RESEARCH TO ACTION ON FGM

ENDING FGM IN EGYPT:

INVOLVING MEN AND BOYS IN EGYPT THROUGH A GENDER TRANSFORMATIVE APPROACH

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BACKGROUND

According to the 2014 Egypt Demographic and Health Survey (EDHS), 92.3 per cent of ever-married women aged 15–49 years had undergone female genital mutilation (FGM).[1] The prevalence of FGM falls to 61 per cent among girls aged 15–17 years, indicating a change in prevalence rates across generations and that adolescent girls could lead the way in efforts towards ending FGM.[2] Nationally, there have been some efforts towards ending FGM in the past few decades, with recent acceleration of steps including establishment of a National Committee for the Eradication of FGM, jointly led by NCW and NCCM, in 2019, and new legislative amendments in 2021. There are indicators of progress nationally in younger generations and a new Egyptian Family Health Issues Survey (EFHS) is in progress, which it is hoped will show updated national figures for FGM in decline.

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The majority of FGM occurs during early adolescence: 7 in 10 girls undergo FGM between the ages of 10 and 14.[3] The practice has become increasingly medicalized in Egypt, and among those who are circumcised, 78.4 per cent of procedures are carried out by health professionals.[4] Even though women are not asked in the national EDHS survey about the type of FGM they have undergone, other available data suggest that Types I and II are the most commonly practiced in Egypt.[5] Just over half of Egyptians think FGM should continue, with 59 per cent of men and 54 per cent of women holding this view.[6] Support for FGM is most common among girls and women in rural areas and in the poorest households, as well as among older and less educated women.[7] Perhaps most significant is that the majority of Egyptian youth support the continuation of FGM. According to the Survey of Young People in Egypt (SYPE), 70.7 per cent of young females and 68.6 per cent of young males intend to circumcise their future daughter(s).[8]

The International Men and Gender Equality Survey (IMAGES) provides some insight into men's attitudes regarding FGM and their participation in decision-making regarding FGM.[9] The majority of Egyptian men approve of the continuation of FGM (70 per cent) as they consider the practice a rooted tradition (74 per cent) and that it ensures women are less demanding sexually. More than half of men in Egypt (68 per cent) agree to circumcise their daughters and approximately a third (32 per cent) of Egyptian men only approve of marriage to uncircumcised women.

METHODOLOGY

The research used qualitative methods (focus group discussions (FGDs) and in-depth interviews (IDIs)) to collect relevant data. Seven IDIs were conducted in Assiut and Giza governorates with decision makers, youth, medical doctors and representatives of NGOs. Separate guides were developed for each of the interviewees; all guides included a section on the opportunities and challenges in involving men and boys in anti-FGM efforts. Each interview lasted 45–60 minutes and was conducted by a trained researcher. All interviewees signed a consent form agreeing to be interviewed and recorded.

Six FGDs were conducted in Assiut and Giza with four different groups: married women, married men, young unmarried men and young unmarried

DATA COLLECTION METHOD	GOVERNORATE		TOTAL
	Assiut	Giza	
IDI with youth	1	-	7 IDIs
IDI with medical doctor	1	1	
IDI with representative of NGO	2		
IDI with government officials	1	1	
FGD with married women	1	1	6 FGDs
FGD with married men	1	1	
FGD with young unmarried women		1	
FGD with young unmarried men		1	

women. Participants had different educational backgrounds, with some having had no formal education. Each focus group included an average of seven participants and lasted from 60 to 90 minutes. All participants verbally consented to participate in the discussion and agreed to be recorded. Socio-demographic data were collected from each participant (age, level of education, residency, employment status and number of children if married). A detailed guide was developed for the FGDs including questions around concepts of masculinity, perceptions around gender roles and decision-making processes in the household. Further questions addressed knowledge and perceptions around FGM, decision-making processes of FGM and male involvement, ways to encourage men to take active role in ending FGM and encountered challenges.

