

ORIGINAL RESEARCH ARTICLE

Attitudes towards comparison of male and female genital cutting in a Swedish Somali population

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Abstract

Introduction: In Sweden, the law treats female genital cutting (FGC) differently from male genital cutting (MGC). However, the comparability of the medical, ethical, and legal aspects of genital cutting of girls and boys are increasingly discussed by scholars, although little is known about how practicing communities view these aspects. This study aimed to explore attitudes towards comparison of genital cutting of girls and boys among Swedish Somalis, and to investigate factors associated with considering the two practices to be comparable.

Material and methods: In a cross-sectional questionnaire with 648 Swedish Somali men and women from four Swedish cities, descriptive statistics and logistic regression were used for the analysis.

Results: Among the Swedish Somalis, 10% considered FGC and MGC to be comparable practices. A majority (98%) of the participants thought FGC could cause long-term health complications, but only 1% considered the physical health disadvantage of MGC would outweigh the physical health benefits. FGC was perceived to be a violation of children's rights by 60%, whereas this proportion for MGC was 3%. Individuals who had a dominant bridging social capital and those who expressed that performing FGC follows religion were more likely to think that FGC and MGC were comparable practices.

Conclusions: The increased global attention and emphasis on the comparability of genital cutting of boys and girls was not reflected in this study among Swedish Somalis. Rather, attitudes reflected the common description of the two practices in global public health campaigns, portraying FGC as a harmful practice violating children's rights, while describing MGC as a public health measure. Social interactions and separation of FGC from religion could explain why FGC and MGC were not considered comparable.

KEYWORDS

circumcision, female genital cutting, female genital mutilation, male circumcision, male genital cutting

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; cOR, crude odds ratio; FGC, female genital cutting; MGC, male genital cutting; VAS, visual analog scale; WHO, World Health Organization.

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1 | INTRODUCTION

In Sweden, the law treats genital cutting of boys and girls unequally. Genital cutting of boys is permissible, whereas genital cutting of girls is not.^{1,2} This separation is common globally in legislation as well as in public discourse.³⁻⁵

The World Health Organization (WHO) defines female genital cutting (FGC) as “all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.” The term includes procedures of varying extent, from pricking, which includes a nick of the clitoris or labia without removal of tissue, to infibulation, and removal of the labia minora/majora and narrowing of the vaginal orifice.⁶ Male genital cutting (MGC) or male circumcision refers to partial or complete removal of the foreskin of the penis. The extent of the procedure can vary.^{7,8}

Male genital cutting is provided by the public healthcare system in many western countries, including Sweden. Although potential risks with the practice have been researched,^{9,10} focus has been to assess the presumed health benefits, such as a measure for human immunodeficiency virus prevention, mostly in low- and middle-income countries.¹¹ The presumed hygienic benefits have also been emphasized in, for example, the USA and Great Britain, where secular MGC dates back to the Victorian era, when it was performed by doctors to curb masturbation, which was thought to cause a variety of diseases.¹² In contrast, the understanding of FGC as a harmful practice gained ground in western society with the publication of the Hosken report in 1979.³ Now, the WHO and other international organizations are unequivocal in their position to eliminate all FGC practices, referring to negative health consequences and the oppressive nature of FGC.¹³ Opponents of this separation are now pointing out the comparable aspects of the practices. Both FGC and MGC are invasive procedures involving removal of densely innervated genital tissue, such as the clitoral glans in females and the foreskin in males.¹⁴ These procedures can cause short-term health complications including excessive bleeding, genital tissue swelling, and urinary retention, regardless of whether the procedure is performed on boys or girls.¹³ Non-sterile equipment and otherwise deficient conditions can be assumed to exacerbate these complications. Long-term health complications have been reported for both procedures, although these studies have been criticized for being biased and having methodological issues.^{5,9,13,15,16}

Historically, rationales for MGC are to a large extent similar to those for FGC. Ensuring social status, improvement of beauty and hygiene, marking the transition to womanhood/manhood and religious identity are rationales for both MGC and FGC.³⁻⁵ Another belief is that FGC and MGC establish gender identity by removing what is considered to be the male remnants on the female body, and the female remnants on the male body.³ However, differences can be found. In Somalia, FGC is considered a requirement for marriage and is thought to serve as preservation of virginity, which is not an established rationale for MGC.¹⁷

Key message

Among Swedish Somalis, 90% did not consider male and female genital cutting to be comparable, 10% highlighted similarities. There was a clear discrepancy in attitude towards health complications and children's rights. Separation of female genital cutting from religion might be part of the explanation.

