18 December 2009

The Committee on the Elimination of Discrimination against Women (CEDAW Committee)

Re: Supplementary Information about Egypt scheduled for review during the 45th Session of the CEDAW Committee

Dear Committee Members:

This submission is intended to supplement the combined 6th and 7th periodic report of the government of Egypt, which is scheduled to be reviewed by the CEDAW Committee during its 45th Session. The Egyptian Initiative for Personal Rights, based in Cairo, and the Center for Reproductive Rights, based in New York, are independent, non-governmental organizations that hope to further the work of the Committee by providing information concerning the rights protected in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW). This submission highlights areas of concern related to the status of reproductive and sexual health and rights of women and girls in Egypt.

Reproductive and sexual rights are fundamental to women's health and social equality and an explicit part of the Committee's mandate under the CEDAW. The commitment of States parties to respect, protect and fulfill these rights deserves serious attention.

We wish to bring to the Committee's attention several areas of concern, including maternal mortality and morbidity, unsafe abortion, inadequate family planning services, deficient adolescent reproductive services and sexual violence against women.

I. The Right to Reproductive Health Services and Information (Articles 10, 12, 14(2)(b), and 16(1)(e))

A. Maternal Health

States parties to the CEDAW have a duty to ensure maternal health by providing women with the "appropriate services in connection with pregnancy" and by promoting a "proper understanding of

maternity as a social function."[1] The CEDAW Committee has emphasized that high rates of maternal mortality and morbidity indicate potential violations of this duty.[2] Similarly, the United Nations Special Rapporteur on the Right to Health has noted that "[a]voidable maternal mortality violates women's rights to life, health, equality and non-discrimination."[3]

Maternal mortality

Challenges with documentation and data-collection

In 1992, the Ministry of Health conducted the first national survey of maternal mortality, and in 1996 it introduced maternal and childcare services in the package of basic health services offered at all primary health care clinics. In 2000, the Ministry of Health conducted the second national survey on maternal mortality and in 2002 the Minister of Health and Population issued decree 197/2002 creating a national commission on safe motherhood, headed by the Minister, and local safe motherhood committees at the governorate level. The same year, the National Maternal Mortality Surveillance System (NMMSS) was established to document every case of maternal mortality in the 27 governorates. As part of this system, the death notification certificate was amended to include a special section on reproductive age mortality for women aged 15-49. This section asks whether death occurred during pregnancy, delivery, post-delivery or up to six weeks after an abortion, as well as particulars about birth outcome, place of childbirth and the delivery attendant. In addition to the amended death notification certificate, the maternal mortality surveillance questionnaire was launched to collect demographic and personal data about the deceased, including information on obstetric history, prenatal care and the latest pregnancy. The questionnaire also includes questions about the place, date, time and attendant during the current labor and/or delivery; complications, referrals and transportation to medical institutions; the direct cause of death and contributing factors; and information about the newborn.[4]

Despite efforts to improve the system of documentation and data-collection, serious flaws remain, most significantly:

- *Lack of transparency*: The Ministry of Health does not publish the complete findings of the surveillance system, only maternal mortality rates based on the findings.
- *Shortcomings in secondary analysis of findings*: Despite the availability of personal and demographic data on maternal deaths, no analysis is conducted to elucidate the relationship between women's educational level and mortality or between wealth and mortality, or other similar analysis conducted by the Demographic and Health Survey.

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[1] Convention on the Elimination of All Forms of Discrimination against Women arts. 12 and 5, *adopted* Dec. 18, 1979, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, at 193, U.N. Doc. A/34/46 (1979) (*entered into force* Sept. 3, 1981) [hereinafter CEDAW].

[2] CEDAW Committee, *General Recommendation 24, Women and Health (art. 12),* para. 17, UN Doc. A/54/38 (Part I) (1999), hereinafter CEDAW Committee, *General Recommendation 24*].

[3] The Special Rapporteur on the Right to Health, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, delivered to the General Assembly* (Oct. 19, 2006).

[4] Ministry of Health and Population. (2007) *National Maternal Mortality Surveillance System*, Egypt: MOHP, USAID, available at: http://www.esdproj.org/site/DocServer/CC8_Nahla_Roushdy.pdf?docID=1118 [hereinafter 2007 *National Maternal Mortality Surveillance System*].

- *Lack of complete information*: Available information about maternal mortality does not give a clear picture about avoidable mortality factors and does not allow a geographic comparison of mortality rates.[5]
- *Punitive practices towards health care providers compromise the accuracy of the data*: Policies continue to place the burden of criminal liability and accountability on health care providers, which could constitute an obstacle to accurate documentation of cause of death. As a result, providers are likely to ascribe death to indirect causes, such as heart disease, to avoid legal liability.
- *Less precise information in rural areas*: Vital data-collection systems are not as precise in rural areas, where the mortality rate is higher.

A 2005 study of global maternal mortality by the World Health Organization, in cooperation with UNICEF and the World Bank, revised the official national maternal mortality rates. The report put maternal mortality in Egypt at 130/100,000 live births, compared to a rate of 84/100,000 as announced by the Ministry of Health for the year 2005.[6] This disparity illustrates the importance of subjecting the NMMSS to an outside evaluation.

State of maternal health in Egypt

In spite of the data collection challenges detailed above, data suggests that the Egyptian government has made significant strides towards the achievement of the fifth millennium development goal regarding improved maternal health and care. According to the Ministry of Health, maternal mortality was 55 deaths for 100,000 live births in 2008, indicating a steady decline from 75 deaths for 100,000 live deaths in 2002.[7]

The findings of the NMMSS for 2007 indicate that nearly half (46.9%) of the maternal deaths occurred during birth and 72.6% of all maternal deaths took place in health facilities. Direct causes were responsible for 69.5% of deaths and indirect causes for 30.5%. Hemorrhage is still the number one direct cause of mortality, responsible for 38.5% of all deaths, followed by high blood pressure disease (16.7%) and blood poisoning – septicemia - (5.9%). Heart and artery diseases are the number one indirect cause, responsible for 13.2% of maternal deaths.[8] While reliable and comprehensive statistics on the prevalence of maternal morbidity in Egypt is also insufficient, one study revealed that as many as 56% of rural Egyptian women suffer from pregnancy-related genital prolapse.[9]

[5] Ministry of Economic Development *(2008), Achieving the Millennium Development Goals: A Midpoint Assessment* ,Egypt, available at: http://www.undp.org.eg/Portals/0/MDG%20Links/Egypt%20MDG%20Mid%20Term%20Assessment%20Report%202008.pdf .

[6] WHO, UNICEF, UNFPA and World Bank, (2005*) Maternal Mortality in 2005, Estimates Developed by WHO, UNICEF, UNFPA and World Bank*, Geneva: WHO, available at: http://www.who.int/whosis/mme_2005.pdf.

[7] Central Agency for Public Moblisation & Statistics (CAPMAS), (2009) *Annual Report*, Egypt: CAPMAS Publications.

[8] 2007 *National Maternal Mortality Surveillance System*, supra note 4.

[9] M. Stewart, *Gynecologic Morbidity is High for Egyptian Women in a Pair of Rural Villages*, 20 INTERNATIONAL FAMILY PLANNING PERSPECTIVES 40, 41 (1994).

Despite Egypt's assertion that "[c]urrently, there are no challenges regarding the protection of maternity,"[10] the 2004 Egypt Service Provision Assessment Survey (2004 ESPAS) found that the vast majority of maternal deaths in Egypt (81%) involve one or more avoidable factors.[11] One such factor, contributing to 54% of maternal deaths, is substandard medical care by health providers.[12] A 2002 study comparing observed medical practices in a large referral hospital in Egypt with evidence-based medicine found that oxytocin is commonly used to induce labor — it is administered in 91% of all cases; however, the use of this drug was largely inappropriate which may lead a ruptured uterus. Furthermore, 19% of women admitted to the hospital did not have their blood pressure taken upon their arrival, making it difficult to identify cases of hypertension in pregnancy (eclampsia) - one of the leading maternal mortality causes.[13] Preventative measures for women in the third stage of labor aimed at preventing hemorrhage during delivery were not applied in most cases. [14] Poor diagnosis and management by providers is aggravated by lack of consistency in standards of care, absence of communication between primary- and next-level care providers, and failure to keep records.[15]

Further, only 33% of delivery facilities contain all of the basic supplies for conducting a normal delivery,[16] and only 18% have all of the items necessary to manage common complications.[17] The extent of this problem was emphasized in a recent study reporting that 30.5% of health care providers would not feel safe being treated in their own facility as patients.[18] Communication and information exchange between patient and caregiver were generally low.[19]
Although many maternal deaths occur during delivery or the first 24 hours after delivery,[20] only 55% of women delivering in a facility were kept in the facility for 24 hours or more after giving birth, and 40% reported that they spent less than six hours in the facility after the birth.[21]

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[10] Government of Egypt, *Consideration of reports submitted by States parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women: Combined sixth and seventh periodic reports of States parties: Egypt*, para. 4.2.3, U.N. Doc. CEDAW/C/EGY/7 (Sept. 5, 2008) [hereinafter Egypt Government Report].
[11] Avoidable factors include "woman and family factors," "health facility factors," or "medical team factors." *See* Karima Khalil & Farzaneh Roudi-Fahimi, *Making Motherhood Safer in Egypt*, POPULATION REFERENCE BUREAU 5 (2004) *available at* http://www.prb.org/pdf04/MakMotherSaferEgypt_Eng.pdf [hereinafter 2004 *Making Motherhood Safer in Egypt*].
[12] MINISTRY OF HEALTH AND POPULATION [EGYPT], 2004 EGYPT SERVICE PROVISION ASSESSMENT SURVEY 111 (Apr. 2005) [hereinafter 2004 ESPAS].
[13] Y. Nabil, K. Khalil, H. Sholkamy, M. Cherine, N. Hassanein , A. Elnoury, L. Mohsen, M. Breebaart and Z. Farahat (2002), *Hospital Practices for Normal Labour: An Observational Study, The Relationship of Observed Practices to Evidence Based Medicine*, Egypt: Population Council [hereinafter 2002 *Hospital Practices for Normal Labour*].
[14] Ibid.
[15] A. Nabhana & M.S. Ahmed-Tawfik, *Understanding and attitudes towards patient safety concepts in obstetrics*, 98 INT'L J. OF GYNECOLOGY AND OBSTETRICS 212, 215 (2007).
[16] Basic supplies for conducting a normal delivery include an instrument to cut the umbilical cord, umbilical cord clamps or ties, a suction apparatus, antibiotic eye ointment for the newborn, and a disinfectant for cleaning the perineal area. *See* 2004 ESPAS, at 135, supra note 12.
[17] The items necessary to address common complications include needles and syringes, intravenous solution and infusion sets, injectable oxytocic medicinces, and suture supplies. *See* 2004 ESPAS, at 111, supra note 12.
[18] 2004 ESPAS, at 213, supra note 12.
[19] 2002 *Hospital Practices for Normal Labour*, supra note 13.
[20] 2004 ESPAS, at 111, supra note 12.
[21] MINISTRY OF HEALTH AND POPULATION [EGYPT] & EL-ZANATY AND ASSOCIATES, 2008 EGYPT DEMOGRAPHIC AND HEALTH SURVEY 125 (Mar. 2009) at 131 [hereinafter 2008 EDHS].

