Fall 2-15-2023

National Policies to End Female Genital Mutilation/Cutting in Egypt: An Analytical Review

Nada Ghanem
nadaghanem@aucegypt.edu

The American University in Cairo

School of Global Affairs and Public Policy

NATIONAL POLICIES TO END FEMALE GENITAL MUTILATION / CUTTING IN EGYPT: AN ANALYTICAL REVIEW

A Thesis Submitted to the

Public Policy and Administration Department

in partial fulfillment of the requirements for the degree of

Master of Public Administration

By

Nada Ghanem

Fall 22

Acknowledgment

I would like to extend my acknowledgment and warmest thanks to my supervisor ‘Dr. Ghada Barsoum’ who supported my first steps in this Master's Degree, inspired my thirst for gender-related studies during the two years courses, and was enthusiastic about my choice of topic when it was just a blurred idea till it formulated into a full-fledged thesis.

I would also like to thank the defense committee members, ‘Dr. Laila El Baradie’ and ‘Dr. Rana Hendy’, for making my defense an enjoyable memory and for intriguing moments of thought to have further areas and perspectives to explore through their comments and suggestions.

I would like to thank my number one support, my husband ‘Omar El Nashar’, for all the pressure he endured over those three years, all the support he gave me along the ups and downs when I was too tired to continue, and for playing the roles of the father and the mother to our beloved daughter ‘Laila’ when I was busy studying and working, especially during the tough time of Covid-19 lockdown when everybody was available trying to destress at home, but I was physically available but mentally unavailable, either working or attending online classes and submitting assignments. Also, I would like to thank my daughter for enduring my absence, and I hope she can forgive me for any fun or challenging moment I might have missed. She has always been a beautiful smile at the background of my online classes videos.

I would like to thank my parents and my parents-in-law for their continuous support and prayers that surrounded me over the three years and were my guarding angels whenever everything was collapsing.

Finally, I want to thank my friends and colleagues who supported me in my downs and were a good ear to listen, and those who supported me with their enlightening technical discussions, including all the distinguished interviewees who enriched my thesis with their information and experiences.

To all my loved ones, I hope I made you proud.

Abstract

Egypt has a high prevalence rate of practicing female genital mutilation/cutting on a national scale that requires continuous interventions till the practice is abolished. This thesis discusses the policies of the government of Egypt to end FGM/C using qualitative methods based on desk review and in-depth interviews with government and non-government experts in the field. The thesis explored the global and national historical contexts on the social and political levels to comprehend the complex roots of the practice within the society and the evolution of the political stance towards it. The main pillars constructing the Egyptian policies towards ending FGM/C since the 2000s are discussed, including legal, health, religious, educational, community social and behavioral change, structures and services, stakeholder coordination, finance, and sustainability pillars. Some policy gaps and implementation obstacles are identified under each pillar to guide the recommendations and findings. The thesis concluded with lessons learned to accelerate ending FGM/C, highlighting the importance of giving the community demand on continuing the harmful practice and their acceptance for change a high level of prioritization to ensure a sustainable change in community behaviors and effective law enforcement. The recommendations included the need to exert more pressure to reduce medicalization, engage young generations in policy formulation and implementation, revisit the conceptualization of the media campaigns concerning their public figures and target audience, increase national funding to ensure sustainable intervention, review reporting mechanisms to allow law enforcement, and strengthening services provided to support victims and those at risk.

Keywords: Female genital mutilation, female cutting, female circumcision, social and behavioral change, law enforcement, public policy.

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List of Acronyms

CAPMAS: Central Agency for Public Mobilization and Statistics

CEDAW: The Convention on the Elimination of all Forms of Discrimination Against Women

CFPA: Cairo Family Planning Association

CRC: Convention on the Rights of the Child

ECOSOC: United Nations Economic and Social Council

EDHS: Egyptian Demographic and Health Survey

EFHS: Egypt Family Health Survey

EFPA: Egyptian Family Planning Association

EVAC: Ending Violence Against Children

EVAW: Ending Violence Against Women

FBOs: Faith-Based Organizations

FGM/C: Female Genital Mutilation/Cutting

INGO: International Non-Governmental Organization

MoHP: Ministry of Health and Population

MoJ: Ministry of Justice

MoSS: Ministry of Social Solidarity

NCCM: National Council for Childhood and Motherhood

NCW: The National Council for Women

NGO: Non-Governmental Organization

NPC: National Population Council

OPP: Office of Public Prosecutor

PHU: Primary Healthcare Unit

SBCC: Social and Behavioral Community Change

UNFPA: United Nations Population Fund

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Y-Peer: Youth Peer Education Network

Chapter One

Introduction and Problem Statement

1.1 Introduction

Female Genital Mutilation or Female Genital Cutting (FGM/C) is a severely harmful practice against girls and women that has been conducted since the early ages of the Egyptian civilization (Caldwell et al., 2000) or even much earlier back to the stone age (Lightfoot-Klein, 1983). FGM/C is defined as "All procedures that involve partial or total removal of the external female genitalia, or other injuries to the female genital organs for non-medical reasons" (WHO, 2022). It is divided into four types according to the severity of the mutilation, reaching the level of stitching the external layer of the vagina to seal it, leaving a small opening for urination and the menstrual cycle, which makes it a life-threatening practice for girls and women.

FGM/C might lead to severe medical, physical, and psychological consequences. It is a sexual and gender-based violence that has been recognized as a sort of human rights violation according to the Universal Declaration on Human Rights (1948), CEDAW (1979), Child Rights Convention (1989), International Covenant on Economic, Social and Cultural Rights (1979), and several regional and international declarations and conventions.

FGM/C is condemned in the broad aspect of being a harmful practice reflecting discrimination against women, violating the right to life, violating the right of physical integrity, violating the right of freedom from violence, violating the right of freedom from physical and mental harm, and violating the rights of child protection (U.N. Women, 2011). Accordingly, the U.N. General Assembly called for ending FGM practices through various resolutions, the latest is no. A/RES/67/146[1] in 2016. Also, the Sustainable Development Goals (SDGs) adopted in 2015 under "Goal 5: Gender Equality" called for eliminating all sorts of violence against women and girls (U.N. Women, n.d.).

[1] UN General Assembly resolution. (2016, 19 Dec.). Resolution adopted by the General Assembly on 19 Dec. 2016: A/RES/71/168. United Nations. Retrieved from: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/71/168&referer=/english/&Lang =E

The Nile valley, African and middle eastern countries, and countries in Asia and Latin America have the FGM/C practiced on a wide range. It is also a growing concern for European countries, North America, Australia, and New Zealand as hosting countries for generations of migrants and refugees from various cultural backgrounds endorsing FGM/C (UNFPA, 2015). The United Nations agencies have estimated that an average of 200 million women and girls globally have undergone a form of (FGM/C), in addition to millions at risk of performing the harmful practice (WHO, 2013).

Egypt has high rates of FGM/C practices reaching 86% of ever-married women and girls aged (15-49) according to the latest family health survey conducted in 2021 (CAPMAS, 2022). The survey shows some positive indicators of the success of national policies in the last decade, represented in a decline in the percentage of girls and women who have undergone FGM/C by 6% compared to the previous demographic and health survey in 2014, a decrease in the number of girls cut at the age of (0-19) by 7.2% compared to 2014, a further decrease in the percentage of circumcised girls and women with higher education than 2014 by 6.4%, and a drastic decline in future projections regarding the willingness of mothers to cut their daughters from 56% in 2014 to 27% in 2021(MoHP, 2015 & CAPMAS, 2022). However, the efforts to end FGM/C in Egypt are still insufficient to meet Egypt's commitment to achieving the total elimination of FGM/C as part of the SDGs targets for 2030.

Unfortunately, Egypt's slow-paced progress toward ending FGM/C aligns with the globally limited development in fulfilling 'SDG 5' under which ending FGM/C is reported. According to technical estimations, universal efforts must be accelerated fifteen times to meet this goal by 2030 (UNICEF, 2020 b). These efforts are hindered even more due to covid-19 restrictions, which might have negatively affected the global progress to decline the harmful practice prevalence (UNFPA et al., 2020).

The slow-paced decline is connected to the slow evolution of the Egyptian state policies, where the consecutive Egyptian governments did not recognize FGM as a harmful practice till the fifties of the twentieth century (Mukherjee, 2014). Since then, policies evolved from controlling to abandonment to reach the present progressive policies on ending FGM/C. Despite the consecutive decades of combating FGM/C, Egypt is still in the top five countries globally performing the harmful practice on girls and women according to the UNFPA FGM global dashboard (UNFPA,

2021a), and is considered to be the first globally in performing FGM/C by health care professionals (Geddah, 2020).

Within this complex context, this thesis aims to contribute to answering the question of "How can the Government of Egypt accelerate the abandonment of FGM/C practices nationally?". This is answered by identifying the different state policies conducted by Egypt to end FGM/C and the role of the main stakeholders, analyzing some policy and implementation gaps faced by the main stakeholders, and highlighting the lessons learned from Egypt's long history with policy attempts to end FGM/C.

The thesis is divided into eight chapters. The first half of the thesis will provide a dive into the global history related to the practice of FGM/C to understand the strong roots of the practice in humanity, followed by a more recent background on the global and national evolution of policies to end FGM/C. A hybrid conceptual framework is developed to help provide a comprehensive answer to the research questions, including political and sociological approaches related to the community and governmental behaviors and how they mutually impact each other. The research methodology is based on qualitative research and in-depth interviews with government and non-government officials and consultants, including civil society and United Nations officials active in ending FGM/C in cooperation with the Egyptian government. The literature review addresses different global assumptions related to FGM/C, successful and unsuccessful policies to end FGM/C, the role of community behavioral change in ending FGM/C, and finally, some studies analyzing the Egyptian national policies to end FGM/C.

The second half of the thesis aims to identify the national policies and the areas of improvement within, in addition to providing alternatives and recommendations based on the best practices and national context to help accelerate the abandonment of FGM/C in Egypt and ensure the continuity of this abandonment. The state policies discussed are classified into two chapters: policy pillars directly affecting the society as the legal, health, education, religious, and community social and behavioral change pillars; and the policy pillars mainly concerned with the government's internal dynamics as the structural and financial pillars, stakeholder coordination, and ending with the sustainability factors to ensure the continuity of the policy adjustments and implementation till the abolition of FGM/C is achieved on the national level. Some lessons learned from the national policies developed and their implementation are highlighted to suggest some modifications and

additives that can support accelerating the ending of FGM/C in Egypt. This thesis is giving a particular focus on the need to prioritize the community's social and behavioral change as a tool to empower all other policies placed to end FGM/C, because without the community's endorsement for the required change, the policies will never succeed.

1.2 Aim of the Research

This research has three main objectives; the first is to explore the historical, social, and policy structures attributing to the current perceptions on practicing FGM/C globally and nationally.

The second is to identify and analyze the existing national policies to end FGM/C by exploring the developments and setbacks under the different policy pillars and the discrepancies in their structure and implementation. These pillars will be informed through a desk review and in-depth interviews with practitioners in the field who are in direct contact with policymakers and the community to ensure that they have a wholistic view of the current status of FGM/C practice in Egypt and that they have real insights on the development of the efforts done by the government and civil society to eradicate FGM/C.

The Third objective is to explore the road map to eradicate FGM/C in Egypt, explore how realistic and feasible this road map could be and determine whether Egypt can continue committing to eliminating FGM/C by 2030 or if revisions should be made to the target or the time frame.

1.3 Policy Relevance of the Research

The efforts to end FGM/C have been continuing for decades, and the awareness of the severity and impact of the practice has expanded to allow the evolution of public knowledge and acknowledgment regarding FGM/C practice from being culturally accepted to being a harmful practice violating human rights.

In Egypt, the official acknowledgment of the necessity to end FGM/C practices started in the 1950s and has faced several challenges on the community and political level, resisting the FGM/C's abandonment. This resistance might have delayed the development of official stances and policies against FGM/C but never stopped it completely. The government's eagerness to end FGM/C is

manifested in the consequent policies, strategies, program interventions, and services provided by the Egyptian government or under their umbrella. The latest policies and strategies include 'The National Strategy to combat violence against Women 2015-2020'[2] in 2015, which is the national strategy endorsed to align with SDG 5, 'The National FGM Abandonment Strategy 2016-2020'[3], and 'The National Strategy for the Empowerment of Egyptian Women 2030'[4] in 2017 which is the national strategy elaborating on the women's empowerment pillar in 'Egypt's Vision 2030'[5], which is the national strategy aligning with the global SDGs 2030. Several national campaigns and interventions followed those strategies, in addition to establishing "The National Committee for the Eradication of Female Genital Mutilation" in 2019, leading and coordinating the national efforts to end FGM/C. Accordingly, this research is highly relevant to the ongoing global and national priorities interlinked with gender equity and girls' and women's empowerment goals.

1.4 Statement of The Problem

With the high prevalence rate of FGM/C in Egypt reaching 86% for ever-married women in EFHS 2021 (CAPMAS, 2022), taking into consideration that ending FGM/C has been an area of concern for the different Egyptian governments since the mid-twentieth century, the decline in the percentage of circumcised girls and women over those decades is not meeting the expectations of the policymakers nor the global guidelines related to gender equity.

The chronicled nature of ending FGM/C is universal and acknowledged by the international community. However, the local policies need to be revised to ensure that all possible alternatives have been explored.

This research will analyze the different policies conducted by the Egyptian government to end FGM/C, clarify its achievements and setbacks to identify the gaps in the national policies and their implementation methodology, aiming to reach applicable policy recommendations that could be

[2] For Reference: https://learningpartnership.org/sites/default/files/resources/pdfs/Egypt-National-Strategy-for-Combating-VAW-2015-English.pdf
[3] For Reference: https://www.eg.undp.org/content/egypt/en/home/library/womens_empowerment/the-national-fgm-abandonment-strategy-2016-2020.html
[4] For Reference: http://ncw.gov.eg/wp-content/uploads/2018/02/final-version-national-strategy-for-the-empowerment-of-egyptian-women-2030.pdf
[5] For Reference: https://www.arabdevelopmentportal.com/sites/default/files/publication/sds_egypt_vision_2030.pdf

adopted to accelerate the abandonment of FGM/C in Egypt and ensure the sustainability of this abandonment on the longer term.

The main research question is **"How can the Government of Egypt accelerate the abandonment of FGM/C practices nationally?"** while the sub-questions include:

1. **What are the policies to end FGM/C? What is the role of the different Stakeholders?**
2. **What are the policy and implementation gaps in ending FGM/C, if any?**
3. **What are the recommended policy amendments to accelerate FGM/C abandonment in Egypt?**

1.5 Conceptual Framework for Research

This research aims to know how the policies could be adjusted to influence community behaviors and norms to reach the elimination of FGM/C at an accelerated pace. Taking into consideration that state policies are affected by several impactful variables that move in parallel with the community needs, including international and global socio-economic trends.

The research adopts a hybrid model of conceptual theories to be compatible with studying the state policies addressing FGM/C as a social and behavioral community-centric practice. This hybrid model includes the **'Political System Analysis Approach'** developed to analyze the impact of the surrounding environment on the decision-making process in a political system by David Easton in 1957, and the **'ACT Framework'** (discussed below) was developed to measure changes in social norms related to FGM by Sood et al. in 2020, both diffused and operating within the **'Socio-Ecological Model'** developed by Bronfenbrenner in 1979 to study child- development.

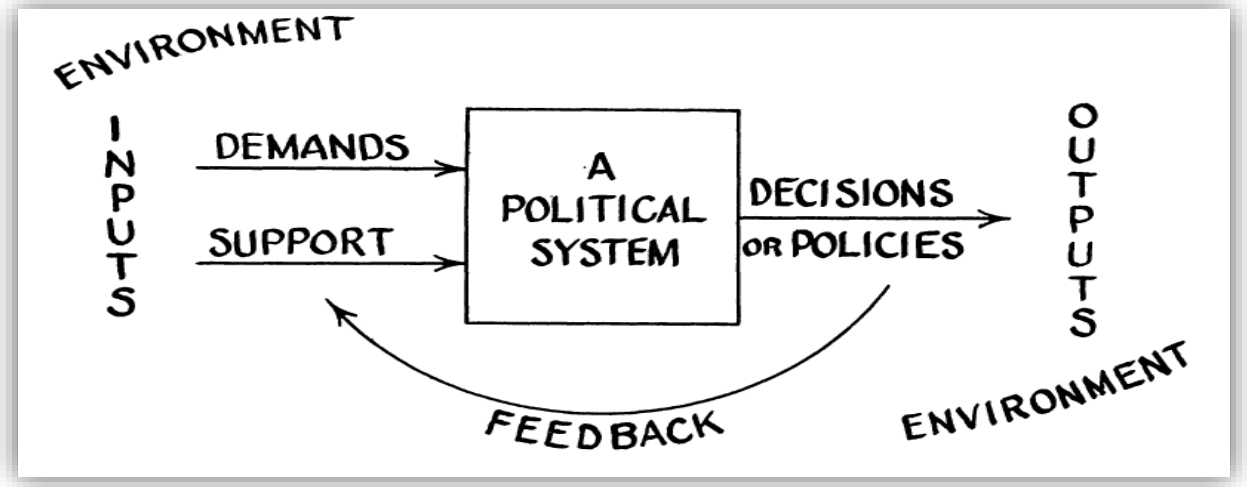
- ### Political System Analysis Approach

In this research, the concern is the policies resulting from the existing political system. In this sense, studying the behavioral change of the community as a stand-alone process is not accurate in understanding the reasons behind the delays in eliminating FGM/C in Egypt. Also, the behavioral change theories alone do not explain the reasons behind the community - living within an environment impacted by the decisions of a political system – resistance to changing a specific norm at a specific point in time.

In this regard, acknowledging the different elements that constitute a political system and formulate state policies is crucial. Also, acknowledging the fact that these political elements do not operate in a vacuum. They are impacted by an environment including international and national pressure elements. Society is composed of diversified political and religious backgrounds and affiliations affecting public opinion, eventually impacting policymakers, law enforcement authorities, and practitioners in contact with FGM/C practice.

Accordingly, David Easton's 'Political System Analysis Approach' (Easton, 1957), shown in **(Figure 1)**, will partially support the conceptual framework to explain the political system behavior toward ending FGM/C. The Egyptian political system has a cycle of inputs represented in community requirements and international commitments (demand and support elements). The political system is responsive to those inputs to provide outputs under the influence of an environment, including national and international laws, religious guidance, etc. These outputs are produced in the form of national legislations, decrees, national programs to end FGM/C, media campaigns, and others (decisions or policies) that impact the community and international expectations from the Egyptian government through a continuous feedback process that informs both the affected population and the policymakers, practitioners, religious leaders, law enforcement authorities, etc.

Figure 1: David Easton's Political System Analysis Model



(Easton, 1957, p.384)

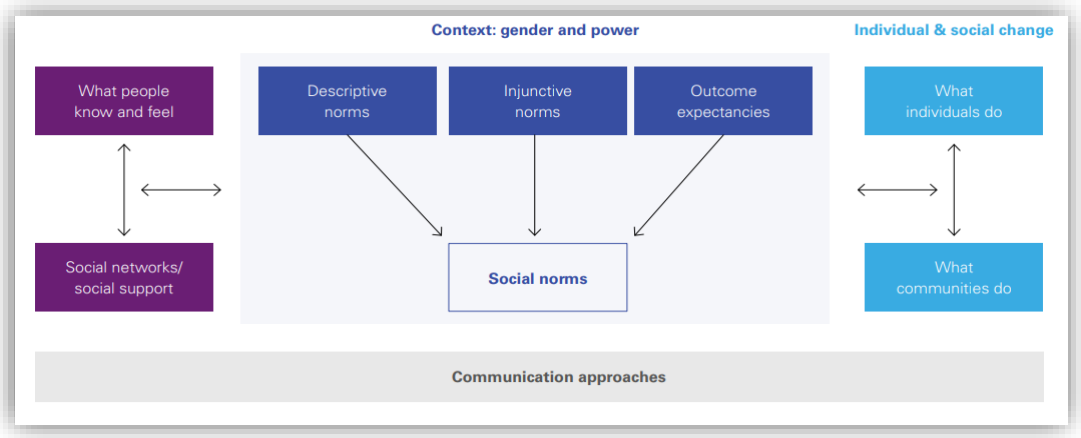
- **ACT Framework**

ACT is an FGM/C specially designed monitoring and evaluation framework to measure the changes in the social and behavioral change related to FGM/C practice using evidence-based quantitative and qualitative data. It is considered an operational conceptual framework to guide the interventions and implementation to end FGM/C based on global practices. It was developed to inform the UNICEF-UNFPA joint program to end FGM/C globally in partnership with Drexel University upon consultations with world experts on FGM/C (UNICEF et al., 2020).

According to Sood et al. (2020), the ACT "is an acronym for the different sections of the framework: (1) **A**ssess What People Know, Feel, and Do; (2) **A**scertain Normative Factors; (3) **C**onsider the Context, Especially Gender and Power; (4) **C**ollect Information on Social Networks and Support; (5) **T**rack Individual and Social Change Over Time; and (6) **T**riangulate All Data Analysis." Each of these six framework sections is reflected in a set of indicators used to measure the change in social norms and behaviors within a community suffering from FGM/C practice (UNICEF et al., 2020, p.6).

The ACT framework will complement the conceptual framework of the research to inform the policies with the needed interventions to successfully impact the community's social and behavioral change to end FGM/C. Although the research does not provide a design for program interventions, understanding the elements that affect community behaviors is a must to have a sustainable policy that can change the social norms in the longer term. The ACT framework is considered to be a communication approach, as shown in its conceptual framework **(Figure 2)**.

Figure 2: Conceptual Model behind the ACT framework

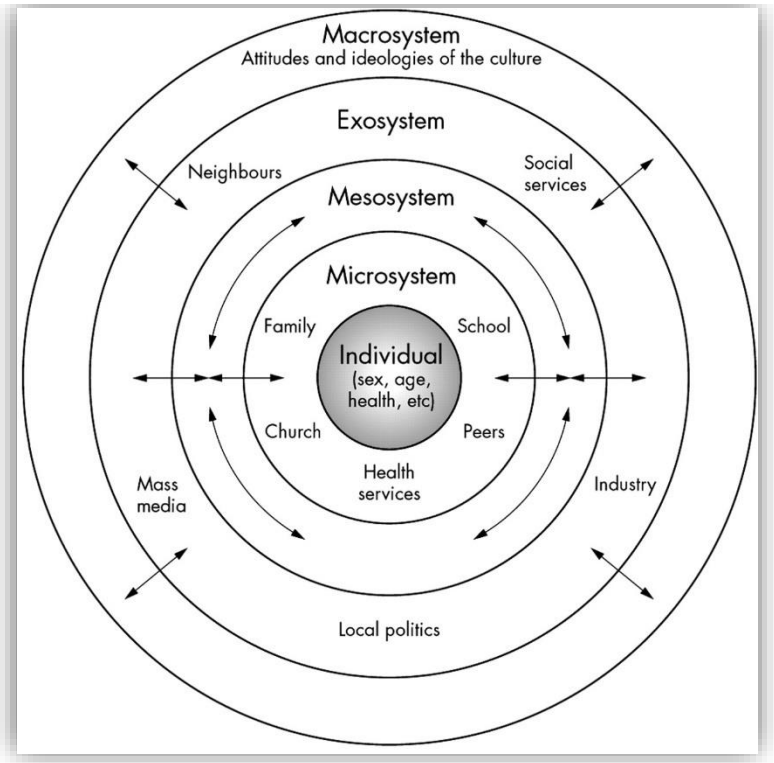


(Sood et Al., 2020, p.18)

- **Socio-Ecological Model**

Both the political system analysis approach and the ACT framework operate within a socio-ecological environment, where layers of influence impact the behaviors of the individual. Although the 'Political System Analysis Approach' explores political entities' behavior, the result of their behavior impacts the well-being of the individual served by the system. The same applies to the ACT framework concerned with the social and behavioral change within the society that is traced to the individual level. In Bronfenbrenner's (1974) socio-ecological theory, the researcher studied the environment surrounding the child and impacting their development. He concluded that five different socio-ecological levels have complex inter-relationships that affect the child's development, as shown in **(Figure 3).** In the Microsystem, the direct first interlocutors impact the individual's behavior, including family members, close friends, and daily work groups. In the Mesosystem, more complex inputs and increasing variables affect the individual's behavior, including school, work environment, peer groups, extended family, and religious structures such as churches and mosques. The Exosystem refers to greater socio-economic and political variables

Figure 3: Adaptation for Urie Bronfenbrennern's Socio-Ecological Theory Model of Child's Development



(McLaren & Hawe, 2005, p.10)

that could affect the individual's behavior as economic crises and political instability. The Macrosystem is the social norms, cultural background, and societal beliefs affecting the individual's behavior within all the ecological circles. There are mutual effects between each circle, one bigger and one smaller across the socio-ecological model (McLeroy et al., 1988).

