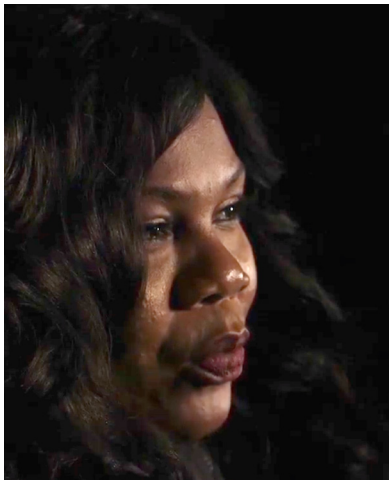

ahafoundation

FEMALE GENITAL MUTILATION/ CUTTING (FGM/C) IN THE UNITED STATES

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Image: Nargis Magazine. All others courtesy of survivors

A STUDY OF THE PREVALENCE, DISTRIBUTION, AND IMPACT OF FGM/C IN THE U.S., 2015-2019

Author: Sean Callaghan

With a foreword by Amanda Parker,
Senior Director of AHA Foundation

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"It's so important to educate and communicate and above all we the victims must be able to share our experiences in order to inspire girls to reject this practice."

— Bayor Chantal Ngoltoingar, FGM/C survivor and activist

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FOREWORD

BY AMANDA PARKER, SENIOR DIRECTOR OF AHA FOUNDATION

In December of 2018, a few of us from AHA Foundation attended Sean Callaghan's presentation to the U.S. Network to End FGM/C (female genital mutilation/cutting) on mapping FGM/C in the United Kingdom. Sean's research was able to show with an unprecedented level of specificity which U.K. communities housed populations from particular countries with high prevalence rates of FGM/C. We were immediately struck by how useful it would be to have such data in the U.S. Exactly one week later, we met with Sean and the idea of replicating his work in the U.S. began to feel like a real possibility. This report is a result of that initial spark of an idea.

Sean's research is not the first attempt at identifying and mapping FGM/C prevalence in the U.S., but his work builds on what others have done and takes it further. Using 2019 census data, Sean has updated the populations included; factored in the age of cutting by ethnicity (so we can discern between which girls are likely at risk of being cut and which girls have likely already undergone FGM/C); and adjusted the rate of cutting to try to account for the impact of migration on the practice. The study then maps those populations down to a very detailed level. We can now see which schools, hospitals, and community centers are situated amongst women and girls who are likely impacted by FGM/C.

The underlying goal of all of AHA Foundation's work to address FGM/C in the U.S. is to prevent girls from ever undergoing the practice. A second, critical goal is to support the needs of survivors who are living with the consequences of FGM/C. With these aims in mind, we are incredibly proud to support this research and make public the results.

Figuring out specifically where FGM/C is happening in the U.S. is the first step in ending this harmful practice. Understanding how and when FGM/C is practiced, and by which populations, coupled with this detailed geographical knowledge, has the potential to empower community leaders, educators, medical professionals, and others to work together to protect girls and support survivors.

Detailed data demonstrates the need to lawmakers at the federal, state, and local levels that comprehensive laws and—crucially—resources are needed to address FGM/C in their districts and nationwide. It shows organizations like AHA Foundation—which train professionals on FGM/C awareness and prevention and work with legislators to enact laws that better protect women and girls—where to focus their efforts. Detailed data can aid law enforcement in prevention efforts, and as a last resort, help hold perpetrators to account.

This report outlines Sean's research methodology before giving an executive summary of his findings. It then details his national findings and provides recommendations based on the research for better addressing FGM/C in the U.S. Pages 26-103 are state-by-state double-page fact sheets for most states and the District of Columbia, placed in alphabetical order. States with the lowest prevalence numbers are clustered together in fact sheets by geographic region. These double-page fact sheets have been designed so that they can be individually printed and used as standalone resources for those who are working on the ground in those areas.

Not published within these pages or elsewhere are much more granular maps that can show the specific locations of schools, medical facilities, community centers, and more within areas of practicing communities. We welcome professionals working to address FGM/C in the U.S. to contact us at info@theahafoundation.org if this information would be useful to your work.

As mentioned more than once in this report, a wide array of community leaders and professionals are needed, working both individually and within networks, to act as part of the solution. We aim to equip as many of them as possible with the information they need to keep women and girls in the U.S. safe from FGM/C.

It is difficult to express just how grateful I and the AHA Foundation team are to Sean for the immense heart and years of thoughtful work he has put into understanding and ending FGM/C in the U.S. and globally. AHA Foundation also wishes to extend our gratitude to Dr. Ness Sandoval, professor of Sociology at St. Louis University, for helping us create a roadmap for this project. Our biggest thank you is reserved for the brave survivors who have selflessly shared their stories with us in the hopes that others would be spared from the pain they themselves have endured.

EXECUTIVE SUMMARY

THIS REPORT FINDS that previous studies of FGM/C in the United States overestimated the potentially impacted population because they did not consider the impact of migration on the practice. Those studies calculated that over half a million women and girls were impacted by FGM/C whereas, based on our calculations, there were 421,000 women and girls impacted by FGM/C in the United States in 2019. While most of those women and girls were already living with FGM/C, it was estimated that 31,000 children remained at risk.

This study utilizes the extrapolation method to estimate the scale and distribution of the FGM/C-impacted population in the United States. The method relies on three input variables: (i) the prevalence rate in the country of origin, (ii) the diaspora population in the country under examination, and (iii) an estimation of the impact of migration and acculturation on prevalence.

Prevalence rates were derived from 81 nationally representative surveys and several academic studies to produce up-to-date age-specific prevalence data for 26 countries of origin. Population data was extracted from the 2015-2019 American Community Survey and assigned an ethnicity based primarily on their identified ancestry, rather than on their place of birth. We developed a mid range scenario in which prevalence was estimated to drop as a result of migration and acculturation.

Applying a similar methodology to previous estimates (therefore disregarding the impact of migration), it was calculated that 577,000 women and girls were potentially impacted by FGM/C in 2019, representing a 12.5 to 14 percent increase on previous studies. That increase was shown to be driven primarily by migration into the U.S. Based on this initial calculation, most of the potentially impacted population identified as Egyptian, Somali, Ethiopian, Nigerian, Indonesian, Sudanese or Malay.

Image: stock

"I just believe by now, civilization should have stopped such an act."

— Gladis, FGM/C survivor and activist

https://www.theahafoundation.org/civilization-should-have-stopped-fgm/

Based on an estimation of the reduction in prevalence due to migration and acculturation we estimated that 385,000 women and girls were living with FGM/C, while 31,000 girls were at risk of being cut in 2019. In addition, 5,500 women and girls from the Dawoodi Bohra community were likely impacted by FGM/C and were not included in the extrapolation calculation. Their inclusion would bring the number of women and girls impacted by FGM/C to 421,000.

In 2019, half of those 31,000 girls at risk of FGM/C lived in six states: Minnesota, California, New York, Texas, Washington, and Virginia. Most had ancestral ties to communities in the wider Horn of Africa.

It was further estimated that there were 68,000 women living with Type 3 FGM/C in the United States in 2019. Half of those women were resident in five states: Minnesota, Ohio, California, Texas, and Washington.

The impacted community was shown to be poorer and more urban than the American average.

This report includes state-by-state analyses, each of which can serve as a stand-alone summary of FGM/C to be used in advocacy and education efforts.

Finally, the report makes recommendations based on the 7P framework, thereby centering prevalence and framing four responses (provision, prevention, protection, and prosecution) within the context of policy and partnership.

- **Prevalence**: it is recommended that these estimates be updated once new population data becomes available and that future analysis be conducted on the full census dataset to account for all the potentially impacted populations more accurately.

- **Partnership**: it is recommended that partnerships between affected communities, civil society organizations, frontline services providers, and local, county, state, and federal governments be established and strengthened.

- **Policy**: it is recommended that policy be shaped by the 7P framework with emphasis placed on building partnerships to strengthen the provision of services to survivors and community-led efforts at prevention.

- **Provision**: it is recommended that healthcare professionals be equipped to treat patients impacted by FGM/C. Training should not only focus on the knowledge and skills required to treat FGM/C but also on building competency in communication and cultural sensitivity required to address such a sensitive issue.

- **Prevention**: it is recommended that prevention strategies start working with families before children are born and continue to engage families at least until after elementary school.

- **Protection**: it is recommended that age of risk be considered when designing protection mechanisms. Finding the balance between protecting girls at risk while not discriminating against the vast majority of girls who are not, requires careful consideration.

- **Prosecution**: it is recommended that laws be honed to include additional provisions to more comprehensively fight FGM/C in the United States beyond the goals of prevention and prosecution, to also support survivors and equip those professionals who may encounter FGM/C cases.

Adopting a comprehensive approach to FGM/C that brings together prevalence, partnership, policy, provision, prevention, protection, and prosecution is vital to efforts to support the communities affected by this practice in the United States.

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INTRODUCTION

THE PRACTICE OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C) is defined by the World Health Organisation (WHO) as the "partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2020). While FGM/C has been observed in various global cultures and contexts, the majority of survivors are from African backgrounds (UNICEF, 2022). Each year, approximately 3 million girls are at risk of FGM/C globally, with almost all of them being cut before the age of 15 (WHO, 2020). Some girls are cut within a few weeks of birth (e.g., in Nigeria and Indonesia), others as children (e.g., in Somalia and Egypt), while yet others undergo FGM/C as teenagers (e.g., in Kenya and Tanzania) (FGMCRI, 2023).

In 2016, UNICEF estimated that 200 million women and girls from 30 countries were impacted by FGM/C (UNICEF, 2016). However, evidence suggests that the practice is prevalent in indigenous and migrant populations in at least 92 countries (Equality Now, End FGM European Network & End FGM/C US Network, 2020). While the quality of prevalence data varies across these countries, it is clear that the impacted population is larger and more diverse than that referenced by UNICEF. Prevalence across these 92 countries ranges from as high as 99% in Somalia to less than 1% in Cameroon, Uganda, and Zambia (FGMCRI, 2023).

Previous studies in the United States estimated that over half a million women and girls were impacted by FGM/C (Mather, 2016, Goldberg et al., 2016). This study refines the methodology previously used and provides revised U.S. estimates of women and girls living with, and girls at risk of, FGM/C. This study also provides a more granular view of the distribution of the potentially impacted population, offering estimates at the county level for the first time.

Image: Richard Schabetsberger

"I survived this horrendous practice myself. That is one of the main reasons why I was driven to found AHA Foundation [16] years ago. I was horrified that [FGM/C] occurred even here in the U.S. and vowed to do all I could to eradicate it."

— Ayaan Hirsi Ali, FGM/C survivor and AHA Foundation Founder

The basis of this report is derived from doctoral research conducted by Sean Callaghan in collaboration with the AHA Foundation from 2021 to 2023. The AHA Foundation actively participated in the project as advisors, playing a crucial role in refining the project's focus, testing data collection methods, and interpreting the results. This collaborative partnership has been instrumental in ensuring the project's significance for women and communities affected by FGM/C.

METHODOLOGICAL CHOICES

This study utilizes the most widely used process for estimating the scale and distribution of the FGM/C impacted population in diaspora contexts, the Extrapolation of FGM/C Countries' Prevalence Data method (herein the extrapolation method) (De Schrijver et al., 2020). This is also the method used in each of the previous United States national estimates. While there is a clear refinement of the method evident in the literature, at its core, the extrapolation method relies on three input variables: (i) the prevalence rate in the country of origin, (ii) the diaspora population in the country under examination, and (iii) an estimation of the impact of migration and acculturation on prevalence.

Previous estimates of FGM/C in the United States

Estimates of FGM/C in the United States were published in 1997, 2004, and 2016. The first of these (Jones et al., 1997) estimated that 168,000 women and girls living in the United States in 1990 were potentially impacted by FGM/C. This estimate was revised by the African Women's Health Center (2004), which calculated that by 2000 there were 227,887 women and girls potentially impacted by FGM/C living in the United States. These estimates were again increased to 507,000 in a Population Reference Bureau (PRB) study (Mather, 2016) and 513,000 in a Centers for Disease Control and Prevention (CDC) study (Goldberg et al., 2016) based on 2013 and 2012 population data respectively.

In their review of research priorities regarding FGM/C in the U.S., Atkinson et al. (2019) note the inaccuracy of these estimates, pointing to issues with both the prevalence and population data as well as highlighting the failure to distinguish between those living with and those at risk of FGM/C – pointing to a failure to account for the age at which cutting takes place as a key shortcoming.

This study seeks to address the following **seven** limitations identified in previous studies of FGM/C in the United States (under headings related to the three variables (i), (ii), and (iii) described above):

(i): Limitations related to prevalence in the country of origin

1. Failure to disaggregate the prevalence data by age.
2. Reliance on the latest prevalence survey data only, thus ignoring historical trends and compounding any social desirability bias in recent data.
3. Failure to consider variations within a country's prevalence data, including demographic factors that potentially skew the data and the ethnic-specific nature of the practice.
4. Failure to take the age of cutting into account.

(ii): Limitations related to United States population data

5. Limiting the countries of origin considered relevant.
6. An overreliance on the country of birth as the primary indicator of risk.

(iii): Limitations related to the impact of acculturation on prevalence

7. Assuming no mitigating effect of acculturation.

Study methodology

While the extrapolation method formed the basis of this study, the three variables—(i), (ii), and (iii) described above—each called for further methodological consideration to address the limitations identified above.

(i) Calculating prevalence-rate-based input variables

Addressing the first two limitations called for prevalence rates that were disaggregated by age and which considered historical and future trends to align the calculated prevalence rates with the population data (Ortensi and Menonna, 2017). This process limited the impact of social desirability bias evident in more recent data (Gibson et al., 2018). These *Age-Specific Prevalence Rates* were calculated based on 81 nationally representative surveys from countries of origin spanning a period of 26 years from 1995 to 2021.

In order to address the third limitation, a *Migration Selection Factor* was calculated based on the mean differential between national prevalence rates and those for more educated, wealthier, and more urban cohorts as evidenced in those same nationally representative surveys (Ortensi et al., 2015). This *Migration Selection Factor* was used to adjust the *Age-Specific Prevalence Rate* to take into account the likelihood that migrants to the United States were more often drawn from these more elite cohorts as highlighted in the third limitation.

The product of these two variables—the *Age-Specific Prevalence Rate* and the *Migration Selection Factor*—was used to calculate the *Prevalence Rate* variable in the extrapolation calculation.

A third prevalence-based input variable was calculated to indicate the typical *Age of Cutting* to address the fourth limitation (UNFPA, 2020). This *Age of Cutting* data was used to estimate the FGM/C status of, and potential risk to, girls below the age of 18 (Kawous et al., 2020).

"To eradicate [FGM/C], education, love, and respect are needed. To tell a community that's been practicing this act in the name of culture or tradition for centuries, we need to be gentle in our approach."

— F.A. Cole, FGM/C survivor and activist

The final prevalence-based input variable to be calculated was the mean proportion of *Type 3 FGM/C* for each ethnic community. Type 3 FGM/C, also known as infibulation, is the most severe form of the practice. This calculation was based on the nationally representative surveys.

(ii) Selecting and tagging population data

Likewise, our refinement of the extrapolation method called for adaptations to the previous methodology used to estimate the number of women and girls impacted by FGM/C in the United States.

To address the fifth limitation, population estimates extracted from the American Community Survey (ACS) 2015-19 U.S. Census data included females associated either by ancestry or place of birth with 26 countries of origin[1]. Populations from a further 11 countries where FGM/C is known to exist were not available in the ACS dataset[2]. Each individual was assigned an *Ethnicity* based primarily on their identified ancestry, rather than on their place of birth, thus addressing the sixth limitation. The resultant geotagged data, with its associated demographic information, was then used as the *Study Population* variable in the extrapolation calculation.

(iii): Initial estimates of the scale and distribution of FGM/C in the United States

The product of the *Prevalence Rate* and *Study Population* provided an estimate of the upper limit of the potentially impacted population. This data was further segmented with the addition of the *Age of Cutting* and *Age of Migration* data to identify *Living-with* and *At-Risk-of* FGM/C cohorts. In addition, this study also calculated the number of women and girls from the Dawoodi Bohra community who were likely impacted by FGM/C based on estimates of congregation sizes.

1 Cameroon, Côte d'Ivoire, Egypt, Ethiopia, Eritrea, Gambia, Ghana, Guinea, Indonesia, Kenya, Kurds (from Iraq and Iran), Kuwait, Liberia, Malays, Nigeria, Saudi Arabia, Senegal, Sierra Leone, Somalia, Sudan, Tanzania, Togo, Uganda, UAE, Yemen, and Zambia.
2 Benin, Burkina Faso, Central African Republic, Chad, Djibouti, Guinea Bissau, Maldives, Mali, Mauritania, Niger, and Oman.

A set of risk profiles was developed based on a literature review of studies conducted in the United States and Europe resulting in a standard *Migration and Acculturation Impact Factor* nuanced by *Age of Cutting* and *Age of Migration* data to establish a set of risk profiles (Kawous et al., 2020). These calculations went some way to addressing the seventh and final limitation.

This report presents results based on a mid-range scenario in which the impacted population was divided into three groups:

a) those who migrated after the typical age of cutting for whom migration was assumed to have no impact on their FGM/C status;
b) those who migrated before or during the typical age of cutting for whom migration and acculturation are assumed to halve their risk of FGM/C;
c) and those born in the U.S. for whom acculturation is assumed to reduce their risk of FGM/C by three-quarters.

Geospatial data was then used to identify potential hotspots and trends based on population density and estimated FGM/C prevalence at various geographic scales including National, State, Metropolitan, County, and Public Use Microdata Area (PUMA) levels.

"By uniting those who are against [FGM/C] and who are willing to speak out, our many voices can become one loud voice that is impossible to ignore."

— Raha Europ, FGM/C survivor and activist

A NOTE ON DATA

Most of the prevalence data used in this study was extracted from either Multiple Indicator Cluster Surveys (MICS) or Demographic and Health Surveys (DHS), both of which provide nationally representative household surveys in countries of origin covering several health and well-being indicators specific to women and children. The FGM/C modules used by MICS and DHS are very similar, with MICS asking 24 questions and DHS asking 21. Information gathered includes respondents' knowledge about and attitudes towards the practice as well as specifics – age of cutting, type of cutter, and type of cut – of the respondent's own FGM/C status and that of her children, thus making the survey results comparable across time, country and implementing agency. In total, 81 nationally representative surveys spanning a period of 26 years from 1995 to 2021 were included in this analysis. Small-scale studies were used to estimate the prevalence of FGM/C in a further three Middle Eastern countries – Kuwait, Saudi Arabia, and the United Arab Emirates – as well as in two ethnic communities of Asian origin: the Malay and Dawoodi Borah communities. Since none of these smaller-scale studies offered age-specific prevalence data, the national average prevalence was used in these cases.

Population data was extracted from the American Community Survey (ACS) 2015-2019 which provides an estimate of community-level statistics for the whole of the United States based on a 5% sample collected over a five-year period. Anonymized record-level data, accessed through the Public Use Microdata Sample, formed the basis of the population analysis in this study. County-level estimates were calculated using the Missouri Census Data Center's Geocorr 2018 application (MCDC, 2018).

Limitations of this study

While this study sought to address several of the limitations of previous studies, a number remain:

1. Like previous studies, this study was an indirect estimate of FGM/C prevalence in the U.S. based on prevalence in countries of origin and a population sample of U.S. households. Both of these input datasets are known to be subject to both sampling and non-sampling errors.

2. Furthermore, there are limitations inherent within the ACS population data that cascaded into this study:
   a. The ACS is a household survey. By its nature, the sample excludes individuals who don't live in households.
   b. It is further unknown if the ACS fully represents undocumented migrants.
   c. The 2015-19 ACS data did not include records for individuals from all the countries where FGM/C is known to be practiced.
   d. The 2015-19 ACS data was used in this study since data collected after that date is known to have been affected by the COVID-19 pandemic, resulting in less accurate estimates in more recent population surveys.

3. The results are based on a mid-level risk scenario that assumes a reduction in risk of FGM/C post-migration. While this scenario is based on findings from other studies, and likely provides a more realistic estimate of those at risk of or living with FGM/C, it still reflects a methodological choice that is seeking to model reality.

4. This study focused on FGM/C prevalence in diaspora communities resident in the United States; however, we know that the practice is also prevalent in U.S. populations with no ancestral ties to FGM/C-practicing communities. Understanding the scale and distribution of that population was beyond the scope of this study and calls for additional research.

As such the results of this study should be considered as indicative of the scale and distribution of the impacted diaspora population within the U.S. rather than of the specific number of cases.

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Image: stock

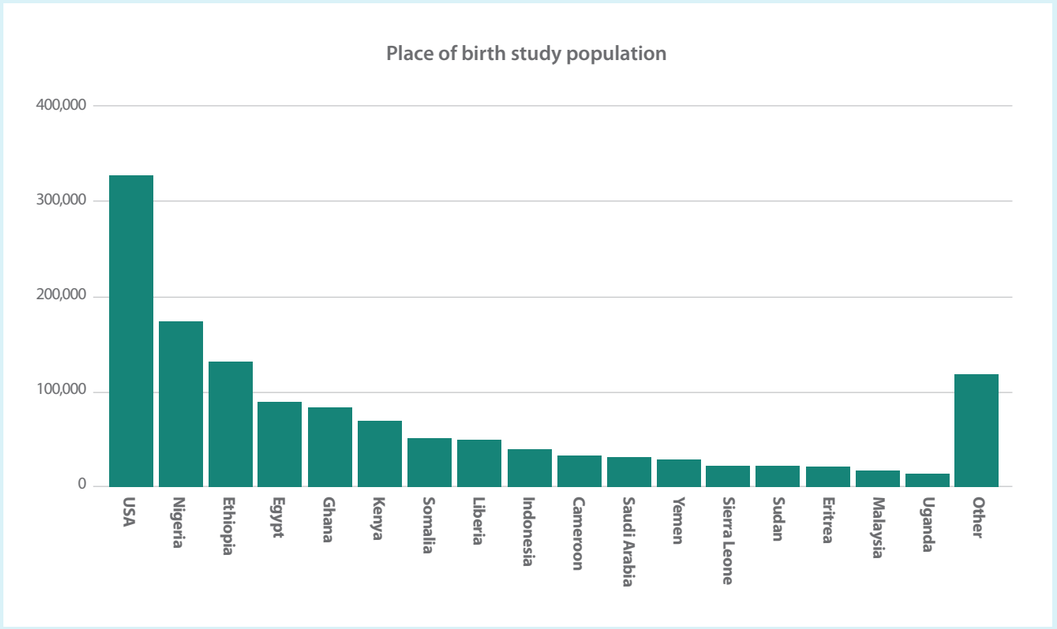
NATIONAL FINDINGS

THIS REPORT FINDS that previous studies of FGM/C in the United States overestimated the potentially impacted population because they did not consider the impact of migration on the practice. Those studies calculated that over half a million women and girls were impacted by FGM/C whereas based on our calculations there were 421,000 women and girls impacted by FGM/C in the United States in 2019. While most of those women and girls were already living with FGM/C, it was estimated that 31,000 children remained at risk.

STUDY POPULATION

A study population of 1.3 million women and girls with ancestral ties to countries where FGM/C is practised was extracted from the ACS 2015-2019 population data. 29% of the study population were born in the United States, while most of the rest migrated from Africa, with smaller yet significant populations originating in either Asia or the Middle East.

1,325,989
STUDY POPULATON:
Women and girls with ancestral ties to countries where FGM/C is practiced



POTENTIALLY IMPACTED POPULATION

Applying a similar methodology to previous estimates (therefore disregarding the impact of migration), it was calculated that 577,000 women and girls were potentially impacted by FGM/C in 2019, compared to 513,000 (CDC) and 507,000 (PRB) based on 2012 and 2013 population estimates respectively, representing a 12.5% to 14% increase in the potentially impacted population.

577,176
(506,795 PRB est;
513,000 CDC est):
Number of women and girls
POTENTIALLY IMPACTED
by FGM/C

Based on this initial calculation, 82% of the potentially impacted population identified as Egyptian (22%), Somali (16%), Ethiopian (16%), Nigerian (12%), Indonesian (7%), Sudanese (5%) or Malay (4%).

Comparing these results with the PRB estimates on a state-by-state basis showed that much of the growth was concentrated in three states: California, Minnesota, and Texas.

