RESEARCH TO ACTION ON FGM

ENDING FGM IN YEMEN:

DISTANCING FGM FROM RELIGIOUS DISCOURSE AND TERMINOLOGY

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BACKGROUND

No recent quantitative or qualitative data are available on FGM in Yemen, and understanding of the issue depends very heavily on the 2013 Yemen Demographic and Health Survey (YDHS). The 2013 YDHS showed that approximately 19 per cent of girls and women in Yemen have undergone FGM, but there is significant geographical variability in the percentages.[1] The prevalence level ranges from zero in governorates such as Al-Baidha to 80 per cent in Hadramout and 85 per cent in Al-Mahrah. Women who have undergone FGM in Yemen have mostly experienced it during infancy: 83.8 per cent of circumcisions occur in the first week after birth, and a further 10.5 per cent before the age of 1 year.

Women with no formal education or only basic schooling are more likely to be circumcised than women with secondary or higher levels of education. Women in the lowest wealth quintile are nearly twice as likely to have been cut than those in the highest wealth quintile. An analysis of the most recent data by age shows that the prevalence among women aged 45–49 is 22.8 per cent, while among the youngest age group this has fallen to 16.4 per cent, suggesting a decline among the younger generations.[2]

FGM in Yemen is carried out as a result of commonly held cultural and religious beliefs and gender norms, passed down among family or community members.[3] The YDHS data also collected information on attitudes toward FGM.[4] Seventy-five per cent of women who have heard of female circumcision say that the practice should be stopped. Opposition to the practice is common even among circumcised women, with one-third saying it should be stopped. Their views on whether circumcision is required by religion vary significantly with level of education, ranging from 9.7 per cent among the most educated women to 27.5 per cent among women with no education.[5]

Anecdotal accounts from community and social workers and site assessments conducted by UNICEF and its partners suggest that FGM has increased in recent years. No national legislation in Yemen specifically criminalizes and punishes the practice of FGM. However, in 2001, a ministerial decree was passed banning FGM in private and public medical facilities.[6] A draft law entitled the 'Protection of Women Act' has been developed and is pending approval from parliament as of October 2022.[7],[8]

One of the challenges the country faces with regard to religious perspectives on FGM is the fragmented nature of religious leadership in the country, meaning there is no single authority to make a clear statement on the practice. As Human Rights Watch wrote in 2015, "Some prominent Yemeni religious leaders who subscribe to the Shafi'i school of jurisprudence within Sunni Islam consider FGM a religious obligation. Others in Yemen, such as those following the Hanafi and Maliki schools of thought, also Sunni, generally either view the practice as optional or do not practice it at all. The Zaidi Shia community, which represents roughly a third of Yemen's population, generally does not practice FGM".[9]

For 13 years, Yemen has ranked at the bottom in the World Economic Forum's Global Gender Gap index, at 153 out of 153; in 2021, Yemen was found at 155 out of 156, followed only by Afghanistan.[10] Gender inequality in Yemen is deeply rooted in a patriarchal society that prevents girls and women from accessing education, health services and labour markets, increasing their vulnerability to different violent and harmful practices, including FGM. FGM is closely linked to gender roles, norms and inequality, "rooted in unequal power relations between men and women that are embedded in a system that sustains itself through discriminatory gender stereotypes and norms, and unequal access to and control over resources".[11]

LOCAL VARIATIONS OF THE PRACTICE

In coastal regions a type of FGM known as al-takmeed is practised, in which a compress made of cotton material and filled with heated salt and/or sand is placed, together with oil and herbs, on a baby girl's genitalia when she is 4 days old. The compress is applied repeatedly for about an hour, and then the process is repeated for at least the following 40 days, possibly for up to 4 months, in an attempt to dull the nerve endings and thus decrease the sexual excitement of the girl.

