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.

The study 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.”

— Bayor Chantal Ngoltoingar, FGM/C survivor and activist
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, country-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.

Based on an estimation of the reduction in prevalence due to migration and acculturation we estimated that 365,000 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.
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 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.

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

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 reconsideration 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 (Oertensi 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 (Oertensi 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).

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. Populations from a further 11 countries where FGM/C is known to exist were not available in the ACS dataset. 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.

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.

“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
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 of the population analysis in this study. County-level through the Public Use Microdata Sample, formed the five-year period. Anonymized record-level data, accessed the United States based on a 5% sample collected over a five-year period.

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.

REFERENCES
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 practiced 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.
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.

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.

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.

“[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
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 31,000 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%.

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.

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

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

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

- Somali: 32.0%
- Egyptian: 27.1%
- Ethiopian: 17.3%
- Sudanese: 8.2%
- Other: 12.9%

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

- Before Kindergarten: 30.7%
- Kindergarten: 29.9%
- Elementary: 16.8%
- Middle School: 15.1%
- High School: 11.1%
- Post School: 1.6%
Prevalence of 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 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 Somali community. This skewing towards Somali poverty impacted by FGM/C live in households below the poverty line, while about a third of girls (U.S. Census Bureau, 2023). About a fifth of adult survivors live below the poverty line – about double the national average across the entire U.S. population – 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). The potentially impacted population was therefore concentrated in the Northern states with just 31% 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.

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.

STUDY POPULATION (outer) vs AT RISK Population (inner)

Ten states’ 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.

Top 20 Metropolitan Areas

<table>
<thead>
<tr>
<th>Study Pop</th>
<th>Living With</th>
<th>At Risk</th>
<th>Total</th>
<th>Prevalence in the study population</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York-Newark-Jersey City, NY-NJ-PA</td>
<td>156,704</td>
<td>44,356</td>
<td>2,734</td>
<td>47,090</td>
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<td>Washington-Arlington-Alexandria, DC-VA-MD-WV</td>
<td>133,213</td>
<td>39,001</td>
<td>2,008</td>
<td>41,009</td>
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<td>Minneapolis-St. Paul-Bloomington, MN-WI</td>
<td>70,417</td>
<td>25,032</td>
<td>4,001</td>
<td>29,033</td>
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<td>Los Angeles-Long Beach-Anaheim, CA</td>
<td>56,353</td>
<td>20,802</td>
<td>1,154</td>
<td>21,956</td>
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<tr>
<td>Dallas-Fort Worth-Arlington, TX</td>
<td>60,450</td>
<td>16,114</td>
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<td>Seattle-Tacoma-Bellevue, WA</td>
<td>39,919</td>
<td>15,175</td>
<td>1,071</td>
<td>16,782</td>
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<td>Houston-The Woodlands-Sugar Land, TX</td>
<td>59,456</td>
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<td>16,382</td>
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<td>54,066</td>
<td>13,849</td>
<td>727</td>
<td>14,576</td>
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<td>Columbus, OH</td>
<td>27,465</td>
<td>9,919</td>
<td>938</td>
<td>10,957</td>
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<td>Philadelphia-Camden-Wilmington, PA-NJ-DE-MD</td>
<td>36,502</td>
<td>9,054</td>
<td>583</td>
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<td>San Francisco-Oakland-Hayward, CA</td>
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<td>400</td>
<td>9,567</td>
</tr>
<tr>
<td>Chicago-Naperville-Elgin, IL-IN-WI</td>
<td>33,054</td>
<td>8,574</td>
<td>492</td>
<td>9,066</td>
</tr>
<tr>
<td>Boston-Cambridge-Newton, MA-NH</td>
<td>31,343</td>
<td>7,801</td>
<td>406</td>
<td>8,281</td>
</tr>
<tr>
<td>Nashville-Davidson--Murfreesboro--Franklin, TN</td>
<td>17,261</td>
<td>6,544</td>
<td>594</td>
<td>7,138</td>
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<tr>
<td>Baltimore-Columbia-Towson, MD</td>
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<td>6,452</td>
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</tr>
<tr>
<td>Riverside-San Bernardino-Ontario, CA</td>
<td>17,937</td>
<td>5,779</td>
<td>387</td>
<td>6,166</td>
</tr>
<tr>
<td>Denver-Aurora-Lakewood, CO</td>
<td>16,407</td>
<td>5,318</td>
<td>375</td>
<td>5,693</td>
</tr>
<tr>
<td>San Diego-Carlsbad, CA</td>
<td>11,207</td>
<td>4,393</td>
<td>479</td>
<td>5,118</td>
</tr>
<tr>
<td>Las Vegas-Henderson-Paradise, NV</td>
<td>12,358</td>
<td>4,755</td>
<td>272</td>
<td>5,027</td>
</tr>
<tr>
<td>Phoenix-Mesa-Scottsdale, AZ</td>
<td>13,821</td>
<td>4,306</td>
<td>408</td>
<td>4,714</td>
</tr>
</tbody>
</table>
This study segments the states into four groups based on the number of girls estimated to be at risk of FGM/C.

### High Prevalence States (Over 1,000 girls at risk)

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

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

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

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

<table>
<thead>
<tr>
<th>State</th>
<th>Study Pop</th>
<th>Living With</th>
<th>At Risk</th>
<th>Total</th>
<th>Prevalence</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL</td>
<td>32,154</td>
<td>9,743</td>
<td>543</td>
<td>10,286</td>
<td>32.0%</td>
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</tr>
<tr>
<td>GA</td>
<td>58,188</td>
<td>14,786</td>
<td>766</td>
<td>15,552</td>
<td>26.7%</td>
<td>Deficient</td>
</tr>
<tr>
<td>IL</td>
<td>37,453</td>
<td>9,311</td>
<td>580</td>
<td>9,891</td>
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<td>Deficient</td>
</tr>
<tr>
<td>MA</td>
<td>41,437</td>
<td>9,416</td>
<td>697</td>
<td>10,113</td>
<td>24.4%</td>
<td>Adequate</td>
</tr>
<tr>
<td>NC</td>
<td>28,315</td>
<td>7,452</td>
<td>586</td>
<td>8,038</td>
<td>28.4%</td>
<td>Deficient</td>
</tr>
<tr>
<td>NE</td>
<td>8,360</td>
<td>3,232</td>
<td>587</td>
<td>3,819</td>
<td>45.7%</td>
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</tr>
<tr>
<td>PA</td>
<td>39,591</td>
<td>10,096</td>
<td>725</td>
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<td>27.3%</td>
<td>Deficient</td>
</tr>
<tr>
<td>TN</td>
<td>24,886</td>
<td>8,948</td>
<td>767</td>
<td>9,715</td>
<td>39.0%</td>
<td>Adequate</td>
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</tbody>
</table>

### Low Prevalence States (Less than 100 girls at risk)

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

### REFERENCES


“[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
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.

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

“[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
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.

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 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.

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.

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 where 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.

REFERENCES


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.
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

SPATIAL DISTRIBUTION

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

<table>
<thead>
<tr>
<th>County</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa</td>
<td>13,993</td>
<td>4,212</td>
<td>409</td>
</tr>
<tr>
<td>Pima</td>
<td>2,102</td>
<td>645</td>
<td>-</td>
</tr>
<tr>
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<td>231</td>
<td>93</td>
<td>-</td>
</tr>
<tr>
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<td>50</td>
<td>-</td>
</tr>
<tr>
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<td>-</td>
</tr>
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<td>-</td>
</tr>
<tr>
<td>Yavapi</td>
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<td>-</td>
</tr>
<tr>
<td>Yuma</td>
<td>33</td>
<td>15</td>
<td>-</td>
</tr>
<tr>
<td>Santa Cruz</td>
<td>37</td>
<td>12</td>
<td>-</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phoenix-Mesa-Scottsdale, AZ</td>
<td>13,821</td>
<td>4,306</td>
<td>408</td>
</tr>
<tr>
<td>Tucson, AZ</td>
<td>2,102</td>
<td>645</td>
<td>59</td>
</tr>
<tr>
<td>Lake Havasu City-Kingman, AZ</td>
<td>291</td>
<td>54</td>
<td>-</td>
</tr>
<tr>
<td>Prescott, AZ</td>
<td>131</td>
<td>28</td>
<td>-</td>
</tr>
<tr>
<td>Flagstaff, AZ</td>
<td>103</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Yuma, AZ</td>
<td>33</td>
<td>15</td>
<td>-</td>
</tr>
</tbody>
</table>

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.
CALIFORNIA

STATE DATA
Based on 2015-2019 ACS population estimates.

