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Female genital mutilation/cutting: a systematic review and meta-ethnography exploring women's views of why it exists and persists.

Wafa Elamin & Amanda J Mason-Jones

Abstract

Objectives: Despite well-documented negative consequences, female genital mutilation/cutting (FGM/C) continues to be widely practised. In this systematic review, we investigated women's views of why FGM/C exists and persists. *Methods:* A meta-ethnographic approach was used in this systematic review of qualitative research. *Results:* Twenty-seven studies were included in this review and they represented the views and experiences of 823 women. FGM/C was considered a 'rite of passage' which was enforced to curb the expression of their sexuality and maintain social and gender norms within its communities. Nevertheless, attitudes towards FGM/C were changing among migrant populations. *Conclusions:* Creating community awareness projects, enforcing strict laws coupled with increasing health professional involvement may reduce the incidence of FGM/C.

Background

Female genital mutilation/cutting (FGM/C), involves the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (World Health Organisation, 2008). The procedure is performed by traditional community practitioners or less commonly by health professionals (Litorp, Franck, & Almroth, 2008). More than 200 million girls and women are affected by FGM/C worldwide and an estimated 3 million girls are at risk of undergoing FGM/C every year (United Nations Children's Fund; 2016). The practice is prevalent in 30 countries across Africa, South Asia and the Middle East, especially in parts of Egypt, North Sudan, Somalia, Sierra Leone, Ethiopia, Eritrea and Yemen (United

Nations Children's Fund; 2016; United Nations Children's Fund & Gupta, 2013; Yoder, & Khan, 2008). In these countries, the practice has been declining gradually over the last 30 years, although this progress has not been uniform (Todkari, 2018). With continued international migration, countries with no previous cases of FGM/C have reported a rise in numbers among their population, because of the influx of new migrants (Werunga, Reimer-Kirkham, & Ewashen, 2016).

The WHO has grouped FGM/C into four different types (WHO, 2008). Type I, otherwise known as clitoridectomy, involves the partial or complete removal of the clitoris. Type II involves the partial or complete removal of both the clitoris and the labia minora. Type III, otherwise known as infibulation, involves the removal of the external genitalia with the sealing of the vaginal opening using sutures. It is a radical form of FGM/C that leaves only a small opening for the passage of urine and menstrual blood. Type IV FGM/C encompasses all other forms of genital mutilation or manipulation. This includes, but is not limited to, pricking and piercing of the female external genital, stretching of the labia or the use of corrosives to tighten the vaginal opening (WHO, 2008).

The negative health consequences of FGM/C are well documented (Berg, Underland, Odgaard-Jensen, Fretheim & Vist, 2014). The practice is extremely painful as it is generally performed without anaesthetics (United Nations Children's Fund & Gupta, 2013). When performed in unhygienic settings, wound contamination can also result in abscesses, ulcers, or gangrene of the scar tissue (Berg et al., 2014). The complications of FGM/C continue into adulthood and affect women's sexual, reproductive and mental health. Severe forms of FGM/C may require surgical intervention during labour as the scar tissue often needs to be reopened to facilitate childbirth (WHO, 2008). FGM/C is also known to cause sexual dysfunction among women and to restrict their socio-sexual orientation (Onyishi, Prokop, Okafor, & Pham, 2016). Despite the suffering experienced by women; the practice persists.

FGM/C has received worldwide attention in recent decades. The word "mutilation" was first coined in the 1990s to emphasise the gravity of the practice. However, many find this problematic and prefer to use the terms 'female circumcision' or 'female cutting' as these don't carry the same negative or judgemental connotation (United Nations Children's Fund; 2016). For this review, the practice will be referred to as female genital mutilation/cutting (FGM/C) as both terms are used in the literature.

Studies have highlighted the social and cultural importance of FGM/C (Efferson, Vogt, Elhadi, Ahmed, & Fehr, 2015). Public health campaigns that aim to stop the practice have been challenged and met with resistance. A systematic review of qualitative research was undertaken to explore women's views of FGM/C; to find out why it continues to exist, and to identify any changes in attitude towards the practice. A qualitative research method was chosen as it provides the opportunity for detailed contextual insight into the phenomenon and gives women who have experienced FGM/C a voice.

Methods

Search Strategy

An initial scoping review of the literature was undertaken to determine the breadth of evidence for the study and to determine keywords. From this, a preliminary search strategy was developed with assistance from an information search specialist. The initial search strategy was as follows: (genital mutilation or genital cutting or genital modification or genital excision or circumcision or FGM) AND (female or woman and women or girl*) AND (qualitative research or focused group discussions or FGD or interviews). This search strategy was piloted on two databases: EMBASE and Medline. It became apparent that using search terms that limited the study design restricted the number of available papers. Therefore, to be as inclusive as possible and to avoid missing critical papers, the study design was removed from the search.

The final search terms were combined as follows: (genital mutilation or genital cutting or genital modification or genital excision or circumcision or FGM)

AND (female or woman and women or girl*). The following electronic databases were used: EMBASE, Medline, Maternity and Infant Care, CINAHL, PsycINFO, African Index Medicus, and Social Sciences Citation Index. To identify grey literature, the Web of Science's Conference Proceedings Citation Index was searched. These databases were selected as they best represent research in medicine and social sciences. Additionally, the reference lists of previously published systematic reviews covering similar topics were hand searched for relevant studies.

Inclusion criteria

An inclusion criteria checklist was created to identify studies that were relevant to the review objectives. Eligible studies were primary qualitative studies published between January 2000 and August 2018, and which investigated the views and lived experiences of women with FGM/C. All four types of FGM/C were included in this review so as to capture the entire picture. Exclusion by type might have produced a fragmented and oversimplified picture. Papers that only studied the views of community members or male participants regarding FGM/C were excluded. Studies that also reported the views of other groups were accepted. However, only women's views were used in the review. Where papers incorporated quantitative data, only the qualitative components were considered. These decisions were made to ensure that the review remained focused (See Table 1). Peer-reviewed published studies, as well as grey literature, were accepted, but only studies written in English were included.

Quality Appraisal

To assess the quality of the included papers, the Critical Appraisal Skills Programme (CASP) appraisal checklist for systematic reviews was used (Singh, 2013). The CASP checklist has been used in other qualitative research (Brunton, Bower & Sanders, 2015). It is composed of 10 individual questions that, once analysed together, determine the quality of the entire paper. Although no quantifiable scoring system exits for the CASP checklist, the

researchers created one to aid in quality assessment in this review. This was guided by other research papers who used the tool effectively (Brunton, Bower & Sanders, 2015). Firstly, each individual question was scored (two for Yes, one for Can't Tell and zero for No). Then, the total scores of the 10 questions were added together to give a final score out of 20. Papers that scored between zero to six were low quality. Those that scored between seven to 13 were moderate quality papers while those that scored between 14 to 20 were high-quality papers. Both researchers appraised the quality of the included studies independently and a consensus was reached. Fifteen of the studies had high methodological quality while twelve were deemed to have moderate methodological quality. No study had low quality.

Data extraction

The RefWorks software was used to sort the references of collected papers. Data extraction was carried out manually using a pre-designed data extraction tool that was created using Microsoft Excel. The information gathered included study title, reference, and author, objectives, number of participants in the study, location of the study, age group of participants, type of FGM/C, key points and quotes from the study, emerging themes, as well as the author's comments and reflections. The characteristics of all included studies were summarised in a table (See Table 2).

Data synthesis

The meta-ethnography approach was employed as it enabled the researchers to develop a wider perspective while still maintaining the specificity of individual studies (Atkins et al, 2008). Initially, the 27 final studies were read multiple times in an iterative process. Key findings across the studies were identified and extracted manually onto Microsoft Word. These findings were coded using an inductive approach. Codes were examined multiple times by both researchers to determine their similarities and contradictions. They were then grouped together to give 'translations' or core themes. The translations represented a condensed summary of the twenty-seven studies. No single study incorporated all the themes (See Table 3). The final stage of meta-

ethnographic synthesis involved interpreting themes and producing a 'line of argument' (Atkins et al, 2008). For this systematic review, the 'line of argument' represented a broader understanding of why FGM/C exists.

Results

Study Selection

The search strategy resulted in 15,969 articles across the eight databases. Manual searching records produced 26 records. There were 6,423 duplicate records. After removing all duplicates, 9,572 titles and abstracts were screened against the review's inclusion criteria (See Table 1). 720 full titles were retrieved and read by both researchers independently to determine their final selection for the review. Discrepancies were resolved through rereading the publications, and discussions between the researchers. The authors of one paper were contacted to provide information about missing data. There were 693 articles excluded, leaving 27 studies that matched the inclusion criteria fully. These were included in the final analysis and synthesis. A PRISMA flowchart has been included (Moher et al.,2009) (See Figure 1).

