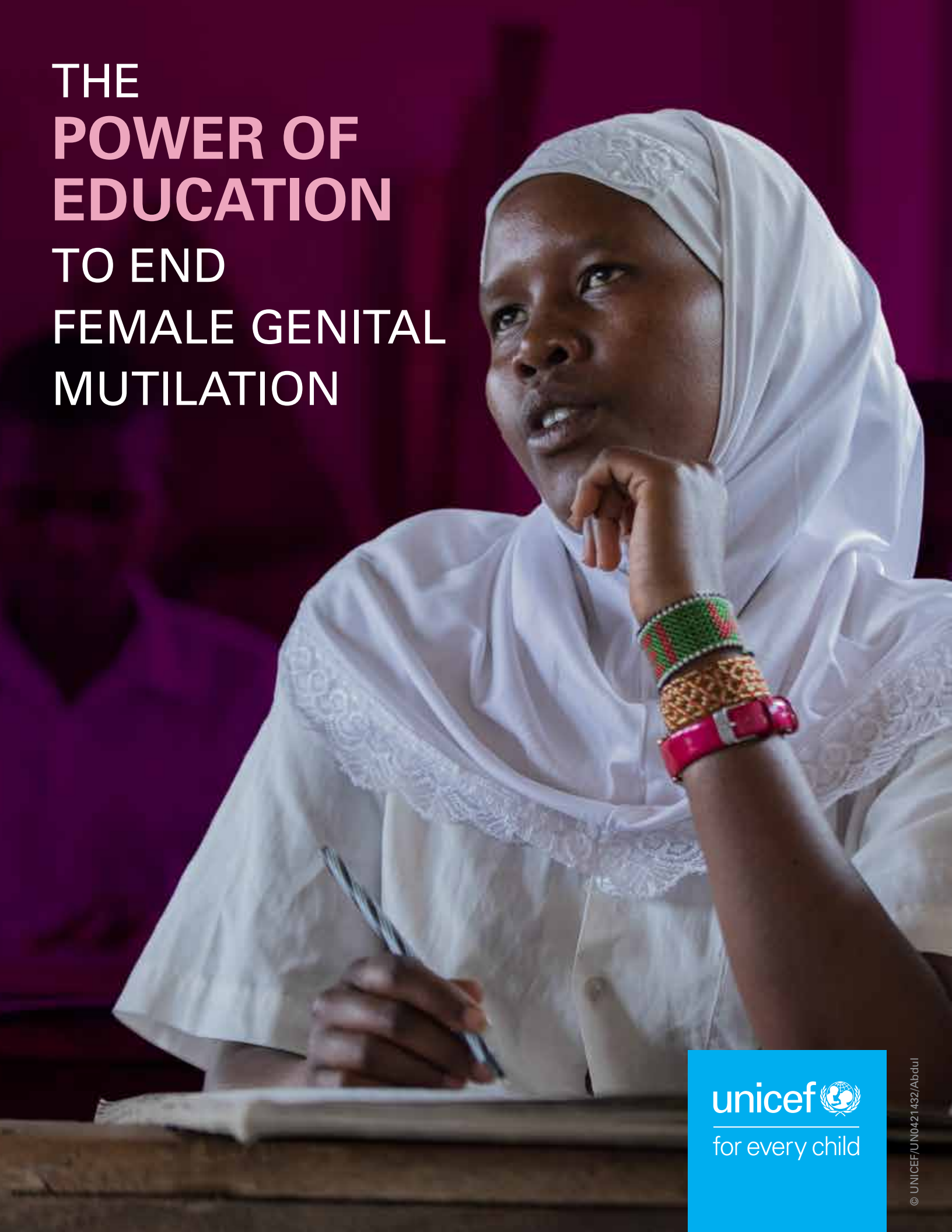

THE POWER OF EDUCATION TO END FEMALE GENITAL MUTILATION

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The practice of female genital mutilation (FGM) has proved remarkably tenacious, despite efforts spanning nearly a century to eliminate it. Nevertheless, a number of countries have seen some declines in the practice – at least up until the COVID-19 pandemic, the impact of which is yet to be fully understood. Other changes in FGM are also evident. These include shifts in attitudes and in the ways the procedure is being carried out.

