Midwifery & Education

A critical review to explore the knowledge and attitude of men from an FGM-practising country on the practice of FGM

Joanna Andrews

ORIGINAL

Abstract

Background: Female genital mutilation (FGM) is a human rights violation of women and girls and the practice remains prevalent worldwide (World Health Organization (WHO) 2016). FGM is an emotive and sensitive subject area, making it difficult to research (Safari 2013). A UK-based study which investigated the perceptions of women who have had FGM found that spouses are influential in decision making (Safari 2013). This finding suggests that there is a need to educate men from FGM-high-prevalence countries about the complications of FGM and the support they need to give women who have suffered FGM (Safari 2013).

Objective: To explore the knowledge and attitudes of men from high-prevalence FGM-practising countries towards the practice of FGM.

Methods: Electronic databases CINAHL, MEDLINE and Scopus were searched using appropriate search terms combined with Boolean operators and truncation. Inclusion and exclusion criteria were established to select suitable research.

Results: Seven research studies were suitable for inclusion in the review. From these studies three themes emerged: variation in men's perception; men's perception of the impact of FGM and men's role in ending FGM.

Conclusions and recommendations: Increasing men's knowledge of the impact of FGM will support the abolition of the practice. However, more research is required to further increase knowledge of men's perceptions of FGM in a local setting.

Keywords and terms: female genital mutilation (FGM), female genital cutting (FGC), female circumcision, men, male, husband, partner, perception, attitude, knowledge, perspective.

An overview of FGM

FGM is a term used to describe procedures involving total or partial removal of the external genitalia or injury to the female genital organs for non-medical reasons (WHO 2016), although the practice can differ depending on the person who carries out the FGM (Jirovsky 2010).

WHO (2016) classifies FGM into four types, with type III where the vaginal orifice is sealed by cutting and opposing the labia minora and/or labia majora. Ninety per cent of FGM is either type I, II or IV, while type III is found in 10 per cent of cases (McCauley & van den Broek 2019).

FGM, or female genital cutting (FGC) which will hereafter be referred to as FGM (Evans et al 2019), is a human rights violation (WHO 2016) and reflects gender inequality and discrimination against women and violation of the rights of the child (McCauley & van den Broek 2019). FGM can cause immediate and chronic health complications (WHO 2016) with short-term symptoms including pain, haemorrhage, shock and infection, and long-term effects, such as fertility problems, urinary infections, and complications at birth (Sakeah et al 2006).

FGM impacts women's short- and long-term psychological wellbeing, causing emotional disorders,

anxiety, depression, low self-esteem, stigma and post-traumatic stress (PTS). Many women who have had FGM experience flashbacks, which are common in PTS (Mulongo et al 2014). Both partners may experience sexual dysfunction as a result of painful intercourse (Sakeah et al 2006).

The rationale for FGM varies in different cultures but in practising cultures it has high societal value (Safari 2013). FGM follows deep-rooted social, cultural and traditional rationales for its continued practice (McCauley & van den Broek 2019): it is considered a symbol of entering adulthood and acceptance in society as a woman (Safari 2013). It is also often a prerequisite for marriage and marriageability, believed to foster virginity, reduce the chances of being raped and reduce infidelity (Sakeah et al 2006). In some cultures, FGM is viewed as connected to cleanliness, improvement of fertility and increased pleasure for the husband (McCauley & van den Broek 2019).

According to Mulongo et al (2014) sociocultural factors that impact the practice of FGM include beliefs, behavioural norms, customs, rituals, and social hierarchies inherent in religious, political and economic systems. FGM is not a religious requirement, there is no description of FGM in religious texts and the practice of FGM is cited before the advent of Christianity or Islam (Mulongo et al 2014).

Deinfibulation is a minor operation involving a vertical incision to expose the urethra and vagina and is usually associated with alleviating the complications of women with FGM type III, particularly in preparation for birth (Safari 2013). Jirovsky (2010) describes deinfibulation as widening of the vaginal opening, removal of scar tissue and reconstructive surgery of the clitoris. Current United Kingdom (UK) standards produced by the Royal College of Obstetricians and Gynaecologists (RCOG) (2015) state that women are likely to benefit from deinfibulation and should be offered the procedure before pregnancy, ideally before first sexual intercourse, and that this can be carried out as an outpatient under local anaesthetic. The RCOG does not currently support the procedure of clitoral reconstruction due to lack of evidence (RCOG 2015).