The 27 studies represented over 823 women who had experienced varying degrees of FGM/C (Table 2). Nine studies included women living exclusively in Africa (Berggren et al., 2006b; Dotimi, 2016; Esho et al., 2017; Fahmy et al., 2010; Fried et al., 2013; Jirovsky, 2010; Parikh et al., 2018; Philips, 2016; Shell-Duncan et al., 2011) and 17 papers identified women living in Europe (Ahlberg et al., 2004; Berggren et al, 2006a; Gele et al, 2012; Johansen, 2016; Johnsdotter, 2003; Johnsdotter et al., 2009; Lundberg & Gerezgiher, 2008; Morison et al., 2004; Norman et al., 2009; Plugge et al., 2018; Safari, 2013) and the United States (Anuforo et al., 2004; Khaja et al., 2010; Upvall et al., 2009) and Australia (Guerin et al., 2006; Ogunsiji et al., 2010; Said, 2015). One study looked at participants living in Europe, USA and Australia and Sierra Leone (Kalokoh, 2017). The type of FGM/C that women experienced was reported in some studies (Table 3). Seven studies reported findings from women with

Type III only while one study reported findings from women with Type I. 11 studies didn't report on the type of FGM/C at all. The remaining eight studies reported findings from women with multiple types of FGM/C. The findings produced by the analysis are presented below with representative quotes from the original papers while the final line of argument is presented in the discussion section. A visual summary of the results is shown in Figure 2.

FGM/C as a rite of passage for girls

Women overwhelmingly reported that FGM/C was deeply embedded within their societies (Anuforo et al., 2004; Dotimi, 2017; Gele et al, 2012; Johnsdotter et al., 2009; Kalokoh, 2017; Lundberg & Gerezgiher, 2008; Morison et al., 2004; Norman, 2009; Said, 2015; Upvall et al., 2009). They described FGM/C as a rite of passage for young girls as it was said to "purify" them of their desire for sexual contact with men (Berggren et al, 2006b). One participant described it as a closed and sacred practice that brings the women together: "It's *a secret society. When they initiate female [genital mutilation] - It's an organization, a society".* (Kalokoh, 2017). But it had other social benefits for the young girls. Often girls were taken to the forest or the "bush" for up to a month where they were circumcised (Kalokoh, 2017). In the bush, they were also taught the basic responsibilities of becoming a woman within their culture:

> *"…the only importance about FGM is just the social interaction and the teaching, how they teach us how to take care of your household. How to behave as a woman. How to speak. How to compose yourself…"* (Kalokoh, 2017).

In this way, FGM/C defined gender norms within the communities that practised it and reinforced these norms from generation to generation. FGM/C, according to the respondents, allowed girls to integrate into their societies by forming new connections and amassing social capital:

> *Yes, [if you are circumcised,] you will have respect, you will know the eye. And it will make you be independent: because of the teachings you*

undergo during circumcision you will be able to stay anywhere. (Shell-Duncan et al., 2011)

FGM/C was so much a part of the local culture and the norm, some participants struggled to grasp why it was garnering negative international attention. For them, not upholding the tradition was an alien concept, especially since they assumed all women around the world practiced it: "*I think too much attention is paid to the subject. Half of the women in the world are circumcised."* (Berggren et al, 2006b). Without FGM/C, women faced exclusion from their communities. This had grave consequences for the women, who relied on their social networks to live fulfilled lives and to be recognised:

> *Circumcision is a traditional rite for all females who want to be recognized, because it is the cultural belief that an uncircumcised woman cannot partake in the ceremony that involves appeasing the gods of the land. She will not be welcomed among her fellow women and her child will be considered an outcast. The fear of being excommunicated or losing my baby and the gift they give during the ceremony made me to go for circumcision* (Dotimi, 2017)

This process was also seen as a joyous event and *"…in the village, people will be looking and listening for that time when they are called to witness the circumcision" (*Anuforo et al., 2004*).* The community members came together to celebrate the girl's ascent into womanhood:

> *"The woman who was just circumcised will be surrounded by these women wrapped in colorful wrappers. They will dance and eat for the entire seven days. The women will cook the food. The girl who is being circumcised is not allowed to do anything; rather, she remains in the company of the unmarried girls in that village but she is fed special food." (*Anuforo et al., 2004)

Women received gifts from their visitors and the atmosphere was reported to be festive and uplifting. The giving of gifts was commonplace and tended to

have great significance for the women: "*The gifts they usually give to the circumcised woman was what influenced me to be circumcised.*" (Dotimi, 2017). It was a time of celebration and many participants reported having positive memories of these events, especially regarding the teaching and community involvement. One participant, who had undergone Type III FGM/C, explained how:

> *"I'm still fascinated about and am still passionate about the culture. The dancing, the singing which I'm involved, that I'm a cultural dancer. I like to, you know, tell her about my culture. . . If we can just keep the culture and the teaching that they do, you know, trying to become a better wife, teach you how to cook, teach you how to clean up, those are really good. I mean, don't get me wrong, I love the culture. I love everything about the culture, because it is like raising a child to become a better person. Manners, they teach us manners and morals."* (Kalokoh, 2017)

While FGM/C was celebrated in a positive manner, one study highlighted that FGM/C was also reinforced in the community through negative stories of 'pollution' and 'hygiene'. Girls and women who were not circumcised were mocked about their personal hygiene: *"Some say that the girl who is not circumcised has a bad odour because she is not clean down there."* (Norman, 2009). This strategy ensured that those who didn't abide by the social norms remained as outcasts. Being outcast was an extremely unattractive position for women and one participant described how she willingly accepted to undergo FGM/C to avoid this fate:

> *I allowed myself to be circumcised because all females who are not circumcised will be excommunicated and stigmatized in the community. She will not partake in the age group meetings and she is treated as an outcast which keeps the uncircumcised female uncomfortable.* (Dotimi, 2017)

FGM/C was largely considered a rite of passage and studies showed that the practice persisted in an attempt to uphold gender norms and traditions. Two other interconnected themes also emerged from the women's narratives:

controlling female sexuality and their marriageability and attractiveness to males.

The importance of marriageability

Marriage was seen to be of paramount importance to those living within communities that practiced FGM/C as it was seen to offer financial and social security for women (Anuforo et al., 2004; Dotimi, 2017; Fahmy et al., 2010; Jirovsky, 2010; Kalokoh, 2017; Morison et al., 2004; Norman, 2009). FGM/C was thought to increase a girl's chance of finding a suitable husband and having a family. Within these societies, virgin girls were seen to be more desirable brides as they were considered "*good girls*" (Johnsdotter et al., 2009). Therefore, female circumcision was a prerequisite to marriage as it was thought to protect a young girl's virginity and *"…attract high bride-price for the girl at marriage…"* (Philips, 2016). As "*nobody wants a girl or a woman who isn't a virgin..."*, parents often felt obliged to circumcise their daughters to maintain their high social value (Johnsdotter et al., 2009). FGM/C would:

> "…*preserve their virginity to wait for their husbands…They will just stay focused with their deeds in school for doing something else until their time to get married arrives*". (Kalokoh, 2017).

Girls were encouraged to seek and welcome marriage as it was a pivotal point in their lives. Even female education was seen only to fill their time until they were ready to settle into married life. This belief was captured by the following quotation from one participant:

> *I was circumcised at the age of 18 years because I was told no man will marry me if I am not circumcised. They also said if I eventually get married, I will be unfaithful to my spouse. I had to do it because I want to be married and be faithful to my husband too.* (Dotimi, 2017).