As the world rallies to accelerate progress against FGM, understanding what drives change in how people think about the practice and act is key to its elimination. Education is one such driver. It is an important mechanism to increase awareness of the dangers of FGM and of groups that do not practise it. Education also fosters questioning and discussion and provides opportunities for individuals to take on social roles that are not dependent on the practice of FGM for acceptance.

The link between FGM and the education of girls and women rests on the assumption that educated women – as opposed to those with little or no education – will be less likely to have their daughters cut. One possible scenario is that, while in school, girls develop social ties with peers and mentors who are opposed to FGM. This could provide a reference group for which no normative sanctions exist for failing to comply with FGM. Educational settings may also provide an opportunity for discussion and a social environment conducive to the formation of new ideas. Additionally, educated women may have greater exposure to intervention programmes, media messages and local and international discourse that denounce the practice, potentially creating sanctions for continuing FGM.

FGM most commonly occurs well before girls complete their schooling. Therefore, the level of education they achieve will not affect their FGM status. Moreover, girls are not usually involved in the decision-making process regarding their own cutting. A more useful analysis of the association between education and FGM status focuses instead on the decisions in which women may be involved, namely the cutting of their daughters. However, because women who are more educated are likely to be younger, wealthier, live in urban areas and have younger daughters, caution needs to be taken in interpreting the findings since other factors may also be at play.

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FGM affects millions of girls and women from diverse backgrounds

At least 200 million girls and women alive today have been subjected to FGM.

This estimate is based on 31 countries with nationally representative data on the practice. Additionally, small-scale studies indicate that FGM exists in communities in at least 20 more countries around the world, where the exact number of girls and women who have experienced FGM remains largely unknown.

There are wide variations in prevalence across countries. FGM is almost universal in Somalia, Guinea and Djibouti, while it affects no more than 1 per cent of girls and women in Cameroon and Uganda.

Across contexts, the practice is closely tied to ethnicity. Many countries include both ethnic groups that practise FGM universally and others in which the practice is virtually non-existent.

FGM is in decline in many places, but progress is not fast enough

FGM has persisted for centuries but is becoming less common.

Evidence shows the practice is declining in areas where it was once universal – Egypt and Sierra Leone, for example – as well as in countries where it only occurred in a few communities, such as Kenya and Nigeria.

