Credit: UNHCR/Andrew McConnell

# Female Genital Mutilation amongst Sudanese Migrants in Greater Cairo: Perceptions and Trends

May 2025

Tadwein for Gender Studies
تدوين لدراسات النوع الاجتماعي

Equality Now
A just world for women and girls.

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Study citation: Fahmy, A., Badr., A and Mohammed, Y. (2025). Female Genital Mutilation amongst Sudanese Migrants in Greater Cairo: Perceptions and Trends. Tadwein for Gender Studies. Egypt, Cairo.

## List of acronyms and abbreviations

| | |
|---|---|
| **CBOs** | **Community-Based Organizations** |
| **FGM** | **Female Genital Mutilation** |
| **GBV** | **Gender-based violence** |
| **HCPs** | **Health Care Providers** |
| **IDI** | **In-Depth Interview** |
| **MICS** | **Multiple Indicator Cluster Survey** |
| **WHO** | **World Health Organization** |
| **TBAs** | **Traditional Birth Attendants** |
| **NCCW** | **National Council for Child Welfare, Sudan** |
| **MoHP** | **Ministry of Health and Population, Egypt** |

## About Tadwein for Gender Studies

Tadwein for Gender Studies is an Egyptian organization established in 2016 with a mission to promote gender equality and address gender-based violence (GBV) through research, advocacy, and community interventions. The organization focuses on empowering women and girls, fostering inclusive communities, and raising awareness about critical issues such as GBV and harmful practices like female genital mutilation (FGM). Tadwein works closely with local communities, stakeholders, and policymakers to implement culturally sensitive and evidence-based programs that drive meaningful change. Through capacity-building initiatives, knowledge production, and grassroots engagement, Tadwein plays a pivotal role in advancing gender-related research and advocating for a safer, more equitable society, with a strong commitment to enhancing women's status in Egyptian society and reducing violence against them.

## About Equality Now

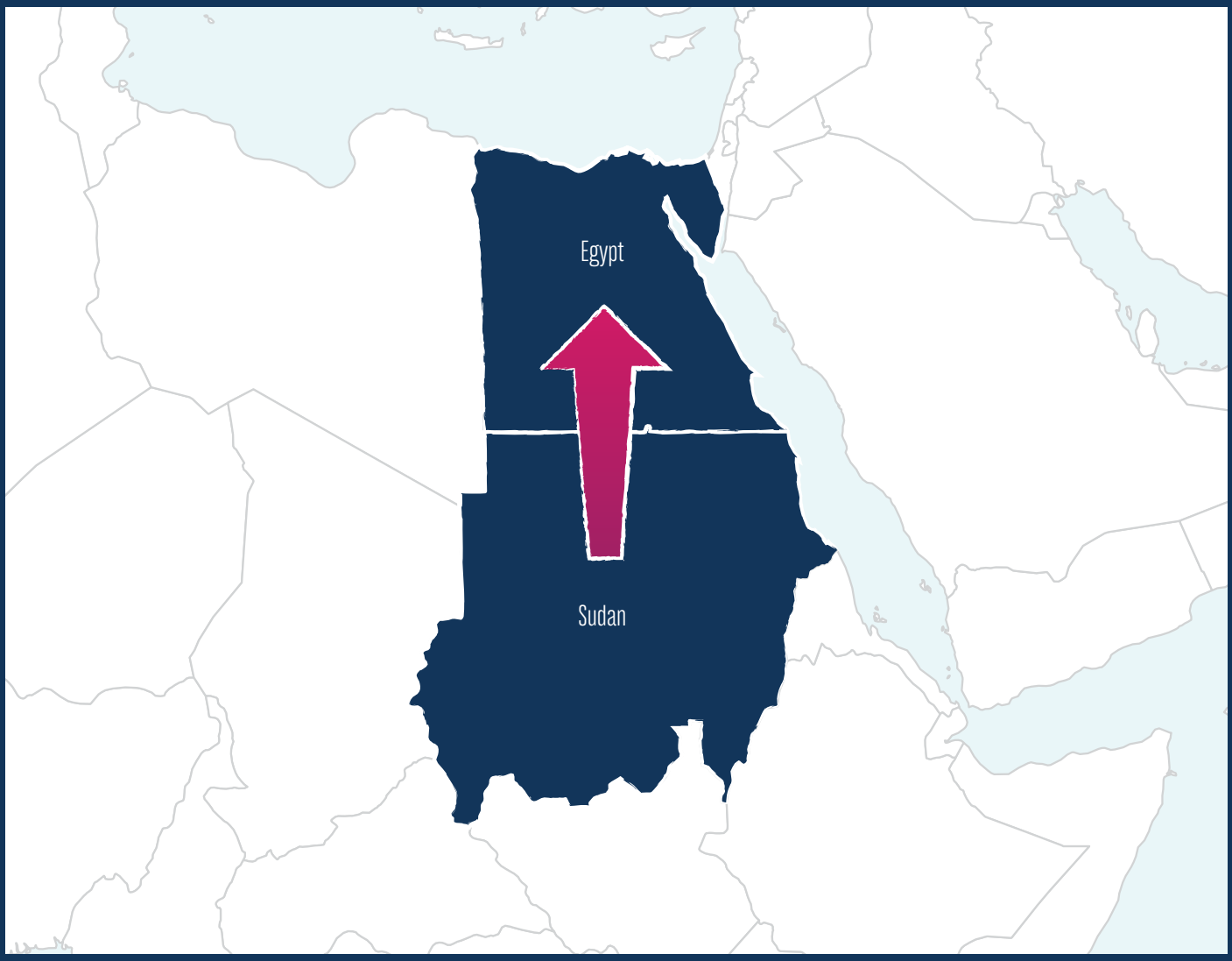
Equality Now is an international human rights organization founded in 1992 to protect and advance the rights of all women and girls around the world. Its campaigns focus on four programmatic areas: achieving legal equality, ending sexual violence, ending harmful practices, and ending sexual exploitation, with a cross-cutting focus on the unique needs of adolescent girls and other vulnerable groups.

Equality Now is a global organization with partners all around the world. You'll find our 80+ team across the world in places such as Beirut, Johannesburg, London, Geneva, San José, New York, Nairobi, Tbilisi, and Washington DC, among many others.

## Acknowledgment

The authors of this study include Tadwein's Managing Director, Dr. Amel Fahmy, the Program Officer, Dr. Yussra Mohammed, and the Head of the Research Unit, Dr. Ahmed Badr. We would first like to express our deep appreciation to all the study participants who generously shared their experiences and perspectives, providing the foundation for this research. Their willingness to contribute their voices has been invaluable in shaping the findings of this study. We also acknowledge the dedicated work of the data collectors and transcribers in ensuring the accuracy and reliability of the data collected. We extend our appreciation to our Sudanese partner CBOs, Volunteer Hub Organization, and the Association of the Fulani Sons for their support in facilitating interviews at their premises. Their collaboration was instrumental in the successful completion of this study. We are also grateful to our Advisory and Ethical Committee, including Prof. Omaima Elgibaly, a public health expert at Assiut University, Egypt, Dr. Randa Fakhereldeen, an Obstetrics and Gynecology Consultant and a national expert on FGM, Egypt and Prof. Nafisa Bedri, a regional expert on reproductive health at Ahfad University for Women, Sudan, for their invaluable technical guidance throughout this project. In particular, we sincerely thank Prof. Nafisa Bedri for her support in developing this study report. Additionally, we appreciate Dr. Shereen El Feki, author of Sex and the Citadel: Intimate Life in a Changing Arab World, for her valuable review of this report. We also thank Tadwein Interns Natalie Sorial and Noa Jacobs for their contribution to the literature review of the study.

Finally, we extend our heartfelt gratitude to Equality Now for their generous funding and continuous support, without which this research would not have been possible. We extend our appreciation to our colleagues at Equality Now: Divya Srinivasan, Global Lead for Ending Harmful Practices; Dr. Dima Dabbous, Regional Representative for MENA; Paleki Ayang, Gender Advisor for MENA; and Naglaa Sarhan, Gender Advisor for MENA for their valuable insights and commitment to this work.




# Executive summary

This is an exploratory study that examines the perception and practices surrounding female genital mutilation (FGM) among Sudanese migrants in the Cairo and Giza governorates. Both Egypt and Sudan have high FGM prevalence rates, though the social and cultural approaches to FGM in these two countries differ significantly. The recent conflict in Sudan, which began in April 2023, has driven more than one million Sudanese migrants, including many women and girls, to Egypt. The influx of Sudanese families into an environment where FGM remains prevalent highlights the importance of understanding how these migrants navigate cultural identity and adapt practices in their new environment.

To be able to explore the perception and practice of FGM among Sudanese families, a qualitative research design was implemented. Thirty in-depth interviews (IDIs) were conducted with members of Sudanese families residing in the Cairo and Giza governorates, focusing on areas with concentrated Sudanese populations such as Nasr City, Faisal, and 6th October. Participants were identified through collaborative efforts with Sudanese community-based organizations (CBOs), networks, and initiatives operating in Egypt, ensuring a diverse and representative sample. Five data collectors, all of Sudanese nationality and including both male and female members, were engaged in the study. Prior to data collection, they received comprehensive training on the interview protocol and ethical considerations.

Data collection was conducted during November and December 2023, and the resulting qualitative data was analyzed using thematic analysis to identify key patterns and themes. The study's focus on the experiences of Sudanese migrants in Egypt provides valuable insights into how migration, social networks, and interactions with the host community influence the practice of FGM among Sudanese families.

