



Research-based Programming Guidance:

PROMOTING MEN AND BOYS' ENGAGEMENT

IN ENDING FEMALE GENITAL MUTILATION IN MENA

ACKNOWLEDGEMENTS

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Chapter 1:

MAKING THE CASE FOR MEN'S ENGAGEMENT IN EFFORTS TO END FGM

INTRODUCTION AND PURPOSE OF THIS STUDY

Female genital mutilation (FGM) is a violation of human rights. Every girl and woman has the right to be protected from this harmful practice, a manifestation of entrenched gender inequality with devastating consequences.

Community-level interventions that focus on elimination of FGM through discussions with girls, mothers/grandmothers and community members on the negative impact of FGM, girl's empowerment and access to services are important; however, in addition, the need to work with men and boys to address harmful masculinities and harmful practices is increasingly being recognized. A more holistic approach is required to ensure a safe and conducive environment for girls, working with men and boys to address the discriminatory gender norms that sustain this practice.

Some good practices and evidence exist on engaging with men and boys for prevention of child marriage and gender-based violence, but research on ending female genital mutilation (FGM) especially in the sociocultural context of the Middle East and North Africa (MENA) region, is inadequate. Men and boys are often missing from the difficult conversations at the community level on gender roles, sexuality of women and girls, and FGM, and community workers are often uncomfortable discussing issues related to FGM.¹ Scepticism also persists on whether men and boys can change their beliefs and gender-related attitudes.

Ending patriarchy and challenging restrictive gender norms is not the sole responsibility of girls and women. Engaging boys and men in holistic, comprehensive and coordinated responses is critical to ensure that our programming creatively brings about shifts in the constraints on women and girls. Programming should support men and boys in mobilizing their own power and privilege to further

the interests of and accountability toward women and girls.² Our interventions must focus on urging men and boys to be change agents for gender equality.

In this context, the UNICEF Middle East and North Africa Regional Office (MENARO) commissioned a qualitative research study in four countries: Djibouti, Egypt, Sudan and Yemen. The focus of the study was on boys and men and household decision-making on FGM, sexuality and FGM, and what could be done to engage men more fully in FGM prevention efforts.

This regional report summarizes the four country studies and synthesizes country-specific guidance to make programmatic recommendations for the region on how to engage men and boys as partners for change in ending FGM.

BACKGROUND

FGM is a challenge to public health and gender justice and a violation of human rights.³ At least 200 million girls and women across 31 different countries have undergone this violent procedure.⁴ The World Health Organization (WHO) defines FGM as including all procedures involving partial or total removal of the external female genitalia or injury to the female genital organs. FGM is performed mainly by traditional circumcisers, except in settings where it has been medicalized and health-care providers perform the procedure, believing they are making it safer.⁵

FGM causes damage to the genital area of women and girls and can cause psychological harm as well as leading to long-term disability or death.⁶ The WHO has classified FGM into four major types:⁷

- **Type I:** Clitoridectomy, which involves the partial or total removal of the clitoris
- **Type II:** Excision, which involves the same procedure as clitoridectomy, along with the removal of the labia minora and with or without excision of the labia majora
- **Type III:** Infibulation, which involves the excision of the labia minora, labia majora and stitching of the remaining tissue together, or leaving a seal over the vagina, while leaving an opening for the passage of urine and menstrual blood
- **Type IV:** All other harmful procedures to the female genitalia such as pricking, piercing, incising, scraping and cauterizing the genital area.

FGM is a harmful practice and all its forms are associated with the risk of immediate consequences such as excessive bleeding (haemorrhage), genital tissue swelling, fever, infection, urinary blockage, shock or even death.⁸ The longer-term complications include vaginal, urinary and menstrual problems, pain and discomfort during intercourse, increased risk of childbirth complications and psychological problems. The risks associated with FGM generally increase with the increasing severity of the type.

More than half of the world's women and girls who have undergone FGM live in Egypt, Ethiopia and Indonesia.⁹ Somalia has the highest percentage of women and girls who have undergone FGM (at 98 per cent), followed by Guinea (95 per cent), Djibouti (94 per cent), Egypt (92 per cent), Mali (89 per cent) and Sudan (87 per cent). Fifty million girls and women have undergone this harmful practice in the Middle East and North Africa (MENA), including in Egypt, Djibouti, Sudan, Yemen and Iraq.

Although FGM has declined in recent years, its downward trajectory has been slow. To reach the SDG target by 2030, the rate of progress would need



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to be 15 times faster for the MENA region overall.¹⁰ As per UNFPA estimates in 2020, it is anticipated that 2 million cases of FGM will occur between 2020 and 2030 that could have been averted, resulting in a 33 per cent reduction in the progress toward ending this harmful practice.¹¹

MAKING THE CASE FOR ENGAGING MEN AND BOYS

For several reasons, engaging men is a fundamental strategy for ending FGM. FGM has historically been seen as ‘women’s business’, as mothers or grandmothers generally organize and support the circumcision of their daughters.^{12,13,14} Paradoxically, it is well understood that the practice is motivated by patriarchy and continues to be practised due to inequalities between women and men.^{15,16} Research has shown that FGM is performed to ensure marriageability^{17,18} and to increase men’s sexual pleasure and prove their virility and masculinity.¹⁹ However, recent UNICEF data indicate that in many countries where FGM is widespread, more men than women want the practice to end.²⁰ In Sudan, 64 per cent of men and boys oppose the continuation of FGM in comparison to 53 per cent of women and girls.²¹ Another UNICEF study showed that in 12 practicing countries, fewer than 10 per cent of men feel that the practice increases their sexual pleasure.²² In Egypt, the 2017 IMAGES-MENA survey finds that more than 80 per cent of women and 90 per cent of men agree that men are involved in deciding whether a daughter is circumcised, with roughly two-thirds of all respondents reporting that male and female family members together have the final say in the matter.²³

These studies show that involving men and boys as partners in the process of prevention and elimination of FGM is crucial. Although women may perform FGM, they are driven by patriarchal values and beliefs that require the involvement of men. Providing men with appropriate information, improving their knowledge, and encouraging communication between women and

men on FGM are essential steps toward ending the practice. Their engagement can relieve women from the social pressures and responsibility of upholding traditions to regulate female sexuality, creating a more favourable environment for ending FGM.²⁴

Men must be involved in the fight against gender-based violence as various forms of violence against women are rooted in patriarchal and discriminatory values. Rigid notions of masculinity are associated with greater acceptance of violence and FGM can be viewed as manifestation of patriarchal oppression. FGM is often regarded as a means to control a woman’s sexuality, preserve virginity until marriage and ensure marital fidelity. Engaging men fully in ending FGM is both logical and efficient. Many men are currently involved in working to end FGM, and their efforts must be strengthened and built upon.

When developing this work, however, it is essential to ensure that men’s involvement is effective and meaningful. One key element of this is to avoid replicating stereotypes of men as heroes and saviours and women as vulnerable victims to prevent further perpetuating already existing power imbalances and inequality in decision-making. Another is to face up to the difficult topics that must be broached to shift FGM practices. Much work in this area has avoided raising difficult topics with men, including sexuality and broader discrimination against women in favour of a focus on the physical consequences of FGM. By trying to appeal to men by working from acceptable religious, cultural and social starting points, the field will compromise the achievement of transformative change in gender relations and reinforce a benevolent, paternalistic form of patriarchy.²⁵ It has been easier to talk about the medical consequences, and to avoid the challenging concepts of rights, sexuality and so on. Avoiding awkwardness is often to avoid touching on the most important issues. The Egypt case study illustrates a context where, over time and with many iterations of anti-FGM work, it has become much easier to speak about these things, which now permits a more holistic discourse on FGM.



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Chapter 2:

A FRAMEWORK FOR PROMOTING MEN'S ENGAGEMENT IN FGM

The suggestion of involving men and boys in moves towards ending FGM is gaining increased attention and support, yet little is known about the role of men in the process of FGM.²⁶ The problem is framed broadly, but operationalization in programmes working with men – and often with women – is narrow (see Figure 1). To effectively engage men and boys in the fight against FGM, we need to examine and understand their attitudes and experiences with regard to FGM, which is difficult as these have not been systematically explored in the literature,^{27,28,29} in contrast with the extensive research on women's knowledge and perceptions of the practice.³⁰

Many studies argue that among the driving forces for the continuation of FGM in many communities is the desire to control women's and girls' sexuality.^{31,32,33,34} In countries that practice Type III or infibulation, FGM is assessed in relation to men's pleasure and the regulation of women's sexual drive. A study in Khartoum that investigated narratives and

experiences of both women and men regarding FGM with focus on re-infibulation described the practice as seen by women as 'normal' and a way to restrain women's sexuality and to ensure that men are sexually happy and "to prevent them from divorcing or having a co-wife".³⁵ Women in the study stated that they had limited influence on the decision of infibulation and re-infibulation and mentioned strong society and peer pressure as the main contributing factors. They pointed out that men often approve the decision of re-infibulation and many times, women receive gifts from their husbands as a show of appreciation after they submit to it. The women in the study who resisted re-infibulation had the support of their husbands and indicated that the role of fathers in preventing FGM for their girls is central. Many of the women in the study attributed the lack of change in the practice to men's silence and argued that men have the necessary influence in society and family to reinforce change but need to speak up more systematically.³⁶

Another study conducted on Egyptian fathers aimed to identify the different psychosocial factors that affect and shape parents' decisions on whether or not to circumcise their daughters.³⁷ The study concluded that many of the fathers acknowledged the negative impact of FGM on marital sexual relationships, while still perceiving that not being circumcised will negatively affect a girl's prospects for marriage. Egyptian fathers believed that uncut women are promiscuous and therefore, to preserve them for marriage, they must undergo FGM. Even when men are aware and knowledgeable of the negative consequences of FGM, reasons such as preserving girls' chastity and ensuring marriageability outweigh the negative consequences leading men to support FGM. Marriageability, in particular, makes it difficult for parents to go against cutting their daughters, as their concerns about future marriage prospects involve other people and involve norms and expectations about FGM.

The widely acknowledged notion of FGM as 'women's business', suggests that men have little stake and interest in knowing about the practice and how it unfolds. This is not the case. Studies confirm that men have good knowledge of the consequences of FGM. A study in Sudan concluded that 75.3 per cent of men think that there is harm associated with FGM and 76 per cent think that women suffer as a result of the practice.³⁸ Another study in Egypt showed that more than half the men and women who participated in the study have good knowledge of the consequences of FGM.³⁹ Furthermore, men are also aware of the negative effects of FGM on themselves: the 'male complications' of FGM include difficulty of vaginal penetration, wounds, infections and other psychological issues experienced by male partners of circumcised women.⁴⁰ In interviews with men from Northern Sudan, it was reported that men also feel they are victims of FGM, as they experience certain complications during the sexual relationship that cause male dissatisfaction and they feel compassion for the women suffering the pain.⁴¹ While the FGM male complications are minor compared with those suffered by women, the fact that they exist offers new opportunities to work against the practice and presents ways to involve men.

