



COUNTRY PROFILE: FGM IN EGYPT

April 2017

28 TOOMANY

FGM...
let's end it.



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v2 November 2017

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Preface

'Your silence will not protect you.'

~ Audre Lorde

The poet and activist Audre Lorde's declaration, 'Your silence will not protect you', is as powerful and true today as it was when she first said it in 1977. It has been central to my work as a writer, a feminist and a Muslim woman who was born in Egypt and who has lived in, and moved back and forth between, several other countries.

Lorde's exhortation to 'learn to work and speak when we are afraid' ripples through this vital report by 28 Too Many on FGM in Egypt, where silence around that harmful practice literally has cost too many Egyptian girls their lives.



Mona Eltahawy,
Egyptian activist and author of
'Headscarves and Hymens.
Why the Middle East needs
a Sexual Revolution'
(Weidenfeld & Nicolson, 2015)

In 2011, Egyptians rose up in a revolution that broke the silence of years of repression. I believe at the heart of any such revolution are consent, agency, and the unequivocal belief that I own my body – not the state, not the church/mosque/temple, not the street and not the family. It is from that belief that we can all help in the fight against FGM, by talking openly and unashamedly about sex, our bodies, and about FGM – something that hurts so many girls and women, yet is kept silent and taboo.

When I say, 'I own my body', fighting FGM becomes a revolutionary act.

We need nothing short of a recognition that ending female genital mutilation is part of the 'social justice and human dignity' revolution that we began in Egypt in January 2011. We can better protect our girls when we recognise that those chants of our revolution are essentially demands for autonomy and consent – for all.

I consider the work of 28 Too Many to embody and amplify the revolutionary spirit that Egypt's anti-FGM activists have poured into their tireless work to liberate our girls and women from that starkest embodiment of their disempowerment.

Mona Eltahawy
Activist and author

Foreword

In January 2017, as the UK representative of the Inter-African Committee, I had the privilege of attending the international BanFGM Conference in Rome, where I worked alongside activists from over 30 countries and the diaspora communities. What struck me was the continuing drive to build upon the foundations that are now in place to end the practice. The issues discussed are extremely pertinent to Egypt – the medicalisation of FGM, the need for robust laws and their enforcement, continuing advocacy and partnerships, the power of education and the importance of supporting girls to finish their schooling.

The prevalence of FGM in Egypt remains high, at 87.2% of all women aged 15-49, but there are welcome signs that this is reducing in younger age-groups. It is clear from this Country Profile that Egypt has the potential to greatly reduce its FGM prevalence, but it will require total commitment and support from the Government and influential leaders, including those from all faiths.

The challenge of medicalised FGM in Egypt is well documented, and it is clear what needs to be done to tackle the problem. The move to train medical personnel is a positive step forward and, with adequate law enforcement, the Government can lead by example when addressing this issue, which is increasingly affecting other countries across the world. We are concerned that the youth of Egypt continues to miss out on quality health and sex education. This perpetuates the misunderstandings about sex and FGM, to the detriment of married couples and their families. Accurate education for both boys and girls, particularly in the rural areas of Upper Egypt, should be made a priority.

We are grateful to the many organisations and individuals who met with 28 Too Many, or provided us with information, during this research. We recognise the importance of partnership, and of enabling international, national and grassroots organisations to combine their knowledge and experience when educating and supporting communities to abandon FGM. Our case study on Plan International Egypt highlights how a partnership approach can make a difference. The NGOS Coalition against FGM also shows that joint working is the way forward for Egypt, and we know that many organisations are looking for opportunities to work with others and scale up their programmes. We therefore call on President el-Sisi to support the vital work being done on the ground by organisations and activists, and to resist the pressure to impose and tighten restrictions on those who are best placed to work with the Government to achieve its stated objective of eradicating this harmful practice.



Dr Ann-Marie Wilson
28 Too Many Executive Director

*Dr Ann-Marie Wilson at the BanFGM
conference in Rome, January 2017*

Information on Country Profiles

Background

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We are building an information base, which includes detailed country profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop networks of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

Purpose

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Egypt, many programmes are making positive, active change.

Use of This Country Profile

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: **28 Too Many (2017) Country Profile: FGM in Egypt. Available at <http://www.28toomany.org/countries/Egypt/>.**

Acknowledgements

28 Too Many would like to thank Christof Walter Associates for their generous sponsorship of this Country Profile (www.christofwalter.com).

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, including community groups, local non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs) and international organisations. We thank them, as it would not have been possible without their assistance and collaboration.

28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the

many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

For more information, please contact us on info@28toomany.org.

The Team

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Jacqueline Hoover is a trustee of 28 Too Many. She teaches Islamic Studies and Muslim-Christian Relations in a number of institutions, including the University of Nottingham. She previously worked for ten years in Egypt.

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Lauren Marc is a research volunteer. She is studying a BSc majoring in Ecology and Physiology and works within the retail industry.

Rose Okoye is a research volunteer. She has an LLM in Public International Law and is currently working within the prison service.

Caroline Pinder is **research coordinator**. She has worked as an international development consultant for 25 years, specialising in gender equality and women's empowerment issues.

Dr Ann-Marie Wilson founded **28 Too Many** and is the **executive director**. She has also written various papers on FGM and has worked extensively in Africa.

We are grateful to the rest of the 28 Too Many team, who have helped in so many ways, including **Sean Callaghan**. **Mark Smith** creates the custom maps used in 28 Too Many's country profiles. Thanks also go to **Malcolm Crawford** for volunteering his time as proof reader.

Cover: ALL best fitness is HERE/Shutterstock.com (2013) Hurchada, Egypt – Muslim girl in hijab on July 08, 2013. Stock photo ID: 436069912.

Please note the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.

List of Abbreviations

INGO and NGO acronyms are found in Appendix 1

AIDS	Acquired Immunodeficiency Syndrome
CBO	community based organisation
CEDAW	Convention on the Elimination of Discrimination Against Women
CSO	civil society organisation
DHS	Demographic and Health Surveys Program
EHIS	Egyptian Health Issues Survey
FBO	faith-based organisation
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
GII	Gender Inequality Index
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
HTP	harmful traditional practice
ICPD	International Conference on Population and Development
INGO	international non-governmental organisation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOHP	Ministry of Health and Population
NCCM	National Council for Childhood and Motherhood
NCW	National Council for Women
NGO	non-governmental organisation
NPC	National Population Council
OECD	Organisation for Economic Co-operation and Development
PPP	purchasing power parity
SDGs	Sustainable Development Goals 2015-2030
SIGI	Social Institutions and Gender Index
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting
US	United States of America
WASH	water, sanitation and hygiene
WFP	World Food Programme
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 2005' refers to:

El-Zanaty, Fatma and Ann Way (2006) *Egypt Demographic and Health Survey 2005*. Cairo, Egypt: Ministry of Health and Population, National Population Council, El-Zanaty and Associates, and ORC Macro. Available at <http://www.dhsprogram.com/pubs/pdf/FR176/FR176.pdf>.

'DHS 2008' refers to:

El-Zanaty, Fatma and Ann Way (2009) *Egypt Demographic and Health Survey 2008*. Cairo, Egypt: Ministry of Health, El-Zanaty and Associates, and Macro International. Available at <http://dhsprogram.com/publications/publication-fr220-dhs-final-reports.cfm>.

'DHS 2014' refers to:

Ministry of Health and Population [Egypt], El-Zanaty and Associates [Egypt], and ICF International (2015) *Egypt Demographic and Health Survey 2014*. Cairo, Egypt and Rockville, Maryland, USA: Ministry of Health and Population and ICF International. Available at <https://dhsprogram.com/publications/publication-FR302-DHS-Final-Reports.cfm>.

'EHIS 2015' refers to:

Ministry of Health and Population [Egypt], El-Zanaty and Associates [Egypt], and ICF International (2015) *Egypt Health Issues Survey 2015*. Cairo, Egypt and Rockville, Maryland, USA: Ministry of Health and Population and ICF International. Available at <https://dhsprogram.com/pubs/pdf/FR313/FR313.pdf>

All cited texts in this Country Profile were accessed between December 2016 and March 2017, unless otherwise noted.

A Note on Data

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries known as the **Demographic and Health Survey (DHS)** and the **Multiple Indicator Cluster Survey (MICS)**. For Egypt, DHS reports have been published at intervals since 1988, the most recent being 2005, 2008, 2014 and 2015. MICS reports were published in 1996 and 2013/2014.

The most recent set of data on FGM available for the country is a split report that was published by the DHS in 2014 and 2015; the two parts are referred to throughout this Country Profile as 'the DHS 2014' and 'the EHIS 2015'. In addition to the usual DHS survey questions, the DHS 2008 was designed to gather data on health issues that are critical in Egypt, such as Hepatitis C. When the latest survey was planned, it was decided to update that additional data, but to split the survey and subsequent report up into two components. Fieldwork for the first component, the **DHS 2014**, was conducted in April-June 2014, and surveyed a sample of **ever-married women** (i.e. women who have been married at some point in their life) on fertility, family planning, and maternal- and child-health indicators. The second component, the **Egyptian Health Issues Survey (EHIS) 2015**, obtained information on other critical health problems that Egypt faces, and surveyed a sample of **all women, as well as men**. As the DHS 2008 and the EHIS 2015 both sample all women, they are somewhat comparable, whereas they are not directly comparable with the other DHS surveys, which only contain data on ever-married women.

As the data obtained on FGM from a sample of all women (and men) gives a more accurate picture of the current situation in Egypt, **this Country Profile has taken the EHIS 2015 as its primary data source**. However, where information is not available in that report, the DHS 2014 is referenced.

A **secondary analysis** of the source survey data from the DHS 2005, 2008 and 2014 was performed by UNICEF¹ in relation to girls aged 0-17, and this is referred to at times throughout this Country Profile, to give a picture of statistical trends. It should be noted that, for this analysis, only the 2008 source data relating to ever-married women was used, to make the data across these years comparable.

UNICEF² emphasises that **self-reported data on FGM** 'needs to be treated with caution' since women 'may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice.' They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

Measuring the FGM status of girls, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses to this question may indicate the effect of laws criminalising the practice, which make it harder for mothers to report that FGM was carried out, as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14.³

This Country Profile includes data on the '**expected eventual percentage**' of FGM among girls, which is referred to in the DHS reports and the secondary analysis as 'expected future prevalence'. It is a prediction of the percentage of girls who will undergo FGM before a certain age, and is calculated by combining the percentage of girls below that age who have

already undergone FGM and the percentage of girls whose mothers plan for them to undergo FGM before they reach that age.

It is important to note that survey results may be based on relatively small numbers of women, particularly when they are further broken down by location/religion/ethnicity/etc. Therefore, in some cases, statistically significant conclusions cannot be drawn. This does not mean that the data is not useful; it simply means that one should be careful about drawing 'hard and fast' conclusions from it, and 28 Too Many has accordingly taken that approach when researching and writing this Country Profile. In the DHS 2014 and the EHIS 2015, an extremely small sample was surveyed from the **Frontier Governorates**, and those results have been, therefore, largely omitted.

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- 1 Dr Fatma El-Zanaty, UNICEF (2015) *Factors and determinants of FGM/C of girls aged 0-17 years: a secondary analysis of the Egypt Demographic and Health Surveys, 2005, 2008 and 2014*. Available at https://www.unicef.org/egypt/FGM_Secondary_analysis_edited_5-08-2016_FINAL.pdf.
 - 2 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.24. Available at http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf.
 - 3 *Ibid.*

Executive Summary

'There is absolutely no reason to cut anybody. . . . It's child abuse; it's gender-based violence; it's a human-rights violation.'

~ Babatunde Osotimehin, Head of UN Population Fund¹

Female Genital Mutilation (FGM) has been performed in Egypt since pharaonic times. An **FGM prevalence of 87.2%** among all women aged 15-49² in a population of nearly 95 million suggests that **Egypt has the greatest number of women and girls who have experienced FGM of any country in the world.**

The first movement against the practice began as early as the 1920s, in the medical sector. Following the International Conference on Population and Development in Cairo in 1994, the public discourse surrounding the issue began to change, and anti-FGM activists' focus shifted from the health-related consequences of FGM to human and women's rights.³

Anti-FGM campaigners have had to work through a turbulent period in Egypt's recent political history, including changes in government and the Arab Spring demonstrations (the Egyptian Revolution) in 2011. Work to end FGM was severely curtailed in 2012 when the Muslim Brotherhood were in power and trying to overturn the previous ban on medical professionals performing FGM. Egypt under President el-Sisi is now relatively stable, although tensions and uncertainties about the future remain.

Egypt is classified by the World Bank⁴ as a 'lower middle income country'. Upper Egypt is the poorest region, especially its rural areas, where FGM is most prevalent.

Regarding FGM, Egypt is classified by UNICEF⁵ as a '**very high prevalence**' country. The DHS 2014⁶ gives a **prevalence of 92.3%** among (**ever married**) women aged 15-49, and the EHIS 2015⁷ gives a **prevalence of 87.2%** among (**all**) women aged 15-49. There has been little change between 2008 and 2015. A more encouraging picture is presented in a secondary analysis⁸, of the DHS data on Egyptian **girls aged 0-17 between 2005 and 2014**, which concludes that the total percentage of girls who had already undergone FGM and those who were likely to undergo FGM before they reached 18 years of age **fell from 69% to 55%** in that period.⁹ As girls are unlikely to experience FGM after the age of 17 in Egypt, this suggests that there will be a continued decline in the overall prevalence of FGM in the future.

FGM in Egypt is usually performed at any time between birth and the age of 17, with most girls undergoing the practice at or before puberty.¹⁰ FGM appears to take place at a younger age in Upper Egypt, and may even be performed in some rural villages when girls are only five days old. There appears to be a move towards cutting girls at a younger age, but this is difficult to confirm at present. **FGM is usually performed in May and June**, before the hottest part of the year.¹¹ Reports suggest that it is usually **Types I and II** that are practised.¹² **The likelihood of a woman or girl experiencing FGM is influenced by both place of residence and wealth.** 77.4% of women (aged 15-49) in urban areas have undergone FGM, compared to 92.6% in rural areas. Prevalence among girls aged 1-14 is 10.4% in urban areas, compared to 15.9% in rural areas, and there is a markedly higher prevalence among girls living in Upper Egypt than among girls living in Lower Egypt and the Urban Governorates.¹³ 94.4% of women (aged 15-49) in the lowest wealth quintile have undergone FGM, compared to 69.8% of women in the highest wealth quintile.¹⁴

While most Egyptians have heard of FGM, knowledge and understanding of the issues surrounding FGM and its dangers are poor. Slightly more girls and young women have heard of FGM (98.3%) than boys and young men (89.4%). Young women are more likely to say FGM is necessary than young men, and less-wealthy and less-educated young people are more likely to say it is necessary than richer and better-educated young people.¹⁵ The percentage of men and women who think FGM makes childbirth more difficult is very low. However, there has been an increase in knowledge about FGM's potential to cause serious consequences/death¹⁶, probably due to the attention given by the media to the deaths of several young girls in recent years. **It is a matter of concern, however, that available data shows a sharp decline in both women's and men's recent exposure to information about FGM.**¹⁷ **Exposure to correct information about FGM is vital** – for example, Lower Egypt has had the greatest decline in prevalence of FGM since 2005, and also has the highest percentages of women who have received information on FGM and discussed it with their peers or relatives.¹⁸

FGM is practised for several reasons in Egypt, but the most commonly cited are tradition, religion and its association with marriage.¹⁹ Important to Egyptian men is the concept of *quama* ('protection'), and men view FGM as part of protecting the women in their families.²⁰ Several commentators have noted that the most problematic reason is the pervasive idea that women are 'oversexed'²¹, and that FGM reduces their sexual appetites; some 48.7% of men and 43.1% of women believe FGM prevents adultery²². **An absence of good-quality sex education** in Egypt, in schools, in the home and through religious leaders increases such misunderstandings about sex and FGM, and thus **contributes to the continuation of the practice.**

Just over half of men and women feel that FGM should be continued. A decline in the percentages of men and women who reply that they are not sure whether FGM should or should not be continued may indicate that societal changes have taken place such that those who were previously unsure have been able to form a definite opinion on the subject.²³ **The belief that FGM is required by religious law is a considerable contributor to the continuation of the practice in Egypt.** Approximately 90% of Egypt's population is Muslim and 10% Christian. Islam is the state religion. Data suggests a decline, more among women than men, in those who believe that FGM is required by their religion. Consistently, a greater percentage of Christian women than Muslim women have opposed FGM, and opposition has spread faster among Christian women.²⁴ Academic reports have been published following a review by senior Egyptian Islamic and Christian leaders of religious texts in relation to FGM.²⁵ Their conclusion was that '[t]here is religious consensus that FGM/C is a detrimental social and cultural practice, which has no relation or justification in religion, either Christianity or Islam. **Hence, abandoning this harmful practice is a religious and moral duty.**'²⁶ Training programmes are being run for religious leaders, encouraging them to include teaching on FGM in their Friday prayers or church services.²⁷ This is vital for dispersing the message to communities, and several NGOs have spoken to 28 Too Many about the necessity of including religious leaders in their work.

Egypt has signed many of the international rights conventions and treaties related to FGM and, although it ratified the Convention for the Elimination of All Forms of Discrimination Against Women, it did so with reservations that demonstrate how Islamic Sharia takes precedence over any international law or treaty. The **new constitution in 2014** is also based on Islamic Sharia principles²⁸, and for the first time **requires that the state protects women from all forms of discrimination and violence.** In 1996, a decree was passed against FGM being performed in government hospitals and private clinics and, subsequently, the National Council for Childhood and Motherhood was launched and went on to develop a national

programme entitled the **FGM-Free Village Model** in 2003. In 2007, following the deaths of two girls due to FGM, the Egyptian Ministry of Health and Population (*MOHP*) banned medical practitioners from performing FGM.²⁹ **On 16 June 2008, FGM was outlawed in Egypt.** Between 2007 and 2013, several girls died undergoing FGM, including Soheir al-Batea, causing public concern that laws were insufficient and inadequately enforced. Therefore, in September 2016 a further amendment was made to the Penal Code, making FGM a felony and increasing penalties. **However, the enforcement of FGM laws is clearly still insufficient in Egypt and needs to be made a priority. It is also essential that community officials, law enforcement officers and justice agents are educated about FGM.**

Physical violence and the sexual harassment of women remains widespread in Egypt, despite harassment being made a criminal offence in June 2014.³⁰ A UN study in 2013 showed that as many as 99.3% of Egyptian women experience sexual harassment during their lives.³¹ Cultural systems and traditions, rather than laws, restrict women's participation in land ownership, business, and decision-making in the home and in relation to their own healthcare. The relative level of participation of women in household decision-making is positively correlated to age and levels of education and wealth, and women in rural areas are generally worse off.³² The legal minimum age for marriage is 18, but early marriages still occur, and a national strategy has been put in place to combat them.³³ The Government's *Sustainable Development Strategy: Egypt Vision 2030*³⁴ includes explicit reference to the need to improve gender equality, but **the effectiveness of these new laws and strategies depends on there being a deeper societal and cultural change in attitude towards women and girls.**

Basic education is free and compulsory in Egypt for the first nine years, and children receive either a secular or an Islamic education, in either state or private schools. Egypt's adult literacy rate is 73.9%; its youth literacy rates are 86.1% for women and 92.4% for men.³⁵ While literacy rates have vastly improved over the years, an estimated **31% of women and girls in Egypt were illiterate in 2014**, compared to 15.7% of men and boys.³⁶ School attendance and, consequently, literacy rates are strongly correlated to place of residence and wealth³⁷; Girls from poorer, more rural areas are the least likely to enter primary school.³⁸ **Nearly a quarter of Egyptian women (22.1%) have not received any education**, although the percentage declines in direct correlation to age.³⁹ Education empowers women and impacts on their ability to make healthy and autonomous reproductive choices. **As such, developing literate, better-educated and employed women should be a priority for the future health and prosperity of Egypt.**

Egyptians who can afford it choose private healthcare for their primary healthcare needs.⁴⁰ One patient said, 'A woman will do everything she can to avoid giving birth in a public hospital'.⁴¹ **Government spending on health is currently well below the 3% of the GDP set in the 2014 constitution.**⁴² In 2015, the Egyptian Government and The World Bank produced *A Roadmap to Achieve Social Justice in Health Care in Egypt*⁴³, which aims to identify and amend problems in the health system. 90.3% of ever-married women aged 15-49 who had a live birth in the five years prior to the DHS 2014 survey received some form of antenatal care from a skilled provider, and 82.8% received regular care (at least four visits during the pregnancy), but these figures varied by wealth and education level.⁴⁴ 86.7% of ever-married women aged 15-49 gave birth in a health facility; the highest percentages of home births were in rural Upper Egypt (23.9%) and among women in the lowest wealth quintile (24.7%).⁴⁵ 26.1% of ever-married women aged 25-49 had their first child by the age of 20, and 44% had their first by the age of 22.⁴⁶ Obstetric fistula in Egypt is rare; those who do experience it often spend months trying to access appropriate treatment.⁴⁷

Since 2008, there has been a shift in Egypt away from traditional practitioners and towards health professionals (particularly doctors) performing FGM.⁴⁸ The primary focus on health issues by early anti-FGM campaigns has been suggested as a contributory factor in families turning to medical staff and facilities, which are perceived as 'safer'. Additionally, doctors, as professionals, are seen as having more 'power' in society than the traditional midwife, and thus are less likely to be punished for performing FGM. **Thus, the medicalisation of FGM in Egypt is a huge challenge in the campaign to end the practice; currently, 78.4% of incidences of FGM are carried out by a health professional.**⁴⁹ Medicalised FGM is most common in the Urban Governorates and Lower Egypt, perhaps because easy access to health professionals and the funds to pay them is more common for families living there.⁵⁰ Nearly two-thirds (64.5%) of girls and women aged 13-35 who have been cut underwent FGM either at home or at another house. 11.5% of those living in urban areas underwent FGM in a private hospital, compared to 2.7% of those living in rural areas.⁵¹ A study as recent as 2016 noted that 'physicians are not discouraging the practice, giving legitimacy to a procedure that has serious medical risks.'⁵² Medical professionals have an economic incentive to continue performing FGM, especially those in rural areas.

Of great concern, too, is the apparent lack of knowledge among medical professionals about the functions of female genitalia, and about FGM itself and what it entails.⁵³ It is essential that adequate education and training programmes around FGM are put in place for health-sector workers. Studies have also shown physicians expressing beliefs that FGM is required by religious precepts, and even defending the practice.⁵⁴ **There is clearly a need for a component of religious teaching to be included in training programmes.** The WHO has issued new guidelines for practitioners on FGM, and the MOPH and the UNFPA have begun retraining 1,000 doctors a year in relation to FGM. Doctors Against FGM also aims to provide appropriate training.⁵⁵

Reporters Without Borders ranks Egypt 159th out of 180 countries in its 2016 World Press Freedom Index.⁵⁶ The organisation calls the current situation 'extremely worrying'.⁵⁷ Egypt's media is widely accessed and therefore highly influential in its region.⁵⁸ Television is overwhelmingly the most popular traditional medium and is therefore an important resource for anti-FGM campaigners to utilise.⁵⁹ Exposure to newspapers and radio, and the use of the internet and social media, increase with education and wealth and are more common in the Urban Governorates and Lower Egypt than in Upper Egypt.⁶⁰ 92% of people in the poor, urban communities of Cairo who access the internet do so through their mobile phones.⁶¹ There is therefore a significant advantage in making anti-FGM websites and campaigns mobile-device 'friendly'. **It is likely that anti-FGM advocacy that only utilises the internet and social media will have little impact in rural areas, where television is far more frequently accessed.** The media's ability to tell stories that subvert social norms and traditional views is being put to good use by many organisations, such as Tadwein Gender Research and Training Centre, Noon Creative Enterprise, NGOs Coalition against FGM/C, the UNDP and BuSSy.

There are many international and national NGOs working throughout Egypt, and 28 Too Many is encouraged by the strong partnerships in communities (such as the NGOs Coalition against FGM/C and Plan International Egypt with Caritas and local civil-society partners). Egypt was also one of the original eight countries chosen in 2008 as part of the United Nations Joint Programme on Female Genital Mutilation and Cutting: Accelerating Change, which aims to end FGM in a generation. **The challenges to continue this work and end FGM remain huge, however, particularly in light of the Egyptian Government's possible tightening of NGO operating laws. Activists who are working to protect the rights of women and girls and enforce the state laws against FGM are increasingly being targeted, and this is a great concern in terms of the future of the**

campaign. Building trust in communities and introducing and maintaining programmes to end FGM takes a considerable amount of time and funding, and needs the total commitment and support of the Government.

In conclusion, specific challenges that need to be addressed include:

- combating the ongoing community pressures, traditions, beliefs about religion and FGM, and misunderstandings due to the lack of sex education;
- the medicalisation of FGM, despite laws forbidding it;
- the implementation and enforcement of anti-FGM laws;
- educating and maintaining influential leaders and role models, especially religious leaders;
- the decline in press freedom potentially making dissemination of information more difficult, or journalists more wary of reporting on sensitive issues;
- inaccessible healthcare, especially for women in rural areas and those without funds to pay;
- obtaining comprehensive and reliable data, made more difficult by respondents' fear of prosecution or lack of knowledge;
- navigating changing political climates, and the ongoing threat of re-emerging support for FGM from some factions;
- the ability to forge partnerships and obtain funding (especially international) for anti-FGM programmes, which will be under threat if the new 'NGO law' is ratified by President el-Sisi; and
- ensuring the security and physical safety of all those working in-country to end FGM.

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Introduction

'It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.'

~ The General Assembly of the United Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) is defined by the World Health Organization (WHO)² as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence (GBV) and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.³

History of FGM

FGM has been practised for over 2,000 years.⁴ Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision'.⁵ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'.⁶

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples⁷, aided by Egyptian slave raids from Sudan for concubines and the trading of maids through the Red Sea to the Persian Gulf⁸.

Global Prevalence and Practices

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices, FGM is carried out by

communities as a heritage of the past, and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

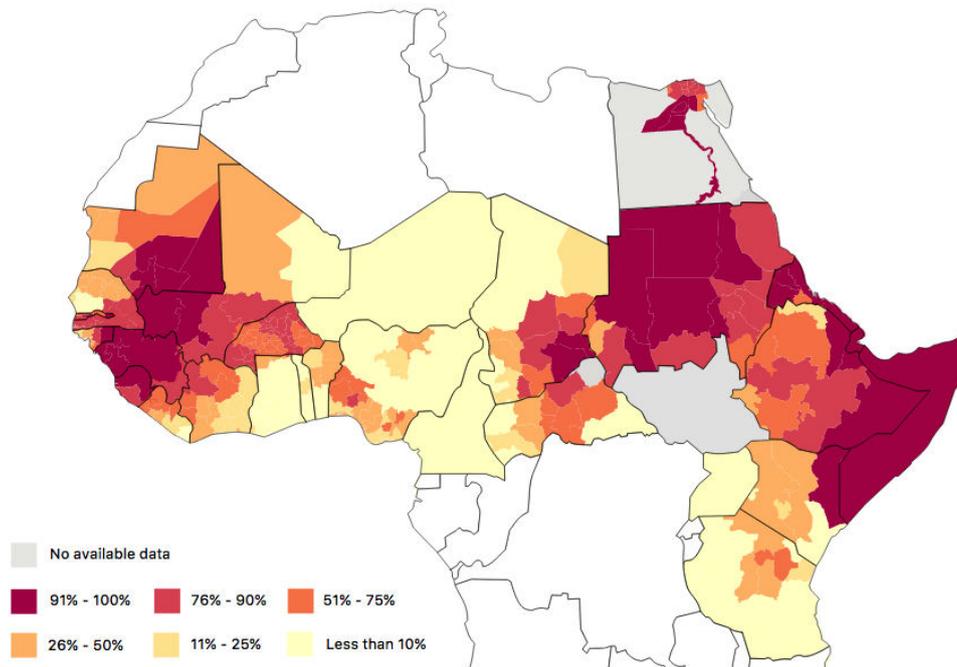


Figure 1: Prevalence of FGM in Africa⁹

The WHO¹⁰ classifies FGM into four types:

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy)
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). Note also that the term ‘excision’ is sometimes used as a general term covering all types of FGM.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes; for example: pricking, piercing, incising, scraping and cauterisation.

Table 1: Types of FGM as classified by the WHO

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls ‘clean’ and aesthetically beautiful. Although no religious texts require the practice, practitioners often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.¹¹ Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth.¹²

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use regarding diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation, and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM, and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we have connected with many anti-FGM campaigners, CBOs, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

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General National Statistics

This section highlights a number of indicators of Egypt's context and development status.

Population

94,925,292 (13 March 2017)¹ Growth rate: 2.51% (2016 est.)
 Median age: 23.8 years Human Development Index Rank: 108 out of 188 in 2014²

Age of Suffrage, Consent and Marriage

Age of Suffrage: 18 Age of Consent: 18
 Age of Marriage: 18, following an amendment to the Child Law in 2008, which prohibits but does not criminalise the registration of child marriages. After the Egyptian Revolution, an attempt was made to reduce the minimum age to nine years. This was defeated, however, and in 2014 a national strategy was introduced, aimed at reducing the prevalence of early marriage by 50% over 5 years.³

Health

Life expectancy at birth (years): 72.7
 Infant mortality rate (per 1,000 live births): <20 deaths (see page 82)
 Maternal mortality rate: 33 deaths/100,000 live births
 (2015 est. by CIA World Factbook; however, estimates greatly vary (see page 82)
 Fertility rate, total (births per woman): 3.53 (2016 est.)
 HIV/AIDS – adult prevalence: 0.02% (2015 est.)
 – people living with HIV/AIDS: 11,500 (2015 est.)
 (country comparison to the world: 98)
 – deaths: 300 (2015 est.)

