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Legislative Efforts and Community Change to Combat Female Genital Mutilation in Egypt

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Abstract

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MA, American University in Cairo, 2004

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Dissertation Submitted in Partial Fulfillment

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Abstract

Female genital mutilation is recognized as a violation of human rights as it violates the bodily rights of young girls by cutting part of their bodies without their consent and leaves long term psychological, physical and sexual harm to women who were exposed to the practice. The World Health Organization estimates that 130 million girls and women are subjected to Female Genital Mutilation/Cutting (FGM/C) in African and Middle Eastern Countries. According to a UNICEF 2020 report, Egypt will not meet the SDG goal of eradicating FGM as the decrease in the practice is too slow despite the policy and community work done and the issuance of the law banning this harmful practice. This policy analysis qualitative study involved using semi-structured interviews with Egyptian governmental, nongovernmental and civil society representatives. NVivo was used to organize and analyze the data. The main research question examined the social issues policy makers need to consider in order to create effective policies to end FGM/C in Egypt. The social norms theory was used to analyze and code the findings of the study. The purpose of the study was to investigate the policy processes for combatting the harmful practice of FGM in Egypt that led to legislative efforts for community change. The study results found that the policy work carried out did not address the fundamental root causes of the issue such as high levels of illiteracy and extreme poverty. Policy makers must consider the social factors behind the practice, as any effort for positive social change, such as public funds spent, and campaigns executed will be wasted if a more holistic approach to combating FGM is not employed.

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Dedication

This study is dedicated to the girls and women of Egypt and my daughter. May you and all the young girls and women around the world be more empowered, protected, enlightened, and in charge of your lives, health, and wellbeing.

Acknowledgments

I thank the Lord for giving me the wisdom, strength, and guidance to finish this study. This research study was completed due to the effort and dedication of several members. First and foremost, I would like to thank all the participants who dedicated their time and effort to conduct the interviews enriching this study with their professional experience and efforts for the welfare of children in Egypt. I am very grateful to Professor Gary Kelsey who has provided me with support and encouragement from the beginning of my PhD program. Dr. Kelsey's guidance during the different residencies and online helped me through my academic and research interests to reach this stage of writing my dissertation. I am mostly grateful to Professor Mark Gordon, my Committee Chair, for his sincere advice, guidance and mentorship. It was a great pleasure and honor to work and write under his guidance. I am grateful to all the love and support from my family and for their prayers that gave me the power and inspiration to carry on. My husband and my children thank you for all the support, blessings and love.

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Chapter 1: Introduction to the Study

Introduction

Female genital mutilation and cutting (FGM/C) sometimes referred to as female genital circumcision (FGC) refers to any procedure that involves cutting part or all of the female external genital areas or any injury to the genital organs for nonmedical reasons (UNICEF, 2018). FGM/C has been declared by several world human rights organizations as a grave violation of girls and women's rights as the procedure is performed on girls before they reach puberty, between the ages of 7 and 14. There are four primary types of FGM/C as categorized by the World Health Organization (WHO) ranging from partial or total removal of the clitoris and/or prepuce to completely stitching or sealing the edges of the labia, which is referred to as infibulation (UNICEF, 2018).

According to UNICEF (2021), an estimated 200 million girls and women today have undergone FGM/C, and it is still practiced in approximately 30 countries. Despite efforts to combat the harmful practice and make it illegal, prevalence rates are still high in countries including Egypt. The practice is not a localized problem to these countries due to the increased number of immigrants; the problem has become relevant to an increasing number of countries such as the United States (US), Canada and United Kingdom (UK). Social workers in these countries who work with immigrants and migrant women encounter this practice as they deal with circumcised women, so it is important for them to expand their cultural knowledge and awareness regarding this issue. In February 2019, the first case of conviction of a mother in the UK occurred for

performing FGM/C on her 3-year-old daughter and coaching her child to lie about it to the authorities (BBC, 2019). The mother in the UK was originally from Uganda, an example of how the issue of FGM/C is not only localized to countries where it is prevalent.

I explored policy work involving legislative efforts to ban FGM/C in Egypt to help explain why the prevalence rate is still high. Only 38% of girls and women in Egypt aged 15-49 have heard about FGM/C and think it should stop (with over 87% prevalence rate for the harmful practice (UNICEF, 2021). This qualitative research provided the depth needed to address the high prevalence of the harmful practice in Egypt. This allowed me to explore the policy process that was carried out in Egypt that led to changes in the Egypt Child Law in 2008. The 2008 Egypt Child Law was issued for the welfare and protection of children and included laws that criminalized harmful practices against children such as early marriage and FGM/C. The amended child law in 2008 included a law banning FGM/C and imprisonment for caretakers and medical doctors who perform these operations. Caretakers include any individual who is responsible for the care of a child and their wellbeing. In 2016, the prison sentence for performing FGM/C in Egypt was increased to 7-10 years and includes caretakers as well as medical practitioners who perform it.

Purpose of the Study

This qualitative research includes information about the policy process that was carried out in Egypt involving FGM/C. I determined if social issues and sociocultural roots of this harmful practice were considered by policy makers to help assess reasons

why the prevalence rate is still high despite issuing a law criminalizing FGM/C in Egypt in 2008. Findings contribute to recommendations for policymakers regarding what social issues need to be considered while formulating policies involving issues with sociocultural roots like FGM/C. Recommendations may be applied to other social problems with sociocultural roots such as early marriage or child labor.

I interviewed professionals who were or are still involved with policy discussions related to efforts involved with combatting FGM/C. This may help to provide an objective view of policy process to address on how society was part of policy discussions and how they were involved in the policy making process. Societal involvement is important, as it may contribute to explaining why the prevalence rate is still high despite a law criminalizing FGM/C.

I provided a venue for interviewees to objectively express themselves, along with their opinions and experiences involving FGM/C without political pressure. I used confidentiality agreements that allowed participants to stay anonymous. Objectivity of data in this study is important to discuss the underlying social factors behind the practice and the analysis of the policy process to combat FGM/C in Egypt.

Research Question

One primary research question framed this research.

RQ1: What social issues should policy makers consider in formulating an effective policy to end FGM/C in Egypt?

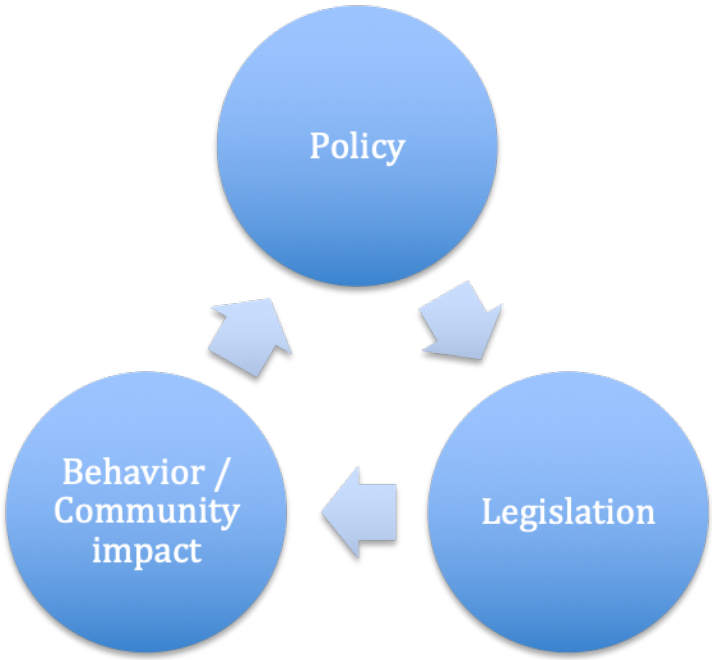
Theoretical Framework

FGM/C is an issue with strong sociocultural roots, so I used three theories: the social norms theory, diffusion of innovation theory, and nudge theory. The three theories are explained in detail later in the document. The social norms theory is used for many public health issues and involves societal and peer pressure and its relationship with positive behavioral change. Diffusion of innovation theory was used to develop recommendations for rejecting FGM/C and thus contributing to more positive behaviors. Finally, the nudge theory contributed to strategies to encourage target groups to adopt positive behaviors depending on which stage of the behavioral change cycle they are in. The nudge theory is used for enforcing positive behavioral changes.

FGM/C in Egypt has several important aspects that should be considered when addressing the issue. They are policy, legislation, and behavioral change (see Figure 1). The policy aspect involves drafting policy, lobbying, and negotiations to formulate policies into legislative action via the Egypt Child Law of 2008.The behavioral change aspect involves changing people's behavior to abandon FGM/C.

Figure 1

Three Aspects that Influence Female Genital Mutilation



The social norms theory has been used to study public health topics such as alcohol or tobacco consumption. The theory involves influences such as peer or community pressure and how they may influence individual decisions to change their behavior. This guided the research in terms of how to correct these misperceptions involving perceived norms and therefore decrease behavioral problems.

Nature of the Study

The study involved using qualitative in-depth interviews with policy experts and community workers who were part of the policy process. Policy experts were selected based on their work with the legislative process for the formulation of the Egypt Child

Law of 2008. Interviewing them helped in terms of gauging perspectives of policymakers and how much their work was engaged with the community. The second category is community workers who were engaged directly with caretakers and girls who have undergone the procedure. Interviewing these participants had two important benefits. First, they provided perspectives of both caretakers who both support and do not support the practice of FGM/C.

Interviews were carried out via videoconferencing software. This format was necessary due to the current global pandemic and location of interviewees, as some who were involved in the process have moved and are stationed in different locations such as Europe and Egypt.

Operational Definitions

Caretakers: A caretaker is any responsible adult who has caretaking or decision-making power for the child in terms of their health and wellbeing.

Sociocultural: The sociocultural aspect of a behavior or a habit compels the researcher to study social conditions and culture in which the practice or habit is carried out.

Social Norms: Set of norms or accepted practices within a society. If anyone decides to abandon a harmful practice that is also a social norm, he or she is likely to face resistance or alienation from society.

Assumptions

Interviewees represented different disciplines such as government, nongovernmental entities, and religious institutions to ensure trustworthiness of data

involving the Egypt Child Law of 2008. I assumed all participants dealt with the issue of FGM/C in Egypt and were aware of the sociocultural roots of the harmful practice and reasons for the practice. I also assumed no participants violated any laws related to FGM/C. For example, if an interviewee was a medical doctor, it was assumed that he or she did not perform the harmful practice. In addition, I assumed that participants were honest and nonbiased in their answers.

I assumed all interviewees were involved in policies addressing FGM/C in Egypt on some level. All interviewees were involved in policy discussions and/or community work addressing the practice using policy recommendations. Interview results depended on their knowledge of discussions that took place, key players, legislative efforts, and implementation of laws.

Another important assumption involves objectivity of participants in terms of their answers and recommendations, despite their involvement in policy processes. I ensured that even though interviewees were involved in policy, legislation, or community work related to FGM/C, they did not try to say only positive things about FGM/C. Qualitative triangulation was used in the study to cross check answers to ensure objectivity of participants' answers as opposed to personal opinions.

Scope of the Study

I conducted in-depth interviews with 10 interviewees who were policy makers and community workers. Interviewees included governmental and nongovernmental personnel. Data were collected from interviews and themes were generated from interviews using NVivo software to guide my analysis.

The transferability of the study was significant as results included recommendations for policymakers who are working on issues that have sociocultural roots like FGM/C. Results can be applied to other practices such as early marriage and child labor. Both issues have strong sociocultural roots and are still prevalent in many African countries despite having laws banning them.

I addressed the issue of FGM/C in Egypt, including the policy process that led to the issuance of the Egypt Child Law in 2008 banning and criminalizing FGM/C officially. The study was limited to the case of Egypt and the process from policy negotiations to legislative action. Even though I focused on Egypt, I examined the policy process of a practice that has strong sociocultural roots, which increased its applicability in terms of addressing other harmful practices with similar roots such as child marriage or child labor. Accordingly, recommendations regarding what social issues policy makers need to consider in order to create effective policies to end FGM in Egypt may benefit other countries when handling issues with sociocultural roots.

Delimitations

The main population that was omitted from the study are girls who were exposed to FGM/C. I was not able to interview this group as the practice is performed on girls as young as 7, and I cannot interview children as a vulnerable group. Another population who was excluded from the study was medical doctors who perform operations or caretakers who consented to performing the operation. However, I believe I was able to get richer and an in-depth perspectives during interviews I conducted with policy makers, practitioners, and interviewees who worked closely with medical doctors and caretakers.

Limitations

One of the main limitations of the study involves the sensitivity of the topic and the positions of interviewees in government positions or international organizations. Their positions may pose limitation in terms of their freedom to express their opinions and present critiques. The sensitivity of the topic may have limited interviewees' willingness to freely express their opinions. In order to control limitations of the study, I tried to compile a list of interviewees that represents a wide variety of disciplines (governmental and nongovernmental personnel, international organizations, and public health workers). In addition, the interview questions included followup questions to for interviewees to express their opinions as honestly as possible.

