



Research to Help Girls and Women Thrive

# CHANGES IN FGM/C IN SOMALILAND: MEDICAL NARRATIVE DRIVING SHIFT IN TYPES OF CUTTING

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**The Evidence to End FGM/C: Research to Help Girls and Women Thrive generates evidence to inform and influence investments, policies, and programmes for ending female genital mutilation/cutting in different contexts.** Evidence to End FGM/C is led by the Population Council, Nairobi in partnership with the Africa Coordinating Centre for the Abandonment of Female Genital Mutilation/Cutting (ACCAF), Kenya; the Global Research and Advocacy Group (GRAG), Senegal; Population Council, Nigeria; Population Council, Egypt; Population Council, Ethiopia; MannionDaniels, Ltd. (MD); Population Reference Bureau (PRB); University of California, San Diego (Dr. Gerry Mackie); and University of Washington, Seattle (Prof. Bettina Shell-Duncan).



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# Table of Contents

List of Acronyms.....	iii
Acknowledgments.....	iv
Executive Summary.....	v
Introduction.....	1
Methods.....	3
Study Design and Data Collection Methods.....	3
Participants.....	3
Sample Size and Sampling.....	3
Recruitment Procedures.....	3
Translations.....	4
Data Management and Analysis.....	4
Informed Consent.....	5
Results.....	5
Characteristics of respondents.....	5
Thematic findings.....	6
Discussion.....	22
Conclusion.....	24
Limitations.....	25
References.....	26

## List of Acronyms

FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/Cutting
IDI	In-Depth Interview
KII	Key Informant Interview
MCH	Maternal and Child Health
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

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# Executive Summary

## Introduction

While the majority of affected countries have adopted legal frameworks prohibiting female genital mutilation/cutting (FGM/C), these measures have been varyingly effective in preventing the practice or significantly accelerating its total abandonment. One possible reason is the inadequacy of the theoretical paradigms framing FGM/C interventions that neglect the collectively held social norms underpinning the practice's continuation. Social norms theory contends the perpetuation of harmful practices (such as FGM/C), and the creation of beneficial new ones, may be attributable to social motivations involving an entire community's beliefs and actions rather than simply those of individuals and their families.

In Africa, where focus is growing on social norms as a theoretical underpinning for preventative interventions, FGM/C is most common in the western, eastern, and northeastern countries. In Somalia, FGM/C prevalence is nearly universal at 98 percent. Despite calls for rigorous research on FGM/C abandonment for the Sustainable Development Goals, there is limited peer-reviewed literature with primary data on FGM/C for Somalia and Somaliland. This qualitative study therefore sought to explore:

1. Views and experiences of married and unmarried men and women on FGM/C and potential changes in its practice (in terms of age, cut severity, and medicalisation);
2. Individual, family, and societal factors contributing to any changes, or continuation, of FGM/C;
3. The knowledge, views, and experiences of health care workers who offer FGM/C services (including corrective services as well as potentially medicalised versions) and their role as change agents rather than providers, and;
4. How health care systems' capacities can be strengthened for management and prevention.

## Methods

The study used a cross-sectional design with mixed qualitative methods (key informant interviews [KIIs], in-depth interviews [IDIs] and focus group discussions [FGDs]), among married (not dyads) and unmarried men and women of reproductive age (20-49 years), from rural and urban areas with varying levels of formal education, and health care workers with familiarity managing FGM/C procedures in two regions of Somaliland – Awdal and Waqooyi Galbeed – in the districts of Borama and Hargeisa. 'Community FGDs' were also conducted among those who had been exposed to anti-FGM/C programmes in the preceding six months. Thematic data analysis used template analysis.

## Results

A total of 16 non-community FGDs and 8 community FGDs among unmarried and married men and women, 20 KIIs with key stakeholders, and 28 IDIs with health care workers and health system administrators were conducted, entailing 280 participants in total.

### *Thematic findings*

- Only two types of cut were described by respondents: pharaonic and Sunna. Sunna, as a perceived milder form, entailed the 'pricking' or 'nicking' of the clitoris for it to bleed, or indeed its excision, and was viewed as being more 'healthy' for the child.

- The practice was framed as mainly either cultural or religious in nature. Specifically, the pharaonic cut was seen as culturally inherited, while the Sunna form was viewed by many as supported by religious teachings.
- Respondents generally reported a shift away from the pharaonic to the Sunna cut, with the transition more evident in urban compared with rural areas, where the former cut is more prevalent.
- The change in the type of cut practiced was attributed primarily to awareness generation and issue sensitisation in the community by two groups: health care workers and religious leaders.
- There appears to be a gradual decrease in the age at which FGM/C is performed on young girls, which now ranges between 5-8 years. The primary reasons for this change are a potential refusal of the girl at an older age to undergo circumcision, exerted parental authority in the ostensible interests of the girl, and a justification in 'tradition'.
- Evidence also exists of the medicalisation of FGM/C in Somaliland, especially undertaking the Sunna form of cut, with health professionals as cutters and cutting occurring at facilities or at individuals' homes.
- Some respondents felt FGM/C has been abandoned recently, especially in the urban areas. However, there were mixed understandings of what constituted 'abandonment'; many respondents reported they had abandoned, or had the intention of abandoning, the practice but this often resulted from the conflating of the abandoning of the pharaonic cut in favour of the Sunna version without the abandonment of the practice *per se* (i.e., as if FGM/C was exclusively synonymous with Type III cutting).
- Positive attitudes towards abandoners arose mainly from health care workers who encouraged abandonment of FGM/C due to the health complications experienced by girls.
- Health care providers managing women and girls with FGM/C face multiple challenges in their work given FGM/C is not a resource priority. Most patients with complications live in the rural areas where there are low-level facilities, providers who have no training in the management of FGM/C and who lack the equipment and medicines necessary to manage complications. They also reported a lack of referral hospitals for FGM/C cases.

## Discussion

This study found important evidence of a fundamental shift in the type of FGM/C procedures conducted in Somaliland. This shift, potentially more evident in urban areas, was from the invasive pharaonic cut to the less severe Sunna form. This transition in cut severity appears to be accompanied by a downward trend in the age at which the procedure is performed (currently around 5 to 8 years old) and with increasing medicalisation of the practice, with health professionals as cutters and cutting occurring at facilities or at individuals' homes.

It appears the shift from the pharaonic to Sunna form of FGM/C is, at least partly, an attempt to address the medical narrative propounded by many anti-FGM/C campaigns (that the practice is deleterious to the girl's or woman's health). The extant socio-cultural expectations purport that a cut of some description (if not pharaonic – which is increasingly seen as not an intrinsic part of Somaliland culture and not sanctioned as obligatory by religious teachings) must be made to ensure, for example, the girl's chastity, to decrease her sexual arousal levels, to maintain her clean reputation, and her marriageability prospects. This need to find an acceptable balance between health preservation and socio-cultural normative expectations has meant many have become

receptive to current religious teachings promoting the Sunna cut as an acceptable and desirable form of FGM/C.

While the normative landscape for abandoning FGM/C is challenging in Somaliland, that social norms are in a contested state of flux suggests opportunities for advocates to contribute to that dialogue. However, that contribution should extend beyond the medical narrative and move the discussion on to issues around bodily autonomy and individual informed consent.

## **Conclusion**

Normative changes appear to be occurring in Somaliland society and there is a growing readiness for change. However, the nature of that change is not towards the abandonment of the practice *per se*, but rather its transformation into a more socially acceptable version. There is a new norm emerging in Somaliland, but that norm appears only to be changing to reinforce the continuity of the practice.

## Introduction

Defined 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” (WHO 2016), and with a four-fold typology (Box 1), the occurrence of female genital mutilation/cutting (FGM/C) is approximately 87 million girls and women aged 15 years and older in the 28 countries where it is most common (27 African countries and Yemen) (Yoder et al. 2013). Annually, approximately 3.6 million girls are at risk of FGM/C, with the number potentially rising to 4.1 million by 2050 (UNICEF 2014).

Associated with multiple deleterious immediate and longer term physical and psychosocial impacts (Berg and Underland 2013, 2014a, 2014b; Utz-Billing and Kantenich 2008), the social determinants for FGM/C and its continuation are diverse: as a rite of passage and cultural obligation, or the

preservation of chastity or curtailing female sexual desire, a formation of religious identity, or augmenting female marriageability prospects. FGM/C has been associated with ethnic identity, religion, personal hygiene, initiation to adulthood, improved fertility, enhanced male sexual pleasure, media exposure, and geographic location, among other variables, all of which are often intertwined within a framework of cultural identity (Njue and Askew 2004; Dalal et al. 2010; Asekun-Olarinmoye and Amusan 2008; Sipsma et al. 2012; Hamilton and Kandala 2016; Van Rossem et al. 2015; Ashimi and Amole 2015; Mohammed et al. 2014; Achia 2014). These diverse factors often operate at the individual, family, community, (including women’s networks, which can be intergenerational and non-geographically specific in nature and include women and men [Shell-Duncan et al. 2011]) and national policy levels, converging and interacting with each other.

While most affected countries have adopted legal prohibitions (Ladjali and Toubia 1990), they have been varyingly effective in preventing the practice or significantly accelerating its total abandonment (Muteshi et al. 2016). Using nationally representative data, Shell-Duncan et al. (2017) found 15 of 29 countries (51.7%) showed no clear evidence of prevalence decline. Recent distinct alterations in the nature of FGM/C, however, include two-fold shifts in cutting severity,<sup>1</sup> cutting at younger ages (UNICEF 2013), and the ‘medicalisation’ of the procedure, from traditional circumcisers – who themselves occasionally medicalise the procedure by using medications to alleviate pain or likelihood of infection – to medical professionals (doctors, nurses, trained midwives), in public or private settings, ostensibly to reduce potential health risks (Shell-Duncan et al. 2017; UNICEF 2016; Njue and Askew 2004). With few exceptions, however (Shell-Duncan, Naik, Feldman-Jacobs 2016, Shell-Duncan 2001; Njue and Askew 2004; Jaldesa et al. 2005), minimal evidence exists on these FGM/C trends.

Potential reasons for the relative ineffectiveness of interventions to prevent the practice, or accelerate its abandonment, include inadequate enforcement of prescriptive legislative measures, unsatisfactory monitoring, and sub-optimal advocacy in communities (Muthumbi et al. 2015). Another possible reason is the inadequacy of theoretical FGM/C intervention paradigms that neglect collective social norms supporting it.