GDP (in US dollars)

GDP (official exchange rate): \$342.8 billion (2015 est.)
 GDP per capita (PPP): \$12,100 (2016 est.)
 GDP (real growth rate): 3.8% (2016 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 73.8-73.9% Youth (15-24 years):
 Female: 65.4% (2015 est.); Male: 82.2% Female – 86.1%; Male – 92.4%⁴

Urbanisation

Urban population: 43.1% Rate of urbanisation: 1.68% annually (2010-2015 est.)

Religions: Muslim (predominantly Sunni) 90%; Christian (majority Coptic Orthodox) 10% (2012 est.)

Languages: Arabic (official); English and French widely understood by educated classes

Unless otherwise stated, all statistics are taken from CIA World Factbook (2017) *Egypt*, 12 January. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/eg.html>.

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Political Background

Historical¹

Egypt's primary neighbours are Israel to the north-east, Sudan to the south, and Libya to the west. On its northern side is the Mediterranean Sea. Egypt is often considered a cradle of civilisation, given that developments in writing, agriculture, urbanisation, religion and organised government can be traced back for millennia.

After being governed by various pharaonic dynasties, Egypt was taken over, in 332 BC, by the Macedonian ruler Alexander the Great. Thus, Egypt became part of the Greek Empire and eventually the Roman Empire, which held power until the 7th century AD. It was in the 1st century AD that Mark, the apostle of Jesus, came from Jerusalem and established the Christian church in Egypt. A majority of the people of Egypt became Christians in the early centuries AD. During the 7th century, the Muslim Arabs conquered Egypt. At first, a majority of the people remained Christian, but there were significant pressures placed on them, including special taxes, so by 1000 AD approximately half of the Egyptian people were Muslims.

In the 15th century, the Ottoman Empire invaded Egypt, but the country did not prosper under its rule. A weakened economic system left it vulnerable. For a brief period in the late 1700s, Napoleon controlled Egypt but then, in 1803, Muhammad Ali conquered the country and worked towards its modernisation. In 1869, Ali's successor built the Suez Canal in partnership with France, although, having built beyond their means, they were then compelled to sell controlling power to the British Empire. Therefore, in 1882, Egypt fell under British colonial rule, which lasted until 1953, when Gamal Abdel Nasser staged a military coup and became president.

Nasser was a charismatic leader, who gained a wide following in the Arab world. He forced the withdrawal of British troops from the Suez Canal area, with some help from the US, and built the Aswan Dam with help from the Soviet Union. He also challenged Israel, but was defeated in the 1967 Arab-Israeli war. In 1970 he was succeeded by Anwar Sadat, who fought the 1973 war with Israel, but later entered into negotiations that led to the 1979 treaty.

Current Political Conditions

Sadat was assassinated in 1981 and replaced by Hosni Mubarak, who ruled until 2011, when massive Arab Spring demonstrations forced him to resign. 'Arab Spring' refers to a series of formidable protests that occurred in six Arab countries, including Egypt, in 2011. The term associates these demonstrations with the fall of Communism in Eastern Europe in favour of democratic systems of government. However, a lack of direction or a consensus on what type of government should be set up in these Arab countries has resulted in political unrest and, in many cases, war.² The particular protests in Egypt have also come to be known as the 'Egyptian Revolution'.

In the 2012 election that followed the Revolution, Mohamed Morsi of the Muslim Brotherhood was elected president but, before long, there were renewed protests. As a

result, the Egyptian Army staged a coup and removed him from office. General Abdel Fattah el-Sisi, who launched the coup, was so revered by the public that in 2014 he ran in the presidential election and won. Since then he has remained president despite political unrest.

Women in Politics

Under Article 11 of the 2014 Constitution (see The Role of Women in Society, page 31), **women's representation** at all levels of government is confirmed, together with their right to hold senior positions within the judiciary and public authorities. Electoral arrangements allow for 120 seats in the House of Representatives to be allotted to districts through electoral lists, a quarter of which must be held by women. In the 2015 elections, 87 women were elected to the House (out of a total of 596 seats), and three were appointed to the cabinet by President Abdel Fattah el-Sisi.³

The Constitution also stipulates the setting up of various national councils, including the National Council for Human Rights and the National Council for Women. The State determines the composition and mandates of these councils, and 'guarantees for the independence and neutrality of their respective members. Each council shall have the right to report to the competent authorities any violations pertaining to their fields of work.'⁴

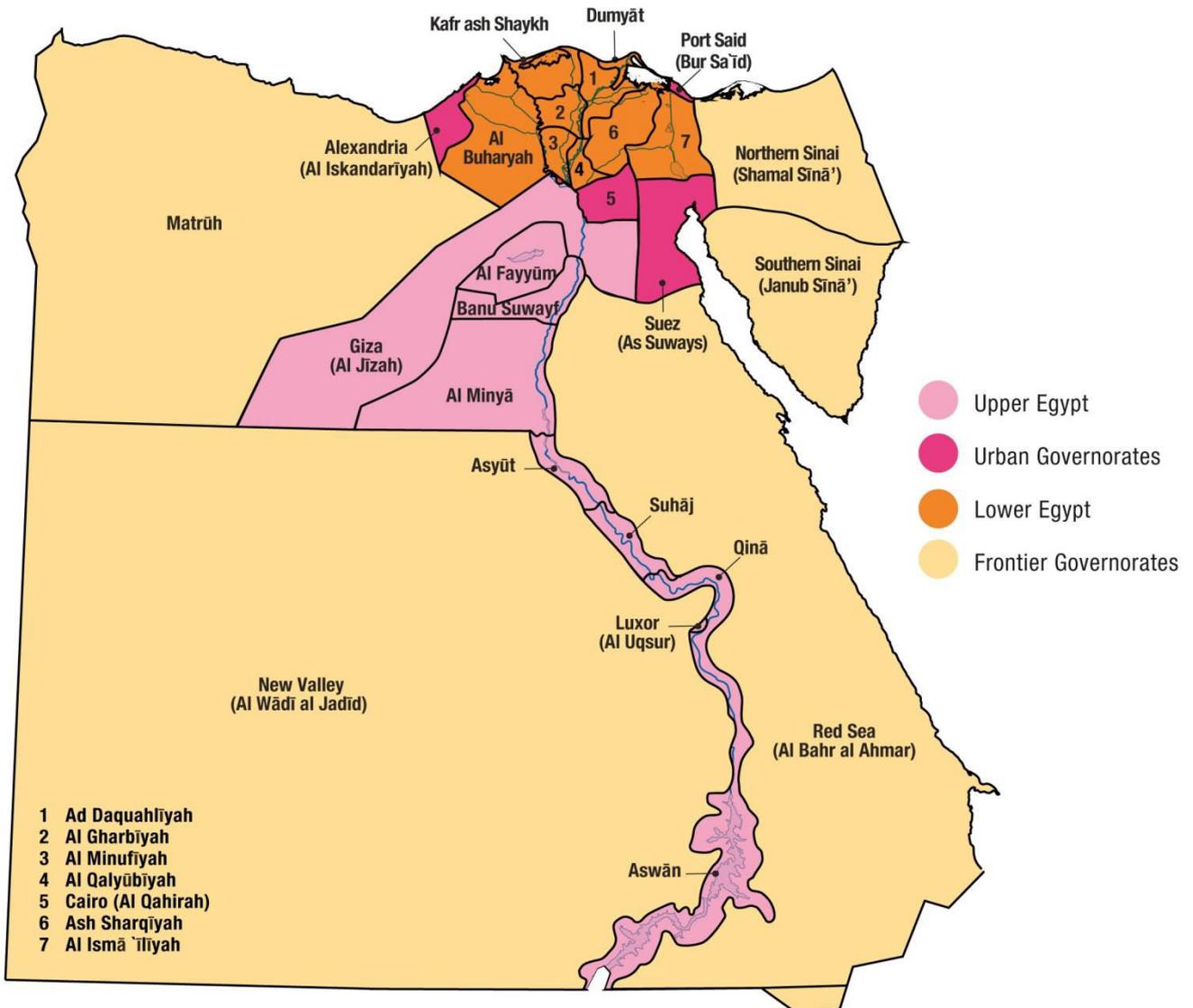


Figure 2: Egypt's governorates (©28 Too Many)

Current Economic Conditions

Egypt is classified by the World Bank⁵ as a '**lower middle income country**', with 28% of the population living below the poverty line in 2015. In rural areas of Upper Egypt, the poorest region, **poverty rates** are estimated to reach as high as 60%. One of the poorest groups in the country are female-headed households, of which, in 2014, over a quarter were living under the poverty line.⁶

In 2016 **unemployment** reached 12.5%, rising from 9% prior to 2011. The highest rates were among women (24.1%) and young people aged 15-29 (26%), indicating a widening of the gender and generation gaps.⁷

Although the **economy** improved throughout 2014 and 2015, with the annual growth rate reaching 4%, this fell away in 2016, and current conditions are not expected to contribute to significant poverty reduction.



Rural areas of Egypt are the poorest and have the highest prevalence of FGM

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- 7 *Ibid.*, p.145.

Image: Ben Barber, USAID (2006) *Young boy and girl harvest farm crops in Egypt* [public domain]. Available at https://commons.wikimedia.org/wiki/File:Young_boy_and_girl_harvest_farm_crops_in_Egypt.jpg.

Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the [law factsheet](#) on our website.

International and Regional Treaties

Many of the **international human rights conventions and treaties** related to the practice of FGM have been signed and ratified by Egypt, with the exception of some optional protocols, which are noted below. The ratification of these conventions and treaties places a legal obligation on the Egyptian Government to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place. Egypt has ratified or signed up to the following conventions and treaties¹:

International

- **The Universal Declaration of Human Rights**, 1948

Egypt is also a signatory to the **Cairo Declaration on Human Rights**², which was adopted at the Meeting of the Foreign Ministers of the Organisation of the Islamic Conference in August 1990.

The Declaration states at Article 6(a):

Woman is equal to man in human dignity, and has her own rights to enjoy as well as duties to perform, and has her own civil entity and financial independence, and the right to retain her name and lineage;

and at Article 2(d):

Safety from bodily harm is a guaranteed right. It is the duty of the state to safeguard it, and it is prohibited to breach it without a Shari'ah-prescribed reason.

- **International Covenant on Civil and Political Rights**, 1976 (signed 1967; ratified 1982) but not Optional Protocol 1976, which gives individuals the right to report violations directly to the Human Rights Committee, or Optional Protocol 1991, which aims to abolish the death penalty
- **International Covenant on Economic, Social and Cultural Rights (ESCR)**, 1976 (signed 1967; ratified 1982), but not Optional Protocol 2013, which gives victims of economic, social or cultural violations the right of appeal to the ESCR Committee
- **Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**, 1987 (ratified in 1986), but not Optional Protocol 2014, which confirms the role of the Sub-Committee for Prevention of Torture in conducting country visits
- **Convention on the Rights of the Child**, 1990 (signed and ratified 1990), but not Optional Protocol 2014, which sets out the ways by which a child can submit complaints to the Convention about violations of their rights

Regional

- **African Charter on Human and Peoples' Rights** (*Banjul Charter*), 1981 (signed 1981; ratified 1984)
- **African Charter on the Rights and Welfare of the Child**, 1999 (signed 1999; ratified 2001), of which Article 21 requires states to 'take all appropriate measures to eliminate harmful social and cultural practices affecting the welfare, dignity, normal growth and development of the child . . .'.³

Egypt is *not* a signatory to the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** (the *Maputo Protocol*), 2003, which calls on states to 'enact and effectively implement appropriate legislative or regulatory measures, including those prohibiting and curbing all forms of discrimination particularly those harmful practices which endanger the health and general well-being of women.'⁴

Although Egypt signed (1980) and ratified (1981) the **Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW)**, it did so with reservations, which demonstrate how **Islamic Sharia** takes precedence in Egypt over any international law or treaty (see also Article 2(d) of the Cairo Declaration on Human Rights mentioned above).

The reservations include:

General reservation on article 2: The Arab Republic of Egypt is willing to comply with the content of this article, provided that such compliance does not run counter to the Islamic Sharia.

Reservation to the text of article 16 concerning the equality of men and women in all matters relating to marriage and family relations during the marriage and upon its dissolution, without prejudice to the Islamic Sharia's provisions whereby women are accorded rights equivalent to those of their spouses so as to ensure a just balance between them. This is out of respect for the sacrosanct nature of the firm religious beliefs which govern marital relations in Egypt and which may not be called in question and in view of the fact that one of the most important bases of these relations is an equivalency of rights and duties so as to ensure complementary which guarantees true equality between the spouses . . .

In respect of article 29 the Egyptian delegation also maintains the reservation contained in article 29, paragraph 2, concerning the right of a State signatory to the Convention to declare that it does not consider itself bound by paragraph 1 of that article concerning the submission to an arbitral body of any dispute which may arise between States concerning the interpretation or application of the Convention. This is in order to avoid being bound by the system of arbitration in this field.⁵

Egypt also did not sign or ratify the Optional Protocol to the CEDAW entered into in 2000, by which 'a State recognizes the competence of the Committee on the Elimination of Discrimination Against Women – the body that monitors States parties' compliance with the Convention – to receive and consider complaints from individuals or groups within its jurisdiction.'⁶

National Laws

A **new Constitution** was introduced in Egypt in 2014, following the suspension of the 2012 constitution during the removal of President Morsi in July 2013. The new Constitution states that the principles of Islamic Sharia are the main source of legislation (Article 2).⁷

For the first time, the Constitution requires that the state protect women from all forms of violence, and provide care to mothers, children, female heads of households and elderly women. **Particularly important in the context of FGM are Article 60:**

The human body is inviolable and any assault, deformation or mutilation committed against it shall be a crime punishable by Law;

and **Article 80:**

The State shall provide children with care and protection from all forms of violence, abuse, mistreatment and commercial and sexual exploitation.⁸

In 1994, following the International Conference on Population and Development in Cairo, the **National Task Force Against FGM** was established to create dialogue, support and network activists across the country, and conduct research.⁹ In 1999, the Task Force was disbanded and its responsibilities in relation to FGM were taken over by **The National Council for Childhood and Motherhood (NCCM)**.

In July 1996, the Minister of Health and Population ordered:

It is forbidden to perform circumcision on females either in hospitals or public or private clinics. The procedure can only be performed in cases of disease and when approved by the head of the obstetrics and gynecology department at the hospital, and upon the suggestion of the treating physician. Performance of this operation will be considered a violation of the laws governing the medical profession. Nor is this operation to be performed by non-physicians.¹⁰

In 2007, following the deaths of two girls due to FGM, the Egyptian Ministry of Health and Population (*MOHP*) issued a ministerial decree **banning medical practitioners** from performing FGM.¹¹

On 16 June 2008, **FGM was outlawed in Egypt**. Two amendments were made. Firstly, the Child Act No. 12 of 1996 was amended by Law No. 126 of 2008, which added Article 7-bis (a):

With due consideration to the duties and rights of the person who is responsible for the care of the child, and his right to discipline him through legitimate means, it is prohibited to intentionally expose the child to any illegitimate physical abuse or harmful practice.¹²

Secondly, Law No. 126 of 2008 added Article 242-bis to the Penal Code:

Without prejudice to the provisions of Article (61) of the Penal Code and notwithstanding any severer punishment in any other law, any person causing injury stipulating punishment as per article 241 and 242 of the Penal Code through female circumcision shall be punished by

imprisonment for no less than 3 months and at no more than 2 years or a fine at no less than one thousand pounds and at no more than 5 thousand pounds.¹³

In the event of permanent disability or death as a result of FGM, a court could refer to the general provisions in Article 240, which covered an injury ‘which results in cutting or separating a member . . . or causing him a permanent irremediable incapacity’, and demands a punishment of imprisonment for three to ten years. However, the specific reference to Articles 241 and 242 in relation to FGM meant that, in the drafting of this legislation, FGM was considered a ‘lesser’ injury, not an injury that could potentially cause permanent disability or death, or one that involved cutting or separating a member.

If FGM was performed by a physician, Article 238 of the Penal Code applied, which demanded a maximum penalty of E£500 and five years’ imprisonment.

EGYPTIAN COALITION FOR CHILDREN’S RIGHTS (ECCR)¹⁴

In 2011, the ECCR was established to campaign in relation to Law No. 126 of 2008, ‘to ensure the full interpretation of the law and the necessary controls of its implementation’, including the application of ‘[A]rticle 242 of the Penal Code, which criminalize[s] FGM and all involved in performing it whether inside or outside the institutions of the Ministry of [H]ealth.’

ECCR also calls on civil society organisations concerned with children’s issues to emphasise ‘the rejection of female genital mutilation and early marriage as harmful practices affecting the health and well-being of girls and women.’

Between 2007 and 2013, a number of girls died undergoing FGM, causing public concern that laws were insufficient, and calls to strengthen and enforce the law with increased sentences.

Therefore, in **September 2016**, a further amendment was made (by Law No. 126 of 2016) to the Penal Code. It replaces Article 242-bis and adds Article 242-bis (A):

242-bis: With consideration to Article (61) of the Penal Code, and without prejudice to any harsher penalty stated by any other law, any person who committed acts of female genital mutilation, by removing any of the external female genital organs, whether in part or in whole, or by inflicting any injuries to these organs without medical justification, shall be punished by imprisonment for a period not less than 5 years and not exceeding 7 years.

The penalty shall be Aggravated Imprisonment [minimum 3 years and maximum 15 years], if such act has resulted in a permanent disability or death.

242-bis (A): Any person who requested a female genital mutilation and the female has been mutilated accordingly and in the manner mentioned in Article 242-bis of this law, shall be jailed for a minimum period of one year and a maximum period of 3 years.

CENTRE FOR EGYPTIAN WOMEN LEGAL ASSISTANCE (CEWLA)

CEWLA was established in 1995 and, as one of the most active NGOs working on human rights in Egypt, was part of the original task force set up to address FGM. Since then it has worked across Egypt to combat discrimination against women through several activities, including raising awareness of the law and advocating for changes to legislation around FGM (for example, it suggested changes to the 2008 amendments criminalising FGM when they were being drafted).

CEWLA offers legal training and advice, and organises round-table discussions with key figures, including community and religious leaders, members of parliament and the prosecution authorities, and representatives from the media. It also offers legal consultations, together with social services and psychological support, to families affected by FGM.

CEWLA has fought for justice in the high-profile cases that have taken place in recent years in Egypt, including the case of Soheir al-Batea. It has faced much opposition to its work, and certain members of the organisation have been directly targeted by the authorities (see page 29).



'My family and people, can you listen to me? Female circumcision is a crime that is punishable by law.'

In many countries where FGM is practised, traditions and beliefs override the law

The Enforcement of FGM Laws

'There were times when people celebrated FGM in public. Now, because it's illegal, people would perform it at 6am while keeping a low profile. In time, more people will start asking why it's illegal and see the full picture.'

~ Germaine Haddad, UNFPA, Egypt¹⁵

Changes in attitudes over the past two decades have resulted in amendments to laws and more work being undertaken to prevent FGM. For example, the previous first lady of Egypt, Mrs Suzanne Mubarak, openly opposed FGM and launched a national campaign, **The Beginning of the End**. That campaign focused on increasing awareness and drafting laws to adequately criminalise FGM.¹⁶

The **first conviction for conducting FGM** was against a doctor, Raslan Fadl, following the death of **Soheir al-Batea** in June 2013. Fadl denied manslaughter and said he was removing genital warts, and that death was due to an allergic reaction to penicillin. After eighteen months, during which he continued to practise medicine, Fadl turned himself in and, following a lengthy appeals process, was convicted of manslaughter in January 2015 and sentenced to two years' imprisonment. In addition, his licence to practise medicine was revoked. Fadl came to a financial arrangement with the family, however, and only served three months of his sentence. Al-Batea's father was also convicted, but on appeal was given a fine and a suspended sentence.¹⁷

THE NATIONAL FGM ABANDONMENT STRATEGY 2016-2020¹⁸

The National FGM Abandonment Strategy 2016-2020 is the State's official strategy for eradicating FGM.

The Strategy document provides an analysis of the key achievements to date and the present gaps in terms of (a) institutional change, (b) socio-cultural change, and (c) change in follow-up and evaluation. It concludes that the required focus is to ensure that campaigns and advocates focus on the cultural and social issues associated with FGM, not merely religious or health issues.

Its overall objective is to reduce FGM prevalence by 10-15% in the next generation by supporting families to make the decision not to cut their daughters.

Its key strategies are to enforce existing laws against FGM, build a culture that supports human rights and develop a system to monitor the abandonment process.

In August of 2016, Egypt's House of Representatives passed a **law that redefined FGM as a felony** rather than a misdemeanour (see Articles 242-bis and 242-bis (A) mentioned above), and increased the penalty for performing FGM to five to seven years' imprisonment (up to 15 years if the child dies). The amendment also provides for the punishment with between one and three years' imprisonment of any individual who requests FGM be performed.¹⁹

This extension was not passed without controversy, however, as several MPs and doctors opposed it, notably MP and Doctor Ahmed El-Tahawy, who maintained that 'when we leave the female without excision, contamination in that area takes place, as well as an undesired state of sexual arousal that could lead to big problems.' He later apologised for his comments, after receiving heavy criticism.²⁰

Despite the increased penalties, in January 2017, disappointing sentences were given to those responsible for the May 2016 death of **Mayar Mohamed Mousa**, aged 17, in a private hospital, while she and her twin sister were undergoing FGM under full anaesthesia. The girls' mother, who is a nurse, the doctor and the anaesthetist were given one-year suspended prison sentences and fines (E£1,000 for the mother and anaesthetist and E£5,000 for the doctor). The attending nurse, who has fled the country, was given *in absentia* a five-year suspended sentence and fined E£50,000, which will be reduced if she voluntarily attends court. Prosecuting lawyer Reda Eldanbouki has stated that he hopes media pressure and further discussion will result in a retrial and tougher sentencing.²¹ Although penalties under the September 2016 amendment would not apply, as Mousa's

death occurred in May, the court could have applied Article 238 of the Penal Code in the doctor's case, which allows for a penalty of up to five years' imprisonment, or Article 240, which allows for up to ten years' imprisonment. Under Article 40 of the Penal Code, Mousa's mother may be considered an accomplice, which would allow for the same penalty as the principle perpetrator (the doctor).

New NGO Law Affecting NGOs Operating in Egypt

A **new law (the NGO law)** covering the activities and governance of Egyptian NGOs and international NGOs operating in Egypt was approved by parliament on 15 November 2016. As a rule, new laws must be approved and ratified by President el-Sisi within 30 days of their being passed by parliament; however, as at the date of publication, he has not done so. This does not, however, mean that the law will not be fully enacted in the future.

The law places more restrictions on the way that civil society functions in Egypt, and extends the authority of the Government over civil society operations, resources and activities. The law also puts in place harsh penalties for its violation.

Organisations campaigning against FGM may find they are restricted in the following ways:

- The NGO law establishes a new national authority for regulating foreign NGOs, which will be responsible for all matters related to foreign NGOs' work in Egypt. This includes granting incorporation permits, supervising activities, approving the receipt of funds, and deciding on all forms of cooperation between foreign NGOs and Egyptian entities. The authority must also be notified of any funding received by local NGOs. As a result, local NGOs may find it harder to accept financial support from international agencies to promote an anti-FGM message and run programmes aimed at discouraging communities from continuing the practice.
- NGOs will be unable to conduct polls or field surveys without firstly obtaining permission from the authority, which will review the content of these types of document to make sure they are unbiased. Again, this may affect organisations who want to undertake evaluations of anti-FGM programmes, or other forms of research into FGM practices.
- The NGO law requires foreign and Egyptian NGOs to submit reports to the authority or the relevant social solidarity department, as the case may be, before any cooperation or partnership between foreign and local NGOs can commence. This may delay the start of anti-FGM partnerships and activities.

The concern expressed by NGOs that the new law will affect their campaigns is strengthened by the recent arrest and interrogation of Azza Soliman, a leading member of CEWLA (see page 27). She is accused of accepting foreign funding. Although Azza has since been released on bail, she has been banned from travelling, and her assets have been frozen, so that her work supporting human rights of women and girls has been severely curtailed.²²

Equality Now has released an urgent alert that provides more information on the situation: <http://www.equalitynow.org/action-alerts/egypt-azza-soliman-activist-human-rights-under-attack>.

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- 2 *Cairo Declaration on Human Rights in Islam* (1990) Available at <http://www.fmreview.org/sites/fmr/files/FMRdownloads/en/FMRpdfs/Human-Rights/cairo.pdf>.
- 3 African Commission on Human and Peoples' Rights (1999) *African Charter on the Rights and Welfare of the Child*. Available at <http://www.achpr.org/instruments/child/#a21>.
- 4 African Commission on Human and Peoples' Rights (2003) *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa*, Article 2(1)(b). Available at <http://www.achpr.org/instruments/women-protocol/#2>
- 5 UN Women (2009) 'Declarations, Reservations and Objections to CEDAW', *Convention on the Elimination of All Forms of Discrimination Against Women*. Available at <http://www.un.org/womenwatch/daw/cedaw/reservations-country.htm>.
- 6 UN Women (2000) *Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women*. Available at <http://www.un.org/womenwatch/daw/cedaw/protocol/>.
- 7 *Constitution of The Arab Republic of Egypt 2014* (unofficial translation). Available at <http://www.sis.gov.eg/Newvr/Dustor-en001.pdf>.
- 8 *Ibid.*
- 9 An Van Raemdonck (2013) 'Egyptian Activism against Female Genital Cutting as Catachrestic Claiming', p.232, *Religion & Gender*, Vol. 3(2), pp.222-239. Available at <https://www.religionandgender.org/artides/abstract/10.18352/rg.9169/>.
- 10 Office of Asylum Affairs; Bureau of Democracy, Human Rights and Labor; U.S. Department of State (1997) 'Order No. 261 of 8 July 1996 of the Minister of Health and Population, *Female Genital Mutilation (FGM) in Egypt*, p.3. Available at <https://cyber.harvard.edu/population/fgm/Egypt.fgm.htm>.
- 11 Gerard Molleman and Lilian Franse (2009) 'The Struggle for Abandonment of Female Genital Mutilation/Cutting (FGM/C) in Egypt', p.59, *Global Health Promotion*, Vol 16(1), pp.57-60. Available at <http://journals.sagepub.com/doi/pdf/10.1177/1757975908100752>.
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- 13 *Amendments to Child Law No. 12 of 1996 – 15 June 2008* (2008). Available at <http://www.ilo.org/dyn/travail/docs/464/Amendments%20to%20Child%20Law%20No%2012%20of%201996%20-%2015%20June%202008.pdf>
- 14 The Egyptian Coalition on Children's Rights (2011) 'Press Release', *Facebook*, 26 October. Available at <https://www.facebook.com/notes/%D8%A8%D9%84%D8%A7%D9%86-%D9%85%D8%B5%D8%B1-plan-egypt/the-egyptian-coalition-on-childrens-rights-press-release/207892279284275>.
- 15 Germaine Haddad cited in Sherif Tarek (2016) 'Egyptian MP's endorsement of FGM stirs controversy but unlikely to have effect', *ahram online*, 12 July. Available at <http://english.ahram.org.eg/NewsPrint/233054.aspx>.
- 16 Gerard Molleman and Lilian Franse, *op. cit.*
- 17 - Equality Now (undated) *Justice for Soheir al-Batea*. Available at <http://www.equalitynow.org/action-alerts/justice-soheir-al-batea-fgm-egypt>.
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- 18 Ministry of State for Population and the United Nations Egypt (2016) *The National FGM Abandonment Strategy 2016-2020*. Available at <http://www.gbvprojectegypt.com/assets/documents/resources/fgm-national-strategy.pdf>
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- 22 Equality Now (2016) *Urgent Alert: Human Rights Defenders Under Attack in Egypt*, 14 December. Available at http://action.equalitynow.org/o/6208/p/dia/action3/common/public/?action_KEY=23881.

Image: © NGOs Coalition against FGM/C, 2016. Anti-FGM campaign advertisement.

The Role of Women in Society

In 2014, Egypt introduced a revised **constitution**, which established **equality for all Egyptians**. Article 9 declares, 'The State shall ensure equal opportunities for all citizens without discrimination', and Article 11 asserts, 'The State shall ensure equality between women and men in all civil, political, economic, social, and cultural rights . . .'¹ The 2014 Constitution is the first to protect women from discrimination and domestic violence (Article 11), a provision that had been omitted from previous constitutions due to the belief of ultraconservatives that the equality of women is dependent on their obedience of religious law.²

The OECD Development Centre assigns **Social Institutions and Gender Index** values to countries based on the laws, attitudes and practices that impede women's access to equality.³ In 2014, Egypt was assigned a value of 0.428, classifying Egypt as having '**very high**' levels of gender inequality'⁴, the highest classification the SIGI gives.

Additionally, the UNDP assigned Egypt a value of 0.573 for its **Gender Inequality Index**, placing it **131 in a list of 188** countries analysed. The Gender Inequality Index is calculated using factors such as maternal mortality, adolescent birth rate, share of seats in parliament held by women, population with some secondary education, and labour-force participation.⁵

89 women were admitted to **parliament** in January 2016. Although this is a record high number for Egypt, it only amounts to 14.9% of the total seats.