149,342 STUDY POPULATION: 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 PREVALENCE RANKING

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

ETHNIC BREAKDOWN
Ethnic breakdown 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

METROPOLITAN AREAS WITH THE HIGHEST
STUDY POPULATION | LIVING WITH | AT RISK population

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 LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient: Existing Legislation, 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

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.

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.

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.

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.
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.

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethiopian</td>
<td>38%</td>
</tr>
<tr>
<td>Somali</td>
<td>29.6%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>7.3%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>6.4%</td>
</tr>
<tr>
<td>Malay</td>
<td>5.8%</td>
</tr>
<tr>
<td>Other</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

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.

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.
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

STATE DATA

Based on 2015-2019 ACS population estimates.

12,613 STUDY POPULATION: 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.

STATE PREVALENCE RANKING

LOW

VERY LOW

MEDIUM

HIGH

HIGHEST

PER STATE AT RISK

90 PER STATE AT RISK

100 PER STATE AT RISK

1000 PER STATE AT RISK

10,000 PER STATE AT RISK

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.

AGE DISTRIBUTION

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

SPATIAL DISTRIBUTION

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

Connecticut

4,419 890 62

Fairfield

3,907 696 52

Middlesex

3,171 652 36

New London

320 75 9

Windham

113 13 3

New Haven-Millford, CT

4,477 870 98

Hartford-West Hartford-East Hartford, CT

3,171 652 36

Bridgeport-Stamford-Norwalk, CT

320 74 -

Norwich-New London, CT

198 Girls AT RISK

1,000 AT RISK

10,000 AT RISK
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.

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

District of Columbia 9,329 2,785 157

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

Washington-Arlington-Alexandria, DC-VA-MD-WV 133,213 39,001 2,008

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

No FGM/C Legislation

IMPROVE BY ADDING

Comprehensive Anti-FGM/C Legislation

STATE PREVALENCE RANKING

ALL ESTIMATES ARE SUBJECT TO BOTH SAMPLING AND NONSAMPLING ERROR.
**STATE DATA**
Based on 2015-2019 ACS population estimates.

32,154

**STUDY POPULATION:**
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

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.

**SUMMARY**

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

**STATE PREVALENCE RANKING**

**AGE DISTRIBUTION**

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

**SPATIAL DISTRIBUTION**

Counties with the highest

**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.

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.

**NOTE:**

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.
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 (21.3%), 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

SPATIAL DISTRIBUTION

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

<table>
<thead>
<tr>
<th>County</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>DeKalb</td>
<td>14,129</td>
<td>4,645</td>
<td>403</td>
</tr>
<tr>
<td>Gwinnett</td>
<td>14,750</td>
<td>3,793</td>
<td>92</td>
</tr>
<tr>
<td>Cobb</td>
<td>8,507</td>
<td>1,754</td>
<td>84</td>
</tr>
<tr>
<td>Fulton</td>
<td>6,119</td>
<td>1,494</td>
<td>70</td>
</tr>
<tr>
<td>Clayton</td>
<td>3,005</td>
<td>523</td>
<td>31</td>
</tr>
<tr>
<td>Henry</td>
<td>2,148</td>
<td>325</td>
<td>11</td>
</tr>
<tr>
<td>Forsyth</td>
<td>1,111</td>
<td>254</td>
<td>20</td>
</tr>
<tr>
<td>Clarke</td>
<td>826</td>
<td>182</td>
<td>1</td>
</tr>
<tr>
<td>Douglas</td>
<td>1,397</td>
<td>174</td>
<td>1</td>
</tr>
<tr>
<td>Fayette</td>
<td>522</td>
<td>172</td>
<td>-</td>
</tr>
</tbody>
</table>

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

AGE DISTRIBUTION

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

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.
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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudanese</td>
<td>235</td>
<td>38%</td>
</tr>
<tr>
<td>Somali</td>
<td>291</td>
<td>15.6%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>174</td>
<td>11.4%</td>
</tr>
<tr>
<td>Liberian</td>
<td>99</td>
<td>11.4%</td>
</tr>
<tr>
<td>Guinean</td>
<td>77</td>
<td>9.3%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>64</td>
<td>8.4%</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

SPATIAL DISTRIBUTION

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

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Polk</td>
<td>3,250</td>
<td>938</td>
<td>146</td>
</tr>
<tr>
<td>Johnson</td>
<td>926</td>
<td>344</td>
<td>-</td>
</tr>
<tr>
<td>Linn</td>
<td>483</td>
<td>166</td>
<td>2</td>
</tr>
<tr>
<td>Dallas</td>
<td>389</td>
<td>160</td>
<td>14</td>
</tr>
<tr>
<td>Woodbury</td>
<td>174</td>
<td>48</td>
<td>-</td>
</tr>
<tr>
<td>Buena Vista</td>
<td>62</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>Carroll</td>
<td>62</td>
<td>36</td>
<td>2</td>
</tr>
<tr>
<td>Wapello</td>
<td>56</td>
<td>32</td>
<td>2</td>
</tr>
<tr>
<td>Crawford</td>
<td>49</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>Warren</td>
<td>91</td>
<td>23</td>
<td>4</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omaha-Council Bluffs, NE-IA</td>
<td>4,377</td>
<td>3,883</td>
<td>1,662</td>
</tr>
<tr>
<td>Des Moines-West Des Moines, IA</td>
<td>926</td>
<td>1,159</td>
<td>344</td>
</tr>
<tr>
<td>Iowa City, IA</td>
<td>235</td>
<td>-</td>
<td>169</td>
</tr>
</tbody>
</table>
All estimates are subject to both sampling and nonsampling error.

**STATE DATA**

Based on 2015-2019 ACS population estimates.

37,453 STUDY POPULATION: 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.

**ETHNIC BREAKDOWN**

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

- Egyptian: 49%
- Ethiopian: 13.8%
- Somali: 14%
- Sudanese: 7.4%
- Malay: 4.1%
- Others: 11.7%

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.

**AGE DISTRIBUTION**

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

- Before Kindergarten: 40.8%
- Kindergarten: 6.9%
- Elementary: 33.5%
- Middle School: 11.1%
- High School: 7.8%

**SPATIAL DISTRIBUTION**

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

<table>
<thead>
<tr>
<th>County</th>
<th>Population</th>
<th>Living</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook</td>
<td>24,060</td>
<td>5,960</td>
<td>380</td>
</tr>
<tr>
<td>DuPage</td>
<td>3,078</td>
<td>1,120</td>
<td>33</td>
</tr>
<tr>
<td>Will</td>
<td>2,730</td>
<td>637</td>
<td>58</td>
</tr>
<tr>
<td>Kane</td>
<td>1,118</td>
<td>299</td>
<td>9</td>
</tr>
<tr>
<td>Champaign</td>
<td>734</td>
<td>227</td>
<td>11</td>
</tr>
<tr>
<td>Lake</td>
<td>720</td>
<td>224</td>
<td>9</td>
</tr>
<tr>
<td>Winnebago</td>
<td>563</td>
<td>104</td>
<td>26</td>
</tr>
<tr>
<td>McLean</td>
<td>148</td>
<td>77</td>
<td>-</td>
</tr>
<tr>
<td>Peoria</td>
<td>164</td>
<td>59</td>
<td>6</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Area</th>
<th>Population</th>
<th>Living</th>
<th>Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chicago-Naperville-Elgin</td>
<td>33,054</td>
<td>8,574</td>
<td>492</td>
</tr>
<tr>
<td>St. Louis, MO-IL</td>
<td>6,943</td>
<td>1,295</td>
<td>218</td>
</tr>
<tr>
<td>Rockford, IL</td>
<td>734</td>
<td>227</td>
<td>11</td>
</tr>
<tr>
<td>Decatur, IL</td>
<td>602</td>
<td>118</td>
<td>27</td>
</tr>
<tr>
<td>Bloomington, IL</td>
<td>148</td>
<td>77</td>
<td>1</td>
</tr>
<tr>
<td>Springfield, IL</td>
<td>328</td>
<td>46</td>
<td>-</td>
</tr>
<tr>
<td>Kankakee, IL</td>
<td>256</td>
<td>40</td>
<td>-</td>
</tr>
</tbody>
</table>

**STATE PREVALENCE RANKING**

LOW: HIGHEST BETWEEN 100 AND 500 AT RISK
MEDIUM: HIGHEST BETWEEN 100 AND 1,000 AT RISK
HIGH: HIGHEST BETWEEN 1,000 AND 10,000 AT RISK

**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.

**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.

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.

