heightened insecurity, further complicating movement across the country. The COVID-19 pandemic has exacerbated needs and food insecurity throughout the Sahel, making access to vulnerable populations a top priority. Action Against Hunger, alongside other organizations, has engaged with the government to ensure adherence to international humanitarian law. In 2020, the organization undertook extensive activities, deploying multisectoral programs from its bases in Maradi, Tahoua, and Diffa. Recovery and resilience projects remain central, improving essential social services such as health, nutrition, water, sanitation, hygiene (WaSH), and food security and livelihoods (FSL). These efforts also strengthen decentralized state structures and community resilience through local engagement.

The three regions where Action Against Hunger operates—Maradi, Tahoua, and Diffa—are heavily affected by population displacement due to ongoing security conflicts in Nigeria, Mali, and Burkina Faso. The organization is committed to providing multisectoral and rapid health response mechanisms to meet the urgent needs of displaced populations. Interventions include emergency drug supplies, mobile clinics, distribution of shelter and non-food item kits, water trucking, rehabilitation of water points, and disinfection.

Food insecurity remains critical, driven by displacement, climate change, and the economic impacts of COVID-19. The nutritional situation is also dire, with only 58% of health infrastructures operational and 1 million people receiving less than 15 litters of water per day.

ALIMA in collaboration with its national partner BEFEN (Well-being of Women and Children in Niger), has been addressing a range of critical health issues in Niger, including maternity care, malnutrition, paediatrics, emergency response, and research. While their work is not specifically focused on FGM, it could have an indirect impact on women affected by FGM, particularly through improvements in maternal and child health services. In 2020, ALIMA and BEFEN cared for 30,292 children suffering from acute malnutrition and continued the "PB-mothers" project in the Maradi and Mirriah regions, which are affected by ongoing armed conflicts**.**

In these conflict-affected regions, such as Maradi and Mirriah, ALIMA and BEFEN have been part of a larger effort to strengthen community-based health surveillance systems. These initiatives, which involve a network of

community health workers, aim to ensure that women and children, including those impacted by harmful practices like FGM, receive the necessary care and support. Through the integration of community health workers into national surveillance systems, there is potential to address and prevent FGM as part of a comprehensive approach to improving public health.

Additionally, many humanitarian organizations are working to strengthen the national system of community-based epidemiological surveillance, particularly through the involvement of a large network of community relays. This system covers nearly all villages in the areas of intervention and builds the capacity of both community actors and the Ministry of Health to respond effectively to public health challenges.

Our review indicates that international support for health transformation in Niger's conflict zones is focused on improving health systems, including the supply and quality of care, the demand for services, and the development of human resources for health, along with improving governance and leadership.

Prevalence of FGM

FGM in Niger has a relatively low prevalence compared to other countries that have high prevalence rates in the region, such as Burkina Faso, where up to 76% of women are affected. Among women aged 15-49 in Niger, those living in rural areas are more likely to experience FGM (2.1%) compared to their urban counterparts (1.2%).(46) The prevalence in Niamey, the capital city, stands at 1.8%. Notably, nearly two-thirds of women from the Gourmantche ethnic group have undergone FGM. According to the 2012 Demographic and Health Survey (DHS 2012)(27), 2% of women aged 15 to 49 have undergone FGM. This represents a slight decrease from 2.2% reported in 2006 and 5% in 1998, indicating a downward trend over the years. This achievement can be attributed to the strong political commitment of Nigerien authorities, exemplified by the law enacted on June 13, 2003.

The prevalence of FGM is more closely linked to cultural and ethnic traditions than to religion in Niger. For instance, ethnic groups like the Gourmantché, who are more likely to practice FGM, are concentrated in certain regions, such as Tillaberi. In contrast, many other Muslim-majority regions have low or negligible rates of FGM. Type I and Type II are the most commonly practiced forms of female genital cutting (FGC) in Niger. However, Type IV (known in Niger as "Dangouria") is also practiced. 84.4% of FGM/C was carried out by traditional cutters. In Niger, FGM is rarely performed by doctors, nurses, or

other medical staff.(46) The practice remains deeply embedded in cultural traditions and is not recognized or supported by the medical community. The belief that FGM is a religious requirement, alongside broader support for the practice, is particularly pronounced in the Tahoua and Zinder regions. Overall, support for FGM tends to be higher in rural areas of Niger.(46) Socioeconomic factors in Niger strongly influence FGM prevalence. Lower income, less education, and rural residence are linked to higher FGM rates with an observed increase from 2006 to 2012, whereas higher socioeconomic status correlates with greater awareness and a lower likelihood of practicing FGM.(27)

While FGM prevalence decreased among those with no education, it rose in all other educational groups, especially among the highly educated. This pattern highlights the need for broad-based awareness campaigns that reach all education levels effectively and more research to better understand the driving factors behind FGM in Niger.

In Niger, FGM is predominantly performed on very young girls. According to the 2012 DHS, 75.7% of women aged 15–49 who have undergone FGM were cut before the age of five. This early age of cutting underscores the cultural entrenchment of the practice, as it is often carried out before girls reach an age where they can express personal consent or resistance.(27)

The most recent DHS conducted in Niger was the 2021 Malaria Indicator Survey (MIS), carried out from August to October 2021. However, it does not include data on FGM prevalence or attitudes. The most recent nationally representative data on FGM in Niger were collected in the 2012 DHS. Since then, there have been no comprehensive national surveys providing updated statistics on FGM prevalence in Niger.(27)

National Policies and Laws

The Constitution of Niger (2010)(202) includes several provisions that protect human rights, particularly those of women and girls but it doesn't prohibit violence against women, harmful practices or FGM. Article 11 imposes an obligation on the State to respect and protect the human person, ensuring fundamental rights and freedoms. Article 14 prohibits torture, slavery, and any cruel, inhuman, or degrading treatment or abuse, specifying that anyone found guilty of such acts will be punished according to the law. Article 22 requires the State to adopt public policies and other measures to eliminate all forms of discrimination against women and girls, and to combat violence against them in both their public and private lives. Additionally, Article 171 establishes that treaties or agreements that Niger has regularly ratified take

precedence over domestic laws, reinforcing the country's commitment to international human rights standards. These constitutional provisions serve as a strong legal foundation for protecting women and girls from violence and discrimination, including harmful practices such as FGM.

The main law prohibiting FGM/C in Niger is Law No. 2003-025 (the Penal Code),(203) adopted in June 2003. According to the law, article 232.1 defines FGM as 'any assault on the female genital organ by total or partial removal of any of its parts, by excision, infibulation, desensitization or by any other means. Article 232.2 criminalizes and sets out the punishments for anyone performing, attempting or assisting in the practice of FGM, including when the act causes the death of the victim. Anyone who violates this article will be sentenced to imprisonment of six months to three years and a fine of 20,000–200,000 francs CFA (US$35–347). If the FGM results in death, the perpetrator will be sentenced to a term of imprisonment between 10 and 20 years. Article 232.3 criminalizes and sets out the punishments for FGM when the perpetrator is a member of the medical or paramedical profession. For practitioners and assistants who violate this law, the maximum sentence will be carried out, and their professional license to practice will be withdrawn for a maximum of five years.

The law has contributed to reducing the occurrence of FGM across the country. However, significant gaps remain in its enforcement, particularly concerning mandatory reporting and cross-border FGM. The Penal Code does not explicitly criminalize the failure to report FGM or address cross-border practices. While Article 186 stipulates that individuals who are aware of a crime or an attempted crime must report it to the authorities immediately, it exempts spouses, relatives, and in-laws of the perpetrator or accomplices from this obligation. This exemption weakens the law's effectiveness in ensuring timely reporting and accountability in FGM cases, ultimately limiting its capacity to address and prevent the practice comprehensively.(204)

The Penal Code does not address cross-border FGM and neither criminalizes nor penalizes the practice when carried out by or on Nigerien citizens in other countries. Additionally, there is limited information on the extent to which cross-border movement for the purpose of FGM occurs in Niger. However, evidence indicates that FGM is predominantly practiced in regions bordering neighboring countries where FGM prevalence remains high, and legal frameworks and enforcement vary significantly. These areas include the Tillabery region, near the borders with Burkina Faso and Mali, and the Diffa region, bordering Chad and Nigeria. Reports from the United Nations have highlighted instances of traditional cutters crossing the Niger–Burkina Faso

border to perform FGM, underscoring the need for cross-border collaboration and strengthened legal measures to address this issue.(205)

Prosecutions for FGM/C in Niger remain rare, with limited details available on the cases or whether sentences were fully carried out. Public awareness of the legal protections is low, and both knowledge of the law and enforcement efforts remain weak across the country. Although the practice was officially criminalized in 2003, enforcement continues to face significant challenges. Despite these obstacles, the president of the Nigerien Committee on Traditional Practices has stated that the law has been effective in reducing FGM/C. Niger’s ongoing efforts position it as a potential leader in West Africa's fight to eradicate female genital mutilation. However, sustained action and strengthened enforcement are essential to achieve this goal.

