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Empowering communities to collectively abandon FGM/C in Somaliland

Baseline Research Report

Katy Newell-Jones

FUNDED BY COMIC RELIEF

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

Acknowledgements

This baseline research was commissioned by ActionAid to inform a four-year project (2015-2018) in Somaliland, “Empowering communities to collectively abandon FGM/C”.

ActionAid contracted Orchid Project to conduct the research, which was led by Katy Newell-Jones.

ActionAid and Orchid Project would like to thank all who contributed to this research from the ActionAid Somaliland team. Special thanks go to the enumerators, translators, transcribers, coordinators of the data collection and the IT support team. The quality of the data collected was the result of their support, commitment and attention to detail.

We are particularly grateful to the support of the staff of ActionAid Somaliland’s partners in Somaliland SOWDA and WAAPO. Their contribution in mobilising the communities, introducing the data collection teams and organising participants for focus group discussions was immensely valuable.

We would also like to thank all those who participated in the community survey, focus group discussions and key informant interviews. The research was greatly enhanced by your openness and willingness to share your thoughts on sensitive and at times, challenging issues.

We are grateful for the support and participation of the Ministries of Labour and Social Affairs (MoLSA), Religious Affairs (MoRA) and Health (MoH) for their willingness to be interviewed and to provide documentation to help us to understand FGM/C in Somaliland from a governmental and policy maker perspective. Particular thanks go to Edna Adan and colleagues at the Edna Adan University Hospital for support throughout the research, including valuable discussions and the provision of skilled enumerators.

This research was made possible through funding from Comic Relief.

Contents

Executive summary

This report summarises the findings of research into female genital mutilation/ cutting (FGM/C) in Somaliland to inform a four-year project (2015-2018), *Empowering communities to collectively abandon FGM/C*, implemented by ActionAid International Somaliland (AAIS) with Women Action for Advocacy & Progress Organization (WAAPO) and Somaliland Women Development Association (SOWDA).

The research took place in 25 communities in two regions of Somaliland, Maroodi Jeex and Togdheer. A participatory, holistic approach was adopted involving 2,132 women, men, boys, girls, religious leaders, health workers, teachers, law enforcers, community leaders, parliamentarians, civil society organisations and national and international agencies.

The research distinguishes between three types of female genital cut commonly used in Somaliland; the pharaonic (WHO FGM type III), the intermediate or sunna 2 (type II) and the sunna (type I).

The overall prevalence rate among community women in Maroodi Jeex and Togdheer remains high at 99.4%, with 80% having undergone the pharaonic cut. There is evidence of a change, particularly in urban communities, away from the pharaonic cut to the intermediate and sunna cuts. Only 34% of girls aged 12-14 years have undergone the pharaonic cut compared to 96% of women aged over 25 years.

There is a strong expectation in communities for girls to be cut, felt more strongly among women (84%) than men (62%). Most community members (84%) intend to cut their daughters in the future, with women in particular intending to select a less severe cut than they perceive the community expects them to use.

Just 5% of girls and women are currently cut by health specialists. However, there is widespread evidence of increased medicalisation of cutting, with younger women more likely to have been cut by midwives, nurses or doctors. Many religious leaders and some community leaders are calling for midwives and nurses to be trained to perform the cut safely and hygienically.

Communication about female genital cutting at household and community levels is low, with just 22% of community members having spoken to others about FGM/C in the last year. Only 16% of community members said that FGM/C had been raised in public meetings with few opinion formers actively discussing FGM/C in public. Most religious leaders oppose the intermediate and pharaonic cuts as harmful, non-Islamic practices but support the sunna cut as honourable under Islamic law.

Decision-making in relation to female cutting is primarily the responsibility of women, with women facing difficult decisions, wanting their daughters to be socially acceptable and able to marry, yet also wanting them not to suffer the kinds of health complications experienced by themselves and other women in their community. Men and boys are only involved in the decision-making process in 8% of households, however, they are influential in creating the social climate within which decision-making about cutting takes place. Overall, only 4% of unmarried men would prefer to marry an uncut girl and only 2% of men would prefer their sons to marry an uncut girl.

All forms of female genital cutting are legal in Somaliland, although FGM/C is identified as a harmful practice in the Gender Policy (2009) and the National Youth Policy (2010-2015). The government is committed to developing FGM/C policy and establishing a sound legal framework based on Zero Tolerance. The Ministry for Religious Affairs (MoRA) supports the continuation of the sunna cut, a position which is slowing the process of policy development and legislative enactment on FGM/C.

There is clear evidence from this research of a desire for change in relation to FGM/C among all stakeholder groups, including religious leaders, MoRA and senior clerics. Only 18% of community members would like to maintain the existing situation in their community, leaving 82% in favour of change of some sort. The preferred option is a move towards the abandonment of all forms of cutting, except the sunna, with less than 10% of community members supporting the introduction of a law based on Zero Tolerance and only around 5% aspiring to an abandonment of all forms of cutting in their community.

A key challenge for INGOs, CSOs, agencies and the government is how to support, measure and value the steps communities are making from the pharaonic to the intermediate cut, and from the intermediate to the sunna cut, whilst maintaining the abandonment of all forms of cutting as the ultimate goal.