Source: Stop FGM Middle East (undated) Yemen. http://www.stopfgmmideast.org/countries/yemen/, cited in https://www.28toomany.org/media/uploads/Country%20Research%20and%20Resources/Yemen/yemen_short_report_v1_(september_2020).pdf

TABLE 1. Data collection methods and research sites

INTERVIEWEE	SANA'A	TAIZ	HODAIDAH	HAJJAH	HADHRAMAUT	ADEN
In-depth interviews						
NGO representative	1					
NGO field worker				1		
Gender specialist	1					
Government official			1	1		
Male religious leader					1	
Male medical practitioner		1				
UNICEF and UNFPA offices					1	1
Focus group discussions: 5						
Married women					1	1
Married men					1	1
Young boys					1	

Methodology

The research used qualitative methods (focus group discussions (FGDs) and in-depth interviews (IDIs)) to collect relevant data (data collection is summarized in Table 1). Ten IDIs were conducted in six different areas (Sana'a, Aden, Hodaidah, Hajjah, Hadhramaut and Taiz) with representatives of NGOs, government officials, medical personnel, religious leaders, and gender and GBV specialists and representatives of UNICEF and UNFPA country offices in Yemen. Separate guides were developed for each category of interviewee; all guides included a section on the opportunities and challenges in involving men and boys in anti-FGM efforts. Each interview lasted from 45 to 60 minutes and was conducted by a trained researcher. All interviewees signed a consent form agreeing to be interviewed and recorded.

Five FGDs were conducted in Hadramout and Aden with married women, married men and young boys. 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 on FGM and male involvement, ways to encourage men to take active role in ending FGM and challenges encountered.

Participants had varied educational backgrounds and some 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 to have the discussion recorded. Socio-demographic data was collected from each participant (age, level of education, residency, employment status and number of children if married).

Data analysis

The recorded IDIs and FGDs were transcribed in Arabic. Researchers read the transcribed data, annotating and sorting it by questions and themes. Later, major themes were identified that corresponded to the objectives of the study and relevant quotes were selected. The data were examined in light of demographic characteristics (age, education, employment, gender) to explain emerging themes and draw conclusions and recommendations. The major themes that emerged related to the practice of involving boys and men in ending FGM were gender roles and power relations within the household, the links between sexuality and FGM, medicalization of FGM, religion and FGM, dynamics of the FGM decision-making process, and boys' and men's roles in ending FGM and the challenges posed by their engagement.

KEY FINDINGS AND DISCUSSIONS

Gender roles and power relations within the household

Household chores: The majority of the participants stated that women are mainly responsible for domestic tasks within the household, including taking care of children and elderly, while men are the main breadwinners. Men are expected to perform related household activities that take place outside the domestic setting such as purchasing household items, and paying bills for electricity and water. Men also usually perform household activities that require muscular effort such as changing gas cylinders. Women explained that their husbands do not participate in household activities as this engagement is perceived as shameful according to the prevailing norms in Yemen. It is viewed as incompatible with the characteristics of manhood.

However, the majority of participating men stated that they do not mind participating in household activities if their wives are sick and not able to perform the tasks, are travelling or are not at home. Confirming women's observations, they added that household activities are mainly women's responsibility, and the participation of men is optional.

"I do housework, when my wife is not at the house."

(married man, Aden)

"When my wife is sick or busy with work, I help her with housework, especially washing the clothes."

(married man, Aden)

On the other hand, younger men and women – mainly from urban settings – reflected positive shifts with regard to male participation in household activities. Some younger women participating in the FGDs stated that their husbands participate in the household work, including raising children, washing dishes and tidying the house, among other activities.

"My husband is a very open person, and did not find any problem in helping me at home."

(young married woman, Hadhramaut)

"My husband and I share the tasks and there is no problem. It is normal, it's the total opposite: he helps me in the housework and takes care of the children even if I did not ask."

(young married woman, Aden)

It was also observed that economic hardships, war and displacement can affect men's perception and practice regarding participating in household activities and also had an impact on women's employment.

"My husband helps me with the housework because I'm working, and I help him with the children's expenses in return. The economic situation became very hard due to war."

(married woman, Aden)

Caregiving: The majority of the participants stated that men are more involved in taking care of children and the elderly than they are in housework. The vast majority of women who were married confirmed that their husbands tend to participate more in care work, such as taking care of children, studying with children and caring for the elderly. Male study participants perceive taking care of children and/or elderly as part of their responsibility towards their families, part of the teaching of Islam and a characteristic of manhood. It is a household activity that brings no shame or disgrace to them.