13,679

STUDY POPULATION: 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 PREVALENCE RANKING

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 LEGISLATION AND POLICY LANDSCAPE

STATUS

Strong

Existing Legislation

IMPROVE BY ADDING

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

STATE DATA

Based on 2015-2019 ACS population estimates.

13,679

STUDY POPULATION: 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

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.

AGE DISTRIBUTION

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

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.

ECONOMIC BREAKDOWN

Ethnic breakdown 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

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>At Risk Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egyptian</td>
<td>25.5%</td>
</tr>
<tr>
<td>Somali</td>
<td>26.1%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>8.8%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>34.5%</td>
</tr>
<tr>
<td>Malay</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

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.

AGE DISTRIBUTION

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

STATE PREVALENCE RANKING

<table>
<thead>
<tr>
<th>State</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>KS</td>
<td>8,073</td>
<td>1,569</td>
<td>2,163</td>
</tr>
<tr>
<td>Wichita, KS</td>
<td>1,569</td>
<td>567</td>
<td>65</td>
</tr>
<tr>
<td>Lawrence, KS</td>
<td>1,569</td>
<td>567</td>
<td>65</td>
</tr>
<tr>
<td>St. Joseph, MO-KS</td>
<td>1,569</td>
<td>567</td>
<td>65</td>
</tr>
</tbody>
</table>

NOTE: All estimates are subject to both sampling and nonsampling error.
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.

AGE DISTRIBUTION

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

AGE DISTRIBUTION

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

ETHNIC BREAKDOWN

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

ETHNIC BREAKDOWN

Ethnic breakdown 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

SPATIAL DISTRIBUTION

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

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

STATE PREVALENCE RANKING

STATE LEGISLATION AND POLICY LANDSCAPE

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Strongest
Existing Legislation

IMPROVE BY ADDING
Nothing

STATE DATA

Based on 2015-2019 ACS population estimates.

8,300

STUDY POPULATION:
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

2017

Girls who were likely LIVING WITH FGM/C

2018

Girls who were likely AT RISK of FGM/C

2019

Girls who were likely LIVING WITH FGM/C

2020

Girls who were likely AT RISK of FGM/C

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.
All estimates are subject to both sampling and nonsampling error.

**STUDY POPULATION:**
Women and girls with ancestral ties to countries where FGM/C is practiced.

- **41,437 STUDY POPULATION:** Women and girls with ancestral ties to countries where FGM/C is practiced.
- **9,416 Living with FGM/C:** Women and girls who were likely living with FGM/C.
- **697 Girls at Risk:** Girls who were likely at risk of FGM/C.

**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

- Egyptian: 31.7%
- Somali: 25.5%
- Ethiopian: 16.3%
- Sudanese: 8.6%
- Liberian: 5%
- Other: 12.9%

**STATE PREVALENCE RANKING**

- **Lowest:** Population with less than 100 FGM/C prevalence
- **Medium:** Population between 100 and 500 FGM/C prevalence
- **Highest:** Population between 500 and 1,000 FGM/C prevalence

**STATE DATA**

- **Based on 2015-2019 ACS population estimates.**

**41,437 STUDY POPULATION:**
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 at Risk:**
Girls who were likely at risk of FGM/C.

**SPATIAL DISTRIBUTION**

Counties with the highest FGM/C prevalence:

- **Middlesex:** 13,885
- **Suffolk:** 8,167
- **Norfolk:** 3,398
- **Worcester:** 6,924
- **Essex:** 3,197
- **Bristol:** 1,672
- **Hampden:** 1,452
- **Plymouth:** 1,590
- **Hampshire:** 374

**Highest:**

- **31,343 Boston-Cambridge-Newton, MA-NH**
- **7,801 Providence-Warwick, RI-MA**
- **7,647 Worcester, MA-CT**
- **1,845 Springfield, MA**
- **90 Pittsfield, MA**
- **48 Barnstable Town, MA**
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

- Ethiopian 48.7%
- Egyptian 14.9%
- Sierra Leonian 12.2%
- Sudanese 7.9%
- Liberian 5.2%
- Other 11.1%

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

<table>
<thead>
<tr>
<th>LOWEST ESTIMATE: LESS THAN 100 PER STATE AT RISK</th>
<th>MEDIUM ESTIMATE: BETWEEN 100 AND 500 PER STATE AT RISK</th>
<th>HIGHEST ESTIMATE: BETWEEN 1,000 AND 10,000 PER STATE AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Montgomery</td>
<td>Prince George's</td>
<td>Baltimore</td>
</tr>
<tr>
<td>Howard</td>
<td>Baltimore city</td>
<td>Harford</td>
</tr>
<tr>
<td>Charles</td>
<td>Washington</td>
<td></td>
</tr>
</tbody>
</table>

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Existing Legislation¹
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;
- Mandatory Reporting;
- Annual Statistical Reporting;
- Mandatory Training for Law Enforcement;
- Mandatory Revocation of Medical License


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 Leonian 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.

**STUDY POPULATION**

Women and girls with ancestral ties to countries where FGM/C is practiced.

**STATE DATA**

Based on 2015-2019 ACS population estimates.

**2,693**

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

---

**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-Auburn metropolitan areas.

---

**STATE PREVALENCE RANKING**

LOW (LESS THAN 100 PER STATE AT RISK)  MEDIUM (BETWEEN 100 AND 500 PER STATE AT RISK)  HIGH (BETWEEN 500 AND 1000 PER STATE AT RISK)  HIGHEST (GREATER THAN 1000 PER STATE AT RISK)

---

**AGE DISTRIBUTION**

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

---

**ETHNIC BREAKDOWN**

Ethnic breakdown 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

Portland-South Portland, ME
Leviston-Auburn, ME
Bangor, ME

---

**STATE LEGISLATION AND POLICY LANDSCAPE**

**STATUS**

No FGM/C Legislation

**IMPROVE BY ADDING**

Comprehensive Anti-FGM/C Legislation

---

**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-Auburn metropolitan areas.

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

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient Existing Legislation

Needs Strengthening

IMPROVE BY ADDING

Comprehensive Expanded Definition of FGM/C

Specification of Mandatory Reporting; Annual Statistical Reporting

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.

STATE DATA

Based on 2015-2019 ACS population estimates.

32,511

STUDY POPULATION: 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 PREVALENCE RANKING

LOW

MEDIUM

HIGH

HIGHEST

Between 100 and 199 AT RISK

Between 200 and 499 AT RISK

Between 500 and 999 AT RISK

Between 1,000 and 2,000 AT RISK

AGE DISTRIBUTION

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

COUNTIES WITH THE HIGHESTpopulations

Metropolitan Areas with the highestpopulations

SPATIAL DISTRIBUTION

Counties with the highest

STUDY POPULATION | LIVING WITH | AT RISK population

Wayne 16,809 99
Oakland 847 98
Macomb 1,666 95
Ingham 1,236 89
Kent 1,100 87
Washtenaw 830 81
Kalamazoo 908 81
Genesee 1,142 80
Berrien 412 71
Shiawassee 141

Before Kindergarten 27.6%

High School 15.3%

Middle School 20.7%

Elementary 30.7%

Kindergarten 2.6%

AGEd AT RISK

Before Kindergarten 27.6%

High School 15.3%

Middle School 20.7%

Elementary 30.7%

Kindergarten 2.6%

GIRLS AT RISK

Wayne 16,809 99
Oakland 847 98
Macomb 1,666 95
Ingham 1,236 89
Kent 1,100 87
Washtenaw 830 81
Kalamazoo 908 81
Genesee 1,142 80
Berrien 412 71
Shiawassee 141

Before Kindergarten 27.6%

High School 15.3%

Middle School 20.7%

Elementary 30.7%

Kindergarten 2.6%

GIRLS AT RISK
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.

