



RESEARCH

“Men have a role to play but they don’t play it”:

A mixed methods study exploring men’s involvement in Female Genital Mutilation in Belgium, the Netherlands and the United Kingdom

O’Neill S., Dubourg. D, Florquin S., Bos M., Zewolde S., Richard F.

SUMMARY

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Men Speak Out

«Men Speak Out» is a 27-month partnership (January 2015 - March 2017) between GAMS Belgium, FORWARD UK, HIMILO foundation in the Netherlands and the Institute of Tropical Medicine, Antwerp in Belgium, which responds to Daphne III priority on harmful traditional practices. The aim of this project was to engage men in the process of ending FGM and, on a larger scale, to end violence against women and promote gender equality through a human rights' approach. Peer educators have been trained in the 3 countries and specific tools (posters, booklet, video, TV and radio programmes) addressing FGM with a human rights and gender approach have been developed for men. Education tools have been disseminated in schools and migrant associations and outreach activities were organised by the male peer educators. National events have been held in the 3 countries with men AND women from the community to invite them to speak out and to engage in dialogue with women about FGM.

In the context of this project a mixed methods study was conducted in Belgium, the UK and the Netherlands to increase knowledge of men's role in the perpetuation of the practice. Four key problems were addressed in this research: (1) Men's understanding of FGM, its health risks and human rights violations, (2) Communication between women and men about the practice of FGM, (3) Men's opinions of FGM, (4) Male involvement in the decision making process to end the practice. For the qualitative research 60 in-depth interviews (IDI) and 9 Focus Group Discussions (FGD) were conducted across Belgium, the Netherlands and the UK (20 IDI and 3 FGD per country). In each country 16 male and 4 female participants were interviewed; 2 FGDs were conducted with men, one with women. Using snowball sampling techniques, the research participants were purposively selected among African migrant communities with a high prevalence of FGM. The objective of the quantitative study was to estimate the proportion of men who are in favour of the continuation of FGM in Europe as compared to their country of origin. The aim was therefore to find out whether migration and residence in Europe affects men's attitudes towards FGM.

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Introduction

Definition of the problem

More than 200 million girls and women alive today in 30 countries in Africa and the Middle East have undergone some form of FGM (UNICEF 2016). Thirty million more are at risk over the next ten years. The WHO and experts around the world agree that FGM can have serious consequences on women and girls' physical and mental health. All EU member states have signed up to international treaties such as the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC) that seek to safeguard these rights and therefore make it mandatory for states to protect women and girls affected by, or at risk of FGM. Different organisations around Europe have developed strategies against FGM and legislative measures have been taken to protect victims. However, despite increasing commitment to combat FGM, there are still significant gaps in the approach to tackle the practice (EIGE 2013).

Since FGM was brought up as an important health issue by the WHO in 1975, it has often been taken for granted that men's domination and control of women has an important role to play in the perpetuation of the practice (Almroth et al. 2001; O'Neill 2013). The UNICEF report (2013), however, showed that in 16 African countries the percentage of men who want to stop FGM is higher than the rate of women who want to stop FGM, apart from in Sudan and Nigeria (UNICEF 2013:70).

This suggests that the role of men in the perpetuation of the practice either seems to have changed or has been misunderstood. The UNICEF report further shows that in 8 countries the rate of women who think that men want FGM to end is significantly lower than the reality. In Guinea Conakry, for example, 12% of women think that men want to stop whereas in reality 42% of men want the practice to end (2013:72). This seems to point to a lack of communication between men and women, which the report confirms (2013:72).

It has also often been claimed that in African countries where FGM is practised, men have a sexual

WHO classifications of FGM (2007)

Type I

Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).

Type II

Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).

Type III

Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).

Type IV

All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

preference for women who have undergone FGM (Hosken 1993). The recent UNICEF (2013) report however shows that in 12 countries only between 1-7% of men feel that the practice increases their sexual pleasure (UNICEF 2013:76).

Regarding health consequences, a study in the Gambia showed that 72% of respondents did not know that FGM had a negative impact on the health and well-being of girls (Kaplan et al. 2013). In a behavior change study by Shell-Duncan et al. (Shell-Duncan et al. 2011) it was found that if men were involved in the decision on whether their daughters should undergo FGM, they were more likely to remain uncut. Little is actually known about African men's views on the practice in Africa and in Europe.

A mixed methods study (qualitative and quantitative research) was conducted in Belgium, the UK and the Netherlands to increase knowledge of men's role in the perpetuation of the practice. This research is part of a European Daphne project "Men Speak Out" coordinated by GAMS Belgique with three main work streams: research, training and an awareness campaign aiming at engaging men in the prevention of FGM.

Objectives of research

The objectives of the qualitative research was to increase knowledge on the men's role in the perpetuation of the practice by addressing 4 key issues:

1. Men's understanding of FGM as a health risk and human rights violation,
2. Communication between women and men about the practice of FGM,
3. Men's opinions about FGM,
4. Male involvement in the decision making process to end the practice.

The objective of the quantitative study was to estimate the proportion of men who are in favour of the continuation of FGM in Europe as compared to in their country of origin. The aim was therefore to find out whether migration and residence in Europe affects men's attitudes towards FGM.

Ethics Review Board

The research received ethical approval from the Ethics Review Board of the Institute of Tropical Medicine, Antwerp (1004/15) and KIT Health, Amsterdam (S64).

Study sites

The study sites were Belgium, The Netherlands and the UK in collaboration with the community based organisations FORWARD UK, GAMS Belgium and HIMILIO foundation (The Netherlands) who have extensive experience campaigning against and conducting research on the practice.

FGM in the national context

Belgium

FGM is practised in the countries of origin of an estimated 48,000 women and girls living in Belgium (Dubourg & Richard 2014). Approximately 13,000 women and girls are likely to have undergone FGM, with a further 4,000 at risk. The Flemish and Brussels regions account for the majority of cases (those affected or at risk are estimated at 6,800 and 5,800, respectively) followed by the Walloon region (3,300). Asylum-seekers account for a further 1,300 cases. The total number of 17,000 affected women and girls in Belgium is a low estimate given the on-going influx of refugees from FGM-practising countries such as Somalia and Eritrea. Historically, the first FGM-affected community to arrive in significant numbers in Belgium were refugees fleeing the war in Somalia in the early-1990s and then families from Guinea Conakry. Since 2012, a third of the FGM-affected women in Belgium come from Guinea, followed by Somalia, Egypt, Ethiopia and Ivory Coast. Article 409 of the Belgian Penal Code (2001) provides for a prison sentence of three to five years for "all persons participating, facilitating or encouraging all forms of female genital mutilation or any attempt to do so, with or without the consent of the person concerned." As of July 2014, encouraging the practice of FGM is punishable with imprisonment, for a period of between eight days and one year. Despite the legislative tools available, however, just 19 FGM-related cases were filed in Belgium between 2008 and 2014, none of which have led to conviction.