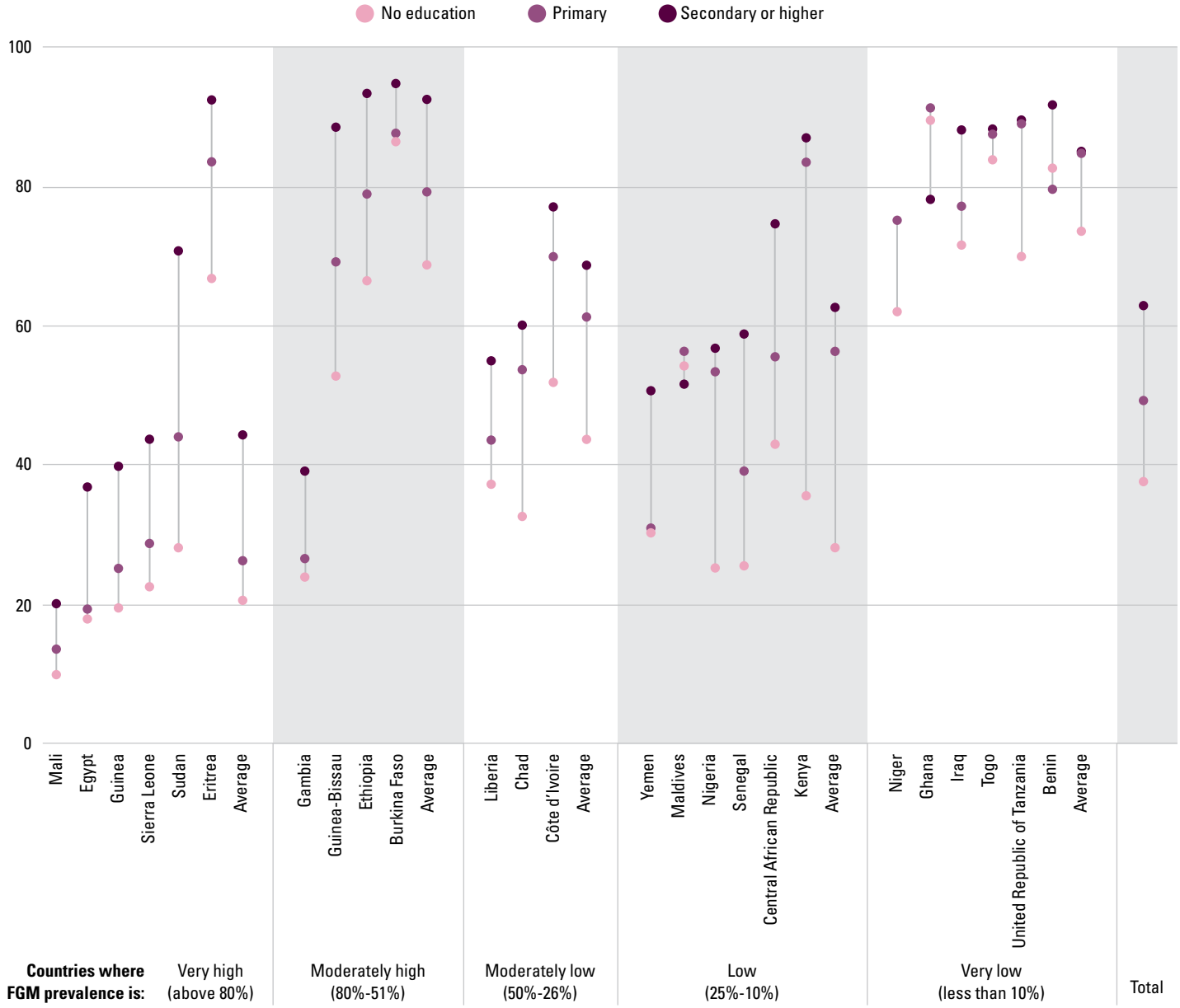
However, progress is not happening everywhere. In many countries, the practice remains as common today as it was three decades ago.

Overall, even in countries where the practice has become less prevalent, progress would need to be at least 10 times faster to meet the global target of eliminating FGM by 2030.

WITHIN COMMUNITIES
THAT PRACTISE FGM, MANY
THINK IT SHOULD END

Opposition to FGM is highest among girls and women with more education

FIG. 1 Percentage of girls and women aged 15 to 49 years who have undergone FGM and think the practice should stop, by level of education



Notes: Values presented here are based on at least 25 unweighted cases. Data for girls and women with secondary or higher education in Niger are suppressed due to an insufficient number of cases to perform the analysis.

In high- and low-prevalence countries alike, opposition to FGM is highest among girls and women who are educated. Furthermore, opposition tends to increase substantially as educational levels rise. This suggests that even when women have little opportunity to interact with women from non-practising groups, education appears to play an important role in shifting normative expectations surrounding FGM.

Girls and women with a primary education are 30 per cent more likely than those with no education to oppose FGM. This rises to 70 per cent higher among girls and women with at least a secondary education.

