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Male complications of female genital mutilation

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Abstract

Female genital mutilation (FGM) is known to cause a wide range of immediate and long-term complications for women subjected to the practice. Male complications due to FGM have, however, not been described before. The objectives of this study were to explore male complications and attitudes with regard to FGM. A village in the Gezira Scheme along the Blue Nile in Sudan constituted the basis of the study. Interviews were carried out according to a pre-tested questionnaire, using structured questions with open-answer possibilities. Married men of the youngest parental generation and grandfathers were randomly selected from up-to-date election lists. All respondents except one agreed to be interviewed. A total of 59 men were interviewed, 29 young men and 30 grandfathers. Male complications resulting from FGM, such as difficulty in penetration, wounds/infections on the penis and psychological problems were described by a majority of the men. Most men were also aware of the female complications. More young than old respondents would have accepted a woman without FGM to become their daughter-in-law ($p<0.03$). A majority of the young men would have preferred to marry a woman without FGM. This proportion was significantly higher than among the grandfathers ($p<0.01$). Female genital mutilation can no longer be considered to be only an issue for women. The acknowledged male complications and attitudes described may open new possibilities to counteract the practice of FGM.

Keywords: Female genital mutilation; Female circumcision; Male complications; Male attitudes; Sudan

Introduction

Female genital mutilation (FGM) has been performed on about 120 million currently living girls and women around the world and another two million are at risk to undergo FGM every year (UNFPA, 1997). A WHO classification recognises three degrees of severity of FGM: clitoridectomy (the removal of the clitoris or other procedures affecting only the clitoris), intermediate forms (in practice a wide range of different forms between clitoridectomy and infibulation), and infibulation (when the clitoris is removed together with the labiae minora and majora to create raw surfaces which are brought together leaving only a very narrow opening) (World Health Organization, 1996). Other terms, such as excision, are sometimes mentioned in the literature. De-fibulation is the procedure when the tight infibulation covering the urethral and vaginal orifices is cut open. A secondary form of FGM is re-infibulation, performed on infibulated women who have given birth, are widowed or divorced, to recreate the narrow vulva of a virgin (Sami, 1986).

In northern Sudan, more than 90% of the women have undergone FGM (El Dareer, 1983a), and in most

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cases it has been infibulation (El Dareer, 1983b), the most severe form. There is a wide range of well-known immediate and long-term complications of FGM for the women subjected to the practice. To our knowledge there are, however, no studies describing male complications of FGM. If men recognise male complications of FGM, such a recognition would presumably affect their attitudes and preferences.

Motives for performing FGM are often expressed as religious, though neither the Koran nor the Bible mention it (El Dareer, 1983b; Abu-Sahlieh, 1994). Others claim female identity, tradition, hygiene and increased fertility (Dirie & Lindmark, 1991), or future marriage (UNFPA, 1997; WHO, 1986; Baker, Gilson, Vill, & Curet, 1993) as motives for FGM. It has been stated that, in most regions where FGM is practised men may refuse to marry a woman who has not undergone FGM (UNFPA, 1997). FGM is here often seen as evidence of virginity and dignity. Sudanese researchers have stated that FGM in Sudan is perpetuated by women and approved by men as a means of controlling female sexuality (Sami, 1986). In Eritrea, men may play a more active role. Among Eritrean mothers whose girls had undergone FGM, 28% said that their father had taken the initiative and 45% stated that their grandparents, particularly the grandfathers, or community leaders had taken the initiative in having the procedures performed (Davis, Ellis, Hibbert, Perrez, & Zimbelman, 1999). In a study from Ethiopia (Missailidis & Gebre-Medhin, 2000), the women believed the practice to be fully supported by men. They also thought that men preferred marrying women who had undergone FGM because the women would then not be sexually overactive and unfaithful. It was concluded that if men openly stated a preference to marry non-circumcised women, FGM would probably cease, since the tradition per se did not carry any value to women. The men were, however, not interviewed. This shows the importance not only of male attitudes towards the practice but also of asking men directly about their experiences, attitudes and preferences.

The aim of this study was to elucidate complications of and attitudes towards FGM among married men of the youngest parental generation, who are in the position of having to choose whether their daughter should undergo FGM or not, and among the generation of grandfathers in a rural area of Sudan.