CA	**76,997** (56,872 PRB est)	35% increase
MN	**53,019** (44,293 PRB est)	20% increase
TX	**50,678** (33,087 PRB est)	53% increase
NY	**46,280** (48,418 PRB est)	4% decrease
MD	**32,975** (31,820 PRB est)	4% increase
VA	**31,440** (30,830 PRB est)	2% increase
NJ	**29,193** (31,023 PRB est)	6% decrease
WA	**25,311** (25,000 PRB est)	1% increase
OH	**21,797** (24,320 PRB est)	10% decrease
GA	**20,730** (20,476 PRB est)	1% increase

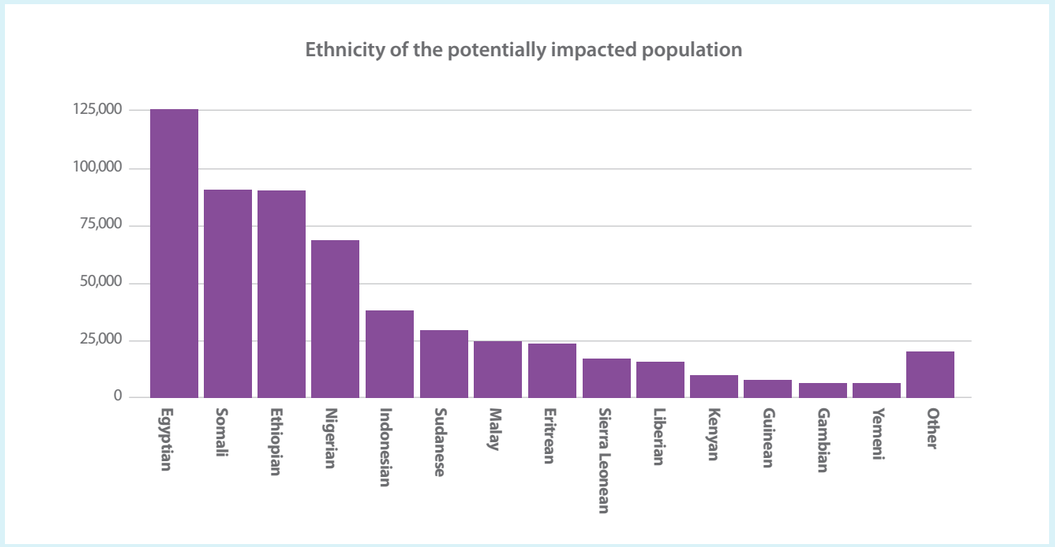


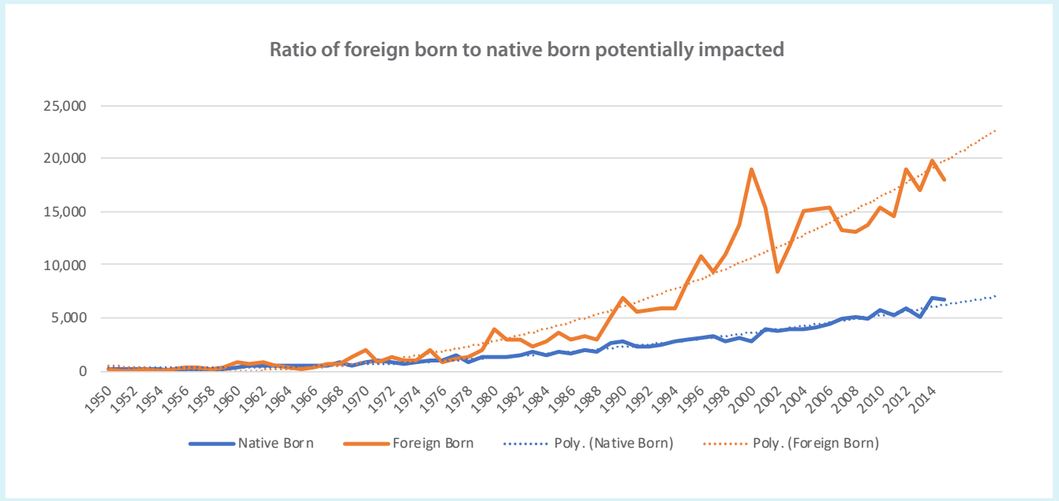

Image: Dreamstime

"[FGM/C] is an uncomfortable issue to discuss, but we must continue calling attention to it and educating ourselves on the signs so that we are equipped to protect young girls from this excruciating practice."

— Senator Joni Ernst, Iowa

Immigration driven growth

Comparing migration data with birth rate statistics among the study population suggested that the greatest impact on the scale of FGM/C in the United States could be attributed to growth in foreign-born migrants, at least up until 2015. Since 78% of foreign-born migrants entered the United States after the typical age of cutting, this inward migration likely had little impact on the number of children at risk of FGM/C. It did however significantly increase the number of women living with FGM/C, many of whom require some level of medical and mental health support.



More recent developments, including the Trump-era travel bans and the COVID-19 pandemic, both of which affected migration trends after 2015, would likely have interrupted the migrant population growth shown above, potentially increasing the significance of native-born populations in more recent years.

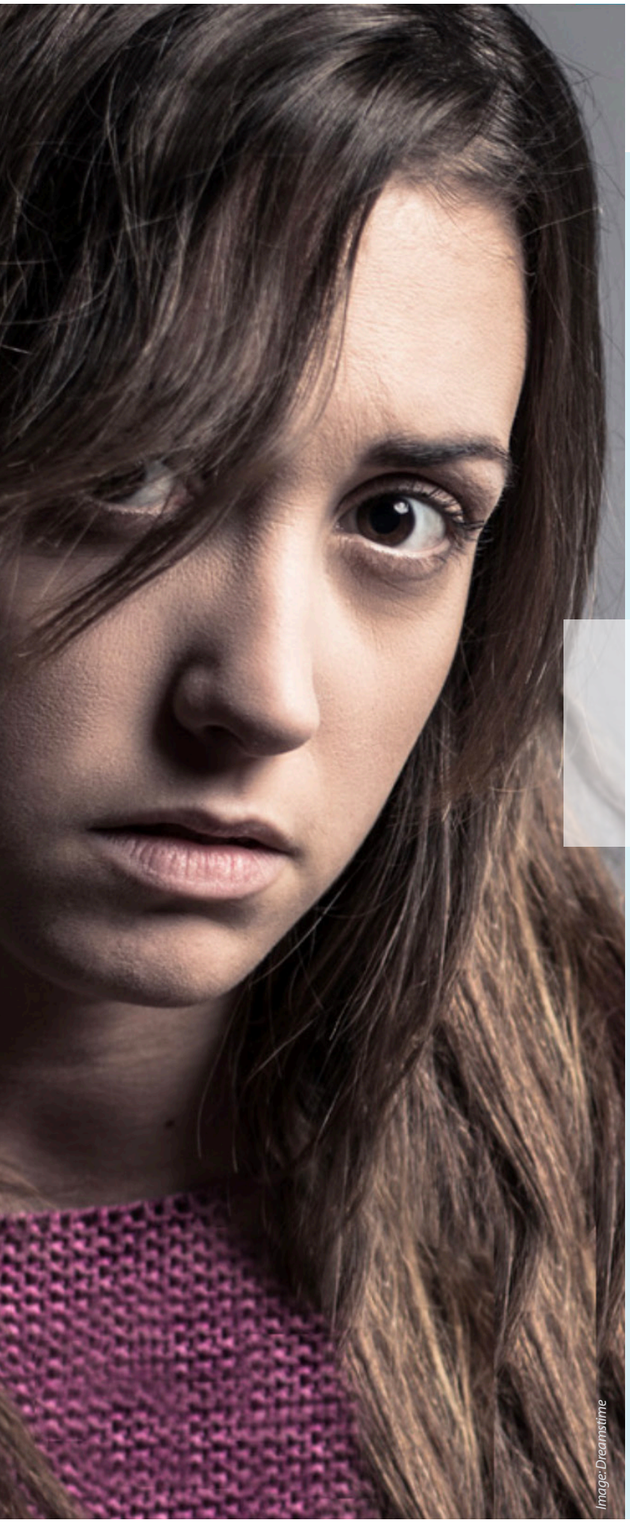


Image: Dreamstime

A MORE REALISTIC ESTIMATE

The estimate of the 577,000 potentially impacted by FGM/C above, like the previous CDC and PRB estimates, did not account for any migratory impact on the practice and thus represents the upper limit of the potentially impacted population. A more realistic estimate of the scale of FGM/C in the United States, based on a mid-range risk scenario (see methodology above) suggests that 385,000 women and girls were living with FGM/C, while 31,00 girls were at risk of being cut in 2019. This more realistic estimate of 416,000 women and girls impacted by FGM/C, compared to 577,000 using a methodology that ignores migratory impact, suggests that previous estimates over-projected the affected population by almost 40%.

384,714
Women and girls who were likely **LIVING WITH** FGM/C

30,956
Girls who were likely **AT RISK** of FGM/C

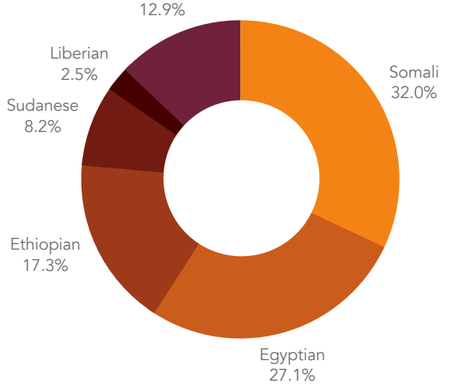
Absent from this calculation are the Dawoodi Bohra community, many of whom are known to continue the practice in the United States. This study estimated that 5,500 women and girls from the Dawoodi Bohra community were likely impacted by FGM/C. Since these women and girls were not included in the extrapolation method estimates above they need to be added to the calculation. Taken together this study therefore estimates that 421,000 women and girls impacted by FGM/C live in the United States.

Growth in the at-risk population

Our analysis shows that while 91% of those estimated to be living with FGM/C in the United States were foreign-born, 58% of those estimated to be at risk of FGM/C were born in the U.S. This more nuanced analysis suggests that while immigration is driving much of the growth in those needing ongoing medical support, it is, in fact, native-born children who make up the bulk of those at future risk of FGM/C. This study also found that 332,000 of the living-with population migrated to the United States after the age of cutting suggesting that 53,000 girls were cut after they migrated to the United States with a further 31,000 remaining at risk.

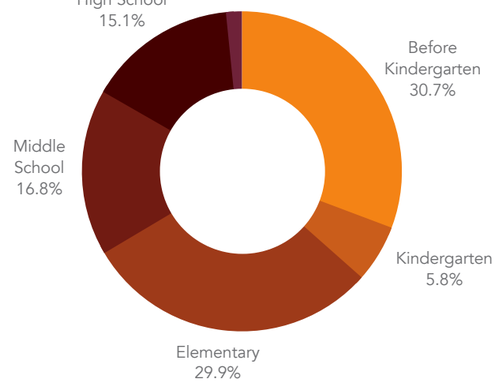
In 2019, half of those 31,000 girls at risk of FGM/C lived in six states: Minnesota (18%), California (9%), New York (7%), Texas (7%), Washington (6%), and Virginia (5%) – and most had ancestral ties to communities in the wider Horn of Africa: Somali (32%), Egyptian (27%), Ethiopian (17%), and Sudanese (8%). It should further be noted that Nigerian and Indonesian at-risk populations are likely under-represented in this analysis since these communities cut girls within the first year of life, resulting in many of them being encoded as already living with FGM/C. To explore this impact, taking fertility rates into account, it was estimated that approximately 32,000 girls were born to the study population in the year following the population survey. By applying the relevant 0-4-year-old prevalence rate and the mid-range risk scenario to that birth cohort, it was calculated that an additional 2,497 girls were at risk of FGM/C by 2020. Indonesians and Nigerians each made up 4% of that at-risk birth cohort, while three-quarters were distributed across five ethnicities: Somali (34%), Egyptian (17%), Ethiopian (11%), Sudanese (7%), and Malay (5%). Based on this analysis and on the typical age of cutting our study found that two-thirds of the girls at risk of FGM/C in 2019 were below middle school age. Our analysis also suggests that 6,200 girls below the age of 15 were already living with FGM/C.

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in the United States



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they cut early, resulting in most girls being encoded as already living with FGM/C.

Distribution of girls most likely to be AT RISK of FGM/C in the United States



NOTE: This graph represents the age at time of survey of the at-risk population. It does not indicate the age at which they are at risk. The age at which they are at risk is dependent on their specific ethnicity.

Estimates are subject to both sampling and nonsampling error.

Prevalence of Type 3 FGM/C

68,378
Women and girls who were likely **LIVING WITH** TYPE 3 FGM/C

Type 3 FGM/C, also known as infibulation or Pharonic Circumcision, is the most severe form of the practice, involving the removal of the external genitalia and the sewing closed of the vaginal opening. Type 3 FGM/C is predominantly (but not exclusively) practiced by communities in the Horn of Africa, including the Somali and Sudanese communities. However, several studies in Europe suggest that most communities abandon Type 3 FGM/C post-migration even if some of them continue to support a less severe form of the practice. Assuming therefore that none of the 31,000 girls was at risk of Type 3 FGM/C, there were still an estimated 68,000 women living with Type 3 FGM/C in the United States in 2019. Half of those women were resident in five states: Minnesota (23%), Ohio (8%), California (7%), Texas (7%), and Washington (6%).

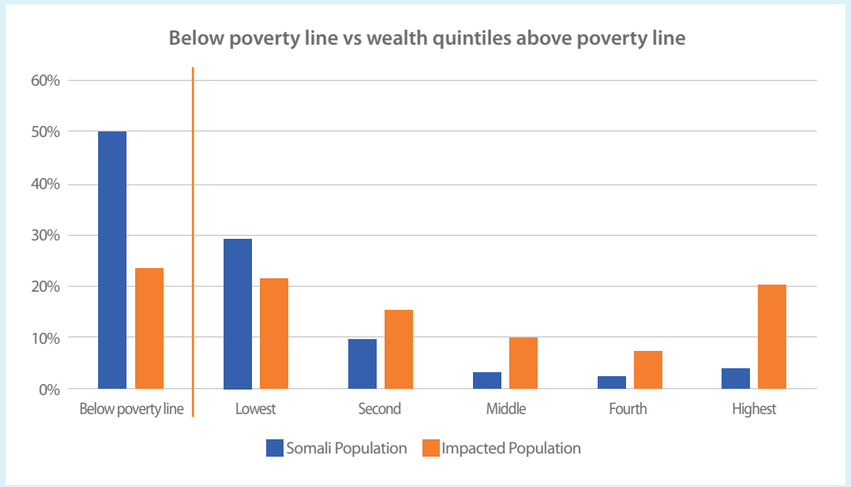
Survivors of Type 3 FGM/C require significant medical support, especially during pregnancy and birth, making specialist training of medical personnel a key priority, especially in those communities with a high concentration of Type-3-affected populations (Evans C *et al.*, 2019).

Communities impacted by FGM/C are often poorer

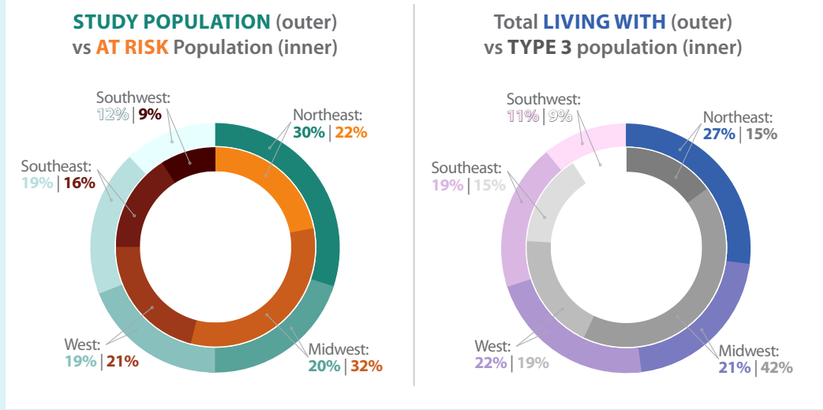
On average, just less than a quarter of the impacted population lives below the poverty line – about double the national average across the entire U.S. population (U.S. Census Bureau, 2023). About a fifth of adult survivors live below the poverty line, while about a third of girls impacted by FGM/C live in households below the poverty line – those proportions are almost doubled for the Somali community. This skewing towards Somali poverty was also evident in the spatial data which highlighted increased deprivation in Minnesota.

Almost three-quarters of impacted women aged 18 or above were employed or self-employed. Unemployment was highest (40%) among women of Middle Eastern or North African heritage and lowest (21%) for West African women. While 72% of Somali women were employed or self-employed, combined with the poverty data above, this would suggest that Somali women are disproportionately employed in low-paying jobs. The skewing of poverty data towards Somali women was also evident in the prevalence data which suggests higher rates of FGM/C in those communities that live below the poverty line.

Furthermore, about 10% of those impacted by FGM/C have no health insurance, while four communities – Kurdish, Somali, Sudanese, and Yemeni – are more often reliant on public health insurance, with the rest more reliant on private health insurance.



Impacted communities are geographically concentrated



Ten states[1] represent two-thirds of the population living with or at risk of FGM/C in the United States. Those same states are also home to three-quarters of the Dawoodi Bohra community estimated to be impacted by FGM/C. The potentially impacted population was therefore concentrated in the Northern states with just 31% of the study population resident in the Southeast and Southwest regions. The at-risk population was disproportionately concentrated in the Midwest, as were those living with Type 3 FGM/C, pointing to the significance of the Somali population in Minnesota.

1 CA, GA, MD, MN, NJ, NY, OH, TX, VA, WA

The FGM/C-impacted population is also more urban than the U.S. average, with 94% living within major metropolitan areas compared to 83% of the general population (University of Michigan, 2022).

Top 20 Metropolitan Areas	Study Pop	Living With	At Risk	Total	Prevalence in the study population
New York-Newark-Jersey City, NY-NJ-PA	156,704	44,356	2,734	47,090	30.1%
Washington-Arlington-Alexandria, DC-VA-MD-WV	133,213	39,001	2,008	41,009	30.8%
Minneapolis-St. Paul-Bloomington, MN-WI	70,417	25,032	4,001	29,033	41.2%
Los Angeles-Long Beach-Anaheim, CA	56,353	20,802	1,154	21,956	39.0%
Dallas-Fort Worth-Arlington, TX	60,450	16,114	1,001	17,115	28.3%
Seattle-Tacoma-Bellevue, WA	39,919	15,175	1,607	16,782	42.0%
Houston-The Woodlands-Sugar Land, TX	59,456	15,615	767	16,382	27.6%
Atlanta-Sandy Springs-Roswell, GA	54,066	13,849	727	14,576	27.0%
Columbus, OH	27,465	9,919	1,038	10,957	39.9%
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	36,502	9,054	583	9,637	26.4%
San Francisco-Oakland-Hayward, CA	26,719	9,167	400	9,567	35.8%
Chicago-Naperville-Elgin, IL-IN-WI	33,054	8,574	492	9,066	27.4%
Boston-Cambridge-Newton, MA-NH	31,343	7,801	480	8,281	26.4%
Nashville-Davidson--Murfreesboro--Franklin, TN	17,261	6,544	594	7,138	41.4%
Baltimore-Columbia-Towson, MD	29,006	6,452	295	6,747	23.3%
Riverside-San Bernardino-Ontario, CA	17,937	5,779	387	6,166	34.4%
Denver-Aurora-Lakewood, CO	16,407	5,318	375	5,693	34.7%
San Diego-Carlsbad, CA	13,207	4,939	479	5,418	41.0%
Las Vegas-Henderson-Paradise, NV	12,358	4,755	272	5,027	40.7%
Phoenix-Mesa-Scottsdale, AZ	13,821	4,306	408	4,714	34.1%

This study segments the states into four groups based on the number of girls estimated to be at risk of FGM/C.

Highest Prevalence States (Over 1,000 girls at risk)

State	Study Pop	Living With	At Risk	Total	Prevalence	Legislation
CA	149,342	51,907	2,940	54,847	36.7%	Deficient
MD	101,243	24,709	1,027	25,736	25.4%	Deficient
MN	84,363	30,228	5,478	35,706	42.3%	Deficient
NJ	63,177	19,940	1,327	21,267	33.7%	Deficient
NY	120,452	31,564	2,137	33,701	28.0%	Deficient
OH	45,770	14,042	1,348	15,390	33.6%	Deficient
TX	142,149	37,033	2,099	39,132	27.5%	Deficient
VA	67,960	21,644	1,598	23,242	34.2%	Deficient
WA	44,761	16,445	1,734	18,179	40.6%	Deficient

High Prevalence States (Between 500 and 1,000 girls at risk)

State	Study Pop	Living With	At Risk	Total	Prevalence	Legislation
FL	32,154	9,743	543	10,286	32.0%	Deficient
GA	58,188	14,786	766	15,552	26.7%	Deficient
IL	37,453	9,311	580	9,891	26.4%	Deficient
MA	41,437	9,416	697	10,113	24.4%	Adequate
NC	28,315	7,452	586	8,038	28.4%	Deficient
NE	8,360	3,232	587	3,819	45.7%	No Legislation
PA	39,591	10,096	725	10,821	27.3%	Deficient
TN	24,886	8,948	767	9,715	39.0%	Adequate

Mid Prevalence States (Between 100 and 500 girls at risk)

State	Study Pop	Living With	At Risk	Total	Prevalence	Legislation
AZ	16,647	5,134	476	5,610	33.7%	Deficient
CO	20,208	6,449	469	6,918	34.2%	Deficient
CT	12,613	2,544	198	2,742	21.7%	No Legislation
DC	9,329	2,786	158	2,944	31.6%	No Legislation
IA	6,788	2,259	235	2,494	36.7%	Deficient
IN	13,679	3,432	280	3,712	27.1%	Strong
KS	6,832	1,995	250	2,245	32.9%	Deficient
KY	8,300	2,083	297	2,380	28.7%	Strongest
ME	2,693	971	317	1,288	47.8%	No Legislation
MI	32,511	6,819	462	7,281	22.4%	Deficient
MO	12,515	2,939	358	3,297	26.3%	Deficient
NH	3,893	1,343	165	1,508	38.7%	Deficient
NV	13,724	5,083	288	5,371	39.1%	Deficient
OK	5,348	1,154	108	1,262	23.6%	Deficient
OR	11,167	3,771	444	4,215	37.7%	Deficient
SD	3,274	1,085	188	1,273	38.9%	Deficient
UT	5,562	1,514	389	1,903	34.2%	Strong
WI	9,018	3,086	253	3,339	37.0%	Deficient

Low Prevalence States (Less than 100 girls at risk)

State	Study Pop	Living With	At Risk	Total	Prevalence	Legislation
AK	1,554	377	61	438	28.2%	No Legislation
AL	5,058	1,059	82	1,141	22.6%	No Legislation
AR	1,589	316	21	337	21.2%	Strong
DE	6,010	1,220	44	1,264	21.0%	Deficient
HI	1,041	304	7	311	29.9%	No Legislation
ID	1,448	321	39	360	24.9%	Deficient
LA	4,987	1,176	71	1,247	25.0%	Deficient
MS	2,249	400	31	431	19.2%	No Legislation
MT	590	88	25	113	19.2%	No Legislation
ND	3,073	932	95	1,027	33.4%	Deficient
NM	1,750	400	15	415	23.7%	No Legislation
RI	5,949	1,347	68	1,415	23.8%	Severely Deficient
SC	4,386	1,144	70	1,214	27.7%	Deficient
VT	693	190	43	233	33.6%	Severely Deficient
WV	1,346	385	6	391	29.0%	Deficient
WY	564	112	4	116	20.6%	Strong

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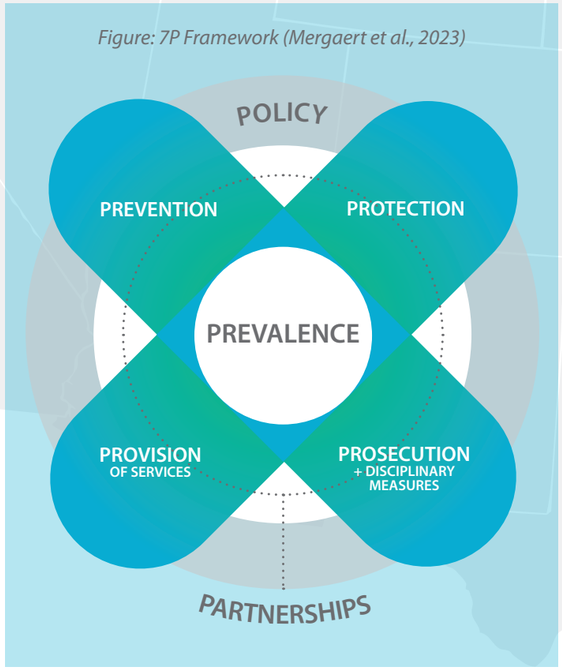
"[FGM/C]...is recognized as a human rights issue by the United Nations and is something that we need to prevent from happening here. It is an issue for women and girls and an issue of public health as well."