This theory is crucial to understanding the core elements affecting human behavior considered as drivers to perform FGM/C. Although this research is not only concerned with victims of FGM/C from children but includes adult women as well, in most cases, the violation occurs during childhood to have a lifetime impact on the female individual. The five socio-ecological levels identified by Bronfenbrenner represent all the social spheres that the program implementation of government policies could target, including family, school, health services, religious organizations, social services, economical solutions, extended communities, and cultural references.

- ## Hybrid Conceptual Framework of the Research

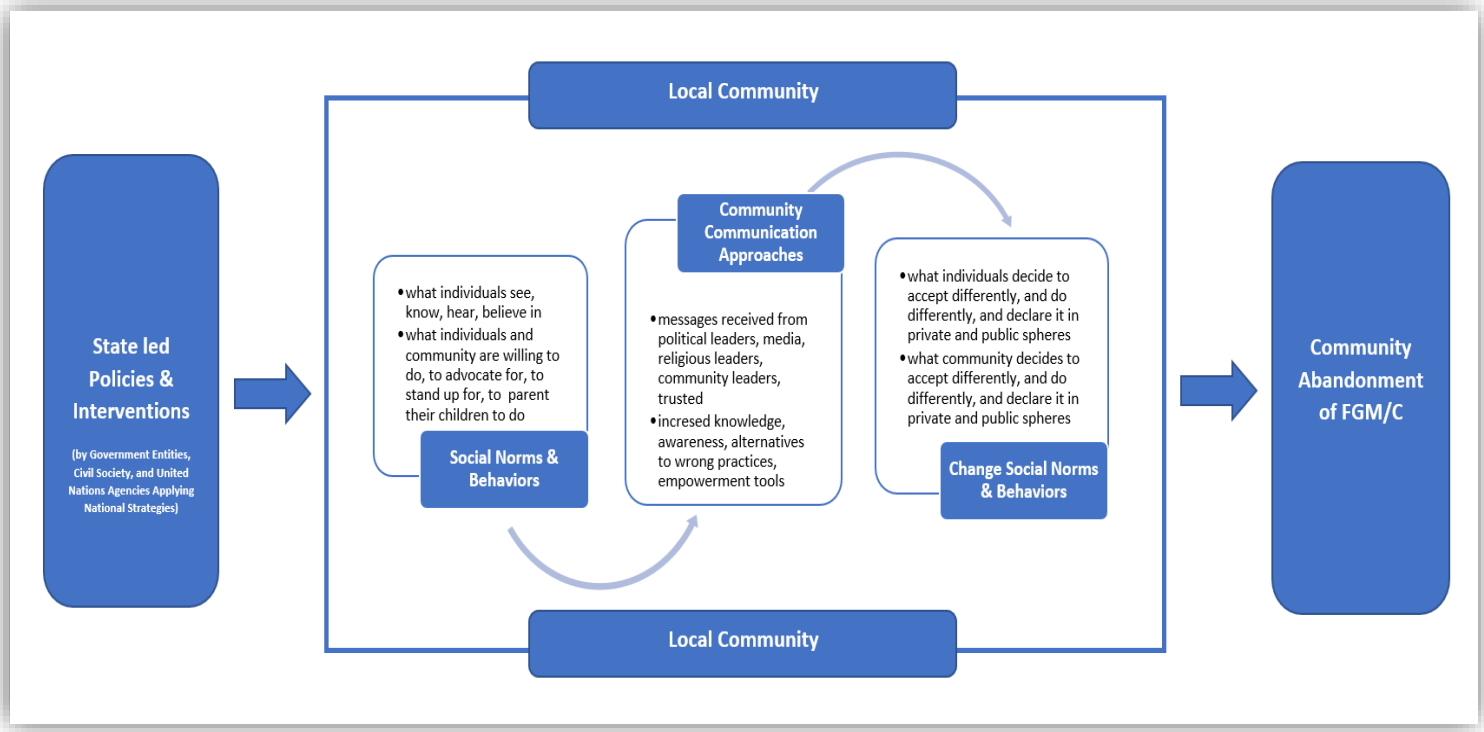
Based on Bronfenbrenner's Socio-Ecological Model, the ACT framework applies across micro and meso systems, while the political system fits in the Exosystem. Accordingly, this research will review the functioning of the ACT approach within the political system analysis approach. The state policies will be the inputs affecting the local communities where the socio-ecological model applies, which will result in ending FGM/C as a final output **(Figure 4).** The framework is divided into three parts conforming to a cycle of actions, impacts, and feedback that inform further actions as follows:

- **The state-led policies and interventions:** This is the starting point of the action cycle, including national laws and decrees, international laws endorsed and ratified by Egypt, official statements, strategies, and official practices related to law enforcement. It is both the legislative framework governing the practice of FGM/C in the state and the governmental strategic framework, which includes the planning and implementation methods adopted by the Egyptian government and their partners to reach the national targets of eradicating FGM/C.
- **The interaction within the local community:** This cycle phase is how and where the government policies and actions impact the community to influence the push and pull factors towards continuing or ending FGM/C. This is where the attempts to change the norms and behaviors

of the community members take place through various community communication approaches. In this phase, the norms, behaviors, and beliefs of the individual are identified, and the individual is subjected to a flow of information from the government, agents acting on their behalf (such as media, civil society, politicians, community leaders, public figures, public servants, etc.), and the surrounding community to influence their norms and behaviors to denounce FGM/C practice. This information formulates knowledge that is expected to change the individual's beliefs and how they choose to act and behave in their private and public spheres.

- **The community abandonment of FGM/C:** The success of the state-led policies and their communication to the community will eventually lead to the abandonment of the harmful practice of FGM/C and the accomplishment of the national target. The delay in the abandonment of the harmful practice will entail that either the policies or the communication approaches or both require changes or fine tunings to address the issue more effectively, which will be a community feedback to the state-led policies to push for further adjustments in addressing the prevalence of FGM/C practice in Egypt.

Figure 4: Hybrid Conceptual Framework to Study the Government Policies to End FGM/C add stakeholders



The ACT approach is chosen to explain how the state-led policies are communicated using tools that positively impact individuals' social norms and behaviors, either through direct government

interventions or other stakeholders applying state policies. It is also used to examine how the community perceives those policies to enable the community members to embrace the change, support it, and protect it to ensure the continuity of this change.

This conceptual framework could be applied to any community-based issue that requires a sustainable change of social norms and behaviors. In this research, the state policies, including law enforcement and awareness messages, and the means to communicate it will be revisited after a profound understanding of the communities' pull and push factors to denounce the harmful practice. Based on that understanding, new policies and interventions or adjustments to the current ones will be developed to reach a sustainable model to end FGM/C at an accelerated rate.

Chapter Two

Global Background on Female Genital Mutilation / Cutting

2.1 FGM/C Definitions, Types, and Overlapping Terminologies

The United Nations defined female genital mutilation or cutting terminology in a joint statement between the World Health Organization (WHO), United Nations Children's Fund (UNICEF), and the United Nations Populations Fund (UNFPA) in 1997. This statement was the first roadmap to clarify the United Nations' directions toward ending FGM/C globally. The statement included the definition, types, causes, and complications of FGM/C and the plan to include civil society and governments cooperating to end FGM/C. In addition to the legal status of the practice compared to the available international legislation at the time. The definition provided in the statement was **"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs whether for cultural or non-therapeutical reasons"** (WHO et al., 1997, p.3).

This statement was fully updated in 2008 through another joint statement that added more United Nations agencies to the leading three organizations: the Office of the United Nations High Commissioner for Human Rights (OHCHR), Joint United Nations Programme on HIV/AIDS (UNAIDS), United Nations High Commissioner for Refugees (UNHCR), United Nations Development Programme (UNDP), United Nations Economic Commission for Africa (ECA), United Nations Development Fund for Women (UNIFEM), United Nations Educational, Scientific and Cultural Organization (UNESCO), and United Nations Development Fund for Women (UNIFEM). In this statement, the definition and the types were updated to include the ones endorsed today. The definition of female genital mutilation and cutting became: **"all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons" (**WHO et al., 2008).

The first attempt to classify FGM/C was in 1847 by William Daniell, a British army surgeon stationed in different African countries during the British colonization of Africa, but he did not address all the FGM/C types (WHO, 1998). Several attempts to describe the types of FGM/C followed based on observing tribes in Africa and Australia (WHO, 1998). However, WHO realized

the need for a unified typology, accordingly they formed a technical working group in 1997, followed by the joint statement between WHO, UNFPA, and UNICEF providing a standardized definition, typology, and clear stance against FGM/C (WHO, 1998) that was updated later in 2008 **(**WHO et al., 2008). According to the WHO, there are four types of female genital mutilation based on the observations and reporting from the different communities known to perform FGM/C globally, to which most recent writings refer. This typology reflects a medical description serving obstetrics and gynecology perspectives to identify the different FGM/C cases. Those types were illustrated in drawing by different researchers, such as (Zurynski et al., 2017), to facilitate an understanding of the different categories of the practice for non-medical professionals and medical doctors who encounter the practice for the first time since it is not included in medical education. The most updated types are quoted from the WHO website as follows (WHO, 2022):

> **Type 1:** this is the partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals), and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans).
>
> **Type 2:** this is the partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva).
>
> **Type 3:** Also known as **infibulation,** this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans.
>
> **Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

The typology currently provided by the WHO became adopted by almost all modern researchers interested in studying FGM/C from a medical, developmental, or policy perspective. However, before the WHO provided the standardized definition and types used today, the researchers used slightly different typologies and terminologies referring to the segregations available in the communities they are studying, which started with the Graeco-Romans in Egypt around two centuries B.C. who were the first to give details on the FGM/C operational process (Meinardus 1967). FGM/C used to be an area of interest for anthropologists, sociologists, and historians -

especially before the U.N. joint statement in 2008 - who added to the medical descriptions a community-based angle that helped clarify the practice's normative origins and how it is deeply rooted in the subconscious of the local communities, and they usually refer to the non-WHO typologies till today whenever needed. A comprehensive example of the society-based typologies of FGM/C was provided by Kouba & Mouasher in 1985 (p.96), as quoted below:

> 1. **Mild Sunna:** the pricking of the prepuce of the clitoris with instrument, such as a pin, which leaves little or no damage. Sunna "tradition" in Arabic.
> 2. **Modified Sunna:** the partial or total excision of the body of the clitoris.
> 3. **Clitoridectomy/Excision:** the removal of part or all of the clitoris as well as part or all of the labia minora. The resulting scar tissues may be so extensive that they cover the vaginal opening.
> 4. **Infibulation/Pharaonic Circumcision:** consists of clitoridectomy and the excision of the labia minora as well as the inner walls of the labia majora. The raw edges of the vulva are then sewn together with catgut or held against each other by means of thorns. The suturing together, or approximating of the raw edges of the labia majora, is done so that the opposite sides will heal together and form a wall over the vaginal opening. A small sliver of wood (such as bamboo) is inserted into the vagina to stop coalescence of the labia majora in front of the vaginal orifice and to allow for the passage of urine and menstrual flow.
> 5. **Introcision:** the enlargement of the vaginal orifice by tearing it downwards manually or with a sharp instrument.

In addition to the aforementioned technical terminologies, there are other Arabic terminologies used by the Egyptian community to refer to FGM/C as **"Khafd"** meaning reduction or lowering (Assaad 1980), which is the least term used in modern days. **"Tahara,"** which means purification (Assaad 1980), and **"Khitan,"** which means circumcision. "Khitan" is usually used by policymakers, community groups involved in the efforts to eradicate FGM/C, and some community groups that endorse the harmful practice. Finally, there is **"khitan Sudani / Tahara Sudani,"** or the Sudanese circumcision, referring to the infibulation type of FGM/C (Abd el salam, 1999 and WHO, 1998).

It is important to note that the different terminologies referring to the harmful practice studied in this research have different annotations to different groups and are context-sensitive. When the research started on the practice of FGM/C, the term used was “female circumcision,” which raised concerns that naming the practice “female circumcision” in resemblance to “male circumcision” would give the impression that it leads to the same health results which are not accurate since female circumcision might lead to severe physical and psychological repercussions (BMZ, 2015). In addition, it could lead to confusion since male circumcision is recommended in many western medical societies and is a religious requirement for Jews and Muslims. To meet the need to distinguish the female from male circumcision and highlight the gravity of the practice, the term “Female Genital Mutilation” was introduced in the 1970s and was used mostly in medical and human rights contexts till the United Nations officially adopted it in 1994 (UNFPA, 2022a).

Nevertheless, the term “Female Genital Mutilation” is still not widely accepted by the research community or the affected population having the harmful practice, which led to adding the word “cutting” to replace “mutilation” when needed. The term “Female genital Cutting” was introduced by the end of the twentieth century to overcome the possible judgmental tone of the word “mutilation.” From the opposing point of view, the word “mutilation” is perceived as insensitive and accusable towards the families and caregivers continuing with the practice as part of their cultural heritage and might lead to stigmatizing the family and the victim (UNFPA, 2022a).

Due to the policy nature of this research, the term **“Female Genital Mutilation / Cutting”** or **“FGM/C”** will be used throughout the paper since it is the terminology adopted in the advocacy and legal documentation internationally and in the Egyptian context.

2.2 Theories about the Origin of the Practice

The origin of female circumcision has been debated among scholars without a consensus on a specific theory. These origin theories varied between pharaonic origins, tribal African sub-Saharan origins, and spreading the practice due to the expansion of the slave trade across and from African territories. The common theme among all those theories is the ancient timing of starting the practice at least two thousand years ago as community-based practice, especially in patriarchal communities (28 too Many, 2017).

- **Theories on Pharaonic Egyptian Origins**

One of the most commonly-cited theories about the origin of FGM/C is the Egyptian Pharaonic Theory. According to Kouba & Mouasher 1985, some ancient Egyptian mummies were circumcised while others remained uncircumcised (Maspero 1889, in Meinardus 1967), which might indicate that the practice varied from one dynasty to the other. This discovery was supported by the writings of Herodotus, the famous Greek historian, who assured that circumcision was practiced for males and females in Egypt upon his visit in 5 B.C. (Kouba & Mouasher, 1985). Also, other Greek historians confirmed the same information in different years B.C (Kouba & Mouasher 1985). Based on Chabas (1861) in Meinardus (1967), the circumcision operation is recorded on the walls of 'the little temple of Chonsu at Karnak, Luxor', returning to 1350 B.C. The drawing shows two assistants supporting the operation, who might be the mothers, although the gender of the circumcised was not apparent.

These findings were reinforced by the analysis of Meinardus (1967) of what he called 'the ancient myth of the bisexuality of the soul'. In his interpretation, Meinardus explained the pharaonic origin of the circumcision of both males and females in light of the assumption that some ancient Egyptian gods had bisexual souls according to their appearances in the drawings on temples. This assumption is derived from the pharaonic belief that all humans carry the spirits of both males and females, where females carry the male spirit in their "clitoris" and males carry the female spirit in their "prepuce". Thus, removing the clitoris from the female makes her an entirely feminine creature ready for sexual life, while removing the prepuce makes the males thoroughly masculine and worth entering the manhood society. This conviction is spread across different African places such as Mali (Isis International, n.d.). It is considered a puberty rite and a pre-marital rite.

This theory about the origin of female circumcision aligns with the current societal norms encouraging the continuity of the practice till today. Nowadays, female circumcision is still correlated with the girl's purity, readiness for sexual life, marriage, and husband obedience as long as she does not carry any male traits (represented in her clitoris) that might collide with her fully masculine partner and prepares her eventually for motherhood.

Female circumcision was connected to fertility as well. Ayrout (1959) and Sonnini (n.d.) in Meinardus (1967) highlighted the specificity of the lunar timing to perform the cutting.

Circumcision was favored during flooding of the Nile or within few days before the new moon, where both timings were connected with beliefs of high fertility.

Female circumcision continued and became universal in Egypt as a prerequisite for the girl to get married, and there is some evidence that it might have been practiced by non-Egyptians living in Egypt as well, maybe as peer pressure impact (Knight, 2001). Female circumcision was recorded in the second century B.C. Greek papyri as a requirement to get the girl a good husband, more considerable dowry, and better clothes (Kenyon n.d. in Meinardus, 1967). The circumcision of boys and girls was affirmed in correlation with the Jewish religion and became a normative practice in Egypt upon the child's birth (Jones 1932 in Meinardus, 1967). Female circumcision continued and was documented by Graeco-Roman physicians who confirmed circumcising boys and girls at the age of fourteen by the time they were expected to reach puberty (Meinardus, 1967). There was evidence that it was not till the Graecor-Roman era in Egypt that female circumcision started to be operated by surgeons using surgical and medical tools rather than midwives or equivalent with primitive tools such as razors, but the traditional performance continued in parallel (Knight 2001). Byzantine physicians in the sixth century A.D. explained in detail how female circumcision is operated on girls and highlighted that the reason behind it was to control the girl's sexual desire, which is triggered when the clitoris enlarges and gets in friction with her underclothes, thus Egyptians believed in the necessity of totally cutting it out (Meinardus, 1967).

Although female circumcision was not mentioned in the Quran or any Christian teachings, the practice prevailed among Muslims and Christians in Egypt from upper to lower Egypt, which was excessively documented by European historians and orientalists in the eighteenth and nineteenth centuries (Meinardus, 1967). Both Muslims and Christians managed to correlate the pharaonic rite with supporting evidence from a religious perspective, even if there was no proof of the religious origin; this was manifested in a quote from Meinardus 1967 saying, 'the Copts share with the Muslims the view that the "ideal woman" is a circumcised woman'. The religious evidence on the obligation to perform female circumcision was weak for Muslims and non-existent for Christians. However, it was necessary to justify the continuity of a pharaonic practice in the era of religious faith.

There are several documentations by scholars on how the practice spread across Africa. In his paper on Christian Nubia, Crowfoot (1927) confirmed the existence of several community practices in Nubia that were similar to those practiced in Ethiopia since pre-Christianity, one of

them is the ‘female infibulation’ known in Ethiopia as the ‘Pharaonic Rite’; which extended from Ethiopia to Nubia and continued till modern ages resisting the efforts of Islam to prohibit it. This observation by Crowfoot refers to channeling the practice from pharaonic Egypt to the rest of Africa rather than assuming that it originated in sub-Saharan Africa and communicated to Egypt. Other scholars mentioned that female circumcision was part of magical rituals that were never clear in the Egyptian context, where sacrificing these special parts of a woman’s body to a God or a demon is done in return for protection (Meinardus, 1967).

- **Theories on Sub-Saharan Africa Origins**

Upon exploring the possible African origins of female circumcision, some anthropologists argue that the FGM/C started much earlier than the evidence cited here, going back to the stone ages by the tribes inhabiting Africa along the equator as part of sacrificing rituals or very primary attempts to control reproduction (Lightfoot-Klein, 1983). On the other hand, some African tribes as The Bambaras and The Dogons from Mali, share the same belief as the Pharaohs, that the male carries female traits through his foreskin or prepuce; in contrast, the female carries male traits through her clitoris, requiring circumcision or excision to be a complete man and a woman (Isis International, n.d.). Nevertheless, the necessity of female circumcision in sub-Saharan Africa extends to other mythical convictions, including death risk if a man sexually encounters an uncircumcised woman and gets touched or stung by her clitoris, according to their belief. For the Mossis in Burkina Faso, the clitoris is believed to be a source of impotence, and if not, it might lead to the child's death upon touching it during birth. Furthermore, in tribes where polygamy is a norm, a woman’s excision is a core need to control her sexual desires when her husband has several wives that require his attention (Isis International, n.d.).

- **Theories on the Slave Trade Route Origins**

Another theory about how female circumcision originated and spread was “The Slave Trade Routes” (Mackie, 1996). Egypt exported enslaved people from sub-Saharan territories and sent them to Egypt and Persia during the pharaonic dynasties and Byzantines, which continued with the expansion of the Islamic trade for Sudanese maids and concubines (Mackie, 1996). The expanding trade routes in western and southern Africa through the Nile valley led to even more spreading of the practice (Mackie, 1996). This theory is argued to be closest to reality since the severity of the practice is at its most on the western shores of the red sea, and the severity decreases

gradually going to the west and south per the trade routes (Mackie, 1996). It is remarkable that not all the territories that were introduced to the cultures practicing FGM/C accepted the practice nor continued to practice it. For example, FGM/C is not practiced in the Arabian Gulf nowadays except in Yemen and Iraq, maybe in some countries on the western shore of the gulf transferred with foreign residents, and it is not practiced in the Kingdom of Saudi Arabia, although there is a probability that it was practiced there at some point in history upon transition by the slave trade.

According to Mackie 1996, This assumption was manifested in the practice of full sewing of the vaginal opening by some tribes in Somalia in the 1600s to ensure that their daughters selected for sending to gulf territories would not be at risk of pregnancy and would be trusted by their owners and sold at higher prices. Still, this theory might explain the spread of the practice with the slave trade but does not explain its origin, which might have been diffused among several cultures across ages, as we can find that the severest type of infibulation is called in Egypt "Sudanese circumcision," while the Sudanese call it "Pharaonic circumcision." (Kouba & Mouasher, 1985).

Finally, it is worth mentioning that the practice of cutting and deforming female genital organs to control her sexual desire or decrease the probability of pregnancy was practiced by different nations around the globe in different historical ages that were not correlated with the practice in Africa, but reflected the need to control the female virginity, sexual life, and preserve chastity. For example, some tribes in the Philippines, Amazon, and Australia practiced FGM/C (UNFPA, 2022a). The Skoptsies cult in Russia practiced male castration and female circumcision in the eighteenth and nineteenth centuries as a path to salvation (Engelstein, 1999). In Europe, gynecologists in the nineteenth century practiced clitoridectomy to treat hysteria and female masturbation as unacceptable behavior that needed to be restrained and continued afterward in the United States till the 1960s (Andro & Lesclingand, 2016). Also, Romans used another method involving the insertion of rings around the labia majora to prevent the pregnancy of enslaved women (Jawad, 1998).

Knight (2001) is quoted as saying that "modern commentators have frequently considered FGM in Egypt an ancient solution to venery - that is, excessive sexual desire and indulgence of sexual desire" (knight, 2001, p.318), which might be the reason embedded in the collective consciousness of the society, even if the modern mind is not admitting it. Nowadays, FGM/C continues to be practiced due to diffused cultures, religious interpretations, and socio-economic reasons, combined with a deep-rooted heritage beyond explanation but still persisting.

2.3 International Interventions to End FGM/C

In our modern history and recent times, ending FGM/C underwent several phases to be comprehended by local communities as a needed change and endorsed by governments in the form of an official narrative to ensure girls and women protection and active policies enforced on vast scales.

In the early 1950s, western governments and the United Nations had already observed FGM/C as a harmful practice to females, but they were reluctant to study it due to its cultural sensitivity to local African communities (Dillon, 2000). Nine years later, the WHO declined a formal invitation from the United Nations Economic and Social Council (ECOSOC) to discuss FGM/C under the umbrella of "ritual operations" affecting girls, justifying the decline as being out of their mandate. They did not start to have an official stance against FGM/C till 1979 (Dorkenoo & Elworthy, 1992, p.17).

Since the fifties and for twenty years later, the United Nations refrained from intervening explicitly in ending FGM/C, either by declaring a clear stance on the practice or providing technical or financial support to the countries with high prevalence. However, this did not discourage civil society and activist movements from addressing the issue in different African countries, and many research papers were developed, published, and distributed, creating social mobilization on the impacts of FGM/C practice on girls and women. Voices demanding to end FGM/C started to be heard primarily in Sudan, Senegal, and Cameroon, extending to western researchers addressing the dangers of infibulation and encouraging action to end it. In addition, local activists requested national campaigns on the negative impacts of excision and demanded support from international organizations and NGOs (Dorkenoo & Elworthy, 1992, p.17-18).

In 1979, the WHO started to address ending FGM/C through a regional seminar on "Traditional Practices Affecting the Health of Women and Children". Ten Arab and African countries attended the seminar, including Egypt, where the seminar's recommendations were directed to the respective governments to set the ground rules to address the abolition of the practice on the national policy level. Those recommendations focused on four main requirements: having an explicit national policy to end FGM/C, establishing a national coordinating body on all government interventions related to abolishing FGM/C including legislation, prioritizing public

awareness of the harmful impacts of FGM/C, especially from a health perspective, and expanding the knowledge of the traditional health practitioners and midwives on the negative impacts of FGM/C (Dorkenoo & Elworthy, 1992, p.18). All the recommendations threw the load on the local governments without tangible assistance from the WHO in implementing those recommendations or providing financial or technical resources.