STATE DATA

Based on 2015-2019 ACS population estimates.

84,363
STUDY POPULATION: 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, 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


MINNESOTA

84,363
STUDY POPULATION

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

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

STATE PREVALENCE RANKING

LOW
MEDIUM
HIGH
HIGHEST

PER STATE AT RISK
BETWEEN 100 AT RISK
BETWEEN 500 AT RISK
BETWEEN 1000 AT RISK

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

STATE PREVALENCE RANKING

ALL ESTIMATES ARE SUBJECT TO BOTH SAMPLING AND NONSAMPLING ERROR.
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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>48.2%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>12%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>11.8%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>17.4%</td>
</tr>
<tr>
<td>Other</td>
<td>7.8%</td>
</tr>
<tr>
<td>Sierra Leonean</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>State</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-100</td>
<td>100-500</td>
<td>500-1,000</td>
</tr>
<tr>
<td>Missouri</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

AGE DISTRIBUTION

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

<table>
<thead>
<tr>
<th>Grade</th>
<th>AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Kindergarten</td>
<td>22.4%</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>12.3%</td>
</tr>
<tr>
<td>Elementary</td>
<td>36.1%</td>
</tr>
<tr>
<td>Middle School</td>
<td>11.8%</td>
</tr>
<tr>
<td>High School</td>
<td>17.4%</td>
</tr>
</tbody>
</table>

SPATIAL DISTRIBUTION

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

<table>
<thead>
<tr>
<th>County</th>
<th>Study Population</th>
<th>Living with</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Louis City</td>
<td>723</td>
<td>597</td>
<td>397</td>
</tr>
<tr>
<td>Jackson</td>
<td>651</td>
<td>582</td>
<td>394</td>
</tr>
<tr>
<td>Clay</td>
<td>383</td>
<td>311</td>
<td>196</td>
</tr>
<tr>
<td>Boone</td>
<td>311</td>
<td>218</td>
<td>119</td>
</tr>
<tr>
<td>Platte</td>
<td>164</td>
<td>130</td>
<td>74</td>
</tr>
<tr>
<td>St. Charles</td>
<td>98</td>
<td>93</td>
<td>53</td>
</tr>
<tr>
<td>Green</td>
<td>93</td>
<td>90</td>
<td>51</td>
</tr>
<tr>
<td>Buchanan</td>
<td>46</td>
<td>46</td>
<td>27</td>
</tr>
<tr>
<td>Jefferson</td>
<td>43</td>
<td>43</td>
<td>27</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Metropolitan Area</th>
<th>Study Population</th>
<th>Living with</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kansas City, MO-KS</td>
<td>2,163</td>
<td>1,925</td>
<td>1,018</td>
</tr>
<tr>
<td>St. Louis, MO-IL</td>
<td>1,295</td>
<td>1,078</td>
<td>596</td>
</tr>
<tr>
<td>Springfield, MO</td>
<td>421</td>
<td>365</td>
<td>193</td>
</tr>
<tr>
<td>Fayetteville-Springdale-Rogers, AR-MO</td>
<td>65</td>
<td>62</td>
<td>38</td>
</tr>
<tr>
<td>St. Joseph, MO-KS</td>
<td>172</td>
<td>154</td>
<td>88</td>
</tr>
</tbody>
</table>

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.
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

- Egyptian: 33.9%
- Ethiopian: 21.3%
- Sudanese: 15%
- Somali: 10.2%
- Sierra Leonian: 7%
- Other: 12.6%
- Nigerian: 11%
- Others: 15%

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

<table>
<thead>
<tr>
<th>State</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100</td>
<td>1,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Low prevalence states</td>
<td>12</td>
<td>50</td>
<td>2,500</td>
</tr>
<tr>
<td>Medium prevalence states</td>
<td>586</td>
<td>1,000</td>
<td>5,000</td>
</tr>
<tr>
<td>High prevalence states</td>
<td>1,212</td>
<td>2,500</td>
<td>5,000</td>
</tr>
</tbody>
</table>

STATE DATA

Based on 2015-2019 ACS population estimates.

28,315

STUDY POPULATION: 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
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 Revocation of Medical License


STATE PREVALENCE RANKING

COUNTIES WITH THE HIGHEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 6

COUNTIES WITH THE LOWEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 6

SPATIAL DISTRIBUTION

COUNTIES WITH THE HIGHEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 6

COUNTIES WITH THE LOWEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 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.

AGE DISTRIBUTION

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

- Before Kindergarten: 33.7%
- Kindergarten: 17.9%
- Elementary: 19.8%
- Middle School: 21.9%
- High School: 17.9%
- Post School: 3.2%
- Before Kindergarten: 33.7%
- Kindergarten: 17.9%
- Elementary: 19.8%
- Middle School: 21.9%
- High School: 17.9%
- Post School: 3.2%

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.

AGE DISTRIBUTION

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

- Before Kindergarten: 33.7%
- Kindergarten: 3.4%
- Elementary: 19.8%
- Middle School: 21.9%
- High School: 21.9%
- Post School: 3.2%

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

COUNTIES WITH THE HIGHEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 6

COUNTIES WITH THE LOWEST
STUDY POPULATION | LIVING WITH | AT RISK population
Wake                  | 6,793       | 1,914  | 193
Mecklenburg          | 6,947       | 1,899  | 150
Guilford             | 3,169       | 969    | 85
Durham               | 2,846       | 605    | 11
Orange               | 2,766       | 252    | 19
Cumberland           | 1,164       | 247    | 25
Forsyth              | 1,108       | 233    | 11
Cabarrus             | 664         | 146    | 13
Union                | 662         | 133    | 19
New Hanover          | 205         | 114    | 6
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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>71.4%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>16.9%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>7.3%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>

STATE PREVALENCE RANKING

<table>
<thead>
<tr>
<th>State</th>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
<th>HIGHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
No FGM/C Legislation

IMPROVE BY ADDING
Comprehensive Anti-FGM/C Legislation

STATE DATA

Based on 2015-2019 ACS population estimates.

8,360
STUDY POPULATION: 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 PREVALENCE RANKING

<table>
<thead>
<tr>
<th>State</th>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
<th>HIGHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.
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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>42.7%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>31.7%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>22.6%</td>
</tr>
<tr>
<td>Other</td>
<td>0.6%</td>
</tr>
<tr>
<td>Total</td>
<td>165</td>
</tr>
</tbody>
</table>

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

All estimates are subject to both sampling and nonsampling error.

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.
**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

- Egyptian: 83.7%
- Sudanese: 2.6%
- Ethiopian: 3.8%
- Liberian: 2.9%
- Other: 7%

**AGE DISTRIBUTION**

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

- Kindergarten: 32.3%
- Elementary: 34.6%
- Middle School: 14.3%
- High School: 11.1%
- Post School: 0.9%

**SPATIAL DISTRIBUTION**

Counties with the highest

<table>
<thead>
<tr>
<th>STUDY POPULATION</th>
<th>LIVING WITH</th>
<th>AT RISK population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middlesex</td>
<td>10,704</td>
<td>2,576</td>
</tr>
<tr>
<td>Hudson</td>
<td>6,984</td>
<td>3,974</td>
</tr>
<tr>
<td>Essex</td>
<td>14,821</td>
<td>3,081</td>
</tr>
<tr>
<td>Bergen</td>
<td>4,795</td>
<td>1,683</td>
</tr>
<tr>
<td>Monmouth</td>
<td>2,741</td>
<td>1,243</td>
</tr>
<tr>
<td>Union</td>
<td>4,035</td>
<td>976</td>
</tr>
<tr>
<td>Burlington</td>
<td>3,733</td>
<td>972</td>
</tr>
<tr>
<td>Somerset</td>
<td>1,942</td>
<td>686</td>
</tr>
<tr>
<td>Mercer</td>
<td>3,219</td>
<td>675</td>
</tr>
<tr>
<td>Morris</td>
<td>1,389</td>
<td>511</td>
</tr>
</tbody>
</table>

Counties with the lowest

<table>
<thead>
<tr>
<th>STUDY POPULATION</th>
<th>LIVING WITH</th>
<th>AT RISK population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Middlesex</td>
<td>1,868</td>
<td>545</td>
</tr>
<tr>
<td>Hudson</td>
<td>200</td>
<td>160</td>
</tr>
<tr>
<td>Essex</td>
<td>20</td>
<td>55</td>
</tr>
<tr>
<td>Bergen</td>
<td>20</td>
<td>31</td>
</tr>
<tr>
<td>Monmouth</td>
<td>20</td>
<td>1</td>
</tr>
</tbody>
</table>

**STATE PREVALENCE RANKING**

- NEW JERSEY
  - LOW: 100 or less
  - MEDIUM: 101 to 500
  - HIGH: 501 to 1000
  - HIGHEST: 1001 or more

**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.
**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

- Ethiopian: 80.2%
- Somali: 9.7%
- Eritrean: 4.9%
- Malay: 2.2%
- Other: 1.2%

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.