Community and National Efforts to Eliminate FGM

The Ministry for the Advancement of Women and Child Protection is the primary government body responsible for coordinating efforts to end FGM in Niger. To address the practice within its cultural context, the government collaborates closely with the National Committee on Harmful Traditional Practices (CONIPRAT), which has been active since 1990. The Ministry supports CONIPRAT’s interventions, including the development of a social-change strategy in 2007, which was implemented through regional campaigns aimed at raising awareness of FGM's harmful consequences among key influencers such as local and religious leaders. CONIPRAT has also facilitated retraining programs and alternative livelihood schemes for traditional practitioners to discourage their involvement in FGM.

Despite the low prevalence of FGM among women aged 15-49, estimated at 2%, Niger has demonstrated a strong commitment to combating the practice through legal measures. The 2003 Penal Code (Law No. 2003-025) explicitly criminalizes FGM and imposes penalties on both practitioners and those who assist. However, gaps remain in enforcement, as the law does not specifically address cross-border FGM or mandate the reporting of incidents, limiting its overall effectiveness. Strengthening these legal frameworks and enforcement mechanisms is essential to sustain progress and ensure the complete eradication of FGM in Niger.

In 2018, the government collaborated with UNICEF as part of the UN Joint Program on gender equality, which was endorsed by all ministries and supported by NGOs and United Nations agencies.(34) FGM elimination interventions under this program focused on raising awareness and providing alternative livelihood options for traditional practitioners. These

efforts included engaging 218 villages in targeted activities to promote the abandonment of FGM.

Innovative outreach methods, such as "awareness caravans," were employed to reach remote communities and foster support for ending FGM. These caravans, accompanied by judges, not only addressed FGM but also educated women on broader gender-based violence issues prevalent in Niger. Additionally, widespread media campaigns in local languages played a vital role in amplifying these messages. Community radio, with 171 stations broadcasting in local dialects, proved particularly effective in reaching marginalized populations. Televised debates featuring key religious leaders and the distribution of informational cassettes further enhanced public understanding and engagement, demonstrating the government's commitment to utilizing diverse communication channels to combat FGM.(206)

In 2020, Niger launched a national program to promote women's leadership, aiming to empower women and enhance their participation in all sectors. Concurrently, the country continued to implement the "Adolescent Girls' Initiative," specifically designed to reduce the prevalence of FGM and address the unique challenges faced by adolescent girls. Additionally, Niger finalized its National Gender Policy, which seeks to reduce inequalities and inequities across all fields. This comprehensive policy includes a robust strategy for combating gender-based violence, with a dedicated framework for the period 2024–2028, reflecting the government's ongoing commitment to fostering gender equality and protecting women's and girls' rights.(207)

FGM in Niger shows that the country has made significant strides toward eliminating the practice, backed by a clear legal framework and active campaigns. The report suggests that continuous training for law enforcement, as well as expanded community education, could further strengthen Niger’s progress in ending FGM and safeguarding women and girls.(18)

Conclusion and recommendations

Niger has made significant progress in combating Female Genital Mutilation (FGM), with a relatively low prevalence of 2% among women aged 15–49. The government's strong legal framework, including the 2003 Penal Code, and proactive community engagement efforts, such as awareness campaigns and alternative livelihood programs for traditional practitioners, have been instrumental in driving this progress. Collaborative efforts with organizations

like CONIPRAT, UNICEF, and the UN Joint Program have further strengthened national strategies to eradicate FGM.
Despite these achievements, gaps remain in enforcement, particularly regarding cross-border FGM and mandatory reporting, and cultural and socioeconomic factors continue to sustain the practice in some areas. Sustained efforts and stronger legal and institutional mechanisms are essential to eliminate FGM entirely and ensure the protection of women and girls in Niger:

1. **Strengthen Legal Frameworks**
   - Amend the Penal Code to explicitly criminalize cross-border FGM and mandate the reporting of all FGM cases, including those by family members or close associates of the perpetrators.
   - Establish stricter penalties for non-compliance with FGM laws and ensure consistent enforcement across all regions.
2. **Enhance Enforcement and Monitoring**
   - Develop specialized training programs for law enforcement officers, judicial authorities, and healthcare professionals to improve the identification, reporting, and prosecution of FGM cases.
   - Introduce a centralized data collection and monitoring system to track FGM prevalence, enforcement of laws, and cross-border activities.
3. **Expand Awareness Campaigns**
   - Scale up community-led awareness campaigns that emphasize the harmful effects of FGM and debunk its cultural and religious justifications.
   - Utilize diverse communication channels, including community radio, televised debates, and social media platforms, to reach remote and underserved populations.
4. **Promote Gender Equality and Women's Empowerment**
   - Continue implementing the National Gender Policy and the "Adolescent Girls' Initiative," with a focus on reducing FGM prevalence and addressing other forms of gender-based violence.
   - Encourage women's leadership and participation in anti-FGM campaigns to empower them as key agents of change in their communities.
5. **Support Alternative Livelihood Programs**
   - Expand retraining and economic empowerment initiatives for traditional practitioners to provide them with viable income alternatives to FGM.
   - Collaborate with local communities to ensure these programs are culturally appropriate and sustainable.

6. **Engage Religious and Community Leaders**
    - Partner with influential religious and local leaders to challenge cultural norms and promote messages that FGM is not a religious obligation.
    - Facilitate regular dialogue between community leaders, government authorities, and NGOs to build consensus and encourage collective action against FGM.
7. **Increase International Collaboration**
    - Strengthen cross-border cooperation with neighboring countries to address the movement of traditional cutters and harmonize anti-FGM laws and enforcement mechanisms.
    - Seek additional international funding and technical support to sustain and scale up ongoing anti-FGM initiatives.

PAKISTAN

Background

Pakistan, situated in South Asia, spans an area of 881,913 square kilometers. Geographically, Pakistan is bordered by India to the east with a 2,912-kilometer shared boundary, Iran to the west with a 909-kilometer border, Afghanistan to the northwest with a 2,430-kilometer border, and China to the northeast along a 523-kilometer frontier. To the south, Pakistan’s 1,046 kilometres of coastline meet the Arabian Sea, providing a vital maritime link.(208)

Today, over 98% of Pakistan's population identifies as Muslim, with Sunnis comprising about 80% and Shias approximately 20%. Minority communities include Christians, Hindus, Buddhists, and the Kalash animists, who primarily reside in Chitral near the Afghan border. Pakistan’s governance system is defined by its Federal Parliamentary structure under the Constitution of the Islamic Republic of Pakistan. The President serves as the Head of State, while the Prime Minister, elected by the populace, acts as the Head of Government. Legislative functions are carried out by a bicameral Majlis-e-Shoora, consisting of the National Assembly and the Senate.(208)

As of 2023, Pakistan has a population of approximately 240.5 million,(35) making it the fifth-most populous country in the world. The nation's economy is significant in the region, with a Gross Domestic Product (GDP) of $338.37 billion (current USD) in 2023. Health spending accounts for 2.91% of GDP (2021), reflecting the country's ongoing efforts to address its healthcare challenges.(35)

Pakistan is home to a diverse range of ethnic groups. Punjabis make up the largest proportion of the population at 44.7%, followed by Pashtuns (15.4%), Sindhis (14.1%), Saraikis (8.4%), Muhajirs (7.6%), and Baloch (3.6%). Other ethnicities collectively account for 6.3% of the population, highlighting the country’s multicultural fabric.

Humanitarian Challenges

Pakistan faces a complex array of humanitarian challenges driven by political instability, natural disasters, economic pressures, and social inequalities. These challenges significantly impact the country’s vulnerable populations, including women, children, and displaced communities.

Pakistan hosts one of the world's largest refugee populations, primarily from Afghanistan. As of 2023, there are between 2.64 and 2.9 million Afghan refugees in the country, including 1.3 million registered individuals and 1.34 to 1.6 million undocumented or otherwise categorized refugees. In October 2023, the Government of Pakistan mandated that all undocumented immigrants, notably the estimated 1.73 million Afghan nationals, voluntarily depart by November 1, 2023, or face deportation. This directive resulted in the departure of over 350,000 Afghans by mid-November 2023.(209)

1. **Natural Disasters and Climate Change Impacts**: Pakistan is highly vulnerable to natural disasters, including floods, earthquakes, droughts, and heatwaves. The catastrophic 2022 floods displaced over 33 million people, destroyed homes and infrastructure, and caused widespread food and water insecurity. Climate change exacerbates these issues, with glacial melting, rising temperatures, and erratic weather patterns threatening agricultural livelihoods and intensifying resource scarcity. Rural communities, heavily reliant on farming, are particularly vulnerable, with many forced to migrate to urban areas in search of safety and opportunities.
2. **Displacement and Refugee Crises**: Pakistan is home to one of the largest refugee populations globally, primarily hosting over 1.4 million Afghan refugees. These populations, alongside internally displaced persons (IDPs) from conflict-affected regions such as Khyber Pakhtunkhwa and Balochistan, strain the country's already limited resources. Refugees and IDPs often live in overcrowded camps or informal settlements with limited access to basic services, including healthcare, education, and clean water. The protracted nature of these crises has created long-term challenges for humanitarian response and resource allocation.
3. **Gender Inequality and Gender-Based Violence**: Women and girls in Pakistan face significant gender inequalities, often exacerbated by cultural norms, economic disparities, and limited access to education and healthcare. Gender-based violence (GBV), including domestic violence, honor killings, child marriage, and harmful practices like Female Genital Mutilation/Cutting (FGM/C), persists in various regions. The patriarchal societal structure often restricts women's mobility, economic participation, and access to justice. Despite legal frameworks to protect women, enforcement remains weak, leaving many survivors of GBV without recourse.
4. **Food Insecurity and Malnutrition**: Food insecurity affects nearly 18% of Pakistan’s population, with malnutrition rates among children alarmingly high. According to UNICEF, 40% of children under the age of five experience stunted growth, while 18% suffer from wasting. These

challenges are linked to poverty, climate-related disruptions in agriculture, and inadequate social safety nets. The situation is particularly severe in rural areas, where subsistence farming is a primary livelihood and access to nutritious food is limited.

