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POVERTY, GENDER, AND YOUTH

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National Efforts toward FGM-free Villages in Egypt: The Evidence of Impact

A Summary of the Evaluation of The FGM-Free Village Project Implemented by Egypt's National Council of Childhood and Motherhood

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ABSTRACT

This report is a midterm evaluation and documentation of the process and approach of the FGM-Free Village Model implemented in Egypt. The report focuses on the impact of the intervention on communities. In a comparison of responses from women and men in intervention groups to those in nonintervention (control) villages, data analysis shows that the program has been successful in changing views and attitudes toward female genital mutilation (FGM). Respondents in both intervention and control groups reported receiving information about FGM from the media, particularly from television. More than 78 percent of women in the intervention group retained the information that FGM has negative health consequences, whereas only 30 percent of women in the control group retained the same information. Moreover, in terms of the impact of information on decisions and attitudes toward FGM, 81 percent of women in the intervention group stated that the information they had received made them re-evaluate their views concerning circumcision of girls, compared with only 17 percent of women in the control group who responded in the same way. In addition, 76 percent of women in the intervention group who received information and whose daughters were uncircumcised stated that the information convinced them not to circumcise their daughters, whereas only 19 percent of women in similar situations in the control sample had the same response. Similarly, support for the continuation of the practice varied significantly between the intervention and control groups. Only 27 percent of women in the intervention group believed that the practice of FGM should continue, while 77 percent of women in the control group believed the same. Finally, women in the intervention group were six times less likely than women in the control group to plan to circumcise their daughters (38 percent of women in intervention groups noted that they would not circumcise their daughters, compared with only 7 percent of women in the control group). FGM is an entrenched generational practice, and eradicating it in a community requires concerted effort over an extended period of time. This evaluation strongly recommends that efforts be continued by means of a sustained and protracted process. Advocacy and awareness-raising efforts that take a holistic multisectoral approach constitute best practices that must to be sustained in order to maintain their impact for future generations.

LIST OF ACRONYMS

DAG	Donor Assistance Group
DHS	Demographic and Health Survey
EDHS	Egypt Demographic and Health Survey
FGD	Focus-group Discussion
FGM	Female Genital Mutilation
ICPD	International Conference on Population and Development
NCCM	National Council for Childhood and Motherhood
NGO	Nongovernmental Organization
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women
UNVs	United Nations Volunteers

BACKGROUND AND SUMMARY

The FGM-Free Village Model is Egypt's national program designed to eradicate of the practice of female genital mutilation (FGM). Launched in 2003, the program is implemented by the National Council for Childhood and Motherhood (NCCM) in partnership with the United Nations Development Programme (UNDP) and the Donor Assistance Group (DAG). In 2008, the project evolved into a joint initiative under the Ministry of Family and Population for family empowerment, taking a holistic approach to the issue of the rights of the child. The objective of the project is to eliminate the social pressure on families to perform FGM on their daughters by fostering a sociocultural environment conducive to the abandonment of the practice through messages in the media, supportive policies, and community-based initiatives. The project was initiated in 60 villages in Upper Egypt and is currently being scaled up in another 60 villages in the rest of the country.

The FGM-Free Village Model promoted a national dialogue concerning FGM and pushed for legal and policy reforms. The advocacy efforts that were mobilized after two FGM-related deaths of young girls in the summer of 2007 were of critical importance. NCCM mobilized a campaign that eventually led to the issuance of a decree by the Ministry of Health (No. 271 in 2007) that bans the procedure FGM in all clinics and in public and private hospitals, overruling an earlier 1996 ministerial decree that allowed the procedure in hospitals in cases approved by doctors. NCCM advocacy efforts were also pivotal in the issuance of a landmark religious *fatwa* by the Grand Mufti of Egypt, which unequivocally condemned FGM. These efforts were crowned with the issuance of the Child Law in 2008, which criminalized FGM.

NCCM mobilized public declarations against the practice of FGM, in communities. Village declarations constitute a pledge and a commitment by officials and religious leaders as well as young community members to end the practice of FGM. These declarations are implemented by networks of young people and by community groups against FGM. At the time of the writing of this evaluation, eight villages had made public declarations against FGM.

This report is a midterm evaluation and documentation of the process and approach of the FGM-Free Village Model. It focuses on the community impact of the intervention.

The evaluation shows significant impact in changing views and attitudes toward FGM among respondents in the intervention groups. Comparing their responses to those of respondents in the nonintervention (control) villages shows the following results:

- Men and women in both intervention and control groups reported receiving information about FGM from the media, particularly from television. More than 78 percent of women in the intervention group retained the information that FGM has harmful health consequences, whereas only 30 percent of women in the control group retained the same information.
- Eighty-one percent of women in the intervention group stated that the information they received convinced them to re-evaluate their views about female circumcision, compared with only 17 percent of women in the control group who responded in the same way. In addition, 76 percent of women in the intervention group who received information and whose daughters were uncircumcised said that the information they had received about

FGM convinced them not to circumcise their daughters, whereas only 19 percent of women in similar situations in the control sample gave the same response.

- Support for the continuation of the practice varied significantly between the intervention and control groups. Only 27 percent of women in the intervention group believed that FGM should continue, whereas 77 percent of women in the control group believed the same.
- Twenty-five percent of women in the intervention group believed that FGM was required by their religion, whereas 59 percent of the women in the control group held similar beliefs. Additionally, women in the control sample were more likely to believe that FGM preserves girls' virginity and protects them from being unfaithful to their husbands when they marry.
- Women in the intervention group were six times less likely than women in the control group to intend to circumcise their daughters (38 percent of women in intervention groups noted that they would not circumcise their daughters, compared with 7 percent of women in the control group).

FGM is an entrenched generational problem, and eradicating the practice in a community requires concerted effort over an extended period of time. This evaluation strongly recommends that efforts be continued by means of a sustained and protracted process. Advocacy and awareness-raising efforts that take a holistic multisectoral approach constitute best practices that must be sustained in order to maintain their impact for future generations.

THE FGM-FREE MODEL PROJECT

Summary of the Project

The FGM-Free Village Model is a project implemented by the National Council for Childhood and Motherhood (NCCM) in partnership with the United Nations Development Programme (UNDP), the Donor Assistance Group (DAG), other UN agencies, Plan International, the Egyptian Task Force Against FGM, and local nongovernmental organizations (NGOs). The project was initiated in 2003 and evolved in 2008 into a joint initiative under the Ministry of Family and Population for family empowerment, taking a holistic approach to the issue of the rights of the child. At the time of the evaluation, the program was implemented in six governorates in Upper Egypt (Beni Suef, Menya, Assiut, Sohag, Qena, and Aswan) and was ready for expansion into other governorates.[1]

The FGM-Free Village Model builds on lessons learned from earlier efforts to eradicate FGM. Of particular relevance are the efforts of the Egyptian Task Force against FGM, which was formed in 1994 soon after the International Conference for Population and Development (ICPD). The task force was a civil society movement that aimed at engaging activists, professionals, policymakers, the media, and grassroots communities in a dialogue to combat FGM. A number of the task-force members have joined the operation of the FGM-Free Model in order to incorporate the earlier experience and support national efforts against the practice.

The model takes a multipronged approach that mobilizes the medical and religious communities, the media, policymakers, and social activists. The approach is designed to create an environment conducive to the initiation of dialogue, interaction, and advocacy and involves reflection on the social

and cultural factors that support FGM rather than a rote-based message approach. Because FGM cannot be abandoned solely through political commitment or legislation, efforts operate within communities to support interactive dialogue with enlightened community leaders, young people and various grassroots groups. The model adopts a sociocultural strategy that encourages critical thinking in a noncoercive, nonjudgmental way; focuses on acknowledging the human rights of the female child; and condemns the practice as harmful and as a violation of girls' human rights.

Project Objectives

The program objectives of the FGM-Free Village Model are:

(1) to enhance awareness of the rights of the female child, as defined by the Convention on the Rights of the Child, with a focus on FGM and its relevance to the well-being of girls, their empowerment, and their right to participate in decisions affecting their lives;

(2) to train local NGOs to support the NGO advocacy network, which addresses FGM locally and regionally;

(3) to create an informal network of community leaders to support advocacy activities within villages;

(4) to implement clearly defined behavioral targets and exert influence by means of a social marketing and advertising campaign;

(5) to promote best practices with local NGOs to enable and empower girls and their families to make informed and healthy choices regarding the practice of FGM;

(6) to implement community-service initiatives as incentives for mothers and families to participate in project activities;

(7) to develop an anti-FGM toolkit with adaptable elements that can be customized to meet the needs of any community;

(8) to implement monitoring and evaluation of the project's impacts within villages that document and disseminate effective methodologies to produce an FGM-Free village; and

(9) to create a replicable knowledge base of updated, reliable, and consistent information nationally and locally that supports best practices, public policy, and communications about FGM.