This is indicative of the difficulty many Egyptian women face in balancing their right to work with their family duties, a widespread expectation in Egypt, which is explicitly stated in the Constitution at Article 11.⁶

During the past few years of political unrest in Egypt, women's role in society has changed. While women's rights were promoted by former first lady Suzanne Mubarak, women's position remained precarious, supported by what some have called a 'state feminism' of formality and legal advancement that was not reflected or embedded in the country's cultural sphere. In several news articles⁷, observers suggest that the advances made by women over the decades deteriorated after Mubarak's resignation in February 2011.

The 2012 elections, which led to the Muslim Brotherhood taking power, saw only ten women enter parliament out of 508 members. Attempts were made to overturn the law against doctors performing FGM, claims were made that

ARTICLE (11) OF THE CONSTITUTION

The State shall ensure the achievement of equality between women and men in all civil, political, economic, social and cultural rights in accordance with the provisions of this Constitution.

The State shall take the necessary measures to ensure the appropriate representation of women in the houses of representatives, as specified by Law. The State shall also guarantee women's right of holding public and senior management offices in the State and their appointment in judicial bodies and authorities without discrimination.

The State shall protect women against all forms of violence and ensure enabling women to strike a balance between family duties and work requirements.

The State shall provide care to and protection of motherhood and childhood, female heads of families, and elderly and neediest women.

Islam permitted marriage for girls as young as ten, and certain legislated rights of women and girls were said to violate Islamic Sharia.

During demonstrations throughout the remainder of 2012 and into 2013, women were openly harassed and public acts of sexual violence took place. 19 women and girls were assaulted in Tahir Square in January 2013 during the celebrations of the second anniversary of Mubarak's departure.⁸

Although the 2014 Constitution gives women equal rights and protection from violence, and establishes minimum quotas for women's representation in local and national government, its impact will depend on there being a deeper societal and cultural change in attitude towards women and girls across the country.

In February 2017, Nadia Saleh was sworn in as governor of the province of Beheira. She is **Egypt's first female governor**, as there has long been a tradition of appointing retired military personnel or police.

NATIONAL COUNCIL FOR WOMEN (NCW)

The National Council for Women was established in 2000 by presidential decree, with the aim of addressing issues faced by Egyptian women such as FGM, sexual harassment and domestic violence. It works to increase awareness of women's and girls' rights, combat GBV and enhance women's access to public services.

The NCW has branches in each of the 27 governorates and works with various state institutions and civil-society organisations that specifically target women in poor, rural communities. Regarding FGM, it works in partnership with the NCCM and, as Government quangos (staffed by civil servants and paid for by the Government), they both report to the MOHP. NCW hosts FGM-awareness campaigns in high-prevalence governorates, and its legislative committee is involved in various projects around GBV issues. It also worked with other Government ministries and national organisations to develop a law against sexual harassment in 2014, and launch the national strategy to combat GBV in 2015. The NCW has undertaken a study too, in partnership with the Central Agency for Public Mobilization and Statistics and the UNFPA, around the economic cost of GBV, including FGM.

Despite all this, the NCW has been widely criticised by some women's rights organisations and policy institutes, who claim that it cannot act as an effective body to combat women's issues while it is so strongly influenced by the Egyptian Government's regime. As its membership reflects its close relationship with the state, so some commentators question its ability to take a firm stance on women's rights moving forward:

With civil society groups currently facing government sanction, and with the NCW tasked by the state with disseminating its agenda over advancing women's causes, the opportunity to tackle the root causes of many of the issues facing Egyptian women today is lost. . . . The NCW has an opportunity to strive to fulfill its mandate to represent Egyptian women. It cannot, however, do so in a genuine manner if it continues to function as an arm of the state rather than as an empowered body.¹⁰

Egypt Vision 2030 and Social Justice

The Government's ***Sustainable Development Strategy: Egypt Vision 2030***¹¹ (*Vision 2030*) (see page 50) includes explicit reference to the need to improve gender equality:

'Empowering women and youth is considered one of the most important factors in the strategy of social justice.'

A key objective of the Social Pillar of Vision 2030 is 'Achieving equal rights and opportunities' which are defined as 'promoting social mobility opportunities through an institutional system in order to achieve equal economic, social, and political opportunities'.¹²

On a practical level, the Government is keen to raise its international ranking in terms of the World Economic Forum's gender-gap indicators from 129th in 2014 to 100th in 2020 and 60th in 2030.¹³ It also aims to reduce the proportion of female-headed households that live under the poverty line from 26.3% in 2014 to 12% in 2020 and 0% in 2030, and to encourage the political and civil participation of women.¹⁴

One state-run programme that will be part of Vision 2030 aims to reduce social, generation and gender gaps by applying a list election system (to encourage more young people and women to participate in political life), and to

Amend the articles of the Penal Code that relate to all aspects of violence against women since harsh punishment shall come into force in order to guarantee the protection of women against violence and discrimination.¹⁵

Physical Integrity

Physical violence and sexual harassment are widespread issues for women in Egypt.

The UNDP reports that **over one-third of Egyptian women have experienced violence by intimate partners** at some point in their lives.¹⁶



Sexual harassment and violence in public places is an ongoing problem for women in Egypt

The OECD Development Centre classified Egypt as having a **'very high' restricted physical integrity value**, the highest classification of the value.¹⁷ The value is calculated through an analysis of the social systems that normalise violence towards women, increase their vulnerability and otherwise restrict control over their bodies.¹⁸

Many Egyptian women are subjected to **domestic violence**, most often enacted by their spouse or one of their parents, an occurrence that is viewed as justifiable to many Egyptians, including some women. The DHS 2014¹⁹ reports that three in ten ever-married women aged 15-49 have experienced some manner of domestic violence enacted by their current spouse. Of the women surveyed, **25.2% experienced physical violence, 18.8% experienced emotional violence, and 4.1% experienced sexual violence**. Just one-third of these women asked for help in the wake of the violence.

The DHS 2014²⁰ also reports that 35.7% of ever-married women aged 15-49 consider **wife-beating** acceptable in at least one of five given situations (goes out without telling her husband, neglects their children, argues with her husband, refuses to engage in sex with him, or burns the food). Acceptance is more likely if a woman lives in a rural area, has little or no education or is of a low socioeconomic status.

A 2013 UN study²¹ shows that as many as 99.3% of Egyptian women experience **sexual harassment** during their lives. 49.2% of the women surveyed report that they experience harassment on a daily basis, and many believe that the incidence of sexual harassment has increased since the Egyptian Revolution of January 2011. A coalition of advocacy groups has compiled reports of more than 500 mass assaults of women since that time.²²

Sexual harassment was made a criminal offence in Egypt in June 2014²³, punishable by up to five years' imprisonment or fines of up to US\$7,000. Prior to this, sexual harassment had never been defined by modern Egyptian law.²⁴ The NCW played a defining role in the evolution of the 2014 sexual harassment laws and helped to develop the 12-point plan instituted by the Government. The law was welcomed by the UN²⁵ and by women's rights organisations; however, many activists believe that the law will not effect change unless it is strictly enforced.

ORGANISATIONS ENCOURAGING WOMEN TO SPEAK OUT

Incidents of sexual harassment are particularly frequent during protests and holiday festivals, where crowding in public spaces is used to the advantage of perpetrators. During recent years there has been a growing movement against public sexual violence and sexual harassment, with the emergence of groups that aim to directly intervene in cases of public harassment, as well as raise awareness through online platforms such as Facebook and Twitter (see page 99).

In September 2016 the Musawah Organization for Training and Counseling launched the Aman (Security) Initiative, whose objective is to achieve safety from sexual harassment for women in Egypt. The initiative encourages affected women to talk about their experiences, in order to directly combat the stigma associated with speaking about sexual harassment. Groups such as this face a lack of funding and safety due to the hindrance of security personnel, and even police, in public spaces.

Resources and Entitlements

The OECD Development Centre classifies Egypt's **Restricted Resources and Assets Value** as 'high'. The determination of this value is based on women's ability to secure and control ownership of resource.²⁷



Social norms may restrict women's ability to benefit from the labour market

While there are no laws restricting the **ownership or inheritance of land** by women in Egypt²⁸, there are low levels of land ownership by women due to cultural systems that discriminate against them.²⁹ The DHS 2014³⁰ reports that approximately 5% of ever-married women (aged 15-49) own a house, and approximately 2% own land. Additionally, women own 5.2% of agricultural land in Egypt.³¹ In most cases, even where a property is secured with a woman's finances, it will be registered under the name of her husband or father.³²

'Egyptian women are undermined and constricted by cultural and social norms and conditions which make them poorer, less able to benefit from the rewards and protection of labor markets, and are more burdened by unpaid work that often goes unsupported and invisible to the state and its social policies.'

~UN Women³³

There are no restrictions on women's access to **financial services**, but CEDAW notes that, in practice, banks are 'reluctant' to give women loans, and women often have more success through credit societies. However, schemes by The Principal Bank for Development and Agricultural Credit and an interest-rate cut in 2009 for women running micro and small businesses have meant that 84.2% of micro-credit recipients are female.³⁴

Civil Liberties

Egyptian **legislation** regarding personal status is principally based on Islamic Sharia, as mandated in the Constitution (Article 2). Legislation is also largely based on the French Civil Code.³⁵

The Constitution (Article 180) requires one-quarter of local council seats to be allocated to women, but there are no other **quotas** in place in relation to **women in political positions**.

While women in Egypt have an equal legal right of **access to public space** as men, cultural and social norms often restrict their movements, particularly in rural areas.³⁶ The problem of sexual harassment and assault in crowds has made many women reluctant to enter public spaces. Prior to 2000, married women in Egypt were required to have their husbands' consent in order to apply for passports and therefore to **travel overseas**. Men were able to withdraw consent at any time in order to prevent their wives from travelling overseas.³⁷ Changes to the Personal Status Law introduced in 2000 eliminated this requirement and allowed women to travel more freely;³⁸ however, a woman's husband or father must still sign her passport and may apply for a court order to bar her from leaving Egypt.³⁹

An essential part of women's empowerment is the freedom to make decisions that affect their own and their family's personal affairs. The DHS 2014⁴⁰ surveyed Egyptian women's participation in household **decision-making** through questions about decisions regarding their own healthcare, visits to family and friends and major household purchases. 58.8% of married women (aged 15-49) report they are involved in all three areas of decision-making. Conversely, 10.4% of women report that they are not involved in any of the three types of decision-making. The relative level of participation of women in household decision-making is positively correlated to their age and level of education and wealth. If a woman is from a rural area or is either unemployed or employed but not for cash (as opposed to being employed for cash), she is less likely to be involved in decision-making with her husband.



*A woman celebrates
International
Women's Day in Egypt*

Under Egypt's Personal Status Law 1.1, **marriage** is a voluntary contract entered into by the free will of its parties.⁴¹ Muslim women cannot marry non-Muslim men. Non-Muslim women may marry Muslim men, and are subject to Islamic Sharia, but are not automatically entitled to its privileges.⁴² Polygamy is legal only for men. Forced marriages continue to occur in Egypt, particularly in more rural areas.⁴³

The legal minimum age for marriage in Egypt is 18, but early marriages are common, with a 2014 study showing that 17% of surveyed women from Cairo, aged 10-29, had been married before the age of 18.⁴⁴ A national strategy to prevent child marriage was developed in 2013 and 2014, which aims to reduce early marriage by 50% within five years.⁴⁵

Both men and women in Egypt have the right to **divorce** their spouse under Personal Status Law 1 of 2000.⁴⁶ Men have the right to divorce without their wife's consent, on the condition that she be compensated financially for at least two years. Prior to 2000, in order for a woman to be granted divorce, she was required to prove that she had experienced harm inflicted upon her during her marriage, or that her husband had married another woman without her approval.⁴⁷ Following new divorce laws introduced in 2000, called *Khula*, women are able to divorce without proof of harm, but are required to relinquish all financial rights, including ownership of property and the return of dowry provided at marriage.⁴⁸ *Khula* is based on traditional Islamic Sharia, and does not require permission from the husband for the divorce to occur.⁴⁹ President el-Sisi recently suggested that the custom of verbal divorce (by which a husband may divorce his wife simply by verbally declaring it so) should be delegalsed, to 'give the couple a chance to reconsider' and prevent divorce from being 'just a word that is casually uttered.'⁵⁰ Significantly, a 2008 study reportedly found that 86% of divorce cases in Egypt were due to the negative impact of FGM on sexual intercourse, although 28 Too Many was unable to examine this study to evaluate its methodology and findings.⁵¹

Child custody laws have been a widely debated and controversial issue in Egypt in recent years. Personal Status Law 4 of 2005⁵² states that, in the case of divorce, children shall remain in the primary care of their mother until they turn 15 years of age, at which time a court may decide that the child should remain under the care of either parent until the age of 21 for males and until the time of marriage for females.⁵³ Where a mother has remarried, the custody of her children is deferred to the maternal grandmother, a maternal aunt or the paternal grandmother.⁵⁴

THE GIRL GENERATION⁵⁵

The Girl Generation, of which 28 Too Many is a member, represents a social-change communications initiative funded by the UK Department for International Development to end FGM in the ten most affected countries, including Egypt. It is currently in the preliminary planning stages, in partnership with Equality Now, of identifying and connecting with key anti-FGM initiatives throughout Egypt, including the UN Joint Programme, with a view to launching the Girl Generation campaign in-country this year.

Once established in Egypt, the Girl Generation will work to facilitate and support collaborative working between activists and national and grassroots organisations in an effort to end FGM and other HTPs such as child marriage.

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The History of FGM in Egypt

FGM has been performed in Egypt since pharaonic times. The reason for its **origin** and the extent to which it was performed in that era are unclear. Various theories have been put forward, including that it was a sign of distinction, that it was done to mirror male circumcision, and that it was seen as a sign of purity and cleanliness. Reports from the late 1700s indicate that, at that time in Egypt, FGM was performed to prevent pregnancy in women and slaves.

The **first movement against the practice** came in the 1920s, when the Egyptian Physicians Association called for a ban on the grounds of its health impacts. The Association's view was supported by senior scholars and physicians working for the Ministry of Health.¹

During the 1950s articles published in health magazines and journals continued to advocate against FGM² and, in 1959, the Ministry of Public Health issued a decree against infibulation (Type III). It did not, however, ban 'partial clitoridectomy' if it was performed by a medical doctor at the parents' request because, although Muslim scholars at the time agreed that infibulation was against Islamic Sharia, there was no such consensus in relation to other types of FGM. In 1978 the Maternal and Child Health Department added that FGM should not be performed in government hospitals and forbade traditional midwives from carrying it out.³ All of this discernibly contributed to the pervasiveness of **medicalised FGM** in Egypt, and it has been suggested that such an exclusive focus on health issues actually prevented the decrease of FGM⁴.

Despite the attention FGM received from the medical sector, it remained a taboo subject and was rarely discussed publicly. It was pioneering activists such as Nawal El Saadawi, a doctor and feminist writer, who started writing about FGM openly in the 1970s.⁵ El Saadawi conducted interviews with women who had undergone FGM and described her own experience (at the age of six) in her book *The Hidden Face of Eve*⁶.



Nawal El Saadawi

The dialogue on FGM in Egypt shifted further in 1994 when the **International Conference on Population and Development (ICPD)**, coordinated by the UN, was held in Cairo. In preparation for the conference, several NGOs met, and the **National Task Force** was created by Aziza Husain and Marie Assaad,⁷ which brought together about 60 organisations, including feminist groups, human-rights activists, doctors, academics and civil-society organisations from different governorates. This Task Force was disbanded in 1999 and, with the support of former first lady Suzanne Mubarak, the **National Council for Childhood and Motherhood** was launched as a quango, which placed it within the Government's sphere of influence. In 2003 the NCCM began a national programme entitled the FGM-Free Village Model (see page 60). The NCCM, along with three other national bodies, was enshrined in the new 2014 Constitution as an independent council.⁸

During the ICPD, CNN caused a storm of controversy by airing a film of a ten-year-old girl undergoing FGM. This, together with resulting international pressure on the Egyptian State,

sparked discussions on whether a total ban would force FGM underground and whether it should be performed in hospitals to alleviate the worst abuses. The result was that, in the autumn of 1994, the health minister allowed **FGM in public hospitals** one day a week, arguing that parents seeking FGM would be convinced by hospital staff that the procedure was unnecessary. He also argued that hospitalisation would protect girls and eventually lead to the disappearance of the practice.⁹ However, reports published a few months later claimed that hospitals were not discouraging parents, and doctors readily performed FGM for a fee.¹⁰

The years after the ICPD saw a shift among anti-FGM activists from a focus on the health-related consequences of FGM to a focus on human and women's rights.¹¹

In 1996, in response to both the USA's decision to link its foreign aid to anti-FGM policies and to the results of the Egyptian DHS, which revealed that the percentage of cut women/girls was bigger than previously assumed and almost universal in Egypt¹², the new **health minister passed a decree against FGM** being performed in government hospitals and private clinics. His decision was challenged in the highest Egyptian court but was upheld.¹³

FGM was outlawed in Egypt in 2008. Between 2007 and 2013, a number of girls died undergoing FGM, causing public concern that laws were insufficient and calls to strengthen and enforce the law with increased sentences.

The new 2014 Constitution requires the State to protect women from all forms of violence.¹⁴ In January 2016 a relatively low sentence was given to the doctor who performed FGM on 13-year-old Soheir al-Batea, causing her death. This situation moved the House of Representatives to pass an extension to the Penal Code, **increasing the sentences** for performing or abetting FGM. Despite challenges to this move, Egypt's Government and legal system has continued to affirm the ban on FGM.

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Image: Haydn (2011) *Nawal El Saadawi@OCCUPY LONDON 22.11.2011* [cropped]. Available at <https://flic.kr/p/ayfrdR>. CCL: <https://creativecommons.org/licenses/by-nc-sa/2.0/>.

FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Egypt. Other sections of this report give more detailed analyses of FGM prevalence set within sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

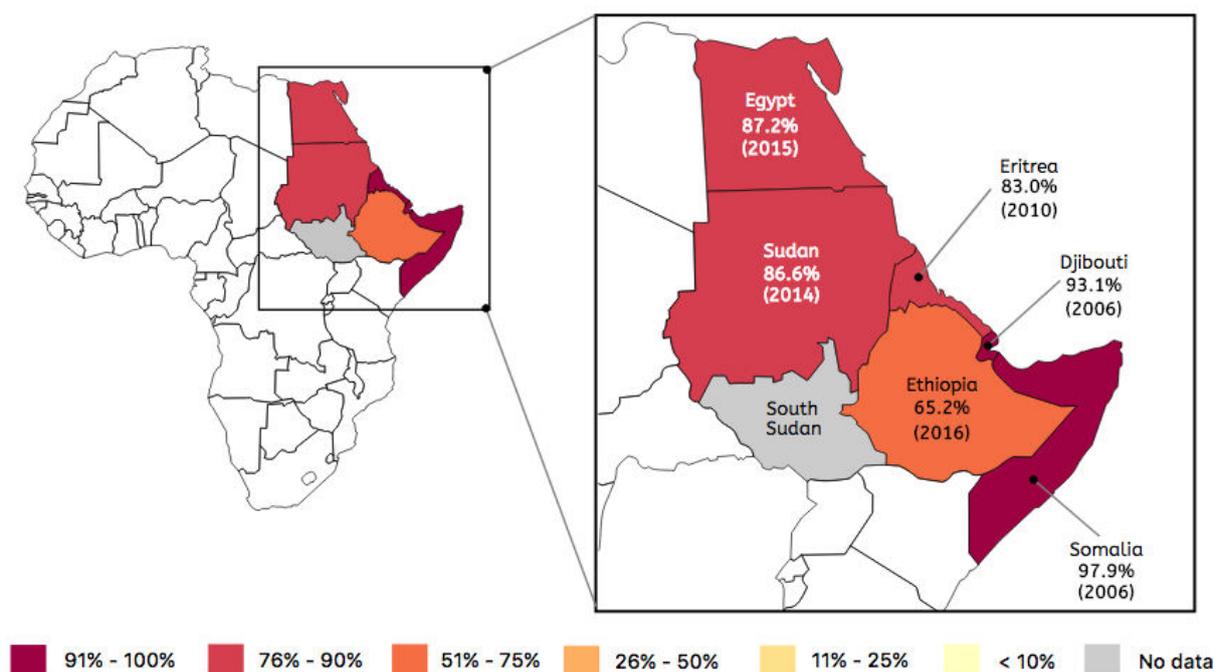


Figure 3: Prevalence of FGM in North-East Africa¹ (@28 Too Many)

Based on the previous DHS survey in 2008, Egypt was classified by UNICEF² as a ‘**very high prevalence**’ country with an **FGM prevalence** of **91.1%** among (all) women aged 15-49. The later DHS 2014³ gives a prevalence of **92.3%** among (ever-married) women aged 15-49, and the EHIS 2015⁴ puts prevalence among (all) women aged 15-49 at **87.2%**.

Despite the slight variance in these figures due to the different groups of women surveyed, it is clear that there has been little change in the incidence of FGM between 2008 and 2015, and therefore Egypt continues to be classified as ‘very high’ in the UNICEF groupings.

With close to **95 million residents**, Egypt is one of the most populous countries of the Middle East and Africa.⁵ An FGM prevalence of 87.2% suggests that Egypt has the greatest number of women and girls who have experienced FGM of any country in the world.

A more encouraging picture is presented in a secondary analysis, commissioned by UNICEF⁶, of the DHS data on **Egyptian girls aged 0-17** between 2005 and 2014. This analysis concludes that the prevalence of FGM among girls aged 0-17 declined over that time from 28% to 18%, and that the total percentage of those who had already undergone FGM and those who were likely to undergo FGM before they reached 18 years of age (the

expected eventual percentage) fell from 69% to 55%.⁷ As girls are unlikely to experience FGM after the age of 17 in Egypt, this suggests that there will be a continued decline in the overall prevalence of FGM in the future.

The EHIS 2015⁸ also records the current prevalence of FGM and the expected eventual percentage among daughters aged 1-14. The current prevalence of FGM is 14.1% and the expected eventual percentage is 54.9%, which is consistent with the 55% figure from the UNICEF analysis.

EXPECTED EVENTUAL PERCENTAGE:
the percentage of girls under a certain age who have already undergone FGM
PLUS
the percentage of girls whose mothers plan for them
to undergo FGM before they reach that age.

Prevalence of FGM According to Place of Residence

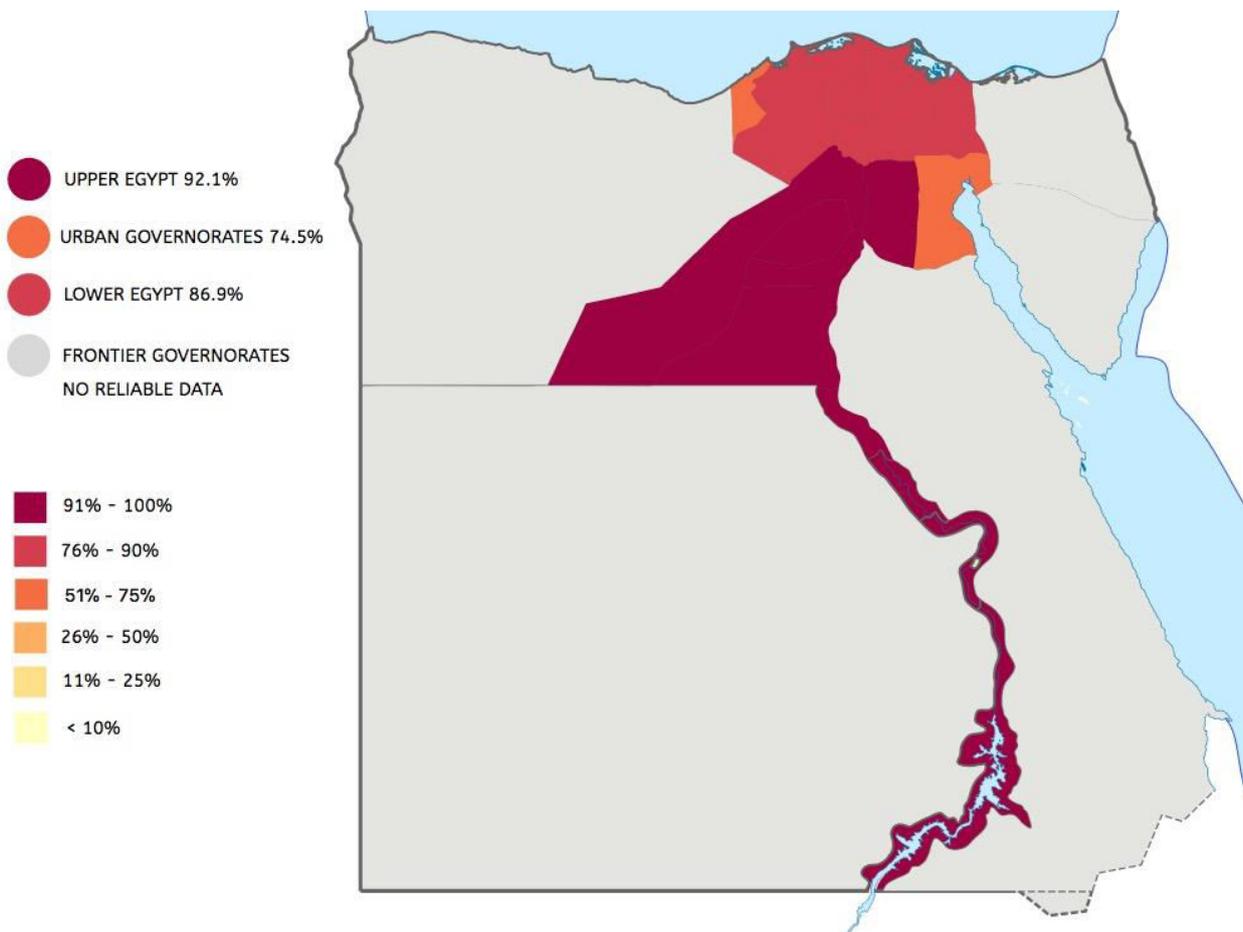
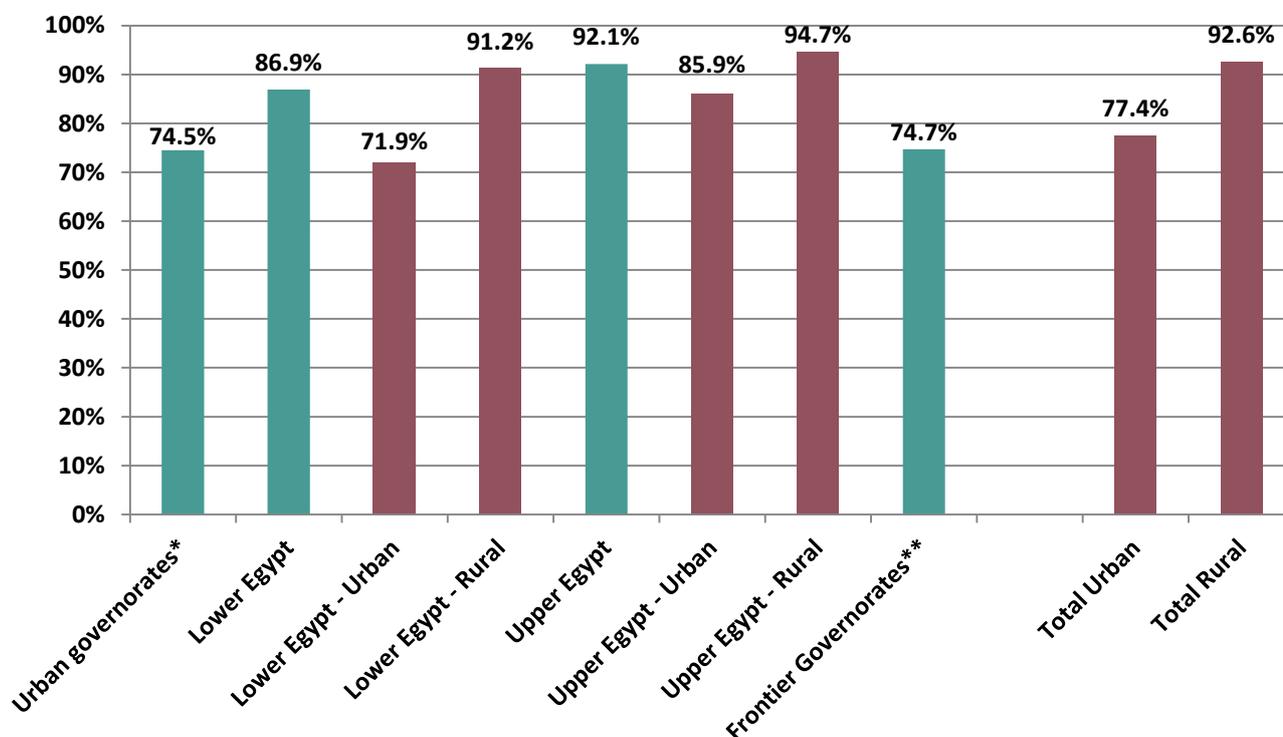


Figure 4: Prevalence of FGM across Egypt⁹ (@28 Too Many)

While 87.2% of women across the whole of Egypt have undergone FGM, there are distinct regional differences in prevalence, as shown in Figure 5 below. The DHS 2014¹⁰ notes that place of residence is strongly associated with the likelihood that a girl will experience FGM.

Figure 5 shows that, in 2015, 77.4% of women living in urban areas were cut, compared to 92.6% of women living in rural areas.