## Key findings of the study

- All female participants were able to distinguish between the different types of FGM. However, these types were identified using local colloquial descriptions of the practice: “Sunna type” (or Type I), “Sandwich type” (or Type II), and “Pharaonic type” (or Type III).

- Gender and age were the main determinants of the participants’ knowledge regarding FGM. Female participants demonstrated a higher level of knowledge in comparison to male participants with respect to FGM types, age of cutting, and FGM performers. Younger respondents were generally less informed than their older counterparts; young men were the least knowledgeable of FGM among all study participants. Participants from older age groups were more knowledgeable about the laws combatting FGM in Sudan compared to younger age groups.

- The study participants' knowledge about the practice of FGM in Egypt (prevalence, types, age of cutting, and who performs it) is limited and full of contradictions. Many of them believe that Egyptians perform Type III FGM “Pharaonic type” as it is named after them.

- Knowledge about the legal status of FGM in Egypt amongst the study participants is quite ambiguous. However, the majority of the participants assume there is an anti-FGM law in Egypt, as there is one in Sudan.

- All study participants mentioned that they have stopped performing FGM within their families, and the majority of them noted that they stand firmly against it.

- Younger participants with higher education and females with negative personal experiences were stronger in their opposition to practicing FGM. The majority of male participants recognized the negative impact of FGM on intimate relationships and cited this impact as the main reason for rejecting the practice for their daughters.

- The majority of study participants, regardless of age and gender, believed that Sudanese families support abandoning Type III.

- Few of the study participants still perceive "Sunna type" as less harmful with limited or no complications.

- Study participants believe that most Sudanese families do not perceive FGM as violence against women or a practice that controls females’ sexuality and violates women and girls’ bodily integrity but rather view it through a medical lens, focusing primarily on its negative health consequences, especially those associated with Type III.

- Study participants stated that Sudanese families who practice FGM in Sudan will most likely continue practicing it in Egypt, while families who have stopped it will not uptake it as a result of migrating to Egypt.

- Study participants cited the presence of “Small Sudan"—neighborhoods with high concentrations of Sudanese population in Egypt—as a major factor that can facilitate the continuation of the practice in Egypt. These neighborhoods are perceived as social networks that support the practice. Through these social networks, families can identify Sudanese midwives to perform FGM in Egypt, locate other families that want to perform FGM, and collectively gather needed financial support.

- Study participants presented some factors that could influence Sudanese families not to practice FGM in Egypt. Among these factors are the absence of influencers of decision makers, mainly elderly family members, and the limited presence of Sudanese midwives who mainly perform the practice. Economic hardship was also mentioned as a potential cause that could lead to the abandonment of FGM. Study participants stated that many Sudanese families are mainly concerned about securing essential needs such as education, healthcare, and housing, making FGM a lower priority. Furthermore, they mentioned that fears of possible legal repercussions, including the risk of deportation, could lead many Sudanese families not to practice FGM in Egypt.
- Most of the study participants stated that their relationships and interactions with members of the host community are fragile due to the negative perceptions of Sudanese migrants held by many Egyptians. In their view, this will drive many Sudanese families not to obtain information regarding FGM from their Egyptian counterparts and thus are unlikely to subject their daughters to FGM by Egyptian doctors or in Egyptian health facilities.

## Key recommendations

Raise awareness about Egyptian laws criminalizing FGM amongst Sudanese migrant communities with campaigns that focus on the legal consequences and penalties for those involved.

Empower parents, especially mothers, with the knowledge and skills to resist societal and familial pressures, enabling them to make informed decisions about their daughters' well-being.

Engage elders and influential community figures within Sudanese communities, such as grandmothers, to shift attitudes and influence family decisions. Leverage trusted networks within "Small Sudan" to foster culturally sensitive and unified anti-FGM efforts.

Ensure that advocacy efforts focus on integrating human rights and gender perspectives, highlighting the violation of bodily autonomy and the societal impacts of FGM. They should also address misconceptions about "Sunna type" FGM by clarifying its illegality, the absence of religious justification for it, and the risks associated with it, ensuring that the messaging challenges harmful beliefs and promotes a better understanding of the consequences of FGM.

Conduct large-scale research on the issue of FGM among Sudanese communities post-migration, including longitudinal or cross-sectional studies to analyze shifts in FGM-related practices after migration to Egypt. These studies should examine changes in the age at which FGM is performed and the shifts in preferred practitioners, such as midwives versus medical professionals.

Investigate intergenerational power dynamics within "Small Sudan" and other similar communities to understand their impact on decision-making regarding FGM and women's autonomy.

Credit: UNFPA Sudan

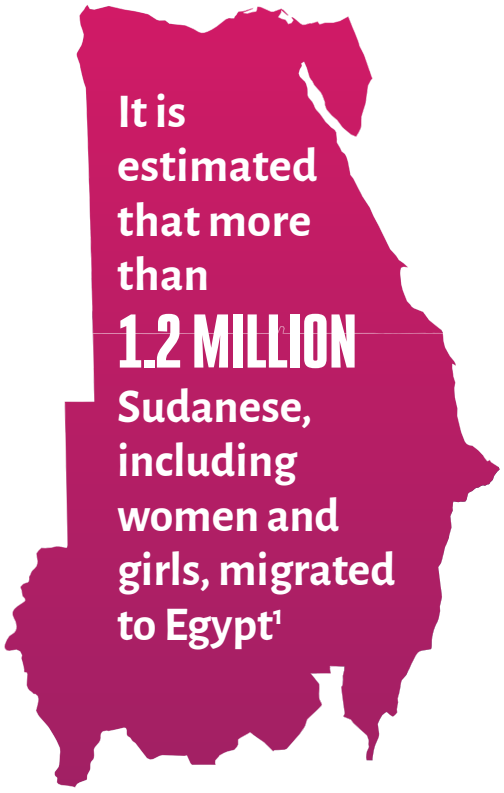
# Introduction

**During periods of war and displacement, FGM is often viewed as a means of protecting family honor and safeguarding girls against sexual violence, particularly through Type III FGM**

Sudan continues to face the deeply entrenched practice of female genital mutilation (FGM), a human rights violation and a form of gender-based violence. According to the 2014 Multiple Indicator Cluster Survey (MICS), 86.6% of women aged 15-49 and 66.3% of girls aged 0-14 have undergone FGM. The practice, typically performed on girls aged 5 to 9 years, is conducted by trained midwives or traditional circumcisers and is deeply rooted in societal norms, including beliefs about purity, modesty, marriageability, and cultural notions of beauty and cleanliness. Religious leaders—especially those who view Type I FGM as an Islamic practice—have contributed to the widespread use of the term 'Sunna type,' leading to greater acceptance and continued performance of this form.

However, attitudes are evolving, with 52.8% of women aged 15-49 expressing support for abandoning FGM, particularly in urban areas where education and awareness programs are challenging longstanding traditions. While these statistics represent the most official and comprehensive data available to date, it is important to note that due to instability in Sudan since the revolution in 2019, further exacerbated by the outbreak of war in April 2023, there are no recent figures reflecting the current situation regarding FGM in the country.

It is evident from the literature that conflict and migration add complexity to the dynamics of FGM in Sudan. During periods of war and displacement, FGM is often viewed as a means of protecting family honor and safeguarding girls against sexual violence, particularly through Type III FGM. However, on the other hand, displacement can also disrupt traditional social structures, weakening the norms that uphold FGM and sometimes resulting in a shift to less severe forms or a reduction in prevalence. After the war erupted in Sudan in 2023, it is estimated that more than 1.2 million Sudanese, including women and girls, migrated to Egypt,[1] - a country with an already high prevalence level of FGM. Despite evidence reflecting how migration and population movement affect the practice of FGM within Sudan, little is known about the practice of FGM when migrating from high-prevalence regions of origin to high-prevalence regions or countries of destination.[2] A literature review reveals that the majority of research and studies investigating FGM among migrant communities are focused on the high prevalence of FGM in refugee camps in Africa or among migrants who have resettled in the West.[3] Currently, there are no existing studies that have specifically examined how Sudanese migrant families navigate their cultural identity and the practice of FGM after migrating to Egypt.




**Problem statement and justification**

In Sudan, FGM is commonly performed by midwives within communities and is deeply embedded in cultural norms. In Egypt, FGM remains widespread, but a shift toward medicalization has been evident, with many procedures (78%) now performed by medical practitioners.[4] The differing contexts of FGM in each country provide a unique framework for studying the experiences of Sudanese migrants, who are now situated in an environment where FGM practices are both medicalized and socially prevalent.

With the large influx of Sudanese migrants, it remains unclear how their perceptions and practices regarding FGM will evolve in this new context, particularly in the absence of any existing data on the issue. This study, therefore, seeks to fill this gap by exploring Sudanese families' perceptions and practices around FGM in Egypt and identifying the factors that may contribute to either the continuation or abandonment of the practice. By exploring the experiences of Sudanese migrants in Egypt, this study provides new insights into how forced displacement, social networks, and interactions with the host community influence the practice of FGM among Sudanese families.

This exploratory study examines migration from one high-prevalence country to another. The insights gained from this research will help fill a significant gap in the research on FGM, offering evidence that can inform policies and interventions tailored to both migrant and host communities. By exploring how Sudanese families navigate Egypt's medical and social context regarding FGM, the study provides valuable information on cultural preservation, adaptation, and abandonment of the practice in the face of migration. For stakeholders committed to ending FGM, such as policymakers, healthcare providers, and social workers, this study will provide data to help shape targeted policies, awareness campaigns, and community support programs that address the unique challenges and perspectives of Sudanese migrant families in Egypt. Ultimately, the findings will serve as an essential resource for initiatives aimed at reducing FGM in both host and migrant Sudanese communities, enhancing the overall effectiveness of efforts to prevent and mitigate this practice in diverse cultural contexts.

