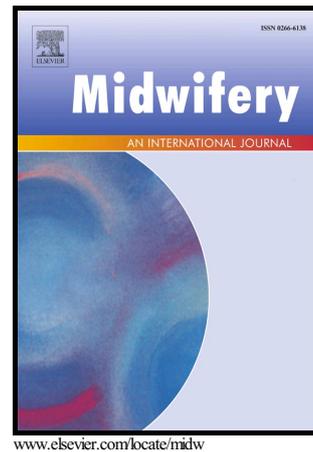


## Author's Accepted Manuscript

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

Ismael Jiménez Ruiz, Pilar Almansa Martínez,  
María del Mar Pastor Bravo



PII: S0266-6138(16)00037-1  
DOI: <http://dx.doi.org/10.1016/j.midw.2016.01.017>  
Reference: YMIDW1805

To appear in: *Midwifery*

Received date: 18 August 2015  
Revised date: 25 January 2016  
Accepted date: 30 January 2016

Cite this article as: Ismael Jiménez Ruiz, Pilar Almansa Martínez and María de Mar Pastor Bravo, Key points for abolishing Female Genital Mutilation from the perspective of the men involved, *Midwifery* <http://dx.doi.org/10.1016/j.midw.2016.01.017>

This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and a review of the resulting galley proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

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

**Author**

**- Dr. Ismael Jiménez Ruiz**

Association DEMUSA president

Address: C/ San Rafael N°17. Santomera, Murcia, Esapaña. CP:30140

Email: ismaeljr1990@gmail.com

**- Dra. Pilar Almansa Martínez**

Vicedecana Facultad de Enfermería. Universidad de Murcia.

Address: C/ Salvador de Madariaga, N°5, 5°B. CP: 30009, Murcia, España.

Email: palmansa@um.es

**- Dra. María del Mar Pastor Bravo<sup>c</sup>**

Association DEMUSA secretary

Address: C/ Pasaje Latino N°:3, 5°B, CP: 30500, Molina de Segura, Murcia, España

Email: mariadelmarpastorbravo@gmail.com

**Corresponding author:** Dr. Ismael Jiménez Ruiz

**Introduction**

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

gynaecological, sexuality, psychological and social (Jiménez, Almansa, Pastor & Pina, 2012)

According to data from UNICEF (2013), it affects a population of approximately 125 million women and girls worldwide, and 30 million girls less than 14 years of age are at risk every year. Furthermore, data from Amnesty International (1998) and UNICEF (2013) point to between two and three million women and girls being denied their rights as a result of this practice every year, which translates to 8,219 women and girls becoming victims of FGM every day.

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

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

### **Aims**

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

### **Material and Method**

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

***Study population***

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

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

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

- Firstly, 15 individual semi-structured interviews were held with members of the population originally from countries where this practice is common and who now live in the region of Murcia (Spain). Access to this initial population was made via the midwife from the Torres de Cotillas Healthcare Centre (Murcia). It should be highlighted that 5 interviews from this first sampling process were excluded from the final sample since 2 of the men decided not to continue on with the study after being interviewed, another 2 considered their participation was not appropriate given they were against the study being performed and 1 of the interviews was discarded due to patent indications the truth was not being told by the interviewee.
- Regarding the second sampling procedure, this took place in eastern Morocco, with a total of 6 semi-structured interviews being performed on scholarship students from Chad and Djibouti. Access to this population was possible thanks to contacts established via the NGO “Enfermeras para el Mundo”.
- The final 5 participants were interviewed in three groups. Access was via the NGO “Murcia Acoge” with the help of a facilitator. In this case, groups of 4, 3 and 2 men were formed, although 3 participants were excluded for not fulfilling the inclusion criteria described in Table 1.