FGM, unlike most forms of gender-based violence, is often perpetuated by women. Many studies suggest that women are the main decision makers when it

comes to deciding when, where and by whom FGM takes place, failing to paint a picture of men's roles and male involvement in the process.^{42,43}

Another study explored the roles of men in continuation and/or abandonment of FGM in a migrant minority community in Sweden.⁴⁴ The research found that study participants acknowledge that FGM remains a 'women's issue' and women are described as both victims and perpetrators of FGM, yet the men's role is not passive. Men are complicit in decision-making; they are semi-involved as heads of households and fully involved as parents and husbands discussing the decision with their wives. Further, a study in Egypt reported that nearly 49 per cent of the participants considered that men should be involved in the debate on FGM. This opinion was significantly more prevalent among males than females (61.9 per cent vs. 43.2 per cent).⁴⁵ Interventions should not downplay the role of men in the decision-making process of FGM by placing sole responsibility for deciding, planning and performing FGM on mothers and other female relatives.⁴⁶ A study conducted in Belgium, Netherlands and the United Kingdom to explore men's involvement in FGM argued that men consent to having their



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daughters cut by not speaking against it, especially as they pay for the process.⁴⁷

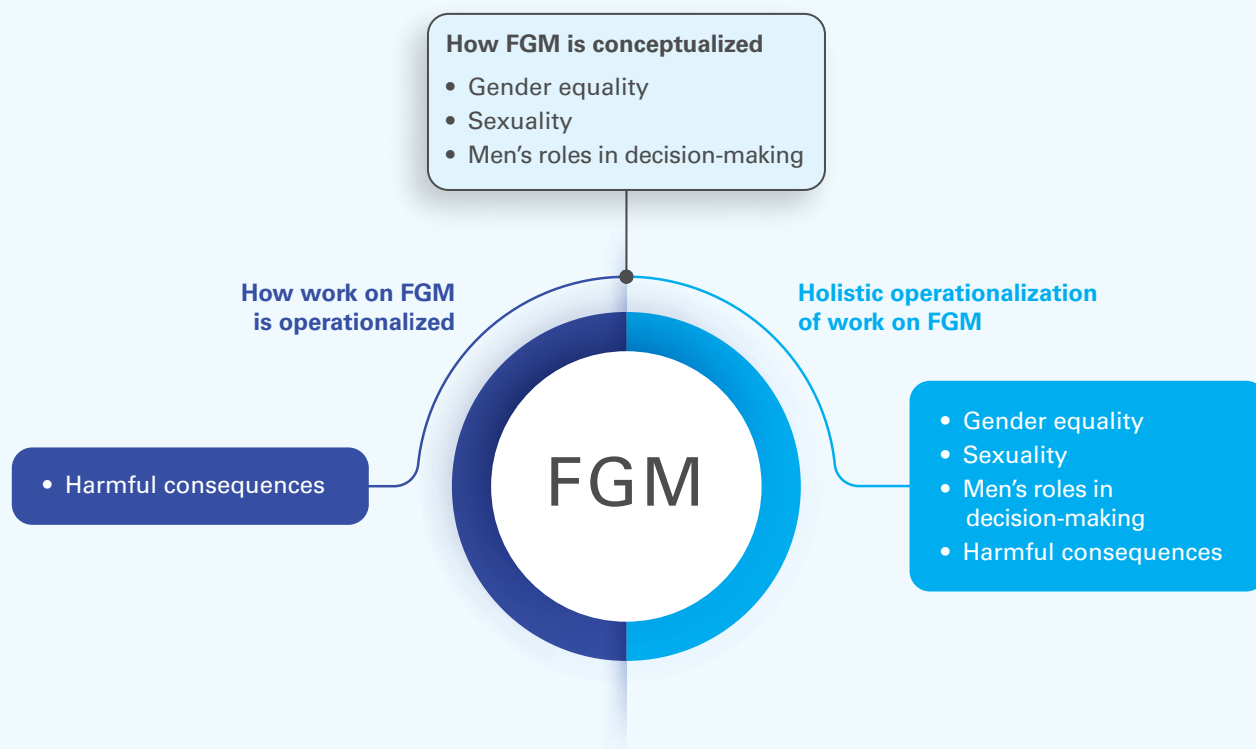
Intersectionality is an important dimension to consider in examining men’s involvement in the process of FGM. As Strid and colleagues have written, conceptualizing FGM “as intersectional gendered violence means recognizing the multiplicity and hierarchy and temporary stability of different structural inequalities simultaneously at play in the FGM process, and how they intersect...”.⁴⁸ Men are different from one another; each man is shaped by age, ethnicity, social positions, marital and parental status, among other characteristics. Paying attention to the dynamics of gendered intersectionality is crucial in formulating male involvement strategies.

Evidence has shown the importance of engaging men in the fight against FGM; men in their roles as fathers, husbands and future husbands, community and religious leaders can play pivotal roles in creating change and contributing to ending FGM.⁴⁹

It is important when designing male involvement strategies to challenge traditional notions of ‘violent masculinity’. Strategies that challenge such notions should underline the need for comprehensive, culturally relevant and sensitive interventions to engage men in violence prevention.⁵⁰ Despite ambivalences and tensions surrounding men’s complicity and oppositionality, efforts to include men in the wider anti-violence work have been found to be essential to success.⁵¹

FIGURE 1: A framework for promoting boys’ and men’s engagement in FGM

Mismatch between what is said and done VS A more complete framing for work on FGM



GENDER-TRANSFORMATIVE PROGRAMMING AND FGM

Gender-transformative approaches actively strive to examine, question and change rigid gender norms and imbalance of power ... Gender-transformative approaches accomplish four things.* They:

- Encourage critical awareness among men and women of gender roles and norms
- Promote the position of women
- Challenge the distribution of resources and allocation of duties between men and women
- Address the power relationships between women and others in the community.

PROGRAMME EXAMPLES:

- Equimundo works directly with nine UNFPA country offices to introduce a gender-transformative lens into the “[Husband Schools](#)” (Écoles des Maris) in the context of the Sahel Women’s Empowerment and Demographic Dividend (SWEDD) programme. For more information, click these links for details on this work in [Burkina Faso](#) and [Niger](#), for example.
- Tostan’s 3-year empowerment programme puts rural communities in charge of their own futures. They set their own community vision while learning about democracy, human rights, hygiene and health, and as part of the problem-solving sessions, decide which practices help or hinder their development.

*Source: Rottach, E., Schuler, S. R., & Hardee-Cleaveland, K. (2009). Gender perspectives improve reproductive health outcomes: New evidence. Washington, DC: Population Reference Bureau for the Interagency Gender Working Group and USAID: p. 8.

WHAT IS BEING DONE

Research has described with considerable nuance the specific drivers of FGM and the norms and relationships that determine the extent, type and timing of FGM. Yet that research has not consistently been translated into interventions that work with boys and men. Figure 1 shows how, despite the holistic understanding of the practice, a fairly typical approach to the work tends to focus on messages related to the harmful consequences; it illustrates the broader spectrum of actions and messages to engage boys and men.

An analysis of what is being done, contrasting that with what ought logically to work in light of research on the root causes and drivers of the issue, identified important gaps in work to engage men to end FGM. In sum, women are often exposed to a broader framing of the gender and social issues related to FGM, while messages directed at men emphasize the negative consequences of the practice. This research explores those drivers in detail with the explicit purpose of expanding the range of messages and actions and generating a more holistic response to men’s roles in FGM.

To date, much work with men on ending FGM has been overly cautious. Men have been approached as religious leaders, physicians, breadwinners, providers and so on, an important strategy but one that runs the risk of reproducing traditional patriarchal values. Second, the messages have avoided topics such as marital happiness and sexuality in favour of a focus on the medical consequences of the practice. There is much to be done to expand work with boys and men to end FGM, and the country case studies provide rich evidence from which to draw.



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Chapter 3:

INTRODUCING THE RESEARCH

METHODOLOGY

The research used qualitative methodologies (focus group discussions (FGDs) and in-depth interviews (IDIs)) to collect relevant data. Separate guides were developed for each type of interviewee (i.e., women, men, young people, grandmothers, NGO staff, government officials, etc.). All guides included a section on the opportunities for and challenges to involving men and boys in anti-FGM efforts.

Another 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 process of FGM and male involvement, ways to encourage men to take active role in ending FGM and encountered challenges.

At least six IDIs were conducted in each country in both urban and rural areas with decision makers, youth, medical doctors and representatives of NGOs.

Five or six FGDs were conducted in each country with different groups: married women, married men, young unmarried men and young unmarried women. Participants had different educational backgrounds and some had no formal education. Socio-demographic data were collected from each participant (age, level of education, residency, employment status and number of children if married). Table 1 summarizes the interviews and focus groups conducted in each setting.

DATA ANALYSIS

The data were examined in light of the demographics (age, education, employment and gender) to explain patterns and draw conclusions and recommendations. The major themes explored, all of which are closely linked to the practice of FGM and the involvement of boys and men in ending FGM, are gender roles and power relations within the household, dynamics of FGM decision-making, sexuality and marriageability, religious discourse around FGM and ways to better involve boys and men in ending FGM.

TABLE 1. Summary of in-depth interviews and focus group discussions conducted in the four focus countries

COUNTRY (AND COVERAGE)	IN-DEPTH INTERVIEWS	FOCUS GROUP DISCUSSIONS
Djibouti (regions and Djibouti City)	11 with various actors, including NGOs, ministry representatives, religious leaders, doctors and grandmothers	5 FGDs were conducted in the regions and 3 in Djibouti city: <ul style="list-style-type: none"> • 3 with married men aged 25–45 • 2 with married women aged 25–45 • 3 with young people aged 15–20
Egypt (Assiut and Giza)	7 with youth, medical doctors, NGO representatives, government officials	6 FGDs were conducted: <ul style="list-style-type: none"> • 2 with married women • 2 with married men • 1 with young unmarried men • 1 with young unmarried women
Sudan (Khartoum State and Northern State)	6 with NGO representatives, 1 with religious leader, 1 with midwife, 1 with young man, 1 with young woman, 1 with grandmother	6 FGDs were conducted: <ul style="list-style-type: none"> • 1 with young women aged 20–25 • 1 with mothers aged 30–45 and grandmothers • 1 with married women aged 30–45 • 1 with young men aged 20–25 • 2 with married men aged 35–50
Yemen (Sana’a, Taiz, Hodaidah, Hajjah, Aden, Hadhramaut)	10 with NGO representatives, 1 with NGO field worker, 1 with gender specialist, 1 with government official, 1 with male religious leader, 1 with nurse	5 FGDs were conducted: <ul style="list-style-type: none"> • 2 with married women • 2 with married men • 1 with young unmarried men



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Chapter 4:

COUNTRY CASE STUDIES

This section features the country experiences and provides specific examples that emerge from each with regard to the roles of men and boys in FGM. The country research has been summarized in these country case studies, with the goal of drawing out important and interesting illustrative themes that may pave the way for other countries aiming to end FGM.

Efforts to work with men to end FGM have been going on for many years in Sudan and Egypt. As these countries move toward accelerating action to achieve the SDGs, a holistic approach that reflects gender-transformative programming will have a critical role in moving the needle. Work in Djibouti has been in place since the UNFPA–UNICEF Joint Programme got under way, and people may be receptive to new approaches to FGM prevention with men. Yemen faces an opportunity to structure work with men and boys from the ground up, as the effort to work with this group has not yet received much attention.

4A. EGYPT: INVOLVING BOYS AND MEN THROUGH A GENDER-TRANSFORMATIVE APPROACH

Among the MENA countries in which the practice is prevalent, Egypt has demonstrated the greatest progress over the past 30 years. A secondary analysis of the 2014 Egypt Demographic and Health Survey (EDHS) showed that the practice among girls aged 0–17 had dropped from 69 per cent in 2005 to 55 per cent in 2014.⁵² Despite considerable efforts to end FGM, it is clear that work is needed to engage boys and men more fully and holistically.