Significance of the Study

The study contributed to filling an important gap in terms of information available regarding FGM/C in Egypt that involves relationships between policy work and social causes of the harmful practice. This qualitative study was intended to provide reasons why the policy and legislative process are not as effective as they could be given that prevalence rates are still high, leading to a large number of girls in Egypt to brutal operations or circumcision.

The study includes recommendations involving important social factors that policymakers need to consider when formulating policies involving issues that have sociocultural roots such as FGM/C, early marriage, and child labor. Recommendations can be used to address FGM/C and understand how to formulate more effective policies in other countries with similar circumstances.

The qualitative design was helpful in terms of probing interviewees regarding the process of policy making.

Summary

In this chapter, I presented the problem statement and the topic of FGM/C by presenting different definitions and approaches. I addressed how the study filled a gap in literature involving FGM/C in Egypt in terms of the relationship between policy work social causes of the harmful practice. This chapter included the scope of the study, assumptions, and limitations. I interviewed 10 interviewees, which included government officials, nongovernmental and civil society officials, and community workers.

Chapter 2: Literature Review

In this chapter, the literature review process was explained. A historical review of literature and current publications related to FGM/C was examined.

Over 90% of women between the ages of 15 and 49 have undergone the procedure of FGM/C in Egypt (EDHS, 2008). The prevalence rate of FGM/C in Egypt is above 87% (DHS, 2015). FGM has been practiced in Egypt by medical professionals with six out of 10 girls cut by doctors and six out of 10 cut by medical practitioners (UNICEF, 2020). The practice has been declining, but the decline has been very slow, despite a law in 2008 that criminalizes the practice (UNICEF, n.d.). Egypt will not meet the Sustainable Development Goal 5.3 of eradicating FGM/C as the prevalence rate decline is very slow (UNICEF, 2020). In fact, the prevalence rate needs to be 15 times higher to reach this goal by 2030 (UNICEF, 2020). The practice continues to be a brutal operation that is done to girls as young as 7 and is viewed by international human rights organizations as a great violation of the rights of girls (UNICEF, n.d.). FGM/C causes long-term psychological, physical, and sexual harm for girls (WHO, 2015).

Extensive quantitative research has been done to gather data regarding the prevalence of the practice and reasons given by caretakers for continuing it. The EDHS is one of the main national quantitative surveys conducted in Egypt in collaboration with the Ministry of Health and Population, USAID, WHO, and UNICEF. Qualitative research is needed to address reasons why caretakers still are resistant to abandon the practice despite the law criminalizing it and proven medical harms. The psychological, sexual, and physical harms of FGM/C in Egypt will continue to affect girls. However, caretakers

still choose to practice FGM/C due to social and cultural pressures. In order for efforts to be effective, social and cultural barriers need to be addressed.

Quantitative literature shows that the prevalence rate is still high despite the presence of the Egypt Child Law of 2008. The prevalence rate of FGM remains above 87% among girls and women between the ages of 15 and 49 (DHS, 2015). In addition, no literature exists regarding how policymakers considered community engagement in order to ensure that legislative work will create positive social change in Egypt.

The chapter includes a comprehensive literature review of qualitative and quantitative data available regarding FGM/C with analysis of related socioeconomic issues and policy making processes. I analyzed a gap in research involving FGM/C in Egypt.

Literature Research Strategy

I started by exploring literature involving the term FGM and different terminologies used. It is globally practiced, and accordingly, the literature review included FGM/C in Egypt and other countries.

In this study, I used the following databases: EBSCOHost, Academic Search Premier, Business Search Premier, ProQuest, SAGE Journals, and SocINDEX. Search terms and keywords used to extract literature were: *Female genital mutilation/cutting*, *FGM*, *female circumcision*, *female genital mutilation and public policy*, *female genital mutilation and legislation*, *female genital mutilation and law*, *female genital mutilation in Egypt*, and *female genital mutilation and health*.

Literature Review

As FGM/C in Egypt is a sociocultural harmful practice, it has several important aspects that should be considered when addressing the issue. These aspects are policy, legislation, and behavioral change. Policy involves lobbying and legislation such as the Egypt Child Law of 2008. Several theoretical frameworks were considered as the research questions and research plan are developed. The theoretical framework continued to evolve and develop as I developed a plan.

The social norms theory is a theory that is used to study public health topics that are related to habits such as alcohol or tobacco consumption. This theory was relevant in terms of studying the issue of FGM/C in Egypt as it involves understanding the environment and interpersonal influences involved with changes in behavior. More specifically, the theory involves influences such as peer or community pressure and how they may influence individual decisions to change behavior. As the issue of FGM/C is driven by sociocultural influences and misconceptions, the theory was used to address perspectives regarding how perceived norms (what is viewed as a standard for a group of people) and actual norms (real beliefs and actions of the group) affect peer influence.

A second theoretical framework is the DOI theory is an old social science theory that explains how individuals can adopt a new behavior or idea because they view it as an innovative one (Boston University of Public Health, 2013). This theory contributed to the recommendations on the ways that could be used to create a positive community impact by introducing the idea of abandoning FGM/C as an innovative action and diffusing it to the rest of the society (Boston University of Public Health, 2013). In order to achieve

that, the social aspects of FGM/C have to be part of the approach such as marriageability of the woman and the rights of protecting the body of the girl child. The characteristics of the target population were considered with this theory approach and the social profile of decision makers in this process such as the caretakers, grandparents, in-laws (who have a strong say on the marriageability of the uncircumcised woman) and community leaders. The five established categories of adopters would be considered: innovators, early adopters, early majority, late majority and the laggards (Boston University of Public Health, 2013).

Policy makers started combining psychological and behavioral prompts to decision making so that citizens or consumers of that policy be nudged to make the right decisions for themselves or their communities (Rhys, et al., 2014). Nudge theory and other public policy theories help to make the transition of communicating policies from one audience to another such as from academics to civil servants and politicians or the general public (Rhys, et al., 2014). In addition, the nudge theory would strengthen the link between the above behavioral change theories and the policy discourse, which has been adopted in behavioral change policies increasingly in many countries including the UK (Rhys, et. al. 2014).

Contemporary Data Involving FGM/C

Extensive quantitative research has been done to gather data on the prevalence of the practice of female genital mutilation/cutting (FGM/C) and the reasons given by caretakers for continuing the harmful practice. The Egypt Demographic and Health Survey (EDHS) is one of the main national quantitative surveys conducted in Egypt in

collaboration with the Ministry of Health and population, USAID, WHO, and UNICEF. EDHS is conducted every 5 years on various public health issues including FGM/C. Qualitative research is needed to find out more about the reasons why caretakers still are resistant to abandon the practice despite the law criminalizing it and the proven medical harms from the practice. The psychological, sexual and physical harms of FGM/C in Egypt will continue to touch the lives of many girl children who will grow to be married women later if the topic is not extensively researched. The practice is of socio-cultural nature and linked to many medical and religious misconceptions. Studies have been conducted by UNICEF, Azhar University (Main Islamic Sunni source in the Middle East) and the Coptic Church on the religious and medical misconceptions on FGM. However, caretakers still choose to practice FGM/C due to the social and cultural pressures on them. Accordingly, in order for the efforts to be effective, the social and cultural barriers on the community level need to be addressed.

Much has been reported about the prevalence of the harmful practice and the reasons behind it. In addition, international organizations and religious institutions have produced publications explaining the religious and medical misconceptions that encourage caretakers to practice FGM/C. Quantitative literature shows that the prevalence rate is still high despite the presence of the law that criminalizes the practice. However, the reasons why caretakers are still reluctant to abandon the practice and where they are on the behavioral change model are not tackled in depth. In addition, no literature is present on how policy makers considered community engagement and social

factors in order to ensure that the legislative work will create positive community social change.

Defining and Conceptualizing FGM/C

Reviewing the literature on FGM/C, it has been presented by some authors as a medical issue and by some as a violation of human rights or as a medical issue given the complications it poses on the girl child in later stages of her life. Early efforts to prevent FGM/C focused on the risks of the practice to health but in the 1980s and 1990s, the harmful practice was framed as a human rights violation (Debelle, 2016). It was important to present the different concepts of FGM/C to position the issue from different perspectives: medical, rights, religious and cultural. In addition, it was important to review literature on the different definitions of FGM/C and typology as the practice is practiced from minor to extreme forms in different African countries.

FGM/C is identified in many of the sources as the cutting of part of the female gentile that involves cutting part or all of the clitoris (Cloward, 2015). Types of FGM/C range from pricking the female clitoris to the removal of a significant part or all of the female genitalia to complete closure of the vaginal area (Akinsanya & Gbadebo, 2011). Types of FGM/C according to the WHO and literature produced by international organizations including the United Nations is divided into four types:

Type I: Partial or total removal of the clitoris and or the prepuce, which is medically referred to as clitoridectomy (Akinsanya & Gbadebo, 2011). Some communities refer to this type of FGM/C as Sunna meaning tradition or duty (UNICEF, 2013).

Type II: Partial or total removal of the clitoris as well as a part of the labia minora, which is medically called excision (Akinsanya & Gbadebo, 2011).

Type III: Narrowing of the vaginal opening by cutting and then bringing together the labia minora and/or labia majora to seal the opening that is done with or without excision of the clitoris (UNICEF, 2013). This type of FGM/C is referred to medically as infibulation (Akinsanya & Gbadebo, 2011) and results in the complete covering of the urethra and vaginal opening which means that a procedure needs to be done to reopen for sexual intercourse and childbirth, which is medically known as defabulation.

Type IV: Includes all other harmful non-medical procedures to the female genitalia such as pricking, piercing, incising, scraping and cauterization (UNICEF, 2013). Pricking or nicking is a procedure where cutting is done to prove blood without removing issues or performing any permanent alteration to the genitalia and is refereed to 'symbolic circumcision' (UNICEF, 2013). Despite the controversy of this type of circumcision, it is proposed that African countries use this kind as a less severe kind to replace the other types that cause permanent damage (UNICEF, 2013).

Any of the above four definitions or a mix of it is considered a performance of FGM/C. (UNICEF, 2013). Female Genital Mutilation/Cutting is practiced in most countries by a traditional health practitioner for social acceptance while in Egypt 77% of girls have been cut by a medical professional with the most cited reasons by caretakers for supporting the procedure (UNICEF, 2013).

FGM/C is not only defined as a socio-cultural issue but a grave violation of human rights (Wood, 2015). It is important to set the definition of FGM/C in the research

not only as a harmful social practice but a major violation for the rights of the girl child as it causes her long-term sexual, medical, emotional and psychological harm (Wood, 2015). Internationally FGM/C is conceived as a grave violation of the human rights of girls and children and reflects a culturally deeply rooted gender in-equality and an extreme form of discrimination against women (Akinsanya & Gbadebo, 2011). As many programs address the issue of FGM/C focusing on its associated health risks but the practice was reconceptualized as a human rights violation at the 1993 World Conference on Human Rights in Vienna, which led several countries to adopt national legislation actions to criminalize the practice (UNICEF, 2013).

A worldwide consensus during the International Conference on Women and Development (ICWD) in Cairo held in 1994, the practice was recognized as a setback to women's rights and long term impact on women's health (Akinsanya & Gbadebo, 2011). The UN general assembly adopted an international resolution for Intensifying global efforts for the elimination of female genital mutilation on 20 December 2012, which is a significant milestone in the global efforts to end the harmful practice (UNICEF, 2013). The resolution called for a unified global stance to eliminate the harmful practice and using a coordinated approach that promotes positive social change at a community, national, regional and international levels (UNICEF, 2013). Accordingly, this resolution places social change as a main tool that effectively eliminates the harmful practice from communities stressing the fact that this practice has strong socio-cultural roots and should be viewed as a socio-cultural issue primarily. The UN Sustainable Development Goals

target to eliminate FGM/C by 2030 through emphasizing the role of health professionals to strengthen the global efforts towards eradication (WHO, 2016).

Globally, FGM/C is viewed as a form of abuse and violence and against the best interest of the child as defined by children's rights convention (Costello, 2015). It is considered a grave violation and an extreme form of discrimination against women (WHO, 2022). The controversy in the human rights perspective is that in practicing communities, FGM/C is performed with the intention of doing what is in the best interest of the child (Costello et al., 2015). This controversy stresses the importance of viewing the issue from the socio-cultural perspective as well and not only from a rights perspective. FGM/C is embedded in many societies as a cultural tradition with historical roots, tribal rituals, marriageability, social status and religion (Arora & Jacobs, 2015). Both Muslim and Christian communities' practice FGM/C in Egypt even though it is more associated to Muslims. It has been argued that no proof is found that FGM/C is referenced in the Quran or by Prophet Mohamed and so there is no religious basis for the practice (Arora & Jacobs, 2015). One of the strongest documents that is used in Egypt to raise awareness on the harms of FGM/C is the one by Al Azhar University in collaboration with international organizations in Egypt presenting the issue in a religious and medical perspective. The document tackles all frequently asked questions about FGM/C and the religious and medical misconceptions related to the issue (IICPSR, UNICEF & NPC, 2013). The importance of the document comes as religion is a big source of authority for Egyptians and if any efforts will be done for behavioral change, religious leaders must be part of it (IICPSR, UNICEF & NPC, 2013). The document

presents the answers about FGM/C in the language that would be understood by religious leaders and can be used by the them as a tool for advocacy and awareness on the harms of FGM/C in the field (IICPSR, UNICEF, & NPS, 2013).

