Female genital cutting in Egypt: drivers and potential responses

Quentin Wodon, Ali Yedan, and Els Leye

Abstract
Female genital cutting (FGC) is a major issue at the interplay of faith and health in development. The practice is in part faith-inspired, and has clear negative health impacts. The prevalence of FGC remains especially high in Egypt. This article reflects on some of the factors that lead to the perpetuation of the practice by analysing data from the 2014 Survey of Young People in Egypt. The focus is on whether religiosity, acceptance of traditional gender roles and discrimination, attitudes towards women's autonomy, and age at marriage affect attitudes towards FGC, controlling for other factors. The results suggest that all these factors do indeed play a role.

Keywords: Gender and diversity – Youth; Social sector – Health; Arab States

Introduction

The interaction between faith and health is an important but still overlooked issue in the literature on development. In a simplified way, at least two types of issues can be considered: the role of faith-based organisations in service delivery, and the interplay between faith and behaviour.

There is clear evidence that faith-based organisations play a major role on the delivery of health services, as illustrated most recently in the case of Africa by Olivier et al. (2015) and Wodon (2015a). While the market share of faith-inspired organisations in health care provision is lower than is often claimed (Wodon et al. 2014), the performance of faith-based organisations is in many cases strong in terms of the quality of the services being provided at a cost affordable for the poor (Gemignani, Tsimpo, and Wodon 2014). This suggests that public–private partnerships for health service delivery between governments and faith-based providers could be expanded. A useful example of such partnership is the work of Christian health associations in African countries.

However, in addition to service delivery, faith also plays a key role in the perceptions and behaviours of individuals and households. Religious beliefs affect how parents choose a school for their children (Gemignani, Sojo, and Wodon 2014). They also affect how individuals behave in areas that matter for health, sometimes in a positive way, and sometimes not. A clear illustration of these tensions is the issue of female genital mutilation, or female genital cutting (FGC) as it is more often referred to in North Africa. The practice is found across much of Africa. So-called sunna (traditional) circumcision involves removing the tip of the clitoris. Clitoridectomy entails removing most or all of the clitoris. Infibulations are the most severe form of FGC and entail the removal of the clitoris and labia, and possibly stitching together the edges of the vulva.

FGC, especially in its most extreme forms, has very serious health risks (for an overview of consequences on health and well-being, see, for example, WHO 2016), and can even lead to death, apart from the psychological trauma it may cause (OHCHR et al. 2008). While efforts at the level of individual countries must take into account the specific context of each country, especially when the prevalence of FGC remains high despite governmental efforts and legal criminalisation, there may be a role to play for international influence and even pressure on local policy-making in order to reduce local resistance. Whether this can work or not is discussed, among others, by Boyle et al. (2001).
In Egypt, the country of focus for this article, the prevalence of FGC remains very high despite efforts by the government to end the practice. Such difficulties have also been observed in other countries, and in some cases there is evidence that legal prohibition of the practice may lead to underreporting in surveys or interviews (see Ako and Akweongo 2009; Jackson et al. 2003, on Ghana; and Gemignani and Wodon 2015, on Burkina Faso).

There have been several media accounts of deaths related to FGC in Egypt. One of the most recent occurred in May 2016 (The Guardian, May 31, 2016). A landmark event that put FGC high on the agenda was the International Conference on Population and Development held in Cairo in 1994, where the Egyptian Minister of Health suggested that progress was being made in ending the practice in the country. That same week however, CNN broadcasted the circumcision of a girl, which triggered policy developments. A National Task Force against Female Genital Mutilation was set up in 1994, but the voluntary organ of the national task force was later disbanded. The subject of FGC was thereafter taken up in 1999 within the official state-appointed National Council for Childhood and Motherhood that carried out a national anti-FGC strategy among other activities. According to Van Raemdonck, the attention placed by the government on FGC was part of a general opening to issues related to human rights and citizenship (Van Raemdonck 2016). In 2007, FGC was criminalised and penalties were toughened in August 2016 (Michaelson 2016).