### BOX 1: Types of FGM/C (WHO 2016)

Type I:	Clitoridectomy—partial or entire removal of the clitoris
Type II:	Excision—removal of clitoris and labia minora
Type III:	Infibulation—removal of clitoris, labia minora and/or labia majora, and stitching together of raw surfaces to leave small opening only
Type IV:	Unclassified—includes pricking, piercing, stretching or incision of clitoris and/or labia, cauterisation of clitoris and surrounding tissue, scraping or cutting of vagina or surrounding tissue, introduction of corrosive substances or herbs into vagina

<sup>1</sup> First, a move from Type 2 or 3 towards Type 1 or 4 cuts, in which the skin around the genitals is ‘nicked’ rather than deeply cut or removed, resulting in a symbolic cutting to draw blood so the family and girl can declare she has undergone FGM/C, but with a reduced likelihood of immediate or long-term health complications; second, a shift from infibulation to a more vaguely defined ‘Sunna’ cut among Muslim populations, that could constitute Types 1, 2 or 4 nicking.

Social norms theory has become a prominent conceptual framework for understanding health behaviours (Rah et al. 2004; Campo et al. 2004; Scholly et al. 2005), including FGM/C (UNICEF 2016), locating human relationships within communities at their centre (Bapu et al. 2017). It contends that the perpetuation of harmful practices, and the creation of beneficial new ones, may be attributable to social motivations that can involve an entire community's beliefs and actions rather than simply individuals and their families. Beliefs about what others do ('typical' behaviour) and what others *think* people should do ('appropriate' behaviour) often guide a person's actions (Bapu et al. 2017; Mackie et al. 2015). If a harmful practice is social in nature, Mackie et al. (2015) contend that programmes concentrating on the education of the individual rather than the community, or on increasing the availability of alternatives or external incentives, may be insufficient to modify social practices meaningfully. Compliance is inevitable if the community is comprised of the individual or family's significant others – their reference group – and it is motivated by expectations of rewards for adherence to the norm (higher chances of marriageability among the girls of the family), and fear of sanctions for non-adherence (social exclusion and stigmatisation). Adhering to a community's social norms is therefore perceived as important, not only to maintain an individual's acceptance and social status in the community, but also to preserve the status of the individual's family. For a beneficial new norm to come into existence, enough members of a group must believe that enough of them are adopting the new norm. This is a prerequisite – and constitutes a 'tipping point' in the status quo equilibrium – to effecting behavioural changes underpinned by societal norms, and often the culmination of a gradual process of normative reflection and transfiguration.

In Africa, where focus is growing on social norms as a theoretical underpinning for preventive interventions, FGM/C is most common in the western, eastern and northeastern countries, with significant intra- and inter-country prevalence variation (Patra and Singh 2015; Bogale et al. 2014). In Somalia, FGM/C prevalence is nearly universal, at 98 percent (UNICEF 2016), a finding echoed by an attitudinal cross-sectional study (Gele et al. 2013a) of 215 men and women in Hargeisa district that reported 90 percent support for its continuation. However, data show apparent anomalies. The 2011 UNICEF multiple indicator cluster survey (UNICEF Somalia and Somaliland Ministry of Planning and National Development 2014) suggests a potential disconnect between actual practice (near universal at almost 99%) and individual female (ages 15 to 49 years) approval (28.9%). This practice and disapproval discordancy suggests possible confirmation of the readiness to change described by Shell-Duncan, Naik, and Feldman-Jacobs (2016) – willing adherent, reluctant adherent, contemplator, reluctant abandoner, and willing abandoner – with the "chasm" (Shell-Duncan, Naik, Feldman-Jacobs 2016: 25) mitigated by the influence of societal factors. What it does not suggest, however, is the nature of that change, if any.

Despite calls for rigorous research on FGM/C abandonment for the Sustainable Development Goals (Powell and Mwangi-Powell 2017), there is limited peer-reviewed literature with primary data on FGM/C for Somalia and Somaliland. Such data is important for countries where primary research is limited and where, in contexts of near universal practice, perceptions of no change in *status quo* prevail. It is critical to establish if anecdotal changes are actually occurring, and explore socio-normative factors possibly influencing attitudinal or behavioural shifts that could result in FGM/C abandonment and eradication, or its transformation and consolidation. Minimal is also known of current capacities of health care systems, and their staff, to prevent and manage FGM/C, how they can be enhanced, and whether health care workers can be change agents. This qualitative study therefore sought to explore:

1. Views and experiences of married and unmarried men and women on FGM/C and potential changes in its practice (in terms of age, cut severity, and medicalisation);
2. Individual, family, and societal factors contributing to any changes, or continuation, of FGM/C;

3. The knowledge, views, and experiences of health care workers who offer FGM/C services (including corrective services as well as potentially medicalised versions) and their role as change agents rather than providers, and;
4. How health care systems' capacities can be strengthened for management and prevention.

## Methods

### Study Design and Data Collection Methods

The study used a cross-sectional design with mixed qualitative methods (key informant interviews [KIIs], in-depth interviews [IDIs] and focus group discussions [FGDs]), a valuable methodological approach for developing theoretical hypotheses and ethnographically informing future research. Population Council's Institutional Review Board granted approval as Protocol 775, followed by Somaliland's Ministry of Labour and Social Affairs (W/SH/AB/02/28/016).

### Participants

Participants were located in two regions of Somaliland – Awdal and Waqooyi Galbeed – in the districts of Borama and Hargeisa, each of which has urban and rural sites. They comprised:

- Families – married (not dyads) and unmarried men and women of reproductive age (20 to 49 years old), from rural and urban areas, with varying education – of daughters who may or may not have undergone traditional, medicalised, or no FGM/C;
- Men and women who had been exposed to anti-FGM/C programmes in the preceding six months, and;
- Health care workers – formally qualified males and females (doctors, clinical officers, nurses, midwives) of varying ages (20 to 60 years old), from rural and urban areas, with differing degrees of professional experience, with familiarity managing and potentially providing FGM/C procedures, working at a facility for at least one year, as well as administrators.

### Sample Size and Sampling

Data collection continued until thematic saturation was attained among study populations. Family and community focus groups – which were intended to have an average of six to 10 participants each – were stratified by two factors: 1) rural versus urban residence and 2) unmarried and married men and women. Data collection among health care workers, who varied in age and length of professional experience, utilised IDIs. IDIs were with senior management and associated key health sector stakeholders in each region and with administrators.

### Recruitment Procedures

Three methods were used to identify participants: 1) a mapping of active organisations working to end FGM/C in Somaliland, informed by The Girl Generation and implementing partners of the UNFPA/UNICEF Joint Programme on FGM/C, 2) creating awareness, with the assistance and guidance of active organisations in the field, for the study among the various target populations, and 3) a purposive sampling technique – after identifying an original 'seed' respondent with local social enablers in the community and health care facilities – to construct the study sample.

IDIs and FGDs were conducted in relevant local languages by trained research assistants (matched by sex and ethnic group, as appropriate) and digitally audio recorded. FGDs had a moderator and observer, and were conducted at a location acceptable to participants. A self-

completed participant record was provided to all literate FGD participants for demographic data; those with literacy challenges were assisted to complete the form. For the assessment of health system capacities, IDIs were held with a range of health care workers who address FGM/C during their work.

## Translations

All study documentation (information and consent sheets, demographic records, and topic guides) were translated and back-translated from English to the local Somali language by experienced staff at the community sites to ensure their conceptual validity and comprehension. Any linguistic or cultural anomalies identified were resolved in conjunction with a staff member bilingual in English and the local language. To ensure their validity and acceptability to participants, and as part of the research assistants' training, translated tools were pilot tested among a small sub-sample of community members.

## Data Management and Analysis

Demographic record data were entered in anonymised form into password-protected Excel spreadsheets and analysed using basic frequencies to profile participants. Digital audio recordings of the interviews and group discussions underwent a multi-stage transcription-translation process to ensure data quality: 1) recordings were transcribed verbatim by experienced Somali-speaking transcribers, 2) these anonymised transcripts were independently reviewed by Somali-speaking translators, checking the transcripts against the original audio recordings for their accuracy, including spelling, in the Somali language; any differences detected between the two formats were identified and discussed between the original transcriber and the translator until agreement was reached and corrections were made, 3) approved transcripts were translated from Somali to English by Somali-English speaking translators, 4) a sample (n=15) of these transcripts were subject to three independent, parallel, forward translations, and 5) differences between the original English translation by the Somali-English speaking translators and the sample of forward-translations were identified and anomalies discussed between the translators until a consensus on an accurate translation was achieved. These finalised translated versions were then analysed.

Thematic analysis used template analysis (King 2012), a pragmatic and iterative approach combining deductive and inductive analyses, balancing a relatively structured process of analysing textual data with the flexibility to adapt to emerging data, producing a non-hierarchical coding framework, or "template". The template was developed by the authors, with two other data analysts, from *a priori* themes in social norms theory, the thematic areas covered by the study questions and the data collection tools. Each code in the framework was described with specific definitions and reviewed for internal consistency. This was especially important as the analysts often worked in different locations.

This template was applied to a sample of interview transcripts (2 IDIs, 2 KIIs and 2 FGDs per analyst) to ensure it covered most anticipated thematic codes and sub-codes. It was subsequently applied to the remaining transcripts, with refining revisions made after discussion among analysts as additional important themes emerged (King 2012). Implementation of the template analysis was facilitated using NVivo11<sup>®</sup> (Bazeley 2007). To ensure methodological rigor and the reliability of the study data, and in addition to using researcher triangulation (using three data analysts) and method triangulation (using three different interviews: IDIs, KIIs and FGDs), inter-rater coding reliability was assessed by running a coding comparison query among a random sample of 10 transcripts (5 FGDs, 3 IDIs and 2 KIIs) coded by the three analysts. This produced a Kappa score of 0.81 score (with 0.75 indicating excellent agreement) (Fleiss 1981), and 98.8 percent agreement between the analysts. Lastly, the study engaged two key Somalilanders stakeholders with

extensive experience working in FGM/C as participant proxies with data checking to ensure researchers' interpretations had veracity.