Key findings

Across the four countries studied, the majority of men and some women support inequitable attitudes and practices when it comes to women's roles. However, in Egypt many of the male study

TABLE 2. FGM and social norms across countries of the region

FGM AS A SOCIAL NORM	% GIRLS AND WOMEN 15–49 WHO HAVE BEEN SUBJECTED TO FGM, 2016	NUMBER OF COUNTRIES	COMMENTS
FGM is a universal/generalized Social Norm	Djibouti (93%), Egypt (87%), Mauritania (69%), Somalia (98%), Sudan (87%)	5	These countries have some of the highest global FGM prevalence rates. FGM affects all faith/ethnic groups and occurs in all/most geographical regions
FGM is a concentrated Social Norm	Iraq (8%), Yemen (19%)	2	FGM is concentrated by faith/ethnic group and geographical regional
FGM is reported but no evidence that there is a Social Norm	Iran, Jordan, Oman, Saudi Arabia, Syria, Tunisia, United Arab Emirates	7	Likely that reported cases of FGM are occurring in diaspora communities from high prevalence regions/countries
No evidence of FGM	Algeria, Bahrain, Comoros, Kuwait, Lebanon, Libya, Morocco, Palestine, Qatar	9	No indication that FGM is occurring

Source: Barrett, HR, Bedri, N, & Krishnapalan, N. (2021). The Female Genital Mutilation (FGM) Matrix: The case of the Arab League Region. *Health Care for Women International*, 42(2), 186-212.

participants did not object to women joining the labour force and contributing to the economy of the household, especially during the current economic hardship. Yet most of them, along with some female participants living in rural settings, believe that certain professions are more suitable for women than others, and that jobs that require leadership or strength are better suited for men. The professions that suit women from the male participants’ point of view are those that are performed within a specific workplace and have specific working hours, such as teaching, administrative jobs and specific medical specialties that are performed within well-regarded entities, allowing women to balance their work requirements with their household chores and caregiving-related responsibilities.

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.

“I’m the one who buys the vegetables and sometimes I cook when she is tired... .”

(married, employed man, 38 years old)

Study respondents noted that FGM has become a topic they are able to discuss at home. This was not always the case, but over many years of public education engagement with many communities, advocates in Egypt have contributed to opening up public discussion and reducing the taboo that supported silence on FGM.

Despite overall shifts toward greater openness, some important differences in family FGM decision-making processes occur by residential area. The majority of parents from urban areas stated that the FGM decision is essentially the mother’s to make, along with some other women of the family, while the father’s role in the decision remains marginal. Participants related this to women being more capable of determining the benefits and harms of this practice on their daughters than men, so it is logical that women ‘own’ this decision. In rural areas, in contrast, group discussions indicated that although many family members may weigh in, the greatest influence is held by the mother and the father. The mother is primarily responsible for reminding the father of the necessity of cutting the girl, and choosing the location and method of

circumcision. For the father, in many cases his opinion is no less important than the mother's, and his decision is final.

Whereas the male and female participants from urban areas believed doctors have the most important role in raising awareness, followed by religious leaders, those from rural areas stated that the role of religious leaders is most important in combating FGM in those areas, followed by doctors. FGDs with men and women in rural and urban areas revealed the need for messages against FGM to include clear references to the physical, psychological and sexual harms that women suffer before and after marriage. Participants noted that messages about the harmful effects of FGM, including reference to the effect of FGM on sexual pleasure and satisfaction for husbands and wives, would persuade men to oppose FGM.

4B. DJIBOUTI: STRATEGIES AND MESSAGES FOR ENGAGING MEN IN THE FIGHT AGAINST FGM

FGM is widespread in Djibouti with approximately 94 per cent of women having undergone FGM,⁵³ although a recent study indicated that only 41 per cent of girls aged 0–17 had undergone circumcision.⁵⁴ FGM is mostly performed on girls between the ages of 5 and 9 (67 per cent) and the majority of procedures (92 per cent) are performed by traditional practitioners. Around 30 per cent of girls in Djibouti undergo the most severe type of FGM, Type III (involving the cutting and sewing of their genitalia).⁵⁵

Support for FGM in Djibouti is decreasing, with younger women and more educated women more likely to denounce the practice. A higher percentage of men than women responded to a survey saying they were 'not at all likely' to circumcise their daughters (25 vs. 16 per cent).⁵⁶ Despite little significant change in FGM prevalence across generations, there is a trend towards practicing less severe types. A survey on violence against women shows a significant abandonment of infibulation and excision in favour of Type I (the cutting or nicking of the clitoris and/or prepuce), which is locally referred to as 'sunna'. Awareness programmes in Djibouti initially emphasized the medical risks involved in Type III FGM, with the unintended consequence of putting in place a risk-reduction strategy. This

encouraged a shift from Type III to Type I, but without ending the practice altogether. Around 21 per cent of girls undergo FGM in Djibouti performed by medical professionals, and Type I is thus much more widely practised today than it was previously, with 94.4 per cent of 0–10-year-old girls having undergone this procedure.⁵⁷

Key findings

Women and men both play important roles in the decision to excise a young girl. Some men (37 per cent) view this as a decision to be made by the mother, and often the cutting of the young girl may occur in the father's absence; the same proportion (37 per cent) believe that the father is the main decision maker.⁵⁸

An important obstacle to engaging men in Djibouti is that it is often difficult to bring them together to discuss FGM prevention. In Djibouti city, the men work and then have their khat sessions after work, and they are not interested in participating during the weekends. In rural areas, they watch over the herds and return only in the evenings. Moreover, men expressed disinterest in this issue. Indeed, in the programmes that have managed to mobilize men and discuss the issue with them, male participants said that they are not concerned with this topic and blame women for practicing FGM.

Yet even when women are the primary decision makers regarding circumcision, men still have an important influence, and in most cases, if a man does not want to circumcise his daughter, she will not be circumcised. Doctors play a limited role but nurses and midwives provide information during pre- and postnatal consultations and are more influential. A male doctor confirmed that FGM is generally discussed with female medical staff.

Even though men in Djibouti are increasingly opposed to circumcision, most are not actively advocating for an end to FGM. The survey reported that while 95.3 per cent of women had heard of FGM, only 60.3 per cent of men had done so, suggesting an opportunity to raise awareness in support of ending FGM.⁵⁹ To date, not much work has been done with men in Djibouti on ending FGM, providing an important opportunity to develop a coordinated and gender-transformative effort to bring them into this movement.

4C. SUDAN: MAKING IT POSSIBLE FOR WOMEN AND MEN TO TALK ABOUT FGM

In Sudan, 87 per cent of women aged 15–49 years have undergone FGM. This percentage differs by state, ranging from 97.5 per cent in Northern State, to 87.5 per cent in Khartoum State.⁶⁰ It is estimated that two-thirds of girls aged 0–14 are at risk of undergoing FGM before reaching age 15. In rural areas, 70.9 per cent are at risk of being circumcised, compared with 56.2 per cent in urban areas, showing that girls living in rural areas are more likely to be circumcised than girls residing in urban areas.⁶¹ In general, the widespread support and practice of FGM in Sudan is perpetuated and sustained by deeply rooted social norms and gender power structures that centre on the need to reduce women’s sexual desire as a protection mechanism for them.⁶² The main driving factors for FGM in Sudan are marriageability of girls, sexual pleasure for husbands who perceive tightness as more pleasurable in intimate relations, and compliance with religion and traditional expectations of families and communities.⁶³

Key findings

Traditional gender roles are reflected in domestic work and decision-making, especially among older generations in rural areas, with women performing the majority of domestic tasks such as cooking or cleaning, and men carrying out tasks such as repairs or shopping for food and supplies. Fathers involve themselves in their children’s upbringing, and may undertake domestic work directly related to their children, such as ironing their clothes.

FGM decision-making is dynamic and men can play a role. Although the majority of male and female participants in urban and rural areas indicated that mothers are the main decision makers in FGM, they agreed that relatives, friends, neighbours and community together create a great pressure that influences the decision on whether to perform FGM on a daughter. The fear of stigma and the loss of community support and personal status often make them hesitate to discuss, question or resist FGM.

Respondents stated that men are the decision makers when the decision is not to cut. They observed that husbands’ decisions are more likely to be obeyed

because women fear men’s reactions; women are better able to manage the social network pressures when they have their husbands’ support in the decision not to cut.

Engaging men in anti-FGM activities in Sudan is challenging because change is resisted, particularly by older adults who are more aligned with social pressures and norms. The younger men who support change are often confronted by these older adults who are more deeply constrained by social pressures regarding the tradition of FGM, especially in rural areas. And fathers worry that they might not find someone to marry their daughters who remain uncircumcised. In addition, conservative communities stigmatize and sanction men who talk about FGM, and refuse to engage in anti-FGM activities or talk about it. If a man interferes by opposing FGM, he faces stigma for meddling in women’s business. Yet outside of the family, men are engaged in FGM prevention as facilitators during community dialogues, as members of community-based protection groups, as messengers in early warning systems that are responsible for reporting the midwives who practice FGM to the Ministry of Health and as youth workers in mechanisms such as Youth Forum and Y-peer.



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4D. YEMEN: DISTANCING FGM FROM RELIGIOUS DISCOURSE AND TERMINOLOGY

No recent quantitative or qualitative data are available on FGM in Yemen, and understanding of the issue relies 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.⁶⁴ 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.⁶⁵



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Poorer women and those with basic or no formal schooling are more likely to be circumcised than women with secondary or higher levels of education. 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.⁶⁶ Yet 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 or punishes the practice of FGM. However, in 2001, a ministerial decree was passed banning FGM in private and public medical facilities.⁶⁷ FGM in Yemen is carried out as a result of commonly held cultural and religious beliefs and gender norms, passed down from family or community members.⁶⁸ Seventy-five per cent of women who have heard of female circumcision say that the practice should be stopped.⁶⁹ 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.⁷⁰

Key findings

Gender roles and power relations within the household remain traditional with some shifts. Women are mainly responsible for domestic tasks within the household including taking care of children and elderly, while men are the main breadwinners. Women may participate in the labour market in professions 'suitable' for them, such as teaching, nursing and administrative work. Male study participants perceive taking care of children and/or elderly as part of their responsibility towards their families, part of the teachings of Islam and a characteristic of manhood. Younger fathers indicated they would encourage boys' participation in household chores, and the majority of female participants of all ages favour encouraging boys to participate in household chores like girls.

Controlling women's sexual activities and limiting their promiscuity lies at the centre of community requirements of men and masculinity. Narratives



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from studies in Yemen and other countries where FGM is practiced suggest that the purpose of female circumcision is to control women's sexuality and protect them from having 'excessive' or 'inappropriate' sexual desire.⁷¹ Religious leaders and medical practitioners interviewed reinforced these ideas about female sexuality. Male and female respondents agreed that 'honour' is a word most closely related to the behaviour of women.

Many physicians and religious leaders support FGM. Medical professionals, especially physicians, are well respected and highly regarded in their communities, and their support or opposition to FGM is extremely influential.⁷² Medical practitioners interviewed in the study stated that they oppose FGM, which they regard as a violent practice that contradicts Islamic teachings. However, they describe Type I as 'purification' or 'sunna', which they practice and advocate for. This is a complex challenge to FGM prevention.

Similarly, many of the study participants stated that religious leaders exert pressure on community members to ensure that girls are circumcised. They perceive 'sunna' as a harmless practice that ensures women's purity and preserves their chastity, corresponding to Islamic teachings which urge women to be pure and honourable. Religious leaders regard men's main role with regard to FGM as to ensure that 'sunna' is performed by a medical practitioner, making it safe and harmless. It should be noted that 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.

Decision-making around FGM is often made without much discussion. The research showed that there is not much deliberation around FGM. 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 family members, as it is shameful to bring up, and they also perceive the practice as a part of Islamic teaching and Yemeni custom and tradition that must be followed without discussion.