Reinfibulation is the procedure of re-suturing the cut scar tissue resulting from previous FGM after delivery or a gynaecological procedure. Reinfibulation is still performed in countries around the world but is not permitted in the UK (Safari 2013).

Over 200 million girls and women are currently either living with the effects of FGM or at risk of FGM (WHO 2016). The practice of FGM is reported worldwide due to migration, however, it is most prevalent in 28 countries in Africa, Asia and the Middle East (WHO 2020).

FGM is an issue for the UK due to the increase in migration from FGM-practising countries (Briggs 2002). Macfarlane & Dorkenoo (2015) state that it is estimated that 137,000 women and girls with FGM lived in England and Wales in 2011, representing 4.8 per 1000 of the population. London had the highest prevalence, at 21 per 1000 of the population, but all local authority areas had a prevalence of above zero. The same study states that the estimated number of women with FGM giving birth in England and Wales was approximately 1.5 per cent of all women.

According to Mulongo et al (2014) the practice of FGM is strongly embedded and relocating to Western countries does not change the perspective of practising populations, resulting in FGM becoming a reality in countries in Europe, North America and Australia.

FGM, or taking a child abroad to have FGM, is illegal in the UK under the 2003 Female Genital Mutilation Act but has been illegal since 1985. UK figures demonstrate an ongoing problem: 321 applications for FGM protection orders and 348 orders were made from the introduction of the protection order in July 2015 to December 2018 (Ministry of Justice 2019).

The Department of Health's FGM Prevention Programme requires mandatory reporting of FGM and outlines professionals' duty of care to report all girls under 18 with FGM to the police (FGM Prevention Programme, Department of Health (DH) 2015). Data from April 2016 to March 2017 show 9179 attendances where FGM was identified, 87 per cent of those attendances were from a midwifery or obstetric service (NHS Digital 2017). Midwives, obstetric and gynaecological medical professionals are in the best position to detect, diagnose and prevent FGM due to their close contact with families and should play an active role in research and preventative efforts to support women at risk or survivors of FGM practices (Jiménez Ruiz et al 2016).

Background

The initial motivation to explore the topic of men and their perception of FGM stemmed from the author's experiences working as a community midwife, specific concerns of a perceived lack of health professional knowledge in FGM and the need for physical and psychological support for women who have been subject to this harmful practice. From further exploration of FGM practice and networking, it was apparent that men from FGM-practising countries had the potential to be instrumental in the abolition of this practice and are influential in enabling women to access support services.

It is important to acknowledge that the author is not from a community where FGM is prevalent and may lack understanding of specific local cultures and dialects. None of the literature used in this review is UK-based and there is, therefore, the potential for

discrepancies in the social context of the study. For example, FGM has been illegal in the UK for over 30 years, however other countries have different legal frameworks and the researcher may not appropriately understand the context of the study in relation to its geographic location (Maltby et al 2010).

Objectives

This critical review aims to explore the knowledge and attitudes of men from high-prevalence FGM-practising countries, who are either residing in their country of origin or in a country of immigration, towards the practice of FGM.

Methods

An initial search confirmed the availability of enough suitable data to enable the critical review to be undertaken in full. CINAHL, MEDLINE and Scopus were searched using appropriate search terms combined with Boolean operators and truncation. References of suitable articles were also checked alongside author-specific searches.

What is a critical review?

A critical review is an exploratory piece of work undertaken when little is known about a topic (Rees 2011) and is a piece of research in its own right (Aveyard 2019). A critical review of the literature aims to analyse the current research surrounding the topic and provide conceptual innovation by presenting, analysing, and synthesising material from a range of sources (Grant & Booth 2009). This method of research provides the opportunity for evaluation of current literature, however, in contrast to a systematic review, it does not demonstrate a structured approach to the literature (Grant & Booth 2009).