— Michigan State Senator Stephanie Chang

RECOMMENDATIONS

THESE RECOMMENDATIONS, based on the findings of this report as well as from the broader work of the AHA Foundation, are presented using the 7P framework (Mergaert et al., 2023), thereby centering prevalence and framing four responses (provision, prevention, protection, and prosecution) within the context of policy and partnership.

Figure: 7P Framework (Mergaert et al., 2023)



"[R]egardless of where we are from, the color of our skin, what we believe, if we were cut, how we were cut, why we were cut, what we call the practice, the impact it had on our lives…we all have to keep working together to support and protect those still at risk."

— Jenny, FGM/C survivor and activist

1: PREVALENCE

This report provides the latest estimate of the prevalence of FGM/C in the United States. Based on an improved methodology, it offers a sense of the scale and distribution of the affected population and for the first time provides state and county level estimates of those living with and at risk of FGM/C as well as those impacted specifically by Type 3 FGM/C.

Due to COVID-19's impact on the accuracy of recent American Community Survey (ACS) data, the estimates in this report were based on population data from before the pandemic. It is recommended that an update be conducted once more accurate post-pandemic population estimates become available. Furthermore, since the ACS sample excludes smaller migrant populations known to be resident in the United States, it is recommended that future analysis be conducted on the full census dataset to account for all the potentially impacted populations more accurately.

2: PARTNERSHIP

It is clear from the scale and distribution of the potentially impacted population that addressing FGM/C in the United States requires the establishment and strengthening of partnerships between several stakeholders including affected communities, civil society organizations, frontline services providers, and local, county, state and federal governments. While many of these partnerships already exist, it is critical that they are strengthened and expanded to support affected women and girls.

3: POLICY

A comprehensive and coherent policy framework is required at local, county, state, and federal levels to address FGM/C in the United States fully. It is recommended that policy be shaped by the 7P framework with emphasis placed on building partnerships to strengthen the provision of services to survivors and community-led efforts at prevention. Child protection and prosecution efforts should be seen as the last lines of defense rather than fronted as a primary response to the practice so as to avoid reinforcing a culture of silence and the profiling and stereotyping of impacted communities.

4: PROVISION

This study found that there are likely 385,000 women and girls living with FGM/C in the United States. While most of those women and girls require some level of medical and mental health support, the 68,000 living with Type 3 FGM/C would likely require additional medical attention. Other research suggests "a prevailing lack of knowledge, competence and understanding about FGM/C" (Evans C et al., 2019, p. 3) among health providers resulting in inadequate care for affected populations.

It is therefore recommended that healthcare professionals be equipped to treat patients impacted by all types of FGM/C, with a focus on Type 3. Importantly, Evans et al. note that the training of health professionals should not only focus on the knowledge and skills required to treat FGM/C but also on building health professional competency in communication and cultural sensitivity required to address such a sensitive issue. This calls for a more comprehensive training program with modules covering FGM/C embedded into college-level healthcare professional curricula and offered as part of continuous professional development training.

5: PREVENTION

This study models the difference between two potential scenarios: one in which FGM/C continues at the same rate as it did before migration and the other in which families increasingly abandon the practice. In the first scenario, it was estimated that 577,000 women and girls were either living with or at risk of FGM/C, while in the second scenario, it was estimated that 416,000 were impacted – 385,000 of whom were living with FGM/C while 31,000 were at risk. This study also found that 332,000 of the living-with population migrated to the United States after the age of cutting, suggesting that 53,000 girls were cut after they migrated to the United States with a further 31,000 remaining at risk.

These findings highlight the urgent need for scaling up prevention efforts that are rooted in the community and supported by professional service providers. Given the age at which girls are at risk, FGM/C prevention strategies should start working with families before children are born and continue to engage families at least until after elementary school.

It is therefore recommended that FGM/C prevention and response task forces be created. These task forces should be interdisciplinary and collaborative, incorporating community leaders from affected communities and representatives from professional categories who may have contact with at-risk

individuals or survivors, including pediatricians, OB/GYNS, midwives, nurses, elementary and pre-K professionals, law enforcement, and child protective services.

Furthermore, educators, particularly elementary school, pre-K teachers, and guidance counselors, together with medical professionals, particularly pediatricians, OB/GYNS, midwives, and nurses, should be trained in FGM/C prevention, including how to recognize the signs a girl is at risk and how to appropriately handle cases.

6: PROTECTION

Care needs to be taken when considering child protection interventions related to FGM/C. The 31,000 girls estimated to be at risk in the United States in this study can be distributed across age-range categories based on their age of heightened risk (UNFPA, 2020). Based on this analysis, our study found that two-thirds of at-risk girls in the United States had not yet started middle school at the time of the population survey. While the age of risk may differ slightly in the diaspora context compared to country of origin, these categories provide an indication of when prevention and protection interventions are required. This age of risk analysis suggests a much more nuanced approach to child protection. For example, consider the case of Indonesian girls in middle school: while some of them might be living with FGM/C, none of them could be considered at risk.

Risk highest in the first year of life	Emirati, Indonesian, Nigerian, Yemeni	Before kindergarten
Risk elevated in the first 5 years of life	Ivorian, Ethiopian, Eritrean, Gambian, Malay, Saudi, Senegalese	Before elementary school
Risk rises after age 5 and into adolescence	Cameroonian, Egyptian, Guinean, Kurdish, Somali, Sudanese, Tanzanian	Elementary school
Risk highest during adolescence	Kenyan, Liberian, Sierra Leonean, Ugandan	Middle and junior high school
Risk across childhood	Ghanaian, Kuwaiti, Togolese	From kindergarten through junior high school

This report also makes the argument that most of the 290,000 girls (in ACS data) under the age of 15 born to parents from historically practicing communities were not at risk of FGM/C. In fact, based on a mid-risk scenario it is estimated that 6,200 girls below the age of 15 were already living with FGM/C and 31,000 were potentially at risk of FGM/C at some point. It was further estimated that an additional 2,500 girls born each year in the United States were potentially at risk of FGM/C in their lifetime. Finding the balance between protecting girls at risk while not discriminating against the vast majority of girls who are not requires careful consideration. This calls for age-appropriate interventions and heightened awareness of age of risk factors by those seeking to intervene.

7: PROSECUTION

While prosecution should always be a last resort, adequate legislation is a key requirement, not only for prosecution but also for each of the other responses outlined above.

Federal law makes it illegal to perform FGM/C on a girl in the U.S., to be the parent or guardian of a minor and consent to or facilitate the procedure for that child, or to remove a girl from the country for purposes of undergoing FGM/C.

Although federal law bans the practice, state anti-FGM/C legislation remains vital for several reasons. State laws against FGM/C send the message that the practice is not acceptable and will not be tolerated within that state. Penalties assigned under those state laws are used by family members as a strong defense against other family or community members pressuring them to have their girls cut.

State laws can also provide crucial tools that federal laws cannot. They can and should mandate education and outreach to practicing communities and professionals and allocate the funding necessary to implement such laws. They provide local law enforcement and prosecutors with the necessary tools to pursue perpetrators. Civil laws can give survivors the opportunity to seek justice in a court of law on their own behalf, should they choose to do so.

AHA Foundation's main goal in supporting efforts to criminalize FGM/C in the United States has always been the prevention of the practice. Over the years, laws to address the problem of FGM/C in the United States have been honed: additional provisions have been developed to more comprehensively fight FGM/C in the United States beyond the goals of prevention and prosecution, to now also support survivors and equip those professionals who may encounter cases.

Provisions Considered in Evaluating the Strength of Anti-FGM/C Legislation

- Felony Offense for All FGM/C Types
- Education and Outreach
- Comprehensive Expanded Definition of FGM/C
- Prohibition of Transporting for FGM/C
- Civil Cause of Action, Extended Civil Statute of Limitations
- Specification that Culture, Ritual, and Religion are Not Defenses to Prosecution
- Specification of Mandatory Reporting
- Annual Statistical Reporting
- Specification of Ability to Prosecute Parents/Guardian
- Mandatory Training for Law Enforcement
- Mandatory Revocation of Medical License

Together these provisions provide a robust framework to facilitate FGM/C prevention, survivor support, and the prosecution of perpetrators. However, there is a wide discrepancy between the laws that have been enacted from state to state. Some states passed their anti-FGM/C legislation prior to the widespread understanding that laws can do more than just punish those who perform the procedure, while other state legislatures elected to pass laws that widely varied in strength. Nine states, plus Washington D.C., have yet to specifically ban the practice.


Image.stock

The strength of existing laws was ranked by AHA Foundation's views on which provisions are most important in anti-FGM/C legislation. Here we discuss a few of those AHA Foundation deems to be most important:

- Classification of all types of FGM/C as a felony is necessary to demonstrate that this human rights abuse is a serious offense that should be banned in all its forms and to ensure that FGM/C is viewed by the law at least as severely as the non-FGM/C specific offenses (such as assault) that could be used to prosecute a case were there no FGM/C-specific law in place.

- Education and outreach programs for both practicing communities and professionals on the harms associated with the procedure, the signs a girl is at risk, and the laws against the practice are important tools that help facilitate prevention. These programs arm families with information, raise awareness with those who are best placed to support at-risk children, and ideally open a dialogue within practicing communities.

- A robust definition of FGM/C, mirroring that of the World Health Organization, further highlights that there is no "acceptable" form of FGM/C. Such a definition also makes it clear to authorities when they encounter different FGM/C types that even less physically invasive versions of the procedure are illegal.

Adopting a comprehensive approach to FGM/C that brings together prevalence, partnership, policy, prevention, protection, provision, and prosecution is vital to efforts to support the communities affected by this practice in the United States.

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STATE-BY-STATE ANALYSIS

Summaries for 34 states and the District of Columbia, as well as three regional summaries that group together those states that have less than 100 girls at risk

Image: stock

ARIZONA

AZ

STATE DATA

Based on 2015-2019 ACS population estimates.

16,647
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

5,134
Women and girls who were likely **LIVING WITH** FGM/C

476
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3P103J0

SUMMARY

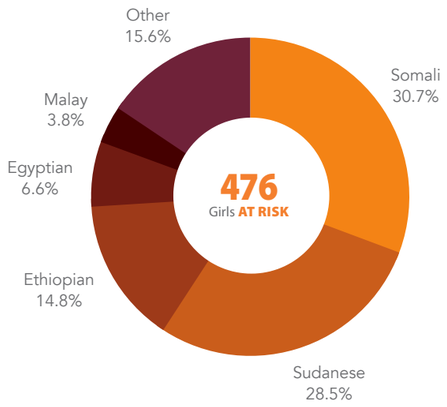
FGM/C prevalence was estimated at 33.7% within the study population in Arizona with over 60% of the impacted population in the state identifying as Somali (16.9%), Sudanese (16.2%), Ethiopian (12.3%) or Egyptian (11.8%).

It is estimated that **1,416** women were living with Type 3 FGM/C in Arizona. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

97% of those impacted by FGM/C in Arizona live in the greater Phoenix-Mesa-Scottsdale (84%) and Tucson (13%) metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Arizona



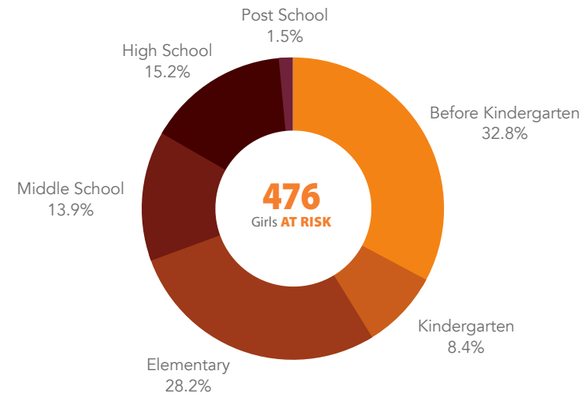
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Arizona



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Maricopa	13,593	4,212	409
Pima	2,102	645	60
Pinal	231	93	-
Mohave	270	50	4
Cochise	97	32	-
Coconino	103	30	4
Yavapai	131	28	-
Yuma	33	15	-
Santa Cruz	37	12	-

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Phoenix-Mesa-Scottsdale, AZ	13,821	4,306	408
Tucson, AZ	2,102	645	59
Lake Havasu City-Kingman, AZ	291	54	4
Prescott, AZ	131	28	-
Flagstaff, AZ	103	30	4
Yuma, AZ	33	15	-

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Phoenix-Mesa-Scottsdale and Tucson metropolitan areas.

Child Protection should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

CALIFORNIA

CA

STATE DATA

Based on 2015-2019 ACS population estimates.

149,342
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

51,907
Women and girls who were likely **LIVING WITH** FGM/C

2,940
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing[1] Legislation[2], Needs Strengthening

IMPROVE BY ADDING
Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3PC5qju
2 https://bit.ly/4690pGd

SUMMARY

FGM/C prevalence was estimated at 36.7% within the study population in California, with over 60% of the impacted population in the state identifying as Egyptian (32.1%), Indonesian (19.5%) or Ethiopian (12.8%).

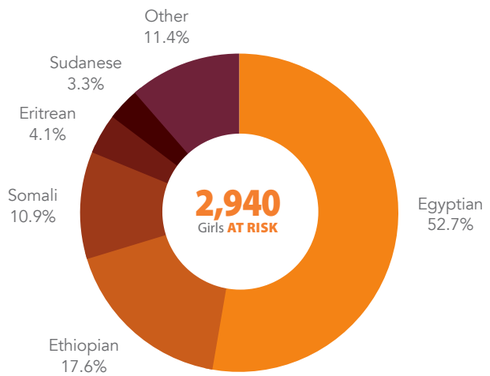
It is estimated that **4,756** women were living with Type 3 FGM/C in California. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

79% of those impacted by FGM/C in California live in one of four metropolitan areas: Los Angeles-Long Beach-Anaheim (40%); San Francisco-Oakland-Haward (18%); Riverside-San Bernardino-Ontario (11%); and San Diego-Carlsbad (10%).

An estimated 1,150 women and girls from the **Dawoodi Bohra** community live in California and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in California



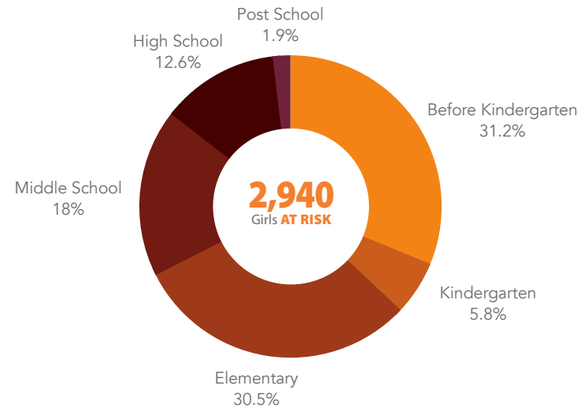
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in California



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Los Angeles	43,377	15,608	738
Orange	12,972	5,193	432
San Diego	13,207	4,942	479
Alameda	12,392	4,530	138
Santa Clara	9,015	3,740	201
San Bernardino	9,878	3,208	149
Riverside	8,062	2,573	236
Contra Costa	7,188	2,304	125
Sacramento	5,844	1,669	114
San Francisco	3,472	1,045	60

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Los Angeles-Long Beach-Anaheim, CA	56,353	20,802	1,154
San Francisco-Oakland-Hayward, CA	26,719	9,167	400
Riverside-San Bernardino-Ontario, CA	17,937	5,779	387
San Diego-Carlsbad, CA	13,207	4,939	479
San Jose-Sunnyvale-Santa Clara, CA	9,017	3,742	200
Sacramento-Roseville-Arden-Arcade, CA	7,315	2,016	128
Oxnard-Thousand Oaks-Ventura, CA	1,851	744	31
Stockton-Lodi, CA	2,499	687	27
Bakersfield, CA	2,229	684	29
Santa Rosa, CA	1,519	570	2

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Los Angeles-Long Beach-Anaheim, San Francisco-Oakland-Haward, Riverside-San Bernardino-Ontario, and San Diego-Carlsbad metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence; and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

COLORADO

CO

STATE DATA

Based on 2015-2019 ACS population estimates.

20,208
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

6,449
Women and girls who were likely **LIVING WITH** FGM/C

469
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Defintion of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/47xgPtj

SUMMARY

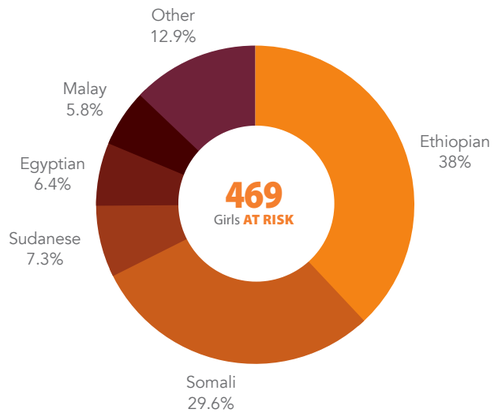
FGM/C prevalence was estimated at 34.2% within the study population in Colorado with over 60% of the impacted population in the state identifying as Ethiopian (35%), Somali (17.3%) or Eritrean (8.2%).

It is estimated that **1,434** women were living with Type 3 FGM/C in Colorado. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

82% of those impacted by FGM/C in Colorado live in the greater Denver-Aurora-Lakewood metropolitan area.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Colorado



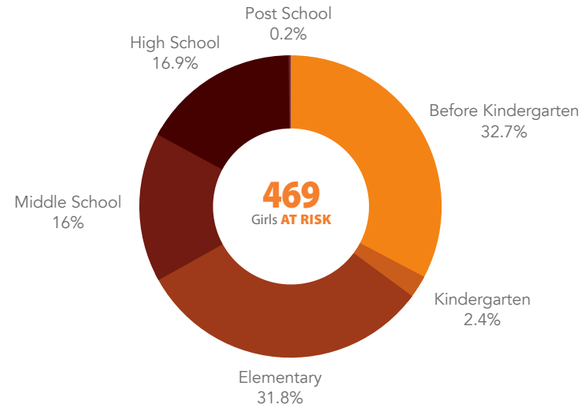
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Colorado



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Arapahoe	7,461	2,566	226
Denver	5,282	1,710	60
Adams	1,826	497	39
Boulder	646	319	1
El Paso	1,166	279	37
Weld	974	274	19
Jefferson	736	271	13
Larimer	710	192	19
Douglas	700	116	29
Broomfield	84	47	-

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Denver-Aurora-Lakewood, CO	16,407	5,318	375
Colorado Springs, CO	1,180	281	38
Fort Collins, CO	710	193	19
Pueblo, CO	32	2	4

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Denver-Aurora-Lakewood metropolitan area.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Sudanese** and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

CONNECTICUT

CT

STATE DATA

Based on 2015-2019 ACS population estimates.

12,613
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,544
Women and girls who were likely **LIVING WITH** FGM/C

198
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
No FGM/C Legislation

IMPROVE BY ADDING
Comprehensive Anti-FGM/C Legislation

SUMMARY

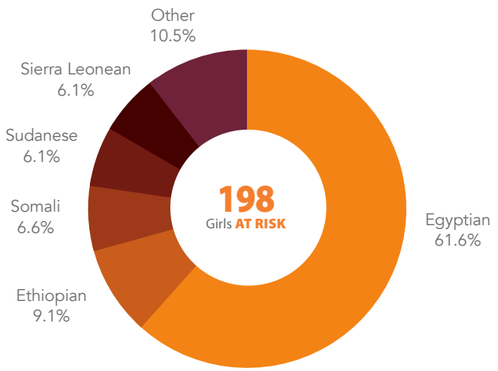
FGM/C prevalence was estimated at 21.7% within the study population in Connecticut with over 50% of the impacted population in the state identifying as Egyptian (33%), Nigerian (14.1%), Malay (8.7%) or Ethiopian (8.5%).

It is estimated that **289** women were living with Type 3 FGM/C in Connecticut. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Connecticut live in the greater Worcester and Hartford-West Hartford-East Hartford metropolitan areas with smaller, yet significant communities across much of the rest of the state.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Connecticut



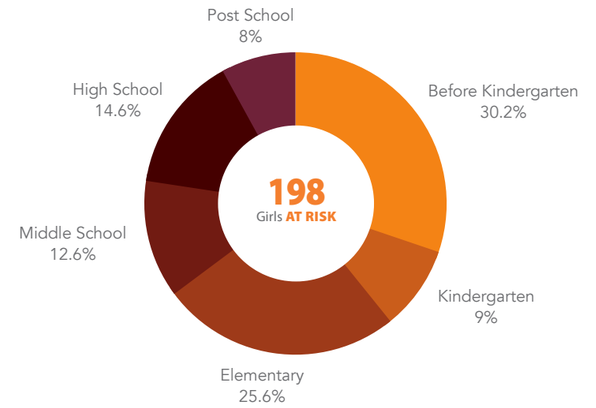
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Connecticut



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
New Haven	4,419	890	62
Hartford	3,907	686	92
Fairfield	3,171	652	36
Middlesex	358	124	5
New London	320	75	-
Tolland	212	59	1
Litchfield	113	54	-
Windham	113	3	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Worcester, MA-CT	6,852	924	109
New Haven-Millford, CT	4,419	890	63
Hartford-West Hartford-East Hartford, CT	4,477	870	98
Bridgeport-Stamford-Norwalk, CT	3,171	652	36
Norwich-New London, CT	320	74	-

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize passing comprehensive anti-FGM/C legislation.

Prevention and response interventions should focus on the greater Worcester and Hartford-West Hartford-East Hartford metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence; and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

DISTRICT OF COLUMBIA

D.C.

STATE DATA

Based on 2015-2019 ACS population estimates.

9,329
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,786
Women and girls who were likely **LIVING WITH** FGM/C

158
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
No FGM/C Legislation

IMPROVE BY ADDING
Comprehensive Anti-FGM/C Legislation

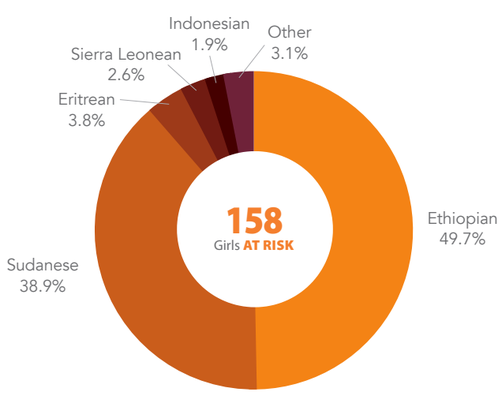
SUMMARY

FGM/C prevalence was estimated at 31.6% within the study population in District of Columbia with over 60% of the impacted population in the district identifying as Ethiopian (52%), Sudanese (13.9%) or Nigerian (10.3%).