Tolo and Terje (2014) similar to Al-Azhar document stressed on the harms of FGM/C and that it has no religious ground as it is practiced in Ethiopia despite religious religions being stated as one of the main reason. Accordingly, the role of religious leader is emphasized in this study as well and advices a power dynamic to occur in the society to ensure that they have enough power to advocate for combatting FGM/C (Tolo & Terje, 2014). Since religious misconceptions is the main reason given to justify the practice in Egypt, this aspect of religious believes is an important perspective that needs to be discussed.

FGM/C has strong cultural ties that are not only related to religion and particularly to the marriageability of the girl where girls would find great difficulty in getting married if they are not circumcised (Arora & Jacobs, 2015). FGM/C is related to the misconception of being linked to the honor of the girl and her marriage fidelity (WHO, 2022). Arora and Jacobs (2015) presented a very important aspect of FGM/C, which is the fact that parents practice it out of love for their children and because they want them to go be acceptable within their societies. Even though FGM/C can be traced back to 2,500 years ago and not tied to a specific religion, it is viewed in many practicing communities as a religious requirement. Religious leaders are divided between supporting and demanding the practice in their communities to others who reject the practice and participate actively in stopping the practice (Costello et al., 2015).

Strong evidence can be generated on the role of social norms to FGM/C linking to the choice of social norms theory used in the study. The evidence can be found when examining the attitude gap between individuals supporting the practice and their actual behavior so individuals can be convinced that FGM/C should end but cannot stop the practice because of the social expectations to conform to the practice (UNICEF, 2013). In Egypt, this is shown through data of mothers who believe the practice should stop but still perform the harmful practice on their girls (UNICEF, 2013).

Prevalence of FGM in Egypt

Systematic data collection and analysis of FGM/C is very recent, which The Hosken Report started in 1979 but a nationally representative data was not collected (UNICEF, 2013). Quantitative reports flag the alarm that despite of efforts to eradicate FGM/C for decades, 7000 women and girls worldwide are in danger of being subjected to FGM/C each day (Costello et al.,, 2015). Quantitative methodology is used to reveal data on prevalence as well as knowledge level, attitudes and practice related to FGM/C. FGM/C quantitative studies collect information on socio-demographic profile, knowledge about FGM/C and its complications through pre-tested and structured interviews (Amusan & Asekun-Olarinmoyr, 2008). Over the years after, two major reports were considered to be the most reliable sources on FGM/C data that are the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS) (UNICEF, 2013). Both kinds of surveys provided national and international organizations as well as government bodies data for planning and allocating resources to combat FGM/C and monitor the progress towards the elimination of the harmful practice (UNICEF, 2013).

FGM/C is mostly prevalent in African countries with the highest rate of 98% in Somalia followed by 96% in Guinea, 93% in Dijibouti and 91% in Egypt represented by 27.2 million girls who have undergone the practice (Yount et al, 2015). The practice is concentrated in 29 African countries, more than 125 million girls and women have undergone the harmful practice and the majority were cut before age 5 and the remaining were cut between the ages of 5 and 14 years of age (Yount et al, 2015). The harmful practice of FGM/C has been around for almost 2,500 years tracing back to ancient Egypt that links it to be a cultural tradition rather than a religious requirement that started with the onset of a specific religion (Costello et al., 2015).

UNICEF (2015) offered a statistical digest for quantitative data on several child related issues. The quantitative dimension of the issue in Egypt is provided through this study with the latest data in Egypt that will complement the quantitative data in the EDHS (2008). The EDHS (2008) provided the correlation between the practice and education level and demography but the UNICEF (2015) statistical digest provided the update of 2015. The comparison between the two data sets will help the research analysis to determine if the prevalence and the decline rate of it is fast enough or too slow given the latest policy changes in the law. EDHS (2015) provided the data about the prevalence in Egypt with a correlation with the demographic location, gender and education level. The practice of FGM/C in Egypt is more prevalent in rural areas and decreases as the level of education increases, which shows that education is an effective tool in raising awareness on the harms of FGM/C (EDHS, 2015). Egypt is a country where 8.5 million girls aged 5-14, 1.6 million girls may be at risk based on the mother's intention to

circumcise them (UNICEF, 2015). Starting 2003, UN organizations and national governmental partners intensified its efforts to combat the harmful practice in Egypt and try to decrease the percentage of the prevalence of performing FGM/C in Egypt (UNICEF, 2015).

Over 90 % of women between the ages of 15 and 49 are circumcised in Egypt (EDHS, 2015) and 500,000 girls are estimated to be living in Europe after circumcision and the number is increasing (Avalos, 2015). Both studies and quantitative data on the prevalence of FGM/C on the international level complement each other in giving both the local and international perspective and therefore placing the problem in the right perspective as a global one and not related to one particular culture or religion. The international interest and perspective comes from the increase in migration rates which brings an influx of immigrants to developed countries such as the UK, which puts the country at risk of an increased rate of FGM/C practice (Avalos, 2015).

Literature presenting the quantitative data on the prevalence of FGM/C locally in Egypt and globally is very important as it helps to track the change if FGM/C practice is changing or not. This change tracking helps to assess the efforts to end the practice and if they are moving in the same direction. When ending the practice is examined, change in quantitative data is very significant noting the variations in the number of years between surveys and the time lapse when analyzing data trends (UNICEF, 2013).

Proven Physical, Psychological and Sexual Harms of FGM on Women

There is no proven health benefit of performing FGM/C but on the contrary, studies have shown that it cases irreversible physical and psychological damage (Costello

et al., 2015). There is a significant number of literatures proving the physical, psychological and sexual harms of FGM/C on women. Literature highlights that the spread and harm of FGM/C does not only include the countries where it is primarily practiced anymore but is extending to other countries due to the increased influx of immigrants and refugees are increasing. This is why harms of FGM/C is today placed as a global public health issue and not just restricted to a few selected countries. Related to the influx of immigrants and refugees, are the cases of childbirth of previously circumcised girls especially ones that have been exposed to infibulation and how this affects the medical care they receive especially obstetrics and gynecology. Shahvisi (2016) highlights an example of a UK doctor who stood trial for being accused of promoting or assisting in FGM/C as he was assisting in childbirth of a Somali mother. The UK doctor had to re-stitch parts of the patients genitalia as a way of repair (re-infibulation) as she was already exposed to infibulation in her homeland when she was 6 years old, which staff at the hospital found illegal and disturbing (Shahvisi, 2016). On February 6, 2016 during the UN Zero Tolerance day for FGM/C by Detective Sergeant Suzanne Bluck from South Yorkshire Police expressed her belief that the practice is considered an incredible taboo and is an under-reported crime in the UK (Women Police, 2016).

Studies have been conducted to prove the psychological, physical and sexual harmful impacts of FGM/C on women. Oyefara (2015) found significant relationship between FGM/C and sexual desire of women, initiation and frequency of sexual activity in marriage. In addition the study provided evidence of the relationship between FGM

and sexual satisfaction and enjoyment of the women during sexual activity (Ovefara, 2015). The grave effect of FGM on women's sexual life has reached the level of fear when their spouses initiate or ask for sex (Overfara, 2015). This fear and lack of initiation of sexual activity comes from reporting acute pain and discomfort from circumcised women during sexual intercourse and lack of enjoyment with almost never reaching orgasm that discourages them from engaging in the activity (Overfara, 2015).

Physical harm caused by FGM/C has been highlighted by several studies starting during the time of performing the surgery throughout the lives of girls and women who had undergone the operation (Costello et al., 2015). Physical harms range from severe injury or death during the operation, urinary tract infections, reduced sexual pleasure, and interfering with natural bodily functions (Costello et al., 2015). Psychological harms are grave from the operation as in many cultures it is done without any form of anesthetics causing girls to suffer extreme pain and shock as well as severe sores (Costello et al., 2015). Psychological harm lasts for long-term causing psychosomatic disorders such as insomnia, depression, anxiety or panic attacks and cognition changes (Costello et al., 2015).

The harmful practice of FGM/C is usually done by a traditional birth attendant from the village and in some cases a medical doctor using any sharp unsterilized object such as knives, scissors or part of a broken glass (Akinsanya & Gbadebo, 2011). In many countries where FGM/C is highly prevalent, between 9% and 74% of the procedures are performed by health professionals, which is part of the so-called 'medicalization' of the practice (WHO, 2016). Accordingly, many international organizations and the U.N do not

accept the term female genital procedure or surgery so it would not give the false impression that it is sometimes acceptable to conduct the harmful practice. In addition to pain and trauma that the girl gets exposed to, the removal of part of healthy genital tissues naturally interferes with the functioning of the body causing immediate and long-term health consequences (Pacho, 2015). The health consequences of FGM/C are divided into short and long-term health complications (Porterfield, 2006). Health complications include severe bleeding and pain, infection, urinary tract infection, chronic pelvic infections that can lead to infertility (Porterfield, 2006). In addition, Portfield (2006) details the health complications of FGM/C to neurological problems that occur as the clitoral nerve develop a neuroma causing the woman to feel extreme pain over the scar in that area (Portfield, 2006).

FGM/C, Public Policy, and Legislation

Public policy and legislation to assist the eradication of FGM/C is essential on a global level. Even though the harmful practice is most prevalent in African countries, the UK and 11 other industrialized countries have introduced legislations to combat the harmful practice while other countries such as France, Germany, Canada, and USA) are relying on existing child protection mechanisms (Shahvisi, 2016). As FGM/C is declared as a grave violation of human rights in 1993 with 28 African states committing to eradicate the practice in 2003, they are committed to take legislative measures and sanctions on the practice (Costello et al., 2015). Relying on child protection mechanisms limits criminalizing he practice for adults such as re-infibulation of the female genitalia if the patient has already had the procedure as a child or is requesting to do it as part of their

freedom on their bodies. Industrialized countries are becoming more concerned with public policy. For example, legislative action is required in western countries since the practice is increasing with the influx of immigrants and refugees to these countries. Debelle (2016) said the issue evolved in the UK as a child abuse case of violence against children. FGM/C has proven physical, psychological, and health harms suggesting measures that should be taken by the pediatricians in the UK for stronger reporting of cases (Debelle, 2016).

Guidelines and legislative advice have been continuously shared and updated through government bodies and international organizations such as the World Health Organization and the United Nations (Bustero, 2016). An important indirect way to implement a strong legislative system as recommended by these organizations was access to information and training to health workers as a preventive measure to avoid having new cases for FGM/C (Bustero et al., 2016). Health workers are considered a very important and strong tool to implement policies and laws when it comes to public health issues in developing countries and so they are an important channel to convey correct information and highlight the negative consequences of the harmful practice (Bustero et.al. 2016). One of the main challenges that face policy work to eradicate the harmful practice that was highlighted by several pieces of literature is the medicalization of the procedure. A main tool to prevent the medicalization of the procedure is to continue educating health workers and creating protocols and guidelines for them that they can use when receiving requested from caretakers to perform FGM/C on girls or re-infibulation for women after childbirth (Bustero et al., 2016).

Even though advocacy and public policy work has been done for over 30 years in communities with high prevalence, the attitudes towards FGM/C has been very resistant (Arora & Jacobs, 2015). This resistance brings a very dangerous trend that came out in some literature sources, which is allowing the practice with certain conditions and limitations. As a result, some scholarly articles such as Arora & Jacobs (2015) argue that countries that have minorities practicing FGM/C could allow the practice if it does not cause long-term harm or spread. They view that the issue is a culturally complex one that cannot be dealt with by completely condemning it by a law. Since the practice has a strong religious and cultural root, any policy or legislative level should be paired with strong condemnation from the religious and cultural spheres that practice it (Arora & Jacobs, 2015). The danger of this suggestion is bending policies to allow the practice of certain kinds of FGM/C is that it would weaken the efforts to eradicate the practice and leaving it up to interpretation on what 'soft' kind of FGM is allowed.

In Egypt, years of policy work and lobbying has resulted in amending the Egypt Child Law in 2008 to include several important clauses including ones on FGM/C and early marriage. The Child Law change in 2008 was a result of intensive policy work by international organizations such as the UN, civil society and child rights organizations in collaboration with relevant government institutions.