## **Informed Consent**

Informed consent was obtained from all participants, with ample time given to ask questions before making their decisions and consenting to take part. Participants had the right to decide not to participate in the IDI, KII, or FGD at any time. If they did not wish their data from the IDI, KII, or FGD used in the analysis, their contribution was deleted from the transcript prior to analysis. Participants were advised that withdrawal was not possible after results have been written for publication. Prior to beginning the IDI, KII, or FGD, all participants were asked to sign the consent form, with a copy provided to them. The consent form was separated from the interview guides and retained in a locked storage cabinet in Population Council's Nairobi office. The information from the informed consent forms was not recorded anywhere or entered into the study database.

## **Results**

### **Characteristics of respondents**

Table 1 shows the socio-demographic and attitudinal characteristics – in terms of strength of FGM/C and spiritual or religious views – of the study respondents. A total of eight community FGDs (those exposed to anti-FGM/C programmes in the preceding six months) and 16 non-community FGDs, among unmarried and married men and women, 20 KIIs with key stakeholders, and 28 IDIs with health care workers and health system administrators were conducted, entailing 280 participants in total. There were proportionately more male KIIs than female, and more female IDIs than male. Mean ages of participants were broadly comparable, but KII respondents were older. Educationally, most were schooled to above secondary level (especially those engaged in IDIs and KIIs) and the mean length of time living in the present community ranged from 17.9 to 29.2 years. Married men and women had a higher mean number of daughters who had undergone FGM/C compared with unmarried men and women. Lastly, while the strength of religious and spiritual views consistently ranked as 'strongly held' on a scale of 1-10, the strength of strongly held views on FGM/C varied (from 35 to 70.1%), with 60 percent of KII participants reporting weakly held views.

Table 1: Respondents' socio-demographic and attitudinal characteristics by data collection method

	Data collection method							
	Community FGDs		Non-community FGDs (Married / unmarried)		KIIs		IDIs	
	(n=78)		(n=154)		(n=20)		(n=28)	
<i>Socio-demographic and attitudinal characteristics</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>	<i>n</i>	<i>%</i>
<i>Location</i>								
Urban	39	50.0	67	43.5	14	70.0	18	64.3
Rural	39	50.0	87	56.5	6	30.0	10	35.7
<i>Sex</i>								
Male	40	51.3	77	50.0	13	65.0	12	42.9
Female	38	48.7	77	50.0	7	35.0	16	57.1
<i>Age (years)</i>								
Range (18-70)								
Median	29		27		32.5		30	
18-19	3	3.8	2	1.3	0	0	0	0
20-29	37	47.4	93	60.4	5	25.0	11	39.3
30-39	15	19.2	25	16.2	9	45.0	8	28.6
40-49	14	18.0	28	18.2	1	5.0	6	21.4
50-59	5	6.4	5	3.25	2	10.0	3	10.7
≥60	4	5.1	1	0.65	1	15.0	0	0
<i>Education</i>								
Primary	27	34.6	29	18.8	2	10.0	1	3.6
Secondary	18	23.1	56	36.4	0	0.0	2	7.1
Above secondary	27	34.6	46	29.9	17	85.0	25	89.3
Not schooled	6	7.7	23	14.9	1	5.0	0	0
<i>Marital status</i>								
Married	53	67.9	75	48.7	17	85.0	19	67.9
Unmarried	25	32.1	79	51.3	3	15.0	9	32.1
<i>Mean number of years lived in present community</i>	17.9		20.6		29.2		23.5	
<i>Mean number of daughters of unmarried men/women who have undergone FGM/C</i>	1.6		1		0.8		0.9	
<i>Mean number of daughters of married men/women who have undergone FGM/C</i>	2.4		2.1		0.9		1.1	
<i>Religion (i.e. Sunni Muslim)</i>	78	100	154	100	20	100	28	100
<i>Profession</i>								
Doctor	0	0	0	0	2	10.0	9	32.1
Nurse	0	0	0	0	2	10.0	5	17.9
Midwife	0	0	0	0	0	0	4	14.3
Clinical officer	0	0	0	0	0	0	0	0
Other	78	100	154	100	16	80.0	10	35.7
<i>Strength of FGM/C views*</i>								
Weakly held views	10	12.8	20	13.0	12	60.0	7	25.0
Averagely held views	29	37.2	26	16.9	1	5.0	2	7.1
Strongly held views	39	50.0	108	70.1	7	35.0	19	67.9
<i>Strength of spiritual / religious views*</i>								
Strongly held views	78	100	154	100	20	100	28	100

Note: Attitudes were scored on a scale ranging from 0 = Weakly held views to 10 = Strongly held views.

## Thematic findings

The study findings cover the following areas: general understanding of FGM/C; changes in practice (including severity of cut, age of cut, medicalisation, and abandonment of the practice); influences upon the practice and its changes; health systems capacity to prevent and manage FGM/C

(including health care workers' knowledge, attitudes, and experiences of FGM/C); challenges managing FGM/C complications; and health system strengthening.

### **General understanding of FGM/C**

Despite the four-fold diversity in the types of FGM/C outlined by the WHO definition, only two types of cut were described by respondents: pharaonic (described by the WHO as Type III and entailing the removal of the inner and outer labia, and the suturing of the vulva) and Sunna, which is Arabic for 'tradition' or 'duty'. The pharaonic cut was perceived as the severe form of circumcision, entailing cutting and stitching, and Sunna as a milder form entailing the pricking or cutting of a small part of the clitoris that, from a well-being perspective, was viewed as more 'healthy' for the child.

'I want to differentiate between the different types of FGM/C<sup>2</sup> ... the cultural circumcision, which we called pharaonic circumcision, and the Sunna type, which our religion allows ... the Sunna one is promoted by our religion, the people are doing what our prophet did (Peace be upon him [PBUH]), and they are doing something which is a must. So that is what is promoting it. And the pharaonic one ... Our religion does not allow it. When I tell you about the pharaonic one is the one they cut people; that one our religion does not allow it for a girl to be stitched, either two stitches or three stitches but it allows the girl to be circumcised the Sunna way. The Sunna is good because it reduces the girls' libido and her feelings are reduced also. It is healthy for the boy to be circumcised and also the girl to be circumcised. That is what is making the Sunna circumcision to continue and the pharaonic type is coming to an end'.  
Religious leader, Hargeisa

'The former FGM/C (pharaonic) was very bad. The current (Sunna) is good, both in religion and tradition. Ladies became healthier than before. Previously they would get problems, such as retained menses and kidney pain, but now they don't suffer from complications. They got healthier with the current one. Sunna is when there is no stitching'.  
Female, Hargeisa

'Somali community only knows two types of circumcision, Sunna and pharaonic. There is no third one that we know of by name. What I'm aware of and is happening in my community is the one of pharaonic circumcision, while the Sunna is done in the clinic'.  
Unmarried male, Hargeisa

Respondents demonstrated a general understanding of FGM/C that framed the practice as mainly either cultural or religious in nature. Specifically, the pharaonic cut was seen as culturally inherited, while the Sunna form was viewed by many – but not all – as supported by religious teachings. Culturally, the primary reasons for undertaking FGM/C were for purification purposes, minimizing sexual arousal, ensuring chastity among girls, and ensuring compliance with socially acceptable norms. The pharaonic type of cutting was understood to be passed through successive generations as a cultural tradition, while the Sunna cut was understood to be what is acceptable according to the teachings of the Koran. However, differing opinions existed on whether it was a religious requirement (from the sayings of the Prophet Mohamed), with some contending that, according to the Koran, it is illegal to cut any part of the human body and the Sunna cut was not obligatory.

'As a religious requirement, it's good to practice the Sunna form of FGM/C but what we initially used to practice was culturally inherited from previous generations and I think it's good to protect the girl's decency'.  
Male, Hargeisa

'Circumcision is a cultural thing that causes problems to our girls when they are pregnant and they give birth.'  
Male, Sheikh Ali Jowhar

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<sup>2</sup> The community generally uses the term "Gudninka gabdhaha" (i.e. female circumcision), which was translated as FGM/C; some use the abbreviation of FGM.

'FGM/C basically is unlawful cutting of girls. What our religion allows is Sunna which is just to have a little bleeding from the clitoris. FGM/C is something that was imported from another land. So the thing is that we support the Sunna way of circumcision.'

Male, Goroyo Cowl

'During the time of Pharaoh is when this practice spread ... It brings many problems. Religiously, if a person dies, the body needs to be washed and becomes clean. If the girl dies while undergoing FGM/C, she cannot be cleaned since she is stitched. So religiously that is a problem according to people's perception; now there is development and it is agreed that the Sunna should be done, of which the Sunna itself is not from a verse in the Quran but the saying of the Prophet, so we just follow that.'

Male, Goroyo Cowl

'If I look it from the point of the religion, I will say our religion recommends the Sunna type which doesn't attract many complications but it totally disregards the infibulation type of the practice.'

Married Male, Borama

'If people practice the one the religion recommends, they won't have any problem but when they practice the cultural pharaonic type, which includes cutting of the genitals and stitching, they will have problems. It is haraam (illegal) to cut the part of the girl's body.'

Male, Sheikh Ali Jowhar

There were also mixed definitions of what constitutes the Sunna cut. Some respondents reported that it entailed only cutting a small part of the female sexual organ, while others defined it as the pricking or nicking of the clitoris for it to bleed, and yet others described it as including stitching.

'The pharaonic type of FGM/C used to be practiced before where girls' external genitals were cut and stitched and the legs of the girls were tied tight together and they were watched after so that they do not walk faster or run around. But, currently, the Sunna type is done, which is just bleeding of the clitoris.'

Married female, Borama

When the girl is cut in the morning, she starts to work for her in the evening, which meant it has less problems unlike the previous one where after cutting and stitching, the cutter used a long rope to restrain the girl by tying her from the waist to the heels to immobilise her for 15 nights so that this 'devilish' stitch stays intact, which I believe was a hard phase women faced, but is now abandoned.

Female, Hargeisa

Yes, this information has caused changes in the community and if FGM/C still exist, it is only the Sunna type since most of the people believe that a girl must be circumcised but even the religious leaders learnt the difference between the pharaonic and Sunna types. Before, both clitoris and labia were totally removed and afterwards infibulation was done but now only the clitoris is pricked.

Married female, Qulujeed

## ***Changes in the practice***

### *Cut severity*

Respondents generally reported a shift away from the pharaonic to the Sunna cut, with the transition more evident in urban compared with rural areas, where the former is more prevalent.

'Both Sunna and pharaonic types are still practiced ... but recently, the pharaonic one has reduced and the Sunna type has increased.'