UK

The United Kingdom has the highest prevalence of FGM in Europe. An estimated 137,000 women and girls with FGM, born in countries where FGM is practised, were permanently resident in England and Wales in 2011 (Macfarlane & Dorkenoo 2015). This represented a prevalence rate of 4.8 per 1,000 population. Estimated prevalence rates for all regions and local authority areas in England and Wales showed wide variations. Prevalence rates varied considerably by region, with London having by far the highest prevalence of 21 per 1,000 population. Rates for individual local authorities varied even more widely. The highest rates were in London boroughs, with 47.4 per 1,000 in Southwark and 38.9 per 1,000 in Brent. Outside London, Manchester, Slough, Bristol, Leicester and Birmingham have high prevalence rates, ranging from 12 to 16 per 1,000. Other authorities, including Milton Keynes, Cardiff, Coventry, Sheffield, Reading, Thurrock, Northampton and Oxford have rates of

over 7 per 1,000. In contrast, many rural areas have a prevalence well below one per 1,000, but above zero.

According to the NHS enhanced dataset on Female Genital Mutilation published in December 2016, over 1200 girls and women with FGM were newly recorded every quarter since April 2015. Four out of every 9 newly recorded women live in London (45%). Ninety percent of these women were cut outside the UK but 5% underwent FGM in the UK according to the report (Health and Social Care Information Centre 2016).

Besides the 1985 'Prohibition of Female Circumcision Act' and related policies and the recent October 2015 'Mandatory Reporting of Female Genital Mutilation' policy of the Home Office, success in tackling the problem has been limited.

The Netherlands

The number of women living in the Netherlands originating from countries where FGM is traditionally practised was almost 70,000, (1% of the Dutch female population) in 2012 (Exterkate 2013). An estimated 40% of them have undergone FGM. Two thousand women originating from these countries live at asylum reception centres (35% of the total number of women in the reception centres), of whom an estimated 74% have undergone FGM. In total, 29 120 women with FGM are estimated to live in the Netherlands. The majority of these women fall within the reproductive ages.

In the Netherlands FGM is punishable as a form of child abuse. It carries a maximum prison sentence of 12 years. A higher sentence can be applied if the cutting is carried out by a parent of the child (articles 300 to 304 of the Dutch Criminal Code). Parents are also liable to punishment if they arrange for someone else to carry out the practice. Those who have their daughters cut in another country (or who arrange for FGM to be carried out by someone else) are also liable to punishment. This applies to everyone who is living in the Netherlands, including those who do not have a residence permit. Parents who are sentenced for having their daughter cut (or arrange for someone else to do so) and who do not hold a Dutch passport, may lose their right to residence (Statement opposing FGM; the State Secretary of Health, Welfare and Sport and the Ministry of Security and Justice, February 2014).

Qualitative Study

Methods

The qualitative research was co-ordinated by Dr Sarah O'Neill, medical anthropologist at the Institute of Tropical Medicine, Antwerp and conducted by researchers from community-based organisations in Belgium (Stephanie Florquin - GAMS Belgique), the Netherlands (Marthine Bos - HIMILO Foundation) and UK (Solomon Zewolde - FORWARD). Research meetings were held on a regular basis for training, planning and analysis under the supervision of Dr Fabienne Richard, Director of GAMS Belgium and Guest Researcher at the Institute of Tropical Medicine, Antwerp.

Qualitative research methods were used to explore the views and perceptions of men and women from FGM practising communities. The data collection tools consisted of semi-structured interviews and focus group discussions (FGD).

Purposive and snowball sampling techniques were used to identify participants who met the selection criteria, which included:

1. gender and age
2. originating from an African country where FGM is practised
3. the role within the community
4. some men from non-practising communities.

The research participants were selected on the basis of being able to provide crucial information on FGM, i.e., African migrants from communities that have the highest prevalence of FGM, opinion leaders whose views are crucial for FGM practising immigrant communities. In total 60 in-depth interviews (IDI) were conducted (20 per country). In each country 16 were undertaken with men and 4 with women. In total, 9 Focus Group Discussions were undertaken (3 per country). In each country FGDs were conducted with:

1. senior Somalian/Djiboutian men;
2. young men from different African countries and
3. with women.

The interview/ FGD guides for each category of informants were developed by the research committee and pilot-tested in the three countries.

Data Analysis

Ritchie and Spencer's (1994) qualitative data analysis method known as «Framework analysis» was used to analyse the data from this research. This method involves the organisation and management of responses through the process of summarizing data according to pre-defined categories, until a robust but flexible matrix is obtained. This allows the researcher to analyse data both by case and by theme. Framework analysis is often associated with policy-oriented research that aims at addressing an identified area of interest (Srivastava & Thomson 2009). Framework analysis has five key stages: 1) transcription 2) re-familiarisation 3) identifying a thematic framework 4) coding and indexing of transcriptions 5) charting, & mapping according to the thematic framework

Limitations of the study

The sample size of the qualitative study could be considered a limitation. The data provides for a basic understanding of issues across Europe, such as the decision-making process around FGM (continuation or abandonment), communication between the sexes regarding FGM and men and women's views on sexuality. The findings are valuable, as little research on these topics has been published. Nevertheless a more indepth study looking at barriers to communication among different African communities would be beneficial.

As in all social science research, responses can be affected by social desirability bias (responding with socially acceptable answers). Although there were initially concerns about having female interviewers interviewing African men on sensitive topics, we have not found that this has reduced the quality of the data. Men did not seem to mind being interviewed by female researchers on sexuality related topics. On the other hand, female research participants refused to speak to the male researcher about personal questions related to sexuality and intimacy.

Results

Reasons for practising FGM

* RELIGION AND CULTURE

Across all three countries religion and tradition were mentioned as the main justifications for practising. Although FGM is practised by Christians, Muslims as well as followers of indigenous religious practice, Muslims perceived “female circumcision” to be an essential element of their religious identity. Particularly younger male respondents, who had not resided in Europe for long, expressed uncertainty about whether the practice was an Islamic requirement or only a recommendation. However, they were certain that it was a religious tradition. Older participants across all three countries suggested that people who were in support of the practice believed that it was an Islamic practice but that this belief was wrong - it was just “cultural”. In the UK none of the interviewed religious leaders said that there was a religious justification for the practice but that it was linked to social expectations, family honour and marriage. Religious leaders interviewed in the Netherlands mentioned purity and cleanliness as important reasons for the practice.

“

FGM has been widely practised in our communities for a long time; people talk about it a lot and it is one of the most important customs; our girls are seen as complete, clean, and marriageable only if they are circumcised.

57, Somalia

”

“

The Imams say it's in the Haddith, it's Sunnah, and you must follow and respect your religion.