A critical review brings together existing knowledge in order to make sense of a particular subject, offering a broader picture of the topic in comparison to a single study and can clarify discrepancies between authors (Leach et al 2009). A critical review can draw conclusions about the state of research in a particular subject, building on the strengths of previous methodologies and avoiding challenges that were met in past research (Parahoo 2014).

A review of the literature is important in health and social care as it supports evidence-based practice (Aveyard 2019). However, review limitations are subject to judgment, preferences and bias and can be particularly influenced by the reviewers' backgrounds and interests (Leach et al 2009).

Inclusion/exclusion criteria

Inclusion criteria

- Primary research relating to the perception of men from FGM-practising countries and their knowledge and attitude towards FGM
- English language only
- Published literature
- 2009 onwards
- Qualitative methodology

Exclusion criteria

- Primary research relating to the perception of healthcare professionals (such as midwives or obstetricians) and their knowledge of and attitude towards FGM
- Primary research relating to the perception of women from FGM-practising countries and their knowledge of and attitude towards FGM
- Non-English language
- Unpublished research
- Pre-2009
- Quantitative methodology

Results

Seven studies were suitable for inclusion, representing six different countries: Italy (Catania et al 2016); United States of America (USA) (Johnson-Agbakwu et al 2014); Gambia (Lien 2017); Spain (Jiménez Ruiz et al 2014, 2016, 2017) and Morocco (Jiménez Ruiz et al 2017). All the included studies were contemporary research, with the earliest paper published in 2014 (Johnson-Agbakwu et al 2014) and the most recent in 2017 (Lien 2017, Jiménez Ruiz et al 2017). The studies represented participants from 18 different countries of origin, all of which were countries in Africa (Table 1).

Table 1: Included study participants and their country of origin.

Study	Country of origin	Region
Brown et al 2016	Kenya	East Africa
Catania et al 2016	Somalia	East Africa
	Eritrea	East Africa
	Ethiopia	East Africa
	Benin	West Africa
	Egypt	North-east Africa
	Nigeria	West Africa
Johnson-Agbakwu et al 2014	Somalia	East Africa
Lien 2017	Gambia	West Africa
Jiménez Ruiz et al 2017	Mali	West Africa
	Senegal	West Africa
	Chad	North-central Africa
	Djibouti	East Africa
	Niger	West Africa
	Ghana	West Africa
	Morocco	North Africa
Jiménez Ruiz et al 2016	Mali	West Africa
	Senegal	West Africa
	Chad	North-central Africa
	Djibouti	East Africa
	Niger	West Africa
	Ghana	West Africa
Jiménez Ruiz et al 2014	Senegal	West Africa
	Mali	West Africa

From the seven included studies three themes were identified:

1. Variation in men's perception
2. Men's perception of the impact of FGM
3. Men's role in ending FGM

Theme 1. Variation in men's perception

Men from high-prevalence-FGM regions vary in their perceptions of FGM and in their support to end it. Brown et al (2016) discussed the link between emerging societal change allowing men to select their spouse based on personal preference and a decline in support of FGM:

'… you have the freedom to marry the women that you want to marry … these days the parents don't look for the girl, you look for the girl yourself' (Brown et al 2016:120).

The Kenyan men from the Brown et al (2016) study voiced that opposing FGM results in social divisions within the local community due to the stigma and marginalisation of women who had not undergone FGM. The Kenyan men who openly opposed FGM were commonly associated with the Christian faith; this change in stance often resulted from anti-FGM efforts taking place in the local community (Brown et al 2016).

Out of the 50 men interviewed in the study by Catania et al (2016), 27 were against FGM. Egyptian men were more likely to support the practice compared to men from Benin who all rejected FGM. The type of FGM affected men's perception: infibulation (type III) was rejected by all the Somali participants, whereas type I was approved by half the participants.

In the Jiménez Ruiz et al (2017) study, which interviewed 25 participants originally from various countries in Africa, men from Senegal and Chad both supported and were against FGM, compared to Mali where all the men were in favour of FGM. This is similar to the findings of the Jiménez Ruiz et al (2016) study in which all the men from Mali supported FGM whereas men from Senegal both supported and opposed the practice.