**AGE DISTRIBUTION**

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

- Before Kindergarten: 25%
- Kindergarten: 8.7%
- Elementary: 26.7%
- Middle School: 13.5%
- High School: 18.8%
- Post School: 7.3%

**STATE PREVALENCE RANKING**

The lowest prevalence of FGM/C was estimated in Clark County at 0.9% of the study population. The highest prevalence was estimated in Clark County at 39.1% of the study population.

**STATE LEGISLATION AND POLICY LANDSCAPE**

**STATUS**

Deficient

Existing Legislation, 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

**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.
**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-Cheektowaga-Niagara 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**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Girls most likely to be AT RISK of FGM/C in New York</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egyptian</td>
<td>57.6%</td>
</tr>
<tr>
<td>Somali</td>
<td>13.2%</td>
</tr>
<tr>
<td>Gambian</td>
<td>3.9%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>4.2%</td>
</tr>
<tr>
<td>Guinean</td>
<td>4.3%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>6.6%</td>
</tr>
<tr>
<td>Other</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

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**

<table>
<thead>
<tr>
<th>State</th>
<th>FGM/C Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens</td>
<td>18,444</td>
</tr>
<tr>
<td>Kings</td>
<td>20,407</td>
</tr>
<tr>
<td>Bronx</td>
<td>30,158</td>
</tr>
<tr>
<td>New York</td>
<td>10,599</td>
</tr>
<tr>
<td>Richmond</td>
<td>6,775</td>
</tr>
<tr>
<td>Monroe</td>
<td>3,890</td>
</tr>
<tr>
<td>Erie</td>
<td>5,065</td>
</tr>
<tr>
<td>Nassau</td>
<td>4,335</td>
</tr>
<tr>
<td>Suffolk</td>
<td>4,456</td>
</tr>
<tr>
<td>Westchester</td>
<td>4,864</td>
</tr>
</tbody>
</table>

**SPATIAL DISTRIBUTION**

**COUNTIES WITH THE HIGHEST STUDY POPULATION | LIVING WITH | AT RISK population**

<table>
<thead>
<tr>
<th>County</th>
<th>Study Population</th>
<th>Living with</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Queens</td>
<td>18,444</td>
<td>6,144</td>
<td>285</td>
</tr>
<tr>
<td>Kings</td>
<td>20,407</td>
<td>6,018</td>
<td>368</td>
</tr>
<tr>
<td>Bronx</td>
<td>30,158</td>
<td>4,989</td>
<td>218</td>
</tr>
<tr>
<td>New York</td>
<td>10,599</td>
<td>3,354</td>
<td>113</td>
</tr>
<tr>
<td>Richmond</td>
<td>6,775</td>
<td>2,338</td>
<td>242</td>
</tr>
<tr>
<td>Monroe</td>
<td>3,890</td>
<td>1,363</td>
<td>139</td>
</tr>
<tr>
<td>Erie</td>
<td>5,065</td>
<td>1,230</td>
<td>111</td>
</tr>
<tr>
<td>Nassau</td>
<td>4,335</td>
<td>1,152</td>
<td>135</td>
</tr>
<tr>
<td>Suffolk</td>
<td>4,456</td>
<td>1,080</td>
<td>68</td>
</tr>
<tr>
<td>Westchester</td>
<td>4,864</td>
<td>1,056</td>
<td>63</td>
</tr>
</tbody>
</table>

**METROPOLITAN AREAS WITH THE HIGHEST STUDY POPULATION | LIVING WITH | AT RISK population**

<table>
<thead>
<tr>
<th>Area</th>
<th>Study Population</th>
<th>Living with</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York-Newark-Jersey City, NY-NJ-PA</td>
<td>156,704</td>
<td>44,356</td>
<td>2,734</td>
</tr>
<tr>
<td>Rochester, NY</td>
<td>4,112</td>
<td>1,462</td>
<td>140</td>
</tr>
<tr>
<td>Buffalo-Cheektowaga-Niagara Falls, NY</td>
<td>5,330</td>
<td>1,409</td>
<td>128</td>
</tr>
<tr>
<td>Syracuse, NY</td>
<td>1,920</td>
<td>584</td>
<td>137</td>
</tr>
<tr>
<td>Albany-Schenectady-Troy, NY</td>
<td>2,188</td>
<td>547</td>
<td>60</td>
</tr>
<tr>
<td>Utica-Rome, NY</td>
<td>688</td>
<td>168</td>
<td>32</td>
</tr>
<tr>
<td>Binghamton, NY</td>
<td>504</td>
<td>147</td>
<td>2</td>
</tr>
<tr>
<td>Genes Falls, NY</td>
<td>79</td>
<td>38</td>
<td>-</td>
</tr>
<tr>
<td>Ithaca, NY</td>
<td>222</td>
<td>34</td>
<td>-</td>
</tr>
</tbody>
</table>
COMBINED STATE DATA

Based on 2015-2019 ACS population estimates.

12,652 STUDY POPULATION: 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), and Severely Deficient Existing Legislation (Rhode Island & Vermont)
Needs Strengthening

CALL TO ACTION
Interventions tailored to the specifics of the context.

STATE PREVALENCE RANKING

 low

medium

high

highest

LOW PREVALENCE STATES DATA

NE REGION

NORTHEAST REGION

ETHNIC BREAKDOWN

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>17.3%</td>
</tr>
<tr>
<td>Liberian</td>
<td>14.7%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>10.3%</td>
</tr>
<tr>
<td>Other</td>
<td>7.7%</td>
</tr>
<tr>
<td>Somali</td>
<td>9.5%</td>
</tr>
<tr>
<td>Liberian</td>
<td>5.0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Category</th>
<th>Delaware, Rhode Island, and Vermont</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOW</td>
<td>MEDIUM</td>
</tr>
<tr>
<td>HIGH</td>
<td>HIGHEST</td>
</tr>
</tbody>
</table>

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 Sudanese (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.

Age Distribution

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

<table>
<thead>
<tr>
<th>Stage</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kindergarten</td>
<td>43.8%</td>
</tr>
<tr>
<td>Elementary</td>
<td>22.9%</td>
</tr>
<tr>
<td>Middle School</td>
<td>7.2%</td>
</tr>
<tr>
<td>High School</td>
<td>15%</td>
</tr>
</tbody>
</table>

SPATIAL DISTRIBUTION

States with the highest

<table>
<thead>
<tr>
<th>Study Population</th>
<th>Living With</th>
<th>AT Risk Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providence, RI</td>
<td>5,278</td>
<td>1,179</td>
</tr>
<tr>
<td>New Castle, DE</td>
<td>4,638</td>
<td>957</td>
</tr>
<tr>
<td>Kent, DE</td>
<td>1,179</td>
<td>247</td>
</tr>
<tr>
<td>Chittenden, VT</td>
<td>319</td>
<td>127</td>
</tr>
<tr>
<td>Washington, RI</td>
<td>332</td>
<td>95</td>
</tr>
<tr>
<td>Kent, RI</td>
<td>222</td>
<td>50</td>
</tr>
<tr>
<td>Franklin, VT</td>
<td>94</td>
<td>37</td>
</tr>
<tr>
<td>Sussex, DE</td>
<td>193</td>
<td>16</td>
</tr>
<tr>
<td>Newport, RI</td>
<td>73</td>
<td>9</td>
</tr>
</tbody>
</table>

Metropolitan Areas with the highest

<table>
<thead>
<tr>
<th>Study Population</th>
<th>Living With</th>
<th>AT Risk Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philadelphia-Camden-Wilmington, PA-NJ-DE-MD</td>
<td>36,502</td>
<td>9,054</td>
</tr>
<tr>
<td>Providence-Warwick, RI</td>
<td>7,647</td>
<td>1,845</td>
</tr>
<tr>
<td>Dover, DE</td>
<td>1,174</td>
<td>246</td>
</tr>
<tr>
<td>Salisbury, MD-DE</td>
<td>1,001</td>
<td>275</td>
</tr>
<tr>
<td>Burlington-South Burlington, VT</td>
<td>428</td>
<td>170</td>
</tr>
</tbody>
</table>

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.