# Background

Female genital mutilation (FGM) is a practice that violates the rights of millions of girls and women worldwide. According to the World Health Organization (WHO), FGM is defined as *"any partial or total removal of the external genitalia or any other injury of the female genital organs for non-medical reasons"*.[5] The WHO classifies FGM into four categories:[6]

## TYPE I

**Type I** refers to the partial or complete removal of the clitoral glans (which constitutes the external and visible portion of the clitoris) and/or the prepuce. In Egypt and Sudan, this type is colloquially known as "Sunna type".

## TYPE II

**Type II** entails the partial or total removal of both the clitoral glans and the labia minora, the inner folds of the vulva, and may also include the removal of the labia majora, the outer folds of vulvar tissue. In Egypt and Sudan, this type is colloquially known as "sandwich type".

## TYPE III

**Type III,** often termed infibulation, involves the narrowing of the vaginal orifice through the creation of a covering seal, achieved by repositioning the labia, with or without excision of the clitoris. In Egypt and Sudan, this type is colloquially known as "pharaonic type".

## TYPE IV

**Type IV** encompasses a broad range of other injurious procedures performed on the female genitalia for non-medical reasons, including but not limited to pricking, piercing, incising, scraping, and cauterization.[7]

**UNICEF estimates that around 230 million women and girls, with the largest share of 144 million in Africa, have undergone FGM**


UNICEF estimates that around 230 million women and girls, with the largest share of 144 million in Africa, have undergone FGM.[8] Recognized as a severe form of gender-based violence (GBV) and a blatant violation of human rights, FGM has drawn international attention, leading to a United Nations General Assembly resolution (A/RES/67/146) in 2012 calling for a global ban.[9] Eliminating FGM has become a specific target under United Nations Sustainable Development Goal 5, aiming for eradication by 2030.

## Female genital mutilation in Sudan

Sudan is a large, culturally diverse African country with 19 main ethnic groups, most of whom are Arabic-speaking Muslims.[10] FGM is widely practiced in the country. According to the Multiple Indicator Cluster Survey (MICS) of 2014, 86.6% of women aged 15-49 have undergone FGM. Among girls aged 0-14, 66.3% have undergone FGM, compared to 88.3% of women aged 30-34 and 91.8% of those aged 45-49.[11] There is a small difference in FGM rates between urban (86%) and rural areas (87%). However, there are large differences between states, with rates varying from 45.4% in Central Darfur to 97.7% in North Kordofan.[12] Girls are typically cut between the ages of 5 and 9.[13] Many of these procedures are done by formally trained midwives (63.6%), while traditional circumcisers perform 28.7% of the cases.[14] The practice of FGM in Sudan is strongly linked to the mother's level of education and wealth index.[15] Approximately 34% of daughters subjected to FGM were born to mothers with no education, compared to 15% born to mothers with higher education. Women from wealthier households are more likely to favor the abandonment of FGM compared to those from poorer households.[16]

FGM in Sudan is a prevalent harmful practice deeply rooted in cultural traditions and societal expectations. Many communities view it as a crucial requirement for marriage, and families often fear that their daughters may struggle to find a husband if they are not cut.[17] This pressure is intensified by the social stigma surrounding unmarried women, which can bring considerable shame to families.[18] FGM is also thought to uphold family honor by ensuring purity, modesty, and control over female sexuality.[19] This stigma reinforces adherence to the practice within communities.[20]

Additionally, the practice is linked to long-standing beliefs about cleanliness and beauty. Many believe that the removal of certain genital parts is essential for enhancing a girl's femininity and conforming to cultural standards of womanhood.[21] Religious beliefs also contribute significantly to the perpetuation of FGM, as it is sometimes regarded as a religious obligation within Islam, particularly Type I FGM - known among Sudanese as Sunna, which refers to words and actions that are attributed to the Prophet Mohammed (PBUH) and that underpin Islamic religious teachings.[22] This belief system strengthens the resolve of families to maintain traditions and honor their cultural heritage.[23] However, despite these entrenched norms, a significant portion of the population—52.8% of women aged 15-49—supports abandoning FGM. Notably, attitudes toward discontinuing the practice are more prevalent among urban women (67.3%) compared to their rural counterparts (45.5%), with state-level variations reflecting differing levels of acceptance, from just 30.6% in East Darfur to 71.0% in Khartoum. [24]

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## Shifts in the practice of female genital mutilation in Sudan

In recent years, there has been a noticeable shift in the trends surrounding FGM in Sudan. This change includes variations in the type of FGM performed, the age at which it is practiced, and the individuals who perform it.[25] Studies indicate a transition from the widely practiced Type III to Type I.[26] This shift is largely attributed to the perception that Type I is less severe, poses minimal health risks, and has a shorter recovery time compared to Type III.[27] This perception may have been influenced by anti-FGM campaigns highlighting the health risks associated with Type III FGM.[28] Additionally, the growing belief that Type I is a practice of Sunna and is therefore approved by Islam has contributed to this trend.[29]

Changes in the age at which the cutting is performed have also been observed in recent years. Analysis of the 2014 MICS data reveals that the percentage of girls who were cut at age ten or older doubled between 1980-1989 and 2000-2014, increasing from 10.1% to 23.1%. Conversely, there was a significant decrease in the proportion of girls cut at age four years or younger during the same periods (from 13.2% to 4.7%). The shift in the age appears to be influenced by various beliefs about health risks and benefits.[30] Some communities delay FGM until girls are older, around 11 or 12 years, due to the belief that older girls heal faster and experience fewer complications.[31] This change is sometimes driven by the belief that FGM demonstrates a girl's maturity and readiness for marriage.[32] In contrast, other communities prefer early-age FGM, even as young as three years, based on the belief that it can cure illnesses.[33]

Medicalization is another observed change in the practice. Medicalization refers to FGM being practiced by any category of health-care providers: physicians, assistant physicians, clinical officers, nurses, midwives, trained traditional birth attendants (TBAs) and other personnel providing health care to the population - in both private and public sectors at home or elsewhere. It also includes the procedure of re-infibulation at any point in time in a woman's life (usually performed after a woman has given birth).[34] Traditionally, FGM in Sudan was conducted by traditional circumcisers who, despite being trusted community figures with a deep understanding of local customs, often had no formal health training.[35]

The findings of 2014 MICS indicate that 58% of girls aged 10-14 who underwent FGM were cut by trained healthcare providers, signaling a shift away from traditional circumcisers, hence the practice is increasingly being medicalized. This trend of medicalizing FGM is further highlighted by secondary analyses showing that the percentage of women aged 15-49 cut by trained midwives rose from 69% to 76% between 1990 and 2014.[36]

**Traditionally, FGM in Sudan was conducted by traditional circumcisers who, despite being trusted community figures with a deep understanding of local customs, often had no formal health training.[35]**

The growing trend of medicalizing FGM in Sudan reflects a combination of health concerns, social influences, and the perceived reliability of healthcare providers. Many families now opt for healthcare providers to perform FGM, believing that these trained professionals offer a safer and more hygienic environment.[37] Awareness campaigns highlighting the serious health risks of FGM have reinforced this preference by making people more cautious about potential complications. In this context, many parents feel reassured that a doctor or trained midwife, with their medical knowledge, will perform FGM in a way that minimizes harm, leading to the common belief that a medical professional would inherently act in the child's best interest.[38]

## Female genital mutilation legislation in Sudan

Sudan was the first African country to introduce legislation on FGM.[39] This happened in 1946 under British colonial rule, when infibulation was prohibited through a supplement to the Criminal Act. However, in 1983, when Sharia law was introduced, the article prohibiting FGM was removed from the Criminal Act.[40] In 1991, the Sudanese government reaffirmed its commitment to eliminate FGM and declared that the practice is against the Islamic laws and Sharia with no mention of the types of FGM.[41] Then, in 2008, the National Council for Child Welfare (NCCW) announced a National Strategy for the elimination of FGM by 2018, [42] with the aim of total abolition and zero tolerance by addressing the religious, social, health, and cultural aspects of FGM.

In January 2008, the Council of Ministries endorsed a law to prohibit the practice, which was, unfortunately, not endorsed by the Sudanese Legislative Assembly.[43] Despite the failure to adopt a national law against FGM, several of Sudan's eighteen states (South Kordofan, Gedaref, South Darfur, Northern State, Blue Nile, and North Kordofan) criminalized the practice.[44] In July 2020, an amendment to Article 141 of the criminal law was ratified, and a national law was passed prohibiting FGM, introducing a three-year prison term and substantial fines for FGM offenders.[45] According to the Minister of Justice, the new law is part of Sudan's efforts to eliminate all laws that violate human rights and 'remove any kind of discrimination that was enacted by the old regime' to enable the country to 'move toward equality of citizenship and a democratic transformation.'