Jiménez Ruiz et al (2014) found that, out of nine men from Senegal and Mali, two considered themselves against and seven were supportive of FGM practice. However, it would have been useful to detail the type of FGM that the men opposed or supported.

In a USA-based study interviewing Somali male refugees (Johnson-Agbakwu 2014) seven out of eight men voiced disagreement with FGM. Although the majority disagreed with the practice they cited matriarchal support for FGM as a reason for its continuation, summarised by one participant from the study:

'Men just agree because they do not want their mothers to feel bad' (Johnson-Agbakwu 2014:447).

Similarly, Gambian men from the Wolof and Mandinka clans disclosed their negativity around FGM practice when comparing women who had experienced FGM with those who had not (Lien 2017):

'… cut women don't have feelings so I was not happy with them. Both partners need to have feeling' (Wolof man quoted in Lien 2017:529).

'Those who are circumcised do not have enough feelings. There is no electricity to spark the relationship' (Mandinka man quoted in Lien 2017:529).

Theme 2. Men's perception of the impact of FGM

Men who recognise the harmful effects of FGM are more likely to reject the practice. Brown et al (2016) found that Kenyan men's perception of their partner's ability to produce healthy children was highly valued and maternal mortality was a key rationale for their opposition to the practice:

'… here some men take it positively to marry uncircumcised women because she doesn't have complications during birth …' (Brown et al 2016:121).

Catania et al (2016) reported that knowledge of the health dangers associated with FGM was high among participants in their study. The study compared the knowledge of men from different countries and found that Egyptian men appeared to be the least informed of the effects of FGM compared to Somali men, with a link between the type of practice that is prevalent in the respective countries. FGM practice in Egypt is commonly type I and often medicalised, a potential reason why Egyptian men are the least informed. This was also reflected in the knowledge of Somali men in the study by Johnson-Agbakwu et al (2014): men were aware of the morbidity associated with FGM, including pain during menstruation, dyspareunia, infections and difficulty during childbirth.

Although the study by Lien (2017) does not explicitly discuss the complications arising from FGM, the Gambian men from both the Mandinka and Wolof clans demonstrated their empathy with the pain women experience as a result of FGM, reflected in one participant's response relating to dyspareunia caused by FGM:

'Sometimes you feel so sorry. I felt so sorry for the pains, the screaming' (Lien 2017:531).

There were similar responses in the study by Jiménez Ruiz et al (2017). Below is a response from a Malian man:

'It hurts some women: it really hurts them' (Jiménez Ruiz et al 2017:485).

The participants in Jiménez Ruiz et al (2016) demonstrated an awareness of mortality and morbidity related to FGM. Below is a quote from a Senegalese male sharing his thoughts around abolishing the practice:

'I know if I were to do this to my daughter, I could kill her. I could kill her if I did this to her …' (Jiménez Ruiz et al 2016:33).

Theme 3. Men's role in ending FGM

Men have an important part to play in the social movements aimed at ending FGM (United Nations Children's Fund (UNICEF) 2013). In abolishing FGM, those leading the efforts should be culturally sensitive (Brown et al 2016). An important factor in the continuation of the practice of FGM is young men within the community and the impact they have on their peers (Brown et al 2016). These young men wanted to see community allies who act as role models in contesting myths about FGM and providing emotional support to other men opposed to the practice, as summarised by a Kenyan man:

'When you love a young girl, and you express your feelings towards her, and at some point you tell her that I really love you, but I am feeling that if I married in this uncircumcised state it's really not good, so the men have to be trained about this so that they themselves say it's really bad' (Brown et al 2016:122).

In contrast, the Catania et al (2016) study, based in Italy, found that length of time since migration had an effect on men's beliefs about FGM: those men who had lived in Italy for a shorter time were more likely to support FGM. Out of the five men who had lived in Italy for 24–35 years, all five responded that they were not in favour of FGM; among men who had only resided in Italy for 0–11 years, 14 supported and 21 opposed FGM. The men from Somali and Eritrea who were opposed to FGM felt unable to oppose FGM due to matriarchal pressure and considered that the involvement of members of the community and their leaders was essential for cultural change. Johnson-Agbakwu et al (2014) acknowledge the same challenges faced by Somali men in the USA. The men in the study viewed themselves as key educators about their own culture, and advocates on behalf of their wives in relation to care for women who had undergone FGM, as demonstrated by this Somali man:

'Providers should take time with patients. Learn about Somali culture and appropriately approach women and the conversation regarding Female Genital Cutting' (Johnson-Agbakwu et al 2014:450).

