I. FEMALE GENITAL MUTILATION (FGM): THE CONTEXT

Female Genital Mutilation (FGM) is a fundamental human rights violation that affects girls and women worldwide. FGM is a practice that includes all procedures of partial or total removal of the external female genitalia. It is harmful to women and girls and has no medical justification. FGM was handed down by deeply entrenched social norms, reflecting an extreme form of discrimination against women. In addition to being a severe form of gender-based violence and a violation of girls’ rights, FGM leads to psychological and health risks. It is mainly concentrated in 30 countries across Africa, Middle East and Asia, where at least 200 million girls and women alive today have been subjected to the practice.¹

![Graph showing the decline in FGM prevalence in Egypt from 2005 to 2014.](https://via.placeholder.com/150)

**Egypt had a remarkable rate of decline of FGM prevalence among the age group of 15-17 years with an overall decline from 77% in 2005 to 61% in 2014.²**

Although there have been significant efforts to end violence against children in Egypt, particularly the practice of FGM, progress in reducing the prevalence has been slow. Over the span of 6 years, FGM prevalence decreased by only 4 percentage points among women in the 15-49 age group; from 91% in 2008 to 87% in 2015. Comparing different age cohorts clearly shows that though the national prevalence was strikingly high in 2015, there was a downward trend in the practice of FGM, suggesting that the practice has been declining ever since. FGM mostly takes place between the ages of 5 and 14 years.

¹ UNICEF, Female Genital Mutilation, February 2018 <http://www.unicef.org/protection/57929_58002.html>

Prevalence rate is very high among elderly women and the highest for women aged 45-49 at 97%. The decline is evident for younger women aged 20-24 years and even more for those aged 15-19. The prevalence of FGM among girls aged 15-19 years is 70%; about 27 percentage points lower than that among the women aged 45-49. FGM prevalence among the age group 15-17 years has declined significantly from 77% in 2005 to 61% in 2014. However, from 2015 to 2030, over 7 million girls are at risk of undergoing FGM.3

II. WHAT ARE THE ATTITUDES AND PERSPECTIVES OF THE FAMILIES?

Though there have been improvements regarding the abandonment of the practice, beliefs remain to be in favour of its continuation. More than half of ever-married women aged 15-49 believe that the practice should continue, a reduction of 10 percentage points since 2005 and 24 percentage points since 1995. The data varies between urban to rural residence with a great support of the continuation in rural governorates - reaching 65% for men and 63% for women, while in urban governorates the support is only from 37% of women and 47% of men. This could possibly be a result of believing it is required by religious precepts and that it prevents adultery. Although some people believe that FGM is religiously mandated, neither the Quran nor the Bible contain any directives from which this could be derived. This standpoint was supported by strong statements from Al Azhar and Coptic Orthodox Church. Even though there’s been a positive change in women’s attitudes about cutting, there is still a large part of the population that supports the continuation of FGM in Egypt, with men slightly more likely than women to have beliefs that are supportive of the practice. The 2015 Egypt Health Issues Survey (EHIS) showed that 59% of men agree with the continuation of the practice compared to 54% of women.


Note: For 2015, data do not include North Sinai and South Sinai governorates.

FGM practice in Egypt is characterized by regional disparities; the practice of FGM is not evenly spread among all regions with a higher prevalence in rural areas (both Upper and Lower Egypt) than urban ones. Over the past years, the situation became further polarized with substantial declines in urban areas and a stagnation of rates in rural areas. These differences become more prominent when analyzing the current situation among girls aged 0-17. In 2015, the FGM prevalence among women was over 90% only in Rural Upper Egypt and Rural Lower Egypt, while in urban governorates the prevalence rate was close to 75%.

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III. WHAT ARE THE DETERMINANTS AND FACTORS THAT HINDER PROGRESS?

The continuation of the practice of FGM is influenced by a number of demographic, socio-economic, and socio-cultural factors. Among these factors are a mother’s status in terms of being cut or not, women or girls having discussions about FGM, and parents’ thoughts about FGM continuation. Other determinants are mother’s current age, wealth quintile, parents’ educational level and age of mother at first marriage.5

If the mother has undergone FGM, she is almost seven times more likely to have the procedure performed on her daughter. Mothers who have undergone FGM are usually in favor of continuing the practice. Moreover, daughters are four times more likely to undergo FGM if the attitude of the mother is to continue the practice and nearly twice more likely if fathers believe that FGM should continue.