While limited data is available on the public perception of the new FGM law in Sudan, one study that explored the shifts in the types and providers of FGM provides some insights.[46] The study also examined the public's awareness of legal frameworks surrounding the practice. Notably, participants from Khartoum State, where no formal law banning FGM existed during the time of the study, reported being "aware" of such a law. This perception contrasts with the legal reality and highlights the widespread fear of legal repercussions, which may drive the practice underground. In Gedaref State, while a law banning FGM existed, its enforcement by state authorities remained insufficient. This has resulted in families and practitioners continuing the practice in secrecy, making it difficult for the state's legal authorities to monitor and address the issue effectively and thus contributing to a complex legal environment surrounding the practice.[47]

## Factors influencing the decision-making process of female genital mutilation in Sudan

In Sudan, as attitudes and perceptions toward FGM shift, family decisions regarding the abandonment of the practice often undergo a complex and prolonged deliberative process involving various individuals both within and outside the immediate and extended family networks. This decision-making typically starts when girls are aged between three and nine years old.[48] In Sudan, FGM decisions are heavily influenced by older generations within a hierarchical family structure where younger women have less power.[49] Studies have placed female members of the household – mothers, aunts, or grandmothers – at the center of this decision-making process. However, their choices are heavily influenced by prevailing social norms and the opinions of other family members and/or neighbors and friends, who themselves are subject to external pressures and norms.[50] Traditionally, men have not been actively involved in the decision-making process regarding FGM. However, as urbanization and medicalization influence societal norms, there is a gradual shift in the role of fathers, who are increasingly involved when the decision leans towards leaving the daughter uncut.[51]

**The decision to perform FGM is not just a matter of individual choice but is deeply interconnected with social expectations and pressures**

The pressure to conform to social norms within these family and community networks is intense. Families often choose to perform FGM to align with the expectations of their social circles, including relatives, friends, and community leaders. In areas where FGM is a deeply entrenched practice, the fear of social ostracism and judgment acts as a powerful motivator to comply with the norm. Religious leaders and other influential figures also play a role in reinforcing the practice, often presenting it as a necessary cultural or religious obligation. This reinforcement perpetuates the practice by embedding it within the community's broader social and religious fabric. Thus, the decision to perform FGM is not just a matter of individual choice but is deeply interconnected with social expectations and pressures. The intertwining of these influences creates a system that sustains FGM within the Sudanese communities.[52]

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## Female genital mutilation in Egypt

FGM is widely practiced in Egypt as well. According to the Central Agency for Public Mobilization and Statistics (CAPMAS) Report of 2022, approximately 86% of women aged 15 to 49 have undergone FGM, with significant variations across geographic, educational, and socioeconomic groups[53]. Urban women are less likely to be subjected to FGM (79%) compared to rural women (90%), with prevalence reaching as high as 93% in rural areas of Upper Egypt and dropping to 62% in Frontier Governorates (border governorates).[54] Socioeconomic and educational factors also play a critical role, with women from economically impoverished households (94%) and those with limited education (95%) experiencing significantly higher rates than their wealthier (72%) and more educated counterparts (82%).[55]

The procedure is typically performed on girls under the age of 15, with around half of ever-married women reporting they were cut between the ages of 7 and 10, slightly before or during puberty.[56] The most common forms of FGM in Egypt are Types I and II.[57] Unlike in Sudan, where midwives often perform FGM, the practice in Egypt is largely performed by doctors.[58] Data from the Egypt Demographic and Health Survey 2014 (EDHS) and Egypt Health Survey (2021) reveal that medicalization rates among girls and young women aged 19 and younger have surged from 55% in 1995[59] to a striking 74% by 2014, positioning Egypt as the country with one of the highest rates of medicalized FGM globally.[60]

Similar to the factors driving FGM in Sudan, the persistence of FGM in Egypt is deeply rooted in societal norms, as well as economic dependencies, as families in disadvantaged communities see it as a way to increase chances of marriageability, while medical professionals rely on performing FGM as a source of income.[61] A significant influence is the belief that FGM is a prerequisite for marriage, particularly in communities where women's economic dependence on men reinforces the practice. In such contexts, FGM is perceived as essential for securing a woman's future and social stability. Additionally, community pressure plays a central role in sustaining FGM. Families often feel compelled to conform to longstanding traditions to avoid stigmatization and social exclusion. This pressure is compounded by the perception that undergoing FGM enhances social capital and acceptance within the community and helps fulfill a religious duty - with 3 in 10 people perceiving it as a religious obligation.[62] Furthermore, FGM is widely promoted in Egypt as a practice that improves hygiene and decreases girls' and women's sexual desire, thus preventing pre-marital sexual activities and adultery.[63]

## Female genital mutilation legislation in Egypt

Following the highly publicized death of an 11-year-old girl in 2007 after being subjected to FGM by a doctor, the Egyptian government responded in 2008 by issuing a law banning all state-licensed health workers from performing FGM. Despite this ban, the 2014 DHS data revealed that up to 82% of FGM cases among young girls were still performed by medical professionals.

In 2016, the law was amended to include the sanctioning of both parents and the person performing FGM, with imprisonment of five to seven years. The law also punishes, with a prison sentence from one to three years, any individual who escorts the victims of such crimes to the perpetrators, and with up to 15 years of imprisonment if the procedure leads to the death of the victim or a "permanent deformity." Since 2008, only 3 cases have been brought to court, and only one doctor has been sentenced.[64] However, the law is hardly ever implemented, given that many Egyptians, in general, still support the practice and will not report cases to notify authorities.

## Factors influencing the decision-making process of female genital mutilation in Egypt

Unlike in Sudan, where older generations of women, particularly grandmothers, play a significant role in decision-making, mothers in Egypt are seen as the primary decision-makers regarding FGM.[65] However, their decisions are significantly impacted by the opinions and approval of their husbands and other family members, indicating that men play an indirect yet crucial role in this process.[66] The decision-making process on FGM in Egypt, just like in Sudan, is complex and influenced by various social, cultural, and familial factors. Many women feel pressured to conform to traditional practices upheld by their families and communities. Women who have higher education levels or have been exposed to anti-FGM messages are more likely to challenge the practice. However, without the support of their husbands or social networks, they may struggle to act on their beliefs.[67]

## Impact of migration on the practice of female genital mutilation

According to many studies, migration and population movements have greatly contributed to the spread and increased prevalence of FGM in Sudan. According to Thiam (2016), population movement among the Sudanese has contributed towards the spread of the practice and uptake among groups who don't normally practice FGM.[68] These groups tend to practice FGM in an attempt to secure fitting in with host communities and reduce social pressure exerted on their daughters by host communities.[69] In cases of forced displacements and war, FGM is perceived as an approach through which the honor of the family could be maintained.[70] In such communities and settings, it is believed that FGM, with particular emphasis on Type III FGM, protects girls from being raped as the external genitalia are tightly closed, making any form of penile penetration difficult.[71]

While FGM rates have been observed to increase in certain conflict-affected regions, they have simultaneously been reported to decrease in others. In contexts of displacement, the underlying social norms supporting FGM may weaken, resulting in a decrease in the practice. Sometimes, the incidence remains unchanged, but there may be a shift towards less radical forms of the practice. Factors that reduce the incidence of FGM in humanitarian settings include the diminished influence of intergenerational households and associated social pressures, host community norms that do not require cutting for marriage, or a declining prioritization of the practice due to financial constraints. These factors underscore the complex and varied drivers of FGM in humanitarian settings. Displacement ultimately appears to present a push-and-pull dynamic in the lives of girls and families considering subjecting their daughters to FGM.[72]

Numerous studies have examined both the prevalence and attitudes of migrants from high-prevalence countries to low-prevalence or high-income countries (particularly in the West). The literature consistently demonstrates that with such migration, FGM practices tend to decrease in severity (such as transitioning from Type III to type I or II) or cease altogether.[73] Potential factors contributing to this trend may include reduced social pressure in the new dominant culture where FGM is not a social norm, a desire to adhere to the laws of the new country, effective prevention interventions, the absence of practitioners performing FGM, or the process of acculturation and assimilation into the new host country. In contrast, there are few studies that have investigated how the practice of FGM changes when migration happens from one practicing country to another, with most of the studies focusing on refugees in settlements and humanitarian settings. [74]

Credit: Emily_M_Wilson / iStock

# Study methodology

**Study design:** A qualitative study that utilized in-depth interviews (IDIs).

**Study area:** Data was gathered from diverse Sudanese households residing in three areas in the Cairo and Giza governorates. The Sudanese families included in the study are residents of Nasr City in Cairo governorate and Faisal and 6th October in Giza governorate.

**Study participants:** Members of Sudanese families (fathers, mothers, young people, and grandmothers) currently residing in one of the three study areas. Selection criteria of mothers and fathers included being ever married at least once and having a daughter below 9 years old, as female genital mutilation (FGM) among Sudanese is usually performed between 5 and 9 years. young womans and males were eligible if they fell within the age range of 18-29 and were unmarried. To participate, grandmothers needed to meet the criteria of being above 40 years old and having at least one granddaughter.

Table 1: Selection criteria of study participants

| Participants | Selection criteria |
|---|---|
| Mother | • Ever married<br>• Has a daughter aged below 9 |
| Father | • Ever married<br>• Has a daughter aged below 9 |
| Young woman | • Between 18-29 years<br>• Unmarried |
| Young man | • Between 18-29 years<br>• Unmarried |
| Grandmother | • 40 years and above<br>• Have at least one granddaughter |

**Sampling:** Data was collected using a convenience sampling method. The data collection process persisted until saturation, at which point data analysis ceased to yield new information, resulting in 30 IDIs. IDIs were conducted with 6 ever-married mothers and 6 ever-married fathers from Cairo and Giza, 6 unmarried young women and 6 unmarried young men from Cairo and Giza, and 6 grandmothers.

**Study tool:** An in-depth interview guide was developed in Sudanese Arabic. The IDI guide comprehensively covered diverse aspects, including socio-demographic characteristics, knowledge, attitudes, and practices pertaining to FGM, as well as challenges and opportunities for ending the practice among Sudanese families in Cairo and Giza.

**Data collection:** Five data collectors, comprising three women and two men, were identified and selected based on three main criteria: being Sudanese, currently living in Cairo, and having prior experience in qualitative data collection.

Data collectors underwent comprehensive training on the data collection tool. Prior to its usage, the study tool was pilot-tested with a non-study sample with the same characteristics as the study sample, after which necessary adjustments were made based on the insights gained.