Subjects and methods

Contacts with the villagers were made through a development project, the Sudan Village Concept Project (SVCP). This project had been working in villages in the Gezira scheme along the Blue Nile since 1994. As a part of the methodology the interviewers should live in the study village during the period the interviews were performed. This was possible only in one of the villages where the project owned a house. Hence this village constituted the basis of this study. According to the SVCP base-line survey there were about 3600 inhabitants in the study village. It was estimated that 50% were under 15 years of age. Many of the male inhabitants did not live in the village at the time of the study. Lack of work opportunities made men move to cities to be able to earn enough money to support their families. This resulted in about 70% of the villagers being women. All inhabitants in the village were Muslims. Most of the families in the village had lived there since they settled in the 1920s. There were no displaced people or refugees in the village.

Two groups of villagers were interviewed: grandfathers and married men under 35 years of age, or older if their oldest child was less than 4 years old. The age limit for the young group was established considering that people marry relatively late in this part of Sudan and that FGM is generally not performed before 5 years of age in this area.

Thirty grandfathers were randomly selected from election lists from 1996 that had been up-dated before the study. All men present in the village and fitting the criteria for the group of young married men were selected, resulting in 29 young married men. All asked to take part in the interviews accepted, except for one old man. Another grandfather was randomly chosen from the election lists to replace him.

The interviews were carried out according to questionnaires with fixed questions and open-answer possibilities. The questionnaires were pre-tested on medical students in Khartoum.

The interviews were carried out at the respondents' home between 25 March and 8 May 1997. Confidentiality was guaranteed before the start of each interview. All interviews were carried out by the first author and a male translator. Three male Sudanese medical students translated. All were known in the village from previous work in the development project.

Chi-square tests were used for the statistical calculations with a value corresponding to $p<0.05$ for significance where not stated differently.

Results

The median age for the young men was 35 (range 26–43) and for the grandfathers 65 (range 50–82). The median age of the oldest child was 3 years for the young men (range 0–15). Two young men had not yet had any children. The level of education in the different groups is shown in Table 1.

Female and male complications of FGM

Most respondents (90% of the young men and 70% of the grandfathers) believed that FGM affects women's health. Level of education seemed to play an important role. Among the young men, the few who denied health effects of FGM ($n=3$) had only been to primary school. All those answering that FGM influences health gave examples of female complications (Table 2). Nobody mentioned positive health effects.

When asked whether men face any problems because of FGM, 63% of all respondents (72% of the young men and 53% of the grandfathers) replied in the affirmative. Those admitting problems were then asked to specify what kind of problems men face because of FGM. The answers to this open question are listed in Table 3.

Attitudes towards women who have not undergone FGM

In answer to the question of what people would think about a Sudanese woman in the village who had not undergone FGM, most of the interviewed men thought that it would be socially very difficult for her. On the other hand, 24% thought that it would be no problem at all (Table 4).

All men were married to women who had undergone infibulation, except one young man whose wife had had a clitoridectomy. Eighty-six percent of young men would have accepted a woman without FGM to be his son's or grandson's wife compared to 57% of old men ($p<0.03$).

The respondents were asked if they would have preferred to marry a woman who had undergone FGM or a woman who had not, 55% of the young men would have preferred to marry a woman who had not undergone FGM, compared to 13% of the grandfathers ($p<0.01$), while 35% of the young men and 80% of the grandfathers preferred to marry a woman who

Table 1
Level of education (highest level attended) in the different groups

	Young men $n=29$	Grandfathers $n=30$
Illiterate	—	5
Koran school	—	17
Primary school	7	4
Intermediate school	4	3
Secondary school	12	—
University	6	1

Table 2
Alleged health consequences of FGM expressed by young and old men

Health effects of FGM	Young men $n=26$	Grandfathers $n=21$
Difficult deliveries	20	11
Infections/inflammations/diseases	11	5
Difficulties/suffer by sexual intercourse/decreased libido	9	4
Menstrual problems	4	2
Bleeding and suffering during the operation	6	7
Might cause death	3	4
Infertility	2	—
Abortions	2	1
Psychological problems	1	2
Difficult pregnancies	1	1
Changes God's creation	—	1
Can't keep clean	—	1
Unspecified	2	4

Table 3
Male problems from FGM expressed by young and old male villagers

Male problems from FGM	Young men $n=21$	Grandfathers $n=16$
Difficulties to penetrate	18	16
Wounds/bleeding/inflammation on penis	6	4
Psychological problems	3	1
He hurts his wife/she suffers	3	3
Decreased sexual desire and enjoyment for the woman	3	—
Economical problems (costs for medical care)	2	—
Problems after re-infibulation	2	—