The project's activities include:

(1) mobilizing the public in 120 villages in Upper and Lower Egypt with the assistance of partner NGOs and young volunteers to form pressure groups that oppose FGM and that will announce their stance against the practice in a public declaration that their village will move toward abandoning FGM. NGOs organize awareness sessions and provide demand-driven services in the villages where they operate. These efforts vary from one community to the other. The list of services include, but are not limited to, sending health caravans to remote communities, providing or renovating health units and nurseries in villages, supplying public libraries and providing vocational training programs.

(2) establishing a network of young UN volunteers (UNVs) who are well trained, dedicated, and persuasive. The UNVs participate in the push to eradicate FGM by operating as field-workers in villages, schools, youth centers, and universities, and by raising awareness and promoting volunteerism.

(3) advocating the abandonment of FGM to concerned groups by raising their awareness and training them to become agents of change in their communities. These groups include members of the legal community and the medical community, media personnel, and involved ministries. The advocacy component of these groups aims to overcome the medicalization of FGM, break the media taboo, encourage behavioral change with the help of media messages, and lobby for a law that unequivocally criminalizes FGM. These advocacy efforts promoted a national dialogue concerning FGM and pushed for legal and policy reforms. The advocacy efforts that were mobilized after two FGM-related deaths of young girls in the summer of 2007 were of critical importance. NCCM mobilized a campaign that eventually led to the issuance of a decree from the Ministry of Health (No. 271 in 2007) that bans the FGM procedure in all clinics and public and private hospitals, overruling an earlier 1996 decree that allowed FGM to be performed in hospitals in cases approved by doctors. NCCM advocacy efforts were also pivotal in the issuance of a landmark religious decree (*fatwa)* by the Grand Mufti of Egypt, which unequivocally condemned FGM. These efforts were crowned with the issuance of the Child Law in 2008, which criminalized FGM.

(4) developing an integrated communications campaign with unified messages disseminated through the media, including television, radio, billboard advertising, and theater. This campaign involves the collaboration of NCCM/UNDP with UNICEF, UNFPA, UNIFEM, and Plan International.

This Midterm Evaluation

The objective of this midterm evaluation is to document and evaluate independently the impact and the process and methodology of the FGM-Free Village Model project.[2] It employs a combination of qualitative and quantitative research methodologies in addition to an extensive review of project documents, documents related to the anti-FGM movement in Egypt and the Egypt Task Force, and international literature on the topic of FGM. Fieldwork and data collection in communities were conducted in December 2006. Building on these data, interviews were conducted with professional groups, including judges, media representatives, doctors, and others throughout the summer of 2007.

The Qualitative Component

The qualitative component of the evaluation documents the processes by which the anti-FGM movement became part of the national agenda. It also documents the implementation process of the FGM-Free Village Model, including its impact and the lessons learned from the process. Focus-group discussions and interviews were conducted with the NCCM Coordinating Group, members of the Egyptian Task Force against FGM, partner NGOs, United Nations volunteers, judges and attorneys, members of the media, religious leaders, project donors, and community members in seven villages across 6 of Egypt's 26 governorates.

The selection criteria for communities included in the qualitative sample was based on a matrix developed with the NCCM Coordinating Group. The criteria included the type of NGO involved, a Christian–Muslim affiliation of villagers, the project's experience and presence in the community, the level of success of the model in the village, and geographic location. In choosing the qualitative sample, an effort was made to ensure representation of various groups, including adult women, adult men, young people aged 16–24, and girls aged 10–15. Focus-group discussions were conducted in two villages in Beni Suef and one village in each of the governorates of Menya, Assiut, Sohag, Qena, and Aswan.

The Quantitative Component[3]

The quantitative component comprised a survey of a random sample of individuals in 18 villages in six governorates of Upper Egypt (6 control sites and 12 intervention sites). A total of 3,150 individuals were interviewed: 2,100 from the intervention sites and 1,050 from the control sites. Only households with daughters aged 7–13 and at least one young adult aged 16–24 were selected for participation in the survey. The sample population included five subgroups: adult women, adult men, males aged 16–24, females aged 16–24, and girls aged 10–15. At the time of data collection, the legal age for marriage for women was 16 years. For this reason, we chose this age as a cut-off point. Data were collected in December 2006, at the midterm point of the intervention.

Five questionnaires were developed, one for each subgroup. This research instrument was designed to collect data concerning a number of social variables, including demographic and socioeconomic data, circumcision status, attitudes toward FGM, exposure to new information, self-efficacy in conveying health messages against FGM, information-seeking behavior, intention to circumcise daughters, openness in discussing FGM, religious beliefs surrounding the practice, gender roles, and reasons for the continuation of the practice.

THE FGM-FREE VILLAGE MODEL'S COMMUNITY IMPACT

The evaluation in this report builds on both qualitative and quantitative data collected as described above. The evaluation analysis focuses on change in knowledge and sources of information about FGM and change in attitudes toward the practice from approval to disapproval in intention to circumcise a daughter.

Community interventions included awareness-raising activities in the form of seminars; small group meetings among target families, young men and women, community leaders, and schools; and services to the community, primarily in education and health. Community efforts also involved mobilizing groups to create public declarations against FGM.

Similarities between Intervention and Control Sites

The evaluation employs a quasi-experimental approach, comparing intervention sites with control sites of similar characteristics in order to detect changes that can be attributed to the intervention. Intervention and control sites were chosen that had similar background characteristics so that any differences between them observed in the data can be attributed to the impact of the project. In analyzing the data concerning sociocultural and social background, we found that two of the intervention sites were predominantly Christian villages, although none of the control sites was. Because these villages differ in some background characteristics, we decided to exclude them from the analysis so as to ensure that the intervention and control villages were as similar as possible. The remaining intervention and

control villages had a comparable mix of Christians and Muslims and were similar in the following characteristics:

(1) Ever-married women's circumcision status: 99 percent of women in the intervention sites were circumcised, compared with 100 percent in the control sites. The circumcision rate of women in predominantly Christian intervention sites was much lower at 81 percent; this finding justifies their exclusion from the evaluation comparison.

(2) Ever-married women's age structure: The mean age of ever-married women in the intervention and control sites was about 39.

(3) Marital status: 91 percent of ever-married women in the intervention sites were still married, compared with 93 percent of women in the control sites; most of the remaining had been widowed.

(4) Socioeconomic status: 28 percent of ever-married women surveyed were in the lowest socioeconomic status, compared with 31 percent in control sites. Only 14 percent of ever-married women were in the lowest status in the predominantly Christian intervention sites.

(5) Practitioner of FGM: 90 percent of circumcised ever-married women in both settings were circumcised by a traditional practitioner (*daya).*

The background characteristics of girls in the 10–15 and 16–24 age groups in both the intervention and control sites were also similar in terms of education: the majority of girls aged 10–15 attended school (about 93 percent). Girls aged 16–24 also shared some similarities related to drop-out rates and nonattendance; fewer than 20 percent of girls in both the intervention and control groups had received no schooling or had dropped out of school before completing primary level. Also, very few girls in the two age groups and in both the intervention and control groups were wage earners.

Circumcision rates among girls in the 10–15 and 16–24 age groups in both the intervention and control sites were not similar. In the younger age group, the circumcision rate was 84 percent and 77 percent in the control and intervention villages, respectively. This finding can be attributed to the impact of the intervention. In the older age group (16–24), the circumcision rate was higher at 96 percent for both category of village.

The Project's Impact on Information about and Knowledge of FGM

In order to create a sociocultural environment that is conducive for the abandonment of FGM, parents must believe that their community does not support the practice. Below, we analyze individuals' perceptions about the views of opinion makers and other leaders in their communities. **Error! Reference source not found.** Table 2 compares the perceptions of women, men, young men, young women, and girls on the extent of FGM in their communities. It shows that in control sites, respondents from all age groups were more inclined to believe in the universality of FGM in their communities than were those in the intervention group. More than 92 percent of women in the control sites agreed with the statement that all people in their communities circumcise their daughters, compared with 45 percent of women in the intervention group. Similarly, the views of young and old men, young and old women, and girls varied widely between the control and intervention sites. For example, young women in the control sample were two times more likely than those in the intervention sample to believe in the

universality of FGM in their communities (86 percent, compared with 40 percent, respectively). Among younger girls, 89 percent in the control sites believed in the universality of the practice in their communities, versus 39 percent who held this belief in the intervention sites. This finding suggests that the interventions had shaken long-held beliefs in the universality of FGM in these communities, which is an important step in changing attitudes and behaviors toward FGM generally because it facilitates the creation of a sociocultural environment conducive to the abandonment of the practice.