"There is no problem in taking care of the children when my wife is ill. I feed the children and clean them."

(married man, Aden)

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"Sometimes I enter the kitchen and cook for the children. My children prefer my cooking more than their mother's."

(married man, Hadhramaut)

"On occasions, my husband helps me by watching the children only, but I prepare everything and do all the housework."

(married woman, Aden)

Gender roles in childhood: Gender inequality starts early in the lives of men and women in Yemen. The majority of male participants said that boys are not expected to perform or assist in household chores, as it is the responsibility of girls. Yet younger fathers indicated they would encourage boys' participation in household activities.

"I teach my son that helping his sisters is masculinity."

(young married man, Aden)

The data on men provide an interesting contrast between norms and actual behaviours, or perhaps show a shift toward more equitable attitudes among younger men. The majority of female participants, regardless of their age, favour encouraging boys to participate in household chores like girls.

"I divide the work between my sons and daughters, so that they learn collaboration and to help his wife in the future."

(married woman, Hadhramaut)

"We must grow these values in our children so that they learn how to preserve their homes in the future."

(married woman, Aden)

Men, women and work: Men strongly support the idea that they should be the main breadwinners. However, the majority of the respondents agreed that women can participate in the labour market, but stated that women should work in professions 'suitable' for them, such as teaching, nursing and administrative work. They added that professions where women do not mix much with men are preferred. The majority of male participants stressed that women's right to work must not be at the expense of men's right to work, or should not compete with men's access to jobs. In their view, men take priority in labour market participation, as they are the main breadwinners, and this precedence should especially be given weight during economic crises. Some male participants suggested the need to distinguish between wages for women and men, so that men receive higher wages because they are responsible for spending on their families.

"There are suitable jobs for women and there are some that are not, being a teacher is quite common and acceptable in the Yemeni community."

(rural married man)

Women's mobility: The majority of men and women in Hadhramaut and Aden agreed that a man does not have the right to control a woman or control her movement and presence in the public sphere. But they made it clear that a woman must obey her husband, and she must obtain permission from him when she leaves the house. Some men stated their belief that obtaining the consent of the man benefits the woman, and keeps her safe.

Sexuality, honour and masculinity: The findings showed that there are differences between men and women in their views regarding the right of a woman to refuse sex with her husband. The majority of female participants challenged the idea that women has no right to refuse sex if the husband requests it. They added that women are like men and there are moments when they have no desire and that their feelings must be respected and appreciated. In contrast, the majority of men believe that a woman has no right to refuse sex with her husband unless she has her period.

Female participants see a good man as someone who treats women with respect, appreciation and kindness, and provides for all of the requirements of his wife and family, while also being a kind and compassionate person. For their part, men believe that manhood means taking responsibility at an early age and being able to provide for all family needs. With regard to the concept of honour, male and female respondents agreed that 'honour' is a word most closely related to the behaviour of women. They therefore viewed women as responsible for preserving their honour and the honour of their families through self-respect, commitment to the teachings of Islam and customs in dealing with others, with prevailing traditions preventing women from talking to men and/or mixing with them, even at work.

Links between sexuality and FGM

Narratives from different studies in Yemen and other practicing countries suggest that FGM is largely practiced to control women's sexuality and protect them from having 'excessive' sexual desire.[12] Controlling women's sexual activities and limiting their promiscuity lies at the centre of community requirements of men and masculinity.

The religious leaders and medical practitioners interviewed for this study drew a strong association between FGM and women's sexual desire. They stated that uncircumcised women have such high sexual desire that their husbands may not be able to satisfy them. It is very crucial for them that women are not 'hypersexual', so they do not become sexual burdens, but still retain 'manageable' libido so they can please their husbands. This narrative is also sustained by some women.

The majority of the participants identified the connections between FGM and reduced sexual pleasure. However, they mentioned that only the 'severe' types of FGM including infibulation lead to sexual frigidity. Many people use the term 'sunna' to refer to and legitimize Type I FGM; the term in Arabic references the Prophet Muhammad's way of life and legal/traditional precedent. They stressed that the 'sunna' type (Type I) does not cause problems; on the contrary, they believe it ensures that girls will grow up to be 'modest' and 'pure', and reduces their sexual desire so they will be sexually satisfied after marriage and will not contract sexually transmitted diseases.

