



Female Genital Mutilation Survey In Somaliland

At the
The Edna Adan Maternity and Teaching Hospital,
Hargeisa, Somaliland
2002 to 2009

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What is Female Genital Mutilation?

According to the definition of the World Health Organization (WHO)¹, Female Genital Mutilation **FGM** comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons and does not include medically prescribed surgery or that which is performed for sex change reasons. It is practiced in more than 20 countries throughout Africa, the Middle East and Asia, and within immigrant populations throughout the world with prevalence rates ranging from 5-99%. Its practice can be found among all religious, ethnic and cultural groups and across all socioeconomic classes. It is estimated that up to 130 million women and girls have already been subjected to some form of **FGM** and 2 million more are expected to experience it each year.

Female Genital Mutilation (**FGM**), also known as Female Circumcision (FC), or Female Genital Cutting (FGC), is a universal practice that results in many health-related and life threatening complications. It also has other physical and psychological effects that do great harm to the wellbeing of women and children who have had it performed on them.



Fig. 1 : Normal female genitalia

In the countries where most or a large number of women have been mutilated, the medical complications that result from these practices place a heavy burden on the health services of these countries.

¹ WHO. Female Genital Mutilation, a teacher's guide. Geneva: WHO, 2003.

Classification

Procedures vary throughout the world but the **WHO** classifies **FGM**² into four types as follows:

Type 1: Excision of the prepuce with or without excision of the clitoris.



Type 2: Excision of the clitoris with partial or total excision of the labia minora.



Type 3: Excision of part or all of the external genitalia and stitching together of the exposed walls of the labia majora, leaving only a small hole (typically less than 5cm) to permit the passage of urine and vaginal secretions. This hole may need extending at the time of the menarche and often before first intercourse.



Type 4: Unclassified, covers any other damage to the female genitalia including pricking, piercing, burning, cutting or introduction of corrosive substances.

² WHO. Female Genital Mutilation, a teacher's guide. Geneva: WHO, 2003.

Global Prevalence

Female genital mutilation is a widespread practice that is carried out on young girls between the ages of 5 and 10 years, and in some countries on grown women as well. Unlike male circumcision, female circumcision is not a Religious obligation required by Islam, Christianity, or any of the other known religions; The practice is nevertheless a cultural tradition. It is practiced mainly in Africa and in some Asian countries. At one time it is said to have even existed in Europe before it was abolished in that continent some centuries ago.

In recent years because of immigration and population movements, the practice is emerging among refugee populations in Europe and North America where the medical and obstetrical complications that mutilated women and girls are seeking treatment for is causing a lot of concern among health-care providers in Western countries. This concern is expressed through the constant attention **FGM** receives from international health and human rights organizations as well as from the world media.

Studies of FGM Prevalence

Prior to this present study that is being reported on, there had been very few studies conducted in the past, or studies had been on a small number of women. Some of the most accurate early data on **FGM** comes from Fran Hosken³ who in 1982 compiled statistics from her many years of studying **FGM** in Africa. Between 1995 and 2002 the Demographics and Health Surveys published data compiled by questionnaire from 16 countries, but Somaliland and Somalia were not included. Countries that have had repeated data collected have shown small declines in prevalence and a trend to less severe forms of mutilation⁴. There are a number of published studies from African countries, (not including Somaliland), in particular Nigeria, which have estimated **FGM** prevalence, but most have involved small numbers and have only been carried out over short periods^{5,6,7,8}. In 1998 a national survey by the Ministry of Health in Somalia stated a 96% prevalence rate. In 1999 Care International studied Somaliland and stated that it was

³ Hosken, F. The Hosken report: Genital and sexual mutilation of females. Lexington, Massachusetts: women's International Network news. 1982.

⁴ Carr, D. Female Genital cutting. Findings from the demographic and health surveys program. Calverton, Maryland 1997: Marco International Inc.

⁵ Ugboma HA, Akani CI, Babatunde S. Prevalence and medicalization of female genital mutilation. Niger J Med. 2004. Jul – Sep;13(3):250-3.

⁶ Dare FO, Oboro VO, Fadiora SO, Orji EO, Sule-Odu AO, Olabode TO.

Female Genital Mutilation: an analysis of 522 cases in South-Western Nigeria. J Obstetric Gynaecology. 2004 Apr;24(3):281-3.) (325)

⁷ Egbuonu AO. The Prevalence and practice of female genital mutilation in Nnewi Nigeria: the impact of female education. J Obstet Gynascol. 200;20(5):520-2) (500)

⁸ Mandara MU. Female genital Mutilation in Nigeria. Int J Gynaecol Obstet. 2004 mar;84(3):291-8.

universal, with 91% undergoing the most severe form, Type 3. A Swedish study published in 1991 questioned 290 Somali women living in Sweden and found that 100% had **FGM**, with 88% being Type 3 despite a relatively high socio-economic level, and the majority was willing to perform FGM on their daughters due to religious reasons⁹. A recent study by the WHO and UNICEF looking for the first time, into HIV prevalence also asked women about their **FGM** status. The study included 769 women and found that 98% had undergone Type 3 circumcision¹⁰.

World Wide Opinions about FGM

The United Nations and other humanitarian organizations consider **FGM** a violation of human rights^{11, 12}. As early as 1979 the WHO recommended, at an international conference, that the practice should be eradicated¹³ and in 1993 the World Health Assembly called for abolition of the practice^{14, 15}. Consequently, most countries have strict laws forbidding the practice.

FGM In Asia

Female Genital Mutilation is occasionally reported to be practiced by a limited few in Oman; Saudi Arabia; United Arab Emirates; Yemen; and by even fewer in certain communities in Indonesia; Malaysia; India and Pakistan.

FGM In Africa

Female Genital Mutilation is reported to exist in many African countries, in some it is performed on all or most women while in others it may be performed only on some women belonging to certain ethnic groups.

The countries where **FGM** is reported to be practiced with varying applications of Types and different prevalence rates are:

Benin; Burkina Faso; Cameroon; Central African Republic; Chad, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Somaliland, Sudan, Tanzania, Togo, Uganda

⁹ Dirie MA, Lindmark G. Femal Circumcision in Somalia and women's motives. Acta Obstet Gynecol Scand. 1991;70(7-8):581-5.

¹⁰ HIV/AIDS ASSESSMENT: sero-prevalence survey. Dr Adan Yusuf Abokor. ICD WHO UNICER. 2000.

¹¹ Sullivan D, Toubia NF. Female genital mutilation and human rights.

Presented at the World Conference on Human Rights, Vienna, Austria, June 1993.

¹² World Conference on Human Rights: the Vienna Declaration and Programme of Action, June 1993. New York: United Nations.

¹³ WHO. Traditional practices affecting the health of woman and children;

Female circumcision, childhood marriage, nutritional taboos etc. WHO/EMRO Tech Publ 1982;2:1-360.

¹⁴ Female circumcision: female genital mutilation. Int J Gynaecol Obstet 1992;37:149.

¹⁵ Female genital mutilation -- World Health Assembly calls for the elimination of harmful traditional practices. Press release of the 46th World Health Assembly, Geneva, World Health Organization, May 12, 1993.

FGM in Somaliland

It has long been accepted that FGM is ubiquitous in Somaliland but accurate data has been lacking. Anecdotal evidence suggests that the procedure was commonly performed on girls between the ages of 4 and 11 and that 95–100% of women had undergone the procedure, the majority of whom having been subjected to the most severe form of mutilation^{16, 17, 18}. The study included in this present report shows that 97 % of the Somaliland women receiving antenatal care at Edna Adan Hospital have undergone **FGM**. In Somaliland the women refer to their procedure by two names, the **Sunna** and the **Pharaonic**. The Sunna correlates with Type 1 and 2 but also involves stitching of the anterior part of the genitalia to varying extent. The Pharaonic correlates with Type 3.