All IDIs were hosted at partner Community-Based Organizations (CBOs) in the specified study areas. Data collection started between November 20th and December 10th, 2023. Female data collectors exclusively facilitated IDIs with female participants, while male data collectors conducted the interviews with male participants. The interviews were recorded using tape recorders after obtaining the participants' written consent.

**Data analysis**: A manual data set analysis was conducted, starting with transcribing recorded interviews into written text to ensure accuracy and completeness. The transcripts were reviewed multiple times to deepen understanding of their context and nuances. Following this, paragraphs were condensed, and the data was manually coded to identify key information. Related codes were then organized into broader themes, which were interpreted to uncover their significance. Finally, the findings were compiled into a report, where the themes and notable quotes were translated into a cohesive narrative that clearly conveyed the study's insights.

**Ethical considerations:** Before each interview, data collectors informed participants about the study's purpose, obtained consent, and ensured confidentiality by recording participants' names only in consent documents. Personal identifiers were removed from transcriptions, and interview recordings were stored securely with limited access and scheduled for deletion after the study report submission. Tadwein prioritized participants' well-being by including a psychosocial expert in the team to support those experiencing distress during the interviews. Conducted at partner CBOs, the interviews involved only the data collector interacting with participants, who were also given Tadwein's office contact for post-interview support or questions.

**Study limitations:** This study has certain limitations. Due to the sensitivities surrounding FGM, some participants may have felt uncomfortable disclosing their true beliefs or practices related to FGM, partly out of concern that discussing their practices might jeopardize their legal status in Egypt, especially where their knowledge of anti-FGM legislation and how they are enforced in Egypt is ambiguous. Another limitation is that most of the study participants interviewed were either from Khartoum, an urban setting with relatively higher rates of FGM abandonment, or had lived in Khartoum prior to the war, and most participants were educated, which may not accurately reflect the knowledge, attitude or practice of FGM among Sudanese migrants in Egypt. We tried to overcome these limitations by conducting the study across two Egyptian governorates and in three areas that are known to host many Sudanese families to ensure the representation of diverse perspectives.

# Study findings

## Knowledge among study participants of female genital mutilation in Sudan:

Types of FGM: Study participants did not refer to the types of female genital mutilation (FGM) as defined internationally (type I, II & III). Instead, they used colloquial terms to refer to the different types. They used the term "Sunna" to describe type I FGM, "sandwich" to describe type II, and "pharaonic" to describe Type III. The majority of female participants were aware of these types, although their level of knowledge regarding which parts are cut in each type varied. Grandmothers were the most informed sub-group and were able to mention which parts are cut in each type, followed by mothers, whereas young woman participants demonstrated the least knowledge regarding FGM types:

> *"The worst type is the complete pharaonic circumcision.... Then there's something called the partial or intermediate pharaonic circumcision, where they remove part of the genitalia (clitoris) and make some alterations, which is somewhat better... There's also a milder type, where alterations are made but without cutting or stitching... this is the least severe and is referred to as 'Sunna'".*
>
> ***(Grandmother, university education, Faisal)***

> *"I know the types of circumcision: these are Sunna, pharaonic and sandwich."*
>
> ***(Mother, university education, Nasr City)***

> *"I am 20 years old... I used to hear that I'm not circumcised... but I didn't really know what that meant or what the procedure itself was"*
>
> ***(Young woman, university education, Nasr City)***

Male participants struggled to differentiate between FGM types and/or recognize the parts that are cut in each type. Younger males had the least knowledge among all participants:

> *"Honestly, I don't know the difference between them; in the end, I know it's just circumcision."*
>
> ***(Young man, university student, 6th October)***

Age of FGM: All female participants stated that FGM is performed at a young age before the girl reaches puberty. They mainly used phrases like "before we started school" or "before puberty" to give an age range that generally falls between 5 and 10 years old. Unlike with the typology of FGM, knowledge of the age at which FGM is performed does not vary among the female participants:

> *"From the age of 5 or 6, usually starting between 5 and 6 years old until about 10 years old, before the stage of adolescence, the girl must be circumcised. These are the ages during which circumcision typically takes place"*
>
> ***(Grandmother, university education, Faisal)***

> *"I don't have information about the types, but the ages are typically ten and below."*
>
> ***(Young woman, secondary education, Faisal)***

*By contrast*, males in different age groups were not able to specify the age at which FGM is performed:

> *"Honestly, what I know about.... and it is done to girls according to her maturity between the ages of 20 and 24"*
>
> ***(Young man, post-graduate, Faisal)***

> *"It is done to girls at around 15 and 16 years of age"*
>
> ***(Young man, university education, Faisal)***

Who performs FGM: Female study participants stated that FGM is mainly performed by midwives in Sudan:

> *"There are traditional midwives, trained midwives, and another category of midwives. All three perform it (FGM)"*
>
> ***(Grandmother, midwifery school, 6th October)***

> *"Some doctors perform it (FGM), but this is very rare. It's mostly midwives"*
>
> ***(Mother, university education, Faisal)***

In contrast, male participants mentioned that medical assistants are the ones who perform FGM. However, young man participants failed to identify who performs FGM. The difference in knowledge among male participants regarding who performs FGM is influenced by their personal experience, familiarity, and expectations. Fathers, for example, may have greater awareness as they are more likely to have encountered FGM when making decisions about their daughters, whereas younger males, who are less directly involved, may rely more on societal beliefs or expectations.

> *"I did not go through the experience of circumcising my daughters. I do not interfere in these things, and I myself did not want to ask who provides this service…. It must be the medical assistant."*
>
> ***(Father, university education, Faisal)***

> *"We don't even know what it is about; I mean, since we grew up, we've never understood what the girls' circumcision is like; what's happening is unknown."*
>
> ***(Father, primary education, 6th October)***

Consequences of FGM: Study participants (females and males) in all age groups had a broad, superficial knowledge regarding the consequences of FGM and failed to give a detailed account of these negative consequences.

However, these consequences were mainly evoked when talking about Type III, the "pharaonic type." In general, the "Sunna" type was perceived as the type with little or no consequences, followed by the "sandwich" and then the "Pharaonic" type.

> *"Sunna is good; it does not cause any complications during delivery, but the pharaonic is bad."*
>
> ***(Mother, uneducated, 6th October)***

Legal status of FGM: The in-depth interviews uncovered noticeable differences in participants' knowledge of FGM legislation in Sudan. In general, participants from older age groups (grandmothers, mothers, and fathers) were more knowledgeable about the laws prohibiting FGM in Sudan compared to younger age groups of men and women who generally had no knowledge of these laws. Although most participants in the older age groups knew about laws against FGM, they could not specify the penalties involved:

> *"There is a law based on which the mother, midwife or doctor who performed this procedure shall be punished"*
>
> ***(Mother, university education, Faisal)***

> *"As far as I remember, a law was issued to criminalize it (FGM) in Sudan"*
>
> ***(Father, university education, 6th October)***

> *"It is (FGM) forbidden… They say that if you bring a midwife to circumcise a girl, the midwife's bag will be confiscated, and you will be imprisoned"*
>
> ***(Mother, uneducated, 6th October)***

## Attitudes and practices of study participants towards female genital mutilation

All participants, regardless of their age or gender demonstrated positive attitudes towards abandoning FGM, more precisely, Type III. However, some study participants perceived the "Sunna type" as a practice with little or no harm. The in-depth interviews unveiled that the participants who had attained a higher education across the different age groups held strong views against the practice and its continuation.

It was also observed that mothers and grandmothers who had negative experiences with FGM were firmer in their refusal to have their daughters undergo FGM. Some of the female participants shared stories of how they stopped the practice in their families because of the harm they experienced. Others talked about the physical and mental harm they still suffer as a result of undergoing FGM.

> *"I am now 53 years old, and its effects are still with me, so this is one of the worst, most hideous things I have come across in my life."*
>
> ***(Grandmother, university education, Faisal)***

These negative experiences were not limited to female participants. Some male participants in the study acknowledged the negative impact of FGM on their intimate relations with their wives and discussed how this motivated their decision not to perform it on their daughters.

> *" My wife and I suffered from it. It caused many problems in our intimate relationship."*
>
> ***(Father, university education, Faisal)***

These findings are consistent with the results of many studies that indicate that younger people with higher education are more likely to have negative views and abandon the practice of FGM:[75]

> *"It's completely illogical and something rooted in ignorance."*
>
> ***(Young woman, university student, Nasr city)***

> *"I am completely convinced that it (FGM) is not right. It causes a lot of problems and complications... I felt like FGM weakens a person's character as if something is taken away from them."*
>
> ***(Mother, university education, Faisal)***

All participants stated that they had abandoned the practice of FGM many years ago, emphasizing that it had not been part of their lives for a significant period, and none of them will subject their daughters to the practice.

> *"Currently, within our immediate family, no one has undergone circumcision... even my younger sisters weren't circumcised, nor were my cousins' daughters, and they don't even consider circumcising them."*
>
> ***(Young woman, university student, 6th October)***

> *"It has completely stopped. My granddaughters and daughters haven't been circumcised... None of my younger sisters have been either. In our entire family, no girls have been circumcised. Thank God. We have six girls, and none of them are circumcised, neither the Sunna nor the pharaonic way."*
>
> ***(Grandmother, university education, Faisal)***

Some of the study participants agreed that families who practice FGM will continue to do so after migrating to Egypt, and others who do not practice it will not take it up:

> *"The ones who originally used to circumcise will circumcise while the ones who don't circumcise won't circumcise. It is all about belief; if a person circumcises there, they will here as well"*
>
> ***(Mother, university education, Nasr City)***

> *"If they practiced it in Sudan and were not convinced to abandon it, they will practice it in Egypt..."*
>
> ***(Mother, university education, Faisal)***

## Practice and trends of change of female genital mutilation in a migrant setting

Most study participants agreed that Sudanese families living in Egypt who practice FGM will continue to do so in a similar manner as they did in Sudan. They will perform the same type they are accustomed to and will likely seek the assistance of a Sudanese midwife. Furthermore, participants mentioned that the age of cutting will not change.