On the other side, The United Nations Children's Fund (UNICEF) did not get involved in ending FGM/C till 1980 after having a joint plan of action with WHO based on primary health care and community-led approaches to end FGM/C. This action plan focused on advocating the need to end FGM/C among UNICEF and WHO staff in the affected countries, supporting national entities involved in ending FGM/C, and encouraging research and surveys to assess the situation and disseminate its results to share knowledge. Still, financial allocations did not support this action plan too. Nevertheless, the responsibility to fulfill this plan was fully assigned to the United Nations agencies' country offices and government counterparts (Dorkenoo & Elworthy, 1992, p.19). Governments hardly implemented any of these recommendations at the time, and they were not tempted by the willingness of WHO and UNICEF to support mobilizing financial resources to them to help achieve the recommendations (Dorkenoo & Elworthy, 1992, p.18).

During the United Nations decade for women (1975-1985), ending FGM/C was widely discussed on international platforms, although not necessarily by government representatives. One of the main milestones was the "Copenhagen Non-Governmental Organizations Forum" held in 1980, in which 8000 women from 120 countries attended to discuss women's health, education, and empowerment issues. FGM/C topic was discussed in extended sessions beyond the planned agenda due to the high demand for addressing the issue, which was considered a paradigm shift for some countries that could not mention anything related to FGM/C in public fewer years before (Dorkenoo & Elworthy, 1992, p.19-20).

The stances of the participating countries varied from showing their advanced programs to end FGM/C as Sudan and Kenya to rejecting the discussion of abolishing FGM/C as Burkina Faso, whose delegation withdrew from one of the sessions in objection to putting the abolishment of FGM/C as a priority by western participants and donors at the expense of other dire issues such as food and clean water (Dorkenoo & Elworthy, 1992, p.20). Different African participants expressed their resentment to the pressure posed by American and European participants and African migrants to the west, who were not adequately aware of the African social and cultural context.

They criticized the extensive push for ending FGM/C to the top of the global political agendas by requesting the "immediate abolition of the barbaric action" at the expense of other core basic survival needs for the African populations, especially that addressing the abolishment of FGM/C was considered an unacceptable colonial and post-colonial interference. At the same time, the open discussions revived the trauma of some African female participants, who started to perceive their circumcision as a painful physical and psychological experience (Dorkenoo & Elworthy, 1992, p.20).

This informal forum and other similar events provided a space for dialogue, helped moderate the extremist views on both ends of the spectrum and paved the road to a global political consensus on ending FGM/C. It also helped manage the related expectations to the roadmap to end FGM/C, where FGM/C became a global cause to safeguard girls and women. This transformative vision was manifested in all international laws and conventions compiled by the World Bank (2021) in the "Compendium of International and National Legal Frameworks on Female Genital Mutilation" and summarized in the annex of the WHO (2016) (p.41- 42), in addition to the United Nations Sustainable Development Goals (United Nations, 2015).

2.4 Implications of FGM/C on Girls and Women

FGM/C is a painful process on the physical and psychological side, with no health benefits. The degree of severity depends on many factors, including the type of FGM/C, the general health status of the woman or girl, their age, the hygiene environment, the operator's skill, the tools used, and the resistance of the victim. The implications can extend to general health, sexual and reproductive health, and pregnancy and childbirth, besides the psychological implications that might persist with the woman or girl throughout their lives (Baron & Denmark, 2006).

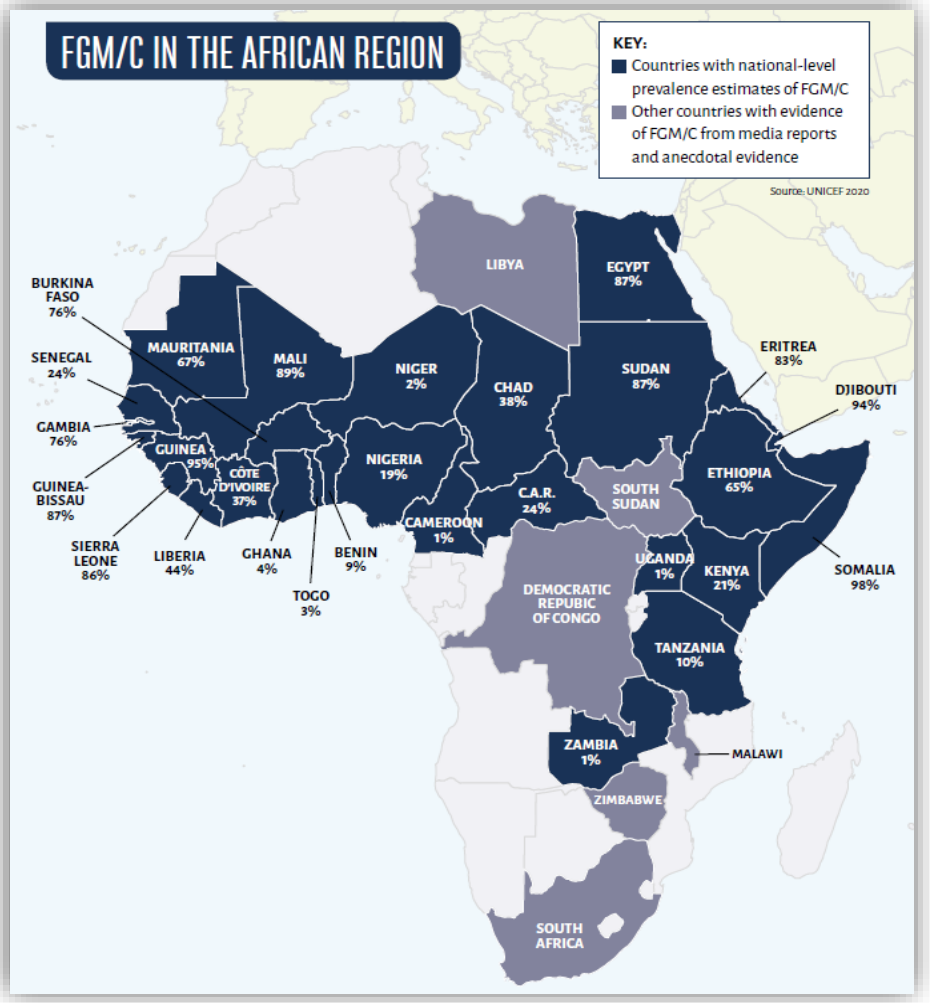
The implications during and right after the circumcision or infibulation might include severe blooding leading to anemia or death, body shock, infection, and gangrene in case the tools or the operators are not sanitized. The resistance of the victim during the operation or the lack of skill of the operator might lead to further damage to the surrounding tissues and organs that might lead to permanent damage to the urinary and reproductive systems (White, 2001). In the longer term, problems in the urinary system might arise in addition to vaginal and menstrual problems. Difficulties in sexual intercourse might arise, including excessive pain and dissatisfaction, anxiety, and marital problems. Upon pregnancy, difficulties in delivery and the probability of needing a

cesarean section increase, including the risk of newborn mortality. In the case of infibulation, the woman might need to be deinfibulated several times upon marital intercourse and with each pregnancy which will keep the woman at ongoing health and psychological risk. Finally, the psychological risks include trauma, depression, stress, stigmatization, and others. (WHO, 2022).

2.5 Geographic Prevalence of FGM/C

There is evidence that FGM/C is now being practiced in 92 countries around the globe, where FGM/C is not necessarily universal but practiced within specific communities inside each country (UNFPA, 2022a). The most affected continent is Africa, with 33 countries suffering from a very high prevalence of FGM/C, as shown in **(Figure 5),** which was based on UNICEF data in 2020 (End FGM European Network et al., 2020).

Figure 5: Prevalence of FGM/C in Africa

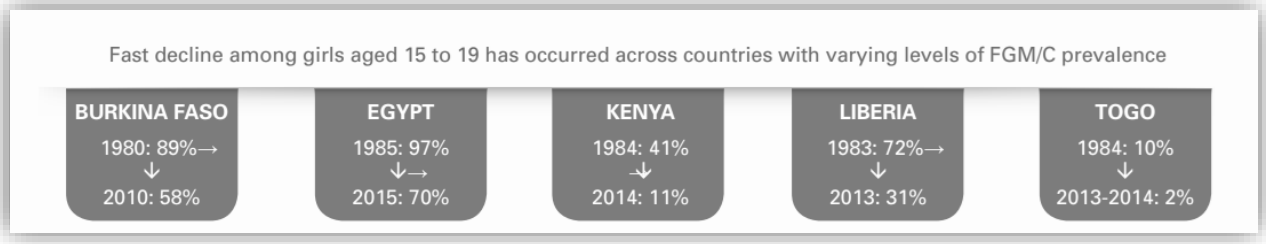


(End FGM European Network et al., 2020)

Followed by Asia, where FGM/C is practiced in some communities in India, Indonesia, Malaysia, the Maldives, Pakistan, and Sri Lanka; and in the Middle East in some communities in Yemen, Oman, the United Arab Emirates, Iraq, Iran, Jordan, and the State of Palestine. In addition to communities in Eastern Europe and South America, such as Georgia, Russia, Colombia, Ecuador, Panama, and Peru (UNICEF, 2022b). Moreover, the occurrence of FGM/C practice has been reported in the last four decades in migrant-receiving developed countries as the United States, United Kingdom, Canada, Germany, and others, where the practice continues by the migrants and refugees from the countries known for its universal practice of FGM/C (UNFPA, 2022a). According to UNICEF's global database, based on the Egyptian Demographic Health Survey (EDHS) 2015, Egypt and Sudan rank fifth in the prevalence of FGM/C among girls and women aged (15- 49) after Somalia, Guinea, Djibouti, and Mali (UNICEF, 2022a).

Among the countries mentioned above, an average of 200 million girls and women survive after being cut in the countries with the highest prevalence of FGM/C (UNICEF, 2022b). In contrast, the number of girls at risk of being cut is still very high, reaching three million annually (WHO, 2013). The global and national efforts led to a decline in prevalence percentages in some countries, although the decline was not in all countries nor at the same rate as shown in some UNICEF statistics in **(Figure 6).**

Figure 6: A Significant Decline in FGM/C Prevalence in Some Countries among girls aged 15-19



(UNICEF, 2016)

This decline was further challenged after the Covid-19 global crisis. There are estimations that the containment measures taken to face the coronavirus, including home confinements and school closure, besides the economic consequences of the pandemic on the households, encouraged an increase in the performance of FGM/C in the most affected communities, causing a setback in the progress achieved so far. In April 2020, UNFPA, with contributions from Victoria University, Avenir Health, & John Hopkins University, published a technical note expecting a one-third

decline in the progress achieved in ending FGM/C globally by 2030 and expecting the occurrence of more than two million FGM/C violations over the coming decade that could have been avoided if it were not for the pandemic. However, there is no statistical evidence published confirming this hypothesis.

2.6 Prevalence Attitudes of FGM/C

Among the countries with the highest prevalence rates and representative data, more than 50% of girls and women believe FGM/C should continue, including Egypt (UNICEF, 2022b). Simultaneously, FGM/C has declined globally in the past thirty years, between 1991 and 2021, from 49% to 34% among girls in the age bracket of 15 to 19 (UNICEF, 2022b), but the decline rates were uneven between most affected countries. The decline rates of FGM/C in countries with the highest prevalence were evidence-based among girls aged (15-19) as in Egypt, Burkina Faso, and Kenya (UNICEF, 2022b).

Chapter Three

Contextual Analysis of FGM/C Policies in Egypt

This chapter will provide a detailed overview of the FGM/C context in Egypt based on the published data till August 2022. An overview of the historical development of policies will be followed by the statistical trends and the factors affecting the persistence of the harmful practice in Egypt to clarify the basics of the policies placed to end FGM/C in Egypt.

3.1 Modern History Policy Development

The speculated origins of FGM/C in Egypt indicate that the society endorsed and honored the practice across generations and history, although the drivers to continue the practice might have varied slightly over time. With the rising global trend criminalizing the act and the awareness about its irrelevance to any medical benefit correlated with mortalities and physical and psychological harms, in addition to labeling the practice as a violation of human and women's rights, the opposition to FGM/C practice started to appear in Egypt among the educated elite in the twenties of the twentieth century and combined with a robust feminist movement to which most of the wins related to women's legal rights are indebted.

In 1920, The Egyptian Physician Association first discussed the topic and called for prohibiting the practice of FGM/C due to its health implications. This initiative was backed up by physicians of the Ministry of Health and significant Islamic scholars. In 1940, it was recorded that a question was directed to a leading Muslim Sheikh in a famous Islamic journal on whether FGM is Sunnah (following Prophet Muhammed's practices) or Fard (Compulsory as an explicit request by Allah for all Muslims), the response was not archived though (Serour & Ragab, 2013).

Since the 1920s, the discussion of banning FGM/C has been sporadic and considered a public taboo, as there is no reachable record of public opinion about the proposed ban at that time. Until the 1950s, no evidence ending FGM/C continued to be discussed by Egyptian scholars or practitioners nor grasped the attention of politicians. In 1951, "Liwa Al Islam", a credible Islamic journal, surveyed the opinion of top religious leaders in Azhar, and they resulted that "FGM/C is a mere matter of habit, which might be abandoned if there is strong scientific evidence that it is harmful," which was considered a progressive opinion at the time. (Serour & Ragab, 2013, p.2).

The first official governmental stance against FGM/C practice was represented in **the ministerial decree 74 in 1959** by the Ministry of Public Health on behalf of a committee structured of fifteen physicians and Islamic religious leaders, including a former and the empowered Mufti of Egypt back then. This decree stated four core regulations: Only medical doctors are allowed to perform FGM/C, and the cutting must be partial and not infibulation or complete clitoridectomy; FGM/C is banned in all official premises of the ministry of health, including the primary healthcare units (PHUs) and public hospitals; All officially licensed midwives are not allowed to perform any surgical operations including FGM/C; And the decree confirmed that the way FGM/C is performed then has medical and psychological implications on women either before or after marriage (Gomaa, 2020). This decree was reconfirmed through the Ministry's Maternity and Child Health Department in 1978, especially regarding forbidding traditional midwives from operating FGM/C and banning FGM/C performance in public hospitals (28 Too Many, 2017). Unfortunately, the decree created much confusion, as it did not ban FGM/C since doctors were allowed to perform it in private clinics upon the request of caregivers, and the traditional midwives and barbers neglected it and continued to perform FGM/C, in addition to the disagreement between Islamic leaders on whether FGM/C of type 1 and type 2 are acceptable in Shariiaa or not (Dillon, 2000).

The national pathway to end the performance of FGM/C in Egypt was fueled by different female activists who paved the road for Egyptian society to open for discussion and accept the ending of female genital mutilation. Marie Assaad was a leading icon who started since the fifties academic research to end FGM/C, and she helped mobilize civil society to research topics related to women's health and FGM/C (NCW, n.d.). Also, Nawal El Saadawi, a physician and activist, started addressing FGM/C in the seventies and conducted field surveys, research, and published articles on the implications of FGM/C on girls and women in Egypt and the urgency to end the practice (28 Too Many, 2017).

In 1963, "Cairo Family Planning Association" (CFPA), led by Aziza Hussein, was a pioneer in addressing family planning and women's health issues. A leading gynecologist, "Dr. Mahmoud Karim," approached them and requested to add FGM/C as a topic on their agenda, but despite being progressive, CFPA leading team was intimidated to address such a controversial topic in addition to family planning, which was already sensitive at the time (Hussein, 1994).

CFPA became the only organization in Egypt to address the issue of ending FGM/C (Hussein, 1994). In 1979, the International Year of the Child, CFPA contracted a researcher to assess the prevalence of FGM/C in Egypt, which resulted in 80% of the interviewees in rural and urban areas being circumcised (Hussein, 1994). Accordingly, CFPA hosted a groundbreaking seminar on the physical mutilation of girls and launched a national plan to end FGM/C by promoting public awareness through media, women's associations, and education platforms. The association developed an independent organization in 1992 called **"The Egyptian Society for the Prevention of Traditional Practices Harmful to Women and Children**" (Hussein,1994), which continued under the leadership of Aziza Kamel till 1996, targeting community leaders and policymakers to build their capacities and raise their awareness on their mandated roles in ending FGM and raising the public's awareness. They reached thousands of officials and community leaders through training workshops and tens of thousands of community members (Dillon, 2000).

The United Nations "International Conference on Population and Development" **(ICPD)** held in Cairo in **September 1994** coincided with many incidents and aspects that accelerated shifting the state policies toward ending FGM/C. The 1994 ICPD is considered a turning point in the battle against FGM/C as it started to recognize the practice as a violation of human and women's rights, not only a health hazard, one of the activists was quoted reflecting on this shift: "Whether or not female genital mutilation leads to infection, shock, or death, it is a violation of women's bodily integrity and their reproductive and sexual rights. It is a human rights violation even if it is done in hospitals under anesthesia and in aseptic conditions" (Abd El Hady, 1997).

It is important to note that at that time, in the mid-nineties, there was no consensus among the governmental leadership on the way forward regarding the issue of ending FGM/C. Although the medical implications were undeniable, the government was aware of the highest possible backlash on any attempt to restrict the performance of FGM/C. The backfire was expected from the population believing in the cruciality of the cutting to preserve their girls' pride, the traditional practitioners (barbers, accredited midwives, Dayas) and medical doctors who make a living from cutting the girls, and above all, the Islamic leaders who vigorously defended the cutting as part of Sharia and attacked all possible policy attempts to control performing FGM/C labeling it as westernized attempts to corrode the Islamic identity of the state. It is worth mentioning that the

mid-nineties was an era of tense confrontations between the government and radical Islamic terrorist groups (Rashwan, 2016).

In preparation for the conference, Marie Assaad and Aziza Hussein mobilized more than 60 NGOs and associations, representing physicians, human rights and women rights activists, and civil society organizations from all over Egypt to support the move to end FGM/C. Before the ICPD, the Minister of Population "Maher Mahran" acknowledged the prevalence of FGM/C practice in Egypt and was skeptical regarding the impact of legislation criminalizing its performance. He feared it might lead to the discrete performance of the cutting, which would entail more danger to girls; as a solution, he called for community education to address the deeply grounded faulty beliefs related to girls' marriageability and passage rites to womanhood. Mahran expressed his view before the ICPD in parallel to discussing a legal motion in parliament to enforce penalties on the parents who circumcise their children. He believed that the parents would rather pay the penalty than halt the circumcision of their daughters (Murphy, 1994).

During the conference, official confusion was apparent in the stances of the Minister of Health "Dr. Ali Abd El-Fattah" who stated that FGM/C is rarely practiced in Egypt (Dillon 2000). Unfortunately, on the second day of the conference, a short documentary was released by the American Cable News Network (CNN) showing a ten-years-old Egyptian girl being circumcised by a traditional barber with the blessing of her father (AP News, 1994), which caused the embarrassment of the political leadership and provoked more strict regulations against practicing FGM/C (Dillon 2000). The video's airing created heated public discussions on the topic and led to arresting the father, the barber, and others who facilitated the crime, but the father was bailed out, and a lawsuit by an independent lawyer was filed against CNN for damaging the reputation of Egypt by airing that footage, but the court rejected it in 1997 (AP News, 1994 & Ghalwash, 1997). Later during the conference, the health minister revoked his stance and promised the international community to have a national legal penal code for the performance of FGM/C (Dillon 2000).

After the conference, the **"Egyptian National FGM Task Force"** was formed in **November 1994** as a development of the NGOs coalition created prior to the ICPD. The task force aimed to encourage public dialogue and raise awareness of the harmful impacts of FGM/C on a national scale, but they were not aiming to create a legislative framework specially designed to deter the performance of FGM/C. They believed that people perform FGM in response to traditions or "Orf"

and not laws. Also, the existing criminal law could be used to deter the performance of FGM/C. They believed that factual awareness and community dialogue could create momentum leading to legislative amendments later as needed (Dillon 2000). This task force continued to strive and spread awareness against FGM/C practices till it was dissolved in **1999** by Suzan Mubarak, the first lady (Dillon 2000), to include its mandate in the roles and responsibilities of **"The National Council for Childhood and Motherhood" (NCCM)** as a formal national structure (28 Too Many, 2017). In this regard, it is a duty to acknowledge the role of Suzan Mubarak in pushing forward all women and children portfolios and supporting the legislation concerned with safeguarding women's and children's rights in Egypt.

After the ICPD, the health minister "Dr. Ali Abd El Fattah" created a **"Higher Committee for the Elimination of FGM,"** which convened only once and was also skeptical about advocating for a legislative ban on FGM/C that might push for underground performance. The minister was pressured to revoke the ministerial decree no.74 in 1959 and released a new statement in **October 1994** to continue performing FGM/C only in public hospitals, exclusively by medical doctors. He ordered the opening of public hospitals to receive cases of girls requesting circumcision once a week, where they would be received by a gynecologist, social worker, religious leader, nurse, and anesthetic committee to convince the caregivers not to perform FGM/C for their daughter. If the caregivers insisted, after several persuasion trials, the operation would take place in proper medical condition. The minister considered this process a mid-way step to eliminate FGM/C (Dillon 2000).

The ministerial statement led to a continuous performance of FGM/C normalized the **medicalization** practice. It deepened the public misconception about FGM/C, as broad clusters believed that FGM/C performed by physicians is not harmful and that cutting through traditional health practitioners is the only harmful type, which led to increasing the reliance on medical doctors to perform FGM/C on a wide scale across Egypt. As a result, a lawsuit was filed by activists and journalists against the minister of health for promoting harmful practices and misleading the public; accordingly, the public hospitals were secretly ordered to halt FGM/C operations.

In 1996, two girls died from performing FGM/C (El Shazly, 2017). Later, the newly appointed minister of health "Ismail Sallam" issued **decree 361/96** to ban FGM/C in all public and private hospitals, except if diagnosed as a medical necessity by the head of the gynecology department. This decision was applauded by physicians and condemned by some Islamic religious figures who

filed a lawsuit against the decision as unconstitutional. A primary administrative court first accepted the lawsuit and halted the implementation of the ministerial decree. The lawsuit acceptance was revoked by the supreme administrative court, which affirmed the ministerial decision, confirmed the ban of physicians and health practitioners from performing FGM/C even upon the request of caregivers, and assured that performing FGM/C fits under the criminal code penalizing the practitioner to three years in jail for causing intentional physical harm (Dillon, 2000). Later that year, the results of the 1995 EDHS were announced, proving an extremely high prevalence rate of FGM in Egypt, with a percentage of 97% among ever-married women and a 90% prevalence among women having secondary and higher education, which meant that there were almost 9 in every ten women circumcised in Egypt (El-Zanaty et al., 1996). The officially published EDHS 1995 in December 1996 excluded the FGM/C section (Abd El Hady, 1997).

FGM/C was not criminalized by law till 2008, which was fortified in 2017, then again in 2021. Over the years, several girls' deaths resulted from performing FGM/C, which kept the issue within the public interest and lowered the voices in favor of the harmful practice. The state policies and the implementation through civil society became more mature over the decades, leading to a decrease in the prevalence rate of FGM/C among ever-married women, reaching 85.6% in EFHS 2021 (CAPMAS, 2022), which is a positive development that still needs to be accelerated. The following sections will discuss in-depth insight into the prevalence rates and policies.

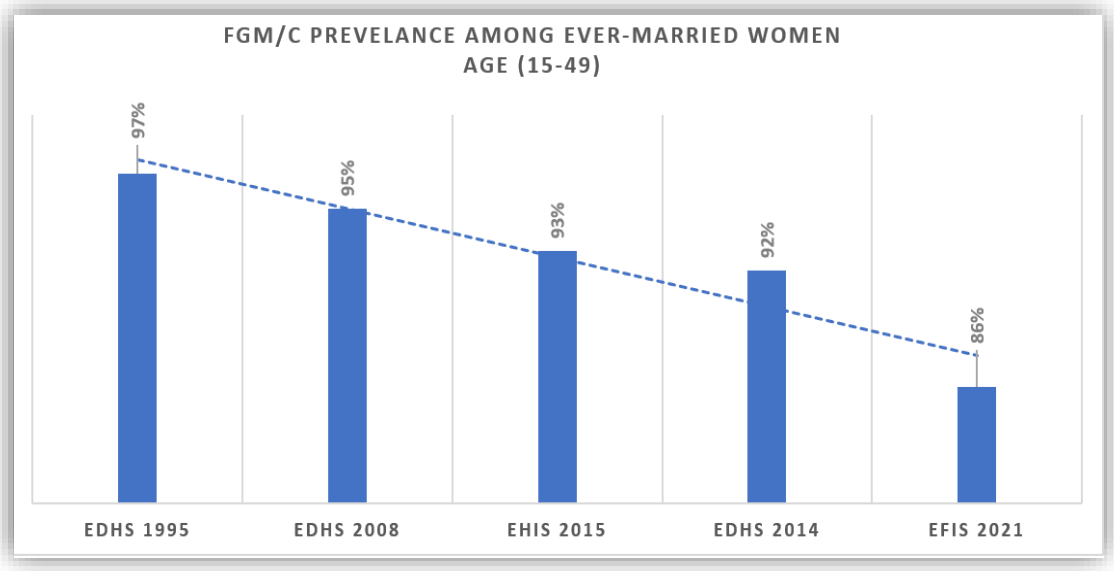
3.2 Evidence-Based Trends

FGM/C prevalence rates have been officially recorded since 1995. Before that date, the FGM/C was not scanned nationally and was not part of the Egyptian demographic and health surveys or other health-related surveys. After the ICPD, the prevalence rates and relevant indicators were surveyed nationally to confirm that FGM/C has a universal prevalence rate of 97% among ever-married women aged 15- 49. This percentage started to decrease steadily in each subsequent survey reaching 86% among ever-married women aged 15- 49 in 2021, as shown in **(Figure 7)** (El-Zanaty et al. 1996, El-Zanaty 2009, El-Zanaty et al. 2015, MoHP 2015, CAPMAS 2022).