**Table 1. Inclusion Criteria**

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

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

**Table 2. Participant Profiles.**

<b>Code</b>	<b>Country of Origen</b>	<b>Age</b>	<b>Position</b>
<b>IMGF.1</b>	Senegal	47	Against
<b>IMGF. 2</b>	Mali	34	In favour
<b>PMGF.1</b>	Mali	25	In favour

<b>PMGF.2</b>	Mali	42	In favour
<b>PMGF.3</b>	Mali	35	In favour
<b>PMGF.4</b>	Senegal	43	Against
<b>PMGF.5</b>	Senegal	41	In favour
<b>PMGF.6</b>	Senegal	20	In favour
<b>PMGF.7</b>	Senegal	29	In favour
<b>PMGF.8</b>	Senegal	51	Against
<b>PMGF.9</b>	Chad	24	Against
<b>PMGF.10</b>	Djibouti	21	In favour
<b>PMGF.11</b>	Djibouti	30	In favour
<b>PMGF.12</b>	Djibouti	22	In favour
<b>PMGF.13</b>	Djibouti	21	Against
<b>PMGF.14</b>	Chad	27	In favour
<b>GMGF.4</b>	Mali	53	In favour
<b>GMGF.5</b>	Niger	33	Against
<b>GMGF.6</b>	Ghana	38	In favour
<b>GMGF.8</b>	Senegal	48	Against
<b>GMGF.9</b>	Ghana	38	Against

### *Instruments utilized*

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

**Table 3. Interview characteristics**

	<b>Semi-structured Individual</b>	<b>Semi-structured Individual</b>	<b>Semi-structured Group</b>
<b>Date</b>	October & November 2013	November 2013	October & November 2014
<b>Interviewer</b>	Main Author	Author of Study	Main Author
<b>Language</b>	Spanish & French	French	Spanish & French
<b>Translator</b>	Yes	No	Yes

Facilitator	Yes	No	Yes
Average Duration	42.8 minutes	35 minutes	58 minutes
Place	Murcia (Spain)	Morocco	Murcia (Spain)
Space	Participant's Home	Participant's Home	Participant's Home

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

### *Data analysis*

Firstly, the data analysis began with the definition and preliminary codification of the data via the creation of an initial list of codes as an orientational guide. Using this method, a number of categories were determined with their respective definitions and descriptive codes, based on which the preliminary analysis was performed. Thus, during the process of hierarchization and analysis, the codes were augmented, reduced and some omitted, until reaching the definitive version as observed in the results. At the same time, a constructive-inductive focus was incorporated whose aim is to allow theory and concepts to be modulated and reconstructed while the collection, handling and analysis of data is performed. This allowed the loss of information to be kept to a minimum and to potentiate the comparative analysis and systematic exploration of the data, via interpretation; in order to provide meaning to the relationships established for each new code, weaving the theoretical patterns and revealing an alternative and more complete vision.

### *Ethical considerations*

At all times, the anonymity of participants was maintained and pertinent ethical considerations were applied. The information was provided in both a verbal and written format, via an initial conversation and the subsequent handing over of a "Study Presentation Letter". Consent was requested in order to record interviews in audio format. Likewise, participants were informed of their right to abandon the interview at any time without prejudice to their person and of the complete confidentiality of the data obtained during the interview.

Subsequently, two copies of the “Statement of Informed Consent” were procured: one for the participant, with the purpose of providing a reference to the written document, and the other copy for the interviewer.

During the transcription of the interviews, IMGF codes were used to designate key informants, PMGF codes were used for referencing those participating in individual interviews and GMGF codes for those participating in group interviews.

This research project was approved by the Research Ethics Committee from the University of Murcia.

### ***Quality criteria***

With the aim of conferring scientific and methodological rigour to the research, a multiple triangulation was applied: a) ***data triangulation***, via the cross referencing of data from two sources; b) ***interview triangulation***, making use of a second interviewer in order to perform semi-structured interviews, as well as involving impartial observers during group dynamics; c) ***methodological triangulation***, by combining different types of data collection as described in the previous section; and d) providing participants with copies for the ***corroboration of results***. All of which was set up during the design stage of the research project.