Communities conflated female virginity with female circumcision. Virgin women were more desirable and as men had the upper hand in marital situations, they could return their brides if they believed they were not

circumcised. Parents went to great lengths to ensure that their sons-in-law were happy with their daughters:

> *"My niece had not been infibulated, because her body failed to stick together after several attempts. When the husband discovered during their first sexual intercourse that she was already open, he informed the family about it…The women explained that although she was open, she had never had sex. She was still a virgin. A deal was therefore made with the husband accepting to live with her."* (Ahlerg et al., 2004)

Controlling female sexuality

In the included studies, virginity was shown to be crucial for a girl's marriageability, and since marriage secures her social and financial standing, ensuring girls remained virgins became a priority. To make matters more problematic, girls were reported to have sexual needs surpassing those of their male counterparts and were seen to be sexually insatiable (Fahmy et al., 2010). Girls were likened to *"a restless bull"* and could *"reach orgasm while walking or even if someone holds their hand"* (Fahmy et al., 2010). If left unchecked, girls were reported to be *'… crazy about men, wanting sex with anyone…'* (Johansen, 2016) and have *"loose morals"* (Norman, 2009). The words "*running after boys"* were used on numerous occasions across different studies, highlighting a fear among both men and women in the localities practicing FGM/C that young girls were deemed sexually uncontrollable (Fahmy et al., 2010; Johnsdotter et al., 2009). The expression of female sexuality was overwhelmingly frowned upon and it was seen to be unacceptable for women to engage in sexual intimacy with men outside of a legal marital arrangement:

> *"Promiscuity is not acceptable for females in Nigeria. When a woman has a child out of wedlock, her chances of getting married to a suitable suitor are very limited, and the dowry could be very meager if at all; otherwise, the family is willing to give her away for nothing to reduce the shame on the family" (*Anuforo et al., 2004).

It was in an effort to solve this apparent 'problem', that parents, and especially mothers and older women encouraged the practice of FGM/C on their young daughters *"…to prevent the children from prostitution*" (Ogunsiji et al., 2018) and to *"… restrain a woman so she will not flirt. The parents will be at peace when the child is circumcised."* (Philips, 2016). It emerged that removing the clitoris was believed to extinguish strong sexual urges while suturing the labia together ensures that sexual intercourse becomes a painful experience for the woman (Dotimi, 2017). In this way, girls were deterred from sexual pleasure or engaging in sexual activity before marriage. The following quote summed up the controlling nature of the practice:

> *"The family thinks the girl will become humbler and, well, that it will calm her down. That's the purpose, I think. That's the purpose that she won't feel her body and feel desire and such things. That's the purpose, to calm her down. That she should just be a wife. She doesn't think sexually or anything, so that she doesn't want to go out. She just stays at home. She must stay at home. All she thinks of is her home. That's the purpose." (*Johnsdotter et al., 2009)

The studies in this review also revealed that parents played an active role in promoting a negative image of sex and sexuality throughout their female child's life. Women reported that from a young age, they received negative messages about sexual intimacy. They were taught that it was shameful and should not be encouraged or desired:

> *"There is this pressure all the time, that they've put on us since early childhood. . . that sex is no good and that you shouldn't be in that way with men and that you shouldn't do this and that. . .. Every time you think of sex those pictures come up…and it's like a film. Well, you know, it's the mothers…all the time…society and mothers…They just talk that way. Nobody says, "sex is a wonderful thing." You never hear that. Like this: "Sex is filthy." It's just that. Most of us… have that picture... You have to*

> *be able to break loose somehow and say, "Sex…What a wonderful thing." That's not easy."* (Johnsdotter et al., 2009)

Even within the boundaries of marriage, women were advised not to initiate sex with their husbands as they could potentially lose their husbands respect (Fahmy et al., 2010; Eshe et al., 2017). The narrative that women were sexually insatiable was also passed down to males who were encouraged to avoid marrying 'uncut' women. These boys were taught that "*if [a woman was] not closed down [she was] not a virgin…"* (Safari, 2013) and should be perceived as undesirable (Jirovsky, 2010). A man could "[*abandon] his bride because he thought she was not a virgin"* (Ahlberg et al., 2004). Uncontained female sexuality was also seen as a threat to the man's sexual performance:

> *Somali men do not marry uncircumcised women. They think that she has extra sexual desire, which will leave them exhausted sexually due to her constant demands of sex. Especially because the men take 'khat' in the evenings, which makes them feel very relaxed, so they would be too tired to perform.* (Norman, 2009)

While girls were always expected to control their sexuality, men were expected to express their desire for sex and demand it from their wives. If women denied their husband's sexual advancements, they were liable to be beaten (Fahmy et al., 2010). These gender expectations had long-lasting social and cultural consequences. In this review, women viewed sex as their duty and obligation; and a necessary step for conception. When asked to express their views on sexual intimacy, some participants described how they "*felt cold during sexual relations"* and *"had no satisfaction out of sex"* (Fahmy et al., 2010). Older women talked about feeling that sexual pleasure was for their husbands and not for them:

> *"[FGM] is pleasurable for the husband, I do not enjoy sex with my husband. Sexual pleasure is something far away for me. I feel I am just a tool for my husband's sexual pleasure."* (Berggren et al, 2006b).

Younger women were more vocal about their sexual desires than older women. One participant, who was a 20-year-old student, admitted that

> *"I do initiate love making with my husband, and he appreciates me doing that. He is educated. He has a college degree. When you are married, it is a give and take issue."*(Anuforo et al,. 2004).

This was not the case for the majority of participants in this review. Communication barriers existed between spouses: *"you cannot tell your husband that you want sex, so you wait for him to ask. If you ask he will think you are 'lustful' and can be mistaken for being a prostitute."* (Eshe et al., 2017). A major hindrance to open communication was the fear of being *"misinterpreted for immorality…."* (Eshe et al., 2017). However, the desire to be intimate was very present for some women who wanted to partake in sexual activities. Unfortunately, the removal of external sexual organs, made this a challenge and one participant highlighted that *"…It really has to take a good man that understand your body to really be patient to even arouse you in bed."* (Kalokoh, 2017). Those who experienced FGM/C after they were married struggled to achieve high libido and compared their sexual health before and after the practice:

> *"There was a lot of change because the body does not feel excited for sex even if you see a man you just see that you are not interested at all. Before I was cut, I used to have a lot of desire for sex such that we would even stop our meal halfway to go and I would tell my husband to go and have sex first..."* (Eshe et al., 2017)

Older women as the primary enforcers for FGM/C

Despite the painful experiences women faced with FGM/C, they assumed the role of enforcers of FGM/C: "*Yes and I have circumcised all my children. Yes, all 4 and there is no problem.*" (Philips, 2016). Older women were the primary instigators of the practice, operating within the expected social norms. They

believed that the benefits of FGM/C outweighed its negative consequences (Gele et al, 2012) and placed social pressure on younger women in their communities to continue the practice (Ahlberg et al., 2004; Jirovsky, 2010). Grandmothers and mothers-in-law compelled *"[their sons and daughters] to circumcise their daughters whether [the parents] agree or not"* (Berggren et al, 2006b). The association between FGM/C and social values was strong for the women in the community. It was so pervasive that at times even young girls themselves insisted on getting cut. Some participants wanted to do this without their parents' knowledge or consent:

> "*I did it without my parent's knowledge…I found my friends going through with it. I did not have any money but the women who were present contributed. When I came home, my mother was surprised but said she was planning to have it done the following season. She was nevertheless happy with my action."* (Ahlerg et al., 2004)

Mothers who rebelled against this system, and refused to circumcise their daughters, faced deep stigmatization. They became the subject of community gossip, which in turn could jeopardise their daughters' future marriage opportunities:

> *"Did I tell you that it is the women who are behind the old tradition? If a girl is not circumcised, the other mothers talk about the girl so that the mother hears it and feels ashamed. No mother can stand such talk. You do not want to feel shame for your daughter. You want her to get rid of her sexual desire, and they think that if you cut away the clitoris, you cut away the sexual emotions, and the girl gets calmer* (Berggren et al, 2006b).

Shame and dishonour were seen as sinful concepts within tight-knit social communities and resulted in families losing their social standing. A family's social standing was linked to a woman's sexuality and virginity: "*In our community the mother usually tells you that you have to protect yourself and your honour and not to bring the family shame.* (Norman, 2009). To avoid this,

continuing to practice FGM/C on their daughters was the so-called "*sacrifice"* mothers made to avoid being socially rejected (Johnsdotter et al., 2009). Fighting this culture was a challenge and they themselves were not able to withstand the social pressures: *"it is better you just accept to be cut"* (Eshe et al., 2017). FGM/C was performed, even when daughters objected: "*I used to say to my mum there is no need for me to have been circumcised, there is no need at all. Still this day I am mad about it"* (Morison et al., 2004). However, the social pressures on mothers to circumcise their daughters sometimes competed with the realisation of their children's experience of pain. One participant, who had experienced Type I FGM/C, explained this pressure:

> "*Yes when I was 17 years old and I have circumcised my girl. We do a traditional one, where the Wanzan (Local Barber) will come to our homes and perform the operation. I had mine at adolescent, and it was a painful and horrible experience, I thought I could be helping to reduce my child pain if she had hers now as a child. I prefer to do it when a child is small."* (Philips, 2016)

Those who rebelled against the system and who forgo FGM/C for their daughters' sake faced an internal struggle about what was right and acceptable. Some were not sure if they made the right decision:

> *I personally have made the decision not to circumcise my girl and I am not sure if I have made the right decision and what the future will hold for my child. My family keep on pressuring me and saying that I have done wrong in not circumcising my daughter.* (Norman, 2009)

The review uncovered issues in the relationship between circumcised girls and their mothers. This was the case for both girls living in Africa and those in the diaspora. For one participant living in Africa, FGM/C put a strain on her relationship with her mother: "*I think the most damage that FGM, the practice has done to me is you know it has destroyed my relationship with my mother.* (Parikh et al., 2018). Participants, especially younger women, discussed the difficulty of coming to terms with the practice (Dotimi, 2017) and how helpless they were to refuse:

> "*…I had mine there when I was a child which I had no control or say in the decisions. A person has no control to refuse it. The parents take the decision to do it."* (Philips, 2016).