Married male, Haleye

'Currently the community is practicing the Sunna type of the FGM/C and you will come to know the Pharaonic is majorly only existing in the villages.'

Married male, Borama

The Sunna type is mostly practiced here. They have abandoned the first one because it had a lot of problems ... Girls are circumcised at the ages of six years to eight years. They are taken to the hospitals where they are circumcised by pricking the top part of the clitoris and they are not stitched.

Married female, Gabiley

'The way people performed the practice previously and now is different. Previously girls used to be cut and stitched together and no space was left open which led to blockage of

urine and difficulty in menstruation; but currently the community is practicing the Sunna type, which is less harmful.’  
Married female, Borama

‘In the previous one, the girls used to be tied together; the young girls also felt a lot of pain during the menstruation period and (experienced) difficulty when giving birth because the clitoris is cut but now the milder form is done which is better than the Pharaonic.’

Married female, Borama

The change in the type of cut practiced was attributed to awareness raising and issue sensitisation in the community by two groups: health care workers and religious leaders, although one respondent mentioned being influenced by their informal social networks (friends). Most respondents thought the change from pharaonic to Sunna cutting was a positive development that has improved the health of the girls and reduced the complications of FGM/C.

‘A lot of change happened, which is good because people were sensitised or got a lot of awareness about the religion and about the health-related problems of the practice.’

Male, Wajaale

‘I can say this is not even an FGM/C because FGM/C is the former infibulation, which was complicated. This one has nothing much. It is a mild Sunna form and I believe is good for the ladies and the current youth. It doesn’t harm their body and health.’

Female, Hargeisa

‘Yes, it is a good change. This current change is good. It does not affect the health of girls. When she goes to deliver, she doesn’t get complications. She suffers no bleeding nor kidney pain. The community want this one.’

Female, Hargeisa

‘Yes, there is a major change because the pharaonic one has been abandoned which had complications on women. There is a major change. Girls are no longer undergoing infibulations. They undergo the Sunna mild type of which some are done with two stitches and some are not stitched but pricked.’

Female, Hargeisa

‘These changes have taken place because people understood the religion and health side of it.’

Male, Wajaale

‘Firstly, there are many changes that happened due to awareness and people understood a lot about the religion. They have also understood about the health as far as the cutting and mutilating girls and woman is concerned because that is not what the Prophet said logically.’

Male, Goroyo Cowl

‘It is as a result of our religion because previously the people had no understanding of religion but now the religion has been understood well.’

Female, Hargeisa

‘For me, I have three daughters all of them have undergone the Sunna type which is much less severe and I can say they are fortunate to be born during this time. The other thing the pharaonic FGM/C that was done in homes used to come with a lot of problems. What changed me is I became aware of so many social issues and I got advice from friends and community education which changed my perception and I believed in them. Immediately, I brought my daughters from the cut, I realised a change because they could work and also attend to their normal activities.’

Female, Gabiley

Unmarried men tended to report a preference for the Sunna cut to their daughters in the future, as it, again, is perceived as entailing less health-related complications and was contended to be recommended by Islam.

‘To me, the practice of FGM/C is of different types. As Muslims and followers of Islam, there is one recommended for us to practice, the Sunna form of the FGM/C. This involves a small prick done to the clitoris but we Somalis did too much cut, which mutilated the women’s sexual organ which diminished their feelings. To eradicate this dangerous practice, we need to educate the society and make them understand the effects of the practice and the religious recommendation. I say FGM/C is a bad practice that spread among the Somalis for years and continued to be practiced by communities especially those in the rural areas. To stop it, I support the practice of the form recommended by religion.’

Unmarried man, Dila

'To me, it's a custom that was inherited from the previous people and the community is not ready to abandon it. They used to be ignorant about it but now people are different because of the awareness creation and education which made the people gain knowledge. The community is practicing the Sunna one and we are told to practice it.'

Unmarried man, Arabsiyo

'No ... I would have done FGM/C on her but the type I would do is the current one, the Sunna/mild. The reason I would do that is because I believe is the religion. That is what our religious and learned leaders advise us. We should always follow the Sunna that is legal and we should leave the other complicated and illegal one.'

Unmarried man, Borama

### *Age at cutting*

There appears to be a gradual decrease in the age at which FGM/C is performed on young girls. Some respondents reported that it is undertaken much earlier than before, previously performed on teenagers (15 to 16 years old), but now children aged 5 to 8 years are cut. There was some variation in the reported age of cutting.

'In our community they are cut at the age of 6, 7, 8 years.'

Married female, Borama

'I don't know the name of that type but the age of cutting is 6 years to 7 years. There are some who get circumcised at hospital facility because of the health of the girl.'

Unmarried male, Arabsiyo

'Only in the rural areas does the culture still exist but in the town areas, the culture is not there, they just do the Sunna one. Some are cut at the age of 10 years, up to 12 years.'

Married male, Haleye

'Right now, it has reduced a lot. Girls are cut at six years, seven years around there but previously, ten years and over were cut.'

Unmarried male, Hargeisa

'Girls are now cut at the age of 7 to 8 unlike before they used to be circumcised at the age of 10 and older.'

Married female, Borama

'The age has changed. Initially girls aged 5 to 10 years were circumcised but nowadays even 2 to 5 years are circumcised.'

Married male, Boon

'Yes, I accept the age has changed as in the old days, it used to happen at the age of 15 to 16 years but today they do it before the girl is taken to school mostly 4 to 6 years.'

Unmarried male, Dila

The primary reasons given for initiating the procedure at a younger age are a potential refusal of the girl at an older age to undergo circumcision, exerted parental authority in the ostensible interests of the girl, and a justification in 'tradition'.

'Previously it was done at 12-15 years of age and but nowadays young girls are cut because it's easier to do it when they are young.'

Unmarried male, Borama

'At a tender age, she does not know the advantage and disadvantage and she is still under the custody of her parents. She doesn't have any rights. Secondly, I think it's in the culture that it should be done at a tender age.'

Unmarried male, Hargeisa

Young girls won't refuse to undergo what the parents tell them to do. They also believe it's good for the girl. So they rush to circumcise the girls at young age.

Unmarried female, Hargeisa

It's being done on young girls this days because it's part of the tradition.

Unmarried male, Borama

### *Medicalisation*

Evidence also exists of the medicalisation of FGM/C in Somaliland, especially undertaking the Sunna form of cut, with health professionals as cutters and cutting occurring at facilities or at individuals' homes.

'Health care workers use hospital equipment, while the others use a knife that is not sterilised. The one performed by the health worker is safer since they can control the situation in case of bleeding, unlike the traditional method where the person might be at risk of bleeding and infection from the contact with infected equipment or blood if the person is sick.'

Unmarried female, Hargeisa

'I have heard the nurses do that and they mostly do nicking; nowadays I don't see the elder women who used to do the practice.'

Married female, Hargeisa

'The Sunna type is mostly done by health workers. The mild one was brought by healthcare workers ... The traditional cutters don't do it nowadays. I can say they left it long ago because they were educated a lot.'

Unmarried female, Borama

'Those who are educated take their daughters to hospital to do medicalised FGM/C so that their daughter is safe from pharaonic complications. The health workers do the Sunna for the girls.'

Married male, Hargeisa

'Firstly, they hardly bring them (girls) to hospital. A few modernised mothers who want health care workers who know how to do by telling them to do Sunna for her (daughter). They mostly do FGM/C in the homes and it's mostly done by TBAs (traditional birth attendants).'

Midwife, Borama

'Those mothers who do it are mothers or midwives who have learnt the practice from other mothers. So, there are some who do it in the town who may be health workers, such as doctors, and they have something to stitch with and stop the bleeding but those in rural areas are mothers who have nothing in their hands. They have only thorns and razor blade. So when they cut, there is nothing to stop the bleeding. Thorns are used to tie the place so the girl might have a lot of bleeding and the circumciser might even run away from the scene.'

Doctor, Hargeisa

'Medicalised FGM/C is recommended by the religious leaders who say it's safe when it's done by a nurse in the health facility.'

Married male, Hargeisa

'Mostly it is nurses and midwives who do it. They are taken to the delivery rooms and mostly it is nurses and midwives who are there. They do the Sunna one only. It is mostly done in the nursing homes and MCH (maternal and child health), or the health centres and mostly doctors don't do it. It is a light operation anyone who is within the hospital can do it.'

Senior Nurse, Hargeisa

### *Abandonment*

Some respondents felt FGM/C has been abandoned recently, especially in the urban areas. However, there was a mixed understanding of what constituted 'abandonment' from the participants' perspective. Some respondents reported they had abandoned, or had the intention of abandoning, the practice, but this was often a result of the conflating of abandoning the pharaonic cut in favour of the Sunna version (which can also take a medicalised form), without the abandonment of the practice *per se* (as if FGM/C was exclusively synonymous with Type III cutting). Indeed, few respondents reported examples of individuals who had completely abandoned the practice. This appears to be an option pursued by a small, apparently invisible minority. This numerically negligible number, including the perception of it being small, has important implications in terms of its insufficiency to challenge existing social norms regarding FGM/C abandonment. It is not currently a sanctioned option, even if the social norm of FGM/C itself is being contested and is changing towards a less severe cut. Social sanctions that arise when one abandons the practice appear to be among the factors impeding that choice. Moreover, the fact that few respondents

reported facing normative-related negative repercussions due to abandoning FGM/C may be attributed to the fact that most community members were not necessarily aware that girls had not undergone FGM/C.

‘No. They (i.e. those who abandon FGM/C entirely) are not there.’ Married female, Qulujeed

‘They will end it after they get enough awareness. They will stop the pharaonic that they used to do when they were ignorant and medicalised FGM/C will be embraced which is why pharaonic is reducing.’ Married male, Hargeisa

‘Yes, they will abandon the bad FGM/C if they are given education. That will help them abandon the complicated FGM/C and they will shift to the medicalised one (Sunna). I believe that. No, FGM/C can’t be abandoned totally but the FGM/C that had complications with pain, can be abandoned. They will go for medicalised FGM/C.’

Married male, Hargeisa

‘The medicalised one (Sunna) will continue but the pharaonic one will be stopped.’

Unmarried female, Wajaale

‘We cannot abandon the practice because it is a religious recommendation to practice the Sunna.’

Married male, Sheikh Makahiye

‘The religion of Islam is recommending us to practice the less severe form of the practice that is my point.’