Data analysis

Data analysis was conducted manually; recorded IDIs and FGDs discussions were transcribed in Arabic. Researchers read the transcribed data, annotating and separating it by questions and/or topical areas. Later, major themes were identified that correspond to the objectives of the study and relevant quotes were selected. Data were examined in light of the demographics (age, education, employment and gender) to explain the patterns observed, and conclusions and recommendations were drawn accordingly. All of the major themes identified are closely linked to the practice of FGM and involving boys and men in ending FGM. The data analysis aimed to provide a practical guide through the voices of community members and grassroots organizations on how to accelerate ending FGM.

KEY FINDINGS AND DISCUSSION

Gender roles and power relations within the household

The study collected narratives from men and women representing different ages, socio-demographic and educational backgrounds to understand existing gender norms and power structures inside the household and examine them within the broader context to introduce an intersectional perspective that addresses the links between gender and other social markers of difference in relation to FGM.

Household chores: Many of the male study participants showed positive attitudes towards participating in some household activities such as purchasing household items (food, drinks or clothes), paying bills, cooking or changing gas bottles. However, their participation is conditioned by some determinants, such as the nature of the performed activity, whether female members of the household (i.e., mother, wife, sister or daughter) are present and capable of undertaking the activities or not, and community perception towards men's participation in these household activities.

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"I'm the one who buys the vegetables and sometimes I cook when she is tired… ."

(urban male, married and employed, 38 years old)

In general, many of the study participants saw men as the main breadwinner for their families, with domestic chores being women's 'normal' responsibility while men can contribute to household chores as they see fit:

"Men's participation in the household is a voluntary and not an obligatory task."

(rural, married, housewife, 32 years old)

"When my sisters were at home, before they got married, I did not do anything, I was spoiled. It is not right to do anything when there are four girls in the house. As a normal Middle Eastern man it was not right to do anything."

(urban, unmarried, employed man, 42 years old)

During the FGDs, women and men discussed the different determinants that affect men's participation in household activities and care. They stressed that prevailing community perceptions around gender roles within the domestic settings significantly affect the degree and frequency of male participation in domestic chores. Women participants said that their husbands often avoid publicly performing domestic chores for fear of being criticized, ridiculed or because it would detract from their masculinity. These narratives highlight the tension between 'the public and private faces of masculinity'.

"When I was pregnant, I was very exhausted, and after I gave birth, I found my husband waking up very early before anyone else to wash dishes when no one could see him. And sometimes he closed the door to clean and if someone knocked on the door, he entered his room and would never show up until this person left, so no one sees him."

(rural, married, housewife, 35 years old)

Family structure is another determinant of men's contribution in household chores that was widely discussed during FGDs. Male participants living in extended families stated that they rarely assist in domestic chores out of fear of being stigmatized or accused of "losing their masculinity" by other male members in the household if they take on feminine roles.

"As I am living in an extended family, women are expected to perform all housework activities alone. Living in an extended family influences men. For example, a man can be very cooperative with his wife but if surrounded by other family members, he can be belittled by his brothers if he helps his wife."

(married, employed man, 35 years old)

Research shows that, for long, extended families have enabled men to maintain power structure and gender roles. As a result, men living in extended families are less likely to contribute to household chores and caregiving in comparison with men living in nuclear families.[10]

Another determinant to men's contribution to household chores was growing up in a household where fathers carry out more traditionally feminine tasks. Mainly urban male participants residing in nuclear families shared these narratives.

Education and place of residency are also determinants to men's contribution to household chores and caregiving. Many male and female participants who are highly educated and living in urban settings stated that division of roles within the household between husbands and wives is quite fluid and that men may participate in some household chores. However, they all agreed that women perform the bigger share of household chores and that men's participation remains optional, as their main duty is to provide for the family.

"[E]ach one has a role, men can carry many duties compared to women. A man can be teaching and working two or three jobs from morning till 10 in the evening, so it's hard on him to do other things at home, it's an effort."