It is estimated that **368** women were living with Type 3 FGM/C in District of Columbia. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in District of Columbia



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

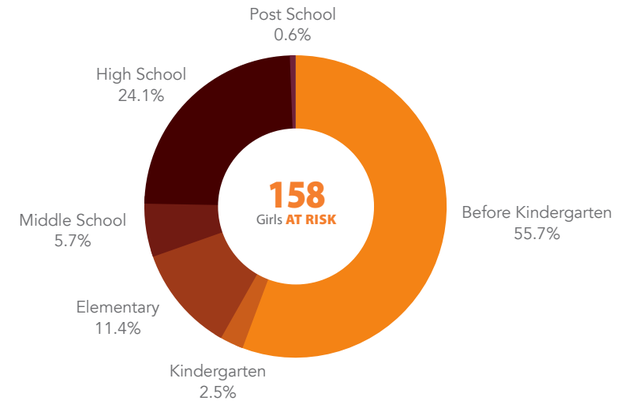
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

36

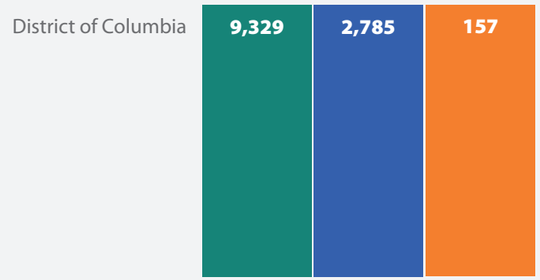
AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in District of Columbia

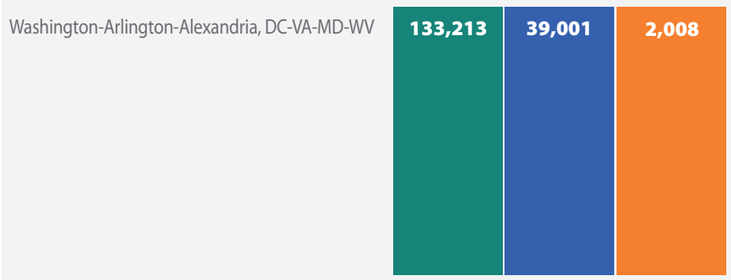


SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population



Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population



37

CALL TO ACTION

Interventions tailored to the specifics of the context.

District of Columbia council members should prioritize passing comprehensive anti-FGM/C legislation.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; and **Sudanese** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

FLORIDA

FL

STATE DATA

Based on 2015-2019 ACS population estimates.

32,154
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

9,743
Women and girls who were likely **LIVING WITH** FGM/C

543
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3DZYXcG

SUMMARY

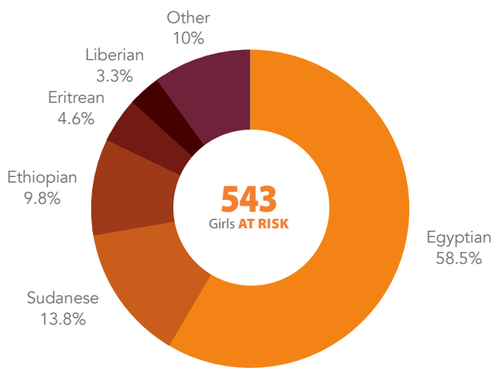
FGM/C prevalence was estimated at 32% within the study population in Florida with over 60% of the impacted population in the state identifying as Egyptian (46%), Nigerian (12.2%) or Indonesian (11%).

It is estimated that **636** women were living with Type 3 FGM/C in Florida. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

70% of those impacted by FGM/C in Florida live in the greater Miami-Fort Lauderdale-West Palm Beach (27%), Tampa-St. Petersburg-Clearwater (26%) and Orlando-Kissimmee-Sanford (17%) metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Florida



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

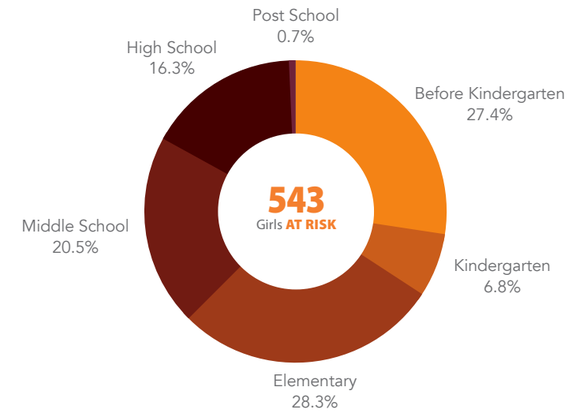
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

38

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Florida



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Hillsborough	4,465	1,169	80
Broward	3,784	1,069	74
Miami-Dade	2,588	800	37
Pinellas	1,938	772	47
Palm Beach	2,608	768	39
Orange	2,645	760	21
Duval	3,069	681	49
Seminole	1,371	545	63
Pasco	1,347	541	22
St Lucie	704	307	11

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Miami-Fort Lauderdale-West Palm Beach, FL	8,976	2,634	151
Tampa-St. Petersburg-Clearwater, FL	7,770	2,482	149
Orlando-Kissimmee-Sanford, FL	4,768	1,650	93
Jacksonville, FL	3,417	776	53
Port St. Lucie, FL	801	345	11
Gainesville, FL	868	286	13
Deltona-Daytona Beach-Ormond Beach, FL	557	230	10
Nort Port-Sarasota-Bradenton, FL	569	198	2
Palm Bay-Melbourne-Titusville, FL	681	182	10
Pensacola-Ferry Pass-Brent, FL	813	164	4

39

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Miami-Fort Lauderdale-West Palm Beach, Tampa-St. Petersburg-Clearwater and Orlando-Kissimmee-Sanford metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Sudanese** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

GEORGIA

GA

STATE DATA

Based on 2015-2019 ACS population estimates.

58,188
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

14,786
Women and girls who were likely **LIVING WITH** FGM/C

766
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3QGiDKr

SUMMARY

FGM/C prevalence was estimated at 26.7% within the study population in Georgia with over 60% of the impacted population in the state identifying as Nigerian (22.1%), Ethiopian (21.5%), Somali (10%) or Egyptian (7.7%).

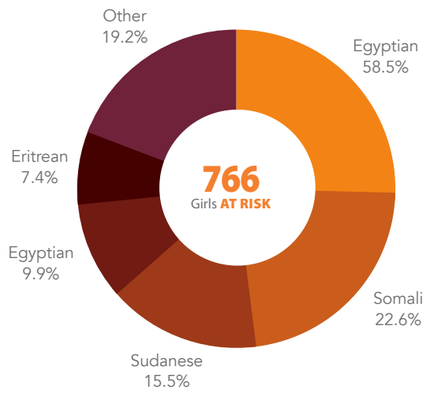
It is estimated that **2,103** women were living with Type 3 FGM/C in Georgia. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

94% of those impacted by FGM/C in Georgia live in the greater Atlanta-Sandy Springs-Roswell metropolitan area.

An estimated 150 women and girls from the **Dawoodi Bohra** community live in Georgia and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Georgia



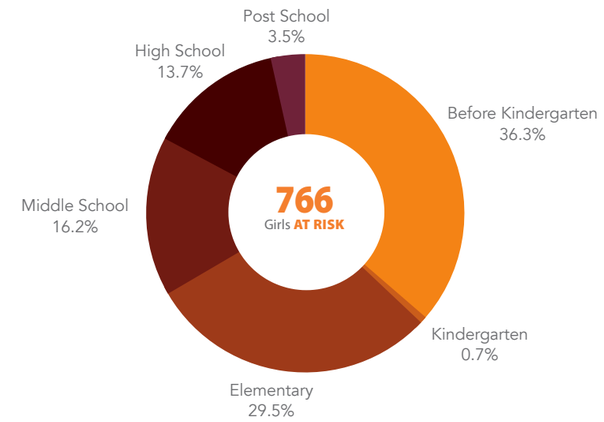
NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Georgia



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
DeKalb	14,129	4,645	403
Gwinnett	14,750	3,795	92
Cobb	8,507	1,754	84
Fulton	6,119	1,494	70
Clayton	3,005	523	31
Henry	2,148	325	11
Forsyth	1,111	254	20
Clarke	826	182	1
Douglas	1,397	174	1
Fayette	522	172	-

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Atlanta-Sandy Springs-Roswell, GA	54,066	13,849	727
Chattanooga, TN	639	152	7
Augusta-Richmond County, GA	440	142	15
Gainesville, GA	263	22	1

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Atlanta-Sandy Springs-Roswell metropolitan area.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Somali** and **Sudanese** girls between the ages of 5 and 15; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

IOWA

IA

STATE DATA

Based on 2015-2019 ACS population estimates.

6,788
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,259
Women and girls who were likely **LIVING WITH** FGM/C

235
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/ Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3qCBoDS

SUMMARY

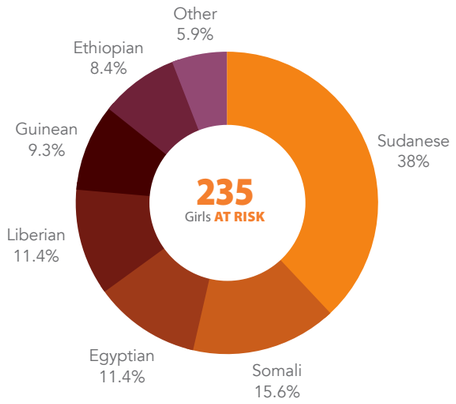
FGM/C prevalence was estimated at 36.7% within the study population in Iowa with over 60% of the impacted population in the state identifying as Sudanese (36.6%), Somali (11.7%), Egyptian (11.5%) or Ethiopian (8.5%).

It is estimated that **898** women were living with Type 3 FGM/C in Iowa. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Iowa live in the greater Omaha-Council Bluffs and Des Moines-West Des Moines metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Iowa



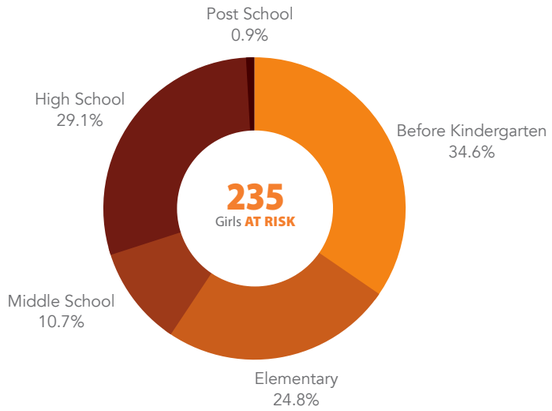
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

42

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Iowa



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Polk	3,250	938	146
Johnson	926	344	-
Linn	483	166	2
Dallas	389	160	14
Woodbury	174	48	-
Buena Vista	62	36	2
Carroll	62	36	2
Wapello	56	32	2
Crawford	49	29	2
Warren	91	23	4

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Omaha-Council Bluffs, NE-IA	4,377	1,562	350
Des Moines-West Des Moines, IA	3,883	1,159	169
Iowa City, IA	926	344	-

43

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Omaha-Council Bluffs and Des Moines-West Des Moines metropolitan areas.

Child Protection should focus on **Sudanese** and **Somali** girls between the ages of 5 and 15; **Egyptian** girls between the ages of 6 and 14; and **Liberian** girls between the ages of 0 and 19.

All estimates are subject to both sampling and nonsampling error.

ILLINOIS

IL

STATE DATA

Based on 2015-2019 ACS population estimates.

37,453
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

9,311
Women and girls who were likely **LIVING WITH** FGM/C

580
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3sjgQ3R

SUMMARY

FGM/C prevalence was estimated at 26.4% within the study population in Illinois with over 60% of the impacted population in the state identifying as Egyptian (30.7%), Nigerian (24%) or Ethiopian (10.6%).

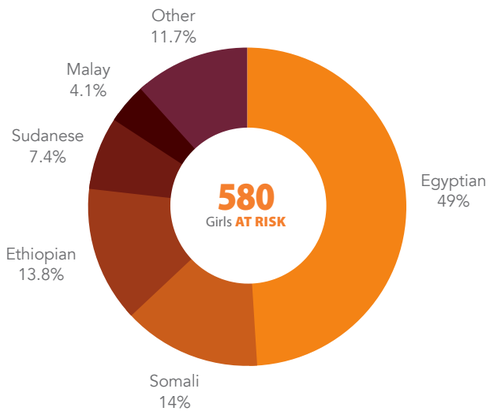
It is estimated that **1,039** women were living with Type 3 FGM/C in Illinois. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Illinois live in the greater Chicago-Naperville-Elgin and St. Louis metropolitan areas.

An estimated 390 women and girls from the **Dawoodi Bohra** community live in Illinois and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Illinois



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

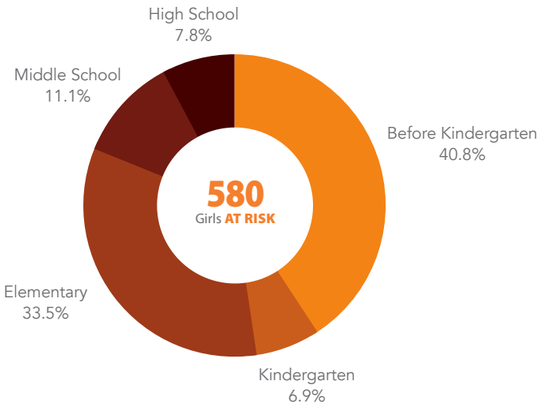
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

44

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Illinois



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Cook	24,060	5,960	380
DuPage	3,078	1,120	33
Will	2,730	637	58
Kane	1,118	299	9
Champaign	734	227	11
Lake	720	224	3
Winnebago	563	104	26
Macon	148	77	-
McLean	268	74	1
Peoria	184	59	6

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Chicago-Naperville-Elgin, IL-IN-WI	33,054	8,574	492
St. Louis, MO-IL	6,943	1,295	218
Champaign-Urbana, IL	734	227	11
Rockford, IL	602	118	27
Decatur, IL	148	77	-
Bloomington, IL	268	74	1
Springfield, IL	328	46	-
Kankakee, IL	256	40	-

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CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Chicago-Naperville-Elgin and St. Louis metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Sudanese** and **Somali** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

INDIANA

IN

STATE DATA

Based on 2015-2019 ACS population estimates.

13,679
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

3,432
Women and girls who were likely **LIVING WITH** FGM/C

280
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Strong
Existing Legislation[1]

IMPROVE BY ADDING
Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3tdreus

SUMMARY

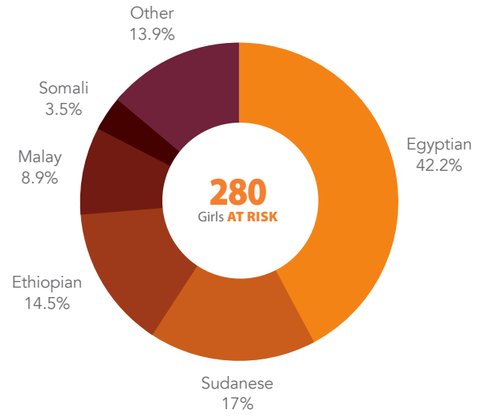
FGM/C prevalence was estimated at 27.1% within the study population in Indiana with over 60% of the impacted population in the state identifying as Nigerian (25%), Egyptian (19.8%), Ethiopian (10.5%) or Malay (8.8%).

It is estimated that **443** women were living with Type 3 FGM/C in Indiana. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Indiana live in the greater Chicago-Naperville-Elgin, Indianapolis-Carmel-Anderson, and Louisville/Jefferson County metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Indiana



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

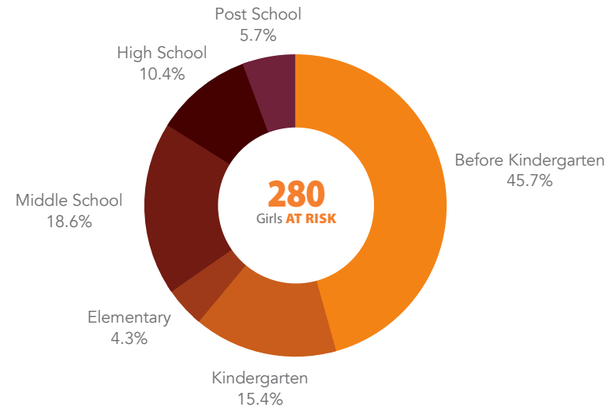
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

46

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Indiana



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Marion	6,243	1,580	74
Allen	831	236	32
Hamilton	1,044	234	43
Monroe	548	200	8
St. Joseph	1,007	194	14
Lake	502	171	1
Hendricks	578	137	23
Tippecanoe	402	114	22
Vanderburgh	413	75	24
Elkhart	274	66	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Chicago-Naperville-Elgin, IL-IN-WI	33,054	8,574	492
Indianapolis-Carmel-Anderson, IN	8,224	2,031	159
Cincinnati, OH-KY-IN	6,543	1,487	108
Louisville/Jefferson County, KY-IN	4,809	1,422	236
Fort Wayne, IN	831	236	31
Bloomington, IN	548	200	8
Lafayette-West Lafayette, IN	402	114	22
Elkhart-Goshen, IN	274	66	-
Michigan City-La Porte, IN	80	11	-

47

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Chicago-Naperville-Elgin, Indianapolis-Carmel-Anderson, and Louisville/Jefferson County metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Sudanese** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Malay** girls between the ages of 0 and 4.

All estimates are subject to both sampling and nonsampling error.

KANSAS

KS

STATE DATA

Based on 2015-2019 ACS population estimates.

6,832
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

1,995
Women and girls who were likely **LIVING WITH** FGM/C

250
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/45vemxy

SUMMARY

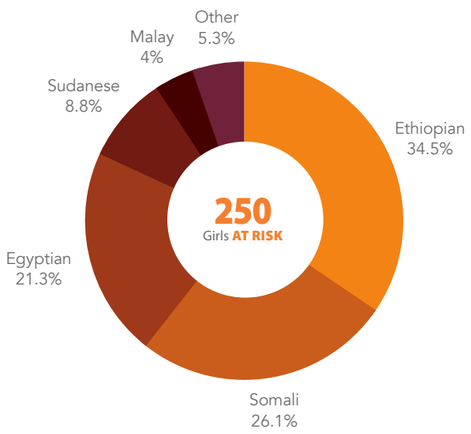
FGM/C prevalence was estimated at 32.9% within the study population in Kansas with over 60% of the impacted population in the state identifying as Egyptian (23.7%), Ethiopian (19.7%), Somali (11.7%) or Sudanese (10.8%).

It is estimated that **384** women were living with Type 3 FGM/C in Kansas. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Kansas live in the greater Kansas City and Wichita metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Kansas



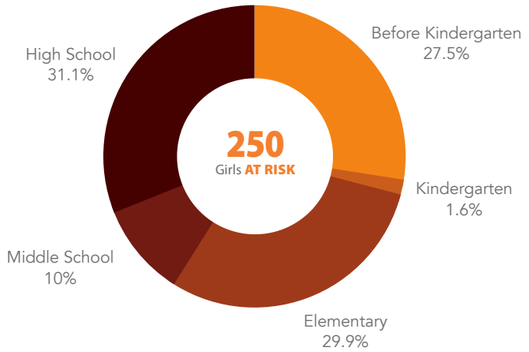
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Kansas



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Johnson	3,352	838	99
Sedgwick	1,224	460	67
Wyandotte	518	147	15
Butler	284	129	14
Douglas	567	105	4
Finney	110	65	5
Ford	98	58	4
Seward	63	37	3
Riley	40	22	-
Grant	21	12	1

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Kansas City, MO-KS	8,073	2,163	208
Wichita, KS	1,509	590	82
Lawrence, KS	567	105	4
St. Joseph, MO-KS	65	62	-

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Kansas City and Wichita metropolitan areas.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Sudanese** and **Somali** girls between the ages of 5 and 15; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

KENTUCKY

KY

STATE DATA

Based on 2015-2019 ACS population estimates.

8,300
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,083
Women and girls who were likely **LIVING WITH** FGM/C

297
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Strongest
Existing Legislation[1]

IMPROVE BY ADDING
Nothing

1 https://bit.ly/3RJRzKy

SUMMARY

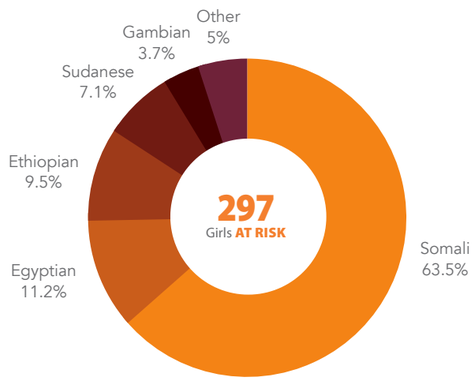
FGM/C prevalence was estimated at 28.7% within the study population in Kentucky with over 60% of the impacted population in the state identifying as Somali (40.8%), Ethiopian (10.8%) or Egyptian (10.7%).

It is estimated that **601** women were living with Type 3 FGM/C in Kentucky. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Kentucky live in the greater Cincinnati and Louisville/Jefferson County metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Kentucky



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

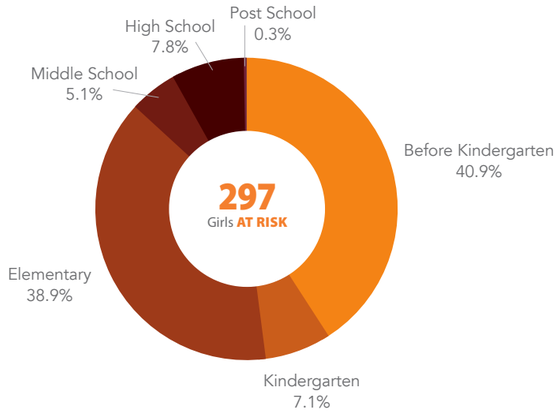
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

50

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Kentucky



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Jefferson	4,550	1,353	226
Fayette	1,249	257	12
Boone	596	142	16
Warren	326	61	11
Madison	145	52	3
Daviess	54	38	-
Campbell	133	19	3
Kenton	159	17	13
Franklin	50	15	-
Woodford	26	8	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Cincinnati, OH-KY-IN	6,543	1,487	108
Louisville/Jefferson County, KY-IN	4,809	1,422	236
Clarksville, TN-KY	631	167	3
Owensboro, KY	59	41	-

51

CALL TO ACTION

Interventions tailored to the specifics of the context.

Prevention and response interventions should focus on the greater Cincinnati and Louisville/ Jefferson County metropolitan areas.

Child Protection should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15; **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

MASSACHUSETTS

MA

STATE DATA

Based on 2015-2019 ACS population estimates.

41,437
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

9,416
Women and girls who were likely **LIVING WITH** FGM/C

697
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Adequate Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/ Guardians; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/47D6A6r

SUMMARY

FGM/C prevalence was estimated at 24.4% within the study population in Massachusetts with over 60% of the impacted population in the state identifying as Egyptian (20.9%), Somali (17%), Ethiopian (13.8%) or Nigerian (13.7%).

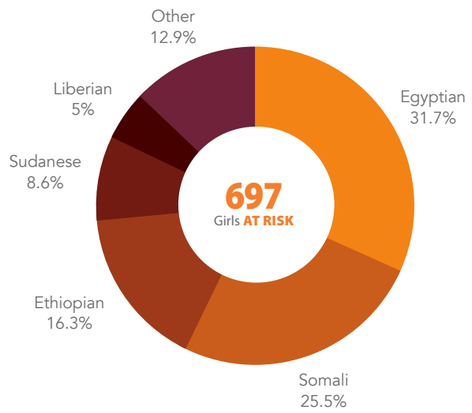
It is estimated that **1,643** women were living with Type 3 FGM/C in Massachusetts. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Massachusetts live in the greater Boston-Cambridge-Newton and Providence-Warwick metropolitan areas.

An estimated 270 women and girls from the **Dawoodi Bohra** community live in Massachusetts and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Massachusetts



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

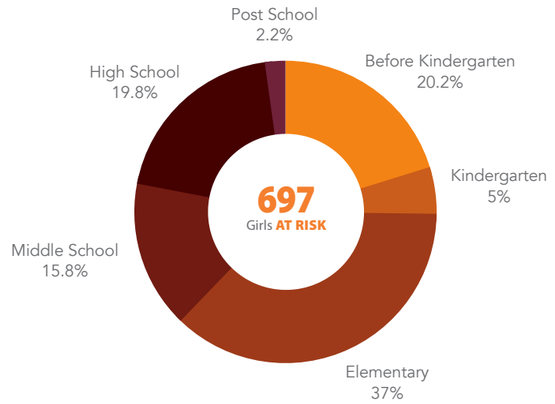
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

52

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Massachusetts



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Middlesex	13,885	2,810	219
Suffolk	8,167	2,711	98
Norfolk	3,398	1,013	82
Worcester	6,924	965	124
Essex	3,197	583	31
Bristol	1,672	488	28
Hampden	1,452	333	85
Plymouth	1,590	293	19
Hampshire	374	80	6
Franklin	229	49	2

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Boston-Cambridge-Newton, MA-NH	31,343	7,801	480
Providence-Warwick, RI-MA	7,647	1,845	95
Worcester, MA-CT	6,852	924	109
Springfield, MA	1,658	376	90
Pittsfield, MA	305	42	6
Barnstable Town, MA	244	48	-

53

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Boston-Cambridge-Newton and Providence-Warwick metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Somali** and **Sudanese** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

MARYLAND

MD

STATE DATA

Based on 2015-2019 ACS population estimates.