Similarly, when we asked respondents about their perceptions of the views of important opinion makers concerning FGM, a significant difference was found between those of the two sample groups.

As Table 3 shows, respondents in the intervention sites were less inclined to believe that teachers, doctors, religious leaders, community leaders, and influential families in the community approved of FGM. In control sites, more informants believed that teachers and influential families were supportive of FGM. Surprisingly, more informants believed that teachers approved of the practice than that religious leaders did. Similarly, among the intervention group, most informants regarded teachers as one of the groups that favored the practice. The data in this table highlight the important role that teachers play in building consensus about FGM.

The data reveal an interesting finding regarding the views of local Muslim preachers *(imams)*. In the intervention communities, a significantly smaller proportion of women believed in the support of imams for FGM, compared with those surveyed in the control sites (33 percent versus 90 percent, respectively). This finding highlights the impact of the program in changing attitudes about the support of local religious leaders for FGM in the intervention sites. The differences between intervention and control sites in this regard are much smaller among husbands and young men than among married women and young women, however, an observation that underscores the need to intensify educational efforts among men.

A central focus of the intervention is to raise awareness about the harmful nature of female circumcision. We asked respondents about their immediate circle of family and neighbors and if they knew of cases of girls who had suffered complications from FGM; if they knew of girls who had died because of FGM; and if they knew of girls who had avoided FGM until marriage. Replies to these questions varied significantly between the intervention and control sites, as Table 4 reveals. Individuals in the intervention group were more knowledgeable about cases of complications and deaths due to circumcision.[4] Interestingly, the young women in intervention sites were the group most aware of the existence of uncircumcised girls who were married (23 percent in the intervention group, compared with 7 percent in the control group). Adult married women in both control and intervention groups were the least aware of such cases.

Sources of Information about FGM

As shown above, the knowledge of the harmful effects of FGM were not exclusively available to the intervention group. Analysis shows that television is a major source of information about the negative consequences of FGM for all groups. The particular emphasis on television as an information source was stronger in control than in information groups, because the intervention group had sources of information other than television, such as seminars and group meetings. Among women in the control group, more than 77 percent received information about FGM through television. Young men and women had even higher exposure to television messages; more than 81 percent of young men and women received information about FGM from television, as indicated in Table 5.

For the intervention group, the importance of other sources of information varied according to the age and sex of its members. For women and girls in both age groups, seminars and home visits ranked second and third as the main sources of information (after television). Relatives also played an important role for women as a source of information. For men in both age groups, seminars and newspapers were the second and third most frequently mentioned sources.

Types of Information Received about FGM and Their Impact

All groups emphasized the health complications of FGM as the message they remembered best concerning the practice of FGM. Young women in the intervention group were the group most aware of the negative psychological effects of FGM, followed by older married women (51 percent, and 43 percent respectively), as shown in Table 6. Older men in both the intervention and control samples were the group most interested in the religious argument concerning FGM, followed by young women and young men (40 percent, 38 percent, and 33 percent, respectively).

We asked those who received information about FGM about their reaction to such information. In the intervention group, women who received information about FGM in the three age groups were more likely to say that the information influenced them and made them re-evaluate the necessity of FGM. The Table 7 shows that men were less inclined to re-evaluate their stance. In the intervention group only 51 percent of men, in contrast to 81 percent of women, were ready to reconsider the practice of FGM as a result of information they had received.

Table 7 presents three degrees of conviction: the first pertains to a re-evaluation of a person's stance concerning FGM, the second pertains to the contemplation stage, and the third to the decision not to circumcise. The table shows that although the information they had received encouraged people to reassess the value of FGM, greater effort is needed to help them to decide against circumcision.

The Impact of the Intervention on the Openness of Discussing FGM

As is the case in many Middle Eastern and North African societies, sexuality is not a subject that is discussed publicly. FGM has been a taboo topic in Egyptian society for a long time. It has always been a private matter. The evaluation study results show that the taboo is lessening significantly, especially in recent years. Today, anti-FGM messages are repeatedly presented in the media, and people are becoming more willing to discuss the practice openly.

Table 8 demonstrates that a minority of respondents from all groups were unwilling to talk about FGM. These results were consistent for the control and intervention groups, revealing the change in attitude is not only the result of local efforts within specific communities but is also a response to the national media campaign. The table shows the current level of openness among young people concerning discussion of FGM. As expected, young men are clearly more comfortable than young women about discussing the practice. The table also shows, however, that women in the intervention group were more open to the idea of attending meetings about FGM, compared with women in the control group.

The table indicates that doctors can be effective conduits for messages opposing FGM, because most respondents (up to 88 percent of young men in the intervention sites) were willing to listen to doctors discuss the practice.

The table includes data collected before the onset of an intensive media campaign that followed the deaths from complications of FGM of two young girls in Upper Egypt. The issue of FGM was

widely discussed as a result of this campaign. For example, the newspaper Al-Masry Al-Youm posted a polling page on its website in August 2007 at which 23,000 people participated. This response reflects widespread interest and openness to discussing the issue. Polling results showed that 50 percent of respondents opposed a ban on FGM, 45 percent were in favor of a ban, and 5 percent were not interested. The results show the necessity of presenting more anti-FGM efforts through varied channels of communication designed to address different segments of the population.

The Impact of the Intervention on Attitudes toward FGM

In Table 9, the data show that women are more receptive than men to messages opposing FGM and that their views are more supportive of efforts seeking abandonment of the practice. For example, although 25 percent of women in the intervention sample believed that FGM is required by religion, more than 50 percent of men in the intervention group believed the same. Moreover, a significant proportion of men in the intervention group supported the notion that men prefer to marry circumcised women. More than half the men in the intervention group noted that they would feel guilty if they did not circumcise their daughters. More men in control sites believed the same (71 percent, compared with 54 percent in intervention group), indicating, again, that men are an important group to reach in the struggle to end FGM.

In both sites, younger men are found to be more amenable to change. They were less likely than older men to believe that FGM should continue. They were also less likely than older men to believe that FGM is required by religion or that the practice is necessary to ensure women's chastity and fidelity. Younger men also showed less interest in marrying circumcised women. Significantly, younger men were unanimously unconcerned about the influence of gossips if their daughters were not married.

We also asked respondents their opinion about whether FGM is an important practice that should continue. Analysis shows that women and girls in the three age groups in the intervention sample were more inclined to believe that FGM is not necessary. We asked respondents explicit questions regarding what they believed about FGM. Table 10 shows a clear difference between the views of the intervention group and those of the control group; more women in the latter group than in the former group believed in the importance of the practice. A particularly dramatic difference is seen between the views of young women aged 16–24 in the intervention and control sites about the necessity of retaining the practice. Those aged 16–24 in the control sites were three times more likely than those of the same age in the intervention group to believe that FGM was very important.

The percentage of males (young and old) in the intervention group who noted that FGM was unnecessary was double that of the control group. The data show, however, that men require more targeted attention from anti-FGM interventions.

These results are confirmed by qualitative fieldwork. In focus-group discussions, women were more inclined to believe that FGM is unnecessary, whereas men were more supportive of the practice. In a focus-group discussion with women in the governorate of Beni Suef, a woman stated:

> This is ignorance [about FGM]. A girl is well behaved if she is well brought up [without need for circumcision].
>
> They try to protect a girl's honor by cutting this part of her body to ensure that she will always remember the pain, but this is unfair and she will be frightened for the rest of her life.

The same opinions were repeated in the governorates of Menya and Assiut:

> This is ignorance; all women have problems because of circumcision. (FGD Menya)
>
> It is enough that a piece of the body is cut. (FGD, Assiut)

To illustrate the difference of opinion between men and women, in the focus-group discussion with men in the same community, three men remarked:

> Circumcision is a must; we must all circumcise [our daughters].
>
> I declare that we are for circumcision; a girl who is not circumcised might as well walk around in the village naked.
>
> If a girl is not circumcised, she will have strong sexual urges that she cannot control.