(married, employed man, 33 years old)

Caregiving: Participants agreed that women carry out the vast majority of the caregiving tasks; however, many men expressed their willingness to be more involved in caregiving for their children. This is consistent with the findings of some relevant studies including the recent International Men and Gender Equality Survey.[11] There is less stigma when it comes to men's participation in caregiving, as providing for children is one of the roles that is expected from men. The FGDs yielded stories of tenderness and caregiving by men towards their children.

"[I] may take care of kids sometimes when she is tired or wants to sleep, I take them to my room and let her sleep."

(educated and employed man, 38 years old)

Gender roles in childhood: Gender inequality starts early in the lives of most men and women as patriarchal views of gender roles begin in childhood, with men and women often following the models established by their parents.[12] Discussions with men participating in the study from rural and urban areas and from different educational backgrounds revealed that the majority of them support 'normal' upbringing, where girls perform or assist in household chores including serving male family members, and boys perform or assist in outside the household activities. In their views, this division ensures the stability of the household.

"We have a norm where the girl serves her brothers. It's a long-inherited norm and we were raised on it, and girls are happy with that."

(married, retired man, 63 years old)

However, women participating in the study – regardless of their education and place of residency – expressed more progressive views towards boys' contribution to household chores and caregiving. They believed that both boys and girls should participate equally in household chores.

"For my kids, I do not differentiate between girls and boys, and they both participate equally in cleaning the apartment: one will clean, one will change the sheets, and one will organize. With regard to household activities, everyone has a role, and everyone should contribute. I do not force the girls to conduct everything. A girl is like a boy, she does something and he does something."

(educated, married and employed woman, 31 years old)

The study narratives shared above are consistent with the findings of the Egypt IMAGES survey,[13] confirming that women are more likely to support gender-equitable views than men and that men – who, as children, saw their fathers involved in housework – are more likely to support gender-equitable views.

Men, women and work: Many of the male study participants did not object to women joining the labour force and contributing to the economy of the household, especially during the current economic hardship. They even stressed the need for equal pay and abolishment of discriminatory employment policies. However, the majority of the study participants stated that women's participation in the workforce should be within certain regulations and determinants.

Many of the male participants, regardless of their geographical location, and some female participants living in rural settings believe that not all professions suit women and that certain professions are more suitable for women than others. For example, male participants believed that jobs requiring leadership or strength, whether physical and mental, are jobs that are better suited for men; these include construction work, driving taxis or trucks and any higher management positions. The professions that suit women from the male participants' point of view are those performed within a specific workspace and with specific working hours, such as teaching, administrative jobs in governmental institutes and specific medical specialties such as obstetrics and gynaecology. It is believed that these professions within well-regarded entities allow women to balance their work requirements with their household chores and caregiving-related responsibilities. Further, when employment is scarce, the majority of men and women who participated in the study agreed that men's employment is more important than women's, as men are obligated to provide for their families, and failure to fulfil this role will greatly hurt their masculine identity.

While many of the men and women participating in the study stipulated some restrictions to women's contribution to the labour market, some women – mainly young and residing in urban settings – stated that women can do any work or hold any jobs, and that they have greater capabilities than men. They noted that women perform their work outside the house, in addition to their work inside the household, unlike men who mostly refuse to contribute to household activities especially if they are working.

Many of the study participants agreed that men have the right to control a woman's mobility and presence in the public space. Religion is often used to justify this act of control, as the majority of participants explained, because a wife's obedience to her husband is a religious duty encouraged by Shari'a. Further, many of the male participants tend to picture men as the protectors, the ones with the 'better brains' and skills, allowing them to take care of women who are less capable. It is of note that women who tend to agree with these narratives are housewives, while women who refuse these narratives and justifications are those participating in the labour market.

These narratives show that support for, and resistance to, women's work outside the household co-exist among many of the study participants. For many, women's participation in the labour market and thus the need to be more present in the public sphere may interfere with their main responsibilities – household chores and caregiving.