* Urban Governorates: Cairo, Alexandria, Port Said and Suez

** Frontier Governorates: Red Sea, New Valley, Matrouh

It should be noted that only a small number of people in the Frontier Governorates were surveyed in relation to FGM in the EHS 2015.

Figure 5: Prevalence of FGM among women aged 15-49, according to place of residence¹¹

Prevalence is lowest in the Urban Governorates and the urban areas of Lower Egypt, perhaps reflecting larger migrant populations or better access to education, although this is merely speculation. It also appears to be low in the Frontier Governorates, but the extremely small number of surveyed women in this area means that these results should be treated with caution. FGM in the urban areas of Lower Egypt is slightly less prevalent than in the urban areas of Upper Egypt.

The majority of Egypt's population (57.2%) lives in rural areas, and this proportion is virtually unchanged over the past two decades.¹² The most densely populated areas are the Urban Governorates (i.e. Egypt's main cities, in which there are no rural areas), with approximately a quarter of the population (23 million) living in Cairo and Alexandria (4.7 million and 18.7 million respectively).¹³ FGM prevalence is lowest in the country in these Urban Governorates (74.5%) and in the urban areas of Lower Egypt (71.9%).¹⁴

Prevalence by current place of residence may not be a telling factor, however, as a woman may have moved since undergoing FGM, particularly if she was cut at a young age. For this reason, it is more helpful to look at prevalence among young girls according to their place of residence.¹⁵ In Egypt the prevalence of FGM among girls aged 1-14 is 10.4% in urban areas compared with 15.9% in rural areas. There is a markedly higher prevalence among girls living in Upper Egypt than among girls living in Lower Egypt and the Urban Governorates.¹⁶

The expected eventual percentage for girls aged 1-14 is 38.5% for girls who live in urban areas, compared to 62.5% for girls who live in rural areas.¹⁷

Prevalence of FGM According to Economic Status

94.4% of women aged 15-49 in the lowest wealth quintile have undergone FGM, as opposed to 69.8% in the highest wealth quintile (Figure 6).¹⁸ An examination of the DHS surveys from 2005 to 2014 shows that the gap between the prevalences of FGM in women from the highest and lowest wealth quintiles appears to be widening.¹⁹

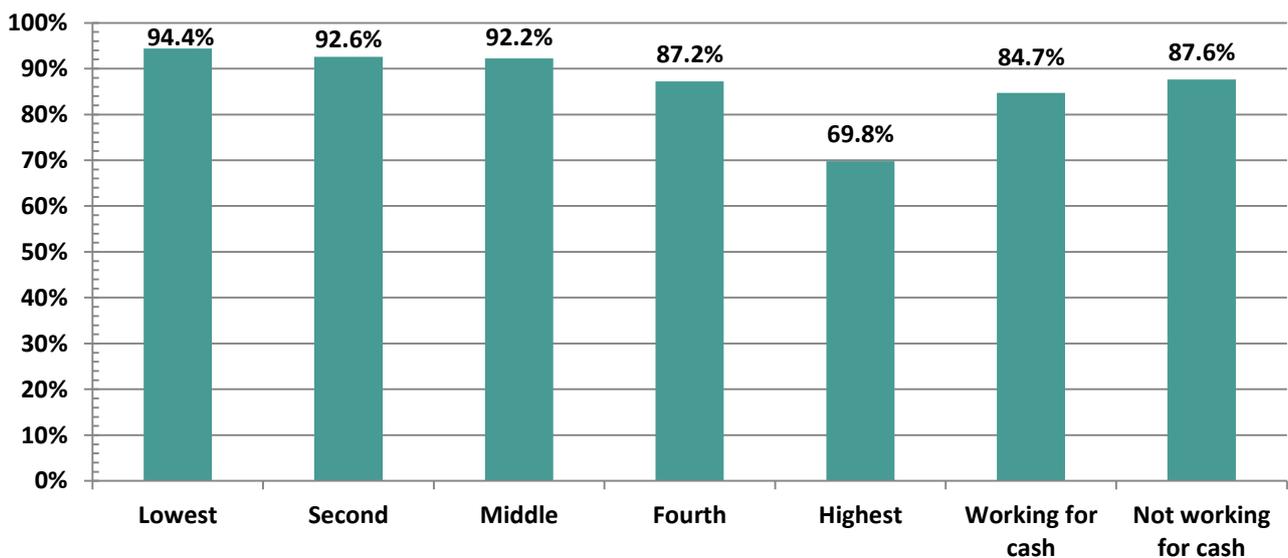


Figure 6: Prevalence of FGM in 2015 among women aged 15-49, according to wealth quintile²⁰

Looking to the future, girls in the highest wealth quintile are far less likely to have undergone FGM (5.4%) than girls in the lowest quintile (22.8%). The expected eventual percentage of FGM for girls aged 1-14 in the highest wealth quintile is 26.2%, and in the lowest quintile is 68.7%, further widening the economic-status/FGM-prevalence gap.²¹

The prevalence for girls in each wealth quintile varies in accordance with their place of residence, as may be seen in Table 2 below, compiled by UNICEF from the DHS 2014 data.

It is interesting to note that girls living in the Urban Governorates (i.e. the main cities of Egypt) who are in the fourth wealth quintile are more than twice as likely to undergo FGM as girls in the highest quintile. What is also evident is that, for every wealth quintile, girls in Upper Egypt are, in general, much more likely to be cut than girls living in other regions.

Wealth Quintile	Urban Governorates (%)	Lower Egypt (%)	Upper Egypt (%)
Lowest	25.4*	66.2	81.2
Second	51.9*	58.2	78.7
Middle	39.7*	52.8	63.7
Fourth	46.7	41.0	51.7
Highest	21.5	23.2	33.6

*Based on extremely small samples

No analysis is available for the Frontier Governorates.

Table 2: Expected eventual percentage of girls aged 0-17 who have undergone FGM, according to level of economic status²²

Age and Probability of Cutting

The age at which FGM takes place varies from country to country, and even between regions within countries, according to custom.

In Egypt, FGM is usually performed at any time between birth and the age of 17, with most girls undergoing the practice at or before puberty.²³

As a result, prevalence among young girls is low, as shown in Figure 7. It rises significantly among girls aged nine and ten, and continues to rise significantly for girls in the next two age-groups. In Upper Egypt (where overall prevalence is higher), FGM appears to take place at a younger age than it does in Lower Egypt and the Urban Governorates (Figure 8), and 28 Too Many understands that, in some rural villages, FGM is performed when girls are as young as five days old.

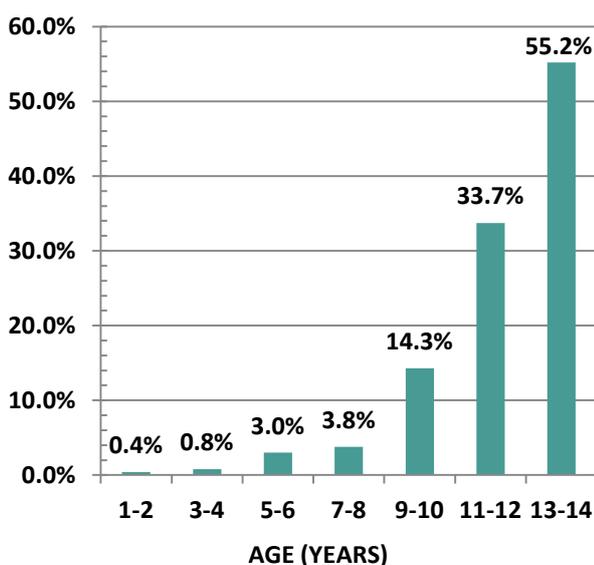


Figure 7: Prevalence of FGM among girls aged 1-14, according to current age²⁴

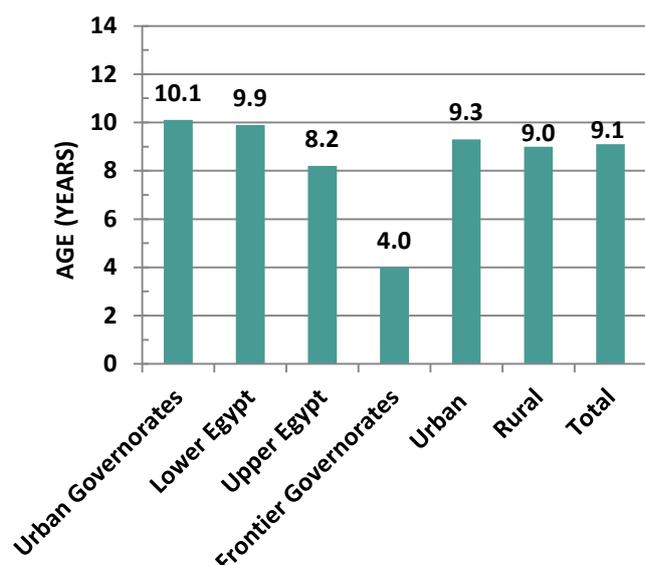


Figure 8: Median age at which FGM is performed on girls, according to place of residence²⁵

It has been suggested that, once FGM is criminalised in a country, more infants may be cut, as they are unable to report parents or excisors to authorities.²⁶ As the law against FGM was only introduced in 2008, it is probably too early to tell whether this is occurring in Egypt. A comparison of the ages of cutting between women and girls, however, as shown in Figure 9, suggests a trend towards cutting taking place earlier, but it is difficult to draw any firm conclusions due to the small sample of girls.²⁷

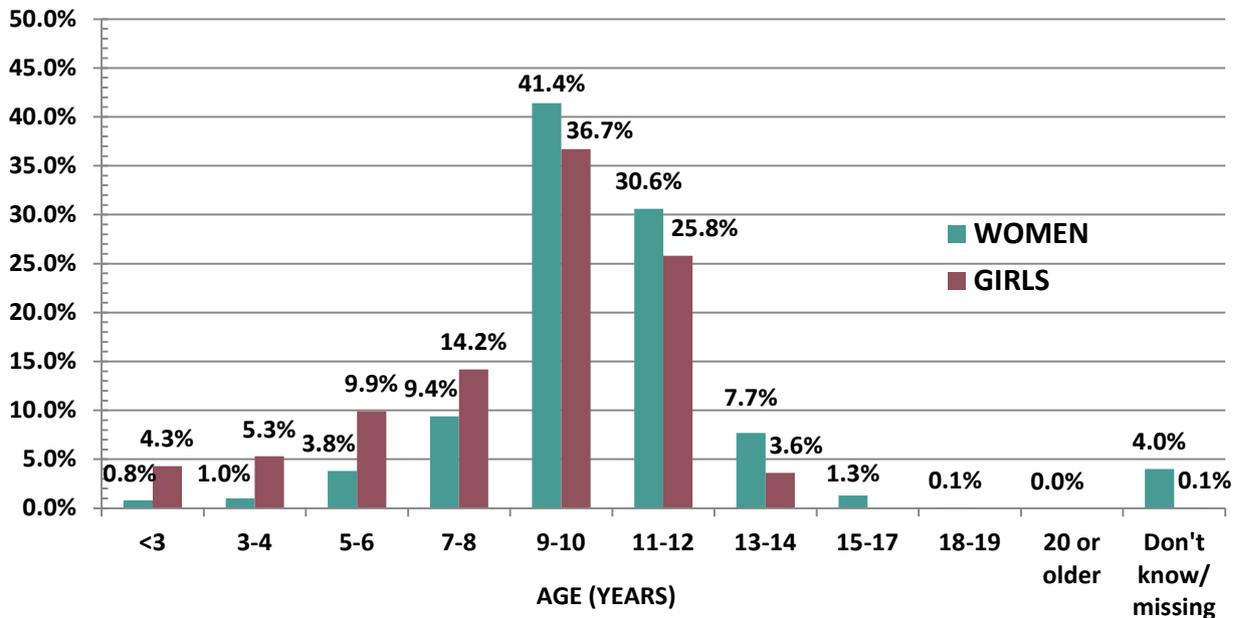


Figure 9: Comparison of the age of cutting for women aged 15-49 and girls aged 1-14 who have undergone FGM.²⁸

Mothers are reportedly the primary decision-makers when it comes to FGM.²⁹ The likelihood that a girl will be cut is affected greatly by her mother's age, FGM status and attitude towards the practice. According to the UNICEF study³⁰, a girl is almost seven times more likely to undergo FGM if her mother underwent it, and four times more likely if her mother supports the continuation of the practice. The younger a girl's mother is, the less likely she is to undergo FGM. A mother's marital status is another determinant, with daughters of currently married mothers being 21% less likely to be cut than daughters of widowed or divorced women. Additionally, the older a woman was when she was first married, the less likely she is to cut her daughters.

One report³¹ notes that a woman can only be regarded as 'saved' from FGM if she has married without being cut, because FGM is seen primarily as a rite of passage to marriage. If her husband does not insist on her being cut, it is very unlikely that she will undergo FGM in the future.

Cutting Season

FGM is usually performed in May and June, before the hottest part of the year.³² The tradition is that 'when the dates on the palm trees turn red, it's time'.³³

Types of FGM Practised

Women taking part in the EHIS 2015 and the DHS 2014 were not asked which type of FGM they or their daughters had undergone. However, other sources report that it is usually Types I and II that are practised in Egypt.³⁴

UNICEF AND UNFPA JOINT PROGRAMME³⁵

Egypt was one of the original eight countries chosen in 2008 by UNICEF and the UNFPA as part of the **UNFPA-UNICEF Joint Programme on Female Genital Mutilation and Cutting: Accelerating Change (UNJP)**, which aims to end FGM within a generation. A wide range of projects have been undertaken with partners at both national and local levels, including:

National Strategy: supporting the National Population Council (NPC) in developing the National Strategy for the Abandonment of FGM/C in 2013.

NGO partnerships: working with the NGOs Coalition against FGM/C through its Kamla awareness campaign, introduced in 2011 (see page 77).

Law enforcement: launching a training programme in 2014 for prosecutors, in partnership with the NPC and the Office of the General Prosecutor, to raise awareness of FGM issues and improve reporting and documentation.

Religion: working with local partners to strengthen the capacity of religious leaders to change attitudes towards FGM in their communities. Several publications and manuals have also been written with partners, explaining that FGM is not a requirement of any religion (for further details see Religion and FGM on page 64).

Peer networks: in coordination with the MOHP, supporting the youth peer (YPEER) network in Egypt, including developing a training manual on FGM abandonment for peer educators to use, and 'youth-friendly' group activities to explore sensitive topics through games and role play.

Schools: developing schoolgirl profile sheets, with partner NGOs, with the aim of monitoring girls' socio-economic, health and education statuses on a yearly basis, and thus detect any potential issues such as FGM, child marriage and school dropout.

Health sector: the UNJP stresses the importance of reaching doctors, nurses and midwives to disseminate accurate information on the health and legal consequences of performing FGM and the need to strengthen reporting systems. It is also working with health professionals to implement the national medical guidelines, and aims to target all public hospitals in Egypt, to ensure standards and that appropriate actions are taken in the identification of FGM cases and the provision of services to survivors of the practice.

Use of media: launching the National Media Campaign with the NPC, which prioritises television, the most accessed form of media in Egypt. A television advertising campaign called Enough FGM was developed and ran throughout 2015. The UNJP also partners with interactive theatre group Noon Creative Enterprise to tackle sensitive issues such as FGM and child marriage (see page 99).

- 1 **Click for source document:** Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Somalia: MICS 2006; Sudan: MICS 2014.
- 2 - UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, pp.26-27. Available at https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf.
- DHS 2008, p.197.
- 3 DHS 2014, p.186.
- 4 EHIS 2015, p.104.
- 5 IndexMundi (2016) Egypt Population. Available at <http://www.indexmundi.com/egypt/population.html>.
- 6 Dr Fatma El-Zanaty, UNICEF (2015) *Factors and determinants of FGM/C of girls aged 0-17 years: a secondary analysis of the Egypt Demographic and Health Surveys, 2005, 2008 and 2014*, pp.2 & 24. Available at https://www.unicef.org/egypt/FGM_Secondary_analysis_edited_5-08-2016_FINAL.pdf.
- 7 Dr Fatma El-Zanaty, UNICEF, *op. cit.*, pp.2-3.
- 8 EHIS 2015, p.108.
- 9 EHIS 2015, p.104.
- 10 DHS 2014, p.188.
- 11 EHIS 2015, p.104.
- 12 DHS 2014, p.1.
- 13 IndexMundi (2016) *Egypt Population*. Available at <http://www.indexmundi.com/egypt/population.html>.
- 14 EHIS 2015, p.104.
- 15 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.37. Available at https://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf.
- 16 EHIS 2015, p.106.
- 17 EHIS 2015, p.109.
- 18 EHIS 2015, p.104.
- 19 - DHS 2005, p 211.
- DHS 2014, p.186.
- 20 EHIS 2015, p.104.
- 21 EHIS 2015, p.109.
- 22 Dr Fatma El-Zanaty, UNICEF, *op. cit.*, pp.21-23.
- 23 Dr Fatma El-Zanaty, UNICEF, *op. cit.*, p.2.
- 24 EHIS 2015, p.106.
- 25 EHIS 2015, p.107.
- 26 Lana Clara Chikhungu and Nyovani Janet Madise (2015) 'Trends and protective factors of female genital mutilation in Burkina Faso: 1999 to 2010', *International Journal for Equity in Health*, 14(42), p.19. Available at <http://www.equityhealthj.com/content/14/1/42>.
- 27 EHIS 2015, pp.105 & 107.
- 28 EHIS 2015, pp.105 & 107.
- 29 Stanford University Medical Centre (2016) 'Egyptian women say doctors don't discourage female genital cutting, study finds', *EurekaAlert!*, 25 August. Available at https://www.eurekaalert.org/pub_releases/2016-08/sumc-ews082516.php.
- 30 Dr Fatma El-Zanaty, UNICEF, *op. cit.*, p.9.
- 31 Pamela A. McCloud Dr. Shahira Aly Sarah Goltz (2003) *Promoting FGM Abandonment in Egypt: Introduction of Positive Deviance*. USAID and CEPDA. Available at http://www.intact-network.net/intact/cp/files/1387977515_Introduction%20of%20Positive%20Deviance.pdf.
- 32 Reda El-Danbouki (2016) 'Girl Dies From FGM; Judge's Sentence: Suspended Jail Terms', *The Clarion Project*, 28 December. Available at <http://www.clarionproject.org/analysis/girl-dies-fgm-judge%E2%80%99s-sentence-suspended-jail-terms>.
- 33 Lucy Westcott (2015) 'How To End Female Genital Mutilation In Egypt', *Newsweek*, 17 March. Available at <http://europe.newsweek.com/how-end-female-genital-mutilation-egypt-314264>.
- 34 World Health Organization (2008) 'Prevalence of female genital cutting among Egyptian girls', *Bulletin of the World Health Organization*, 86(4), April, pp.241-320. Available at <http://www.who.int/bulletin/volumes/86/4/07-042093/en/>.
- 35 - UNFPA-UNICEF (2014) *Voices of Change: 2014 Annual Report of the UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change*. Available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_UNICEF_FGM_14_Report_PDA_WEB.pdf.
- UNFPA-UNICEF (2015) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change Phase II – Provisional Highlights of Progress in 2014*. Available at <https://www.utanrikisraduneyti.is/media/throunarsamvinna/felagasamtok/Provisional-FGMC-Highlights-Report-2014-for-SC.pdf>.
- UNFPA (undated) 'Female Genital Mutilation Programme of UNFPA', *Egypt*. Available at <http://egypt.unfpa.org/topics/female-genital-mutilation-programme-unfpa>.

The Sustainable Development Goals

The eradication of FGM was pertinent to six of the UN's eight **Millennium Development Goals (MDGs)**, which reached their deadline in 2015. In September 2015 the UN adopted the **Sustainable Development Goals (SDGs)**, which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – **people, planet, prosperity, peace and partnership**.¹



Figure 9: The Sustainable Development Goals

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development*², details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. **They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls.**

In March 2015 Egypt published its *Sustainable Development Strategy: Egypt Vision 2030*³, a complex document that is closely aligned with the SDG Agenda and demonstrates a strong commitment to achieving the SDGs. The UN also notes that Egypt's new Constitution 'marks significant improvement compared to the previous one in securing citizens' rights to education, health, protection, and development.'⁴

The SDGs go further than the MDGs and **make explicit reference to the elimination of FGM**. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.



Sustainable Development Goal 5: Achieve gender equality and empower all women and girls

Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality, such as **Goals 3 and 4**.

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the **African Women's Decade**.⁵ This declaration will assist in promoting gender equality and the eradication of FGM and other forms of GBV in Egypt.

Please see our **Global Goals** document for a summary of all 17 SDGs.

1 UN Department of Economic and Social Affairs (2015) *Transforming our world: the 2030 Agenda for Sustainable Development*. Available at <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

2 *Ibid.*

3 Ministry of Planning, Monitoring and Administrative Reform (2016) 'Reports', *Sustainable Development Strategy: Egypt's Vision 2030*. Cairo, Egypt: Ministry of Planning, Monitoring and Administrative Reform. Available at <http://sdsegypt2030.com/category/reports-en/?lang=en>.

4 UN Department of Economic and Social Affairs (2016) 'Egypt: 2016 Voluntary National Reviews at the High-level Political Forum', *Sustainable Development Knowledge Platform*. Available at <https://sustainabledevelopment.un.org/hlpf/2016/egypt>

5 African Union (2011) *The African Women's Decade*, p.2. Available at <http://pages.au.int/carmma/documents/african-womens-decade>.

Case Study: Plan International Egypt



Plan International Egypt has a long history of working in Egypt, and addresses FGM and early marriage through its projects focussed on protecting vulnerable individuals from all forms of violence and HTPs. Programmes have evolved ‘to address the root causes of gender inequality and discrimination that underpin the continuing prevalence of HTP’.¹

Its **approach** to addressing a topic as sensitive as FGM in Egypt has been threefold:

- establishing a presence and acceptance within communities, and building up trusting relationships;
- partnering with other international NGOs (for example, Caritas – see below – and the Association of European Parliamentarians with Africa) and, importantly, local grassroots organisations in communities; and
- using the concept of group working, where participants can come together to discuss sensitive issues and support one another.

Plan works at both the local and national level, and over the last eight years has focussed its projects to tackle HTPs, including FGM, in the **rural communities of Upper Egypt**. It aims to reduce the pressure on families to continue these practices and to support local partners as they implement activities that involve all members of the community (including community and religious leaders, schools, local government representatives and both men and boys, as

well as women and girls). Plan also works alongside the NCCM at a national level, responding to the increasing issue of **medicalisation**.

Support to empower women and girls takes various forms, including developing leadership skills; increasing girls' participation in extracurricular activities, including sports, as a way of supporting the completion of primary school and progression to secondary level; and increasing the capacity of community leaders and groups to support local initiatives that promote and protect girls' and women's rights.

Successful activities supported by Plan that **promote dialogue around FGM** include the use of interactive theatre (often performed by local youth). This has proved successful in explaining girls' rights to participants, raising awareness of the harms of FGM and relating the issue to Egyptian law. By focussing programmes on **all community members and the family unit**, everyone participates in the empowerment of women and girls and realises the positive effects this will have, including for men and boys. A **peer approach** is used for both women and girls (known as the Elder Sister project) and for men and boys.

Increasingly, **public declarations against FGM** are being made by community leaders. and both men and women are finding the courage and knowledge to speak out and act as agents of change in their communities. Plan emphasises the importance of avoiding public confrontation with those opposed to change, and instead focussing on finding **local champions** to educate and influence the wider community.

Plan is also part of a regional project known as **Obligation to Protect**, which aims to complement the work of the UNJP in the rural governorates of Assiut and Giza. A wide range of activities, including training and workshops, are being undertaken to increase awareness and advocate for an end to FGM at government, civil-society and community levels.

CARITAS EGYPT

Caritas Egypt is a key partner of Plan International Egypt and works as part of a wider group of NGOs against FGM at a national level. It operates from Cairo, Alexandria, Al-Minya, Assiut, Sohag and Luxor.

A major aim is to increase awareness around reproductive health and how FGM and child marriage affects it. Family members of all ages, together with local and religious leaders and education professionals, are targeted through advocacy workshops and training, public seminars in villages, and activities for children such as competitions focused on sports and the arts. Caritas also utilises media, particularly in the form of anti-FGM advertisements on television, posters and brochures and in theatres.

Particularly successful activities to date have been those that involve young families and children (who have some education) and the use of theatre to convey anti-FGM messages.

1 Plan International (2017) *Plan Egypt Gender Story – 31st January 2017*. Plan International.

Image: © Plan International Egypt

Understanding and Attitudes

A widespread, correct understanding of FGM is a prerequisite to changing attitudes; thus, exposure to correct information is essential. The DHS 2008 and the EHIS 2015¹ asked women and men whether they had received information on FGM during the year prior to the surveys and, if so, where that information had come from. The results show a sharp decline in both women’s and men’s **recent exposure to information about FGM**:

Women aged 15-49	% receiving information recently about FGM	Source from which respondent last saw/heard about FGM		
		Television (%)	Other Media (%)	Spouse/other relatives/friends/neighbours (%)
DHS 2008	72.2	96.3	13.9	22.3
EHIS 2015	26.0	80.6	3.8	49.2
Men aged 15-49				
DHS 2008	51.7	96.7	21.7	15.7
EHIS 2015	18.1	90.3	11.8	32.7

Table 3: Level of recent exposure to information about FGM and source of that information²

In 2008, 96.3% of women and 96.7% of men who had **received information about FGM** received it via **television**. In 2015, those figures were 80.6% and 90.3% respectively. That suggests that television is a crucial method for getting across anti-FGM messages in the future, a point made strongly in the Media section below.

However, the receipt of information from both television and other media has decreased, while the receipt of information from spouse/other relatives/friends/neighbours has more than doubled, suggesting that, overall, public discussion of FGM is declining, while private discussion is becoming more common.

In the EHIS 2015³, women and men were also asked whether they had **discussed FGM with relatives, friends or neighbours**. 19.4% of women and 11.2% of men aged 15-49 had done so. Although the DHS 2014 also asked this question, the results are unfortunately not directly comparable, as the DHS 2014 only surveyed ever-married women. Therefore, although in that earlier survey a greater percentage (27.7%) of ever-married women reported that they had discussed FGM with relatives/friends/neighbours, this may or may not contradict the conclusion that public discussion of FGM is declining. The difference may simply indicate that ever-married women feel more comfortable discussing the subject publicly than women who have never been married.

However, the UNICEF secondary analysis⁴ notes that exposure to information about FGM does appear to have decreased over the decade 2005-2014. This is a matter of concern. The author of the UNICEF analysis makes the point:

'Outreach efforts must be intensified through national campaigns tailored to both women and men that provide information about the negative consequences of FGM/C for girls and women.'

~ Dr Fatma El-Zanaty⁵

To support this statement, she cites the finding in the DHS 2014 that Lower Egypt has had the greatest decline in prevalence of FGM since 2005, and notes that that region also has the highest percentages of women who have received information on FGM and have discussed it.

In 2014 a survey carried out on **younger Egyptians⁶** (in two groups – ages 13-17 and ages 30-35) found that almost all respondents (94%) had heard of FGM. Slightly more girls and young women had heard of it (98.3%) than boys and young men (89.4%). Those in the youngest age-group and those living in rural Lower Egypt were least likely to have heard of it.

When asked if they believed FGM was necessary, female respondents were slightly more likely to say it was (64.6%) than male respondents (57.8%) (61.3% overall), but, again, when broken down by age group, the figure was lower for respondents aged 13-17 (53.3%) than for those aged 30-35 (66.1%). 50.3% of those in the highest wealth quintile said it was necessary, compared to 70.9% in the poorest quintile, and 32.8% of respondents with a university education said that it was unnecessary, compared to 11.1% of illiterate respondents.

Respondents to the DHS 2008⁷ and EHIS 2015⁸ were asked whether or not they believed that (a) **circumcision can cause serious consequences that can lead to a girl's death** and (b) **childbirth is more difficult for a woman who has been circumcised**. The results are shown in Figure 10. While there has been a small increase in the percentage who think FGM makes childbirth more difficult, the figures remain very low. It is probable that the increase in knowledge about FGM's potential to cause serious consequences/death is a result of the attention given by the media to the deaths of several young girls in recent years.