In 2021, The Central Agency for Public Mobilization and Statistics (CAPMAS) conducted a national family health survey (EFHS). The executive summary only was published in august 2022, showing the main highlights related to FGM/C's current status without quantitative analysis or

details on the background of the announced figures(CAPMAS, 2022). The results in the executive summary confirm a significant decline in the percentage of FGM/C performance among ever-

Figure 7: FGM/C Prevalence Rates among Ever-married Women aged (15-49) in Egypt

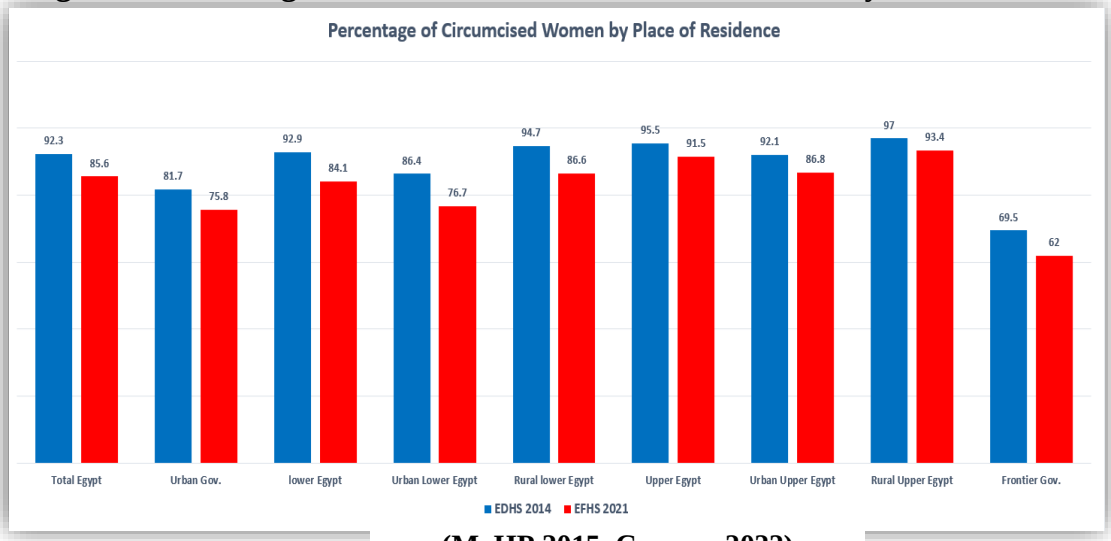


(El-Zanaty et al. 1996, El-Zanaty 2009, El-Zanaty et al. 2015, MoHP 2015, CAPMAS 2022)

married women to reach 86%, with a 6% decline in seven years since the last EDHS in 2014 (MoHP, 2015). All published results will be covered in the following section.

Geographical Prevalence: The percentage of circumcised women in urban areas stays significantly lower than in rural areas, with 79% to 90%, respectively. The overall circumcision in

Figure 8: Percentage of Circumcised Ever Married Women by Place of Residence

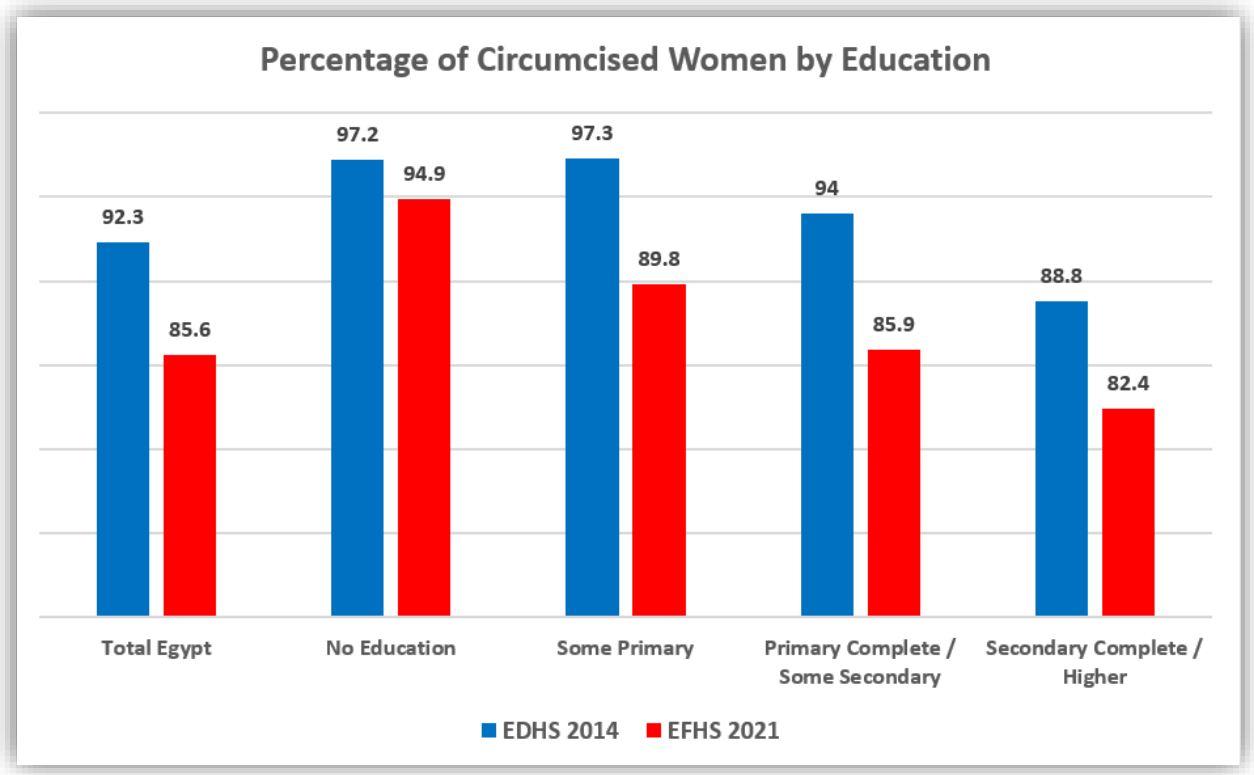


(MoHP 2015, Capmas 2022)

upper Egypt is still higher than in lower Egypt, with 91.5% and 84.1%, respectively. The decrease in the overall circumcision rate is reflected in the geographical prevalence, where FGM/C in EDHS 2014 in upper Egypt was 95.5% and in lower Egypt was 92.9% **(Figure 8).**

Education: The correlation between higher education and lower FGM/C rates is persisting, although the gap in favor of education is widening, which confirms the basic policy theory that more education and awareness will allow more empowerment to girls and women to denounce FGM/C and any other violation to their rights. However, this theory needs to be affirmed with more data on the economic status and employment that are not yet revealed and plays a substantial role in girls' and women's empowerment alongside education **(Figure 9).** In 2014, the percentage of circumcised women with no education was 8.4% higher than the ones who completed secondary school or had higher education. In 2021, the gap increased to 12.5% in favor of highly educated women.

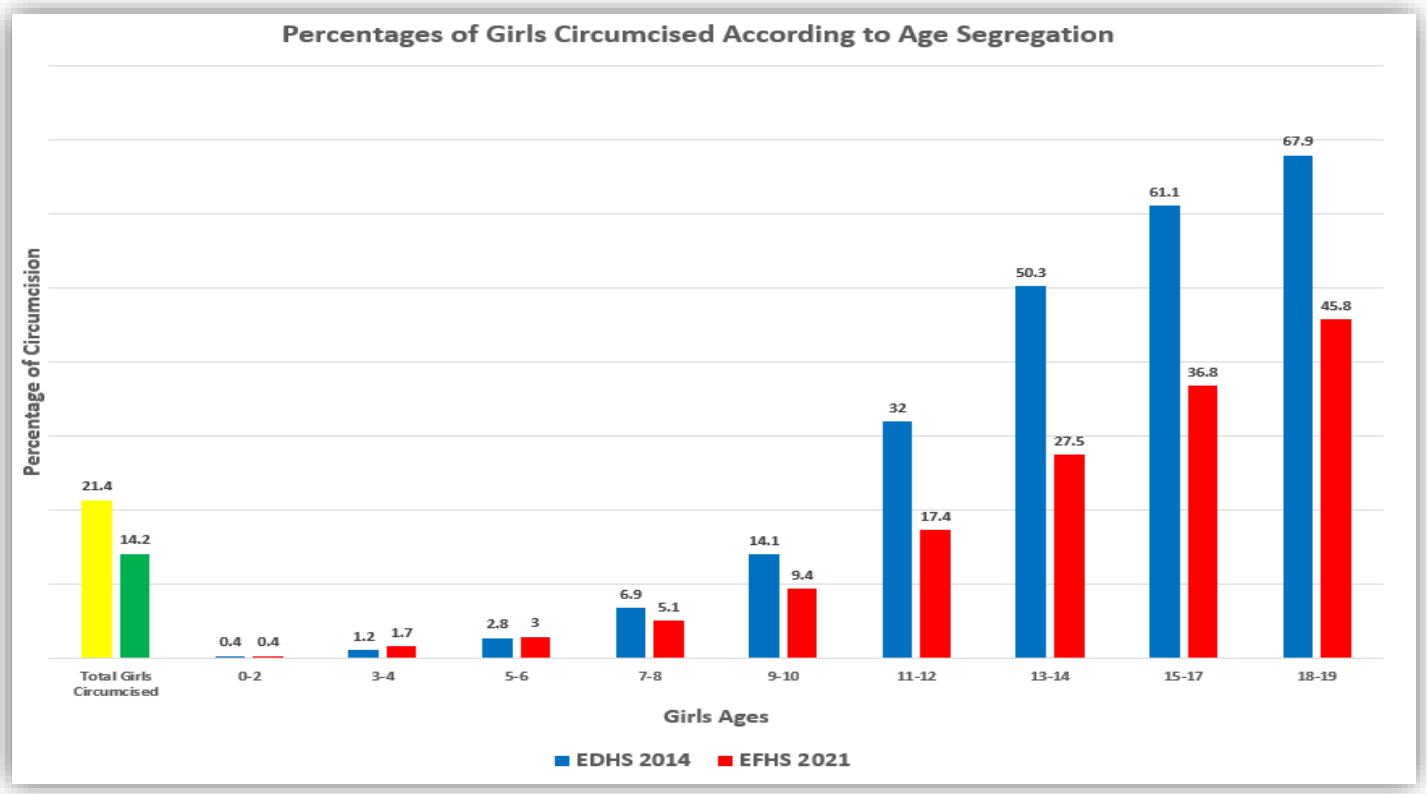
Figure 9: Percentage of Circumcised Ever Married Women according to their Level of Education



(MoHP 2015, Capmas 2022)

Age of Cutting: According to EFHS 2021, the number of girls circumcised between the age of zero to nineteen has dropped by 7.2%, which is consistent with all other decreasing FGM/C percentages but does not guarantee that the girls would not be circumcised at a later age. In **(Figure 10),** it is clear that the rate of circumcision increased sharply at the age of (11-12) which is relatively later than the typical rush to circumcision before puberty at the age of (9-10) as in 2014. This shift requires more data to analyze its causes, whether hesitancy to perform FGM/C or peer pressure or if the average puberty age for Egyptian girls has changed to an older range. The total number of girls surveyed in this regard was 23,090 in EDHS 2014 and 24,182 in EFHS 2021.

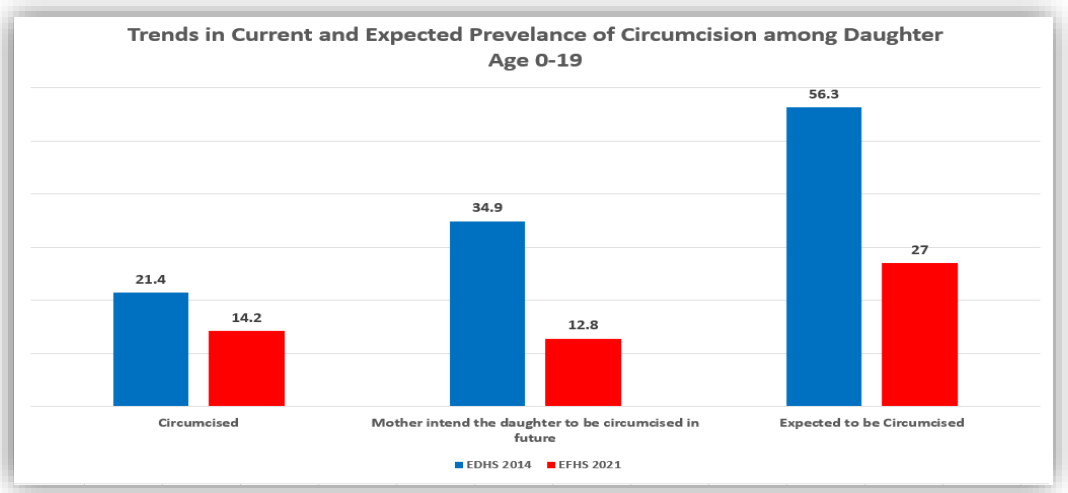
Figure 10: Percentages of Girls Circumcised according to Age Disaggregation



(MoHP 2015, Capmas 2022)

Future Projections: The expectations for women to circumcise their daughters in the future decreased dramatically from 56% in 2014 to 27% in 2021, which will be undeniable proof that the state policies are on the best track to end FGM/C **(Figure 11).**

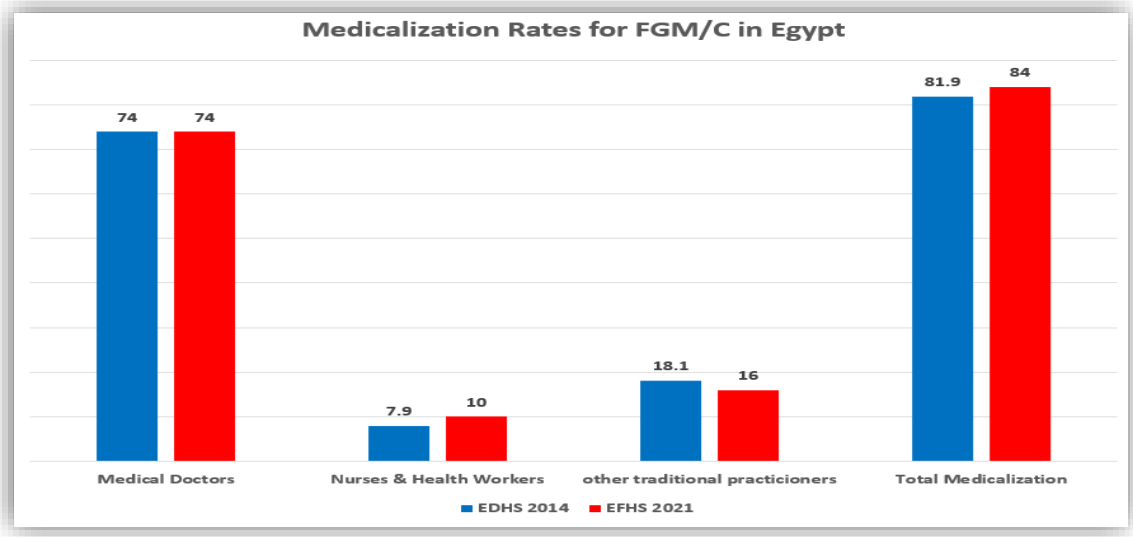
Figure 11: The Expectations for Women to Circumcise their Daughters in the Future



(MoHP 2015, Capmas 2022)

Medicalization: The medicalization rates continue to be high, where medical doctors performed FGM/C on 74% of circumcised girls aged (0-19), and nurses performed another 10%, where the remaining 16% are unidentified in the executive summary of EfHS 2021. This percentage has been high since 2014 EDHS when medical doctors performed 74% of the cases, nurses performed 7.9%, and other traditional practitioners performed the remaining 18.10%, which

Figure 12: Percentages of Medical Professionals Performing FGM/C on Girls aged (0-19)



(MoHP 2015, Capmas 2022)

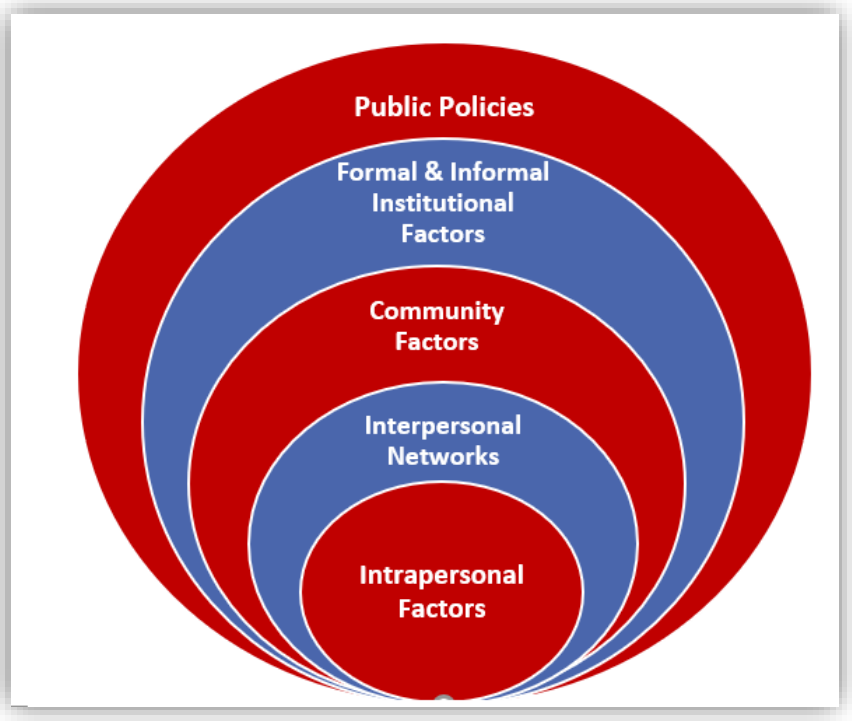
means that medicalization has slightly increased, even if not by medical doctors; it increased by trained nurses and official health workers **(Figure 12).**

3.3 FGM/C Drivers and Risk Factors

As clarified in the conceptual framework, Bronfenbrennern's Socio-Ecological Model is the umbrella theory under which studying the individual, community, and political behaviors toward ending FGM/C practice can fit. It assembles all the elements that affect the behavior, knowledge, and attitude of a person, a society, and government policies, including variables formulating the impact of international relations and global policies on individual behavior and showing the reciprocal impact between those layers of influence.

In McLeroy et al. 1988, Bronfenbrennern's Socio-Ecological Model was adapted to study methods to promote health interventions. Although policies and interventions to end FGM/C are no longer exclusively health-centric, McLeroy's adaptation fits studying the different drivers of FGM/C and is further adapted to fit the aspects studied in this research, as shown below **(Figure 13).**

Figure 13: Drivers to Adopt or Denounce FGM/C in Egypt



Adaptation of Mcleroy et al. (1988) for Bronfenbrennern's Socio-Ecological Model (p.355-366)

The Intrapersonal factors refer to the components of the individual's character, what makes a person who they are, so they are a combination of the person's upbringing conditions, knowledge, attitudes, life experience, beliefs, and basic concepts (McLeroy et al. 1988). In the FGM/C context, we can add the sex and gender perceptions in the local communities as a determinant for personal character.

The intrapersonal factors in FGM/C include what the girl and woman do not have control over, such as the age of cutting, place of residence, level of education, and to some extent, her marital status. In Egypt, girls are usually cut before age 15, and the most common age range for cutting is 9-12 based on the EFHS 2021, where girls cut at the age of 9-10 were 9.4%, and girls cut at the age of 13-14 are 27.5% which aligns with the norm that girls are usually cut before or at puberty in Egypt (El Zanaty et al., 2015). It is essential to consider that levels of cutting in girls younger than 25 are much less than the cutting of women in the age bracket 25-49, but this is linked to their marital status, where the percentage of never-married women between 15-24 cut is 68%, while the ever-married 93% of them are cut in 2015 survey. Concerning the residence factor, the percentage of FGM/C in urban areas is lower than in rural areas, and in lower Egypt is lower than in upper Egypt, which has been a steady trend in all the national surveys. This trend magnifies the impact of the residential location on girls and women at risk of circumcision. The girls living in rural areas or upper Egypt suffer from impoverished infrastructure, fewer services, and difficulty in accessing available services, and they become more subject to the risk of being cut as the lack of equitable conditions between rural and urban districts becomes magnified by gender inequalities, making girls and women more vulnerable to family and community pressures. Those disparities apply to education, where cutting among girls and women of higher levels of education is less than girls and women cut with a lower level of education (MoHP, 2015 and CAPMAS, 2022), and to the economic status, where girls and women in upper wealth quintiles are less circumcised than girls in lower wealth quintiles (81.4% to 97% respectively) in EDHS 2014.

The Interpersonal Factors refer to the primary groups affecting individual behavior as family, friends, and work relations (McLeroy et al. 1988). In Egypt's FGM/C context, the decision to cut a girl is not made by the child but by the caregivers either out of a social or religious belief, to abide by norms, in response to social pressure and fear of stigma, or a combination of all motives. There is a debate on the involvement of men in the decision to cut among researchers, as

it is unclear in the surveys how influential they are in the decision. However, it is worth mentioning that although the decision is made by the dominant female figures in the household, the decision is based on the beliefs of male bias toward circumcision. Referring to the research interviews, the discussions with men and boys from upper Egypt confirmed that they do not get involved in the decision taking of cutting other females in the family based on their knowledge that all girls and women in their community are circumcised by default.

In some cases recorded on social media, school girls requested to be circumcised due to peer pressure and to escape stigmatization in communities with a high prevalence of FGM/C. In a survey conducted in 2005 on school girls in Egypt (average age 6-18), with a sample of 38,816 girls from ten different governorates representing the rich geographical and economic spectrum of Egypt; girls agreed that the causes behind FGM/C were religion, tradition, and social pressure (Tag-ElDin et al., 2008). Nowadays, with the increasing medicalization rates and costs of performing FGM/C in response to the higher risk on the medical staff, fathers and male caregivers have become more explicitly involved in the circumcision decision. Finally, with the increasing awareness of FGM/C implications, the mother's experience plays a role in saving the girls from cutting, where the projections of circumcision based on mothers' anticipations show that there will be a continuous decline in cutting for future generations.

The remaining three FGM/C drivers will be discussed in detail in the following sector as part of the public policy pillars. The FGM/C drivers include **The Community factors** referring to the different social norms and inherited beliefs that are pushed by the community to tailor the behavior of the individual, including the possible religious polarizations within communities; **The Formal and Informal Institutional Factors** referring to the relations between formal and informal institutions, and the relations between different pressure groups in the community having an impact on the individual behavior; and **The Public Policies** referring to state policies, ministerial decrees, standard operational procedures, and laws shaping the individual behavior.

Chapter Four

Literature Review

The literature review will be divided into three sections. **The first section** will examine the challenges facing FGM/C by addressing the operational process of FGM/C, its root causes, its prevalence nationally and globally, the policies to end the practice of FGM/C, analyzing the success and failure factors in these policies, and finally, the lessons learned from these interventions. **The second section** will explore the social and behavioral community change tools as a methodology to end FGM/C and a core requirement in Egyptian policies to abandon FGM/C rapidly. **The third section** will focus on Egypt's policies and interventions to end FGM/C.

4.1 Challenges Facing Ending FGM/C

This section of the literature review explores the main reasons behind the continuity of this practice until the modern age, its consequences, and different perspectives associated with the practice.