46, Somalia

”

FGD senior men, UK

* SOCIAL PRESSURE

Men and women from different backgrounds in West and East Africa spoke of the difficulty of stopping the practice on their own because of social pressure. A number of participants said that even if they chose not to have their daughters cut, it was common for the elders in their community to override their decisions and have the girls cut. This especially concerned people from countries where the practice is linked to initiation rites and the cutting is taken care of by female elders who are part of secret societies that initiate and instruct girls on how to become ‘women’ of a particular social identity (i.e. ethnicity or clan). Others spoke of social pressure in the sense that if people chose not to practice, they would be outcast, disowned and not included in decisions regarding the community. Regardless of the husband’s preferences, uncut wives are said to be insulted as being ‘impure’, oversexed and lazy. Food they have prepared may not be eaten and they have little help as far as housework is concerned. Other informants said that social pressure affects marriageability – no one wants to marry uncut women. In any case, no matter which form of social pressure is exercised, resisting the social norm and not having one’s daughters cut is risky because of social exclusion and the decision not to cut may be overridden by elders who prefer the girls to conform to the social norm.

“

In my society [Guinea], [...] they exclude the woman who is not cut. It's like they exclude you from society. If your female friends know that you are not cut, they will put you aside. At school or for eating, they put you aside. They won't come and play with you. They make fun of you.

FGD women, 38, Guinea, Belgium

”

“

In my society it was just a tribal mark. In my family all the girls had to get this mark. My father was the only one who said 'I don't want my daughters to be marked'. Do you know what these old women did? My father left, and they went to my mother and forced her to give them the girls. Because of the tradition and being part of our community. So it's social pressure.

”

FGD men, mixed background,
50, Ghana,
The Netherlands

* VIRGINITY AND CONTROL OF DESIRE

Across all three countries men and women said that FGM would ensure that a girl stays a virgin until marriage and that women would not commit adultery during marriage. In the countries of origin of all respondents virginity upon marriage is highly desirable and linked to family honour and reputation. Women whose reputation is compromised through their sexual behaviour are not just socially excluded but their behaviour is perceived to be damaging to the family as a whole. If a girl loses her virginity before marriage she jeopardises her marriageability and “success” later on in life. The data clearly shows that a girl's marriageability is linked with FGM. A girl who has been cut is perceived to be a virgin upon marriage and a better wife, in control of her sexual desires.

“

In Ethiopia they call uncut girls 'bale antenna' - girl with antenna [laughter]. Men prefer them for sex...they are seen as having lots of feelings and are good at sex. But not for marriage. The man thinks she goes around and sleeps with men because she needs too much sex. Circumcised girls are without feelings. They say 'she just lies there' - and she is not responsive to the man [during sex]. So the man goes and sees a bar lady.

”

FGD young men, 20, Ethiopia,
UK

“

In Fulani one says that an uncut girl “cannot sit” meaning she doesn't stay still, she runs around [with boys].

”

FGD young men, 17, Guinea,
Belgium

* CLEANLINESS AND BEAUTY

Across all three countries male and female respondents from all over sub-Saharan Africa said that female circumcision was perceived to render a woman cleaner and purer. Aesthetic notions were linked to this conception of purity. According to informants, women's genitalia, and especially the clitoris, are considered «ugly», «unclean» and «impure» when uncut and FGM is thus practised so that the vulva corresponds to social norms of beauty. Infibulation is believed to make the skin smooth.

“

It was very important for my parents. They said I have to marry a clean girl.

”

FGD senior men, 62, Somalia,
UK

Men's knowledge of FGM

* KNOWLEDGE OF THE CONSEQUENCES OF FGM

More than 50% of the respondents indicated that they knew some of the consequences of FGM. Most of them said that it was only after arriving in Europe that they realized that the health problems their partners were experiencing were related to FGM. Older Somali men's accounts of sexual and health related problems were the most descriptive and detailed. Younger men of different origins in all three study countries tended to say that women with FGM did not enjoy sex as much as uncut women. Commonly cited health consequences were pain and problems related to menstruation, pregnancy and child-birth, infertility, illness, or death. Psychological consequences, such as trauma, were rarely mentioned by male participants. In all three study countries some

research participants said that they did not know of any health consequences or that they had not seen anything negative about the practice.

“

Yes, when they sew it like that and her period comes, the blood can't come out and that will affect her. I think women suffer three times. When they cut her; during her marriage the pain of sex and again when they open her for birth.

”

Muslim Religious Leader, Somalia, UK

“

I talked about it with a woman I was seeing and she said that she did not have any [sexual] feelings.

”

Senior man, Djibouti

“

She said that she did not enjoy herself sexually [another man laughs]. Like other girls.

”

Senior man, Djibouti

FGD senior men, Belgium

* AWARENESS OF THE LAW AGAINST FGM

Across all three study countries, most participants were aware that there is a law against FGM in their European country of residence and in their country of origin. In the UK, all participants seemed to think that the law had an impact, that it was enforced and that punishment was severe, entailing imprisonment and loss of childcare. Research participants in the Netherlands and in Belgium thought that the law had a positive impact and discouraged people from practising. However, in the Netherlands some interviewees expressed concerns about the practice being driven underground, in the sense that people would not consult the help of a healthcare assistant in case something went wrong. For instance, if a girl hemorrhaged after the cutting this would not be reported because people would be scared of prosecution. Others

suggested that people would take their daughters home for FGM instead of having them cut in Europe.

“

You cannot do it [FGM] here; it's against the law.

”

37, Somalia

“

Yes, if you cut in UK, you are big trouble. Police can investigate you.

”

47, Somalia

Interviewer: “do you know the law?”

“

It's not legal; social service take your child and police prosecute you.

”

As a group, Somalia

FGD women, UK

“

I saw a beautiful girl dying because of circumcision [in Ghana] because she could not stop bleeding, and we could not bring her to the hospital because it was supposed to be a secret.

”

FGD men, mixed background, 55, Ghana, The Netherlands

Men's perceptions of FGM

* DOES FGM AFFECT THE SEX LIVES OF MEN AND WOMEN ?

The research aimed to get a better understanding of men's perceptions of how FGM might be related to

sexuality and marriage. Some research participants were very open whereas others were uncomfortable providing only brief responses. Across all three countries, young men were more open to talk about the effects of FGM on sexuality than older men, and West African men were more comfortable to address the effects of FGM on sexuality than East Africans. Across all three countries some men suggested that FGM affected their sex life negatively. Some of the issues that were raised were that cut women had less desire for sex, were less sexually active, asked for sex less frequently, sometimes “have to be persuaded” to have sex, were in pain during intercourse or did not feel a lot of pleasure. Other men had not had sexual experiences with uncut women or reported that they had not noticed a difference and it was impossible for a man to tell if his partner was cut or not. Some men vehemently disagreed with the idea that cut women do not experience any pleasure and said that they just took longer “to prepare” or “warm up”.