Table 4
Attitudes the individuals interviewed thought people would have towards a village woman without FGM

	Young men $n=29$	Grandfathers $n=30$
Shame/socially unacceptable/ people turn away/insult her	17	19
No problem nowadays/people wouldn't care/know	7	7
Nobody would marry her/reason for divorce	4	6
Blame parents for not caring enough for their daughter	—	4
Depends on level of knowledge/ education/age	4	1
Lost part of her religion	—	2
Not correct way according to tradition	1	—
No complete woman	—	1
Doesn't exist/couldn't imagine	—	1

Table 5
Reasons for preferring to marry a woman who has undergone FGM

	Young men $n=10$	Grandfathers $n=24$
To be socially accepted	2	9
Tradition	4	4
Religious	2	5
Non-circumcised has too much sexual desire	2	1
No choice	—	3
Good for him	—	3
To be sure that she is a virgin	1	1
Good for her	—	1
Good for both	—	1
Clitoridectomy to avoid complications of infibulation	1	—
No knowledge about different forms	1	—
Unspecified	—	1

Table 6
Reasons for preferring to marry a woman who has not undergone FGM

	Young men $n=16$	Grandfathers $n=4$
Avoid problems of delivery	11	1
More sexual enjoyment/avoid suffering during sex	7	1
Because of the suffering a circumcised woman has to face	3	2
Wants her to be as she was created	1	—
Avoid costs for medical care	1	—
Unspecified	1	1

had undergone FGM. The rest did not know or did not care. There was no difference related to level of education in the young group. Reasons mentioned for preferring a woman who had or had not undergone FGM are listed in Tables 5 and 6, respectively. Of the men who preferred to have a wife who had undergone FGM, two-thirds would want the FGM to have been a clitoridectomy and only one-third wished for infibulation.

Discussion

Female genital mutilation is a sensitive subject both for the respondent and the interviewer. Thus, it is not strange that other studies have had problems with respondents unwilling to take part in the interviews or unwilling to answer particular questions (El Dareer, 1983a; Samia El Hadi Nagar, Sunita Pitamber, & Ikhlas Nouh, 1994). Therefore, it is remarkable that only one out of 60 eligible men was unwilling to participate in this study and that the respondents spoke openly about different aspects concerning FGM and sexuality. The fact that we tried to avoid being considered as strangers by living in the village and our connection to the development project, may have made the villagers more willing to participate fully in the interviews. This connection might also have influenced the answers in other ways. Since the village had been part of a development project, it is possible that the men there were more receptive to ideas about the negative impact of FGM on health and marriage than men in Sudan generally are.

Representation of population sample

By our living in the village, it was important for us to take precautions to avoid contamination of the results. Thus, the research team stayed in a house belonging to the development project to avoid being associated with certain villagers. The older respondents were randomly selected, and all the younger fitting the selection criteria were interviewed. None of the respondents was acquainted to the interviewers. The young men were about the same age as the interviewers and might have answered what they thought were appropriate answers. To avoid bias, open questions where the respondents had to name — for instance — complications themselves were used to motivate their answers.

It may be argued that the sample is not representative, since many young males had left the village. However, this out-migration is not a permanent but rather a dynamic situation where the young men stay for periods in cities to earn money but return to their families in the village in between these periods. This was true also for most men participating in the study: they happened to be at home when the survey was undertaken. Thus, one can presume that the men taking part in the study do not differ very much from those being away.

The whole of the village population at the time of the study is thought to be representative for a village in this area. The village is, however, not representative for Sudan as a whole. The socio-economic conditions in this area are presumably better than in many other regions in Sudan, and the level of education for the young men is probably higher than average. It might not be possible to generalise our results, but the study reveals new remarkable findings that should be explored in other areas and points to an approach that might be applicable and useful in other areas where FGM is prevalent.

Complications

There was a high level of awareness, especially in the young group, that FGM influences women's health

negatively. It is remarkable that a majority of the grandfathers also answered that FGM affects health negatively. These results differ from other studies performed in Sudan (El Dareer, 1983a; Samia et al., 1994). Still, in this study the respondents had to name the complications themselves and could not choose from a list with enumerated complications. The complications mentioned cover almost all those related to FGM in the literature, which indicates a high level of knowledge among the respondents.