The above quotes show the connection in the men's minds between circumcision and behavioral propriety for women. Some of those in favor of the practice associated the anti-FGM campaign with Western conspiracy and international politics, remarking:

> This is a Western conspiracy to distract us from what is happening [with the war) in Iraq. (FGD, men in Sohag)

Moreover, as the quantitative data show, not all women are convinced that FGM is harmful. In some focus-group discussions, some women supported, the practice:

> [We do it] so that the girl is clean and chaste and she can have a future with her husband.
>
> We do it for cleanliness, and for the girl not to be [morally] loose. Nothing [wrong] will happen if this part is taken. (FGDm women in Qena)

Data from the field show the strong role of local religious leaders in presenting conflicting messages about FGM. As was shown above, quantitative data reveal that community members, particularly in the control villages, believe that mosque preachers support the practice. A young woman in a focus-group discussion in Qena notes:

> Some sheikhs came to the seminars. They didn't say haram [forbidden] and they didn't say halal [legitimate]. (FGD, young women in Qena)

These focus-group discussions took place before the issuance of a *fatwa* in the summer of 2007 that declared FGM as prohibited in Islam.

The campaign against FGM confronts many challenges. Even when the religious and medical arguments are refuted, parents continue to worry about the necessity of circumcising their daughters, as the following quote from the women's focus-group discussion in Sohag illustrates:

> Both my husband and I are religiously and medically convinced that FGM is wrong. However, we are still worried about the girls because we didn't circumcise them.

The Impact of the Intervention on Girls' Circumcision Status and the Intention to Circumcise

Our analysis shows that girls aged 10–15 in the intervention group were less likely than those in the control group to be circumcised (see Table 11). Among all six governorates in the study, data shows an 8 percentage-point difference in the likelihood of circumcision between the intervention and control groups. Although we must be cautious in interpreting these figures because younger respondents might

have been circumcised after the time of the survey, the difference between the two groups reflects the impact of the intervention.

The data reveal no differences in the circumcision rates of young women aged 16–24 between the intervention and control sites. This outcome is expected because the three-year intervention could not have affected these older girls.

We asked mothers to provide information about the individuals who performed the circumcision of their daughters. Their responses confirm the growing medicalization of the practice, first detected by the 2005 DHS, which reported that more than 65 percent of circumcised girls in rural areas had been circumcised by doctors. Table 12 compares data about the providers who circumcised mothers and their daughters and highlights the generational differences concerning which providers performed the procedure. Although 90 percent of mothers in both the control and intervention sites had been circumcised by *dayas* (midwives), more than 42 percent of their daughters in both groups were circumcised by doctors. These results correspond with data from the 2005 Egypt Demographic and Health Survey, which shows that 68 percent of circumcisions were performed by doctors (Zanaty and Way 2006).

Qualitative research further explains this trend toward the medicalization of FGM. A woman in Sohag stated:

> The doctor is better than the daya because his tools are sterilized, he uses anesthesia, and he can save the girl if she starts hemorrhaging.

This statement, from a villager in Upper Egypt, reflects an unintended consequence of the health-related messages opposing FGM. Activists opposing FGM on the community level have long stressed the dangers of employing a daya for performing circumcision because doing so often leads to as a infection as a result of a septic procedure. Consequently, villagers have begun to rely upon to medical practitioners. The focus on the health outcomes distorted the message, shifting FGM to became a medical procedure.

We asked parents of uncircumcised girls as well as young men and women (as future parents) whether they intend to circumcise their daughters. Table 13 shows the differences in intentions between the control and intervention groups. Women in the intervention group were more than six times less likely than women in the control group to circumcise their daughters. The responses from this group reveal, however, that a great deal of ambivalence about the practice, remains; a significant proportion of women stated that they did not know their future intentions. Responses from young unmarried women show that those in the intervention group were three times less likely than those in the control sample to circumcise their daughters. Similarly, the table shows that men in the intervention group were less likely than men in the control group to circumcise their daughters. Data for young men were comparable to those for older men.

Reasons for Intending to Circumcise Daughters

Data concerning respondents' reasons for intending to circumcise their daughters reveal the areas that the intervention will need to target in the future. The three reasons women mentioned most frequently were respect for customs and traditions, beautification, and the necessity of decreasing women's sexual desire and preserving their virginity (see Table 14). Although the majority of men also highlighted customs and traditions, many were inclined to consider their religious beliefs as a reason for circumcising their daughters.

Those who were receptive to the messages opposing FGM and who had decided not to circumcise their daughters were asked about their reasons for that decision. Table 15 shows the polarization of men's and women's rationale. For women, the decision not to circumcise is primarily based on not wanting to inflict pain and cause health complications for their daughters. Although this reason is mentioned among men's responses, they gave other reasons as well. Among their additional reasons are that FGM is not required by religion (their second most important reason) and to ensure sexual pleasure for both male and female partners. The religious argument was most important for young men. For young women, as for their mothers, the desire to avoid inflicting pain and the worry about girls' health complications from FGM convinced them not to circumcise their daughters. The lack of religious requirement was also important for young women and for their mothers. For young men and women, the notion that FGM is an old custom was highlighted as an important reason not to circumcise daughters. This response is expected because young people tend to question custom and tradition. This group should receive a clear message that FGM is a custom that is not required by their religion.

Committed Community Groups Opposing FGM

Below, we examine the impact of the project on various groups committed to the fight against FGM. Data are based on interviews with doctors, youth volunteers, religious leaders, and NGO activists. The focus on this group is essential to understand paths for success in interventions against FGM.

The formation of community support groups is essential for the implementation of the project. This finding is consistent among all communities included in the intervention. Group members could choose to include the local NGO working with NCCM, village officials, influential members from large families, and members of youth centers. The composition of the groups varies among communities. These groups are responsible for the community workplan and for the project's activities. Project implementation of Benban is an example of effective coordination between a local NGO and a community group. NGO provided girls in the community with effective training in communication to help them confront opposition. Another successful example is the effect in Kom Gharib village in Sohag, where a declaration against FGM has been signed. The team there consists of nine young Muslim and Christian women. With support from the local NGO, project activities include setting up a vocational center, day-care center, and a community school, and providing microcredit and awareness-raising classes. Support groups are an essential component for ensuring the sustainability of the project and a process of change within these communities. Successful support groups address a range of development issues and community problems.

Doctors are influential members of their communities, and interviews with doctors show their dedication and commitment to the effort to end FGM. As we note in the national impact analysis, the program trained doctors and mobilized the Declaration of Doctors in Aswan against FGM in December 2006. Medical students are another important target group. Interviews with community doctors show that their influence is significant because people are receptive to their explanations concerning the harmful consequences of FGM. Unfortunately, the procedure is a source of income for some doctors, which limits their support in efforts to eradicate FGM. In an interview, one doctor highlighted the impact of the media in supporting doctors in their fight against FGM. For instance, she explained that she uses an article on the Benban Village Declaration to talk with families about the dangers of FGM. She uses other arguments in order to challenge myths associating FGM with girl's chastity. The same doctor highlighted the challenges posited by the religious discourse. She states that greater effort is needed to gain the support of local religious leaders, teachers of religion in schools, and religious

programs in the media. She notes that the film "*Asrar El Banat*," which depicts an uncircumcised unmarried girl becoming pregnant and then being circumcised by a religious doctor, gives a strong negative message associating FGM with chastity.

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

Another doctor interviewed in Qena noted that he is known in the community as "the doctor against FGM." This doctor, a gynecologist, noted that when women face complications during pregnancy, he is careful to explain to them if the types of complications they are experiencing are caused by FGM. He also emphasized the financial incentives that doctors have for performing FGM, making the point that doctors have limited salaries and that many complement their meager incomes by performing the procedure.[5]

UN Youth Volunteers (UNVs) are an important link to the community, as mentioned above. The project relies on UNVs to spread anti-FGM messages throughout targeted communities. UNVs receive training about FGM and about how to communicate messages opposing the practice. Interviews with UNVs show that the medical, religious, and psychological health information they received helped them to develop a stance against FGM and a desire to combat the practice. UNVs are responsible for targeting young people and presenting them with information about the dangers of FGM. Among the UNVs interviewed, one was a teacher. Through relations and rapport established with the administration of a number of schools in his governorate, he managed to arrange several seminars about the harmful consequences of FGM in these schools. UNVs hold meetings with school administrators, teachers, parents, and students. They also provide school libraries with publications about FGM. In interviews, they note that despite the resistance of certain individuals, in every school a group of students can be found that supports the eradication of FGM.

Apart from schools, UNVs participate in summer camps organized by the National Council for Youth. These summer camps are well attended by university students. The students participate in seminars and also engage in individual counseling. In interviews, UNVs remark upon the volume of questions they are asked by campers eager to know about FGM. Female UNVs also talk with young girls and newly married girls to convince them not to circumcise their future daughters.