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Further, men resist what they perceive as the growing presence of women in the public sphere, as this threatens patriarchal gender roles. Women's presence in the public space, participation in the labour force and economic empowerment challenge power dynamics within the household and force a situation on men through which they may come to feel emasculated. Findings from different studies suggest that when women are economically empowered through participation in the labour market, they become more influential in the decision-making process inside the household.[14]

Sexuality, honour and masculinity: Many of the study respondents – across different demographics or educational levels – stated that men have the right to control women's presence in the public sphere (i.e., where to go and with whom, what to wear, when to return). Controlling the presence of women and girls in public places aims to "preserve her honour". As explained by many female participants, "honour means [the] sexual practice of women".

> "If sexual practice is within marriage, that means she preserves her honour and her family honour, while if a woman has sex outside the marriage, she will dishonour her family."
>
> *(married housewife, 35 years old)*

Therefore, performance in the public space (e.g., how a woman is dressed, talks to others, walks, etc.) is considered indicative of women's sexual behaviour, which in turn is perceived as closely linked to family honour. Being considered the providers for and protectors of the family, male family members have the right and the duty to control women's presence in the public sphere to ensure that family honour is intact.

> "Man is responsible for the security and financial support to his house, this is masculinity, to be responsible for the house and is the protection of the home."
>
> *(diploma, unmarried male worker, 42 years old)*

On the same lines, female and male respondents discussed FGM as a practice intended to preserve a girl's virginity until marriage and maintain fidelity after marriage through the reduction of her sexual drive. They further elaborated that an intact virginity means maintaining family honour.

As these findings show, sexuality, honour and masculinity are closely interlinked, and restricting women's mobility or performing FGM are intended to ensure that women's and girls' sexuality is controlled by men. Religion is often invoked to further normalize and justify such control, so that obeying male members or performing FGM becomes part of the Islamic teaching.

Talking about FGM and sexuality: Study findings suggest that FGM is no longer a taboo topic in Egypt and that it is openly discussed in the household between husbands and wives and/or with extended families (such as grandmothers or aunts) if living in a family house. Study participants mentioned that husbands and wives discuss the harms and benefits of FGM for girls before and after marriage, the timing of the circumcision, who will perform it and the possibility of stopping it.

However, participants reported difficulties talking about sexual issues with family members, especially children and older relatives. Both women and men said that, to a large extent, they talk about sexual issues with their spouses but more freely with their friends, where they can elaborate around topics of sexual desire and satisfaction. Female participants mentioned that discussions around puberty take place separately, mothers talk to their daughters and fathers talk to their sons. Female participants stated that they often discuss with their daughter topics such as the menstrual cycle and hygienic practices, and can provide limited information on 'how the wife should treat her husband' and 'how the husband should act with his wife'.

A recent qualitative study with young mothers of girls in Greater Cairo designed to understand mother–daughter communication about puberty also concluded that mothers are more open to discussing some aspects of puberty such as hygiene and menstrual cycle, other than issues around sexuality. However, these conversations take place at the socially perceived 'appropriate age' and delivered messages are often fear-based and stigmatize girls' sexuality.[15]

Dynamics of FGM decision-making

WHO MAKES THE DECISION ABOUT FGM?

The study discussions reveal the complexity of male engagement in FGM decision-making. Many study participants (men and women) maintained that men do not play a major role in decisions on FGM, rather that mothers make these decisions. Some female participants stated that they participated in the decision to circumcise other girls in their families, and the families of their friends and/or neighbours.

"Certainly, the man is not the person who could stop circumcision, women can stop it, because I could say no I don't want to circumcise my daughter, and she could say no, it benefited me."