As prevalence rate are declining too slowly, international organizations have started linking lowering the prevalence with the importance of shifting social norms when it comes to socio-cultural issues like FGM/C (UNICEF, 2016). Social norms are identified as shared beliefs within a community about what is typical, accepted and

appropriate behavior that people need to conform to within this community (UNICEF, 2016). Recent studies from international organizations are highlighting the combined drivers for practicing FGM/C to be considered by policy makers including inherited beliefs, attitudes community factors, level of poverty, religious ideologies and gender cultures (UNICEF, 2016). All of these factors are tied with social norms shaping expectations and beliefs that of appropriate behaviors that individuals of the community are expected to do are the main resisting factors that face shaping policies and laws to criminalize a practice like FGM/C (UNICEF, 2016). Individual beliefs with the sanctions and rewards of choosing FGM/C placed upon him by the community act as a more powerful driver than a law (UNICEF, 2016). Accordingly, a social norm intervention has been highlighted as a possible catalyst among other that existing programs and organizations need to consider when forming policies and laws for socio-cultural issues and expecting them to work (UNICEF, 2016).

In order for policies to be enforced for an issue like FGM/C, a new set of beliefs need to be created within the community's reference groups, which will change the expected behavior of the individual (UNICEF, 2016). This brings up the complexity of social factors that need to be considered by policy makers when formulating policies and legislative recommendations for socio-cultural issues such as FGM/C. Some of the catalysts for public polices highlighted by recent literature from U.N organizations and rights based organizations working for decades on combatting FGM/C include shifting social expectations in addition to individual attitudes, publicizing the wanted change on a large scale and continuing to reinforce the new wanted norm and positive behavior

(UNICEF, 2016). The main challenge is again brought back as mentioned above in placing the issue as a socio-cultural perspective for practicing communities view FGM/C as a pathway for the social security of women with parenting believing that it is in the best interest of the child (Costello et al., 2015). This strong belief causes the main resisting factor to all laws and policies as parents would sneak off their children to any illegal or hidden source to perform the operation (Costello, et al., 2015). In addition, it is very difficult for one family or one individual to stand alone in front of the societal challenge in a society where FGM/C is the norm and deviate from that by refusing the operation (Costello et al., 2015).

The tension between the practice of FGM/C between being a human rights violation and a cultural norm or value has started from the time of categorizing the practice as a human rights violation. Similar to many other human rights violations that are embedded in the culture, the adoption of the Universal Declaration on Human Rights has raised the debates on socio-cultural issues and their now criminalization as they violate human rights such as early marriage or FGM/C (Krivenko, 2015). This is one of the main challenges for policy makers and legislators as in the experience of Egypt as even if the policies and laws are manufactured perfectly around the issue, there is a cultural resistance in viewing the practice as a violation for human rights. Krivenko (2015) noted an important point on how it is urgent to interrupt this vicious circle of resistance by revisiting placing the issue in a human rights framework with policy and legal legislation but rather with a lot of space for negotiation and dialogue. This emphasizes the motive behind the research question of this dissertation on the missing

dialogue and community engagement needed to make the policies more effective and decrease the resistance of the community. This open dialogue should not only include decision makers or policy creators, but it is very important to involve the affected persons, international organizations, activists and civil society (Krivenko, 2015).

Qualitative data has been historically used to provide data that are rich in descriptions attempting to explain better human behavior (Miles & Huberman, 2014). Literature on qualitative methodology has started to be more extensive starting the 1970s with books and peer reviewed articles dedicated just for qualitative methodology and inquiry making its way to research associations as well (Miles & Huberman, 2014). One of the most fascinating aspects of qualitative research is that it challenges the relationship between planning and chance as Maxwell (2013) described it. Qualitative research has the flexibility that allows it to follow a plan but giving the researcher room for flexibility when collecting and analyzing the data as Maxwell (2013) followed the historical path of qualitative methodology. Maxwell (2013) presented historical examples such as Eisenhower in his reference to how warfare planning is important but how plans are worthless when it is time for actual implementation.

Given the complex nature of a harmful practice like FGM/C and other practices that have socio-cultural roots, qualitative methodology would allow the flexibility and in-depth needed for the researcher. As Maxwell (2013) described it, qualitative research is a "do-it-yourself" compared to the "off-the-shelf" process of quantitative methodology. In this research and as will be discussed in detail in chapter 3, a flexible research methodology like the qualitative one would be ideal to allow the space for human

interaction and for reflections by the researcher. No matter what qualitative model is adopted, it would revolve around the main components presented by Maxwell (2013) in what he calls the 'interactive' model: goals, conceptual framework, research questions, methods and validity. The way Maxwell (2013) presented the interactive model is that research questions are always the central part of the model adopted and the remaining elements go back and forth to serve answering the research questions. This concept is the core of all the different literature written on qualitative methodology that stresses that the researcher should always keep focused on the research questions and not be distracted by the flexibility of the methodology and drift away from the core question/s.

Even though qualitative methodology is considered a flexible research model or a 'do-it-yourself' model as described by Maxwell (2013), literature on the topic has defined a few set approaches to qualitative research. Creswell (2013) set a few approaches: narrative study, phenomenological, grounded theory, ethnography and a case study). Some studies such as the one presented here on FGM/C might not fall directly in one or the other but can be a blend of two typologies. The research on FGM/C discussed a phenomenon as a social harmful practice is one the rise as well as shadowing over being a case study as it discusses case studies of individuals who have undergone the harmful practice and the impact it had on them as part of the interview questions.

Phenomenological studies discussed the experience and stories of one or more individuals who have undergone and lived an experience of a concept or a phenomena (Creswell, 2013). Phenomenological researchers focused on what the individuals who have undergone the experience went through with the purpose of reducing the individual

experience of that phenomena (Creswell, 2013). Reducing the phenomena and the individuals exposed to FGM/C is one of the purposes of this study and part of the interview questions will ponder on what and how they experienced and how it made them feel, which is one of the aspects of the phenomenological approach (Creswell, 2013). The study will include interviewees who are caretakers of young girls who are pro and against the harmful practice and would have undergone themselves FGM/C as young girls. This inclusion of caretakers would meet the phenomenological aspect of the methodology as well as case studies methodology as it will touch on what the caretakers went through when experiencing FGM/C or when deciding to perform or stop performing the practice on their children.

Summary

In this chapter, I reviewed FGM/C globally to address the impact of the harmful practice on girls globally. The literature review established human rights issues involved with FGM/C and psychological and medical harms to girls. In addition, I addressed prevalence of FGM/C in Egypt. Finally, I discussed policies and legislative work carried out in Egypt. I showed existing quantitative data and the need for qualitative studies that provide in-depth information about the slow decline of prevalence rates despite policy and legislative work.

Chapter 3: Research Method

Introduction

In 2008, more than 90% of Egyptian women between the ages of 15 and 49 have undergone the procedure of FGM/C (EDHS, 2008). The practice has been declining, but the decline has been slow, despite a law issued in 2008 that criminalizes the practice (UNICEF, n.d.). Today, more than 87% of Egyptian girls and women have undergone the harmful practice (UNICEF, 2020). According to UNICEF (2020), the prevalence rate is very slow in Egypt and needs to be 15 times faster in order to meet the SDG goal of eradicating FGM/C. The practice continues to be is done to girls as young as 7 and is viewed by international human rights organizations as a great violation of the rights of girls. FGM/C causes long-term psychological, physical, and sexual harm to girls (WHO, 2015).

According to UNFPA (2018), FGM/C is an integral part of a cultural identity. Parents who reject the practice face a great risk of being outcast or condemned from society (UNFPA, 2018). This made the issue of trustworthiness of the researcher and protection of participants vital to the success of this research.

This chapter includes the methodology that was used and why it was the best approach to address the problem and research question. A review of the methodology, data sampling, collection, and presentation is presented. In addition, I address ethical considerations such as protecting participants' rights and trustworthiness.

Research Design and Rationale

The primary research question is: What social issues should policy makers consider in formulating an effective policy to end FGM/C in Egypt? A dialogue would be initiated with policy makers who worked on community intervention activities. Qualitative in-depth interviews facilitated collection of information regarding the policy process that led to the issuance of the Egypt Child Law of 2008. The qualitative methodology was used to provide information that would complement quantitative data that showed the harmful practice is still prevalent in Egypt. The qualitative methodology was used to formulate in-depth interviews to gather data from participants as well as develop subquestions and followup questions for triangulation. In addition, I used the qualitative methodology to target participants who were directly involved and/or familiar with the policy process that led to the Egypt Child Law of 2008.

Purposeful sampling guided semi-structured qualitative in-depth interviews. Purposeful sampling is used in qualitative research to identify and select participants who are involved with a phenomenon of interest (Palinkas et al., 2015). Particularly combining sampling strategy served the purpose of the study, as it ensured sampling from a variety of categories.

Qualitative interviews were conducted via videoconferencing with policy experts and community health workers. Followup questions were conducted as needed when interviewees presented answers that required clarification or expansion.

Role of the Researcher

FGM/C is a culturally sensitive issue in Egypt. Some parents who perform the operation do it out of love for their children and do not view it as a violation of their rights. As I researched the issue of FGM/C in Egypt, I had the opportunity to talk with caretakers regarding the practice. Talking to parents conveyed to me as a researcher how parents decide to support this practice out of their love for their daughters and as a means to protect them. UNICEF (2005) defined FGM/C as a traditional practice that stems from beliefs of caretakers that it enhances girls' beauty, marriageability, and chastity. Working in the field of humanitarian development in Egypt, my professional path may have crossed with some participants. However, there is no current supervisory or work relationship with any participants.

Setting and Sample

I investigated the policy process involving addressing the harmful practice of FGM/C. I attempted to address perspectives regarding the policy formulation process, the legislative process that followed, and social factors. Accordingly, it was important to interview key players who are involved in the policy formulation process that led to the Egypt Child Law of 2008 that included criminalization of FGM/C.

The 10 interviewees in the study included government, civil society, and international organization employees. I approached community workers, as they were more open to talk about the issue from caretakers' perspectives.

I scheduled 10 interviews. This generated enough data to draw conclusions and make recommendations. This number was sufficient due to the limited geographical

location of the study and limited pool of participants. The interview confidentiality agreement guaranteed confidentiality and anonymity for all participants.

Data Collection Procedures

Qualitative data involves well rounded and rich descriptions and explanations of the topic (Miles et al., 2014). Face-to-face interviews allow the researcher to address in-depth information and obtain a large amount of data, especially involving issues of a sensitive nature (O'Sullivan et al., 2015). Data collection commenced with conducting interviews and involved journaling, sketching ideas, taking field notes, and identifying themes, codes, or keywords that were notable during the interview stage. All interviews were conducted over video. Video call interviews were conducted in a private conference room setting in the USA during times that were convenient and suitable for interviewees to ensure privacy of data. Interviews are stored on a password-protected and secured computer file with a backup on an external hard drive in a locked cabinet in my office. It will be kept for a period of 5 years and then destroyed. Keywords and codes were drawn and noise words were removed to facilitate analyzing data using NVivo. Interviewing about 10 people was recommended for in-depth rich data collection in qualitative studies (Creswell, 2013).

Data Analysis

The data analysis stage started after conducting interviews. NVivo was used to organize collected data in Microsoft Word.

Data from interviews were designed to correspond to the theoretical frameworks chosen formulating the first level of data coding. The four coding categories related to the theories are:

Definition of FGM

I asked the interviewees on the definition of FGM/C and how they view it. The answers to this part of the interview contributed to the coding categorizing FGM/C in a framework of being a rights issue, medical or a socio-cultural issue. The categorization of the practice was essential in the analysis stage and in recommending further research as it influenced what policy recommendations and what interventions are needed depending on the categorization.

Theoretical Framework Coding

The second coding category is social norms related to the practice. The second theory assumes that if the social norms of the society changed to abandoning the practice, the prevalence rate will decrease (Boston University of Public Health, 2013).

This level of coding helped in identifying innovative ways that can be used in the society as part of the efforts to combat FGM/C. This coding level strengthened the research recommendations for innovative approaches that could be used to support the policy and legislative process (Miles, Huberman & Saldana, 2013).

The nudge theory is a relatively new theory but it is based on an already used approach for behavioral related issues (Rhys, Jessica & Mark, 2014). The nudge level of coding might contribute to ways of nudging the target about the harms of FGM/C, the

existing laws criminalizing the practice of FGM/C and the long-term harms they are exposing their girl child

Primary Research Question

RQ: What social issues do policy makers need to consider in creating an effective policy to end FGM in Egypt?

This question was the anchor of the interview as the main focus of the study. Answers to different questions carried social issues that the interviewee believes to be related to the policy process of FGM/C. The social issues were compiled during the analysis to be part of the final study recommendation.