In Somalia, the practice of MGC is close to 100%, similar to the rest of the global Muslim community.¹⁸ FGC is also highly prevalent in Somalia, but public rejection of the severest form of FGC, infibulation, is growing and a gradual change towards less invasive forms of FGC is taking place.¹⁷ Research suggests that the support and practice of FGC decreases when individuals migrate from a country where FGC is practiced, to a place where it is not.^{19,20} In Sweden, Somali immigrants have been found to largely oppose FGC, with the proportion of opponents increasing with years spent in Sweden.²¹ However, in a qualitative study among Swedish Somalis the same development of decreased support towards MGC was not seen.²²

Several scholars have recently argued that the cutting of any person's genitals without their informed consent is a violation of their right to bodily integrity and impermissible in relation to universal human rights, unless it is medically necessary.²³⁻²⁶ The medical, ethical, and legal aspects of FGC and MGC, and their comparability, are increasingly discussed. However, less is known about how practicing communities view the comparability of these two practices.

The aim of this study was to quantitatively investigate attitudes towards comparison of FGC and MGC among Somali immigrants in Sweden and factors associated with considering the two practices to be comparable.

2 | MATERIAL AND METHODS

2.1 | Setting

In Sweden, all FGC practices have been criminalized since 1982, whereas MGC is legal.^{1,2} Around 66 000 Somali-born men and women live in Sweden.²⁷ About half of them are between 15 and 34 years old, 60%-70% have primary or unknown level of education, and 25%-30% are employed.²⁸

2.2 | Study design

This was a cross-sectional questionnaire study with Swedish Somali men and women from four major cities in Sweden: Malmö,

Stockholm, Gothenburg, and Uppsala. Inclusion criteria were men and women born in Somalia, 18 years of age or more, and verbal consent to take part in the survey.

2.3 | Data collection

Data collection was performed between January and December 2015. Participants were recruited through purposeful sampling in Somali organizations, mosques, and public places and at Swedish courses for immigrants. From there, snowball sampling was adopted to reach a larger number of participants. Six Somali-born data

collectors performed the interviews face-to-face in Somali with the participants. The data collectors took part in the recruitment of participants and tried to establish a trusting relationship with the participant. They also made sure that the anatomical extent of different forms of FGC was understood by the participants. For more information on data collection, see Anna Wahlberg's dissertation.²⁰

2.4 | Variables

A validated 49-item questionnaire was used.²⁹ It was piloted and translated from English to Somali and then back-translated to English

TABLE 1 Descriptive and explanatory variables

Variable	Answer alternatives and categorization of VAS answers
In your opinion, are circumcisions of girls and boys comparable practices?	Yes; no Missing values $n = 25$ (3.9%)
Gender	Man; woman
Age	Odds ratios for 10-year intervals
Marital status	Single; divorced/widowed; married/partner
Education	No education; Koranic school; Primary school (1–9 years)/Secondary school; University/College
Somali origin	Urban; rural (village/nomadic)
Occupation	Unemployed; work full-/part-time/student
Years lived in Sweden	0–4 years = newly arrived; 5 years and more = established
Social capital	
Social trust ^a	Low; high
Social participation ^a	Low; high
Bridging/bonding social capital ^a	Low; high
Received information from mass media in Sweden regarding FGC	Yes; no
Benefits	
A benefit of undergoing FGC is social acceptance	Yes; no
There are no benefits from avoiding FGC	No benefit from avoiding FGC; there are benefits
Not to undergo FGC follows religion	Yes; no
Health risk	
FGC: When, if ever, will the circumcision cause long-term health complications for girls/women?	Never; All forms of FGC (0–10 mm); FGC with removal of tissue (>10 mm)
MGC: In regard to physical health, where would you place the effects of male circumcision?	More beneficial (<50 mm); more harmful (>50 mm). No value was exactly 50 mm
Children's rights	
FGC: When, if ever, will the circumcision become a violation of children's rights	Never; all forms of FGC (0–10 mm); FGC with removal of tissue (>10 mm)
MGC: Some people say that male circumcision is a violation against children's rights, do you agree?	Yes; no
Continuation	
FGC: There are people who want female circumcision to be abolished and other people who want it to be continued. What of the following do you want to continue?	Pricking but no flesh removed; some flesh removed; flesh removed and stitches; all should be abolished
MGC: Do you see any reason for questioning circumcision of boys?	Yes; no

Abbreviations: FGC, female genital cutting; MGC, male genital cutting; VAS, visual analog scale.