Antenatal care

Although antenatal care visits have become more common in Egypt,[22] lack of such care remains a factor in 19% of maternal deaths.[23] The likelihood that a woman will receive antenatal care is related to the birth order of the pregnancy, with mothers of first-order births almost twice as likely as mothers of sixth-order and higher births to have regular antenatal care.[24]

The problems women face in accessing antenatal care may disproportionately harm women who are poor, rural and less-educated, since these women tend to have higher fertility rates and less access to family planning services and information. The 2008 Egypt Demographic and Health Survey (DHS) found that 66% of women had made four prenatal care visits while 26.4% received no care at all. Some 39.5% of women received one dose of tetanus toxoid vaccine and 41.3% received two or more doses; 18.8% received no doses, but an analysis based on the social status of women reveals that differences in geographical coverage remain. While 80.5% of women living in urban areas received regular prenatal health care, only 57.4% of women living in rural areas did. Similarly, 92.4% of women belonging to the highest wealth quintile received regular prenatal care, compared to only 53.55% of women in the lowest wealth quintile.[25]

Furthermore, according to the 2004 ESPAS, only 5% of facilities have all necessary items for antenatal counseling.[26] Full client assessment, including eliciting information about pre-existing risk factors, age, date of last menstrual period, previous pregnancies and medications, is conducted in only 26% of first visits.[27]

Notwithstanding Egypt's media campaign to promote safe pregnancy,[28] only 21% of ever-married women have heard about the danger signs to watch for during pregnancy.[29] This lack of knowledge is extremely problematic, as failure to recognize danger signs results in a delay in seeking care, contributing to 30% of all maternal deaths.[30] Where delay in care produces an emergency, women are generally left to their own devices to arrange for transportation for help, as only 10% of facilities have a transportation system for obstetric emergencies.[31] This lack of emergency support represents a breach of Egypt's duty to "ensure women's right to safe motherhood and emergency obstetric services."[32]

Recommendations: Egypt should release all findings of the NMMSS and allow independent external parties to evaluate the current documentation system. The government must also devote greater attention to training physicians in best delivery practices and postnatal birth control

[22] 2004 ESPAS, at 106, supra note 12.
[23] 2004 *Making Motherhood Safer in Egypt*, at 110, supra note 11.
[24] 2008 EDHS, at 128, supra note 21.
[25] 2008 EDHS, supra note 21.
[26] 2004 ESPAS, at 115, supra note 12.
[27] 2008 EDHS, at 123-4, supra note 21.
[28] Egypt Government Report , at para 12.1.2., supra note 10.
[29] 2008 EDHS, at 143, supra note 21.
[30] 2004 ESPAS, at 111, supra note 12.
[31] 2004 ESPAS, at 130-31, supra note 12.
[32] CEDAW Committee, *General Recommendation 24*, at para 27, supra note 2.

consultations. The government should also conduct more extensive research on maternal morbidity.

B. Unsafe Abortion

The CEDAW Committee considers state refusal to provide legitimate reproductive health services as a form of discrimination against women. It considers criminalization of medical procedures sought by women to be an obstacle preventing them from receiving appropriate medical services. It recommends revising laws criminalizing abortion and eliminating punitive measures against women who seek an abortion.[33] The Committee has stated its concern about laws restricting abortion and tolerating no clear exceptions allowing the practice.[34] The Committee has often framed restrictive abortion laws as a violation of the rights to life and health.[35] It also recommends that legislation should permit safe abortions to the victims of rape and incest.[36]

1. The legal status of abortion in Egypt

Egyptian law criminalizes abortion in the Penal Code, according to articles 260, 261, 262, 263,[37] with no clear legal exceptions permitting the procedure, which could deter health care providers from performing the procedure for fear of legal penalties. Abortions performed by doctors are regulated in article 29 of the physicians' Code of Ethics which states that physicians are allowed to perform the procedure to protect the pregnant woman's health provided they obtain written approval from two other specialists. The stipulation that two specialized doctors must sign off on to the procedure could hinder a woman from receiving necessary medical attention in a timely fashion, when it is not clearly an emergency. In an emergency, where the pregnant woman's life is threatened, a doctor is permitted to

[33] CEDAW Committee, *General Recommendation 24*, supra note 2.

[34] Concluding observations: **Andorra**, ¶ 48, U.N. Doc. A/56/38 (2001); **Antigua and Barbuda**, ¶ 258, U.N. Doc. A/52/38/Rev.1,Part II (1997);**Belize**, ¶ 56, U.N. Doc. A/54/38 (1999); **Bolivia**, ¶ 82, U.N. Doc. A/50/38 (1995); **Chile**, ¶ 139, U.N. Doc. A/50/38 (1995); **Chile**, ¶ 228, U.N. Doc.A/54/38 (1999); **Chile**, ¶ 19, U.N. Doc. CEDAW/C/CHI/CO/4 (2006); **Colombia**, ¶ 393, U.N. Doc.A/54/38 (1999); **Cyprus**, ¶ 55, U.N. Doc. A/51/38 (1996); **Dominican Republic**, ¶ 337, U.N. Doc. A/53/38(1998); **Ireland**, ¶ 185, U.N. Doc. A/54/38 (1999); **Jordan**, ¶ 180, U.N. Doc. A/55/38 (2000); **Liechtenstein**,¶ 169, U.N. Doc. A/54/38 (1999); **Luxembourg**, ¶ 210, U.N. Doc. A/52/38/Rev.1, Part II (1997); **Mauritius**, ¶196, U.N. Doc. A/50/38 (1995); **Mauritius**, ¶ 30, U.N. Doc. CEDAW/C/MAR/CO/5 (2006); **Namibia**, ¶ 111, U.N.Doc. A/52/38/Rev.1, Part II (1997); **Nepal**, ¶¶ 139, 147, U.N. Doc. A/54/38 (1999); **Panama**, ¶ 201, U.N. Doc.A/55/38/Rev.1 (1998); **Paraguay**, ¶ 131, U.N. Doc. A/51/38 (1996); **Peru**, ¶ 339, U.N. Doc. A/53/38/Rev.1 (1998); **Portugal**, ¶ 345, A/57/38 (2002); **Saint Vincentand the Grenadines**, ¶ 140, U.N. Doc. A/52/38/Rev.1 (1997); **Suriname**, ¶ 29, U.N. Doc. CEDAW/C/SUR/CO/3 (2007); **United Kingdom of Great Britain and NorthernIreland**, ¶ 309, U.N. Doc. A/55/38 (1999); **Venezuela**, ¶ 236, U.N. Doc. A/52/38/Rev.1 (1997); **Zimbabwe**, ¶ 159, U.N. Doc. A/53/38 (1998).

[35] CEDAW Committee's Concluding Observations to: **Belize**, 01/07/99, ¶ 56, U.N. Doc. A/54/38; **Chile**, 09/07/99, ¶ 228, U.N. Doc. A/54/38; **Colombia**, 04/02/99, ¶ 393, U.N. Doc. A/54/38; **Dominican Republic**, 14/05/98, ¶ 337, U.N. Doc. A/53/38; **Paraguay**, 09/05/96, ¶ 131, U.N. Doc. A/51/38.

[36] Concluding observations: **Dominican Republic**, ¶ 309, U.N. Doc. A/59/38 (SUPP) (2004); **Jordan**, ¶ 9, U.N. Doc. CEDAW/C/JOR/CO/ (2007); **Jordan**, ¶ 180, U.N. Doc. A/55/38 (2000); **Myanmar**,¶¶ 129–130, U.N. Doc. A/55/38 (2000); **Panama**, ¶ 201, U.N. Doc. A/55/38/Rev.1 (1998); **Venezuela**, ¶ 236, U.N. Doc. A/52/38/Rev.1 (1997).

[37] Article 260- Anyone who intentionally aborted a pregnant woman either through beating or other means of harm is punishable by imprisonment; Article 261- Anyone who intentionally aborted a pregnant woman by giving her medication or other means causing this or assisting her, whether with her consent or not, is punishable by incarceration. Article 262- A woman who willingly accepts taking medication or the use of previously mentioned methods or enables another in using these methods resulting in an abortion is punishable by the above mentioned penalty. Article 263- If the person performing the abortion is a doctor or surgeon or pharmacist or traditional birth attendant he will be sentenced to imprisonment.

perform an abortion without getting the written approval from the other two doctors and must follow it up with a detailed written report on the medical reasons for the abortion.[38]

Egyptian law also finds a woman guilty if she willingly chooses an induced abortion, which carries a prison penalty (six months to three years imprisonment) according to article 262 of the Penal Code.[39] The courts will find a woman guilty if she seeks an induced abortion, even in cases when the woman has died as a result of an unsafe abortion.[40] Several cases before the Court of Cassation dealing with induced abortion have been pursued by the families of the women who died from unsafe abortion at the hands of an unspecialized physician,[41] inexperienced doctor,[42] or traditional birth attendant who used unsterilized tools[43] which caused severe consequences and resulted in the woman's death.

2. The prevalence of unsafe abortion

Unsafe abortion is a major concern to those in the fields of health and reproductive rights in Egypt. Given the reality of the failure of all forms of birth control, and since individuals do not use contraceptives correctly every time, abortion will remain a fundamental issue in reproductive health.[44] Despite legal, social and religious limitations regarding abortion, women in Egypt continue to use the procedure to end an unwanted pregnancy.[45] Women choose abortion for various social, economic and medical reasons, which are detailed in a recent research paper entitled *Determinants of Induced Abortion in Cairo*. Reasons for terminating pregnancies include the stigma around pregnancies occurring outside of marriage, divorce or marital problems and lack of financial resources. Medical conditions, including anemia and chronic illness, can contribute to a woman's decision to end a pregnancy, as can the illness of another child who requires constant care.[46]

The vast majority of these women seek illegal abortions because of the legal restrictions on abortions. These restrictions tend to harm poorer and younger women disproportionately. Well-to-do women are treated at private clinics and hospitals which provide high quality abortion services and have the necessary equipment in case of emergencies. Meanwhile, poor and adolescent women who lack financial means often resort to shady clinics which do not meet minimal medical standards, are unsanitary and lack blood and oxygen supplies. It is also likely that the provider who administers the anesthetic also performs the abortion, without any knowledge of obstetrics or gynecology. In many cases, women's right to dignity is violated by harsh and discourteous treatment by the staff at these facilities.[47]

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[38] Physicians' Code of Ethics Article, issued by Minister of Health Decree 238 for the year 2003, 5 September 2003, Article 29.
[39] Case No. 167/66, Court of Cassation, 4 November, 1998.
[40] Case No. 167/66, Court of Cassation, 4 November, 1998.
[41] Case No. 302/40, Court of Cassation, 27 December, 1970.
[42] Case No. 195/29, Court of Cassation, 23 November 1959.
[43] Case No. 118/57, Court of Cassation, 12 May 1987.
[44] M. Berer, (2009) '*The Cairo Compromise on Abortion and its Consequences for Making Abortion Safe and Legal*', in L. Reichenbach, and N. Roeseman , (ed) *Reproductive Health and Human Rights, the Way Forward*, p154. Reproductive Health and Human Rights, the way forward, 2009, P154.
[45] SD. Lane , MT. Mouelhy, and J. Jok , (1998) *Buying Safety, the Economics of Reproductive Risk and Abortion in Egypt*, USA: University of Syracuse [hereinafter 1998 *Buying Safety, the Economics of Reproductive Risk and Abortion in Egypt*].
[46] H. El-Damanhoury (2009), *Determinants of Induced Abortion in Cairo*, Egypt: New Woman Foundation (unpublished) [hereinafter 2009 *Determinants of Induced Abortion in Cairo*].
[47] 1998 *Buying Safety, the Economics of Reproductive Risk and Abortion in Egypt*, supra note 45.