Mothers’ current age and the age at first marriage are strong determinants of their daughters’ odds of undergoing FGM. The older the mother is, the more likely her daughter will undergo the practice. This goes back to the fact that for older generations, the practice of FGM was almost universal among women, which, as previously mentioned, is one of the factors influencing the continuation of the practice.

Engaging in recent discussions about FGM (i.e. in the year preceding data collection) significantly reduced the daughter’s risks of undergoing the practice. The exposure to information regarding FGM is crucial, however there has been a sharp decline over the years in the proportion of women who have recently received information about FGM.

5 Determinants of FGM is based on ‘Factors and determinants of FGM of girls aged 0-17 years’ which is a secondary analysis of the Egypt Demographic and Health Survey
The impact of mothers’ education on daughters’ FGM status was significant among all education levels, with the odds of the girl undergoing the procedure decreasing as her mother’s educational level increased.

A mother’s wealth quintile affects her daughter’s chances of getting cut. In Upper Egypt, 8 out of 10 girls aged 0-17 years in the lowest wealth quintile were expected to undergo FGM compared to 3 out of 10 girls within the same age group in the highest wealth quintile.

Although FGM is considered a criminal offence in Egypt and is punishable by imprisonment, the practice continues to flourish with the cutting facilitated by doctors, nurses, and health workers. This continued trend of medicalizing the practice is as high as 79% in 2015 among girls aged 1-14, conducted by either a doctor, nurse, or a health worker. Some of the reasons behind medicalization are that health workers “consider it their duty to support the patient’s or family’s requests that are socially or culturally motivated.” The health practitioners might also believe that they are reducing the risks of the procedure by performing it themselves, and/or are interested in the financial gains.

The Government of Egypt’s commitment to eliminating FGM is represented in the signing and ratifying of regional and international rights conventions and treaties related to FGM; including the Convention on the Rights of the Child (CRC), Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW), the African Charter for Child Rights and Welfare and African Union Ouagadougou Declaration.

Furthermore, throughout the past years, Egypt has worked on developing and implementing legislative and policy measures to protect girls from FGM. Since 2003, NCCM highlighted FGM as a priority childhood policy topic and encouraged breaking the silence around this harmful practice. By adopting multi-sectoral collaborative approach, NCCM promoted partnerships with relevant Ministries, NGOs, faith-based organizations, UN agencies, and development partners. In addition to that, Egypt has taken serious steps towards strengthening national legislation on FGM and developing new strategies, programmes, and initiatives to abandon the practice. These steps include: the Egyptian Constitution (article 80), Child Law no. 12 for 1996 amended by law 126 2008, Penal code 2008 amended in 2016, National FGM Abandonment Strategy 2016-2020, National Childhood and Motherhood Strategy 2018-2030, Ending Violence Against Children Strategic Framework, National Women Strategy 2030, the Sustainable Development Strategy Egypt Vision 2030, MOHP Decree no. 271 for 2007, Circular no. 14 for 2016, “Doctors against FGM” Initiative, and Girls’ Empowerment Initiative “Dawwie”.


6 On August 31, 2016, the Egyptian People’s Assembly approved the amendment of article 242 (bis) of the Penal Code. The article (242 bis): “... a prison term of no less than five years and no more than seven years shall be levied against anyone who circumcises a female, namely, by partial or total removal of the external genitalia or causing injury to the genitalia without medical justification. The penalty shall be hard imprisonment if the act results in a permanent disability or if it leads to death.” Source: The Egyptian Initiative for Personal Rights Website.

In 2007, the Minister of Health and Population issued decree no. 271 on the prohibition of FGM that was also supported by strong statement by Egyptian Medical Syndicate in the same year.

UNFPA, UNICEF and WHO, June 2018. Calling for the End of the Medicalization of Female Genital Mutilation
The commitment was translated into more solid actions. In 2019, Egypt has formed the National Committee for the Eradication of FGM under leadership of the National Council for Women and the National Council for Childhood and Motherhood to lead FGM elimination policy dialogue, coordinate advocacy work and interventions, and to accelerate efforts to protect and empower girls.