“

I had a girlfriend who was circumcised, she lived with me in the Netherlands. I asked her if she had an orgasm she told me she does not feel much,.... it made me sad and then she became sad as well.

”

IDI single man, 33, Sierra Leone,
The Netherlands

“

Sincerely, I'm not saying that excision doesn't do anything, it's not that, but in the experiences that I have had, honestly, no differences. [...] not in terms of sensations, reactions, behaviour, sexual taboo, or anything. None. [...] there were no barriers or, at any moment, some blockage or something. Very sincerely, that's not the experience I've had, and I've had a couple.

”

IDI man, 62, Senegal, Belgium

“

A women who is not cut can be hot instantly but she is not like this all the time; a women who is cut will take time, but if you are with her it will happen.

”

FGD men, 34, Somalia,
The Netherlands

* SEX WITH UNCUT WOMEN

About half the men across all three countries suggested that sexual relations with uncut women were completely different to sex with women who have undergone FGM. Uncut women were reported to be sexually active and having a lot of sexual desire – sometimes more than the man. Although the respondents clearly enjoyed their sexual experiences with uncut women, the undertones, particularly among senior East African men were condescending - uncut women were dirty, not trustworthy, “an open door”, prostitutes and not desirable for marriage.

“

One believes that a uncut women can have an orgasm 5 times in one night “ [...] “men would say to someone who is with a woman who is not cut “you're lucky, you can do it.

”

53, Somalia

“

I was looking for a women who was not circumcised, to have sex with [laughter...] “[others] we all do” [laughter] “everyone wants to have sex with a women who is not cut but everyone wants to marry a woman who is circumcised.

”

51, Somalia

FGD senior men, Belgium

* WOMEN'S PERCEPTIONS REGARDING FGM AND SEXUALITY

Some respondents said that their husband knew how to satisfy them. Particularly in the UK many women refused to speak about their sexual pleasure or satisfaction. Sadly, the majority of female respondents in the Netherlands and in Belgium said that they did not enjoy sex very much. Some women explained that they sometimes faked pleasure, others explained that they never made an issue out of it. They had been taught to be passive sex-partners. Some explained that female sexuality and the sexual intercourse were not only affected by FGM and its psychological factors but that their relationships with men were affected too.

“

Now I don't have any feelings [...] I can go one year without having sex, I can do one year with my man, no sex. [...] I do not feel like a woman

”

FGD women, 33, Mali,
Belgium

“

I don't like sex, my husband comes home late, I make sure I sleep then, and during Ramadan you don't need to have sex.

”

FGD women, 58, Egypt,
The Netherlands

“

You know, I have been taught to listen to my husband and just obey him. If he wants to have sex, in Sierra Leone it's not possible to speak about pleasure. The wife is not active, more like waiting till it's over. I only learned the difference in the Netherlands through the primary health care service GGD and from television and social media.

”

IDI women, 33, Sierra Leone,
The Netherlands

* HOW CAN WOMEN BE SUPPORTED?

Some respondents from the Netherlands had followed education programmes within the health department at the centre for asylum upon arrival in the country. Migrants were taught about anatomy, men and women's sexuality, and sexual pleasure. Participants said that it was new to them to hear how they could enjoy sex. Other individuals invited professionals to their organisation to speak about sexuality in relation to FGM. They said it was good to learn that it was possible for women to have an orgasm despite FGM. Some were referred to a sexologist. The sexologist explained that women who have undergone FGM could be very tense and contract the muscles around

the vagina. Relaxation exercises were used to learn how to open the vagina. Advice was given on pain and, for example, to look where the pain was coming from by using a mirror. The research participants explained how helpful the advice and the medical and psychological support had been for them. They also emphasized how important communication between partners was for an improvement of the sexual experience.

“

When I arrived in the Netherlands someone from the primary health care service talked with me, she was teaching us in a group of women to feel sexual pleasure not only in your vagina. We saw the body of a woman who was not cut and a body of a woman who was cut. She showed us that the clitoris is only partly damaged and that there are other spots that can feel. We talked about sexuality as something you like doing, not as a duty. It is in your mind. She showed us the importance of the mind and the knowledge of how to cope with being circumcised and to experience sexual pleasure...And then it's very important to talk about it with your husband. At the time I did not have a boyfriend but later I experienced it myself, I could allow myself to relax.

”

IDI married woman, Guinee,
The Netherlands

“

...there are probably links [between infibulation and lack of sexual pleasure]. It's probably related, but.. it also depends because if in her [a woman's] youth she has been really traumatized with really strong things, very emotional, so, she is really traumatized, so nobody touches her. [...] If she had the chance to have, to meet people that would take care of her, a psychologist, to help her psychologically, it could, I think that it could help. The feeling is always there. [...] I think that she could learn to live with her excision.

”

FGD woman, 38, Somalia,
Belgium

* FGM AS A CRITERIA FOR MARRIAGE

Across all three countries, almost all participants admitted that FGM was an important criteria for marriage and that among their communities back home, uncut women were not considered desirable for marriage. Particularly older men from East Africa suggested that it had been an important criteria for their marriages and that their families made sure that their spouses were cut. A few older East African men said that no enquiry about whether the girl was cut was made, mainly because it was taken for granted that everyone in the community was cut. Some men thought that if the family found out that a bride was not cut it would be problematic. If made public, she was likely to return home or her husband might become jealous and uncertain about her fidelity. Marriages were usually arranged, with a bride price paid to the bride's family so the young woman was expected to be a virgin and to remain faithful to her husband. Nevertheless, most men felt that times were changing and that nowadays FGM was becoming a less important criteria for marriage. Although most young men admitted that female circumcision was an important criteria for marriage in their communities back home, it would not determine their personal choice in marriage partner and love was a more important criteria.

“

For me personally it was not; but for the community yes it was. Yes, it was important. They do not advise you to marry someone uncircumcised. If I decided to do otherwise, they wouldn't have approved.

”

IDI man, 53, Sudan,
UK

“

Because if the family of the bride doesn't know, they won't ask because it's a secret, but if they know they will beware, they will not want to marry the girl.

”

IDI young man, 20, Guinea,
Belgium

Communication between men and women about FGM

Exploring communication between men and women on the practice of FGM was another major objective of this qualitative study. FGD participants were asked if they ever talked to the opposite sex about the practice and if they knew what their partner thought of it. With a few exceptions the initial reaction of the majority of participants across all three countries was that it was extremely difficult to talk about FGM with anyone. For most research participants the taboo around the practice was linked to codes of social decency and shame. In the Netherlands participants from Sierra Leone felt that FGM was not talked about because no member of an initiation group was allowed to reveal anything that happened in the bundu. Some suggested that there were ways to talk about taboo topics, like drama performances and songs. Although some men said that they could not speak to their wives directly about the practice, they had voiced their opinions about FGM in their presence so they were certain that their wives were aware of their views.