4.1.1 FGM/C Assumptions

Baron and Denmark (2006) highlighted alarming facts regarding FGM/C practices globally, such as the under-reporting of FGM/C, which affects the real known numbers of girls and women subjected to the harmful practice globally. They discussed how the legislation against FGM/C breaches the individuals' internal and external freedom and imposes a western perspective of what is "normal" and "beautiful" (Baron and Denmark, 2006, p.349). The researchers also highlighted the increasing numbers of female cutting in developed countries and how the obstetric society is confused in handling this situation to ensure political correctness and cultural sensitivity. Finally, Baron and Denmark (2006) briefly summarizes the best interventions to end FGM/C and the obstacles that might face each intervention.

The debate on the need to reduce/eradicate FGM/C is very substantial to this thesis because if the practice of FGM/C is proven to be not as harmful as it is portrayed, then the significance of this policy analysis might need to be reconsidered. In this regard, an academic medical paper was

introduced in 2003 by Mackie to challenge three main hypotheses about the actual impact of FGM/C. The first is that FGM/C might not be as harmful as it seems since it is widespread among the educated and the less/none educated, which is a hypothesis that could be argued in Egypt since the percentage of tertiary education reached 38.9% in 2018 (UNESCO, 2019) while the prevalence of FGM is average 91%. The second hypothesis is that FGM/C might have limited harmful effects since it is performed on broad scales, like in Africa. The third hypothesis assumes that FGM/C has a limited harmful impact since the relation between the clitoris and sexual enjoyment for females is more of a psychological assumption based on social anticipations rather than a physiological fact.

The author deconstructed these three hypotheses using factual scientific and social evidence from the same countries used to develop these hypotheses based on generalizations rather than evidence-based research. Accordingly, the research proved that FGM/C is a harmful practice that should be eradicated and highlighted a vital research pillar that it is incorrect to use survey results as facts when researching a practice that is based on deep-rooted social norms as the results could be biased and affected by the "local universality of the practice" (Mackie, 2003, p.154).

4.1.2 Successful and Unsuccessful Practices in Ending FGM/C

Upon reviewing the main concepts related to FGM/C, the following part will explore examples of the best practices in ending FGM/C and unsuccessful interventions to end FGM/C. One of the successful practices in changing the social perspective regarding FGM/C and is expected to decrease the FGM/C rates was the 'Saleema' initiative in Sudan. 'Saleema' started in 2004 and was scaled up cross-nationally in 2014 to continue till the present (CDavin, 2019). Saleema aimed to change the social norms related to FGM/C to create a positive correlation between uncut girls and being 'Saleema,' meaning well preserved and full as created by God. The campaign's long-term goal was to abandon FGM, and the medium was to have a positive community acceptance of the natural anatomy of girls' and women's bodies. Evans et al. (2019) evaluated the "outcomes and dose-response effect" of Saleema interventions using a mix of qualitative and quantitative analysis for a sample of 11,268 females and males along the three waves of the initiative in the 18 states. Their analysis concluded that the social norms were changing during the campaigns, and the high exposure to the different campaign elements correlates with high anti-FGM/C attitudes. The evaluation proved that FGM/C practice could be

ended by concentrating on changing the community norms. Still, this evaluation did not reflect on the methods to sustain 'Saleema' if not funded by a United Nations agency and needs to be followed by a national health and demographic survey to measure the actual decrease in numbers of cut girls and women in Sudan.

On the other side, Boyden (2012) discussed the challenges facing efforts to end FGM/C in Ethiopia. The research highlights the impact of social pressure on the continuity of the harmful practice despite the awareness of the health risks. Also, the paper discusses how the negative impact of government interventions leads to substituting a risk type with another while continuing with the harmful practice. The qualitative study was carried out over 15 years on a sample of 3000 boys and girls from two different generations born in 1994 and 2001 across urban and rural areas. The study resulted in the continuity of FGM/C in Ethiopia despite government efforts for many social, economic, and religious reasons. These reasons included the support of boys to continue with the harmful practice more than girls, the existence of a religious aspect in the continuity of practice as perceived to be part of 'Shari'a' for Muslims, the need to secure a social and economic status for girls, especially in the increasingly poor rural areas, and the uncircumcised girls are more likely to be stigmatized. The paper also highlighted that outlawing the harmful practice is the least effective method to end it.

McChesney (2015) tracked and compared the development of different methods to end FGM/C. He found six unsuccessful methods and two successful ones based on African trials and errors (McChesney, 2015). The unsuccessful methods started with 'cultural Absolutism,' where ending FGM was introduced as a superior western culture condescending to the local African culture, which led to correlating ending FGC to imperialism and increasing FGC practice by local communities became a patriotic act and symbolic of freedom from colonialism. The second method is 'Cultural Relativism,' where FGC was considered a non-challenged cultural practice by the community or the WHO in the 1950s.

The third method was 'Health Education' when the WHO decided to consider FGM/C as an actual health threat in the early eighties. Accordingly, FGC was tackled from a medical perspective only to avail its harmful health side effects, which led to a consistent result that most African countries are suffering from today, 'the medicalization' of FGM/C practice (McChesney, 2015).

Another impactful method was the ‘Feminist Method’ which introduced the term ‘Female Genital Mutilation’ in the late seventies as a replacement for ‘Female circumcision’ to highlight the sexual and health implications of the practice and to stress its oppressive patriarchal nature. This perspective was fiercely rejected by African women who perceived it as racist and insensitive to women who do the practice to other women, especially when it is done upon consent (McChesney, 2015).

The fifth method is the ‘Human Rights Legislations’ that started to develop in the nineties of the twentieth century, with the rising wave of United Nations declarations and agreements on human rights, women's rights, and child's rights. This phase ended with almost all African countries' ratifying the Child Rights Convention (CRC), which implied banning FGM/C. Still, the WHO recognized the legislative restriction as ineffective since the FGM/C practices continued despite fortifying the penalties in Egypt’s case. It also raised another concern regarding denying women's right to control their bodies, thus undermining women's empowerment (McChesney, 2015).

The last ineffective approach was the ‘Individualistic Psychosocial Approach,’ which focused on defining FGM/C as a human rights and gender violence issue. This approach had minimal success as the families were targeted individually in isolation from the community, and the ones that denounced FGM/C were vulnerable to community pressures to the extent that they had to seek refuge and protection. Eventually, the levels of FGM/C abandonment were insignificant (McChesney, 2015).

On the other side, the successful approaches were manifested in Kenya and Ethiopia through community-led programs that empowered women and aimed at "changing the social norms at the community level” (McChesney, 2015, p.18). The author highlighted that the community-led programs enabled the society to decide on their priorities and their need to change, thus committing to the desired change. In addition, the successful approaches included enhancing women’s empowerment and changing the social norms at the grass-root level.

4.2 Role of Normative and Behavioral Change in ending FGM/C

Almost all researchers in the field cannot refute the impact of culture and social norms on the continuity of FGM/C. Thus, promoting Social and Behavioral Community Change (SBCC) as a methodology to support reducing FGM/C harmful practices has been tackled by several scholars

applying in different affected countries as Grose et al. (2019) taking Kenya as an example, and Owojuyigbe et al. (2017) and Ilo et al. (2018) examining different contexts in Nigeria. Also, many studies discussed the importance of addressing community behavioral change as an effective tool to end FGM/C. They proposed theoretical guidelines on how to address ending FGM/C from a social and behavioral change angel, including some applied cases, as in Shweder (2000), UNICEF IRC (2008), Ahmed et al. (2009), Varol et al. (2014), Schmied, (2019), Cislaghi (2019), and Cappa et al., (2020), in addition to the studies reviewed below.

Brown, K. et al (2013) stated that there are four traditional approaches to ending FGM/C that include: Bodily and Sexual Integrity Approach, Human Rights Approach, legislative Approach, and Health Approach, which proved to have limited success in preventing FGM practices in the African communities resident in Europe, including the media campaigns that were ineffective. This research argues that the proper integration between the two behavioral change approaches: The individual behavioral change (decision-theoretic model) and the community change approach (game-theoretic model), will create more effective interventions leading to ending FGM in Europe. This research highlighted that lacking the knowledge on how to apply the two behavioral approaches and their integration methods hindered using them to prevent FGM/C, thus proposing different integration approaches.

Another empirical research on the impact of behavioral change interventions on women's tendency to denounce FGM/C practices was conducted through a quantitative analysis of primary data provided by EDHS 2003. Dalal et al. (2010) showed through their analysis that the media and religious leaders' awareness messages directed to women helped increase women's tendency to discontinue this harmful practice. This result also applied to the women who participated in community dialogues, faith-based organizations (FBOs) meetings, and those who received knowledge on the negative health impacts of FGM/C. The research concluded that the systematic improvement of public education, community change through awareness from the community and religious leaders, and the media messages on television and radio might positively impact increasing the numbers of women choosing to stop performing FGM. Still, the research suggested the former positive correlation. However, it did not confirm it since there might be other variables impacting women's decision to continue or discontinue the practice as the patriarchal impact, peer pressure, and deep-rooted cultural dogmas that supersede the health or legal awareness.

One of the essential methods in creating SBCC regarding FGM/C is targeting Men and Boys to ensure their rejection of the harmful practice to reduce the community pressure for its continuation. In this aspect Brown, E. et al. (2016) used the PEER approach to examine the attitudes toward marital life and FGM/C and the community's perceptions of the efforts to end FGM/C. The researchers trained 12 unmarried men (age 18-25) from the society to conduct in-depth interviews with their peers, a methodology that proved to be successful in researching sensitive topics. The research was based on 72 interviews conducted in a small town with a high prevalence of FGM/C in Kenya, ranging between 85% and 96%. According to Brown, E et al., the results showed that "The majority of young men who viewed themselves as having a 'modern' outlook and with aspirations to marry 'educated' women were more likely not to support FGM" (p.118). However, it is still challenging to declare this in their communities since marrying circumcised women is connected to social status and wealth, while marrying uncircumcised women is connected to evil and men's demeaning social status. These findings reflect the need to target changing the social norms and community behavior as a prerequisite to ending FGM/C, especially in small and conservative communities.

4.3 Analysis of Egypt's National Policies to End FGM/C

The academic literature addressing FGM/C in Egypt using qualitative analysis are limited and was primarily conducted in the early 2000s or before as the research by El-Gibaly et al. (2002) or quantitative analysis addressing the prevalence trends of FGM in Egypt based on the EDHSs as in (Van Rossem & Meekers, 2020).

Most of the recent literature discusses the medical impacts of FGM from an obstetric perspective, which is unrelated to this paper's area of study. It is also worth noting that most of these medical research papers were based on quantitative analysis, either providing primary data sampling and analysis or secondary analysis of the consecutive EDHSs to test the impact of FGM on women's and girls' health as provided by Abdelhafeez et al. (2020) and El-Defrawi et al. (2001).

Other research papers on FGM in Egypt focused on the medicalization of FGM from medical and public policy perspectives, as in Serour (2013) and Refaat (2009). While the legal regulations related to the abandonment of FGM/C in Egypt were not academically researched by scholars but

addressed from a comparative systems perspective through reports by international organizations, as done by 28 too Many, published in 2018. Those two domains could be researched separately and deeply and will be covered briefly in this research.

Few researchers study the assumed cultural and religious reasons behind the continuity of the FGM/C practice, as explored by Hoffmann (2013) and Sorur & Ragab (2013). Finally, the last type of research paper on FGM/C in Egypt provides evaluations and assessments of program interventions published by non-governmental organizations (NGOs), international non-governmental organizations (INGOs), and United Nations agencies, as provided by Barsoum et al. (2009). The selected literature reviewed below will reflect the most related qualitative and quantitative research to this paper's research question.

One of the pieces of literature on FGM in Egypt was published by Van Rossem & Meekers (2020), providing quantitative analysis to prove the steady decline in the FGM/C rates in Egypt based on the different EDHSs published in 2005, 2008, and 2014. The researchers proved that the FGM rates had been steadily declining since the late 1990s on equal bases between rural and urban areas, different religions, and different community social and economic segments. Accordingly, the researchers expected the FGM/C rates would continue declining in Egypt significantly and that the decline would not be correlated with girls' and women's empowerment status since the achieved decline rates were equal in all regions. Still, the research did not dig deeper into the reasons behind the declining rates nor the best approach to maintain this declining rate.

Another research by El-Gibaly et al. (2002) highlighted the correlation between the decline in the number of circumcised girls with the massive public campaigns against FGM/C practices. Also, it ensured that the persistence of the practice was based on traditional social, economic, and religious reasons. The paper highlighted the increase in medicalization levels of the practice, reflecting on the current situation after almost two decades, where Egypt rates the highest globally in the medicalization of FGM/C.

As shown in the three sections above, the literature on FGM/C is vast and geographically diversified. However, the core concepts are almost the same everywhere, especially those related to the falsified assumptions about FGM/C, the community drivers to continue the practice, the

resentment of the community members to renounce the practice, moving to clear similarities in the policy obstacles facing the government and civil society implementing the national strategies. Despite many studies in the Egyptian context, qualitative studies are still limited and do not address all aspects of government policies as a comprehensive mechanism to end FGM/C. The dynamics between different policy pillars in Egypt are usually not addressed simultaneously, leading to overseeing the overall picture in some cases, especially since the focus is usually on a specific policy angle as the medical complications or the quantitative analysis of the findings of the demographic and health surveys without listening to the policymakers, practitioners or the community members. Accordingly, this thesis aims at connecting those missing dots as a primary effort in a comprehensive analysis of the Egyptian context.

Chapter Five

Research Methodology

This section will cover the methods applied in this research to have a qualitative study on the government policies applied in Egypt to end female genital mutilation/cutting by exploring the primary aim of the research, the research design and data collection, the ethical considerations in this research on FGM/C in Egypt, and the research limitations.

5.1 Research Design

5.1.1 Methodology

This research is based on qualitative analysis (Lune & Berg, 2017) using in-depth interviews with government officials, members of non-governmental organizations, and United Nations Agencies officials.

Qualitative methods were found to be more convenient for studying a community-based phenomenon such as FGM/C, especially since the scope of the research is to review the state policies to end FGM/C and suggest practical and feasible adjustments. The questions posed for this research require analysis beyond numbers and statistics used in quantitative analysis, especially since the latest national scale detailed data on FGM/C in Egypt was released eight years ago and was used extensively in several quantitative research to cover all possible aspects, as shown in the literature review.

The data collected through in-depth interviews and official government strategies and statements were analyzed using coding and decoding techniques to respond to the research questions. The content analysis approach was based on 'collaborative social research' (Lune & Berg, 2017, p.183), which was applied through the content analysis of the interview transcripts of the state, NGOs, and United Nations officials to reach out to the shared perspectives and agreed upon gaps in the FGM policy designs and implementations.

In-depth interviews were conducted using semi-structured methods to ease the discussion with the interviewee and allow the expression of their feelings and the flow of their thoughts regarding such a sensitive topic as FGM. The semi-structured questions avoided the ‘yes’ and ‘no’

answers and encouraged the participants to elaborate to cover different aspects of the interview topic (French et al., 2010, p.103-113).

Finally, the data collected were validated through the triangulation between the primary data decoded from the interviews and the desk reviews of official documents released by the government, the reports and research by academics and United Nations agencies, in addition to the data available on the programs implemented by the government, NGOs /INGOs, and United Nations agencies that were available through their published official documents and program evaluation reports. This triangulation allowed the cross-validation of the results of different data sources, enabled a comprehensive analysis of the research results (Lune & Berg, 2017, p.11-15), and ensured its credibility. The data was collected after acquiring the Institutional Review Board (IRB) approval in November 2021.

5.1.2 Research Time-Frame

Egypt did not start discussing the abandonment of FGM till the early 1920s on a sporadic basis, as it was still considered a taboo topic, but the ongoing global discussions on the issue started to reflect on the national context and formulate national policies in the longer term. The research covers the development of national policies reflected in legislation, ministerial decrees, national policy structures, activists' stances, and media campaigns since the 1950s. This date marks the first published evidence on public discussions related to FGM/C in Egypt (Serour & Ragab, 2013); with a closer focus on the policies in the last two decades (2000 – 2022) that are impacting Egypt's current socio-political reality in terms of efforts to eradicate FGM/C.

5.1.3 Research Geographical Coverage

The research is applied on a national geographical scale since the policies analyzed are national. However, there was a special significance for interviewees from Upper Egypt since EDHS (2014) concluded that the girls between the age of one till 14 who have been cut in urban areas are 5.5% less than the ones cut in rural areas (28 too Many, 2018), which confirms a slightly higher prevalence of FGM in rural governorates. Also, the interventions to end FGM started the earliest in Upper Egypt, which gave the practitioners in Upper Egypt, especially in Assiut, Menia, and Qena, a much broader and longer experience in the different policies and the best and least promising practices to end FGM/C in Egypt which was reflected in their in-depth interviews.

5.2 Data Collection

5.2.1 In-Depth Interviews

This research was informed by ten in-depth interviews, where the interviewees were selected using 'purposive sampling' and 'snowballing' techniques (Lawrence W., 2014, p.273-275). The interviewees were reached out through different development networks. The interviews were directed to officials in contact with the policy-making process in government, NGOs, and the United Nations. The selected officials were in direct contact with the community members and reflected a broad spectrum of the community perspectives in the absence of direct interviews with the affected population from the community members.

The government officials were interviewed to reflect on the perspective and role of their organization in formulating the policies against FGM/C. The interviewees included current and previous members from the National Council for Women (NCW), National Council for Childhood and Motherhood (NCCM), Ministry of Social Solidarity (MoSS), and Al Azhar affiliated agencies.

The interviews with the NGOs were conducted with members of "Assiut Childhood and Development Association" (ACDA), which operate in four governorates in upper Egypt (Assiut, Qena, Aswan, and Sohag). Since the early nineties, this NGO has been rolling out activities targeting women's and girls' empowerment, including ending FGM/C, which created an institutional memory of the best and least favorable policies to end FGM and their impact on the local communities in upper Egypt. The NGO has a vast database of women, girls, and families in the four governorates as part of the interventions against FGM, and they have well-established networks with other local NGOs working in similar domains. In addition, they have extended experience in participation in community and government dialogues regarding FGM/C policies. The interviews through ACDA targeted the manager of the NGO and other former governorate coordinators.

Interviews with the United Nations focused on the two agencies having community-level interventions in ending FGM, the United Nations Children's Fund (UNICEF) and the United Nations Populations Fund (UNFPA). These UN agencies cooperate to end FGM/C by advocating for policies supporting ending the harmful practices and providing services to girls and women at

risk of FGM/C or who have already been cut. The interviews were conducted with current and previous staff and consultants.

The interview questions **(Annex 1)**, were concerned with specific themes such as the most impactful policies applied to end FGM, the least effective interventions, the gaps perceived in the policies and services provided to abandon FGM based on the interviewee's practice, the feedback they get from the community on different policy implementations, and the means to overcome any identified gaps. The interviewees were allowed to elaborate on specific methods they applied or witnessed in the interventions to end FGM/C and to reflect on their personal and professional points of view regarding the harmful practice and the policy interventions.

The ten interviews included two interviews with professionals from civil society with 10-20 years of experience in ending FGM/C in upper Egypt, five interviews with current and previous Egyptian government officials affiliated with different entities involved in ending FGM/C, and three interviews with United Nations officials currently and previously involved in programs on ending FGM/C in Egypt.

5.2.2 Desk Review

Although extensive research has been done on FGM/C globally and nationally, tracking the origins and developments of efforts to end FGM/C requires extensive desk review to have a comprehensive background on the practice as it is not compiled in one place in details that can feed in the policy development process. This desk review includes the policies and strategies released by the Egyptian government addressing ending FGM/C since the beginning of the twentieth century to demonstrate the efforts of the state and the professionals and volunteers active in the field.

These policies include ministerial decrees, laws, national strategies, institutional reform supporting FGM abandonment, media campaigns, initiatives, and community-level interventions directly through the government or in coordination with the government in line with the national strategies. These data were extracted through a desk review of national and international journals, reports, dissertations, books, online news and data from credible resources, and in-depth interviews with government and non-government officials.

5.3 Ethical Considerations

The research is aligned with the global standards of academic research discussed in (Babbie 2012, p.32-42), taking all ethical considerations into account as follows:

Voluntary Participation: Due to the cultural sensitivity of the topic, the officials targeted for the individual interviews were free to accept or decline participation.

Clarity and transparency: The discussion was in simple English and Egyptian languages according to the interviewee's preference to ensure the same understanding.

Confidentiality: The individual interviewees were notified before the interview to inform them that their names would be revealed as their statements would represent their organizational points of view, which is needed for the policy analysis and to ensure the credibility of the research. Nevertheless, due to the changes in different government-appointed positions since the interviews were held, the names and entities of the interviewees will remain confidential to ensure that they are not possibly subjected to any risks or retaliations by the time of publishing the thesis.

No Harm: Due to the severity of the FGM/C experience and to avoid reviving the trauma of cutting, the research focused only on officials who have extensive experience with the community and did not interview the community members being the affected population, especially the girls and women at risk of undergoing FGM/C or who have undergone FGM/C to avoid panic if undergoing FGM/C was inevitable for them.

Institutional Review Board: the research proposal and interview questions got the IRB required clearances before conducting the research to ensure the rights of the participants involved, and the research alignment with the ethical requirements of the university and academic community.

5.4 Research Limitations

There were several limitations to this research in general and the methodology in specific, including the following:

First, FGM/C in Egypt has suffered for a long time from the data gap since the last EDHS was published in 2015. In September 2022, the executive summary of the Egyptian Family Health Survey (EFHS) conducted in 2021 was published, containing headline data only on the current

status of FGM/C in Egypt. The detailed data were not published till the submission of the thesis. Accordingly, the causality relations behind the new decline are unclear without the detailed report, and the detailed analysis of the samples surveyed is still unknown, so there is still a high dependency on 2015 data. In addition, the impact of the covid-19 situation on FGM/C practice and law enforcement in Egypt is still unknown, which was speculated to negatively impact the declining global trends of FGM/C due to confinements (Kennedy, 2020).

Second, difficulties in reaching some government officials and getting their acceptance to conduct the interviews prevented the research from having interviewees from each government entity involved in ending FGM/C in Egypt.

Third, the precautionary measures of covid-19 pandemic recurrent waves posed difficulty in conducting some interviews when some of the officials refused to have an on-phone interview, and at the same time, it was not possible to have face-to-face interviews with the increasing numbers in covid-19 infections despite applying the hygiene measures.

Third, due to the chronicle nature of the harmful FGM/C practice in Egypt, the number of government and non-government entities involved in the efforts to end FGM is huge, and it is impossible to conduct in-depth interviews on a representative sample. Thus the interview approached samples from the most influential entities to inform the research.

Fourth, due to Egypt's long history of combating FGM/C, the narrative used by officials regarding national efforts to end FGM/C is almost the same. This similarity posed a considerable obstacle while conducting the interviews, as the responses to the in-depth questions were almost the same despite the different affiliations of the interviewees. This could be explained in light of the interlinked efforts between all stakeholders to end FGM/C, so there was no individualistic narrative per entity or policy maker. Also, this is the result of the slow pace of progress in this portfolio, making non of the stakeholders capable of having a success story not known to other stakeholders to reflect on during the interview. This problem discouraged the researcher from digging for more interviewees that were expected to repeat the same information and views in different wording.

Fifth, there are few published studies regarding the direct impact of the different policy tools (legislation, media campaigns, public speeches, and others) on the national rates of FGM/C, which led to depending on the content analysis of the limited research samples.

Sixth, upon conducting an in-depth desk review, there is no proper or comprehensive documentation of the efforts done to end FGM/C, including the ministerial decrees and decisions, national action plans before the establishment of the current national councils, legal correspondence on FGM/C cases submitted to courts, and any efforts to end FGM/C before the online based documentations. The data mentioned in the thesis was based on the testimonials of pioneer icons who fought to end FGM/C in Egypt, either through their personal published writings, news interviews, news articles, or records by other researchers who witnessed the era.

Chapter Six

Public Policy Pillars and Implementation Discrepancies in Egypt

This chapter addresses all the policy pillars forming and crosscutting with the public policies contributing to ending FGM/C in Egypt. The policy pillars discussed are the legal, health, religious, educational, and community social and behavioral change. Those are the policy pillars directly interlinked with the community; they affect and are affected by the citizens and local communities directly. All the policy pillars underwent several changes until they reached the current operational phase, but most of them are facing some application discrepancies due to the topic's sensitivity and the complexity of the FGM/C drivers correlated to them. In this chapter, the policy details and the reflections of policymakers and practitioners on the policy implementation will be discussed to identify the policy gaps, policy limitations, and obstacles, suggesting some steps to narrow the gap and accelerate the decline in FGM/C in Egypt. The chapter will be supported by analyzing the opinions of officials and staff members from the Egyptian government, the United Nations, and NGOs, who were approached to inform the research.