In one case, an unwed young woman narrates:

> There were no preparations, ultrasound, equipment or nurse. He [the physician] didn't even ask me about my medical history or take any blood tests. He inserted the drip and I was shivering. He looked at me and said: 'It's a good thing you have blood [an Arabic axiom for shame].' I was very insulted, and if it wasn't an absolute necessity, I wouldn't have gone through with it. I stayed and proceeded out of terror because I just wanted it to be over."[48]

Women who cannot afford these shady clinics are left with inexpensive but highly dangerous traditional methods, including drinking a combination of cinnamon, boiled onions and Coca Cola, and sometimes these are administered individually. Other unsafe methods used to terminate pregnancies include: ingesting high doses of malaria medication or measles vaccine; inserting sharp objects or a stem of a local herb into the vagina or cervix; and injecting cleaning agents into the vagina.[49]

The harmful consequences of unsafe abortions, some of which can be fatal, include hemorrhage, septicemia (blood poisoning), perforation of the uterus or intestines, and shock. Unsafe abortions can also have debilitating long-term consequences, including anemia, chronic pain and infections of the reproductive organs, and infertility. All these factors affect the health condition of a woman and her quality of life.[50] Women can legally seek medical attention for post-abortion complications at any public hospital.[51] However, for every identified hospital case, there are many other women who do not seek medical care for complications resulting from unsafe abortion, either because they do not have sufficiently worrying complications or because they fear abuse, ill-treatment or legal reprisals.[52]

Misoprostol, which is reasonably priced and readily available at pharmacies, has helped reduce the risks of unsafe abortions with both younger and older women using it as an alternative to more harmful indigenous methods. The ideal method of medical abortion is using misoprostol simultaneously with mifepristone, which is however not available in Egypt. At the same time, many women do not know the correct regimen for using misoprostol or the dangerous symptoms of a partial abortion when using this drug. Nonetheless, the availability of this drug provides a safer option over traditional methods.[53]

Lack of access to abortion for victims of rape and incest

The law does not explicitly permit abortion in cases of rape and incest. A proposed amendment allowing for abortion in cases of rape was submitted to the People's Assembly more than two years ago, and was approved by the Parliament's Committee of Proposals and Complaints and the Ministry of Religious Endowments" Supreme Council for Islamic Affairs. Despite civil society support for the proposed amendment, the Parliament's Constitutional and Legislative Affairs Committee never debated

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[48] 2009 *Determinants of Induced Abortion in Cairo*, supra note 46.
[49] 1998 *Buying Safety, the Economics of Reproductive Risk and Abortion in Egypt*, supra note 45.
[50] S. SINGH, D. WULF, S. HUSSAIN , A. BANKOLE AND G. SEDGH, (2008) *ABORTION WORLDWIDE, A DECADE OF UNEVEN PROGRESS*, USA: GUTTAMACHER [hereinafter 2008 Abortion Worldwide].
[51] 1998 *Buying Safety, the Economics of Reproductive Risk and Abortion in Egypt*, supra note 45.
[52] WORLD HEALTH ORGANIZATION, UNSAFE ABORTION: GLOBAL AND REGIONAL ESTIMATES OF THE INCIDENCE OF UNSAFE ABORTION AND ASSOCIATED MORTALITY (5TH ED., 2003), *AVAILABLE AT* HTTP://WWW.WHO.INT/REPRODUCTIVEHEALTH/PUBLICATIONS/UNSAFE_ABORTION/9789241596121/EN/INDEX.HTML.
[53] M. Fernandez , F. Coeytaux , D. Harrison and R. Leon, *'Assessing the Global Availability of Misopristol* , l *Journal of Gynecology & Obstetrics*, Vol 105, (2009), p180-186.

it-which is the next step after a proposal is submitted to the Committee of Proposals and Complaints. At the same time, the Ministry of Justice has not pushed for the passing of the proposed amendment.[54]

The lack of an exception allowing for abortion in cases of rape and incest is even more problematic because of the lack of access for sexual violence victims to emergency contraception which can prevent the pregnancy in the first place. Health units across the governorates do not provide emergency contraceptives since they are not currently procured by the Ministry of Health. They are only available at private pharmacies. Moreover, a Ministry of Health protocol defining standards of practice and care in the areas of family planning, reproductive health and maternal and child health care, entitled, the *Practice for Integrated Maternal and Child Health and Reproductive Health Services*, contains a section on emergency contraception which emphasizes use by married couples, highlighting that "[e]effectiveness depends on starting as soon as possible after *marital relations*."[55] Furthermore, the guidelines make no mention of the provision of emergency contraception for victims of sexual assault, in spite of the World Health Organization's statement in its *Guidelines for Medico-Legal Care for Victims of Sexual Violence* that "[i]f a woman seeks health care within a few hours and up to five days after the sexual assault, emergency contraception should be offered.[56] The only exposure about this method in the media came in the form of a commercial advertisement by pharmaceutical companies producing emergency contraceptives which promote their use in the context of a woman who is surprised by the return of her husband from overseas, and who was not using any form of contraceptive.

Recommendations: The state must incorporate article 29 of the physicians' Code of Ethics - which permits a physician to carry out an abortion to protect the pregnant woman's health and life - into the law, and eliminate the need for approval by two other specialists to protect the woman's health. Egypt must also revoke article 262 of the Penal Code which penalizes a woman who seeks an illegal abortion. The government should also amend the current law to allow for abortion for victims of rape and incest. The Ministry of Health should also promote emergency contraceptives and raise awareness about them among women of all ages, highlighting their benefit in protecting against unwanted pregnancies in instances of rape.

3. Post-abortion care

Post-abortion care is the only hope for women – especially the poor – in light of the restrictive abortion laws. A woman needing post-abortion care will seek this care from public hospitals. The World Health Organization (WHO) and the United States Agency for International Development (USAID) have specified the required components for post-abortion care, including treating the medical side-effects of a partially induced or spontaneous abortion and providing contraceptive counseling and services.[57]

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[54] Ipas, *(2002) Human Rights, Unwanted Pregnancy & Abortion Related Care, Reference Information & Illustrative Cases*, USA: Ipas.

[55] Ministry of Health & Population (MOHP), (2005) *Standard Practices for Maternal & Child Health & Reproductive Health Services*, Egypt: MOPH Publications, available at: http://www.drguide.mohp.gov.eg/NewSite/E-Learning/ICD10/front%20&back%20covers.pdf [hereinafter 2005 *Standard Practices for Maternal & Child Health & Reproductive Health Services*].

[56] World Health Organization (WHO), (2003) *Guidelines for Medico-Legal Care for Sexual Violence*, Geneva: WHO, at p64, available at: http://whqlibdoc.who.int/publications/2004/924154628X.pdf.

[57] United States Agency for International Development , (2007) *Report of the Post-Abortion Care Technical Advisory Panel*, USA USAID available at: http://pdf.usaid.gov/pdf_docs/PNADJ329.pdf [hereinafter 2007 *Report of the Post-Abortion Care Technical Advisory Panel*].

Treating the medical side-effects of a partially induced or spontaneous abortion

The Population Council, in cooperation with the Egyptian Fertility Care Foundation and with funding from USAID, carried out a number of studies during the 1990s to improve post-abortion care and services, and establish a model of globally approved standards of care for Egypt. A review of these studies finds that most surgical procedures to completely empty the uterus were done using uterine scraping (dilatation and curettage-D&C) along with a general anesthetic. Doctors' knowledge of the short- and long-term side-effects, as well as of dangerous symptoms associated with abortion, was limited. Studies also indicated that doctors were unsure of when ovulation begins after an abortion and were overzealous in administrating antibiotics but neglected giving painkillers before and after the procedure. Post-abortion patients were usually kept waiting for a long time while doctors tended to other patients.[58]

The WHO recommends the use of the less painful manual vacuum aspiration (MVA) method instead of D&C, as the ideal technique to remove the contents of the uterus. MVA does not require general anesthesia and uses smaller doses of painkillers.[59] The user-friendly equipment does not require a specialized practitioner and can be utilized by a mid-level healthcare provider.[60] During the same period the Population Council studies were being conducted, Egypt received MVA equipment through the UN Population Fund (UNFPA). Doctors and health care providers found that MVA technology was easier to use, had fewer side-effects than uterine scraping and was more effective in emptying the uterus.[61] The Population Council studies showed that the use of D&C dropped significantly after physicians were trained to use MVA. These studies recommended more distribution and use of MVA equipment, but the Ministry of Health denied requests for importation of MVA equipment. Refusal by the Ministry of Health to import the equipment prevented the post-abortion care program from being standardized and physicians stopped using this modern technology.[62] Today, MVA equipment is only available at teaching hospitals and in the private market, but not in public hospitals which remain the most frequented institutions for women seeking post-abortion care.

The WHO specifies that MVA can be carried out by a mid-level healthcare provider, such as midwives who are found everywhere in rural Egypt, which will positively influence the health of women in these areas. Thus, importing MVA equipment and training mid-level providers on its use would raise the standard of healthcare for post-abortion patients, especially in rural areas which lack trained doctors and nurses.

The Ministry of Health's unreasonable refusal to procure MVA equipment harms the health of women and violates their right to enjoy the benefits of scientific progress, protected by article 15 of the

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[58] D. Huntington , L. Nawar , M. Naguib , EO. Hasan , and N. Attallah, (1995), *Improving the Medical Care and Counselling of Post-abortion Patients in Egypt,* Egypt: Population Council; D. Huntington , L. Nawar , H. Yossef , N. Abdel-Tawab, and E. Osman, (1998) *The Postabortion Caseload in Egyptian Public Hospitals: a Descriptive Study,* Egypt: Population Council and Egyptian Fertility Care Society; D. Huntington , L. Nawar , H. Yossef , N. Abdel-Tawab, and E. Osman, (1997) *Scaling- up Improved Postabortion Care in Egypt, Introduction to University and Ministry of Health and Population Hospitals*, Egypt: Population Council and Egyptian Fertility Care Society.