“

If I raise and talk about such thing, my wife says 'what's wrong with you today? Are you not an adult please stop it, please behave? She is too embarrassed for such topic.

”

FGD senior man, 53, Somalia,
UK

“

...For us over there it's easy to insult a woman, you will talk about something that you don't know, it's an insult, she will tell you that you are insulting her.

”

IDI, Imam, 42, Guinea,
Belgium

“

Why would I talk about excision with my wife? [...] but it's not the centre of interest, you see... It's not our primary concern. [...] her health is not affected. She has... of course in her youth she suffered from it. And afterwards? Life goes on. What do you want me to..? You see what I mean? ..It's not... spontaneously... Why would I talk about excision with my wife?

”

IDI man, 46, Djibouti,
Belgium

“

If she doesn't want to talk, we don't talk.

”

“

If you talk to a girl who is cut, she will tell you everything.

”

18, Guinea

FGD young men, Belgium

* COMMUNICATION ON FGM IN EUROPE

Regarding willingness and ease of communication, there were differences between participants of different generations as well as region of origin. In Belgium, young men from West Africa seemed to talk about this subject with women more often than older men from West Africa and more than all male informants from East Africa. In the FGD with young men in Belgium all participants (from Guinea, Senegal or Mauritania) were under the age of 25 and had discussed this subject with female partners or friends. They claimed that it was easy to talk to female friends and lovers and explained that they discussed FGM in relation to how the procedure was carried out, including “what is cut”.

Many research participants explained that the ways in which they talk about FGM had changed since they had come to Europe. Some explained that it had become easier to speak to their partners about FGM and sexuality openly. It also frequently happened that they were expected to discuss the topic when engaging with public services and governmental bodies, such as hospitals, social services etc. Across all three countries men reported that they changed their mind about the practice after they learnt that it was harmful to women's health.

“

Girls like to talk about it all the time, with boys.

”

Interviewer: “Do they talk about it with pride sometimes or...?”

“

Yes. With pride and joy too.

”

Interviewer: “With joy, yes... And sometimes with pain too?”

“

No, no pain.

”

“

We really changed once we came here; we didn't have the chance to talk about it back home

”

FGD young men, mixed
background, 23, Somalia,
UK

“

I started talking to women after I came to Europe. I didn't talk to women when I was back home.

”

FGD senior men, 50, Somalia,
UK

Men's involvement in decision making processes of FGM (continuation or abandonment)

* WHO DECIDES TO HAVE GIRLS CUT?

The research explored whether men are involved in the decision making process of FGM. In all countries the FGDs and interviews with men and women show that decisions on whether or not to cut a girl, when to cut, where to cut, who should cut, is mainly made by women. It emerged that the mother, the grandmothers and elder women wield the ultimate power. In Belgium and in the Netherlands women from West Africa said that girls could be taken away for cutting without the mother being informed. It was also reported that on occasion the mother's wishes regarding the practice were ignored and even if a mother objected to her daughter being cut, older women such as grandmas, aunts and neighbours would have the girl cut. Most research participants agreed that men are traditionally less involved or uninvolved in decisions regarding FGM. The father is more often than not uninformed about the whole process. Most men suggested that it was not their place to get involved in the practice, that it was women's business.

“
It is my mother who talked to my grandmother and decided to cut me

49, Somalia

“
Yes, it's mothers who usually decide to cut.

33, Somalia

“
My grandmother used to tell me cut women get husbands and uncut women can't marry.

36, Somalia

“
Grandmothers, neighbours, friends talk about circumcision to each other, and they make decision.

38, Somalia

“
Yes. I agree, the man rarely gets involved. It is a woman's issue.

38, Somalia

FGD women, UK

Nevertheless many participants agreed that although women are the practitioners of FGM, the practice is done for men's benefit and control over the female body. By not speaking out against it or by silencing the issue, men consent to having their daughters cut. In addition, men are the ones who pay for the practice or the party, if there is one. Many respondents suggested that decisions regarding FGM are also a communal matter and the man has the final say. If he opposes the practice then it is more likely to stop. If he shows support for the practice then it is more difficult for other members of the family who are opposed to it to stop. However some men felt very powerless as far as their say in an abandonment of the practice was concerned.

“
[Men] have a role to play, but they don't play it. [...] When you are not against something, it means that you are in favour.

IDI man, 27, Guinea, Belgium

“

The flesh it belongs to the tribe, even if you have a child, our child belongs to... [...] And the husband can sometimes agree with the wife to oppose, but there is the tribe, the weight...

”

IDI man, 46, Djibouti,
Belgium

“

Women can never stop it by themselves. I am very sure about that. Because I know that man uses circumcision to control the woman. So if man wants that always then how can you stop it?

”

IDI man, 58, Ethiopia,
UK

* WHAT CAN BE DONE TO STOP THE PRACTICE?

Across all three countries male and female research participants suggested that communication between men and women was crucial for an abandonment of FGM. On an interpersonal and private level, it is important that husband and wife speak to each other about the practice and discuss the decision not to have their daughters cut. As we have seen, however, it is not always easy for men and women to break the taboo. Some suggested that having access to adequate information would make the task easier and that many who supported the practice simply 'did not know'.

“

It would be good if there is an interactive information session about FGM/C with women in Sierra Leone done by a professional but then also speak about sexuality. To stop this practice we need men and women working together, first get knowledge and also dare to speak up

”

IDI married man, 50, Sierra Leone,
The Netherlands

“

... but we need to educate the women back home they need to know all the things I could see on the internet. We as parents need to learn how to raise our children in a good way so that circumcision is not the same as virginity anymore.

”

IDI married man, 23, Eritrea,
The Netherlands

* THE ROLE OF LEADERS

Many participants mentioned that it was very important to involve different kinds of leaders in the abandonment movement, such as religious leaders, opinion leaders and community leaders. People thought that it would help if they spoke out about the practice.

“

We need to stop it. The leaders must campaign hard.

”

IDI Muslim leader, 68, Ethiopia,
UK

“

Yes, I believe that I can play a great role by discussing it publicly; that it's harmful and has to stop, starting from my close family and friends.

”

IDI Christian priest, 67, Ethiopia,
UK

“

It would not bother me, but, for that you need to have all the tools at your disposal so at the moment, I would be incapable of talking about it publicly because I don't have much to say. But with training, with documentation, why not, if I managed to assimilate it as needed, to understand in order to repeat it. [...] talking in public it's risking to get loads of questions and you have to be able to respond to those questions, one cannot just come like that...