Introduction

In Somaliland, over 99% of women and girls have undergone Female Genital Mutilation/Cutting (FGM/C). There have been significant efforts to bring about change, however, gaps remain in the knowledge of community attitudes towards FGM/C and the most effective strategies to promote its abandonment.

ActionAid International Somaliland (AAIS) is part of a global federation working to end poverty and injustice. ActionAid has been working in Somaliland since 1992, with a key objective of ensuring that women in Somaliland break the cycle of exclusion and gain access to justice, and control and own productive resources.

ActionAid International Somaliland (AAIS) is working in partnership with Women Action for Advocacy & Progress Organization (WAAPO) and Somaliland Women Development Association (SOWDA) to implement the project *"Empowering communities to collectively abandon FGM/C in Somaliland"*. The project, funded by Comic Relief, is being implemented from October 2015 to October 2019, in 35 communities in two regions of Somaliland, Maroodi Jeex and Togdheer.

The project takes a multi-pronged approach to addressing FGM/C. The intended outcomes of the project are:

1. **Target communities commit to abandon all forms of FGM/C**
2. **Women and youth are empowered to reject FGM/C**
3. **Religious leaders publicly denounce all types of FGM/C**
4. **Policies and laws promoting Zero Tolerance against FGM/C progress through the legislative process**
5. **Partners and Somaliland CSOs have greater capacity to drive forward nationally-led anti-FGM movement**

The overall objective of the research was to collect qualitative and quantitative data on attitudes, knowledge and behaviours relating to FGM/C in Somaliland.

This document summarises the findings of the more detailed baseline study[1].

1. The Context of FGM/C in Somaliland

This section summarises the existing data on prevalence rates, the gaps in the current evidence which this research aimed to fill and the legal status of FGM/C in Somaliland.

The legal status of FGM/C

Somaliland currently lacks a legislative structure on FGM/C, although such a structure has been identified as a key element in achieving abandonment[2]. The first move to introduce legislation on FGM/C in Somalia was in 2012 when a Provisional Constitutional decree was introduced stating that the circumcision of girls is prohibited[3]. However, the decree does not specify the penalty, the person who would be considered responsible or the process to secure a ruling when girls or women undergo FGM/C.

The Ministry of Labour and Social Affairs (MoLSA) and the Ministry of Religious Affairs (MoRA) are preparing a draft FGM/C policy to be presented to, and endorsed by, the cabinet. There is agreement between these Ministries on the proposed policy in relation to the pharaonic and intermediate cuts (WHO FGM types II and III), but not on the sunna cut (WHO FGM type I). MoRA currently supports the banning of all types of cut except the sunna cut, whereas MoLSA are in favour of Zero Tolerance, which would ban all types of female genital cutting, including the sunna cut.

FGM/C is mentioned specifically in the Republic of Somaliland documentation:

- **National Constitution (2001)** which under article 36, sub-article 2 states, "the Government shall encourage, and shall legislate for, the right of women to be free of practices which are contrary to Sharia and which are injurious to their person and dignity"
- **Gender Policy (2009)** which states "the most predominant forms of violence against Somaliland women are traditional practices such as female genital mutilation/cutting and virginity checks"
- **National Youth Policy (2010-15)** which suggests there is a need to "sensitize public about the eradication of Female Genital Mutilation and advocate for laws prohibiting it fully".

Whilst these statements strongly oppose FGM/C, they do not define what constitutes FGM/C. This research concludes that most consider the sunna cut as approved under Sharia law and not FGM/C. As such, these policies would only relate to the pharaonic and intermediate cuts and not the sunna cut.

The lead ministry for drafting the policy on FGM/C is MoLSA. Seven other ministries are involved in the task group on FGM/C, namely, the MoRA and the ministries of Health (MoH), Education (MoE), Justice (MoJ), Interior (MoI), Planning (MoP) and Youth (MoY). All support Zero Tolerance with the exception of MoRA. Once formulated, the policy would need to be approved by the cabinet before being signed by the President.

Work began on the drafting of a *National Policy for the Abandonment of Female Genital Mutilation* in 2009. Anti-medicalisation of FGM/C will be included within the proposed strategy. Currently, the focus for health specialists is on training to safely open a woman who has undergone the pharaonic cut and the prohibition of re-infibulation (the re-closing of the vaginal orifice after childbirth). The draft policy prohibits health care workers from performing FGM/C, however, it does not state that FGM/C includes the sunna cut. The United Nations Population Fund (UNFPA) in collaboration with AAIS and others, had hoped to present the final policy to the cabinet in 2016, with the support of the First Lady. However, further discussion between ministries is required before the policy can be agreed and presented to cabinet.

Another complicating factor is the progress of the bills on Quota (representation of women) and Sexual Offences, which currently does not include FGM/C. Both are well developed but have yet to be approved. UNFPA feel that priority should be given to these bills before pushing for the Anti-FGM Bill. UNFPA sees the Quota Bill as more sensitive than the Anti-FGM bill and wider reaching.

Existing data and gaps in the evidence

Data from Multiple Indicator Cluster Survey (MICS) (2006[4] & 2011[5]), Crawford and Ali (2015), Edna Adan University Hospital (EAUH) (2009[6] & in prep.) and NAFIS Network (Network Against FGM in Somaliland) (2015)[7] all indicate that Somaliland has an overall prevalence rate of around 99% of girls and women undergoing FGM/C.