Many successful awareness campaigns have been run in Somaliland since 1997 and as a result more Somalilanders are willing to openly discuss the topic of **FGM** and are becoming increasingly concerned about the health risks associated with the procedure.

¹⁶ WHO. Traditional practices affecting the health of woman and children; Female circumcision, childhood marriage, nutritional taboos etc. WHO/EMRO Tech Publ 1982;2:1-360.

¹⁷ Female circumcision: female genital mutilation. Int J Gynaecol Obstet 1992;37:149.

¹⁸ Female genital mutilation -- World Health Assembly calls for the elimination of harmful traditional practices. Press release of the 46th World Health Assembly, Geneva, World Health Organization, May 12, 1993.

The Procedure

The day of the **FGM** is considered an important event but it is kept secret from the pre-menarche child, and then sprung upon her once the necessary preparations have been made. Senior female members of the community, relatives, traditional birth attendants (TBA's) or occasionally healthcare workers may be called upon to carry out the procedure.

No anesthesia is used while this very sensitive part of the female body is being brutally cut and manipulated, except when the operation is being performed by a health professional who has access to anesthetics and who the required knowledge in their use.

The age at which female genital mutilation is performed varies from country to country and according to the type of mutilation being done. **The SUNNA** is generally the type that is performed at a very young age and may be carried out soon after birth, during the first week of life or at any time before the Menarche. In the case of **EXCICION and INFIBULATION** when more tissues are to be removed which entail more manipulations, the child is allowed to grow older so that the tissues intended for excision are also given a chance to grow. This gives the operator a better pinch or grip. According to the findings of our survey, it was found that the usual age when Excision and Infibulations are performed is between seven and nine years of age.

Instruments and methods

The Instruments

- Any sharp cutting instrument such as a knife, broken glass, razor blade will do, or the operator may have somehow acquired medical instruments like a scalpel, forceps or scissors.
- The instruments may be new or may have already been used for other purposes and/or on other persons.
- Sterilization is seldom known nor performed by these traditional operators.

The Sutures

- Regular surgical Catgut, Silk or Cotton thread.
- Domestic sewing thread.
- Vegetable or nylon fiber pre-selected by the operator.

The Needles

- Regular surgical suturing needles (round bodied or sharp and any size)
- Domestic sewing needle.

Approximating the wound

In some cases, instead of suturing together the raw edges of the wound, these are held together with thorns that are inserted on opposite sides of the wound and then laced together with thread and left in place for seven days or until the tissues of the wound have had time to fuse together. This type of infibulation is often practiced by nomads and agro–pastoralists.

Condition of Hands

- No gloves are worn during the operation.
- Hands may or may not be washed and in any case wet fingers are slippery and should the operator have difficulty in pinching the skin being removed, it is not unlikely for the operator to wipe his/her hands on the thighs of the child or even on the sand on the ground in order to dry them and thus improve dexterity!
- The operator allows his/her nails to grow as they are used as pincers during operations. Rings, amulets and other hand ornaments are rarely removed, as these items are not recognized by the traditional healer as likely sources of contamination.

Clothes and bedding

Since bleeding will occur and since there will be some secretions for some days, the family usually finds an old mat or floor covering that can later be discarded.

Sometimes sand is placed on the mat under the buttocks of the child in order to absorb blood and other secretions.

In the case of more affluent or educated families, they may be more likely to be aware of the risks of infection and usually such families would have clean sheets and also gauze pads to absorb any blood or secretions from the wound.

The Operation Itself

The child is made to squat on a stool or mat facing the operator at a convenient height that offers the operator a good view of the parts to be handled. This is important for the operator is often an elderly person whose sight may be impaired and who may find bending over difficult.

Understandably, it is vital for the child to be held as still as possible in order to avoid inflicting cuts other than those intentionally being carried out for the purpose of Infibulation. For this, adult helpers grab and pull apart the legs of the little girl. Usually, two persons grab one leg each and also hold down her hips; a third person holds back the head and torso. To prevent kicks, the child's legs are held back by tying a rope to each of her ankles which is then tied to her thighs thus keeping each leg in a tightly flexed position in what can roughly be described as a modified and forced Trendelenberg. If available, this is the stage at which a local anesthetic would be used.

The element of speed and surprise is vital and the operator immediately grabs the clitoris by pinching it between her nails aiming to amputate it with a slash. The organ is then shown to the senior female relatives of the child who will decide whether the amount that has been removed is satisfactory or whether more is to be cut off. After the Clitoris has been 'satisfactorily' amputated, and also after the female relatives have 'ululated' to let those outside know that the business at hand is progressing well, the operator can then proceed with the total removal of the labia minora and the paring of the inner walls of the labia majora. Since the entire skin on the inner walls of the Labia Majora has to be removed all the way down to the perineum, this becomes a very messy business as the child who is by now screaming and struggling is also bleeding profusely making it difficult for the operator to hold with bare fingers and nails the slippery skin and the parts that are to be cut or sutured together.

It needs to be stressed here that it is important for the wound to heal by first intention not only to protect the child from a repeat operation, but also mainly to preserve the popularity of the operator who would otherwise acquire a bad reputation and also would lose future potential clients if the wounds that she handles do not heal well. Having made sure that sufficient tissue has been removed to permit the desired fusion of the skin, the operator pulls together the opposite sides of the labia majora, ensuring that the raw edges where the skin had been removed are well approximated. The wound is now ready to be stitched or for thorns to be applied.

If a needle and thread are being used, close tight sutures will be placed to ensure that a flap of skin covers the vulva and extends from the Mons Veneris to the Perineum and which, after the wound heals, will form a bridge of scar tissue that will totally occlude the vaginal entroitus. A small hole having the diameter of a matchstick will be left un-stitched in order to permit the flow of urine and vaginal secretions. If thorns are being used, an equal number would have been inserted into each side of the labia majora, and a string would then be used to pull the

thorns together and thus bring the raw edges of the labia majora together. The string would be wound in the same way that sports shoes with hooks are laced. If the female genital cutting is being done by a person who has some knowledge of dressing wounds, they would apply regular medical disinfectants.

After the stitching, a raw egg is broken over the wound, which is then sprinkled, with whatever herbs, sugar or concoction that were prepared according to the dictates of the local custom, or the practice of the 'operator'. This concoction, consisting of egg, herbs, sugar, and the blood of the child, would all clog together and form a crust over the sutures or the strips of cloth holding the thorns together. One can only wonder why more girls do not develop infections after this rich culture medium for bacteria has been placed between the legs of these little girls. In order to prevent leg movement, the child's legs are bound together from the hips down to her toes and the child is then made to lie on her side.

No dressing is used and the legs are kept together for a week after which the leg bindings are slightly loosened and the child allowed taking small steps. The leg bindings will be removed altogether after a further week. To ascertain that the urethra has not been accidentally closed, either by a blood clot or suture, the child is encouraged to urinate a few hours after the operation. Whether sutures or thorns were inserted, these will be removed on the seventh day but only after the operator is satisfied that the two sides of the labia majora have fused together and that the remaining hole for urination is not wider than three to five millimeters in diameter.

De-infibulation at the time of Marriage

The closure of the introitus must be reopened at the time of marriage so that the woman is able to have sexual intercourse. The opening up of the infibulation occurs as part of a ceremony and in the presence of female members from the bride and groom's families to verify that the bride is a virgin at the time of marriage. The opening of the infibulation is performed by a senior female member of the community, a TBA, or in a hospital by medical staff. Occasionally, the husband forcibly performs penetration and bursts through the scar of the infibulation.