Muslim and Christian religious leaders are important links in the effort to end FGM. Sheikhs and priests opposing the practice participate in community seminars and answer queries about FGM. In the national analysis, we highlight changes that are occurring in the religious discourse on FGM.

In a discussion with a Christian religious leader, he described how he was opposed to FGM before the project began but had no venue or opportunity to talk to people about it or discuss the topic openly. He pointed out that the Church had already taken a clear stance against FGM and instructs people to avoid it. The task of this group of religious leaders is to influence people in the community to abandon the practice. Although the message against FGM from a Christian perspective is clear, Christians who continue to practice FGM must be convinced that it is harmful. In Benban, daily church meetings that tackle the issue separately for different groups (young women, older women, and young men) have been instrumental in disseminating the message. In Menya, a priest noted that he had had to

threaten a man with excommunication if he chose to circumcise his daughter. Interviews show that older people in this group are usually resistant to messages opposing FGM.

For Muslim religious leaders, the task is much more complex. In village communities, Muslim religious leaders opposing FGM face accusations that they are seeking financial benefits by supporting anti-FGM views. They are also accused by fundamentalist groups of backing the government at the expense of giving honest religious advice. These allegations make open support of messages to abandon FGM difficult for this group.

Seminars related to the negative health consequences of FGM were useful in convincing religious leaders and in supporting them with arguments against the practice. One such conference, held in Alexandria in 2002, covered topics of maternal and rural health as well as FGM. In Sohag, the Upper Egypt Association gathered 35 official imams from Tama, Tahta, and Maragha Markaz and presented them with various arguments against the practice (particularly from the medical perspective) and sought to convince them to preach against it.

A Muslim religious leader in Sohag was a member of the health caravan and was able to provide the religious point of view opposing FGM. This same man was already convinced of the harms of FGM before the intervention. The FGM-Free Village Model allowed him the opportunity to talk to people about his conviction. In speaking publicly, he highlights the evidence supporting the religious argument against FGM and points out that those supporting the practice do not have strong evidence of its benefits. He also states his conviction that married couples should enjoy a healthy sex life and that FGM hinders that possibility.

In interviews, religious leaders suggested intensifying efforts in already-targeted villages, especially through home visits, by focusing on a media campaign and by increasing the number of seminars on the topic presented for religious men.

NGO activists are important in the effort to end FMG. According to in-depth interviews, some NGO activists were not opposed to FGM until they were presented with religious and medical information during various project trainings and seminars that convinced them to change their stance. Activists face strong local resistance in several communities. An activist from Assiut recounted how he would received abuse from people who accused him of wanting to corrupt their girls. He added that the situation has improved with villagers' exposure to a television advertising campaign and to FGM information seminars. Interestingly, he noted that individuals from Saudi Arabia are a unique group of supporters in the fight against FGM in the communities where they live. They point out that FGM is not practiced in Saudi Arabia, a country respected for its religious role in the Muslim world.

In a focus-group discussion with local NGOs in the FGM-Free Village Model project, participants highlighted the role of the needs-assessment stage in helping them understand the real problems that people face in their everyday lives. In addition, the needs assessment helped to gain the trust of community members through direct contact and networking with influential local leaders. The project encouraged organizations to identify and address other needs in the community. Through this process, NGOs gained new experiences in formulating alternative entry points for interventions in each village. The project allowed NGOs to undertake activities in villages where they had not previously worked. According to the NGOs, the project allowed them to expand their own areas of work. Moreover, networking activities allowed NGOs to broaden their knowledge about other organizations, especially about those working in the same field. NGO focus-group members said that working under the umbrella of NCCM rendered them credible and legitimate as civil society organizations working in partnership with a government entity. One aspect highlighted by NGOs was that the project did not

allow for the disbursement of monetary incentives to community members and participants, which gave credibility to the FGM-Free Village Model intervention.

Discussions also showed that individual NGO team members gained new skills in communicating and negotiating with community leaders as a result of the project. NGO members said that they became better informed about the negative consequences of FGM and became knowledgeable about the medical and religious arguments concerning the issue.

Data show that the *omda* (mayor) and the sheikh el-Balad are two prominent figures in village communities. Two factors are essential for these officials to be effective in the fight against FGM: the level of support and respect that community members give to these figures and these officials' open declaration of their position against FGM. In the case of Benban, for example, the signing of the anti-FGM declaration presented, an opportunity for the whole village to learn about their community leaders' clear stance against FGM

VILLAGE DECLARATIONS AGAINST FGM

A village's declaration against FGM is a momentous event, celebrated and remembered by most village members. The event demonstrates the existence and effectiveness of pressure groups that favor abandonment of the practice. It also shows the support of influential community members who are willing to oppose FGM. Public declarations help alter long-standing beliefs in the universality and inevitability of the practice. Moreover, the declaration ceremony itself gives strong visibility to local efforts to combat FGM. It legitimizes the role of the local NGO in its efforts to end the practice through the endorsement of community leaders.

A village declaration does not represent an end to program interventions, but it is a milestone in the creation of an environment conducive to the eradication of FGM. Our analysis shows that the decision to circumcise is greatly affected by the views of individuals or groups outside of local society. Declarations make villagers aware that opinion makers in their communities, including officials, doctors, and religious leaders, are opposed to FGM. Moreover, a visit from officials of the sort who attend these declarations is an important event for a village. Before the ceremony, banners are hung throughout the village to welcome the guests. A large crowd convenes, including men and women who have been affected by the intervention and many others from neighboring villages who are curious to see the visiting officials and curious to learn the nature of the declaration. During declarations, community leaders openly announce their views concerning FGM and denounce the practice. In the declaration attended by a member of the research team, the event included performances by young girls from the village depicting the harms of FGM. The songs and music made it a special night to be remembered by villagers.

The Path to Village Declarations

Village declarations are the outcome of years of concerted effort by program staff, community leaders, NGO staff, official and religious leaders, women activists, youth networks, and political leaders in the governorates. The project's technical unit provides training about FGM for the NGO project teams and coordinators, local community members, officials, religious leaders, and youth volunteers. These training activities pave the way for further anti-FGM advocacy and awareness-raising efforts by those who have received training. Awareness activities include seminars in youth clubs, mosques, churches, and homes of community leaders, and home visits to families with daughters at risk of circumcision.

Gradually, these efforts help create core groups of anti-FGM advocates in the targeted villages, including community leaders and families who are ready to declare publicly their commitment to abandon FGM and to take a stand against those who want to perpetuate the practice. Committed project coordinators working with local NGOs are important to the in building of these core groups. In Benban, for example, the personal commitment and dedication of the project coordinator helped to gain the trust and respect of the community and reinforced the project's anti-FGM messages and credibility.

Declarations are usually organized in the form of a public ceremony attended by NCCM's Secretary General, the media, and local, religious, and women leaders, NGO representatives, representatives of international organizations, and young villagers of both sexes. The declaration is signed by community members and leaders at the end of the ceremony, making it an official document that the village can be proud of.

Declarations have a great impact on groups that were not reached directly by program activities. Those who are present at a declaration ceremony because they are curious receive, first-hand, views opposing FGM, perhaps for the first time. The setting and the official endorsement of these views constitute a perfect occasion for increasing the project's visibility and for deepening its impact. In Sohag, one community member from Kom Gharib commented:

> I learned about this more on the day of the declaration.

Recent declarations received extensive media coverage. Families spoke openly on national television against the practice. Individuals called for action against FGM service providers and traditional practitioners.

A Focus on the Village of Benban

The experience of the FGM-Free Village Model in the Benban village in the governorate of Aswan is a major success story. The project was received with tremendous support by community members. Twenty community leaders, including religious, political, and women leaders together with a group of youth activists signed a public declaration that calls for preventing the practice of FGM in Abou Shawareb hamlet in Benban village of Aswan governorate. The declaration ceremony was held on 22 June 2005 and was attended by the NCCM Secretary General, the Governor of Aswan, community leaders, media personnel, UN representatives, donors, and members of the project's steering committee.

This event resulted in increased support for the project from the Governor of Aswan. At the event, he issued a decree banning the services of doctors who perform FGM and subjecting them to legal interrogation.

Fieldwork and focus-group discussions conducted in Benban confirm that it is one of the most successful villages of the intervention sites in terms of the impact the project has had on residents' expressed perceptions and positions opposing FGM. Data from the field show that the villagers' knowledge and information about the practice were gleaned primarily through the intervention. In focus-group discussions with married women, participants were outspoken against the practice. The information they had assimilated was uniform across all groups. One participant commented:

> Circumcision causes hemorrhaging and death. There is a story we all know of a girl who became paralyzed after she was circumcised. We also heard of a girl who died from it in a village nearby.