AGENCY


All estimates are subject to both sampling and nonsampling error.
All estimates are subject to both sampling and nonsampling error.

**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, Cincinnati 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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>53.5%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>12.3%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>10.8%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>6.4%</td>
</tr>
<tr>
<td>Eritrean</td>
<td>6.8%</td>
</tr>
<tr>
<td>Other</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

**AGE DISTRIBUTION**

Distribution of girls most likely to be at risk of FGM/C in Ohio

- Before Kindergarten: 34%
- Kindergarten: 6.2%
- Elementary: 25.8%
- Middle School: 16.7%
- High School: 16.7%
- Post School: 0.6%

1,348 girls at risk

**SPATIAL DISTRIBUTION**

Counties with the highest study population | Living With | At Risk population
--- | --- | ---
Franklin | 25,104 | 9,236 | 998
Cuyahoga | 4,140 | 1,060 | 321
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 | 691 | 114 | 4
Delaware | 575 | 103 | 2

Metropolitan Areas with the highest study population | Living With | At Risk population
--- | --- | ---
Columbus, OH | 27,465 | 9,236 | 1,038
Cincinnati, OH-KY-IN | 6,543 | 1,060 | 108
Cleveland-Elyria, OH | 4,816 | 1,060 | 145
Dayton, OH | 2,380 | 461 | 27
Toledo, OH | 1,638 | 189 | 37
Akron, OH | 2,093 | 69 | 12
Youngstown-Warren-Boardman, OH-PA | 522 | 69 | -
Canton-Massillon, OH | 289 | 66 | -
Lima, OH | 39 | 7 | -
Mansfield, OH | 126 | 2 | -

**STATE PREVALENCE RANKING**

<table>
<thead>
<tr>
<th>LOW</th>
<th>MEDIUM</th>
<th>HIGH</th>
<th>HIGHEST</th>
</tr>
</thead>
<tbody>
<tr>
<td>LESS THAN 100 PER STATE AT RISK</td>
<td>BETWEEN 100 AND 500 PER STATE AT RISK</td>
<td>BETWEEN 500 AND 1,000 PER STATE AT RISK</td>
<td>OVER 1,000 PER STATE AT RISK</td>
</tr>
</tbody>
</table>

**STATE LEGISLATION AND POLICY LANDSCAPE**

**STATUS**

Deficient: Existing Legislation
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


**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.

**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.

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.

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.
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

- Malaysian: 22.2%
- Ethiopian: 45.4%
- Kuwaiti: 14.8%
- Eritrean: 9.3%
- Saudi: 3.7%
- Other: 3.7%

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

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Deficient Exisiting Legislation, 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

All estimates are subject to both sampling and non-sampling error.
All estimates are subject to both sampling and nonsampling error.

**All estimates are subject to both sampling and nonsampling error.**

---

**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

- **Somali**: 61%
- **Ethiopian**: 20.5%
- **Other**: 2.2%
- **Egyptian**: 11.9%
- **Indonesian**: 2.2%
- **Sudanese**: 2.2%

**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**

<table>
<thead>
<tr>
<th>State Prevalence Ranking</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low: Less than 100 per state at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medium: Between 100 and 500 per state at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High: Between 500 and 1,000 per state at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest: Between 1,000 and 10,000 per state at risk</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**State Legislation and Policy Landscape**

- **Status**: Deficient
- **Existing Legislation**: 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

---

**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.

**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

- Egyptian: 26.9%
- Guinean: 10.1%
- Liberian: 12.7%
- Sudanese: 13.4%
- Ethiopian: 14.9%
- Other: 22%

**State Prevalence Ranking**

- Low: Less than 100 per state at risk
- Medium: Between 100 and 500 per state at risk
- High: Between 500 and 1,000 per state at risk
- Highest: Between 1,000 and 5,000 per state at risk

**Spatial Distribution**

Counties with the highest study population living with FGM/C

- Philadelphia: 13,117
- Delaware: 6,795
- Allegheny: 3,611
- Lancaster: 2,015
- Montgomery: 1,499
- Chester: 1,947
- Bucks: 1,035
- Dauphin: 841
- Erie: 665

Metropolitan Areas with the highest study population living with FGM/C

- Philadelphia-Camden-Wilmington, PA-NJ-DE-MD: 36,502
- Pittsburgh, PA: 4,038
- Lancaster, PA: 2,015
- Allentown-Bethlehem-Easton, PA-NJ: 1,499
- Harrisburg-Carlisle, PA: 1,369
- Erie, PA: 841
- Reading, PA: 456
- East Stroudsburg, PA: 365

**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.
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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Study Population</th>
<th>Living with FGM/C</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>188</td>
<td>520</td>
<td>76</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>40.4%</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Egyptian</td>
<td>13.3%</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Eritrean</td>
<td>5.3%</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1.1%</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Somali</td>
<td>39.9%</td>
<td>1,085</td>
<td></td>
</tr>
<tr>
<td>Ethiopian</td>
<td>40.4%</td>
<td>2,039</td>
<td></td>
</tr>
</tbody>
</table>

AGE DISTRIBUTION

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

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Study Population</th>
<th>Living with FGM/C</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>High School</td>
<td>4.2%</td>
<td>181</td>
<td>20</td>
</tr>
<tr>
<td>Middle School</td>
<td>21.2%</td>
<td>62</td>
<td>9</td>
</tr>
<tr>
<td>Elementary</td>
<td>13.2%</td>
<td>43</td>
<td>2</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>1.6%</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Post School</td>
<td>1.1%</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Before Kindergarten</td>
<td>58.6%</td>
<td>56</td>
<td>9</td>
</tr>
</tbody>
</table>

SPATIAL DISTRIBUTION

Counties with the highest

<table>
<thead>
<tr>
<th>Study Population</th>
<th>Living with FGM/C</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnehaha</td>
<td>2,039</td>
<td>76</td>
</tr>
<tr>
<td>Lincoln</td>
<td>181</td>
<td>20</td>
</tr>
<tr>
<td>Brown</td>
<td>84</td>
<td>12</td>
</tr>
<tr>
<td>Codington</td>
<td>62</td>
<td>9</td>
</tr>
<tr>
<td>Yankton</td>
<td>43</td>
<td>2</td>
</tr>
<tr>
<td>Union</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Clay</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Brookings</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>Roberts</td>
<td>23</td>
<td>3</td>
</tr>
</tbody>
</table>

COUNTY DISTRIBUTION

<table>
<thead>
<tr>
<th>Study Population</th>
<th>Living with FGM/C</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minnehaha</td>
<td>2,039</td>
<td>76</td>
</tr>
<tr>
<td>Lincoln</td>
<td>181</td>
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<td>43</td>
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</tr>
<tr>
<td>Union</td>
<td>31</td>
<td>1</td>
</tr>
<tr>
<td>Clay</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Brookings</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>Roberts</td>
<td>23</td>
<td>3</td>
</tr>
</tbody>
</table>

STATE PREVALENCE RANKING

<table>
<thead>
<tr>
<th>Prevalence Rank</th>
<th>Less than 100</th>
<th>Between 100 and 500</th>
<th>Between 500 and 1,000</th>
<th>1,000 or More</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Dakota</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>HIGH</td>
<td>HIGHEST</td>
</tr>
</tbody>
</table>

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.

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient

Existing Legislation

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

STATE DATA

Based on 2015-2019 ACS population estimates.

3,274

STUDY POPULATION: 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

SD
SOUTHEAST REGION

LOW PREVALENCE STATES DATA

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.