5. **Healthcare System Challenges**: Pakistan's healthcare system struggles to meet the needs of its rapidly growing population, especially in rural and underserved areas. High maternal and child mortality rates, outbreaks of infectious diseases such as dengue and polio, and limited access to clean water and sanitation are critical issues. The COVID-19 pandemic further strained the healthcare infrastructure, highlighting gaps in resources and service delivery. Women and children, particularly in remote areas, often lack access to prenatal and postnatal care, exacerbating health disparities.
6. **Education Disruption and Inequality**: Education in Pakistan is marked by inequities, with over 22.8 million children out of school, making it the world's second-largest out-of-school population. Girls are disproportionately affected due to cultural barriers, early marriages, and safety concerns, particularly in conflict-affected regions. Schools in rural and tribal areas often lack basic facilities and trained teachers, further limiting educational access and quality. Additionally, natural disasters and displacement frequently disrupt schooling for thousands of children.
7. **Conflict and Insecurity**: Armed conflicts and extremist violence in regions like Khyber Pakhtunkhwa, Balochistan, and the former Federally Administered Tribal Areas (FATA) have caused widespread displacement, loss of lives, and destruction of infrastructure. Civilians in these areas face ongoing threats from landmines, improvised explosive devices (IEDs), and sporadic militant attacks. The insecurity hinders humanitarian access and the delivery of essential services to affected communities.
8. **Economic Instability and Poverty**: Pakistan's economy faces persistent challenges, including high inflation, low foreign reserves, and soaring unemployment. Poverty affects nearly 40% of the population, with rural communities disproportionately impacted. Economic instability also limits the government's ability to invest in essential services such as education, healthcare, and disaster preparedness. Vulnerable groups, including women, children, and refugees, are particularly affected by the lack of economic opportunities and social safety nets.
9. **Humanitarian Access and Funding Gaps**: Delivering humanitarian aid in Pakistan is often hampered by security concerns, bureaucratic hurdles, and insufficient funding. Many international organizations face challenges in accessing remote and conflict-affected areas, leaving the most vulnerable populations underserved. Despite ongoing efforts by

the government and humanitarian agencies, the scale of Pakistan's crises often exceeds available resources, underscoring the need for sustained international support.

Prevalence of FGM

The practice of Female Genital Mutilation (FGM) in Pakistan is a significant yet under-recognized issue, occurring primarily within the Dawoodi Bohra community, particularly in Karachi. Girls as young as seven are subjected to FGM in secret, rendering them unable to resist or protest. This practice extends beyond Pakistani borders, as young British girls of Pakistani origin are reportedly brought to Pakistan by their families for the procedure. FGM has also been reported in some Muslim communities near the Iran-Pakistan border. Estimates suggest that up to 90% of Bohra girls undergo FGM, with approximately 1,000 girls affected annually.(46)

The Dawoodi Bohra community, numbering over a million people worldwide, is spread across 40 countries. While most members reside in India, significant populations are also found in Pakistan, Yemen, and the Middle East. In 2011, approximately 100,000 Dawoodi Bohras were estimated to live in Pakistan, primarily in the southern region. A survey conducted by Sahiyo on FGC among the Dawoodi Bohra in India revealed that 5.7% of respondents resided in Pakistan, while 14.2% reported undergoing the procedure there. Research by the Orchid Project has also highlighted that Bohra girls from countries where FGC is prohibited, such as the United States, have been taken to Pakistan for the procedure.(46)

FGM in Pakistan is justified by some as a cultural or religious tradition, although it lacks support in Islamic scripture, and most religious groups in the country do not practice it. Many Bohra women who have undergone FGM themselves continue to perpetuate it for their daughters, despite its violation of basic human rights.(46)

There is limited data available on the prevalence of female genital cutting (FGC) in Pakistan. Media reports have occasionally highlighted its occurrence, particularly within the Dawoodi Bohra community, which has historical ties to India. Among this community, the prevalence of FGC is estimated to range between 75% and 85%. If the practice in Pakistan mirrors that of the Dawoodi Bohra in India, it is likely more common among older women. For instance, one survey reported that 92% of women aged 46 and above had undergone FGC, compared to 68% of women aged 18–25.(46)

Sahiyo, derived from the Bohra Gujarati word for “saheliyo,” meaning friends, emerged in 2014 from a conversation between five women deeply concerned about the practice of ‘khatna,’ or Female Genital Cutting (FGC), within the Dawoodi Bohra community. They came together to create an organized and informed platform within the community to spark meaningful dialogue and drive a movement to end the harmful ritual of khatna.

In 2015, Sahiyo took a significant step by launching an online survey to collect data on FGC practices within the Dawoodi Bohra community, both in India and globally. This study marked a critical effort to fill the gap in knowledge about the prevalence of khatna, particularly Type I FGC, in these communities. The insights gathered aimed to inform the development of strategies to eradicate FGC, including the creation of hotlines for affected girls, educational resources for educators, healthcare workers, and law enforcement, public awareness campaigns, and securing funding to support these initiatives.

The survey titled "Understanding Female Genital Cutting in the Dawoodi Bohra Community: An Exploratory Survey," was conducted by Sahiyo to shed light on the practice of Female Genital Cutting (FGC) within the Dawoodi Bohra community. Published in February 2017 and authored by Maria Taher, this survey aimed to fill the gap in data and understanding of the prevalence and impact of FGC. Sahiyo sought to achieve several objectives through this study: to gather credible statistics on the prevalence of FGC among Dawoodi Bohra women, to examine its perceived physical, psychological, and sexual effects, and to explore the various justifications given for continuing the practice. Furthermore, the survey aimed to identify potential community-based interventions that could help end the practice.

The survey included 385 eligible participants, all of whom grew up in the Dawoodi Bohra community, with only responses from those meeting this criterion used for data analysis. Most participants (87%) were aged 18-45, and 13% were 56 or older. Nearly 80% of respondents held at least a bachelor's degree, a figure significantly higher than the global average, likely due to the survey's methodology. The majority of participants were married (76%), with 18% identifying as single.

While the survey offered critical insights, it faced significant limitations. First, its findings were generalized to the global Dawoodi Bohra community and were not specific to Pakistan. This limited its applicability for understanding FGC practices in a localized context. Additionally, participants were recruited using the snowball sampling method, which, while effective for accessing hard-to-reach populations, does not allow for random sampling. This

introduced bias and reduced the generalizability of the results across the broader community.

Another limitation was the survey's web-only administration, restricting participation to individuals with internet access, computer or mobile devices, and English language proficiency. This likely excluded lower-income community members who lack these resources, further limiting the study's representativeness. As a result, the conclusions drawn from this survey are best considered indicative trends rather than definitive findings. Sahiyo acknowledged these challenges and emphasized the need for further research using more sophisticated methodologies to obtain a more representative understanding of FGC within the Dawoodi Bohra community.

Despite these limitations, the survey marked an important step forward in addressing FGC. It not only highlighted the prevalence and effects of this practice but also laid the foundation for future research and community-based interventions aimed at promoting the abandonment of FGC.
A total of 80% of the survey participants, equating to 309 individuals, reported that they had experienced female genital cutting (FGC). In contrast, 20% of the respondents, or 76 individuals, indicated that they had not undergone the procedure. This indicates a significant majority of participants who have undergone FGC, while a smaller portion of the sample has not been affected by this practice.(46)

The figures indicate a clear trend where the likelihood of having undergone FGM increases with age. Among the youngest group (18-25), 68% of participants reported having undergone FGM, while 32% did not. In the 26-35 age group, 75% had undergone FGM, with 25% not affected by the practice. This trend continues with 78% of participants in the 36-45 age group reporting FGM, and only 22% having not undergone it. The highest prevalence is seen in the oldest group (64+), with 92% of participants reporting FGM, leaving just 8% who have not undergone the procedure.

These numbers highlight the generational difference in FGM prevalence, suggesting that the practice is more common among older generations and is likely to be less prevalent in younger groups. This shift may reflect changes in cultural practices, awareness, and possibly the influence of legal or societal efforts to reduce FGM in more recent years.

Seventy-four percent of women reported that they had undergone FGM performed by a traditional cutter. Meanwhile, 15% of respondents indicated that a health professional was responsible for the procedure. This group included 9% who were cut by a general practitioner or family doctor, 5% by a

gynaecologist, and 1% by a nurse. Additionally, 5% of participants were uncertain about who had performed the procedure. The remaining 6% of respondents selected the 'other' category, and upon further elaboration, it was revealed that they were cut by other women from the Dawoodi Bohra community, rather than by health professionals.