MICS (2011) found that 99.1% of women responding had been cut, with 85% of them having been sewn closed, therefore experiencing the most extreme form of FGM/C, infibulation or pharaonic (WHO type III). EAUH found in its survey from 2002 – 2006 that 97% of women had been cut, and in the second survey from 2006 – 2013 that 98.4% of women participating in antenatal examinations had undergone FGM/C, 82.2% of whom had experienced the pharaonic cut. Given the very high FGM/C prevalence rate in Somaliland, and the slow pace of change (UNICEF 2013[8]), the most significant gaps in existing knowledge and data are around people's understanding of cutting as a tradition and a social norm, ie why they are cut, why they believe they are cut, what is expected of them, by whom and what they expect others in their "reference group"[9] to do.

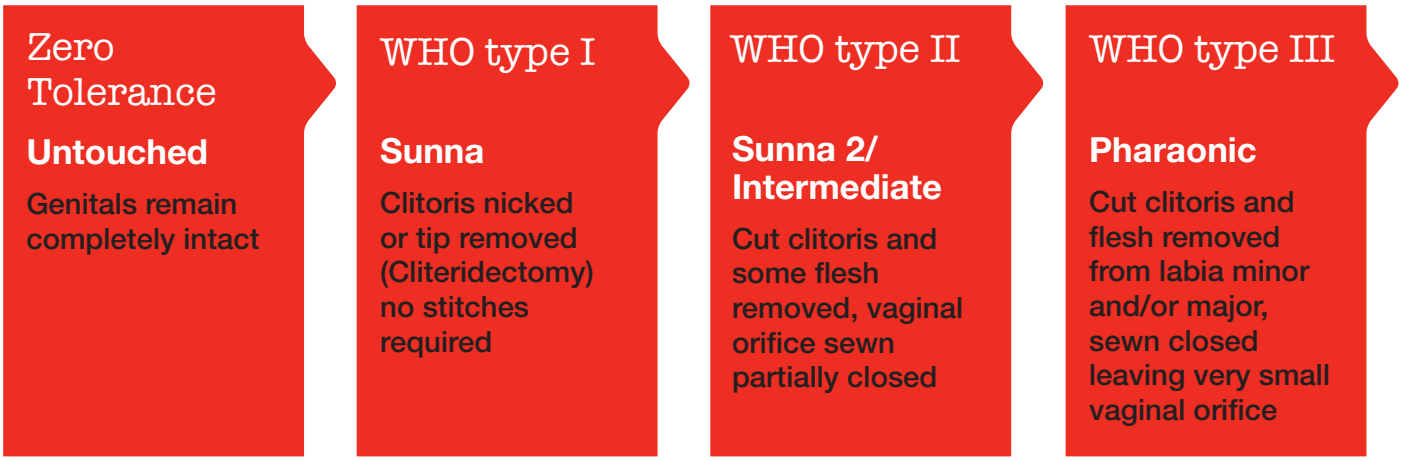
MICS and EAUH surveys both show that women are not universally in favour of the continuation of FGM/C, yet almost all of them are cut themselves and many of them intend to cut their own daughters. Crawford and Ali (2015) interviewed some men about their attitudes, however, the numbers involved are relatively small and they identify the need for more research data from men and boys about their knowledge, attitudes and beliefs around FGM/C in Somaliland. Given that FGM/C is identified as a pre-requisite for marriage, the attitudes and expectations of men and boys are an important factor in understanding the drivers in relation to the continuation of the practice. Religion is often given as a reason for cutting in Somaliland. As elsewhere, although FGM/C is not mandated by Islam in the Qur'an, some religious leaders and scholars interpret a weak *hadith* as suggesting that FGM/C is "sunnah". To conform to religious expectations, some families choose the "sunnah" form of cutting as opposed to the more extreme "pharaonic", believing it to be a more religious and less damaging option.

This research was an opportunity to better understand the drivers around the continuation of FGM/C, to both inform efforts to abandon the practice and to measure the impact of the ActionAid project.

2. Terminology

The terminology used in relation to female genital cutting in Somaliland is complex. With Somaliland being predominantly Sunni Muslim, from the Shafi'i school of thought, female genital cutting is considered by most to be subject to guidance, called a "Hadith" (or "Sunnah") under Sharia law. If a hadith is *"obligatory"* then under Islamic law community members should abide by it. If it is *"honourable"* it is preferred, if *"not required"* then religious leaders may advise against. The term sunna is used both in a generic sense to mean Islamic guidance and also is the name given to the purification process young girls go through. The sunna, as defined by religious clerics in Somaliland, usually, but not always, equates to WHO FGM type I (chart 1). In this research the term *"sunna cut"* is used in recognition that even in its mildest form, blood is drawn from the girl's genital area.

For most in Somaliland, there is a distinction between two different acts: the traditional pharaonic cut, which equates to WHO type III, and the sunna cut. One of the challenges at policy-making and community levels, is that the definition of the sunna cut varies between different stakeholder groups. For most religious leaders the term sunna does not include the intermediate cut, WHO type II. However, as reported by NAFIS (2014), the AAIS research team found that among community members, especially women, the terms "sunna" and "sunna 2" are being used widely to refer to WHO types I and II, with the term "pharaonic" being used for WHO type III.