Semi-Structured Interview Questions

1- How would you define the practice of Female Genital Mutilation / Cutting? This question was a very important baseline for the interview. The issue of FGM/C has been viewed from different perspectives: social, cultural, religious, political, medical, human rights, psychological and sexual. It was important to establish the viewpoint of the interviewee and his/her standpoint on where the harmful practice should be placed. The framework in which the interviewee places the harmful practice will influence his/her views as well as the intervention method believed to be most effective.

2- Which term do you prefer to use? Why? The term similar to the above definition and categorization of the issue in question one determined how the interviewee places the issue. An analysis was drawn from both interview questions 1 & 2 on where the interviewee's perspective on the issue of FGM/C (medical, religious, cultural, social or human rights violation).

3- What was your role in the design, lobbying, legislation or implementation of FGM/C related policies in Egypt? Data analysis from this question included the role of the interviewee as one of the key players in the policy and legislative process of FGM/C. Analysis of the question answer determined the category that the interviewee belonged to (governmental, non-governmental or civil society). In addition, this categorization will help in data analysis of limitations of the research results depending on the biases that they might carry representing their different respective entities.

4- What are the steps / stages that were taken to formulate the policy for FGM/C in Egypt?

This question served the part of the data analysis examining and evaluating the policy process that took place in Egypt for combatting FGM/C. The analysis revealed the steps that were done with any gaps that were missing such as involving certain target groups or addressing the correct root causes for the practice.

5- Who were the key main players in formulating FGM/C public policy in Egypt? This question helped with analysis on key players that were involved in the policy process and whether all key influential players were included. The importance of this question is that the issue of FGM/C is related to several disciplines, namely, medical, religious, cultural, social, psychological and physical. Accordingly, key players in these disciplines needed to be well represented during the policy formulation process.

6- From formulating the policy to the legislation stage, how were the target audience involved in the process? This question focuses specifically on the most important category of the target group that includes caretakers who take the decision to

perform FGM/C on their girls or grown up women who have undergone the harmful practice. From my professional experience in working on the issue of FGM/C in the field, these groups carry reasons of resistance to behavioral change and community pressures that they are exposed to that prevent the positive social change. Inclusion of these reasons are a key in order for the policy to effectively address the root reasons and deal with them to have the positive effect needed. This question allowed the interviewees to express if the target audience were involved in the process through a participatory approach or enough field studies or not.

7- How would you evaluate the success of the FGM/C policy in Egypt? Why do you evaluate it that way? This question served to clarify the standpoint of the interviewee on the policy process. The analysis showed that either that most of the interviewees view that the policy process is successful even if prevalence rate is very slowly decreasing or that it had flaws and part of the policy process might need to be changed as the decline of the prevalence rate is very slow.

8- In your point of view, how do you rate the success of the FGM/C policy and law in terms of its effect on the high prevalence rate of FGM/C in Egypt? This question contributed to the data analysis on the direct relation between the success of the policy process and the prevalence rate of FGM/C.

9- What are the social factors that you believe should have been considered during the policy process phase? This question directly answered any social factors that the interviewee thought should have been addressed and was not mentioned as part of the earlier questions.

10- Would you like to give any other general recommendations to strengthen the FGM/C policy and law enforcement of the policy in Egypt? (Social, political, communication, social mobilization or behavioral change). This is a final open-ended question that provided a chance for the interviewees to give any final recommendations that should be considered to strengthen the FGM/C policy in Egypt.

Trustworthiness

A qualitative study is not someone's personal opinion about a research topic but rather it is defendable observation that can be backed up by evidence (Langbein, 2012). Despite its simple appearance, qualitative data requires a great deal of care and self-awareness from the researcher when handling the data and drawing conclusions (Miles et al., 2014). A core component of qualitative data collection is validation and accuracy. Validity of data is essential or otherwise we will be left with some amusing stories without being able to test them (Miles et al., 2014). As the researcher is a central part of data collection, analysis and interrelating facts together, validation factors play an important role in ensuring that the data is trustworthy and credible. The subjectivity of the qualitative researcher or often referred to as bias is how the researcher's personal experiences, theories and beliefs might have positively or negatively affected the research (Maxwell, 2013). The two main validity threats to a qualitative study are researcher bias and reactivity (Maxwell, 2013).

The researcher bias stems out from his existing beliefs and theories driven from the field experience with the topic. The researcher's previous experience is not necessarily a negative thing in qualitative research. As a matter of fact, bringing in the

researcher's values, beliefs and experiences can positively or negatively influence the research. Accordingly, it is important for a qualitative researcher to acknowledge any negative impacts and set analytical guidelines that will avoid them and ensure validity of the study's results. The second potential influence of the researcher on the study, which could influence the results, is reactivity or the researcher's effect on the setting or individuals studied (Maxwell, 2013). To avoid potential threats to the validity of the study, I used several methods to minimize any bias preset assumptions from my previous experience working in the field of combatting FGM/C. These methods included triangulation by collecting information from a wide range of individuals and settings to provide a better analysis without biases. The interviewees were selected from different backgrounds from governmental and non-governmental organizations to compare the data collected and ensure the validity of the analysis and recurrence of keywords from the interviews that will guide the analysis. A second method to ensure validity was trying to provide 'rich data' or as Maxwell (2013) describes as intensive interviews to enable the collection of rich data that are detailed enough to provide a full reading of the picture without much room for individual interpretation from the researcher. This method was used in my research through the qualitative in-depth interviews that were conducted with thorough research questions and follow-up questions when necessary. Finally, I believe any method of validation for data and ensuring the trustworthiness of the analysis will not be foul proof without evidence. Evidence is one of the strongest validation methods for a qualitative research. The interviewees have experience with the topic of FGM/C and public policy and therefore, were asked to provide evidence or data that backs up their

views or share case studies that they have witnessed that would help validate the information and leave less room for my interpretation or the influence or my background, beliefs and experience with FGM/C.

Protection of Participants' Rights/Ethical Procedures

A total number of 10 interviewees were ideal for the study to enable me to go in-depth with the research and generate enough data for the analysis and recommendations of the study. Sufficient journaling and note taking were done during the interviews that enabled observations and analysis of the study. The email invitation, interview protocol and consent forms are included in the study's appendix. The interview started by briefing the interviewee on the purpose of the study, the length of the interview in terms of expected time and number of questions. In addition, the interviewees were prompted that they have the freedom to opt out of the interview at any point if they feel they no longer wish to participate in the interview or do not wish to answer a specific question. Most participants were public figures known to have worked in the issue of FGM/C in Egypt. However, they were offered the option that the identity can be kept confidential if they wish. In addition, the interview data will be kept safely so it is not shared, viewed or tampered with in any way without their previous knowledge and consent. The raw data and copies of the interviews will be kept for a period of five years on a personal computer and backed up on an external hard drive both protected with a passcode and then destroyed. All issues raised and that I learned in the protection of human participants course were considered to ensure the interviewees rights and protection are considered and kept during the process of data collection.

I finished the NIH web-based training course for Protecting Human Research Participants and ensured that the confidentiality and anonymity of the participants is well protected.

Presentation of the Results

One of the most challenging aspects of qualitative research is the presentation of results since they are not easily quantifiable with numbers and figures as in the case of quantitative data. Qualitative study analysis involves organizing the data, coding and dividing the data into themes and keywords (Creswell, 2013). The results of the study were presented in raw format and then analytical format. The analyzed format was keywords that were derived from the interview results and linked to the main research questions to predict a pattern in answers or agreement on concepts among interviewees including deriving themes and keywords.

Data representation started from the phase of collecting data by writing side notes during the interviews, journaling and noting down any relation between different interview categories or themes that were noted during the interview process.

Summary

In this chapter, I introduced my role as the researcher and ethical and trustworthiness considerations that were made. The methodology was introduced along with qualitative in-depth interview practices. The qualitative data methodology is an approach that helped to generate rich and in-depth data to examine the policy process that was conducted for FGM/C in Egypt. In addition, it allowed participants to express their professional analysis of social issues that were considered or should be considered when

addressing a harmful practice with sociocultural roots like FGM/C. The participants' list included a variation to represent governmental, non-governmental and international organizations to adequately represent all views and perspectives.

Data were collected via in-depth interviews. Interviews were conducted via videoconferencing. Interviews are stored on a computer file and a backup was created on an external hard disk, which will be saved confidentially for 5 years protected with a password and then then destroyed. Data were analyzed using NVivo to extract keywords and key concepts from qualitative interviews. Participants were given the option to keep their names anonymous to protect their confidentiality.

Chapter 4: Results

Introduction

I explored policies and legislative work involved with efforts to combat FGM/C in Egypt. I investigated the policy process for combatting this practice in Egypt and how much policymakers considered social issues involved with the practice. The main research question for the study was: What social issues do policymakers need to consider in creating effective policy to end FGM/C in Egypt? The purpose of the study was to answer this question in terms of FGM/C as a sociocultural harmful practice that is deeply rooted in society. As an estimated 200 million girls and women have undergone FGM/C globally, the prevalence rate is still high considering global policies and legislative efforts to combat the harmful practice (Kahn, 2016). Understanding social issues that need to be considered while formulating policies related to FGM/C is important, as they contribute to and strengthen efforts involved with eliminating the practice. In addition, the recommendations may be applied to better understanding other harmful practices with socio-cultural roots as part of the efforts in order to eliminate them such as early marriage and child labor.

The research method was in-depth semi-structured qualitative interviews with 10 key policymakers who worked in the field of FGM/C in Egypt involving policy formulation, legislative efforts, and community intervention activities in the field. An email invitation was sent to 17 participants with information as per study guidelines. Ten participants agreed to participate in interviews, and seven participants declined invitations to participate. It was anticipated that FGM/C is a sensitive topic and taboo. In

addition, some participants still hold governmental positions and did not feel comfortable talking about the issue with a third party, even if their identity was not revealed. Participants who agreed to participate in interviews signed the consent form or replied with the words “I consent” by email. I conducted 10 in-depth qualitative interviews that led to data saturation. Interviewees who consented to participate in interviews had the following roles:

Two government employees (either working at a government counterpart or as a consultant working inside a governmental organization full time with their consultancy contract.

Two participants from religious institutions (1 Christian and 1 Islamic institution)

Four participants worked at non-governmental organizations including NGOS, civil society organizations. Two of these participants eventually started working as staff members with UN organizations during the last few years.

Two participants from international organizations (United Nations organizations and/or donor groups).

Overview

All interviews were conducted via videoconferences with participants. This was due to the global pandemic and different geographical locations of participants, as well as to better enable me to accommodate their busy work and travel schedules. Due to the politically sensitive nature of the study, participants were told that there would be no recording. Per my protocol and IRB, no video or audio recordings were taken during

interviews to reassure participants of confidentiality of interviews and protection of their privacy. Only note taking was used during interviews.

The study included three main categories of participants: Government, international organizations, and civil society representatives. Data collection commenced with note taking and identifying themes, codes, and keywords. Interviews took place in a private conference room in Dallas, TX to ensure privacy of all interviewees. All interviews are stored on a password-protected secured computer file and backed up on an external hard drive.

I explored the issue of FGM/C in Egypt, including the policy process that resulted in the issuance of Egypt 2008 Child Law in 2008 banning and criminalizing FGM/C and mandating legal punishments for caretakers and medical doctors performing the practice.

Findings of Interviews

RQ1- How would you define the practice of Female Genital Mutilation / Cutting?

As FGM/C has been viewed from different perspectives, including: social, cultural, political, medical, human rights, psychological and sexual. This question helped to determine how the interviewees who represent a range of policy makers from different disciplines view the issue of FGM/C and how they categorize it. Categorization of the issue will affects how approaches of policymakers and which sectors they will try to lobby their policy in.

All participants agreed that FGM/C is not a medical issue, as this practice has no medical basis. Participants gave reasons for the practice as they tried to categorize it. All

interviewees agreed that the issue has social roots and socio-cultural aspects. Two participants attributed the practice to countries having a patriarchal society by being misled that FGM/C is needed to enforce male dominance over women. One of the participants said, "FGM/C is a tool to strengthen the patriarchal society that is built on listening to the male figure and the dominant figure." Seven participants emphasized the importance the spread of this practice among illiterate circle and all 10 participants stressed that the harmful practice is not related to any religious background. One participant said, "There is no religious basis for the practice and even verses from the Quran is misinterpreted to wrongfully support this harmful practice." Eight participants defined the issue as a grave violation of women's rights. "Most severe violation against women. It is the first violence that a female is exposed to from the inner circle…from the ones that should be the source of her protection." Said one of the participants. Another interviewee said " It is not related to religion as it is practiced by both Christians and Muslims and it is not practiced in the gulf area where some religious practices are more strict."

RQ 2- Which term do you prefer to use? Why?

The term FGM/C is the term agreed used by international and human rights based organizations. However, it was important to ask the participants which term they would like to use prefer as it also contributed to the categorization and placement of the issue combined with answers from question 1. All participants agreed that they preferred the official term FGM/C is the correct one. Six participants said that "Circumcision" is the term most commonly used with by the public to talk with target group.