In the Dawoodi Bohra community, FGC typically involves the removal of part of the clitoral hood, which the World Health Organization classifies as Type 1 genital cutting. However, most survey respondents were uncertain about the specific procedure they underwent, with 65% indicating that they did not know. Among the remaining respondents, 21% reported that only part of their clitoral hood was removed. Five percent said their entire clitoral hood was removed, while another 5% noted that both the clitoral hood and part of their clitoris were cut. Three percent of participants reported that their entire clitoris was removed. The "other" category included three responses, two of which were non-responses, and one participant mentioned that her labia was also cut.

This data shows a wide range of experiences within the Dawoodi Bohra community, with many women unable to identify the exact procedure they underwent, while others reported variations of FGC. The findings emphasize the need for greater awareness and clarity around the practice, especially in communities where the procedure is culturally entrenched.

National Policies and Laws

Pakistan currently has no specific law prohibiting Female Genital Cutting (FGC), nor is the practice explicitly mentioned or recognized in any existing legal framework. However, *Article 332* of the Pakistan Penal Code (1960; amended 2012) provides that: “Whoever causes pain, harm, disease, infirmity, or injury to any person or impairs, disables, disfigures, defaces, or dismembers any organ of the body or part thereof of any person without causing their death, is said to cause hurt.” While this article does not explicitly address FGC, it could potentially be invoked to prevent, control, or punish the practice. However, the absence of clear recognition of FGC as a harmful practice under the law leaves gaps in its effective enforcement and accountability.

In 2006, the Government of Pakistan acknowledged the existence of FGC by including its eradication as a goal in the National Plan of Action for Children, targeting its elimination by 2010. Unfortunately, this was the only government document to explicitly address FGC, and the objective was not effectively implemented. Despite its inclusion in the national plan, FGC

remains widespread in certain communities, reflecting a lack of follow-through and prioritization of the issue.

Pakistan has ratified key international human rights instruments, including the Convention on the Rights of the Child (CRC) in 1990 and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1996. However, FGC was not specifically referenced in Pakistan's fourth periodic report to the Committee on the Elimination of Discrimination Against Women (2013) or its fifth periodic report to the Committee on the Rights of the Child (2016). This lack of focus on FGC in these reports suggests that the practice is not yet regarded as a priority issue in Pakistan's human rights agenda, further limiting progress in its eradication.

To comprehensively address FGC, Pakistan would need to take deliberate steps to integrate the issue into its legislative framework, strengthen enforcement mechanisms, and ensure that it is systematically addressed in human rights reporting and national development plans.(210, 211) Regrettably, the alternative report (commonly referred to as a shadow report) submitted to CEDAW in response to Pakistan's fourth periodic report did not include any mention of the practice of Female Genital Mutilation (FGM) in the country. Similarly, UNICEF's 2012 report titled "Situation Analysis of Children and Women in Pakistan" also omitted any reference to FGM.

This lack of recognition of FGM as a harmful practice by NGOs, INGOs, UN agencies, and the Government of Pakistan has resulted in the issue being overlooked by international monitoring bodies. Consequently, the CEDAW Committee and other related bodies did not address FGM in their deliberations or provide recommendations to Pakistan on this matter.

The absence of acknowledgement and advocacy around FGM in these reports and analyses highlights a significant gap in addressing this harmful practice, underscoring the need for stakeholders at all levels to actively document and advocate against FGM in Pakistan. Systematic inclusion of FGM in future reports and analyses is essential to ensure that this issue receives the attention it requires and to pave the way for meaningful recommendations and interventions.(212)

Community and National Efforts to Eliminate FGM

For Pakistan, there are some small-scale studies, media, academic and civil society reports that indicate a much broader problem, but the true scale of the problem remains unknown because of gaps in data. Pakistani government's lack of recognition and public dialogue on the FGM issue, there

remains no official laws, statistics, or empirical research about the ritual. There is no debate on FGM in the domains of government, political activism, or academia.(213) The only official document to address FGM in Pakistan was the National Action Plan for Children (NAPC), introduced in 2006. This initiative, presented by the federal government and supported by various health, educational, and social welfare institutions, included goal no 9: to "end harmful traditions or customary practices" by 2010, which encompassed female genital mutilation.(214) The NAPC proposed several strategies to tackle FGM, such as awareness campaigns, educating girls about the practice, and enacting new legislation. However, the plan lost momentum when the supporting institutions were dissolved, and responsibility for its implementation was passed to provincial governments.(212) Since then, no other national policy or government plan in Pakistan has specifically addressed FGM. There are no records or reports to indicate that any provincial government ever enacted any part of the NAPC, nor was the plan included in the compulsory report to the UN Committee on the Rights of the Child or the UN Convention on the Elimination of All Forms of Discrimination Against Women.(215) To date, there is no national policy, strategy, plan or initiative for FGM elimination in Pakistan.(210)

There are some anti-FGM organizations like Sayiho and We Speak Out, these two NGOs studied the FGM problem in the Dawoodi Bohra Community and this community’s beliefs with regard to the practice of FGM.(216) In 2017, another study about FGM in this community was published.(217) Grey literature is also a source of information about FGM in the country. Newspapers have been the primary medium discussing FGM in Pakistan. In 2011, an English-Pakistani newspaper called The Express Tribune reported on FGM being practiced within a small and insular community of Dawoodi Bohras.(218) Additional Pakistan news articles have since covered this topic.(219)

Pakistan presumably requires years to catch up and mobilize national action on FGM. It has been argued that without recognition, there can be no debate, research, or action at the community or government level. Khoso recommended legal reform, community mobilization, increased public awareness campaigns, and having the Pakistan Federal government decree FGM as a harmful practice.(212)

An anti-FGM movement slowly growing from within the Bohra community, often among younger females. Notably, five Dawoodi Bohra women created the organization Sahiyo in 2015 to end FGM by raising awareness about the harmful impact of FGM, through research, education, activism, and legislation.(220)

Conclusion and Recommendations

Pakistan faces a significant yet under-acknowledged issue with Female Genital Mutilation/Cutting (FGM/C), primarily concentrated within the Dawoodi Bohra community. Despite its presence, FGM/C is neither recognized nor addressed in Pakistan's legal framework or human rights reporting. The practice remains culturally entrenched, with little to no public debate or government action to confront it. While the National Action Plan for Children (2006) briefly included a goal to eliminate FGM, it lacked follow-through, leaving the issue largely unaddressed. This gap is exacerbated by insufficient data, lack of empirical research, and minimal advocacy efforts. Without acknowledgment at the governmental and societal levels, the eradication of FGM/C in Pakistan faces significant challenges.
To progress toward eliminating FGM/C, Pakistan must take concrete steps to recognize the issue, strengthen legal and policy frameworks, and engage communities in addressing cultural and religious drivers. Collaborative efforts between government, civil society, and international organizations are essential to ensure the protection of women and girls from this harmful practice.

By adopting the following recommendations, Pakistan can take meaningful steps toward acknowledging and addressing FGM/C. This would not only safeguard the rights and well-being of women and girls but also align the country with international human rights commitments and global efforts to eradicate FGM/C:

1. **Legislative Reform and Legal Recognition**
    - Enact specific legislation criminalizing FGM/C and include provisions for cross-border practices to prevent families from taking girls abroad for the procedure.
    - Amend existing laws, such as the Pakistan Penal Code, to explicitly define FGM/C as a harmful practice and outline penalties for practitioners and facilitators.
    - Mandate the reporting of FGM/C cases and hold healthcare professionals accountable if they are complicit in performing or enabling the practice.
2. **National Policy and Strategic Planning**
    - Revive and expand the National Action Plan for Children with a renewed focus on eliminating FGM/C.
    - Develop a comprehensive national strategy for addressing FGM/C that includes awareness campaigns, educational programs, and legislative enforcement.
    - Integrate FGM/C into existing policies on gender equality, child protection, and violence against women.

3. **Data Collection and Research**
    - Conduct nationwide, comprehensive studies to gather reliable data on the prevalence, distribution, and cultural drivers of FGM/C in Pakistan.
    - Establish mechanisms to systematically monitor and report FGM/C cases, ensuring robust data for policy-making and advocacy.
    - Support community-based research to understand the socio-cultural and religious justifications for FGM/C and develop tailored interventions.
4. **Community Engagement and Awareness Raising**
    - Partner with local religious leaders, community influencers, and NGOs like Sahiyo to challenge misconceptions and cultural norms supporting FGM/C.
    - Launch targeted awareness campaigns to educate communities about the physical, psychological, and social harms of FGM/C.
    - Provide alternative livelihood programs for traditional practitioners to discourage their involvement in FGM/C.
5. **Capacity Building and Training**
    - Train healthcare professionals, social workers, and law enforcement agencies to identify, prevent, and respond to FGM/C cases.
    - Integrate FGM/C education into medical and public health curricula to equip future professionals with the knowledge and tools to combat the practice.
    - Build the capacity of provincial governments to implement anti-FGM/C strategies effectively.
6. **International Collaboration and Reporting**
    - Include FGM/C as a priority issue in Pakistan's periodic reports to international human rights bodies, such as CEDAW and the Committee on the Rights of the Child.
    - Collaborate with international organizations like UNICEF and UNFPA to leverage resources, technical expertise, and global best practices for eliminating FGM/C.
    - Advocate for the inclusion of FGM/C in regional discussions on women's rights and gender-based violence to build cross-border solutions.
7. **Monitoring and Accountability**
    - Establish a dedicated task force within the Ministry of Human Rights or the Ministry of Law to oversee the implementation and enforcement of anti-FGM/C measures.
    - Strengthen judicial mechanisms to ensure timely prosecution of FGM/C cases and provide support for survivors seeking justice.