> *"They will go to the Sudanese midwives; they will not go to the Egyptian midwives"*
>
> ***(Mother, uneducated, 6th October)***

> *".... [T]hey will continue to do it in the same way, and they will find a Sudanese woman to perform what they want."*
>
> ***(Mother, university education, Faisal)***

Participants who believed that FGM would continue in Egypt among Sudanese practicing families mentioned that the presence of "Small Sudan" - referring to areas that are heavily populated with Sudanese who came and settled before the war will facilitate the decision of whether to perform FGM, as families will be able to find midwives who can perform it according to the Sudanese customs. Sudanese families who have lived in Egypt long before the war will serve as references for the newly migrated families:

Furthermore, they mentioned that these social networks could exercise pressure to urge mothers to perform FGM to preserve chastity and protect family honor, especially when living in another country:

> *"A mother worries about her daughter here.... the fear is that this is not our country, we don't know it. That's why they'll continue they will say it is to preserve their daughters"*
>
> ***(Mother, uneducated, 6th October)***

In contrast, some participants argued that Sudanese families who migrated to Egypt would be reluctant to perform FGM. They stated that there are several reasons that might lead to the abandonment of the practice:

1) Absence of a traditional social network that supports the decision-making of FGM

Many families have migrated without their elderly members, who are key influencers in the decision-making process and strong advocates of the practice:

> *"When she came here, the influence of the grandmother was not as strong. So, she said she didn't want to practice FGM. Yes, there are families like that."*
>
> ***(Mother, university education, Nasr city)***

> *"Sudanese women changed after coming here; even their character became stronger. They can now openly express their opinions, be assertive and be like, 'These are my daughters, and I am free to make decisions about them,' even around grandmothers or fathers. Many fathers are also becoming more aware of these issues."*
>
> ***(Mother, university education, Faisal)***

### 2) Fear of not practicing FGM in the traditional manner

Study participants indicated that finding a Sudanese midwife to perform FGM might be increasingly difficult in Egypt. This, in turn, might lead to the delay or the abandonment of FGM as Sudanese families will be reluctant to seek the services of Egyptian healthcare providers out of fear that they will not perform FGM in a fashion that they are accustomed to:

> *"Even if someone has the idea of wanting to do this (FGM), they won't find a place to do it or the person who can assist with the procedure."*
>
> ***(Grandmother, university education, Faisal)***

> *"They will not come across anyone performing circumcisions, nor will they find a midwife to do it for them."*
>
> ***(Grandmother, uneducated, Nasr city)***

> *"Here, there's no need for circumcision. Will you take your daughter to a doctor? Of course not. You would only take her to a midwife. Even an Egyptian midwife doesn't do it. Unless it's a Sudanese midwife."*
>
> ***(Mother, uneducated, 6th October)***

### 3) Economic hardship

Sudanese families in Egypt experience economic hardships that force them to spend their income on essentials such as food, clothing, and rent. Some participants believe that the practice of FGM would not be perceived as a priority:

> *"War and migration may have had some effects, and they may have contributed to decreasing the practice itself because the catastrophe of war is a huge one that threatens human lives, their safety, and security. This is something that occupies a person a lot more than circumcision. So, of course, now what has happened has affected and decreased the practice a lot based on my personal opinion, people will not be focusing on circumcision, especially now when they have greater worries and greater things occupying them, like how do they secure their life? So, they will be busy with their basic needs more than with circumcision"*
>
> ***(Father, university education, Nasr City)***

### 4) The presence of an anti-FGM law

Many of the study participants assumed there is an anti-FGM law in Egypt, based on the fact that Sudan has an anti-FGM law. However, they did not provide clear or accurate information about the scope of the law or its penalties. In general, information about the FGM legal framework in Egypt was quite ambiguous to them.

> *"There is a law that punishes the parents and midwife. They are sent to jail, but I am not sure for how many years, maybe from 4 to 10 years"*
>
> ***(Mother, university education, Faisal)***

Some participants mentioned that the presence of anti-FGM law in Egypt might be a driving force that will motivate some families that practice FGM to stop out of the fear of being deported:

> *"You live in their country, and if you do things against the law, you will be punished for it"*
>
> ***(Young man, university student, 6th October)***

## Tension with the host community

The participants' knowledge of the practice of FGM in the host community (Egypt) was found to be limited. The majority of the participants were not aware of the extent of FGM prevalence in Egypt, types of FGM, and age of cutting. However, there was a general assumption that Egyptians performed Type III FGM, the "Pharaonic type," as it was named after them.

> *"Since there is already Pharaonic circumcision, that means who started it? Our older brother, the Pharaoh, so it means that the Egyptians also practice circumcision."*
>
> ***(Young woman, university education, 6th October)***

> *"Theirs is Pharaonic because they are known for Pharaoh, and ours is Sunni."*
>
> ***(Young man, university education, 6th October)***

> *Perhaps the family might struggle to find someone to perform the circumcision, which could be the obstacle."*
>
> ***(Young woman, university education, 6th October)***

The study results also indicate that Sudanese families were generally hesitant to form significant relationships with Egyptian families. Most study participants agreed that their interactions with Egyptians were limited. Some justified this reluctance by pointing to the negative perception that Egyptians have of the Sudanese community, believing that the large-scale migration of Sudanese families contributed to Egypt's recent economic crisis and inflation. Consequently, most Sudanese avoid building relationships with Egyptians to prevent potential problems that could jeopardize their legal status. Because of this limited interaction, most Sudanese families find it challenging to rely on Egyptian families for seeking assistance or advice on FGM for their daughters:

> *"You always feel they (Egyptians) are distant, like they are not comfortable with us. I feel they don't want us, except if you are a doorman, they may accept you, accept what you say, or listen to you. Otherwise, you feel from their looks that they are disgusted by us. We hear a lot of things on public transportation, like "you are disgusting," "we hope disasters befall you, "and" you've filled the whole country". Lots of harassment like this"*
>
> ***(Grandmother, university education, Faisal)***

> *"No no, I don't interact with them [Egyptians], and I don't have friends. All of my friends are Sudanese, and all of them are here. I don't deal with them [Egyptians] at all, except in a few situations if I am going somewhere and I want to ask about something, but I don't interact with them."*
>
> ***(Young woman, university student, Nasr City)***

Credit: UNHCR/Tiksa Negeri

# Analysis of study findings

This section provides a more in-depth analysis and reflects on the study's main findings. In particular, it discusses the determinants that shape knowledge of female genital mutilation (FGM), how it is perceived and shaped as a harmful practice by the participants, the effectiveness of anti-FGM law, the impact of social networks on the perpetuation or abandonment of the practice, and finally, FGM from a migrant lens.

## Gender and age as determinants that shape knowledge of female genital mutilation

The study showed different levels of knowledge among the participants regarding types of FGM, age of cutting, and who performs it. The study's findings noted that gender and age are the main determinants of knowledge level. Regardless of their age, women were found to be more knowledgeable than men, which can be attributed to various social, cultural, and practical factors. In many countries where FGM is practiced, such as Sudan, women are widely viewed as the primary agents involved in decision-making around the practice, both as practitioners and as recipients or survivors of the practice. Several studies noted that older women (mothers and grandmothers) are the main decision-makers when it comes to performing FGM[76] and are responsible for the transmission of knowledge about FGM to younger generations.[77] As a result, older women tend to have more detailed knowledge of the various types of FGM (Type I, II, and III), the age at which it is typically performed, and who performs it.

Men, by contrast, are conventionally viewed as less involved in the decision-making process and, therefore, are less informed about FGM.[78] The widely acknowledged notion of FGM as 'a women's issue'[79] can suggest that men are less involved in the decision-making and, therefore, are less likely to have detailed information about it. However, this understanding has been argued and refuted by many studies.[80] In a recent study conducted by UNICEF MENA, participants stressed that men are involved in the decision-making process of FGM, yet they generally do not interfere in the preparation for the procedure, as this is the role of female family members.[81] Other studies reported that a decline in support for the practice of FGM is observed in the practicing communities when males are included in the awareness programs.[82] In Sudan, a study reported that men are more likely to be involved in a debate around whether to perform FGM or not, rather than the type of FGM performed.[83] This, in turn, can explain the limited information about the practice for male participants.