[59]World Health Organization, (2003) *Safe Abortion Technical & Policy Guidance for Health System,* Geneva: WHO.

[60] 2007 *Report of the Post-Abortion Care Technical Advisory Panel*, supra note 57.

[61]D. Huntington , L. Nawar , H. Yossef , N. Abdel-Tawab, and E. Osman, (1997) *Scaling- up Improved Postabortion Care in Egypt, Introduction to University and Ministry of Health and Population Hospitals*, Egypt: Population Council and Egyptian Fertility Care Society.

[62] D. Huntington, and L. Nawar , (2003), *Moving from Research to Program the Egyptian Postabortion Care Initiative*, International Family Planning Perspectives, Vol 29, No. 3.

International Covenant on Economic, Social and Cultural Rights. It also represents state neglect of its responsibility to train healthcare providers and equip them with the necessary tools to make legal abortions safe and accessible, a commitment made at the International Conference for Population and Development (ICPD) five year review and appraisal of the implementation of the ICPD, paragraph 63.3.

Absence of a comprehensive post-abortion care protocol remains a problem, since the term "post-abortion care" is mentioned only within guidelines for managing bleeding in pregnancy.[63] The available protocol emphasizes providing family planning counseling to all post-abortion patients,[64] but there is no mention of recommended procedures or devices, for example the use of MVA, in addition to the absence of pain management guidelines.

Post-abortion contraceptive counseling and services

The second component of post-abortion care - counseling patients on contraception, fertility and dangerous symptoms following an abortion - is vital because it protects women from repeating an unwanted pregnancy, putting themselves at risk of an unsafe abortion and its consequences, which could be fatal. The CEDAW Committee has recognized that, in the absence "of appropriate service in regard to fertility control," women may be "forced to seek unsafe medical procedures such as illegal abortion."[65]

With family planning services physically and administratively segregated from post-abortion care services, post-abortion patients "do not receive family planning counseling nor are offered any family planning services before their discharge from the hospital and many of them return to the hospital with another unplanned/unwanted pregnancy."[66] This is further exacerbated by some obstetrician-gynecologists (OB/GYNs) who believe that family planning services are irrelevant to post-abortion care and whose hectic clinic hours prevent them from counseling patients. At the same time, since OB/GYNs do not make any revenue out of selling the family planning methods – as the only among family planning doctors receive such revenue – and so they are not interested in promoting family planning. In addition, OB/GYNs are not well trained on providing family planning services. All these factors indicate that post-abortion patients almost never receive counseling after the procedure, although this counseling has been proven to increase their self-confidence and knowledge of their medical condition, which makes them less fearful and more able to take care of themselves.[67] One study found that only 23% of all post-abortion patients – and only 48% of those who indicated that they wanted to use contraception – were provided with a method prior to their discharge from the hospital.[68]

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[63]Population Council, (2004,) *Lessons from Introducing Postabortion Care in Egypt*, Population Briefs, Vol 10, No3, available at: http://www.popcouncil.org/publications/popbriefs/pb10%283%29_5.html.
[64]2005 *Standard Practices for Maternal & Child Health & Reproductive Health Services*, supra note 55.
[65]CEDAW Committee, *General Recommendation 19, Violence Against Women*, para. 24(m), U.N. Doc. A/47/38 (1992).
[66]N. Abdel-Tawab, H. Yossef , and J. Bratt , (2007), *Linking Family Planning with Postabortion Services in Egypt : Testing the Feasibility, Acceptability and Effectiveness of Two Models of Integration*, Egypt: Population Council and Family Health International., *available at* http://www.popcouncil.org/frontiers/projects/ane/Egypt_FP_PACLinks.htm [hereinafter 2007 *Linking Family Planning with Postabortion Services in Egypt*].
[67]2007 *Linking Family Planning with Postabortion Services in Egypt*, supra note 66.
[68]D. Huntington , L. Nawar , H. Yossef , N. Abdel-Tawab, and E. Osman, (1998) *The Postabortion Caseload in Egyptian Public Hospitals: a Descriptive Study*, Egypt: Population Council and Egyptian Fertility Care Society, at 28 [hereinafter 1998 *The Postabortion Caseload in Egyptian Public Hospitals*].

Recommendations: The government should immediately adopt a protocol regarding treatment of post-abortion patients specifying the ideal dosages of painkillers and antibiotics, counseling for post-abortion patients, especially with regards to family planning methods, and recommending the use of MVA. The Ministry of Health should also make such a procedure and equipment available to public and private hospitals. It should train doctors and midwives to use this equipment and incorporate this method in the syllabus of medical schools.

4. Availability of information on abortion

Unsafe abortions, no doubt, cause fatalities among pregnant women. Abortion-related deaths are most common in developing countries, especially in Africa where 650 women died for every 100,000 unsafe abortions in 2003.[69] It is impossible to calculate the number of unsafe abortions in Egypt, or the resulting deaths because there is no national database on unsafe abortions.[70] Estimates, however, can be made based on studies carried out by international bodies and non-governmental organizations. A 30-day study conducted in 1998 by the Population Council, in cooperation with the Egyptian Fertility Care Society concluded that the abortion rate in Egypt is 14.8% for every 100 births (which includes certainly induced, probably induced and most probably induced abortions).[71] In a study on abortion in rural areas in Egypt, Dr A Ragab found that 14% of subjects performed an abortion on themselves at least once.[72] These figures, however do not factor in abortions which take place outside public hospitals, induced abortions which do not result in side-effects, or abortions where women do not seek medical care out of fear of stigma or family rejection.[73]

The Ministry of Health's current database is not fully accurate with regards to post-abortion care and does not categorize data according to the type of abortion (spontaneous or induced). According to the Ministry of Health's maternal mortality rates, the number of deaths resulting from abortion for the years 1992, 2000 and 2006 are 4.6%, 4,% and 1.9%, respectively. These figures, however, do not indicate whether these abortions were spontaneous or induced.

The lack of any database about the number of induced abortions or the reasons behind them represents a major obstacle in reforming post-abortion healthcare programs, and identifying healthcare and social awareness services, which women need to avoid multiple abortions.[74] It also contradicts the CEDAW Committee's General Recommendation No. 9, in that the information collected by national surveys does not assist researchers and relevant bodies in collecting needed information on women, especially regarding abortion.[75]

Recommendation: **The government should conduct national surveys on the rate and reasons behind induced abortions, and on the methods used, amongst married and unmarried women.**

[69] 2008 Abortion Worldwide, supra note 50.
[70] R. Dabsh and F. Fehmy , (2009), *Abortion in the Middle East and North Africa*, USA: Population Reference Bureau.
[71] 1998 *The Postabortion Caseload in Egyptian Public Hospitals*, supra note 68.
[72] A. Ahmed , R. Sorour, N. Ford. and A. Ankoumah , A. (1996), *Abortion Decision-Making in an Illegal Context: A Case Study from Rural Egypt*, Conference proceedings, Abortion Matters Conference, The Netherlands.
[73] 2008 Abortion Worldwide, supra note 50.
[74] 1998 *The Postabortion Caseload in Egyptian Public Hospitals*, supra note 68.
[75] CEDAW, *General Recommendation 9, Statistical Data Concerning the Status of Women*, UN Doc 44/38 (1989) .

C. Access to Comprehensive Family Planning Services and Information

Access to contraceptives and family planning is central to protecting women's rights to life and health. The CEDAW Committee has reiterated that a lack of access to contraceptives impedes women's right to "decide freely and responsibly on the number and spacing of their children."[76] In order to protect these rights, "women must have information about contraceptive measures and their use, and guaranteed access to sex education and family planning services."[77]

The government of Egypt encourages family planning and the 2009 World Health Statistics confirm that about 60% of Egyptians use some form of contraception.[78] The government attributes this relatively high rate of contraceptive use to its "intensive efforts to inform women of available health services," including family planning services.[79] However, the 2008 DHS found that one third of women were not exposed to any family planning messages during the six months prior to the survey, representing a "clear decline in exposure to family planning" since the 2005 DHS,[80] and resulting in a large gap in the information available to Egyptian women. According to the 2008 DHS, only 30 percent of women were counseled on postnatal birth control methods, a very low number, especially considering that not using birth control places women at risk of unwanted pregnancy soon after a previous birth, which may carry health risks and cause complications and death during pregnancy.[81] Unmet need for family planning in Egypt is around 10%.[82] About one-third of this need represents an interest in spacing the next birth, and the remainder represents an interest in limiting births.[83] While rural use of public sector family planning services increased by 33% between 2005 and 2008,[84] unmet need for family planning remains greatest among rural women, especially those in Upper Egypt and the Frontier Governorates.[85] Overall, 14% of births in the five year period prior to the 2008 DHS were not wanted at the time of conception; of those, 5% were wanted at a later time and 9% were not wanted at all.[86]

Barriers to access also remain. Even with increasing numbers of family planning centers,[87] 63% of women cited the lack of a health care provider as "potentially a major problem" in accessing health

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[76] CEDAW at 193, supra note 1.
[77] CEDAW Committee, *General Recommendation 21, Equality in marriage and family relations*, para. 22, U.N. Doc. A/47/38 (1994).
[78] WORLD HEALTH ORGANIZATION, WORLD HEALTH STATISTICS 2009, 18, *available at* http://www.who.int/whosis/whostat/2009/en/index.html. (reporting 59.2% contraceptive prevalence) [hereinafter 2009 World Health Statistics]; *see also* Egypt Government Report, at para. 14.2.b.1, supra note 10, (reporting 59% contraceptive prevalence); EGYPT STATE INFORMATION SERVICE, YEAR BOOK 2007, *available at* http://www.sis.gov.eg/En/Pub/yearbook/book2007/ (reporting 63.3% contraceptive prevalence) [hereinafter 2007 Egypt State Information Service]; 2008 EDHS at 71, supra note 21 (reporting 60% contraceptive prevalence among currently married women).
[79] Egypt Government Report, at para. 12.1.2, supra note 10.
[80] 2008 EDHS at 62, supra note 21.
[81] 2008 EDHS, supra note 21.
[82] 10.3%, 2009 World Health Statistics, at 21, supra note 78; 9% 2008 EDHS, at 108, supra note 21.
[83] 2008 EDHS, at 108, supra note 21.
[84] 2008 EDHS, supra note 21.
[85] 2008 EDHS, at 114, supra note 21.
[86] 2008 EDHS, at 113, supra note 21.
[87] The number of family planning centers increased from 4400 in 1992 to 6550 in 2007. 2007 Egypt State Information Service, supra note 78; 2008 EDHS, at 147, supra note 21.