Married male, Sheikh Makahiye

‘Yes, there are changes, for example people understood the problems of FGM/C, how it affects a person and getting to know the uncut girl is healthier than the circumcised girl. So, in short people getting educated about the importance of FGM/C and the effect it has. The main change that happened is it has been abandoned in towns though people in villages still practice it.’

Male, Wajaale

‘Yes. There are changes, a big change I can say from the 1990’s due to the community awareness and religious teachings that have reached most of the towns. I believe the practice has been changed to the less severe or abandoned in the areas that have received the community awareness.’

Female, Borama

‘Yes. In the old days, there was an FGM/C called the pharaonic. It was the most severe form but today people have shifted to the less severe called the Sunna. The Sunna practice is also reducing, the practitioners do it in secrecy and I believe the practice will come to end soon.’

Female, Borama

‘Today it seems the mothers are also abandoning the Sunna due to the awareness they are getting from the media, like the TVs and the majority have taken the view to leave uncut the young daughters and those who will be born.’

Female, Borama

Respondents reported mixed community attitudes towards the abandoners of FGM/C, ranging from negative to positive. Negative attitudes included: abandoners being perceived as being non-Muslims because of the strong view that abandoning FGM/C is abandoning the Islamic religion; discrimination and isolation from the community; rejection from potential suitors who will not marry an uncut girl; and negative perceptions associated with an uncut girl (impure and promiscuous).

‘The other is community influence; the community stigmatises and isolates the person who is not cut, mostly when the other people are doing FGM/C. So they isolate whoever is outside that (not cut). I believe they stigmatise.’

Unmarried male, Borama

‘I believe they are a family who oppose Islam and they have excluded themselves from Muslims and their practices. They are family whom we cannot marry from.’

Married male, Borama

‘The society is a major player in the decision taking for undertaking FGM/C for the girl because once they hear a certain family has uncut girl, they shame and disgrace the girl ensuring the girl will be embarrassed. So, for me, I will say the parents and the community are linked together when it comes to the decision taken.’

Married male, Borama

‘Previously uncut girls were never married and abused by others and her age mates.’  
Married female, Borama

‘I believe social pressure is there because if a girl is not circumcised, her age mates will abuse her.’  
Married male, Boon

‘The mother was forcing her because they believed if the girl is not cut, when she gets married, the man will think she has had uncountable number of sex with men. So this will attract shame for the mother and family and that’s why mother choose to do this type which is mild so that their daughters don’t face those problems.’  
Married female, Borama

‘Yes, they are there but the cut girls shame and gossip about the uncut girl that she was not circumcised. So, the daughter comes to complain to the mother why she was not circumcised and want to undergo it.’  
Married female, Borama

Positive attitudes for abandoners were mainly from health care workers, who encourage FGM/C abandonment due to the health complications experienced by girls who have been cut. The general view was that those who chose to abandon the practice were doing something intrinsically good, as it helps minimise health consequences that circumcised girls’ experience.

‘Yeah, they are excellent people, to my understanding. Those people are good people and what they are doing is very beautiful.’  
Clinical manager, Hargeisa

‘Health providers with knowledge like me ... a nurse and a midwife, I think they are with my opinion that it should be stopped. It should not be done because they have understood the complications that arise from it and it has no advantage to the person if performed.’  
Clinical manager, Hargeisa

‘For me, I think they are right and I am happy with them because the practice is a torture and mutilation to the girls.’  
Unmarried male, Dila

‘I believe there exist families who do not cut their daughters although we can’t know exactly how many they are unless a research is carried. Such families I don’t think their daughters will be faced by a problem or any issue and for me personally I don’t have a problem leaving the daughter uncut.’  
Unmarried male, Dila

Other reported gaps influencing the abandonment of FGM/C included the lack of a comprehensive anti-FGM/C law, the religious basis for the practice, medicalisation of FGM/C, and a lack of implementation of de-medicalisation policies.

‘I haven’t seen a written policy/law on FGM/C, though I heard that there is a policy made by the Ministry of Labour and Social Affairs but it is still in parliament and not yet made a law ... There is none also on how to manage its complications.’  
Doctor, Borama

‘I can’t guess the stand of the government and its policy and law but it could have been better for the government to have a stand on FGM/C. The Government of Somaliland has draft policy but it’s not effective and not implemented and no law yet.’  
System administrator, Borama

‘Yes, I will do the Sunna form to her because am a Muslim and the religion recommended that one for me. All the times I’m being ruled and guided by the religion.’  
Married male, Borama

‘The government is the decision-maker. They can reach any decision to stop it unless the religion of the people stands against it. It is something they can talk about and say it should be stopped. I heard the Ministry of Health has a de-medicalisation policy but it’s not implemented and there is no law that has been passed by parliament to stop it. There is no government statistic on FGM/C that is there in all health facilities.’  
Doctor, Hargeisa

‘There is a draft anti-medicalisation code of conduct for health care workers but it is not implemented.’  
Nurse, Borama

Some respondents also articulated the view that if the community was receptive to the less severe type of FGM/C, potentially they could abandon FGM/C entirely. Others expressed the intention to abandon the practice in the future. However, due to awareness creation, community members could also shift to a medicalised form of the practice because of its associated safety measures. Participants were uncertain whether medicalisation is currently occurring and its legality – some respondents, from the health sector especially, feel it is a hidden practice, given its illegality.

‘Yes, it has changed a lot. The community previously used to do mutilation that was risky but right now they do an easy one easier than that and that has low health complications. Young girls are cut nowadays and the cut is Sunna. Some midwives do the Sunna for the girls. The reason for the change is the awareness done and the fight against it.’

Senior midwife, Borama

‘The community have woken up because of their lack of knowledge because of awareness that was done by the religious leader which made the pharaonic type to reduce. So there is change in the way the circumcision is done. Girls are done Sunna when they are young nowadays. There are nurses and midwives go to the homes of mothers who want their daughters to be circumcised and do it for them.’

Married male, Haleye

### ***Influences upon the practice and its changes***

In terms of those individuals, groups, or other determinants that influence the practice and any change occurring within it, immediate decision-making on whether to undertake FGM/C is conducted at the individual and familial levels. In a few cases, the girl decides on her own, especially when her parents are against the practice but the girl wants to conform to engendered peer pressure:

‘No one forced them, it’s their decision due to the effects on the girls and women but those who continue to do it are forced by the community, they are forced by their daughter. She forces them because she is in the community and she will encounter a lot of insults and shame that, if she had not left FGM/C, would not have occurred, but if they leave it, it will come.’

Unmarried female, Borama

‘If her friend, who is her neighbour, is getting cut, she will be told, “you have impure thing”. So, the girl who knows nothing about the complications of FGM/C forces her mother to cut her and tells her mother, “Mother cut me, I have the impure thing”, as my friend and neighbour has been cut.’

Midwife, Borama

Within families, the decision on when and whether the daughter undergoes FGM/C is arrived, in most cases, by both parents and, in a minority of cases, by the male head alone. It is worth noting that most respondents felt FGM/C decisions are a “woman’s affair”, and mostly the girl’s mother, grandmother, and excisors make FGM/C decisions on a girl’s behalf:

‘I will say the decision is a series and it existed for many years ago. It revolves around the community, the parents and brothers and sisters of the girl. Each one of them plays a role in their own decision.’

Married male, Borama

‘The parents especially the father and mother of the girls are the only decision-makers in this field of FGM/C because they believe in the culture.’

Married male, Borama

‘I will say the decision is from both parents. They are the key decision-makers when it comes to the FGM/C but again I will say the mother is stronger and a key influencer in decision taking than the father, who just accepts when it is proposed to him.’

Married male, Borama

‘It’s a cultural reason because these are things which the people like. They say it is their culture. Both parents make the decision to circumcise their daughter but the mother makes the most important decision on her girls with the support of the grandmother.’

Married male, Haleye

While the individual and family constitute proximate agents, in terms of actual decisions influencing FGM/C, often they are only conduits through which socio-cultural, normative, and other factors manifest: these include religion, culture, anti- and pro-FGM/C messaging, and medical reasoning. The Somaliland community is predominantly Islamic, with the religion providing the framework for individuals' daily ways of life. Community members often decide to practice FGM/C because it is seen as a religious requirement. This perceived religious sanctioning is overlaid by cultural and community traditions, with FGM/C a practice viewed as passed down generationally. It appears religious, cultural, and health messaging are the main drivers for FGM/C's persistence:

'This is something that existed and passed from generation to another and practiced culturally and also people believe it is a religious requirement. So, the main factors and drivers are culture and religion.'

Unmarried female, Dila

'The other is it comes from the religion, ten or twenty years ago, our Somali community believed that it is part of the religion of Islam though we now know, but I can say it is a practice that has been there for long and is changing and generation after generation, it has been passed on.'

Unmarried male, Borama

'There are some who didn't take up the awareness because they still believe the culture of which the girl must be circumcised for them to avoid shame after the girl marries. They used to believe the practice differentiates between the girl that was used by other men before her marriage and the one which was not.'

Male, Wajaale

Anti-FGM/C messages, often spread through NGO awareness creation programmes in communities, have also contributed to decision-making on FGM/C abandonment, while religiously grounded pro-FGM/C messages promote the practice in a less severe form. Awareness of the physical, social, and psychological consequences of FGM/C on women and girls, especially by health care providers and religious leaders, has also guided community members in making decisions to either abandon FGM/C totally or practice its less severe forms:

'The pharaonic circumcision has reduced nowadays. Many people don't circumcise their girls with pharaonic type because a lot of parents have been sensitised about the health effects of FGM. The pharaonic circumcision puts the health of women at risk, that's why some don't do it.'

Unmarried male, Hargeisa

'The community is educated about the complications of FGM/C by the doctors and religious leaders.'

Male, Sheikh Ali Jowhar

'Sensitisation has increased in the community. They are educated about the negative effects of FGM/C on the girls.'

Male, Sheikh Ali Jowhar

'Messages or awareness reached them and people decided to abandon the pharaonic FGM/C. The previous cultural practices had many difficulties but they are happy with the cultural change that has currently happened.'

Female, Gabiley

'It's because of the culture and religion but after awareness of the FGM/C, the communities have decided that the first one (pharaonic type) is not a good practice. And yes, there are messages that are done on FGM/C. I hear them most of the time. We are taught on the effects of the pharaonic FGM/C on how this practice should be abandoned. People now do the Sunna type which is good.'