(urban, basic education, married, employed man, 42 years old)

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Relevant literature suggests that women in Egypt challenge the practice of FGM for different reasons, such as negative experiences, exposure to anti-FGM messages or attainment of higher education.[16] However, they are unable to challenge the decision of circumcision and leave their daughters uncircumcised, even if they want to, without the support of their social network, in particular the fathers, as men are able to free them from the responsibility of carrying on traditions.[17] Some of the study participants, who argued that men are equally involved and that they are the main decision makers, especially in rural areas, share that sentiment. Still, the majority of study participants agreed that men's support to the decision of ending FGM is vital for it to happen. Some of the female study participants mentioned that when they decided not to circumcise their daughter, they had to discuss with their husbands and get their approval:

"[W]hen I remember the day I got circumcised, my body chills, and I don't like to remember it. And then I attended seminars and we talked, and in one of the sessions I attended, I recorded the session on my phone, and I showed it to my husband who was insisting on cutting our daughter, and refused to let her go uncut. And I continued to talk to him to convince him."

(married, educated and employed female, 31 years old)

"The first daughter was 7 years old and I decided not to circumcise her, and I found opposition from my mother who is now 80 years old. She said, why, all people do that and what people would say. I continued to convince her and then I told her that I'm the one who owns the decision."

(rural, educated, married, employed man, 43 years old)

"The man is responsible for circumcising his daughters; my husband was convinced to circumcise my daughter. However, I reminded him of my niece who had haemorrhaged and went to hospital. Therefore, he was convinced not to circumcise our daughter, and this was a very good example. I mean, I convinced him but he has the final decision."

(married, educated and employed woman, 37 years old)

Study participants drew a distinction between urban and rural settings with regard to decisions on FGM. The majority of participants from urban areas stated that the FGM decision is essentially the mother's to make, with a few other women participating (such as aunts, uncles' wives), while the father's role in the decision remains marginal. Participants perceived women as more capable than men in determining the benefits and harms of FGM on their daughters. In rural areas, group discussions concluded that men participate more in the decision of FGM; however, there is no evidence from the literature to support this observation. A cross-sectional study among men working in seven governmental schools in Benha city concluded that men play a major rule in the decision of FGM, where 56.4 per cent of the participants believed that men are the ones who take the decision regarding FGM.[18] The decision of FGM is not a simple one-way process, and it is influenced by multiple factors at interpersonal and society levels.

The narratives yielded from the study discussions are consistent with available literature in Egypt, which largely regards women as the main decision makers for FGM and acknowledges their role in its continuation, desiring to optimize their daughters' future prospects but not challenging traditions.[19],[20] However, this does not mean that men have no or little role to play in decisions about FGM. On the contrary, the findings of this study challenge the widely acknowledged notion of FGM as a 'women's issue' as men are consulted and/or expected to interfere, in particular when the decision of FGM is interrupted or challenged.

Further, secondary analysis of the 2015 Egyptian Health Issues Survey (EHIS) showed a significant association between men's supportive attitudes towards FGM and the actual and intended practice of circumcising girls.[21] The EHIS analysis also found significant associations between men's rejection of violence against women and their decisions about whether to have girls circumcised by health-care providers, suggesting that men are quite influential in the decision to medicalize FGM.[22]

WHO ELSE IS INVOLVED IN THE DECISION-MAKING ABOUT FGM?

Family members: Study discussions suggested that family members play a major role in reinforcing decisions for FGM in both rural and urban areas, although pressures are perceived to be stronger in rural areas where extended households are common. Some of the study female participants mentioned that although they are against FGM, they failed to persuade their husbands due to pressure from their extended families to perform FGM, and their fear of being criticized or shamed by them.

"I was circumcised when I was little, and I did not know anything, and when I got married and had girls, I did not want to circumcise them and it was very difficult to convince my husband as my mother-in-law wanted to circumcise the girls because of traditions and norms that we know in rural areas."

(rural, educated, married, employed women, 41 years old)

Data from relevant studies also concluded that family members and social networks influence decisions regarding FGM. A mixed-method study concluded that 32 per cent of female participants said their mother's opinion mattered.[23]

Religious leaders: Many men and women study participants, especially residing in the rural areas, stressed that religious leaders have great influence on the decisions of FGM. They explained that it is usually men who are in contact with religious leaders as they meet them regularly during prayer times in the mosque, listen to their sermons and religious lessons, and take their opinions on many matters of life, including FGM.