Jiménez Ruiz et al (2017) argue that men perform a passive role in maintaining the tradition of FGM practice by refusing to marry uncut women, and that engaging in meaningful dialogue regarding families in communities will support efforts to end FGM. The study presents demythologisation as a tool for health education to eradicate FGM practice. The authors acknowledge the limitation of the study, as it does not detail the justification behind FGM within different ethnic groups but is, rather, a 'snapshot' of the participants' beliefs. An earlier study by Jiménez Ruiz et al (2016) identified health care workers as being best placed to play an active role in research and health promotion efforts against FGM and other practices harmful to women's health:

'Without raising awareness, if no one explains it to them, they will never agree. Now, there is no awareness-raising or sensitization and people continue to do this' (Jiménez Ruiz et al 2016:32).

There should be a focus on health education in relation to prevention and awareness efforts in rural areas, as summarised by a Senegalese male who considered himself against FGM practice and who made the following statement:

'In the city it is more difficult, that is why they go to the villages and it is done there' (Jiménez Ruiz et al 2016:33).

Jiménez Ruiz et al (2014) offer a male perspective relating to FGM practice, with the intention of increasing knowledge and proposing new health promotion interventions to support its eradication. Expanding knowledge of the tradition will contribute to health promotion practices and ultimately work towards progressive abandonment of these practices (Jiménez Ruiz et al 2014).

Conclusion and implications for research

FGM is a human rights violation of women and girls. This harmful practice remains prevalent worldwide and more needs to be done to abolish it. This critical review highlights the vital need to support women and girls who have undergone FGM and abolish FGM practice.

Increasing men's knowledge of the impact of FGM will support these efforts. However, more research is required in meeting the needs of specific populations. Research in this area is challenging due to the complexity of FGM, the diversity of FGM practice within countries and tribes, the length of time of migration and the country of migration.

Author

Joanna Andrews (she/her) RM, RN, MSc, BSc, PGCE, FHEA, Senior Lecturer for Midwifery, Birmingham City University. Email: joanna.andrews@bcu.ac.uk. Twitter: @joannamandrews

References

Aveyard H (2019). *Doing a literature review in health and social care: a practical guide*. 4th ed. London: McGraw Hill Education, Open University Press.

Briggs LA (2002). Male and female viewpoints on female circumcision in Ekpeye, Rivers State, Nigeria. *African Journal of Reproductive Health* 6(3):44-52.

Brown E, Mwangi-Powell F, Jerotich M, le May V (2016). Female genital mutilation in Kenya: are young men allies in social change programmes? *Reproductive Health Matters* 24(47):118-25.

Catania L, Mastrullo R, Caselli A, Cecere R, Abdulcadir O, Abdulcadir J (2016). Male perspectives on FGM among communities of African heritage in Italy. *International Journal of Human Rights in Healthcare* 9(1):41-51.

Evans C, Tweheyo R, McGarry J, Eldridge J, Albert J, Nkoyo V, Higginbottom GMA (2019). Seeking culturally safe care: a qualitative systematic review of the healthcare experiences of women and girls who have undergone female genital mutilation/cutting. *BMJ Open* 9(5):e027452. https://doi.org/10.1136/bmjopen-2018-027452 [Accessed 28 September 2021].

Female Genital Mutilation Act 2003. (c31). London: The Stationery Office.

FGM Prevention Programme, Department of Health (DH) (2015). *FGM Prevention Programme. Understanding the FGM enhanced dataset - updated guidance and clarification to support implementation*. London: DH. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/461524/FGM_Statement_September_2015.pdf [Accessed 28 September 2021].