101,243
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

24,709
Women and girls who were likely **LIVING WITH** FGM/C

1,027
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3E1x445

SUMMARY

FGM/C prevalence was estimated at 25.4% within the study population in Maryland with over 60% of the impacted population in the state identifying as Ethiopian (27.6%), Nigerian (23.9%) or Sierra Leonian (15.8%).

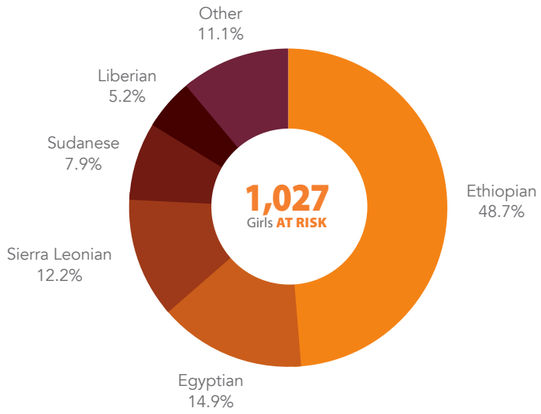
It is estimated that **2,230** women were living with Type 3 FGM/C in Maryland. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Maryland live in the greater Washington-Arlington-Alexandria, Philadelphia-Camden-Wilmington and Baltimore-Columbia-Towson metropolitan areas.

An estimated 240 women and girls from the **Dawoodi Bohra** community live in Maryland and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Maryland



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

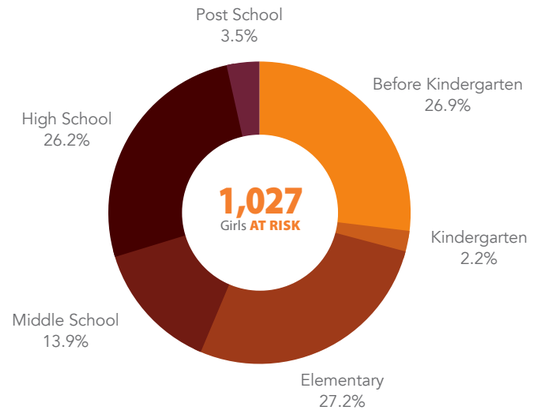
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

54

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Maryland



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Montgomery	33,669	9,289	536
Prince George's	33,348	7,861	150
Baltimore	13,351	2,844	168
Howard	5,346	1,421	35
Baltimore city	5,297	1,054	54
Anne Arundel	3,774	762	36
Harford	962	311	3
Frederick	1,907	297	9
Charles	914	215	3
Washington	1,002	185	19

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Washington-Arlington-Alexandria, DC-VA-MD-WV	133,213	39,001	2,008
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	36,502	9,054	583
Baltimore-Columbia-Towson, MD	29,006	6,452	295
Salisbury, MD-DE	1,001	275	12

55

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Washington-Arlington-Alexandria, Philadelphia-Camden-Wilmington and Baltimore-Columbia-Towson metropolitan areas.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Egyptian** girls between the ages of 6 and 14; **Sierra Leonean** girls between the ages of 10 and 19; and **Sudanese** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

MAINE

ME

STATE DATA

Based on 2015-2019 ACS population estimates.

2,693
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

971
Women and girls who were likely **LIVING WITH** FGM/C

317
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
No FGM/C Legislation

IMPROVE BY ADDING
Comprehensive Anti-FGM/C Legislation

SUMMARY

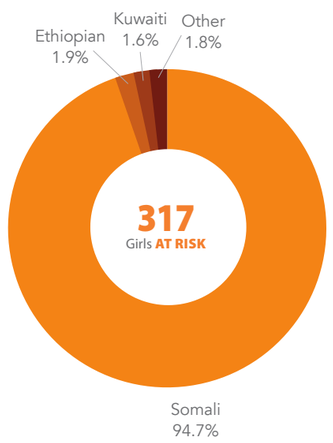
FGM/C prevalence was estimated at 47.8% within the study population in Maine with 85% of the impacted population in the state identifying as Somali.

It is estimated that **672** women were living with Type 3 FGM/C in Maine. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

95% of those impacted by FGM/C in Maine live in the greater Portland-South Portland and Lewiston-Aubum metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Maine

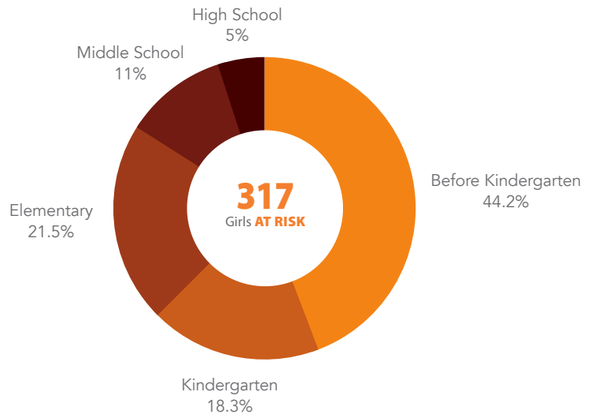


STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Maine



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Cumberland	1,421	594	180
Androscoggin	825	290	126
York	103	30	-
Penobscot	42	14	2
Hancock	76	8	2
Knox	55	6	1
Waldo	54	6	1
Lincoln	48	5	1

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Portland-South Portland, ME	1,534	625	181
Lewiston-Auburn, ME	825	290	126
Bangor, ME	42	14	2

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize passing comprehensive anti-FGM/C legislation.

Prevention and response interventions should focus on the greater Portland-South Portland and Lewiston-Aubum metropolitan areas.

Child Protection should focus on **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

MICHIGAN

MI

STATE DATA

Based on 2015-2019 ACS population estimates.

32,511
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

6,819
Women and girls who were likely **LIVING WITH** FGM/C

462
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Comprehensive Expanded Definition of FGM/C; Specification of Mandatory Reporting; Annual Statistical Reporting

1 https://bit.ly/3RF5RMv

SUMMARY

FGM/C prevalence was estimated at 22.4% within the study population in Michigan with over 50% of the impacted population in the state identifying as Egyptian (23.6%), Yemeni (22.9%) or Nigerian (9.1%).

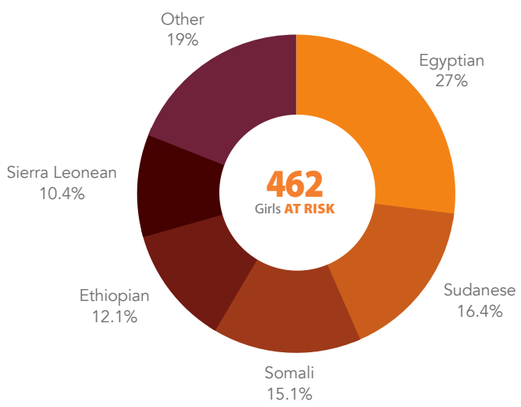
It is estimated that **631** women were living with Type 3 FGM/C in Michigan. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

70% of those impacted by FGM/C in Michigan live in the greater Detroit-Warren-Dearborn (59%) and Lansing-East Lansing (11%) metropolitan areas.

An estimated 260 women and girls from the **Dawoodi Bohra** community live in Michigan and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Michigan



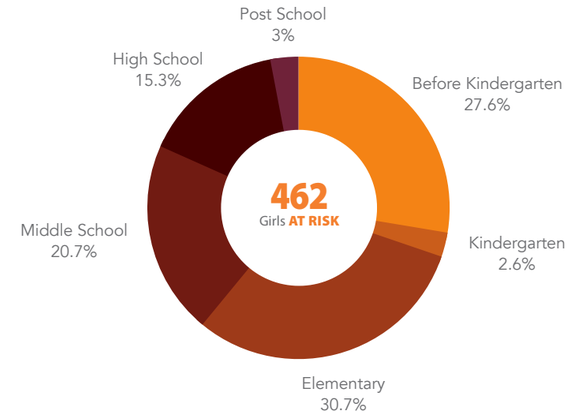
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Michigan



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Wayne	16,809	2,553	99
Oakland	3,191	847	69
Macomb	1,666	665	19
Ingham	2,065	662	115
Kent	1,912	500	91
Washtenaw	1,743	383	18
Kalamazoo	1,142	231	4
Genesee	908	214	11
Berrien	412	106	1
Shiawassee	141	48	1

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Detroit-Warren-Dearborn, MI	21,808	4,099	186
Lansing-East Lansing, MI	2,252	706	115
Grand Rapids-Wyoming, MI	1,961	517	90
Ann Arbor, MI	1,743	383	17
Kalamazoo-Portage, MI	1,179	238	5
Niles-Benton Harbor, MI	412	106	1
Jackson, MI	118	33	9
Monroe, MI	84	25	-
Saginaw, MI	113	23	-
Muskegon, MI	141	10	2

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Detroit-Warren-Dearborn and Lansing-East Lansing metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Sudanese** and **Somali** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Sierra Leonean** girls between the ages of 0 and 19.

All estimates are subject to both sampling and nonsampling error.

MINNESOTA

MN

STATE DATA

Based on 2015-2019 ACS population estimates.

84,363
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

30,228
Women and girls who were likely **LIVING WITH** FGM/C

5,478
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/ Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/47AqizU

SUMMARY

FGM/C prevalence was estimated at 42.3% within the study population in Minnesota with over 70% of the impacted population in the state identifying as Somali (67.9%) or Ethiopian (12.1%).

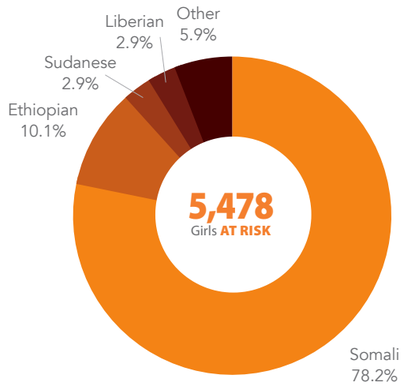
It is estimated that **15,795** women were living with Type 3 FGM/C in Minnesota. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Minnesota live in the greater Minneapolis-St. Paul-Bloomington metropolitan area.

An estimated 80 women and girls from the **Dawoodi Bohra** community live in Minnesota and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Minnesota

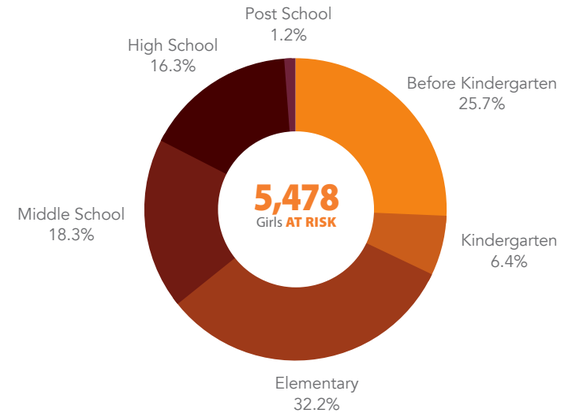


STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Minnesota



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Hennepin	38,915	13,990	2,262
Ramsey	12,561	4,142	730
Dakota	7,144	3,264	394
Anoka	6,452	1,933	315
Stearns	4,688	1,842	717
Olmsted	2,781	1,210	221
Washington	1,969	604	109
Scott	1,789	536	128
Sherburne	470	310	14
Rice	614	205	105

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Minneapolis-St. Paul-Bloomington, MN-WI	70,417	25,032	4,001
La Crosse-Onalaska, WI-MN	140	58	1

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Minneapolis-St. Paul-Bloomington metropolitan area.

Child Protection should focus on **Somali** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

MISSOURI

MO

STATE DATA

Based on 2015-2019 ACS population estimates.

12,515
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,939
Women and girls who were likely **LIVING WITH** FGM/C

358
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3YFCIIT

SUMMARY

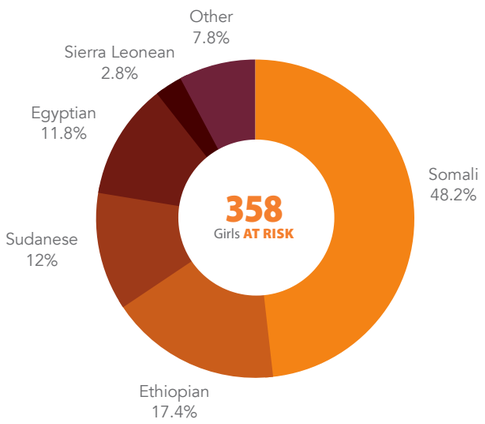
FGM/C prevalence was estimated at 26.3% within the study population in Missouri with over 60% of the impacted population in the state identifying as Somali (22.1%), Ethiopian (13.9%), Nigerian (13.9%) or Egyptian (10.5%).

It is estimated that **607** women were living with Type 3 FGM/C in Missouri. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Missouri live in the greater Kansas City and St. Louis metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Missouri



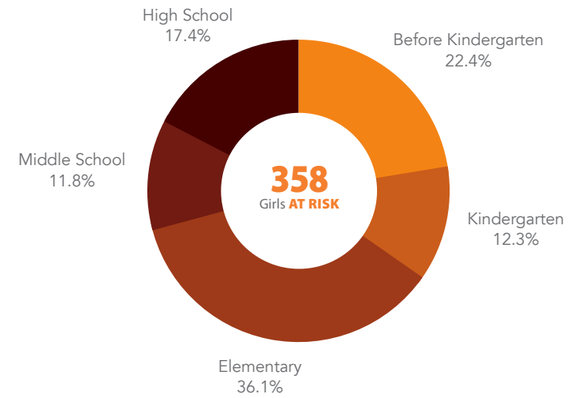
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Missouri



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
St. Louis	3,408	723	95
Jackson	2,562	651	76
St. Louis city	2,003	383	88
Clay	927	311	4
Boone	709	218	7
Platte	585	154	13
St. Charles	582	98	10
Greene	587	93	34
Buchanan	48	46	-
Jefferson	72	43	-

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Kansas City, MO-KS	8,073	2,163	208
St. Louis, MO-IL	6,943	1,295	218
Columbia, MO	709	218	7
Springfield, MO	597	94	33
Fayetteville-Springdale-Rogers, AR-MO	381	78	10
St. Joseph, MO-KS	65	62	-
Jefferson City, MO	172	8	-

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Kansas City and St. Louis metropolitan areas.

Child Protection should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

NORTH CAROLINA

NC

STATE DATA

Based on 2015-2019 ACS population estimates.

28,315
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

7,452
Women and girls who were likely **LIVING WITH** FGM/C

586
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/48twkCT

SUMMARY

FGM/C prevalence was estimated at 28.4% within the study population in North Carolina with over 50% of the impacted population in the state identifying as Egyptian (23.8%), Ethiopian (12.6%), Nigerian (11%) or Sudanese (9.4%).

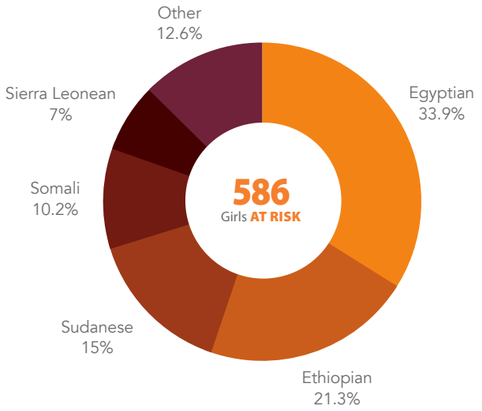
It is estimated that **1,212** women were living with Type 3 FGM/C in North Carolina. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in North Carolina live in the greater Charlotte-Concord-Gastonia, Raleigh, Virginia Beach-Norfolk-Newport News and Greensboro-High Point metropolitan areas.

An estimated 100 women and girls from the **Dawoodi Bohra** community live in North Carolina and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in North Carolina



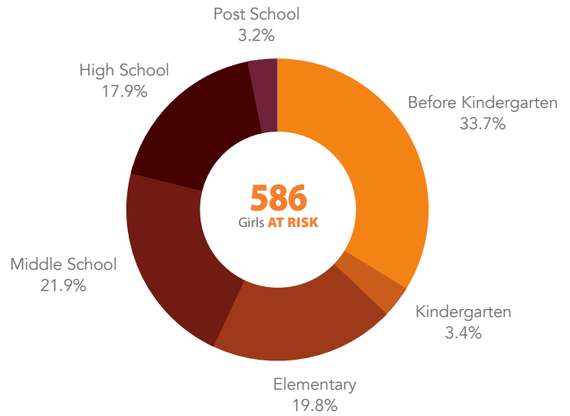
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in North Carolina



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Wake	6,793	1,914	193
Mecklenburg	6,947	1,898	150
Guilford	3,169	969	85
Durham	2,846	605	11
Orange	606	252	19
Cumberland	1,164	247	25
Forsyth	1,108	233	11
Cabarrus	664	146	13
Union	682	133	19
New Hanover	245	114	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Charlotte-Concord-Gastonia, NC-SC	9,121	2,405	178
Raleigh, NC	7,313	2,055	193
Greensboro-High Point, NC	3,281	1,001	85
Virginia Beach-Norfolk-Newport News, VA-NC	3,989	992	103
Fayetteville, NC	1,166	247	25
Winston-Salem, NC	1,153	238	12
Wilmington, NC	273	121	-
Greenville, NC	368	69	6
Goldsboro, NC	239	52	-
Asheville, NC	295	51	6

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Charlotte-Concord-Gastonia, Raleigh, Virginia Beach-Norfolk-Newport News and Greensboro-High Point metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence; and **Sudanese** and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

NEBRASKA

NE

STATE DATA

Based on 2015-2019 ACS population estimates.

8,360
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

3,232
Women and girls who were likely **LIVING WITH** FGM/C

587
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
No FGM/C Legislation

IMPROVE BY ADDING
Comprehensive Anti-FGM/C Legislation

SUMMARY

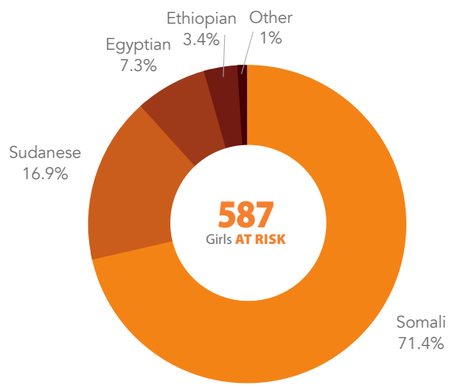
FGM/C prevalence was estimated at 45.7% within the study population in Nebraska with over 60% of the impacted population in the state identifying as Somali (47.5%) or Sudanese (30.8%).

It is estimated that **1,880** women were living with Type 3 FGM/C in Nebraska. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Nebraska live in the greater Omaha-Council Bluffs and Lincoln metropolitan areas with smaller, yet significant communities across much of the rest of the state.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Nebraska

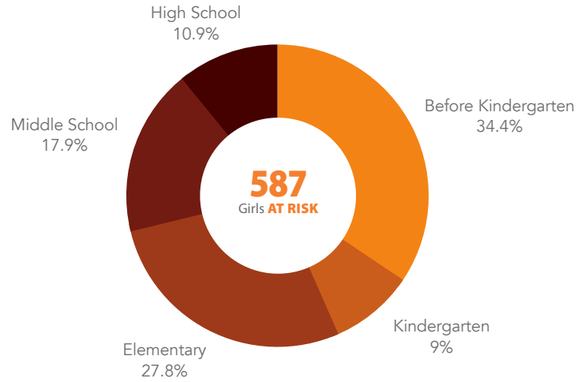


STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Nebraska



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Douglas	4,174	1,515	345
Lancaster	2,436	885	103
Hall	238	131	38
Lincoln	193	99	23
Dawson	134	69	16
Madison	50	40	1
Platte	48	38	1
Red Willow	60	30	7
Keith	46	24	6
Custer	40	22	6

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Omaha-Council Bluffs, NE-IA	4,377	1,562	350
Lincoln, NE	2,436	885	103

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize passing comprehensive anti-FGM/C legislation.

Prevention and response interventions should focus on the greater Omaha-Council Bluffs and Lincoln metropolitan areas.

Child Protection should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

NEW HAMPSHIRE

NH

STATE DATA

Based on 2015-2019 ACS population estimates.

3,893
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

1,343
Women and girls who were likely **LIVING WITH** FGM/C

165
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3PrwwcY

SUMMARY

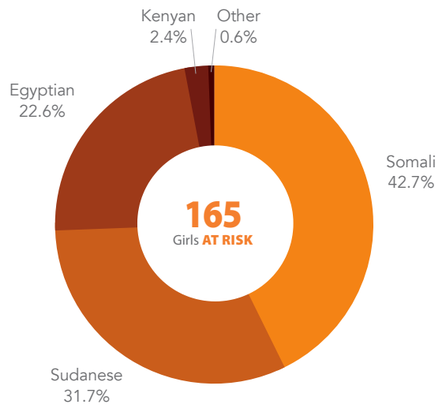
FGM/C prevalence was estimated at 38.7% within the study population in New Hampshire with over 60% of the impacted population in the state identifying as Sudanese (24%), Somali (21.8%) or Indonesian (17.8%).

It is estimated that **390** women were living with Type 3 FGM/C in New Hampshire. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Those impacted by FGM/C in New Hampshire live in the greater Boston-Cambridge-Newton and Manchester-Nashua metropolitan areas with smaller, yet significant communities across much of the rest of the state.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in New Hampshire



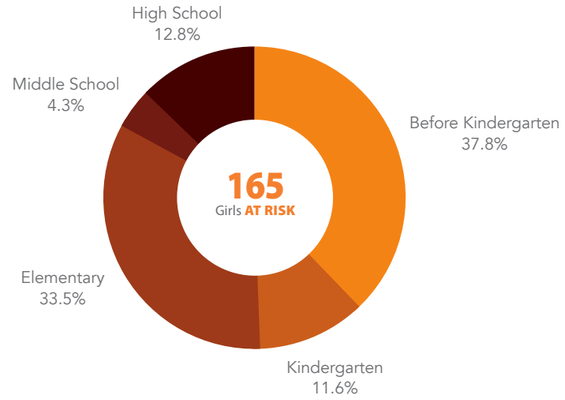
NOTE: Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in New Hampshire



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Hillsborough	2,312	696	145
Strafford	503	228	8
Merrimack	340	158	1
Rockingham	391	110	7
Grafton	207	91	-
Coos	71	31	-
Carroll	39	17	1
Belknap	26	11	1

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Boston-Cambridge-Newton, MA-NH	31,343	7,801	480
Manchester-Nashua, NH	2,219	691	145

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Boston-Cambridge-Newton and Manchester-Nashua metropolitan areas.

Child Protection should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

NEW JERSEY

NJ

STATE DATA

Based on 2015-2019 ACS population estimates.

63,177
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

19,940
Women and girls who were likely **LIVING WITH** FGM/C

1,327
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3taS3zi

SUMMARY

FGM/C prevalence was estimated at 33.7% within the study population in New Jersey with over 70% of the impacted population in the state identifying as Egyptian (63.6%) or Nigerian (12.9%).

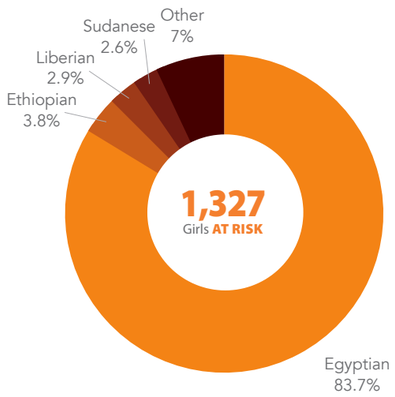
It is estimated that **879** women were living with Type 3 FGM/C in New Jersey. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in New Jersey live in the greater New York-Newark-Jersey City and Philadelphia-Camden-Wilmington metropolitan areas.