One participant living in the diaspora begrudged the notion that mothers performed it to safeguard a future marriage and argued that "*the mother is not thinking about her daughter – she is thinking about a man she does not know."* (Norman, 2009). Anger towards their mothers was the predominant feeling girls expressed when they reflected on their FGM/C experience and the pain they went through. Mothers were also thought to be thinking of themselves and saving themselves from social complications rather than thinking about their daughter's long-term health and wellbeing (Parikh et al., 2018). However, not all women resented their mothers for performing FGM/C on them as children. One woman relied on her religion to help her move past her mother's actions: *"I'm a Christian like I don't hold grudges and stuff …" (Parikh et al., 2018).* Another woman tried to understand her parent's intentions and to come to terms with their actions the cultural aspects,:

> *"I can understand that she wanted to do what she thought what's best for us so I kind of forgive her at that point and umm despite I feel sometimes they my parents both of them have failed me as a daughter at that time like when I was getting it but I try to move on by saying that they thought at that time that was the best for me." (Parikh et al., 2018)*

While many women experienced feelings of betrayal and anger, most wanted to speak openly about these feelings and find "*answers and solutions"* (Philips, 2016). They were met with secrecy and told to forget about these questions which only added fuel to their frustration.

Changing attitudes among women

There was some evidence emerging that attitudes towards FGM/C were changing, especially among migrant populations in countries that don't

practice FGM/C *(*Johnsdotter et al., 2009; Lundberg & Gerezgiher, 2008). In the diaspora, greater emphasis was placed on female empowerment through education and independence, rather than through marriage and family ties (Upvall et al., 2009). Although the focus on virginity and morality remained, migrant parents felt that they were more able to protect their daughters *"…through discussion and talking, but it doesn't work through circumcision.* (Norman, 2009). Therefore, educating families about FGM/C was suggested as a way to halt the practice:

> *"Educate the family, that's the right way educate them. Tell them it's not right. Use religious part, the medical part. You can explain the consequences, what is going to happen. She may have psychological trauma, bleeding, she may get infection, it may affect fertility, may infect. They will understand. The Somalian people understand when you explain to them and make them understand. They just need explanation..."* (Khaja et al., 2010)

Another important factor was the changing religious views regarding FGM/C. Women in the diaspora were beginning to refute the association between FGM/C and religion (Ogunsiji et al., 2018). They believed that the practice was *"groundless…there is no evidence in religion"* (Ahlberg et al., 2004). A clear distinction between culture and religion was made:

> *"Those who today have decided to leave this tradition of infibulation … what reason for giving it up do you think is the most important one? It's not in the Qur'an. It is something that belonged to our culture, it is absolutely clear that it's not in the Qur'an…*" (Khaja et al., 2010).

This transformed FGM/C a religious problem to *"a cultural problem"* (Said, 2015). Migrant women also acknowledged that "*uncircumcised girls are healthier"* and "*enjoy sex much better than circumcised women*" (Gele et al, 2012). Therefore FGM/C was no longer viewed as being prestigious and a mark of high social standing. Also, there seems to be a growing trend of younger men raised in the diaspora who prefer uncircumcised women:

> *"Men always ask if I am circumcised or not, that is their first question. I ask them why they ask that question, but it seems that they don't want circumcised women"* (Gele et al, 2012).

According to the participants, increased awareness of the negative health consequences of FGM/C and the legislations within Western host counties played a vital role in halting the practice among migrant populations (Anuforo et al., 2004; Gele et al, 2012; Jirovsky, 2010; Lundberg & Gerezgiher, 2008). However, participants were vocal about the negative depiction of FGM/C in Western media and the victimisation of their communities:

> *"Somalis felt insulted that while they clearly loved and adored their children, international laws against circumcision made them look like abusers" (*Khaja et al., 2010)

This change in attitude, while more pronounced among migrant populations, was also present among non-migrants. Women residing in African countries noticed that those living without FGM/C were not suffering or experiencing negative consequences. One participant summarised her feelings about the practice by stating *"… I don't believe in it because I have a friend from another tribe who is not circumcised, but have three kids and they are all alive."* (Dotimi, 2017). There was growing discontentment with FGM/C and in the Odi community in Nigeria, where FGM/C was traditionally practiced, women were increasingly more vocal about it:

> *"The cultural belief is barbaric. Things are changing. It is a violation against the right of the woman. Especially, the belief that the clitoris is like penis, if not circumcised can make a woman not to control her urges when she comes in contact with a handsome man (Dotimi, 2017)".*

Some participants living in the diaspora doubted the role of legislation back in their countries of origin: *"The law might be fine here but it will not change the reality back there.* (Plugge et al., 2018). Despite this viewpoint, legislation within African countries was already proving to be impactful:

> *"I heard about the law against female circumcision over the radio. It said females should not be circumcised. The law is good because it will prevent women from suffering. I personally stopped my children from being circumcised, and I also advised my sister's children not to go for circumcision."* (Dotimi, 2017).

Studies also noted changing religious views among women living in African countries. There is increased awareness that FGM/C was a cultural or social practice and not a religious one. Yet, women were still hesitant to abandon the practice entirely and instead encouraged the adoption of milder types of FGM/C. One woman living in Somaliland, who had experienced Type III FGM/C, explained how:

> *"I heard that FGM is not religious. Later I found out on the many problems. I think the majority of the people are aware now that it is not religious…Sheiks say sunna must be practiced but religion prohibits the Pharaonic [Type III FGM/C]…When circumcising her daughter every mother asks the sheiks, who advise them to circumcise on sunna [Type I FGM/C]."* (Fried et al., 2013)

Emotional and physical healing from FGM/C

Some women in studies within this review found FGM/C to be an extremely painful experience (Berggren et al., 2006b; Jirovsky et al., 2010; Johansen, 2016; Kalokoh, 2017; Norman, 2009; Parikh et al., 2018; Philips, 2016). These participants had vivid memories of the day they were cut:

> *"I remember her breaking the razor blade into two pieces. There are four or five women holding me. She holds up the razor blade and she cuts me. She has some homemade analgesic, but it does not help. I feel the most terrible pain. I feel how she cuts in me, I felt the razor in me, I felt as they cut away a part of myself, so painful was it. I thought I was going to die."* (Berggren et al., 2006b)

The pain of the procedure was one of the first things participants recalled when the subject of FGM/C was opened: "*What comes in my mind, it's like when*

they take you in the forest, and go through the pain, we call that the pain…"(Kalokoh, 2017). This was especially the case when participants underwent "*Pharaonic circumcision*", a radical type of FGM/C as *"…Your genitals are sliced and stitched and the menses is blocked and very painful. All kinds of ills follow* (Fried et al., 2013). The pain was only made worse if the site of the wound became infected (Kalokoh, 2017). Being cut caused numerous issues throughout their lives and women remembered that "…*I had the menstrual pains and I was told that the problem was caused by FGM/C…"* (Fried et al., 2013). Another woman, who had experienced Type III FGM/C, felt relieved from these menstrual problems only *"…when the doctor opened me…"* (Fried et al., 2013). Sexual intercourse was a painful experience and one participant discussed her experience:

> *"It was very difficult for my husband to penetrate. It took many days before he could do it. Before my marriage, I had no idea that it would be hard and painful. After the first contact with my husband I knew that I was sutured and that it had to be opened." (Johnsdotter et al., 2009).*

Despite all this suffering, many women refused to reopen the scar tissue before marriage because of the shame this would bring upon the family. One woman with Type III FGM/C described her experience:

> *"I used to have very painful menses when I was a girl and before I got married I used to vomit. The doctor suggested that I be opened, but I did not do it because it was shameful to be opened those days"* (Fried et al., 2013)

In Parikh (2018), participants living in Africa, spoke about how it felt to live with FGM/C and the effect it had on their identity as women. Participants felt that they were *"missing something"* and others wished to be *"…normal you know just a normal woman."* (Parikh et al., 2018). These feelings of loss were augmented by feelings of low self-esteem:

> *I was questioning why it happened to me- that definitely affected my self-esteem when I went to high school and university well most of the girl*

> *didn't had it so it affected me like I'm kind of illiterate'.* (Parikh et al., 2018)

Acceptance was another interconnected factor that emerged and circumcised women took measures to protect themselves from judgement *"I wouldn't necessarily speak to my work colleagues…its just not something that you feel proud of."* (Parikh et al., 2018). They also tried to protect themselves from rejection *"I've decided not to date black men because they know so much about it…they probably wouldn't accept me"* (Parikh et al., 2018). Physical and emotional healing was alluded by women living both in Africa and in the diaspora (Parikh et al., 2018; Philips, 2016; Plugge et al., 2018). Reversing the procedure through extensive reconstructive surgery was increasingly seen as a way to recapture what was lost through FGM/C:

> *One thing I thought to myself I would like to change deep down I wouldn't say it out loud but it would be having turn back my time and have it even if I have to pay the most expensive if I can afford it I would have an operation where I could be as normal as I could be.* (Parikh et al., 2018)

Those who have undergone surgical reconstruction were positive about the outcomes: *"I am healed, can now have sex. Initially I was ashamed but later, I am not ashamed anymore.* (Philips, 2016). Sexual intimacy remained an important influencing factor and this showed just how important it was for a growing number of women living with FGM/C:

> *"Such women [who reversed FGM/C using reconstructive surgery] often raise their head-high and often brag about being healed of their illness and now capable of having enough fun with their husband without any stress or difficulties compared to their pre-FGM/C state"* (Philips, 2016)

While the majority of women were discontent with FGM/C and wished they had not endured the practice, not everyone shared these sentiments. Some participants believed that they had benefited from the practice. This viewpoint was more prevalent among women living in Africa, but it was still present

among some women in the diaspora. One participant living in Nigeria explained her experience:

> *"I was very active and attractive to men. So, I got married at a very tender age but was unable to achieve pregnancy despite unprotected sexual intercourse with my husband for 5 years. Then the elderly women in the community advised me to be circumcised if I want to be pregnant. I adhere to their advice and allowed myself to be circumcised. True to their words, I became pregnant*." (Dotimi, 2017)

Some women believed that the association between FGM/C and childbirth was a positive one and that it facilitated childbirth: *"The reason is to prevent the clitoris from covering the head of the baby, because if the clitoris is not removed the baby will not be born alive."* (Dotimi, 2017). Another participant living in Nigeria, believed that Type I FGM/C was a form of healing in itself as it allowed women to grow and mature: "*It makes a woman responsible; she has respect. It is healing to the woman."* (Philips, 2016). Here, the word healing took on a different meaning. FGM/C was not viewed as a source of pain that needed to be alleviated. In some cases, it was a source of joy and happiness, and one woman living in Australia explained this further:

> *"Other women, some other girls, they are happy, because they kept [FGM/C] sacred and they think it's all about pleasure and happiness, and other things, like magical things, the way they explain it to you sometimes, like magical things happened." (Kalokoh, 2017).*

Men's role in FGM/C

Men played a vital role in FGM/C by reinforcing the social and gender norms within these communities. They insisted on marrying only virgins and were able to differentiate between a virgin and non-virgin:

> "*When a man has sex with a virgin, he will always notice. It is painful, and it sort of 'pops' when the hymen breaks. It did so with me. It could, of course, be due to my circumcision, but I think it was the hymen as well.*

> *I have asked my husband, and he says that a man will always notice. With a virgin it is tight, and the man has to force himself in."* (Johansen, 2016)

There was a social expectation on men to prove their masculinity by opening the wound of a circumcised woman, even if this caused her pain: *"When the man opens her, he feels proud of her crying pain and blood, and she feels proud too."* (Norman, 2009). Men were expected to use force if necessary to devirginize their wives:

> *"There is a lady who is my cousin. She was married in Somalia by an old man. She was a virgin and the old man wanted to devirginize her on the first night by using force. But he couldn't tear her sutured body by force. He took a knife and inserted the knife deep into her vagina, tearing her body. She bled a lot, and eventually fainted..."* (Gele et al., 2012)

The themes of masculinity and femininity were alluded to within this review. Women discussed how men were pressured to ensure that wives and daughters were circumcised. One participant spoke about how "*friends of the husband put a lot of pressure by refusing to eat her [his wife's] food until she is cut"* (Eshe et al., 2017). This pressure experienced by men to avoid uncut women and prove their masculinity may explain why women continued to promote the practice. At the same time, women reported that while some men openly objected to the practise, the social and cultural norms of the community prevailed and overshadowed their objections:

> *"…my father was not happy, he even disagreed. But my mother and my mother's parents, even myself by the time, we were saying oh daddy, of course myself and one of my step sister, daddy we really want to go there, we want to be a woman. My mother went to people asking them to go and plead to dad for him to accept, then our father's elder sister was also there, she also went and met our father, our father disagreed. But we our self, myself and my sister went and met our dad, dad we really want to go there. So dad had no choice because it's our own voice" (Ogunsiji et al., 2018).*

Women acknowledged that FGM/C affected the married couple's sexual life: *"…My husband told me that he used to enjoy sex more before I got cut than now when I am cut..."*(Eshe et al., 2017). Wives were less likely to desire or engage in sexual activities and participants reported that there was frustration in their household. One participant with Type I FGM/C described this frustration:

> *"…I have a depreciating urge for sex. I am married sometimes we fight with my husband over sex. My husband asks me to consult with others on my predicament, and I was often told that it maybe the effects of the circumcision..."* (Philips, 2016).

Informants in the studies in this review had conflicting views about the role of men in continuing FGM/C. Many women believed that men played a role in promoting the practice by remaining silent or allowing it to persist. They argued that as men had a higher social standing, they could put an end to the practice. Some participants acknowledged that men must be brought into the discussion around FGM/C: *"Yes, men are crucial in this"* (Plugge et al., 2018). However, others feared that listening to men's views on FGM/C would be detrimental. If men were to reject it, this would leave many circumcised women at a disadvantage:

> *"We cannot encourage men to be involved in this. We fear what would happen to the already circumcised women. There would be no husbands for us if men decided to marry only uncircumcised women."* (Ahlberg et al., 2004).

Discussion

This is the first systematic review and meta-ethnography of qualitative research that incorporates women's views of why FGM/C exists and persists. A comprehensive line of argument emerged from the data. Firstly, FGM/C is a rite of passage for girls that reinforced the value of women in their communities. It is believed to remove their sexual desire and prevent them

from engaging in pre-martial sexual relations, thereby securing them a good social standing and marriage. Secondly, while women acknowledge the negative consequences of FGM/C in their lives, they remain a major driving force behind the practice, operating under the accepted cultural and social norms in their communities. They do this by exerting pressure on younger women within their social groups and encouraging their sons to only marry "cut" women. Finally, attitudes towards FGM/C are changing in all populations, but it is more pronounced among migrant populations living in the diaspora. This change is credited to increased education about the practice, the new legislations against FGM/C, changing religious beliefs and the ability for women to have lives that are not defined by marriageability.

FGM/C is a sociocultural phenomenon that is deeply embedded within the communities that practice it. It is influenced by both social and gender norms relating to masculinity and femininity. Gender norms refer to the value placed on men and women. Often within the communities that practise FGM/C, women have a lower social standing. FGM/C is used to maintain the power dynamics between men and women within the community. It is also used by older women to control younger women within their social groups. Social norms are a closely associated phenomenon and refer to how an action is accepted by a group (Mackie et al., 2015). FGM/C is the normalised behaviour for community members and this social norm makes it difficult for individual women to reject the practice. Together these two factors ensure that the FGM/C continues despite external pressure.