Participants stressed that men are the final decision makers, yet they generally do not interfere in the actual cutting, which mothers are supposed to arrange. Men will intervene only if there is a debate around whether to perform FGM or not, or who will perform it. Most female participants believe that men can play an important role in ending FGM if they choose to, and that if they understood the harmful effect it could have on their daughters, they would not permit it in their families. Older men tended to agree with female participants; they believe that as the main decision makers of the household, men can prevent the practice if they wish. In contrast, unmarried younger male participants did not believe that men can combat FGM and stand up against the traditions and religious discourse.



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Chapter 5:

PRACTICAL GUIDANCE EMERGING FROM THE FOUR COUNTRY RESEARCH STUDIES

DIRECT SPECIFIC ACTIVITIES AND MESSAGES TO BOYS AND MEN

Men and boys should be motivated and encouraged to stand against FGM by reflecting on how decision-making takes place in their homes and extended families, and by receiving relevant information in home, community and work settings. FGM prevention messaging is often developed for and directed to the general population, and programme messages are not always directed toward men. Further, men often do not see themselves as particularly influential over the decision of whether or not to cut their daughters. Simply highlighting to men the influence they might have if they chose to take a stand against FGM in their families could have an important impact.

Messages need to draw on men's own concerns. Respondents in Sudan mentioned that the men could be reached and convinced to take action through

community dialogue during which they raise questions regarding how FGM affects them and their family lives. In Djibouti, an NGO staff member observed that talking to men about the physical harms to women of FGM receives less attention from men than talking about the effect of FGM on the intimate and sexual relationship between wives and husbands.

ADDRESS INTERSECTIONALITY WITH BOYS AND MEN OF DIFFERENT COMMUNITIES, ROLES AND AGES

Develop strategies that focus on and are tailored to specific kinds of men with intersecting identities. A key aspect of promoting men's engagement in the prevention of FGM is to develop different messages for different men's groups and ages, family life stages, social classes, education levels and geographical settings. For example, the fieldwork in Sudan showed that older men have more influence than younger men

when it comes to opposing the decision of FGM in the family; in Egypt, fathers appear to be an especially important group to work with.

Identify different entry points and activities to boys and men depending on their context and characteristics. The age at which FGM is generally performed – for example, at birth in Yemen or after age 10 in Sudan – determines which groups of boys and men to target with specific messages and where. In some instances, it makes sense to reach them through health centres, whereas in others, their meeting places for leisure activities may be most effective. Many men will not come to activities specifically focused on FGM prevention, and it is important to reach out to them where they normally spend their time. Messages in Djibouti, for example, are delivered across several channels, including preaching in mosques to target men, and TV/radio shows that are aired two to three times a month. One of the effective ways to enhance men’s engagement identified in Sudan has been to conduct anti-FGM activities in the places that men normally gather, such as men’s clubs and before and after the Friday Gumaa sermon in the mosque. In Djibouti, possible male gathering spaces could include khat sessions, while not inadvertently promoting drug use. Other locations include cafés, youth centres, or before or after sports matches, where men have come together for some other purpose and may be open to discussing their shared experiences.

To enhance young men’s engagement, participants in Sudan recommended targeting them through different social media platforms, engaging content developers, influencers and bloggers, as these are the platforms that attract the younger generation. These platforms also require gender-transformative messaging. Young people trained through the Y-Peer network generally follow traditional methods to reach out to young people; this work could be enhanced through the use of online platforms, where young people feel safer (and more anonymous) addressing issues related to sexuality and pleasure.

Educate students of middle and high school age, whether in or out of school, to understand and question FGM. Engaging young men in FGM prevention is vital, as one means of preparing them for marriage and parenthood, and activating them to play roles in standing up for their sisters. Young men

will play critical roles as future husbands, fathers and leaders in FGM prevention.

A recommendation emerging from Djibouti is that, with the help of the Ministry of Education, content on FGM could be integrated into the school curriculum. Young adolescents have a strong sense of justice and they are learning about gender roles and the injustice of gender inequality. A basic understanding of women’s rights and health could make it easier for future spouses to talk about these important issues. Expanding the UNICEF girls’ clubs system in schools to include boys clubs also creates a platform for a broader effort to address gender inequality.

ENSURE A HOLISTIC, GENDER-TRANSFORMATIVE APPROACH TO WORKING WITH MEN AND BOYS TO PREVENT FGM

Gender-transformative programming promotes critical awareness of gender inequality, challenges power imbalances, advances the rights of women and contributes to the redistribution of resources. Men must be engaged more fully in the discussion of women’s rights and well-being, and how these things affect them and their families. By involving men in examining concepts of masculinity, honour and shame, programmes can give them the tools they need to challenge the practice of FGM. The framework for this report makes the point that these concepts are being invoked as causes and drivers of FGM, but are not being acted upon in practice.

Gender-transformative messages go beyond a focus on FGM complications. They reflect a broader framework of rights and relationships, a discourse some organizations have hesitated to use. The pathway to expanding these messages is through discussion about the role of boys and men in the family, and indeed, what it means to be a man. Also important is to raise the connections between FGM, child marriage and other practices that limit girls’ and women’s opportunities and well-being throughout their lives, including their right to bodily integrity and to experience pleasure.

Promote gender-equitable manhood that models being generous, supportive husbands, caring brothers, and engaged and protective fathers. Build on the idea that a healthy sense of manhood includes

caring for others, and prevents FGM from taking place. Messages about men as good husbands may also be powerful, engaging men as husbands who successfully communicate and discuss FGM with their wives, are engaged in the household and whose closeness with their wives contributes to enjoyable sexual lives.

Challenge the discriminatory reasons for FGM.

Although the majority of male study participants in Yemen referred to FGM as a religious obligation, they further mentioned that FGM is a necessary practice to ensure girls’ ‘purity’. It is thus important that developed messages chip away at the discriminatory reasons for FGM, that is, girls and women are viewed as inherently impure, and the practice is promoted to control women’s sexuality. As this is a key reason people give for practicing FGM, it calls for the development of messages that provide a more accurate perspective on female sexuality.

One successful model for working with young men has been the Future Husbands Clubs (Clubs des Futurs Maris), implemented by Equimundo and UNFPA and their partners through the SWEDD programme in West Africa. The programme adds a gender-transformative component to UNFPA’s traditional Écoles des Maris and focuses attention on young men.

ENSURE A MULTISECTORAL APPROACH TO WORKING WITH BOYS AND MEN

A gender-transformative approach to working with boys and men requires coordination across sectors to generate holistic messages and activities. Governmental, non-governmental, donor and UN agencies must be engaged together to ensure a gender-transformative approach to preventing FGM. Non-governmental organizations, including women’s rights groups, are key to ensuring the resonance of FGM prevention efforts with the women’s movement and with concepts of rights and bodily integrity.

Strengthen the coordination of actors involved in responding to FGM. Responding to FGM – and to people who have already experienced it – can reinforce efforts to prevent the practice.⁷³ It can help people speak about the practice more openly, as well as reducing stigma for those who have experienced it. Governmental institutions such as the Ministries of Health, Education, Justice, Women and Family, Muslim Affairs and others play important roles in ensuring a holistic approach to prevention efforts and messaging. These actors can establish protocols for the management of FGM, including reporting and steps to intervention. Better coordination of religious leaders, community development centres and the Ministry of Health is needed as well as greater involvement of the local government, district councils and other relevant bodies to ensure broader reach.

HELP MEN TAKE A STAND AGAINST MEDICALIZATION USING A VARIETY OF STRATEGIES

Go beyond the health consequences of FGM to communicate a more holistic, gender-transformative vision for well-being and family life. These messages should also address the fact that FGM practitioners – whether midwives, nurses or doctors – are violating girls’ and women’s bodily rights. Messages regarding family planning, maternal health and other areas of health should also integrate content on FGM.

Understand the aspects of medicalization that are gendered and reflect the roles of men and boys. Men and boys must be made aware of laws and decrees banning FGM, for example, in Yemen,



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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, and in Egypt, the laws that prohibit doctors from practicing FGM and include penalties. The prevention and care of FGM must be integrated into service delivery messages directed at fathers and husbands (e.g., deliveries, pre- and post-natal care, and vaccination campaigns). Delivering messages within health-care units is also wise, as many advocates are fearful about Islamist opposition to FGM messaging, saying that “If people knew we were talking about FGM they would kill us”.

Fight increased medicalization of FGM by integrating FGM and related ethical guidelines into medical, nursing and midwifery education, not just about FGM itself but how to speak to men, and reflecting a rights and gender equality perspective on the practice. Many men seek advice and information from doctors when they do not want to circumcise their daughters and older women in the

family insist on doing so. At this time, they must be offered information that takes women’s rights into account. The challenge is to integrate into health-care delivery messages that counter the idea that there exist ‘safe’ or ‘light’ medicalized versions of cutting girls’ and women’s genitals. Ensure that doctors, nurses and other health-care practitioners, male and female, are provided with consistent, holistic messages about health, gender equality and sexuality. An overemphasis on the medical consequences of FGM has driven the focus on Type I. Djibouti’s experience illustrates the challenge: medical language emphasizing the health consequences of FGM has been used to discourage Type III (infibulation) and promote Type I or (‘sunna’). Type I is now one of the most persistent practices and has increased as a share of the overall number of girls being circumcised.

IDENTIFY AND EXPAND WORK WITH POSITIVE DEVIANTS, MEN WHO REJECT FGM

Identify men who are ‘positive deviants’ and amplify their voice and influence. The experiences of positive models of men who oppose FGM must be shared widely, so that these men are known to their peers; this will contribute to persuading men to prevent FGM among the girls and women in their families. Establishing a wide network of men who support ending violence against women in general, and FGM in particular, will empower other men to engage in similar ways in the future.

DEVELOP MESSAGES ABOUT THE CONNECTIONS BETWEEN FATHERHOOD AND FGM PREVENTION

Work to end FGM must actively engage fathers. In Djibouti, Egypt and Sudan, many men stated that they are involved or would like to be more involved in the lives of their children. They spoke about their children with intimacy and affection, and they see themselves as their children’s main protectors. The transition to fatherhood heightens men’s emotional vulnerability, and provides an opportunity to engage men in the future well-being of their daughters. Making the most of fatherhood as an opportunity to engage men is a strategy that has potential everywhere.

Messages directed at fathers may be quite diverse, addressing men as protectors, caregivers and partners making good decisions on FGM with the mothers of their children. The research in Sudan, for example, indicated that the issue of protection should be emphasized in messages directed to men. Fathers are influenced by messages that explore the role of a father in protecting his daughter from harm. These messages must be framed within the broader context of gender equality promotion within the family, for example, improving family communication and joint couple decision-making. Work with future parents in anticipation of the decisions they will have to make about their daughters.

BRING MORE NUANCE TO WORK WITH RELIGIOUS LEADERS AND RELIGIOUS DISCOURSE ON FGM

Religious messages are influential among all men, especially the older generation, and can support older men to stop FGM within their families.

Religious leaders opposed to FGM could play a role

with newlyweds as they get to know each other and prepare to become parents. Doctors opposed to FGM already have an important role in informing and influencing people, and could focus special attention on the first pregnancies of young couples. The government could itself play an important role, encouraging young men to learn about FGM by offering a financial incentive to new parents to attend courses on the connections between FGM and women's rights and health, and on the health and well-being of infants and young children who undergo the practice.

Challenging religious discourse around FGM can be difficult as religious leaders are important figures within the patriarchal structures and it can be in their interest to reinforce traditional norms.⁷⁴ Indeed, the vast majority of Djiboutians, for example, who practice FGM believe they are doing so in accordance with Islam. The long experience of Egypt suggests that work with religious leaders must include formulation of broader, more gender-transformative messages. Egypt has the most unified religious leadership, yet despite wide denouncement of FGM by religious prominent entities such as



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Al-Azhar, the majority of interviewed men and women still believe that female circumcision is part of the teachings of Islam. In other countries such as Yemen, a more fractured religious leadership makes it difficult to present a singular and authoritative message to religious leaders.