An estimated 500 women and girls from the **Dawoodi Bohra** community live in New Jersey and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in New Jersey



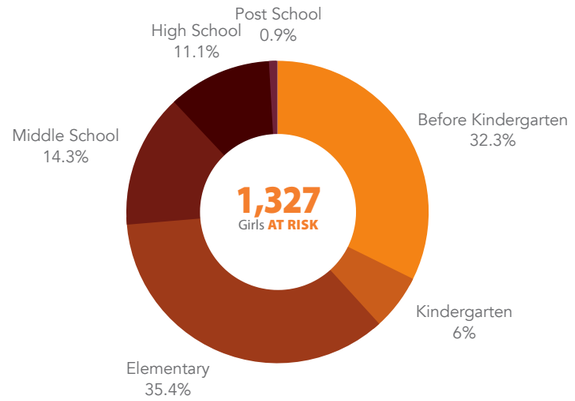
NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in New Jersey



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Middlesex	10,704	4,273	257
Hudson	8,984	3,974	345
Essex	14,821	3,081	74
Bergen	4,795	1,683	119
Monmouth	2,741	1,243	63
Union	4,035	976	53
Burlington	3,733	972	80
Somerset	1,942	686	84
Mercer	3,219	675	55
Morris	1,389	511	8

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
New York-Newark-Jersey City, NY-NJ-PA	156,704	44,356	2,734
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	36,502	9,054	583
Trenton, NJ	3,216	674	55
Allentown-Bethlehem-Easton, PA-NJ	1,868	545	31
Atlantic City-Hammonton, NJ	381	160	-
Ocean City, NJ	90	20	1

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater New York-Newark-Jersey City and Philadelphia-Camden-Wilmington metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

NEVADA

NV

STATE DATA

Based on 2015-2019 ACS population estimates.

13,724
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

5,083
Women and girls who were likely **LIVING WITH** FGM/C

288
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/45htFua

SUMMARY

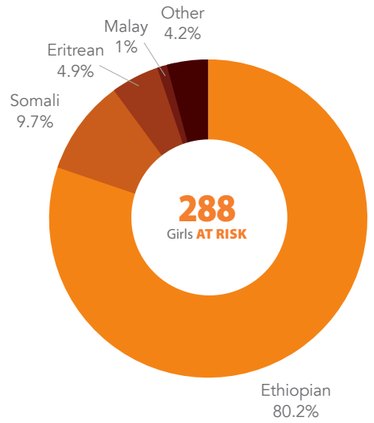
FGM/C prevalence was estimated at 39.1% within the study population in Nevada with over 70% of the impacted population in the state identifying as Ethiopian (66.3%) or Indonesian (7.2%).

It is estimated that **383** women were living with Type 3 FGM/C in Nevada. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

94% of those impacted by FGM/C in Nevada live in the greater Las Vegas-Henderson-Paradise metropolitan area.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Nevada



NOTE: Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

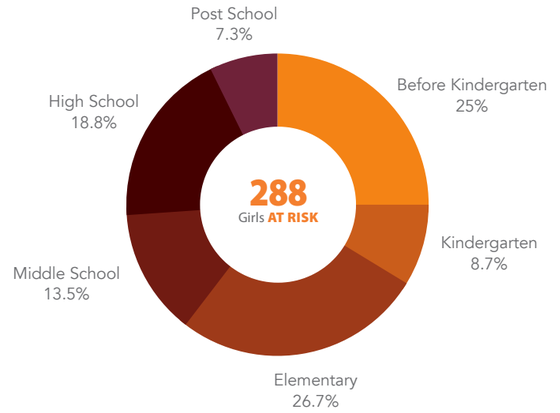
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

72

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Nevada



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Clark	12,358	4,756	271
Washoe	993	250	10
Elko	62	15	1
Nye	60	14	1
Lyon	56	9	-
Carson City	56	9	-
Douglas	47	8	-
Churchill	30	7	1
Humboldt	20	5	-

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Las Vegas-Henderson-Paradise, NV	12,358	4,755	272
Reno, NV	993	251	10

73

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Las Vegas-Henderson-Paradise metropolitan area.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

NEW YORK

NY

STATE DATA

Based on 2015-2019 ACS population estimates.

120,452
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

31,564
Women and girls who were likely **LIVING WITH** FGM/C

2,137
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3ZxvYHg

SUMMARY

FGM/C prevalence was estimated at 28% within the study population in New York with over 50% of the impacted population in the state identifying as Egyptian (35.5%) or Nigerian (15.8%).

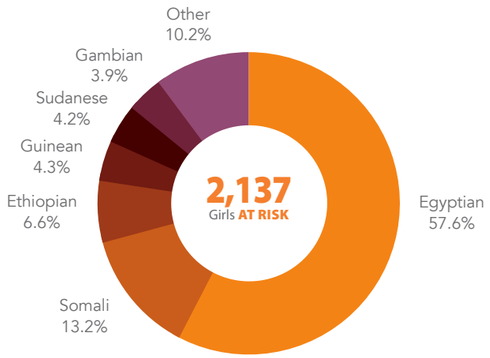
It is estimated that **2,906** women were living with Type 3 FGM/C in New York. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in New York live in the greater New York-Newark-Jersey City, Rochester and Buffalo-Cheektowage-Niagra Falls metropolitan areas.

An estimated 300 women and girls from the **Dawoodi Bohra** community live in New York and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in New York



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

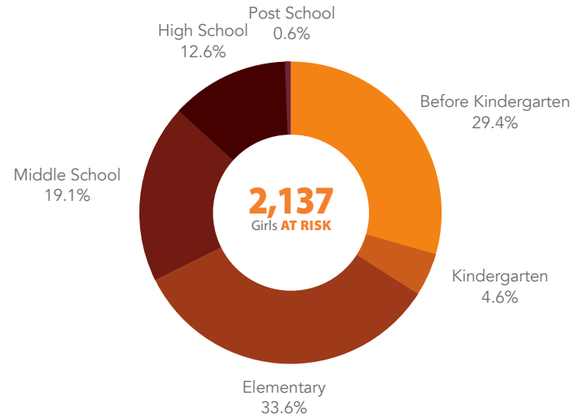
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

74

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in New York



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Queens	18,444	6,144	353
Kings	20,497	6,018	368
Bronx	30,158	4,989	218
New York	10,599	3,354	113
Richmond	6,775	2,338	242
Monroe	3,890	1,363	139
Erie	5,065	1,320	111
Nassau	4,355	1,152	135
Suffolk	4,456	1,080	68
Westchester	4,864	1,056	63

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
New York-Newark-Jersey City, NY-NJ-PA	156,704	44,356	2,734
Rochester, NY	4,112	1,442	140
Buffalo-Cheektowaga-Niagara Falls, NY	5,330	1,409	128
Syracuse, NY	1,920	584	137
Albany-Schenectady-Troy, NY	2,188	547	60
Utica-Rome, NY	688	168	32
Binghamton, NY	504	147	2
Glens Falls, NY	79	38	-
Ithaca, NY	222	34	-

75

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater New York-Newark-Jersey City, Rochester and Buffalo-Cheektowaga-Niagara Falls metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Somali** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

NORTHEAST REGION LOW PREVALENCE STATES DATA

DELAWARE, RHODE ISLAND, AND VERMONT

NE REGION

COMBINED STATE DATA

Based on 2015-2019 ACS population estimates.

12,652
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,757
Women and girls who were likely **LIVING WITH** FGM/C

155
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient Existing Legislation (Delaware[1]), and Severely Deficient Existing Legislation (Rhode Island[2] & Vermont[3]) Needs Strengthening

1 https://bit.ly/3LGt0zj
2 https://bit.ly/3Pc7pwd
3 https://bit.ly/3saH7kC

SUMMARY

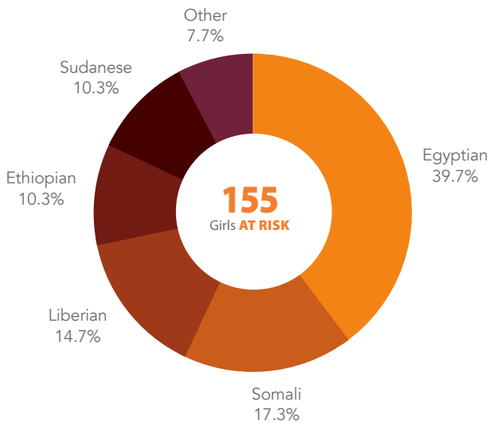
FGM/C prevalence was estimated at 23.0% within the study population in Delaware, Rhode Island and Vermont. The majority of the impacted population in Delaware and Rhode Island identify as Nigerian (24.9%), Liberian (21.4%) or Egyptian (20.5%), while most of the impacted population in Vermont identify as Somali (48.9%) or Sundanese (28.0%).

It is estimated that **264** women were living with Type 3 FGM/C in Delaware (25.4%), Rhode Island (26.5%) and Vermont (48.1%). While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C live in the greater Philadelphia-Camden-Wilmington, PA-NJ-DE-MD, Providence-Warwick, RI and Burlington-South Burlington, VT metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Delaware, Rhode Island, and Vermont



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

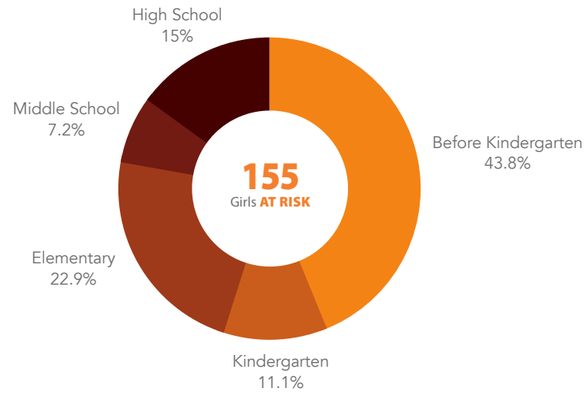
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

76

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Delaware, Rhode Island, and Vermont



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Providence, RI	5,278	1,179	45
New Castle, DE	4,638	957	37
Kent, DE	1,179	247	6
Chittenden, VT	319	127	32
Washington, RI	332	95	16
Kent, RI	222	50	2
Franklin, VT	94	37	9
Sussex, DE	193	16	2
Newport, RI	73	16	3
Bristol, RI	43	9	2

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	36,502	9,054	583
Providence-Warwick, RI	7,647	1,845	95
Dover, DE	1,174	246	6
Salisbury, MD-DE	1,001	275	12
Burlington-South Burlington, VT	428	170	43

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CALL TO ACTION

Interventions tailored to the specifics of the context.

Prevention and response interventions should focus on the greater Philadelphia-Camden-Wilmington, PA-NJ-DE-MD, Providence-Warwick, RI and Burlington-South Burlington, VT metropolitan areas.

Child Protection in DE and RI should focus on **Egyptian** girls between the ages of 6 and 14; and **Liberian** girls from birth throughout their adolescence. Child Protection in VT should focus on **Somali** and **Sudanese** girls between the ages of 5 and 15.

State legislators should prioritize strengthening existing legislation.

DE Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

RI Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

VT Improve Legislation by Adding: Felony Offense for All FGM/C Types; Education and Outreach; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

All estimates are subject to both sampling and nonsampling error.

OHIO

STATE DATA

Based on 2015-2019 ACS population estimates.

45,770
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

14,042
Women and girls who were likely **LIVING WITH** FGM/C

1,348
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/ Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/45eA1ua

SUMMARY

FGM/C prevalence was estimated at 33.6% within the study population in Ohio with over 60% of the impacted population in the state identifying as Somali (41.6%), Ethiopian (12.1%) or Egyptian (11.7%).

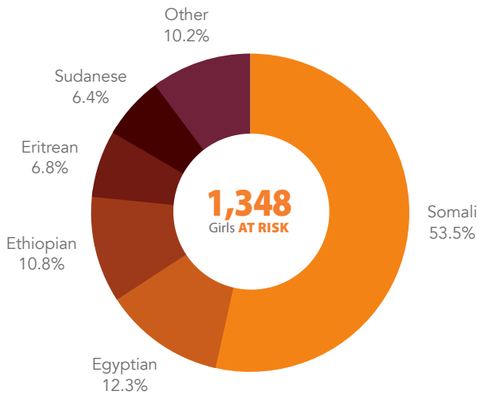
It is estimated that **5,212** women were living with Type 3 FGM/C in Ohio. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Ohio live in the greater Columbus, Cincinnatti and Cleveland-Elyria metropolitan areas.

An estimated 100 women and girls from the **Dawoodi Bohra** community live in Ohio and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be **AT RISK** of FGM/C in Ohio



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

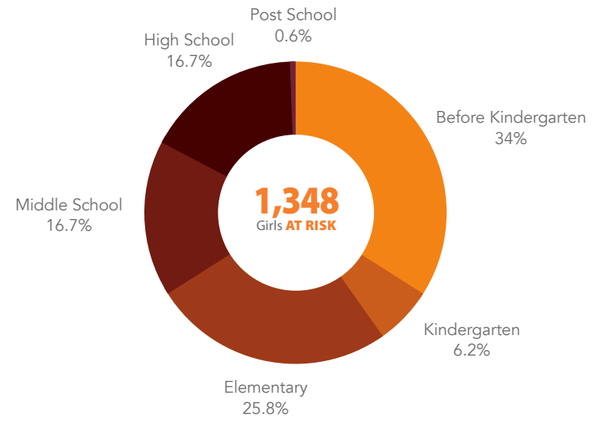
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

78

AGE DISTRIBUTION

Distribution of girls most likely to be **AT RISK** of FGM/C in Ohio



SPATIAL DISTRIBUTION

Counties with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Franklin	25,104	9,236	998
Cuyahoga	4,140	1,060	121
Hamilton	3,205	960	66
Fairfield	1,317	487	25
Montgomery	1,582	473	5
Lucas	1,345	371	19
Butler	1,784	237	5
Summit	1,697	148	32
Greene	601	114	4
Delaware	575	103	2

Metropolitan Areas with the highest
STUDY POPULATION | **LIVING WITH** | **AT RISK** population

	STUDY POPULATION	LIVING WITH	AT RISK
Columbus, OH	27,465	9,919	1,038
Cincinnati, OH-KY-IN	6,543	1,487	108
Cleveland-Elyria, OH	4,816	1,195	145
Dayton, OH	2,380	664	10
Toledo, OH	1,638	461	27
Akron, OH	2,093	189	37
Youngstown-Warren-Boardman, OH-PA	522	69	12
Canton-Massillon, OH	289	66	-
Lima, OH	39	7	-
Mansfield, OH	126	2	-

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CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Columbus, Cincinnati and Cleveland-Elyria metropolitan areas.

Child Protection should focus on **Somali** girls between the ages of 5 and 15; **Egyptian** girls between the ages of 6 and 14; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

OKLAHOMA

OK

STATE DATA

Based on 2015-2019 ACS population estimates.

5,348
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

1,154
Women and girls who were likely **LIVING WITH** FGM/C

108
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/ Guardian; Mandatory Training for Law Enforcement

1 https://bit.ly/3thZUej

SUMMARY

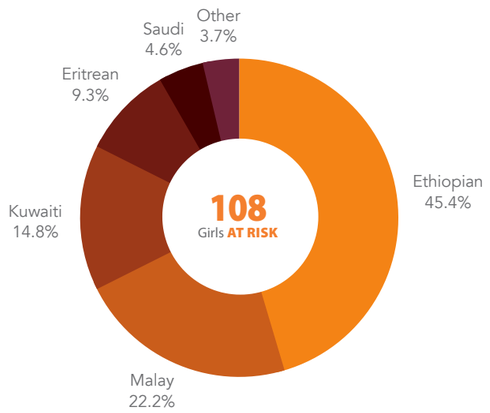
FGM/C prevalence was estimated at 23.6% within the study population in Oklahoma with over 60% of the impacted population in the state identifying as Nigerian (22.3%), Ethiopian (16.9%), Malay (14.4%) or Eritrean (12.3%).

It is estimated that **93** women were living with Type 3 FGM/C in Oklahoma. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

52% of those impacted by FGM/C in Oklahoma live in the greater Oklahoma City metropolitan area.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Oklahoma



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

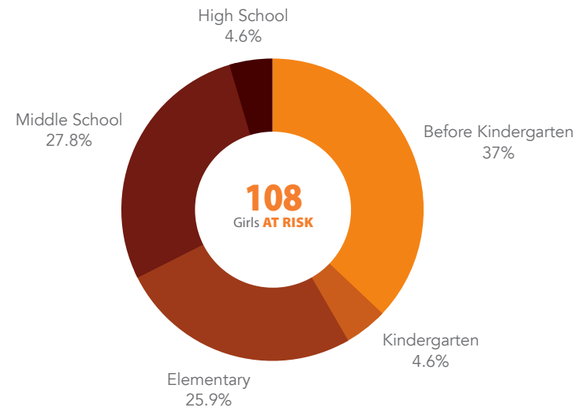
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

80 — 81

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Oklahoma



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Oklahoma	2,337	442	52
Tulsa	1,646	343	23
Cleveland	422	110	-
Payne	156	53	-
Rogers	75	29	3
Wagoner	64	26	3
Canadian	27	26	-
Comanche	186	22	16
Seminole	45	15	-
Creek	61	14	5

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Oklahoma City, OK	2,876	599	53

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Oklahoma City metropolitan area.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Malay** girls between the ages of 0 and 4; and **Kuwaiti** girls between the ages of 4 and 12.

All estimates are subject to both sampling and nonsampling error.

OREGON

OR

STATE DATA

Based on 2015-2019 ACS population estimates.

11,167
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

3,771
Women and girls who were likely **LIVING WITH** FGM/C

444
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3tgcZoq

SUMMARY

FGM/C prevalence was estimated at 37.7% within the study population in Oregon with over 60% of the impacted population in the state identifying as Somali (37.7%), Ethiopian (18.1%) or Indonesian (13.3%).

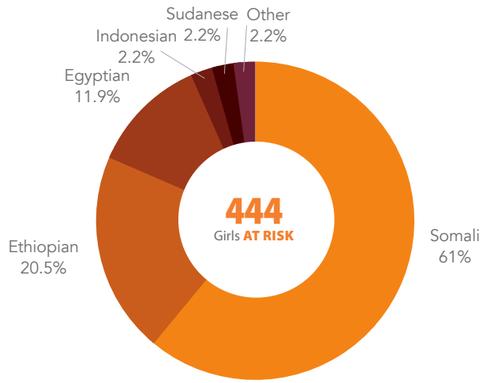
It is estimated that **1,007** women were living with Type 3 FGM/C in Oregon. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Oregon live in the greater Portland-Vancouver-Hillsboro metropolitan area with smaller, yet significant communities across much of the rest of the state.

An estimated 100 women and girls from the **Dawoodi Bohra** community live in Oregon and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Oregon



NOTE: Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

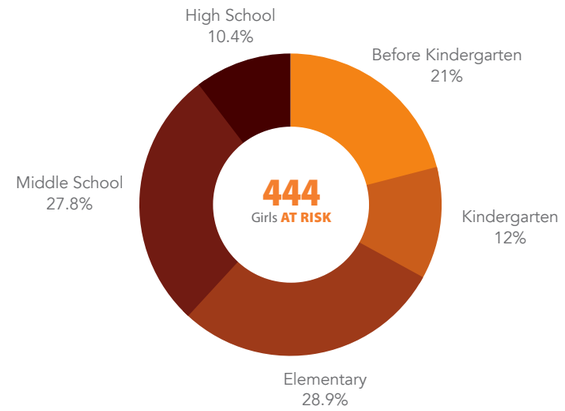
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

82

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Oregon



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Multnomah	5,947	2,319	302
Washington	2,651	927	69
Lane	537	149	7
Clackamas	695	127	42
Linn	227	42	10
Benton	168	31	7
Douglas	67	29	1
Marion	256	27	-
Yamhill	118	25	-
Polk	95	20	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Portland-Vancouver-Hillsboro, OR-WA	10,636	3,851	444
Eugene, OR	537	149	7
Bend-Redmond, OR	129	18	-
Medford, OR	30	16	-

83

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Portland-Vancouver-Hillsboro metropolitan area.

Child Protection should focus on **Somali** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

PENNSYLVANIA

PA

STATE DATA

Based on 2015-2019 ACS population estimates.

39,591
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

10,096
Women and girls who were likely **LIVING WITH** FGM/C

725
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3qv8aH9

SUMMARY

FGM/C prevalence was estimated at 27.3% within the study population in Pennsylvania with over 60% of the impacted population in the state identifying as Egyptian (24.7%), Liberian (14%), Nigerian (11%) or Ethiopian (10.3%).

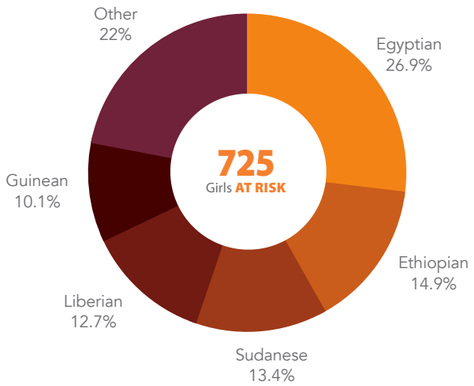
It is estimated that **1,124** women were living with Type 3 FGM/C in Pennsylvania. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Pennsylvania live in the greater New York-Newark-Jersey City, Philadelphia-Camden-Wilmington and Pittsburgh metropolitan areas.

An estimated 120 women and girls from the **Dawoodi Bohra** community live in Pennsylvania and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Pennsylvania

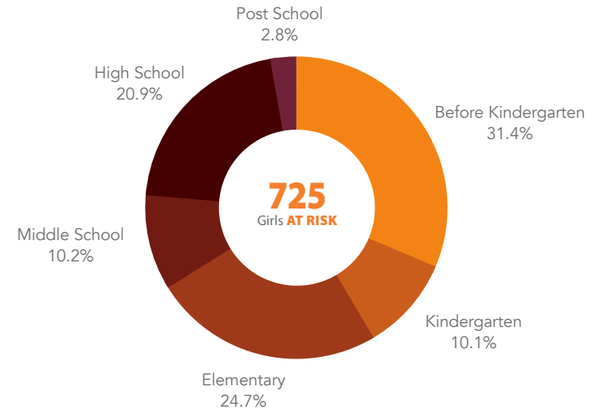


NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Pennsylvania



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Philadelphia	13,417	3,686	179
Delaware	6,795	1,664	80
Allegheny	3,611	629	117
Lancaster	2,015	618	57
Montgomery	2,019	468	26
Chester	1,499	462	44
Bucks	1,947	380	86
Dauphin	1,035	361	4
Erie	841	310	37
Lehigh	665	241	9

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Philadelphia-Camden-Wilmington, PA-NJ-DE-MD	36,502	9,054	583
Pittsburgh, PA	4,038	792	134
Lancaster, PA	2,015	618	57
Allentown-Bethlehem-Easton, PA-NJ	1,868	545	31
Harrisburg-Carlisle, PA	1,369	442	23
Erie, PA	841	311	37
Scranton-Wilkes-Barre-Hazelton, PA	394	154	5
Reading, PA	456	152	14
East Stroudsburg, PA	565	131	3

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater New York-Newark-Jersey City, Philadelphia-Camden-Wilmington and Pittsburgh metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence; **Sudanese** girls between the ages of 5 and 15; **Liberian** girls between the ages of 0 and 19; and **Guinean** girls between the ages of 5 and 17.

All estimates are subject to both sampling and nonsampling error.

SOUTH DAKOTA

SD

STATE DATA

Based on 2015-2019 ACS population estimates.

3,274
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

1,085
Women and girls who were likely **LIVING WITH** FGM/C

188
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/45htxLc

SUMMARY

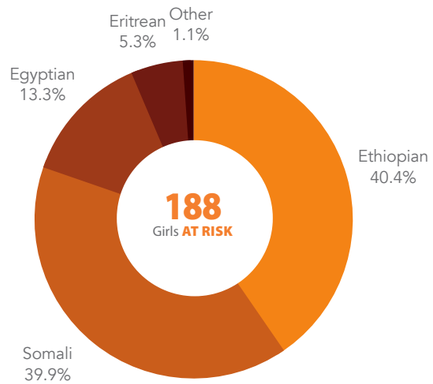
FGM/C prevalence was estimated at 38.9% within the study population in South Dakota with over 60% of the impacted population in the state identifying as Ethiopian (35.1%) or Somali (31%).