Other reasons participants gave for opposing the practice include its effect on women's sexual relations with their husbands.

> Circumcision also causes a lot of problems between a woman and her husband, and there are a lot of divorces because of it.

Women in focus-group discussions also mentioned that they had access to the project's publications. One woman who is unable to read stated:

> My sons would read [the publications] to me and tell me, "Mother, do not circumcise."

The project and the declarations have facilitated the trickling down of knowledge about the harmful effects of FGM to a variety of groups in the village.

Focus-group discussions with men in Benban show that their perceptions of the views of opinion makers concerning FGM are positive. One man noted that "at present more than 90 percent of the village members are against FGM, and the remaining undecided 10 percent are older men and women." Although these statistics cannot be verified quantitatively, they show that a common perception exists of the universal abandonment of the practice in the village. As noted above, this perception is essential for the sociocultural approach to ending FGM.

The Role of the NGO

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

The NGO responsible for Benban is the Egyptian Association for Community Development Initiatives. The community support group was comprised of a team of 12 local field-workers selected by the local NGO in Aswan. The NGO added two individuals for the project team to support village activities in the village and provide project oversight.

The project's success in Benban shows that each village has a unique character that requires a different approach. In Benban, the entry strategy was announcing prizes for papers written about FGM. This competition succeeded in drawing the villagers' attention to the issue.

The project coordinator, an active and committed woman, has been closely involved in all aspects of the project's activities. Circumcised at the age of seven, the coordinator later researched the issue and learned that the procedure was not a religious requirement. She decided to dedicate her energy to saving her daughter and other village girls from the suffering that she had endured.

Activities in Benban started with small group meetings in which women voiced their understanding of FGM and asked all of the questions they did not feel comfortable about asking at larger seminars. Later, group meetings for men were also organized. These were attended by a doctor and a religious leader at the mosque or church. Discussions with NGO staff revealed that most women were unable, at first, speak about their decision not to circumcise their daughters. One strategy these women used was to pretend to take their daughter to another village for the procedure. After the village declaration, however, they felt supported by the larger community.

Another aspect of Benban's success was the support of community leaders for the effort to end FGM and their involvement in the project. Discussions with NGO staff reveal that community leaders interacted with and responded to people they trust and respect. They also attended meetings and seminars.

The lesson that can be drawn from Benban's example is the importance to the effort of a strong NGO and committed community groups.

The Role of Community and Religious Leaders

The success of the Benban declaration reflects a unequivocal degree of commitment among community leaders and families who decided to abandon the practice of FGM and among the many women who were willing to speak publicly about their bitter experience of the practice and take a stand against those who wish to perpetuate it. The declaration event was publicized in neighboring communities, emphasizing FGM as a key issue of child rights.

Comments of focus-group participants indicate that the support of influential people was essential to the effort to abandon FGM. They stated:

Our mayor is against FGM.

Our doctors stopped circumcising.

The collaboration between the priest and the sheikh serving the village produced a unique situation that is reminiscent of Egypt's 1919 revolution. Benban exhibits an unusual degree of religious harmony, which allowed for a united message opposing FGM from all religious leaders. The Coptic Orthodox priest, Father Mousa, and the Muslim religious leader, Sheikh Khairallah feel that Benban's example should be replicated to bring communities together for the good of all. Both men have denounced the practice of FGM from their pulpits.

Stories from the Field

Amal is a 38-year-old mother of three girls who supported FGM before the project was implemented. She feared that village people would criticize her if she abandoned the practice and that her husband and family would not understand her questioning of this custom. She also refused to discuss the issue openly because she felt that it was a private matter. The FGM study coordinator approached her with information, gave her an opportunity to air her views, and presented her with brochures about adolescence, sexuality, and other topics relevant to her daughters' health. Amal then asked the coordinator to convince her husband to attend seminars and after doing so, the couple decided to consult local leaders about their opinions concerning FGM. Luckily, the doctors and sheikhs they consulted advised them to renounce the practice and to ignore peer pressure and gossip. Amal and her husband approached their families and are slowly attempting to convince them that FGM is harmful. Amal feels that the project is helping to change the views of many people and that FGM is gradually be eradicated.

Hanan is a 23-year-old mother of three who strongly supported the practice of FGM during the initial stage of the project. She intended to circumcise her daughters despite having suffered from the procedure herself. Her parents led her believe that the procedure confers many benefits, and she ignored all warnings from doctors that FGM is harmful. She talked with her husband, who thought that FGM is unnecessary. The couple sought advice from the sheikh who also advised them that FGM is not required by religion. Hanan attended seminars with the coordinator, which helped her to convince her extended family and neighbors of the harmful consequences of FGM. She is grateful to the project staff that she was able to learn about and save her daughters from the perils of FGM.

Mervat is the mother of one daughter and two sons. She insisted that her daughter be circumcised and, as a result, the daughter hemorrhaged severely and is still fearful of marriage and sexual contact. After receiving the project's messages, Mervat was convinced that FGM is harmful and without potential benefit. When her neighbor decided to circumcise her daughter, Mervat attempted to dissuade her and brought the project coordinator to talk with her to save the daughter from danger. Although her arguments did not convince her neighbor, she was more successful with her brother who had intended to circumcise his daughter. Mervat informed him about the dangers of FGM and gave him the books distributed by the project. He changed his mind. Mervat feels that the project was important for her community's well-being, particularly because of the social services it provided such as microcredit and its introduction of water and sewage services to houses.

Hoda is 22 years old and the mother of three girls. She circumcised one of her daughters, who consequently suffered chronic infections and pain. The project coordinator spoke with her about the long-term dangers resulting from FGM and gave her books and brochures that convinced her to change her attitude. She has become an advocate against FGM, speaking with her neighbors to dissuade them from circumcising their daughters.

Mona is 20 years old and unmarried. She recalls how she was circumcised at age 13 with 11 of her family members present. She bled heavily after the procedure and was hospitalized for a month to recover. As a result, she fears marriage and childbearing. She is certain that she will not have any future daughter circumcised. With the support of project doctors and staff, she encourages her colleagues and neighbors to attend seminars and meetings to be aware of the harmful consequences of FGM in the hope of saving other girls from undergoing the procedure.

CHALLENGES AND OPPORTUNITIES

The analysis presented here highlights a number of key opportunities and challenges for community interventions against FGM. One key finding is the impact of the media. Villagers' widespread ownership of television sets presents a major opportunity to disseminate anti-FGM messages to a large population. Media messages must be carefully crafted, however. Because of the association in the public's mind between FGM and chastity, information invalidating this link must be emphasized in the media. Men and women who support the tradition specifically mention girls' cleanliness and chastity as important reasons to continue circumcising their daughters. Another issue for women who wish to perpetuate FGM is their respect for traditions. The media messages can address this issue with the simple message that customs and traditions must be evaluated critically rather than taken for granted.

Opposition to FGM must formulated as part of the human-rights framework and as a matter of female children's bodily integrity. It must be embedded within the framework of girls' rights together with education, play, and nourishment. The focus on the harmful physical consequences of FGM must be qualified so that it does not lead, as it has in the past, to an increase in the medicalization of the practice. This focus also discredits interventions against FGM when women who experienced the procedure state that they did not suffer the symptoms described by those opposed to the practice. The anti-FGM message should emphasize that the procedure is an unnecessary and harmful tradition without religious backing that constitutes a violation of the female child. Similarly, the focus on sexual dysfunction as a result of FGM must be qualified. Data show that this line of argument had two unintended repercussions. The impact of FGM differs among individual women according to the severity of the procedure. Therefore, not all women who are subjected to FGM have this problem.

Second, the argument can produce a sort of backlash if members of the community are led to believe that FGM can protect girls' virtue if it results in their being uninterested in sexual relationships. Messages concerning FGM should incorporate some sexuality education. In focus-group discussions, participants revealed misconceptions about the female genitalia, and what would happen if a girl were not circumcised. Target groups for physiological information are not only women and girls. Men, young and adult, also must learn that females' sexual desire is not localized in their reproductive system.

The analysis also shows that greater efforts should be made to provide men with information about the effect of FGM. Data show that men are the group that is least receptive to messages opposing FGM. Data also show that men are primarily concerned with religious arguments concerning FGM, as are young people of both sexes. If through sustained efforts and media messages men learn that FGM is not required by Islam, they may become more receptive to messages opposing the practice. A lack of support from local religious leaders poses a great challenge to interventions against the practice. Greater effort is required to provide training for this group.