RQ 3- What was your role in the design, lobbying, legislation or implementation of FGM/C related policies in Egypt?

All participants had a role in the formulation of FGM/C policies in Egypt. Seven participants were directly involved in community work and implementation of policies as well as field data collection. Three participants were involved in research, data collection, desk review and some field visits and fully involved in policy negotiations and writing. All participants were involved in the discussions of the drafting of Egypt Child Law that called for criminalizing FGM/C. One participant described their role as "planning for programs to have strategic direction to cooperation with international organizations to raise awareness on grass root levels and break the silence against the issue." Another interviewee said, "on national and regional level to support the government's response to combat FGM and reflect our model in the Church to spread a positive model to society." A participant said, "I worked on the international level to support local government efforts and response to combat FGM/C and raise funds to implement the policy work on the ground".

RQ 4- What are the steps / stages that were taken to formulate the policy for FGM/C in Egypt? This question was included to serve as part of the data analysis and evaluation of the policy process that took place in Egypt as well as any potential gaps in national policy.

All participants agreed that the Egyptian government worked closely with international organizations, civil society organizations, religious institutions and children

rights NGOs. Years of field visits, field studies and reports by different international organizations and NGOs preceded the policy work on FGM/C.

Participants also mentioned the intense awareness activities including field level awareness activities as well as media campaigns. However, the government's yearly DHS report and other quantitative reports showed the high prevalence of FGM/C despite of all the efforts. Eight participants emphasized that the efforts did not address the root level causes of FGM/C. 1 participant said "After FGM/C was criminalized in 2009 Egypt Child Law, the penalty was increased in 2016 where practitioners and caretakers would be sentenced to an imprisonment up to 7 years. Yet, the practice is still very highly prevalent and caretakers find alternate ways of performing the practice."

Eight participants agreed that the policy work carried out did not address the real root causes of the issue like high levels of illiteracy and extreme poverty. One participant said "During field visits we see children knocking on church's doors asking for bread to eat. Their mother leaves them for a week to find work and they are left alone without any food or care. How can you talk to them about the concept of rights, violence and FGM/C when they living in that extreme poverty?." "If you want to talk to people and raise their awareness about rights…then you should talk about all human rights…all rights are equal."

Stages of policy work started as early as 1990s in trying to raise awareness on the field level on FGM/C. One interviewee mentioned particularly "FGM/C was bundled as part of the maternal health and nutrition public health package as it was awkward and irrelevant to the target group to talk to them about FGM/C alone. Instead it was bundled

as part of the maternal health and nutrition package hoping that this would help us to gain the trust of the target audience."

Another policy implementation stage mentioned by the participants is the recently established National Council to combat FGM/C. One participant said " The national council established in 2019 is jointly headed by the National Council for Women and the National Council for Childhood and Motherhood to unify the efforts of the government and civil society. This is a good start but it is still not addressing the root causes of the problem. Also, the structure is good but monitoring and evaluation and periodical assessment is lacking. So for example, when another public health issue comes up like the recent pandemic, the issue of FGM/C is put aside and not followed up through."

RQ 5- Who were the key main players in formulating FGM/C public policy in Egypt? This question helped to identify any gaps in the policy process in relation to the involvement of key players from different disciplines.

All participants agreed that the government of Egypt involved all relevant partners from international organizations, NGOs, public health sectors and relevant government ministries. One participant mentioned particularly all the studies and quantitative data carried out in cooperation with all the relevant government bodies and international organizations. Another participant stated " In the years leading to the formulation of the 2008 Child Law, the Egyptian government was transparent about sharing the high prevalence rate of FGM/C and admitting the severity and importance of the issue. A lot of political support was given to the international organizations and NGOs to raise the level of awareness on the field level. International organizations played a very

important role in fundraising and funding of the different activities." All participants mentioned the National Council for Childhood and Motherhood as the lead Government counterpart for the national efforts to lobby for the policy of FGM/C. Political support was stressed by many interviewees as an important factor. One interviewee said" Political support greatly facilitated the policy formulation, legislative efforts and the approval of the child law that included many important articles related to children's rights including FGM/C."

RQ 6- From formulating the policy to the legislation stage, how were the target audience involved in the process? This Interview Question 6 question helped to directly tackle the involvement of the target group in the policy formulation. The target group does not only include victim girls who are exposed to the harmful practice but also the caretakers who hold the decision-making power and are most resistant to behavioral change.

Participants defined who are the target audience as two important categories: medical doctors who perform the practice and caretakers who hold the decision making power. One participant said" The decision making power starts with grandparents insisting on performing FGM/C on their grand-daughters then the power is transferred to the mother who decides to do it. However, recently we have witnessed father's get involved more in the decision making process and insist that their daughters perform FGM/C. Participants said that the involvement of target groups was limited at the beginning as more awareness activities needed to be done on the field level. One

participant said “It is completely useless to talk about harms of FGM/C when many people do not even feel that they have a problem to start with.”

Participants expressed the lack of representation of women and girls in the process, as there is not enough women representation on grassroots level. One interviewee expressed the lack of representation saying “there is no representation of women on the grass root level but were represented through civil society organizations and all ministries and religious institutions but no participatory approach. The civil society can represent groups to a certain extent but you can not consider that to be a community representation or a participatory approach from the target group.”

RQ 7- How would you rate the success of the FGM/C policy in Egypt? Why do you rate it that way?

RQ 8- In your point of view, how do you rate the success of the FGM/C policy and law in terms of its effect on the high prevalence rate of FGM/C in Egypt?

As the interview proceeded, questions seven and eight were found to be similar so they were asked together to the interviewees. Both questions helped to clarify the standpoint of the interviewee on the policy process success and if the prevalence rate is decreasing fast enough. In addition, both questions helped to identify any flaws or gaps in the policy process.

All participants rated the success rate between 60% and 70% of success rate. Four participants believed that the success rate was not fast enough and that the prevalence rate is declining but very slowly or too slowly given the effort and the high funds getting spent on the combatting efforts. Five participants addressed the slow

prevalence rate from a behavioral change point of view mentioning that behavioral change takes time and the prevalence rate will show over a longer period of time. One participant said "behavioral change can not do magic. When we introduce the topic to the people, it has to be relevant. People need to feel directly how the issue is affecting their everyday life." Seven participants mentioned that the mega media campaigns carried out costing a lot of money help in raising awareness but are not enough to make people feel the harm of the practice, as it does not directly change their mentality. 1 participant said " in order to change the behavior of the people, you need to change their mentality about the issue.

In order to change the mentality of the people, you need to address the root causes." Another participant said "a lot of behaviors are criminalized by law, but it takes more than media campaigns for the individuals to abandon the negative behavior and adopt the positive one." An interviewee clarified this point further by giving examples "child marriage disappeared in countries when women got educated and child labor disappeared in Europe when people got educate. The image of the target groups about themselves changed when they got educated. You have to think of different ways on how to change the lives of people and this is where you should invest money and resources… in changing the lives of people to the better and not in media campaigns."

RQ 9- What are the social factors that you believe should have been considered during the policy process phase? This question served to directly answer the main research question if there are any social factors that should have been considered in the policy process that was not included in the questions above. This question took the most time

with the interviewees as it allowed them to express themselves about all social factors and reasons behind the harmful practice.

Interviewees brought up several social factors that must be considered, as they are part of the grass root causes that cause the high prevalence rates of FGM/C in Egypt and many parts of the world.

1- Marriageability of the girl / approval and conformity to the demands of the society: All participants mentioned that FGM/C is practiced, as it is part of the marriageability of the girl. In other words, the husband and even the mother in law expect the girl to be circumcised. One participant said "we have seen girls returned to their parents house on their wedding night if the husband or mother in law find out that she was not circumcised." Another interviewee said "fathers and mothers feel the pressure of circumcising their girls even if they have some doubts internally on the harms of the practice. If they do not perform it, they are not able to face the society in their local community."

2- Power of society's decision: Patriarchal society and male dominance

Participants brought up this social factor through two branches of thought: religious lens and power index framework. The religious lens addresses the social pressure of performing FGM/C for wrongfully understood religious roots and for the conservative "It is not a religious issue but affected by the misinterpretation of Quran versus…it is a social practice regardless of religious beliefs" said one interviewee. Another interviewee said "FGM/C is not related to a religion as it is practiced by both Christians and Muslims in Egypt and it is not practiced in the Gulf who is even more

conservative." An interviewee tried to explain this idea further by using the term "public religion". This interviewee clarified "even if FGM/C is not related to a religion but people justify it as part of their public religion as in some communities they can not read or write but someone explains to them religious interpretations and they believe it without a proper reference." Another example given to the "public religion" was when a participant said that women head cover in villages is done regardless of their religious background or belief. "women cover their head regardless of religion. It is the power of decision of the society."

Eight participants referred to the increased conservative trend in the Egyptian society after they were artificially exposed to other cultures especially in the 1980s when Egyptians started to travel to the Gulf and bringing back more conservative beliefs "leaving no room for modernizing social structure." Said one of the participants. The religious lens was also attributed by interviewees to the control of the Islamic groups to Upper Egypt in the 1980s and 1990s with a "separation between the society and government due to the lack of political participation…"said one of the interviewees. The lack of political participation affected the trust between the people and the government, which was brought up separately by the interviewees as a social factor of "trust" as a strong social factor when addressing FGM/C in the Egyptian society.

The male dominance lens viewed the harmful practice of FGM/C as a way to "control" women's sexual desires and have a male dominating society. One interviewee said, "FGM/C is a tool to strengthen the patriarchal society that is built on listening to the male figure and the dominant figure that affects all Arab countries". All interviewees

mentioned the social factor of how FGM/C is carried out as a way of controlling women and their sexual desire. An interviewee mentioned that during field visits "some men talk to us saying that they can not leave their women at home or if they travel for work, they can not leave them along if they are not circumcised as they will not be able to control their sexual desires and can cheat on them". Another father mentioned to one of the interviewees "I trust my daughter but I do not trust people around her so I need to protect her and keep her under control by circumcision".

Another important social factor related to male dominance brought up by three interviewees was how the media portrayed women in Egypt over the past 40 years. "Women were portrayed with more respect and empowerment in the 1960s. Women's image became worse in the media…with women beaten in media and more violence against them in all forms." said one of the interviewees. Another interviewee expressed "no real representation for women and women issues in drama and media today." Male dominance was also discussed by participants from the lens of real women empowerment on the ground. "real empowerment is to break the structure that forms the violence against women. The male judge himself reviewing a case of FGM/C in the court might not be convinced that FGM/C is a crime so he will not give a verdict with the toughest sentence." said one of the participants.

3- Illiteracy rates

Illiteracy was another factor that affected the impact of any social work, community intervention efforts and behavioral change activities to combat FGM/C. All interviewees agreed that during their fieldwork, it was much easier to address caretakers

who had some level of education more than uneducated parents. Interviewees referred to the quantitative data in the National Demographic and Health surveys (DHS) carried out by the Egyptian Ministry of Health, population council, USAID and other international organizations that consistently showed how FGM/C prevalence rates decrease with the increase of literacy rates. One interviewee said " educated target groups are much easier to approach and talk to as they ask for data and proof to make an informed decision."

4- Extreme poverty levels:

All participants expressed the extreme level of poverty they witness when they go to field visits. "when we conduct field visits, we see extreme poverty and malnutrition in children…how can we talk to them about FGM/C when they are struggling to find daily bread". Poverty is a social factor that influences the slow decrease in prevalence of FGM/C rate as participants mentioned that when people are overwhelmed by poverty, hunger and malnutrition, it is very difficult to approach them for issues like FGM/C. Accordingly, the government social protection programs that are being implemented now are very important as they may relief the pressure on people. "for example "Takafol and Karama programs and social housing programs implemented by the government are very important and will contribute to combatting FGM/C and other harmful socio-cultural habits." said one of the participants.

5- Trust:

All interviewees acknowledged the importance of the Egypt Child Law in 2008 and the amendment in 2016 that increased the prison sentence time for both caretakers and medical doctors performing FGM/C. However, all participants repeated the word

"Trust" in many forms in relation to the effectiveness of applying the law and implementation of field activities. "Trust…the target group needs to trust the source of information telling them that FGM/C is harmful" said one of the participants. "Why is the government obsessed about FGM/C and ignoring other issues like health and education. Trust in government sources talking to them about FGM/C is affected when other survival rights are ignored" said another participant. Another participant said "people ask if children are dying from malnutrition…public education is dropping and parents pay a lot of money for private tutoring. And it looks like the government does not care about our daily life so why do they care about this issue (FGM/C)?".