"I must circumcise my daughter so that she is not reckless."

(married woman, Aden)

"My husband decided to circumcise my daughters, because the uncircumcised girl is impure."

(married woman, Aden)

"I circumcised my daughter to protect her and her honour."

(man, Hadhramaut)

Medicalization of FGM

An analysis of the 2013 YDHS by the Joint Programme finds that Yemen is among the nine countries with the highest percentages of girls aged 0–14 who had been circumcised by health-care providers, alongside Egypt, Sudan and Djibouti.[13] Among Yemeni women aged 15–49, 92.8 per cent of those who had undergone FGM had been circumcised by traditional practitioners, while 12.8 per cent of circumcised girls aged 0–14 years had been circumcised by health professionals. A shift toward medicalization seems to be under way, as the majority of the participants including medical personnel and religious leaders believe that FGM is safer if performed by trained health professionals.

"In fact, I can say that those who are affected by circumcision are those who go to the traditional practitioners only, but those who perform circumcision at the hands of doctors are not harmed by circumcision."

(male health professional, Hadhramaut)

The shift towards the medicalization of FGM reflects the desire to minimize health risks while conforming to social expectations,[14] and it represents both a threat and an opportunity. The involvement of health professionals may influence decision-making on FGM and advocate for abandonment, given that health regulations, legal reforms and relevant training are in place. At the same time, the belief that FGM performed by health professionals has no negative consequences poses a huge challenge; the perception of FGM as a harmless practice could lead to its complete medicalization. Further, medical professionals, especially physicians, are well respected and highly regarded in their communities, and if some of them started to perform FGM in an effort to sustain cultural norms that they themselves support, for financial gain or as means of harm reduction, this would further normalize and expand acceptance of FGM.[15]

The problematic use of language by medical practitioners poses another challenge. The medical practitioners who participated in the study stated that they oppose FGM and regard it as a violent practice that contradicts Islamic teaching, and by removing a large part of the clitoris and the labia, causes substantial physical and sexual harm to women. Yet like others in their communities, they describe Type I as 'purification' or 'sunna', which they practice and advocate for. In their view, the removal of the prepuce of the clitoral hood resembles a scratch or a piercing and is not harmful or against Islamic teaching.

"There is a difference between female circumcision and 'purification' or 'sunna' practice. The 'purification' practice is taking something small at the tip of the girl's clitoris. As for female circumcision, which is performed by traditional practitioners, it is a violation of girl's genitalia and some of them perform Pharaonic circumcision."

(male health professional, Hadhramaut)

Their use of the terms 'purification' and 'sunna' legitimizes and glorifies the practice; their reframing frees them from the blame and any ethical burden.[16]

Religion and FGM

Religious leaders are highly influential when it comes to decisions about FGM. Community members tend to consult them to confirm that FGM is part of Islamic teaching. There are many prophetic 'hadiths' circulating about FGM, and many divergent religious opinions regarding the degree of its necessity.

Religious leaders play a key role in reinforcing FGM. Many of the study participants stated that they exert pressure on community members to ensure that girls are circumcised. Discussions with religious leaders in Yemen highlighted their strong convictions that what they call the 'sunna' practice is an integral part of Islamic teaching and there is nothing that forbids it.

"I consider it one of the matters that came in the Shari'a, and the base of our view is Shari'a, and the Shari'a says as the scholars say, it is either obligatory, sunna, or honourable, and some scholars see it as permissible. For me the base of this thing is Shari'a and scholars say, I'm not with those who prohibit circumcision and we do not have in Shari'a that circumcision is forbidden. If religion forbids circumcision, it would come in our law to show us that; yet there is nothing in the law that calls on us to prevent circumcision. Islam did not leave out any important issue but touched on it."