There are differences among clerics about the precise nature of Islamic guidance on female genital cutting. The majority view in Somaliland is that the pharaonic cut is considered non-Islamic and therefore, on the whole, not supported by religious leaders and defined as "not required" under Islamic law. The sunna cut, however, is regarded within the Shafi'i school of thought as subject to guidance, with the predominant thinking that it is considered "honourable" or preferred, rather than obligatory.

In recent years, the intermediate cut, requiring two or three stitches and partially closing the vaginal orifice, has risen in popularity in Somaliland. It is usually called "sunna" or "sunna 2" to sound more acceptable than the pharaonic cut. However, it is not considered to be Islamic by most religious leaders.

"...the Pharaonic cut is nothing at all to do with Islam. You can tell by the name that it pre-dates Islam. The Pharaonic cut is culturally normal, practised by the society in Somaliland. Islam has always spoken out against the Pharaonic cut. It is about history and social attitudes... The sunna type 2 has moved a bit from the Pharaonic but it is still not Islamic."

Mohamed Ibrahim Jama, Head of Department of Islamic Propagation, MoRA

An additional complication arises as many in Somaliland see the terms FGM and FGM/C as relating only to the pharaonic cut, with the sunna not being perceived as a cut. Statements such as "we have stopped cutting" need careful unpicking as many, including community leaders, teachers, lawyers and health workers support anti-FGM campaigns at the same time as their daughters are undergoing the sunna cut.

The inclusion of the intermediate cut as a specific category in this research revealed that only 10% of men are familiar with the intermediate cut. This highlighted the lack of specificity in the conversations between women and men about female cutting. It was also challenging for the enumerators as they had to learn to question what participants meant when they responded "sunna".

However, the inclusion of the intermediate cut was beneficial as it made the conversations extremely practical. It helped people to discuss, and later agree on what they understand as the sunna cut. Religious leaders found it useful as a means of demonstrating their position and it helped clarify, in discussions with religious leaders, the type(s) of cut which they consider to be Islamic and those which they do not.

Given the increasing use of the intermediate/sunna 2 cut in Somaliland, recognising the spectrum of cuts being used and the direction of change could be an important factor in developing successful strategies for the abandonment of female cutting at policy and community levels.

3. Methodology

The aim of this research was to obtain detailed information on FGM/C in in Somaliland, specifically in Maroodi Jeex and Togdheer, the two regions where the AAIS project *Empowering communities to collectively abandon FGM/C in Somaliland* is being implemented.

AAIS adopts a social norms-based approach to FGM/C – recognising that the decisions individual households make about whether or not to cut their daughters and the type of cut to use, are influenced by the expectations, real and perceived, of their *"reference group"* (those whose opinions and approval matter to them). The overall approach adopted, therefore, was holistic, involving interactions with a wide range of stakeholder groups at community and national levels.

A mixed methodology was adopted to gather quantitative and qualitative data. Project and non-project communities were involved for comparison purposes at the end of the project during impact assessment. All data presented in this report is from all communities combined.

The research took place in 25 selected communities in Maroodi Jeex and Togdheer which represent a range of types: large and small, urban and rural, accessible and less accessible, with and without NGO activity. In each of the 25 communities surveyed, data was collected, using mobile data collection tools, from *community members:* women and men, girls and boys (aged 12 and above) and *key opinion formers:* religious leaders, community leaders, teachers, health workers, law enforcers. The sample size of the community survey was 1956 (999 women, 758 men and 209 opinion formers). Additionally, key informant interviews and focus group discussions were held with parliamentarians, representatives from Government Ministries, UN agencies, and CSOs. A total of 23 key informant interviews took place (10 women, 13 men) and a total of 22 focus group discussions (80 women participants, 73 male participants). In total, data was collected from 2,132 participants (1135 women and 997 men).

4. Summary research findings

This section summarises the findings of each of the key stakeholder groups. Particular attention is given to the knowledge, attitudes and belief of community members. The views of religious leaders, community leaders and other stakeholders are also summarised in turn.