Age is another factor that determines the level of knowledge about FGM. Older women are found to be the most knowledgeable about FGM. They can explain in detail the different types of FGM and how they are performed. Again, this is due to the fact that these women are most likely survivors of FGM themselves, and their knowledge is derived from their own lived experience with FGM, thereby making them more aware of the procedure's different forms and its impact. Furthermore, FGM has been carried out by traditional cutters who were mainly older females and grandmothers.[84]

## Shifts in attitudes and practices among study participants

The study findings also concluded that younger and highly educated participants showed a stronger and more firm opposition to the practice of FGM. This finding is consistent with the findings of a study conducted among university students in Sudan to explore their perception, knowledge, and beliefs towards FGM. The study found that a significant majority of the university, both female (72.7%) and male (75%), supported the non-continuation of FGM, indicating a shift in attitudes among the younger generation against this practice.[85] Another study by Johnson et al. also highlighted that educated individuals in Sudan show a steady decline in support for FGM, with 52% believing the practice should stop, indicating that education influences opposition to FGM among both women and men.[86]

All study participants mentioned that they had abandoned the practice of FGM. Yet during the discussions, few of them mentioned that they still believe that the "Sunna type" has limited or no effect on women. This perception has been reported in Sudan by several studies and was attributed to the strong opposition of trained midwives to Type III "Pharaonic" and the understanding that they may have created awareness in the communities that this type is illegal.[87] Here, it is important to acknowledge that practices do not always reflect convictions, beliefs, or attitudes. The decision of whether to perform FGM is a complex one, and while some individuals may continue to view FGM favorably due to cultural or traditional beliefs, the decision to perform FGM or not is often a collective one shaped by extended family, neighbors and social networks rather than personal convictions alone.[88] In contexts of migration, cultural adaptation, and increased awareness of the harmful effects of FGM, a divergence between attitudes and practice can emerge.[89] Even when individuals express support for the practice, external factors such as legal restrictions, social integration challenges, and shifts in family dynamics can lead to its discontinuation. This suggests that while supporting attitudes toward FGM may persist within migrant communities, actual engagement in the practice is shaped by broader social, legal, and environmental factors.

**While supporting attitudes toward FGM may persist within migrant communities, actual engagement in the practice is shaped by broader social, legal, and environmental factors**

This complexity is further reflected in the participants' indication that Sudanese families that practice FGM will continue to practice it in Egypt, and they are most likely to perform the "Sunna type." This assumption can be validated as Sudanese families in Egypt attempt to differentiate themselves from their host community (Egypt), whom they perceive as performing the "Pharaonic type." The expected increase in shifting towards the "Sunna type" can be a way for families to minimize possible complications that girls might experience as a result of undergoing a harsher type and thus avoid being admitted to the hospital and facing legal repercussions.

Despite all exerted efforts in Sudan to introduce FGM as a broader violation of human rights and bodily integrity, the majority of study participants (women and men) largely focused on the negative health consequences of FGM, especially Type III, rather than discussing it as a harmful social norm that violates the rights of girls and women's and impedes their bodily autonomy and violates bodily integrity. In Sudan – as in many other practicing countries – there were longstanding efforts to create an alternative social norm around the practice of FGM by encouraging people to talk about the health and well-being of women and girls who have not undergone FGM. These efforts aim to emphasize the normalcy of intact bodies, promote community acceptance for uncut women and girls, and address FGM from a holistic perspective that highlights the practice as a violation of women's and girls' rights by demonstrating its impact on women's sexual and reproductive rights. The initiative "Saleema" is the most notable example of these endeavors.

In partnership with the National Council for Child Welfare, UNICEF Sudan has been at the forefront of the effort to shift social norms around FGM through its ongoing Saleema campaign, which was launched in 2009. The campaign aims to change how communities view the practice by creating a positive cultural narrative around girls who remain uncut. The Saleema campaign sought to make it socially desirable and honorable for girls to remain free from FGM, presenting uncut girls as a symbol of strength, purity, and freedom rather than an act of defiance.[90]

However, the impact of these social change attempts was not visible during the discussions with the participants. Women and girls are still widely not seen as autonomous beings with individual rights; instead, they are perceived as the property of their families or communities. The idea of "protection" through FGM is deeply ingrained, and human rights frameworks that emphasize bodily autonomy and

the rights of women and girls have not yet succeeded in dismantling these deeply held beliefs. This results in an ongoing tension where communities acknowledge the negative health effects of FGM but rarely understand it as an issue of women's rights. Furthermore, the persistence of the medicalization of FGM could be perceived as a barrier to broader social change. The broad shift to "medicalized" FGM in Sudan allowed communities to view the practice through a medical lens—something that needs to be "controlled" or "reduced" in severity rather than something that should be entirely abolished.[91]

## Female genital mutilation in a migrant context

This study is an exploratory one that looks at cross-national migration from a country with high FGM prevalence rate to another high prevalence country. Only a few existing studies looked at populations moving from high prevalence rate countries to others, but these studies focused only on refugees living in refugee settlements outside their home country. This contrasts with the context of Egypt, where Sudanese families live with the host community and not in segregated spaces. Further, these studies have not fully investigated how the drivers of FGM are changed or attenuated in emergency or forced migration contexts.[92] Therefore, little is known about FGM when people migrate from countries with a high FGM prevalence rate, such as Sudan, to another with a high prevalence rate, such as Egyp,t and whether or not it will be reinforced, abandoned, or altered. Also, little is known about how social norms from the country of origin and host community interact and thus shape the practice and its continuation.

The findings in this study suggest that significant changes to the practice of FGM among migrant Sudanese families in Egypt are less likely. Study participants believe that families who have already abandoned FGM will not practice it with their daughters in Egypt, while families who are practicing FGM will continue to do so. Further, they think that there will be no change to how FGM is performed among practicing families with regards to type, age, or who performs it. Among those who will continue, the majority will still perform "Sunna type," performed before puberty and by a Sudanese midwife.

**The continuity and regularity of how FGM is expected to be practiced among Sudanese in Egypt can be attributed to the presence of "Small Sudan," through which families can identify Sudanese midwives to perform FGM in Egypt**

The continuity and regularity of how FGM is expected to be practiced among Sudanese in Egypt can be attributed to the presence of "Small Sudan," through which families can identify Sudanese midwives to perform FGM in Egypt. The presence and influence of Sudanese midwives can be crucial to continuing the practice in Egypt and needs further investigation. Practicing FGM can be an important source of income for them and their families, and therefore, they are expected to promote the practice. A study was conducted to investigate FGM within three refugee camps in the Somali Regional State, Eastern Ethiopia.[93] The findings of this study acknowledged the influential role that FGM cutters play in reinforcing the practice, and 77% of them reported that they relied on the income obtained from performing FGM as they do not have other sources of income. However, the study reported that the majority of the cutters would refrain from performing Type III FGM.

Another factor that might promote the continuation of the practice is the adherence of the Sudanese to their tradition of how FGM is practiced in their home country. The adherence to a familiar practice is widely seen as an effort to distinguish themselves from the host Egyptian community, particularly given the lack of integration observed between Sudanese and Egyptian families as reported by the study participants and some relevant studies.[94] A study conducted by the IOM, which explores FGM abandonment in the context of migration, reached similar results, highlighting that when integration is limited, communities may cling more tightly to their cultural practices as a way of preserving identity.[95]

A possible decrease in the prevalence of FGM among practicing Sudanese families living in Egypt was discussed and reflected upon by study participants. The fact that many of the migrants who arrived in Egypt have crossed the borders without their extended family members could increasingly motivate the process of abandonment, as younger women will be able to decide without the influence of the elderly or extended family members. However, elderly women and grandmothers within the Sudanese social network can negatively influence the desire for change, persuading the family to cut the girls and continue the practice. This finding was observed in several studies on FGM in Sudan in the broader context of the practice.[96]

Moreover, some of the participants said that financial hardship and a shift in the priorities of Sudanese families living in Egypt with respect to housing and access to food might also delay or stop the practice. A recent UNICEF study noted that Sudanese families prioritized education (at 61%) when asked about the services they wish to provide for their children. This was followed by 29% who mentioned health care services, 11% who focused on access to food, and 8% on suitable housing.[97] However, some other study participants refuted the statement that financial hardship alone would lead to reduction in FGM, as they mentioned the importance of social networks in the host community and how they can reinforce the continuation of the practice.

It can be argued that FGM will continue to be practiced among Sudanese migrant families in Egypt and even encouraged as the Sudanese families will be assured of the rightfulness of the practice, seeing that it is widely practiced in Egypt. Further, drawing on the findings of relevant studies, it can be assumed that FGM can continue among Sudanese families in Egypt as a protective measure, a way to manage intense financial pressure, preserve social tradition, or as a means to conform to the new host community social norms.[98] Studies in Africa and Europe that investigated how migration and forced displacement dynamics affect FGM suggest that the practice of FGM is perceived as a protective measure to prevent girls from being the victims of sexual violence, including rape, with some families believing that FGM can safeguard girls' virginity and family honor.[99] Studies suggested that the fear of sexual violence is a main determinate for practicing FGM among Somali refugee communities in European countries.[100] Financial hardships faced by displaced families can also lead to an increase in FGM. Several studies have established a strong correlation between FGM and a girl's marriageability, and thus, FGM could be seen as a means to secure marriage and reduce financial hardship.[101] Also, FGM is often seen as an important cultural tradition, particularly for transnational displaced populations who may view it as a way to maintain cultural identity and/or means to maintain social status and to strengthen their connection by adhering to cultural norms and facilitating integration between migrant communities and the host population with host communities.[102]

Credit: ERA Design/iStock

# Conclusion

The study findings reveal that gender and age play a crucial role in shaping knowledge about female genital mutilation (FGM). Women, especially mothers and grandmothers, were more familiar with the different types of FGM, age of cutting, and FGM performers, while younger participants, particularly young men, had the least awareness. Women described the different types of FGM using colloquial terms such as "Sunna type" (Type I), "Sandwich type" (Type II), and "Pharaonic type" (Type III). Older participants were also more informed about Sudanese laws combating FGM compared to younger generations. Knowledge about FGM in Egypt was limited, with many participants assuming that Egyptians primarily practice the "Pharaonic type," given its association with ancient Egyptian traditions.

Regardless of age and gender, most Sudanese families who were part of the study supported abandoning Type III FGM. However, some still viewed the "Sunna type" as less harmful, believing it causes no or minimal complications. Younger participants with higher education and women with negative personal experiences had the strongest opposition to the practice, while fathers who opposed FGM often cited its negative impact on their intimate relationship with their wives. Despite these shifting attitudes, FGM was not perceived as a form of violence against women or as a violation of bodily integrity. Instead, discussions primarily focused on its health risks rather than its role in controlling female sexuality.