### **Results**

This catalogue of key points for eradicating FGM emerges in the form of a road map, as a result of the reasoning of those men now opposed to this tradition. This set of recommendations is based mainly on actively listening to people with firsthand knowledge of this practice and its foundations. These individuals, who have undergone a process of sensitization regarding this issue, come from families in which FGM is or was performed and have personally experienced the complications arising from this tradition within their own families.

### ***Sensitizing and awareness-raising***

Action aimed at discovering the reality of FGM and awareness-raising of the biopsychosocial (BPS) problems arising from FGM, are crucial to generating reflexive dialogue on the abolition, or otherwise, of this practice.

*“Ablation causes disease in Africa. There is still much to be done in Africa in order to make people aware, firstly in terms of healthcare and secondly, as a community. To explain that through this practice part of someone’s life is taken away. Their sensitivity is lost for life. They may take a long time to become aroused. Women do not feel in the same way as men and may take a long time to feel.”* PMGF.8

*“Without raising awareness, if no-one explains it to them, they will never agree. Now, there is no awareness-raising or sensitization and people continue to do this.”* PMGF.14

Awareness-raising, therefore, promotes the recognition of the complications and pathologies associated with performing this act, and is an excellent tool for gradually eradicating FGM (Table 4).

**Table 4. Sensitized Male Vs Non-sensitized Male**

Sensitized Male	Non-sensitized Male
<i>“If it were my daughter, she could die, if I saw my daughter bleeding to death like that, death... To do that to her... sex education, that’s what can save her. It’s something we didn’t have and more and more”</i> PMGF.8	<i>“No, no, no. If it is done properly, women will be fine and there is no problem whatsoever. In my country there are people who say they have problems, but this is not so. There are also people who say it is good for childbirth. There is no problem if it is done well. People can say what they like but I know that what we think is okay and hurts no-one, because it is our decision and it must be respected.”</i> PMGF.7

Furthermore, via awareness-raising and health education for parents, the protection of the right to life and the physical and mental integrity of women and girls may be promoted and passed on to the next generation.

*“When I speak to my daughter about this I ask her please not to attempt this, she is now of a woman’s age and I say to her: look, do you know the suffering this causes women?”* IMG.F.1

Thus dialogue promotes knowledge, knowledge promotes critical thinking and critical thinking, the abolition of FGM/A.

*“If I were to speak about it, I know if I were to do this to my daughter, I could kill her. I could kill her if I did this to her. I, for example, I say to my wife that I would never do this. Never, ever. To other people’s daughters I would say it is better not to do it because it is harmful. Speak with people.”* GMGF.8

### ***Team effort***

The abolition of FGM must be a team effort on behalf of governments, communities, families and external sources, such as NGOs or Associations dedicated to the cause. Such a team effort requires systematic caring for the entire community, and as such the awareness and coordination of all members of the team is paramount for the planning and execution of activities promoting the eradication of such a detrimental practice for the health of women and young girls (Table 5).

**Table 5. Team Effort**

<b>Level</b>	<b>Verbatim</b>
<b>Government and External agents</b>	<i>“There are many means, such as publicity, to explain this to the people. The government is working against it and they are the ones who will create the publicity for this. There are also NGOs that fight against this and women’s associations. It is important to work on all fronts”</i> PMGF.9
<b>Families</b>	<i>“The father and mother will say to do it, because it is a tradition. But families are not like before, they are studying and learning the consequences of Sunna and eventually people will give it up.”</i> PMGF.9
<b>Community and Governments</b>	<i>“Thus the people, the governments, are also doing things, making a move, and with that, people are becoming aware, it’s something that has to happen, has to change”</i> PMGF.8

### ***Focus on rural areas***

Prevention and awareness efforts must be performed more intensely in rural areas, since the isolation inherent to such areas propagates traditions of this nature.