Continue to reduce the influence of religious leaders on FGM decision-making, given that religious leaders can often be the main advocates for FGM. FGM in Egypt in particular is increasingly not addressed as a religious obligation, and messages should continue to stress established facts such as: “Al-Azhar issued a statement banning FGM and stated that it is not part of the religious teaching” or that “FGM is not mentioned in the Qur’an, and the prophet did not circumcise his daughters” and that “FGM is not practiced in Saudi Arabia where the Prophet Muhammad was born and spent his life”.

WORK TO ENSURE AN ANTI-FGM LAW/LEGAL FRAMEWORK IS IN PLACE, RECOGNIZING THAT THIS IS NECESSARY BUT NOT SUFFICIENT TO END FGM

Keep pushing for FGM to be banned by law. Research around the world has shown that while passing laws against harmful practices can have a limited direct effect, laws establish a public standard and the basis for public advocacy as well as the government investment and regulations in support of the law. Sudan outlawed FGM quite recently in 2020, although the Saleema Initiative had been working for two years before that. In Yemen, it will be important to work to obtain Parliamentary approval for the ‘Protection of Women Act’ currently in draft. A key aspect of the emphasis on the law is to enforce messages that FGM is illegal, and that boys and men have an important role to play in opposing it.

INCREASE ATTENTION TO SEXUALITY AND COUPLES’ SATISFACTION AND HAPPINESS

Focus greater attention on the psychological, social and sexual consequences of FGM and not just the health consequences. Although further

research is required on these consequences of FGM, quite a lot is already known. For example, a 2010 systematic review of quantitative studies substantiate 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”.⁷⁵

Anti-FGM messages should describe the consequences of FGM for sexuality and the couple’s intimate 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.

OVERCOME THE POWER OF THE SILENCE AROUND FGM

Build people’s willingness and ability to talk about FGM and related topics, shifting FGM from a taboo topic to one that is freely discussed in the family context. When people cannot speak freely about a practice, it becomes much harder to shift, as people are uncertain of and must assume what others think. Egypt exemplifies success in the long-term shift in national discourse. By ensuring that FGM is not off limits for discussion, it becomes easier to integrate messages of gender transformation, rights and sexuality, which need not be as alarming as people think. In Yemen, for example, FGM is currently a taboo subject as it was for many years in Egypt. A need exists to normalize discussions about FGM to pave the way for more effective prevention programmes. When men and women are uncomfortable discussing FGM, there is little conversation in the household, with each assuming the other approves of the practice. Discussing the practice in health clinics during prenatal visits can be an effective entry point, as are discussions of FGM in different media channels – these can help lift the taboo on talking about FGM and coming to decisions together.



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CONCLUSION

The fight against FGM has faced two major obstacles that relate to the profound gender inequalities that drive the practice:

First, as countless studies have observed, FGM is a challenge to public health and gender justice and a violation of human rights.⁷⁶ Yet as countless programmes have unfortunately shown, the emphasis of interventions has tended to be on the health and medical consequences of the practice.

Second, the great majority of interventions to end the practice have focused on the women who often take the lead in deciding about FGM and the girls and women who are subjected to circumcision. Yet as a social norm, FGM involves everyone in society, including men and boys, as well as women and girls. Shifting social norms requires everyone in society to participate in reflecting on and challenging a practice.

To get to the root of how men and boys are implicated in the practice of FGM, this initiative conducted research on the roles of men and boys in Djibouti, Egypt, Sudan and Yemen. The purpose of this research to action initiative has been to explore the attitudes of men toward FGM and to identify the

barriers to male engagement that exist and must be addressed in programming. Based on the findings, recommendations are given on how to amplify the contributions of men and boys to ending FGM.

The initiative has also offered practical guidance to ensure the effective involvement of boys and men in supporting women's empowerment in general and ending FGM in particular while under social norms and institutions that uphold gender-inequitable views.

FGM is a symbolic as well as a concrete act of violence. As it cuts the bodies of women and girls, circumcision communicates to them and to everyone that they must be controlled, reined in and prevented from acting on any dangerous or inappropriate expressions of sexuality, and that their sexual pleasure is not valued by the society. The practice reflects profound gender inequality that subjects women to sexual control and manifests their broader social subordination. The rights of girls and women are sharply constrained by the practice of FGM.

It is critical to engage men and boys in eliminating FGM. They, as well as women and girls, must come to share a commitment to the wholeness and integrity of women's bodies and their personhood, and a commitment to their rights and well-being.

RESEARCH
TO ACTION
ON FGM



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ENDING FGM IN EGYPT: INVOLVING MEN AND BOYS IN EGYPT THROUGH A GENDER TRANSFORMATIVE APPROACH

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).⁷⁷ 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.⁷⁸ 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 14.⁷⁹ 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.⁸⁰ 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.⁸¹ Just over half of Egyptians think FGM should continue, with 59 per cent of men and 54 per cent of women holding this view.⁸² 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.⁸³ 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).⁸⁴

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.⁸⁵ 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.⁸⁶

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.⁸⁷ 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.⁸⁸ 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,⁸⁹ 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.⁹⁰

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.⁹¹

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.⁹² 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.⁹³ 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 role 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.⁹⁴ 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.^{95, 96} 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.⁹⁷ 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.⁹⁸

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 woman, 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.⁹⁹

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 EDHS¹⁰⁰ 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.¹⁰¹ 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.¹⁰²

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).¹⁰³ 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.¹⁰⁴

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.¹⁰⁵ 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”.¹⁰⁶ 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 lives¹⁰⁷ 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.¹⁰⁸

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,¹⁰⁹ 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.¹¹⁰ 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.¹¹ 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.

RESEARCH
TO ACTION
ON FGM



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ENDING FGM IN DJIBOUTI: STRATEGIES AND MESSAGES FOR ENAGAGING MEN IN THE FIGHT AGAINST FGM

BACKGROUND

Female genital mutilation (FGM) is widespread in Djibouti, with approximately 94 per cent of women having undergone FGM.¹¹² It is mostly performed on girls between the ages of 4 and 9 years (67 per cent) and the majority of procedures (92 per cent) are performed by traditional practitioners. Around 30 per cent of girls in Djibouti undergo the most severe type of FGM, Type III (involving the cutting and sewing of their genitalia).¹¹³

Support for the practice is decreasing in Djibouti, with 48 per cent of women between the ages of 15 and 49 supporting the continuation of FGM.¹¹⁴ Younger women and more educated women are more likely to denounce the practice.¹¹⁵ Unfortunately, there has been little significant change in FGM prevalence across generations, but there is a trend towards practicing less severe types.¹¹⁶

A decrease has occurred in the prevalence of infibulations in Djibouti. In urban areas, prevalence fell from 78.5 per cent to 69.1 per cent between 2012 and 2019.¹¹⁷ According to a recent UNICEF study examining social norms in relation to FGM, an important shift took place from Type II and Type III (infibulation) to Type I (the cutting of the clitoris and/or prepuce), which is locally referred to as 'sunna'.^{118,119} Type I is much more widely practiced today than it was previously, with 41 per cent of girls between 0 and 17 years having undergone Type I at the age of 4.¹²⁰

Further, a recent UNICEF study stated that 47 per cent of women and men respondents discuss FGM as a couple, with only 4 per cent of people seeking the opinions of others when deciding about FGM; only 6 per cent of men and 8 per cent of women see grandmothers as FGM decision makers.¹²¹ However, there can be pressures from parents or other older family members who support FGM.

The government of Djibouti passed a law in 1995 prohibiting FGM (Article 333 of the Criminal Code). However, the law did not provide a definition of FGM, nor criminalize aiding or abetting FGM. In 2009, Law No. 55 introduced amendments to supplement and strengthen Article 333 of the Penal Code, including a definition of FGM and criminalizing the failure to report FGM to the authorities. The law also tightens penalties for 'accomplices' of FGM.¹²² Yet, there have been no convictions in Djibouti to date. The 2016

annual report of the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (UNJP) did not list any cases of legal enforcement of the anti-FGM legislation in Djibouti before 2016, and no other source suggests any cases since then.¹²³

Reinforcing the anti-FGM legislation, the following national bodies and strategic documents provide a supportive policy environment for the work on FGM in Djibouti:¹²⁴

- The National Steering Committee for the Abandonment of All Forms of Excision (2009) serves as a national coordination mechanism for the work on FGM
- National Policy for the Integrated Development of Djiboutian Early Childhood (2005)
- National Gender Policy (2010)
- National Strategic Plan for Children in Djibouti (2010)
- National Health Development Plan (2012)
- A National Strategy for Abandonment of All Forms of Excision (2016).



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Djibouti was one of the first countries to join the UNFPA–UNICEF Joint Programme in 2008, and most of the anti-FGM activities in the country take place under the auspices of the UNJP.¹²⁵ The Joint Programme has collaborated with different government departments, including the Ministry of Women and Family, the Ministry of Islamic Affairs and the Ministry of Health. It has also collaborated with different civil society organizations such as the National Union of Djiboutian Women.¹²⁶ The work of the Joint Programme in Djibouti during Phases I and II is structured at these three levels:¹²⁷

- Policy and legal framework: strengthening the anti-FGM legislative framework and training government officials
- Provision of FGM-related services: Integrating FGM Prevention in Adolescent Sexual and Reproductive Health (SRH) Programmes and including FGM within governmental counselling services
- Galvanizing social dynamics: raising the awareness of community members in relation to FGM and other forms of violence against children as well as through public declarations, where communities/villages declared themselves free of FGM. In this area, working with religious leaders is pivotal to sustained behavioural change.

METHODOLOGY

Study sample

At the administrative level, the country is made up of five regions in addition to Djibouti City: Ali Sabieh, Dikhil, Tadjourah, Obock and Arta. Statistics on FGM in Djibouti are available only by region and not by ethnic group. The prevalence of FGM varies across the regions, from 68.5 per cent in Djibouti City, 61.2 per cent in Ali Sabieh, 82.0 per cent in Dikhil, 88.2 per cent in Tadjourah, 73.6 per cent in Obock, to 76.4 per cent in Arta.¹²⁸

Given their high prevalences of FGM, Tadjourah, Dikhil and Obock were selected for the data collection effort. Tadjourah and Obock are located in the north of Djibouti and have populations of 86,704 and 37,856, respectively. These two regions are mainly populated by the Afar community. The Dikhil region is located in the west of the country with a population of 88,948 and is populated by both Somali and Afar communities. The large populations of the Afar community in the selected regions means that they may be over-represented in this study.

Data collection

The research used qualitative methods (focus group discussions (FGDs) and in-depth interviews (IDIs)) to collect relevant data. Eleven semi-structured IDIs were conducted with various actors, including non-governmental organizations (NGOs), ministry representatives, religious leaders, doctors and grandmothers. The themes discussed included:

- Programmes/projects implemented by various organizations to combat FGM
- Men and boys' engagement in activities to combat FGM
- The difficulties of involving men in the fight against FGM
- The roles of religious leaders in the fight against FGM.

Focus groups

The focus groups targeted all communities in Djibouti City and in the interior regions. There were eight

focus groups in total (five in the regions and three in Djibouti City), composed as follows:

- Three focus groups including married men aged between 25 and 45
- Two focus groups including married women aged between 25 and 45
- Three focus groups including young people aged between 15 and 20.

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 for FGM and male involvement, ways to encourage men to take an active role in ending FGM and challenges encountered. The guide was developed in English and translated into relevant languages (French or local languages).