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>AT RISK Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egyptian</td>
<td>46%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>8.6%</td>
</tr>
<tr>
<td>Dawoodi Bohra</td>
<td>46%</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>3.6%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>31.7%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>46%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>8.6%</td>
</tr>
<tr>
<td>Dawoodi Bohra</td>
<td>46%</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

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 Alabama, Arkansas, Louisiana, Mississippi, South Carolina and West Virginia

SPATIAL DISTRIBUTION

COUNTIES WITH THE HIGHEST POPULATION AT RISK

Metropolitan Areas with the highest

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 6 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 Impose 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 Impose 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.

1 https://bit.ly/3P2wXvp
5 https://bit.ly/3P2wXvp
7 https://bit.ly/3ZOySrv
8 https://bit.ly/3P2wXvp

SE REGION

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

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
- Alabama and Mississippi have No Existing Legislation
- Arkansas has Strong Existing Legislation
- Louisiana, South Carolina and West Virginia have Deficient Existing Legislation that Needs Strengthening

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; Mandatory Revocation of Medical License

WV Impose 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.
STATE DATA
Based on 2015-2019 ACS population estimates.

24,886
STUDY POPULATION: 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, Needs Strengthening

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


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.

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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Girls AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Egyptian</td>
<td>767</td>
</tr>
<tr>
<td>Sudanese</td>
<td>17%</td>
</tr>
<tr>
<td>Egyptian</td>
<td>53.9%</td>
</tr>
<tr>
<td>Somali</td>
<td>4.8%</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>15.9%</td>
</tr>
<tr>
<td>Other</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

NOTE: Egyptian 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 Tennessee

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Girls AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before Kindergarten</td>
<td>767</td>
</tr>
<tr>
<td>Kindergarten</td>
<td>96</td>
</tr>
<tr>
<td>Elementary</td>
<td>1,173</td>
</tr>
<tr>
<td>Middle School</td>
<td>664</td>
</tr>
<tr>
<td>High School</td>
<td>2,040</td>
</tr>
<tr>
<td>Post School</td>
<td>4,224</td>
</tr>
</tbody>
</table>

SPATIAL DISTRIBUTION

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

<table>
<thead>
<tr>
<th>County</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davidson</td>
<td>13,168</td>
<td>5,280</td>
<td>451</td>
</tr>
<tr>
<td>Shelby</td>
<td>4,224</td>
<td>1,077</td>
<td>96</td>
</tr>
<tr>
<td>Rutherford</td>
<td>2,040</td>
<td>547</td>
<td>47</td>
</tr>
<tr>
<td>Wilson</td>
<td>664</td>
<td>316</td>
<td>45</td>
</tr>
<tr>
<td>Knox</td>
<td>910</td>
<td>158</td>
<td>21</td>
</tr>
<tr>
<td>Montgomery</td>
<td>421</td>
<td>163</td>
<td>11</td>
</tr>
<tr>
<td>Hamilton</td>
<td>540</td>
<td>132</td>
<td>7</td>
</tr>
<tr>
<td>Williamson</td>
<td>378</td>
<td>129</td>
<td>12</td>
</tr>
<tr>
<td>Sumner</td>
<td>474</td>
<td>107</td>
<td>37</td>
</tr>
<tr>
<td>Bradley</td>
<td>189</td>
<td>70</td>
<td>4</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Metropolitan Area</th>
<th>Study Population</th>
<th>Living With</th>
<th>At Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nashville-Davidson-Murfreesboro-Franklin, TN</td>
<td>17,261</td>
<td>6,244</td>
<td>606</td>
</tr>
<tr>
<td>Memphis, TN-MS-AR</td>
<td>4,421</td>
<td>1,609</td>
<td>101</td>
</tr>
<tr>
<td>Knoxville, TN</td>
<td>1,173</td>
<td>193</td>
<td>30</td>
</tr>
<tr>
<td>Clarksville, TN-KY</td>
<td>631</td>
<td>167</td>
<td>3</td>
</tr>
<tr>
<td>Chattanooga, TN-GA</td>
<td>639</td>
<td>152</td>
<td>7</td>
</tr>
<tr>
<td>Jackson, TN</td>
<td>82</td>
<td>18</td>
<td>2</td>
</tr>
</tbody>
</table>

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.

AGE DISTRIBUTION

Before Kindergarten 30%
Kindergarten 2%
Elementary 39.8%
Middle School 16.7%
High School 9.3%
Post School 1.7%

STATE PREVALENCE RANKING

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

STATE PREVALENCE RANKING

STATE DATA

Based on 2015-2019 ACS population estimates.

142,149

STUDY POPULATION: 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

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.

AGE DISTRIBUTION

Distribution of girls most likely to be at risk of FGM/C in Texas

SPATIAL DISTRIBUTION

Metropolitan Areas with the highest

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.

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient Existing Legislation; Needs Strengthening

STATE PREVAILANCE RANKING

LOW

MEDIUM

HIGH

HIGHEST

PER STATE AT RISK

BETWEEN 100 AND 1,000 AT RISK

BETWEEN 1,000 AND 10,000 AT RISK

TEXAS
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

- Somali: 70.6%
- Sudanese: 7.2%
- Ethiopian: 7.7%
- Egyptian: 11.3%
- Other: 3.2%
- Indonesian: 3.2%

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.

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.

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS
Strong Existing Legislation

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

STATE PREVALENCE RANKING

LOW 
LESS THAN 100 PER STATE AT RISK
MEDIUM 
100 TO 499 AT RISK
HIGH 
500 TO 999 AT RISK
HIGHEST 
1,000 AT RISK

All estimates are subject to both sampling and nonsampling error.
All estimates are subject to both sampling and nonsampling error.

67,960

STUDY POPULATION: 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 DATA

Based on 2015-2019 ACS population estimates.

67,960

STUDY POPULATION: 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

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

SPATIAL DISTRIBUTION

Counties with the highest

STATE PREVALENCE RANKING

Low

Medium

High

Highest

Between 100 and 1000

PER STATE AT RISK

BETWEEN 100 AND 1000 AT RISK

BETWEEN 1000 AND 5000 AT RISK

BETWEEN 5000 AND 10,000 AT RISK

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient

Existing Legislation; 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

https://bit.ly/3RANsAv

STATE LEGISLATION

AND POLICY LANDSCAPE

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.

AGE DISTRIBUTION

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

BEFORE KINDERGARTEN 27.5%

HIGH SCHOOL 20.5%

MIDDLE SCHOOL 16.7%

ELEMENTARY 27%

KINDERGARTEN 6.3%

POST SCHOOL 2%

SPATIAL DISTRIBUTION

Metropolitan Areas with the highest

STUDY POPULATION | LIVING WITH | AT RISK population

Washington-Arlington-Alexandria, DC-VA-MD-WV

Richmond, VA

Virginia Beach-Norfolk-Newport News, VA-NC

Harrisonburg, VA

Blackburg-Chrisiansburg-Radford, VA

Lynchburg, VA

Roanoke, VA

FAIRFAX 24,047

ALEXANDRIA CITY 8,502

PRINCE WILLIAM 10,731

ARLINGTON 4,037

LOUDOUN 2,563

HERNCO 1,598

RICHMOND CITY 1,359

VIRGINIA BEACH CITY 778

NEWPORT NEWS CITY 764

CHESAPEAKE CITY 805

9,238

3,763

2,202

1,567

1,243

647

274

236

176

173

572

183

166

96

75

125

31

34

24

19

2

96

81

173

900

136

170

17

2

173

31

34

24

19

2

96

81

173

572

183

166

96

75

125

31

34

24

19

2

96

81

173

572

183

166

96

75

125

31

34

24

19

2

96

81

173

2008

2,008

175

103

17

2

19

2

All estimates are subject to both sampling and nonsampling error.
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-Hillsboro 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

- Somali: 46.8%
- Ethiopian: 22.7%
- Egyptian: 12.4%
- Sudanese: 4.6%
- Eritrean: 5.5%
- Other: 8%

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

STATE LEGISLATION AND POLICY LANDSCAPE

STATUS

Deficient Existing Legislation; 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

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.

STATE DATA

Based on 2015-2019 ACS population estimates.