(male religious leader, MSc in Islamic Studies, married, 35 years old)

Religious leaders refer to the practice as 'sunna', and do not use any other terms. However, they draw a clear distinction between 'sunna' and other types of FGM, including infibulation. They perceive 'sunna' as a harmless practice that ensures women's purity and preserves their chastity in keeping with Islamic teaching that urges women to be pure and honourable.

"Many studies have confirmed that women are not harmed at all by sunna circumcision. Rather, those studies have proven the opposite, that not circumcising is what harms women."

(male religious leader, MSc in Islamic Studies, married, 35 years old)

Religious leaders advocate for the medicalization of the practice as they perceive it to be harmless if performed by medical practitioners. They regard men's main role in FGM as ensuring that 'sunna' is performed by a medical practitioner. Religious leaders in Yemeni society believe that men's participation in activities against female circumcision should be limited to opposing the 'wrong' forms of circumcision that are performed by popular practitioners, in which the entire clitoris or large parts of it are removed and the labia majora removed; this is known in Yemeni society as Pharaonic circumcision.

"Whoever wants to talk or do activities, let him talk about the deformities of the woman's organs in the reproductive system, or about exhaustion in circumcision or pharaonic circumcision."

(male religious leader, MSc in Islamic Studies, married, 35 years old)

The discussions with informants made it clear that many religious leaders in the different practicing communities stand against anti-FGM efforts by national or international organizations and urge community members not to listen or cooperate with them. This was stated by different interviewed experts, men and women as well as religious leaders themselves.

"I advise men not to be tempted to stop circumcision or what the organizations call for, and rather, they rely mainly on what the Shari'a says. What is stated in the Shari'a is good, the good came from the Shari'a and not from the organizations. The organization has good and evil and the organization is a human creation, [reflecting] human judgments, human research and studies, but what came to us in the Shari'a is from God."

(male religious leader)

Further, interviewed experts challenged initiatives and programmes that aim to train religious leaders to advocate publicly against FGM. They noted that,

"It's difficult to convince scholars to change their attitude on FGM because their only reference on that is Sharia and nothing in Sharia says it's haram."

(female gender expert)

This expert was sceptical that working with religious leaders to end FGM could accomplish much in Yemen at this time.

Dynamic of the FGM decision-making process

Earlier research showed that when husbands and wives did not agree on whether to circumcise their daughters, FGM was less likely to occur.[17] Yet discussion about whether to circumcise a daughter does not always occur inside the household. The 'silent culture' around FGM, particularly between the sexes, is an obstacle to change in Yemen and elsewhere,[18] and discussions around FGM in Yemen likewise often do not involve much family deliberation. Mothers arrange for their daughters to be circumcised shortly after birth, mainly by traditional practitioners at the home. Study participants stated that they do not discuss FGM with their spouses or other family members, as it is considered an inappropriate topic and they feel ashamed to mention it. They further explained that discussing sexuality-related topics within the household is absolutely forbidden and they are not accustomed to having such discussions. They also perceive the practice as a part of Islamic teaching and Yemeni custom and tradition that must be followed without discussion.

"I did not discuss it with my husband because it is a necessary thing for him because it is a 'sunna'."

(married woman, Hadhramaut)

Although the majority of the participants referred to mothers as mainly responsible for ensuring that girls are circumcised, they also stressed that men are the final decision makers. It was further explained that men are primarily responsible for their families and therefore, they are the ones responsible for any decisions regarding them.

"The opinion is the man's opinion, and the decision is the man's."

(married man, Hadhramaut)

"No one listens to women's views; the decision is for men to take."

(married man, Aden)

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The majority of the female participants stated that the decision to perform FGM is taken by men – fathers – and that most women do not participate in the decision as they have no influence. However, some female participants living mainly in urban settings stated that they were involved in the discussions regarding the circumcision of their daughters but the final decision was taken by their husbands.

"I participated, but the final decision is in my husband's hands."

(married woman, Hadhramaut)

In general, there is consensus among male and female participants that men are the main decision makers. However, few men or women view FGM as a matter that needs to be discussed, as the practice is perceived to be a necessity and must be performed.