Despite efforts to end FGC in Egypt, the practice remains highly prevalent. The first time FGC was included in the Demographic and Health Survey in Egypt was in 1995. At the time, 97% of women between 15 and 40 years had some form of FGC (Van Raemdonck 2016). The latest Demographic and Health Survey (DHS), implemented in 2014, suggests that 92.3% of married women aged 15-49 years have been subjected to the practice. A majority (51.7%) believe that the practice is a religious requirement even though, as will be discussed in this article, Egypt’s Administrative Court has clearly said it is not on the basis of its interpretation of Shari’a (Balz 1998). Less than a third of married women (31.2%) believe that the practice should be stopped even if more than half understand that it could lead to death in the case of complications. Finally, about half of married women (49.8%) believe that men prefer the practice to continue, and only a third (35.0%) recently heard information about the practice.

Another characteristic of FGC in Egypt is that the practice is highly medicalised. According to data from the 2014 DHS, the percentage of circumcisions carried out by medical personnel (doctor, nurse, or other health worker) was 38% among respondents (the mothers) versus 82% among their daughters. The risk of medicalisation is that it may create legitimacy for FGC. Results are similar in the 2014 Survey of Young People in Egypt (SYPE) among girls and women aged 13-35, with 43.2% of girls and women who underwent the procedure by a doctor, an additional 11.3% for nurses, and 27.7% by dayas (midwives mostly in rural areas). The rest were female circumcision specialists (14.2%) and other individuals (about 1% each for barbers, relatives, other persons, and in a few cases individuals not recalling who performed the procedure).

Within the context of this Development in Practice special issue devoted to faith and health in development, FGC is clearly relevant given that the practice is in part faith-inspired, and that it has clear negative health impacts – including sometimes fatal impacts – on girls, not to speak of other negative implications of the practice, including possibly for gender discrimination.

Why does FGC remain so prevalent in Egypt? This article’s objective is to try to answer this question, at least tentatively, by reflecting on the proximate determinants of the practice using data from the 2014 SYPE. The survey has information on FGC as well as the perceptions of youth – defined for the survey as individuals from 13 to 35 years of age – on topics such as religion,
traditional gender roles and gender discrimination, and women’s autonomy. Before delving into the data, it is worth discussing briefly from a conceptual and policy point of view the role that religion may play in the perpetuation of the practice, or more precisely controversies about that role in the specific case of Egypt.

Religion, FGC, and health in Egypt

Religion, and specifically Islam, has played a role in the perpetuation of FGC in many countries, but this role is more complex than often believed, including in Egypt. Research on the role of religion in FGC discourse in Egypt shows how the relationship between FGC and religion, both in Islam and Christianity, is a function of underlying interconnected and interrelated socio-cultural values that express social norms on gender and sexuality. This basically means that religious and cultural/ secular practices are often inextricably intertwined (Van Raemdonck 2016).

FGC long predated Islam and is found in many ethnic groups in Africa regardless of religion. There is no one-to-one relationship between Islam and the practice. Some Muslim communities oppose FGC (Gruenbaum 2001; Renders 2005) and FGC is not widely practiced across much of the Middle East, albeit with exceptions (Von der Osten-Sacken and Uwer 2007; WHO 2006). The connection between Islam and FGC is by no means universal (Abusharaf 2007; Asmani and Abdi 2008), but this does not mean that there is no connection either.

Arguments from Islamic law or Shari’a have been used to defend the practice, but they tend to be weak (Abu-Sahlieh 1994; Wodon 2015). Three main sources inform Shari’a: the Qur’an, the Sunnah (the teachings, deeds, and sayings of the Prophet), and fiqh (Islamic jurisprudence). There are no references to FGC in the Qur’an but some (minority position) theologians interpret Abraham’s exemplary circumcision to infer that FGC is also obligatory. That is, because Abraham was circumcised, some have argued that all Muslims should be, but this may not apply to female cutting which is much harsher than male circumcision.

With regards to the Sunnah, several hadiths, and especially the excisor’s narration, discuss FGC. When asked by an excisor of female slaves whether excision was permitted, the Prophet responded that it is allowed, but should not be overdone. This hadith considered as recommending mild forms of circumcision, but its genealogy (isnad) as well as its normative value are considered as weak. Finally, within the realm of fiqh, support for FGC is limited, with different schools of Islamic thought holding different positions. Historically, all schools were favourable towards the practice (for a review, see Van Raemdonck 2016). But the number of religious opinions against FGC has increased, especially since the beginning of the twentieth century when the first national debates on FGC erupted in the context of concerns with modernisation and women’s status in society.