"Yes, they listen to the sheikh [religious leader] and he affects their decision. I have a brother who if the sheikh told him to go east he would go east, go west would go west. When I tried to convince him to not circumcise the girl he refused, and told me no, the sheikh told us to circumcise. I said no sheikhs or doctors say that, he told me no, the sheikh that I listen to said that."

(rural, diploma, married, employed woman, 41 years old)

The findings of the 2014 EDHS[24] are that just over half of ever-married women aged 15–49 (52 per cent) believe that female circumcision is a religious requirement and that women residing in rural areas are more likely to agree than women in urban areas. Similarly, the findings of the 2015 EHIS are that 50 per cent of men are more likely to perceive FGM as a religious requirement in comparison to 46 per cent of women.[25] Further, men living in rural areas (58.3 per cent) are more likely to regard FGM as a religious obligation than men and women living in urban areas (37.9 per cent). Younger, never-married women under the age of 25 are less likely than older women to regard FGM as a religious requirement.[26]

Medical doctors: The majority of women residing in urban areas stressed the importance of doctors in decision-making about FGM. They mentioned that they take their daughters to the doctor to determine whether they need FGM or not (largely on the basis of the length of the clitoris). The fact that doctors do not offer the same opinion for all the girls is confirmation that they are informed and to be trusted.

"The doctor knows this stuff, he can tell you that your daughter needs to be circumcised and will tell someone else that she does not."

(urban, basic education, married, unemployed woman, 32 years old)

Men, especially those living in urban settings, also regard medical doctors as a trusted source for information on FGM.

"If a doctor showed me that my daughter would be harmed from this thing if I do it to her, Wallhi (in name of good) not my wife and not even if my wife or entire family tried to convince me, if the doctor showed me that it will harm my daughter, I wouldn't do it."

(urban, married, basic education, self-employed man, 44 years old)

The influence of medical doctors as discussed among participants of the study varies, from urban to rural; doctors are not as influential in rural areas. Secondary analysis of the 2015 EHIS data suggests the same, where medicalization is higher in urban areas (84.7 per cent of circumcised girls in urban areas versus 78.2 per cent in rural areas).[27] Further, fathers and mothers who have FGM performed for their daughters by a medical doctor had statistically significant higher scores of rejecting violence than those who have performed it by a non-medical circumciser.[28]

Involving men in ending FGM

CAN MEN MAKE A DIFFERENCE?

Men are involved in decision-making on FGM, as concluded in our study as well as existing literature on FGM in Egypt. Further, the father's role in continuation of the practice is evident through the significant association between their supportive attitudes towards FGM and their actual and intended practice of circumcising their daughters.[29] Hence, male involvement in FGM programming will have impact on accelerating efforts to end FGM in Egypt.

Study discussions with community leaders revealed a clear impact of men's roles in anti-FGM activities, even in cases where men are not interested in the subject. The presence of men who refuse or oppose FGM within their families would reduce the prevalence of FGM.

"Their good example has more influence on changing other men's minds than any activity the programme could develop."

(rural, representative of NGO, married man, 35 years old)

Study participants stated that the presence of men who are against FGM in a given community encourages other to stand against the practice. They further stated that positive models can persuade other men to stop.

"First, it is enough that they support their women in the decision to stop circumcision, also they can raise awareness of their peers, so that they can convey awareness, while they are sitting on coffee, or anywhere they gather. They can also raise awareness with them, because any women's issue with a man appearing in it, the effect will be higher."

(rural, representative of NGO, married man, 35 years old)

In conclusion, study discussions stressed the importance of the role of men in ending FGM; however, this role can vary depending on related customs and traditions and family pressure and men's ability to stand against them, as we discussed earlier in the report.