Grant MJ, Booth AA (2009). A typology of reviews: an analysis of 14 review types and associated methodologies. *Health Information and Libraries Journal* 26(2):91-108.

Jiménez Ruiz I, Almansa Martínez P, Alcón Belchí C (2017). Dismantling the man-made myths upholding female genital mutilation. *Health Care for Women International* 38(5):478-91.

Jiménez Ruiz I, Almansa Martínez P, del Mar Pastor Bravo M (2016). Key points for abolishing female genital mutilation from the perspective of the men involved. *Midwifery* 34:30-5.

Jiménez Ruiz I, Bravo M, Martínez P, Meseguer C (2014). Men Facing the Ablation/Female Genital Mutilation (A/FGM): Cultural Factors that Support this Tradition. *Procedia–Social and Behavioral Sciences* 132:631-8. https://doi.org/10.1016/j.sbspro.2014.04.365 [Accessed 28 September 2021].

Jirovsky E (2010). Views of women and men in Bobo-Dioulasso, Burkina Faso, on three forms of female genital modification. *Reproductive Health Matters* 18(35): 84-93.

Johnson-Agbakwu C, Helm T, Killawi A, Padela I (2014). Perceptions of obstetrical interventions and female genital cutting: insights of men in a Somali refugee community. *Ethnicity & Health* 19(4):440-57.

Leach M, Neale J, Kemp PA (2009). Literature reviews. In Neale J *ed. Research methods for health and social care*. London: Red Globe Press: 49-62.

Lien I-L (2017). The perspectives of Gambian men on the sexuality of cut and uncut women. *Sexualities* 20(5-6):521-34.

Macfarlane A, Dorkenoo E (2015). *Prevalence of female genital mutilation in England and Wales: national and local estimates*. London: City University London. https://www.city.ac.uk/__data/assets/pdf_file/0004/282388/FGM-statistics-final-report-21-07-15-released-text.pdf [Accessed 28 September 2021].

Maltby J, Williams GA, McGarry J, Day L (2010). *Research methods for nursing and healthcare*. Harlow: Routledge.

McCauley M, van den Broek N (2019). Challenges in the eradication of female genital mutilation/cutting. *International Health* 11(1):1-4.

Ministry of Justice (2019). *Family Court Statistics Quarterly, England and Wales, Annual 2018 including October to December 2018*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/789792/FCSQ_October_to_December_2018_-_final.pdf [Accessed 28 September 2021].

Mulongo P, Hollins Martin C, McAndrew S (2014). The psychological impact of female genital mutilation/cutting (FGM/C) on girls/women's mental health: a narrative literature review. *Journal of Reproductive and Infant Psychology* 32(5):469-85.

NHS Digital (2017). *Female Genital Mutilation Datasets*. https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/female-genital-mutilation-datasets [Accessed 24 March 2019].

Parahoo K (2014). *Nursing research: principles, process and issues*. 3rd ed. London: Palgrave Macmillan.

Rees C (2011). *An introduction to research for midwives*. 3rd ed. Edinburgh: Churchill Livingstone Elsevier.

Royal College of Obstetricians and Gynaecologists (RCOG) (2015). *Female genital mutilation and its management (Green-top Guidelines No.53)*. https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg53/ [Accessed 28 September 2021].

Safari F (2013). A qualitative study of women's lived experience after deinfibulation in the UK. *Midwifery* 29(2):154-8.

Sakeah E, Beke A, Doctor HV, Hodgson AV (2006). Males' preference for circumcised women in northern Ghana. *African Journal of Reproductive Health* 10(2):37-47.

United Nations Children's Fund (UNICEF) (2013). *Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change*. London: UNICEF. https://data.unicef.org/resources/fgm-statistical-overview-and-dynamics-of-change/ [Accessed 28 September 2021].

World Health Organization (WHO) (2016). *WHO guidelines on the management of health complications from female genital mutilation*. Geneva: WHO. https://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/ [Accessed 28 September 2021].

World Health Organization (WHO) (2020). *Female genital mutilation: fact sheet*. Geneva: WHO. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation [Accessed 28 September 2021].

Andrews J. MIDIRS Midwifery Digest, vol 31, no 4, December 2021, pp 425-430.