I asked participants a follow-up question on how to get around the issue of trust to reach the target group. Eight participants agreed that it is best to bundle the FGM/C interventions as part of the maternal health and nutrition package. "Community health workers already conduct door to door visits and talking about FGM/C can continue being integrated as part of the health bundle" said one participant. Another participant said "Trust can be built when target groups find someone talking to them about their health and providing services for them so they would trust that they have their best interest at heart and would listen to what they say" Along the same line of thought another participant gave an example "….CEOSS for example was one NGO with strong community presence providing social services for local communities…people knew them and trusted them and they had good access to households."

Another tool mentioned by interviewees to gain the trust of the target group is through influential community leaders. "Religious leaders, community leaders and

influential figures are great partners for community intervention activities as people trust them and trust they have their best interest at heart." said one participant. Four participants mentioned specifically the government programs for affordable housing social inclusion and social reform like "Takafol and Karama" could be a way to strengthen the trust between the government and target group because it will make them feel that they have their best interest at heart.

RQ 10- Would you like to give any other general recommendations to strengthen the FGM/C policy and law enforcement in Egypt? (Social, political, communication, social mobilization or behavioral change).

This open-ended Interview Question 10 gave the chance to the interviewees to freely express themselves with any final recommendations or feedback on the policy process and overall on FGM/C and their outlook on the future steps.

Interviewees responded to this question by recapping the social factors they mentioned in the previous questions. Participants mentioned the need to reduce illiteracy rates, tackle extreme poverty, increase women empowerment to be part of the decision making process. Women empowerment was mentioned specifically in the line of thought that when are empowered and educated, they would be part of the decision making process when it comes to their health and their children's health and it will be reflected on their daughters too.

A final recommendation that was mentioned by 8 interviewees was that in order to combat FGM/C effectively, the root causes should be addressed and the real reasons why people are still adopting this harmful practice. "The social factors behind the

practice should be considered by policy makers as any effort, funds spent and campaigns executed would be gone to waste if these factors still exist…people will still feel they have to circumcise their girls" said one of the participants.

Finally, all interviewees stressed on the importance a solid monitoring and evaluation framework to monitor the progress, impact and ensure consistency of the activities executed. Seven interviewees mentioned the importance of door to door visits that are carried out by community health workers that are part of the Ministry of Health and Population system and by NGOs "Regular family visits by outreach workers to monitor caretakers and doctors as we used them in maternal health checkups are very important and they also help medical doctors to join our efforts in combatting FGM/C" said one of the participants.

Data Analysis

Data was collected in correspondence to the theoretical frameworks chosen formulated the first level of data coding. The four coding categories related to the theories were definition of FGM/C, social norms, innovation and nudging related to FGM/C.

Data coding was performed to analyze content and identify patterns relevant to FGM/C combatting efforts in Egypt. Patterns were identified to contribute to answering the research question of what social issues should be considered by policy makers when formulating policies to end FGM/C in Egypt. The patterns also contributed to the four coding categories for defining FGM/C, social norms, innovation and nudging target group. Themes were drawn from the patterns found to help develop the categories that

were used to for data interpretation, analysis, recommendations and action points. Journaling was done for each interview in a separate sheet divided by answers to each question to facilitate identifying patterns for all 10 interviews and comparing answers when needed during the data analysis for each question separately. Direct quotes were noted during journaling for all significant concepts and key answers for all participants.

Interview sheets were uploaded to the qualitative data analysis software Nvivo. An initial data query was run on the software to generate the data word cloud and examine keywords and codes generated. The first query in generated carried a lot of word noise in the word cloud. Data noise was cleaned out by reviewing and deleting repetitive words from summary words and a query was re-run. The second word map still carried some data noise that was further cleared out and the query was re-run again in

Figure 2

Participants Word Map with Data Noise

Nvivo. The third re-run resulted in which clearly mapped the data codes and keywords that stood out from the interviews.

The final participant word map for the prevalence of terms highlighted several keywords that correspond to the four categories and to answering the main research question. Main themes that resulted from the final word map included: Trust, poverty, education, empowerment. These four themes branch out into the social factors that

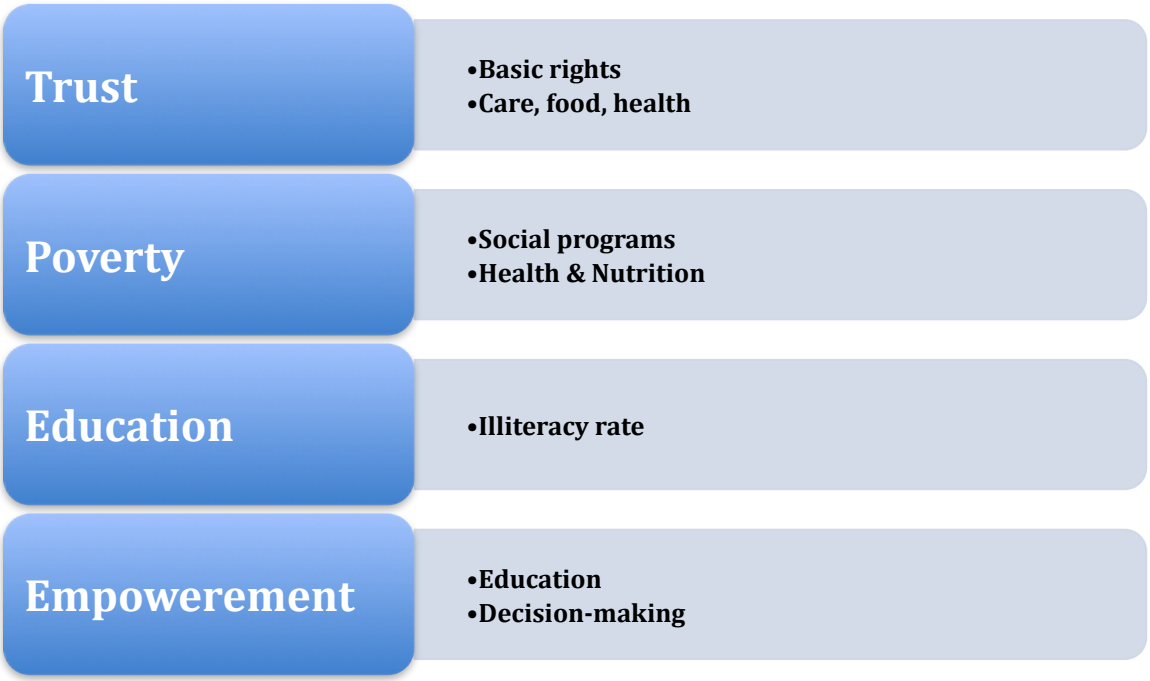
Figure 3

Participants Word Map for Prevalence of Terms

should be considered by policy makers when formulating policies for combatting FGM/C.

Figure 4

Four Emergent Themes



Trust was repeated as a keyword and an entry point for any community intervention activities that would be implemented to combat FGM/C.

Evidence and Trustworthiness

Qualitative data requires a great deal of care and self-awareness from the researcher when handling the data and drawing conclusions (Miles et al. 2014). The researcher's bias is stems from their personal experiences, theories and beliefs might have positively or negatively affected the research (Maxwell, 2013). The two main validity threats to a qualitative study are researcher bias and reactivity (Maxwell, 2013). In the case of this research, my field experience in development programs and particularly

FGM/C resulted in strong feelings about combating FGM/C and preset opinions about grass root reasons and solutions for effective interventions. However, to avoid any bias and any preset and predetermined solutions, a well semi-structured interview questions were set that carried no implication for the participants to direct them to an answer or theme. In addition, my previous professional position and experience were positively used by utilizing a set of analytical guidelines to ensure the validity of the study. In addition, in order to avoid potential threats to the validity of the study, several methods were used to minimize any bias preset assumption such as triangulation. Triangulation included colleting information from a wide range of individuals who were selected from different backgrounds ranging from governmental to non-governmental organizations and religious institutions to provide better analysis without bias. Also, desk reviews for the latest research and data provided on FGM/C enabled me to validate the participants' answers with the repetition and recurrence of keywords through journaling and running queries in Nvivo to guide the analysis. Finally, evidence of participants' first hand experience of in the field with the topic of FGM/C and public policy helped to validate their answers as the interviewees were able to provide data and examples of cases witnessed to back up their answers. Clear field examples and direct experience from the participants leave less room for my personal interpretation or influence from my background, beliefs and field experience with FGM/C.

The transferability of the study is significant as the results of the interviews suggested social factors that need to be considered by policy makers when formulating policies on FGM/C but can be applied to other issues that have socio-cultural roots. In

addition, the transferability to other countries is high as social issues like poverty government trust, education, women empowerment are applicable to most countries that suffer from similar harmful practices so they would benefit from the study results.

Summary

This chapter includes data collection findings of 10 semi-structured interviews with participants who were closely involved in the process of policymaking to combat FGM/C in Egypt. Participants included interviewees from governmental organizations, international organizations, non-governmental institutions, and civil society. Data analysis was conducted via journaling during interviews. Journaling included direct quotes from interviewees as well as identifying themes and keywords from answers. Journals were run through NVivo qualitative analysis software that generated a word map with data noise. Further work was done to remove data noise and generate a final word map to enable me to further confirm and identify themes and keywords that resulted from interviews for further data analysis. Themes that resulted from data analysis were trust, poverty, education, and empowerment.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

FGM is recognized as a violation of human rights and the rights of children, specifically young girls. It involves cutting part of their bodies with no medical justification and without their consent. FGM/C leads to long term psychological, physical, and sexual harm to women who are exposed to this harmful practice, and an estimated 100 to 130 million girls and women have been exposed to this practice (WHO, 2008). Despite great efforts in Egypt since the 1990s to combat FGM/C ending with a law that criminalizes the practice as part of the Egypt Child Law in 2008, the prevalence rate is still very high, with more than 87% of girls and women between the ages of 15 and -49 who have undergone the practice (EDHS, 2015). Egypt is not on track to the reach the SDG goal of eliminating FGM with the current rate of decline monitored over the last 15 years, and needs to be 15 times faster to reach elimination goals by 2030 (UNICEF, 2020).

I examined legislative efforts and community change to combat FGM/C in Egypt from the perspectives of community leaders. I explored social issues that policy makers need to consider when formulating policies related to combatting FGM/C. The main theory used in the study to analyze and the findings of the study is social norms theory. I conducted 10 in-depth semi-structured interviews with participants from governmental and non-governmental organizations as well as civil society institutions. I conducted data analysis to develop a list of recommendations for policymakers, which may contribute to the formulation of more effective policies for socio-cultural issues such as FGM/C.

Interpretation of findings

FGM/C was agreed to be defined with the commonly used professional terminology of Female Genital Mutilation/Cutting as it is representative of the brutality of the practice and it is the official term approved to use by international organizations. FGM/C has no medical basis and no justification, and accordingly is seen by the participants as a social issue with socio-cultural roots. The harmful practice is performed by both Christians and Muslims in Egypt so it is not a religious practice even though it is sometimes wrongfully justified with misinterpreted versus of the Quran.

The Egyptian government worked closely with international organizations, civil society organizations religious institutions and children rights NGOs. Good representations of all policy makers were present during the formulation of public policy and legislative efforts to combat FGM/C in Egypt. Quantitative research, field studies and reports by international organizations and NGOs were used for policy work and to feed community action plans and field level activities. Strong political support from the Egyptian government was given to combatting FGM/C and commitment to completely eradicating the harmful practice. Political commitment on higher levels of the government was vital to ensure the issue remained a high priority for international organizations and government bodies with funding allocated for projects and field activities. Despite this good representation, research work done in all stages of policy and legislative work and strong political commitment, real root causes of the harmful practice were not addressed.

Stages of policy work started as early as the 1990s in trying to raise awareness on the harms of FGM/C. It was later bundled through the package of maternal health and nutrition and recently accompanied by a strong media campaign to raise awareness and help stop the practice. The media campaigns and awareness activities only touched on the first stage of behavioral change as the target group realized that a problem exists and that they need to change a behavior but it did not push the target to adopt the positive behavior of abandoning the practice.

The Egyptian government in collaboration with research bodies and international organization was transparent about prevalence rates of FGM/C in Egypt and shared publically quantitative data. However, Monitoring and evaluation with periodical assessment to FGM/C intervention and field activities was not strong enough. As other public health issues arose such as public health pandemics or and diseases, FGM/C was dropped from the priority list of the main stakeholders. As expressed by participants, stronger commitment by ABC through a solid monitoring and evaluation framework log is important to ensure the consistency and strength of efforts.