*“The girls that go from a city to a village far from the capital city come to spend the dry season, this is when they are to undergo ablation and they have to walk back but they can’t because it’s very far away. This is why awareness-raising must be performed in isolated towns”* PMGF.8

*“In the city it is more difficult, that is why they go to the villages and it is done there”* PMGF.4

### ***The means for abolition***

It is essential that workshops are held using graphic material such as videos and a range of pamphlets in which FGM is represented. Thus ideas can be confronted and a mutual cultural reconciliation reached whose ultimate goal is the wellbeing of the women and children associated with a pro-mutilation society.

*“I was shown all the consequences at school, what’s more with photos, they would say: Look, this is the vagina and this is the clitoris. That way we learn and avoid many women from losing their lives, that they might have their health and their sex lives”* GMGF.8

*“If you come I will listen to you, and later there will be a confrontation of ideas, the thing is, to raise awareness you have to use videos, what can happen, pamphlets, and see the problems and diseases this can cause”* PMGF.8

In this sense, the human and cultural side of globalization plays a fundamental role in path towards the eradication of FGM. The sensitization process is nurtured by comparisons between cultures and perspectives on life, whereby the assimilation of the struggle against this practice, reveals its complications and weakens the arguments of those ethnic groups in favour of this tradition.

*“I believe that within 15 to 20 years it will be over, the people of Africa are not like before, people are travelling a lot, lots of contact, lots of television. Now we see things unlike before, there was no television, no light, nothing”* PMGF.8

***The application of educative measures prior to punishment***

Sensitized populations know of and support punitive measures for the eradication of FGM, however, they prefer other means which although slower, are of greater reach and less repressive for communities.

*“There are ethnic groups that do not wish to give it up because they say it is our ancient custom, it is traditional and the government is banning it by law. It might be alright, but it is better to make people aware saying that Sunna has many consequences [...] I think the government should not stop it by force but by sensitization and little by little, until everyone understands it. By force, people won’t stop it because it would be like a dictatorship and people are not going to stop their customs, but if you explain why, people will change. [...]”* PMGF.8

Thus sensitization prior to prohibition favours the acceptance of penal legislation against this practice.

*“You have to sensitize first, then prohibit.”* PMGF.12

**Discussion**

These results suggest a number of recommendations and measures for the abolition of FGM. Furthermore, it becomes patently clear how sensitized men who have participated in awareness-raising and health education programmes, can change their viewpoint with regard to this practice, thus demonstrating that no conviction is unchangeable. In this context, a study published in 2015 by Abolfotouh *et al* points to the need for improved communication and education regarding FGM in order to shift the attitudes of men and women towards the cessation of this harmful practice.

Along these same lines, another study shows how the level of formal education in men has a direct influence on their preference for circumcised women, such that those men with higher academic qualifications prefer uncut women, while those of lower levels of formal education are inclined towards cut women (Sakeah, Beke, Doctor & Hodgson, 2006). Likewise, in female circles, those women of higher academic qualifications are

less likely to accept more severe forms of FGM than those with lower levels of formal education (UNICEF, 2005). Thus, higher levels of formal education favour the development of cultures and critical thinking, at the same time advancing the acquisition of new knowledge regarding the consequences of FGM and propitiating the reconsideration of cultural premises. In line with this discussion, research by Kaplan *et al* in 2013, establishes that the greater proportion of those men with further knowledge of the consequences of ablation are against this tradition.

Therefore, suggested key factors for eliminating FGM might be tools such as *health education* (Simonelli, Barbieri, Beraldo & Simonelli F, 2013) and establishing empowerment and development mechanisms via *awareness-raising campaigns* and *educational intervention* (Isman, Ekéus, Berggren, 2013), since these promote the assimilation of a greater amount of information and the establishment of cognitive maps which favour the comprehension of the risks associated with different forms of female genital mutilation, thus positively reinforcing its gradual eradication.

A further conclusion which stems from the results is that of the need for teamwork, as mentioned by those informants who have ceased to practice FGM when speaking of the importance of joint action on behalf of families, communities and governments. Such teamwork endeavours should be based on the creation of local initiatives and programmes in which all members of the family, including men, and schoolchildren, take part in awareness raising programmes on the consequences of FGM. Furthermore, and in accordance with Wuest *et al* (2009), it is essential to involve all the healthcare personnel of the area in training programmes specific to the effective detection and proper handling of cases of women having undergone or being at risk of FGM over the different stages of their lives.