care.[88] Given that health insurance is not applicable for family planning clients in public sector facilities,[89] and that 92% of facilities have some type of user fees,[90] 44% of women cited lack of funds for treatment as a potential problem.[91] In addition, 40% of women expressed concern that no female health care provider would be available.[92] While the Egyptian government asserts that it will urge the Ministry of Health "to assign female physicians to work in health units and family-planning centers in rural areas to encourage rural women to frequent these units," this effort will not address the larger general need for female providers, who make up only 25% of all physicians.[93]

Even where women overcome barriers to access, family planning clinics themselves have many shortcomings. Despite the government's assertion that "[a]ll components of reproductive health services are provided" at Women's Health Centers,[94] the 2004 ESPAS indicates that "[t]he proportion of health offices offering the four [most common contraception] methods has substantially decreased, from 89% in 2002 to 70% in 2004."[95] According to the 2004 ESPAS, family planning guidelines or protocols were available in only 37% of family planning service areas, and all assessed items to support quality counseling were available in only 29% of all facilities.[96] Sixteen percent of centers lacked sufficient privacy.[97]

Persistence of negative attitudes toward certain aspects of family planning constitutes another barrier to access. Only 2% of ever-married women aged 15-49 regard use of family planning before a woman's first pregnancy as appropriate.[98] Opposition to the use of contraception – either from a woman's side or from that of her husband – was a factor for 6% of total nonusers, and 11% of younger nonusers.[99] There is an especially noteworthy resistance to condom use, with 16% of discontinuations due to the husband's unwillingness to use them.[100]

Disturbingly, the 2004 ESPAS also indicated that all items for infection control (hand-washing supplies, clean or sterile latex gloves, disinfecting solution, and a sharps box) were available in the family planning service area in only 18% of facilities, with Ministry of Health infection control guidelines present in only 4%.[101] The items most often lacking were latex gloves (lacking in 70% of facilities), followed by soap and sharps boxes (both lacking in about one-third of facilities).[102] The 2004 ESPAS revealed that only one in ten providers washed his or her hands before performing a pelvic examination or IUD procedure, and only two in ten washed their hands afterward.[103]

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[88] The number of family planning centers increased from 4400 in 1992 to 6550 in 2007. 2007 Egypt State Information Service, supra note 78.
[89] 2004 ESPAS, at 98, supra note 12.
[90] 2004 ESPAS, at 98, supra note12.
[91] 2008 EDHS, at 147, supra note 21.
[92] 2008 EDHS, at 147, supra note 21.
[93] Fayssal M. Farahat, *Challenges Facing Female Physicians in Egypt*, 64 ARCHIVES OF ENVTL. & OCCUPATIONAL HEALTH 121, 121-23 (2009).
[94] Egypt Government Report, supra note 10.
[95] 2004 ESPAS, at 87-8, supra note 12.
[96] 2004 ESPAS, at 91, supra note 12.
[97] 2004 ESPAS, at 93, supra note 12.
[98] 2008 EDHS, at 68, supra note 21.
[99] 2008 EDHS, at 92-3, supra note 21.
[100] 2004 ESPAS, at 92, supra note 12.
[101] 2004 ESPAS, at 92, supra note 12.
[102] 2004 ESPAS, at 92, supra note 12.
[103] 2004 ESPAS, at 102, supra note 12.

Major gaps in reproductive information persist. The 2008 DHS found that more than four in ten respondents either were unable to say when a woman is most at risk of pregnancy or believed that a woman's risk is the same throughout the ovulatory cycle.[104] While knowledge of the pill, IUD, and injectable is nearly universal among married women aged 15-49, only half of these women know about the condom and only 6% are aware of emergency contraception.[105] Of the women who use contraception, only two thirds reported that the provider discussed alternative methods, only 56% were informed about potential side effects, and only 46% were told what to do if they experienced side effects.[106] This is especially problematic given that "[s]ide-effects and health concerns accounted for around three in ten of all [contraceptive] discontinuations."[107]

Recommendations: The government should exert more effort to ensure that women in rural areas face no barriers in accessing information about family planning, especially by ensuring the availability of female health practitioners at the health care units. The government of Egypt should also ensure that campaigns to raise awareness of family planning methods tackle negative attitudes towards certain aspects of family planning, encourage the use of contraceptives adapted to each woman's needs and correct misinformation connected to certain types of contraceptives.

D. Adolescent Access to Reproductive Services and Information

The duty of States parties to protect women's rights to life and health requires that they "address the issue of women's health through the woman's lifespan . . . therefore, *women* includes girls and adolescents."[108] The Committee on Economic, Social and Cultural Rights has emphasized that the "realization of the right to health of adolescents is dependent on the development of youth-friendly health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."[109] According to the Committee on the Rights of the Child, these services must provide "access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases," as well as "information on the harm that early marriage . . . can cause."[110] The CEDAW Committee has also noted that "adolescent girls are often vulnerable to sexual abuse by older men,"[111] and has expressed "concern about the high number of early marriages of girls [in Egypt], especially in rural areas."[112]

Trends in Egypt over the past decade demonstrate that, in general, the average age at marriage is rising for both sexes.[113] While this represents a positive step toward gender equality, "the [growing] gap between menarche and marriage is a risk factor for pre-marital sexual activity without access to health

[104] 2008 EDHS, at 63, supra note 21.
[105] 2008 EDHS, at 50-60, supra note 21.
[106] 2008 EDHS, at 87, supra note 21.
[107] 2008 EDHS, at 89-90, supra note 21.
[108] CEDAW Committee, *General Recommendation 24*, at para. 8, supra note 2.
[109] Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, para. 23, U.N. Doc. E/C.12/2000/4 (2000).
[110] *Committee on the Rights of the Child, General Comment 4, para. 27, U.N. Doc CRC/GC/2003/4 (2003).*
[111] CEDAW Committee, *General Recommendation 24*, at para. 12(b), supra note 2.
[112] *Report of the Committee on the Elimination of Discrimination Against Women*, 24th & 25th Sessions, para. 352, U.N. Doc. A/56/38 (2001) [hereinafter 2001 CEDAW Committee Concluding Observations on Egypt].
[113] 2008 EDHS, at 99-100, supra note 21.

services."[114] The combination of an increased prevalence of premarital sex and a growing young population – 10-24 year olds now account for 31.3% of Egypt's population[115] – makes it all the more important that adolescents have knowledge of and access to reproductive health services. Unfortunately, researchers have found otherwise:

> In general, young people in Egypt lack accurate and accessible information on issues such as family planning (FP) and sexually transmitted infections (STIs). Due to their poor knowledge of [reproductive health] issues and low contraceptive use, young people have an unacceptable number of new HIV/AIDS cases, high maternal mortality rates, and unmet health needs.[116]

While the government of Egypt has begun to promote youth-friendly clinics, these clinics do not generally offer family planning services.[117] In the small number of centers offering these services, few young people utilize them due to ineffective promotion, feelings of shyness, and uncertainty as to whether a female physician is available.[118] In a 2008 study of eight youth-friendly centers, four of the assessed centers consisted of just one room, "breaching the confidentiality and privacy of the client,"[119] four lacked a basin with running water, and none had a copy of the National Guidelines of Infection Control.[120] No materials were available on condom use, STIs, family planning, HIV/AIDS, or nutrition.[121]

Despite the "considerable unmet needs of this age group," [122] the government persists in its "policy of silence" on adolescent family planning,[123] and explicitly addresses the issue "only through provisions of healthcare for girls prior to marriage and premarital exams and counseling."[124] Failure to address adolescents' reproductive and sexual health is a symptom of the persistent negative attitudes toward pre-marital sex, including the "judgmental and unsympathetic attitudes of health personnel."[125] In a 2007 study of girls in Upper Rural Egypt, researchers found that "sources of health information were scarce, hidden from girls as being 'shameful' until they are married."[126]

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[114] DeJong, et al., *The Sexual and Reproductive Health of Young People in the Arab Countries and Iran*, 25 REPRODUCTIVE HEALTH MATTERS 53 (2005) [hereinafter 2005 *The Sexual and Reproductive Health of Young People*].
[115]USAID, *Egypt: Youth Champions Working for Policy Implementation*, YOUTH REPRODUCTIVE HEALTH POLICY COUNTRY BRIEF SERIES NO. 4, 2 (2005), *available at* www.policyproject.com/pubs/.../Egypt%20country%20brief.pdf (citing 2005 USAID study) [hereinafter 2005 USAID Youth Reproductive Health Policy Paper].
[116] Doaa Oraby, et al., *Assessment of Youth Friendly Clinics in Teaching Hospitals in Egypt* 1 (ed. Mariam Shouman, 2008) Family Health International with UNFPA, *available at* http://www.fhi.org/NR/rdonlyres/esvin7blgv2r3bq6dqhpiwbyzthu3wvu7oa7gzqaunnsctfnohdiadwcy4bjqep66xubgutujbhykm/Assessmentreportmay28final2.pdf [hereinafter 2008 *Assessment of Youth Friendly Clinics*].
[117] Ibid.
[118]Ibid.
[119]2008 *Assessment of Youth Friendly Clinics*, supra note 116.
[120]2008 *Assessment of Youth Friendly Clinics*, supra note 116.
[121]2008 *Assessment of Youth Friendly Clinics*, supra note 116.
[122]2005 *The Sexual and Reproductive Health of Young People*, supra note 114.
[123]Ibid.
[124]2005 USAID Youth Reproductive Health Policy Paper, supra note 115.
[125] A.A. Olukoya et al., *Special Communication from the World Health Organization: Unsafe abortion in adolescents*, 75 INT'L J. OF GYNECOLOGY & OBSTETRICS 140 (2001).
[126]Martha Brady, et al., *Providing New Opportunities to Adolescent Girls in Socially Conservative Settings: The Ishraq Program in Rural Upper Egypt* 9 (2007) Population Council, *available at* www.popcouncil.org/pdfs/IshraqFullReport.pdf.

Married adolescents also have a host of unmet reproductive health needs. While "[u]nmarried young people are unlikely to be able to avail themselves of services and risk stigma in using family planning . . . equally those who *marry early* often lack knowledge and access to services such as for contraception."[127] Of the currently married adolescent girls ages 15-19, only 23% currently use contraception – significantly less than the number of older married women who use contraception.[128] The result is that about 9% of Egyptian girls aged 15-19 and as many as 20% of 19 year olds have already begun bearing children.[129] According to UNFPA statistics, "[t]eenage mothers face a higher-than-average risk of maternal death and their children have higher levels of morbidity and mortality; the risk of maternal death among pregnant women aged 15-19 is four times higher than among 25-29 year-olds."[130]

Comprehensive sexuality education

Articles 10, 14 and 16 of the CEDAW addressed women's equal right to education and to information on matters related to marriage and family relations. The Cairo Agreement in 1994 and the Platform of Action of the Fourth World Conference on Women in Beijing in 1995 tackled the importance of comprehensive sexuality education for achieving sexual and reproductive health and rights (SRHR).