^aSee explanation in Section 2.5.

(for Questionnaire see Supporting Information Appendix S1). From this questionnaire, variables were selected to constitute the primary outcomes and the explanatory variables in this study (Table 1).

A visual analog scale (VAS), with a score ranging from 0 to 100 mm, was used for variables regarding health complications of FGC/MGC and the relation of FGC to children's rights. A higher score indicated an anatomically more extensive FGC. Table 1 presents the variables and the use of the VAS score, and Figure 1 provides an interpretation of the VAS scale and translation into WHO classification and Somali terminology.

A schematic picture of different forms of FGC was available to help the participant in discriminating between different forms of FGC and to associate this with the adequate VAS score. Pricking was placed to the very left on the VAS and defined as procedures in which the skin of the clitoris or labia is pricked with a sharp object; blood may be let, but no tissue is removed, and there is no permanent alteration of the external genitalia, according to the WHO definition. The Somali translation of pricking that was used was *Dhijjin aan cad la jarin*.

2.5 | Social capital variables explained

Three variables regarding social capital were constructed: social participation, social trust, and bridging social capital. Social participation was quantified by assessing the participants' attendance of 13 different social activities during the last 12 months (see Supporting Information Appendix S1, question 46). Social trust was measured through a variable based on four sub-questions commonly used in epidemiological studies (see Supporting Information Appendix S1, question 45).²⁹ Using the median, a relative measurement of high/low social participation/social trust within the study population was constructed. The third social capital variable was bridging/bonding social capital. A distinction can be made between bonding social capital, referring

to social connection within the family or people with similar sociodemographic background, and bridging social capital, referring to social connection with people of different sociodemographic background. The three different questions meant to be used to assess bridging and bonding (see Supporting Information Appendix S1, questions 47–49) were highly correlated, and therefore merged into one variable. The participants who had “dominant bridging” in at least one of these questions were categorized as “dominant bridging social capital” whereas those who had non-dominant bridging in all three questions were categorized as “non-dominant bridging” social capital. Further details on the social capital variables are given elsewhere.²⁹

2.6 | Sample size

The sample size was calculated with a statistic power set to 80% and margin of error set to 0.05. The outcome measuring “attitudes towards continuation of FGC” was used to estimate the sample size. The first 107 collected questionnaires were analyzed and the support of continuation of FGC came out as 24%. To adjust for the cluster sampling design effect, which demands a greater sample size, the estimate was multiplied by 2.25, a number based on Demographic and Health Surveys studies' mean design effect. These data resulted in a sample size of 633.

2.7 | Statistical analyses

The primary outcome, whether FGC and MGC are comparable, is presented by means of descriptive statistics and multiple logistic regression, which was used to quantify the influence of the explanatory variables on the primary outcome (see Table 1). The data from the VAS score were recoded into a categorical data level. Cut-off for statistical significance was set to 0.05. SPSS version 24.0 was used for the statistical analysis.

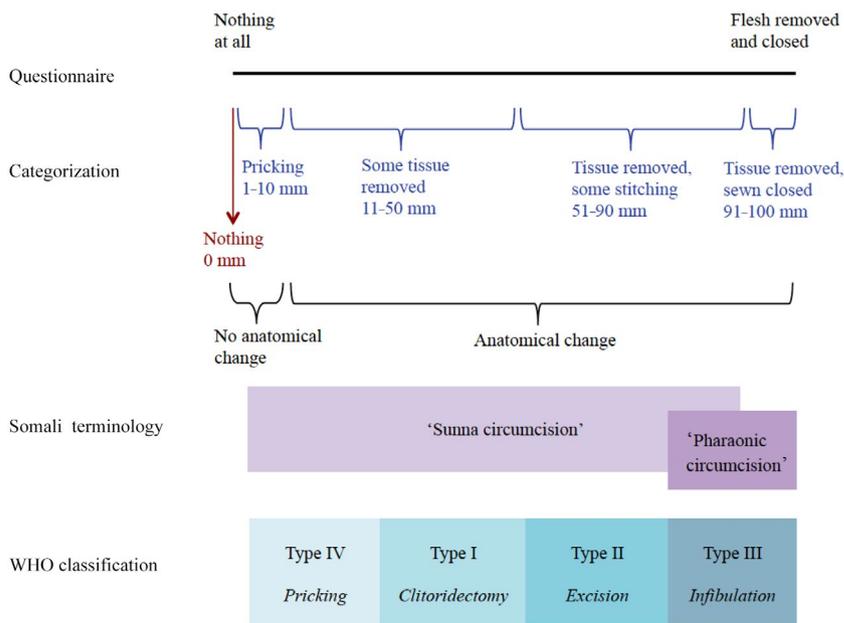


FIGURE 1 The visual analog scale was used to capture all different forms of female genital cutting. The figure shows translation for the visual analog scale, ranging from 0 to 100 mm, into WHO classification and Somali terminology. Graphics²⁹ [Color figure can be viewed at wileyonlinelibrary.com]