44,761

STUDY POPULATION: 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

SPATIAL DISTRIBUTION

Counties with the highest study population | living with | at risk population

King 29,217 11,501 1,354
Snohomish 6,364 2,803 114
Pierce 4,335 870 73
Clark 1,129 443 31
Spokane 981 269 15
Thurston 524 123 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

Seattle-Tacoma-Bellevue, WA 39,199 0
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 -

ALL ESTIMATES ARE SUBJECT TO BOTH SAMPLING AND NONSAMPLING ERROR.
WESTERN REGIONS

COMBINED STATE DATA

Based on 2015-2019 ACS population estimates.

10,020

STUDY POPULATION: 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. Idaho1 and North Dakota2 have Deficient Existing Legislation that Needs Strengthening. Wyoming3 has Strong Existing Legislation.

NOTE: All estimates are subject to both sampling and nonsampling error.

Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota, and Wyoming

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

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

STATE PREVALENCE RANKING

LOW PREVALENCE STATES DATA

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 759 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

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>AT RISK Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Somali</td>
<td>246</td>
</tr>
<tr>
<td>Sudanese</td>
<td>759</td>
</tr>
<tr>
<td>Lakota</td>
<td>57</td>
</tr>
<tr>
<td>Liberian</td>
<td>46</td>
</tr>
<tr>
<td>Ethiopian</td>
<td>49</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>1,295</td>
</tr>
</tbody>
</table>

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.

STATES DATA

Low Prevalence Western States Data

<table>
<thead>
<tr>
<th>State</th>
<th>Girls AT RISK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska, HI</td>
<td>2,295</td>
</tr>
<tr>
<td>Native American</td>
<td>1,239</td>
</tr>
<tr>
<td>Nevada, NV</td>
<td>1,171</td>
</tr>
<tr>
<td>Oregon, OR</td>
<td>1,082</td>
</tr>
<tr>
<td>Washington, WA</td>
<td>943</td>
</tr>
<tr>
<td>Idaho, ID</td>
<td>846</td>
</tr>
<tr>
<td>Montana, MT</td>
<td>796</td>
</tr>
<tr>
<td>Wyoming, WY</td>
<td>734</td>
</tr>
<tr>
<td>Colorado, CO</td>
<td>684</td>
</tr>
<tr>
<td>New Mexico, NM</td>
<td>532</td>
</tr>
<tr>
<td>Texas, TX</td>
<td>523</td>
</tr>
<tr>
<td>Arizona, AZ</td>
<td>493</td>
</tr>
</tbody>
</table>

NOTE: All estimates are subject to both sampling and nonsampling error.

STATE LEGISLATION

Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota and Wyoming

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; Comprehensive Expanded Definition; Adding: Education and Outreach; Extended Civil Statute of Limitations; Specification of Mandatory Reporting; Annual Statistical Reporting; Mandatory Training for Law Enforcement; Mandatory Revocation of Medical License

NOTE: All estimates are subject to both sampling and nonsampling error.


Included are the following states:

Alaska, Hawaii, Idaho, Montana, New Mexico, North Dakota, and Wyoming

Metropolitan Areas with the highest

<table>
<thead>
<tr>
<th>Metropolitan Area</th>
<th>STUDY POPULATION</th>
<th>LIVING WITH</th>
<th>AT RISK Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anchorage, AK</td>
<td>1,399</td>
<td>328</td>
<td>53</td>
</tr>
<tr>
<td>Boise City, ID</td>
<td>1,092</td>
<td>217</td>
<td>35</td>
</tr>
<tr>
<td>Albuquerque, NM</td>
<td>864</td>
<td>209</td>
<td>9</td>
</tr>
<tr>
<td>Urban Honolulu, HI</td>
<td>832</td>
<td>271</td>
<td>3</td>
</tr>
<tr>
<td>Las Cruces, NM</td>
<td>409</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>Coeur d’Alene, ID</td>
<td>92</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Santa Fe, NM</td>
<td>243</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Bismarck, ND</td>
<td>190</td>
<td>24</td>
<td></td>
</tr>
</tbody>
</table>

STATE PREVALENCE RANKING

LOW PER STATE AT RISK

<table>
<thead>
<tr>
<th>State</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Prevalence</td>
<td></td>
</tr>
</tbody>
</table>

MEDIUM PER STATE AT RISK

<table>
<thead>
<tr>
<th>State</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medium Prevalence</td>
<td></td>
</tr>
</tbody>
</table>

HIGH PER STATE AT RISK

<table>
<thead>
<tr>
<th>State</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Prevalence</td>
<td></td>
</tr>
</tbody>
</table>

HIGHEST PER STATE AT RISK

<table>
<thead>
<tr>
<th>State</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest Prevalence</td>
<td></td>
</tr>
</tbody>
</table>
SUMMARY

FGM/C prevalence was estimated at 3.7% 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.

STATE DATA

Based on 2015-2019 ACS population estimates.

9,018

STUDY POPULATION:

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

382

Girls AT RISK

OTHER

4.7%

Somali

34.8%

Ethiopian

36.8%

Malay

17%

Egyptian

6.7%

Somali

34.8%

Ethiopian

36.8%

Malay

17%

EGYPTIAN

6.7%

STATE PREVALENCE RANKING

LOW

MEDIUM

HIGH

HIGHEST

PER STATE AT RISK

BETWEEN 100 AND 1,000 AT RISK

BETWEEN 1,000 AND 3,000 AT RISK

BETWEEN 3,000 AND 10,000 AT RISK

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.

AGE DISTRIBUTION

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

SPATIAL DISTRIBUTION

Metropolitan Areas with the highest

STUDY POPULATION | LIVING WITH | AT RISK population

Minneapolis-St. Paul-Bloomington, MN-WI

MILWAUKEE-WAUKEsha-West Allis, WI

OSHKOSH-NEENah, WI

La Crosse-Onalaska, WI-MN

Racine, WI

Sheboygan, WI

Janesville-Beloit, WI

Eau Claire, WI

70,417

33,054

10,001

25,032

7,001

4,001

7,001

4,001

106

5

1

10

3

0

3

4

10

0

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3
### TABLE 1: STUDY POPULATION

<table>
<thead>
<tr>
<th>Country</th>
<th>Total</th>
<th>Zambian</th>
<th>Ugandan</th>
<th>Tanzanian</th>
<th>Senegalese</th>
<th>Kurdish</th>
<th>Ethiopian</th>
<th>Cameroonian</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,089</td>
<td>100,735</td>
<td>98,393</td>
<td>90,538</td>
<td>91,319</td>
<td>102,674</td>
<td>119,315</td>
<td>132,607</td>
<td>126,396</td>
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### TABLE 2: AGE-SPECIFIC PREVALENCE RATES

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<th>20-29</th>
<th>30-39</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70-79</th>
<th>80-89</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,089</td>
<td>3,854</td>
<td>5,239</td>
<td>3,473</td>
<td>5,546</td>
<td>6,821</td>
<td>6,404</td>
<td>8,188</td>
<td>7,526</td>
<td>8,827</td>
<td>1,037</td>
</tr>
</tbody>
</table>

## APPENDIX

"I would like to say a big thank you to AHA Foundation supports. 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

### 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 calculated for each also. The figure shows the total prevalence rates for each age group.
OVERVIEW OF THE EXTRAPOLATION METHOD CALCULATIONS

Study population (ACS 2015-2019): **1,325,989** women and girls connected with a country of interest

- **940,760** were foreign-born (71%)
- **385,229** were native-born (29%)

- **732,148** migrated after the age of cutting (78%)
- **208,612** migrated before/during the age of cutting (22%)

Prevalence in country of origin segmented by age and extrapolated from 81 national surveys

- **332,395** cut before migration
- **88,317** at risk at migration
- **156,463** potentially at risk

- **577,175** potentially impacted by FGM/C - similar to PRB and CDC method

NO migration and acculturation impact

- **50% migration and acculturation impact**

- **75% migration and acculturation impact**

- **415,670** most likely impacted by FGM/C

- **384,714** living with FGM/C

- **30,956** at risk of FGM/C

- **19%** Egyptian
- **16%** Ethiopian
- **15%** Nigerian
- **12%** Somali
- **7%** Indonesian
- **32%** Somali
- **27%** Egyptian
- **17%** Ethiopian
- **8%** Sudanese
- **3%** Liberian

“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

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SUGGESTED CITATION:

For more granular prevalence data contact info@theahafoundation.org