The limits of Shari’a support for FGC can be illustrated in the case of Egypt by recalling events from twenty years ago. In July 1996, the Egyptian Minister of Health promulgated a decree prohibiting FGC (Balz 1998), unless done by health professionals for medical reasons (Laws of the world on female genital mutilation, Egypt, Order No. 261 of 8 July 1996 of the Minister of Health and Population).[1] The decree was challenged in Cairo’s Administrative Court by Islamic leaders who argued that it violated Shari’a. The plaintiffs won, but the Minister of Health appealed to the Supreme Administrative Court which adjudicates disputes on how to apply Shari’a in particular cases. The Supreme Administrative Court ruled in favour of prohibiting FGC in 1997 and based its decision on the principles of bodily integrity and no damage, no infliction (Islamic prohibition to inflict damage on others if they in return do not inflict damage as well), which are also part of
Shari’a. At the same time, the Supreme Administrative Court kept the exception regarding medical grounds for performing the practice. According to UNICEF, this clause – together with a strong focus on the negative health impact of FGC – contributed to the rapid medicalisation of the practice in the country (UNICEF 2005). In 2007, another ministerial decree by the Ministry of Health (n° 271) was issued that banned FGC in all medical clinics, private and public, but the decree is barely implemented. In most lawsuits against doctors performing FGC, the doctors are found to be innocent or only convicted to paying a fine (Van Raemdonck 2016).

FGC remains widespread today, and is declining very slowly according to the available data from DHS and other surveys. In August 2016, Egypt’s parliament approved tougher sanctions against the practice, including prison terms of five to seven years for those carrying out the procedure, and up to 15 years in prison if the procedure results in a girl’s death. Those escorting girls to undertake the procedure may face up to three years in prison. It remains to be seen, however, whether these tougher sanctions will help in a more decisive way to end the practice. For context, it is important to note that the question of FGC and the link with religion may be politicised, so that opinions from state-appointed Islamic representatives may differ from those of some Islamic organisations, with debates as to whom has the authority to speak about FGC and religion.

Within this challenging context, this paper’s objective is to reflect on some of the proximate determinants of the continuation of the practice in Egypt using data from the 2014 SYPE survey, with the hope that this can give additional insights on how to help end the practice. The next section explains the data used for the analysis and reflects on the results of a regression analysis of the proximate determinants of FGC. A conclusion and discussion follows, including in terms of the programmes and approaches that could help end FGC in Egypt.

Data and analysis

The analysis is based on data from the SYPE implemented by the Population Council in 2014. The survey has a relatively large sample size with data on 5,843 women and 5,073 men between 13 and 35 years of age. The main advantage of the SYPE over the DHS for our analysis is that it includes a range of questions that can be used to construct indices of religiosity and perceptions about gender that are not available in the DHS. In addition, the SYPE focuses on youth whose perceptions are essential for the perpetuation of the practice, while the sample of youths included in the DHS is smaller.

The aim of this article is to reflect on the proximate determinants of the continuation of the practice in Egypt. The reason for using the SYPE data is that they provide rich data in terms not only of perceptions regarding FGC, but also attitudes related to religion, traditional gender roles and gender discrimination, and women’s autonomy. The underlying question is whether attitudes towards religion (as they can be measured through the level of religiosity of an individual) as well as attitudes towards gender (in terms of both tolerance towards traditional gender roles and discrimination, and approbation of women’s autonomy to divorce a husband) affect attitudes towards the perpetuation of FGC, controlling for a wide range of other individual and household characteristics such as education, geographic location, age, actual age at marriage and perceived ideal age to marry, and socio-economic status, among others.

Three questions are asked in the SYPE about attitudes towards FGC which may lead to the perpetuation of the practice over time. First, youths are asked if they consider FGC to be necessary, and if so why. Potential answers as to the reasons are for religious reasons, for customs and traditions, to get married (for girls/women), and for medical reasons. Next, youths are
asked whether they would like their daughter to be circumcised. Finally, they are asked whether they would like their son’s wife to be circumcised. There is also a question in the survey as to whether women have been circumcised themselves, but since most women have indeed been circumcised, and since this may be related to some of the same values/perceptions, this is not controlled for. The objective is not to look at past circumcision, but rather at the correlates of the perpetuation of the practice over time as expressed by attitudes towards future circumcision.