2.8 | Ethical approval

Ethical approval to conduct the study was obtained from the Uppsala Regional Ethical Review Board in Sweden (20 August 2014, Dnr 2014/274). All participants received verbal and written information about the study before engagement and were informed of their right to refrain from answering questions and to terminate the interview at any time without further explanation.

3 | RESULTS

There was an even distribution of men and women in the study population ($n = 648$).

Regarding years of residency in Sweden, 43.1% had lived in Sweden for 0–4 years, 25.2% had lived in Sweden for 5–10 years, and 31.7% had resided in Sweden for 10 years or more. A majority had primary or secondary school as highest declared education (72.0%) and most people were from an urban setting in Somalia (80.4%). Of all participants, 98.4% had undergone FGC/MGC (see Table 2).

3.1 | Comparison of FGC and MGC

One in ten (10.4%) considered the practice of MGC to be comparable to some form of FGC: “pricking” ($n = 19$, 3.0%), “some flesh removed” ($n = 19$, 3.0%), “flesh removed and closed” ($n = 13$, 2.1%), and “flesh removed and some stitching” ($n = 14$, 2.2%) (see Figure 2).

Most (98.0%) thought FGC could cause long-term health complications, and only 1.1% considered the physical health disadvantage of MGC outweighed the physical health benefits. About half (55.4%) did not consider pricking (FGC without removal of tissue) to cause long-term complications (see Figure 3).

Genital cutting of girls, regardless of form, was perceived to be a violation of children’s rights by 60.3%; this number for genital cutting of boys was 2.5%. One in three did not think pricking (FGC without removal of tissue) was a violation of children’s rights, and a minority (5.9%) reported that they thought no form of FGC was a violation of children’s rights (see Figure 4).

Around eight in ten were of the opinion that all forms of FGC should be abolished, but a minority (17.5%) claimed that pricking should be continued. The rest (4.1%) thought at least one of the following should continue: “some flesh removed”, “flesh removed and some stitching”, and “flesh removed and closed”. Regarding MGC, a small minority (1.7%) saw a reason to question its continuation (see Figure 5).

3.2 | Factors associated with the attitude that FGC is comparable to MGC

Individuals with non-bridging social capital, that is, those with strong social connection to family and people with similar sociodemographic

TABLE 2 Background variables

	Total ($n = 648$)		Females ($n = 318$, 49.1%)		Males ($n = 330$, 50.9%)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Age						
<26 years	91	14.0	42	13.4	49	14.9
26–35 years	217	33.5	114	36.4	103	31.3
36–45 years	166	25.6	83	26.5	83	25.2
>45 years	168	25.9	74	23.6	94	28.6
Marital status						
Single	246	38.2	94	29.7	152	46.3
Married/Partner	343	53.3	183	57.9	160	48.8
Divorced/ widowed	55	8.5	39	12.3	16	4.9
Education						
No education	75	11.6	54	17.0	21	6.4
Koranic school	43	6.6	36	11.3	7	2.1
Primary school (1–9 years)	257	39.7	141	44.3	116	35.6
Secondary school	207	31.9	73	23.0	134	41.1
University/ College	62	9.6	14	4.4	48	14.7
Somali origin						
Urban	521	80.4	254	80.6	267	81.7
Rural (village/ nomadic)	121	18.7	61	19.4	60	18.3
Respondent’s own MGC/FGC status						
Has undergone FGC/MGC	626	98.4	310	98.4	316	98.4
Has not undergone FGC/MGC	9	1.4	5	1.6	4	1.2
Don’t know	1	0.2	0	0	1	0.3
Occupation						
Unemployed	347	53.5	195	61.9	152	46.5
Work full-/ part-time	252	40.1	101	32.1	151	46.2
Student	43	6.4	19	6.0	24	7.3
Years lived in Sweden						
≤2	168	26.0	90	28.4	78	23.6
3–4	111	17.2	52	16.4	59	17.9
5–9	163	25.2	82	25.9	81	24.5
10–14	80	12.4	38	12.0	42	12.7
≥15	125	19.3	55	17.4	70	21.2

Note: Missing values ranged between 0 and 9.