Although FGM is not currently performed among Sudanese families in Egypt, many participants believed that families who practiced FGM in Sudan would likely continue it in Egypt, while those who had already abandoned it would not resume it. The presence of "Small Sudan" was seen as a major factor in maintaining the practice, as it allows families to connect with Sudanese midwives and preserve their traditions.

**Economic hardship has also shifted priorities toward basic necessities like education, healthcare, and housing, leaving little room for traditional practices like FGM**

At the same time, several factors that may encourage the abandonment of FGM were observed. The absence of traditional support networks, particularly elderly family members who influence decision-making, makes it easier for younger families to break away from the practice. Economic hardship has also shifted priorities toward basic necessities like education, healthcare, and housing, leaving little room for traditional practices like FGM. Additionally, legal fears, including the risk of deportation under Egypt's anti-FGM laws, have become a strong deterrent for many families.

Sudanese families who have lived in Egypt for years are becoming important sources of guidance for newly arrived families. At the same time, many Sudanese families feel socially disconnected from Egyptians and are hesitant to seek information or assistance from them regarding FGM. They described their relationships with the host community as fragile, shaped by negative perceptions of Sudanese migrants.

# Study recommendations

The following recommendations are derived from the main findings of the present study and address the issue of female genital mutilation (FGM) within Sudanese communities in Egypt. These recommendations aim to provide actionable strategies for intervention, advocacy, and further research, focusing on key areas that can lead to meaningful change in the effort to reduce and ultimately eliminate the practice of FGM within affected communities.

## A. Recommendations for interventions

| | |
|---|---|
| **1. Awareness raising and education:** | Raising awareness within the Sudanese community about Egyptian laws that criminalize FGM is crucial. Campaigns should focus on highlighting the legal consequences of engaging in FGM, emphasizing the penalties for those who perform the procedure and the accountability of all involved parties. It is equally important to involve young men in these efforts, as their awareness and perspectives can influence their attitudes and empower them to become advocates for change. Moreover, with many families relocating to Egypt with daughters at risk, it is essential to include young girls in these educational initiatives to help empower them to stand against the practice. |
| **2. Engaging key influencers:** | It is critical to engage individuals within the community who are vocal opponents of FGM. These advocates, whether women or men, can participate in dialogues and influence undecided families, helping them reject the practice. Furthermore, targeting influential figures, such as grandmothers in Sudanese communities, through awareness sessions can be particularly impactful. These individuals often hold significant sway over family decisions and can act as key allies in advocating against FGM within their communities. |
| **3. Strengthening community networks:** | Strengthening partnerships between Sudanese and Egyptian civil society organizations is crucial for creating unified and effective anti-FGM messaging and campaigns while also promoting community integration initiatives. "Small Sudan" communities can play a pivotal role in promoting these initiatives by serving as channels for change. These culturally-relevant and trusted networks can foster meaningful connections and facilitate attitude shifts. |
| **4. Empowering women and families:** | Empowering mothers to make informed and independent decisions about their daughters' well-being is a vital component of these efforts. Mothers should be provided with the knowledge and confidence to resist societal and familial pressure to continue FGM. Creating safe spaces for Sudanese women and girls in Egypt is also essential, as these spaces offer a platform to discuss experiences, seek advice, and gain support in rejecting FGM. Through these interventions, women and girls can be equipped to make choices that prioritize their health and rights. |
| **5. Integrating FGM awareness into humanitarian aid programs in Egypt:** | Humanitarian aid organizations should prioritize the inclusion of FGM in their agendas as the prevention of and response to FGM is often not prioritized in these settings.[103] Migrant populations are often not exposed to anti-FGM messages or are involved in awareness-raising programs on harmful traditional practices. Therefore, efforts should be made to integrate FGM awareness into humanitarian initiatives to ensure these vulnerable groups receive the necessary information and support to combat FGM. |

| B. Recommendations for advocacy messaging | |
|---|---|
| 1. Integrating health, human rights, and gender discourses: | While study participants have a good understanding of the health complications associated with the practice, this knowledge alone is insufficient to deter the practice of FGM. Advocacy efforts must integrate human rights and gender perspectives into awareness and community dialogue sessions, emphasizing the violation of bodily autonomy and the broader social implications of FGM. |
| 2. Addressing misconceptions about Type I FGM: | Messaging should specifically target misconceptions surrounding Type 1 FGM, popularly known as the "Sunna type" of cutting. This includes clarifying that the so-called "Sunna type" is harmful and is also illegal, especially for older women populations who may hold strong traditional beliefs about it. Efforts must also stress that having the "Sunna type" performed by a doctor does not make the practice legitimate or safe. |
| 3. Legal accountability of healthcare providers: | Advocacy must also highlight that the involvement of healthcare providers, including midwives, doctors, and nurses, in FGM is a punishable offense under the law, reinforcing the legal consequences for medical professionals who engage in the practice. |
| 4. Expanding platforms for advocacy: | To reach a wide audience, diverse platforms for advocacy are critical. These platforms should include seminars, workshops, lectures, social media campaigns, and verbal, visual, and written advocacy materials. Tailored messaging through these channels ensures that information is accessible and resonates with different population segments. |
| 5. Enhancing the role of media: | Media should play a central role in combating FGM by disseminating accurate information and challenging harmful norms. Strategic use of traditional media, such as television and radio, alongside social media platforms can normalize anti-FGM messaging, counter misinformation, and foster community-wide dialogue on the practice. |

| C. Recommendations for research | |
|---|---|
| 1. Intergenerational dynamics and decision-making power: | There is a need to investigate intergenerational power dynamics within "Small Sudan" social networks and their impact on the mothers' autonomy in decision-making regarding the health and well-being of their daughters. |
| 2. Shifts in FGM practices post-migration: | Conduct longitudinal or cross-sectional studies to analyze shifts in FGM-related practices among Sudanese families after migration to Egypt. This includes examining changes in the age at which FGM is performed and shifts in preferred practitioners, such as midwives versus medical professionals. |
| 3. Conceptualization and religious framing of Type 1 FGM: | To explore the conceptualization of Type I FGM as "Sunna" within Sudanese communities to address misconceptions and variations in its understanding. This includes examining the cultural and religious justifications associated with this type. |
| 4. Trends in care-seeking behavior and medicalization: | Examine any evolving patterns of care-seeking behavior among Sudanese families, particularly whether there is a shift towards consulting medical doctors instead of midwives for FGM. |
| 5. Male perspectives and negative experiences: | Explore male negative experiences associated with the practice and their influence on household decision-making after migration. |
| 6. Scaling research efforts: | Design large-scale, population-based studies to provide statistically robust data on the prevalence, attitudes, and practices of FGM among Sudanese migrants in Egypt. |

# Annex

*Table 1: Sociodemographic Distribution of Study Participants:*

| No. | Category | Area | Education | Origin/area from Sudan |
|---|---|---|---|---|
| 1 | Father | Faisal | University education | Lived in Khartoum |
| 2 | Father | Faisal | Uneducated | From East Darfur. Lived in Khartoum. |
| 3 | Father | Nasr City | University education | From North Kordofan. Lived in North Kordofan |
| 4 | Father | 6th October | University education | From Eastern states. Lived in Khartoum. |
| 5 | Father | 6th October | Primary education | Lived in Khartoum. |
| 6 | Father | Nasr City | Medical Doctor | From White Nile state. Lived in Khartoum |
| 7 | Grandmother | Faisal | University education | Lived in Khartoum |
| 8 | Grandmother | Nasr | Uneducated | From Darfur States. Lived in Khartoum. |
| 9 | Grandmother | 6th October | Uneducated | From North Darfur. Lived in Khartoum. |
| 10 | Grandmother | Nasr | Postgraduate | Lived in Khartoum |
| 11 | Grandmother | 6th October | Midwifery school | From South Darfur. Lived in North Darfur. |
| 12 | Grandmother | Faisal | University education | Lived in Khartoum |
| 13 | Mother | Faisal | University education | From Northern State. Lived in Khartoum. |
| 14 | Mother | Nasr City | Medical Doctor | Lived in Khartoum |
| 15 | Mother | 6th October | Uneducated | From North Darfur State. Lived in Northern State. |
| 16 | Mother | 6th October | University education | Lived between Khartoum and Saudi Arabia. |
| 17 | Mother | Faisal | University education | From Western States. Born and raised in Gezira State. Moved to Khartoum State later. |
| 18 | Mother | Nasr City | University education | From Northern State. Lived in Khartoum. |
| 19 | Young woman | Faisal | University education | From Gezira State. Lived in Khartoum. |
| 20 | Young woman | 6th October | University education | From South Darfur. Lived in Khartoum. |
| 21 | Young woman | 6th October | University student | Lived in Khartoum |
| 22 | Young woman | Nasr City | University education | Lived in Khartoum |
| 23 | Young woman | Nasr City | University student | Lived in Khartoum |
| 24 | Young woman | Faisal | High school student | Lived in Khartoum |
| 25 | Young man | Faisal | University education | Lived in Khartoum |
| 26 | Young man | Nasr City | University education | Lived in Khartoum |
| 27 | Young man | Faisal | Postgraduate | Lived in Khartoum |
| 28 | Young man | Nasr City | University student | From Gezira State. Lived in Gezira State |
| 29 | Young man | 6th October | University education | Lived in Khartoum |
| 30 | Young man | 6th October | University Student | Lived in Khartoum |

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