Regarding local and international political commitment to the eradication of FGM, this must be based on establishing legal measures, facilitating educational resources to dismantle unfounded justifications of FGM and endeavouring to end inequality and poverty in the world (Abdulcadir, Margairazb, Boulvaina, & Iriona, 2011). As is demonstrated in a study by Fasu (2014), the probability of young girls from families living below the poverty line being mutilated is much higher since they have limited access to education and culture. Therefore, the data compiled from the present study

reveals the particular need for action in rural areas. Previous studies show that FGM is performed on women from all social classes and places of residence, although originating from rural areas means a greater risk of being cut, as well as of being subject to a more cruel form of mutilation. Such statements are supported by studies such as those of UNICEF (2013) and Abolfotouh *et al* (2015), which are in accordance with the statements made by the participants of the present study and by previous quotations. Thus, political efforts should be threefold: on the one hand providing legal support for families and communities towards the gradual abolition of FGM, on the other hand the provision of economic resources and the establishment of framework programmes for the development of awareness raising campaigns on the consequences of FGM and education on human values and rights, as well as gender equality and lastly, the application and extension of emergency measures against poverty in urban areas in general and in rural areas in particular.

According to the data gleaned from the interviews, the use of visual and communication media in health education programmes facilitates the familiarization of the population with the reality of FGM and its consequences for women's health. In this sense, other studies include the following as measures for promoting abolition: public education, information broadcasting via written media, radio programmes or community television, as well as discussing the issue directly with family members, friends and local religious leaders (Dalal, Lawoko & Jansson, 2014; Alcaráz, González & Solano, 2014). All the aforementioned means of exposure, together with health education and FGM eradication programmes, contribute to the creation of critical thinking by the populace towards this tradition (Masho, Matthews, 2009; Abdulmajid, Nakamura, Seino, Kizuki, 2013).

Finally, it should be stressed that although the men opposed to this practice support legislating against FGM, they prefer the use of less aggressive, farther-reaching measures. This phenomena is also manifest in the literature consulted, in which authors such as Nawal (2013) or Pastor (2014), arrive at the conclusion that imposing legal measures is not effective in reducing the prevalence of FGM and highlight the need to

organize effective action in collaboration with local, national and international groups, based on the knowledge of both human rights and the complications of FGM.

In contrast to these authors and in reference to a study performed in Yemen, a large part of the change in attitude of the population with regard to FGM can be attributed to a ministerial order prohibiting healthcare providers from taking part in its practice, even though it may be certain that, in the long term, sensitization and awareness raising are more effective than mere legal impositions

### ***Study limitations***

Firstly, the fact the present study is of a qualitative methodology means the results are the interpretation of the data according to the authors and as such, there is a risk of falling into the temptation of imposing cultural precepts inherent to said authors above those of the study subjects or *vice versa*. In order to avoid bias of this nature, the quality assurance criteria described earlier were applied during the codification and interpretation of the compiled data, among which the performing of periodical feedback sessions with key informants should be highlighted, as well as the utilization of paraphrasing ideas or examples which reinforce those affirmations described in the study.

In second place, the range of different justifications behind the practice of this tradition depending on the ethnic group, implies a significant limitation when extrapolating results from the study population to others, thus the present study presents a snapshot of the participants' beliefs. Nonetheless, in an attempt to mitigate such restrictions, it was decided that interviews in other geographical contexts as well as including participants against FGM, yet originally from countries where this is common practice, would be included.

### ***Implications for practice***

A series of key points are proposed on which to investigate further in order to be able to implement and apply (obstetric) nursing interventions focused on the prevention and eradication of this tradition.