Data analysis

Data analysis was conducted manually; recorded IDIs and FGDs 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 DISCUSSIONS

Gender roles and power relations in the household

Household chores: The majority of the study participants supported traditional gender roles, where husbands are the main provider and women are

responsible for the management of the household and performing domestic chores.

“I do all the tasks in the home: the follow-up of the children’s education and health, the housework, the management of the home, etc. ... My husband contributes financially with his retirement pension.”

urban, married, uneducated woman, 45 years old

Many of the women participating in the study stated that men rarely help in any household chores or caregiving, although many of them tend to have more free time than women, in which they spend socializing with their friends, including getting together to chew khat.¹²⁹

“My husband does not help me since he works in the morning and in the afternoon he has his khat session.”

Afar, rural, married, educated woman, 25 years old

A UNICEF 2022 study of social norms and behavioural drivers on FGM in Djibouti stated that more than 70 per cent of men believe that women’s main role is to carry out household-related activities and caregiving, and 37 per cent believe that educating men is more important than educating women.¹³⁰

“My father was not interested in our excision [circumcision] because the mother is the one who takes care of the children.”

urban girl, 19 years old

Regarding household gender roles, differences are reported by study participants according to level of education and demography. Both women and men who are higher educated and living in urban areas are more likely to adopt more gender-fluid roles. Women are increasingly involved in household finances and men participate more in household tasks. A similar shift among the younger generation can also be observed, but to a lesser extent.



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“If we don’t have a housekeeper, I do the cooking and my husband does the cleaning. As far as finances are concerned, my husband finances the household and I am in charge of managing the budget. However, if there are any unexpected expenses, I pay them.”

urban, married, educated woman, 29 years old

Decision-making process on FGM and men’s involvement

Many of the study participants stated that the decision to perform FGM is mostly taken by females in the family as men view this as a ‘women’s issue’

and therefore do not interfere. Often the circumcision of young girls occurs in the men’s absence, but the men are asked to finance the procedure. Whether Afar or Somali or Arab, educated or uneducated, urban or rural, many study participants stated similar perceptions during the discussions.

“It often happens that she [the mother or grandmother] performs it in secret from the father. I know a woman in my neighbourhood who circumcised a young girl at home and in the absence of the father. The girl had a haemorrhage and had to be taken to the hospital. A neighbour took them there.”

female religious leader

“I came home from work to find my wife in a panic because our 6-month-old daughter had a fever and she refused to take her to the hospital. I forced her to take her to the hospital and the doctor informed me that the fever was due to the infection of the wound following the FGM. I did not understand and asked my wife when she had circumcised her. She told me in a low voice that she had circumcised my little girl while I was away. I went straight to the police station taking my wife and the matron with me. Since that day, she stopped circumcising our daughters.”

Afar, married man, 27 years old, FGD in rural region, Obock

In Djibouti, men are largely expected to support and uphold social norms and traditions. Therefore, they are expected to endorse FGM as a normalized practice in the community and not to oppose family and community members.

“In [some¹³¹] rural areas, people marry cousins. In this case, if the bride and groom are cousins, the husband will find it difficult to say no to his aunt, who is also his wife’s mother, if she is going to circumcise his little girl.

male doctor

At the same time, many participants stated that men’s decisions are very important as they are the heads of the families and could play a decisive role in ending FGM. Further, they stated that if any man did not want his daughter circumcised, she would not be circumcised, stressing that only men can stand up against the elderly or contain the family pressure to perform FGM. Some study participants stated that men with higher levels of education tend to oppose FGM.

“They have a decisive role in rural areas. However, it is valid in the other direction too. When they want her to be circumcised, she will be.”

male rural religious leader

“There is a change in mentality with the increase in the level of education and the fact that men travel and see what happens in other countries. This gives a certain open-mindedness.”

medical doctor

During the discussions, study participants mentioned the power held by men to stop FGM, but that, in many cases, the men choose not to interfere because of their beliefs that FGM is ‘women’s business’ or that their responsibility is to maintain traditions, not oppose them. This finding is consistent with findings from other countries in which similar studies were performed (e.g., Egypt, Yemen and Sudan), and is shared by other relevant studies.¹³² In a recent UNICEF study in Djibouti,¹³³ 46 per cent of women and 53 per cent of men stated that men expressed anti-FGM views. However, 96 per cent of all study

participants stated that there is rarely any argument or disagreement regarding decisions about FGM. Although men may oppose FGM, they rarely enter into confrontation or challenge decisions

Many female study participants stated that the decision to perform FGM is taken despite the majority of women being aware of the negative consequences of FGM. Social pressure and women’s responsibility to carry on traditions are stronger than their knowledge and sometimes their negative personal experiences.

“They are aware of all the harm it causes, but there is pressure from parents who force them to circumcise our young girls. Some of them sometimes cry at the time of the awareness sessions and testify about what they have experienced.”

female religious leader

As mentioned by study participants, the decision to perform FGM is largely taken by family members, with girls undergoing the practice not being consulted, especially given that in Djibouti the average age of circumcision is 4 years.¹³⁴ Age at circumcision differs between the Afar and Somali communities; the Afars circumcise young girls as babies, before they are 1.5 years old, while the Somali community circumcises them before the age of 6.

“In Tadjourah, girls are circumcised before they are 5 years old and usually when they are 1.5 years old. Therefore, they do not participate in the decision-making process.”

urban medical doctor

Families largely feel that girls do not have the capacity to discern or have anything to say about the decision, and usually the girls are not informed that they will be circumcised for fear that they might run away. However, some study participants expressed the need to consult girls in the decision about whether to perform circumcision.

“ ... [M]y young daughter is not circumcised and the other children made fun of her to the point where she came to me and told me to cut her. But with time, she understood that it was for her own good.”

female religious leader

A recent study by UNICEF stated that 28 per cent of men and 26 per cent of women believe that it is important to ask the opinion of the girls regarding FGM.¹³⁵

Unlike other countries, medical doctors in Djibouti are largely not involved in the decision-making, as non-medical professionals perform the majority of circumcisions and medical doctors rarely discuss FGM with the families. Many of the study participants stated that some parents discuss the health impact of circumcision with their physicians; however, if the parents wish to have the girl circumcised they usually call upon midwives, as around 78 per cent of FGM cases are performed by traditional practitioners.¹³⁶ Still, doctors can play an important role by providing clear and effective information about the negative consequences of FGM.

Religious leaders play an important role in advocating for continuation of the practice, as stated by many study participants. The recent UNICEF study found that 51 per cent of study participants believe that FGM is a religious obligation.¹³⁷

“Fathers discuss with us before making a decision about circumcising their daughters.”

male religious leader

There is no uniform position on FGM among religious leaders, according to study participants: while some oppose the practice, some promote its continuation and others stress the need to shift from Type III infibulation to Type I, widely referred to as ‘sunna’. Study participants stated that religious leaders who oppose FGM are often referred to by community members as the ‘religious elite’, and while they are influential, people can sometimes doubt their veracity when they are perceived as receiving financial benefits from donors.

The constant use of the word ‘sunna’ to refer to the practice of FGM is quite problematic, as it strengthens the perception that FGM is a religious obligation. According to study participants, many Djiboutians relate FGM to ‘proper’ behaviour for Muslims.

“Yes, I made the right decision to excise my daughter. It is about ‘sunna’. We have followed what religion has advised us. It allows us to maintain the family honour.”

married man, FGD urban region

“The sunna reflects the actions of the prophet. However, the prophet did not circumcise any of his daughters. We tell them about the hadiths on this subject and we also mention the medical reasons.”

male religious leader, IDI

Challenges to engaging men in Djibouti

An important obstacle to engaging men in FGM is the difficulty of getting them together. Men may have limited interest in awareness-raising workshops on FGM (although anecdotal reports suggest as many as 40 per cent of participants in some workshops are men). It is more difficult to mobilize men in Djibouti City, as the men work and then have their khat sessions after work, and are also reluctant to be disturbed during the weekend. Men in rural areas have more time and are more likely to attend awareness sessions; however, they watch over the herds and only return in the evening. Younger men have stated they are not concerned with FGM and blame women for the practice; they state that they would rather attend sessions tackling issues in which they are more interested such as unemployment.

“Young people, on the other hand, tell us that there are more interesting issues like unemployment. [In general] men at the regional level are more interested and ask more questions on FGM.”

male, religious leader

RECOMMENDATIONS

Approaches

Utilize a gender-transformative approach that links FGM to broader challenges faced by women and men.¹³⁸ Initiate discussions around power, gender inequality, sexuality and sexual pleasure, meaning of fatherhood and manhood, and examine the inter-relationships between these concepts and FGM. This will ensure that men and women, young and old will be more engaged and interested in the discussion.

Rely on a ‘community conversations’ approach rather than a 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 platforms such as social media can be powerful.

Encourage intergenerational dialogues at the family level. Most important are discussions between members of the same family, such as a daughter asking her mother why she was circumcised or why her mother chose to circumcise

her. These discussions could also take place prior to the decision to perform FGM, with girls encouraged to participate.

Positive deviance is an effective approach. Many male study participants stated that men opposing FGM would most likely contribute to the reduction of the practice within their immediate family. Therefore, using those male figures who have taken a stand against FGM could also have an impact on their peers at the community level.

Diversify awareness activities to suit the nature and interest of different targeted groups.

Awareness-raising activities, meetings and seminars are more suitable for older men and women, while other engaging activities such as sports, street theatre or artistic performances such as short films are more interesting to the younger generation.

Apply a simple approach to the religious debate around FGM, which clarifies that FGM is not religious (Islamic) but cultural. For the purposes of countering FGM, the simple question of whether or not FGM is Islamic requires a one-dimensional and definitive response in the negative. Although this reduction



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oversimplifies the connections between FGM and religion,¹³⁹ this strategy is necessary to accelerate the abandonment of FGM. According to the recent UNICEF study on social norms and FGM, around 51 per cent of study participants stated that FGM is a religious obligation, while more than 70 per cent perceive it as cultural and traditional.¹⁴⁰

Utilize creative methods to spread anti-FGM messages. In addition to diversifying activities for different target groups, creative methods/ways in which to spread messages should be considered. For example, khat sessions provide a male gathering space in which to initiate discussion; however, this should not inadvertently lead to promotion of drug use. Other possible locations include cafés, youth centres, or before or after sports matches, where men have come together for some other purpose and may be open to discussing their shared experiences. Anti-FGM messages are currently widely spread through Friday sermons, which are largely attended by men. However, this medium has been criticized as many community members feel that religious leaders are paid to talk about FGM or forced to talk about it by the state authorities. In such mediums, it is recommended to address FGM within broader family-related issues or the child protection framework.



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Target groups

Reach out to young people, although they are not involved in decision-making on FGM. Although it can be quite difficult for young people to argue against their elders, they could play a critical role as future fathers and leaders in FGM prevention. Their skills must be developed to be able to convey their views. Religious leaders will continue to be important stakeholders. Programmes should continue to work with religious leaders as influential community members and also as men, who face the same challenges as other men in engaging in anti-FGM prevention.

Educate students of middle- and high-school age to understand and question FGM. Working with the Ministry of Education, courses on FGM could be integrated into the school curriculum. Young adolescents have a strong sense of justice and they are also at an age where they are learning about gender roles and the injustice of gender inequality. The introduction of this topic and its links with women's rights and health could facilitate discussions around FGM within the household.

Work with married future parents in anticipation of the decisions they will have to make about their daughters. Religious leaders could play a role with newlyweds as they get to know each other and prepare to become parents. Doctors often already play an important role in informing and influencing people, but special attention could be focused on the first pregnancies of young couples. The government could play an important role, encouraging young men to learn about FGM by offering a financial incentive to new parents to attend courses on connections between FGM and women's rights and health, and on the health and well-being of infants and young children who undergo the practice.