The Dangers of FGM

FGM puts children at risk of life threatening complications at the time of the procedure as well as health problems that remain with her for life. They may suffer bleeding at the time of the procedure or develop severe infection, both of which can lead to death if not treated promptly. Those who do not develop life-threatening complications will still suffer from severe pain and trauma.

The procedure also permits the transmission of viral infections such as hepatitis which can lead to chronic liver diseases and even HIV. The women may suffer complications such as recurrent infections, pain and obstruction associated with urination and they are at higher risk of painful menstruation and intercourse, pelvic infection and difficulties in becoming pregnant. Retention of urine and recurrent infections often require repeated hospital admissions and some women carry a risk of developing nephritis. The development of cysts and keloids at the site of the scar are very common, often causing embarrassment and marital problems, and usually require surgery for removal.

During pregnancy there are many further complications that may occur as a direct result of the **FGM**. Labour may become obstructed and if early medical intervention is not provided this may lead to the death of both baby and mother. WHO estimates that many women giving birth die in the process, simply as a result of **FGM**¹⁹. If the mother and baby survive there is the risk of damage to the vagina leading to the formation of fistulas into the bladder or bowel, which cause constant incontinence as a result of a vesico-vaginal fistula or recto-vaginal fistula. Women in this condition are often rejected by their family and become social outcasts. During the seven years that the Edna Adan Hospital has been functional, the fistulae of over 100 women have been surgically repaired. Apart from the many physical complications, the girls and women experience considerable psychological problems including depression, anxiety and post-traumatic stress disorder. These psychological problems are exacerbated at the time of marriage and often lead to increased distress and fear of intercourse. If de-infibulation is performed the woman is again exposed to the life threatening complications of sepsis and bleeding, and the transmission of chronic infections such as HIV and Hepatitis and also damage to the urethra if, as is common, the operator makes an error when performing the cut.

Complications

Considering the clumsy and un-hygienic conditions under which female genital mutilation is usually performed, complications are frequent and numerous and can be classified in the order in which they are likely to occur.

1. Immediate

- Shock
- Fear
- Pain
- Hemorrhaging
- Other lacerations: in addition to the intentional cuts on the clitoris, labia minora and majora, there may be accidental lacerations inflicted on the child as a result of her struggles. These cuts may involve the vagina, urethra, anus and thighs. As a result, quite a few children are taken to hospitals for the control of hemorrhage, or for the repair of severe lacerations.

1. Within the first 10 days

- Infection: infection to the wound and septicaemia are often encountered and tetanus is not uncommon.
- Retention of Urine: (5 possible causes)
 1. Post-Traumatic Oedema of the vulva resulting from the damages inflicted on the clitoris and labia impedes or obstructs the passage of urine through the swollen urethra
 2. Obstruction of the urethra by a blood clot or by the thorns that were inserted to hold the sides of the labia majora together.
 3. Accidental suturing of the Urethra itself
 4. Over-tight application of the binds that were used to keep the thighs and legs together
 5. Psychosomatic urine retention out of fear and pain
- Failure to Infibulate: when the two sides of the labia majora fail to fuse, it necessitates that the child undergoes a repeat operation at a later date.

1. At the onset of menstruation

- Dysmeorrhoea: when the post-infibulation vaginal whole is too small there is a constant stagnation of menstrual blood and other vaginal secretions, causing bacteria to spread into the vaginal and uterine cavities. This is likely to increase the risk of chronic pelvic inflammation that might cause the severe abdominal cramps experienced by infibulated females during menstruation

- Recurrent Urinary Tract Infection: because of the flap of skin obstructing the urethra after infibulation, urine does not jet out during micturition. Instead, it hits the flap of skin obstructing the vulva and is then sprayed back into the vagina and then trickles out in drops. This obstruction also prevents proper vaginal hygiene and drainage and causes urinary stasis which is likely to cause recurrent urinary tract infection
- Possible Second **FGM**: because the small artificial opening that had previously permitted the passage of urine becomes insufficient to permit the drainage of the more viscous consistency of menstrual bleeding, doctors often have to convince the parents of these girls that the small vaginal opening be enlarged to permit the flow of menstrual blood. This the families resist because they fear that if the opening is too wide it may not be sufficient proof that their daughter is a virgin when her time comes for her to get married.

2. At the time of Marriage

- De-infibulation: The infibulation opening that had until then permitted the passage of urine and vaginal secretions is no longer able to permit intercourse. This will require that the husband make a forcible penetration to burst the skin obstructing the entrance to the vagina, or the opening will have to be cut open with scissors or a knife to allow the consummation of marriage
- Dyspareunia: the scar tissue that surrounds the vaginal orifice may be rigid and inelastic and can cause pain during sexual intercourse
- Infertility: because of the constant stagnation of menstrual blood and other vaginal secretions that have accumulated in the vaginal cavity, the resulting pelvic inflammation may obstruct the fallopian tubes and block the normal travel of the ovum along the tubes, preventing it from becoming fertilized by the male spermatozoa
- Vulval keloids and dermal cysts: apart from their unaesthetic appearance, these may interfere with consummation of marriage or with childbirth during delivery

3. During Pregnancy

- It is not uncommon for an infibulated and pregnant woman to attend the antenatal clinic for follow up of the pregnancy or for a pregnancy related complaint and find that the opening of the infibulation will not admit the introduction of even one finger into the vagina for diagnostic and exploratory purposes. Such women will require a de-infibulation during pregnancy if complications are to be avoided at the time of delivery

4. During Labour and Delivery

- Caesarian: Some women arrive at the maternity hospital in labour with a very small infibulation opening. If the vagina is seen to be too rigid and scarred, and thought to be a possible cause of severe vaginal lacerations or third degree tears, it is likely that an elective caesarian section will be decided upon. If keloids have formed and are too large, a Caesarian section might be the best option to deliver this woman.
- Prolonged second stage of labour: because the vagina, perineum and the labia have all undergone mutilation that has left extensive scar formation, the vaginal canal becomes inelastic and the pelvic floor muscles rigid. Thus preventing the normal and gradual dilation of the vagina as well as the descent of the presenting part of the child during the second stage of labour
- Foetal Complications:
 1. Large caput formation
 2. Excessive molding of the head
 3. Intra-cranial hemorrhage
 4. Hypoxia
 5. Foetal distress
 6. Intrauterine death
- Maternal Complications:
 1. Obstructed labour
 2. Extensive vaginal and perineal lacerations
 3. Third degree tears
 4. Uterine inertia
 5. Uterine rupture
 6. Impacted foetus
 7. Maternal distress
 8. Maternal death

5. Post-natal Complications

- Infection of the lacerations
- Delayed healing of the repaired perineum and vaginal tissues
- Sloughing of the vaginal wall, resulting in Vesico-vaginal fistula and/or recto-vaginal fistula
- Anemia
- Puerperal infection
- Cystocele and Rectocele: because of the prolonged labour during each delivery, there is added stretching of the vaginal wall muscles. This causes a prolapse of either the bladder or rectum to bulge into the vagina

5. Other Complications

In recent years and since the HIV/AIDS pandemic, likelihood of transmission of the AIDS virus has become added to the long list of complications associated with female genital mutilation. The risk is made real because the traditional healers who perform circumcisions do not know the dangers of using unsterilized instruments that have previously been used on different individuals who might have been carriers of the AIDS virus

Reasons Given for FGM

The reasons that drive the practice of FGM lie deep within tradition and cultural heritage and are complex and difficult to determine. Although there is variation between societies there are common themes. FGM is often wrongly believed to have a religious origin or to be a requirement of certain religions but this is not the case.