Abbreviations: FGC, female genital cutting; MGC, male genital cutting.

background, were less likely to think that FGC and MGC were comparable (adjusted odds ratio [aOR] = 0.43, 95% CI = 0.24–0.77) (see Table 3).

Those who expressed that avoiding FGC follows religion were less likely to think that FGC was comparable to MGC (aOR = 0.26, 95% CI = 0.13–0.50). The individuals who thought there were no benefits to gain from avoiding FGC were more likely to think that FGC and MGC were comparable (aOR = 7.98, 95% CI = 3.37–18.89). Furthermore, participants were more likely to think that FGC and

MGC were comparable if they considered FGC to prevent premarital sex (aOR = 7.03, 95% CI = 1.19–41.54) (see Table 4).

4 | DISCUSSION

There was a great difference in views of the comparability of genital cutting of girls and boys. Most considered that all forms of FGC caused health complications, that the practice was a violation of children's right, and that it should be discontinued. The opposite was found in relation to MGC. A vast majority considered MGC to be more beneficial than harmful, almost none thought it was a violation of children's rights, and very few saw a reason for questioning its continuation. Swedish Somalis who had a dominant bridging social capital, and those who expressed that performing FGC follows religion were more likely to think that FGC and MGC were comparable practices.

Perceptions of what constitutes the ideal male and female bodies are influenced by several factors, for example, culture and context.^{30,31} As both culture and context change with migration from Somalia to Sweden, so may perceptions of what constitutes ideal bodies. Although FGC no longer seems to be viewed as a way to create an ideal female body, perceptions of what constitutes the ideal male body seem not to have changed to the same extent. This perception may have been influenced by public health campaigns, which in general have focused on the negative aspects of FGC but

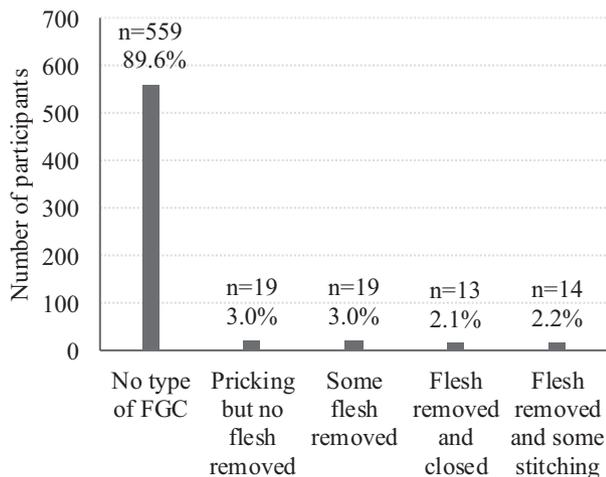


FIGURE 2 Attitudes among Swedish Somalis on whether female genital cutting (FGC) and male genital cutting are comparable practices, and if yes, which forms of FGC are comparable to male genital cutting (n = 623)

FIGURE 3 (A) Attitudes among Swedish Somalis on whether genital cutting cause long-term health complications for girls/women (n = 646) and (B) whether male genital cutting is more harmful or more beneficial (n = 647). FGC, female genital cutting