To understand the complexity of FGM/C, these factors must be discussed in greater detail. In previously published studies, FGM/C is viewed as a rite of passage and the natural step girls took towards womanhood (Efferson et al., 2015). In many studies within this review, FGM/C carries similar values and is a respected practice within its communities. Women celebrate the social benefits it entailed with music, dancing, and gift-giving. FGM/C is normalised within practising countries and women don't consider themselves "mutilated" (Ahlberg et al., 2004; Berggren et al., 2006a; Fahmy et al., 2010; Fried et al.,

2013; Jirovsky, 2010). Instead, “cut” women feel a sense of belonging with their peers and therefore have a strong social identity. The social capital gained from performing and maintaining the practice shouldn’t be taken lightly. Women are proud of their customs and work to preserve them. This may explain why they adopt such an instrumental role in passing it down to younger generations of women, often against their will. These actions are developed within a system that normalised the practice and makes it a necessary rite of passage.

Interestingly, another factor also influences women’s views of FGM/C. Women’s acceptance of the practice varies according to the type of FGM/C they themselves have endured. Studies show that women who have experienced the mildest form of FGM/C (also known as Sunna or Type I), are more inclined to perform this mild type on their daughters. As they have endured minimal suffering, they see no reason to stop the practice (Guerin et al., 2006). They argue against removing all of the female external genitalia but settle on removing “just a little” of it to preserve the culture (Shell-Duncan et al., 2011). On the other hand, women who have experienced a more severe form of FGM/C (also known as infibulation or Type III) are more inclined to reject the practice altogether (Johnsdotter, 2003).

Numerous reasons are given as to why FGM/C exists and continues to persist. The literature suggests that FGM/C is carried out to enhance male sexual pleasure during intercourse by tightening the opening to the vaginal orifice (Johansen, 2017). However, in this review, women do not believe that this is the key reason they continued to practice FGM/C. In fact, many men complain that it has detrimental effects on their sexual lives with their wives (Eshe et al., 2017). Some men even ask their wives to seek help to remedy the problem. Whether women actually seek assistance is not discussed in detail by study participants. However, women acknowledge that FGM/C also negatively impacts their own sexual experiences and consequently, their marital relationships. While this is frustrating for both men and women, it does not seem to deter parents from performing FGM/C on their daughters. The

discourse continues to centre around the need to control female sexuality and ensure a girl's marriageability. This is especially the case among participants living in Africa.

Female sexuality, marriage, and FGM/C are closely interlinked factors and produce a picture that is reflective of the role of women and girls in these societies. A woman's worth is still dominated by her 'marriageability', offering her both financial and social standing. However, in order to secure a good marriage, women need to preserve their virginity. Once married, they are also expected to remain faithful to their husbands. Participants are warned to maintain these social values and not to bring shame upon their families (Norman, 2009). In the literature, studies highlight that women who remain virgins until they marry uphold the important codes of 'family honour' and their families are greatly valued and respected within their respective societies (Efferson et al., 2015). In these societies, the individual actions of each family member affect the social standing of the entire group (Mosquera, 2013). In studies within this review, daughters are viewed as a direct threat to their family's core values, as their sexuality is seen to be a threat to the social order. In an effort to avoid shame and community gossiping; FGM/C is used to control female sexuality (Berggren et al, 2006 b). This suggests that if families stop FGM/C, they would risk their social status within the community (Muteshi et al., 2016).

In this review, mothers' role in FGM/C is a point of concern for many participants. Daughters are angry that their mothers didn't protect them from FGM/C when they were children (Philips, 2016). When reflecting on their experiences, participants remember the feelings of helplessness and fear they felt when they were pinned down and forced to be cut (Parikh et al., 2018). It makes no sense to participants that their own mothers had also endured similar pain and trauma, and yet chose the same fate for their children. This ultimate betrayal of trust causes tension in many mother-daughter relationships. Feelings of betrayal are compounded when mothers refuse to talk about FGM/C openly and honestly with their daughters. These findings

echo those of Koukoui, Hassan, & Guzder, (2017). In their paper, the authors discuss how elders in the communities admonish women who felt compelled to ask questions about FGM/C (Koukoui et al., 2017). Demanding silence from younger women has ensured that open debate and discussion about the negative consequences of the practice remains almost non-existent. This may be one of the reasons why the practice has thrived over thousands of years and continues to do so in communities in parts of Africa and the Middle East.

Although the subject remains largely taboo and engulfed in secrecy, more and more younger women are choosing to reject FGM/C for their children (Khaja et al., 2010; Norman, 2009). To justify and reinforce this bold step against tradition, women are increasingly relying on the lack of religious evidence regarding FGM/C. At the same time, women living in the diaspora view the laws and restrictions of their new host countries in Western Europe and the USA as a reason to stop the practice (Ahlberg et al., 2004; Khaja et al., 2010). For many women, such as those now living in Sweden, FGM/C no longer carries the same social importance and they are willing to abandon the practice altogether (Gele et al, 2012). This is welcome news. While stopping FGM/C does not seem to relieve parents of the angst they feel about their daughters' sexuality and virginity, it does put an end to the cycle of pain young girls endure throughout their lives (Koukoui et al., 2017). These changes are more prevalent among migrant populations however this review shows that a similar change is happening in countries that practice FGM/C. In Dotimi (2017), some women from the Odi community in Nigeria rejected the practice as they were no longer confident in its cultural standing. It was seen as "barbaric", "a lie" and "not good" - with a number of women refusing to practice FGM/C on their daughters and advising others against it (Dotimi, 2017).

These findings are a positive step towards the abolition of the practice, and for empowering women. The issue of controlling female sexuality, on the other hand, will not be automatically solved once FGM/C is abolished. To avoid the emergence of another harmful practice that aims to control female sexuality;

researchers, policy makers, and community members must delve into this subject with care and find viable solutions that give women of all ages a platform to voice their concerns, needs, wants and values.

Limitations

This study has some limitations. Of the 27 studies included in this review, 18 identified women living in Europe, the USA, Australia or New Zealand while nine studies interviewed women living exclusively in African countries. This may have introduced bias.. To overcome this bias, the influential role of a different environments was taken into consideration when analysing and interpreting the findings of this review and when translating them into pragmatic solutions for the African region and beyond

Another limitation is that FGM/C has distinct forms of varying severity and so women's experiences of the practice were different. In this review, 11 studies didn't report on the type of FGM/C. However, the majority of participants in the remaining 16 studies had undergone Type III FGM/C. As this is the most severe form; exploring studies that only looked at milder types may paint a different picture of the women's experience of FGM/C. Another factor is the age at which participants experienced FGM/C. Some women experienced FGM/C as an infant or young child while other girls experienced it as teenagers. Some women even waited until they had married and engaged in sexual intimacy with her husband before undergoing FGM/C. These diverse experiences mean that creating a single all-inclusive narrative around FGM/C is challenging. However, our review has fulfilled its aim to describe the most common views of women across a varied number of settings and has attempted to understand why the practice exists.

Conclusion and Recommendations

FGM/C has profound public health and child rights safeguarding implications. Taking into consideration the sensitive nature of the practice, a range of recommendations are suggested.

Firstly, women lie at the heart of FGM/C and continue to suffer its negative consequences. Involving women in the mission to abolish FGM/C is of utmost importance. However, to do this, the blanket of secrecy that exists around the practice needs to be removed. This review shows that younger women have many questions that they wish their mothers would answer openly and honestly without being silenced or dismissed. Creating mother-daughter projects that allow both parties to discuss their feelings and emotions in a safe and blameless environment may provide tremendous opportunities for debate and progress and to heal relationships. It may also help remove some of the pressure new mothers feel from elders and community members to continue the practice. There is a possibility that elders may be open to reassessing norms and practices whilst maintaining their cultural identity (Shell-Duncan, Moreau et al., 2018).

Secondly, involving men in the conversation is extremely critical. While women appear to be a major driving force behind the practice, often they do this to fulfil men's presumed sexual desires for circumcised women. However, men's views and acceptance of FGM/C appear to be changing and increasingly, younger men are seeking uncircumcised women. Hosting, recording and disseminating local, national and international round-table discussions with willing men about FGM/C can give a voice to their concerns; especially as it relates to their daughters and wives. Encouraging women of all ages to view or listen to these recordings, and engage in open dialogue with men, may break some of the communication barriers that exist. Also, as men have a higher social standing in these communities, engaging men about the harm associated with FGM/C might change community attitudes towards the practice and ensure adoption of anti-FGM/C initiatives. Ultimately, changing social norms may be the only solution to tacking the issue of FGM/C on a long-term basis.

Using appropriate forms of media outlets can help dissemination information widely. Opportunities with digital health technologies exist. Building a dedicated SMS (short message service) platform, targeted at individuals who have access to and regularly use basic mobile phones, may be one potential solution. These services can educate users about FGM/C: why it exists, its harmful consequences, and what can be done to prevent the problem for future generations. Men and women can engage with mobile technologies privately and without being recognised by their peers. Leveraging such innovations can be advantageous as FGM/C remains a sensitive subject both in African countries and among migrant populations in the Western world. All solutions should be adapted to the languages of their target audience and tailored to suit the settings and needs of these communities.