”

IDI Leader of a Malian diaspora organisation, 42, Mali, UK

* INFORMATION PROVISION THROUGH IMMIGRATION AND PRIMARY HEALTHCARE SERVICES IN EUROPE

In the Netherlands, the majority of the respondents from Somalia had received information on FGM upon arrival in the Netherlands. When they first arrived most of them were convinced that FGM was required by religion. The majority changed their minds and now think that FGM is outdated. Some respondents thought that the main problem was that there is still an awkward silence among African men and women who have experienced initiation and female circumcision. In the UK, the influence of migration on people's views and attitudes towards FGM was also highlighted in interviews and FGDs. Men reported that they were able to talk about FGM much more openly in ways that were not possible back home. FGM and sexuality were not just addressed at governmental and public health institutions (hospitals, social services etc.) but in general, many men felt that they were able to talk about sexuality with their partners in ways that was not done in their country of origin.

“

If we had known that circumcision was so dangerous ... we should have stopped before, but we did not know, this is the first time I can talk about FGM, in the AZC -centre for asylum- we could only listen. Nowadays I like interaction, I can give my opinion and think about my girls. One is cut and the other not.

”

40, Somalia

“

In Somalia people need to start teaching in schools and speak about FGM in primary healthcare.

”

36, Somalia

“

Use the media, there are still people in Somalia who are prisoners of their lack of knowledge. I was set free, I am aware now, I have knowledge. Somalia is one big village, a lot of cutting still happens. Knowledge is needed. A bridge from Europe to Somalia.

”

51, Somalia

FGD men, The Netherlands

Quantitative Study

Methods

The quantitative part of the research was coordinated by Dr Dominique Dubourg, medical doctor and demographer and conducted by researchers in Belgium, the Netherlands and UK. Research meetings were held on a regular basis for training, planning and analysis under the supervision of Dr Fabienne Richard, Director of GAMS Belgium and Guest Researcher at the Institute of Tropical Medicine, Antwerp.

Sampling

Due to the large number of migrants from Guinea Conakry, Sierra Leone, Somalia and Sudan residing in the 3 study countries, it was decided that men from these four countries would be interviewed.

The sample size calculation was based on the hypothesis that after migration (to the UK, the Netherlands or Belgium) the proportion of men who think the practice should continue would be significantly lower.

The baseline for the study was men's views of FGM as indicated in the Demographic and Health surveys (DHS) (Sierra Leone Demographic and Health Survey 2013; Guinée Enquête Démographique et de Santé et à Indicateurs Multiples 2012) or the Multiple Indicator Cluster Surveys (MICS) (UNICEF 2006), which is done every 3 or 4 years in the respective African countries.

Required sample size in order to reach a significant result for each country:

- **Belgium:**
Guinean migrants: 331 + Somali migrants: 120
- **UK:**
Sudanese migrants: 239 + Sierra Leonean migrants: 200 + Somali migrants: 196
- **The Netherlands:**
Sierra Leonean migrants: 113 + Somali migrants: 265

Questionnaire

The questions were identical to the ones in the questionnaire of the Demographic Health Surveys of Guinea 2012 and Sierra Leone 2013. A few additional questions were included to capture some demographic characteristics.

Questionnaire

- Q1.** Year of birth (or age)
- Q2.** When did you arrive in Europe? (Year of arrival)
- Q3.** Have you ever heard of female circumcision, that is, a practice in which a girl may have part of her genitals cut? Yes/No
- Q4.** Do you believe that female circumcision is required by religious precepts? Yes/No
- Q5.** Do you think that the practice of female circumcision should be continued or should it be stopped? Yes/No

Recruitment of interviewers and training

The interviewers were male peer educators, who were recruited through the three organisations (HIMILO, Forward and GAMS Belgium) and extensively trained. Some key figures of the community were also involved in the survey and facilitated access to populations that were difficult to reach, such as the Sierra Leonean community.

In total, 32 interviewers (11 in The Netherlands, 14 in the United Kingdom and 7 in Belgium) were trained for a time period of 2-3 days in which they practised administering the questionnaire on members of the community.

Recruitment of study participants

Migrant populations can be considered "hard-to-reach" populations, as they are effectively impossible to sample using conventional survey methods with predefined sampling frames. The sampling was purposive – a systematic method by which controlled lists of specific populations within geographical districts are developed, and detailed plans are designed to recruit adequate numbers of cases within each of the targets.

Interviewers (peer educators) were placed at various selected locations, and were instructed to interview a specific number of study participants.

The interviewers identified and targeted social spaces and areas inhabited by community members and visited these locations to randomly pick potential respondents who consented to participation. The locations included cafes, train and bus stations, community events (celebrations, sport tournaments), community centres, restaurants, mosques and churches, koranic schools, shopping malls, hairdressing salons, asylum seekers centres and migrant organisations.

Data were collected from February until April 2016 in Belgium, from April until October 2016 in The Netherlands and from May until September 2016 in the United Kingdom.

Respondent's selection criteria

- Men aged between 15-59 years.
- Born in Guinea, Somalia, Sudan or Sierra Leone.
- Having lived in a European country for at least one year.

Analysis

The completed questionnaires were entered into EPI Info in each study country (Belgium, the Netherlands and the UK) and subsequently cleaned and analysed in Belgium.

Results

Data description

In total 1618 men between 15 and 59 years of age were interviewed.

Table 1. Number of respondents by country of residence and country of origin, MSO 2016

	Country of residence			
	BE	NL	UK	Total
Country of origin				
Guinee	436			436
Sierra Leone		112	200	312
Somalia	148	264	196	608
Sudan			262	262
Total	584	376	658	1,618

Source: Men Speak Out survey 2016

Duration of stay in Europe

The Guinean men had lived in Belgium for 7.8 years on average. For Somali men, the average duration of stay varied between countries of residence: 6.5 years in Belgium, 9.8 years in The Netherlands and 12.6 years in United Kingdom.

The Sudanese men had lived in Europe for 12.9 years on average and Sierra Leonean men for 14.6 years on average.

Table 2. Duration of stay by country of residence and country of origin

	Country of residence			
	BE	NL	UK	Total
Country of origin				
Guinee	7.8			7.8
Sierra Leone		15.8	14.0	14.6
Somalia	6.5	9.8	12.6	9.9
Sudan			12.9	12.9
Total	7.5	11.6	13.1	10.7

Source: Men Speak Out survey 2016

Knowledge of female genital mutilation

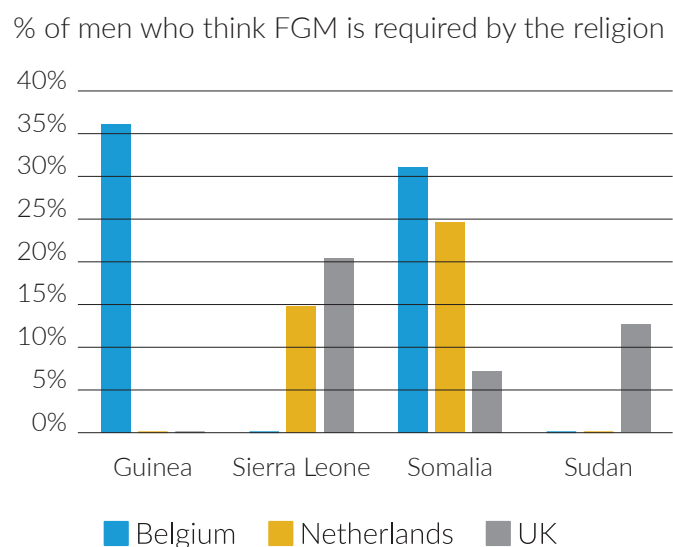
Almost all the respondents had heard of the practice. There were no marked variations in knowledge by country of origin or country of residence. The youngest respondents, aged 15-19 years, were less aware of the practice. In this age group, only 90.9 % had heard of the practice. The difference to awareness among older men is statically significant (p value = 0.001).