Medical practitioners are often asked about the benefits and disadvantages of FGM for women and girls by parents in their local communities who come to their clinics to seek their advice on whether or not to perform circumcision on their daughters. They also ask them about the benefits of circumcision, and whether it harms the woman's sexual life after marriage or not. According to the medical practitioners, the information and guidance that they offer parents is very influential over the decision whether to circumcise or not. To respond to the fears that some parents have about the impact of FGM on a girl's sexual life in the future, medical practitioners are keen to clarify the difference between circumcision and FGM, in an attempt to convince parents that what is done to the girl in medical centres is the former and does not cause any harm.

"Most of the questions are, what do you do and how, and whether or not it will affect the girl and her sexuality, and most of them ask me, will the woman become sexually cold like our wives who were circumcised and ruined (they had sexual frigidity)? People always ask me this kind of question."

(male-health professional married, 35 years old)

Boys and men's role in ending FGM and challenges

The majority of study participants stated that men support the practice of FGM and its continuation. They perceive FGM as a religious obligation and "part of the Prophet Muhammad's sunna", with the purpose of reducing a girl's sexual desire and protecting her from engaging in improper sexual relations, including premarital relations. Men were especially concerned with ensuring that girls enter only into sexual relationships that are acceptable in Yemeni culture. Some of the female participants stated that their husbands advocate for FGM and encourage their friends to circumcise their daughters. Many of the female participants believe that if men were educated on the sexual consequences of FGM and the possible effect of the practice on their marital sexual relations, this would encourage them to take an active role against the practice.

Although men are the final decision makers with regard to FGM, they do not interfere in the actual cutting, as mothers are expected to arrange for FGM to be performed on girls. Men will interfere only if there is a debate around whether or not to perform FGM, or who will perform it. Thus, the majority of female respondents in the study believe that men could have an important role in ending FGM if they chose to. Older men tend to agree with this perspective, stating that as the main decision makers of the household, men can prevent the practice if they wish. In contrast, unmarried younger male participants do not believe that men can combat FGM and stand up against the traditions and religious discourse.

The effect of religious discourse on men's ability and willingness to take a stand against FGM and participate in anti-FGM activities was often raised by the participants. Religious leaders hold men responsible for girls' 'purity' and regard FGM as the practice that maintains it, therefore men are expected to uphold and support FGM.

"There was a campaign three years ago that was launched by men, headed by the head of an association. I participated in the campaign, and one of the challenges we faced is that there is currently a trend against the work of civil organizations on the issue of female circumcision due to the strictness of the religious leaders, which makes it difficult. Imams will be the first to oppose any campaign."

(young male participant, Hadhramaut)

Respondents stated that men and women in practising communities are not aware of the anatomy of the female body, which makes them regard Type I, what they call 'sunna', as harmless. Explaining the physical, mental and sexual consequences of FGM, regardless of the specific form practiced, will help in better understanding the impact of the practice and facilitate its abandonment.

RECOMMENDATIONS

Fight the medicalization of FGM through messages to men and to medical personnel. Develop a clear message to denounce the medicalization of FGM, stressing the possible long-term consequences of FGM regardless of who performs it. This effort should include publicizing the 2001 ministerial decree banning FGM in public and private health facilities, and disseminating information on legislation in other countries, for example, laws in Egypt that prohibit doctors from practicing FGM and include penalties. Medical personnel need to have their mindsets changed, and to be provided with messages they can use when they are approached about the health consequences of FGM.

Introduce anti-FGM messages to be delivered by medical professionals during antenatal and prenatal health visits. FGM is performed in Yemen at a very young age, so this intervention is timely, sustainable and inexpensive. Encouraging fathers to attend these sessions as well as mothers would be optimal.

Build the skills of 'positive deviants' to speak to their peers about abandoning FGM. This approach identifies boys and men who stand against FGM and do not practice it within their families to serve as models and start discussions within the community on FGM. The men who have chosen not to circumcise their daughters can speak to other men about their experience. Indeed, most participants in the study stated that peer-to-peer education is the most effective way to address FGM.