Work with medical professionals (nurses, trained midwives and doctors) and train them to deliver effective anti-FGM messages. Given that FGM is performed on very young girls, messages could be integrated during antenatal and prenatal visits. Delivered messages should be comprehensive, explaining the physical, emotional and sexual possible consequences of FGM and stressing that all types of FGM whether Type I or Type III (infibulation) are harmful practices and are considered violations of women's human rights.

Work with men not only as parents or future parents, but also as influential members of the households. Highlight to men that they are more influential than they think in resisting FGM. Men need to be shown that they have a say even though it is the women in their families who are affected by the practice. It is necessary to motivate them to recognize their role and be more active in countering FGM, and for that, there should be more training in the urban areas as well as in the rural areas.

Key messages

Develop messages for boys and men around sexual satisfaction and pleasure and the importance of a healthy intimate life. Explain the possible negative impact of FGM on their closeness with their wives and on their sexual lives. The idea here is to further engage men in the decision to perform FGM, by increasingly making them view FGM as ‘everybody’s issue’ rather than just a ‘women’s issue’.

Ensure that the messages directed to men reflect the language of positive parenthood and care rather than protection, to ensure that inequitable gender power relations are not reproduced and reinforced.

Encourage women to understand FGM in the context of violence and gender inequality and to be able to draw linkages between FGM and other forms of violence such as early marriage and intimate partner violence.

Messages should address misconceptions around female sexuality and anatomy. The female genitalia, in particular the clitoris, are regarded as a source of sexual desire rather than sexual pleasure. This effort will clarify that FGM is strongly associated with reduction of women’s sexual satisfaction and pleasure and not sexual desire. This subtle distinction is important, as it will help to address some of the harms of Type I, which is so widely practiced.

Avoid overemphasizing the medical consequences of FGM. The heavily disseminated medical messages lead to the wide adoption/ acceptance of the lesser type of FGM rather than complete abolishment. Among circumcised girls between the ages of 0 and 17, 70 per cent have undergone Type I in comparison with only 1 per cent who have undergone infibulation.¹⁴¹

Develop messages around the importance of male involvement in ending FGM. Many men among the study participants perceive themselves as lacking influence over the decision-making process, despite the fact that 53 per cent of men in the recent UNICEF study think that female circumcision (FGM) should end.¹⁴²

Fight the medicalization of FGM by incorporating rights-focused content in training curricula. Twenty-one per cent of FGM cases are now performed by medical professionals: nurses, trained midwives and doctors.¹⁴³ Including anti-FGM messages in relevant curricula of medical, nursing and midwifery schools would expose medical personnel to a rights-oriented framing of FGM that would influence how they respond to families seeking information and services.

Messages that implement a strategy of working with religious leaders must be clear and definitive. Messages that address the relationship between FGM and religion should be simple and straightforward, for example, “FGM is a cultural practice that existed before Islam” or “In many practicing countries FGM is practiced by both Muslims and Christians” or “FGM is not practiced in many Muslim countries, including Saudi Arabia”. As one step toward this clarification, it will be important to develop messages that discourage the use of the word ‘sunna’ in reference to FGM and introduce other culturally known terms to describe Type I.

RESEARCH
TO ACTION
ON FGM



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ENDING FGM IN SUDAN: MAKING IT POSSIBLE FOR WOMEN AND MEN TO TALK ABOUT FGM

BACKGROUND

In Sudan, 87 per cent of women aged 15–49 years have undergone female genital mutilation (FGM). This percentage differs by state, ranging from 97.5 per cent in Northern State, to 87.5 per cent in Khartoum State.¹⁴⁴ It is estimated that two-thirds of girls aged 0–14 are at risk of undergoing FGM before reaching the age of 15. In rural areas, 70.9 per cent are at risk of being circumcised, compared with 56.2 per cent in urban areas, showing that girls living in rural areas are more likely to be circumcised than girls residing in urban areas.¹⁴⁵

FGM in Sudan is perpetuated and sustained by deeply rooted social norms and in equal gender power structures, and is centred on the need to reduce women’s sexual desire to protect them.¹⁴⁶ The 2010 Sudanese Household and Health Surveys (SHHS) found that the most common reasons stated by women for the continuation of FGM in Sudan were “purification, cleanliness and hygiene, acceptability within the group and reducing sexual desire”.¹⁴⁷

A 2019 cross-sectional study concluded that decision-making regarding FGM may involve discussions between relevant family members, whether nuclear or extended family, and sometimes non-family members; however, a girl’s parents are the main decision makers.¹⁴⁸ The discussions not only focus on whether girls should undergo circumcision but also the timing and the type of FGM performed.¹⁴⁹ Mothers play an important role in the decision to perform FGM as concluded by many studies^{150,151} Still, studies stress the influence of older family and non-family members, especially grandmothers, in decision-making, as younger women have less power than older women.¹⁵² Fathers have an important role to play in the decision of FGM, as they tend to be the final decision maker when the decision is taken not to perform FGM.¹⁵³ This suggests fathers’ participation is required to free mothers from the social pressures and responsibility of maintaining traditions, and that they could have a central role in moves towards ending FGM.¹⁵⁴

A national law was passed in Sudan in 2020 to amend the Sudanese criminal law of 1991 and include Article 141, which prohibits FGM practice inside a hospital, health centre, dispensary or clinic or other places¹⁵⁵. However, this must be translated into real social change if women and girls are to experience the gains. An effort to shift general norms around the practice

is represented by the Saleema Initiative, a campaign established in 2008 by the National Council of Child Welfare (NCCW) with support from UNICEF Sudan. It supports the protection of girls from FGM, particularly in the context of efforts to promote collective community abandonment of the practice.¹⁵⁶ Saleema aims to strengthen existing or new positive values for girls and women within society. The campaign grew out of the recognition of a critical language gap in colloquial Sudanese Arabic, which does not include a positive term for an uncut woman or girl. The initiative introduced the term Saleema, a positive term for an uncut girl that portrays her as whole, healthy and complete. The campaign uses varied communication tools to mobilize communities to shift away from traditional practices and beliefs to new social norms through the use of positive language and messages.¹⁵⁷

METHODOLOGY

The study was conducted in two states, Khartoum State and Northern State, representing an urban and a rural site. In Khartoum State, the study was conducted on Tuti Island, in the heart of Khartoum city. In Northern State, the study was conducted in the rural areas of Dongla in Nawa and Sharq Elnil Villages.

The research used qualitative methods (focus group discussions (FGDs) and in-depth interviews (IDIs)) to collect relevant data. Eleven IDIs were conducted in Khartoum State. The interviews included key informants from NGOs and institutions such as the National Council of Child Welfare, UNICEF and UNFPA Sudan, Y-Peer, Family and Child Association and Entishar organization, along with midwives and religious leaders. Each interview lasted 45–60 minutes and was conducted by a trained researcher. All interviewees verbally agreed/signed a consent agreeing to be interviewed and recorded.

IN-DEPTH INTERVIEWS TARGET GROUP	NUMBER CONDUCTED
NGO representatives	6
Religious leader	1
Midwife	1
Young man	1
Young woman	1
Grandmother	1

Six FGDs were conducted with young women and men, and older married women and men. Participants had different educational backgrounds and some had no formal education.

FOCUS GROUP DISCUSSION TARGET GROUPS	NUMBER CONDUCTED
Young women aged 20–25 years old (youth)	1
Mothers aged 30–45 years old, and grandmothers	1
Mothers aged 30–45 years old (married)	1
Young men aged 20–25 years old (youth)	1
Men aged 35–50 years old (married)	1

Data collection and tools

Data collection began in January 2022 and ended in May 2022. The data were collected through different semi-structured guides tailored for the different categories of the targeted participants. The guides were initially developed in Arabic and were translated into local languages as needed. The IDIs took an average of 45–60 minutes each, whereas the FGDs took an average of 90–100 minutes each. Both IDIs and FGDs were audio-recorded after obtaining permission from the participants. Socio-demographic data was collected from each participant (age, level of education, residency, employment status and number of children if married). All interviews were conducted in places and times of participants’ choosing and were done privately.

A detailed guide was developed for the IDIs and 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 an active role in ending FGM and encountered challenges.

The IDIs with an NGO representative asked about their implemented projects to end FGM, and the extent of men’s engagement in these projects. For the midwives, doctors and religious leaders, the main questions were around the information requested by

people, men’s engagement in the activities aimed to end FGM and the medicalization of FGM.

Data analysis

The data from the IDIs and FGDs were analysed using thematic analysis of the audio-recordings and transcriptions. A blended approach of deductive and inductive coding was used. The initial thematic framework was developed based on the objectives of the study, and updated with emerging themes identified through familiarization, indexing and sorting. This comprehensive process involved reading through the transcripts for familiarization and then identifying key themes and codes that were entered into the final thematic framework. The interviews were conducted in Arabic, while codes and themes were translated into English in anticipation of writing the country report.

KEY FINDINGS AND DISCUSSIONS

Gender roles within the household

FGM is a gendered violent practice and a manifestation of gender inequality deeply entrenched in social, political and economic structures. Therefore, it was important to understand the perceptions of the different practicing communities regarding gender norms to develop recommendations on ways to transform the unequal structures and norms that perpetuate FGM.

Household chores: Study findings showed a wide acceptance of the traditional division of housework, especially among older generations in rural areas, where women perform the majority of domestic tasks such as cooking or cleaning, while men carry out tasks such as repairs or shopping for food and supplies. However, men are expected to help if needed, especially in cases when the wife cannot carry out those activities due to travel or sickness.

“We are sharing outside work, and they are sharing with us the housework but still it’s our responsibility and he is helping.”

(urban, married woman)

“Life is sharing. We share with them the work and payments, and they share with us housework, but the paid work and paying is men’s responsibility, and housework is for women.”

(urban, married woman)

The clear division of gender roles is further extended to children, where young boys are expected to perform tasks and chores outside the household and girls to help with activities inside the house.

“Boys do not have any kind of work inside the house, and girls are responsible for inside the house activities.”

(rural, married man)

Participants mentioned that when boys are asked to perform or help in any domestic chores such as washing clothes or cleaning the house, this could be viewed as punishment, as it is regarded as humiliating.

“We used to be punished by washing clothes in front of our sisters’ friends. It was very humiliating and I will not let my boys do that.”

(rural, married man)

Changes are observed among younger women and men in urban communities, who are more in favour of more fluid gender roles. Still, men’s participation in house chores is conditioned by their availability and willingness to help. For them men’s primary responsibility, still, is to provide the main income for the household.

Fatherhood: Many male participants indicated that they take fatherhood very seriously. They involve themselves in their children’s upbringing, and they can undertake domestic work directly related to their children, such as ironing their clothes or getting them ready for school.

“I participate in the small things inside the house such as preparing the tea, juice or anything light except cooking. I also help with the children and ironing their clothes.”

(rural, married man)

Sexuality, marriageability and family honour: The majority of the study participants stated that girls need to conform to social norms and to maintain good reputations, which greatly affect the reputation of their families and their opportunities to get married. The term ‘good reputation’ revolves around making sure that girls do not engage in any premarital sexual relations or get pregnant outside marriage.

“Any pregnancy before marriage that appears in a woman would destroy the whole family and the whole family would lose their honour.”

(rural, married woman)

Dynamics of FGM decision-making

WHO MAKES THE DECISIONS ABOUT FGM?

FGM is largely portrayed among study participants as a collective decision, in which different family and non-family members are involved. Yet study participants often highlight the influential role played by grandmothers. Many stated that grandmothers often change the opinion of someone who decides against FGM, persuading them to circumcise the girls and continue the practice. This finding is shared by several other studies on FGM in Sudan.^{158,159}

“The final decision is in the grandmother’s hand.”