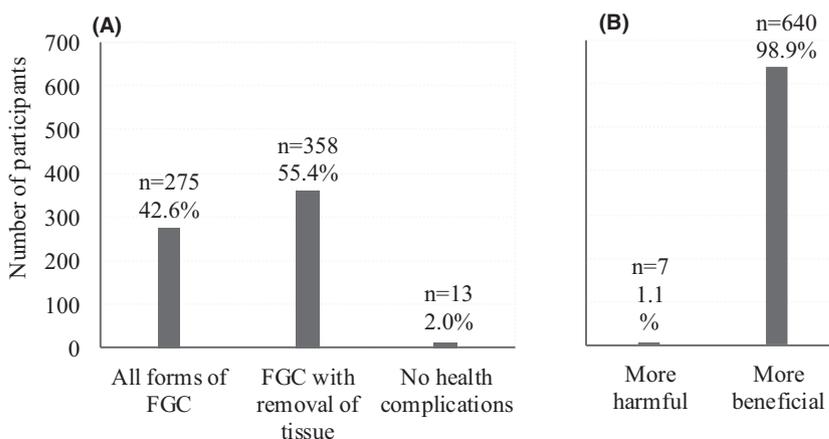
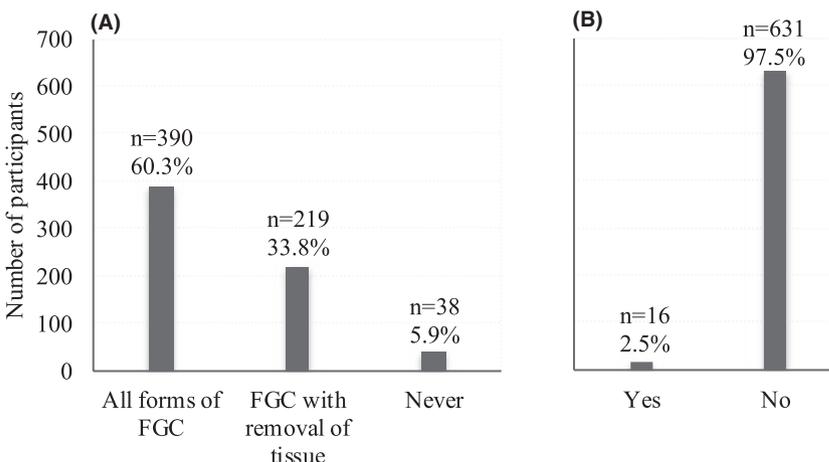


FIGURE 4 (A) Attitudes among Swedish Somalis on whether female genital cutting (FGC) is a violation of children's rights (n = 647) and (B) whether male genital cutting is a violation of children's rights (n = 647)



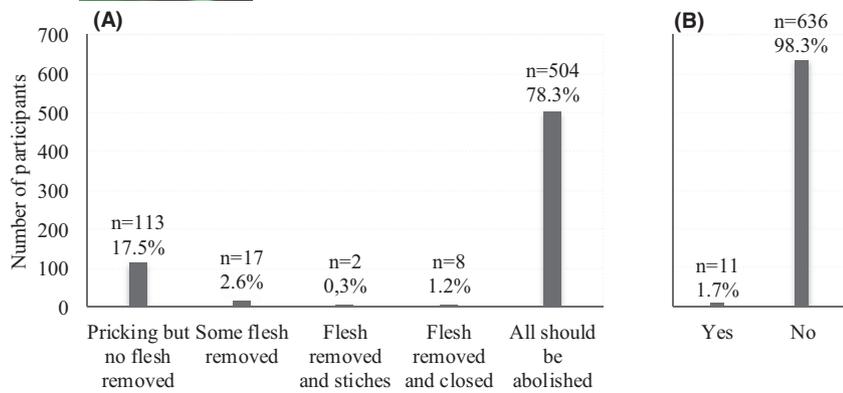


FIGURE 5 (A) Attitudes among Swedish Somalis on whether female genital cutting should continue, and if yes, which forms of female genital cutting that should continue (n = 644). (B) Attitudes among Swedish Somalis on whether they see a reason for questioning male genital cutting (n = 647)

	N	%	cOR	95% CI	aOR ^a	95% CI
Social trust^b						
Low	571	88.1	0.54	0.28–1.19	0.59	0.27–1.29
High	69	10.6	1.00	Ref.	1.00	Ref.
Social participation^b						
Low	368	56.8	1.92 [*]	1.10–3.37	1.81	0.97–3.37
High	277	42.7	1.00	Ref.	1.00	Ref.
Bridging social capital^b						
Non-dominant bridging	299	46.1	0.47 ^{**}	0.27–0.81	0.43 ^{**}	0.24–0.77
Dominant bridging	337	52.0	1.00	Ref.	1.00	Ref.
Received information from mass media in Sweden regarding FGC						
Yes	57	8.8	1.00	Ref.	1.00	Ref.
No	585	90.3	2.11	0.64–6.96	1.81	0.53–6.2

TABLE 3 Social capital; descriptive statistics and odds ratios for the attitude that female genital cutting to male genital cutting (N = 648)

Note: Missing values for explanatory variables ranged between 3 and 12.

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; cOR, crude odds ratio; FGC, female genital cutting.

^aAdjusted for sex, age, education, marital status, Somali origin, years of residency in Sweden, and occupation.

^bSee explanation in Section 2.5.