- Monitor progress toward the elimination of FGM/C through regular evaluations and public reporting, ensuring transparency and accountability.

OVERALL FGM PREVALENCE
Comparison and synthesis

The comprehensive analysis of the 12 countries involved in this study highlights significant links between GBV, literacy rates, economic indicators, poverty levels, and FGM prevalence. Countries with higher GBV, high illiteracy rates, weak economies, and high poverty levels exhibit high FGM prevalence, underscoring the impact of socio-economic and educational progress.

The data analysed in this section is sourced from the UNICEF Global Databases, 2024, which are compiled from reliable national surveys, including the Demographic and Health Surveys (DHS), the Multiple Indicator Cluster Surveys (MICS), and other national studies. These databases are recognized for their robust methodology and adherence to international standards, ensuring the quality and reliability of the information presented. They provide comprehensive insights into the prevalence and characteristics of FGM in countries where such data is available.

Data was examined for 12 countries. Among these, ten countries—Somalia, Mali, Egypt, Sudan, Ethiopia, Mauritania, Chad, Yemen, Iraq, and Niger—had available data in the UNICEF Global Databases. However, data for Pakistan and Indonesia were not included in the source due to the absence of relevant national surveys or data collection on FGM prevalence. This limitation underscores the need for expanded data collection efforts in these countries to enhance global understanding of FGM practices and trends.

The dataset has several limitations that should be considered when interpreting the findings. Some data refer to years or periods other than those specified in the column heading, and such data are excluded from the calculation of regional and global averages. Additionally, certain datasets differ from standard definitions or cover only a part of the country; while these may be included in the calculations if they fall within the noted reference period, they introduce variability and may affect comparability. Furthermore, in many cases, the data reflect the most recent year available during the specified period rather than being uniformly collected across the same time frame, leading to potential inconsistencies when comparing trends or making regional analyses. These limitations underscore the need for standardized and synchronized data collection to improve accuracy and reliability.

The association of the FGM prevalence with the main striking contextual factors found to have an impact on the country's prevalence of FGM (Figures 1-3 and Table 1).

Prevalence among girls and women aged 15 to 4G years

The data highlight significant variations in the prevalence of FGM among girls and women aged 15 to 49 years across ten countries. While Somalia exhibits the highest prevalence at 99.2%, almost universal among the demographic, countries such as Niger report the lowest prevalence at only 2%. These variations reflect differences in cultural, societal, and policy factors influencing the practice in each country. Notably, data for Pakistan and Indonesia are not available.

In Ethiopia (65.2%) and Mauritania (63.9%), FGM prevalence is moderately lower but still significant, demonstrating that while progress may have been made, the practice remains widespread. These rates suggest ongoing challenges in addressing cultural barriers and ensuring effective interventions to combat FGM. On the other hand, Chad (34.1%) and Yemen (18.5%) show further reductions in prevalence, possibly reflecting successful localized interventions, greater public awareness, or differing cultural perspectives that make FGM less pervasive.

Iraq, with a prevalence of 7.4%, provides a unique case, as the data reflects the entire country while FGM has been practised mainly in Kurdistan region. Niger stands out with the lowest prevalence of just 2%.

Countries with high prevalence, such as Somalia (99.2%), Mali (88.6%), Egypt (87.2%), and Sudan (86.6%), indicate that FGM is deeply entrenched in cultural traditions, societal norms, societal expectations, the perceived association of FGM with marriageability, family honor, and social acceptance. In all four countries, FGM is normalized within communities, making it difficult to challenge or abandon. Religious misconceptions also play a significant role, with many communities falsely linking FGM to religious obligations. Socioeconomic disparities further exacerbate the practice, as poverty, limited education, and rural residency perpetuate adherence to harmful traditions. Additionally, weak enforcement of anti-FGM laws and the medicalization of FGM, where healthcare providers perform the procedure under the guise of safety, undermine eradication efforts in these nations.

The lower prevalence of FGM in Iraq, Niger, and Pakistan is primarily due to its limitation to specific ethnic or cultural groups rather than being a widespread societal norm. For instance, in Iraq, FGM is concentrated in the Kurdistan Region among Kurdish communities, while it is nearly absent in Arab-

majority areas. Similarly, in Niger, the practice is primarily linked to specific ethnic groups, such as the Gourmantché, and is not prevalent among the larger Muslim population. In Pakistan, FGM is largely confined to the Dawoodi Bohra community, with no significant presence among the wider population. This localized nature of FGM helps keep national prevalence rates low, highlighting the importance of culturally specific interventions.

FGM Prevalence and Gender-Based Violence:

The correlation between FGM (Female Genital Mutilation) prevalence and gender-based violence (GBV) is striking, as similar socio-cultural and economic factors deeply influence both. High FGM prevalence is often accompanied by high rates of GBV, suggesting that societies where one form of gender-based violence is common are more likely to experience others. Countries with high GBV rates, such as Mali (GBV: 45%, FGM: 91.4%) and Sudan (GBV: 34%, FGM: 86.6%), typically have strong patriarchal structures that perpetuate both practices. The normalization of violence against women, whether in the form of FGM, domestic violence, or sexual violence, reflects entrenched gender inequalities and cultural beliefs that justify controlling and subjugating women.

In contrast, countries with lower GBV prevalence, such as Indonesia (GBV: 16%, FGM: minimal in urban areas), tend to have lower FGM rates, often due to progressive cultural norms, greater gender equality, and higher literacy levels. Indonesia’s lower GBV rate is associated with better access to education, healthcare, and economic opportunities, which also contribute to the decline in practices like FGM

When comparing FGM prevalence to gender-based violence (GBV), it is important to note that even countries with generally positive socio-economic indicators, such as Pakistan and Iraq, still experience localized issues with these practices, particularly within specific communities. These affected communities often have higher rates of FGM and GBV despite the national averages not reflecting such a severe situation. This illustrates how cultural practices that persist in certain regions or communities can overshadow economic development and progressive policies.

In Pakistan, while the country generally has good indicators in terms of literacy rates and economic development, the Dawoodi Bohra community still practices FGM, with estimates suggesting that 90% of girls within this group undergo the procedure. This localized issue highlights the discrepancy between national data and the situation in specific communities. The Bohra community's adherence to this practice is deeply rooted in religious and

cultural beliefs, even though Pakistan, as a whole, has made significant strides in terms of economic growth and educational improvements. The gender-based violence within this community is similarly high, as women are often expected to conform to these traditional practices. This stark contrast suggests that while national indicators may reflect positive trends, FGM and GBV remain prevalent due to the cultural and religious norms that dominate in these localized communities

Similarly, in Iraq, despite having relatively higher GDP per capita and literacy rates, Kurdistan faces a similar situation with FGM prevalence. Kurdish communities in this region report FGM rates of around 37%, which is significantly higher than the national average for Iraq. While the rest of the country benefits from economic growth and improved education, Kurdistan continues to struggle with traditional gender norms that justify FGM and other forms of gender-based violence. The Kurdish culture places a strong emphasis on family honour and traditional gender roles, which contribute to the persistence of these harmful practices. In contrast to the overall improvements in the Iraqi economy, this disparity in Kurdistan suggests that the economic development of a nation cannot completely eliminate cultural practices, especially when these practices are upheld by strong regional identities and social norms

Thus, while economic indicators such as GDP per capita, education, and poverty levels offer a broad picture of a nation's progress, they do not always account for the localized persistence of practices like FGM and GBV. Addressing these issues requires culturally sensitive interventions that consider both socio-economic progress and the deeply ingrained cultural norms that continue to perpetuate violence and discrimination against women in certain communities.

FGM Prevalence and social determinants:

A strong negative correlation persists between FGM prevalence and literacy rates. Countries such as Indonesia (95.7%) and Iraq (85.6%), with high literacy levels, report minimal FGM prevalence. In contrast, countries with low literacy rates, like Somalia (37.8%) and Chad (22.3%), continue to have higher FGM rates. These findings emphasize the transformative power of education in combating harmful practices. A positive correlation between poverty and FGM prevalence remains evident. Sudan, with a poverty rate of 57%, alongside Somalia (73%) and Yemen (48.6%), experiences high FGM prevalence. These statistics reinforce the connection between economic challenges and the persistence of traditional practices, including FGM. Conversely, countries with

lower poverty levels, such as Indonesia (9.8%), have significantly lower FGM prevalence.

FGM prevalence decreases as GDP per capita increases. For example, wealthier countries like Iraq ($5,512) and Egypt ($3,512) have lower FGM rates compared to Somalia ($644) and Yemen ($533). This trend suggests that economic development fosters improved access to education and healthcare, reducing FGM prevalence.

Religious interpretations continue to play a crucial role in shaping FGM prevalence. Countries like Indonesia, where progressive religious interpretations prevail, show reduced FGM rates. In contrast, countries such as Somalia and Sudan, where more traditional religious beliefs dominate, have higher FGM rates. This underscores the importance of religious dialogue in challenging FGM-supportive norms.