SUPPORTING MEN TO WORK TOWARD ENDING FGM

Men were described through the study discussions as the main protectors of cultural values, and it was stated that they seldom attempt to challenge these values. Therefore, even if they oppose FGM, their willingness to take a stand against it is doubtful, and determined by family and peer pressure. This narrative carries the risk of portraying men as "prisoners of their tradition and undermines their individual agency to interpret their culture and the differences in their choices".[30] Therefore, narratives from the study discussions were closely examined to present practical ways to better involve men in ending FGM.

Many of the study participants believed that men would support ending FGM if they were given creditable and clear information on its harmful effects, including the negative effect of FGM on sexual relations and the possibility of death. Literature on gender-based violence (GBV) explains that men do not regard discussions around GBV as relevant to their lives[31] and they believe there is very little they can contribute to ending GBV. Any potential actions are hindered by the worry of being labelled 'weak' by peers if they interfere against disrespectful or abusive behaviour taken by another man towards a woman.[32]

Most of the study participants agreed that wide dissemination of messages around the negative consequences of FGM on couple's sexual relations could contribute to men being interested in stopping FGM and in advocating against it. Those participants indicated that the problems husbands faced in their sexual relations with their wives may lead them to oppose cutting their daughters, fearing that their daughters will suffer from the same problems in the future with their husbands.

"The thing that most influences men is when you talk about the effect of FGM on their sexual relations. This is the only entrance for men, and that's why he engages and says yes, that happened with my wife, and this is the most important point you can play on."

(rural, NGO representative, married man, 35 years old,)

Group discussions held with men revealed that anti-FGM seminars contributed to their decision not to circumcise their daughters. However, men can be reluctant to attend such gatherings, because of a lack of free time, demands of work or the absence of direct financial benefit to men for participation in these activities. Therefore, implementing educational and awareness-raising programmes at appropriate times for men, preferably evenings, is crucial. Holding the gatherings in attractive venues such as clubs, public parks or popular cafes, and applying participatory approaches will ensure wider male participation.

"Men liked the Hakkawi Al-Qahawi (café tales) initiative, where we invited them to share their stories and experience with regard to FGM; this took place in a café. Men loved the experience and many came to attend."

(rural, NGO representative, married man, 42 years old)

RECOMMENDATIONS

General recommendations

Fatherhood heightens men's emotional vulnerability and work to end FGM should engage fathers. In the study, many men stated that they are involved or want to be more involved in the lives of their children. They talk about their children with intimacy and affection and they see themselves as responsible for their welfare. The positive perception of fatherhood and the increased willingness of fathers to take more involved roles with their children suggests that fatherhood may offer a pathway for engaging men in standing against FGM, especially if messages focus on the connections with positive fatherhood. To avoid reproducing patterns of inequality and power and reinforcing damaging gender and sexuality stereotypes,[33] these messages need to be framed within the understanding of care and rights rather than protection.

Make better use of social media. Study participants, especially those from urban areas, suggested that social media could play an important role in targeting men, in particular younger men, and educating them about the harmful effects of FGM. Therefore, developing new materials as well as recording and publishing awareness-raising seminars through these various virtual platforms will increase men's exposure to anti-FGM messages.

Use engaging activities. Gatherings of men participating in activities of an entertaining nature can be used as platforms for anti-FGM messaging. Some success has been achieved here with activities that specifically target men, such as a traditional dance game with sticks called tahteeb in Upper Egypt, the traditional flute and football leagues.

Work with medical professionals (nurses, trained midwives and doctors) and train them to deliver effective anti-FGM messages to both men and women during antenatal and prenatal visits. Messages should be comprehensive, explaining possible physical, emotional and sexual possible consequences of FGM and stressing that all types of FGM, whether Type I or infibulation, are harmful practices and considered violations of women's rights.

Develop programmes with relevant sectors beyond health. For example, the majority of the population in rural areas have primary occupations in the agricultural sector, and receive direct services from agricultural developmental associations. Study participants suggested implementing a programme through the agricultural development associations to integrate health-related content with the agricultural extension services they provide. The programme would include clear and specific messages related to various demographic phenomena, such as fertility reduction, family planning, FGM and so on.