4.1 Overall prevalence rates, age and types of cut

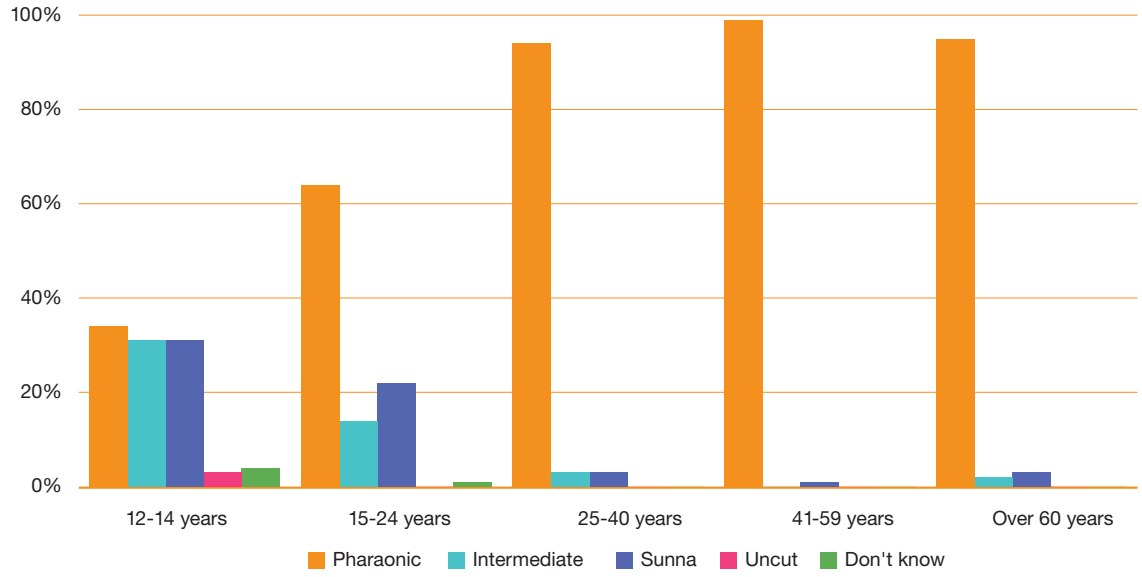
Of the 999 community girls and women who participated in the community survey, 902 agreed to answer questions about whether they had undergone the sunna cut or another type of genital cutting. Only five of these were uncut, giving an overall prevalence rate of 99.4% (98.7% in urban and 99.8% in rural communities). This is in line with MICS 2011 (99.1%), research from Edna Adan University Hospital (2006-2009, 97%, 2009-2011 98%) and NAFIS 2014 (100% in rural and 99.8% in urban communities).

There is a perception among policy-makers, NGOs and CSOs, that a substantial proportion of the urban community have abandoned all forms of cutting. However, this is not borne out in this research. It may be that policy-makers are talking disproportionately to young, educated professionals who aspire not to cut their own daughters and that there will be a change in prevalence in the next 10-15 years as those daughters phase into the datasets.

The average age at which the women were cut is 9.7 years. There is a trend away from girls over the age of 14 being cut with 9.5% of older women (over 60 years) being cut over age 14 compared to 5.3% of younger girls and women (aged 15-24 years).

Although the prevalence rate remains stubbornly high, there is strong evidence of a significant change in the type of cut which girls and women are undergoing. Overall, 80% of girls and women interviewed had undergone the pharaonic cut. However, there has been an increase in the proportion of girls undergoing the intermediate and sunna cuts in recent years, with equal numbers of 12-14 years old girls undergoing the three types of cut (chart 2- page 10). This change has resulted in fewer girls requiring cutting open on their wedding night (and thus experiencing the trauma involved) and a reduction in the medical complications reported.

Chart 2: Type of cut by age in community survey

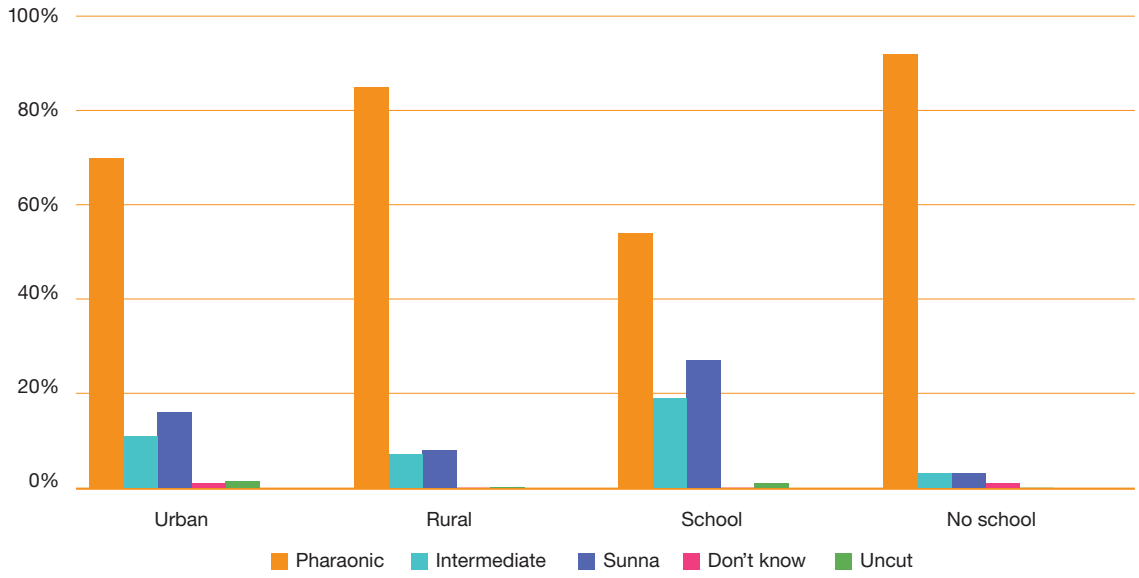


The move away from the pharaonic is stronger in urban than rural communities. Among girls aged 12-14 years only 26% in urban areas underwent the pharaonic cut, compared to 38% of rural girls.

The trend away from the pharaonic cut is evident in the difference in the percentage of women needing to be cut open on their wedding night, with 97% of women over 25, compared to 85% of the married women aged 15-24.