* $p < 0.05$,

** $p < 0.01$.

on the positive aspects of MGC, and governmental decisions only legislating against one of the two practices.^{32,33}

The results of this study are in line with previous research showing that support for FGC decreases with migration from an FGC-practicing country to a non-practicing country.^{19,20,34,35} Johnsdotter³⁶ found, in a Swedish Somali migration context, an ongoing separation between FGC and religion. Similarly, Wahlberg et al²² showed a conceptual split between attitudes towards MGC and FGC where the religious imperative of the practice on girls was increasingly questioned, while the perceived necessity of MGC for Muslim men was largely preserved. This renegotiation of FGC, but not MGC, in relation to Islam is in line with the results in this study. Swedish Somalis who stated that it was according to religion not to undergo FGC were less likely to think that FGC and MGC were comparable. This indicates a change in attitudes away from FGC as

religiously imperative, assuming that MGC is still held as a mandatory Muslim practice among the Somali diaspora. However, the concept of *sunna* circumcision, including several forms of FGC for example pricking, ties the practice closely to religion as, in Islam, the term “sunna” means the tradition of the Prophet Mohammed.³⁷ Several studies have reported a general acceptance of sunna circumcision, described as a religiously beneficial, but not obligatory, practice.^{22,33}

This study found diametrically differing perceptions of whether FGC and MGC have a negative health impact. These findings are in line with earlier studies in Sweden and Norway.^{22,38} However, in a recent study among Kurdish-Norwegians this differentiation between the practices was not as evident, describing a renegotiation of the potential harm a boy may be exposed to with some informants stating they regretted or will refrain from circumcising their boys as they perceive MGC as painful.³³ The Norwegian government's

TABLE 4 Attitudes and knowledge; descriptive statistics and odds ratios for the attitude that female genital cutting is comparable to male genital cutting (N = 648)

	n	%	cOR	95% CI	aOR ^a	95% CI
Forms of FGC perceived to cause health complications						
None	13	2.0	1.00	Ref.	1.00	Ref.
All forms of FGC	275	42.2	0.55	0.14–2.10	0.93	0.18–4.83
FGC with removal of tissue	358	55.2	0.25*	0.07–0.98	0.39	0.08–2.00
MGC is more beneficial than harmful						
Yes	640	98.8	0.67	0.08–5.68	0.88	0.09–8.59
No	7	1.1	1.00	Ref.	1.00	Ref.
FGC of any form is a violation of children's rights						
Never	38	5.9	1.00	Ref.	1.00	Ref.
All forms of FGC	390	60.3	1.53	0.45–5.21	2.20	0.49–10.01
FGC with removal of tissue	219	33.8	0.91	0.25–3.28	1.25	0.26–5.92
MGC is a violation of children's rights						
Yes	16	2.5	1.00	Ref.	1.00	Ref.
No	631	97.4	0.41	0.11–1.51	0.44	0.11–1.72
A benefit of undergoing FGC is social acceptance						
Yes	88	13.7	0.61	0.25–1.45	0.41	0.14–1.18
No	554	86.3	1.00	Ref.	1.00	Ref.
There are no benefits from avoiding FGC						
No benefit from avoiding FGC	49	7.6	5.46**	2.80–10.66	7.98**	3.37–18.89
There are benefits	595	92.4	1.00	Ref.	1.00	Ref.
Not to undergo FGC follows religion						
Yes	274	42.5	0.29**	0.16–0.55	0.26**	0.13–0.50
No	370	57.5	1.00	Ref.	1.00	Ref.

Note: Missing values for explanatory variables ranged between 1 and 6.

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; cOR, crude odds ratio; FGC, female genital cutting; MGC, male genital cutting.

^aAdjusted for sex, age, education, marital status, Somali origin, years of residency in Sweden, and occupation.

* $p < 0.05$,

** $p < 0.01$.

different treatment of FGC and MGC, including the harm-reduction strategy for MGC, is suggested to be a potential explanation for the changes in meaning of MGC, and that this may result in some parents or guardians deciding not to circumcise their sons.³³ Based on the results from this study, such a renegotiation of the harm caused by MGC is not evident. It is of interest to further investigate how the Swedish government's position towards MGC may have influenced Swedish Somalis' perception of MGC. Further, while FGC type III is the predominant form of FGC in Somalia, the Kurds mainly practice FGC types I, II and IV.³⁹ As these are less extensive forms of FGC, it may have been easier for the Kurdish-Norwegians to draw parallels between FGC and MGC than for the Swedish Somalis in this study. Another explanation to why views on MGC did not seem to have changed or been questioned could be that MGC to some extent is normalized in Sweden and what is in the best interest of young boys has not been discussed in the same way as safeguarding girls. In societies where MGC is the norm, adverse effects from the practice

might not be noted because the negative effect would not explicitly be connected to the removal of the foreskin. In the same way as it has been suggested that the negative impact of FGC is "hidden" in a setting where it is normalized, false beliefs (ie, thinking MGC is harmless) about the effects of MGC increase men's satisfaction with their cut genitals.⁴⁰ In addition, social pressure and fear of having one's masculinity questioned can make a man ignore his complaints.¹⁰