Access to information and education programs about the sexual and reproductive health and rights (SRHR) of individuals in Egypt remains limited. A small number of national and international non-governmental and governmental organizations working in Egypt have integrated awareness-raising programs on SRHR in their projects. However, sustainable information channels on SRHR issues are not available or accessible to a significant majority of Egyptian youth and adults.[131]

Despite Egypt's assertion that the Ministry of Education has incorporated reproductive health in educational curricula,[132] research indicates that "education curricula that include sexual and reproductive health topics are rare and, where they do exist, relevant sections are frequently skipped over by teachers who are unprepared or embarrassed to teach them."[133] Furthermore, the contributions of the Ministries of Education and Media in addressing SRHR in their mandates have been minimal and largely compliant with social taboos about discussing sexuality and reproduction with unmarried men and women.[134]

Available information and education programs under the aegis of non-governmental organizations, the National Council for Childhood and Motherhood and the Ministry of Health are confined to health service seekers and voluntary participation.

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[127] 2005 *The Sexual and Reproductive Health of Young People*, supra note 114.
[128] 2008 EDHS, at 106, supra note 21.
[129] WORLD BANK, GENDER ASSESSMENT SURVEY OF EGYPT, para. 50 (June 2003).
[130] S. Douki, et al., *Women's mental health in the Muslim world: Cultural, religious, and social issues*, 102 J. OF AFFECTIVE DISORDERS 177, 183 (2007).
[131] Roudi-Fahimi, Farzaneh and and Loris Ashford, *Sexual and Reproductive Health in the Middle East and North Africa*, (Cairo: Population Reference Bureau, 2008), 43-7.
[132] Egypt Government Report, at para 59, supra note 10.
[133] 2005 *The Sexual and Reproductive Health of Young People*, supra note 114.
[134] Y. Affifi (2009), *Tadmeen al-Siha al-Injabiyya fi al- Manahij al-Dirasiyya* (paper presented at the Collaboration to Raise Youth Awareness about Reproductive Health Issues Seminar, Cairo, Egypt, Nov. 2009); F. Fouad (2009), *Munaqashat Mawdu'at al-Sihha al-Injabiyya fi Wasa'il al-I'lam"* (paper presented at the Collaboration to Raise Youth Awareness about Reproductive Health Issues Seminar, Cairo, Egypt, Nov. 2009).

Accounts by field workers and research findings in the last fifteen years point to a remarkable deficiency in knowledge about SRHR in Egypt.[135] They reveal a deficiency in evidence-based information among youth about the physiological and emotional developments during puberty, prevention of sexually transmitted infections,[136] female circumcision,[137] as well as protection from abusive sexual behavior. These subjects remain largely beyond the scope of school curricula and media message and thereby inaccessible to never married men and women.

Recommendations: The government of Egypt should recognize and affirm the right of individuals to age-appropriate evidence-based education on SRHR and collaborate with civil society institutions to identify and develop comprehensive curricula for national sexual education. The government should also develop youth friendly clinics that provide reproductive health services to adolescents ensuring the privacy and confidentiality of users.

II. The Right to be Free from Discrimination, Including Gender-Based Violence (Articles 1, 2, 12, 14, and 16)

The CEDAW Committee has made clear that the Convention's definition of discrimination "includes gender-based violence, that is, violence that is directed against a woman because she is a woman or that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty."[138] The Committee has also emphasized that "discrimination under the Convention is not restricted to action by or on behalf of Government," and that "States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation."[139]

A. Sexual Violence and Harassment

Sexual violence[140] (SV) in Egypt remains severely under-researched and existing research remains limited in terms of the issues tackled, the population groups addressed and the methodologies used. Egypt's report to the CEDAW Committee lacks the required data on the prevalence of SV and on measures introduced to deal with it. The state does not publish statistics of the Ministry of Interior on the numbers of SV crimes reported to or recorded by the police, or the numbers of sexual violence crimes convicted by the courts. Despite these numbers being recorded yearly in a public security report, the Ministry has refused access to the report since 1997 to journalists, researchers, academics or members of the general public.

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[135] G. Barsoum (2009), *'Ard Ba'd al-Nata'ij al-Awaliyya li Bahth al-Nash' w'al-Shabab fi Misr* (paper presented at the Collaboration to Raise Youth Awareness about Reproductive Health Issues Seminar, Cairo, Egypt, Nov. 2009).

[136] 2008 EDHS, at 145-6, supra note 21.

[137] El-Mouelhy, Mawaheb, Amel Fahmy & Ahmed Ragab, *Investigating Women's Sexuality in Relation to Female Genital Mutilation in Egypt*, study briefing disseminated at the Cairo Family Planning and Development Association Study Briefing Session, Cairo, 11 Nov. 2009 [hereinafter 2009 *Investigating Women's Sexuality*].

[138] CEDAW General Recommendation No 19, UN GAOR, 1992, Doc. No. A/47/38, at para6.

[139] Ibid at para 9.

[140] Sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (The World Health Organization)

The available evidence suggests that SV against women in Egypt is very widespread, occurs across all geographical areas, all social classes and against women of all ages. Yet, the vast majority of women confronted with such violence are unable or unwilling to seek help or protection from the state's authorities.

1. Sexual violence against adult women

Rape and sexual assault

The incidence of rape and sexual abuse against women is difficult to estimate, as only a small proportion of victims report such incidents to the police, or seek help from state services. In the 2005 DHS, 6.6% of ever-married women reported having been physically forced to have sex with their husband at least once in their lifetime and 2% had been exposed to this type of violence in the past 12 months, with rural women being more likely to have been sexually abused than urban ones.[141] Elnashar and colleagues[142], who conducted the first epidemiological study on sexual abuse of women, reported that 11.5% of respondents had been exposed to sexual abuse by their husbands. Other studies looked at rape or sexual assault outside of the home as well. A recent study found that 9 to 13% of women knew a female who had been raped or sexually molested.[143] These figures are alarmingly high, despite the fact that the interviewing methods used in the surveys are likely to have caused an under-reporting bias.[144]

Despite the high rates of rape and sexual abuse, the vast majority of victims do not seek help from anyone.[145] Of those who do seek help, the vast majority turns to their family, but refrains from seeking legal remedies or from getting in touch with social or medical services.[146] The low help-seeking behavior rate is largely due to the absence of accessible and effective help services, as will be detailed further below. It can also be explained by the societal acceptance of violence against women in general and domestic violence in particular. While the 2008 DHS results show that acceptance of domestic violence, including marital rape, is declining, almost 40% of married women still think that a man is sometimes justified in beating his wife.[147] Alarmingly, the youngest respondents (age 15-19) are the most likely to believe that a husband is justified in beating his wife. The acceptance of marital sexual violence is even more entrenched as a vast majority of women believe that they have no right to refuse sexual intercourse with their husband.[148] This highlights the urgent need for awareness-raising campaigns among the young generation.

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[141] El-Zanaty Fatma and Ann Way, (2006) *Egypt Demographic and Health Survey 2005* (Egypt Ministry of Health and Population; Egypt National Population Council) [hereinafter 2005 EDHS].

[142] Elnashar A.M., EL-Dien Ibrahim M., Eldesoky M.M., Aly O.M., El-Sayd Mohamed Hassan M. 'Sexual abuse experienced by married Egyptian women', *International Journal of Gynecology and Obstetrics* (2007) 99, 216–220

[143] National Council for Women (2009) Egypt, *Violence against Women Study, Summary of findings*, USAID and the National Council for Women, Cairo: Egypt [hereinafter 2009 *Violence against Women Study*].

[144] The interviewing techniques used in the surveys did not provide sufficient confidentiality to respondents and it is likely that many women refrained from revealing intimate or private matters in front of other people.

[145] 2005 EDHS, supra note 141.

[146] Boy A. and Kulczycki A. (2008) 'What We Know About Intimate Partner Violence in the Middle East and North Africa', *Violence against Women* 2008; 14; 53 [hereinafter 2008 'What We Know About Intimate Partner Violence...']

[147] 2008 EDHS, supra note 21.

[148] 2008 'What We Know About Intimate Partner Violence...', supra note 146.

Sexual harassment

Milder forms of SV are even more widespread. A survey carried out in 2008[149] found that 83% of Egyptian women and 98% of foreign women reported being exposed to sexual harassment in the street, out of which more than half on a daily basis. This harassment was reported to occur at all times of the day and night, against women of all ages, all economic backgrounds and against women dressed conservatively as well as women dressed with western-type clothes. More than 90% of female respondents agreed that sexual harassment was a recently growing phenomenon.

Recently, Egypt has witnessed the growing phenomenon of mobs of young men violently harassing women in public spaces during feast times. These incidents have involved hundreds of men trapping a handful of women in a closed circle, ripping their clothes off and touching their bodies, while law enforcement authorities have remained idle.[150] Such incidents have become widespread over the past three years and require serious attention from the law enforcement authorities.

Sexual harassment in the workplace is also very widespread and a study looking at female factory workers found that the majority had been exposed to sexual harassment by colleagues and supervisors.[151]

Despite the pervasive nature of the problem, studies revealed that the vast majority of women did nothing when confronted with sexual harassment. Only 2% of Egyptian women reported the sexual harassment to the police. Public attitudes are still highly problematic as both men and women tend to place the blame for sexual harassment on the females.[152] These attitudes affect the reporting of sexual harassment incidents, as most women feel that, should they report the harassment, society will blame them for being careless in protecting themselves. Interviewed women explained that they would not report harassment to their family, friends or the police for fear of tainting their reputation.[153] Many women said that police officers are often themselves the harassers, thus further constraining the possibility of filing a complaint. In addition, there are no disciplinary or inspection mechanisms within workplaces allowing women to complain about sexual harassment and seek protection from harassers.[154]

Except for one study mentioned above, most attention from government and non-governmental bodies have focused on sexual harassment in the street, at the expense of tackling other forms of harassment, such as sexual harassment in the workplace, in schools, social care institutions or medical facilities. Further research is needed to identify the nature of harassment in other settings, in order to elaborate comprehensive policies that fight sexual harassment in all settings.

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[149] Mohammad, R. and Shoukry, A. (2008) *"Clouds in Egypt's Sky" Sexual Harassment: from Verbal Harassment to Rape, A Sociological Study*, Egyptian Center for Women's Rights, Cairo.

[150] New Woman Foundation (undated) *Malaf al Taharosh al Gensy* (Sexual Harassment), available at www.nwrcegypt.org/.

[151] Ezzat, M. 2009, *Istighlal Agsad al Nisaa bayn al Haymana al Zokoreya wa Soltat al 'Amal,* New Woman Foundation, Cairo [hereinafter 2009 *Istighlal Agsad al Nisaa*] .

[152] Abdel Hameed, A. and Eleleimy Z. (2009) *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, New Woman Foundation, Cairo [hereinafter 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*].

[153] Ibid.

[154] 2009 *Istighlal Agsad al Nisaa*, supra note 151.