It is estimated that **331** women were living with Type 3 FGM/C in South Dakota. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in South Dakota live in Minnehaha county.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in South Dakota

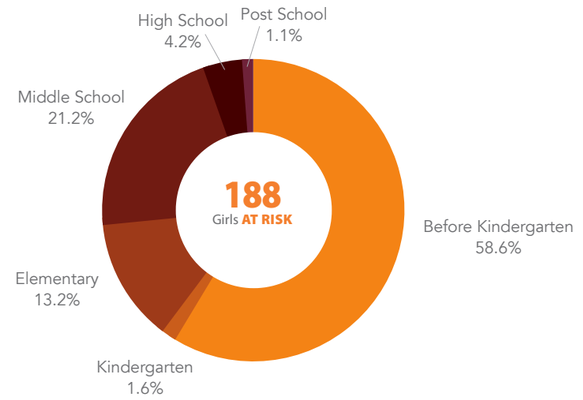


STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in South Dakota



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Minnehaha	2,039	703	76
Lincoln	520	181	20
Brown	84	33	12
Codington	62	25	9
Yankton	43	17	2
Union	31	12	1
Clay	28	11	1
Brookings	56	9	9
Roberts	23	9	3

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
No Metropolitan Areas	-	-	-

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on Minnehaha county.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

SOUTHEAST REGION LOW PREVALENCE STATES DATA

ALABAMA, ARKANSAS, LOUISIANA, MISSISSIPPI, SOUTH CAROLINA AND WEST VIRGINIA

COMBINED STATE DATA

Based on 2015-2019 ACS population estimates.

19,615
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

4,480
Women and girls who were likely **LIVING WITH** FGM/C

281
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Alabama and Mississippi have No Existing Legislation

Arkansas[1] **has Strong Existing Legislation**

Louisiana[2], **South Carolina**[3] **and West Virginia**[4] **have Deficient Existing Legislation that Needs Strengthening**

1 https://bit.ly/3Z0ySrv https://bit.ly/3PTwdZX https://bit.ly/46edlec
2 https://bit.ly/3P2wXvp
3 https://bit.ly/3EUrf93
4 https://bit.ly/45vxH1B

SUMMARY

FGM/C prevalence was estimated at 24.3% within the study population in Alabama, Arkansas, Louisiana, Mississippi, South Carolina and West Virginia. The largest impacted population across these states, except Mississippi, identify as Egyptian (30.1%). While the second largest identify as Nigerian (16.1%) with significant populations in all states except South Carolina and West Virginia.

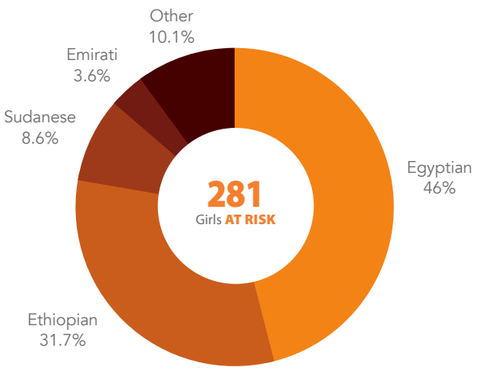
It is estimated that **431** women were living with Type 3 FGM/C in Alabama (36%), Arkansas (3.2%), Louisiana (28.3%), Mississippi (16.7%), South Carolina (9%) and West Virginia (6.7%). While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Those impacted by FGM/C in Alabama, Arkansas, Louisiana, MIssissippi, South Carolina and West Virginia live in the greater Washington-Arlington-Alexandria, DC-VA-MD-WV and Charlotte-Concord-Gastonia, NC-SC metropolitan areas with smaller, yet significant communities across much of the rest of the region.

An estimated 30 women and girls from the **Dawoodi Bohra** community live in South Carolina and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Alabama, Arkansas, Louisiana, Mississippi, South Carolina and West Virginia



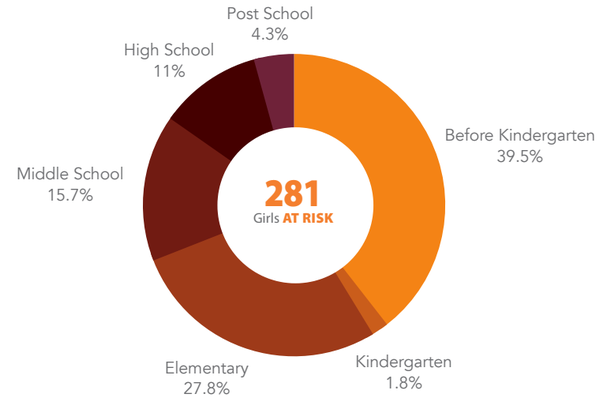
NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Alabama, Arkansas, Louisiana, Mississippi, South Carolina and West Virginia



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Jefferson, AL	1,040	250	7
Madison, AL	1,351	237	18
Richland, SC	864	237	7
Jefferson Parish, LA	756	231	14
Orleans Parish, LA	921	190	9
East Baton Rouge Parish, LA	956	143	6
Lafayette Parish, LA	239	123	-
Hinds, MS	452	114	2
Greenville, SC	410	112	8
Tuscaloosa, AL	434	107	1

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Washington-Arlington-Alexandria, DC-VA-MD-WV	133,213	39,001	2,008
Charlotte-Concord-Gastonia, NC-SC	9,121	2,405	178
Memphis, TN-MS-AR	4,421	1,609	101
New Orleans-Metairie, LA	2,138	515	51
Birmingham-Hoover, AL	1,328	317	18
Columbia, SC	1,129	313	13
Huntsville, AL	1,664	303	23
Greenville-Anderson-Mauldin, SC	672	220	8
Charleston-North Charleston, SC	668	193	22
Lafayette, LA	605	179	5

CALL TO ACTION

Interventions tailored to the specifics of the context.

Prevention and response interventions should focus on the greater Washington-Arlington-Alexandria, DC-VA-MD-WV and Charlotte-Concord-Gastonia, NC-SC metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence, particularly in LA, MS and WV; and **Sudanese** girls between the ages of 5 and 15 in AL and MS.

AL and MS state legislators should prioritize passing comprehensive anti-FGM/C legislation while LA, SC, and WV state legislators should prioritize strengthening existing legislation.

LA Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

SC Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement

WV Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

All estimates are subject to both sampling and nonsampling error.

TENNESSEE

TN

STATE DATA

Based on 2015-2019 ACS population estimates.

24,886
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

8,948
Women and girls who were likely **LIVING WITH** FGM/C

767
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Adequate Existing Legislation[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/47Ewvek

SUMMARY

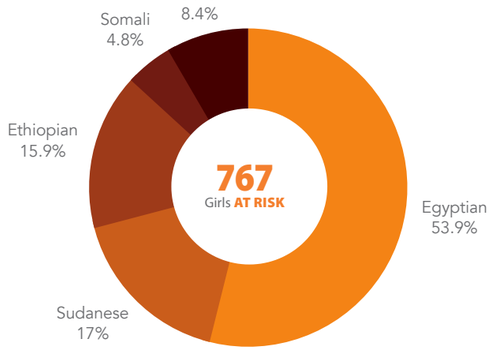
FGM/C prevalence was estimated at 39% within the study population in Tennessee with over 60% of the impacted population in the state identifying as Egyptian (43%), Ethiopian (14.7%) or Sudanese (8.6%).

It is estimated that **1,385** women were living with Type 3 FGM/C in Tennessee. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Tennessee live in the greater Nashville-Davidson-Murfreesboro-Franklin and Memphis metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Tennessee



NOTE: Nigerian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

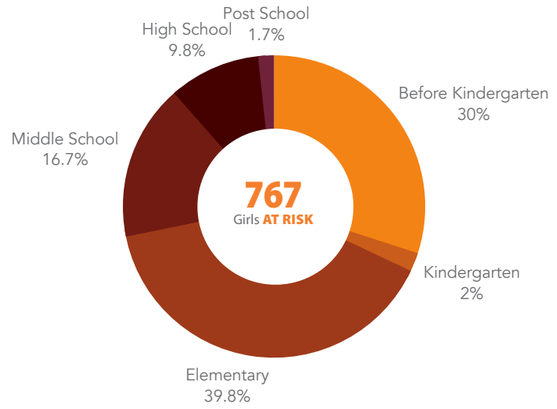
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

90

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Tennessee



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Davidson	13,168	5,280	451
Shelby	4,224	1,577	96
Rutherford	2,040	547	47
Wilson	664	316	45
Knox	910	158	21
Montgomery	421	153	1
Hamilton	540	132	7
Williamson	378	129	12
Sumner	474	107	37
Bradley	189	70	4

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Nashville-Davidson-Murfeesboro-Franklin, TN	17,261	6,544	594
Memphis, TN-MS-AR	4,421	1,609	101
Knoxville, TN	1,173	193	30
Clarksville, TN-KY	631	167	3
Chattanooga, TN-GA	639	152	7
Jackson, TN	82	18	2

91

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Nashville-Davidson-Murfreesboro-Franklin and Memphis metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Sudanese** girls between the ages of 5 and 15; and **Ethiopian** girls throughout their childhood and adolescence.

All estimates are subject to both sampling and nonsampling error.

TEXAS

TX

STATE DATA

Based on 2015-2019 ACS population estimates.

142,149
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

37,033
Women and girls who were likely **LIVING WITH** FGM/C

2,099
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3P3mkbY

SUMMARY

FGM/C prevalence was estimated at 27.5% within the study population in Texas with over 60% of the impacted population in the state identifying as Nigerian (30.7%), Ethiopian (16.2%) or Egyptian (14.9%).

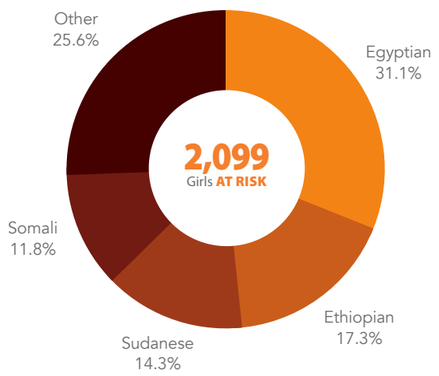
It is estimated that **4,755** women were living with Type 3 FGM/C in Texas. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

86% of those impacted by FGM/C in Texas live in the Dallas-Fort Worth-Arlington (44%) and Houston-The Woodlands-Sugar Land (42%) metropolitan areas.

An estimated 1,150 women and girls from the **Dawoodi Bohra** community live in Texas and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Texas



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

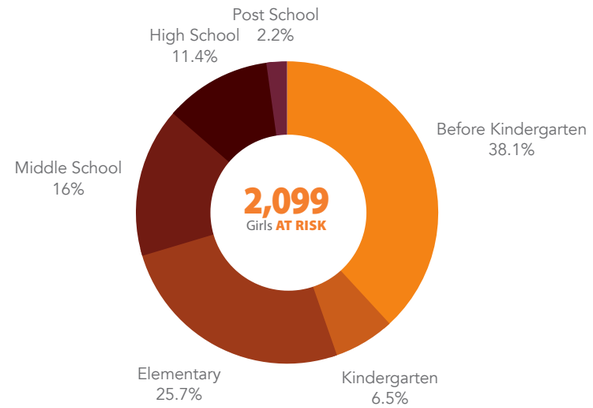
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

92

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Texas



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Harris	39,879	10,386	550
Dallas	26,042	7,195	402
Tarrant	19,121	4,861	482
Fort Bend	15,917	4,312	163
Collin	9,415	2,422	87
Travis	5,442	1,532	33
Denton	4,919	1,351	18
Bexar	4,419	1,009	86
Williamson	2,101	550	46
Montgomery	1,770	515	17

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Dallas-Fort Worth-Arlington, TX	60,450	16,114	1,001
Houston-The Woodlands-Sugar Land, TX	59,456	15,615	767
Austin-Round Rock, TX	7,691	2,132	80
San Antonio-New Braunfels, TX	4,667	1,080	99
Amarillo, TX	940	285	80
Tyler, TX	470	168	-
Midland, TX	741	127	6
Odessa, TX	380	121	3
El Paso, TX	741	115	1
College Station-Bryan, TX	519	113	9

93

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Dallas-Fort Worth-Arlington and Houston-The Woodlands-Sugar Land metropolitan areas.

Child Protection should focus on **Egyptian** girls between the ages of 6 and 14; **Ethiopian** girls throughout their childhood and adolescence; **Sudanese** and **Somali** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

UTAH

UT

STATE DATA

Based on 2015-2019 ACS population estimates.

5,562
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

1,514
Women and girls who were likely **LIVING WITH** FGM/C

389
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Strong Existing Legislation[1]

IMPROVE BY ADDING
Annual Statistical Reporting; Mandatory Training for Law Enforcement

1 https://bit.ly/3qGwohq

SUMMARY

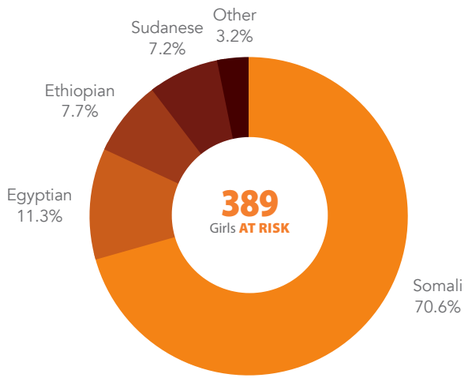
FGM/C prevalence was estimated at 34.2% within the study population in Utah with over 60% of the impacted population in the state identifying as Somali (51.2%) or Sudanese (13.1%).

It is estimated that **710** women were living with Type 3 FGM/C in Utah. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

81% of those impacted by FGM/C in Utah live in the greater Salt Lake City metropolitan area.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Utah



NOTE: Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

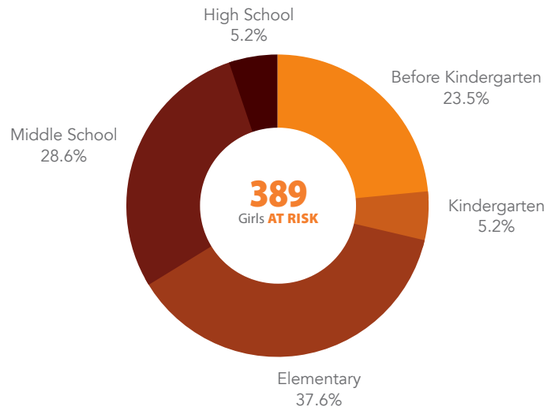
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

94

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Utah



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Salt Lake	3,897	1,210	328
Cache	226	95	-
Utah	481	77	14
Washington	418	39	31
Summit	71	30	-
Weber	125	23	-
Davis	199	14	11
Morgan	20	9	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Salt Lake City, UT	3,976	1,212	333
Provo-Orem, UT	481	76	14
Ogden-Clearfield, UT	418	39	31

95

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Salt Lake City metropolitan area.

Child Protection should focus on **Somali** girls between the ages of 5 and 15; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

VIRGINIA

VA

STATE DATA

Based on 2015-2019 ACS population estimates.

67,960
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

21,644
Women and girls who were likely **LIVING WITH** FGM/C

1,598
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Specification that Culture, Ritual, Religion are Not Defenses to Prosecution; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/3RANsAv

SUMMARY

FGM/C prevalence was estimated at 34.2% within the study population in Virginia with over 60% of the impacted population in the state identifying as Ethiopian (37.4%), Egyptian (20%) or Somali (8.1%).

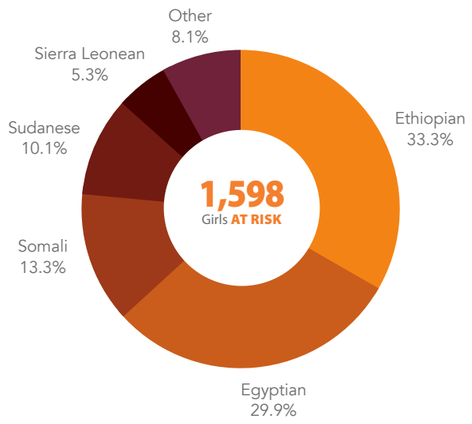
It is estimated that **3,495** women were living with Type 3 FGM/C in Virginia. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Virginia live in the greater Washington-Arlington-Alexandria, Richmond and Virginia Beach-Norfolk-Newport News metropolitan areas.

An estimated 100 women and girls from the **Dawoodi Bohra** community live in Virginia and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Virginia

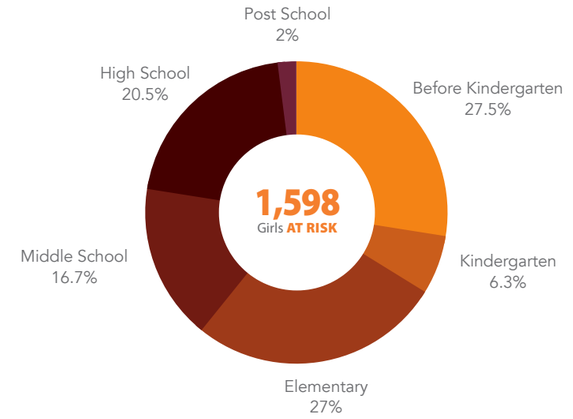


STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Virginia



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Fairfax	24,047	9,238	572
Alexandria city	8,502	3,763	183
Prince William	10,731	2,202	166
Arlington	4,037	1,567	96
Loudoun	3,737	1,243	75
Henrico	2,563	647	125
Richmond city	1,359	274	31
Virginia Beach city	778	236	16
Newport News city	764	176	34
Chesapeake city	805	173	31

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Washington-Arlington-Alexandria, DC-VA-MD-WV	133,213	39,001	2,008
Richmond, VA	5,145	1,187	175
Virginia Beach-Norfold-Newport News, VA-NC	3,989	992	103
Harrisonburg, VA	942	197	17
Blackburg-Chrisiansburg-Radford, VA	603	164	2
Lynchburg, VA	552	96	19
Roanoke, VA	235	81	2

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Washington-Arlington-Alexandria, Richmond and Virginia Beach-Norfolk-Newport News metropolitan areas.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Egyptian** girls between the ages of 6 and 14; and **Somali** and **Sudanese** girls between the ages of 5 and 15.

All estimates are subject to both sampling and nonsampling error.

WASHINGTON

WA

STATE DATA

Based on 2015-2019 ACS population estimates.

44,761
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

16,445
Women and girls who were likely **LIVING WITH** FGM/C

1,734
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing[1] Legislation[2], Needs Strengthening

IMPROVE BY ADDING
Felony Offense; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/4650P0v
2 https://bit.ly/453mZPe

SUMMARY

FGM/C prevalence was estimated at 40.6% within the study population in Washington with over 60% of the impacted population in the state identifying as Ethiopian (27.6%), Somali (27.4%) or Eritrean (10.1%).

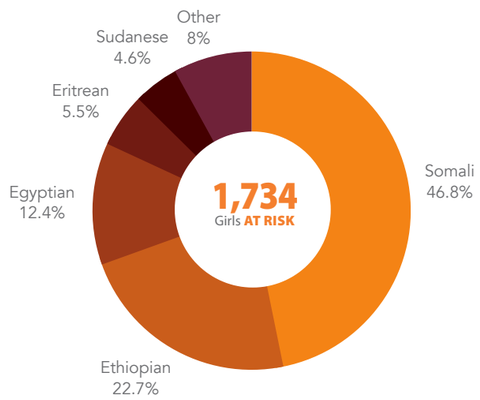
It is estimated that **4,185** women were living with Type 3 FGM/C in Washington. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Washington live in the greater Seattle-Tacoma-Bellevue and Portland-Vancouver-Hillsbro metropolitan areas.

An estimated 240 women and girls from the **Dawoodi Bohra** community live in Washington and are not included in the population extrapolation calculation.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Washington



NOTE: Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

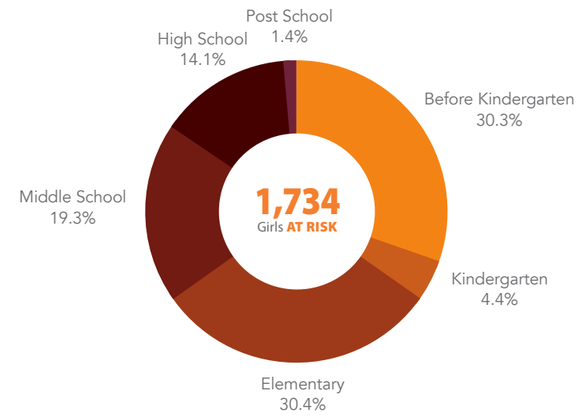
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

98

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Washington



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
King	29,217	11,501	1,354
Snohomish	6,364	2,803	184
Pierce	4,335	870	73
Clark	1,129	443	31
Spokane	981	269	15
Thurston	524	121	12
Kitsap	378	115	-
Benton	355	86	19
Yakima	243	40	20
Whatcom	163	35	4

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Seattle-Tacoma-Bellevue, WA	39,919	15,175	1,607
Portland-Vancouver-Hillsboro, OR-WA	10,636	3,851	444
Spokane-Spokane Valley, WA	1,001	272	16
Olympia-Tumwater, WA	523	120	12
Bremerton-Silverdale, WA	378	115	1
Yakima, WA	243	41	20
Bellingham, WA	163	35	4
Wenatchee, WA	48	2	-

99

CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Seattle-Tacoma-Bellevue and Portland-Vancouver-Hillsboro metropolitan areas.

Child Protection should focus on **Somali** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Egyptian** girls between the ages of 6 and 14.

All estimates are subject to both sampling and nonsampling error.

COMBINED STATE DATA

Based on 2015-2019 ACS population estimates.

10,020
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

2,534
Women and girls who were likely **LIVING WITH** FGM/C

246
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Alaska, Hawaii, Montana, and New Mexico have No Existing Legislation

Idaho[1] **and North Dakota**[2] **have Deficient Existing Legislation that Needs Strengthening**

Wyoming[3] **has Strong Existing Legislation**

1 https://bit.ly/3skpyif
2 https://bit.ly/47zTGq3
3 https://bit.ly/46d2EID https://bit.ly/46qw8SV

SUMMARY

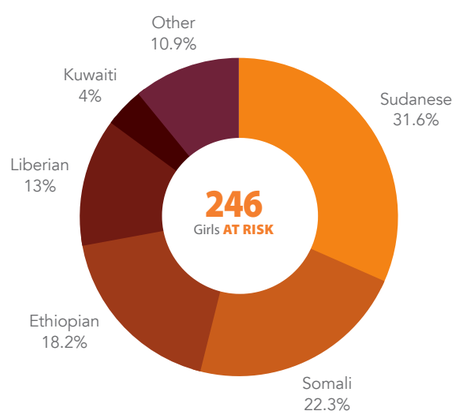
FGM/C prevalence was estimated at 27.7% within the study population in Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota and Wyoming. Significant impacted populations across these low prevalence western states identify as Sudanese (resident in Alaska and Idaho), Somali (resident in North Dakota) and Indonesian (resident in Hawaii, New Mexico and Idaho).

It is estimated that **750** women were living with Type 3 FGM/C in Alaska (23.2%), Hawaii (0.4%), Idaho (8.7%), Montana (0.1%), New Mexico (5.2%), North Dakota (62.3%) and Wyoming (0.1%). While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Most of those impacted by FGM/C in Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota and Wyoming live in the greater Anchorage, AK, Albuquerque, NM, Boise City, ID and Urban Honolulu, HI metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota, and Wyoming



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

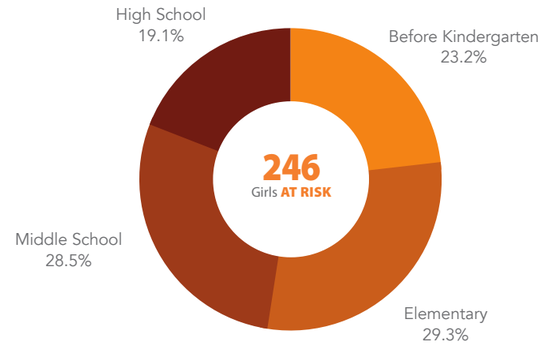
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

100

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota, and Wyoming



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Cass, ND	2,367	644	92
Anchorage Borough, AK	1,295	316	53
Honolulu, HI	832	272	3
Bernalilo, NM	651	173	-
Ada, ID	796	141	21
Grand Forks, ND	205	158	-
Dona Ana, NM	403	87	-
Kootenai, ID	94	54	-
Santa Fe, NM	241	46	3
Gallatin, MT	175	46	-

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Anchorage, AK	1,398	328	53
Boise City, ID	1,022	171	35
Albuquerque, NM	864	209	9
Urban Honolulu, HI	832	271	3
Las Cruces, NM	403	87	-
Coeur d'Alene, ID	92	54	-
Santa Fe, NM	243	46	3
Bismarck, ND	190	24	2

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CALL TO ACTION

Interventions tailored to the specifics of the context.