Among the Swedish Somalis in this study, FGC was commonly described as a violation of children's rights, whereas MGC was not. This is in line with the stance taken by the WHO, which calls upon human rights when promoting its position for both procedures: when stating that FGC should be banned the WHO refers to the human right of physical integrity, while simultaneously stating that MGC "provides an opportunity to reinforce HIV [human immunodeficiency virus] prevention efforts and thereby promote human rights".^{7,13} The WHO positioning and the prevailing western discourse distinguishing between the practices of FGC and MGC

may have had an influence on the Swedish Somali perceptions of the two practices,⁴¹ and be one explanation for the vast differences observed in attitudes towards genital cutting of boys and girls. This view of opposing FGC while accepting MGC has been challenged, for example by Möller,²⁴ who argues that the justifications for this differential treatment relating to “the harm involved in the respective practices, possible medical benefits of male cutting, the absence of a religious motivation with regard to female cutting, and patriarchal power structures enabling female but not male cutting—are insufficient”. Further, Möller argues that both practices are intrinsically wrong because they violate the right to physical integrity.

Adaptation to social norms has been suggested to be a reason for the continuation of FGC and MGC in countries where they are traditionally practiced.⁴ Migrating from a country with high prevalence of FGC and/or MGC to a country where it is neither a custom nor a social norm—such as Sweden—could lead to a renegotiation of the practice(s). In this study, having a dominant bridging social capital, in the sense of having good social connection with people of different sociodemographic background, meant higher likelihood of thinking that FGC and MGC were comparable practices. This could be understood from a social norms perspective: as neither FGC nor MGC is practiced or favored among the vast majority of the Swedish population, this perspective might have influenced the Swedish Somalis who had predominantly a bridging social capital.

This study had a large number of questionnaire responses and included a diverse group of Swedish Somalis with respect to age, years of residency in Sweden, and socioeconomic factors. Having data collectors who themselves were Somalis and who built trust with the participants was perceived as a crucial aspect when surveying this sensitive topic. It has been suggested that the anatomical extent of FGC rather than the WHO classification of FGC should be used in research.⁴² Therefore, a VAS to assess the anatomical extent of FGC was used, a novel and useful approach to describe the different forms of FGC.

The use of snowball sampling when recruiting participants could lead to sample bias. There were no data on participants' opinions before migration to Sweden. Hence, it is not possible to know whether the assumed change in attitudes towards FGC is a case of sample bias where a non-proportionally large group who were already opposing FGC before migration was included. However, in a study based on the same sample, it was found that support for FGC decreased with time spent in Sweden, suggesting that attitude change is happening after migration.²⁰

As the questionnaire data were collected face-to-face with a data collector, there was a risk that the participants would adapt their response and give normative and favorable answers in the view of the data collector and the research team,⁴¹ especially because of the anti-FGC discourse and because FGC is illegal in Sweden. An indication that participants answered sincerely in the questionnaire is that a considerable support for pricking was found, although participants had high awareness of its illegal status in Sweden.²⁰

5 | CONCLUSION

Attitudes towards genital cutting of girls and boys varied widely among the Somali diaspora in Sweden. From an almost 100% prevalence of both practices in Somalia, in Sweden a majority oppose the continuation of FGC, but support of MGC remains high. On the one hand, FGC was said to be harmful and a violation of children's rights, whereas MGC, on the other hand, was described as a harmless practice not violating children's rights. Separation of FGC from religion, and the influences of contemporary Western discourse on FGC and MGC might be part of the explanation. With the adoption of the Child Convention into Swedish law in 2020, it remains to be seen if and how this will affect the policy and legislation around non-therapeutic genital cutting of boys in Sweden.

This is, to the best of our knowledge, the first quantitative study based on empirical data comparing attitudes towards MGC and FGC among a community traditionally practicing both. Longitudinal studies are needed to better understand changes in attitudes towards FGC and MGC over time, both in countries of origin and after migration.

CONFLICT OF INTEREST

None.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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