2. Sexual violence against the girl child

Little evidence is available on sexual violence against girls in Egypt but some targeted studies show that exposure to SV is systematic for some population groups. For girls even more than for adult women, seeking protection or help from the state is nearly impossible.

Street girls and girls in conflict with the law

Civil society organizations estimate that of Egypt's two million street children, almost half are girls.[155] Street girls, by the nature of their circumstances, are extremely vulnerable to SV. ECPAT, an organization working for the elimination of the sexual exploitation of children, suggests that children are exploited for pornography, prostitution and sex tourism in Egypt, and that these practices are spreading. [156] In addition to the risks associated with them spending the night on the streets without protection, street girls are regularly exposed to SV from their peers and from law enforcement officials. A study by Human Rights Watch[157] showed that police officers often use the threat of violence or arrest to obtain sexual favors from girls. Girls also reported agreeing to have sexual relations with low-level police officers in exchange for police protection from sexual violence by other men.

Girls who had previously been arrested all reported that sexual harassment and abuse, including rape, was common in police custody. Girls arrested for vice-related offences are particularly vulnerable to sexual abuse, as police officers consider that they have relinquished their right to refuse sexual contact. When girls are institutionalized in social care institutions, they are further exposed to SV by the staff and by other children.[158] Because of their situation, street girls have no possibility of complaining about violence directed at them and their access to health and social services is limited to a few NGOs providing *ad hoc* services to street children.

Early marriage and 'tourist' marriage

Early marriage is also a form of sexual violence against girls. In many cases, these marriages are contracted in return for a large financial compensation to the family and constitute a form of sexual exploitation. A significant – albeit declining - proportion of women in Egypt get married before the age of 18. Data from the 2008 DHS reveals that 27.8% of women aged 25-49 were married by the age of 18. In poor areas, the marriage of under-age girls is even more widespread. A 2007 study found that girls in Upper Rural Egypt were far more likely than their urban counterparts to marry early, "followed rapidly by successive pregnancies, thus perpetuating the cycle of illiteracy and poverty into the next generation."[159] In addition, evidence has begun to surface of 'summer' marriages, "whereby young Egyptian girls from low-income families are married off to wealthy, visiting Arab tourists in return for a bride-price, but are often divorced at the end of the visit."[160] While it is difficult to estimate the scale

[155] N. Ammar, (2008) 'The Relationship Between Street Children and the Justice System in Egypt', in *the International Journal of Offender Therapy and Comparative Criminology*.
[156] ECPAT International (2008) *Global Monitoring Report on the status of action against the commercial sexual exploitation of children, Egypt*, Bankok.
[157] Human Rights Watch. 2003 Charged *with being children: Egyptian police abuse of children in need of* protection. New York: Human Rights Watch.
[158] Social Research Center (submitting to NGO Coalition on Child Rights), (2007) *The inclusion of the excluded, A rights based approach to child protection policies in Egypt*, American University Press
[159] Martha Brady, et al., *Providing New Opportunities to Adolescent Girls in Socially Conservative Settings: The Ishraq Program in Rural Upper Egypt* 1 (2007) Population Council, *available at* www.popcouncil.org/pdfs/IshraqFullReport.pdf.
[160] 2005 *The Sexual and Reproductive Health of Young People*, supra note 114.

of the phenomenon due to the frequent forgery of age certification documents, the Ministry for Family and Population estimated that this phenomenon concerns over 70% of girls in some areas.[161] Since the 2008 legal amendment raising the legal age of marriage for girls to 18 years (to be the same as boys), a family counseling hotline, operated by the National Council for Women, received a large number of complaints relating to early marriage, which have resulted in the conviction of at least two religiously trained registrars (*ma'zoun*) for contracting the marriage of under-age girls.

Recommendations: The Ministry of Interior should render accessible statistics on the reporting and conviction rates for each type of sexual violence offense. The state should also initiate and fund research on sexual violence against women, using a broad understanding of SV, covering all geographical areas, all population groups (including non-married women) and using rigorous methodologies.

B. The State's Response to Sexual Violence

Under the CEDAW, the state has a duty of due diligence to prevent violations of rights, to investigate and punish acts of violence, and to provide compensation to victims.[162] As part of this obligation, the state is required to establish effective legal and protective measures for the support and rehabilitation of victims of sexual violence. Yet, according to the CEDAW Committee, Egypt has, until now, not taken a holistic and comprehensive approach to address sexual violence.[163] It is noteworthy, however, that the 2008 amendments to the Child Law established a child protection system based on the coordination of services for 'at risk' children through local multi-agency committees. However, in the absence of implementing regulations to the law, the new protection system remains unimplemented to this date.

1. The law and the legal and judicial services

The rape provision and its interpretation by the courts

The penal code defines rape as sexual intercourse with a woman without her consent, an act punished by imprisonment (or by the death penalty in cases of rape with abduction). While the law provides an acceptable definition to protect women from rape, the judicial interpretation of the law is problematic on a number of points. First, although the law does not explicitly exclude wives from the definition of rape, the Court of Cassation has ruled that a woman is not allowed to refuse sexual intercourse with her husband "without a valid reason according to Sharia,"[164] which means that, in practice, marital rape is not criminalized. Second, while the law does not explicitly require the use of threats or force in defining rape, the courts have required that the complainant prove her lack of consent by providing evidence that she was physically forced into sexual intercourse.[165] In contradiction with international procedural standards,[166] judges require proof - supported by forensic evidence - that the victim physically resisted during the rape. Verbal expression of her refusal to engage in sexual intercourse is

[161] Egynews 09/08/2009 available at http://www.egynews.net/wps/portal/news?params=73902
[162] CEDAW Committee, *General Recommendation 19*, supra note.
[163] 2001 CEDAW Committee Concluding Observations on Egypt, at para. 344, supra note 112.
[164] Case No 45/1193, Court of Cassation, 22 November 1928.
[165] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.
[166] See for example the ICC's Rules of Evidence and Procedure, rule 70(c): "Consent cannot be inferred by reason of the silence of, or lack of resistance by, a victim to the alleged sexual violence"

not considered sufficient.[167] This evidentiary requirement makes it difficult for many women to prove rape, as marks of her resistance may not be visible on her body, especially if the forensic evidence was not collected soon enough after the rape. Third, Egyptian law does not restrict the admission of evidence related to the victim's reputation or previous sexual conduct.[168] A review of the Egyptian case law reveals that a victim's marital status, her reputation and her 'morals' are key factors considered by judges when using their discretionary power in sentencing decisions.[169]

Sexual assault and sexual harassment provisions

The law punishes sexual assault, defined as "indecent assault on any person by force or threats", and attempted sexual assault. If the victim is under 18, any sexual assault, even without the use of force or threats, is punishable. In addition, the Penal Code criminalizes sexual harassment against women by words or actions, including harassment over the phone. Sexual assault is punishable with three to seven years imprisonment and sexual harassment is punishable with one year imprisonment and/or a fine.

There is a gap in the law, as no provision criminalizes acts that do not amount to sexual assault but that are more severe than sexual harassment (for example acts that involve unwanted touching but do not constitute sexual assault). This gap results in the inadequate protection of women exposed to this kind of violence and has yielded calls by women's rights organizations for the enactment of a new comprehensive law on sexual harassment.

Article 17 of the Penal Code and the mitigation of sentence

Article 17 of the Penal Code grants judges the discretionary power to reduce the sentence imposed on the defendant to one lower than the minimum penalty stipulated for the crime, if there are mitigating circumstances. The law does not define mitigating circumstances and does not require the judge to justify the reduction of the penalty. Case law analysis reveals that judges use this discretionary power in most rape and sexual assault cases, including in cases where the judgment does not allude to any circumstances that could explain the reduction.[170] This judicial practice can result in undue leniency for defendants and constitute an infringement on the victim's right to justice.

Due diligence obligations of the state to prevent, investigate and punish acts of sexual violence and to provide compensation for victims

According to the CEDAW Committee,[171] states have a responsibility to prevent and investigate cases of sexual violence. Yet, the process complainants have to go through at the police station lacks gender sensitivity and empirical evidence shows that victims of SV are discouraged by police officers from filing complaints.[172] Women reporting a sexual violence complaint must answer intimate questions in front of those present at the station; these questions are generally asked by male officers without consideration for the privacy of the complainant; and victims report being systematically questioned about their personal behaviors and moral integrity, thus turning the complainant into the suspect.[173] These practices clearly violate a UN General Assembly resolution on measures to eliminate violence

[167] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.
[168] International Criminal Court Rules of Evidence and Procedure, rule 71
[169] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.
[170] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.
[171] CEDAW Committee, *General Recommendation No 19*, supra note 138.
[172] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.
[173] 2009 *Jarayem al Ightisab bayn al Waqe' wal Tashree'*, supra note 152.

against women, which states that investigative techniques should "not degrade women subjected to violence and [should] minimize intrusion."[174]

The state also has an obligation to punish acts of SV and to provide victims with compensation. Egyptian laws provide for a range of punishments for perpetrators of SV, but some perpetrators are allowed to escape punishment because of their relationship with the victim. A man raping or sexually assaulting his wife will not be punished. In addition, despite the amendment abolishing the possibility for a rapist to escape punishment by marrying his victim, ignorance of the law and social pressures often result in a marriage contract being concluded at the police station to avoid filing a rape complaint.[175] Concerning compensation, the Code of Criminal Procedure provides the possibility for sexual violence victims to file a civil suit for damages parallel to the criminal case. However, a substantial amount of documentary evidence is required from the victim, such as police and medical reports, some of which is very difficult to obtain.[176] This effectively prevents many victims from enjoying their right to compensation.

Lastly, the due diligence duty of the state includes a duty to protect complainants from further violence. Yet, Egyptian law does not provide the possibility to impose a protection or restraining order on the suspect to ensure that the complainant is protected from further violence.[177] This is clearly insufficient to protect women from harm, constitutes an infringement on their right to protection and can restrict their access to justice.

Recommendations: The government of Egypt should amend the law to explicitly criminalize marital rape and provide guarantees that domestic violence and marital rape will be effectively prosecuted. Article 17 of the Penal Code should be amended so that judges are required to justify any mitigation of the sentence in writing in their judgment; appeal and the Court of Cassation would be responsible for reviewing the legality of the penalty reduction and the admissibility of the mitigating circumstances justifying it. The government should enact a comprehensive law on sexual harassment providing for a range of sanctions applicable to different degrees of sexual harassment and containing protective measures for women exposed to harassment. Procedures to obtain compensation for SV should be simplified to ensure that the right of victims to compensation is secured.

Rules of evidence and procedure should be revised in accordance with international standards to minimize the burden of proof on victims of rape and sexual assault. Evidence pertaining to the victim's reputation, previous conduct or 'morals' should be made inadmissible.

Police stations should provide a safe, confidential and gender-sensitive environment for sexual violence complaints, including separate rooms for questioning, the involvement of female officers and the special training of investigation officers in sexual abuse complaints.