In the majority of societies FGM is believed to preserve the woman's virginity before marriage and ensures fidelity during marriage. Other common beliefs include that it is hygienic, aesthetically pleasing or increases fertility.

For many women it is part of social integration and the mutilating process is accepted in return for benefits such as the promise of acceptance in society and the improved prospect of marriage. Older women often believe they have benefited from FGM and that it has been essential to their identity. By the same reasoning they allow it to be performed on their daughters fearing that failure to do so may bring them suffering and social isolation.

Understanding these complex, multifaceted thought processes within societies is key to the design of successful, culturally acceptable and correctly targeted eradication campaigns.

Campaign to Eradicate FGM

The International Campaign

The International Campaign against **FGM** has a long and difficult history. Advocacy and resistance started with individual health professionals from practicing African countries working in their communities. Their efforts are to be commended as they worked in unreceptive environments with little support. However there are not many records of these efforts and the extent of their impact is not known.

UN involvement in the eradication of FGM

Although the UN support for the eradication of **FGM** is now strong and active, it was slow in coming. Lack of knowledge on the subject first prevented UN agencies from addressing the issue. When awareness finally came to the UN about the extent of the practice and the serious health and psychological effects that result from it, they recognized it as a major Human rights issue. Conferences were held, studies were commissioned and discussions were finally opened on the topic. However, the mainly European representatives chairing these discussions did not understand the deep cultural ties that propagated the practice and they were unprepared for the resistance they faced by recently decolonized African nations who saw the attention on the issue as another intrusion. There were exceptions however. East African countries, including Somalia where the most severe forms of **FGM** are practiced and who had more active campaigns were more appreciative of UN involvement. After these first rounds of conferences around the 1980s, it was realized even talking about the topic was sensitive, so immediate abolition was impossible. While mandates condemning Female Circumcision, as it was known then, were taken, in terms of actual field work, the UN took the approach of funding local efforts. These local efforts concentrated on the areas of education and advocacy. Training was needed for the health professionals dealing directly with the victims. Governments were lobbied to create policies against **FGM** or if such policies already existed to implement them proactively. The general public was educated on the subject, and this was the most important work that permitted the timid steps towards change to be achieved. The struggle continues to this day with varying degrees of success. Complete eradication has not been achieved, nothing close has even been attained, but the topic is more openly discussed now than it was thirty or forty years ago.

The Campaign in Somalia/Somaliland

In March 1977, during the formation of the Somali Women's Democratic Organization (SWDO), Edna Adan Ismail was the first Somali person to publicly denounce **FGM** and pioneered the campaign for its eradication in Somalia and in Somaliland. From that time she has campaigned against **FGM** at many important occasions, including during the WHO Seminar in Khartoum in 1979 on the Mental and Physical Complications of **FGM**; in 1980 during the Mid-Decade Conference for women in Copenhagen; in Lusaka in the same year; In Dakar in 1984 when she co-founded and was elected the Vice-President of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children; In 1986 in EMRO Egypt; 1987 in Addis Ababa and the lobbying of the Organization of African Unity. During the Beijing Women's Conference in 1995 and between 1988 and 1997 when she tirelessly along with international colleagues, lobbied WHO/UNICEF and every Human Rights Organization.

That first gathering of SWDO was a golden opportunity to address the future leaders of women in their respective regions of the country and Edna Adan took full advantage of the opportunity. It was the first time the problem of **FGM** was spoken about in public in Somalia/Somaliland. Thereafter Edna Adan lectured medical students at the University of Mogadishu as well as nursing students in various nursing schools in Asia and Africa. The subject was included in the curricula of these schools and future health professionals all finished their education with knowledge of the harmful effects of **FGM**.

In the early 1980's research into the physical, psychological and sociological aspects of **FGM** was carried out by the Somalia academy of arts and Sciences. In 1988 the government campaigned to eradicate the practice on health and religious grounds. The SWDO continued their struggle and joined with the Italian Association for women and development (AIDOS) in 1987 and over the following years founded a campaign based on health complications fearing that one based on human rights would fail. Both campaigns collapsed in 1991 with the overthrow of Siyad Barre and of the disintegration of the government in Somalia.

In 1997, at the time when Edna Adan Ismail was WHO Representative in the Republic of Djibouti, UNICEF requested her to assist to obtain the approval of the government of Somaliland for a seminar to be held in Hargeisa to launch the first seminar to revive the campaign to eradicate **FGM**. The seminar was approved and held and a national committee and a regional task force were established to develop formal policies. This work continues and at the same time a variety of NGO's and women's groups also run their own eradication campaigns.

There have been encouraging signs that the awareness campaigns are having the desired effect. A recent Save the Children publication on child rights in Somaliland found that most girls and boys, and some care givers, community leaders and government officials, point to the harmful traditional practices of **FGM** as the most negative aspect of Somaliland society and culture ²⁰.

Education and the empowerment of women brought about by eradication campaigns are changing the views of Somalilanders on **FGM**, but it is only by the implementation of audits like this one conducted at the Edna Adan Hospital that the rate of change can be accurately recorded and evaluated. In a society where the practice is almost universally accepted change will occur slowly for as long as people fear discrimination for choosing to break with tradition.

The **Edna Adan Maternity and Teaching Hospital** is a major player in the campaign against FGM. The next pages provide information about the hospital and its vital role in this work.

Location of Study: The Edna Adan Maternity and Teaching Hospital

The Edna Adan Maternity and Teaching Hospital is situated in Hargeisa, which is the capital of the Republic of Somaliland. **The hospital is a non-profit charity** that was built by Edna Adan Ismail who donated her UN pension and other personal assets to build the hospital in order to address some of the health problems that endanger the lives of women and children in the Horn of Africa.

The construction of the hospital was started on the 1st of January 1998 and the hospital opened its doors to the sick on the 9th of March 2002 with 25 maternity beds. However, as the need for hospital beds became pressing, and as personnel became trained, the hospital services expanded to accommodate an additional 8 pediatrics and 16 medical and surgical beds, and several Private Rooms. Mrs. Edna Adan Ismail was asked to join the Somaliland government soon after the hospital's opening. She was first appointed Minister of Social Welfare in August 2002 and then Minister of Foreign Affairs in May 2003 and served in that post until August 2006. She continued to run the hospital while holding those posts but is now the full time Director and runs the hospital activities with appointed Deputy Directors and the Hospital Administrators. A 9 Member Honorary Board of Trustees, consisting of persons of good standing, and from different nationalities and different clans of Somaliland, have been identified and invited by the proprietor, Mrs. Edna Adan Ismail, to advise on Management and verify to the Authorities the Charity Status of the facility as well as to scrutinize Auditing results.

Health Profile of the People of Somaliland

The health of the people of Somaliland is among the worst in Africa. This statement is supported by the fact that even before the civil war and the separation of the two Somali states, Somalia had one of the highest Maternal and Child Mortality rates in the world (**Ref. UNICEF, The Progress of Nations, 1997, 160 maternal deaths per 10,000 live births**).

While recent valid data is not available, what national Maternal and Child Mortality rates have become after the destruction that has taken place during the civil war is a frightening thought. Maternal Mortality rates for **Edna Adan Hospital are listed on the next page**.

²⁰ Child Rights situation Analysis in Somaliland. Save the Children Publication, Magdalene Lagu, July 2003.

The hospital was created to provide quality care to this population and to have that care continue to all areas of Somaliland by training nurses and midwives in the soundest methods and with the most recent technologies. The nurses and midwives that graduate from Edna Adan Maternity and Teaching Hospital are a beacon in the country and they ensure a solid base of knowledge and professionalism for this struggling nation.