(urban, married man)

“The problem is the grandmothers, they insist.”

(rural, married man)

“There is a pressure to obey the elders’ talk, and the grandmother is the most insistent person, and sometimes people do a little thing (sunna) to please her.”

(rural, married man)

The study findings point to changes in perceptions regarding the decision-making process based on the participants’ education level and socio-demographic characteristics. Younger and more educated participants (males and females) are more likely to argue that things have changed and, for them, the father and mother take the decision together. These findings are supported by other studies highlighting a complex web of social, religious, cultural, economic and political factors, as well as individual and collective experiences, which influence the decision of FGM.¹⁶⁰

“Yes, I talked to my wife about cutting our daughter, we discussed its harmful consequences, and she was very determined to cut her, so we talked for long period to convince her not to cut our daughter.”

(rural, highly educated, married man)

Others stated that there is intergenerational change, where the current grandmothers are less insistent to circumcise the girls.

“In the past the grandmothers were insisting, but the generation after them are less insistent.”

(rural, married man)

THE ROLE OF MEN IN DECISIONS ABOUT FGM

The role of men in the decision-making of FGM is largely described in the study as complementary or supportive. Many participants stated that fathers are only expected to support the decision of FGM by paying the cost or agreeing on the type to be performed or the time of performing it.

“The decision is taken by the women, the decision is either from the mothers or the grandmother, but men are only complementary.”

(urban, married man)

“I told him that I want to circumcise the girl, and he had to pay only.”

(rural, married woman)

Many of the study participants stated that men are often consulted in the type of FGM to be performed, and that the majority of them prefer to choose Type I, which is widely referred to as ‘sunna’. Participants tend to believe that men choose the Type I/‘sunna’ type as it is widely perceived to be the type approved by Prophet Mohammed.

“He wouldn’t say something [against FGM]. He did not say this or that because it is our custom and it is sunna.”

(rural, married woman)



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“He had a role, to determine the place of circumcision either at home or in the midwife’s house. He was involved in the discussion.”

(rural, young, unmarried man)

“Our men decide the type of circumcision; they asked us to circumcise sunna.”

(rural, married woman)

These findings are confirmed by a recent cross-sectional household survey conducted in Khartoum and Gedaref States, which concluded that 21 per cent of fathers and 2 per cent of uncles were involved in the discussions on type of circumcision to be performed.¹⁶¹

Further, the role of men was largely framed by study participants as supporters of the decision not to perform FGM when taken rather than being the initiators of such a decision. They stated that men often shy away from standing against traditions out of fear of being stigmatized or losing their social status within the community.

“Yes sure, because these are customs and norms, and when you stand against them, they consider you changed after you study and deny your people [and roots], and you become socially isolated.”

(rural, highly educated, father)

“No one talks to you directly, but he knows that people talk about his girls and may call them names [curse them].”

(rural, young, unmarried man)

“Parents are responsible, but there are customs and norms and social obligations. If you abandon them in one day, they will consider you as outsiders.”

(rural, married man)

During his interview, a religious leader who holds anti-FGM views stated that he would not loudly voice his opinion so as not to compromise his credibility at the community level.

“I’m an Imam at the mosque, but I cannot talk about this issue (FGM), because the community does not accept speaking about such an issue.”

(urban, married father)

Still, study participants confirmed that only men could take the decision not to perform FGM and stand against elderly in the family, freeing women from the responsibility of carrying on traditions. Some of the female study participants mentioned that when they decided not to circumcise their daughter they had to get their husbands’ approval.

“It’s very common to hear the grandmothers talking to the fathers [to convince them that it has no harm]. [They say] we are in front of you to show what happened to us [it did not affect us].”

(rural, married woman)

“Most people who abandon circumcision do so because of men’s decision to abandon.”

(rural, married woman)

“A man’s role is very influential, because he can punish the woman either by divorce or marry another one, or cut her off from money.”

(rural, female midwife)

Experts and NGO representatives who are working in the field of social protection and advocacy to end FGM mentioned that men are very influential in the decision-making and could, if they choose, play a very strong role in ending FGM, in which they as decision makers are able to stop the practice among their daughters and sometimes their relatives.

In conclusion, the study discussions described men's role in the decision-making of FGM is being conditioned by several determinants, such as the pressure of social norms including family pressure especially from elderly relatives, men's level of education and the nature of their work. However, it is widely agreed by study participants that FGM is most likely not to happen if men support the decision of not circumcising their daughters and that they can play an instrumental role in ending the practice. This conclusion is supported by findings from other studies.¹⁶²

EFFECTIVE MALE ENGAGEMENT IN ANTI-FGM INTERVENTIONS: OPPORTUNITIES AND CHALLENGES

Key informants from community NGOs who were interviewed stated that men were effectively engaged in FGM prevention, being facilitators during community dialogues as well as members of community-based protection groups. Men are also involved as messengers in early warning systems that are responsible for reporting the midwives who practice FGM to support the reporting system in the Ministry of Health, and now to support implementation of Article 141 which criminalizes the practice of FGM.

“Yes, in my niece’s circumcision, I told them that there is a law that criminalizes FGM.”

(young rural man)

Another early warning system that can engage men in FGM prevention is led by UNICEF's Sudan Country Office in partnership with Entishar, a local NGO. The purpose is to establish a community-based risk-mapping mechanism, currently being implemented in 10 communities, which aims at reporting cases of girls at risk of FGM. When

cases are reported, they are referred to a local intervention taskforce that responds to prevent FGM. The local intervention taskforce consists of three system reporters and three community leaders in each community.

“We have two messengers in each community, one man and one woman, and also we have men in a local intervention task force, and system reporters.”

(representative of NGO)

Engaging men in anti-FGM activities in Sudan is challenging, as older men consider themselves as the protectors of social norms and culture and are resistant to any change, while younger men who are more open to change find it difficult to challenge and confront elderly in the community.

“Although youth are much easier to change, community influencers (mostly elders) have a higher impact in the community.”

(rural, member of Y-Peer network, young man)

FGM is widely perceived as a 'women's issue' in both rural and urban areas, and efforts to engage men in the decision-making can be resisted by women, and might subject men to wide community critiques.

“Men consider FGM as women’s issue and they have no relation with it.”

(representative of an NGO)

Most community key informants interviewed stated that men are mostly not interested or motivated to attend FGM-related activities. They added that they rarely managed to plan an activity to capture their attention and motivation, especially the elder ones, and thus there is always gender imbalance in FGM-related community functions.

“Bad planning creates weakness in engaging men in FGM”

(government official)

According to study participants, the strong link established between FGM and religion makes it challenging to talk or involve men in anti-FGM activities, as they could be stigmatized when seen as opposing their religion.

“Perceptions toward FGM – especially related to religion – make it hard to convince them to abandon the practice and stigmatize those who talk about it.”

(representative of UN agency)

Some participants, especially in the rural areas, indicated that the belief communities will not accept uncircumcised girls and that uncircumcised girls will find it difficult to get married, is one of the main reasons that fathers do not oppose the practice of FGM.

“Men refuse to marry an uncircumcised girl.”

(rural, unmarried, young man)

RECOMMENDATIONS

Discuss **FGM among community members as a violation of rights** by explaining the harms inflicted on girls and women and the long-term consequences as a result of the practice. Further, debate the relationship between gender inequality and FGM so it can increasingly be recognized as a form of gender-based violence (GBV).

Stress the importance of **open communication between husbands and wives** around issues of sexuality, sexual pleasure and FGM in relation to greater enjoyment of the marital relationship. This will ensure the flow of knowledge, reduce the dangerous silence around FGM within many families and encourage men to be more involved in ending FGM.

Shift concepts of fatherhood among study participants. Many stated that they are involved or

would like to be more involved in the lives of their children, which offers a pathway for engaging men in standing against FGM. Therefore, messages should focus on positive fatherhood in association to ending FGM. However, these messages should be framed in the wider context of gender equality within the family, that is, improving family communications and joint couple decision-making, rather than developing messages focused on protection, where father protecting their daughters from FGM contribute to reinforcement of the gender-inequitable power structure.

Develop **different messages for different men’s groups and ages**. It is essential to apply concepts of intersectionality when developing and examining FGM messages targeting men. For example, messages developed for older married men should be different from the ones directed to young married men, and different from those directed to young unmarried men. The messaging should take into consideration social class, education and geographical settings. The fieldwork showed that older men have more influence than younger men when it comes to opposing family decisions about FGM, and this should be reflected in messaging.

Religious messages are very influential in all men’s groups, especially with the older generation. These messages can encourage older men to stop and end FGM within their families, and create pressure on their sons to stop circumcising their daughters. However, due to the unified position of religious leaders on the position of Islam regarding FGM, it is recommended to use simple and straightforward messages that address the relationship between FGM and religion, such as, “FGM is a cultural practice that existed before Islam”, or “In many practicing countries FGM is practiced by both Muslims and Christians” or “FGM is not practiced in many Muslim countries, including Saudi Arabia”.

Shift the focus away from the physical harms such as bleeding, infection and infertility and towards emotional and sexual consequences, mistrust, trauma or shame. Health messages are very influential across all age groups; however, there is a risk that increased health messages can contribute to the medicalization of the practice. Focus messages on sexual pleasure and satisfaction in relation to FGM.

Develop **specific messages to address and condemn the medicalization of the practice.**

Messages should clearly implicate health practitioners, whether midwives, nurses or doctors, who are violating girls' and women's bodily rights, which is not in accordance with their ethical medical code.

Anti-medicalization messages should also stress that the medicalization of FGM does not ensure freedom from complications. Messages, especially directed to men and religious leaders should explicitly mention that all types of FGM including Type I, or what they call 'sunna', will not prevent the negative consequences of FGM and especially the emotional and sexual effects. **Messages regarding family planning, maternal health and other areas of health can also integrate content on FGM.**

Rely on **'community conversations' rather than the didactic, information-based health-heavy approach** that has been most common. Being aware of the negative health consequences of FGM does not seem to lead to abandonment. Instead, knowledge

of the harms has been noted to contribute to the medicalization of the practice and a measurable shift from the 'severe' Type III pharaonic to the Type I 'sunna' circumcision, which is perceived to be 'less harmful or 'not harmful'. Although not frequently perceived as a religious duty, the religious connotations in the use of the term 'sunna' (meaning 'Prophetic traditions' in Islam) may play an important function in disguising the main intention behind the practice, and work to normalize it.

Use a **gender-transformative approach to end FGM.** FGM interventions and programmes should challenge gendered social norms that support the regulation of women's sexuality and tighten these norms to concepts of masculinity and family honour. This requires designing interventions that empower girls by building girls' and women's agency. Design and organize sustained dialogues with parents, communities and gatekeepers debating concepts of masculinity and gendered power structure. Support girls' education, and ensure access to sexual and reproductive health services and justice in these messages to combat FGM.



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ENDING FGM IN YEMEN: DISTANCING FGM FROM RELIGIOUS DISCOURSE AND TERMINOLOGY

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.¹⁶³ 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.¹⁶⁴

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.¹⁶⁵ The YDHS data also collected information on attitudes toward FGM.¹⁶⁶ 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.¹⁶⁷

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.¹⁶⁸ A draft law entitled the 'Protection of Women Act' has been developed and is pending approval from parliament as of October 2022.^{169, 170}

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".¹⁷¹

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.¹⁷² 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".¹⁷³

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](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.¹⁷⁴ 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.



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“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.¹⁷⁵ 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,¹⁷⁶ 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.¹⁷⁷

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.¹⁷⁸

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.



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“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.¹⁷⁹ 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,¹⁸⁰ 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”.¹⁸¹

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.¹⁸² 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.¹⁸³ 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



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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).¹⁸⁴

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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