In order to assess the potential impact of attitudes towards religion and gender on perceptions of FGC, three indices are constructed. The first index measures the religiosity of individuals. The second index measures the tolerance of individuals towards traditional gender roles and gender discrimination. The third index measures the level of approbation of individuals towards women’s autonomy in the case of a divorce. All three indices are constructed from a range of questions in the survey using factorial analysis, with normalisation so that each index takes on a value between zero and one.

As mentioned in the introduction, there may be relations between political and religious views on FGC in Egypt. For this reason, the question into the religiosity of respondents and the measurement of the level of religiosity may miss out on certain other relevant factors such as political leanings/positioning and how individuals understand the meaning of religion. These nuances are not capture here due to limitations in the data, so the findings should be treated as tentative or initial.

The detailed analysis for the construction of the three indices as well as the regressions on the correlates of perceptions towards FGC are not included due to space limits (and to avoid a rather technical paper). We focus here on the main results of the analysis and their potential implications.

Table 1 provides the shares of individuals declaring that FGC is necessary, that they would like their daughter to be circumcised, or that they would like their son to have a wife who is circumcised, according to values of the indices of religiosity, tolerance towards traditional gender roles and gender discrimination, and tolerance to women being able to divorce their husband. For each index three groups (terciles) are created – the individuals in the bottom tercile have the lowest value for the index, while those in the top tercile have the highest value. For example, individuals in the bottom tercile of religiosity are the least religious, while those in the top tercile are the most religious. In addition to perceptions of FGC according to where individuals are situated in terms of the three indices, Table 1 also considers perceptions of FGC in relationship to the question of whether girls/women married before the age of 20, or whether they consider the ideal age for marrying as being lower than 20 (we did not consider the child marriage threshold of 18 because in Egypt and especially in the SPYE the incidence of child marriage is low). These variables are included in the analysis because they are another way to capture potential gender effects. Statistics are provided by gender, separating women and men who may differ in attitudes.

A few interesting findings emerge from Table 1. Consider first religiosity. While among all women, 64.58% believe FGC to be necessary, the proportion is higher among those who are less religious than among those who are more religious. The same is observed for the desire to have a daughter circumcised, and the preference for a son to marry a woman who is circumcised. This suggests a negative relationship between the belief that FGC is necessary and religiosity for women. For men, differences according to religiosity tend to be less salient. When considering tolerance towards traditional gender roles and gender discrimination, the relationships tend to be similar for men and women, in that men and women with higher sympathy for traditional gender roles and gender
discrimination are more likely to state that FGC is necessary, that daughters should be circumcised, and that sons should marry women who are circumcised. The directionality for men and women is observed for the index capturing the approbation of women divorcing – those who approve more are less likely to be in favour of FGC. Finally, when considering the age at marriage, or the perceived ideal age to marry, there is also clear directionality that is common to men and women. Those favouring marriage at an earlier age are more likely to be in favour of FGC. The question considered in the next section is whether those patterns remain when controlling for other individual characteristics that may affect perceptions towards FGC.

For the econometric analysis of the correlates of attitudes towards the perpetuation of FGC, three dependent variables are used, namely whether an individual responds in the affirmative to the questions about whether FGC is necessary, whether their daughter should be circumcised, and whether their son should marry a woman who is circumcised. A wide range of controls are used as independent variables apart from the three indices mentioned above and variables related to the age at marriage (actual or ideal).

Table 2 summarises the main findings for the variables of interest. Impacts are measured as an increase or decrease in percentage terms in the probability to support FGC. Coefficients that are statistically significant at least at the 10% level are displayed.

For women as a whole, a higher level of religiosity leads to a reduction in the probability of considering FGC as necessary (-9.24 percentage points), or suitable for one’s daughter (-9.03 points) or the wife of one’s son (-6.91 points). By contrast, for men, religiosity does not affect the likelihood of considering FGC as necessary or preferring one’s daughter to be circumcised, but it does affect preferences regarding the wife of one’s son with a positive effect observed (large increase in preferences of 13.39 points). In other words, highly religious women tend to be less in favour of FGC, while highly religious men are more in favour of the practice, at least for the future wife of their son, while the index of religiosity does not seem to be correlated in a statistically significant way with their attitudes towards the circumcision of their daughter. The differences between men and women in the pattern of partial correlations for the impact of religiosity on attitudes towards FGC is an interesting finding, with the regression results confirming what was already observed in the statistical analysis in Table 1. As expected, for both men and women, being in the religious minority (i.e., being a Christian in most cases) is associated with a very large reduction of the likelihood of being in favour of FGC (effects ranging from 21 to 34 points), suggesting that adhering to the Islamic faith has a large positive impact on being in favour of FGC. This difference by religion has been documented elsewhere, both quantitatively and qualitatively (see Van Raemdonck 2016).