These key points promote the cooperative approach on behalf of the nursing discipline towards the establishment of investigative research for the creation and implementation of health education programmes involving the voice of those having suffered from Female Genital Mutilation and the inequalities generated by the androcentric network prevailing in the majority of the world's social structures and which perpetuate not only harmful practices for women's health but also many other attempts against their physical integrity, dignity and human rights.

### Conclusion

This study demonstrates that professionals of the nursing and obstetrics fields can be a key element in the process of eradicating FGM via sensitization, awareness building and teamwork of families, communities and governments. The development of health education programmes involving graphic media and focused on demonstrating the existence of real health consequences resulting from this practice, play a fundamental role in the eradication of FGM in the medium to long term as a complementary measure to that of prohibitive legislation.

### Bibliography

Abdulcadir, J., Margairazb, C., Boulvaina, M., & Iriona, O. (2011). Care of women with female genital mutilation/cutting. *The European Journal of Medical Sciences*, 1-8.

Abdulmajid Al-Khulaidi, G., Nakamura, K., Seino, K., & Kizuki, M. (2013). Decline of Supportive Attitudes among Husbands toward Female Genital Mutilation and Its Association to Those Practices in Yemen. *Plos One*, 8(12). Obtenido de <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0083140>

Abolfotouh, S., Ebrahim, A., & Abolfotouh, M. (2015). Awareness and predictors of female genital mutilation/cutting among young health advocates. *International Journal of Women's Health*, 7, 259-269. Obtenido de [http://www.dovepress.com/front\\_end/awareness-and-predictors-of-female-genital-mutilationcutting-among-you-peer-reviewed-fulltext-article-IJWH#](http://www.dovepress.com/front_end/awareness-and-predictors-of-female-genital-mutilationcutting-among-you-peer-reviewed-fulltext-article-IJWH#)

Affara, F. (2002). Female genital mutilation is a human right issue of concern to all women and men. *International Nursing Review*, 49, 195-197

Alcaráz, M., González, S., & Solano, C. (2014). Attitudes towards female genital mutilation:an integrative review. *International Nursing Review*, 61(1), 25-34. Obtenido de <http://onlinelibrary.wiley.com/doi/10.1111/inr.12070/pdf>

- Amnistía Internacional. (1998). *La mutilación genital femenina y los derechos humanos. Infibulación, excisión y otras prácticas cruentas de iniciación*. Londres: EDAI.
- Dalal , K., Lawoko, S., & Jansson, B. (2010). Women's attitudes towards discontinuation of female genital mutilation in Egypt. *Journal of Injury and Violence Research*, 2(1), 41-47.
- Fosu, M., Nyarko, P., & Anokye, M. (2014). Female Genital Mutilation/Cutting among Ghanaian Women: The Determinants. *Research on Humanities and Social Sciences*, 4(18), 61-68. Obtenido de <http://www.iiste.org/Journals/index.php/RHSS/article/view/14881/15689>
- Grande Gascón, M., Ruiz Seisedos, S., & Hernández Padilla, M. (2013). El Abordaje Social y Político de la Mutilación Genital Femenina. *Portularia*, XIII(1), 11-18. Obtenido de [http://rabida.uhu.es/dspace/bitstream/handle/10272/6742/El\\_abordaje\\_social\\_y\\_politico.pdf?sequence=2](http://rabida.uhu.es/dspace/bitstream/handle/10272/6742/El_abordaje_social_y_politico.pdf?sequence=2)
- Isman, E., Ekéus, C., & Berggren, V. (2013). Perceptions and experiences of female genital mutilation after immigration to Sweden: An explorative study. *Sexual & Reproductive Healthcare*, 4(3), 93-98.
- Jiménez Ruiz, I., Almansa Martínez, P., Pastor Bravo, M., & Pina Roche, F. (2012). Aproximación a la Ablación/Mutilación Genital Femenina (A/MGF) desde la Enfermería Transcultural. Una revisión bibliográfica. *Enfermería Global*, 411-424.
- Kaplan, A., Cham, B., Njie, L., Seixas, A., Blanco, S., & Utzet, M. (2013). Female Genital Mutilation/Cutting: The Secret World of Women as Seen by Men. *Obstetrics and Gynecology International*, 1-10. Obtenido de <http://www.hindawi.com/journals/ogi/2013/643780/>
- Masho, S., & Matthews, L. (2009). Factors determining whether Ethiopian women support continuation of female genital mutilation. *International Journal of Gynaecology and Obstetrics*, 107(3), 232-235.
- Nawal, M. (2008). Female Genital Cutting: A Persisting Practice. *Reviews in Obstetrics and Gynecology*, 1(3), 135-139.
- OMS. (2012). *Mutilación Genital Femenina*. Obtenido de Nota descriptiva N°241: <http://www.who.int/mediacentre/factsheets/fs241/es/>
- Pastor, M. (2014). *La voz de las mujeres sometidas a mutilación genital femenina : saberes para la disciplina enfermera. Tesis Doctoral*. Obtenido de TDR. Tesis Doctorales en Red: <http://www.tdx.cat/handle/10803/284894>
- Royal College of Obstetricians and Gynaecologists. (2009). Green-top Guideline Female Genital Mutilation and its management. (53), 1-17.