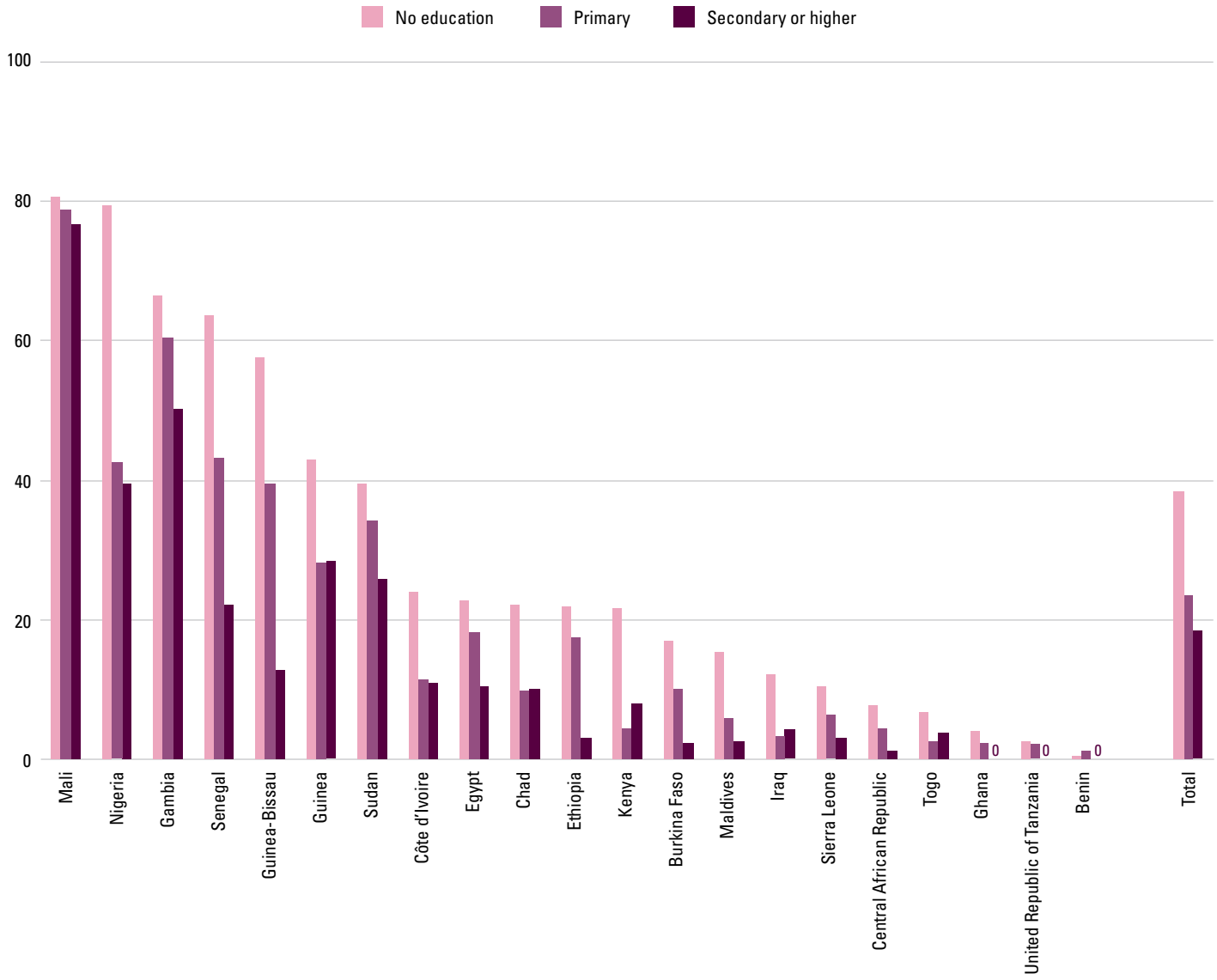
In half of affected countries, at least three quarters of girls and women with a secondary education think the practice should end.

In some countries – such as Kenya and Nigeria – any amount of education is associated with a significantly higher level of opposition. In others – such as Egypt and Sudan – education beyond the primary level is associated with a more dramatic shift in attitudes.

EDUCATION CAN HELP PREVENT THE PASSING OF FGM **TO THE NEXT GENERATION**

Educated mothers are less likely to subject their daughters to the practice

FIG. 2 Percentage of girls aged 0 to 14 years who have undergone FGM, among those whose mothers have undergone FGM, by mother's level of education