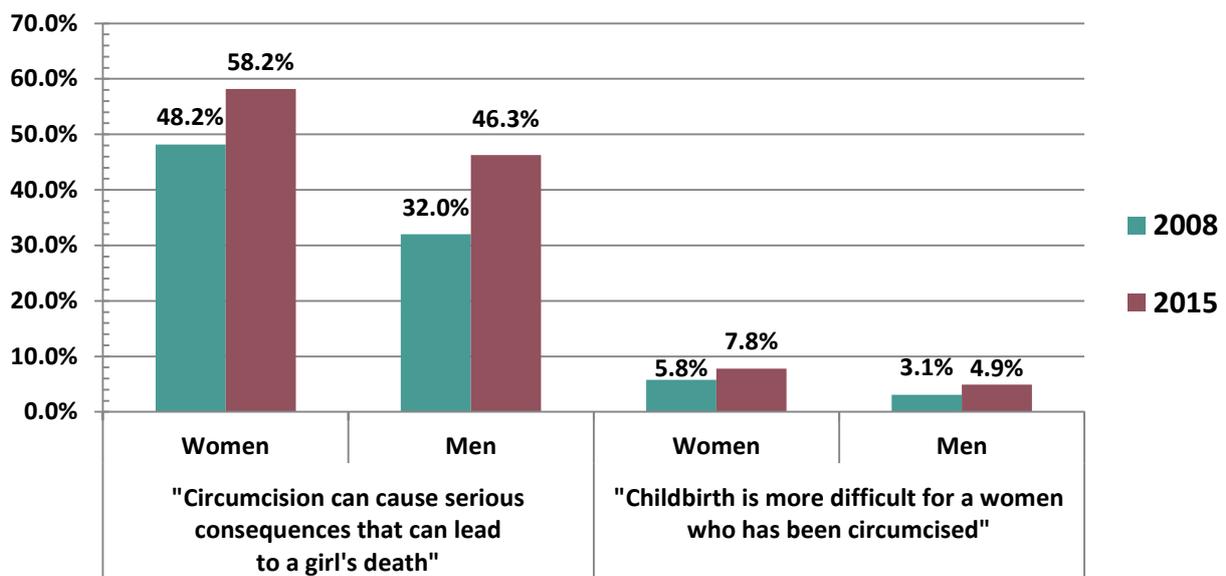


Figure 10: Percentages of men and women aged 15-49 who responded affirmatively to certain statements about FGM⁹

Reasons for Practising FGM and Its Perceived Benefits

There are various reasons for the practice of FGM in Egypt. Sahar Talaat, Professor of Pathology at Cairo University, notes that motives include ‘families being incapable of challenging the family patriarchs; perceptions that the practice is a part of a girl’s maturity; repulsion among some men by the idea of an uncut wife; and economic reasons: financial gifts are often received as part of the FGM ceremony.’¹⁰

When respondents to the 2014 survey¹¹ of younger Egyptians were asked why they thought FGM was important, the reason most often given was ‘**customs and traditions**’ (56.7%), followed by ‘**religious reasons**’ (35%) and ‘**to get married**’ (5.3%). ‘Customs and traditions’ was most often cited among girls and women from the lowest wealth quintile and from Upper Egypt, while ‘religious reasons’ was most often cited by those who were better off and living in other areas.

Fidelity/Virginity and Marriage Prospects

‘The main motivation behind FGM is to control female sexuality. It is believed to reduce a girl’s sex drive, thereby helping to maintain her virginity and, later, her marital fidelity.’

~ Mona Eltahawy¹²

Dr Amr Seifeldin notes that the idea of Arab women being ‘oversexed’ is ‘in the collective imagination’, and says, ‘This is why she is more prone to FGM.’¹³

In September 2016, Egyptian MP Elhamy Agina stated that women must undergo FGM to curb ‘sexual weakness’ in men and reduce women’s ‘sexual appetites’. He claimed, ‘If we stop [FGM], we will need strong men [i.e. not “sexually weak”] and we don’t have men of that sort.’¹⁴

Although the Egyptian parliament’s Disciplinary Committee has recommended that Agina’s membership be withdrawn because of these and other comments¹⁵, Agina’s remarks are an example of a commonly held view in Egypt. The EHIS 2015¹⁶ asked men and women whether or not they agreed with the statements ‘**A husband will prefer his wife to be circumcised**’ and ‘**Circumcision prevents adultery**’. Men were slightly more likely than women to agree that a husband would prefer his wife to be cut (57.5% and 53%, respectively) and to agree that circumcision prevents adultery (48.7% percent and 43.1%, respectively).

One 2010 study¹⁷ noted the importance to Egyptian men of the concept of **quama**, which roughly translates as ‘responsibility’, ‘superiority’ and ‘protection’. Men view FGM as an important part of protecting the women in their families. The study also found that the majority of men interviewed believed that FGM stopped women from being sexually demanding (‘oversexed’) and having extra-marital relationships.

Egyptian journalist Angelina Fanous notes that **sex education** for women is often left to the days before her wedding, when the responsibility for it is sometimes passed to her beautician, who likely has an incorrect understanding herself. Psychologist Dr Wagid Boctor believes that the lack of sexual education for both men and women in Egypt is an enormous problem. He is a sex counsellor and teaches a course to Christian Egyptians

(the Coptic pope is making sex education a prerequisite for marriage). Doctor says that a lack of knowledge about sex is 'the number one issue affecting marriages', and that Egyptians 'don't understand that desire comes from here [pointing to his head], and not from the genitals.' This lack of understanding combined with the importance men place on marrying a 'pure' woman contributes to the continuance of FGM – which is still called *tahara* ('cleanliness') in various communities.¹⁸

MEN AND BOYS

Since the late 1990s, NGOs have increasingly encouraged men and young people to attend awareness-raising sessions, and several working to end FGM in Egypt stress the importance and necessity of including men and boys in their work; for instance, projects run by Plan International Egypt, in partnership with Caritas and others, include men and boys in community discussions and use a manual called *Champions for Change* to build their skills to support women and girls and tackle gender inequality. BLESS also offers classes to men, run by either doctors or religious leaders from the community, focusing on sexual health and relationships. This way of teaching is accepted and enables the introduction of FGM into the discussion.

At the time of writing, Tadwein Gender Research and Training Centre is planning a qualitative study into the influence of men in decision-making on FGM, the results of which are due in March 2018, and a module promoting positive gender roles, to be trialled with adolescent boys and girls.¹⁹

Community/Social Acceptance/Tradition

UNICEF notes that family and community ties are strong in Egypt, and that 'each family member is responsible for the integrity and behaviour of his or her family members.' Therefore, the opinions of family and neighbours greatly influence decision-making, including the decision whether or not to continue practising FGM.²⁰

THE NATIONAL POPULATION COUNCIL (NPC)²¹

The National Population Council targets new young mothers, particularly in rural areas, to raise awareness early on and produce a 'trickle down' effect on society. Part of its strategy in 2017 will include a campaign called *Kefaya* (meaning 'Enough') which includes a series of posters in health centres and clinics across the country. The information on them reads:

FGM is a crime punishable by law because it can lead to severe bleeding, permanent disability, or death to girls, and also because religious figures do not sanction this practice. Our girls deserve to live with dignity, free from abuse. Enough circumcising our girls!

Foldable cards will also be given out to parents at vaccination clinics, which will include the name of the girl and the *Kefaya* messages, thus placing the responsibility on them to protect their daughters.

Religious Requirement

The EHIS 2015²² reports that about half the adult population (46.2% of women and 50.1% of men aged 15-49) believes that FGM is required by religious precepts. For a fuller discussion of the relationship between FGM and Religion, please refer to the Religion section on pages 62-67.

Support for FGM

The EHIS 2015 obtained information from both women and men on several indicators of support for FGM, including whether they believe that it is required by religious precepts and their opinion as to **whether it should continue or be stopped**. In addition, women were asked if they thought men supported continuation of the practice, while men were asked what they perceived to be women’s attitude to its continuation.

With regard to the estimated level of support for FGM among the opposite sex, both men and women were largely correct in their perceptions, although men significantly underestimated the number of women who wish to see FGM stopped. Men estimated that 24.5% of women want it to end; the actual percentage is 37.5%.²³

	Women aged 15-49 (%)			Men aged 15-49 (%)		
	Continue	Be Stopped	Not Sure	Continue	Be Stopped	Not Sure
2008	54.0	34.5	11.5	56.7	26.6	16.7
2015	53.9	37.5	8.6	58.5	27.9	13.6

Table 4: Attitudes about the continuation of FGM in 2008 and 2015²⁴

53.9% of women and 58.5% of men feel that FGM should be continued, 37.5% of women and 27.9% of men feel that it should be stopped, and the remainder are unsure.²⁵ These figures have changed very little since the DHS 2008 (see comparison in Table 4 above), although the UNICEF secondary analysis²⁶ reports that, among men and ever-married women, there was a decline in support overall for the period 2005-2014.

For both men and women, the percentage who were not sure decreased over the period 2008 to 2015. As the percentages of women who believe FGM should be stopped, men who believe it should be stopped and men who believe it should continue have all increased, it is possible that societal changes have taken place such that those who were previously unsure have been able to form a definite opinion on the subject.

Looking in more detail at the changes in levels of support for continuance/discontinuance of FGM between 2008 and 2015²⁷, there are some points of interest:

- **Education** – surprisingly, there has been a small increase in the percentage of men with a secondary or higher level of education who believe FGM should be continued (56.5% to 58.3%); however, there has also been a slight increase in the percentage who believe it should be stopped (31.7% to 33.4%), and a decrease in the percentage who are not sure (11.8% to 8.3%), indicating once again that perhaps more are aware of the issues surrounding FGM and are therefore sure of their opinion.

- *Wealth quintile* – in general, women's support for FGM has declined among those in all wealth quintiles except the 'middle' quintile. It is difficult to say why this may be. Of men, the percentage who believe it should continue has increased among those in the lowest three quintiles, but dropped substantially among those in the highest quintile (46.3% to 39%).
- *Place of residence* – there has been a large decrease in support for continuance from both women (37.2% to 28.2%) and men (43.5% to 38.4%) living in the Urban Governorates. Among those living in Upper Egypt, there has been an increase in support for continuance from men (60.2% to 64.6%), and a smaller increase in support from women (59.2% to 61.9%). There has also been an increase in the percentage of men living in rural areas who believe FGM should continue (60.8% to 65.2%).

A 2015 study²⁸ examined the **relationship between Egyptian women's social positions and their attitudes towards FGM**, and investigated whether the spread of anti-FGM attitudes is related to observed improvements in the position of women over time. Changes in attitudes towards FGM were tracked using data from the Egyptian DHS surveys from 1995 to 2014. The study concluded,

The improvement of women's social position has certainly contributed to the spread of anti-FGM attitudes in Egyptian society. Better educated and less traditional women were at the heart of this change, and formed the basis from where anti-FGM sentiment has spread over wider segments of Egyptian society.



As Egyptian women's social position improves, anti-FGM attitudes spread

THE FGM-FREE VILLAGE MODEL²⁹

The National Council for Childhood and Motherhood (NCCM), in partnership with the United Nations Development Programme (UNDP), the NPC and the Donor Assistance Group, launched Egypt's national FGM-Free Village Model in 2003 with the objective:

eliminate the social pressure on families to perform FGM on their daughters by fostering a sociocultural environment conducive to the abandonment of the practice through messages in the media, supportive policies, and community-based initiatives.

The project has been implemented in 120 villages across Egypt and provides information on the harmful effects of FGM, bringing together medical and religious communities, the media, policymakers, and both international and local NGOs. Through community discussions and awareness-raising seminars, the project has mobilised local officials, religious leaders, community groups and young people to make public declarations against FGM. These declarations are often the culmination of years of advocacy work in the community, and officially recognise in the presence of NCCM officials and local leaders the progress made by those who have been through the programme. It has been reported that people from other villages attending such ceremonies out of curiosity often hear opposition to FGM for the first time, which deepens the impact of the project.

*'When probed about the main factors that turn the views of the community against FGM, respondents listed the NGOs' activities, including home visits, seminars, and research about the issue and the strong support of religious leaders advocating abandonment of the practice.'*³⁰

A midterm report published on the impact of this initiative shows positive results: 81% of women who live in a village where the programme took place stated that information they had received about FGM convinced them to re-evaluate their views on it, and 76% of those whose daughters had not yet been cut had been convinced by information they'd received not to have them undergo FGM. These same figures in villages where the programme did not take place were only 30% and 17%. The intervention has also proved to have positive influence over attitudes. Only 27% of female participants supported the continuation of FGM, and only 25% now believed it was required by their religion, compared to 77% and 59% respectively for those who had not been through the programme.

- 1 - DHS 2008, pp.207-208.
- EHS 2015, pp.115-116.
 - 2 - DHS 2008, pp.207-208.
- EHS 2015, pp.115-116.
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 - 5 Dr Fatma El-Zanaty, UNICEF, *op. cit.*, p.11.
 - 6 Rania Roushdy and Maia Sieverding (eds.) *Panel Survey of Young People in Egypt (SYPE) 2014: Generating Evidence for Policy and Programs*, p.30-3. New York and Cairo: Population Council. Available at https://www.popcouncil.org/uploads/pdfs/2015PGY_SYPE-PanelSurvey.pdf.
 - 7 DHS 2008, pp.205-206.
 - 8 EHS 2015, pp.113-114.
 - 9 - DHS 2008, pp.205-206.
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 - 16 EHS 2015, pp.112-114
 - 17 Mawaheb T. El-mouelhy, Elise Johansen, Ahmed R. Ragab and Amel Fahmy (2013) 'Men's Perspectives on the Relationship Between Sexuality and Female Genital Mutilation in Egypt', *Sociology Study*, 3(2), February. Available at https://www.researchgate.net/publication/273440839_Men%27s_Perspectives_on_the_Relationship_Between_Sexuality_and_Female_Genital_Mutilation_in_Egypt.
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Religion

Egypt has a population of almost 95 million.¹ The CIA World Factbook² estimated in 2012 that 90% of Egypt's population is Muslim and 10% Christian – figures that are widely cited. However, a study which drew on Egypt's 2006 census data puts the figure for Christians at 5.3%.³ For the sensitivity of figures such as these, see page 18 of Hassan⁴.

Most Muslim Egyptians are Sunni. The majority of Egyptian Christians belong to the Coptic Orthodox Church (92%). The rest belong to the Coptic Catholic and Coptic Evangelical (Protestant) communities.⁵ There are also small Baha'i and Shiite communities, and a remnant of Jews.

Muslims and Christians live together in all parts of Egypt. However, there are larger concentrations of Christians in southern Egypt, especially in the governorates of Minia, Assiut and Sohag, as well as in the big cities of Alexandria and Cairo. They are fewer in number in the Delta.⁶ A discourse of Egyptian national unity has held Muslims and Christians together, and there is much cooperation between the two groups. Nevertheless, Christians encounter 'some legal but mostly social forms of prejudice'⁷.

RELIGION AND THE CONSTITUTION

Article (2): Islam is the religion of the State and Arabic is its official language. The principles of Islamic Sharia are the main source of legislation.

Article (3): The principles of Christian and Jewish Sharia of Egyptian Christians and Jews are the main source of legislations that regulate their respective personal status, religious affairs, and selection of spiritual leaders.

Article (4): Sovereignty belongs only to the people, who shall exercise and protect it. The people are the source of powers, and safeguard their national unity that is based on the principles of equality, justice and equal opportunities among all citizens, as stated in the Constitution.

Article (64): Freedom of belief is absolute. The freedom of practicing religious rituals and establishing worship places for the followers of Abrahamic religions is a right regulated by Law.

Under Article 2 of the 2014 Constitution⁸, Islam is the state religion, and Islamic law is the main source of legislation. All the constitutions of Egypt since 1980 have included this principle. The Constitution maintains the equality of all citizens (Article 4) and freedom of belief (Article 64). However, freedom of practice and the freedom to build places of worship is provided only for the Abrahamic religions (Article 64), and both are regulated by law; thus, the Baha'i are not a recognised religious group. Previously restrictive laws on church buildings were eased under Mubarak⁹, and further amended in August of 2016. The new law has been criticised, however, in view of the fact that Christians may still face difficulties when applying for permits to build and repair churches.¹⁰

The middle of the 19th century brought the emancipation of Christians from centuries of legal discrimination.¹¹ In the 20th century, the ideology of Arab Socialist Nationalism offered equality for all citizens, and many Muslims and Christians therefore supported it. However, there later came the growth of Islamic revival movements, a failure of Arab Socialist Nationalism and a certain Islamisation of the State. At the same time, Christianity

also experienced a revival. The recent tendency of both groups to keep more to themselves has led to greater alienation between them.¹² Additionally, some radical Islamic groups aiming to overthrow the government have targeted Christians since the 1970s and 1980s.¹³



*Coptic Christian girls celebrating
the traditional Sham El Nessim
(the Festival of the Smelling Breeze)
in Cairo*

During the Arab Spring, Muslims and Christians participated side by side in demonstrations.¹⁴ In the summer of 2013, after the fall of President Muhammad Morsi, security forces cracked down on Muslim Brotherhood protesters, killing hundreds of people. Later in the summer, many Christian institutions and churches were attacked by Muslim Brotherhood supporters who blamed Christians for Morsi's fall, and similar attacks have continued sporadically to the present.¹⁵

A CONSISTENT MESSAGE IS NEEDED FROM RELIGIOUS LEADERS

Evidence suggests that inconsistent messages around FGM are still being given to the public by different religious groups in Egypt. These contradictions, including the different interpretations of Islamic Hadiths, remain a challenge to those working to end FGM in the country.

This being the case, NGOs across Egypt have stressed to 28 Too Many the importance of including leaders from all faiths in their work. Plan International Egypt, for instance, has run workshops for religious leaders, both Christian and Muslim, with local partners in Assiut, and CEWLA has also implemented a range of training programmes for imams and representatives of al-Waqf to discuss FGM. The NGOs Coalition against FGM/C has run seminars led by religious leaders, which have included discussion around the interpretation of the Hadith. In recent years, Christian FBOs such as the Bishopric of Public, Ecumenical and Social Services (*BLESS*) and the Coptic Evangelical Organization for Social Services (*CEOSS*) have introduced training workshops for both priests and imams to discuss issues around GBV, including FGM.

In terms of progress, Plan International Egypt has noted that when a religious figure comments in support of FGM in Egypt, there are increasingly others who will speak out and challenge such views.

Religion and FGM

'This is precisely the two points that we need to address if we are at all serious about abolishing this appalling violation of girls' bodies and souls: the convictions of parents and doctors, and the discourse of the clergy on the matter.'
~ Hussein Gohar, Gynaecologist¹⁶

It is clear that the belief that FGM is required by religious law is a considerable contributor to the continuation of the practice in Egypt.

The DHS 2008 and the EHIS 2015 asked both men and women whether they believed FGM is required by religious precepts. The results are shown in Figure 11 below.

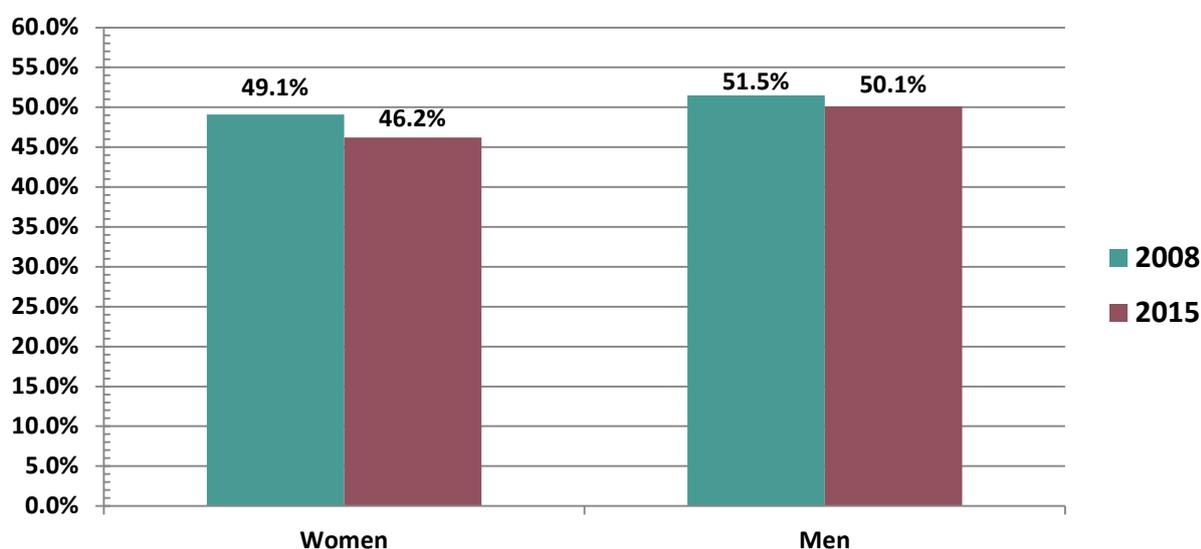


Figure 11: Percentage of women and men aged 15-49 who believe that FGM is required by religious precepts¹⁷

There does appear to have been a small decline in the proportion of people who believe that FGM is required by their religion; however, the decline in belief is greater among women than among men.

A secondary analysis of the source DHS data for the period 1995-2014¹⁸ notes that 'Religion has a clear effect on the belief that FGM should be stopped.' The results of an analysis of the belief among ever-married women that FGM should be discontinued are shown in Table 5 below:

Religion	DHS 1995	DHS 2005	DHS 2008	DHS 2014
Muslim	11.3%	21.4%	26.8%	29.5%
Christian	39.0%	56.7%	67.4%	76.1%
Other*	0.0%	No data	No data	41.2%
Missing*	0.0%	13.3%	20.0%	0.0%

* Figures pertain to extremely small samples; therefore, no certain conclusions can be drawn from them

Table 5: Proportion of ever-married women who believe FGM should be discontinued, by religion¹⁹

Consistently, a greater percentage of Christian women than Muslim women have opposed FGM. Opposition also increased more rapidly among Christian women (39% in 1995 to 76.1% in 2014) than among Muslim women (11.3% in 1995 to 29.5% in 2014). This is consistent with the conclusions of a report by USAID and the Centre for Development and Population Activities²⁰ on the introduction of positive deviancy to encourage the abandonment of FGM:

The data indicates that there is a higher success rate with Christian communities than there is with Muslim communities. The NGO partners have suggested that this is because many Muslim communities see FGM as a religious requirement, whereas Christians quickly recognize it as a traditional practice and find no support for it in their literature.²¹

FGM is not required by any of the major religious texts, and many Egyptian faith leaders have spoken out against it. For example, in June 1951 the *Liwa Al-Islam Journal* surveyed several senior Muslim scholars, and their unanimous conclusion was that FGM 'is a mere matter of habit, which might be abandoned if there is strong scientific evidence that it is harmful.'²² Additionally, in 1998, Muslim scholars from 35 countries met at Al-Azhar University in Cairo. They too concluded that FGM is a habit and non-obligatory in Islam.

*'In 2007, Egypt's top Islamic official, the grand mufti, issued a fatwa (a religious edict) stating that the practice is forbidden in Islam.'*²³

In 2013 the International Islamic Center for Population Studies and Research at Al-Azhar University (IICPSR) and UNICEF worked together to expand and republish a 2005 booklet on FGM. The new book was titled ***Female Circumcision: Between the Incorrect Use of Science and the Misunderstood Doctrine***, and its aim was to refute some of the incorrect information about FGM in relation to biology and religion that had resurfaced and was circulating in Egypt. Its publication was considered 'a first step in a long process to avail this valuable knowledge to Imams and Sheikhs, medical students and physicians, NGOs [sic] activists and media whom each have a role to play to end this practice.'²⁴

The book considers that previous declarations by Muslim jurists that FGM is *makramah* (a 'virtuous deed') were based on the knowledge and understanding available to them at that time, which has since been proven incorrect and should therefore be discounted;

regardless, the use of 'makramah' means that FGM was never declared a religious duty (*wajib*) or a Prophet-recommended practice (*Sunnah*).

The book also notes that FGM cannot be considered a beautification process, since humans were created 'in the best stature' as they are²⁵, and that 'Islam forbids inflicting harm upon health'; therefore, FGM 'must be prevented on the grounds of its harm.'²⁶

Finally, the book calls for partnership among 'many influencing groups' to end FGM in Egypt, for religious scholars to educate themselves about FGM before giving their opinion, for physicians to talk about the risks to anybody who asks them to perform FGM, for teaching on reproductive health to be introduced in schools, for the media to 'shed light on the true and negative facts about FGM/C, through citing opinions of Muslim and non-Muslim scholars', and for parents to 'perform their duties properly' towards their children.²⁷



Al Hakim Mosque, Cairo

In 2016 **three landmark publications** were released as part of a collaboration between the International Islamic Centre for Population Studies and Research (*IICPSR*), the Bishopric of Public, Ecumenical and Social Services (*BLESS*) for the Coptic Orthodox Church and UNICEF:

- *The Islamic perspective on protecting children from violence and harmful practices*, prepared by the IICPSR;
- *The Christian perspective on protecting children from violence and harmful practices*, prepared by BLESS; and
- *Peace. Love. Tolerance. Key Messages from Islam and Christianity on protecting children from violence and harmful practices*, a joint document.

The documents are reviews of religious texts by senior Egyptian leaders of Islam and Christianity in relation to violence and harmful practices that affect children.

Regarding FGM, the joint document notes:

the Quran is empty of any text that mentions FGM/C, even remotely. Calling it 'Sunnah circumcision' is merely a deception to give it a degree of holiness and deceive people that the practice comes from Islam. . . . Also, there is not one authentic proof in a hadith from which could be derived a Sharia ruling in a matter as dangerous to human life as this one.²⁸

and:

This harmful practice has absolutely no basis in Christianity and there is not a single verse in the Old and New Testaments of the Holy Bible that refers to FGM/C.²⁹

and concludes:

Both Christianity and Islam honour women and girls. Both religions agree that God has created humans in the best form and the sanctity of the human body must always be protected from harm.

On these grounds, there is religious consensus that FGM/C is a detrimental social and cultural practice, which has no relation or justification in religion, either Christianity or Islam. Hence, abandoning this harmful practice is a religious and moral duty.³⁰

The IICPSR has also set up **training programmes** for Muslim religious leaders, encouraging them to include teaching on FGM in their Friday prayers.³¹ This is vital for dispersing the message to communities, especially considering the high rates of illiteracy among Egypt's older citizens and the recent drop in the amount of information on FGM being received through the media. It is also important that these messages reach medical professionals and trainees – as several people with knowledge of the subject have noted³², for some medics, the word of the clerics supersedes anything they are taught in medical school.

*Global Voices*³³ reports the experience of two sisters living in a small village in the Minya governorate. The sisters stood up to their mother and grandmother, who wanted one sister's daughter to undergo FGM, but they were at a loss how to convince the older women that FGM was not necessary, until they heard of the visit to their village of a well-respected Muslim scholar. His visit was organised by an NGO as part of an FGM-awareness campaign.

'We took our mother and grandmother to attend the awareness campaign and they were convinced,' said Laila Rashad, the aunt of the girl at risk.

Global Voices notes, 'Al-Azhar scholars and Christian clerics have repeatedly said that FGM is not a religious duty, but rather a centuries-old habit.'

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Education



*Better-educated women
are less likely
to subject their
daughters to FGM*

Quality, universal education is a vital step in the eradication of FGM in Egypt, as it is everywhere, and a good level of literacy in the population makes the anti-FGM message easier to spread.

Under Article 19 of the 2014 Constitution¹, **basic education** is free and compulsory for all Egyptian citizens for the first nine years. Articles 19 and 21 state that government spending to the equivalent of 4% of Gross National Product will be allocated to education, and an additional 2% to university education. Both of these amounts are to be increased gradually to reach international standards. Under Article 20, the available technical, technological and vocational training is also to meet international quality standards, as well as the country's needs for skilled labour. Private and non-profit-making institutions are to be overseen to ensure they comply with the State's educational policies and standards.

The **education system** in Egypt consists of several stages. Children may begin their education at four years of age, in pre-school, but attendance at primary school becomes mandatory at six years of age. Six years of primary school is followed by three years of preparatory school. After grade nine children may continue with either general or technical secondary schooling. While primary and preparatory school are mandatory for all children, secondary school is not.²

The general secondary system prepares students for tertiary education, which is highly competitive and accessible upon the successful completion of school-leaving examinations. Tertiary education is offered in both universities and technical colleges.³

Children may be given either a secular or an Islamic education, and there are broadly four types of private schools: 'ordinary' schools, which simply tend to have better facilities; language schools, which teach in English and add a third language to the curriculum; schools affiliated with a particular religion; and international schools.

Literacy

The UNDP's Human Development Report 2015⁴ records Egypt's **literacy rates** as follows:

Adults aged 15 and over who are literate (2005-2013)	Youths aged 15-24 who are literate		Population aged 25 and older with at least some secondary education
	Female	Male	
73.9%	86.1%	92.4%	52.1%

Table 6: Literacy rates in Egypt⁵

Additionally, the EHIS 2015⁶ recorded the **highest level of education attained** by respondents (all aged 15-59). It found that the median number of years completed by women was 9 and by men was 10.3, and the percentage of those with no education rose with age. For example, 50.5% of women aged 55-59 had received 'no education', compared to only 2.7% of women aged 15-19. This would indicate that literacy has vastly improved over the past few decades. However, an estimated 31% of women and girls in Egypt were illiterate as of 2014, compared to 15.7% of men and boys.⁷

	No education	Some primary completed	Completed primary	Some secondary completed	Completed secondary	More than secondary
Women	22.1%	8.4%	3.4%	22.1%	30.6%	13.4%
Men	8.3%	9.2%	4.7%	24.9%	34.9%	18.0%

Table 7: Percentage distribution of EHIS 2015 respondents' highest level of education attained⁸

Education and the Development Goals

The two **Millennium Development Goals** most pertinent to the campaign to stop FGM were 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

Enrolment and Attendance

During the period 1978 to 2009, enrolment rates in primary school increased from 64% to 96%.⁹

However, UNICEF reports that for the school year 2014/15, the **net enrolment rate** was 91% in **primary school**, and 84% in **preparatory school**.¹⁰

Although children in Egypt currently attend primary and preparatory school at a relatively high rate, as is often the case, attendance declines with age, so that the net enrolment rate for **secondary education** is only 60% and, according to a study conducted by UNICEF and the Ministry of Education¹¹, 3% (some 320,000) of primary-school-aged children never enrol at all, or drop out before the end of the mandatory six years.¹²

Reasons suggested by UNICEF for the non-attendance of Egyptian children include poverty (although attendance at school is free, books and uniforms have to be purchased); the perceived low relevance of education, particularly to families living in rural areas; distance from the nearest school; and social and cultural issues, which mainly affect girls' attendance.¹³

The EHIS 2015¹⁴ confirms that attendance and, consequently, literacy rates are strongly correlated to place of residence and wealth. 28.5% of women and 10.5% of men (aged 15-59) living in rural areas have had 'no education', compared to 10.8% of women and 4.8% of men living in urban areas. 40.5% of women and 15.5% of men in the lowest wealth quintile received 'no education', compared to 5.1% and 2.1% respectively in the highest quintile.