The gender indices as well as the variables related to the age at marriage also reveal strong effects. Those who are more tolerant towards traditional gender roles as well as gender discrimination tend to be more in favour of FGC, and this is observed for both men and women. The effect of the index of approbation for the autonomy of women when seeking a divorce is less strong, but it has the expected negative sign, and does lead to a few statistically significant effects. This is more the case for men than women, suggesting that especially for men, a lack of approbation for women’s autonomy in divorce decisions is associated with support for FGC. Finally, those who never married are less likely to be in favour of FGC than those who have married, and those who believe that it is best to marry at a young age are more in favour of the practice.
These results suggest that in the sample as a whole, attitudes towards gender roles and prerogatives (or the lack thereof) play a fundamental role in the perpetuation of the practice, which is not surprising. Although this is not shown in Table 2, there are also differences in terms of support for FGC depending on the education, age, and socio-economic status of the individual, with larger effects often observed for women than men along those variables. But the result that is perhaps surprising is the fact that religiosity appears to affect attitudes towards FGC in a different way for men and women. More religious women seem to support the practice less than less religious women, while more religious men seem to support FGC more for the future wife of their son.

This does not mean, however, that these effects of religiosity hold in the same way for all individuals, as there is heterogeneity within groups. Some of the results do change when disaggregating further the data on perceptions to consider separately three groups: those who say that FGC is necessary for religious reasons, because of customs or traditions, for women to be able to get married, or for medical or other reasons. In general, the relationships do not change too fundamentally, but there is a change in the impact of religiosity. When considering those who state that FGC is necessary for religious reasons, the likelihood of a positive response is higher for more religious individuals, whether one considers men or women, while more religious individuals are less likely to consider FGC as necessary due to customs or traditions. In other words, for the sample of women as a whole, more religious women tend to be less likely to be in favour of FGC, but when considering only those women who consider FGC to be necessary due to religious women, this response is associated with a higher degree of religiosity.

Discussion

The persistence of very high rates of FGC, and the slow decline in prevalence, is a serious health issue in Egypt. It is also an issue that affects the rights of the girls who undergo the practice. The aim of this article was to reflect on some of the factors that lead to the perpetuation of FGC using data from the 2014 SYPE. The results suggest that multiple factors lead to the perpetuation of the practice, including religiosity, acceptance of traditional gender roles and gender discrimination, and attitudes towards women’s autonomy. Education, geographic location, age, conceptions of the ideal age at marriage, and socio-economic status also play a role.

One interesting finding was that in the sample as a whole, more religious women were less likely to be in favour of FGC, while more religious men were more in favour of the practice, at least for their future wife or their son. When looking at sub-samples of individuals according to the reason why they believe that FGC is necessary, more traditional results hold, in that among those who indicate that FGC is necessary for religious reasons, the probability of saying so is higher for more religious women. But again, for women as a whole, a higher level of religiosity is associated with less support for FGC, which suggests that the relationship between religion and the practice is rather complex. Simply stating that religion and religiosity lead to support for FGC is not correct.

What could this suggest for policy and programme interventions? One should be careful not to draw definitive policy conclusions from the simple analysis reported in this article, but a few suggestions can be made taking into account both the results from the article and the broader literature on FGC, especially in Egypt. The findings reported in the previous section clearly suggest a need to take into account the local context and how religious factors are intertwined with other aspects of culture, gender norms, and rights. As the analysis suggests, many factors come into play for the perpetuation of FGC, including gender roles and norms. As a result, to be successful interventions towards ending FGC typically need to be driven by, and involve, the community. This
requires gaining in-depth knowledge of the community and paying careful attention to strategies to successfully engage with communities (Johansen et al. 2013). In a recent publication by UNFPA and NORAD, religion is mentioned as an influential aspect of culture, while at the same time cultural dynamics influence religion and religious practices. Cultures and religious institutions and teachings about daily life are often changing, sometimes in significant ways, in response to urbanisation, global and national politics, new information and technologies, and raising education levels (especially for women). There is therefore a need to expand stakeholders’ literacy about religious dynamics that underpin FGC (UNFPA and NORAD 2016).