Married female, Gabiley

Respondents felt that there are negative impacts for not conforming to expected norms. Girls who have not undergone FGM/C are isolated from the community and fail to secure marital partners since they are seen as "impure". The girl's family is also isolated and the mother viewed as a failure for not protecting the dignity of her daughter through FGM/C. These potential repercussions lead to social pressures from community members, neighbours, personal networks, and the extended family (such as grandmothers and her peers), which influence community members' FGM/C decisions. Health care providers appear predominant in influencing FGM/C abandonment, or the shift to less severe forms, due to the health consequences associated with pharaonic cutting.

Religious leaders have also been comparably influential in decisions to adopt the Sunna type of circumcision.

‘Yeah, I will say social pressure exists when it comes to FGM/C because Somalis are vocal people and girls ask each other on womanhood and what relates to that. Once they hear a certain family has not cut their daughter, they will come to the family and say why have they done that? Are you ready to bring shame for yourself? That is how pressure can fall on the mothers who abandon the cut.’  
Married male, Borama

‘For me, I will say the circumcisers. These women who do the cut are the drivers of the main pressure. She knows whom she has cut and who she did not. She pressures the parents to come for the cut.’  
Married male, Borama

‘Yeah it is possible for actual behaviour of others to affect the practice of the FGM/C in the families. Because people are not that educated and the practitioners of the old behaviour are more than those who go for the medicalised FGM/C.’  
Married male, Borama

### ***Health systems capacity to prevent and manage FGM/C***

#### *Knowledge, views, and experiences of health care workers*

Health care providers and system administrators, in addressing their level of preparedness to manage patients with FGM/C complications, reported knowledge of the physical, psychological, and social consequences associated with the practice. Physical consequences included bleeding, infections, fistula, obstructed labour, urine retention, menstrual blockage, keloids, and infertility. Psychological consequences were mainly associated with later consequences of FGM/C, such as fistula, which can force women to withdraw from others in their community due to embarrassment, and the fear of sexual intercourse when married given the associated pain. Social consequences were reported as including withdrawal from the community, again due to the embarrassment occasioned by fistula and broken families, and a strained sexual life caused by the pain associated with FGM/C:

‘Yes, there are health consequences. There can be psychological harm to the girl that has undergone the procedure. She will get affected when she compares herself and others and discovers that she is the one with the complications. The other thing is that she will have problems during delivery as she can’t deliver easily, which will make the girl to undergo Caesarean surgery ... An immediate consequence is bleeding and pain ... Obstructed labour is when this young girl who is circumcised cannot have normal delivery and will require equipment to hold the baby so that the baby can be pulled (out) ... Gynaecologically, the girl will have infections of the birth canal, inflammation, urinary problems and some will have menstrual problems when FGM/C is done to them. Sexually, when we talk about FGM/C, its effect is that it reduces the girl’s feelings and desires, which can lead to break-ups in the family ... Traditionally, the girls were cut and stitched, with most girls undergoing infibulation, which brought severe pain during sexual intercourse. There are some who are deinfibulated and reinfibulated to ensure it’s done correctly. Hence some of the girls may have different thoughts about getting married and having a family...’  
Midwife, Ahmed Dhagah

‘There are some things that affect the person who has undergone FGM ... like health complications when the person who has undergone FGM later gets pregnant. The pharaonic circumcision brings problems to the woman who has been cut. For instance, when the woman has obstructed labour due to FGM, a procedure called episiotomy is done to the mother, which can cause fatal damage to the soft tissue ... if it’s not done by a trained person. She can also have damage to erectile tissues which can have effects on her libido, which can reduce.’  
System administrator, Hargeisa

‘Late consequences include fistula, which ... will lead the person to report leakage of urine. She might not be able to tell the doctor and the people she sits with say she smells and that will lead to social withdrawal. Psychologically, the person becomes isolated from the community. The psychological problems it causes include social stigma because the

girl with this problem is afraid or shy to tell the doctor of her problem. She is afraid / shy to tell her husband or her mother that she has this problem that causes leakage of urine, a lot of bleeding, and a lot of other problems.’  
Doctor, Borama

‘The social consequences that can happen is that the girl may have problems in interacting with others, especially men. She may fear having sexual contact with her husband and when she gets pregnant, she suffers a lot and can even decide not to get pregnant again due to the previous problems and the process encountered.’  
Midwife, Ahmed Dhagah

Respondents felt that all health care workers have skills in managing patients with FGM/C complications, mostly through work experience in handling patients directly, and during training in college or university. Most health workers did not have specialised training for patients with FGM/C, but a few reported on-the-job training, including managing FGM/C patients by stopping bleeding, blood transfusion, and deinfibulation. Patients who presented with fistula complications were referred to hospitals specialised in dealing with such clinical work, as not all facilities have the required capacity. Surgical techniques and counselling skills are also employed to manage FGM/C patients.

‘All health workers have skills to manage the complications. There are those who manage it.’  
Clinical manager, Hargeisa

‘Yes, the health care workers do get trainings, like the midwife and the nurses at the hospital facility are trained on the management of FGM/C. The training is done by organisations who work for UNFPA ... I can manage the complications of FGM/C but most of the health workers ... need to get training on how to treat complications of FGM/C.’  
Doctor, Hargeisa

‘In this hospital, our people are trained on how to manage the girl who has the pharaonic type of circumcision and who might be at risk. They have been given the skills to do deinfibulation and they use sterile techniques and give proper medication for the pain and they treat those with infection, such as UTIs (uterine tract infections) whose urine does not come out since the girl body is sewed due to the stitching that has been done ... We have training on how to do reinfibulation on the girl.’  
Doctor, Hargeisa

Historically, health care providers have generally received and managed patients with FGM/C complications. With the adoption of the less invasive Sunna cut, coupled with poor health care-seeking behaviour among patients with FGM/C complications, they are reportedly seeing less patients presenting with severe complications. Patients presenting with complications from the Sunna cut are considered as ‘manageable’ through treatment and counselling, compared to those who have undergone the pharaonic cut. Nevertheless, health care providers feel they need additional training on FGM/C management, given most of them have not received specialised training but rely on their general knowledge and experiences:

‘I require the necessary instruments and supplies that I will use to handle the girl when she comes to me. I need a training on deinfibulation when I receive an infibulated girl. A training on counselling girls and FGM/C complications and how to disseminate the knowledge on complications.’  
Nurse, Borama

‘Previously, they were never treated. The person had problems. The girl would die of bleeding or other complications, like urine retention or faced other complications. At times, some girls would die, but right now they can be treated. If a person has complications, they can be treated. Previously, they would cut the whole external female reproductive organ, now they cut slightly.’  
Nurse, Borama

‘We cannot manage all problems resulting from FGM/C but we can manage small consequences, but my opinion is the creation of social awareness, by telling people that not doing FGM/C is better technique to prevent these consequences and that health education might play a great role rather than managing small consequences. We can

manage to stop the bleeding. We can do small things but the social awareness will play a great role.'

Doctor, Borama

'Those who manage FGM/C are health managers and health workers. Some hold diplomas, while some possess degrees but what is important is that they need to get specific trainings on FGM/C prevention and management because they are professionals and they are important people that can talk about FGM/C.'

Midwife, Hargeisa

'I have experience in dealing with FGM/C cases because girls who are cut are brought to us after they have been stitched either when they are pregnant or when they come for infibulation. They also come to us even before their marriage when they experience problems with menstrual period, urine retention and kidney pain ... They have the skills to manage people with FGM/C ... They work with their experience and use their knowledge to work for the people.'

Clinical manager, Hargeisa

'I have seen many women who have undergone FGM/C. I took part in many seminars and workshops on FGM/C. I am trained to work and manage women who have complications of FGM/C. I can do counselling. Counselling requires a different approach, which a person should know so as to understand the person whom he is speaking to, what he/she should tell him/her, and be able to listen to the person so that she opens up to you and tell you everything and not be shy from what you are telling him/her. The approach matters so that you can make the person to talk and that's why we need more training on that.'

Midwife, Ahmed Dhagah

#### *Health care workers' attitudes*

In terms of the practice's future, whether abandonment in totality or modification into a less invasive form, most reported a preference for total abandonment from a professional perspective, suggesting that medicalisation may not be a future trend. The rationale for this viewpoint is that it has no benefits, but many negative physical, psychological, and social consequences that, as providers, they have witnessed when managing affected patients. Moreover, they argued that prevention is much easier than a cure, and that the practice is not an obligation in Islam, but only a recommendation that, therefore, should be stopped, given its repercussions:

'It is better not to do it because it causes health complications. It affects the society and community by affecting a lot the community through reduction of reproduction. I say since it has very negative consequences on mothers and girls, especially on the health and psychological aspects, I will welcome and support the complete abandonment of FGM/C through strengthening of preventive measures or reducing practices that enforce it, like telling people that it is not a must to do FGM/C in the religion, that there are no religious obligations or laws that says it should be done and that it has negative effects on health. I invite awareness creation for mothers themselves, and for the mothers we mentioned previously who don't do it on their daughters, to tell the community that they practiced (not doing FGM/C) and they are happy and that it has brought a positive influence on the community.'

Doctor, Borama

'When we value something, we compare its advantages and disadvantages. So, which of the girls is better when we compare the cut girl and the uncut girl. Personally, I believe the girl who is left untouched is better 100 percent when compared to the cut girl ... I wonder if this is an obligation that is a must. It is not an obligation, it is a Sunna (a prophet's, PBUH, tradition which is optional). There are 150 Sunnas that are not done; if it is done, it will be following the Sunna. I believe things should not be done in excess and if it is not done, there is no offence or sin because it is Sunna. I support that FGM/C is abandoned.'

Doctor, Borama

'I would like it to be discontinued. There are many complications and problems that it had caused on us, on our women. I like FGM/C to stop totally, be it Sunna / mild form or pharaonic / infibulations. If it is not in our religion and there is no one who is threatening us or making it our obligation, I would say it should be discontinued totally. Even the mild form to discontinue. It is not in the Quran as we asked many religious leaders. We asked them, "Is there a sin on us if we discontinue?" They said it is not mandatory Sunna

(Prophet's PBUH tradition), is what many religious leaders told us. It is not authentic Sunna is what many religious leaders we asked said. If it is like that, it is better to leave it.'

System administrator, Borama

A few health care providers supported the continuity of the less severe, Sunna FGM/C, arguing it is recommended by Islam and poses no health risks to girls and women:

'The Sunna type is good, which the people are practicing. Those people are good also ... First, I don't have any objection about circumcision but those things that bring damage like the pharaonic FGM is what I am against because it damages the soft tissues and brings a lot of problems.'