Sakeah, E., Beke, A., Doctor, H., & Hodgson, A. (2006). *Males' Preference for Circumcised Women in Northern Ghana*. Obtenido de <http://www.bioline.org.br/pdf?rh06025>

Simonelli, I., Barbieri, A., Beraldo, F., & Simonelli, F. (2013). Female genital mutilation between culture and health: a quanti-qualitative study. *Research and Best Practice*, 3(3), 90-97. Obtenido de [http://clinhp.org/iframe/Vol3\\_Issue3\\_p90\\_97.pdf](http://clinhp.org/iframe/Vol3_Issue3_p90_97.pdf)

UNAF. (2013). *Guía para Profesionales. La MGF en España. Prevención e Intervención*. Madrid: Unión Nacional de Asociaciones Familiares. Obtenido de UNAF- Unión Nacional de Asociaciones Familiares: <http://unaf.org/wp-content/uploads/2014/02/Guia-MGF.pdf>

UNICEF. (2005). *Female Genital Mutilation/cutting. A statistical exploration*. Obtenido de United Nations Children's Fund: [http://www.unicef.org/publications/files/FGM-C\\_final\\_10\\_October.pdf](http://www.unicef.org/publications/files/FGM-C_final_10_October.pdf)

UNICEF. (2011). *Más de 6.000 comunidades en África abandonan la práctica de la mutilación genital femenina*. Obtenido de UNICEF: <http://www.unicef.es/sala-prensa/mas-de-6000-comunidades-en-africa-abandonan-la-practica-de-la-mutilacion-genital-femenin>

UNICEF. (2013). *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. Obtenido de United Nations Children's Fund : [http://www.unicef.org/media/files/FGCM\\_Lo\\_res.pdf](http://www.unicef.org/media/files/FGCM_Lo_res.pdf)

Wuest, S., Raio, L., Wyssmueller, D., Mueller, M., Stadlmayr, W., Surbek, D., & Kuhn, A. (2009). Effects of female genital mutilation on birth outcomes in Switzerland. *International Journal of Obstetrics and Gynaecology*, 116(9), 1204-1209.

- Healthcare professionals from the fields of nursing and, more precisely, obstetrics, should play an active role in the research and prevention of FGM.
- Dialogue promotes knowledge, knowledge promotes critical thinking and critical thinking, the abolition of FGM/A.
- Sensitization via health education is fundamental to the eradication of this practice.
- Those men who are aware of the consequences of FGM are less likely to choose mutilated women.

**Acknowledgements**

The authors would like to thank the men making up the sample for their participation. Without their altruistic contribution, this study would never have been possible. We would also like to extend our thanks to the Faculty of Nursing of the University of Murcia for allowing access to their facilities and also to thank the association DEMUSA, thanks to their existence we have been able to reach the study population.

Accepted manuscript