Emphasize the psychological, social and sexual consequences of FGM rather than the medical consequences. Evidence on the psychological, social and sexual consequences of FGM is insufficient and further in-depth research is required, yet one 2010 systematic review of relevant quantitative studies substantiates the argument that "a woman whose genital tissues have been partly removed is more likely to experience increased pain and reduction in sexual satisfaction and desire".[19]

Diversify the channels through which the public is made aware of the harms of FGM. Study participants recommended disseminating anti-circumcision messages by showing films about the

dangers of circumcision, making posters explaining the harm and dangers of circumcision and developing leaflets explaining the health problems resulting from circumcision. They suggested describing cases where girls were injured by the practice, and also recommended seminars on these topics led by religious leaders.

Work with religious leaders, instilling, disseminating and reinforcing the idea that FGM is not a religious requirement. Respondents asserted that the best ways to raise awareness about the harmful effects of FGM are through religious education to stop this practice. The long experience of Egypt suggests that working with religious leaders needs to include formulating broader, more gender-transformative messages. The fragmentation of religious leadership in Yemen, noted in the Background, suggests that working with religious leaders as a group may be challenging.[20] However, challenging existing religious discourse is much needed and will provide community members with needed arguments to counter those in support of FGM. Experience of working with religious leaders on other challenging issues, such as sexual and reproductive health and rights, has shown that the process must not be rushed, and should lead with substantial sensitization sessions to form a shared basis for understanding.[21] FGM is not practiced in many Muslim countries, most notably Saudi Arabia, the country where Islam was born. In addition, many communities within Yemen do not practice FGM and they do not view themselves as performing something against the religion.

Tackle the secrecy and silence that allow FGM to persist. Currently, FGM is a subject that is not openly discussed within the households in Yemen as both men and women reported that they are not comfortable discussing sexual related issues including FGM with

other family members. Encourage fathers and mothers to discuss the practice of FGM together, to obtain information, and to make the decision together. Given that in Yemen FGM is predominately practiced on infants, (83.8 per cent of women who have undergone FGM were cut in the first week after birth), discussing the practice in health clinics during prenatal visits could be an effective entry point. Also talking about FGM in different media channels will help lift the taboo (81 per cent of women 15-49 years make use of at least one type of information media at least once a week (newspaper, magazine, television or radio).[22]

Create a social behavioural change strategy on the empowerment of girls and women and their agency. FGM exists for reasons of profound discrimination against women and girls, and the issue thus requires a holistic approach. Although the majority of study participants referred to FGM as a religious obligation, they also highlighted that FGM is a necessary practice to ensure girls' 'purity.' As this is a main reason people give for practicing FGM, it calls for the development of messages that provide a more accurate perspective on female sexuality, and link FGM to other challenges faced by girls and women.

Speak out about the risks and realities of FGM: Many assume that having medical personnel perform Type I (what they call the 'least' or 'sunna' type of FGM) will diminish its consequences. Develop clear messages that reflect the personal experiences of the long-term consequences for women and girls as result of FGM. Encourage women to share their stories, their memories and own suffering. Encourage men to talk about their sexual experiences and how some might be affected by their partners' experiences of circumcision.

Ensure that information includes the consequences of FGM for sexuality and the couple's sexual life, not just for health. Design messages to provide basic information on sexuality and challenge the myth that FGM ensures women's and girls' chastity and decreases their sexual desire. Further explain the correlation between FGM and women's inability to reach pleasure and the possible impact on the couple's sexual life. The fact that most men believe women have no right to refuse sex with their husbands shows there is much work to be done to build more mutualistic sexual relationships.

Promote ideas of gender-equitable manhood: Spreading the idea that supporting one's spouse and being engaged in the household is part of responsible manhood. This suggests the need to promote a healthy sense of manhood that includes caring for others, and potentially, preventing FGM from taking place. To avoid reproducing patterns of inequality and power and reinforcing damaging gender and sexuality stereotypes, these messages need to be framed within the understanding of care and rights rather than protection.

Keep advocating for FGM to be banned by law: Research in other countries has shown that while passing laws against harmful practices can have a limited direct effect, it establishes a public standard and the basis for public advocacy as well as the government investment and regulations in support of the law. In Yemen, it will be important to work to obtain Parliamentary approval for the 'Protection of Women Act' currently in draft.

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