6.1 Legal Pillar

The first law against FGM/C in Egypt was in 2008. Child law no.126 in 2008 was issued to amend child act no.12 in 1996 to prohibit exposing the child to any physical abuse or harmful practice on an intentional basis under article 7-bis(a)[6]. In article 96, the law criminalized putting any child at risk and stated an imprisonment punishment of at least six months or paying a fine ranging between 2000 EGP and 5000 EGP or applying both penalties. Besides, article 116-bis states that the minimum penalty in any law must be doubled if an adult commits a crime against a child, even if the criminal is the parent or the caregiver (NCCM, 2008).

Child law no.126 in 2008 also amended the penal code issued by law no. 58 in 1937, through adding article 242-bis, which explicitly stated “The Female Genital Mutilation” and criminalized performing FGM/C with a penalty of imprisonment for not less than three months and not more

[6] “Bis” in legal context means an article change, addition, or replacement in a law.

than two years, or with paying a fine of no less than 1000 EGP and not more than 5000 EGP (NCCM, 2008).

The Egyptian courts started dealing with FGM/C crimes, but the number of cases addressed was not correlating with the high prevalence percentages. In 2013, an FGM/C crime was committed, and the doctor was sentenced in 2015 to two years imprisonment, his private clinic was closed for operating FGM/C on a child leading to her death, and the father was sentenced to three months of suspended imprisonment. In March 2016, a doctor was sentenced to six months imprisonment for operating FGM/C on a child, causing severe bleeding and leading to her death (El Shazly, 2017). Later in May 2016, a 17 years old girl in the Suez governorate died due to an FGM/C operation by a medical doctor in a private hospital. The prosecution office directed charges against the operating doctor, the anesthetist, the nurse, and the child's mother, accusing them of unintended killing and creating an injury that led to death during an illegal female circumcision operation. The doctor, the mother, and the anesthetist were sentenced to one-year imprisonment and a five thousand Egyptian pounds fine, while the escaping nurse was sentenced to five years. In addition, the governor ordered the closure of the private hospital that witnessed the crime in alignment with the law (El Shazly, 2017). The crime created public rage reaching the parliament, where heated discussions arose between parliamentarians supporting FGM/C and those against it till a law proposal to fortify the penalties was released in August 2016 and the president issued the law in September 2016 (El Shazly, 2017).

Law no. 78 in 2016 was introduced to amend law no.126 in 2008[7]. The laws against FGM/C were strengthened by amending article 242-bis in the penal code, where the imprisonment duration was increased to five to seven years for the person performing FGM/C and clarified the FGM/C as partial or total removal of the external genitalia or even making unnecessary cuts in the female reproductive organs without medical need. Moreover, if the cutting led to the victim's death or a permanent deformity, the perpetrator would be penalized with fortified imprisonment. Article 242

[7] Law 126 in 2008, amending articles in the Child Law no. 12 in 1996, Egyptian Parliament, Legal Publications (in Arabic) (2008). Retrieved from: https://manshurat.org/node/28842

bis(a) was added, stating a one to three years imprisonment penalty for any person who requests that a girl be cut [8].

The last legal amendment was conducted by law no.10 in 2021, amending law no.126 in 2008. The amendment confirmed the imprisonment of the performer of FGM/C with no less than five years and clarified that if the cutting led to permanent deformation, the performer would be sentenced to rigorous imprisonment of no less than seven years, and if the cutting led to the death of the victim, the performer would be sentenced to rigorous imprisonment of no less than ten years. The penalty was specifically aggravated against medical doctors and nurses, if the cutting led to permanent deformation, the performer would be sentenced to rigorous imprisonment of no less than ten years, and if the cutting led to the death of the victim, the performer would be sentenced to rigorous imprisonment of no less than fifteen years and not more than twenty years. In addition to prohibiting the performer from continuing his professional practice in the health sector for no less than three years and no more than five years after finishing the imprisonment sentence. The medical facility where the crime was committed will be forcibly closed, and its license will be withdrawn for the same duration of prohibition of the medical practice of the perpetrator, in case the perpetrator owned the facility or if the owner knew about the crimes committed within. Finally, anyone who promotes, encourages, or advocates for female cutting shall be punished by imprisonment, even if the female was not cut [9]. Few months after the last fortification of the penalty against FGM/C, the Egyptian penal court in Shubra El Kheima in Cairo applied the first sentence against performing FGM/C in absentia on a father and a nurse for violating the law and causing permanent mutilation of the daughter of the first. The father was sentenced to three years imprisonment, and the nurse was sentenced to ten years of rigorous imprisonment (Abd El Hafiz, 2021).

The efforts for legal amendments were partnered with capacity building for law enforcement bodies, including public prosecutors and judges, on awareness related to child law and anti-FGM laws to ensure that the correct processes are followed when a case of FGM/C is reported to authorities. UNICEF mainly led these efforts in coordination with the government. The efforts

[8] Law 78 in 2016, amending articles in the penal code, Egyptian House of Representatives, Legal Publications (in Arabic) (2016). Retrieved from: https://manshurat.org/node/20421

[9] Law 10 in 2021, amending articles in the penal code, Egyptian House of Representatives, Legal Publications (in Arabic) (2021). Retrieved from: https://manshurat.org/node/72082

related to law enforcement were strengthened upon establishing a child protection department in the public prosecutor's office to address cases of violence against children under which FGM/C is reported. In 2016 and 2018, legal periodicals were published and distributed to all public prosecutors addressing the activation of child protection committees (CPCs) and the quick coordination with the child helpline (16000) operated by NCCM on the child cases reported. They are considered a reference for public prosecutors working on any FGM/C case (NCW, n.d.).

Current Policy Obstacles:

One of the obstacles facing legal reforms to support ending FGM/C is the low reporting rate of FGM/C crimes, although the prevalence rate is high, which was confirmed by a technical specialist: "we cannot judge the prevalence based on reporting because we know that the percentage of reported cases is minute compared to the overall prevalence of the practice." Moreover, despite aggravating the laws against perpetrators and abettors, the reporting rate is still insignificant compared to the actual number of crimes committed against girls and women. Interviewees have explained this in light of the difficulty of reporting a parent, a family member, or a trusted doctor serving a small community. An interviewee said: "the law is fundamental, but the most important is community awareness and changing the attitude and behavior of the community members. Because sometimes, when you harshen the penalty, people do not report the crime, and since people believe in FGM, they try to have any chance to do it without any legal responsibilities". Some interviewees highlighted the concern that the harsher the penalty for FGM/C, the higher risk it would be performed in secrecy as in "Sometimes, the penalties are counterproductive. Most of the time, there is another reason why the cases are reported. Either the girl died due to the practice, so it's not something that no one can hide, or there are other issues within the family. So, for example, you would find that the parents are separated or divorced or one parent is reporting the other because they have issues. So these are the exceptional cases where you would find the cases being reported, but it is very unlikely to find family members reporting each other or even reporting the local doctor who is a trusted and well-respected member of the local community." Based on the interviews, it is neither a healthy nor practical solution to encourage family members to report each other. The encouragement in that direction will create further segmentation problems within Egyptian families that will have repercussions on the stability of the society, family cohesion, and the economic status of individuals far beyond the impacts of the harmful practices of FGM/C. The continuous aggravation of the penalties against

FGM/C without addressing the community's acceptance of those laws will not only lead to the practice of FGM/C in secrecy, but it will also tempt the population to lie in the surveys causing a massive inaccuracy in data collection and unclarity about the actual prevalence rate in the country. An alternate solution must be proposed, or at least the penal codes need to be communicated more thoughtfully to have a positive impact and not extreme deterrence. The alternative solution in law enforcement could be encouraging the communities to contribute to holding perpetrators accountable, which is not an easy strategy in the context of a widely accepted practice such as FGM/C.

Another policy obstacle is the need to continuously enhance the capacities of law enforcement officials, mainly the newly appointed public prosecutors and judges. Continuous investment is needed to ensure they are fully aware of the updated laws and related procedural applications.

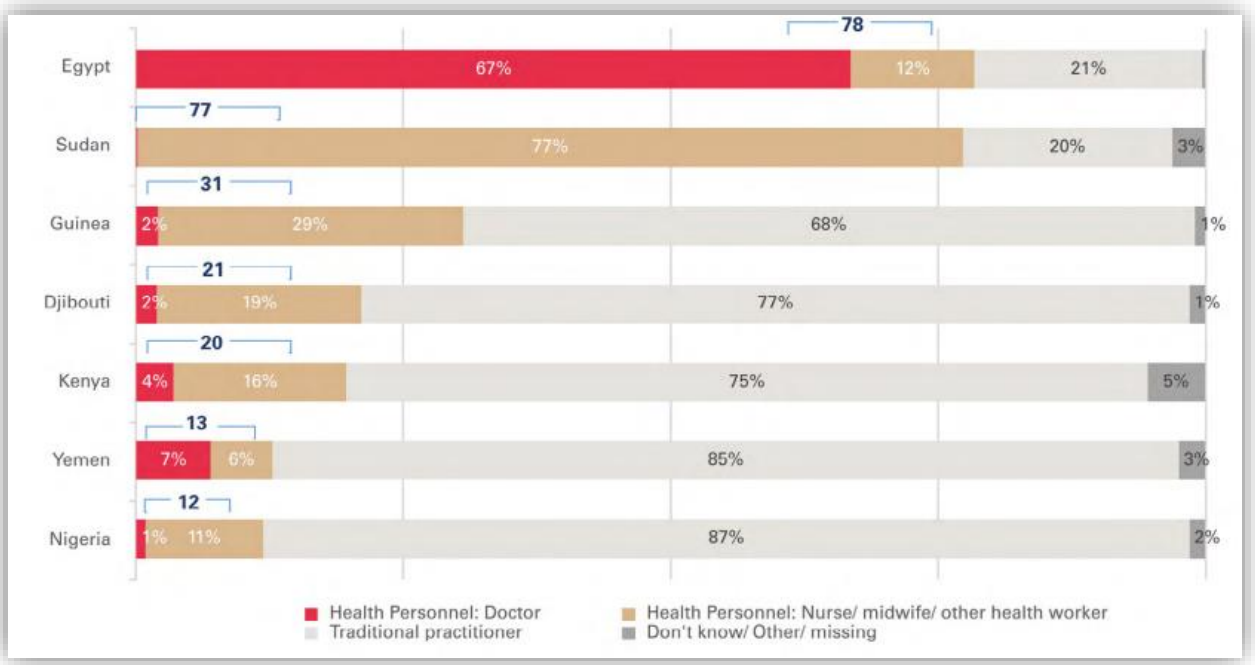
6.2 Health Pillar

FGM/C has been addressed for decades as an exclusive health and medical violation. The awareness efforts against FGM/C across all countries with high prevalence focused on the health implications of cutting, which led to perceiving the negative consequences of FGM/C as avoidable if done by healthcare professionals. Egypt was not an exception; the focus on the possible bleeding and contamination of girls upon cutting unconsciously directed the community towards depending on medical doctors and nurses to use sterile medical tools in hygiene settings and with medical knowledge to be capable of adequately responding to any of the possible complications mentioned in the anti-FGM/C awareness campaigns. The official stance from the consecutive health ministers reflected the sensitivity of addressing ending FGM/C on the community and political level. The efforts made by the Ministry of Health through the different ministerial decrees to end the severe forms of FGM/C and control its negative impact unintentionally led to encouraging the medicalization of FGM/C, causing Egypt to be the highest in performing FGM/C by medical doctors on the longer term in comparison to all other countries with highest prevalence rates of FGM/C as shown in **(Figure 14)** based on 2014 statistics (UNICEF & UNFPA, 2019).

As explained by interviewees, performing FGM/C became a primary source of income for medical

doctors and nurses, especially in rural areas suffering from low economic standards. Although medical students never studied female cutting as a medical practice in medical school, as confirmed by several medical school deans in consultations with NGOs in upper Egypt, the doctors learned to perform it from grandmas, traditional health practitioners as the health barber, traditional midwives, and gypsies.

Figure 14: Medicalization Rates in African Countries with High Prevalence Rates of FGM/C for girls aged 0-14



(UNICEF & UNFPA, 2019, p.3)

It is worth noting that medical doctors had no consensus on the best way to address FGM/C at the early stages of fighting the practice in the nineties. A group was fully supporting ending FGM/C and halting any performance on all levels, and they collaborated with civil society in spreading awareness of the negative implications of FGM/C, while others were in favor of the practice either out of their personal beliefs that it is a requirement or out of the fact that it is profitable, or out of fear from the society and peer pressure among which they live and practice medicine. Another group was relatively neutral among which was the "Egyptian Medical Syndicate," which welcomed minister "Dr. Ali Abdelfattah" decision to resume FGM/C operations in public hospitals

but was silent concerning the 361/96 decree by the minister “Dr. Ismail Sallam” to halt FGM/C in public and private entities (Abd El Hady, 1997). The stance of the Egyptian Medical syndicate changed over time, and they are now supporting the state policies in ending FGM/C and coordinating with the national committee on the activities related to spreading awareness among medical doctors regarding ending FGM/C.

NCCM, NCW, UNFPA, and UNICEF made a lot of efforts in collaboration with the ministry of health to raise the awareness of medical professionals on the impacts of FGM/C on girls and women, the legal consequences of performing or facilitating the performance of FGM/C, and their role to dissuade caregivers from cutting their girls. UNFPA has a long history of supporting the government on family planning strategies, reproductive health awareness and services, and providing women clinics in university hospitals to respond to violence cases, including FGM/C. The child helpline and women's complaints hotline respond to females at risk or victims of FGM/C and refers them to adequate medical, legal, or mental health and psychosocial support services as needed. As explained in the interviews, the child protection committees play a role in safeguarding and rescuing girls at risk of being cut. Once they receive a report that girls will be cut on a specific date at a specific time, either directly from NGOs or citizens or through a referral from the child helpline 16000, some social workers within the CPCs have the legal authorization to stop and arrest perpetrators.

Current Policy Obstacles:

The legislation in place focused on ending FGM/C through ending medicalization, as phrased in one of the interviews: “The biggest advantage of the most recent legal changes is the focus on medicalization because it is something that the government needs to be held accountable for, the Ministry of Health, including the oversight and supervision on the healthcare provision centers.” The interview highlighted the need for governmental supervision of private medical facilities where FGM/C is conducted. The cutting is not restricted to homes and public medical facilities. The ministry needs to play a more visible role in holding perpetrators accountable because holding the health professionals accountable for their actions will help limit their availability to perform FGM/C, thus, helping in reducing the rates of cutting; “So the policies will not contribute to much change if the enforcement and the acceptance and demand are not given the same level of prioritization.”

Another governmental interview ensured the MoHP's influence on law enforcement, as there is a need to affirm the laws criminalizing the performance of FGM/C through a new ministerial decree that reassures the ministry's commitment to end FGM/C and medicalization. The interviewee assured, out of the experience with the health sector in Egypt, that a ministerial decree is more effective and enforced within the health facilities than the national laws, as it is widely disseminated even in the minor communal health facilities. In addition, a decree could be an effective way to ensure that all medical doctors and health practitioners are fully aware of the legal penalties of performing FGM/C. This did not happen till the death of 'Bedour' in 2007, the 13-year-old girl who died in Menia Governorate as a result of an FGM/C operation and triggered a new round of policy adjustments and campaigns (El Shazly, 2017), including the last ministerial decree released by Dr. Hatem El Gabaly in 2007, forbidding all medical doctors and nurses from performing any type of FGM/C in public and private hospitals or any other place. Otherwise, they will be considered violating the regulations governing the practice of the medical profession[10].

In addition to law enforcement, the interviews with government officials showed that national councils that started the advocacy efforts to end FGM faced many difficulties in convincing doctors to denounce FGM/C; "Many doctors believe that FGM is good for the girls and the doctor can decide. It is their mind. They are thinking like their communities. They are not different." Nowadays, we cannot assume that professional health staff is fully sensitized and entirely abandon FGM/C, which needs evidence generation through adding to the EDHS and other health-related national surveys surveillance among health sector staff to measure their knowledge about FGM/C, legislation, personal attitudes towards performance, and willingness to provide awareness against it. The results of this surveillance could be used to design more effective policies and interventions, assess the probability of reducing the medicalization of FGM/C, and determine whether medical sector professionals are ready to be deployed to campaign against FGM/C nationally.

6.3 Religious Pillar

One of the drivers for the continuity of the FGM/C practice in Egypt was the Islamic misconceptions on the community level caused by the lack of consensus between Islamic religious leaders regarding the prohibition of FGM/C practice in Islam. This was caused by reciting more

[10] Ministerial Decree no.271 in 2007, by Dr. hatem El Gabaly, Minister of Health and Population, Legal Publications (in Arabic) (2007). Retrieved from: https://manshurat.org/node/12581

than one 'Hadith'[11] quoting Prophet Muhammed (Peace Be Upon Him) that was interpreted as encouraging the performance of FGM/C, although they were all classified as 'Weak Hadith' meaning that "its narration is untrustworthy, and that it is, therefore, unreliable" (Serour & Ragab, 2013, p.9).

One of the most famous Hadith that is still recalled by the local communities today to ensure that Islam obligates them to perform FGM/C is the one known as "Umm Attia's Hadith," where Prophet Muhammed (PBUH) was reported telling her:

> "O Umm 'Attiyah, when you do circumcise, restrict yourself to cut a minute part and do not excise. That will be far more pleasant for the wife and satisfying for the husband" (Serour & Ragab, 2013, p.8).

In addition to being a weak hadith, Sheikh Ali Gomaa, the former Minister of Endowment, clarified that during Prophet Muhammed (PBUH) times, FGM/C has expanded from Africa to several Arab areas, including Al-Madinah, but was not performed in Mekkah. So when Prophet Muhammed (PBUH) migrated from Mekkah to Al-Madinah, where FGM/C was practiced, he did not request to halt the practice since the negative impacts of the practice on health were not recognized then, while Islam already prohibits any practice that negatively impacts the health, accordingly the prophet gave that advice to the Muslim women who approached him with the question on the performance of FGM/C, but once the harmful medical implications of FGM/C became recognized, prohibiting FGM/C became a duty and obligation for Islam and Muslims (Gomaa, 2020).

Based on the research interviews, this Hadith is usually still recalled by community members, either women or men during the awareness sessions, especially those provided by the religious leaders where the community seeks their religious advice as experts to confirm their beliefs and will continue performing FGM/C to their daughters and wives. The well-informed religious leaders have the capability to convince the community that FGM/C is not part of Islam with a lot of religious evidence and other Strong Ahadith, especially since Prophet Muhammed (PBUH) has never circumcised his daughters (Serour & Ragab, 2013, p.8).

[11] A 'Hadith' is a report attributed to the Prophet Muhammad (PBUH), it is what the prophet said, did, silently approved by others, and a description of what the prophet was like as agreed by several Islamic researchers (Al-'Uthaymin, 1994).

In addressing the religious pillar within the policies aiming at the abolishment of FGM/C, it should be noted that the struggle to confirm that FGM/C is part of Islam is not confined to the less educated or less impoverished within the Egyptian society, as lawsuits were filed against the legislations aiming at outlawing FGM/C practice. These lawsuits claimed that the legislations were against Islamic Shariaa. Accordingly, it is unconstitutional since the Egyptian constitution is based on Islamic Shariaa. The lawsuit against ministerial decree 261 in 1996 was a clear example, and the national administrative court rejected it (Gomaa, 2020).

In 1994 the conflict among Islamic leaders regarding the Islamic jurisdictions of female circumcision was at its peak. Sheikh Al Azhar "Gad Al-Haq Ali Gad Al-Haq" first released a Fatwa in 1981 in response to a question from a citizen about the requirement of FGM/C in Islam (Gad Al-Haq, 1994/2007). During the public debate on FGM/C in 1994 with the Mufti "Sheikh Muhammed Sayyed Tantawi," who supported the opinion by saying that it is a tradition not Sunna, and not required by Islam; Sheikh Al Azhar "Gad Al-Haq Ali Gad Al-Haq" re-published his Fatwa in a book including a detailed explanation of all evidence proving it is a genuine requirement by the prophet Muhammed (PBUH) (Abd El Salam, 2007). It was republished again by his followers in 2007, along the rising debate on intensifying the penalization of performing FGM/C.

It is essential to know that this debate still rises till now. Although the confrontation is not as radical as in the nineties, the argument which gets raised to courts frequently against the laws criminalizing FGM/C is that even if FGM/C is not obligatory in Islam, it is a preferred and favored practice without obligation, accordingly, it should not be criminalized, and citizens are to choose whatever suits them. Meaning that any criminalization of a favored practice in Islam goes against Islamic Sharia and consequently against the second article of the Egyptian constitution, which commits all state authorities to resort to Islamic Sharia in framing their decisions, laws, and actions as clarified within the lawsuit against the minister of health in 2007 for issuing decree no.271 in 2007 to ban FGM/C (Abd El Galeel, 2009).

Nowadays, Al Azhar is actively raising awareness against FGM/C, primarily through "Al Azhar University's International Islamic Center for Population Studies and Research" (IICPSR). According to an interview with an IICPSR member, they work on educating the Islamic male and female preachers from Al Azhar and Al Awqaf (Ministry of Endowment), in addition to Al Azhar students who will be the future Islamic leaders and preachers on the religious, medical, social, and

psychological aspects of FGM/C. Those preachers include the mosque Imams and the preachers who directly communicate with the community and provide family counseling on the grassroots level. They focus on female preachers who can access homes and meet family members. IICPSR focuses work on the 52 branches of Al Azhar, including the non-Egyptians from countries with high FGM/C prevalence.

Regarding Christianity, the Christian religion has a clear stance against FGM/C and considers cutting girls and women a sin. There is no reference to FGM/C in the Old and New Testaments of the Holy Bible (Bless & UNICEF, 2016). Christianity rejects FGM/C as a discriminatory act against women that disrespects their human rights and dignity and enforces perceptions that women are not equal to men, reinforcing the social stereotyping of the imbalanced relation between men and women. The rejection of bodily mutilations is confirmed in the Holy Bible, asserting that the body is sacred and no harm should happen to it: “if anyone defiles the temple of God, God will destroy him. For the temple of God is holy, which temple you are” (Corinthians 3:17). Also, the Holy Bible confirms that humans are not allowed to make changes to the body since the body is not theirs but belongs to God: “Or do you not know that your body is the temple of the Holy Spirit who is in you, whom you have from God, and you are not your own?” (Corinthians 6:19). Despite the clear stance, FGM/C is spreading between Christians as a social norm and tradition that needs to be stopped (Bless & UNICEF, 2016).

The church has participated in community-based awareness programs in upper Egypt since 1981 through “The Care for Girls Committee”, under the auspices of the diocese of Beni Sueif. The committee members moved from one village to another using street theatre, publications, posters, and audio/video tapes to discuss sensitive issues such as FGM/C, child marriage, and inheritance. They also made home visits to discuss specific cases and provide counseling services to combat the harmful practice (Dillon, 2000). Nowadays, in addition to community-based awareness, the Church includes FGM/C in the sexual education program in Sunday Schools and keeps publications available for all church visitors. Also, the different churches and their developmental institutions provide awareness against FGM/C through lectures and family counseling services (Bless & UNICEF, 2016).

Current Policy Obstacles:

The religious and sensitive debate between prestigious Islamic religious leaders increased the issue's complexity and the public's confusion. This confusion was apparent in the resistance from the community to open up to ending FGM/C and forced a hostile attitude against state policies in the matter, as explained by a government interview: “Some community members saw that government is pushing families to get rid of female circumcision because it is a religious habit. However, other people were trying to understand the information, but this issue is very complex.”

Refuting this misperception on the community level is very difficult, especially with the recurrent division among Islamic religious leaders on the issue of ending FGM/C. However, the government stakeholders made positive steps in this regard, as explained by one of the government interviewees: “We coordinated with Al-Azhar and the Church to have a fatwa that FGM is not related to any religion. We had a fatwa from ‘Dar Al-Ifta’. Also, we talked about the prevalence of FGM in many African countries and that it does not exist in Saudi Arabia, for example. Also, we were trying to cooperate with some independent Islamic expert leaders like Mohamed Selim El-Awwa, because when you are talking with the communities about this specific issue and you are a governmental association trying to convince them through fatwa from Dar Al-Ifta or Al-Azhar, they believe that those organizations are aligned with the government and repeating the decisions of the government. So we collaborated with different independent people who could convince the community.”