The analysis of the success of the project in Benban shows the important role of strong and committed NGOs in mobilizing communities against FGM. Organizations that have formed solid relationships with communities and a list of successful developmental activities are shown to have a strong positive impact. These provide entry points for interventions against FGM and deepen the influence of awareness-raising efforts. Similarly, organizations that are run by successful, influential, and respected community leaders showed a notable level of program effectiveness. Young people and UNVs are other important links to the community. Their roles should be reinforced by recruiting additional young people in the effort to end FGM.

Raising awareness of the deleterious consequences of FGM should be combined with the provision of counseling services for women who have undergone the procedure and for their husbands. The intervention's efforts to date have led many people to associate problems within marital sexual relationships to FGM. The intervention has not offered them ways of dealing with the consequences of FGM, however. Counseling should be provided for these women, particularly with regard to marital problems and unfulfilling sexual relationships.

NOTES

1 The project was implemented with support from the European Union; the Italian Debt for Development Swap; the governments of Canada, Denmark, Finland, Netherlands, and Switzerland; USAID; UNDP; UNIFEM; and UNFPA, with matching funds from Plan International and UNICEF. The total project budget was US$5,835,088.

2 This document focuses on community-level findings. For a detailed description of the program and its impact, see Barsoum et al. (2010).

3 This component was designed by Ragui Assaad, Regional Director of the Population Council in West Asia and North Africa at the time of the study, in collaboration with Omaima El Gibaly.

4 Data were collected before the deaths of two girls who were circumcised in the summer of 2007. The control sites were, therefore, less aware of such cases. In light of the wide media coverage of these two deaths, the difference in such awareness between intervention and control communities likely declined considerably.

5 This interview was conducted before the enactment of the Ministry of Health's decree in 2007 banning doctors from performing FGM (Decree No. 271), and prior to the criminalization of FGM in 2008.

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Table 1 Intervention and control villages, by governorate, quantitative component of FGM-Free Village Program, Egypt, 2006

Governorate	Intervention sites		Control sites
Beni Suef	El-Shokr	Bani-Bekheit	El-Sheikh Haroun Tezment El-Gharbia
Menya	Tall'a	Abukorkas Elbalad	El-Hawarta
Assiut	Abnoub El-Hammam	Bani Zeid-Bouk	Bani-Ibrahim
Sohag	El-Kheyam	Banweit	Nagaa' Taye'e
Qena	El-Marees	Awlad Negm Bahgroua Nage' Kombol	El-Samayna
Aswan	El-Sa'ayda Kebly	Elkhatara	Wady Abbady

Table 2 Percentage distribution of respondents, by survey-sample subgroup, according to their perceptions concerning the extent of female genital mutilation (circumcision) practiced in their communities, Egypt, 2006

Perception of community practice	Women		Men		Young men		Young women (16–24)		Girls (10–15)	
	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village
All practice female circumcision	93	45	81	57	74	52	86	40	89	39
Most practice female circumcise	5	31	10	20	17	22	10	41	7	38
Only a few practice circumcision	1	11	6	16	7	15	2	11	0	8
No one practices female circumcision	0	11	1	5	2	7	1	6	1	5
Don’t know	2	3	1	2	2	4	2	2	4	10
Total (N)	(202)	(303)	(171)	(269)	(176)	(287)	(189)	(289)	(162)	(255)

Table 3 Percentage of respondents, by survey-sample subgroup, according to their perceptions concerning local influential individuals' approval of the practice of female genital mutilation, Egypt, 2006

	Women		Men		Young men (16–24)		Young women (16–24		Girls (10–15)	
Opinion makers	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**
Teachers	94	48	90	76	88	69	99	43	94	49
Health-clinic doctors	82	29	80	55	78	53	76	23	85	44
Imams	90	33	88	67	86	66	83	33	88	42
Community leaders	96	44	87	68	89	69	98	54	97	51
Influential families	97	57	91	73	91	77	97	62	99	64

Table 4 Percentage of respondents, by survey-sample subgroup, according to their awareness of cases of complications resulting from female genital mutilation and of girls who had avoided circumcision, Egypt, 2006

Knowledge of specific cases of complications caused by FGM and any who avoid practice	Women		Men		Young men (10–24)		Young women (16–24)		Girls (10–15)	
	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village
Heard of a girl that died of FGM	3.0	7.6	1.2	13.3	0.6	2.1	1.6	8.0	0.6	5.8
Know of girls who have not been circumcised	8.0	7.3	11.1	15.9	5.7	10.6	7.1	22.9	4.9	6.9
Witnessed any serious complications	18.2	27.0	9.9	13.3	7.3	9.4	23.8	37.5	23.3	11.1

Table 5 Percentage of respondents, by survey-sample subgroup, according to their sources of information about female genital mutilation, Egypt, 2006

Sources	Women		Men		Young men		Young women (16–24)		Girls (10–15)	
	Control village	Inter-vention village	Control village	Inter vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village
Television	77	62	84	74	81	73	82	68	74	53
Radio	8	3	18	2	14	4	4	1	5	1
Newspapers/ magazines	8	3	16	17	12	13	15	6	0	3
Pamphlets	0	10	2	3	7	0	7	9	11	10
Flyers	3	12	2	2	2	0	11	16	5	4
Community gatherings	0	4	6	6	0	13	6	1	0	4
Husband	3	2	0	0	0	0	2	0		
Home visits	15	52	0	2	2	0	13	30	5	20
Health-center staff	5	11	0	3	2	4	15	4	0	1
Educational classes/group meetings	11	14	0	10	5	7	9	10	5	7
Relatives	18	10	8	8	12	4	13	6	21	16
Seminars	8	67	16	50	19	39	18	71	0	66
Other	2	2	6	6	5	5	6	7	16	14
Total (N)	(66)	(187)	(50)	(91)	(42)	(110)	(55)	(166)	(19)	(74)

Note: Responses do not sum to 100 percent because multiple answers were allowed.

Table 6 Percentage of respondents, by survey-sample subgroup, according to the type of information they received about female genital mutilation, Egypt, 2006

Information type	Women		Men		Young men (16–24)		Young women (16–24)		Girls (10–15)	
	Control village	Intervention village	Control village	Intervention village	Control village	Intervention village	Control village	Intervention village	Control village	Intervention village
FGM is a harmful practice	59	73	62	69	52	69	64	70	68	72
Religious views about FGM	23	23	40	40	33	31	38	31	37	34
Health complications of FGM	30	78	48	37	45	40	53	78	42	78
Psychological complications of FGM	15	43	0	14	14	17	29	51	21	32
FGM is damaging to the marital relationship	9	37	8	4	24	10	16	26	5	12
Discussion of attitudes and beliefs in Egypt	5	18	10	3	10	5	18	15	11	10
Other	12	6	4	6	0	7	9	2	11	5
Total (N)	(66)	(187)	(50)	(91)	(42)	(110)	(55)	(166)	(19)	(74)

Note: Responses do not sum to 100 percent because multiple answers were allowed.

Table 7 Percentage of respondents, by survey-sample subgroup, according to the impact of the information they had received about female genital mutilation on their views and behaviors related to the practice, Egypt, 2006

Stages of FGM re-evaluation	Women		Men		Young men (16–24)		Young women (16–24)		Girls (10–15)	
	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village	Control village	Inter-vention village
Made you reassess female circumcision and its value	17	81	31	51	41	58	47	86	47	76
Made you consider not circumcising your daughter	19	80	27	49	29	56	38	80	53	84
Made you decide not to circumcise your daughter	13	77	39	59	26	53	42	78	47	80
Total (N)	(48)	(130)	(49)	(90)	(42)	(110)	(55)	(166)	(19)	(74)

Table 8 Percentage distribution of respondents, by survey-sample subgroup, according to their willingness to discuss female genital mutilation openly, Egypt, 2006

	Girls (10–15)		Girls (16–24)		Young men (16–24)	
Willingness to discuss FGM	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**
"I would be shy about talking with my family about circumcision, even if it is my own or my sister's circumcision."						
Always	40	32	36	34	60	19
Most of the time	16	23	23	29	16	26
Rarely	20	32	32	16	16	32
Never	24	13	10	21	8	23
Is it shameful to talk about circumcision?						
Yes	24	29	70	77	75	84
No	56	53	16	8	25	16
Sometimes	20	21	14	14		
If your friend/neighbor comes to talk with you about the necessity of a girl's circumcision, would you talk to her?[a]						
Yes	28	33	45	63	na	na
No	46	48	39	27		
Don't know	25	19	16	10		
If your teacher asks you to talk to your class about female circumcision, would you agree?						
Yes	22	26	na	na	na	na
No	67	63				
Not applicable	12	12				
If the doctor of your rural health unit (RHU) invites people of the village to a discussion on circumcision, would you go?						
Yes	61	71	76	81	83	88
No	25	20	19	14	17	9
Don't know	14	10	6	5	0	3

[a]Different respondent subgroups were asked different questions.