Programmatic recommendations and approaches

Rely on a 'community conversations' approach instead of the didactic, health-information-heavy approach. Community-mobilizing activities implemented by locally engaged community activists who initiate discussion and advocacy within their social networks and through other mediums such as social media can be powerful.

Use a gender-transformative approach that links FGM to broader challenges faced by women.[34] Interventions should focus on initiating conversations around power and gender-inequality, and examine the inter-relationship between the different concepts and FGM.

> "We can create a network of supportive men and call it the network of men supporting women. It remains very different and its impact would be greater. We had the women's network with Plan so I am sure that men could be in a similar network. Imagine what would happen when the man is the one who talks about women's issues; this really would have a different impact on women."
>
> *(rural, coordinator in an NGO, married man, 35 years old)*

Recruit men with more positive messaging. Men need to be convinced that ending FGM is relevant to their sexual lives and well-being, and that they can contribute to ending it. Men can be recruited

through social networks, whether through existing relationships or by mobilizing community-specific ambassadors or positive deviants.

Messaging

Messages should present FGM as a symbol of violence and disempowerment. Link different forms of violence such as early marriage, restricted mobility, violence in childhood so both men and women can comprehend the practice of FGM as a form of GBV.

Move the narrative against FGM away from the physical medical harms such as bleeding, infection and infertility, towards narratives around trauma, shame and in particular discuss sexual pleasure and satisfaction in relation to FGM.

Messages should address misconceptions around female sexuality, where the female genitalia, in particular the clitoris, are regarded as a source of sexual desire rather than sexual pleasure and therefore FGM is strongly associated with reduction of women's sexual desire rather than their sexual satisfaction and pleasure. This subtle distinction is important.

Messages should stress the importance of open communication between husbands and wives about FGM in relation to greater enjoyment of the marital relationship, thus encouraging men to be more involved in ending FGM.

Reduce the link between FGM and religion by developing a simple and categorical message that FGM is not religious (Islamic) but cultural practice. The one-dimensional question of whether or not FGM is Islamic already expects a one-dimensional and definite negative answer. We are aware that these reductions are problematic and further promote religion as a "universalized and decontextualized category", a fear that is shared by many scholars.[35] However, in an attempt to accelerate ending FGM we need to start to address it on neutral grounds.

Develop different messages for different target groups (men, women, boys and girls, religious leaders and medical doctors) and take into consideration the different intersectional elements such as place of residence and education levels. One message does not fit all:

- **Men:** The findings of the study show that men are interested in knowing more about the effects of FGM on their sexual lives. Develop messages for boys and men around sexual satisfaction and pleasure and the importance of healthy intimate life and explain the possible negative impact of FGM. Further, ensure that the messages directed to men are developed within the language of positive parenthood and care rather than protection, to ensure that inequitable gender power relations are not reproduced and reinforced.
- **Women:** The findings of the study show that women rarely understand FGM within the parameters of violence and inequality even when they oppose the practice. Develop simple messages that frame FGM as a violation of women's rights and a manifestation of gender inequality.
- **Community members:** The study findings show that doctors are widely consulted prior to decisions about FGM due to a strong belief that medicalization of the practice will reduce the complications. Develop messages to stress the fact that FGM being performed by a medical professional does not reduce the inflicted physical harm, and will not prevent the possible sexual and psychological consequences.
- **Medical doctors:** The study findings show that the majority of FGM cases are performed by medical doctors. Develop messages directed to medical doctors to stress the fact that FGM is a violation of their medical ethical code, and a violation of women's rights as well as an unlawful act. The messages should also ponder the immense role that medical doctors could play to foster efforts to support the abandonment of FGM, especially given that the family's FGM decision is increasingly in their hands.
- **Religious leaders:** The study findings revealed that religious leaders are very influential, especially in rural settings, and that men often seek their advice regarding FGM. Working with religious leaders can be challenging and therefore it is recommended the programmes should work with them both as influential community members but also as men, who face the same challenges in engaging in anti-FGM endeavours.

ENDNOTES

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