There is a significant link between school attendance and the type of cut girls undergo. Overall 32% of the women interviewed had attended school with school attendance being higher among urban (43%) than rural (25%) girls and women. Girls and women who attended school, even just the first two years of primary school, were more likely to have undergone the intermediate or sunna cuts (chart 3)

Chart 3: Prevalence rates for FGM/C by rural/urban community and school/no school



Of those girls and women who had undergone the pharaonic cut just 21% had attended school (17% in rural and 29% urban communities).

Further evidence of a trend away from the pharaonic cut and towards the sunna and intermediate cuts comes from the types of cut participants' daughters have undergone. Only 44% of participants' daughters had the pharaonic cut compared to 80% of their mothers. This decrease is matched by corresponding increases in the intermediate and sunna cuts. However, the trend from the pharaonic towards the sunna is not always supported, even within the girl's family, as illustrated by the following account from a focus group discussion:

"My older sisters were cut and totally closed, every month their periods are extremely painful. They often get infections and end up in hospital. They miss time from school as well. I was cut, sunna with only two stitches, and am so much more healthy. But my younger sister is cut with the sunna with no stiches. She is more outgoing and rebellious and we all feel that this is because she has not been cut properly. Even in the house we call her names and mock her. We fear she will bring shame on the family and may never marry. When I marry I will have my daughters cut properly, sunna with two stitches, as this gives us the girls who are healthy and respect others."

Young woman, aged 18, Stadium, Urban community Maroodi Jeex

Differences between FGM/C in urban and rural communities

There are substantial differences in attitudes and behaviours in relation to FGM/C between urban and rural communities which were evident throughout the research.

Urban communities have a higher concentration of CSOs working on social issues like FGM/C. Levels of school attendance are higher (45% in urban compared to 25% in rural communities), as are access to health facilities and access to information through the media.

The key differences identified are:

- the move away from the pharaonic to the intermediate and from the intermediate to the sunna is stronger in urban than rural communities
- the percentage of girls and women cut by health specialists is higher in urban (11%) than rural communities (2%)
- religious leaders are more likely to support the abandonment of all forms of cutting in urban (29%) than rural communities (8%)
- religious leaders are more traditional in their interpretation of Islamic law with more considering the pharaonic cut to be honourable in rural communities (23%) than urban communities (15%)
- community leaders are more likely to support abandonment of all forms of cutting in urban (20%) than rural (6%) communities
- community leaders are more likely to speak in public about FGM/C in urban (93%) than rural (31%) communities
- decisions about whether young men marry a cut or uncut girl are more likely to be left to the son in urban (20%) than rural communities (17%)
- more community members aspire to the abandonment of all forms of cutting in urban (7%) than rural communities (3%)

4.2 Communities' knowledge, attitudes and beliefs in relation to FGM/C

Reasons for cutting

The reasons given for female genital cutting are complex with apparently contradictory evidence from the community survey and the discussions with individuals and groups. The strongest reason given is that cutting is a traditional practice (62%), which was stated most highly among men (84%). Religious reasons for cutting were cited less often, 22% overall, and more often by men (36%) than women (13%). Purification, which comes from the Somali word "xalaalayn", is associated with reducing the sexual desire of girls, which in turn protects girls from sexual activity and the associated dangers of lack of virginity or pregnancy. The links between purification and marriage were made by women and men in the focus group discussions.

"The sunna is to purify the girl... so she will be ready for marriage."

Community woman, Taysa, rural community

Marriage was given as a reason for cutting by just 20% of community members in the survey, however, in the focus groups discussions marriageability was repeatedly raised by women and men. They stressed the importance of a girl's virginity before marriage, how this was to be verified and the impact if the family was not able to prove it.

"...on her wedding night, the TBAs came to cut her and she told them to go away as she was not cut. They left but cutting a hole in her curtain to show the whole community that she was not cut. The man divorced her immediately and she left the community in shame."

Community woman, Salahlay, rural community

"If they are not cut they cannot get married. Being cut is to protect the girl from intercourse with men before marriage and to prove her virginity. If she is found to be open on her wedding night there will be an instant divorce, the cows will be returned and there will be great shame on the family."

Community woman, Taysa, rural community

Advantages and disadvantages of cutting

Women in the community survey were asked about the advantages and disadvantages of being cut and uncut. The advantages of being cut focus on social and religious acceptability, being seen as beautiful and able to marry. Protection from rape and sexual advances was also frequently cited as an advantage of girls being cut, although in discussion most agreed that girls who have been cut are still vulnerable to rape.

"The sunna has only advantages. When she is cut a girl is able to be married, the sunna protects her from men and preserves her for marriage."

Community woman, Salahlay, rural community

The disadvantages of being cut focus almost exclusively on the harmful health consequences which they have seen women around them experience. The women are often quite descriptive here and the responses are highly individual.

The advantages of being uncut focused mainly on the absence of the disadvantages of being cut. This is perhaps because over half of community members did not know any uncut girls or women and so cannot imagine this situation. The people who were mentioned as not cutting their daughters at all were from the diaspora, professional, educated women or Sheikhs, rather than relatives, neighbours or friends of community members.

The disadvantages of being uncut focus on social and religious exclusion and unacceptability for marriage, whilst also highlighting the perceived lack of protection from rape and sexual advance.