Services Provided by the Hospital

Since the existing Public Maternal and Gynecological facilities were over-crowded, ill-equipped and under-staffed, the establishment of the Edna Adan Maternity Hospital has provided much needed Reproductive Health Care to meet the requirements of the expanding population of Hargeisa and in the rest of Somaliland. The Hospital was designed to be run according to strict internationally accepted standards of Maternal and Child Care. With the services and supervision that is carried out by highly qualified Medical, Midwifery and Nursing personnel, it is possible to provide patients with the type and quality of personalized care that women and their babies everywhere have a right to expect. It is gratifying to note that during the short time that the hospital has been functional, the facility has become a referral hospital for obstetrical as well as medical emergencies. Cases with severe complications have been received from a wide geographical area in the Horn of Africa, including all parts of Somaliland, Somalia, as well as from the 5th Region of Ethiopia. **Maternal Mortality Rate of the patients referred or admitted to the Edna Adan Maternity Hospital** from March 2002 to December 31st 2008 has been dramatically lower than the national rate and has been 32 deaths out of the 8164 women who were delivered, or who were referred to the hospital after being delivered elsewhere. **This makes the MMR for the Edna Adan Maternity Hospital 39.1/10,000. MMR has been going steadily down every year.** With continued training of personnel, and with better equipment and supplies, we are confident that this can be reduced even further.

Objectives of the Hospital

- To make available in Somaliland a modern, well-equipped and efficient health care facility that provides a much higher standard of patient care than that which was previously available to women and children
- To make available a model Health Care Institution, which provides not only good health care, but which also provides Training and Research opportunities to Medical and Para-Medical personnel.
- To serve as an example to others and thus encourage national as well as international initiatives to invest in health services in order to improve the over-all welfare of the nation.
- To make available to women and children 69 beds for Obstetrical, Neonatal care and general patient care, including Incubators for premature babies.

- To make available to women Pre-Natal and Post-Natal outpatient services, as well as Immunization for women and children
- To make available to women and children, diagnostic Laboratory facilities as well as a Blood Bank for emergencies.
- To make available Ultrasound and visual monitoring facilities.
- To make available treatment for Gynecological problems including Management of Infertility, as well as the diagnosis and treatment of Sexually Transmitted Diseases including testing for HIV/AIDS and providing counselling as appropriate.
- To make available facilities for carrying out medical research, studies and counselling, with particular attention to the health problems associated with Female Genital Mutilation (**FGM**), as part of the Comprehensive Reproductive Health services that are offered by the hospital
- In collaboration with the Ministry of Health, UNICEF, and WHO, carry out training programs for health workers, with particular attention to the training of nurses and midwives

The Hospital and FGM

The **Edna Adan Maternity and Teaching Hospital** confronts the effects and complications of **FGM** almost on a daily basis. Cases include children who have been mutilated hours and sometimes days before being brought to the hospital and who are still bleeding quite heavily or unable to pass urine because of their new stitches. The severest case of a mutilated child seen at the hospital was one where the child had been so badly cut, that there was virtually no skin to suture together to stop the gushing blood coming from her little body. Common cases also include newly married girls and women just de-infibulated and suffering from bleeding, infection or just plain pain. Also, women in Labour for much longer than they need be because scarring due to FGM prevents the birth canal from dilating properly. Some of those women end up with third degree lacerations and other post natal complications. Edna Adan has been dealing with cases of this nature in her 50 years of midwifery experience and has been engaged in a life-long struggle to see the end of this practice. With the establishment of her maternity hospital and with the still much needed services to deal with **FGM**, It has become essential for the hospital to lead the campaign. it is fast becoming a repository of all information relating to FGM in Somaliland and the region. The hospital has started an auditing process to have baseline data about the prevalence of **FGM** and the survey in this report is the first data to come out of that auditing initiative and it is believed to be the first of its kind in Somaliland. The hospital holds educational and sensitization seminars for concerned groups. At a patient level, counselling services are provided to the victims of **FGM** and their families. There is no other institution in the country better equipped with the experience, knowledge, facilities, and above all, dedication and sheer 'Will' to tackle this issue.

The Study

This study was compiled from a survey carried out on the women attending the Prenatal Clinic at the Edna Adan Maternity and Teaching Hospital in Hargeisa, Somaliland between March 2002 when the hospital was opened up to August 2006. The findings were diligently recorded on the Prenatal Charts of each woman so that the information could be compared with future findings during subsequent surveys.

The data that was obtained has provided information on the prevalence of **FGM**, the type of procedures that had been performed on the persons examined, the ages when the procedure had been performed on them, and details of those who had performed it on them. The data also provided an insight into what motivates the continuance of the practice and a prediction of the future risks to young girls. It is believed that the results from such a reliable audit on the prevalence of **FGM** would be a crucial element in achieving the goal of eradication of the practice since the information obtained can be used as a baseline data for directing future awareness campaigns and auditing their success. Finally, the data collected is of interest to the local community in Somaliland and also to medical professionals, NGO's, International Aid agencies, women's groups, and to all those who are fighting the practice wherever they may be in the world.

The Edna Adan Maternity and Teaching Hospital is the main site in Somaliland for holding campaigns against **FGM**. Its founder and director, Mrs. Edna Adan Ismail is a pioneer in the fight to end **FGM** in Somalia and Somaliland who started her advocacy work on the subject as far back as 1977.

Purpose of Survey:

- To obtain baseline data on the current prevalence of FGM among women of childbearing age attending the prenatal Clinic of the hospital.
- To obtain information about the prevalence of each type of FGM
- To record data on observed complications in pregnancy, Labour, and delivery
- To collect data on the age when the procedure was performed, who performed it and where
- To collect information on why the women think the practice is done; whether they are pleased it was done on them; whether they will do it to their daughters and why
- To determine whether any progress has been made towards attitudinal changes after 32 years of campaigning
- To use the information obtained for future planning of actions to eradicate the practice

Methodology of the Data Collection.

Physical Examination

Examination of the vulva of the patient as part of the physical examinations carried out on all pregnant women attending the clinic for Antenatal Care. On occasions, it was not clear whether the person had undergone any form of FGM and a confirmation was obtained from the woman herself to record whether the answer should be a 'Yes' or a 'No'. If the answer was a 'No', it would be recorded as such and the finding was included in the number of women who had no FGM performed on them. If the answer was a 'Yes' then the rest of the questionnaire would be completed.

Questionnaire

In order to ensure the uniformity of the data, a simple questionnaire was developed and printed on the Antenatal Cards of the hospital so that all women who attended the Antenatal clinic had the findings recorded on their individual patient card.