Related to the obstacles with the religious entities: “I think one obstacle in that time - I am talking before 2007 - was to have a written fatwa from Al-Azhar or Dar Al-Ifta that FGM is not related to religion because they are very sensitive in this issue, but I think the death of a young girl, her name was ‘Bedour’ in 2007, It was the time to have a commitment from all of them at this time. Without this accident, we would have had more time to convince them.” The latest Fatwa was provided by the Grand Mufti of Al Azhar ‘Dr. Shawki Allam’ analyzing all aspects raised about the Islam's stance from FGM/C, which was published on Dar Al-Ifta official website under number (16487) (Allam, 2021). The fatwa included a profound elaboration of the prohibition of FGM/C that is summarized by saying that female circumcision is not required by the Islamic laws and teachings of ‘Sharia’. All related ‘Hadith’ implies constraining the practice to reach its prohibition, explaining its great evil, and warning against violating a woman’s body with this habit to ensure

that it is not allowed to claim that the practice of female circumcision is part of the religious practices of Islam. On the contrary, the related ‘hadiths’ reflected the ceiling of human knowledge at that time. So, upon increasing people’s knowledge and changing their living conditions and environments, changing the ‘sharia’ rules becomes a must to suit the new conditions, which is a ‘Sahria’ rule as its texts mention that the rules resulting from norms change according to the change of the related circumstances (Allam, 2021).

Since ‘sharia’ applies the concept of “Do No Harm” (meaning that Allah does not request any practices that apply harm to believers, nor are believers allowed to harm), and circumcision has confirmed physical and psychological harm on females, not only on the personal level but also on the family level without any benefit on her nor her husband, but on the opposite, it leads to destruction, exhausts the paths, and takes away the full benefit. For that reason, it was necessary to say that it is forbidden and considered a crime, according to the rules of Islamic law and its practical purposes (Allam, 2021).

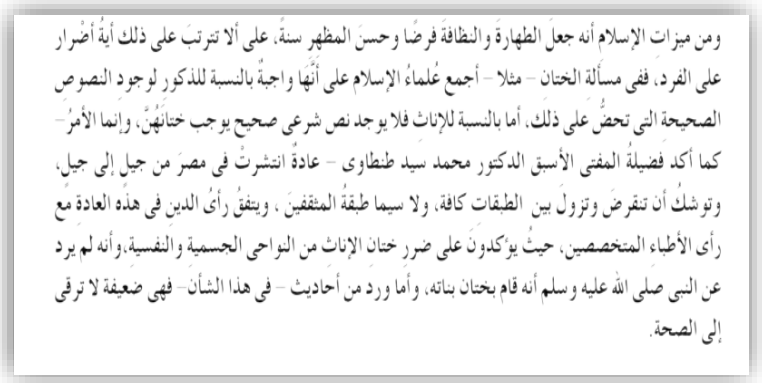
6.4 Education Pillar

Most of the research on FGM/C refers to awareness as education. It was challenging to break the silence on FGM/C and earn the community’s patience to listen to messages contradicting their core beliefs, one of the interviewees elaborated on that saying: “Some people believe female cutting is something very initial for their lives because when we were advocating that this practice can harm young girls and women, they instantly told us: NO, we were already circumcised, and we do not have any consequences. Although maybe they are suffering but they do not know, Like having some women problems and other sexual problems, but they cannot link things to each other.”.

Sensitizing the community and stakeholders against FGM/C has been ongoing for decades by all NGOs, government, and non-government players to ensure that frontliners, practitioners, and the community are ready to end FGM/C or denounce the practice. The efforts are not yet entirely successful based on the FGM/C surveys measuring the community's attitudes towards ending FGM/C in the future and medicalization levels. This implies the need to analyze the components and impacts of awareness efforts to adjust them as needed and expand the efforts in the right direction.

According to the different interviews, there is a strategic gap in formal education due to missing the opportunity of including information on FGM/C in school curriculums at different stages. This policy intervention will help spread awareness among the children and their parents about FGM and its implications, especially if the information is part of obligatory studies. The efforts to include FGM/C in school education are not systematic or consistent since the ministry of education does not have a powerful stance regarding the practice of FGM/C, although they are members of the national committee to eliminate FGM, which implies their alignment with state policies in this regard. An example of reference of school education to FGM/C was in the Islamic religion book of the first preparatory stage (average age 12) shown and translated in **(Figure 15)**, in a lesson on the beauty of Allah's creation and confirming the official stance of Azhar. They stated in the lesson that "Islam made cleanliness and hygiene a must for all Muslims, on the condition that it does not harm the individual. Regarding circumcision, there is a consensus among Muslim scholars that it is a must for males based on validated texts, which is not the case for females where there is no validated text confirming they must be circumcised. As confirmed by the previous grand Mufti, Dr. Muhammed Syed Tantawi, it is a norm spread in Egypt and inherited through generations, but it is almost extinct, especially among well-educated people. In this regard, Islam agrees with the medical doctors who confirmed the psychological and physical negative impacts of female circumcision, and there is no reference that the prophet Muhammed (PBUH) has circumcised his daughters, and all Hadiths related to female circumcision are weak and not confirmed" (Al-Husseiny et al., 2020, p.25).

Figure 15: Text on the Islamic stance from FGM/C in the Islamic religion book of the first preparatory stage



ومن ميزات الإسلام أنه جعل الطهارة والنظافة فرضًا وحسن المظهر سنةً، على ألا تترتب على ذلك أيةُ أضرار على الفرد، ففي مسألة الختان – مثلا – أجمع عُلماءُ الإسلام على أنَّها واجبةٌ بالنسبة للذكور لوجود النصوص الصحيحة التي تحضُّ على ذلك، أما بالنسبة للإناث فلا يوجد نص شرعي صحيح يوجب ختانَهُنَّ، وإنما الأمرُ – كما أكد فضيلةُ المفتي الأسبق الدكتور محمد سيد طنطاوي – عادةٌ انتشرتْ في مصرَ من جيل إلى جيل، وتوشكُ أن تنقرضَ وتزول بين الطبقات كافة، ولا سيما طبقةُ المثقفينَ ، ويتفقُ رأيُ الدين في هذه العادة مع رأي الأطباء المتخصصين، حيثُ يؤكدونَ على ضرر ختان الإناث من النواحي الجسمية والنفسية، وأنه لم يرد عن النبي صلى الله عليه وسلم أنه قام بختان بناته، وأما ورد من أحاديث – في هذا الشأن – فهي ضعيفة لا ترقى إلى الصحة.

(Al-Husseiny et al., 2020, P.25)

Statements like this need to be widely discussed in other school subjects tutored to Muslims and Christians at all stages, starting at the age of ten. The school awareness of FGM/C should not be restricted to religion classes but expand to extracurricular activities such as school theatre, school newsletters, awareness convoys, sports competitions, and others. It is worth mentioning that the

National Strategy to End Violence Against Children specified that one of the roles of MoETE is to spread awareness among parents on the different forms of violence, including FGM/C (NCCM, 2018).

The inclusion of awareness on FGM/C in education extended to higher education through advocacy efforts of UNICEF with NGOs to include lessons on FGM/C in schools of medicine and nursing. In this regard, Assiut for Childhood Development Association (ACDA), a local NGO in upper Egypt, succeeded in having round table discussions with the deans and professors of some medical schools in upper Egypt to discuss the inclusion of anti-FGM/C lessons in the obligatory curricula of medical and nursing students, in addition to organizing extra-curricular activities within the university to raise the awareness among students. This initiative is a trial to have early sensitization of medical staff before they start pursuing their professional career. This initiative is planned to upscale to the minister of higher education to mainstream it in all medical schools across Egypt.

6.5 Community Social and Behavioral Change Pillar

Being a controversial and sensitive issue in a country with excessively high prevalence rates, expecting to end FGM/C by applying policies and legislation only is a misleading assumption, the communities must be prepared and endorse the expected change to have a positive impact, which was expressed by one of the interviewees, "you cannot work at the level of policies without making sure that there is an acceptance of those policies on the ground." In this regard, designing programs and interventions to create social and behavioral change goes hand in hand with state policies to pave the road for proper policy application and law enforcement on the grass root level.

The media is one of the most critical tools to direct and accelerate social and behavioral change. The government-owned media played a crucial role in the fight against FGM/C, especially in the nineties when national television, radio, and newspaper were the most credible news source to the Egyptian population and the most accessible. Before 1994, FGM/C was still considered taboo, and the tension between the Islamic religious leaders made it very critical for the media to interfere and take sides in alignment with the political leadership at that time. This neutral attitude started to change in 1995, and the national media began to report news on deaths due to performing FGM/C, which created public opinion mobility and enabled the FGM/C to be more openly

discussed on several platforms. One of the activists recognized this trend: "This attitude of the press is vital for raising public awareness. It is important to show people that these hazards are not theoretical and that it can happen to their beloved daughters" (Abd el Hady, 1997). Nowadays, anti-FGM/C campaigns are aired on national television and radio, including the national Islamic Quran radio channel, in addition to publishing articles in national newspapers and official social media platforms. Different national campaigns were conducted over the past decades, including "Bedour," "Gamalha fe Kamalha," and "Protect Her from Circumcision."

The media campaigns to end FGM/C paralleled awareness and advocacy efforts to prepare the community for the change. The community-based campaigns usually include awareness from religious leaders, medical doctors, nurses, health and village pioneers, and community leaders through convoys and door-knocking campaigns directed to family members, including health, religious and legal information on the implications of FGM/C. When NCCM started its community-based efforts to open channels with the local communities to open up about the issue of FGM/C, they depended on many NGOs to reach the most affected population. To reach this result, as explained by government interviews, NCCM had the burden of convincing other government entities to intervene to end FGM/C, especially with the ministry of health and population, Al-Azhar, and the media who did not find ending FGM/C a priority vis-à-vis other child-related dire issues as education and poverty.

According to interviews with NGO staff, NGOs in Upper Egypt started addressing FGM/C in 2003, under the supervision of NCCM as part of the reproductive health awareness campaigns. They started in two districts in Assiut only. The strategy used at the beginning was "Breaking the wall of Silence" to encourage people to talk about the topic because the issue's sensitivity led to extreme rejection from the community to talk about it. The NGO representative recalled, "When the NGO's female social workers went to the villages to talk to families, they were used to being kicked out, dirty water was thrown on them, and were threatened with weapons because they dared to discuss such private and "indecent" issues." These efforts were part of the 'Free-FGM Village' project run by NCCM and UNDP in 10 governorates starting in 2003 to break the silence in the most affected communities about FGM/C and advocate for legal reform to criminalize FGM. This project adopted a multidimensional approach to redirect the social context to accept the abandonment of FGM/C practices. The project focused on reducing the peer pressure on families to perform FGM on their girls, having a well-trained youth volunteer base advocating against FGM

in their communities and acting as agents of change, mobilizing the community for public declarations, and enhancing the capacities of NGOs involved in ending FGM/C, in addition to other activities that boosted the efforts to end FGM/C in the past two decades (Barsoum et al. 2011).

In 2007, after the death of ‘Bedour’, NCCM launched a campaign to end FGM/C under the name "Bedayet El Nehaya" (Beginning of the End), which an interviewee described as "one of the most powerful campaigns in Egypt." Moreover, they explained, "It was not only focused on TV and radio, but also round tables with decision-makers, and round tables with media and journalists to mobilize the community." The campaign was in seven governorates, mainly in upper Egypt, and included NGOs in the implementation and cascading, which was an excellent opportunity to familiarize the community and decision-makers to talk about FGM. They also used the slogan "Break the Silence" to break the taboo of not talking about FGM/C. The campaign wanted to encourage people to talk about FGM/C and understand its negative impacts. In this regard, the interviewee said, "I think this campaign was the first to raise awareness about the terminology of FGM." The campaign encouraged publishing about FGM, which was not the norm before the campaign. Unfortunately, the campaign faced massive resistance from community members who believed that ending FGM/C was "a foreign agenda" that the Egyptian government was forced to apply. There is always public backlash on the government and non-government stakeholders participating in ending FGM/C programs whenever an FGM/C campaign has been rolling since the early 2000s. Those backlashes revolved around three main themes, as expressed by one of the interviewees "One of the backlashes was the foreign agenda and that the government is trying to have a fund, We are trying to get people apart from their religion, and we are advocating for the freedom of women and to have sexual relations (out of marriage)."

Later, the NGOs started applying a community mobilization modality based on the "Agents of Change," who were community members representing "positive models" rejecting the FGM practice. Although they were raised to support FGM/C, they had their personal beliefs that denounced the practice. Most of the cases were men rejecting FGM/C because, for example, when they got married, they suffered from the sexual frigidity of their wives; in another case, his daughter had severe bleeding during the FGM process and was barely saved, a third case had a daughter who died during the FGM procedure. So all these cases had incidents that posed a "transformation point," but they could not declare their opinions openly in the community, fearing

that their daughters would not get married or that their daughters would be labeled with a bad reputation related to their chastity. Nevertheless, once they found someone sharing their same beliefs, they started opening up and sharing the reasons for their transformation and expressed their willingness to participate in eradicating this harmful practice and saving the community from this unfair practice. Those positive models were already rejecting to circumcise their daughters but were afraid to announce their beliefs to society to avoid more social pressure.

Local NGOs supported by national councils and UN agencies in Egypt used other forms of community mobilization that were proven successful in other African countries, the "Public Declarations.[12]" The public declarations of villages that they denounce FGM/C did not mean that those villages were free from FGM/C, but it was an affirmation tool showing the expected trend in the village and capitalizing on the agents of change in each village who believed in the urgency to eliminate FGM/C but were faced by peer and social pressure. The public declarations attended by community leaders, government officials, and covered by the media were tools to affirm the support for all who denounce FGM/C in the community and an awareness event for those who were not reached out by the campaigns (UNICEF Innocenti Research Center, 2010).

Capitalizing on the "Agents of Change" method was later capitalized on through UNICEF's girls' empowerment initiative and program Dawwie, which means in Arabic the echoing voice. The initiative is coordinated with NCCM and NCW, and focuses on encouraging girls to share their experiences, enhance their skills through digital literacy, and access services to help create better opportunities for their future. The activities rolled out by Dawwie were used to increase awareness against FGM/C and other gender-related issues[13]. They include storytelling, experience sharing to capitalize on agents of change, and generation dialogues between girls, boys, and parents to decrease the gap in views related to the most critical issues. The initiative was endorsed and supported by the first lady Mrs. Entissar El Sisi, to be cascaded nationally (UNICEF, 2022a). A similar initiative was later launched by UNFPA called 'Noura' (UNFPA, 2021b).

[12] **Public Declaration / Statement** is defined as "An explicit affirmation and public manifestation of the collective will and commitment to abandon a practice.10 A public declaration or statement does not mean that the declaring village is free from FGM/C; rather it represents a milestone in the process of abandonment because it signals the change in social expectations. It may take various forms, for example, an authoritative written statement or public declaration at a large public gathering. It may involve a village; lobby groups such as doctors, religious leaders and youth; or individuals and families." (UNICEF Innocenti Research Center, 2010)

[13] Dawwie website: https://dawwie.net/en/about-dawwie

Other community-based interventions targeted empowering the grass-root community members to be capable of changing their own norms. Based on an interview with a UNFPA consultant and gender specialist, UNFPA worked on localizing the "Generation Dialogue Approach". It is a methodology adopted and developed by GIZ[14] and implemented in a few African countries but not in Egypt. According to the consultant, "It is a community-based mechanism designed to engage the community to work on and combat their harmful practices and achieve social change. It is mainly telling us that unlike the other awareness-raising methodologies or approaches or community engagement previous approaches, this one is not based on transferring information from the experts to the Community, On the contrary, we are more listening to the people themselves, asking questions and listening, and we act as social researchers not as experts". The approach takes a year to be applied, giving the people time to think and reflect, assess, and do public meetings. It depends on merging males and females, and two generations from 18 to 35 and from 45 to 60 in a relaxed process to be capable of discussing the relevant issues related to norms and customs that need to be changed or kept. The discussion starts broad till it reaches the FGM/C. The process ends with selecting agents from each community who are considered agents of change to support their community. This model depends on creating community groups on the grass-root level that are knowledgeable and equipped with the skills and tools of social accountability to support in raising the awareness of other community members and help raise the demand from within the community to enforce the laws in such a sensitive matter. This mechanism and others aiming at community engagement can enhance the policy dialogue and help identify the gaps and where things need to be done differently.

One of the most recent interventions connected to the social and behavioral change of the community is the positive parenting sessions provided through different platforms, including the 'Takaful and Karama' program under the ministry of social solidarity (MoSS), connecting financial support to the most vulnerable families to participate in the positive parenting programs sponsored by UNICEF and including awareness modules on FGM/C in different interactive ways.

National Committee for the Eradication of Female Genital Mutilation (FGM), with NCW and NCCM, hold consecutive door-knocking campaigns on the village level in the most vulnerable

[14] GIZ is The Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH, shortened to GIZ. It is the main German development agency that operates in 120 countries around the globe, including Egypt.

governorates to raise awareness of the families on the implications of FGM/C. The health pioneers and village pioneers in the campaigns have regular access to households where the families trust them, so they have space to talk to family members on sensitive issues such as FGM/C. They are trained to respond to their questions, convince them not to cut their girls, and direct them to services as needed. Most door-knocking campaigns are not exclusive about ending FGM/C, but they address a broader scope of violence against women and girls (Egypt Today, 2021).

Current Policy Obstacles:

As discussed, all stakeholders have massive efforts to ensure continuous community mobilization to end FGM/C. Unfortunately, these efforts are not coordinated or persistent enough to change society's beliefs and norms, and in some cases, the campaigns used for community mobilization are triggered by the death of a girl due to FGM/C or other related misfortunate incidents. The efforts are subject to the availability of funds and trained facilitators. Upon discussing the effectiveness of media campaigns on TV and radio, and social media campaigns, one of the interviewees expressed that "it is good to keep the debates alive, but I do not see it as an effective tool to change behaviors or to have a real impact."

According to the interviewees, having measurable behavioral change on the community level requires continuity and persistence of the message with the targetted audience, which requires continuous communication with the same individual for at least six months up to one year through a figure they trust since they continuously receive messages that support the harmful practice from their close and trusted circles. This figure could be a rural community worker, a social worker, a health pioneer, or a religious figure who is always available to repeat the information and respond to all questions arising in relevance to ending FGM/C because the issue has very complicated aspects that entail repeated explanations and discussions to convince an individual to denounce a social behavior despite the community pressure to continue. Unfortunately, most campaigns and programs to end FGM/C do not persistently address the same target groups till a behavioral change is confirmed. Also the qualifications of the knowledge provider are not always guaranteed since there is no standardization of training for all community-based workers. A technical specialist stressed this point in the interviews: "I think more community-based campaigns are needed using local actors that have actual influence in the local communities, that are trusted, that have access to the households, that know the families, and know what the issues are. But this also requires a

lot of preparations and not just deploying campaigns without investing sufficiently in the knowledge, the attitudes and the skills of the outreach workers that you are using to contribute to this change."

Another critical policy obstacle related to the social and behavioral change challenges is increasing the public demand for services. The media campaigns raise awareness and raise public expectations as well. Sometimes media campaigns raise the demand for services that are not yet available or at least not comprehensive and developed enough to respond to public demand. This shortfall happened in the case of anti-FGM/C, as the protection services were unavailable in some areas or at least insufficient to respond to the rising demand, national helplines were not developed enough to respond to all public inquiries and family counseling needs, and non-governmental services were insufficient to prevent and adequately respond to cases of girls and women at risk. The insufficiency of services is not restricted to FGM/C only but all violence-related issues.

All global and national efforts to spread awareness of the negative impacts of FGM/C ignored the needs of already circumcised girls and women who might be indirectly stigmatized for being cut. The stigma might happen in communities where FGM/C is not common, among the new generations with higher awareness, or in communities highly impacted by the awareness campaigns driving community members to take a radical stance on female circumcision. This needs to be further addressed in terms of specialized services needed by already cut girls and women and monitoring the tone and exact messages provided by awareness providers on all platforms to avoid having extremist messages that corner FGM/C victims and affect their self-portrayal.

Chapter Seven

Structural and Administrative Policy Pillars

This Chapter discusses the remaining policy pillars affecting the state target to end the practice of FGM/C in Egypt. The chapter focuses on the structural and administrative pillars within governmental control slightly affected by the community perspectives. The chapter includes pillars on structures and services related to FGM/C cases, stakeholder coordination, financing, and sustaining the interventions till achieving the target in a blurred global economic situation. Some pillar obstacles are discussed to explore the possibility of policy adjustments in some areas.

7.1 Structures and Services Pillar

Many government and non-government stakeholders are directly involved in ending FGM/C and influence the policy design and implementation. The government stakeholders have 'the elimination of FGM/C' as part of their mandate, such as the National Council for Childhood and Motherhood (NCCM), the National Council for Women (NCW), the latest national coordination committee 'The National Committee to Eradicate Female Genital Mutilation,' and each ministry has a role reciprocal to their functionality and they are all members in the national committee. In addition to service provision mechanisms and structures such as the NCCM Child helpline, the NCW women's complaints office and hotline, the Child Protection Committees, and the Safe Women Clinics in University Hospitals and primary health care units managed by the ministry of health and population. Finally, the United Nations agencies support the government in implementing its policies.

National Council for Childhood and Motherhood (NCCM): NCCM was established in 1988 by a presidential decree to lead the coordination, advocacy, policymaking, implementation, and evaluation of activities related to the protection of children and mothers (NCCM, n.d). NCCM became involved in ending FGM/C in 1999 to be the first formal structure mandated to address the issue upon the dissolution of the Egyptian National FGM Taskforce and included their tasks in NCCM's mandate. According to government interviews, NCCM started a series of interventions under the "FGM-Free Village" project to facilitate ending FGM/C, catalyzed by the girl's initiative

launched by the first lady, Mrs. Snnnn Mubarak, in 2003. The efforts of NCCM in creating community mobilization to accept ending FGM/C was crowned by their success in criminalizing FGM/C/. Later, when NCCM became part of the Ministry of Family and Population in 2010, the FGM/C abandonment program expanded to include aspects of family empowerment.

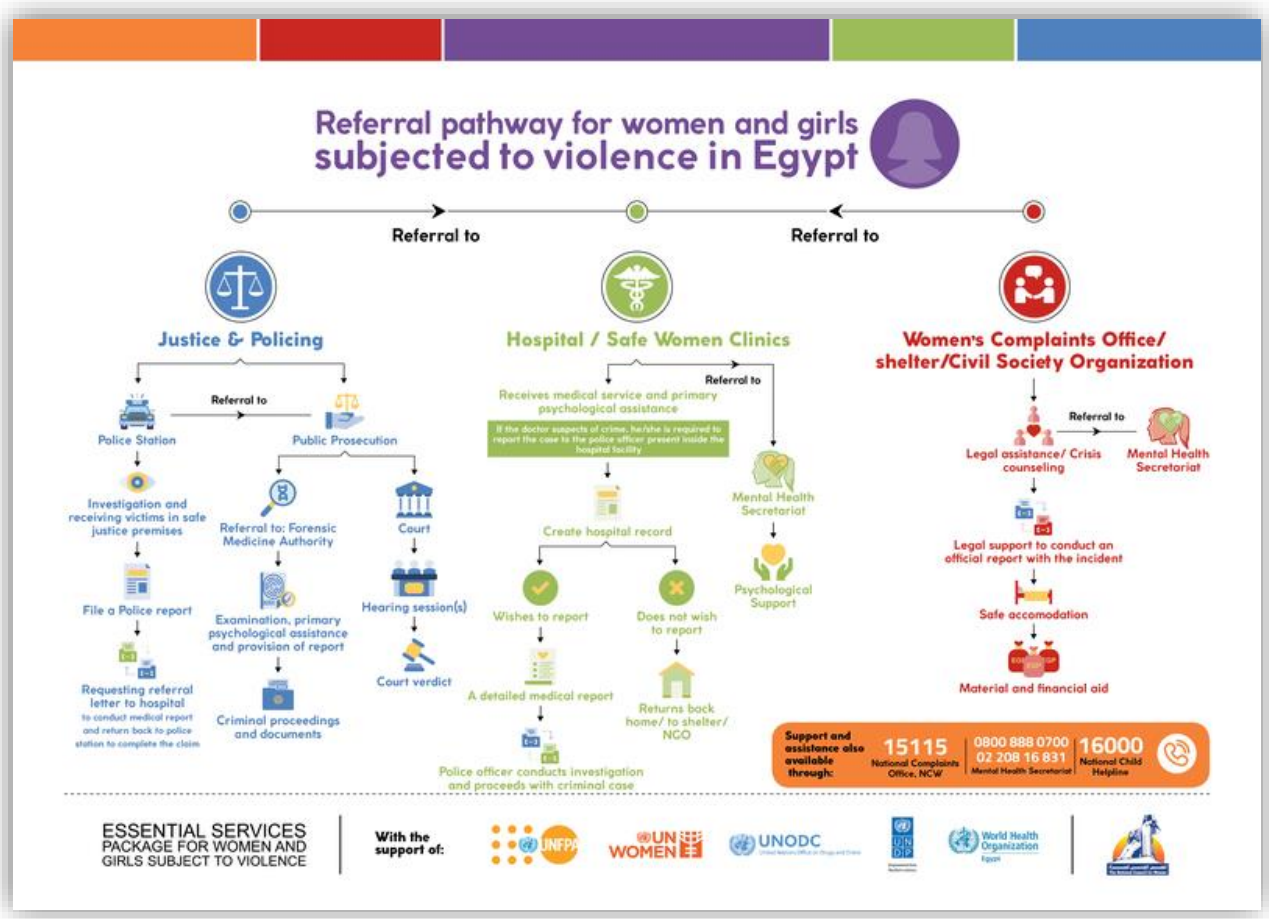
NCCM developed a national child helpline (CHL) as a prevention and response mechanism for child protection. The child helpline is mandated to receive, record, and respond to complaints regarding children being subject to any kind of violations and address them in a way that ensures saving the child quickly in cases of imminent danger, including FGM/C. The helpline refers the inquiries or cases reported to service providers in different ministries and NGOs to safeguard children and respond to their protection needs. NCCM included ending FGM/C in the National Strategy to End Violence Against Children published in 2018.