The interconnected nature of education, poverty, and religious beliefs is evident. Higher literacy rates are often associated with lower poverty levels and progressive religious views, all of which contribute to reducing FGM prevalence. Conversely, countries facing economic and educational challenges, like Sudan and Somalia, continue to struggle with high FGM rates.

The inclusion of gender-based violence (GBV) as a comparative parameter offers valuable insights into the socio-cultural and economic factors shaping Female Genital Mutilation (FGM) prevalence. Both practices are deeply rooted in patriarchal norms and traditional practices, creating overlapping patterns in many regions. Countries with high GBV prevalence, such as Mauritania (46%) and Iraq (46%), often report notable FGM rates, particularly within specific regions or communities. Similarly, Somalia, Sudan, and Mali, where GBV prevalence ranges from 34% to 45%, show extremely high FGM rates (above 85%). This correlation underscores the role of cultural traditions and the lack of gender equality initiatives in perpetuating both practices.

In contrast, Indonesia demonstrates the lowest GBV prevalence (16%) alongside minimal FGM cases in urbanized areas, highlighting how economic development, education, and progressive social norms can help mitigate both GBV and FGM. However, this is not universal. Yemen (GBV: 26%, FGM: 18.5%) and Chad (GBV: 29%, FGM: 38.4%) reveal that, even with lower FGM prevalence, systemic inequalities sustain high GBV rates. Similarly, Pakistan, with a GBV prevalence of 28%, shows isolated but alarmingly high FGM prevalence among the Dawoodi Bohra community, emphasizing the influence of minority cultural practices. Iraq’s Kurdistan Region provides

another example of the intersection of GBV and FGM within specific ethnic and cultural groups, despite national progress in economic and educational indicators.

These findings reveal that while socio-economic factors like literacy and GDP per capita play a role in influencing FGM and GBV prevalence, they are insufficient on their own. Cultural norms and traditions often persist in the absence of targeted interventions. Addressing these issues holistically requires tailored strategies that focus on raising awareness, promoting education, and enforcing anti-violence laws. Community-driven advocacy and culturally sensitive approaches are essential to challenge entrenched norms, foster gender equality, and ultimately reduce both GBV and FGM on a global scale.

A comprehensive analysis of the updated data reveals significant correlations between FGM prevalence and socio-economic indicators such as gender-based violence, literacy rates, GDP per capita, poverty levels, and religious beliefs. Gender-based violence (GBV) shows a similar pattern, with higher GBV rates often coinciding with high FGM prevalence in regions where gender inequalities are deeply embedded. Countries with lower economic development and education levels also tend to have higher GBV rates, highlighting the need for holistic approaches that address both FGM and GBV together Countries with higher literacy rates, such as Indonesia and Iraq, exhibit lower FGM prevalence, highlighting the role of education in raising awareness and challenging harmful traditions. Conversely, nations like Somalia and Chad, with low literacy rates, show significantly higher prevalence. Similarly, poverty is positively correlated with FGM; countries with higher poverty rates, including Somalia, Sudan, and Yemen, tend to have higher FGM prevalence, while wealthier nations like Indonesia, with lower poverty levels, report lower rates. GDP per capita also shows a negative correlation with FGM, as countries like Iraq and Egypt, with higher GDP per capita, exhibit reduced prevalence compared to economically disadvantaged countries like Somalia and Yemen. Religious beliefs further influence FGM rates; progressive interpretations, as seen in Indonesia, are associated with lower prevalence, while traditional beliefs in countries like Sudan and Somalia contribute to higher rates. These findings emphasize the interconnectedness of education, economic conditions, and cultural factors in shaping FGM prevalence.(221, 222)

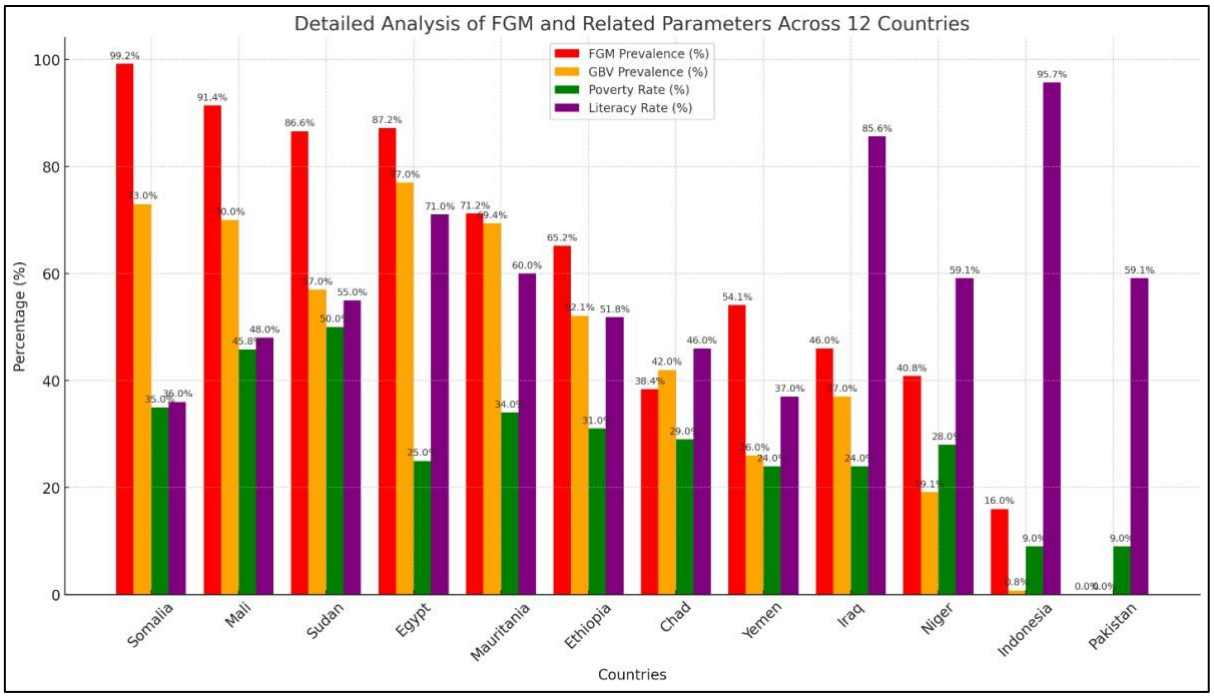

Figure 2. Comparison of FGM prevalence across 12 countries. (Source: UNICEF Global Databases, UN Women Global Database, WHO Factsheets, World Bank Data)

Country	Data source	Year of survey	FGM/C prevalence (%)	Females population (15-49) (in thousands)[1]	Estimated number of FGM/C affected (in thousands)
Chad	DHS	2014-15	38.4	3215	123454
Egypt	DHS	2015	87.2	25011	2180984
Ethiopia	DHS	2016	65.2	25546	1665622
Indonesia	Basic Health Research Survey (Riskesdas)	2013	51.2*	68774	10448
Iraq	MICS	2011	8.1**	7995	1467
Mali	DHS	2012-13	91.4	3777	345219
Mauritania	MICS	2011	69.4	836	58010
Niger	DHS	2012	2	3656	7312
Pakistan***	N/A	N/A	N/A	N/A	N/A
Somalia	MICS	2006	97.9	2351	230178
Sudan	MICS	2014	86.6	9278	803484
Yemen	DHS	2013	18.5	7142	132126

* Prevalence data is for (0 - 11) age group.

** Prevalence data is for the whole country while the practice is mostly prevalent in Kurdistan region.

*** No data available.

1 source: UN Department of Economic and Social Affairs (https://population.un.org/wpp/Download/Standard/Population/)

Table 2. FGM prevalence and sources of data across 12 countries. (Source: UN Department of Economic and Social Affairs)