Different aspects of sexuality turned out to be a central issue. Sexual problems for women attributable to infibulation have been recognised previously in the literature (El Dareer, 1983b; Abdalla, 1982; Hosken, 1993). Often the male dimensions of FGM in general and the sexual aspects in particular are not mentioned. In this study, almost two out of three men — but especially the young men — admitted male sexual complications related to genital mutilation of women. In previous studies sexual aspects have been limited to include almost only male satisfaction (Lightfoot-Klein, 1989; Gruenbaum, 1991), or FGM as a means of controlling female sexuality (WHO, 1986; Dorkenoo, 1994; Toubia, 1994). The results of this study indicate that the focus should be on sexual problems for both men and women due to FGM rather than on male satisfaction. The fact that the wife is suffering during sexual intercourse affects sexual satisfaction negatively for the man. Our finding that men experience their wives' suffering as their own problem merits attention, since other authors like El Dareer (1982) have argued that men let their wives suffer in order to enjoy sex more themselves. One of our respondents (age 34) said:

"I discovered the first night that my wife had a big cyst. She has undergone several operations and suffered from recurrent infections during many years. Sexual intercourse is problematic. I am afraid she will stop loving me if only I reach climax and I can't satisfy her."

Marriageability

The significant difference between the young men and the grandfathers in which woman they would have preferred to marry shows that attitudes towards women without FGM have changed dramatically and rapidly.

Several studies have mentioned marriageability as one of the main reasons for performing FGM (UNFPA, 1997; WHO, 1986; Baker et al., 1993; Gruenbaum, 1991). In this study most young men answered that they would have preferred to marry a woman without FGM (some frankly giving "more sexual satisfaction" as a motive for this), in spite of the fact that all of them reported being married to women who had undergone FGM. No man mentioned more sexual satisfaction as a reason for preferring a wife with FGM. The answer "good for him" can possibly be interpreted as "good for his sexual satisfaction," but only old men answered so. The tight opening created when performing infibulation and re-infibulation after delivery is thought to increase sexual satisfaction for men. However, a majority of those wanting a wife with FGM preferred clitoridectomy to infibulation.

The authors of a recently published study from Ethiopia (Missailidis & Gebre-Medhin, 2000) conclude that men still seem to prefer marriage to circumcised women. It is important to note that this is the presumed preference, since only women were interviewed. This mistake is often repeated. To understand the role of men in FGM, the men have to be addressed directly, preferably by men. Otherwise' a vicious circle of false expectations could be perpetuated.

Social pressure

For the men the main motives for preferring a wife who had not undergone FGM were to facilitate delivery and to be able to enjoy sex more. For those who preferred a wife who had undergone FGM the main motives were social acceptance, followed by tradition. This shows that social pressure is of great importance for the men. The common answer "to be socially accepted" has to do with the importance of being respected and to become married to a "decent" woman. The Sudanese expression "Rhalfa" ("child of an uncircumcised woman") is extremely insulting to use. As in many other African–Arab cultures the purity and chastity (linked to the virginity) of the woman reflect the moral quality of the entire family. This makes our findings that so many young men would have preferred a wife who had not undergone FGM even more interesting. It suggests not only that the attitudes of men have changed, but also that there is a change in attitudes in the whole society. This is supported by the fact that other studies in Sudan have noticed similar changes in attitudes. A large study in Northern Sudan (El Dareer, 1983b) showed that the younger and/or better educated people tended to oppose the practice or favour milder forms, which indicated a change of attitudes among these groups. Other Sudanese studies have shown an emerging questioning of the value of the practice (Cederblad & Rahim, 1986) and intergenerational differences of opinions about FGM (Gruenbaum, 1991).

A change in attitude can be the first step towards a change in practice. One of our respondents (grandfather, age 62) bore evidence of such a change. Of his nine daughters (age 10–40), the three youngest had not undergone any form of FGM. Many young respondents told of young families having the ambition not to let their daughters undergo FGM. It was, however, not easy to withstand the pressure from the grandmothers,

and there were several stories of girls taken away by their grand-mother to have it done. The change in attitudes is evident, and it would be interesting to follow up how this affects the practice.

Conclusion

FGM can no longer be considered to be only a matter for women. By exposing male complications to the practice, and attitudes and preferences strikingly different from what might be expected according to the literature, the findings draw attention to the importance of addressing men in future research about and campaigns against FGM. Some may argue that the male complications are only minor ones compared to the suffering women have to face because of FGM. This is true, but the fact that they exist opens possible new ways to work against the practice, especially since marriageability and male satisfaction are often mentioned by women as motives for performing FGM.

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