FGM a religious practice?

Twenty-three percent of respondents believed that religion required female circumcision.

Guinean men living in Belgium thought so most frequently (36.7%) while only 13% of Sudanese men believed that the practice was mandated in Islam. The opinion of Somali men varied in the three countries of residence, especially in the United Kingdom where only 7% believed that religion required FGM (see figure 1).

Figure 1. Percentage of respondents between 15-59 years of age, who have heard about FGM by opinion on whether their religion requires female mutilation



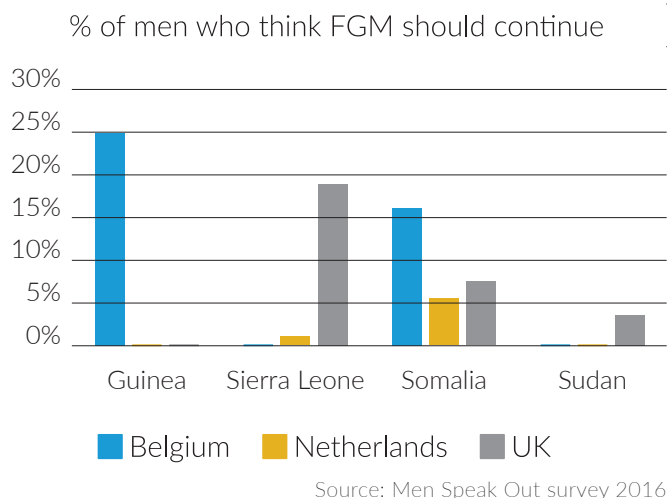
Source: Men Speak Out survey 2016

Attitudes towards continuing FGM

Thirteen percent of men aged between 15-59 years who had heard of female circumcision believed that the practice should be continued. Guinean men were more likely to believe that FGM should be continued (24.7%) than Sierra Leonean men (12.7%) and Somali men (8.7%). Only 3.8 % of Sudanese men thought that the practice should continue.

We observe noteworthy differences in the attitudes of men between countries of residence for Somali men: 16% of Somali men living in Belgium believed that the practice should continue, in contrast to 5.7% of the respondents who lived in The Netherlands and 7.3% and UK.

Figure 2 Distribution of respondents who have heard of female circumcision by their opinion on whether the practice of circumcision should be continued, by country of residence



New migrants were more likely to think the practice should continue. Those who arrived within the last five years were 2.5 times more likely to think that the practice should continue than men who arrived more than five years ago (Odds ratio 2.5, IC 1.83-3.41).

Comparison with Demographic Health Surveys

We were able to compare the results of our study with the demographic health surveys of Guinea Conakry (DHS 2013) and Sierra Leone (DHS 2014). Unfortunately there was no baseline available for Sudan (Sudan MICS 2016) and Somalia.

* GUINEAN MEN LIVING IN BELGIUM

The proportion of men aged 15-59 who believed that the practice was required by religion was 56% in 2012 (DHS) in contrast to 37% in Europe in 2016 (MSO). The difference is statistically significant (Chi square=34.184, p-value< 0.005).

The proportion of men who believed that the practice should be continued was 58.8 % in 2012 (DHS) and 25 % in 2016 (MSO). This decrease is statistically

significant (Chi-square=122.98, p-value<0.05).

There was no variation in attitudes towards female genital mutilation by men's age except for the young men. In the MSO 2016, 53% of men aged between 15-19 still believed that FGM should be continued (in contrast to 55% in the DHS 2012).

* SIERRA LEONEAN MEN LIVING IN UNITED KINGDOM AND IN THE NETHERLANDS

The proportion of men aged between 15-59 who believed that the practice was required by religion was 47.6% in 2013 (DHS) and 19% in 2016 (MSO). The difference is statistically significant (Chi square=44.27, p-value< 0.005).

The difference is statistically significant for all age groups above the age of 24.

The proportion of men who believed the practice should continue was 46.8% in 2013 (DHS) and is 13% in 2016 (MSO).

The difference is statistically significant (Chi-square=153.52, p-value <0.005). This decrease was observed in all age groups.

The influence of migration on the continuation of FGM

There was a correlation between the age of respondents, their age at arrival and their length of stay in Europe as well as a correlation between age, year of arrival and the belief that FGM is required by religion. To find out which one of these three determinants is the most important in their influence on the attitude regarding continuation of the practice, we used a logistic regression.

The model shows that the (believed) role of religion on the practice is the most important factor influencing attitudes regarding continuation of the practice. Men who thought that FGM was required by religion were 15 times more likely to think the practice should continue. The length of stay in Europe also influences attitudes; men who have been in Europe for a long time were less likely to think that the practice should continue. Neither the age of the respondent nor age at

arrival influenced attitudes regarding the continuation of FGM. Regardless of the age of the respondent and their age at arrival in Europe, the oldest migrants were fewer to believe that FGM was required by religion.

Table 3. Estimated Odds Ratio for attitude regarding the continuation of FGM by age, length of stay in Europe and the belief that FGM is required by religion, MSO 2016

		Country of residence		
		Odds Ratio	95% CI	P-Value
Variable	Age	1.0196	0.9981 1.0417	0.0749
	Length of stay in Europe	<u>0.9332</u>	<u>0.9005</u> <u>0.9671</u>	<u>0.0001</u>
	Required by religion	<u>15.2165</u>	<u>10.6958</u> <u>21.6481</u>	<u>.0000</u>
	Cases included:	<u>1,579</u>		

Source: Men Speak Out survey 2016

Table 4. Estimated Odds Ratio for attitude regarding the continuation of FGM by age at arrival, length of stay in Europe and the belief that FGM is required by religion, MSO 2016

		Country of residence		
		Odds Ratio	95% CI	P-Value
Term	Age at arrival	1.0196	0.9981 1.0417	0.0749
	Length of stay in Europe	0.9515	0.9254 0.9784	0.0005
	Required by religion	<u>15.2165</u>	<u>10.6958</u> <u>21.6481</u>	<u>.0000</u>
	Cases included:	1,579		

