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Key points for abolishing Female Genital Mutilation from the perspective of the men involved

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ABSTRACT

Introduction: female Genital Mutilation is internationally considered an affront on human rights and an act of violence against women and young girls. Furthermore, it hierarchises and perpetuates inequality and denies the right to bodily and psychosocial integrity of women and young girls.
Aims: to detect the key points for the abolition of Female Genital Mutilation as well as the necessary resources for its eradication.
Material and Method: a qualitative methodology with an ethnonursing perspective, via semi-structured interviews, held both individually and in groups, in 21 men familiar with Female Genital Mutilation.
Findings: through the voices of men familiar with this tradition, five key points are presented for its gradual eradication: sensitisation and awareness building, team action, abolition-promoting media, focusing action on rural areas and applying educational means before punitive ones.
Conclusion and practical implications: awareness-raising via the combined efforts of families, communities and governments, together with the promotion of health education programmes in demonstrating the complications derived from this practice, play a vital part in eradicating Female Genital Mutilation.

Introduction

Female Genital Mutilation (FGM) is defined by the World Health Organization (OMS, 2012) as '*all procedures involving partial or total removal of the external female genital organs or other injury to the female genital organs for non-medical reasons*' . The majority of these procedures are performed in precarious and unhygienic conditions (Royal College of Obstetricians and Gynaecologists, 2009) and as such can cause a wide range of complications in several health-related areas: physical, obstetrico-gynaecological, sexuality, psychological and social (Jiménez Ruiz et al., 2012)

According to data from UNICEF (2013), it affects a population of approximately 125 million women and girls worldwide, and 30 million girls less than 14 years of age are at risk every year. Furthermore, data from Amnistía Internacional (1998) and UNICEF (2013) point to between two and three million women and girls being denied their rights as a result of this practice every year, which translates to 8219 women and girls becoming victims of FGM every day.

FGM is performed mainly in 29 countries of Sub-Saharan Africa, as well as in Yemen, Iraq, Malaysia, Indonesia and certain ethnic groups in South America (UNICEF, 2013), however, current globalisation and migratory phenomena mean that cases are being seen throughout the entire industrialised world (Grande Gascón et al., 2013).

It should be highlighted that health-care services are in the best position to detect, diagnose and prevent FGM due to their close contact with families and ongoing care of young girls over their developing stages (UNAF, 2013). Furthermore, nursing and more precisely obstetrics and gynaecological professionals, being health-care occupations based on respect for human rights, should play an active part in research and preventative efforts against harmful practices imposed on women's health (Affara, 2002).

Aims

To detect the key points for the abolition of Female Genital Mutilation, as well as the necessary resources for its eradication.

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Material and method

The present study is based on a qualitative methodology, with an ethnomethodological focus. This approach, in addition to being pertinent in as much as documenting knowledge and opinions regarding values and beliefs which might interfere with cultural care and the state of health of those performing cultural care, is the fundamental basis underlying ethnonursing as established by Madeleine Leininger.

Study population

A total of 21 men from Mali, Senegal, Republic of Chad, Djibouti, Niger and Ghana who met the inclusion criteria (Table 1), participated in this study. Amongst these, participants both in favour and against FGM were included (Table 2).

Regarding sample selection, the use of a triple purposive sampling method was applied based on the strict definition of the theoretical criteria expressed in Table 1. Previously, participants were incorporated via a snowball sampling method until theoretical saturation or data redundancy was reached.

The sample configuration was structured according to the three sampling criteria:

Firstly, 15 individual semi-structured interviews were held with members of the population originally from countries where this practice is common and who now live in the region of Murcia (Spain). Access to this initial population was made via a midwife from the Torres de Cotillas Health-care Centre (Murcia). It should be highlighted that five interviews from this first sampling process were excluded from the final sample as two of the men decided not to continue with the study after being interviewed, another two considered their participation was not appropriate given they were against the study being performed and one of the interviews was discarded due to patent indications that the truth was not being told by the interviewee.

Regarding the second sampling procedure, this took place in eastern Morocco, with a total of six semi-structured interviews being performed on scholarship students from Chad and Djibouti. Access to this population was possible thanks to the contacts established via the NGO 'Enfermeras para el Mundo'.

The final five participants were interviewed in three groups. Access was via the NGO 'Murcia Acoge' with the help of a facilitator. In this case, groups of four, three and two men were formed, although three participants were excluded for not fulfilling the inclusion criteria described in Table 1.

Instruments utilised

The instruments utilised in order to meet the objectives were documentary analysis, informal conversations, semi-structured interviews and semi-structured group interviews. Table 3 provides a detailed description about the interviews and their characteristics.

The interviews were recorded in audio format, transcribed and analysed both on paper and via the Atlas Ti7 software.

Table 2
Participant profiles.

Code	Country of origin	Age	Position
IMGF.1	Senegal	47	Against
IMGF. 2	Mali	34	In favour
PMGF.1	Mali	25	In favour
PMGF.2	Mali	42	In favour
PMGF.3	Mali	35	In favour
PMGF.4	Senegal	43	Against
PMGF.5	Senegal	41	In favour
PMGF.6	Senegal	20	In favour
PMGF.7	Senegal	29	In favour
PMGF.8	Senegal	51	Against
PMGF.9	Chad	24	Against
PMGF.10	Djibouti	21	In favour
PMGF.11	Djibouti	30	In favour
PMGF.12	Djibouti	22	In favour
PMGF.13	Djibouti	21	Against
PMGF.14	Chad	27	In favour
GMGF.4	Mali	53	In favour
GMGF.5	Niger	33	Against
GMGF.6	Ghana	38	In favour
GMGF.8	Senegal	48	Against
GMGF.9	Ghana	38	Against

Table 1
Inclusion criteria.

Data gathering techniques	Inclusion criteria
Informal Conversations	No inclusion criteria.
1st Semi-structured individual Interviews	Male gender. Living in Spain. Originally from countries where FGM is performed. Having lived at least until 18 years of age in their country of origin.[1] Having personally been in contact with women who had undergone FGM. Comprehending the Spanish language, or in the presence of a translator during the interview.
2nd Semi-structured individual Interviews	Male gender. Living outside Spain. Originally from countries where FGM is performed. Having lived at least until 18 years of age in their country of origin.[1] Having personally been in contact with women who had undergone FGM. Comprehending the Spanish or French language, or in the presence of a translator during the interview.
Group Interviews	Male gender. Living in Spain. Originally from African countries with a Muslim majority. Having lived at least until 18 years of age in their country of origin.[1] Familiar with FGM. Comprehending the Spanish language, or in the presence of a translator during the interview.

[*] This inclusion criterion was included due to the need for participants to have been exposed to the problem long enough so as to be able to divulge relevant knowledge of the issue.