Egypt has made great strides towards achieving gender parity in schools

Gender Parity

Across Egypt nearly a quarter of all women aged 15-59 (22.1%) have not received any education, although the percentage declines in direct correspondence to age (50.5% of women aged 55-59, compared to 2.7% of women aged 15-19), reflecting the progress that Egypt has made in recent years.¹⁵

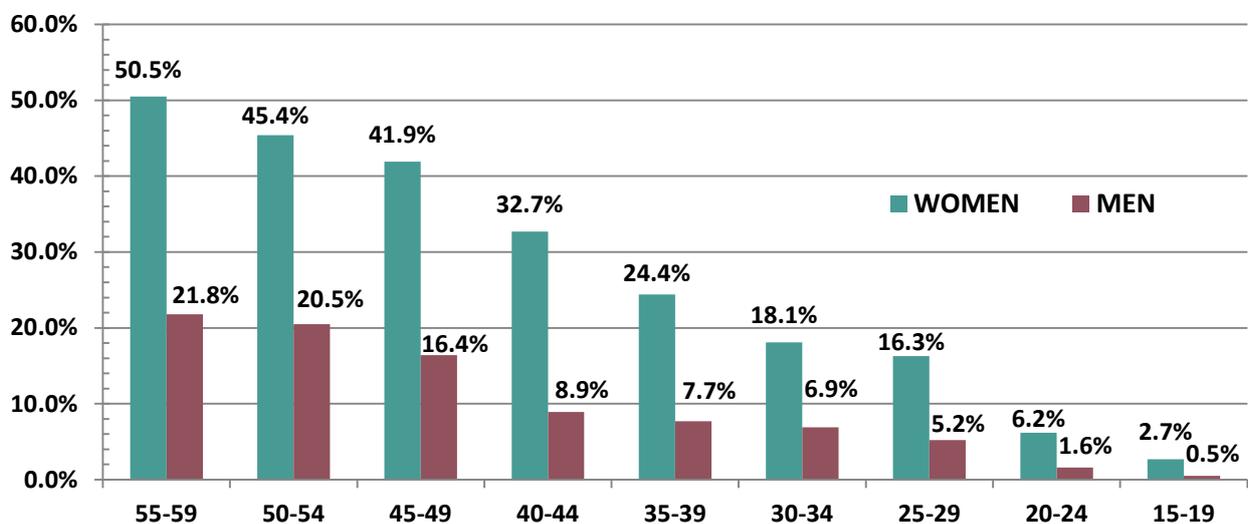


Figure 12: Percentage of men and women who have received 'no education', according to age group¹⁶

It is known that girls from poorer, more rural areas are the demographic that is **least likely to enter primary school**.¹⁷ As mentioned above, the EHIS 2015¹⁸ found that in the rural areas of Egypt as many as 28.5% of women have never received an education.

However, for the 2014/15 school year, **gender imparity** was actually in favour of girls, in some cases:

	Pre-primary	Primary	Preparatory	Secondary	General secondary	Vocational secondary
Males	27.7%	90.0%	80.8%	57.9%		
Females	27.6%	92.2%	87.1%	62.7%		
Total	27.7%	91.1%	83.8%	60.3%		
Gender parity index (net) (1=perfect parity)	1.00	0.99	1.08	1.08	1.26	0.93

Table 8: Net enrolment rates for different levels of education, by gender, and gender parity index (2014/2015 school year)¹⁹

In 2014 the Government published **Education for All 2015 National Review Report: Egypt**²⁰, in which it set out its achievements of 2000-2013 against six goals, three of which make specific reference to girls:

- ‘Ensuring that by 2015 all children, particularly girls, children in difficult circumstances and those belonging to ethnic minorities, have access to and complete, free and compulsory primary education of good quality’;
- ‘Achieving a 50 per cent improvement in levels of adult literacy by 2015, especially for women, and equitable access to basic and continuing education for all adults’; and
- ‘Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls’ full and equal access to and the achievement in basic education of good quality’.

The outcome of this National Review contributed to Egypt’s Vision 2030, its strategy for achieving the Sustainable Development Goals, in which the above three goals are confirmed and expanded.

Towards 2030

The Seventh Pillar of Vision 2030 is Education & Training.²¹ It applies to three strands of education – general, technical and higher – and sets out targets up to 2030, in accordance with the date of termination of the Sustainable Development Goals.

Egypt’s Strategic Vision for Education to 2030
A high quality education and training system should be available to all, without discrimination, within an efficient, just, sustainable, and flexible institutional framework. It should provide the necessary skills to students and trainees to think creatively, and empower them technically and technologically. It should contribute to the development of a proud, creative, responsible, and competitive citizen who accepts diversity and differences, and is proud of his country’s history, and who is eager to build its future and able to compete with regional and international entities.²²

Goal 4 of the new **SDGs** is relevant to FGM in that it relates to education:

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

FGM is a violation of human rights, and progress towards achievement of this target will be supported by the subject's inclusion in school and healthcare-training curricula, building on the work undertaken on this to date.

Education and FGM

Education empowers women and impacts on their ability to make healthy and autonomous reproductive choices. This was the conclusion of a study of Egyptian women's changing attitudes to FGM as reported in the DHS surveys during the period 1995 to 2014. The study found that literate, better-educated and employed women are more likely to oppose FGM.²³ Respondents with the highest level of reported education were 3.12 times more likely to oppose FGM than those who reported having no formal education, and there were similar results in relation to literacy.

The study also noted that, in addition to a knowledge of basic facts, education brings 'modernity . . . the idea that society is makeable and that people control their own fate'²⁴. Modernity gives people permission to 'challenge the traditional views and practices, and helps them look beyond what they are accustomed to.'²⁵

As is the case in many other countries, there is a clear trend in the DHS data whereby the more education a woman has completed, the less likely it is that she has undergone FGM, and the less likely she is to have subjected her daughter to FGM (see Figure 13). These trends are less evident in the EHIS 2015²⁶ data (Figure 14), but this is perhaps due to the small sample sizes of less-educated women, or other factors of which 28 Too Many is unaware.

The UNICEF secondary analysis also concludes that 'the education of the mother is a strong determining factor for a daughter undergoing FGM/C'.²⁷

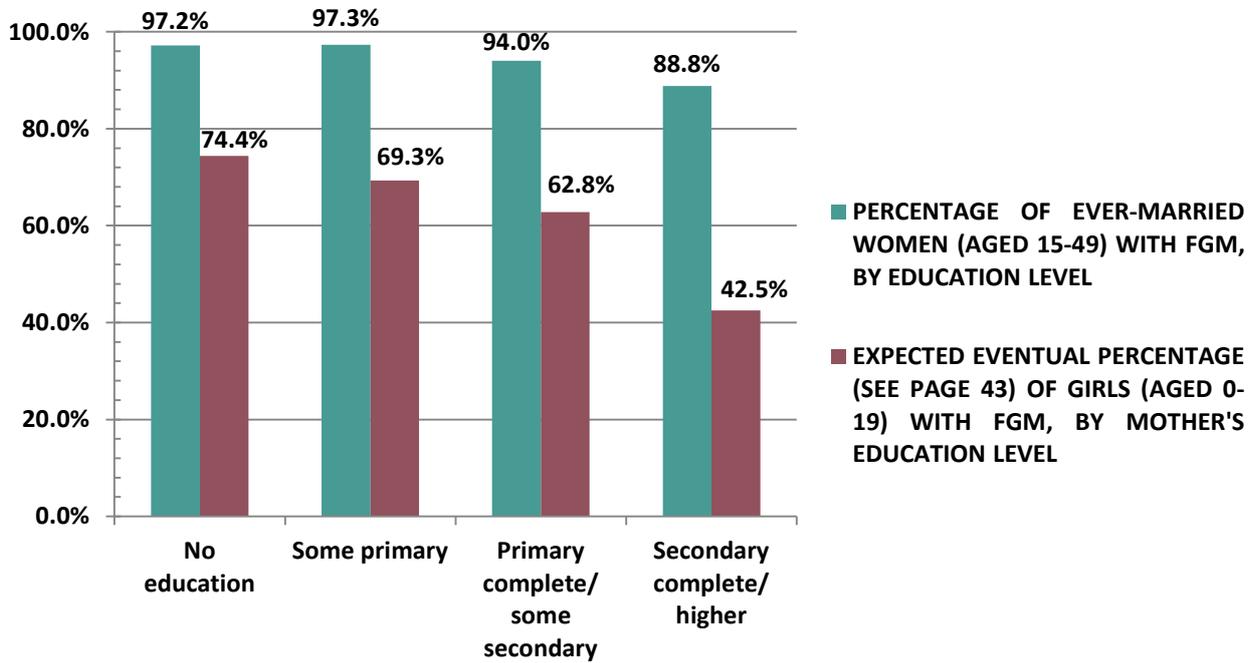


Figure 13: Prevalence of FGM according to education level – DHS 2014²⁸

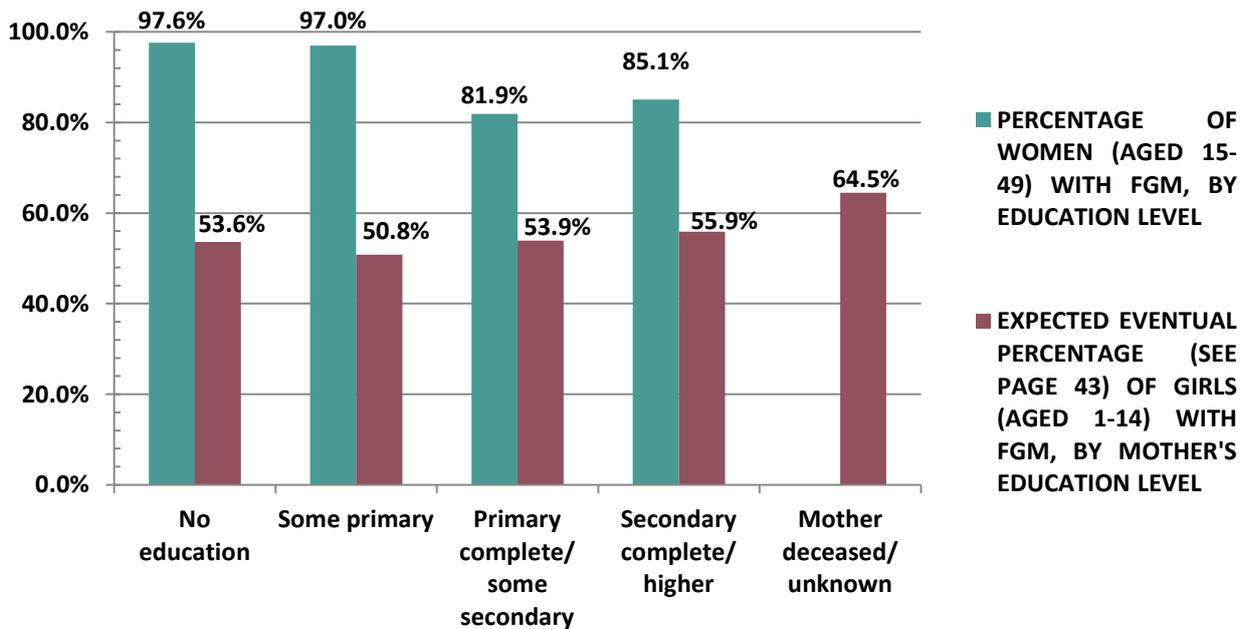


Figure 14: Prevalence of FGM according to education level – EHS 2015²⁹

In all regions the gap in percentage points between the expected eventual percentage for girls whose mothers have had ‘no education’ and those whose mothers have completed secondary level or higher has shrunk since 2005.³⁰ However, in the Urban Governorates, girls whose mothers have had ‘no education’ are still more than twice as likely to undergo FGM than girls whose mothers have completed secondary level or higher, as can be seen in Table 9 below.

	Urban Governorates (%)	Lower Egypt (%)	Upper Egypt (%)	Total (%)
No education	50.1	66.6	80.8	74.4
Some primary	48.3	65.6	74.8	69.3
Primary complete/some secondary	40.7	58.6	72.7	62.8
Secondary complete/higher	21.8	41.5	52.7	42.5

Table 9: Expected eventual percentage of girls aged 0-17, according to level of mother’s education and area of residence (2014)³¹

KEEPING GIRLS IN SCHOOL

Think and Do³², a Christian development organisation founded in 1995, identifies girls who have dropped out of school or young women who are most in need of support, particularly in the villages of Upper Egypt, and offers classes that include literacy, vocational training and awareness-raising sessions around issues such as FGM. The consequences of FGM are discussed with doctors, and participants are taught that it is against the law in Egypt and an act of abuse. Think and Do reports that, after attending these sessions and with follow-up home visits to provide ongoing support, participants take the messages and go on to raise awareness in their communities.

The importance of education and keeping girls in school was also a key part of a project focused on FGM and child marriage undertaken jointly by the Better Life Association for Comprehensive Development and Diakonia in poor rural villages of Minia between 2012 and 2014. Through community education, workshops and home visits, awareness of FGM and the need for girls to finish their education was successfully raised in the 11 targeted communities.³³

The importance of education to the eradication of FGM is also demonstrated in the links between the lack of sexual education in Egypt and the misunderstandings about sex and FGM that contribute to FGM’s continuation (see page 54).

Education is also critical to ensure that medical practitioners are unwilling to perform FGM, law enforcement and justice agents are willing and able to identify, prosecute and convict those who are responsible for it, and parents are equipped to resist social pressures to perform it on their daughters.

NGOS COALITION AGAINST FGM/C³⁴



The Kamla campaign is active on social media, using messages such as 'If you love her, don't circumcise her.'

Since it started in 2009, the NGOs Coalition against FGM/C has brought together an expert network of 120 organisations from different sectors across Egypt. It advocates for an end to FGM through its Kamla campaign*. The Kamla campaign was launched in 2011 across 11 governorates**, with support from the UNFPA, and focuses on raising awareness and supporting children and families, although it has also trained numerous doctors through the Doctors Against FGM/C programme. The Coalition receives funding from the Wallace Global Fund and promotes its activities widely through social media.

An important component of its work is the community programmes that are held in schools to educate on sexual and reproductive health, including the harms of FGM and the relevant laws in Egypt. The contents of these seminars are tailored to the community and conducted by Coalition experts. This work gives schoolchildren the opportunity to learn about FGM and opens the dialogue in families and the wider community. This has been successfully achieved with the help of partners such as Noon Creative Enterprise, which brings interactive theatre into the schools. In 2014, for instance, 61 seminars were held across eight school catchment areas, including activities for schoolgirls in Assiut, Ismailiya and Menya (awareness-raising of the harms of FGM and myths surrounding the practice, with the support of theatrical performances and painting competitions). The Coalition has also developed a number of youth programmes that address reproductive health issues, FGM and child marriage (for example, in Portsaid in April 2016).

Coalition partners also identify girls (usually aged 9-12) who are most in need of help, including those at risk of FGM, and provide financial assistance towards their schooling (for example, for fees, uniforms and equipment). 136 girls have benefited from this scheme so far.

* Kamla means 'perfection' in Arabic and is used to emphasise that girls are born complete and perfect, and do not need to be cut.

** Assiut, Cairo, Giza, Portsaid, Ismailiya, Luxor, Menofya, Menya, Qena, Qualiobya and Sohag.

- 1 *Constitution of The Arab Republic of Egypt 2014* (unofficial translation). Available at <http://www.sis.gov.eg/Newvr/Dustor-en001.pdf>.
- 2 DHS 2014, p.24.
- 3 Organization for Economic Cooperation and Development (OECD) and International Bank for Reconstruction and Development (IBRD)/The World Bank (2010) *Executive Summary: Higher Education in Egypt*, p.19. Available at: <https://www.oecd.org/education/skills-beyond-school/44820471.pdf>.
- 4 United Nations Development Programme (2015) *Human Development Report 2015*, p.243. New York: United Nations Development Programme. Available at http://hdr.undp.org/sites/default/files/2015_human_development_report.pdf.
- 5 *Ibid.*
- 6 EHS 2015, pp.14-15.
- 7 Ministry of Planning, Monitoring and Administrative Reform (2016) 'Reports', *Sustainable Development Strategy: Egypt's Vision 2030*, p.145. Cairo, Egypt: Ministry of Planning, Monitoring and Administrative Reform. Available at <http://sdsegypt2030.com/category/reports-en/?lang=en>.
- 8 EHS 2015, pp.14-15.
- 9 Ragui Assaas and Caroline Krafft (2015) 'Is free basic education in Egypt a reality or a myth?', *International Journal of Education Development* 45, p.18.
- 10 UNICEF (undated) *Egypt/Education*. Available at <https://www.unicef.org/egypt/education.html>.
- 11 UNICEF (2015) *Children in Egypt: a statistical digest*, p.35. Cairo: UNICEF Egypt. Available at https://www.unicef.org/egypt/eg_Education_2015.pdf.
- 12 UNICEF (undated), *op. cit.*.
- 13 *Ibid.*
- 14 EHS 2015, pp.14-15.
- 15 EHS 2015, pp.14-15.
- 16 EHS 2015, pp.14-15.
- 17 Ragui Assaas and Caroline Krafft, *op. cit.*.
- 18 EHS 2015, p.14.
- 19 UNICEF (2015) *op. cit.*, pp.14 & 31.
- 20 National Centre for Education Research and Development (2014) *Education for All 2015 National Review Report: Egypt*. Available at <http://unesdoc.unesco.org/images/0022/002299/229905E.pdf>.
- 21 Ministry of Planning, Monitoring and Administrative Reform, *op. cit.*, pp.171-216.
- 22 *Ibid.*, pp.172.
- 23 Ronan Van Rossem, Dominique Meekers and Anastasia J. Gage (2015) 'Women's position and attitudes towards female genital mutilation in Egypt: A secondary analysis of the Egypt demographic and health surveys, 1995-2014', *BMC Public Health*, 15(874), p.3. Available at <http://bmcpublihealth.biomedcentral.com/articles/10.1186/s12889-015-2203-6>.
- 24 *Ibid.*, p.11.
- 25 *Ibid.*.
- 26 EHS 2015, pp.104 & 109.
- 27 Dr Fatma El-Zanaty, UNICEF (2015) *Factors and determinants of FGM/C of girls aged 0-17 years: a secondary analysis of the Egypt Demographic and Health Surveys, 2005, 2008 and 2014*, p.4. Available at https://www.unicef.org/egypt/FGM_Secondary_analysis_edited_5-08-2016_FINAL.pdf.
- 28 DHS 2014, pp.186 & 189.
- 29 EHS 2015, pp.104 & 109.
- 30 *Ibid.*
- 31 *Ibid.*, pp.21-23.
- 32 - Think and Do (2017) *Who We Are*. Available at <http://www.thinkanddo.org/index.php/2015-11-11-16-31-36>.
- Think and Do (2017) *Correspondence with 28 Too Many*.
- 33 Dr. Rafeek R Farag, BALCD Foundation (2014) *Final Evaluation Report: Women & Girls Empowerment And Abandonment of Harmful Traditional Practices against Girls*.
- 34 - NGOs Coalition Against FGM/C (2017) *Correspondence with 28 Too Many*.
- NGOs Coalition Against FGM/C (2017) *The Coalition Against FGM*. Available at <http://www.banatkamla.net/english/the-coalition-against-fgm.html>.
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- Image p.70:* USAID Egypt (2014) *Early Grade Reading*. Available at <https://flic.kr/p/AcF4FP>.
CCL: <https://creativecommons.org/licenses/by-nc/2.0/>.
- Image p.72:* USAID Egypt (2014) *Remedial Reading Programme*. Available at <https://flic.kr/p/FjhBfE>. CCL: <https://creativecommons.org/licenses/by-nc/2.0/>.
- Image p.77:* © NGOs Coalition against FGM/C, 2016. Anti-FGM campaign advertisement.

Healthcare

Egypt's health service is provided by a mix of government, parastatal and private suppliers. The MOHP is the major **provider** of service delivery, with 66,440 beds and 3,645 facilities. Other government departments have additional facilities, such as those managed for the police and prison services. There are also 36 university hospitals and 14 Faculties of Medicine. These are run by the Ministry of Education and are considered to be superior in terms of technology and medical expertise. Cairo University's hospital is regarded as the most modern and advanced in this group.¹

The **parastatal sector** comprises organisations established by the MOHP to carry out specific functions, notably teaching hospitals, health insurance and curative care.²

The **private sector** manages approximately 16% of in-patient beds. Private-sector provision includes traditional healers, midwives, private doctors, hospitals and pharmacies. It also includes NGOs and other charitable facilities that are registered with the Ministry of Social Affairs. Many physicians employed in the public sector supplement their salary by also working in private facilities. A survey carried out in 1999 showed that 89% of physicians had multiple jobs.³ Private hospitals in Egypt have a high occupancy rate, at 95%, in contrast to public hospitals, at 49%.⁴ Those who can afford it choose private healthcare for their primary healthcare needs, including maternity care.⁵ One patient said, 'A woman will do everything she can to avoid giving birth in a public hospital'.⁶

The 2014 Constitution set **government spending** in the health sector at 3% of the GDP, yet the WHO found that, for 2014-2015, the actual figure allocated was only 1.7%.⁷ The consequence of this is that health services suffer from a lack of staff and medications, overcrowding, and poorly maintained equipment and facilities.

In order to address some of the concerns in the healthcare system, in 2015 the Egyptian Government worked together with The World Bank to produce *A Roadmap to Achieve Social Justice in Health Care in Egypt*⁸. This report aimed to assist in identifying inequality in health status, and a World Bank loan led to the start of **improvements** to primary healthcare in 1,000 of the poorest villages in Upper Egypt. In addition, in 2015 the Egyptian Government increased its health-sector budget, with the aim of reaching the proposed 3% of the GDP by 2017.⁹ The increase is to establish the Programme for Healthcare for the Poor, which is aimed at subsidising healthcare for people covered by the Social Pension Assistance Program, and has started with those living in Upper Egypt.¹⁰

Currently, only 52% of the population is covered by the existing **health insurance** system, but a proposed health insurance bill would see the establishment of a social health insurance system paid into on a monthly basis by all citizens.¹¹ The health insurance bill aims to reduce out-of-pocket health expenditure, which in 2014 was estimated at 55.66% of the total health expenditure¹² (although another report puts this figure as high as 72%¹³), to 40% by 2020 and 28% by 2030¹⁴.

Women's Health

Barriers To Care

A series of focus groups conducted in 2015 identified that cost is a major barrier to women accessing healthcare, with hidden costs, even in free public hospitals, often leaving families in debt.¹⁵

Additionally, the DHS 2014¹⁶ identified that **common barriers** to accessing healthcare for ever-married women aged 15-49 are 'concern no drugs available' (54.0%), 'concern no health provider available' (47.5%), 'not wanting to go alone' (31.3%) and 'concern no female provider available' (28.9%). 68.1% of women surveyed identified at least one serious barrier to accessing healthcare. Girls aged 15-19 are the most likely age-group to cite each of these common barriers.

Reproductive Healthcare

Contraceptive and family-planning resources are accessible in most areas of Egypt. 58.5% of Egyptian, ever-married women use a form of contraception, according to the DHS 2014.¹⁷ Of these women about half use an IUD, 16% use the pill and 8.5% use injectables. The difference in usage of contraception between women living in rural and urban areas is small. The survey found that almost all women think it inappropriate to use family-planning methods before the birth of their first child.¹⁸

Of ever-married women aged 15-49 who had a live birth in the five years prior to the DHS 2014 survey, 90.3% received some form of **antenatal care** from a skilled provider, and 82.8% received regular care (at least four visits during the pregnancy).¹⁹ Figure 15 below shows a comparison between the care received by women with different levels of education and in different wealth quintiles.

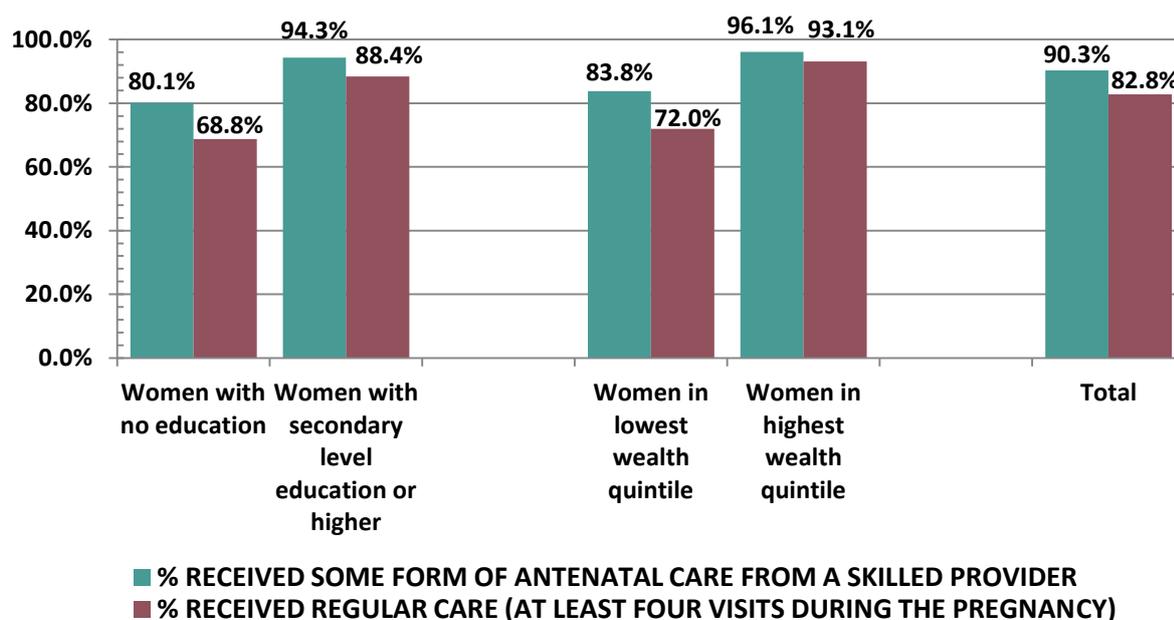


Figure 15: Of ever-married women aged 15-49 who had a live birth in the five years prior to the DHS 2014 survey, percentages who received different levels of care, according to levels of wealth and education²⁰

For the same demographic (ever-married women aged 15-49 who had a live birth in the five years prior to the DHS 2014 survey), antenatal care was provided by a doctor in 90% of cases and by a midwife in only 35.8%²¹, which may be a reflection of the shortage of nurses and midwives in Egypt. This shortage is due in part to the low wages paid to nurses in public hospitals, but also the social stigma attached to the profession of nursing in Egypt, where, according to one doctor and researcher, 'They are often seen as second-class citizens, who provide services similar to a maid or cleaner.'²²



*There is a shortage
of nurses and
midwives in Egypt*

The majority of this demographic of women (86.7%) gave birth in a health facility, with 61.1% of these being private health facilities. The highest percentage of **home births** was in rural Upper Egypt (23.9%). 24.7% of the women in the lowest wealth quintile had home births, compared to only 2.3% of those in the highest wealth quintile.²³

43.8% of ever-married women aged 15-49 who have given birth have had at least one **Caesarean delivery**.²⁴ The incidence of Caesarean deliveries in Egypt has increased rapidly over the past decade, and is now seen as the norm²⁵ – Egypt now has the highest rate in Africa and one of the highest in the world.²⁶ 28 Too Many has been unable to find clear reasons why this is so.

Although the **fertility rate** in Egypt has been declining since the 1970s, since 2008 there has been an increase, from 3.0 children per woman in 2008²⁷ to 3.5 in 2014²⁸. The reasons for this are unclear.

26.1% of ever-married women aged 25-49 had their first child by the age of 20, and 45% had had their first by the age of 22. The median **age for the first birth** is 22.6, and this rises in accordance with levels of both wealth and education.²⁹

Figures on **teenage pregnancy** show a worrying upward trend from 9.4% in 2005 to 10.9% in 2014, with teenagers in rural areas almost three times as likely to have begun childbearing than those in urban areas.³⁰

Health and The Development Goals

Despite fears that Egypt would not achieve the **MDGs**, it was actually the first African country to achieve 79% of them.³¹

Egypt achieved **Goal 4: Reduce Child Mortality**, reducing the under-five mortality rate by more than half. Egypt also made good progress towards reducing maternal mortality (**Goal 5: Improve Maternal Health**), but failed to fully meet the goal.³²

Goal 4: Reduce Child Mortality

Over the period 1995-2014, the **under-five mortality rate** fell from 81 deaths per 1,000 live births to 27³³ (although the UNDP reports a figure of 21.8 deaths per 1,000 live births in 2013³⁴). However, these figures conceal regional differences, with Upper Egypt and rural areas having higher rates of 38 and 34 deaths.³⁵ Nevertheless, Egypt met the 2015 target of 44 deaths per 1,000 live births.

Over the same period, the **infant mortality rate** fell from 60 deaths per 1,000 live births to 22 deaths per 1,000 live births in 2014.³⁶ The UNDP reported the 2013 rate as 18.6 deaths per 1,000 live births.³⁷ This indicates that Egypt likely met the 2015 target of 21 deaths per 1,000 live births.

The DHS 2014³⁸ indicates that the age of the mother is a key factor in early childhood mortality rates, with the highest rates of death being in children born to mothers who were under 20 at the time of the birth. The mortality rate is also much higher where the interval after a previous birth is less than two years.