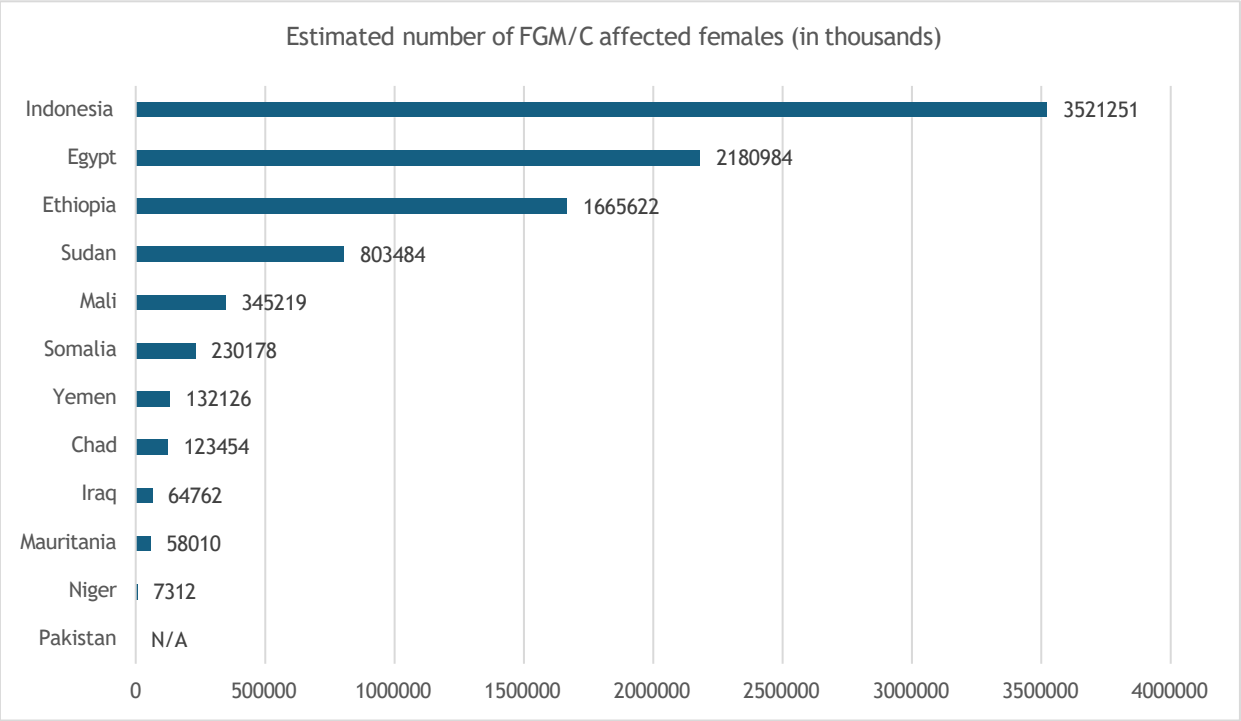

Figure 3. Estimated number of FGM/C affected females (in thousands) across 12 countries. (Source: UNICEF Global Databases, UN Women Global Database, WHO Factsheets, World Bank Data)

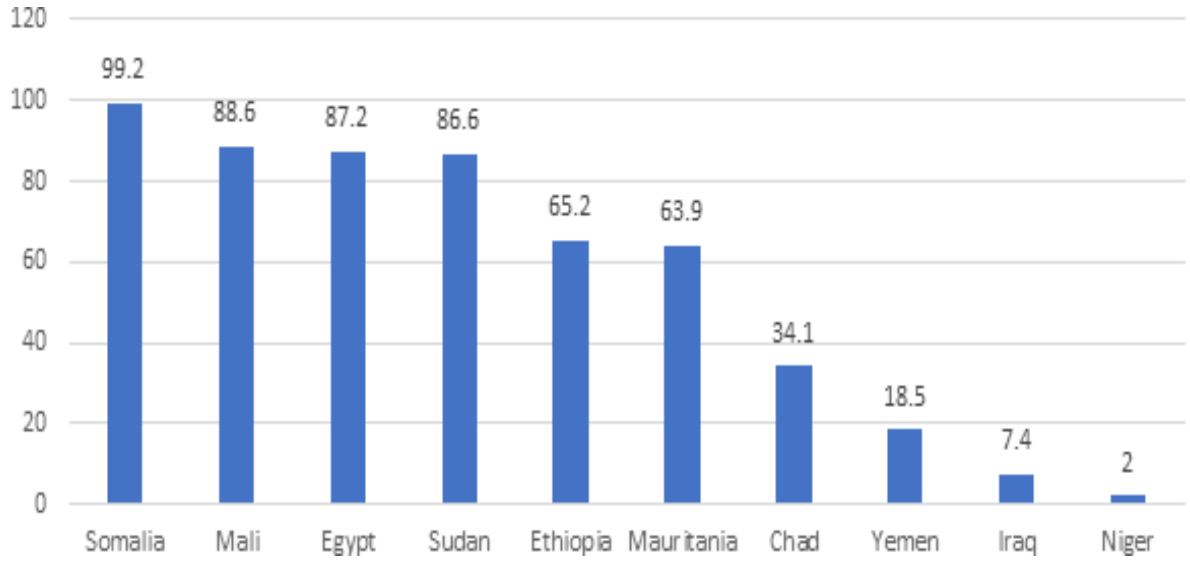

Figure 4. Comparing the prevalence rate of FGM among females aged 15-49. (Source: UNICEF Global Databases, UN Women Global Database, WHO Factsheets, World Bank Data)

Challenges and Strategic Pathways

Humanitarian crises, whether caused by natural disasters, human-made catastrophes, or complex emergencies, have become more frequent and prolonged in recent years, leading to an increased likelihood of more countries experiencing such crises in the future, obviously, this happening in many countries now. Gender-based violence (GBV) is a pervasive issue within all types of crises, with displaced populations, particularly women and children, being at heightened risk. These displaced individuals often endure physical, social, and emotional upheaval, exacerbating their vulnerability. They frequently lack access to essential services, including healthcare, education, and legal support, which are crucial for their protection from GBV practices like FGM.(34)

In some countries, during the humanitarian crises, there was a marked increase in FGM cases due to school closure, while in some other contexts, it gave rise to earlier cutting seasons.(223, 224) Also, the increased militarization, lack of community and State protections, displacement, scarcity of essential resources, and disruption of community services are increasing the incidence of FGM(225) as a type of GBV. Social issues are key factors such as social belonging and identity, marriageability, social pressure, changing cultural and gender norms, disrupted and weakened relationships, and the perception that the practice promotes cleanliness (226-229) and protection from sexual violence.(168)

The practice of FGM in humanitarian settings significantly increases the risks for women, especially in environments with poor hygiene, such as overcrowded camps or unprepared shelters. In these conditions, the lack of proper medical equipment, sanitation, and infection control makes women more susceptible to infections and other complications following FGM. Additionally, in settings where women are already subject to violence and rape, FGM can compound the harm, leading to severe pregnancy-related complications, particularly for young girls.

In some displaced communities, women and girls may undergo FGM on their daughters to adapt to the cultural norms of their new environment where FGM is highly practiced.(230) Facing pressure to conform, they may perceive FGM as necessary for social acceptance. This highlights the need for targeted interventions that protect displaced populations from harmful practices like FGM, while promoting awareness and cultural sensitivity to safeguard the health and rights of women and girls.

FGM also exacerbates the risks during childbirth, increasing the likelihood of obstructed labour, haemorrhage, and other life-threatening complications. The intersection of FGM and the challenging conditions in humanitarian crises underscores the urgent need for targeted interventions that not only prevent the practice but also ensure proper healthcare and support for women who have already undergone FGM, protecting their health and well-being in such vulnerable situations.

As a result, addressing FGM and ensuring the provision of adequate support systems for vulnerable groups during humanitarian crises is paramount. Strengthening these interventions and safeguarding the rights of those most at risk, especially women and children, will be critical to improving outcomes for affected populations and building resilience in the face of future crises.

FGM interventions in humanitarian settings face significant challenges due to a combination of context-specific factors, the nature of the FGM problem, and the inherent limitations of emergency response programming. During crises, communities and authorities are often focused on life-saving interventions and addressing the immediate needs of vulnerable groups, leaving issues like FGM and broader gender inequalities under-prioritized. This lack of attention is compounded by inadequate human and financial resources to effectively prevent, mitigate, and respond to gender GBV in general and FGM mainly.

Furthermore, funding for FGM and GBV interventions in humanitarian settings is often insufficient, and when available, it is typically short-term and inflexible, failing to address the long-term needs of vulnerable groups, especially young girls. Internally displaced adolescent girls are particularly marginalized, as they often lack safe spaces to voice their concerns or hold governments and humanitarian actors accountable for their commitments.(231) Their age and gender further isolate them, depriving them of access to essential information on their rights and available support services.

National system capacity is the cornerstone to having effective GBV programming in general and FGM, particularly in a humanitarian context. The capacity of the government, through its different horizontal and vertical layers, to work jointly with the nongovernmental sector, local community-based organizations and communities is critical to ensure the effective utilization and use of available resources. This also plays a role in having a comprehensive approach to addressing the whole dimensions of the FGM problem in terms of its prevention, management of its impact on individual females and the community and its complications.(225) This entails having

functioning community-based interventions, health, and legal support services for the victims and communities. This approach ensures that measures to protect women and girls are prioritized in national emergency response planning, programmes and budgets. A strong national system can play a role in assisting humanitarian actors and communities affected by armed conflict, natural disasters, and other humanitarian emergencies to coordinate, plan, implement, monitor and evaluate essential actions for the prevention and mitigation of FGM across all sectors of humanitarian response. Furthermore, working with international players helps in reflection and learning from international best practices. On the other hand, the strength of the national system creates context relevant services and ensures its sustainability during and after crises. Integrating FGM interventions into humanitarian plans requires anticipating, contextualizing and addressing factors that may contribute to the problem in certain contexts, such as societal, community or parent/family perceptions and beliefs.

Learning from the humanitarian approach and its way of work, FGM interventions can plan and intervene not only to meet the immediate needs of the affected populations, but also implement strategies—as early as possible in any humanitarian action—that promote long-term social and cultural change towards behaviour and perception change, and information sharing about FGM and gender equality. Such strategies include ensuring leadership and active engagement of women and girls, along with men and boys, in community-based groups related to the humanitarian area/sector; conducting advocacy to inform about FGM and its complications and impacts on women; and enlisting females as programme staff, including in positions of leadership.
According to UNJP 2023 report, with current countries' performance, no country involved in this study will eliminate FGM by 2030, and those who are not part of the UNJP program are even lagging behind in paying attention to the problem or addressing it properly.