System administrator, Hargeisa

'The community practices the Islamic religion and what they do is something that is good for the people. I want the Sunna one to be practiced. That's my opinion as a practitioner and doctor. No, it does not have any problems. Every day it is practiced and there is no problem. It is simple routine in the community. It's healthy and it is good for the body. This one is only for few days, no antibiotic is even needed. A cut is done and the girl walks. She will walk after a short period.'

Doctor, Hargeisa

### *Challenges managing FGM/C complications*

Most health care providers felt that managing patients who present with FGM/C complications is problematic, given that most delay care and some damage caused by the pharaonic cut is irreversible – minimal options are available to restructure those genitalia to their original forms. Lack of equipment and medicines in most facilities also makes it difficult for providers to manage FGM/C. It was also reported that some patients are unwilling to talk to providers about their problems, especially unmarried women, for the fear of deinfibulation, because they believe they will not get married. Some providers have also not been trained specifically on FGM/C management, rendering it harder for them to manage complications than those who have been trained:

'It's not easy. If those complications have already occurred, to treat the person is hard. An injury that the person suffered before, if everything was cut, does it have treatment? No. Now that girl has neither feelings nor anything.'

Nurse, Borama

'It is not easy to manage the complications of FGM/C because you may need to train people who know how to treat the complications of FGM/C. It's also difficult because most facilities don't have life-saving equipment and medicines and those that have are expensive for the people to get.'

Doctor, Hargeisa

Health care providers managing women and girls with FGM/C face multiple challenges in their work, given that FGM/C is not accorded prioritised attention and resources. Most patients with complications live in rural areas where there are low-level facilities, providers have no training in FGM/C management, and there is a lack of equipment and medicines necessary to manage complications that are compounded by late patient presentation. They also report a lack of referral hospitals for FGM/C cases.

'The challenges are the girl who has FGM/C will arrive late when she already has the complications of FGM/C. For example, it causes scarring of the vagina (vulva), which is actually irreversible. There is lack of support and attention from the communities and colleagues, lack of trained or skilled doctors, lack of referral hospitals and good supplies. All these challenges are there. Inadequate hospitals is also a factor.'

Doctor, Borama

'First, you need to know that health care is concentrated in urban areas and our people are more in the rural areas. The place where FGM/C is done mostly is the rural areas and small towns. The rural areas have few hospitals with no professionals. You can only find a midwife who has got [minimal] training, maybe six months training. Auxiliary nurses and midwives are mostly there in the better facilities. So, the main challenge is the facilities are not available everywhere and well-trained professionals are not there and if they are there, I can say they are few. The other thing is a person should have health seeking behaviour and here people don't. The girl sees it as a shame to talk about her

personal issues and see a doctor. So, it is important the girls get enough awareness, awareness should bring her out of her house and should encourage her to go to the hospital and say I have a problem. This often leads to delayed management. There is lack of team work between hospitals, government and organisations ... I don't think the problem is given the attention it deserves because the community sees it as a sensitive issue to talk about.'

Doctor, Borama

### *Health system capacity and its strengthening*

Health care providers and system administrators outlined the strengths and weaknesses of the health system, with the latter often outweighing the former. Some strengths include: health care providers are involved in creating awareness on FGM/C within their facility and community; integration of FGM/C awareness in maternal and child health clinics; health facilities in urban areas have the capacity to handle FGM/C complications; some health care providers have been trained on the management of FGM/C complications; and patients can be referred to other specialists, such as gynaecologists and obstetricians, not necessarily trained on FGM/C management.

'The ability of health care system is good here but in the rural areas it's not. The system that is there in clinic is to do sensitisation for the people and educate them about impacts of circumcision on the lives of a people.'

Doctor, Hargeisa

'Those victims of FGM practice come to us when they start experiencing problems such as menstrual difficulty, infections, urine retention and when they require deinfibulation. We do manage all these problems when they come to us. We also manage women who come with miscarriage who have the condition of FGM. So, I can treat and manage them.'

System administrator, Borama

'The health system can prevent the practice of FGM by doing awareness creation. Now, it's involved in the creation of awareness for the people by educating them about the problems of FGM/C.'

System administrator, Borama

'I have seen many women who have undergone FGM/C. I took part in many seminars and workshops on FGM/C. I have been trained to treat and manage women who have complications of FGM/C.'

Midwife, Ahmed Dhagah

The health system reportedly has multiple weaknesses that limit its capacity to manage FGM/C complications. Most providers have no training on FGM/C management; no guidelines/policies/standard operating procedures on FGM/C management are in place; de-medicalisation policies are not available or are not being implemented; there is no FGM/C referral system; there is a lack of supplies and equipment for FGM/C management, due to no budgetary allocation; most facilities that can manage FGM/C complications are in urban centres, whereas most patients are in rural places where pharaonic FGM/C is mostly practiced; there is no support supervision for FGM/C; and there is no integrated health information system capturing statistics for future planning.

'The capacity of the health system is very poor because there is no connection. There is no team that is ready to receive a girl with FGM/C. I think it is very poor. There are no hospitals well equipped because of lack of training and lack of adequate staff. Supplies are also very poor, very poor. This doesn't exist at all (standard operating procedures, cascaded policy on FGM/C care) ... There is no supportive supervision. There is no health programme that I have seen right now that anchors FGM/C ... Some statistics are available and I have seen it in many places but I haven't seen the one linking FGM/C with maternal and infant health.'

Doctor, Borama

'I think the skills and training to manage complications of FGM/C is very low ... First, generally in our country, there are few specialist doctors, gynaecologists who are trained for such tasks. So, we need to get health care workers who are doctors ... who should be trained adequately to manage FGM/C complication for those who were cut ... I think the health facilities can do something but it's not enough ... If I quantify those people who

can handle these issues are less than 10 percent ... Secondly, I haven't seen a written policy or protocol, it is possible it could be there but I haven't heard nor have I seen it, a written protocol on treating the complications of FGM/C, de-medicalisation. There is no supervision on FGM/C issues I am aware of ... So, these are some of the things that need to be looked at once again and to have written protocols and policies on these issues.'

Doctor, Borama

'I think it's about funds. Certainly, training deficits are there and hospitals lack some essential supplies. But there is one hospital in Borama, so it will be good to find it everywhere. Now it is only possible for people to come from far places to that of Borama (fistula hospital). It could have been better if every county/province had such hospital and people who can educate them. Girls with FGM/C problems mostly don't come to the health facilities, so it's not given much attention. There are no support and supervision. There is no referral system in place at the time that I am aware of and no support available and certainly, the problem doesn't get the attention it deserves.'

System administrator, Borama

'The health care system is not adequate. There is need for health care facilities to have ready obstetric emergencies departments with well-trained health personnel and they should have all the instruments they need because if the person has the training but has no pair of sterile gloves she/he can't do much. Adequate supplies and health workers will be the best if it's available but it is not ... So, it's necessary to take to every district adequate staff with training and adequate supplies and a facility where obstetric emergencies can be managed which should be standardised throughout the country.'

System administrator, Borama

Participants provided several suggestions on how to strengthen the capacities of health care systems to respond to the management of women and girls who have been cut and to prevent cutting, including awareness creation, training, service integration, dedicated resources and services, and policy clarifications.

'The important thing they must do is that the health worker should educate the people about the complications associated with FGM/C. They should also be trained to convince the community about the problems of FGM/C so that they can stop practicing it.'

Unmarried female, Hargeisa

'It is important to talk about the psychological issues. Girls need to get support, like in support groups. In the world, there are people, like the disabled who have support groups. They encourage one another when they come together. They discuss their issues. They share their stories. When they meet for instance, they get relieved of their problems. They believe the problem is not individual/personal because they might see a person who has worse problems than them ... The people who are affected by FGM/C, especially those who are cut, need to have support groups where they get together and get helped with education so that they can protect their children, get relieved from the psychological problems they suffered and to share their stories.'

Doctor, Borama

'All health workers should be trained and educated on FGM/C so that they can educate the people and treat people with complications of FGM/C. The health facilities should have good medicines and equipment for treating women with FGM/C so that they don't suffer.'

Unmarried male, Hargeisa

'The people who are many in the villages and rural areas are people who don't have health facilities in their places. They are the ones with high rates of FGM/C in their areas, so I would have added that health care management should be taken up to there so that they can help with that or prevent the risks that can result from it so that they take part in ensuring eradication of FGM/C. We also need a policy that is geared towards ending FGM/C, which makes interventions that are connected to the hospitals that treat people and that ensures their data is collected and recorded. The most important aspect is the ministry of health has to come up with a policy that is known to all health sector

stakeholders for people to work with them but the ministry itself has no policy. There has to be policy that is developed, which is then implemented and followed up.'

Clinical manager, Borama

'I would add, like in this hospital, there is no place where we can do the awareness/health education. We require a team who will be responsible for educating and for creating awareness. We receive second time mothers (para 2), first time mothers (para 1) and are delivering. A team has to be made so that those mothers are given education on FGM/C.'

Nurse, Borama

## Discussion

This study found important evidence of a fundamental shift in FGM/C procedures in Somaliland. This shift, potentially more evident in urban areas, is from the invasive pharaonic cut to the less severe Sunna cut that is varyingly interpreted to entail a 'pricking' or 'nicking' of the clitoris for it to bleed, or indeed its excision. This transition in cut severity appears to be accompanied by a downward trend in the age at which the procedure is performed (currently 5 to 8 years of age), stemming from a potential refusal of the girl at an older age to undergo circumcision, exerted parental authority in the ostensible interests of the girl, and a justification in 'tradition'. The medicalisation of the procedure – with health professionals as cutters and cutting occurring at facilities or at individuals' homes – resonates with findings reported elsewhere in Africa (Chege et al. 2001; Ministry of Health/GTZ 2004; Njue and Askew 2004; Shell-Duncan 2001; Shell-Duncan et al. 2017). The framing of women who decide to pursue medicalised FGM/C as "modernised mothers" has the potential to reinforce normatively the more "discerning" choice of the Sunna cut, despite the responses of some health care workers suggesting their preference for the practice's total abandonment. Indeed, a study of 1,847 individuals in 20 communities in the Awdal, Maroodi Jeex, Sanaag, Saaxil and Togdheer regions of Somaliland found evidence of increasing pressure towards medicalisation of cutting, with 16 percent of women reporting their own daughters were cut by a health professional (nurse, midwife or doctor) (Newell-Jones 2017).