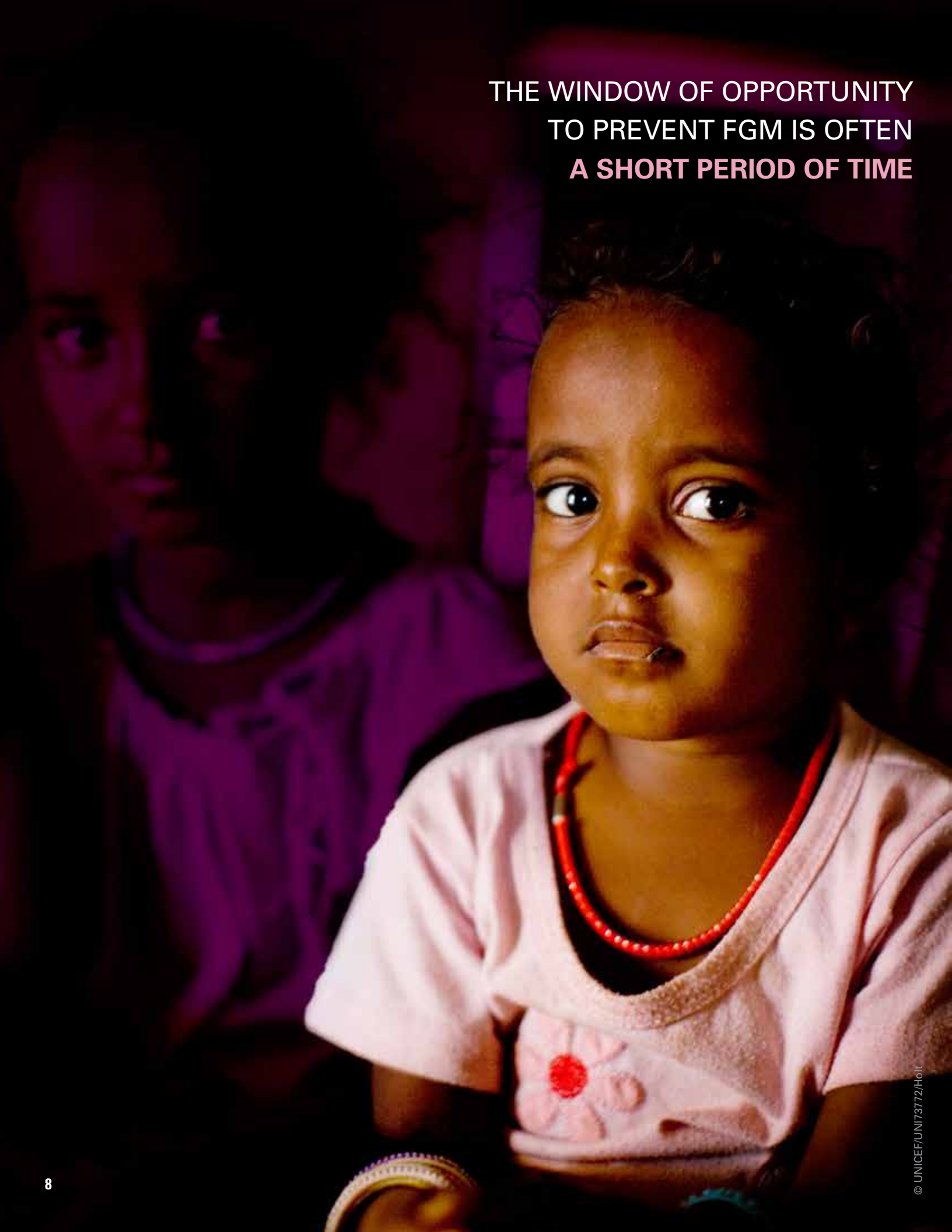
Notes: Information collected on FGM among girls under age 15 reflects their current but not final FGM status. Some girls who have not been cut may still be at risk as they age. The prevalence in successively older cohorts of girls will increase until all girls have passed the risk period for FGM. Therefore, FGM prevalence for girls under 15 is an underestimation of the true extent of the practice. Since age at cutting varies among settings (see Figure 3), the amount of underestimation also varies. This should be kept in mind when interpreting all FGM prevalence data for this age group.

FGM is generally more common among daughters of women with no education, and it tends to be substantially less prevalent as a mother's educational level rises.

Girls whose mothers have a primary education are 40 per cent less likely to be cut than those whose mothers have no education.

In many countries, women with a secondary education are even less likely to continue the practice of FGM into the next generation: In Ethiopia, levels of FGM are 85 per cent lower among daughters of women with a secondary education versus those who are uneducated.