Source: Men Speak Out survey 2016

Conclusions / Summary

Research on men's views on FGM and their implication in the decision making process regarding the practice is limited (Shell-Duncan et al. 2011). Previous research suggests that their implication in the abandonment process may have a significant impact (Kaplan et al. 2013). In line with existing literature on FGM (Varol et al. 2015; Shell-Duncan & Hernlund 2000; Kaplan-Marcusan et al. 2009), our qualitative research found that commonly mentioned reasons for practising were religion (although the practice is not mentioned in the Koran), control of desire, the preservation of virginity, marriageability, cleanliness and aesthetics as well as social pressure. In the quantitative survey, 23% of respondents believed that religion required female genital mutilation. Guinean men living in Belgium were more numerous to think so (36.7%) compared to Sudanese men (13%). The opinion of Somali men varied in the three countries of residence. The qualitative research showed that younger research participants from West Africa were more uncertain of whether FGM was a religious obligation than older research participants who had resided in Europe for longer. The latter suggested that FGM was commonly believed to be a religious requirement in their communities but that this belief was erroneous.

The belief that FGM is a religious requirement is an important factor influencing attitudes regarding the continuation of the practice. Men who think that FGM is required by Islam are 15 times more likely to think the practice should continue. This finding corresponds with the DHS Guinea, which showed that if FGM was considered to be accepted by religion, men were more likely to be supportive of the practice (Gage & Van Rossem 2006).

Our quantitative and qualitative data show that migration influences men's attitudes regarding the continuation of the practice. Men who have been in Europe for a long time were less likely to think that the practice should continue. In the qualitative research, men reported that they changed their mind about the practice after migrating to Europe when they learnt that it was harmful to women's health. Previous studies on attitudes towards FGM and migration examined the attitudes of Somali men in Norway (Gele et al. 2012) and the US (Johnson-Agbakwu, Crista E. Helm et al. 2014), and Eritrean and Ethiopian men in Sweden (Johnsdotter et al. 2009) found that migrants rejected the practice. As far as the attitudes of African migrants in Belgium, the Netherlands and the UK are concerned, only very limited data are available (Dieleman 2010).

In the MSO qualitative research, most men were aware of the problems associated with the practice. Commonly mentioned consequences were pain, bleeding, pregnancy and child-birth related problems, infertility, illness, or death. Psychological consequences were

rarely mentioned. Very few men did not know any health consequences or said that they had not seen anything negative about the practice. The majority of men and women reported that FGM affected their sex lives in a negative way. Many men thought that cut women have less desire for sex, were less sexually active and "have to be persuaded" to have sex. Pain during intercourse and lack of pleasure were also commonly mentioned. Other men had not had sexual experience with uncut women or reported that they had not noticed a difference and said it was impossible for a man to tell if his partner was cut or not. This finding is in line with Ahmadu (2007) whose ethnographic research in the Gambia showed that men often cannot tell the difference between cut and uncut women during sex (Ahmadu 2007). As we have no information regarding the type of FGM the women who these men had sex with had undergone, it is not possible to draw further conclusions on this. However it is likely that these women had undergone less severe forms (not type II and III). During the MSO research a few men vehemently disagreed with the idea that cut women do not experience any pleasure and said that they just took longer "to prepare" or "warm up". No one reported that FGM enhanced their sexual pleasure.

New female migrants in the Netherlands who were experiencing difficulties during sexual intercourse, were affected by trauma or were not experiencing pleasure found the immigration support services provided upon arrival very helpful. Men and women reported benefitting from lessons on FGM and sexuality and some women spoke positively of the support they had received from a sexologist. To our knowledge an evaluation of the support services received by women who have undergone FGM in Europe (including clitoral reconstruction, psychotherapy and sexology) has not been made (WHO n.d.; WHO n.d.; Abdulcadir et al. 2015). In the MSO research most men and women were aware that FGM was a punishable crime in their country of origin and in their European country of residence. They believed that perpetrators risked imprisonment and loss of childcare.

As previously shown in research on FGM (Hosken 1993; Abdelshahid & Campbell 2015; Shell-Duncan & Hernlund 2000; Varol et al. 2015), the MSO research participants also stated that FGM was an important criteria for marriage and in their communities back home, uncut women were not considered desirable for marriage. Particularly older men from East Africa reported that their families back home made sure that their spouses were cut. Younger unmarried men said that they would not make FGM a criteria when choosing their wives. This is in line with previous research which shows that although FGM is an important criteria for marriage many men are ambivalent

about the practice, and would prefer abandonment (Abdelshahid & Campbell 2015; Fahmy et al. 2010; Varol et al. 2015).

Across all three countries men and women reported that traditionally, it was extremely difficult to talk about FGM across gender or cross-generationally. For most research participants, the taboo around the practice was linked to codes of social decency and shame. In Belgium, young men from West Africa seemed to talk about this subject with women more often than older men from West Africa and more than all male informants from East Africa. Many said that the ways in which they talked about FGM had changed since they came to Europe. Some explained that it had become easier to speak to their partners about FGM and sexuality openly. A recent systematic review suggests that further research on communication and FGM is needed but the literature suggests that although many men want to abandon, 'the silent culture' around FGM is a major obstacle to change (Varol et al. 2015; Berggren et al. 2006).

As indicated in anthropological literature on the practice (O'Neill 2013; Dilley 2005), the decision of whether or not to cut a girl, when to cut, where to cut, who should cut, is mainly made by women. Most research participants agreed that men are traditionally less involved or uninvolved in decisions regarding FGM. The father is more often than not uninformed about the whole process. Nevertheless, respondents suggested that decisions regarding FGM were a communal matter and that the man had the final say. By not speaking out against it or by staying silent on the issue, men consent to having their daughters cut. The participants thought that if the father opposed the practice then it was more likely to stop. If he showed support for FGM then it was more difficult for other members of the family who were opposed to the practice to stop. However some men felt very powerless as far as their say in an abandonment of the practice was concerned.

How to stop FGM?

Across all three countries male and female research participants suggested that communication between men and women was crucial for an abandonment of the practice. On an interpersonal and private level, it is important that husband and wife speak to each other about the practice and discuss the decision not to have their daughters cut. Some suggested that having access to adequate information would make the task easier and that many of those who supported the practice simply 'did not know'. Involving different kinds of leaders, such as religious leaders, opinion leaders and community leaders in the abandonment movement was considered to be beneficial. Furthermore, data from the Netherlands has shown that the information new migrants and asylum seekers receive upon arrival has a strong impact on their attitudes towards the practice. Most men and women said that having more detailed knowledge of the consequences had changed their minds. Information provision for African migrants should no longer remain the responsibility of NGOs and associations but the MSO research shows that receiving such information through a governmental institution and public service may be of benefit and is likely to improve knowledge of the practice and reduce the willingness to continue.

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