In the focus group discussions, the men were concerned about the impact of the pharaonic cut in particular, on the health of their wives, yet they also felt the need for evidence of virginity. For many this was the first time they had discussed this dilemma.

"We need this evidence of them being untouched. How else are we going to know whether she has been touched if she is not sewn? But we do not want a lady who is going to have health problems all of her life and not be able to be a good wife."

Young man, Stadium, urban community

Both men and women talked about the impact of the wife being cut on relationships within marriage, as explained by a focus group participant.

"...when a man marries he wants an active wife and sex nowadays and that doesn't happen with an FGM girl. There is a problem here though which we need to resolve. I no longer support the pharaonic as it is a mistake, it damages our girls too much. The sunna will give us more pleasant experiences with our wives"

Community member, Ina afmadoobe, rural community, Togdheer

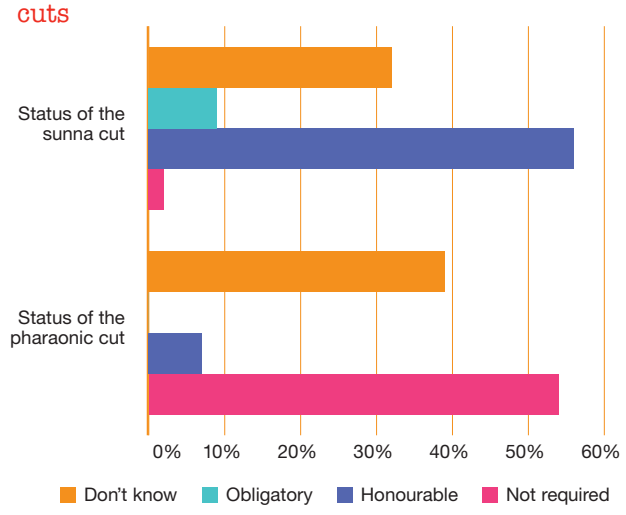
Knowledge of types of cut

Almost 90% of women knew there were different types of cut being used in communities in Somaliland, although only 77% of men were aware of this. Those who were unaware tended to be the youth (aged 12-14). Only 11% of men interviewed in the community survey were aware of the intermediate cut, or sunna 2. This was also clear in the focus group discussions where many of the men thought the decision was between either a cut which required no stitches (the sunna) or the pharaonic cut.

Religious status and guidance of female genital cutting

Of the two thirds who expressed an opinion, the difference in perception between the Islamic status of the pharaonic and sunna cuts is marked with the pharaonic perceived as not required, whereas the sunna cut is seen primarily as honourable, with 9% considering it obligatory. There were no differences in opinions on the hadith between rural and urban communities or between community women and men.

Chart 4: Community members' perceptions of the Hadith in relation to the pharaonic and sunna cuts



The majority of community members, women (64%) and men (59%), see religious leaders as primarily supporting the sunna cut and opposing the pharaonic cut, with 1-2% opposing all forms of cutting.
The following quotations are examples of how religious leaders are supporting the sunna with no stitches and opposing the pharaonic cut, which is seen as FGM and non-Islamic.

"...religious leaders support the sunna, they tell us this is required and that ALL girls should have it done. They do not support the pharaonic, only the sunna."

Community woman, Qoyale, Rural community, Togdheer

"Islam doesn't approve of any cutting. You can do Sunna without stitches. This is what the religious leaders here recommend. They say we should not be doing FGM, as it is against Islam."

Community woman, Daami B, Urban community, Maroodi Jeex

Legal status of cutting in Somaliland

Only 38% of community members were correct in their understanding of the legal status of FGM/C in Somaliland. This was higher among urban (44%) than rural (38%) communities, higher among men (60%) than women (28%) and higher among those who had attended secondary school or further education (66%). Only 3% of men thought the pharaonic cut is illegal, as opposed to 42% of women.

The majority of community members (62%) interviewed would like to see the law strengthened on FGM/C, with a higher percentage of women (67%) than men (55%) and higher in urban (67%) than rural communities (60%).

The most popular new law would be one which bans all forms of cutting except the sunna, favoured by 80% of men and 63% of women community members interviewed. Less than 10% of community members favoured a ban on all types of cutting.

Expectations by the community and intentions to cut their daughters

Overall, 74% of community members (84% women and 62% men) think that people in their community expect them to cut their daughters. A slightly higher

percentage (84%) say they intend to cut their daughters in future. Both men and women favour the sunna cut, with women in particular intending to use a lesser cut than they perceive the community to be expecting them to use (charts 5 and 6).

Decision-makers on whether a girl is cut and type of cut she undergoes

Mothers are the principle decision-makers about whether a girl is cut and the type of cut she undergoes, taking the decision 76% of the time (chart 7). Men and women deciding jointly occurs in only 8% of families. Girls are reported to be involved in the decision-making less than 0.5% of the time. (chart 7)

There a small difference in the balance in decision-making between mothers and grandmothers with grandmothers being more involved in rural (15%) than urban (10%) families. Linking this to the data on types of cut, it is clear that where grandmothers are less involved, the type of cut is less likely to be pharaonic.