Legislation remains an important preventative route for the discontinuation of FGM/C. Strict laws in Western countries have made it difficult for migrant parents to perform it on their daughters. Policy makers in countries where FGM/C is widely performed should actively enforce laws that prohibit the practice. However, this must be done with caution. The evidence suggests that it while it is important to have a law that criminalises FGM/, this will not eliminate the practice entirely (Aberese and Akweongo, 2009). Parents may find ways to continue to circumcise their daughters in secrecy, thereby avoiding legal prosecution. Involving community members in the discussion through grass-root organisations, as well as co-developing interventions, may produce better outcomes overall (Aberese and Akweongo, 2009). Health professionals can also play a vital, complementary role by identifying females with FGM/C and educating them about the long-term negative health consequences. These measures may help safeguard young girls from FGM/C and help them deal with complications that may arise later in life.

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Appendix

Table 1: Inclusion/exclusion criteria

Criteria	Inclusion	Exclusion
Population	Women who experienced FGM/C and are living in any part of the world were included.	The views of women who have not experienced FGM/C, community members, partners or health workers and male views were excluded.
Exposure	Any of the four types of FGM/C were included. Studies that didn't specify the type of FGM/C were also included in the review	Studies that discussed only the surgical interventions used to reverse FGM/C (deinfibulation) or to close open wounds

		(Reinfibulation) were excluded.
Study Design	Qualitative research that included the views of women who experienced FGM/C. Studies that also included the views of other groups were included as long as women's views were present. Only these views were used in the review analysis.	Quantitative research that has no qualitative component was excluded. Mixed method research was included, however only the qualitative component was used in this review.
Publication Type	Studies were peer-reviewed published studies or grey literature such as dissertations.	Other types of publications
Publication Date	January 2000 – August 2018	Before 2000
Language	Studies published in English	All other languages

Table 2: Characteristics of the included studies

Author, year	Methodology	Characteristics of participants and Type of FGM/C experienced	Context/setting	Quality Score
Ahlberg et al., 2004	Individual interviews and Focus group discussions	60 females (50 women and 10 girls); Exact age not defined. Type of FGM/C was not reported.	Participants of Somalian Origin; study conducted in central Sweden	High
Anuforo et al., 2004	Individual interviews	Number of females not defined; all between 15 to 75 years old. Type I and Type II FGM/C were reported.	Women from Nigeria. Study conducted in USA and Nigeria. Ethnic tribes: Igbo, Yoruba and Hausa	Moderate
Berggren et al., 2006 (a)	Focus group discussions and individual interviews	22 females; No mention of age. Type III FGM/C was reported.	Migrant women from Eritrea, Somalia and Sudan. Study conducted in Sweden	Moderate
Berggren et al., 2006 (b)	Individual Interviews	12 females; No mention of age. 18 out of 21 women had Type III FGM/C. One woman had Type II and two had type I.	All women are from Sudan; Study conducted in Khartoum State, Sudan	High

Dotimi, 2016 (Dissertation)	Individual interviews and	7 females aged over 18 years. Type of FGM/C was not reported.	Women are from Odi community in Nigeria who reside in the Odi community.	High
Esho et al., 2017	Focus group discussions and case narratives	Mixed method study of 318 females. No mention of number/age of women for qualitative study. Type of FGM/C was not reported.	Women are from the Mauche location, Nakuru County in Kenya.	HIgh
Fahmy et al., 2010	Focus group discussions and individual interviews	102 females all older than 35 years. Type of FGM/C was not reported.	Women from Egypt; study conducted in 2 rural communities in Upper Egypt and slum area in Cairo	Moderate
Fried et al.,2013	Individual interviews	7 females aged 23 to 40 years. All 7 women had Type III FGM/C.	Women from and study conducted in Hargeisa, Somaliland	High
Gele et al., 2012	Focus group discussions and individual interviews	21 females aged 19 to 56 years. Type of FGM/C was not reported.	All women from Somalia; Study conducted in Oslo, Sweden; most had secondary school education	High
Guerin et al., 2006	Individual interviews; focus group discussions and participant observation	-255 females aged 19 to 50 years (in Australia Study) -10 females aged 16 to 50 years (in New Zealand	Refugee immigrants from Eritrea, Sudan, Nigeria, Egypt, Lebanon, Iraq, Jordan, Saudi Arabia and Syria living in Australia and New Zealand.	High

		Study). Type I and Type II FGM/C were reported.		
Jirovsky, 2010	Participant observation and individual interviews	24 females aged 18 to 89 years. Type III FGM/C was reported	All women are from and live in Bobo-Dioulasso in Burkina Faso	Moderate
Johansen, 2017	Individual interviews and participant observation	21 females aged 18 to 65 years. All women, except one, had Type III FGM/C.	Somali and Sudanese women residing in Norway	Moderate
Johnsdotter, 2003	Individual interviews	15 females; No mention of age. Type of FGM/C was not reported.	Somalis residing in Malmo, Sweden	Moderate
Johnsdotter et al., 2009	Individual interviews	Number of females not given; aged between 35 to 45 years. Type of FGM/C was not reported.	Women from Ethiopia and Eritrea; Study conducted in Sweden. More Christian women than Muslim women	High
Kalokoh, 2017 (Dissertation)	Individual interviews	12 females aged 20 to 60 years. Type of FGM/C was not reported.	Women from Sierra Leone who resided in Europe, the United States, Sierra Leone, and Australia	High
Khaja et al., 2010	Individual interviews	17 females aged 20 to 79 years. Type of FGM/C was not reported.	Somali women living in Ontario, Canada, and Salt Lake City, Utah	High

Lundberg & Gerezgiher, 2008	Individual interviews	15 females aged 31 to 45 Years. All women had type III FGM/C.	All women from Eritrea; living in Sweden for 2 years	Moderate
Morison et al., 2004	Mixed methods study: Qualitative part uses individual interviews	10 females aged 16-22 years. All women had Type III FGM/C.	Women of Somali origin living in London, England	High
Norman et al., 2009	Individual interviews	9 females aged 25 years or older. All types of FGM/C were reported.	Women from Sudan, Eritrea and Somalia living in London, England.	High
Ogunsiji et al., 2010	Individual interviews	4 females; No mention of age. Type of FGM/C was not reported.	Women from Liberia, Sudan and Sierra Leone residing in Sydney, Australia	High
Parikh et al., 2018	Individual interviews	13 females aged 19 to 47 years. Seven women had Type III FGM/C, two had Type I FGM/C, one had Type II FGM/C, one had Type IV FGM/C. 2 cases were unknown.	Women from Sudan, Somalia, Somaliland, Gambia, Nigeria, Sierra Leone and Saudi Arabia	High
Philips, 2016 (Dissertation)	Individual interviews and observation data	10 females aged 18 to 59 years. Type I FGM/C was reported.	Women from and residing in Kaduna, Nigeria.	High

Plugge et al., 2018	Focus group discussions and individual interviews	44 females aged 18 to 83 years. Type of FGM/C was not reported.	Women from Sudan, Somalia, Kenya and Nigeria living in Oxford, England.	Moderate
Safari, 2003	Individual interviews	9 females aged over 18 years. All women had Type III FGM/C.	Women from Somalia and Eritrea; Study conducted in London, UK	Moderate
Said, 2015 (Dissertation)	Focus group discussion and individual interviews	4 females aged 20 to 50 years. All types of FGM/C were reported.	Women from Somalia, Eritrea, Indonesia and Kurdish communities residing in New Zealand	Moderate
Shell-Duncan et al., 2011	Focus group discussions and individual interviews	Over 3000 females aged 18 and 40 years. All types of FGM/C were reported.	Women residing in Senegal and Gambia	Moderate
Upvall et al., 2009	Focus group discussions	23 female aged 19-43 Years; all women are married. Type III FGM/C was reported.	Somali Bantu refugee women; study conducted in Pennsylvania, United States	Moderate

Table 3: Formation of themes

Major themes	**Number of different codes**	**Number of studies that**	**Contributions to the line of argument**

	within the themes	**addressed each theme**	
FGM/C was a rite of passage and a step towards womanhood	48	16	FGM/C was believed to remove girls' sexual desire and prevent them from engaging in pre-martial sexual relations. This insured they remained virgins and could easily find a husband as men preferred marrying virgins. In this way, FGM/C reinforced the gender and social norms within the community.
There was a desire to control female sexuality and improve a girl's chances of getting married.	65	16	
Women suffered lifelong pain and hardship because of FGM/C.	36	14	Women acknowledged the negative consequences of FGM/C however they continued the practise by exerting social pressure within their social groups. Also, the decision by mothers to circumcise their daughters created rift in many mother-daughter relationships.
Women played a key role in continuing the practise.	33	14	
There was changing attitudes towards FGM/C among migrant and non-migrant women	69	20	Attitudes towards FGM/C were changing and were influenced by cultural, legal and religious factors. Many women were rejecting the practise and wanted to heal from the emotional consequences of FGM/C and/or reverse the process.