Post-Natal Chart

Date of delivery: _____
Type of delivery: _____
Reason for operative delivery: _____

Complication of 3rd stage:
PPH _____ Retained placenta _____ Other _____

Birth weight: _____ Sex: _____ Alive Still Birth Died

Feeding: Breast Bottle Both

Post Natal Visit

Mother

Vital signs: T _____ P _____ BP _____ Weight _____
General health: _____
Breasts: _____
Uterus: _____
Lochia: _____
Perineum or abdominal scar: _____

Baby

General health: _____
Weight: _____

Feeding: Breast Bottle Both Nutritional advice given (tick):

Vaccinations: OPV BCG Other: _____

Family Planning: _____
Remarks: _____

Edna Adan Maternity Hospital, Pregnancy Record

Hospital Number: _____

High risk: Yes No
Reason: _____ Colour red if high risk

Name: _____ Age: _____
Address: _____ Tel no: _____
Education: _____ Occupation: _____
Marital Status: _____ Height: _____ Weight: _____

History

No of pregnancies Para 5 or more Y N
No of normal deliveries Caesarean section Y N
No of assisted deliveries Post-partum haemorrhage Y N
No of caesarean sections Retained placenta Y N
No of abortions Labour over 1 day Y N
No of abortions Last baby stillborn or Y N
No of abortions died in the first week
No of abortions
No of abortions NB: If yes to any of the above = high risk
No of abortions

Previous Pregnancies

Other problems with past pregnancies: _____

Current Pregnancy

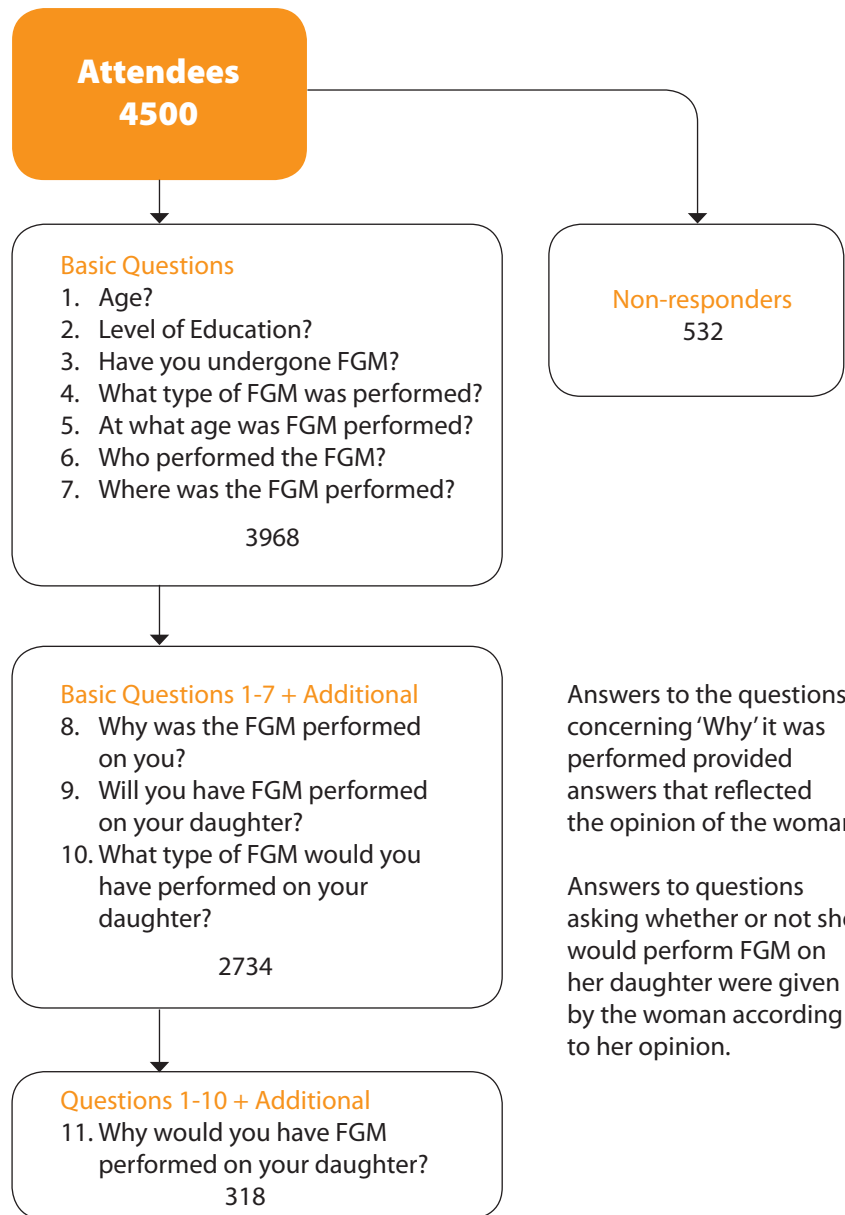
LMP _____ EDD _____
Blood group _____ Rhesus _____
Allergies _____ Vaccinations _____

FGM: YES NO

Where: _____ Age: _____ Type: _____
By whom: _____ Why: _____
Will you do it to your daughter YES NO Why: _____ Type: _____

The survey questions developed and changed over time. The number of questions asked of each attendee increased with time, so the women involved at the beginning of the study were asked fewer questions than those involved later on. There were no differences to bias the results between the women who attended early in the study compared to later attendees. The next page contains a flow diagram of the number of women that answered each question.

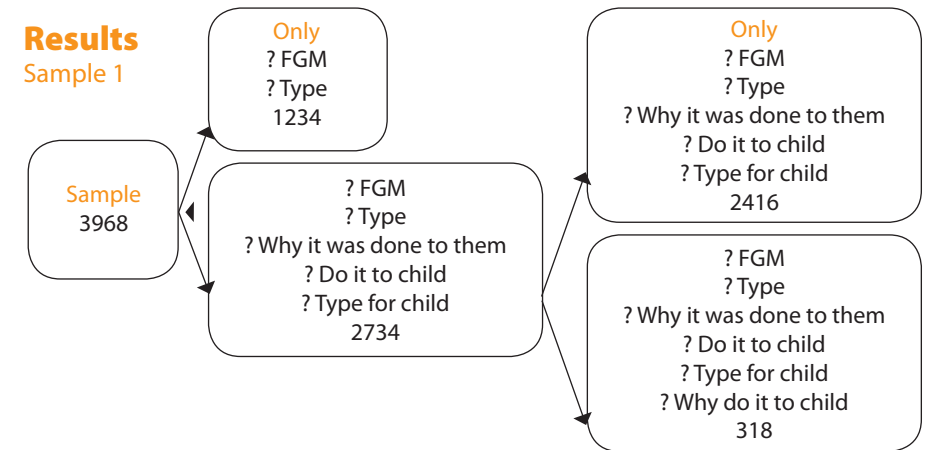
Flow diagram of Sample:



Answers to the questions concerning 'Why' it was performed provided answers that reflected the opinion of the woman.

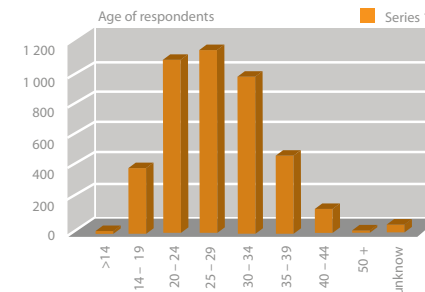
Answers to questions asking whether or not she would perform FGM on her daughter were given by the woman according to her opinion.

Results Sample 1



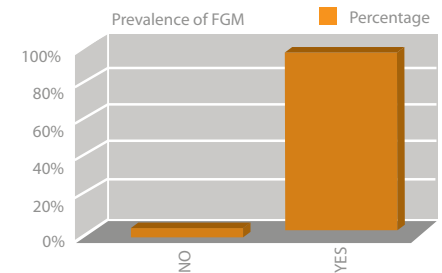
Sample 2: Age of women

Age was collected on all 3968 patients. Ages ranged from 13 to 51. In 28 cases the age was not determined.



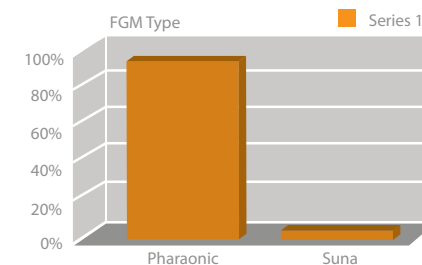
Sample 3: Prevalence of FGM

Details of whether or not the women had undergone **FGM** was recorded on all 3968 women. As shown below 97% (3833) had undergone **FGM** and 3% (135) had not.