Almost in all these countries, FGM elimination is led by national committees that coordinate sectors work to address FGM, and some don't have designated responsible authority. This situation leaves the FGM responsible committee –if available- without full authority to impose inclusion or support of FGM planning in these sectors plans. Also, this structure narrows down the committee's role towards coordination only. This structure leaves the FGM responsible body without the designated accountable staff, who engage and work with communities to implement activities or give feedback regularly about interventions implementation. The absence of intermediate or locally accountable staff within the existing hierarchical structure disrupts the planning, implementation, and re-planning cycles, while significantly

undermining the monitoring and evaluation of activities. This structural gap explains, in part, why FGM remains highly prevalent in affected countries despite decades of efforts and interventions aimed at its elimination.

A significant shift in the current approach employed by the countries involved in this study is essential to achieve substantial progress in eliminating FGM within a reasonable timeframe. This shift should prioritize the establishment of a comprehensive national program for FGM elimination, with a clearly defined and accountable governing body extending from the national to intermediate and local levels. This fully structured body would be responsible for developing a cohesive national policy and a strategic plan for the next seven years aimed at eradicating FGM. Furthermore, national governments, in collaboration with partners and civil society organizations, must allocate dedicated budgets to support and sustain the implementation of this program.

With the allocated budget, the program should develop and implement a comprehensive national plan for FGM elimination in collaboration with all sectors, partners, and communities. This plan must include targeted interventions to address gaps in the country's performance in eradicating FGM. In addition to, formulating a clear and, where necessary, unified policy, the development of a robust legal framework is essential to provide the foundation for FGM elimination efforts. This programmatic approach would enhance government commitment to the cause, holding them accountable for ensuring adequate support, taking decisive actions to scale up current efforts, and systematically monitoring and evaluating the implementation of policies, strategies, and plans.

The national plan for FGM elimination needs to address the FGM problem in context relevant manner. Therefore, regional variation and differences should be considered in design of the strategies and selection of the activities and approaches used to prevent or mitigate FGM. This approach helps in selection of the interventions that deal with root causes of FGM that is culturally sensitive to suits the affected communities', and lead to their mobilization and sensitization.

The countries examined in this study exemplify the challenge of addressing high FGM prevalence within the context of complex humanitarian crises. These nations operate in prolonged emergency settings characterized by institutional and social disruption, widespread poverty, food insecurity, and significant population displacement, both internally and across borders in search of safety. The overwhelming nature of these crises, coupled with severely weakened development indicators, has significantly influenced their

capacity, commitment, and effectiveness in implementing and sustaining efforts to eliminate FGM.

The UNJP program advocate to adoption of humanitarian-development and peace nexus approach to deal with FGM in humanitarian context/countries. However, this approach is not yet implemented in most of these countries. UNJP should actively mobilize the countries to develop humanitarian-development and peace nexus at national level and move to its activation at local level. In this report we recommend adoption of the nexus approach in all countries of high FGM prevalence. This entail development of coordination between the nexus clusters, organizations and teams at national and down to local and community level. Forums for dialogue, information sharing and comparative advantages understanding should be held regularly to create teams' harmony and improve nexus teams joint working. Capacity building of humanitarian teams on FGM problem helps in their active participation in FGM intervention integration in humanitarian plan and can contribute to its implementation and monitoring and evaluation. Also, understanding of the humanitarian teams of FGM interventions helps in bridging the gap between the nexus teams in planning, implementation and monitoring. FGM suggested program teams at local level will play vital role in operationalization of FGM integrated intervention in humanitarian plans. Also, FGM teams can provide technical support and capacity building to other nexus teams at local level and participate in monitoring and evaluation and reporting.

The information gap is one of the major challenges that limit the national and international efforts to eliminate FGM. In some countries, FGM indicators were not included in national routine surveys, in some other countries, there is no detailed information about the regional prevalence of the FGM. There is a need to study the association of contextual factors like education, poverty and GBV on the FGM, especially in a humanitarian context. Assessment and evaluation of countries' policy in the elimination of the practice to oversee policy gaps and factors behind the stagnant prevalence of the practice in some countries despite the ongoing interventions. Also, assessment of the countries' interventions impact on the practice prevalence reduction. Assessment of the feasibility of the implementation of the nexus approach in a humanitarian context to address the FGM and oversee the needed reform to ease the nexus development, implementation and evaluation. Assessment and comparison of countries' experiences in developing and implementing multi-sectoral approaches and coordination on the FGM prevention and mitigation and reduction to see the strengths and limitations of these countries' approaches.

RECOMMENDATION AND WAY FORWARD

To address Female Genital Mutilation (FGM) effectively within humanitarian settings, the following recommendations are proposed, focusing on systemic reforms, evidence-based strategies, and multi-sectoral collaboration:

1. **Strengthen National Systems and Structures for FGM Elimination**
   - **Establish Comprehensive National Programs:** Develop well-structured national programs with a dedicated governing body that operates across national, intermediate, and local levels. These programs should be empowered to enforce inclusion of FGM elimination strategies in multi-sectoral plans.
   - **Develop Cohesive National Policies:** Design and implement a unified national policy and a seven-year strategic plan for FGM eradication. This should include context-sensitive approaches that account for regional variations and the cultural nuances of affected communities.
   - **Allocate Dedicated Budgets:** Governments must allocate specific, sustainable budgets to FGM elimination programs. Collaboration with partners, including civil society organizations, is critical to resource mobilization and effective utilization.
   - **Enhance Legal Frameworks:** Establish robust legal structures to support FGM elimination efforts. Laws should explicitly address FGM as a form of gender-based violence (GBV) and include provisions for prosecution, protection, and victim support.

2. **Integrate FGM Elimination into Humanitarian-Development-Peace Nexus**
   - **Adopt Nexus Approaches:** Countries with high FGM prevalence should implement the humanitarian-development-peace nexus model, fostering coordination between humanitarian, development, and peace actors.
   - **Operationalize Nexus Teams:** Create integrated teams at the national and local levels to plan, implement, monitor, and evaluate FGM interventions. Capacity-building initiatives should target humanitarian actors to enhance their understanding of FGM and its integration into broader plans.
   - **Promote Multi-Sectoral Coordination:** Establish forums for regular dialogue and information sharing among nexus clusters to harmonize efforts, share comparative advantages, and improve joint action.

3. **Focus on Prevention and Long-Term Social Change**
   - **Behavioral Change Interventions:** Implement strategies to shift social norms, including community mobilization and education campaigns, targeting the root causes of FGM such as marriageability, social belonging, and misconceptions about cleanliness and protection from sexual violence.
   - **Engage Communities:** Ensure women, girls, men, and boys actively participate in community-based groups addressing FGM and GBV. Leverage these groups to promote awareness and advocacy for gender equality and women's rights.
   - **Gender-Responsive Programming:** Include women in leadership roles within program teams to enhance trust and effectiveness in community-level interventions.

4. **Address the Information Gap**
   - **Improve Data Collection:** Integrate FGM indicators into national surveys and routine data collection systems. Collect detailed regional data to inform targeted interventions.
   - **Conduct In-Depth Research:** Study the intersection of contextual factors—such as education, poverty, and GBV—with FGM prevalence, especially in humanitarian settings. Evaluate the feasibility of nexus approaches and assess gaps in existing policies and interventions.
   - **Monitor and Evaluate Interventions:** Establish mechanisms to systematically assess the impact of interventions, ensuring that strategies are adapted to reflect progress or challenges.

5. **Enhance Funding and Resource Mobilization**
   - **Ensure Long-Term Funding:** Advocate for sustained and flexible funding mechanisms for FGM interventions in humanitarian settings, addressing both immediate and long-term needs.
   - **Engage International Partners:** Strengthen partnerships with global stakeholders, including donors and international organizations, to align funding priorities with FGM elimination goals.

6. **Integrate FGM into Humanitarian Response Plans**
   - **Anticipate and Contextualize FGM Risks:** Include FGM interventions in emergency preparedness and response plans, addressing factors such as disrupted community norms, social pressures, and the needs of displaced populations.
   - **Provide Holistic Services:** Ensure access to health, legal, and psychosocial support for women and girls affected by FGM, particularly in overcrowded camps or unprepared shelters where risks are amplified.

7. **Promote Accountability and Transparency**
   - **Strengthen Governance:** Hold governments accountable for their commitments to FGM elimination by monitoring policy implementation and ensuring regular progress reporting.
   - **Involve Local Actors:** Equip local teams with the skills and resources necessary to implement, monitor, and evaluate FGM-related interventions. Their active involvement enhances accountability and ensures culturally relevant solutions.

Conclusion

Addressing FGM in humanitarian settings requires a paradigm shift in approach, focusing on sustainable, multi-sectoral collaboration and the integration of long-term strategies into humanitarian response frameworks. Strengthened national systems, informed by robust data and supported by international best practices, are essential to overcoming the socio-economic, cultural, and logistical challenges associated with FGM. The adoption of the humanitarian-development-peace nexus, coupled with targeted interventions and adequate funding, offers a pathway to protect vulnerable populations and accelerate progress toward the elimination of FGM. These collective efforts will not only address the immediate impacts of FGM but also contribute to fostering gender equality, improving health outcomes, and building resilience against future crises.

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