Similar to recent FGM/C statistical digest by UNICEF in 2020, Study participants confirmed that the success rate for combatting FGM/C and its prevalence rate in Egypt was not enough. Participants rated the success rate between 60% and 70% as the prevalence rate was declining very slowly over the past 15 years with over 87% prevalence rates today. Egypt will not be able to meet the SDG goal of eradicating FGM/C from Egypt if the prevalence rate remains the same. The reasons behind the prevalence rate went back to the same issue or root causes that were not addressed or solved that

caused the target group to continue practicing FGM/C. The social factors that need to be considered when policymakers formulate policies for FGM/C included marriageability and power of patriarchal societies and male dominance. Marriageability of the girl meant that even if caretakers were convinced that FGM/C is a harmful practice, they would not abandon the practice. If the girl is not circumcised, she will not be accepted as a wife in a society that only accepts circumcised girls as a sign of honor and fidelity. Accordingly, caretakers have to conform to social norms of their local society and circumcise their daughters to be accepted within their community. A second important social factor is male dominance of the existence of a patriarchal society. FGM/C is still seen as a way for men to control women, particularly their sexuality and behavior. Even if a strong law exists that criminalizes FGM/C, the urge to perform the practice will remain as long as those two social factors still exist. Caretakers still need to conform to their society and feel obligated to prepare their girls for marriage properly and protect their honor and have them under control by circumcising them.

I highlighted social factors and themes that were found to be the true reasons behind the practice of FGM/C. The main four overarching themes were trust, poverty, education, and empowerment. These issues hindered the prevalence rate to quickly decrease even with creating a strong policy with strong legislative arm.

Trust

The study clearly revealed that trust between the target group and the body that is implementing the awareness activities, behavioral change interventions and enforcing the policy and legislation is vital. It is hard to reach the target group and change their

behavior on performing FGM/C when they view the same body that is addressing them as not taking care of their basic rights such as health and education. If trust is established between the institution that is addressing the target group and they feel that they have their best interest at heart, they will be reached more effectively. Moreover, NGOs such as CEOSS who has evidence of strong developmental work in the field and supported many families in areas of high poverty gained their trust. Target groups feel that CEOSS and similar non-governmental organizations have their best interest at heart and are helping provide basic needs to them and accordingly are more likely to listen to their advice about FGM/C.

Poverty

Practitioners working in the field of FGM/C who were part of the policy process for combatting FGM/C witnessed extreme poverty in areas of intervention with high prevalence of FGM/C. Extreme poverty is another strong barrier and indirect motive for performing FGM. It is very difficult to enforce the law criminalizing FGM and implement community awareness raising activities when the target groups are struggling to find their daily bread and their children suffer from malnutrition. People will view the issue of FGM/C as an irrelevant issue when they are struggling to stay alive.

Education

This study supported quantitative studies that showed that the prevalence of FGM/C is higher in rural areas and among uneducated groups. Participants in the study with strong field experience expressed the difficulty of talking with target groups when they are illiterate and uneducated. Educated target groups are easier to approach as they

request evidence, scientific reports and can be convinced that FGM has no religious or medical justification. Education is also important to help target groups understand the material presented to them through the media campaigns and community field activities. In addition, education will strengthen the legislative efforts, as the target group will realize the importance of following the law and the legal repercussions of practicing FGM.

Empowerment

The increase of trust, eradication of poverty, and education lead to the fourth theme found by the study that is empowerment. Empowerment is another social factor that has been strongly identified by the study participants, as it will cause caretakers to have the power of decision-making. The power of decision-making means that mothers can have the power to overcome the male dominance of a patriarchal society and say no to FGM and would not agree to perform the practice on their young daughters. Educating women and making them more informed about their rights and their bodily integrity might achieve more women empowerment.

Limitations of the Study

I focused on one national culture in one geographic location, which is Egypt. This was necessary to capture the local socio-cultural context of the issue. Generalizing the findings beyond Egypt or a country with similar demographics is limited. Caution should be given but there are lessons to be learned from this study. The four themes that emerged from the study findings can be applicable to other countries with issues of poverty, education or empowerment having global presence in many countries. Even

with the limitation that the study results only applies to the policy process that took place in Egypt, the results of the study can be used to explain the existence of the practice in other countries.

A second limitation that still exists is that participants might not freely express their opinion due to the sensitivity of the topic that may have limited the interviewees' freedom. This limitation was overcome by the confidentiality agreement with the participants that their identity, names and positions will not be revealed. This might have allowed participants to feel more confident that they can express their opinion without revealing or exposing their identity. In addition, triangulation techniques, follow-up questions and open-ended questions were used to give more room to the interviewees to express any additional recommendations or reflections about FGM/C in Egypt.

Recommendations

The issue of FGM/C, with its high rate of practice, has a socio-cultural dimension that is deeply rooted in the Egyptian society. The study findings offer recommendations that might assist policy makers in formulating more effective policies to eliminate FGM/C. The emphasis on the policy work to formulate a law to criminalize FGM/C was a very important stop towards the eradication of the practice but it is not enough to eliminate it. In order to decrease the prevalence rate fast enough to eradicate FGM/C from Egypt, the root causes of practicing FGM/C must be addressed. In addition, social factors revealed by the study need to be considered by the policy makers while addressing the root causes in order to reach the target group.

Trust needs to be built between the government and the target groups through strong family wellness programs of social inclusion. Programs of social inclusion might make the target group feel the official source of information and legislation i.e. the government has their best interest at heart. This may lead to increased trust and the target groups would listen to the key messages by the government about the harms of FGM/C that is disbursed through the ongoing media campaign and community awareness activities. It would be beneficial to continue the inclusion of FGM/C messages through maternal health and nutrition programs as the target group would feel the government is providing them with essential services for their best interest and accordingly be more receptive of the messages on FGM/C.

Social inclusion programs need to be continued and strengthened, as they would help to alleviate extreme poverty. In addition, these programs help to provide citizens with their basic needs of shelter, food and health access such as the National program of "Hayah Karima" in Egypt or "Takaful and Karama" implemented by the Ministry of Social Solidarity. "Takaful and Karama program aim to "break cycles of intergenerational poverty and promote human capital accumulation" (World Bank, 2022). In addition, government social housing programs and economic reform programs might contribute to decreasing increased poverty and fulfilling the basic needs and human rights of the target group. The alleviation of poverty might make the target groups more receptive when they are addressed about the issue of FGM/C and their bodily integrity and children's rights.

Education and reducing illiteracy levels is another important component that policy makers need to consider as a drawback to the efforts of FGM/C eradication. Education programs and addressing education problems in Egypt including high illiteracy rates and school drop outs will contribute to the effectiveness of FGM/C messaging received and effectiveness. This study strengthens the findings of quantitative studies on FGM/C that it s practiced more amongst uneducated groups which pushes the recommendation of reducing illiteracy in Egypt as a way to help reduce the prevalence of FGM/C among these groups.

Women empowerment is another social factor and recommendation that policy makers must consider when tackling a socio-cultural issue like FGM/C. Empowerment will allow women to be in control of their health, their children's health and bodily integrity. Mothers when empowered might be able to hold the decision making power to stop FGM/C for their young daughters. Women when empowered, the male dominance and patriarchal society might be decreased so they would have a say in their health choices for themselves and their children.

A strong monitoring and evaluation system needs to be done for monitoring the progress of FGM/C activities and prevalence rates in Egypt. This monitoring and evaluation system needs to be done in collaboration between the government and all stakeholders working on combatting FGM/C in Egypt. The strong monitoring and evaluation framework will help to coordinate, organize and report on the efforts executed by all stakeholders and keep the progress of eradicating FGM/C as one of the SDGs strong, consistent and would not be lost when other public health issues arise.

Finally, policy makers need to consider the social misconceptions that still exist around FGM/C. Marriageability of girls is an issue that needs to be broken as a social norm in society so a caretaker can have the courage not to circumcise their daughters if they reach the level of behavioral change. Marriageability of the girl only when circumcised will be corrected when the religious and cultural misconceptions around FGM/C is corrected. Strong religious speech banning FGM and explaining that it has no religious basis from religious leaders of both the Christian and Muslim societies need to be continued and strengthened. In addition, religious leaders can emphasize that honor and control of women's fidelity does not arise from FGM/C but from other set of religious morals. Moreover, the public health sector can plan an important role in raising people's awareness that FGM has no medical basis but on the contrary will hold harmful physical, psychological and sexual harms to the girl. This can be done as part of the maternal health and nutrition package.

Implications

The study might have implications on the policy process for further policy work on FGM/C in Egypt. Recommendations of the study might help guide policy makers on finding the reasons behind the very slow decrease in prevalence rates and why Egypt is not able to meet the SDG goal or eradicating FGM/C.

The study might be helpful to the target groups of women and girls when the real root causes of FGM/C are addressed to provide them with more empowerment to deliver the key messages for them more effectively. Delivering the key messages more

effectively will help the target group to make more informed decisions and be able to go further towards positive behavioral change and abandoning the harmful practice.

Social Change

The study might contribute to more positive social change by helping policy makers create more effective policies to combat FGM/C in Egypt and reach a higher decline in prevalence rate which will lead to the elimination of the practice. More positive social change might also result from the recommendations of the study to strengthen social inclusion programs, as this will improve the welfare of the target group and their quality of living. The strengthening of social inclusion programs might also help to fulfill part of their human rights, children's rights and basic needs.

Quantitative studies have been done regularly to monitor the prevalence level of FGM/C in Egypt. This study presents qualitative research that might complement the efforts of the of the problem with opening a discussion with policy makers, practitioners who have strong field experience on the social factors that need to be considered when formulating policies on FGM/C in Egypt. This study might contribute to understanding the reasons behind the slow decline in the prevalence rate as monitored by the quantitative study and discussed in the recent UNICEF 2020 report. This study might help bridge the gap between the existing literature and future research on how to incorporate the social factors identified in future policies.

Tangible Improvement

I addressed the legislative efforts and community change to combat FGM/C in Egypt. The study attempted to answer the research question of what social issues should

policy makers consider in formulating an effective policy to end FGM/C in Egypt. The study provided a tangible improvement by better understanding reasons that help back a significant decrease in prevalence rates despite the great efforts done to eradicate FGM/C in Egypt. This would provide a tangible improvement to the policy process when targeting an issue with socio-cultural roots like FGM/C.

Recommendations for Practice

I recommend that policy makers consider the social factors and root causes that is behind the practice of FGM/C in Egypt. Considering the social factors, root causes and the four themes that emerged from the study may help formulate more effective policies to target the root causes and result in a higher level of decrease in the prevalence rate of FGM/C in Egypt.

Conclusion

Female Genital Mutilation/Cutting is a harmful practice that has been established by human rights international organizations and world governments as a violation of human rights and a violation of children rights. Despite the decline in the prevalence rate of FGM/C in Egypt, it is still too high with over 87% of women between the ages of 15-49 undergone FGM. The study investigated the social issues that need to be considered by policy makers when formulating effective policies for combatting FGM/C in Egypt. Social issues that were revealed by the study were factors like the marriageability of girls, male dominance and patriarchal societies with four main overarching themes: Trust, Poverty, Education and Empowerment. The study provided recommendations for policy makers including strengthening social inclusion programs

and fighting poverty to target the root causes of the issue and eradicate FGM/C from Egypt.

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Appendix A: Initial Email Contact

To:
Position:
Address (City, Country)

Dear

My Name is Maryam Berkshire. I am a doctoral student at Walden University, the school of Public Administration and Public Policy with a specialization of policy analysis. As part of my doctoral degree, I am conducting a qualitative research study on the topic of Female Genital Mutilation / Cutting (FGM/C). My main research question is What social issues do policy makers need to consider in creating effective policy to end FGM/C in Egypt?

I appreciate your agreeing to participate in my study as one of the interviewees. The qualitative in-depth interview will take between 45-60 minutes. The interview will be conducted online via a videoconference or in person according to your convenience and schedule. Attached to this email a consent form for your review. Please read this form carefully as it contains information on the procedures, nature of the study, privacy policy, and the voluntary nature of the study. During the interview, you have the freedom to stop the interview at anytime that you do not feel comfortable and have the freedom of withdrawing from the study. Any information or answers you provide during the interview will remain anonymous and confidential. The data from the interview will be protected and will not be shared with any party. Your participation in this interview will

add a lot of value to wealth of information and knowledge on the topic and is greatly appreciated.

Feel free to come back with any questions on the interview process and to set up a date and time that is convenient to your schedule.

Looking forward to hearing from you.

Sincerely,

Maryam Berkshire

Appendix B: Interview Questions

1. How would you define the practice of Female Genital Mutilation / Cutting?

2. Which term do you prefer to use? Why?

3. What was your role in the design, lobbying, legislation or implementation of FGM/C related policies in Egypt?

4. What are the steps / stages that were taken to formulate the policy for FGM/C in Egypt?

5. Who were the key main players in formulating FGM/C public policy in Egypt?

6. From formulating the policy to the legislation stage, how were the target audience involved in the process?

7. How would you evaluate the success of the FGM/C policy in Egypt? Why do you evaluate it that way?

8. In your point of view, how do you rate the success of the FGM/C policy and law in terms of its effect on the high prevalence rate of FGM/C in Egypt?

9. What are the social factors that you believe should have been considered during the policy process phase?

10. Would you like to give any other general recommendations to strengthen the FGM/C policy and law enforcement of the policy in Egypt?