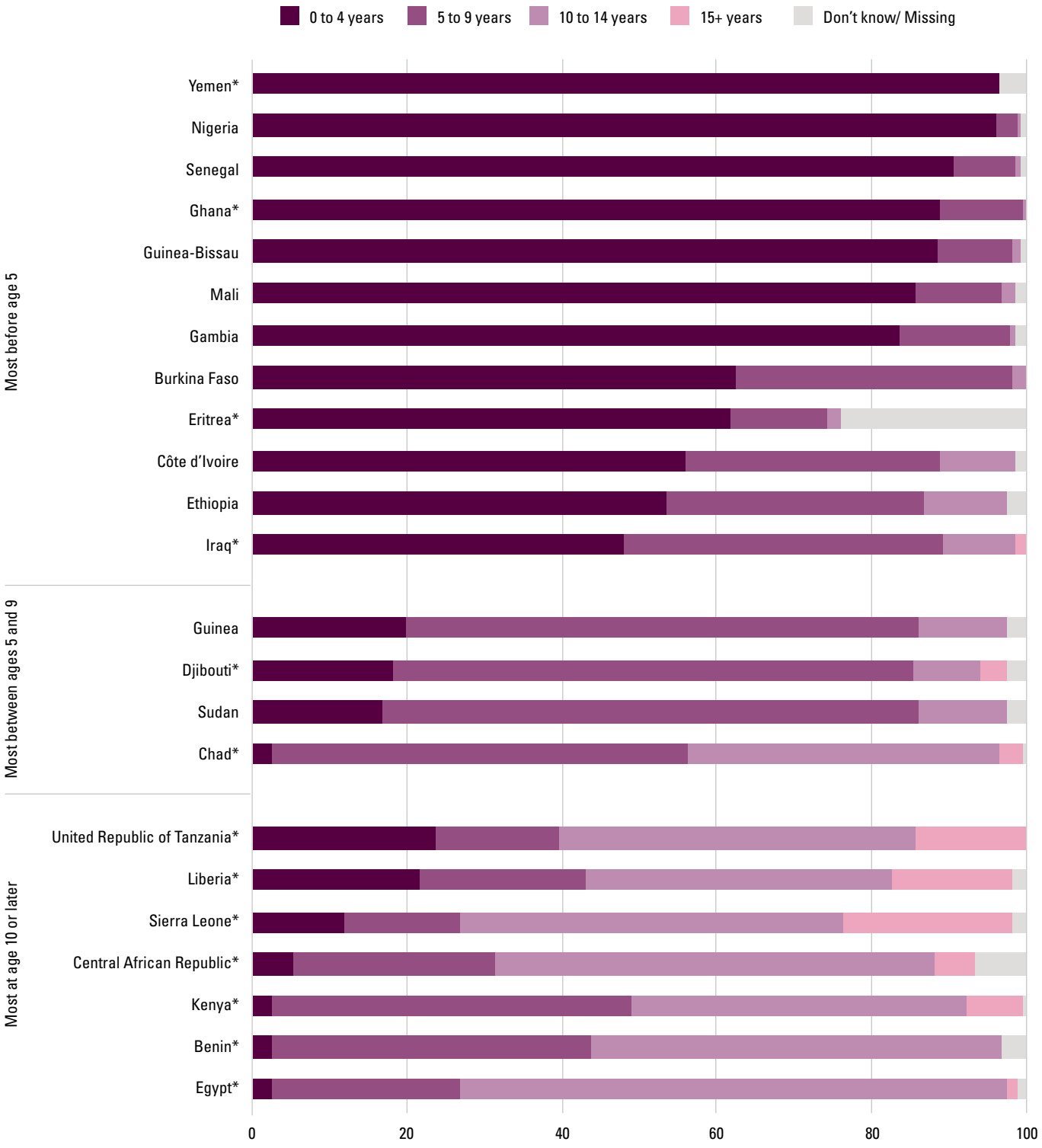
Still, some educated women have daughters who have undergone FGM, especially in countries where the practice remains universal and societal pressure is fierce. In the Gambia, for example, half of girls whose mothers have a secondary education have undergone FGM, and in Mali the share rises to over 75 per cent.