[174] General Assembly resolution 52/86; A/52/635, para 8 (b).
[175] 2009 *Violence against Women Study*, supra note 143.
[176] 2009 *Violence against Women Study*, supra note 143.
[177] From interviews with lawyers working on SV cases, December 2009.

2. The medical and psychological care services

Victims of SV experience a range of health consequences such as injuries, unwanted pregnancies, abortions, depression, anxiety and eating disorders, sexually transmitted infections and premature death.[178] Although SV survivors need quality medical and psychological care, medical professionals are not adequately trained to identify victims of sexual violence and respond to their needs. Studies in the MENA region show that there is generally no discussion between physicians and patients on domestic and sexual violence, because physicians have little awareness of the issue and feel unable to assist victims.[179] While Egyptian medical professionals noted that they frequently come across cases of women exposed to violence, they said that there are no specific services to address their needs.[180] There is no mechanism in place to identify cases of sexual violence, no protocols for dealing with cases of sexual abuse, nor are there referral mechanisms to appropriate psychological or social services.[181] Victims who do seek medical care are usually only given the basic required medical treatment. No counseling is provided inside the medical units.[182]

Another type of practitioner that often comes into contact with women who have experienced sexual violence are the 'community leaders' (*ra'idat al rifiyat*) - workers attached to health units or rural hospitals who are responsible for disseminating information on women's health and hygiene.[183] While the community leaders reported often being the first person women turn to in cases of violence, a recent study showed that they have little training in how to deal with victims of violence and do not know where to refer them for appropriate services.[184] Moreover, the strong stigma associated with mental health services can discourage abused women from seeking such assistance.

Recommendations: Medical practitioners and local paramedical practitioners should be trained to identify and address cases of sexual abuse. Protocols for dealing with cases of sexual abuse should be put in place in each hospital and health care centre; the health and well-being of women being the priority consideration.

3. Social support services

Victims of SV may need support from social services such as counseling, temporary shelter in a safe place and financial support to her and her dependents. However, in Egypt, these services are very deficient and poorly coordinated.

Shelters

There are only eight shelters for women victims of domestic violence in Egypt, of which seven are run by the Ministry of Social Solidarity.[185] This represents 214 beds available across the country, far below the minimum of 10,000 beds recommended by the Council of Europe's Group of Specialists for

[178] World Health Organization (2009) *Women and Health: Today's Evidence Tomorrow's Agenda*, available at http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf
[179] 2008 'What We Know About Intimate Partner Violence...', supra note 146.
[180] 2009 *Violence against Women Study*, supra note 143.
[181] Ibid.
[182] Ibid.
[183] Ibid
[184] Ibid.
[185] Ibid.

Combating Violence against Women.[186] In addition, in some governorates, women have no access to shelters altogether. The vast majority of women do not know that such shelters exist and fears leaving an abusive husband and consequently becoming homeless.[187] Further compounding the problem is that professionals who come in contact with abused women – social workers and police officers – are also often unaware of the existence of such shelters, and are thus unable to refer victims.[188] Even when referrals do occur, shelter directors reported refusing women referred by the police, as these women were seen as bringing trouble.[189]

Eligibility criteria for a place in the shelter are very strict, despite there being free places in shelters most of the time. Only divorced or widowed women experiencing familial difficulties are admitted to shelters, while unmarried victims of physical or sexual violence are not eligible.[190] The nature and quality of care received inside shelters is also problematic. Psychologists are not present in all shelters and shelter workers see their role as primarily aimed at reconciling families with a view to returning the women to their husbands, rather than providing protection from violence and help and support to treat the causes of the violence.[191] Further, in violation of the woman's right to confidentiality and protection from violence, it is common practice for a shelter to inform an abusive husband where his wife is staying.[192]

Other services

A number of NGOs provide services to victims of physical and sexual violence. These services range from legal aid to psychological support and social counseling. For instance, the Nadeem Centre operates the only 24-hour hotline for victims of violence, as well as rehabilitation and psychological support for sexual violence victims. Other organizations provide listening and counseling services and refer clients to psychologists and legal specialists.[193] However, despite these examples of NGO-provided quality services, too few organizations provide these services and their geographical coverage is not comprehensive. Yet, the government does not replicate successful models developed by civil society and there are no locally-accessible, state-funded centers for the counseling and psychological care of women victims of violence. The state has recently set up two national hotlines to help women and children exposed to violence or experiencing familial difficulties. It remains to be seen how effective these hotlines are in terms of referring victims to appropriate services.

Recommendations: There is a need to increase the number of shelters and ensure an adequate geographical distribution. The state should replicate existing good practices from the non-governmental sector and set up local centers which are accessible for women regardless of their geographic location. These centers should provide victims of violence with the necessary legal assistance, counseling, psychological care and social support, and be committed to ensuring the health and welfare of women, as well as their protection from further harm.

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[186] The Council of Europe estimates that there should be one bed for every 10,000 inhabitants, which would require Egypt to have more than 10,000 shelter beds.
[187] Human Rights Watch (2004) *Divorced from Justice: Women's Unequal Access to Divorce in Egypt*. New York: Human Rights Watch, [hereinafter 2004 *Divorced from Justice*].
[188] Ibid.
[189] 2004 *Divorced from Justice*, supra note 187.
[190] Ibid.
[191] 2009 *Violence against Women Study*, supra note 143.
[192] 2004 *Divorced from Justice*, supra note 187.
[193] 2009 *Violence against Women Study*, supra note 143.

C. Female Genital Mutilation (FGM)

After issuing a ministerial decree in 1996 banning FGM in public and private health facilities, a legal amendment was introduced in 2008 criminalizing anyone conducting FGM on a girl. The crime is punishable by imprisonment (three months to two years) or a fine.[194] The ban on FGM has been accompanied by governmental and non-governmental efforts to raise awareness of the negative impacts of the practice on girls and women's health, through the broadcasting of television and radio programs criticizing the practice and the initiation of community projects to raise awareness of women and community leaders. In addition, both the Sheikh of al-Azhar and Pope Shenouda III have repeatedly stated that FGM is not required by Islam or Christianity.[195] The National Council for Childhood and Motherhood also encourages citizens to use the Child Rescue helpline to report girls facing the risk of FGM or physicians conducting the practice.

Despite these efforts, studies show that FGM is still widely practiced throughout Egypt. The 2008 DHS reports that 91% of all women aged 15-49 have undergone FGM[196] and although rates of FGM are slightly lower among women under 25, they still exceed 80%.[197]

Beliefs of women and men are the driving force behind the perpetuation of FGM. Although the proportion of ever-married women (aged 15-49) believing that FGM should go on has dropped over the past decade, 63% continue to favor the practice.[198] Support for the practice is more widespread among women in rural areas than women in urban areas.[199] In addition, 57% of men (aged 15-49) believe the practice should continue.[200] A recent quantitative study revealed that men are now taking an increasing role in decisions about FGM, and some men request that their wife-to-be undergo FGM before getting married.[201] Support for the practice is based on the belief that FGM reduces women's sexual desire and therefore helps protect their purity and 'marriageability'.[202]

Moreover, families are misinformed about the medical risks associated with FGM and the majority of women believe that the practice does not pose significant risks to women's health.[203] Equally problematic are the attitudes of medical professionals, given that physicians now undertake more than half of all FGM procedures.[204] Though the government has been successful in shutting down a small number of clinics where FGM was performed,[205] the risk of criminalization does not appear to have

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[194] Article 242bis of the Penal Code, amendment brought about by the Child Law 126/2008.
[195] The Special Rapporteur on Violence Against Women, its Causes and Consequences, *Report of the Special Rapporteur on Violence Against Women, its Causes and Consequences, delivered to the Economic and Social Council*, E/CN.4/2003/75/Add.1 (Feb. 27, 2003) at para. 725.
[196] 2008 EDHS, at 197, supra note 21.
[197] 2008 EDHS, at 197, supra note 21.
[198] 2008 EDHS, at 203, supra note 21.
[199] 2008 EDHS, at 204, supra note 21.
[200] 2008 EDHS, at 203, supra note 21.
[201] 2009 *Investigating Women's Sexuality*, supra note 137.
[202] Ibid.
[203] 2008 EDHS, at 207, supra note 21.
[204] S.R.A. Mostafa, et al., (2006) *What do medical students in Alexandria know about female genital mutilation?*, 12 E. Mediterranean Health J. 78, 89 at 89 [hereinafter 2006 *What do medical students in Alexandria know about female genital mutilation?*].
[205] The Female Genital Cutting Education and Networking Project, *Egypt: Doctors Face Trial Over Female Circumcision* (Sept. 5, 2007), *available at* http://www.fgmnetwork.org/gonews.php?subaction=showfull&id=1189017291&archive=&start_from=&ucat=1&.

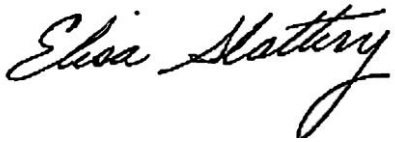
offset the financial gains of physicians for undertaking FGM procedures. Besides, in a 2006 study exploring the knowledge, beliefs and attitudes of 5th year medical students toward FGM, a worrying 52% of the students supported continuation of the practice.[206] More than half of the students (55.4%) did not believe that FGM violates the human rights of girls and women, and 51.3% believed that mild forms of FGM (cutting only the clitoris) does not lead to any complications and is therefore acceptable.[207] Nearly half (49.3%) believed that FGM prevents promiscuity in girls.[208]

Recommendation: **The state should endeavor to raise the awareness of women and men, as well as health care providers, focusing on the health consequences of FGM and correcting misconceptions on the link between FGM and women's chastity.**

There remains a significant gap between the provisions of the CEDAW Convention and the reality of women's reproductive health and lives in Egypt. We appreciate the active interest that the Committee has taken in the reproductive health and rights of women and the strong Concluding Observations and General Recommendations the Committee has issued to governments in the past, stressing the need for governments to take steps to ensure their realization.

We hope that this information is useful during the Committee's review of Egypt's compliance with the provisions of the CEDAW Convention. If you have any questions, or would like further information, please do not hesitate to contact the undersigned.

Sincerely,



Soha Abdelaty
Deputy Director

Egyptian Initiative for Personal Rights
soha@eipr.org

8 Mohamed Ali Jinnah, Garden City
Cairo, Egypt
Tel/fax: + (202) 2794 3606- 2796 2682
www.eipr.org

Elisa Slattery
Legal Adviser, Africa Program

Center for Reproductive Rights
ESlattery@reprorights.org

120 Wall Street
New York, New York 10005
Tel. 917 637 3600 Fax. 917 637 3666
www.reproductiverights.org

[206] 2006 *What do medical students in Alexandria know about female genital mutilation?*, at 78, supra note 204 at 78.
[207] 2006 *What do medical students in Alexandria know about female genital mutilation?*, at 85 supra note 204 at 85.
[208] Ibid.