Interventions that aim at reducing the prevalence of FGC probably also need to be multifaceted since multiple factors play a role in the perpetuation of the practice (Johansen et al. 2013; UNFPA 2004; UNICEF 2010). One the one hand they need to prevent and protect, but on the other hand they also need to prosecute when needed. It is also essential that different stakeholders such as policymakers, NGOs, religious leaders, and health professionals work together towards ending FGC. Especially in the case of Egypt, health personnel could play an important role in ending the practice given high rates of medicalisation. This medicalisation is due in part to the perceived safety of health professionals in performing the procedure in comparison to traditional practitioners. Yet a problematic structure of incentives is at fault when doctors performing an FGC may be earning more than from a regular doctor’s visit. Perhaps countervailing financial incentives not to carry out the procedure might be helpful to end the practice.

Proper training about FGC in the medical and nursing curricula is also important in order to make sure that healthcare providers do not consider FGC as medically indicated for women or harmless. Medical students must be made aware of risks associated with FGC and information campaigns must also properly target the population. In addition to conveying information about the potentially harmful effects of female genital cutting for health, successful programmes do this in a way that puts the community in the lead, aims to changes social norms at the community level instead of only individual attitudes, and empower women (McChesney 2015; see also Rahlenbeck and Mekonnen 2010; Shell-Duncan 2008).

Overall, due to their sensitivity and complexity, practices such as FGC must be countered with multi-sectoral engagements and the combined efforts not only from ministries (health, women’s affairs and education), but also civil society. Ideally FGC should be treated as a human rights issue and not simply a health issue. Some interventions in Egypt have shown some level of success. For example, an evaluation of the FGC-Free Village Model indicated that the programme was successful in changing views and attitudes towards FGC (Barsoum et al. 2011). The evaluation emphasised the role of mass media and the need to engage men and religious leaders. It cautioned against just focusing on the physical consequences of the practice as this could simply lead to medicalisation. Fundamentally, FGC remains prevalent in societies with pronounced gender inequalities and power imbalances and cannot be ended without ensuring women’s empowerment, as the results provided in this article contribute to document.

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Notes on contributors
Quentin Wodon is a Lead Economist in the Education Global Practice at the World Bank, where he
leads global programmes on equity and inclusion in education, child marriage, and out-of-school children, as well as country work. Previously, he managed the World Bank’s unit working on faith and development, served as Lead Poverty Specialist for West and Central Africa, and as Economist/Senior Economist in the Latin American region. He holds graduate degrees in business engineering, economics, and philosophy, and PhDs in Economics, Environmental Science, Health Sciences, and Theology and Religious Studies.

Ali Yedan is a Consultant in the Education Global Practice at the World Bank. He holds a PhD in Economics. He is actively contributing at the World Bank to global research projects on child marriage and out-of-school children, as well as country work.

Els Leye is Assistant Professor attached to the International Centre for Reproductive Health at Ghent University. She holds a PhD in Comparative Sciences of Culture. Her research interests include harmful cultural practices, and more specifically female genital mutilation, forced marriages, and honour-related violence.

Notes
1. See www.hsph.harvard.edu/population/fgm/Egypt.fgm.htm.

References


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Source: Authors’ estimations using 2014 SYPE.
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</tr>
<tr>
<td><strong>Gender</strong></td>
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<tr>
<td>Discrimination</td>
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<td>0.09</td>
<td>0.09</td>
<td>0.12</td>
<td>0.17</td>
<td>0.20</td>
</tr>
<tr>
<td>Autonomy</td>
<td>NS</td>
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<td>-0.05</td>
<td>NS</td>
<td>-0.04</td>
<td>-0.03</td>
</tr>
<tr>
<td><strong>Age at marriage</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married &lt;20</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Never married</td>
<td>-0.07</td>
<td>-0.06</td>
<td>-0.09</td>
<td>-0.07</td>
<td>-0.05</td>
<td>-0.07</td>
</tr>
<tr>
<td>Best if married &lt;20</td>
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<td>0.05</td>
<td>0.06</td>
<td>0.08</td>
<td>0.07</td>
<td>0.06</td>
</tr>
</tbody>
</table>

Notes: All statistically significant coefficients at the 10% level or higher are reported. ‘NS’ = not statistically significant.

Source: Authors’ estimations using 2014 SYPE.