Goal 5: Improve Maternal Health

Egypt has made significant improvements in maternal healthcare in recent years. The maternal mortality ratio dropped from 174 deaths per 100,000 live births in 1992³⁹ to 43.5 deaths per 100,000 live births in 2014⁴⁰, which was the MDG target. However, other sources have reported higher figures⁴¹, and regional variations show that there are still many problems to address, particularly in rural Upper Egypt.

Studies undertaken have identified that poor quality health services and equipment, a lack of suitably trained staff, poor health behaviours, and women's failure to seek timely medical advice are hindering progress in healthcare, particularly in areas of high poverty and deprivation.⁴²

Addressing maternal mortality is a priority for **the MOHP** and there have been several initiatives in recent years. From 1993-2009 the MOHP implemented a number of programmes through the Healthy Mother/Healthy Child Project, to reduce risk factors of maternal and neonatal mortality, including improving obstetric and emergency-care skills, and midwife and nurse training. Other programmes include:

- National Child Survival Project (1990-1996);
- Mother Care (1996-1998); and
- National Maternal and Child Health Acceleration Plan (2013-2015), supported by international donors, the WHO, UNICEF and the UNFPA.⁴³

UNICEF has worked since 1996 with the MOHP to implement schemes aimed at reducing maternal and neonatal mortality, including immunisation programmes, the Baby Friendly Hospital Initiative, polio and tetanus programmes, and neonatal- and child-illness management. The current UNICEF programme in Egypt focuses on reducing neonatal mortality and improving nutrition by increasing access to, and quality of, maternal and child health services, and is built on the basis of an existing UNICEF/MOHP scheme that has run in Upper Egypt since 2008. This Child Survival and Development programme has three components: child and maternal health, nutrition and WASH (water, sanitation and hygiene).⁴⁴

In addition, a **joint project** of the MOHP, USAID, Save the Children, Jhpiego, ICF and other partners identified strengths, weaknesses and opportunities in Egypt's Raedat Rifiat (community health worker) programme as part of USAID's Improving Maternal, Child Health and Nutrition Services project.⁴⁵



USAID partners with the MOHP and others in a joint project as part of its Improving Maternal, Child Health and Nutrition Services project

Goal 6: Combat HIV/AIDs, Malaria and Other Diseases

Unlike in other African countries, the prevalence of **HIV** in Egypt is considered low compared to the global average, and the MOHP has various programmes in place to continue to prevent transmission.⁴⁶ The targets for **malaria** and **tuberculosis** had already been met by Egypt.⁴⁷

2015-2030 – Challenges and Opportunities

The MDGs have now been replaced by the **SDGs**, which have a deadline for achievement of 2030. Please see our **Global Goals** document for a summary of all 17 SDGs.

In addition to **Goal 5.3 (Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation)**, which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

Goal 3 (Ensure healthy lives and promote wellbeing for all at all ages) aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Vision 2030 was developed to implement the SDGs. It recognises the major factors relevant to improving healthcare in Egypt and sets out clear guidelines and targets for what should be achieved by 2030. The strategy and a working plan for 2016/2017 were approved by parliament in 2016⁴⁸ and seek to address current weaknesses in the healthcare system such as health insurance coverage, shortage of qualified staff, lack of a referral system between service levels, lack of public awareness of health and nutrition, and failings in information and data systems.⁴⁹

Hygiene is also a major concern and is seen as contributing to Egypt's high prevalence of Hepatitis C, which affects 14.7% of the population⁵⁰. The spread of Hepatitis C is also linked to 'inappropriate community practices, such as folk medicine and female genital mutilation (FGM).'⁵¹



Healthcare and FGM

Obstetric fistula is a condition caused by prolonged obstructed labour, which results in a hole between the vagina and the rectum or bladder.⁵² Although FGM does not directly cause obstetric fistula, it can lead to complications in labour that in turn lead to obstetric fistula.

Obstetric fistula is common in Africa, accounting for the majority of the estimated 200 million women who are affected globally, and it is usually the result of poor maternal care or giving birth at a young age.

However, cases in Egypt are rare and, when they do occur, they are most likely to be the result of a surgical or gynaecological error. Obstetric fistula is easily treated with surgery, but because it is not common in Egypt, sufferers often spend months trying to access appropriate treatment, with specialised facilities only available at training hospitals.⁵³

For more on the healthcare system and FGM, and medicalised FGM (an enormous issue in Egypt), please refer to the following section, Practitioners and Medicalisation.

TRAINING COMMUNITIES – BLESS AND CEOSS

Organisations based within the Coptic church have been working to end FGM across Egypt for many decades. Their primary approach is to cooperate closely with others working in communities to gain trust and raise awareness of the harms of FGM, particularly in terms of its impact on health. Two examples are as follows:

Bishopric of Public, Ecumenical and Social Services (BLESS)

BLESS has been working on the anti-FGM issue in Egypt since the early 1960s. Health education, particularly women's reproductive health, is an essential element of its community projects and it stresses the importance of working with the whole family. It identifies villages where girls are particularly at risk of FGM, and builds up trust within the local community before offering seminars and public meetings. It invites doctors to these events and offers classes to groups of 20 women and girls at a time, which focus on reproductive health. BLESS aims to reach over 60 communities with its Comprehensive Integrated Development programme. It is currently running a three-year project (2016-2019), for instance, with funding from the Norwegian Embassy, entitled Improving Women's Reproductive Health and Combating FGM. The programme is taking place in 20 communities across Greater Cairo and the El-Menia and Assiut governorates. Classes are held for different target groups, including postnatal classes for women, general health awareness for children, and family-health education for youth before marriage. BLESS also works nationally within various networks and, as a member of the NGOs Coalition against FGM/C, it has also organised seminars for both nurses and teachers to discuss the law.

Coptic Evangelical Organization for Social Services (CEOSS)

CEOSS has also been working to end FGM in Egypt since the 1960s and, in a similar approach to BLESS, seeks to cooperate with CBOs that are already established within villages, slowly building up trust and advocating for an end to the practice. It works alongside all faiths, and has included both local male cutters and *dayas* (traditional birth attendants) in education programmes and final declarations to stop performing FGM. It has also helped practitioners find alternative incomes. CEOSS has worked in partnership with the NCCM to bring health education to all ages, including establishing small groups in schools to raise awareness and inform children of their rights.

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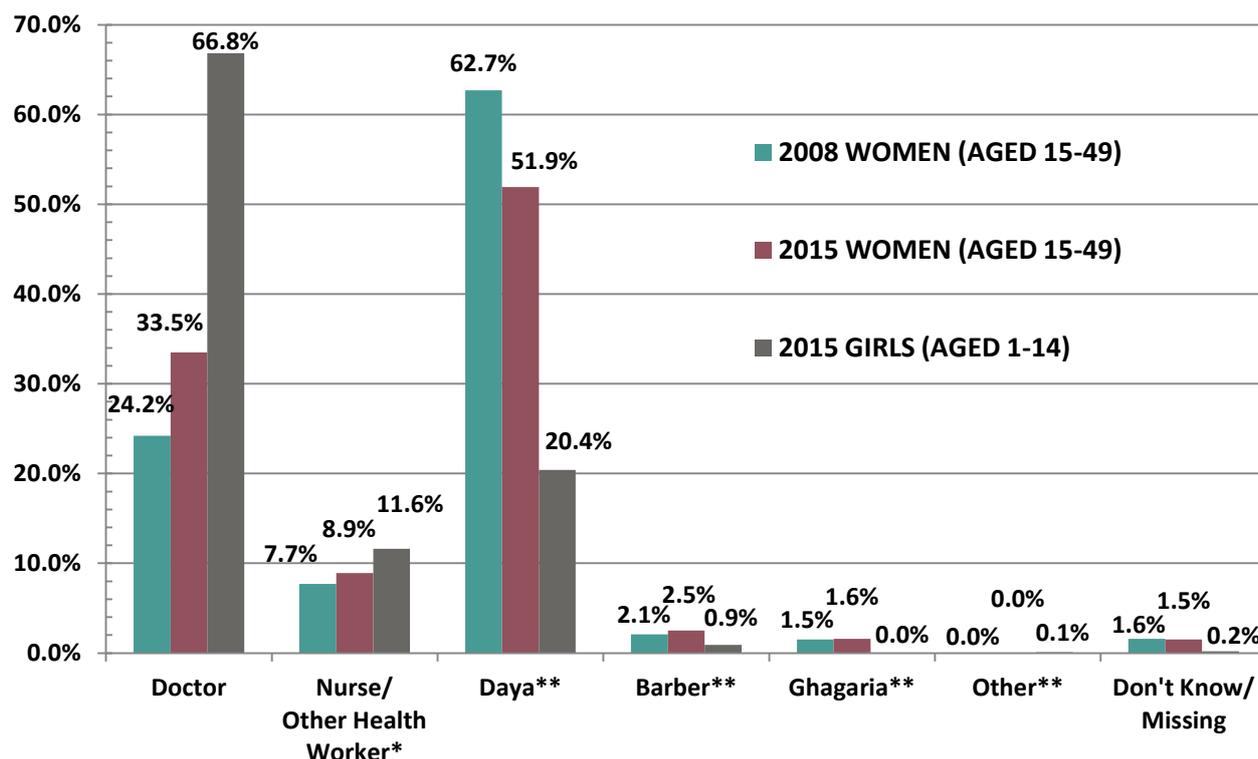
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Practitioners and Medicalisation

FGM Practitioners

Since at least 2008, there has been a shift in Egypt away from traditional practitioners and towards health professionals performing FGM.

This is particularly evident in Figure 16 below.



* 'Other Health Worker' includes midwives

** These are all classed by UNICEF as 'Traditional Practitioners'¹

Figure 16: Percentage distribution of women who have had FGM and girls who are reported to have had FGM, according to the type of practitioner who performed it²

Currently, the **use of health professionals** to perform FGM is more frequent in urban areas (78.3% of girls and women aged 0-19 who have been cut) than in rural areas (72.7%), and is therefore more common in the Urban Governorates and Lower Egypt than it is in Upper Egypt.³ This is perhaps because easy access to health professionals and the funds to pay them is more common for families living in urban areas.

No data is available in the EHIS 2015 about **where FGM is performed**, whether in a hospital or other medical facility, at home, or in the practitioner's home. A survey of young people carried out by the Population Council in 2014⁴ found, however, that nearly two-thirds (64.5%) of female respondents aged 13-35 who have been cut underwent FGM either at home or at another house, and that this was more common in rural areas (69.5%) than in urban areas (58.8%) and informal urban areas (52.3%). There was a wide disparity in the frequency of use of medical facilities, with 11.5% of female respondents living in urban

areas having undergone FGM in a private hospital, compared to 2.7% of those living in rural areas and 1% of those living in informal urban areas.

28 Too Many's research has revealed an understanding in certain sectors that FGM is no longer **performed openly in medical facilities**. However, it is worth noting that the 2013 death of Soheir al-Batea as a result of FGM took place in a private clinic⁵, and the 2016 death of Mayar Mohammed Mousa as a result of FGM took place in a public hospital⁶.

From the above analysis, it would seem that health professionals continue to be the **main practitioners of FGM**, regardless of recent prosecutions of doctors for performing FGM and a strengthening of the laws against it.

Medicalisation

The shift towards health professionals performing FGM, known as **the medicalisation of FGM**, is a particularly important issue in Egypt as, currently, 78.4% of incidences of FGM are medicalised.

The focus placed historically by activists on the negative effects of FGM on women's physical health, without giving equal weight to FGM as a violation of a woman's rights, or to the negative psychological and social effects it may cause, is widely considered to have contributed to the increase in medicalisation in Egypt. Anecdotal evidence from NGOs suggests that, as awareness of the health risks became more widespread, families chose to go to doctors instead of traditional practitioners. There was also a perception that doctors, as professionals, had more 'power' in society than the traditional midwife, and thus would be less likely to be punished for performing FGM. This idea was reinforced when, in 1994, the health minister allowed FGM in public hospitals one day a week, in an attempt to protect girls from the risks. At the time he made the argument that health workers would try to persuade parents that FGM was unnecessary.⁷ Subsequent studies showed that this was not the case⁸, and one study as recent as 2016 noted that 'physicians are not discouraging the practice, giving legitimacy to a procedure that has serious medical risks.'⁹

While there is currently no **law** specifying that the performance of FGM is medical malpractice (a draft law is under consideration), the health minister in 1996 passed a decree against FGM being performed in government hospitals and private clinics. In June 2007 the MOHP also adopted decree no. 271, which closed a former loophole whereby non-government medical practitioners could perform FGM in a private home.¹⁰

FGM was outlawed in Egypt in 2008, and medical professionals are now required to report any cases of FGM that they come across. Nevertheless, medical professionals have an **economic incentive** to continue performing FGM, especially those in rural areas. Barsoum *et al*¹¹ observe, for instance, in their interim report on the progress of Egypt's national FGM-Free Village Model that,

Doctors, as part of the community, are subject to the pervasive social pressures to circumcise girls. Their medical training fails to offset the influence of these traditional views. Moreover, doctors require the acceptance of their communities and of families in order to provide their services and generate income for their private clinics. Many do not want to sacrifice their reputations by opposing a traditional and widely sanctioned practice. If they refuse to perform the

procedure, their loss of income would affect not only their fee but also might cause entire families to seek the services of another doctor.

*Newsweek*¹² reports:

Doctors can earn up to \$26 for one, much more than the \$2.60 they can charge for a regular doctor's visit (although still significantly less than they can make for other specialty procedures – Lasik eye surgery, for example, costs about \$655). Advocates say that in recent years doctors have begun making clandestine visits to villages, arriving at night and often under the guise of circumcising boys.

Knowledge of FGM Among Healthcare Professionals

Of great concern is the apparent **lack of knowledge among medical professionals** about the functions of female genitalia, and about FGM itself.

Activist and performing-arts troupe manager Nada Sabet says about medicalised FGM,

[T]here's this idea that it's cleaner[;] there's anaesthesia. But the truth is there is no medical procedure for FGM, so doctors improvise. We had a performance with Doctors Without Borders, and three of the doctors got in an argument because doctors don't agree on what it is and what is removed and why. They were disagreeing on what the procedure is and what the effects of the procedure are based on what is removed.¹³

A study¹⁴ carried out in 2013 on 600 **student** members of the International Federation of Medical Students – Egypt (representing nineteen medical schools across the country) found that only 30.5% had a good level of knowledge about the health consequences of FGM. Female participants displayed a good level of knowledge almost twice as often as male students. (Just over half – 53.3% – of the participants in the study were female, and, of these, 14.7% had undergone FGM. The majority of those were from rural areas.)

Only 33.3% of the students knew that FGM could cause difficulty with urination, and 37.5% were aware of FGM resulting in complications during childbirth. However, 78.2% responded correctly to a question about how FGM predisposes girls and women to infection and 69% knew that it increases susceptibility to HIV transmission, if the same instruments are used on several girls.

Just under half of the students (49.5%) were aware that FGM is an illegal act.

The study concluded that 'medical students in Egypt – the future leaders of programs to support the discontinuation of FGM/C in their region – have a low level of knowledge about this practice' and recommended, 'These young advocates of health should be the target group to start with . . .'

A further study, published in 2011, reviewed the effects of the criminalisation of FGM on the incidence of the practice.¹⁵ Parents, nurses and both junior and senior physicians were surveyed.

Parents who had had their daughters undergo medicalised FGM gave several reasons for practising FGM: religious beliefs (44.2%), tradition (36.5%) and the necessity to preserve the girl's chastity (19.3%). None believed that FGM was dangerous in any way.

Most surprising to the researchers was that, of the parents who had *not* had their daughter undergo FGM, only 6.4% believed that it was dangerous, despite having received information to that effect.

None of the nurses surveyed had performed FGM. However, 33.8% had no information about its risks, almost half said that they would subject their daughters to FGM and 88.2% were in favour of continuing the practice out of respect for tradition.

34.3% of the young physicians and 14.9% of the senior physicians 'defended the practice'; 40.4% and 64.8% respectively did not. The remainder gave no opinion. Of those who defended FGM, 97.4% of the young physicians and 100% of the senior physicians thought that it was required by religion.

These figures indicate a severe lack of education about the realities of FGM for younger physicians and a need for a component of religious teaching in relation to FGM to be included in any education programmes initiated for medical professionals.

MEDICALISATION IS...



...A THREAT TO THE HEALTH & WELLBEING OF WOMEN & GIRLS



...A HUMAN RIGHTS VIOLATION



...A BREACH OF PROFESSIONAL ETHICS



...ABSENT OF INFORMED CONSENT



...A FORM OF CHILD ABUSE

28 TOOMANY

“FGM changes lives. It changed mine when I was six years old and causes lifelong pain and difficulty whether or not it is medicalised. We must end all FGM.”

Hibo Wardere
Author and FGM Survivor

“It has been recognized that stopping the medicalization of FGM is an essential component of the holistic, human-rights-based approach towards the elimination of the practice: when communities see that health-care providers have taken a stand in favour of the abandonment of the procedure and have refrained from performing it, this will foster local debate & questioning of the practice.”

World Health Organisation (2016)

FGM

END IT. DON'T MEDICALISE IT

UNDERSTANDING MEDICALISATION

Providing access to medical equipment or training



Healthcare providers performing FGM on girls or women



Girls or women having FGM performed in a healthcare facility



Replacing severe forms of FGM with more symbolic types of cutting



Transporting girls to health facilities overseas



Procedures to re-establish FGM after women have given birth (known as reinfibulation)



TO READ THE FULL REPORT ON THE MEDICALISATION OF FGM VISIT WWW.28TOOMANY.ORG

28 Too Many has produced information on the medicalisation of FGM, including a full report and information leaflets, which are available at www.28toomany.org.

Education, Training and Guidelines for Healthcare Professionals

'This is not just about the submission of women, but also about the overall ignorance about sexology – and I am not really excluding the schools of medicine here.'

~ Hussein Gohar, Gynaecologist¹⁶

The education of healthcare workers on the subject of FGM is vital to moving towards abandonment: as social norms regarding FGM begin to change in response to advocacy, about a third of Egyptian women are consulting a doctor before deciding whether to subject their daughters to it¹⁷, and many women still report receiving ambiguous advice¹⁸.

In 2015 the MOHP and the UNFPA began retraining 1,000 doctors a year in relation to FGM. While this is a small percentage of the medical community (about 9,500 new clinicians graduated in 2016), at least one positive effect has come from it to date: the conviction of Raslan Fadl for performing FGM on Soheir al-Batea was partially based on the testimony of a health official who had gone through the training and 'saw an injury in the area of the clitoris.'¹⁹

Many of the organisations in communication with 28 Too Many stress the importance of increasing education and dialogue around the medicalisation issue. The NGOs Coalition against FGM/C has been attempting to address the problem through its activities, including providing FGM-awareness training targeting medical students, and holding a conference called 'No to Allowing Doctors to Circumcise Females', which brought together CSOs and health professionals to discuss and find solutions to the problem of medicalisation in Egypt.

WHO GUIDELINES FOR MEDICAL PROFESSIONALS

Health workers have a crucial role in helping address this global health issue. They must know how to recognize and tackle health complications of FGM.

~Dr Flavia Bustreo, WHO Assistant Director General²⁰

Following the inclusion of a target for the elimination of FGM in the SDGs, the WHO has issued new guidelines on the management of health complications arising from FGM. These aim to provide up-to-date, evidence-informed recommendations for the treatment of obstetric complications resulting from infibulation, mental-health disorders arising from the experience, sexual dysfunction, and information and education on deinfibulation.

The guidelines are also intended to provide standards that may serve as a basis for designing professional training curricula for doctors, nurses, midwives and public-health workers who have the responsibility for caring for girls and women who have undergone FGM. Additionally, the document provides guidance for policy-makers, healthcare managers and others in charge of planning, developing and implementing national and local healthcare protocols and policies.

It is hoped that the advocacy of healthcare professionals among their peers will help to educate and sway the opinions of those who do not oppose FGM. A group of professors and junior doctors established a movement called Doctors Against FGM/C in the mid-2000s, publicly supporting abandonment and working with the NCCM to increase awareness in the medical profession.²¹ On 3 February 2017, a similarly named initiative, **Doctors Against FGM**, was launched as part of the Abandonment of FGM and Empowerment of Families Joint Programme (a partnership between the MOHP and the UNDP, in connection with the NPC). The scheme's launch was marked by a formal denouncement of FGM by doctors on the International Day of Zero Tolerance to FGM. One of its aims is to educate doctors how to counsel families so that they abstain from cutting their girls. Another is to train doctors to become Ministry-of-Health-certified trainers of their medical colleagues. Doctors Against FGM/C is responsible for the recent inclusion of an **FGM module in medical-school curricula**, which will teach students about FGM from medical, religious and legal perspectives. Doctors Against FGM has been supported by many of the deans of university medical schools, the Supreme Council of Universities and the MOHP.²²

For detailed information about the medicalisation of FGM, please see 28 Too Many's report, which is available at <http://28toomany.org/fgm-research/medicalisation-fgm/>.

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Media

By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.

~Former UN Secretary General, Kofi Annan¹

Press Freedom

Reporters Without Borders ranks Egypt
159th out of 180 countries
in its **2016 World Press Freedom Index²**.

The organisation calls the current situation 'extremely worrying', due to a law introduced in 2015 that restricts news outlets to reporting the official version of any event labelled a 'terrorist attack' and what is being called a 'Sisification' of the media, which is allegedly curbing the emergence of privately-owned media and news outlets that began after the Egyptian Revolution in 2011³. A report by *The Guardian*⁴ suggests that the situation is more complicated than top-down oppression, however, and that some previously outspoken reporters are now self-censoring on certain topics, purportedly to avoid threatening national security. Still others have simply become discouraged over time by the lack of progress. The Committee to Protect Journalists has also expressed concern over the number of journalists imprisoned in Egypt.⁵

In December 2016 a **controversial law** was approved and ratified that provides for the creation of a **Supreme Council for the Administration of the Media**. This body will have the authority to fine, sue and/or suspend the output of broadcasters and publishers, and revoke foreign media licences, if any such bodies are found not to be following the council's rules and regulations.⁶

No one has ever made me say something I didn't want to say, but they have made me not say what I wanted to say.

~TV presenter Mahmoud Saad⁷

In 2015 six **female journalists** founded the Union of Media Women in Egypt, a network to help women in Egypt's media 'connect, receive advanced training and discuss gender-related obstacles' to working in a male-dominated field. The network was recently awarded the Responsible Leader's Award 2016 by German BMW Foundation Herbert Quandt.⁸

Major Media Outlets in Egypt

The UK-based BBC reports⁹ that Egypt's media is widely accessed and therefore highly influential in its region, and many of the Arab-speaking world's television and film productions are made in Egyptian Media Production City, near Cairo.

Popular **newspapers** include the state-owned *Al Gomhuria*, *Al-Ahram* and *Al-Ahram Weekly*; *Al Wafd*, which is owned by the Wafd party; and the privately owned *El Fagr*, *Al-Youm Al-Sabea*, *Al-Shorouk*, *Al-Masry Al-Youm* and its (English) weekly publication *Egypt Independent*.¹⁰

The Government’s Egypt Radio Television Union (*ERTU*) owns and controls the terrestrial **television** broadcast sector. While satellite networks are also monitored by the Government, privately-owned networks include Dream TV, Al-Hayat and ONTV.¹¹

ERTU also controls **radio** broadcasting in Egypt and runs stations with a variety of content. In collaboration with ERTU, two private stations were launched in 2003, *Nile FM* and *Nogoum FM*.

Access to Media

Traditional Media: Television, Newspapers and Radio

It should be noted that, in regard to all types of media, only small numbers of people in the Frontier Governorates were surveyed in the EHIS 2015.

The EHIS 2015¹² reports that, despite the proliferation of print media in Egypt, **television** is overwhelmingly the most popular traditional medium, with 99% of women and 98.8% of men aged 15-59 watching television at least once a week (see Figure 17 below). There is very little variation between the figures for television access across different areas of residence (urban or rural; Upper and Lower Egypt and the Urban Governorates), levels of education, or wealth quintiles. In 2015 80.6% of women and 90.3% of men **who had received information about FGM received it via television**.¹³ Television is therefore an important resource, and anti-FGM campaigners would do well to use it where possible.

Newspapers are more often read in urban areas (by 19.3% of women/30.9% of men) than in rural areas (8.7% of women/16.5% of men) and, as one would expect, newspaper reading increases with education and wealth.

Similarly, exposure to **radio** increases with education and wealth. There is a greater level of exposure to radio in the Urban Governorates and in Lower Egypt than there is in Upper Egypt. This is presumably because the majority of radio stations broadcast from the Greater Cairo area and, therefore, reception in Upper Egypt would be more limited.

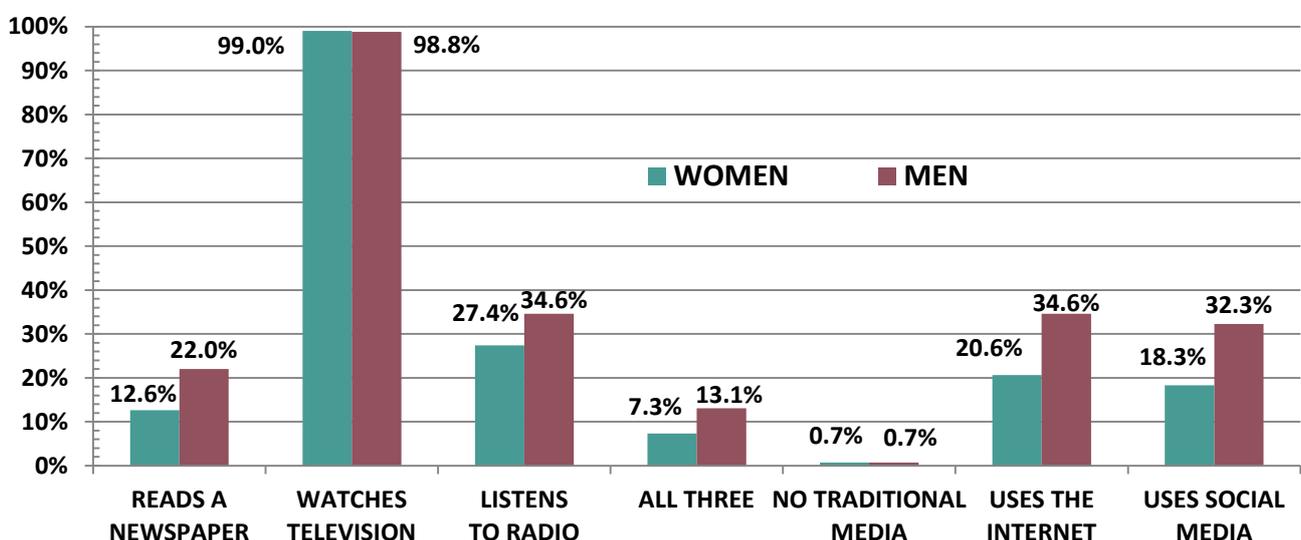


Figure 17: Percentages of men and women aged 15-59 who access media at least once a week¹⁴

The Internet and Social Media

*'[W]omen's access to social media is limited in Egypt as they make up a disproportionately large share of the unemployed and illiterate.'*¹⁵

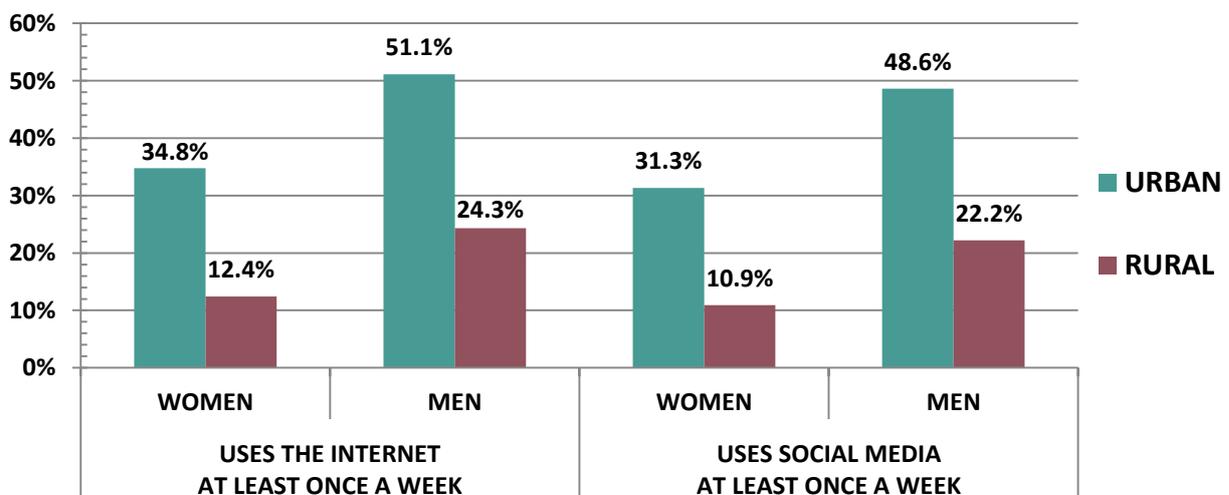
As at 2014, 38% of Egypt's population has ADSL **internet**, and **mobile phone** penetration is greater than 100%, which is not a helpful indicator of how many people own a phone, because the available data does not show how many people own more than one phone. It is also unclear how many of these phones have internet connections enabled; however, a study conducted in the poor, urban communities of Cairo found that 92% of people who access the internet do so through their mobile phones.¹⁶ In a study by the Northwestern University in Qatar, Egyptians reported spending three hours per day on **social media** apps on mobile devices.¹⁷

There is therefore a significant advantage in making anti-FGM websites and campaigns mobile-device 'friendly'.