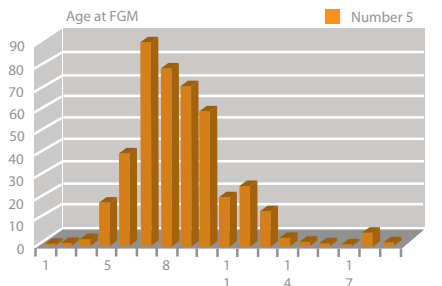
Sample 4: Type of FGM

99% (3796) of the 3833 women who had undergone FGM had the most severe mutilation, the pharaonic or WHO type



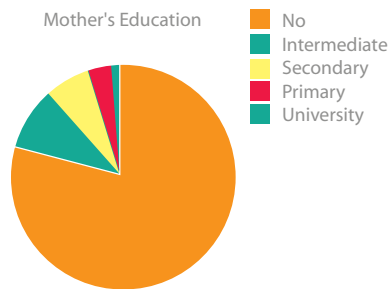
Sample 5: Age at which FGM was performed

The average age for **FGM** to be carried out was 8 years in our sample and ranged from 2 days of age to 17 years.



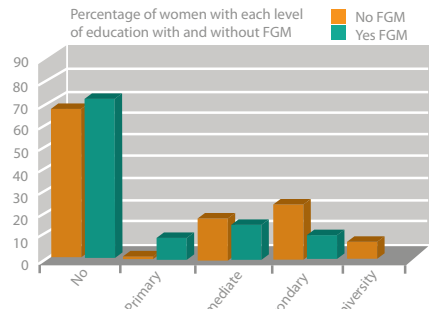
Sample 6: Women's level of education

Details on the education of the women were recorded on all 3968 respondents. A majority of 3142 (79%) had received no education. 157 (4%) had received a primary education, 390 (10%) an intermediate level of education, 258 (7%) a secondary level and only 21 (<1%) had received a university education.



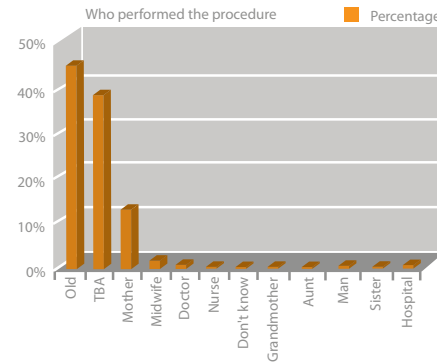
Sample 7:

The mother's education was compared to whether she had undergone FGM.



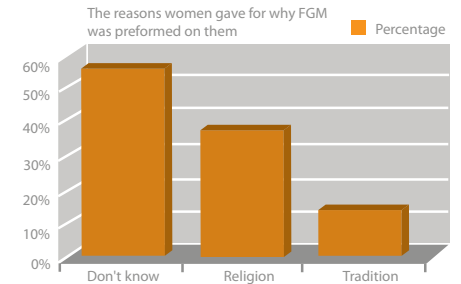
Sample 10 : Persons performing FGM

84% of procedures on our respondents were performed by Old women or TBA's (46% and 38% respectively). 1.9% were performed by midwives, 1.4% by doctors and 1% by nurses. Therefore a total of 4.3% were performed by professional medical staff.



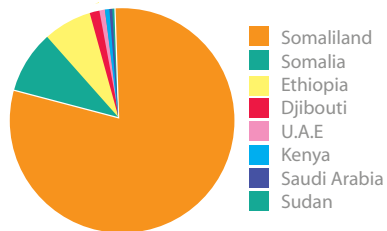
Sample 11: Reasons given for why FGM had been performed on them

2735 of the respondents were asked why they thought **FGM** had been performed on them. They were given the options of 1) Traditional/cultural reasons, 2) Religious reasons or 3) did not know the reasons. 55% did not know a reason, 34% felt it was because of religion, and 11% because of tradition/culture.



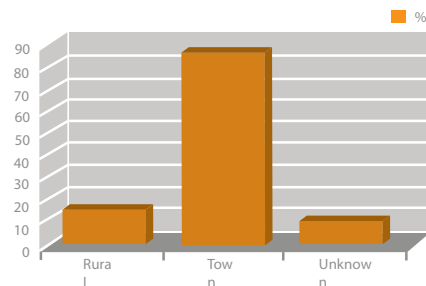
Sample 8: Countries where FGM had been performed

The 3833 women with **FGM** were asked where this had been performed. Sixteen different countries were mentioned. Eighty four percent of procedures were performed in Somaliland, 7% in Ethiopia, 6% in Somalia and 1% in Djibouti. Other countries were Egypt, Kenya, Kuwait, Nairobi, Qatar, Saudi Arabia, South Africa, Sudan, The United Arab Emirates, Yemen, Norway and the United Kingdom.



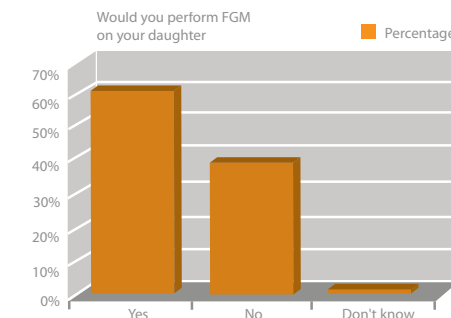
Sample 9:

It was also recorded whether the procedure was carried out in the rural areas or the towns. 84% of women questioned had had FGM performed in towns.



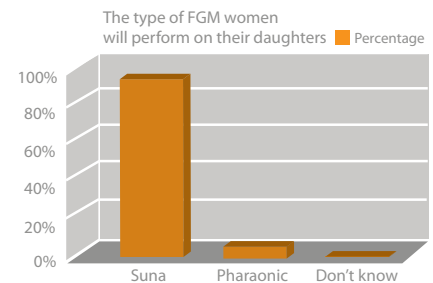
Sample 12: Number of women who would perform FGM on their daughters

2734 of the women were asked if they would perform **FGM** on their daughters. 62% said they would perform FGM on their daughter, 37% said no, and 1% did not know.



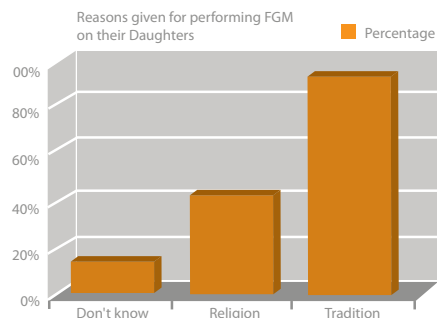
Sample 13 : Type of FGM women would perform on their daughters

Of the 1701 62% of woman who said they would perform **FGM** on their daughters 92% said they would perform the Sunna type, 6% pharaonic and 2% did not know



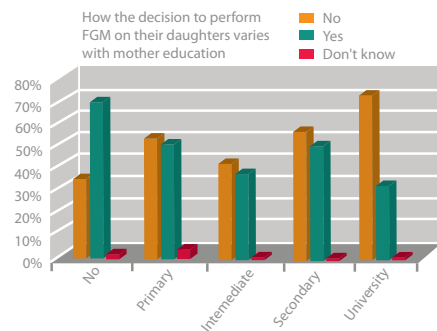
Sample 14: Reasons for wanting to perform FGM on their daughters

318 women were asked their reasons for performing FGM on their daughters. 235 (74%) stated they would do it for traditional or cultural reasons, 65 (20%) for Religious reasons and 18 (6%) did not know why.