Prevention and response interventions should focus on the greater Anchorage, AK, Albuquerque, NM, Boise City, ID and Urban Honolulu, HI metropolitan areas.

Child Protection should focus on **Sudanese** and **Somali** girls between the ages of 5 and 15; **Ethiopian** girls throughout their childhood and adolescence; and **Liberian** girls from birth throughout their adolescence.

State legislators in AK, HI, MT, and NM should prioritize passing comprehensive anti-FGM/C legislation, while Idaho and ND state legislators should prioritize strengthening existing legislation.

ID Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

ND Improve Legislation by Adding: Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

All estimates are subject to both sampling and nonsampling error.

WISCONSIN

WI

STATE DATA

Based on 2015-2019 ACS population estimates.

9,018
STUDY POPULATON: Women and girls with ancestral ties to countries where FGM/C is practiced

3,086
Women and girls who were likely **LIVING WITH** FGM/C

253
Girls who were likely **AT RISK** of FGM/C

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient **Existing Legislation**[1], Needs Strengthening

IMPROVE BY ADDING
Education and Outreach; Comprehensive Expanded Definition of FGM/C; Prohibition of Transporting for FGM/C; Civil Cause of Action; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Specification of Ability to Prosecute Parents/Guardian; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

1 https://bit.ly/46vKwcC

SUMMARY

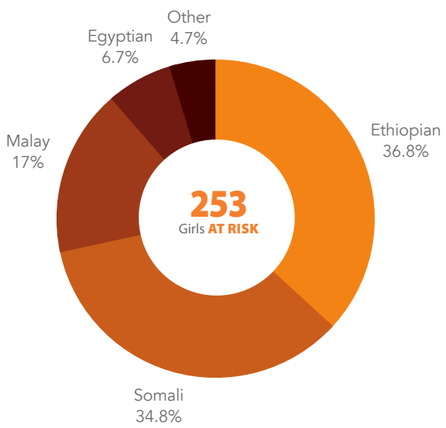
FGM/C prevalence was estimated at 37% within the study population in Wisconsin with over 50% of the impacted population in the state identifying as Somali (33.4%), Malay (12.7%) or Gambian (9.5%).

It is estimated that **1,041** women were living with Type 3 FGM/C in Wisconsin. While all survivors may require some level of medical and mental health support, those living with Type 3 would likely require additional medical attention.

Those impacted by FGM/C in Wisconsin live in the greater Minneapolis-St. Paul-Bloomington, Chicago-Naperville-Elgin and Milwaukee-Waukesha-West Allis metropolitan areas.

ETHNIC BREAKDOWN

Ethnic breakdown of girls most likely to be AT RISK of FGM/C in Wisconsin



NOTE: Nigerian and Indonesian girls are likely underrepresented in this data since they are cut at a very young age, resulting in most girls being encoded as already living with FGM/C.

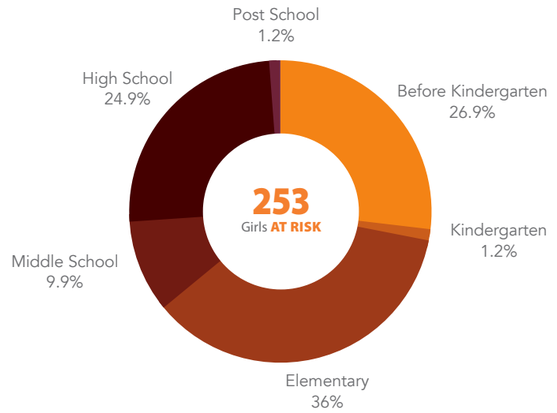
STATE PREVALENCE RANKING

LOW	MEDIUM	HIGH	HIGHEST
LESS THAN 100 PER STATE AT RISK	BETWEEN 100 AND 500 AT RISK	BETWEEN 500 AND 1,000 AT RISK	BETWEEN 1000 AND 10,000 AT RISK

102

AGE DISTRIBUTION

Distribution of girls most likely to be AT RISK of FGM/C in Wisconsin



SPATIAL DISTRIBUTION

Counties with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Minwaukee	3,846	1,215	92
Dane	2,397	837	67
Brown	578	382	22
Winnebago	304	69	5
La Crosse	140	58	1
Barron	77	49	10
Waukesha	142	48	-
Polk	74	47	10
St. Croix	124	36	1
Clark	57	36	7

Metropolitan Areas with the highest STUDY POPULATION | LIVING WITH | AT RISK population

	STUDY POPULATION	LIVING WITH	AT RISK
Minneapolis-St. Paul-Bloomington, MN-WI	70,417	25,032	4,001
Chicago-Naperville-Elgin, IL-IN-WI	33,054	8,574	492
Milwaukee-Waukesha-West Allis, WI	4,173	1,276	106
Oshkosh-Neenah, WI	304	69	5
La Crosse-Onalaska, WI-MN	140	58	1
Racine, WI	77	24	-
Sheboygan, WI	19	10	-
Janesville-Beloit, WI	104	4	-
Eau Claire, WI	89	3	-

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CALL TO ACTION

Interventions tailored to the specifics of the context.

State legislators should prioritize strengthening existing legislation.

Prevention and response interventions should focus on the greater Minneapolis-St. Paul-Bloomington, Chicago-Naperville-Elgin and Milwaukee-Waukesha-West Allis metropolitan areas.

Child Protection should focus on **Ethiopian** girls throughout their childhood and adolescence; **Somali** girls between the ages of 5 and 15; and **Malay** girls between the ages of 0 and 4.

All estimates are subject to both sampling and nonsampling error.

APPENDIX

	00-04 yr	05-09 yr	10-14 yr	15-19 yr	20-24 yr	25-29 yr	30-34 yr	35-39 yr	40-44 yr	45-49 yr	50-54 yr	55-59 yr	60-64 yr	65-69 yr	70-74 yr	75-79 yr	80+ yr	Total
Cameroonian	2,815	2,631	2,346	1,997	3,008	4,693	4,534	4,790	3,991	3,239	2,173	1,863	1,473	1,211	627	355	286	**42,032**
Egyptian	12,224	11,286	11,028	10,945	9,411	11,692	13,096	12,906	10,276	9,311	6,685	5,815	5,624	4,889	3,883	2,754	3,249	**145,074**
Emirati	419	496	307	468	315	633	657	490	155	108	41	30	-	41	1	-	9	**4,170**
Eritrean	2,573	2,108	1,967	2,093	2,490	2,367	2,869	3,235	3,586	2,494	2,114	1,936	1,398	800	489	190	158	**32,867**
Ethiopian	13,529	13,912	11,610	10,886	9,453	12,170	18,278	19,211	14,973	12,259	8,992	6,637	4,590	3,548	1,780	1,072	1,069	**163,969**
Gambian	423	344	547	639	1,413	1,063	849	1,021	720	1,214	551	349	66	92	65	115	-	**9,471**
Ghanaian	7,084	6,245	6,647	5,007	7,860	8,869	10,278	11,187	11,433	9,721	6,950	6,239	4,595	3,246	1,556	928	226	**108,071**
Guinean	197	255	260	639	953	1,160	790	533	1,099	857	758	305	401	69	157	37	102	**8,572**
Indonesian	3,041	4,149	4,260	4,390	4,911	4,475	5,259	6,055	6,815	6,651	4,850	3,915	4,015	3,144	1,580	1,001	1,655	**70,166**
Ivorian	36	34	196	654	740	640	923	585	680	517	622	405	205	96	24	-	-	**6,357**
Kenyan	3,854	5,239	3,473	5,546	6,821	6,404	8,188	7,526	8,827	4,736	3,804	2,916	2,411	1,285	670	410	161	**72,271**
Kurdish	1,422	1,529	1,500	1,036	1,282	1,560	1,276	1,475	820	874	397	338	212	387	247	193	159	**14,707**
Kuwaiti	553	921	403	631	723	920	924	986	1,107	1,124	348	71	44	159	133	-	-	**9,047**
Liberian	3,979	3,821	4,438	5,050	5,001	5,217	6,143	5,821	4,802	4,295	4,315	3,833	2,395	1,431	1,293	746	1,082	**63,662**
Malay	1,401	1,526	751	1,538	2,948	2,106	2,083	1,698	2,289	2,003	2,590	1,486	1,242	1,168	749	310	303	**26,191**
Nigerian	18,424	17,632	17,480	18,902	19,893	22,224	23,461	24,813	19,705	18,534	16,318	14,186	9,861	6,969	4,353	2,699	2,480	**257,934**
Saudi	2,707	2,840	920	1,883	4,955	7,937	5,638	2,119	1,125	407	452	595	251	42	36	-	66	**31,973**
Senegalese	967	1,058	1,157	907	862	1,052	1,534	1,529	1,770	1,681	1,212	413	251	236	7	58	28	**14,722**
Sierra Leonean	641	766	1,196	1,254	2,210	2,870	2,780	2,425	2,199	2,056	2,234	1,722	1,488	1,263	655	249	360	**26,368**
Somali	13,324	11,335	8,849	7,778	8,243	8,629	9,844	7,120	5,246	4,469	2,690	2,053	1,507	999	1,099	519	1,097	**94,801**
Sudanese	4,560	3,551	3,668	2,658	2,732	3,728	3,337	2,713	3,840	2,323	1,623	1,182	574	453	420	237	239	**37,838**
Tanzanian	792	421	1,425	1,200	720	632	1,020	1,393	1,135	1,218	464	304	641	349	123	37	50	**11,924**
Togolese	335	334	418	477	1,022	1,236	1,324	1,393	1,344	879	658	439	526	255	97	81	-	**10,818**
Ugandan	763	1,350	1,012	802	739	2,069	2,038	1,650	1,524	1,049	872	557	429	391	268	101	107	**15,721**
Yemeni	4,627	4,298	4,621	3,486	3,447	4,455	4,513	3,102	2,366	1,376	1,396	1,146	899	867	397	172	263	**41,431**
Zambian	45	312	59	453	522	514	971	620	737	514	307	281	320	55	103	19	-	**5,832**
Total	**100,735**	**98,393**	**90,538**	**91,319**	**102,674**	**119,315**	**132,607**	**126,396**	**112,564**	**93,909**	**73,416**	**59,016**	**45,418**	**33,445**	**20,812**	**12,283**	**13,149**	**1,325,989**

TABLE 1: STUDY POPULATION The *Study Population* was extracted from the American Community Survey 2015-2019 population data and then assigned an ethnicity based on ancestry or place of birth if ancestry data was incomplete.

"I would like to say a big thank you to AHA Foundation supporters. Without their support, my journey towards true and lifelong healing would not have been possible. I can now truly enjoy a healthy lifestyle with good mental well-being."

— Survivor of Female Genital Mutilation

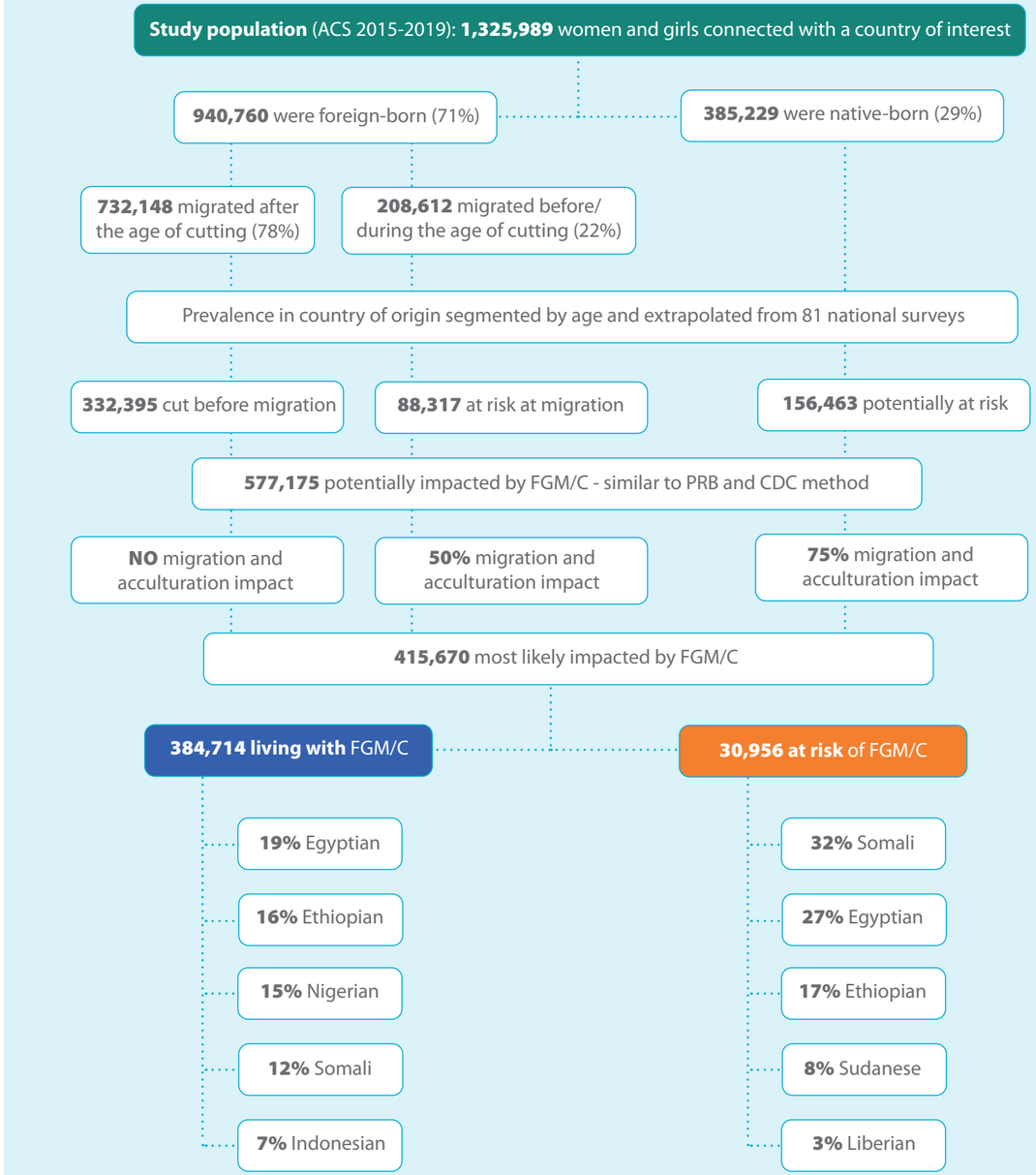
	00-04 yr	05-09 yr	10-14 yr	15-19 yr	20-24 yr	25-29 yr	30-34 yr	35-39 yr	40-44 yr	45-49 yr	50-54 yr	55-59 yr	60-64 yr	65-69 yr	70-74 yr	75-79 yr	80+ yr	Migration Selection Factor
Cameroonian	0.0	0.0	0.0	0.0	0.0	0.1	0.4	2.5	1.6	1.1	1.2	1.8	2.4	2.4	2.4	2.4	2.4	0.48
Egyptian	82.9	84.3	85.8	87.6	89.6	91.8	93.9	95.6	96.2	96.3	96.3	96.3	96.6	96.8	96.7	96.7	96.7	0.94
Emirati	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	51.9	1.00
Eritrean	45.7	50.0	54.7	60.0	65.9	72.6	79.6	85.7	89.9	92.6	93.7	94.2	94.8	94.8	95.1	95.1	95.1	0.95
Ethiopian	27.1	31.5	36.8	43.0	50.5	58.6	66.9	74.0	76.8	78.7	81.9	81.4	81.8	82.1	82.1	82.1	82.1	0.91
Gambian	79.8	79.1	78.3	77.6	77.0	76.8	75.3	75.2	75.0	75.3	75.7	75.8	75.4	75.4	75.4	75.4	75.4	0.95
Ghanaian	0.5	0.7	0.8	1.0	1.4	1.8	2.5	3.2	4.5	5.7	5.9	5.8	6.5	6.7	6.7	6.7	6.7	0.40
Guinean	80.5	82.7	85.0	87.3	89.8	91.9	94.1	96.3	97.6	98.3	98.7	98.7	99.0	99.1	99.1	99.1	99.1	0.99
Indonesian	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	49.0	1.11
Ivorian	23.7	25.2	27.0	29.2	31.7	34.7	37.1	39.0	41.8	43.2	44.7	43.7	45.7	45.6	45.6	45.6	45.6	0.68
Kenyan	4.5	5.7	7.3	9.3	11.9	15.4	19.7	24.3	30.0	35.8	40.2	45.8	46.3	46.2	46.2	46.2	46.2	0.63
Kurdish	3.3	5.6	9.6	16.7	29.3	34.2	48.4	54.3	61.0	56.2	55.0	56.4	56.4	56.4	56.4	56.4	56.4	0.81
Kuwaiti	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	1.00
Liberian	22.0	22.6	23.6	25.2	27.7	35.3	45.4	55.6	56.5	61.9	65.1	66.1	66.1	66.1	66.1	66.1	66.1	0.56
Malay	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	96.2	1.00
Nigerian	6.9	8.3	10.0	12.0	14.6	17.6	20.4	23.5	26.7	29.1	31.2	32.7	34.0	34.2	34.2	34.2	34.2	1.28
Saudi	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	12.8	1.00
Senegalese	18.6	19.4	20.2	21.1	22.1	23.7	25.0	25.7	26.0	26.5	26.4	26.5	26.5	26.5	26.5	26.5	26.5	0.74
Sierra Leonean	30.0	36.8	45.2	55.8	69.0	80.1	89.0	94.1	95.4	96.3	96.3	96.4	96.4	96.4	96.4	96.4	96.4	0.79
Somali	93.9	94.5	95.2	95.9	96.7	97.8	98.4	98.5	98.8	98.9	98.7	98.7	98.9	98.9	98.9	98.9	98.9	0.99
Sudanese	67.6	70.3	73.1	76.0	79.1	82.2	84.7	86.4	86.6	89.5	90.3	89.9	90.2	90.0	90.1	90.6	90.6	0.98
Tanzanian	1.7	2.2	3.0	4.1	5.7	7.8	10.4	13.1	15.9	18.0	19.4	20.0	20.7	21.2	21.3	21.3	21.3	0.44
Togolese	0.3	0.5	0.6	0.8	1.2	1.7	2.9	4.2	5.6	6.9	7.7	8.0	8.0	8.0	8.0	8.0	8.0	0.52
Ugandan	1.0	0.8	0.6	0.6	0.5	0.5	0.7	1.0	1.0	1.0	1.0	1.0	0.9	0.9	0.9	0.9	0.9	0.72
Yemeni	10.8	11.5	12.3	13.2	14.2	15.3	16.2	19.0	21.8	22.0	22.5	23.1	23.7	23.9	23.9	23.9	23.9	1.02
Zambian	0.2	0.3	0.3	0.4	0.5	0.7	0.9	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	3.8	1.00

TABLE 2: AGE-SPECIFIC PREVALENCE RATES The *Age-Specific Prevalence Rates* were calculated from 81 national surveys and several smaller academic studies and aligned to 2019 age groups to match the *Study Population*. A *Migration Selection Factor* was also calculated for each one.

	00-04 yr	05-09 yr	10-14 yr	15-19 yr	20-24 yr	25-29 yr	30-34 yr	35-39 yr	40-44 yr	45-49 yr	50-54 yr	55-59 yr	60-64 yr	65-69 yr	70-74 yr	75-79 yr	80+ yr	Total
Cameroonian	0	0	0	0	0	1	9	57	31	17	13	16	17	14	7	4	3	**190**
Egyptian	9,530	8,938	8,891	9,007	7,928	10,093	11,557	11,594	9,289	8,431	6,053	5,263	5,105	4,447	3,531	2,504	2,954	**125,117**
Emirati	217	257	159	243	163	329	341	254	80	56	21	16	-	21	1	-	5	**2,164**
Eritrean	1,118	1,001	1,022	1,193	1,559	1,631	2,169	2,633	3,062	2,194	1,881	1,732	1,260	720	442	172	143	**23,930**
Ethiopian	3,335	3,993	3,888	4,264	4,341	6,489	11,134	12,944	10,464	8,776	6,698	4,916	3,418	2,651	1,330	801	799	**90,240**
Gambian	321	258	407	471	1,033	776	608	729	513	868	396	251	47	66	47	82	-	**6,874**
Ghanaian	15	16	21	21	45	64	104	143	207	220	163	144	120	86	41	25	6	**1,443**
Guinean	157	209	219	552	847	1,055	736	508	1,062	834	740	298	393	68	154	36	100	**7,968**
Indonesian	1,654	2,257	2,317	2,388	2,671	2,434	2,860	3,293	3,707	3,617	2,638	2,129	2,184	1,710	859	544	900	**38,163**
Ivorian	6	6	36	130	160	151	233	155	193	152	189	120	64	30	7	-	-	**1,631**
Kenyan	109	188	159	325	513	621	1,017	1,151	1,670	1,067	964	842	703	374	195	119	47	**10,064**
Kurdish	38	69	117	140	304	432	501	649	405	398	177	154	97	177	113	88	73	**3,931**
Kuwaiti	210	350	153	240	275	350	351	375	421	427	132	27	17	60	51	-	-	**3,438**
Liberian	491	483	586	714	774	1,032	1,562	1,814	1,519	1,490	1,574	1,418	886	529	478	276	400	**16,026**
Malay	1,347	1,467	722	1,479	2,835	2,025	2,003	1,633	2,201	1,926	2,490	1,429	1,194	1,123	720	298	291	**25,183**
Nigerian	1,632	1,869	2,226	2,908	3,718	5,004	6,132	7,461	6,739	6,901	6,508	5,941	4,290	3,048	1,904	1,180	1,085	**68,547**
Saudi	346	363	117	240	633	1,014	720	271	144	52	58	76	32	5	5	-	8	**4,083**
Senegalese	133	152	173	142	141	184	284	291	340	330	237	81	49	46	1	11	5	**2,602**
Sierra Leonean	152	223	427	552	1,205	1,817	1,955	1,803	1,658	1,563	1,700	1,312	1,133	962	499	190	274	**17,424**
Somali	12,381	10,609	8,344	7,388	7,887	8,356	9,589	6,942	5,132	4,376	2,627	2,005	1,476	978	1,076	508	1,074	**90,748**
Sudanese	3,021	2,446	2,627	1,980	2,116	3,003	2,770	2,296	3,258	2,038	1,436	1,041	507	399	371	210	212	**29,734**
Tanzanian	6	4	19	21	18	22	47	80	79	96	40	27	58	33	12	3	5	**569**
Togolese	1	1	1	2	6	11	20	30	39	31	26	18	22	11	4	3	-	**226**
Ugandan	5	7	5	3	3	8	10	12	10	7	6	4	3	3	2	1	1	**90**
Yemeni	512	506	581	469	498	694	745	601	526	308	320	270	217	212	97	42	64	**6,661**
Zambian	0	1	0	2	3	4	9	24	28	20	12	11	12	2	4	1	-	**130**
Total	**36,736**	**35,672**	**33,218**	**34,874**	**39,677**	**47,600**	**57,466**	**57,742**	**52,778**	**46,195**	**37,101**	**29,540**	**23,304**	**17,775**	**11,949**	**7,100**	**8,449**	**577,176**

TABLE 3: POTENTIALLY IMPACTED POPULATION The product of the *Study Population*, the *Age-Specific Prevalence Rate*, and the *Migration Selection Factor* produced the *Potentially Impacted Population* which represents the upper limit of those affected by FGM/C without consideration of the impact of migration on the practice.

OVERVIEW OF THE EXTRAPOLATION METHOD CALCULATIONS



"I can't believe that this many girls are at risk in the community where I am a school counselor. I am happy to be educated about the prevalence of FGM/C, so I can be a part of fighting to eradicate it."

— Testimonial from an attendee of one of our Chicago anti-FGM/C trainings

Image: Dreamstime

FEMALE GENITAL MUTILATION/ CUTTING (FGM/C) IN THE UNITED STATES

A STUDY OF THE PREVALENCE, DISTRIBUTION, AND IMPACT OF FGM/C IN THE U.S., 2015-2019

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For more granular prevalence data contact **info@theahafoundation.org**

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