Figure 1: Prisma Flowchart of Female Genital Mutilation/Cutting (FGM/C) – From Moher et al., 2009

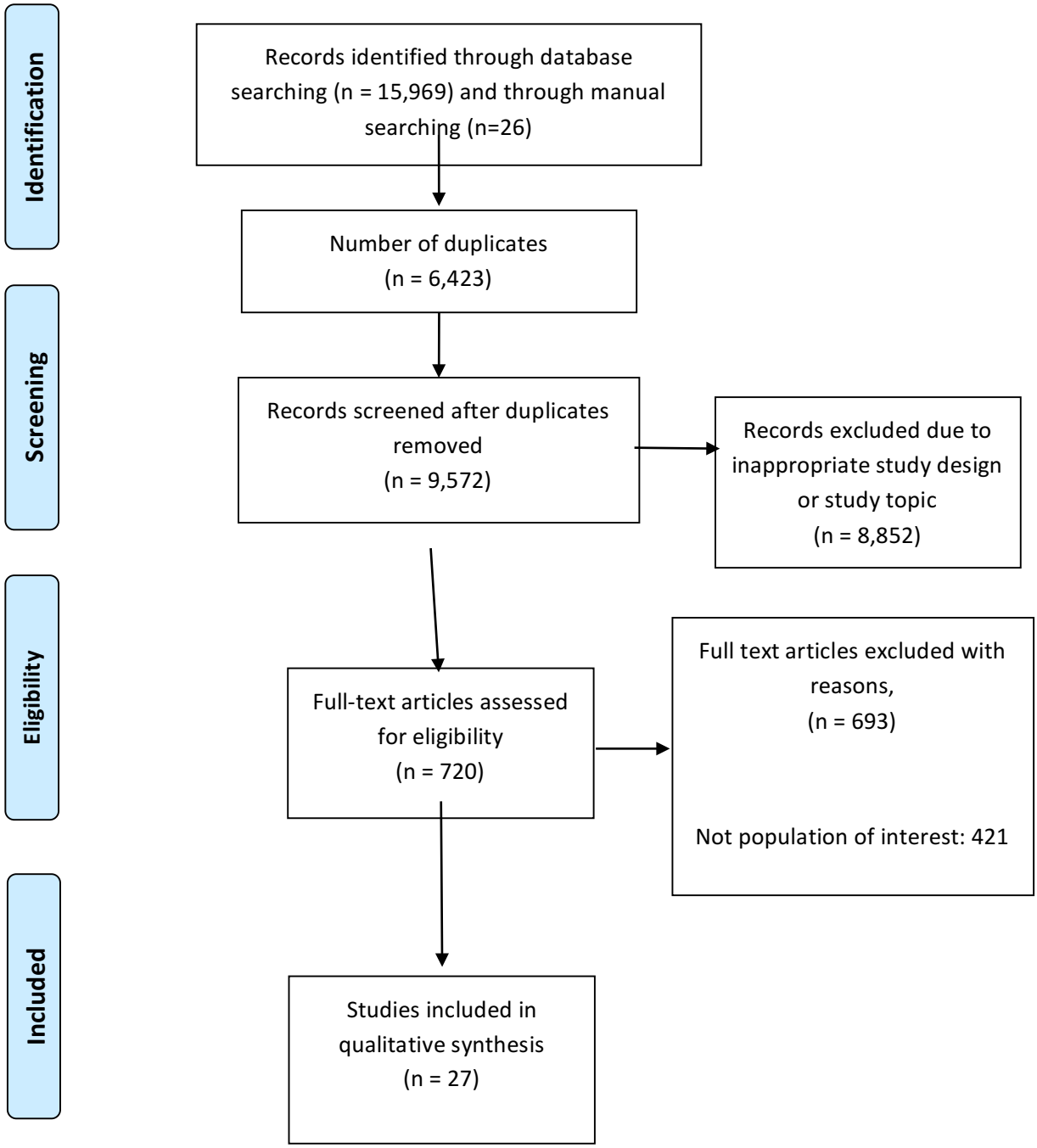
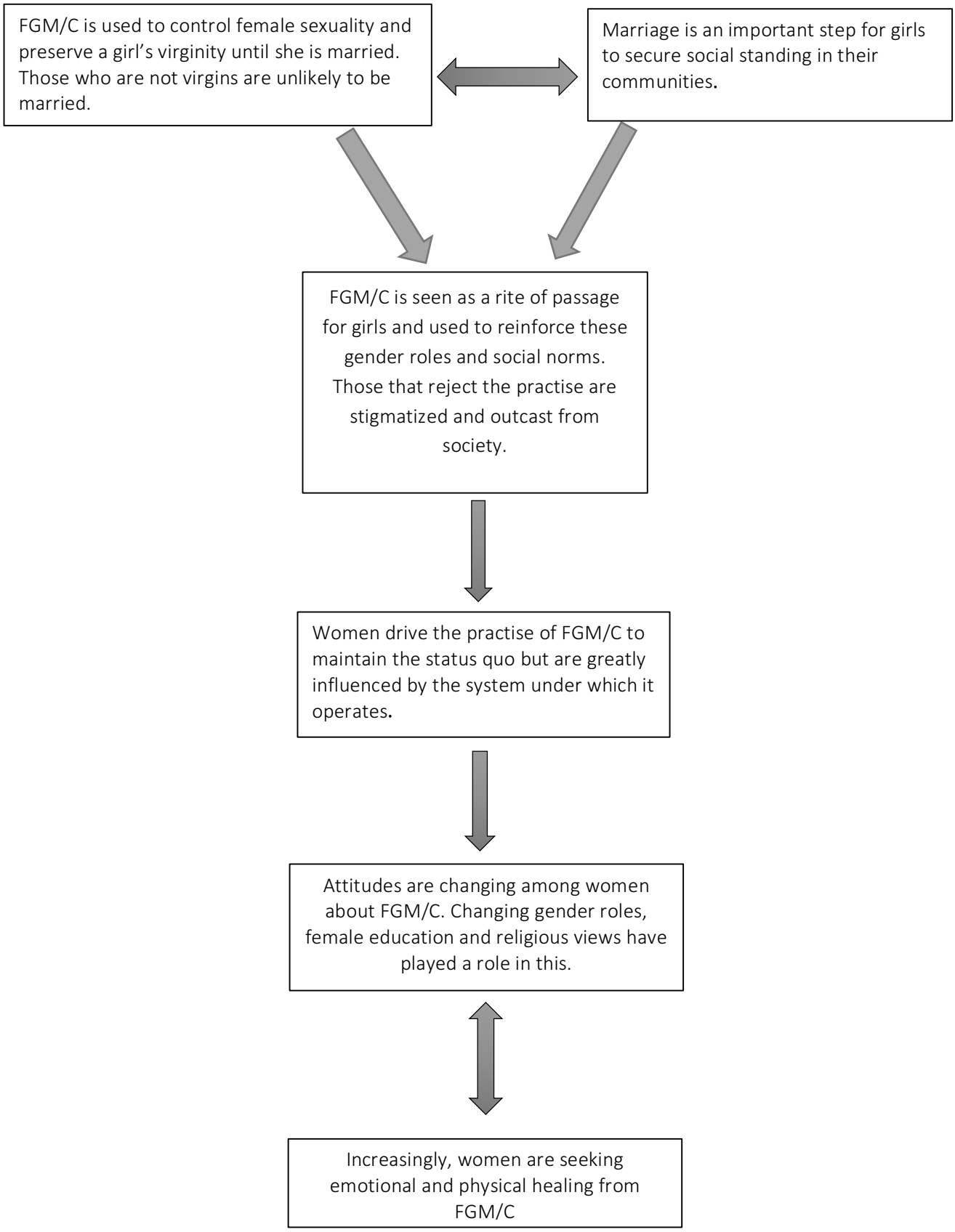
Figure 2: A summary of the results relating to FGM/C