Table 9 Percentage distribution of respondents, by survey-sample subgroup, according to their attitudes concerning female genital mutilation, Egypt, 2006

	Women		Men		Young men (16–24)		Young women (16–24)		Girls (10–15)	
Attitude	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**	**Control village**	**Inter-vention village**
FGM is a religious obligation										
Yes	59	25	63	51	55	47	50	27	48	25
No	15	58	20	29	26	37	29	64	25	24
Don't know	26	17	18	20	19	16	21	9	28	51
FGM should continue										
Yes	77	27	80	63	72	52	51	26	67	26
No	12	63	18	30	20	43	38	65	21	61
Don't know	10	10	2	7	8	6	11	9	13	14
Men want FGM to continue										
Yes	63	30	82	67	75	61	43	26	35	22
No	7	42	14	26	18	30	5	31	7	23
Don't know	30	28	5	7	7	9	52	43	57	56
Men prefer to marry circumcised girls										
Yes	68	39	85	68	70	60	55	32	39	25
No	6	31	12	25	10	25	43	15	4	14
Don't know	25	31	3	7	20	16	2	54	57	61
I worry about gossip if I don't circumcise my daughter										
Yes	74	33	61	44	0	0	69	27	60	26
No	24	65	38	53	100	100	27	71	24	58
Don't know	3	2	1	3	0	0	4	2	16	15
Women want FGM to continue										
Yes	89	43	85	67	68	57	84	52	78	44
No	6	46	9	22	10	22	6	37	3	30
Don't know	6	11	6	11	22	21	10	11	19	26
FGM prevents women from committing adultery										
Yes	40	13	66	45	50	38	23	10		0
No	38	77	25	42	31	48	48	72	100	100
Don't know	22	10	9	14	19	15	29	18		0
FGM can cause health complications										
Yes	23	67	27	41	26	40	37	72	27	63
No	68	30	68	51	64	51	56	24	60	28
Don't know	9	3	5	8	10	9	7	4	14	9
FGM can cause death										
Yes	8	47	15	23	13	20	16	48	11	41
No	87	49	79	68	77	68	77	47	79	48
Don't know	6	5	6	9	10	12	7	5	11	11
Physicians who perform FGM can be put in jail										
Yes	14	47	24	39	24	30	21	54	19	46
No	68	37	59	40	50	49	62	37	59	33
Don't know	18	17	17	21	25	21	17	9	23	20
I would feel guilty if I didn't circumcise my daughter										
Yes	78	33	71	54	0	0	2	24	62	26
No	16	63	27	42	100	100	27	69	21	16
Don't know	6	4	2	5	0	0	11	7	17	58
FGM is necessary to ensure a girl's chastity										
Yes	77	29	84	67	73	50	53	25	50	22
No	16	69	14	30	18	36	33	67	22	53
Don't know	7	3	2	3	9	14	14	8	29	24
Total (N)	(202)	(303)	(171)	(269)	(177)	(287)	(189)	(289)	(162)	(255)

Table 10 Percentage distribution of respondents, by survey-sample, subgroup, according to their beliefs concerning the importance of female genital mutilation Egypt, 2006

Subgroup/views	Control village	Intervention village	Percentage point difference
Women			
Very important	67	35	−32
Somewhat important	6	13	+7
Not very important	5	10	+5
Unnecessary	17	38	+21
Don't know	5	5	0
Girls (10–15)			
Very important	56	23	−33
Somewhat important	12	15	+3
Not very important	7	9	+2
Unnecessary	9	36	+27
Don’t know	16	17	+1
Young women (16–24)			
Very important	61	21	−40
Somewhat important	13	19	+6
Not very important	5	6	+1
Unnecessary	12	47	+35
Don’t know	9	7	−2
Young men (16–24)			
Very important	66	50	−16
Somewhat important	9	14	+5
Not very important	6	14	+8
Unnecessary	8	16	+8
Don’t know	11	7	−4
Men			
Very important	69	56	−13
Somewhat important	9	13	+4
Not very important	6	14	+8
Unnecessary	6	13	+7
Don’t know	9	3	−6

Table 11 Percentage of female respondents aged 10–15 and 16–24, by governorate, according to their circumcision status, Egypt, 2006

Governorate	Girls (16–24)		Girls (10–15)	
	Control	Intervention	Control	Intervention
Beni Suef[a]	85	97	33	56
Menya	100	97	88	57
Assiut	96	97	90	75
Sohag	100	91	97	62
Qena	100	97	85	94
Aswan	97	97	97	98
Average	96	96	84	77

[a]The number of Beni Suef girls surveyed is too small to allow for analysis at the governorate le

Table 12 Percentage distribution of circumcised mothers and daughters, by survey-sample subgroup, according to provider who performed the procedure, Egypt, 2006

	Daughters		Mothers	
Circumcision provider	**Control**	**Intervention**	**Control**	**Intervention**
Doctor	43	48	—	—
Nurse	18	8	11[a]	10
Daya/ midwife	36	42	90	90
Barber	1	1	0	0
Gypsy woman from outside the village	—	1	0	0
Don't know	2	0	0	0 **[0's OK?]**
Total number of circumcised daughter (N)	(465)	(631)	—	—

— = Not applicable.

[a]Includes nurses, doctors, and others.

Table 13 Percentage distribution of respondents, by survey-sample subgroup, according to their intention to circumcise their daughters, Egypt, 2006

	Women		Men		Young men (16–24)		Young women (16–24)	
Intention	**Control**	**Intervention**	**Control**	**Intervention**	**Control**	**Intervention**	**Control**	**Intervention**
Will not circumcise	7	38	17	42	27	43	19	57
Will circumcise	53	13	81	54	65	45	62	24
Don't know	41	49	2	4	10	12	19	19
Total (N)	(190)	(280)	(84)	(135)	(177)	(287)	(189)	(289)

Table 14 Percentage of respondents, by survey-sample subgroup, according to their reasons for intending to circumcise their daughters, Egypt, 2006

	Women		Men		Young men (16–24)		Young women (16–24)	
Reason	**Control**	**Inter-vention**	**Control**	**Inter-vention**	**Control**	**Inter-vention**	**Control**	**Inter-vention**
To decrease girl's sexual desire and preserve her virginity	24	50	34	32	36	26	21	31
For cleanliness			38	47	49	38	41	34
To follow customs/traditions	82	90	79	80	89	82	86	81
To follow religious beliefs	30	28	59	58	65	47	33	35
To increase pleasure for the husband	13	22	10	8	7	8	9	10
To increase daughter's marriageability	24	14	7	4	4	5	19	21
To increase daughter's esteem **[self-esteem or esteem for daughter and her beauty?]** and beauty	43	56	4	3	5	2	20	28
Other	6	3	12	14	0	1	9	6
Don't know	5	3	2	0	1	2	6	4
Total (N)	(101)	(36)	(68)	(73)	(113)	(130)	(118)	(68)

Note: Responses do not sum to 100 percent because multiple answers were allowed.

Table 15 Percentage of respondents, by survey-sample subgroup, according to their rationale for not intending to circumcise their daughters, Egypt, 2006

	Women		Men		Young men (16–24)		Young women (16–24)	
Rationale	**Control**	**Intervention**	**Control**	**Intervention**	**Control**	**Intervention**	**Control**	**Intervention**
Not convinced of FGM benefit	61	42	50	36	36	55	56	57
FGM is not a religious obligation	44	28	21	34	45	48	36	38
Wish to avoid causing pain and complications for daughter	78	85	50	45	40	35	58	80
Religion forbids FGM	28	20	7	5	23	13	33	24
Increases daughter's marriageability	22	21	7	2	9	3	19	21
Ensures greater sexual pleasure for the husband	33	22	0	18	9	1	25	22
Ensures greater sexual pleasure for girl **[OK?]**	28	21	7	18	4	4	19	19
FGM is an old custom	61	46	7	11	21	20	58	47
FGM is a violation of a girl's body and human rights	44	35	7	9	13	8	36	39
Other	0	0	21	5	11	12	11	10
Don't know	22	6	0	0	0	0	3	2
Total (N)	(18)	(116)	(14)	(56)	(47)	(123)	(36)	(166)

Note: Responses do not sum to 100 percent because multiple answers were allowed.

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