The shift in cut severity is supported by a qualitative study among 24 activists, practitioners, men, and women living in Hargeisa and Galkayo districts of Somalia (Gele et al. 2013b). Underpinned by limited literature on the country (Lunde and Sagbakken 2014; Vestbøstad and Blystad 2014), this finding is suggestive of a long-term downward trend in the practice; nearly three decades ago, a study reported only 5.5 percent (n=16) of 290 Somalian women had a Sunna cut (Dirie and Lindmark 1991), compared with Newell-Jones's (2017) recent study that found 27 percent of women and girls aged 15-24 reported undergoing the same cut.

While the study was not designed to establish causality, it appears the shift from the pharaonic to the Sunna form of FGM/C is linked to health and well-being issues, specifically attempts to at least minimise any adverse impact upon them. In their study of FGM/C attitudes and knowledge among 648 Somali male and female immigrants in Sweden, Wahlberg et al. (2017) reported 113 (17.4%) supported the continuation of pricking, with these more likely to believe it was acceptable religiously, not a violation of children's rights, and does not cause long-term health complications. Moreover, in 1985 Gallo, reporting positive attitudes to FGM/C among respondents, concluded such positivity partly found support in the ignorance of the negative aspects of the practice; given the often-delayed detrimental impact of the cutting years after its occurrence, not all women acknowledged the connection between cause and effect. This absence-of-causality hypothesis appears to have underpinned many subsequent anti-FGM/C messaging, which emphasised the procedure's adverse immediate and longer-term health implications (Muteshi and Sass 2005; Toubia and Sharief 2003).

In this study, it appears the shift from the pharaonic to Sunna form of FGM/C is, at least partly, an attempt to address the medical narrative propounded by many anti-FGM/C campaigns; that the

practice is deleterious to the girls' and women's health. This is combined with an attempt to balance that consideration with extant socio-cultural expectations that a cut of some description, if not pharaonic (increasingly seen as not an intrinsic part of Somaliland culture and not obligatory by religious teachings), must be made to ensure a girl's chastity, to decrease her sexual arousal, maintain her reputation as "clean", and ensure her marriageability prospects. It is an argument that has also been postulated for the increase in medicalisation of the practice in many countries (Shell-Duncan et al. 2017). This need to find an acceptable balance between health preservation and socio-cultural normative expectations has meant many have become receptive to current religious teachings promoting the Sunna cut as an acceptable and, indeed, desirable form of FGM/C. This finding was echoed by Newell-Jones (2016), who found support for the Sunna cut as honourable under Islamic law, and decision-making being much less informed by inaccurate knowledge of the practice but rather to balance conformity to social expectations with minimising adverse health consequences (Newell-Jones 2017).

Normative changes, therefore, appear to be occurring in Somaliland society, and there is a growing readiness for change. The nature of that change, however, is not for abandonment of the practice *per se*, but rather its transformation into a more socially acceptable version. This finding is supported by Newell-Jones (2017), who found while 90 percent of men and women want to see some kind of abandonment, this primarily concerns the pharaonic cut; only 5 percent interviewed wanted to abandon all types of cutting. Indeed, the prospect of abandonment in the near future appears poor. The 2011 UNICEF Multiple Indicator Cluster Survey (UNICEF Somalia and Somaliland Ministry of Planning and National Development 2014) among females aged 15 to 19 years, found 45.3 percent wanted the practice to continue, the largest percentage among girls/women in favour of its continuation. There is a new norm emerging in Somaliland which appears only to be changing to reinforce the continuation of the practice. Given its universality, that of the pharaonic cut specifically, and the health-related anti-FGM/C messaging, this change is not surprising. These findings echo those of Newell-Jones (2016) in the Maroodi Jeex and Togdheer regions of Somaliland, who found a change, especially in urban areas, from the pharaonic to intermediate and Sunna cuts: only 34 percent of girls aged 12 to 14 years had undergone the pharaonic cut compared to 96 percent of women over 25 years. Similarly, while 84 percent of community members intended to cut their daughters in the future, women particularly intended to select a less severe cut than what they perceive the community expects.

The notion of abandonment itself is potentially problematic from programming and evaluation perspectives. With FGM/C used to refer to the pharaonic cut only, as Johansen also found in a study of Somali immigrants in Norway (Johansen 2006), respondents often appeared to conflate abandonment of the pharaonic cut – and a move to the Sunna form – with abandonment of the practice in its entirety, a finding echoed among 1,261 respondents in six communities in three districts of Somalia (Anon 2017). This misrepresentation, or reinterpretation, of the concept of abandonment could not only potentially result in erroneous messaging by anti-FGM/C abandonment programmes, but also under-represent the extent of actual FGM/C if linguistic nuances are not addressed. This conceptual reinterpretation of FGM/C may account for an outlier report on the prevalence of the practice in Somaliland. A gender-based violence study (Perrin et al. 2016) among 1,517 men and women aged 15 and older, reported only 66 percent of women had undergone FGM/C. This figure contrasts significantly with other national and site-specific studies, and could be attributed to methodological issues, including the community definition of FGM/C and whether it is synonymous with the pharaonic cut.

The challenging normative landscape for abandonment changes in FGM/C in Somaliland, but rather towards the Sunna cut, led Gele et al. (2013b) to conclude in Somalia that the failure of a 'zero tolerance policy' means consideration be given to promotion of the 'pinch of the clitoral skin' with the goal of leading to total abandonment. It is an argument for 'de minimis' forms of FGM/C

not entailing long-term medical risks echoed by medical ethicists (Arora and Jacobs 2016) and refuted by opponents (Askew et al. 2016). The proposition that a less severe cut could be a transitional stepping stone on a change continuum resulting in abandonment is a contestable assumption; indeed, it could equally result in a modified consolidation of the practice. It could also be argued that this landscape, while challenging, offers opportunities for change. For example, discourse around religious sanctioning of the Sunna cut affords opportunities to engage with religious leaders, and similarly those young unmarried men who are in favour of complete abandonment. The extent to which health care workers can genuinely play fundamental change-agent roles – as opposed to maintaining the practice by adopting its medicalisation or indeed providing study responses that are known to be more socially acceptable to researchers – also merits targeted engagement with health care professions within Somaliland to understand how they see their role in that change process.

The fact that social norms are in a contested state of flux therefore suggests an opening for advocates to contribute to the ongoing dialogue. However, that contribution should also extend beyond the medical narrative emphasizing the negative health consequences of the practice and harm reduction as a driving consideration, and move the discussion to issues around bodily autonomy and individual informed consent (Earp 2015) as part of a human rights-based approach that emphasises children's rights. This approach was employed in Kenya, where the human rights discourse challenged existing power relations and ways of thinking to pave the way for the Children's Act of 2001 that protected children under 18 years from numerous violations, including FGM/C (Shell-Duncan and Olungha 2009). Such a dialogue transition would also enable a more equitable discussion around what currently is a geographic dichotomy in ethical discourse where extensive genital modifications, including reduction of labial and clitoral tissue, are considered acceptable and legal in many European countries, but where FGM/C is considered intolerable and illegal (Johnsdotter and Essén 2010).

In the foreseeable future, however, changes in the perceived severity of cut, which can reduce the number of complicated cases presenting to health care facilities, do not obviate the need to strengthen existing capacities (both human resources, in terms of training and other resources) to manage FGM/C cases, both on a preventative and corrective basis. Special attention in this regard must be devoted to facilities and personnel in rural areas, where resources are minimal, and where pharaonic cutting practices can produce greater need for corrective medical interventions, as well as the introduction of effective referral networks (including the provision of means to address transport-related barriers to accessing necessary care). Additionally, there is need for the introduction of routine, integrated monitoring and evaluation data collection systems into those services that address the needs of women and children, so the precise extent and nature of FGM/C being undertaken is more accurately determined and reported.

## Conclusion

The shift from the invasive pharaonic cut to the less severe Sunna form can, on the one hand, be seen as a positive harm reduction development for the practice in Somaliland. However, programmatic work that focuses on the eradication of more invasive forms of FGM/C without addressing the Sunna cut as part of an agenda of total abandonment of the practice could be perceived as condoning and reinforcing its continuation. Finding common ground between these two agendas (retention of the Sunna cut versus total abandonment of FGM/C) is problematic and, at the national level (Somalia) has led to a stalemate in the introduction of a national anti-FGM/C policy.

It is argued that central to this irreconcilability is the dominant medical narrative that emphasises the deleterious health consequences associated with the practice and renders the Sunna cut as

an acceptable resolution to the 'cultural expectation-minimise harm to the individual' conundrum. Programmatic interventions should reflect upon moving the dominant narrative to issues around bodily autonomy and individual informed consent.

Further research should explore, using existing datasets, the extent to which adoption of the Sunna cut by mothers upon themselves is correlated with their commitment to the practice's abandonment compared to those women who have undergone the pharaonic cut. There is also a need to enumerate the study's qualitative findings to determine not only the prevalence of commitment to the Sunna versus pharaonic cut but also the status of the Somaliland population on the 'readiness to change' continuum and if indeed this change is solely to the Sunna cut or if abandonment *per se* is also evident.

## Limitations

This study has several limitations: first, given the subject's sensitive nature, participants may have not felt safe or comfortable answering questions (Askew 2005). Given the procedure's health consequences, and the predominantly health-orientated messaging of anti-FGM/C campaigns, participants may have been inhibited in responding honestly and openly from shame, stigma, and guilt or from fear of retaliation if supporting the practice. Given the indication, however – at least in parts of Somaliland (Vestbøstad and Blystad 2014) – that FGM/C is openly discussed in public, if not as much in private, combined with the rigorous training of research assistants in conducting sensitive interviews, it is anticipated that socially acceptable responses were minimised. Second, the quality of the study findings could have been influenced by interviewers' personal idiosyncrasies and biases. Again, it was anticipated that the training programme, in which personal prejudices and behavioural interactions were discussed as potential bias sources, reduced this risk. Third, the risk that interviewer-interviewee exchanges were affected adversely by differing genders of both parties was off-set by matching both genders. Fourth, to minimise the possibility of the authors' invalid interpretation of the data – and ensure the findings are an "accurate representation of the phenomena they are intended to represent" (Anderson 2010: 2) – the study used proxy respondent validation with Somalilanders with extensive experience working in FGM/C.

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