THE WINDOW OF OPPORTUNITY TO PREVENT FGM IS OFTEN **A SHORT PERIOD OF TIME**

FGM is practised differently within different cultures, and the age at which it is performed varies across contexts. In some countries, it is carried out very early in life, while in others it occurs in adolescence

FIG. 3 Percentage distribution of girls aged 10 to 14 years (or 15 to 19 years*) who have undergone FGM, by age at cutting

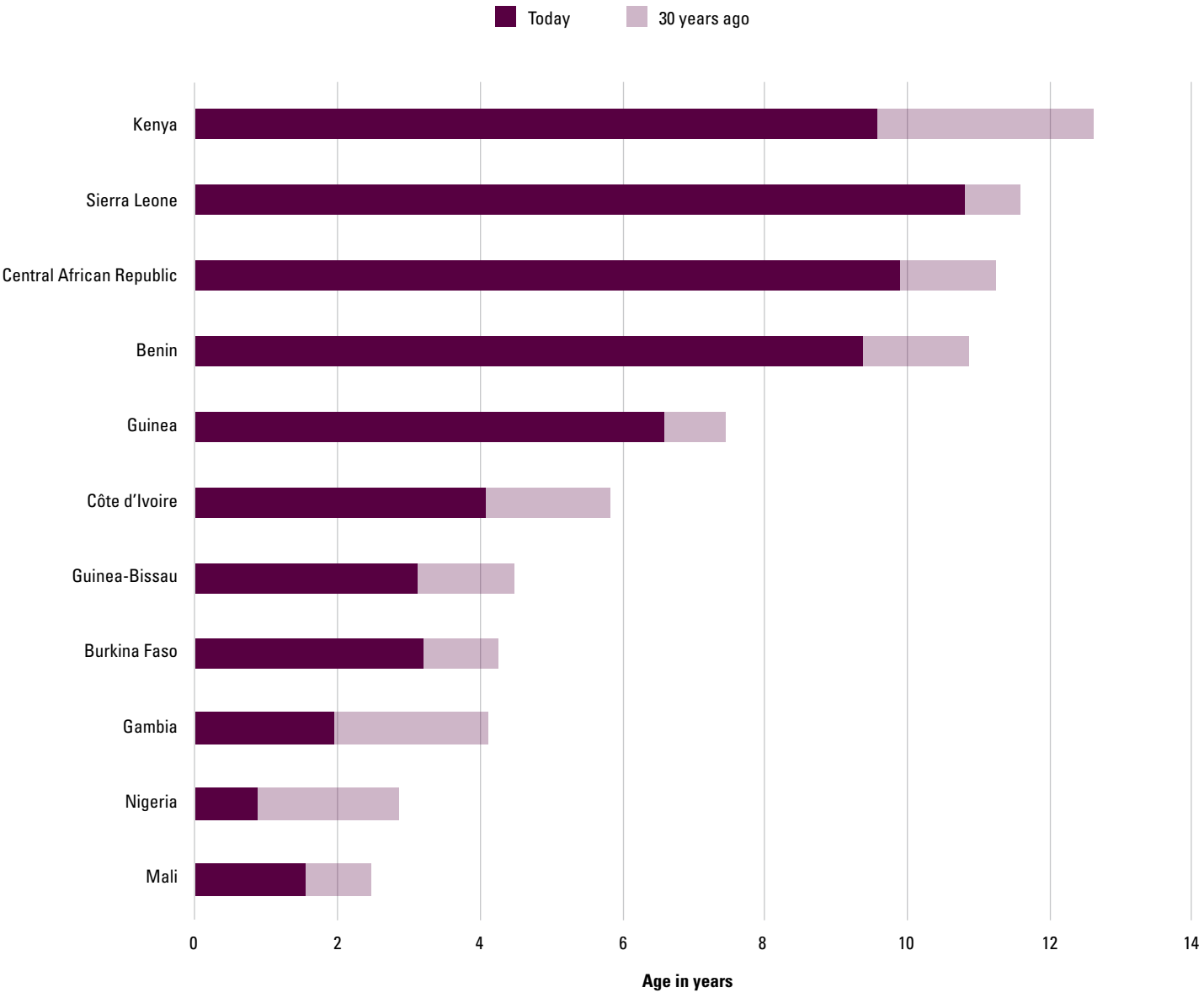


Notes: Data on age at cutting are presented as measured among girls aged 10 to 14 years, when possible. This age cohort is preferred for analysis since it provides information on cutting that has occurred relatively recently, as opposed to data on FGM among older women, which reflect cutting that occurred many decades ago. Alternatively, the age group 15 to 19 years is used for some countries in cases where data on the preferred age group are not available or if a substantial proportion of cutting is performed after age 10.

THE PERIOD TO ACT **IS SHRINKING**

In many countries, girls are being cut at younger ages, meaning that the window of opportunity to intervene is closing

FIG. 4 Among adolescent girls aged 15 to 19 years who have undergone FGM, the average age at which it was performed



Note: Data are presented for countries in which there was a statistically significant change in the average age at cutting.

Where FGM is practised on very young girls, there is a short window of opportunity to intervene. In some countries this window is getting narrower, as a larger proportion of FGM is being performed on the youngest girls.

In half of practising countries, the average age at which FGM is performed is lower today than it was 30 years ago. In the Gambia and Nigeria, for example, the average age at cutting has dropped by two full years: from age 4 to just before age 2 in the Gambia, and from before age 3 to before age 1 in Nigeria. In Kenya, the average has dropped by over three years, from age 12 to age 9.

USING DATA AS A SPRINGBOARD FOR ACTION

Owing to deep social and cultural roots, FGM has proved highly resistant to change. Yet, a growing body of evidence suggests that education can be a powerful lever in shifting attitudes about FGM, and ultimately changing behaviour.

Opposition to FGM is highest among girls and women who are educated – in both countries where the practice is rare and where it is widespread. This opposition increases as education levels rise.

Education influences not only attitudes, but behaviour as well. Girls whose mothers have a primary education are 40 per cent less likely to be cut than those whose mothers have no education. And in many countries, women with a secondary education are even less likely to continue the practice of FGM into the next generation.