The EHIS 2015¹⁸ records greater **internet and social-media usage** among men and women under the age of 30. There is notably more frequent usage among people who have completed a primary level of education, and a marked increase in usage in accordance with increasing wealth, although none of these figures is above 50% for women or 70% for men.

Usage is highest in the Urban Governorates and the urban areas of Lower Egypt. However, the greatest division when it comes to place of residence is between urban and rural areas, as shown in Figure 18.

It is therefore probable that anti-FGM advocacy that only utilises the internet and social media will have very little impact in rural areas, where television and radio are far more frequently accessed.



*Figure 18: Urban/rural divide between the percentages of men and women aged 15-59 who access the internet and social media*¹⁹

The Media and FGM

'Digital and social media have had a positive impact on the ability of [Health Social Movements] to challenge powerful stakeholders and influence policy.'

~ Sheila Peuchaud, Academic²⁰



Anti-sexual harassment march to Tahrir

Sheila Peuchaud writes that social media was crucial to the coordination of Egypt's January 2011 protests against the Mubarak regime.²¹ Dahlia Kholaf, writing for the *Wall Street Journal*, attributes the 2014 passage of Egypt's first law against sexual harassment to a social media campaign and 'global pressure', and notes that the death of 17-year-old Mayar Mohammed Mousa as a result of FGM in May of 2016 'sparked an uproar on Twitter'.²² *Newsweek's* Lucy Westcott reports that Raslan Fadl, the first person to be committed in Egypt for performing FGM (after Soheir al-Batea, his 13-year-old 'patient', died from her injuries), turned himself in 'because of the increasing pressure on him from Egyptian and international media, who are reporting more stories about girls like Souheir who die from FGM'.²³ *Watan's* Agelene Reda notes that the 'modern-day' media's reporting of the deaths of several girls as a result of medicalised FGM shocked many Egyptians and 'forcefully brought to the fore the need to take action against FGM'.²⁴ The 45,000 members of the Egyptian Facebook group Confessions of a Married Woman anonymously discuss taboo topics such as domestic violence and FGM.²⁵

All this would indicate that the media, including social media, is having an increasing social and political influence in Egypt, although communications and technology consultant Clay Shirky warns that social media is most effective when it is used to *coordinate* 'real-world action', not replace it.²⁶

'Egyptians generally enjoy dramas and telenovelas. They are also headstrong and don't like things imposed on them. This method [i.e. using locally-produced dramas to change attitudes] could be effective, but the diversity within Egypt would have to be studied first.'

~Sahan Talaat, Professor of Pathology at Cairo University²⁷

The media's ability to subvert social norms and circumvent people's persistent opinions is being put to good use by many organisations.

Particularly subversive is a piece of **comedy theatre**, in five acts, commissioned by the **UNFPA** and produced and performed by **Noon Creative Enterprise**, a company that also runs workshops in schools, where children create short skits, songs or dance pieces incorporating what they have learned about FGM and their attitudes towards it. Director Nada Sabet notes that changing people's practices by simply talking at them is difficult, but that, 'once people laugh at what they do, they can't really pretend they like it.' She does feel that, based on audience feedback, the UNFPA needs to fund a sequel performance wherein the company can discuss coping skills, for those women who have already been cut. Sabet reports that the response from younger audience members has generally been an acknowledgement that FGM must be fought against, while older women's opinions were not so easily changed. However, the comedy made people feel safe to air differing points of view without needing to prove a point, and many were inspired to tell their own stories.²⁸

CROWDSOURCING APPLICATIONS USEFUL TO COMBAT FGM?

Sheila Peuchaud, in her paper entitled *Social media activism and Egyptians' use of social media to combat sexual violence: an HiAP case study²⁹*, states that she hopes to 'inspire public health ministries and activist NGOs to incorporate crowdsourcing social media applications' in their work and policies. A crowdsourcing application is one which relies on the general public to contribute the bulk of its content.

Peuchaud looks at an English/Arabic application called HarassMap, which was founded in 2010 and allows victims or witnesses of sexual harassment to make a report through social media or text message. Each report is plotted on a map of Egypt and can be read by clicking on the map marker. An automated email is also sent out, directing the reporter towards support.

Writes Peuchaud, 'Ultimately, HarassMap's goal is to undermine the climate of social acceptability for sexual harassers.' Given that one of the greatest obstacles to achieving the abandonment of FGM is that it is culturally ingrained and therefore acceptable to many people, HarassMap could foreseeably be used as a precedent for an FGM-focused application at some point in the future.

Peuchaud points out that crowdsourcing social media applications may also be useful for sensitive research, because respondents are able to remain anonymous. Although this does bring its own difficulties, such an application may be put to use in countries where FGM has 'gone underground' because laws against it have been introduced.



*Noon Creative Enterprise uses storytelling and comedy
to prompt people to question their practices*

Storytelling, it seems, is frequently utilised in Egypt by NGOs and other organisations attempting to bring about social change.

The Egyptian organisation **NGOs Coalition against FGM/C** is highly active on social media, and has posted videos on Facebook of girls and women telling their stories, which are then easily disseminated by followers and news websites.³⁰ Its activities receive newspaper and radio coverage (for example, on the Arabic radio station for teenagers called Awald W Banat).

The **NCCM**, too, uses social media, as well as print media, radio and TV, to raise awareness of its work.

One of the **UNDP's** goals in Egypt is to 'provide communications expertise to "change the story" on FGM'. Its mass-media campaign in Egypt has spread the message through media as varied as music (teaching girls in remote communities songs to perform), online videos, an 'op-ed' piece printed in several newspapers, and television advertising. Its advertising campaign reportedly prompted widespread discussion in communities where FGM was previously scarcely mentioned.³¹

'How can such cultural conventions be ended? To change a habit, the stories told through history that gave rise to it must be changed. We must replace the old story with a new one.'

~The UNDP³²

BuSSY is a theatre company that originated in the American University in Cairo and aims to 'tackle the complexity of gender issues from the perspectives of both women and men', including FGM and forced marriage. BuSSY dramatizes, performs and films, often as monologues, a selection of true stories collected from various sources, including the general public. The company also stages street theatre in various locations (including on the female carriages of the Cairo Metro), to gauge and record the public's reactions. Although they have faced censorship, BuSSY has turned that situation on its head by creating additional performances about censorship.³³

In the past, **films** that directly address FGM, such as *Dunia*³⁴ and *The Planting of Girls*³⁵, appear to have caused extreme controversy in Egypt, with the lead actress in *Dunia*, who is Egyptian (although the film is not), bursting into tears at a symposium when she was accused by journalists of starring in a film that 'damages her country's reputation'³⁶. More recently a short film documentary called *In The Name of Tradition*³⁷ received critical praise. Although the film is set in Paris, it was made by Egyptian director and artist May El-Hossamy.³⁸

The **New Woman Foundation (NWF)** and **CEWLA** both use different media in their work to combat FGM. NWF writes articles and papers, conducts media interviews and channels anti-FGM-awareness messages through a magazine called *Reproductive Health Matters*. CEWLA has produced television programmes and podcasts, as well as hosting interactive theatre, particularly for the youth in communities, and offers round-table discussions for journalists.

TADWEIN GENDER RESEARCH AND TRAINING CENTRE³⁹

The use of research and media tools in the campaign to end FGM in Egypt is demonstrated through the work of Tadwein Gender Research and Training Centre, which was set up in 2014. Tadwein aims to share evidence-based knowledge on gender-related issues and bridge the gap between research and practice through effective partnerships. It issues policy briefs and position statements aimed at the Government and policy-makers, and has been instrumental, in partnership with the NGOs Coalition against FGM/C, in the setting up of a GBV-mapping system that brings together organisations and presents details of their programmes to tackle GBV, including FGM, across Egypt (www.gbvprojectegypt.com).

Social media is used widely to target young people. For example, the #Ididnotforget campaign in 2016 focused on sexual health and wellbeing. An accompanying short film and a series of comics were widely shared online. However, evidence to date suggests that, while such social media campaigns have been very successful in urban areas, there remains a challenge in Egypt to reach out to more young people in rural areas, where FGM prevalence is highest.

'I did not forget!'
Tadwein uses images and film to spread its message on social media



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 - Image p.100:* © Noon Creative Enterprise.
 - Image p.101:* © Tadwein Gender Research and Training Centre. Social media campaign.

Ending FGM: Challenges

Challenges faced by anti-FGM advocates fall into two categories.

Firstly, there are cultural challenges related to the structure of Egyptian society that must be negotiated or surmounted, such as traditions, beliefs and social norms that support the practice of FGM.

Secondly, there are practical challenges, such as how to deliver the kind of support needed by those who go against social norms, how to enforce the law in a way that curbs FGM and prevents it being driven underground, and how to maintain a consistent, clear message about FGM when civil society is impacted by political unrest.

Cultural Challenges

Combating traditions, beliefs and social norms that support the continuation of FGM and override the law

FGM remains a deeply-entrenched tradition in Egypt that continues to be reinforced from generation to generation by family and community pressures. More than half of women (53.9%) and men (58.5%) support the continuation of FGM, and 46.2% of women and 50.1% of men believe it is required by their religion.¹

Social acceptance and improved marriage prospects are also closely linked to the continuation of the practice; it is still considered a point of pride for men to marry what they perceive to be a 'pure' woman (because the myth that FGM is associated with both cleanliness and chastity persists). The idea of women being 'oversexed' is pervasive, and buoyed by a lack of sex education.

Without a holistic approach that includes all members of the community as well as appropriate religious and sexual education, myths and misunderstandings around FGM will continue.

The medicalisation of FGM

A critical challenge in Egypt is the growing medicalisation of FGM. Among girls aged 1-14 who have undergone FGM, 78.4% were cut by health professionals², despite successive decrees by the MOHP and national laws forbidding FGM and the involvement of medical practitioners.

It is likely that women and their families will continue to put their trust in doctors and other medical personnel, as respected members of the community, when making decisions about FGM. Doctors have an economic incentive to continue performing FGM and, for some medics, the word of religious leaders supersedes anything they are taught in medical school. Therefore, efforts to educate medical practitioners about FGM and address the issues surrounding medicalisation need to be urgently scaled up by government and health agencies.

Practical Challenges

Reaching most at-risk girls

Girls in poorer rural areas, particularly in Upper Egypt and the Frontier Governorates, are the most at risk of undergoing FGM. In these communities, exposure to messages via in-person campaigns as well as social media, the internet, radio and printed material is less frequent, restricted by isolation and higher levels of poverty and illiteracy.

Implementing and enforcing anti-FGM laws

The gap between the law and its enforcement can be attributed to several challenges, including:

- a lack of awareness of the law and that FGM is a crime, especially in rural areas;
- girls undergoing FGM too young to report it;
- girls not wanting to get their parents into trouble and so failing to report FGM;
- the practice of FGM 'going underground'/being carried out in secret; and
- a lack of education and support among justice agents, such as police and judges.

There have been very few prosecutions to date for practising FGM and, despite the recently increased penalties, disappointing sentences were given to those responsible for the May 2016 death of Mayar Mohamed Mousa.

Certain rights groups are concerned that the tougher penalties will have little impact, due to the lack of state-based monitoring and the need for police and judges to follow through, making arrests and convicting offenders.³

Security and physical safety

The problem of guaranteeing women's safety from assault in public places may inhibit activists in their work, and deter women from attending events such as peaceful demonstrations and rallies, particularly as the topic of FGM is controversial and taboo.



There is a risk of girls being cut younger to avoid detection by law enforcers

Funding and operating environment

Obtaining funding for anti-FGM campaigns is inherently challenging under normal circumstances, but the new 'NGO law', if fully implemented, could seriously jeopardise valuable sources of foreign funding and threaten the vital partnerships between international NGOs and grassroots organisations and activists in Egypt.

Evidence supplied during the research of this report shows that, under the government of Muhammed Morsi, many organisations had to keep a low profile and curtail their work, as the Muslim Brotherhood campaigned for the continuation of FGM. While work could resume once President el-Sisi came to power, there is growing concern that conditions are being tightened again and activists are already being targeted.

Coordination of anti-FGM campaigns

It has become clear during this research that both international and national organisations are constantly striving to coordinate their activities across Egypt; the NGOs Coalition against FGM/C, for instance, has been increasing its membership since 2009 and working to end FGM through its Kamla campaign (see page 77). Evidence also suggests that several organisations, including the New Woman Foundation and EIPR, are working together to revive anti-FGM working groups through which to step up pressure and raise awareness of the urgency of eliminating the practice.

However, poor coordination between the Government and civil society, reportedly due to different, and even conflicting, visions around the most effective ways to end FGM, hinders this process and remains a challenge for the country.

Educating and maintaining influential leaders and role models

There is still the belief among certain religious authorities that FGM is required by religious law. As mentioned above, medical practitioners will often value the word of their imam over the teaching they receive at medical school. Education is needed from respected clerics to local leaders, and teaching against FGM then needs to be disseminated to communities at churches and mosques.

Inaccessible healthcare

The taboos that still surround FGM may prevent women who have undergone FGM from seeking help, but, additionally, the cost of healthcare, particularly for poorer women and families, could make reparative or reconstructive surgery or psychological treatment impossible. As obstetric fistula is relatively rare in Egypt and treatment is only accessible in specialist facilities, women have found that it is difficult to get a diagnosis and, subsequently, proper treatment. Women in more rural areas are more likely to give birth at home, where obstructed labour due to FGM could lead to death without medical intervention.

The decline in press freedom

Although there are no discernible effects at this time, the decline in press freedom and the creation of the Supreme Council for the Administration of the Media may make disseminating information about FGM through the media more difficult, in some cases, or may make journalists more wary of reporting on sensitive issues.

A lack of comprehensive and reliable data

The collection of accurate data in relation to FGM is potentially compromised by, for example, respondents' fear of prosecution or lack of knowledge about FGM; the difficulties associated with accessing a significant number of respondents that closely resembles a cross-section of the population, especially in sparsely populated areas such as the Frontier Governorates; differing survey techniques and interpretations of questions by surveyors, and inconsistencies from survey to survey; and social and cultural pressures. There is a need for further surveys gathering data on FGM prevalence and abandonment, which take into account these and other factors that may affect results.

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Conclusions and Strategies for Moving Forward

After a period of unrest, Egypt's **political situation** appears to have stabilised, although some tensions and uncertainties remain. While certain voices in public positions, such as MP Elhamy Agina, have maintained their support for FGM, the Government's official position has remained firmly against it.

In keeping with this position, the new 2014 Constitution¹ takes a leap forward by, for the first time, obligating the State to protect women from all kinds of violence, and to provide care to women and children. An amendment was made to **the law** in September 2016, redefining FGM as a felony rather than a misdemeanour and strengthening the applicable penalties.

However, convictions to date have been rare (largely for high-profile cases such as the death of Mayar Mohamed Mousa), and sentences have not been handed down that carry the full weight of the law. The Government's official strategy for tackling FGM, the *National Abandonment Strategy 2016-2020*, notes that there is an 'Inconsistency on FGM within legal culture'². More, therefore, needs to be done in terms of the **implementation and enforcement of the law**, including educating community officials, law enforcement officers and agents of the judicial system (such as judges) about FGM, so that decisions are made throughout the reporting and judiciary processes that reflect the gravity of this criminal practice. Girls themselves must be encouraged to take advantage of the law and report more often, and safe spaces need to be provided for girls in this position who are in need of support.

Although the 2014 Constitution established equality for all Egyptians, and advances have been made over the past few decades, there is a feeling that **women's position in society** has deteriorated since Mubarak's resignation, evidenced by an increasing number of public sexual assaults.

The Government's extensive *Sustainable Development Strategy: Egypt Vision 2030*³, which is closely aligned with the **Sustainable Development Goals** Agenda⁴ document, lists improving **gender equality** as an important goal. Deep cultural changes will be required, however, to achieve this. Many women still lack the power to make decisions in the home or about their own health. Schemes such as Plan International Egypt's leadership programmes, which work to empower girls, are vital, and several NGOs have stressed the importance of involving the whole community in campaigns and advocacy work. The positioning of more women in top-level and parliamentary roles may also help to further positive change.

There was little change in **the incidence of FGM between 2008 and 2015**, and, with a **prevalence** of 87.2%⁵ for women aged 15-49 and a population of almost 95 million, Egypt has the greatest number of women who have undergone cutting of any country.

There is evidence of a decline in practise, although it is a slow one. Programmes should continue to **focus on rural areas and Upper Egypt**, where FGM is most prevalent, and on less-wealthy and less-educated segments of the population.

Law enforcement and community leaders should be especially vigilant for FGM during the **cutting season**, which peaks between May and June.

There has been a sharp decline recently in men and women's level of **exposure to information about FGM**. The vast majority of those who have received information have done so via television. Television is therefore an extremely valuable medium for getting across anti-FGM messages. There is some evidence to suggest that, while public discourse on the issues surrounding FGM has decreased, private discussion among family members and relatives or friends has increased. While this may indicate that the taboo nature of the subject is being changed, the lack of public discussion is of great concern. Dr Fatma El-Zanaty recommends national campaigns tailored to both men and women be urgently created or intensified.⁶

Knowledge and understanding of the issues surrounding FGM and its dangers is poor, although there has been an increase in knowledge about FGM's potential to cause serious consequences or death. This is likely due to the media attention that has been given to the deaths of several young girls during the past few years, once again showing the vital role that the media has to play.



FGM is practised for several **reasons** in Egypt, but the most commonly cited are tradition, religion and its association with marriage. Several commentators have noted that the most problematic reason is the pervasive idea that women are 'oversexed', and that FGM reduces their sexual appetites. An absence of good-quality sex education in schools, in the home and from the religious community means that these ideas are not opposed. This lack of education and understanding extends even to the medical community, and many parents are uneducated in these matters. A promising development is that the Coptic pope is making sex education a prerequisite for marriage. This would be of great benefit if offered by all religious and community leaders moving forward.

Just over half of men and women feel that FGM should be continued. A decline in the percentages of men and women who reply that they are not sure whether FGM should or should not be continued may indicate that societal changes have taken place, such that those who were previously unsure have been able to form a definite opinion on the subject.

The National Council for Childhood and Motherhood, which is the body officially responsible for matters relating to FGM, together with the UNDP, launched Egypt's national **FGM-Free Village Model** in 2003. The aim of the scheme is to reduce the pressures on families to have their daughters undergo FGM. The methodology used to achieve change is long-term, 'sustained and protracted' intervention and advocacy. A midterm evaluation⁷ revealed that women in villages where the intervention took place who had received information about FGM retained that information much better than did women in villages where no intervention had taken place (78% versus 30%), and were much more readily convinced by that information to oppose FGM (81% versus 17%). The evaluation concludes, 'Advocacy

and awareness-raising efforts that take a holistic multi-sectoral approach constitute best practices that must to be sustained in order to maintain their impact for future generations.’

The formation of **partnerships**, such as the one behind the FGM-Free Village Model, and **peer networks** is a popular and successful strategy across Egypt and must be supported.

It is clear that the **belief** that FGM is required by **religious law** is a considerable contributor to the continuation of the practice in Egypt. About 50% of people believe that FGM is required by religious precepts.⁸

Islam is the State religion, and Islamic Sharia takes precedence over any other law or convention. Often, medical practitioners will defer to the word of their cleric over anything they are taught in medical school. This being the case, it is vital that **religious leaders** are clear about the fact that FGM is not required by – is, in fact, contrary to the principles of – Islamic and Christian practice. Several fatwas have been issued declaring that FGM is forbidden, as well as a series of joint Muslim/Christian publications containing detailed arguments on the subject, but the Abandonment Strategy notes, ‘The official religious discourse is now settled on rejecting FGM, while the popular discourse is still variable.’⁹

Given the trusted position that **religious leaders** have in society, it is essential that they – Muslim and Christian leaders, as well as leaders from the minority religions – are engaged in anti-FGM programmes, and are encouraged to speak out against the practice and support its abandonment. Local religious leaders must be educated on the relevant principles and disseminate that information to their community members (by, for example, teaching on FGM in Friday prayers and church services). A unified and consistent message is extremely important to the abandonment of FGM. NGOs have also noted a higher rate of success in communities that practice FGM when ‘positive deviants’ who were also community leaders (doctors or religious leaders) spoke out against the practice.¹⁰

Great strides have been made in the **education system** towards achieving universal enrolment and gender parity, although improvement is still needed in relation to the education of girls in poorer, rural areas. Progress in education is important, as there are clear links between a person’s level of education and their opinion as to whether or not FGM should be continued. Lack of basic education is also a root cause of the perpetuation of social norms and stigmas that surround FGM as it relates to health, sexuality and women’s rights. In turn, FGM can hinder girls’ ability to pursue higher education and employment opportunities. More programmes are required, such as those run by Think and Do, to support girls who are most in need or who have dropped out of school to gain an education. Education empowers people and brings with it a sense of ‘modernity’, which gives them the ability to challenge harmful practices such as FGM.

Doctors Against FGM/C’s work to include an FGM module in medical-school curricula is to be applauded. The WHO has introduced guidelines for designing **professional training** curricula for doctors, nurses, midwives and public health workers, which should be used as a basis for any further training that is developed by the MOHP, as well as by NGOs.

More education and resources are particularly required across the public **health system**. The Government’s plan to increase spending in the health sector is welcome, and it is hoped that a proposed social health insurance system will decrease the barriers women face to obtaining appropriate healthcare. Egypt has made a great deal of progress in terms

of the MDGs and SDGs, and its Vision 2030 should continue to push the country towards achieving the SDGs.

Early marriage/pregnancy and teen pregnancy (i.e. mothers younger than 20) is the dominant factor in child deaths, and further work needs to be done in this regard.

Obstetric fistula as a result of FGM is relatively rare in Egypt, meaning that women are often left undiagnosed and untreated for long periods; therefore, work needs to be done to raise health practitioners' awareness of the problem and to train more specialist practitioners.



Historically, anti-FGM advocacy and campaigns have focused solely on the medical problems surrounding FGM, and this is believed to have contributed to the high rate of **medicalised FGM** in Egypt. Evidence reveals that medical practitioners are not discouraging FGM, as a rule, despite harsher penalties and recent prosecutions, and currently 78.4% of incidences of FGM are medicalised¹¹.

The pressures of tradition, economic incentives, a lack of understanding of FGM and sexual desire, and, most significantly, the belief that FGM is required by religious precepts all contribute to the continuation of the practice by members of the medical community.

As stated above, more training is required for medical professionals (and by medical professionals, as peer training can be very effective), and such training should discuss the official position of religious leaders.

The Abandonment Strategy also notes that the monitoring and supervision of clinics and hospitals, and the enforcement of penalties by the MOHP and the Doctor's Syndicate on FGM are weak and must be stepped up.¹²

There is evidence to suggest that the general population's level of **exposure to information** about FGM has decreased of late, and this is perhaps due to an increased level of caution among journalists and broadcasters when discussing controversial topics. **Television** is overwhelmingly the medium through which most people receive their information, and it should therefore be utilised continuously by the Government and where possible by activists. The use of **social media** is on the rise in urban areas, but people in rural areas or Upper Egypt are more difficult to reach with social media, print media and

radio, whereas the vast majority of Egyptians have access to television. Internet usage on **mobile devices** is common, and therefore any internet resources should be made mobile-device 'friendly'. Social media and the internet are being used to undermine the 'norm' of sexual harassment in Egypt, and it is possible that similar methods may be used to undermine the FGM culture.

The subversive nature of **storytelling** through different mediums, including theatrical performances, songs, social media and the more traditional forms of mass media, can be highly effective in bringing about social change in Egypt and is being utilised by several NGOs.



The report on the FGM-Free Village Model found that carefully crafted **media messages**, especially those invalidating the links in the public consciousness between FGM, chastity and cleanliness, and spreading the message that traditions can and must be questioned and re-evaluated, have been highly effective and easily spread via television.¹³

Many anti-FGM workers have noted the importance of involving **men and boys**, and this is no different in Egypt. 28 Too Many recommends that the Government and NGOs continue to include men and boys in their anti-FGM programmes.

Programmes and research studies concerned with the elimination of FGM require **long-term funding** to be effective. Continued publicity of current FGM cases, particularly through the UN and the WHO, is crucial for ensuring that NGOs and charities are given the support and resources they require in the long term. Obtaining charitable aid and grant funding is inherently challenging, as programmes for ending FGM tend to be given less attention than those related to broader health and poverty issues. This is one area where support from the media and the generation of discussions on social media platforms is important.

The proposed **NGO law** would challenge anti-FGM workers' ability to obtain international funding, and slow down administrative processes, thereby curtailing programmes and the spread of the message. Additionally, activists are increasingly being targeted, which is a cause for concern. Such restrictions on the functions of civil society will curb progress towards the Government's goal of eradicating FGM.

There is a need for **continued research and data collection** to inform anti-FGM programmes and analyse trends and practices across Egypt, including changes in attitudes. Consistency in the questions asked and the age cohorts of subjects will allow for more accurate analysis, and future DHS surveys should focus on all women, not merely ever-married women. The Abandonment Strategy calls for a 'national comprehensive survey' on FGM in Egypt, and the social and cultural changes that are occurring.¹⁴

The challenge of **collecting reliable data** on an illegal practice needs addressing at both a national and global level, and more research is needed into whether or not anti-FGM laws are pushing the practice 'underground', or causing a trend for it to be performed on younger girls.

Agencies such as the NCCM have been working in Egypt for the past three decades to eliminate FGM, supported by the MOHP. These efforts have led to some communities and practitioners publicly condemning and pledging to abandon the practice. Therefore, 28 Too Many recommends that successful projects and strategies be **communicated** more widely and publicly, to encourage **collaboration** and raise awareness. The fight against FGM will be strengthened by networks of organisations, such as the NGOs Coalition against FGM/C, continuing to work against it (and, more broadly, for women's and girls' rights), integrating anti-FGM messages into other development programmes; sharing best practice, success stories, operations research, training manuals, support materials and advocacy tools; and providing links and referrals to other organisations.

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 - 9 Ministry of State for Population and United Nations Egypt, *op. cit.*, p.20.
 - 10 Pamela A. McCloud Dr. Shahira Aly Sarah Goltz (2003) *Promoting FGM Abandonment in Egypt: Introduction of Positive Deviance*, p.6. USAID and CEPDA. Available at http://www.intact-network.net/intact/cp/files/1387977515_Introduction%20of%20Positive%20Deviance.pdf.
 - 11 EHS 2015, pp.106-107.
 - 12 Ministry of State for Population and United Nations Egypt, *op. cit.*, p.20.
 - 13 Barsoum et al. *op. cit.*, p21.
 - 14 Ministry of State for Population and United Nations Egypt, *op. cit.*, p.22.
- Image p.109:* Tribes of the World (2013) *Two Egyptian Women*. Available at <https://flic.kr/p/f4MLQd>.
CCL: <https://creativecommons.org/licenses/by-sa/2.0/>
- Image p.111:* UNDP (2015) Screenshot taken from 'Combating FGM in Egypt', *YouTube* [video]. Available at <https://www.youtube.com/watch?v=T2ROOQ9FSTs>.
- Image p.112:* © NGOs Coalition against FGM

Appendix 1: List of International and National Organisations Contributing to Women's and Children's Rights in Egypt

Please note that this is not a comprehensive list of all INGOs and NGOs working in Egypt; it is a selection.

Al-Shehab Institution for Comprehensive Development
 Alliance for Arab Women
 Association of Egyptian Female Lawyers (AEFL)
 Association of European Parliamentarians with Africa (AWEPA)
 Assiut Childhood and Development Association (ACDA)
 Assiut Human Rights Association
 Better Life Association for Comprehensive Development (BLACD)
 Bint al-Nīl
 Bishopric of Public, Ecumenical and Social Services (BLESS)
 Campaign Against Female Genital Mutilation (CAGeM)
 Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA)
 CARE Egypt
 Caritas Egypt
 Centre for Egyptian Women Legal Assistance (CEWLA)
 Coptic Evangelical Organisation for Social Services (CEOSS)
 Coptic Organisation for Services and Training (COST)
 Department for International Development (DFID UK)
 Egyptian Aid Society
 Egyptian Association for Community Participation Enhancement (EACPE)
 Egyptian Coalition for Children's Rights (ECCR)
 Egyptian Family Planning Association (EFPA)
 Egyptian Foundation for Family Development (EFFD)
 Egyptian Initiative for Personal Rights (EIPR)
 Egyptian Organization for Human Rights (EOHR)
 Egyptian Society for the Care of Children
 Egyptian Society for the Prevention of Harmful Practices to Woman and Child (ESPHP)
 Embrace the Middle East
 Equality Now
 Eve Future Association for Family and Development
 Inter-African Committee (IAC)

International Islamic Center for Population Studies and Research (IICPSR)

Jesuits and Brothers Association for Development

Karama

Musawah Organisation for Training and Counselling

National Council for Childhood and Motherhood (NCCM)

National Council of Women (NCW)

New Woman Foundation (NWRC)

NGOs Coalition Against FGM/C

Oxfam

People's Health Movement (PHM)

Plan International Egypt

Save The Children

Tadwein Gender Research and Training Centre

Tearfund

The Girl Generation

Think and Do

United Nations Children's Fund (UNICEF)

United Nations Development Programme (UNDP)

United Nations Population Fund (UNFPA)

USAID

UN Women

Women and Memory Foundation (WMF)

Women Living under Muslim Laws (WLUML)

World Health Organisation (WHO)

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