Despite the national decline in prevalence rate among younger age groups, the magnitude of FGM is expected to remain high given the rapid population growth in Egypt. Thus, collective action is required to accelerate the abandonment of FGM as well as the protection and empowerment of girls in order to reach 2030 SDG 5.3 that calls for elimination of all harmful practices such as FGM and reach the planned Zero target.

**Strengthen national systems**

**FGM reporting, protection, and care**

There is a need for more investment in local and national FGM prevention, protection and care mechanisms, and strengthening the child protection system and child protection committees. The systematic engagement of all child protection actors should be complemented with capacity strengthening opportunities for national stakeholders to be able to respond to the needs of FGM survivors (i.e. rehabilitation and care) as well as preventing the further spread of FGM by protecting girls at risk.

**Mainstreaming of FGM in existing national systems and programmes** is essential, including national programmes on ending violence against children, gender-based violence, and sexual and reproductive health.

**Promoting enabling legal and policy frameworks to address FGM and stopping the growing trend of medicalization**

Recognizing the role of medical professionals/healthcare providers is a necessary component in ending FGM. Strengthening and systemizing monitoring and surveillance of healthcare providers on a national scale is essential for the protection of girls at risk and addressing FGM medicalization. Furthermore, it is important to focus on developing clear policies and national guidelines to help medical professionals in responding to families who request the procedure.

**Access to quality services**

**Mapping of existing services** at the national/local level is recommended including the referral services through the National Child Helpline 16000.

**Strengthening the capacities** of Child Helpline staff, social workers, Child Protection Committees, law enforcement officials, and healthcare providers is needed for the provision of quality prevention, protection and care services related to FGM. More documentation of good practices and investment in care services for FGM survivors are required.

**Social and behavioral change communication**

Changing social norms usually takes a very long time. When a social norm such as FGM is in place, a growing divergence between attitudes and behaviour is to be expected until a “tipping point” is reached. Thereafter behavioural change can be quite sudden.

Among the most effective strategies to discontinue norms that are harmful to children, especially girls, are to increase the visibility of alternative behaviours and to facilitate critical reflection on the issue.

Accordingly, efforts to end FGM must focus on influencing collective rather than individual attitudes and demands collaboration between willing and motivated parties. Addressing the root causes of the normative framework is also instrumental to discontinue the harmful practice. In the case of FGM, promoting a more equitable relationship between genders is expected to result in the reduction of the practice as well as reductions in violence and fertility rates. Effective approaches to promote
alternatives norms are engaging with faith-based organizations and influencers, media advocacy, modelling behaviours, community dialogue, peer-to-peer activities, social marketing, and engagement of those who are most ready to change such as adolescent boys and girls.

Girls’ empowerment should go in parallel with providing parents with the right knowledge, skills, and tools to protect their children as well as enhancing the inter-generational dialogue through a positive parenting program.

**Generate evidence and connect community learning with research and policy**

Despite the advances in FGM understanding, evidence gaps exist, especially in terms of new national data on prevalence and trends in social norms change. Accelerating government efforts to collect data and track quantitative trends on the national level, including conducting national surveys, is crucial to guide policy actions and programming.

In addition, the heterogeneity of FGM types and determinants requires a more practice-specific understanding of the FGM causality model, focusing on mechanisms and local contexts. Findings at grassroots levels need to be strategically collected to be actionable at higher levels of intervention and programming. Profiling of communities in terms of attitudes and influencing determinants is recommended to feed public policy and programming. Continued documentation and sharing of good practices and lessons learnt on local, national, regional, and international stories and programmes is also recommended.

**Consider economic drivers of FGM in FGM interventions’ design and implementation**

It is strategic to enhance access to quality education for girls and enhance women’s participation in economic development to accelerate elimination of FGM among future generations. It might also be beneficial to emphasize the cost associated with violence against children, including FGM, that is reflected in more spending on response and care services.

**Invest in sustainability of interventions, accountability, and partnerships**

The development of a costed national action plan on FGM with clear milestones, roles, and responsibilities for partners is the way forward to coordinate efforts of partners, monitor progress, and implement impactful interventions. To ensure sustainability, the interventions should capitalize on girls’ engagement and empowerment, community sensitization and dialogue, and strengthening national systems.