Still, even educated women have daughters who have undergone FGM, especially in countries where the practice is universal and societal pressure is strong. This indicates that other factors – especially expectations within the larger social group – prevent women from abandoning the practice. These findings suggest that efforts to end the practice need to go beyond a shift in individual attitudes and address entire communities in ways that can decrease social expectations to perform FGM. Such a collective approach may be necessary to generate the shift in social norms required to catalyse changes in the practice of FGM and could help bring down prevalence levels more rapidly.

There is no time to lose. Evidence also shows that girls today are being cut at younger ages than their mothers and grandmothers. This means that the window of opportunity to prevent FGM through various interventions is closing.

Acting on this knowledge will help accelerate progress against FGM, with the ultimate aim of ending the practice by 2030, in accordance with target 5.3 of the Sustainable Development Goals.

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Technical notes

Nationally representative data on FGM are available for 31 countries. In this publication, data are presented for all countries with the relevant information available from the latest published data sources. Countries may not appear if the necessary data are not available from the latest data sources, or if there is an insufficient number of cases to perform the analysis.

In Figures 1 and 2, analysis is limited to girls and women who have undergone FGM. Across contexts, girls and women who have not experienced FGM are exceedingly likely to oppose the practice and very unlikely to have FGM performed on their daughters. By restricting the analysis to those who have undergone FGM, these results are meant to illustrate the situation within practising communities.

In Figure 4, trends in the average age at cutting are evaluated by comparing the circumstances of FGM among adolescent girls aged 15 to 19 years at the time of the latest survey with the circumstances of those aged 45 to 49 years — that is, women who were adolescents 30 years earlier.

Confidence intervals are not shown in this publication. Caution is therefore warranted in interpreting the results since apparent differences among groups may not be significant. All messages were developed in light of the confidence intervals, so where a difference among groups is mentioned in the text, it has been confirmed as statistically significant.

Data sources

UNICEF global databases, 2022, based on Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and other nationally representative surveys, 2010–2020. For detailed source information by country, please see <data.unicef.org>.

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