National Council for Women (NCW): NCW was established by a presidential decree in 2000 to ensure women's empowerment and support them socially, economically, culturally, and politically. In addition to advocating for policies and laws safeguarding women's rights (NCW, 2016). NCW plays a pivotal role in ending FGM/C by leading the door-knocking campaigns, participating in media campaigns, and providing various services to end and respond to violence against women, including FGM/C. From those services, establishing women's complaint offices in all governorates and their corresponding hotline to receive complaints regarding violations against women, analyze and respond to those complaints, and refer them to specialized entities for resolution (NCW, 2022). Also, since 2020, they established with the UNFPA the safe women's clinics in national universities and primary health care units in MoHP, in which they trained the medical staff to receive women victims of violence and provide them with adequate medical treatment and refer them to women's complaints office to receive socio-economic and legal support upon need (UNFPA, 2022b).

In coordination with UNFPA, UNODC, UN Women, UNDP, and WHO; NCW established a **'National Referral pathway for Women and Girls Subjected to Violence,'** which shows the referral pathways for women and girls victims of violence to receive the essential services in areas of health, policing and justice, and socio-economic services. The referral pathways include the services provided through NCW, MoHP, MoI, MoJ, OPP, and MoSS **(Figure 16). (UNFPA, 2021c)**

The National Committee for the Eradication of Female Genital Mutilation: The national committee was established in 2019 by NCW and NCCM to coordinate all the national efforts to end FGM. The committee includes ministries and national councils, Al- Azhar, the Churches, CAPMAS, and NGOs. The committee is mandated to review and discuss the policies and legislations, provide a platform to exchange information and experience between stakeholders, propose funding resources to implement the national plan, and monitor its implementation with stakeholders (The National Committee to eradicate FGM in Egypt, 2021). As expressed by one of the interviewees, "the establishment of the National Committee was a very positive step because it shows a stronger political commitment and a clear leadership on the portfolio to avoid redundancies between different government counterparts."

Figure 16: National Referral Pathway for women and girls subjected to violence



(UNFPA, 2021c)

United Nations Development Program (UNDP) and National Population Council (NPC): UNDP has worked closely with MOHP and NPC on ending FGM/C since 2003. From 2009 till 2019, the 'FGM Abandonment and Family Empowerment Joint Programme (JP)' was launched, with the European Union as their leading donor, aiming at creating sustainable socio-economical and political changes to empower families to be able to abandon FGM/C (UNDP, 2019). The project made interventions in fifteen governorates at the village level and aimed at building the capacities of local NGOs to raise public awareness of FGM and mobilize local communities. The project had many achievements, including publishing the **National FGM Abandonment Strategy (2016-2020)** by the NPC as a framework for national efforts to end FGM/C, launching the **'Doctors Say No to FGM'** initiative by medical professionals in 2017, and launching the media campaign **'Enough FGM'** which showed testimonials of families who changed their behavior and denounced FGM/C upon persistent interventions with them for ten years (UNDP, 2019).

United Nations Children's Fund (UNICEF) and United Nations Populations Fund (UNFPA): Currently, UNICEF and UNFPA are leading the implementation and coordination with the government counterparts under the umbrella of the global joint program on FGM. As elaborated by a UN interview, UNICEF and UNFPA support the Egyptian government on the policy level and the legislative framework related to FGM abandonment; accordingly, they support the National Committee and its members to achieve the national goal. They coordinate efforts between the different stakeholders for evidence generation, develop a comprehensive national plan of action, and provide technical and financial support in the committee's work toward reforming the legislative framework. The UN also supports the government in community mobilization and raising awareness through multimedia campaigns and community-based interventions. The UN works on FGM medicalization with the Ministry of Health in terms of raising the awareness of healthcare professionals of existing laws and policies and mobilizing them to raise the awareness of the public who use healthcare facilities. UNICEF's role emphasizes sensitizing the national child protection system to FGM/C in terms of prevention and response and providing services for survivors, while UNFPA focuses more on the awareness and services of reproductive health.

Child Protection Committees (CPCs): The CPCs are multi-sectoral committees at the governorate and district levels. They are administratively under the Ministry of Local Development (MoLD) and technically guided by NCCM. The CPCs were established by article

97 in law no. 126 in 2008, amending the child act of 1996. The law established general and sub-committees to protect children from violence and abuse and intervene immediately when the child is at risk in coordination with other parties (NCCM, 2018). As clarified in the interviews, The General CPC is headed by the governor and includes the heads of directorates of MoI, MoSS, MoETE, MoHP, a civil society representative, and whomever the governor finds needed. The District CPCs have a similar structure on the district level, and each GCPC and DCPC has a child protection unit with a full-time social worker, legal specialist, psychologist, and secretary. The CPCs are mandated to intervene directly with children at risk, including girls at risk of FGM/C, and ensure a care plan is designed for the child with referral to the needed services. The CPCs ensure that the care plan is followed and that the child is safeguarded. They can intervene with the family or child caregiver to ensure the child is safe through family counseling or legal services. Some CPC members from the case workers have legal authorization to arrest perpetrators.

7.2 Stakeholders Coordination and Ownership

The coordination between stakeholders on ending FGM/C is progressing compared to the previous decades. Also, the government is more committed to achieving the total eradication of FGM/C with clear ownership. The interviewees applauded this development: “I think lately there has been more alignment between the direction of UN agencies and the government as well as civil society. The fact that the issue is acknowledged shows that there is better alignment. The fact that there are frequent meetings, briefings, and reporting on the progress achieved is definitely improving the coordination efforts and the fact that there is a clear leadership on the portfolio as a whole, which also leads the policy dialogue with the Parliament and any legislative reforms that are needed is an improvement from before, makes it more sustainable than before.”

However, there are still areas of development that could be enhanced, such as having a consultative National Action Plan covered by a sustainable fund, which an interviewee clarified: “coordination mechanism between the different actors, like a National Action Plan would be beneficial, provided that there is a sustainable entity that will continue to play the role of coordination and monitoring. And there are sustainable funding sources for the interventions and the coordination and monitoring of those interventions”.

Current Policy Obstacles:

As confirmed by the interviewees, further coordination is needed between the different ministries and NCCM and NCW as co-leaders of the National Committee to eradicate FGM/C. Although the committee includes all the ministries in Egypt, most ministerial efforts to end FGM/C are neither systematic nor coordinated through the committee or reported to, so capitalizing on those efforts nationally is impossible. In some cases, those efforts are unknown, which delays achieving the ultimate goal of ending FGM/C in Egypt and wastes resources.

It is essential to understand the synergies between the different issues addressed by the government counterparts and UN agencies as education, health, economic empowerment, employment, and others, that manifest themselves in FGM and other harmful practices and other forms of violence against women and girls, which was reflected by one of the interviewees saying "FGM does not happen in a vacuum. It is a manifestation of many issues that women and girls face in certain local communities."

In relevance to the high medicalization rates, one of the UN interviewees highlighted a significant coordination gap, "Medicalization is an area where the roles and responsibilities are not still clear. It's clear that this is the Ministry of Health's mandate because they are responsible for enforcing the policies and holding doctors accountable when they break the law. But other actors may also be involved. So how is this being coordinated between the different actors? It is unclear whether it's the National Committee, the National Council for Childhood and Motherhood, or other law enforcement agencies. And how then changes in the law will be effective, even if only focusing on the issue of medicalization rather than the overall prevalence, it remains to be seen. So this requires much coordination. Also, coordination with a child protection system, the CPCs, and the governorates with high prevalence with doctors conducting the practice. All of this requires much stronger coordination when it comes to medicalization specifically."

Another obstacle is the lack of coordination between the service providers mandated to serve children and those mandated to serve women. If there is a case of an adolescent girl at risk at the age of 17, once she is over the age of 18, she will be under the umbrella of a different service provider. This requires extensive coordination between NCCM and NCW, different UN agencies, the CPCs, the Child helpline, and the women's complaints offices. This was manifested in the

national referral mechanism for women and girls victims of violence endorsed by NCW but excluding other child-related services.

7.3 Financial pillar and Sustainability Factors

Funding FGM/C abandonment programs has always been the role of international donors directly or through the United Nations agencies, with minor funding contributions from local governments and civil society.

The most prominent program to end FGM/C is **"The Global Joint Program on the Elimination of Female Genital Mutilation,"** which started in 2008 (UNICEF, 2022c) and is implemented by UNICEF and UNFPA in 17 African countries with high prevalence rates of FGM/C including Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Nigeria, Senegal, Sudan, Somalia, Uganda and Yemen (UNICEF, 2022c). The joint program (JP) is funded by a coalition of western governments, including the United States of America, The United Kingdom, The European Union through the Spotlight Initiative Africa Regional Programme (SIARP), Spain, Sweden, Norway, Luxemburg, Italy, Iceland, France, and Austria (UNICEF & UNFPA, 2020a). In 2021, Phase III ended with a total budget of 103,594,230.68 USD covering interventions in the 17 countries for four years with an average of 25 million USD per year (UNICEF & UNFPA, 2022b). Currently, JP is implementing Phase IV, which started in 2022 for nine years to end in 2030, with a planned budget of 334,545,455 USD to accelerate the abandonment of FGM globally to meet the SDG 5 target to eliminate FGM/C globally in 2030, with an average of 37 million USD per year that is still to be confirmed upon the donor contributions in the pooled funding mechanism (UNICEF & UNFPA, 2022a). During the four years of phase III (2018-2021), Egypt spent 3,821,250 USD on programming and interventions related to ending FGM/C (UNICEF & UNFPA, 2022b).

Current Policy Obstacles:

In light of the global financial and political crises, namely the aftermath of Covid-19 and the 2022 war in Ukraine, the funding priorities of donors are being reshuffled, causing a decline in the fund for developmental programming in low and middle-income countries by the developed countries. Accordingly, the discussion with different interviewees highlighted the issue of funding sustainability as a possible risk to ensure the continuity of interventions to end FGM/C.

Almost all interviewees were skeptical about the possibility of universal elimination of FGM/C by 2030 based on the decline rates in countries with available data. Consequently, there is a high probability that SDG 5 will not be fully achieved, and this will also apply to Egypt's 2030 Sustainable Development Strategy (SDS), based on the latest prevalence decline rate of 6% in eight years (CAPMAS, 2022), which implies that Egypt might need more than a century to entirely eliminate FGM/C if we continued the interventions with the same pattern, keeping all variables constant. Interviewees expressed their worry about a possible 'donor fatigue,' which they explained by saying: "donors have been investing in ending FGM for decades while the results - even if there is an improvement - do not match up to the amount invested." In this context, it was suggested that more government ownership and commitment to ending FGM/C should be shown to donors in terms of developing an updated National Action Plan to end FGM/C, evidence generation through continuous national surveillance to be used to advocate for more resources, and allocating stable fund from the national budget to support the core interventions to end FGM/C on a cross-sectoral basis is required to ensure the continued interventions to end FGM/C till target is achieved.

Chapter Eight

Conclusion: Road Map to End FGM/C in Egypt

This chapter concludes the research by identifying the broad lines of a national road map to end FGM/C in Egypt. The chapter will include the lessons learned from the running and previous policies and their application, in addition to reviewing possible recommendations for more successful policy implementation and interventions. The chapter will also highlight some intervention approaches that could be integrated into policy design, theory of change, and implementation to end FGM/C in Egypt.

Lessons Learned and Policy Recommendations

The role of the different stakeholders, either government or non-government, needs to be refined beyond continuing the interventions in the same conventional way, which requires a focus on addressing specific areas as follows:

- **Inclusion in Formal Education:** Despite the quality of formal education services in Egypt, it is undeniably a cornerstone in the leverage and progress of the nation and forms the basic foundation for all educated population. The inclusion of awareness messages on the harmful impacts of FGM/C in formal education - as part of the obligatory lessons - will ensure keeping the discussion on FGM/C alive and will provide girls and boys the opportunity to question the harmful norms endorsed by their local communities, which might lead to rescuing more girls from being mutilated and cut on a longer term, and might encourage parents to reconsider the falsified assumptions correlating FGM/C and chastity and assumed religious obligations. This step requires a strong endorsement from the Ministry of Education and Technical Education (MoET) and the engagement of the Center for Curriculum and Instructional Materials Development (CCIMD) in collaboration with the Ministry of Health and Al-Azhar to include scientifically and religiously correct information in a simple way suitable to each educational stage. In addition to expanding the awareness to teachers in different grades on FGM/C and ensuring their personal denunciation of the practice through social and behavioral change programs as needed, keeping a robust monitoring system to ensure that the information is cascaded accurately to the students and their parents.

- Stakeholders Coordination: Despite a national coordination committee to coordinate interventions to end FGM in Egypt, the actual policy and implementation coordination is not ripening enough due to competitive attitudes among the national stakeholder and among the UN agencies. To have a remarkable improvement in the declining rates of FGM/C standardized modalities need to be applied, ensuring non-duplication of geographical coverage and expanding and diversifying the Ns' operations in ending FGM/C activities across upper and lower Egypt. NGOs with long experience in activities to end FGM/C could be capacitated as master trainers to train other NGOs. The annual plans of activities should be monitored through the national committee to ensure complete alignment between all stakeholders and to ensure that the staff and frontliners of all stakeholders have open communication channels to exchange experience, collaborate on cases, and are empowered to cross-refer cases according to the mandate of each entity and availability of service. The central concept guiding the coordination between stakeholders should be the child's and women's and families' best interests.

- Reducing the medicalization of FGM/C as a way to reduce the prevalence of FGM/C: To reduce the medicalization of FGM/C, more advocacy is needed to strengthen law enforcement within the health sector directly from the office of the minister with close monitoring to hold medical staff accountable for their actions, and ensure they are fully aware of the legal and career implications on any medical staff involved in FGM/C performance. The role of the UN should not end at the level of spreading awareness among medical staff on the penal code and the implications of FGM/C, but having close coordination with MoHP and other stakeholders to enhance the services available for victims of FGM/C which is highly demanded based on the prevalence rates in Egypt. The services provided should not be confined to responding to FGM/C cases only but include all sorts of sexual and gender-based violence (SGBV) against women and girls. In order to have these services operational, funding gaps should be addressed both on the national and donor level, and coordination with MoHP on the public and private levels of service provision is required to ensure that the medical staff has adequate knowledge about the psychological and medical repercussions of undergoing FGM/C and being subjected to SGBV. The way forward is to design social and behavioral change programs for the medical staff, social workers, and para-social workers affiliated with the health sector to avoid personal judgment on victims and avoid providing misleading or harmful advice. All the medical and social workforce frontliners must be fully equipped with psychological first-aid knowledge since they might be the first to deal with

victims. They must know all alternative service providers if the victim requires further interventions out of their capacities, such as women's shelters for survivors of SGBV under NCW and MoSS, where they can receive more specialized interventions and social protection packages based on the needs per case. Moreover, they must be fully aware of the legal referral points in case the victim decides to report and needs legal advice or support.

- Law Enforcement: the reporting mechanisms need to be further simplified and accessible to girls, women, and the general public. The process needs to be clear to all people, confirming the confidentiality and non-disclosure of details of the reporter. The helplines need to be responsive and active. The helpline agents need to be capacitated to provide on-phone psychological first aid, be adequately trained to sympathize with callers, and have an open channel with the office of the public prosecutor to refer cases. This applies to all frontliners responsive to ending FGM/C and ensuring they have direct access to CPCs, women's complaint offices, and various helplines. The ease and accessibility to reporting, ensuring the confidentiality and anonymity of the reporter, might encourage the reporting, save more girls and women, and submit more violators to justice.

- Community Mobilization: Community mobilization is critical in ending FGM/C and needs to be approached differently than in previous decades to ensure that the community denounces FGM/C practice at an accelerated pace. Accordingly, community mobilization efforts should be coordinated between multiple stakeholders and planned at scale under the supervision of the national committee using unified modalities and non-duplicated geographical scope. This includes standardizing training modules, having unified master trainers, and creating a unified monitoring and evaluation framework to ensure that all communities at risk are included, no one is left out, and ensuring the quality and effectiveness of the intervention in the long term. The community mobilization requires developing deep social and behavioral change modules, with robust monitoring and evaluation tools and more strengthed capacity-building programs addressing the frontliners who provide awareness and services on FGM/C. Those programs will ensure that the frontliners are equipped with the proper knowledge, attitudes, and skills to ensure that the correct information reaches the families to educate them on reproductive health and sexuality issues. The continuous long-term monitoring and evaluation will confirm or refute the behavioral change of frontliners, upon which the interventions could be adjusted to be more effective.

These extensive and coordinated programs will ensure conveying of accurate messages to victims of FGM/C or those at risk from women and girls to ensure that no further harm is caused to the case through unintended stigmatizing, discrimination, or reviving traumas. Those frontliners include health pioneers and health educators who participate in the knocking-door campaigns, the helplines agents, the facilitators in the NGOs providing awareness sessions on different platforms related to mitigating the risks of FGM/C, the family counselors, facilitators providing positive parenting sessions, religious community leaders, case workers, psychologists, and psychiatrists providing mental health and psychosocial support (MHPSS), and final medical professionals providing medical interventions.

To have better outreach of social and behavioral change interventions, regular national campaigns could be a good tool to disseminate messages and test their effectiveness. One example is the national health campaigns as vaccination campaigns or "100 million Health" campaigns, which reachout to millions of boys, girls, women, and men across Egypt. The campaigns could spread awareness messages on FGM/C, respond to questions, and direct to relevant services, which requires including them in the national capacity building plans.

Finally, Social and behavioral change approaches need to continue focusing on men and boys as agents of change for the community's perception of FGM/C. If men and boys representing fathers, brothers, and husbands stopped perceiving female cutting as a hygiene, beautifying, and chastity requirement, the pressure on women and girls to cut as a response to males' favoritism would decrease, and the cutting rates would decrease.

- **Media Campaigns:** It is a good practice to invest in local media channels known to local communities, such as the governorates' local radio and tv channels, social media platforms, and newspapers. This investment includes enhancing the capacities of the staff operating those media channels and the journalists who are usually influential in their communities and well-connected with government officials on the local level, which will enable them to raise awareness on FGM/C and keep the discussion ongoing and in the spotlight. Usually, every local community has its own media influentials that have a strong presence and a say in the local community, which enables them to address controversial issues seen as extremely culturally sensitive and debate it to sensitize the community about it. An interviewee clarified this: "Someone who already has a level of trust and credibility is more effective than national-level platforms that do not necessarily resonate with all communities, especially closed communities such as in rural upper Egypt or even in the delta."

So it is vital to use the media, but use different media platforms and different categories of media people that make each one feel that they belong to the message disseminated and that it is not addressing a specific cluster or socio-economic class that they do not relate to.

- Focusing on Young Generations: It is crucial to focus on adolescents and the young generation in formulating policies related to ending FGM/C. This could happen through a national consultation process with children and adolescents, including girls and boys. This consultation is crucial to include the opinions of future parents, which will demarcate the trend of FGM/C prevalence within a few years. Including young generations entails designing program interventions addressing boys who will become future husbands and fathers because the over-focus on girls and women in the past decades discarded the fact that girls and women are under-empowered in the community since the power dynamics within Egyptian families are usually inclined towards males. Empowering girls and women without ensuring their families and communities support them can put them at extended risks beyond FGM/C. The main argument was that - usually - the decision to circumcise the girl is taken by the mother, grandmother, or the most influential female figure in the family. However, addressing adolescent girls can help convince them as future mothers not to circumcise their daughters to protect them from the suffering they went through. Changing the attitudes of younger generations is always easier than older ones, which is also core to community mobilization.

- Complementarity of Services: Several problems face the service provisions to victims of violence in Egypt, including the insufficiency of those services to respond to all the needs of either prevention or response to the physical or psychological assault, the lack of financial resources to provide services, the lack of qualified capacities to provide services, the lack of understanding of the problem of FGM/C and the required kinds of services, and the service providers for the current services are bisected between services provided to women only and services provided to child girls only, which creates many complications, taking into consideration that FGM/C does not happen in a vacuum, it is correlated with a lot of other issues related to gender inequalities and SGBV inside and around domestic spheres. For example, if a girl is subjected to FGM/C and proceeds with psychological support through a case management plan, this plan will be interrupted when she reaches the age of eighteen, and the services she receives will stop because she will be an adult by law, and she will need to move from the service providers addressing children to service providers addressing women. Accordingly, she falls into a gap between different service providers

that puts her at risk of a relapse since each service provider has tailored requirements for identifying the cases needing intervention, which might not apply to this woman anymore. To resolve these problems, there should be an agreement among government and non-government stakeholders on the required services to be provided to girls and women at risk of FGM/C and victims. Mapping for all the services provided through all stakeholders should be created and continuously updated to facilitate the response to any identified case. A standard operating procedure should be created under the two leading national councils, NCW and NCCM, to address the complementarity of the services provided to girls and women, to avoid leaving anyone at risk or victim behind. These SoPs should include a cross-coordination and a precise referral mechanism between the caseworkers under the child helpline operated by NCCM and the women's complaints hotline under NCW to receive needed services. These SOPs, if created, will address FGM/C and the nexus between violence against girls and violence against women, which FGM/C falls under its umbrella. Both councils and the national committee must closely monitor the operationalization of these aspired SoPs to ensure that the service providers reporting to different entities effectively collaborate for the best interest of the girls and women. This mechanism will enable a smooth transition of cases between childhood and adulthood, in addition, it will allow the inclusion of both children and their mothers in case of being subjected to mutual risk.

- Financial Resources Mobilization: With the increasing risk of a possible decline in donor funds to ending FGM/C due to global crises, the government's ownership and commitment to end FGM/C should be shown to donors to qualify for receiving more funds. The national commitment could be manifested through developing an updated national action plan to end FGM/C, continuous evidence generation through national surveillance to have an accurate assessment of the policy impacts, and allocating stable funds from the national budget to support the core interventions to end FGM/C on a cross-sectoral basis through all stakeholders.

- Insufficient Policy Documentation: Since Egypt started the battle to eliminate FGM/C, the accountability of ending FGM/C was moved from one national council and UN agency to another. Unfortunately, there was not enough channeling of experience and handing over of the achievements from one stakeholder to the other, resulting in redoing the same advocacy and interventions, leading to duplication of efforts and waste of time. An example of this duplication is the advocacy efforts done by the UNDP and NPC joint program to mainstream anti-FGM/C

lessons in the curricula of medical schools, teacher's colleges, social service institutes under the ministry of higher education, and in primary and secondary school curricula under MoETE (UNDP, 2019). UNICEF, UNFPA, NCW, and NCCM are repeating these efforts under the currently running joint program to end FGM/C, which was clarified in the interviews with the operating NGOs and senior government consultants involved in ending FGM/C a decade ago.

To overcome this problem and to save time and resources, a documentation project needs to be launched, gathering official documents from all stakeholders who worked on ending FGM/C at any point in time, in addition to testimonials from experts, practitioners, policymakers from all government and non-government stakeholders, and donors. This documentation will inform the policy formulation and help connect the dots between what has been achieved and what will be planned. It could be used as a fundraising document to secure more support for the cause.

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Annex 1: Questions for the Semi-Structured Interviews

1. Please introduce yourself and your role in your organization organization.
2. What is the role played by your organization in ending FGM/C?
3. There are many stakeholders involved in ending FGM/C in Egypt. What are the entities most involved now? And what are the entities that need to be involved more or less? To what extent are the coordination efforts successful/effective, and why?
4. What are the most and least effective policies in ending FGM/C, currently and historically?
5. What do you think is the most impactful media community campaign provided to end FGM? And why? And what was its impact on the community's perception of the FGM/C practice?
6. How effective is aggravating penalties for performing/abetting FGM in decreasing FGM/C rates? Explain.
7. What is the best way to address ending FGM medicalization?
8. What do you think are the obstacles facing the policy design and implementation in ending FGM/C?
9. What do you think is an area of improvement for the national policies? Explain.

Note: *Answers to questions (5, 6, and 7) were sometimes included in the answer to question (4). In this case, they were not asked.*