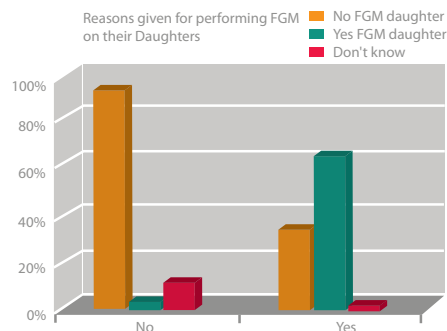
Sample 16: Factors influencing the mothers decision to mutilate their daughters

The mother's education has been compared to their decision to perform FGM on their daughters. There is a trend for a greater proportion of those with a better education not to want to perform FGM on their daughters. 71% of those with a university education said they would not infibulate their daughters compared with 29% who said they would. For those with no education 66% said they would infibulate their daughters compared with 34% who will not. 318 of the respondents were asked for both the reasons why they believed FGM had been performed on



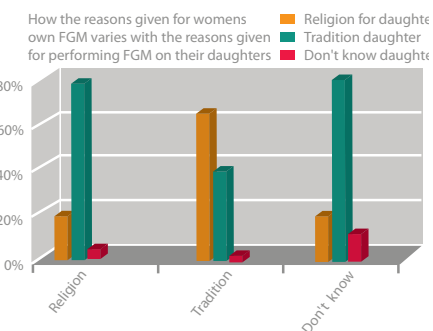
Sample 15: How the decision to perform FGM on their daughters differs between women with and without FGM

We have compared how the decision to perform FGM on their daughters varies with whether or not they had undergone FGM themselves. Of the women that did not have FGM 90% would not perform it on their daughters compared with 3% who would. Of those who had FGM themselves 63% would perform FGM on their daughters compared with 36% who would not.



themselves and why they would perform it on their daughter. Of those who thought their own FGM had been performed for traditional reasons 64% would perform it on their daughters for religious reasons

For those who thought theirs had been done for religious reasons the majority (79%) stated tradition as the reason for performing it on their daughters



Recommendations

The battle for the abolition of **FGM** is definitely one that is too difficult to be left to individual crusaders and little old women. It has to be fought by all and particularly by government and by professionals such as Obstetricians, Gynecologists, Pediatricians, Nurses and Midwives who are the ones who have to deal with the serious complications caused by female genital mutilation.

Strategies for the eradication of FGM

1. GETTING A LAW IN PLACE IN SOMALILAND

- To date the government has made no legal declaration or resolution against **FGM**. The first priority is to lobby the government to enact a law forbidding the practice.
- The international community needs to play a more important role in assisting the government to put such a law in place.

2. RELIGIOUS LEADERS ARE KEY

- More than any other group, religious leaders are looked up to for trusted advice and social direction. If they state with a unanimous voice that **FGM** is prohibited in the Islamic religion, it will go along way in convincing the general population to abandon the practice.
- UNDERSTAND: **FGM** is thought of as a women's issue. Somali men don't generally think very much of it, that includes religious Somali men too. Most have probably never considered the legality or illegality of FGM in a religious context. They can be made aware of existing religious scholarly work available on the subject. If possible they can be sent for training and sensitization to religious centres and universities in Islamic countries to learn from the experiences of communities who have abandoned the practice.
- SUPPORT: Other initiatives that have undertaken the sensitization of religious leaders have found that once this group understands the issue and the severity of the problem, they become strong supporters of its abolition.
- ADVOCATE: from support to advocacy. Once religious leaders are on board their stand must be shown to the public; Through the weekly sermons

in Mosques, through television and radio programs, through religious schools or madrasas. Information tools such as video cassettes and tapes with recorded messages can be developed so their testimony can be taken to remote locations. These key agents of change must be put to full use.

SENSITIZING FRONT LINE HEALTH PROFESSIONALS

- **MORE PEOPLE:** Sensitizing front line health professionals will increase the number of persons in the field actively working against FGM
- **ONE VOICE:** FGM training must be uniform, to increase impact and avoid mixed messages. Partners working against FGM need to coordinate efforts to ensure a consistent training approach
- **TOOLS:** training needs to include tools health professionals can use to counsel and if possible intervene in FGM. Tools could include booklets and pamphlets, videos and cds etc, all in the local languages of the communities being addressed
- **DATA:** informed and equipped health professional can help collect data about the current state of FGM in Somaliland as well as keep a record of the progress they make in their individual locations

3. SENSITIZING THE COMMUNITY

- **GIRLS AND YOUNG WOMEN:** need to be targeted directly so they become informed about their condition and options. Establishing communication with this group at an early age can influence decisions they make regarding their own daughters later on.
- Efforts should be made to make FGM education as part of the regular curriculum of all schools for health professionals.
- **PARENTS:** and especially **MOTHERS** As the primary decision makers of FGM, are the most essential group to persuade. Contact with them needs to be consistent and continuous if progress is to be made in the campaign.
- **MEN:** FGM : although they may not think much of it, FGM is done primarily to garner their pleasure, and to secure marriage proposals from them. They need to be brought into the picture and informed of the undesirability of the practice from a health stand point, cultural standpoint and sexual relations standpoint. If this group no longer feels that a girl must go through FGM in order to be suitable for marriage, then the stigma of being free of FGM can be alleviated and more families will have the freedom to abandon it.

BUSINESS PEOPLE and PROFESSIONALS

This group falls into the category of those who have weight within the community. Generally they have a higher level of education and have an appreciation for Health matters. Educating them about FGM can effect the decisions they make in their own families and the advice they dispense in their circles of influence

4. USING MEDIA TO ESTABLISH A PERMANENT PRESENCE

The campaign against FGM cannot be a sporadic nor an annual event. This is a serious human rights and health violation issue that effects young children and women. There must be a strong and permanent presence, through boards and pamphlets, videos and cds, seminars and workshops, websites and blogs. But these efforts need to have a smart design that combines sensitivity with practicality.

5. RESEARCH

- Much research needs to be done on FGM in the Somali regions. As of now there is no reliable data although this study aims to remedy that. But there is still much more work that needs to be done.

POSSIBLE RESEARCH QUESTIONS:

- More data on Prevalence is needed and types of FGM performed.
- Which type of FGM is more frequent?
- Why do those who choose type 3 make that decision?
- Why do those who choose a less invasive type make that decision?
- Can the underlying reasons for choosing one type vs. another be used to influence families to choose a less invasive procedure or to abandon the practice altogether?
- What about those that have not undergone FGM? How did they come to that decision? What kind of difficulties have they faced? What would have made their choice easier to live with?
- What are the correlations between education and FGM? Income and FGM?
- Most Somalis have family members living abroad who maintain strong ties and who send remittances. How do Somalis in the Diaspora feel about FGM? Do they have any influence over their families in their homelands regarding FGM? Can this connection be used in the eradication campaign?
- What ideas about women's sexuality are inherent in the practice of FGM? Are those reasons openly spoken about or more hidden?

- What about Age, Attitude and FGM? How do youth, male and female feel about it? Can intensive education campaigns aimed at this group help to stop this practice?
- What about health professionals? They're expected to be partners in the elimination of FGM but what are their personal views on the subject? Do they practice the custom in their private lives?
- How about religion and FGM? Can a campaign more focused on the religious impermissibility of the practice be more effective than one that stresses health complications or human rights violations?

6. MONITORING AND DOCUMENTING

- To take full advantage of resources and to measure achievements when necessary, careful monitoring and documenting techniques must be applied.

These recommendations show the need for a wide, and all-encompassing approach in the fight to eradicate Female Genital Mutation. Because the practice is so pervasive, all areas of society must be targeted, simultaneously and continuously.



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Female Genital Mutilation Survey In Somaliland

At the
The Edna Adan Maternity and Teaching Hospital,
Hargeisa, Somaliland
2002 to 2009

By Mrs. Edna Adan Ismail, Nurse/Midwife