Chart 5: Community women's expectations and intentions of cutting their daughters

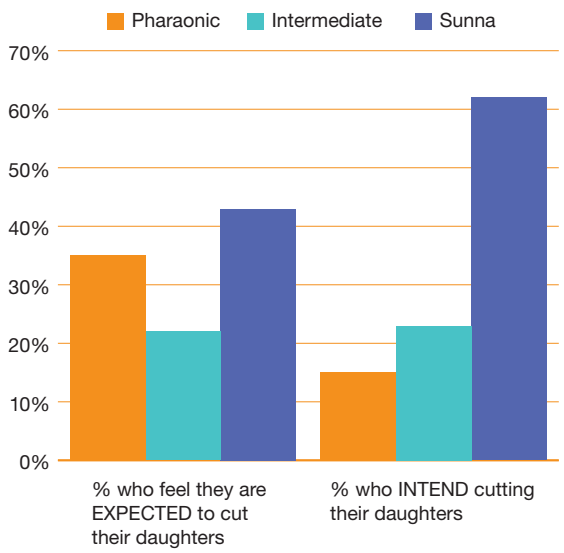


Chart 6: Community men's expextations and personal intentions of cutting their daughters

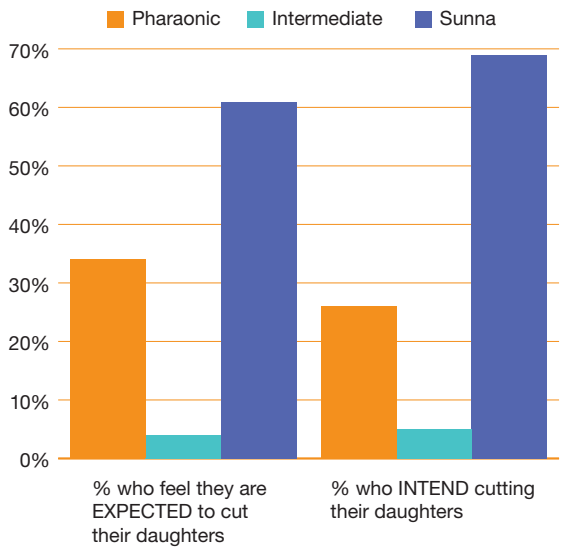
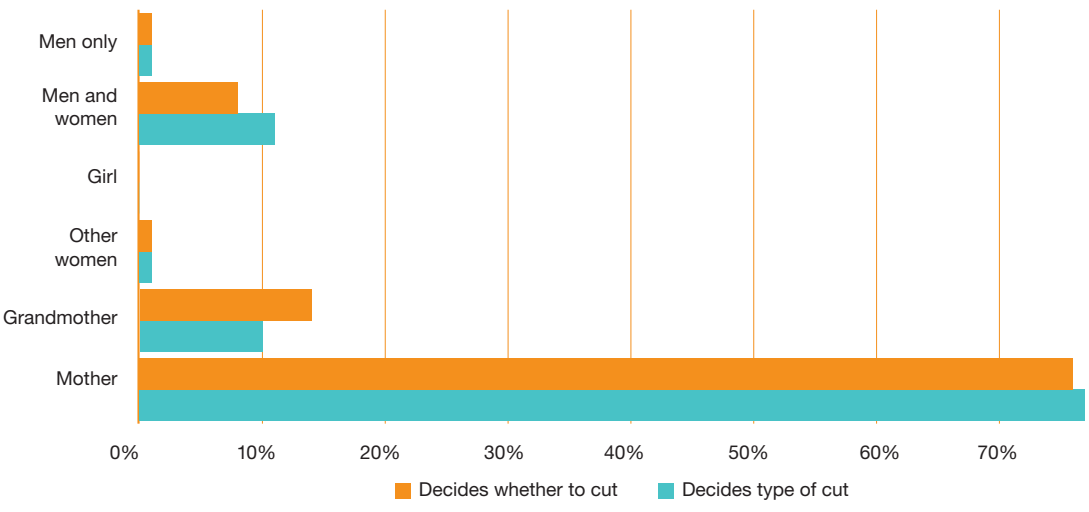


Chart 7: Decision-makers about whether a girl is cut and which type of cut she undergoes



Who cuts

Overall 95% of girls and women surveyed were cut by a traditional cutter or traditional birth attendant and 5%by a health specialist (doctor, midwife or nurse).

There is evidence of a recent increase in using health specialists to cut girls, accompanied by a decrease in the reliance on traditional birth attendants. Chart 8 shows a total of 14% of girls aged 12-14 years have been cut by a health specialist with 9% being cut by a midwife. The proportion of women being cut by health specialists was significantly higher in urban (11%) than rural (2%) communities (chart 8)

Although the number of girls cut by health specialists currently is low, communities would like this to increase, as demonstrated by men in Ina afmadoobe, a rural community in Togdheer when asked who cuts their daughters:

> **"only the TBAs and traditional cutters, we do not have anyone else. It would be much better if it could be done at the MCHs [Mother and Child Health centres] safely and without so many complications."**

The medicalisation of cutting is evident from the types of people who participants report have cut their daughters (chart 9). The change is most dramatic in urban communities where the percentage of daughters cut by health specialists (doctors, nurses

Chart 8: Type of cutter of community women by age

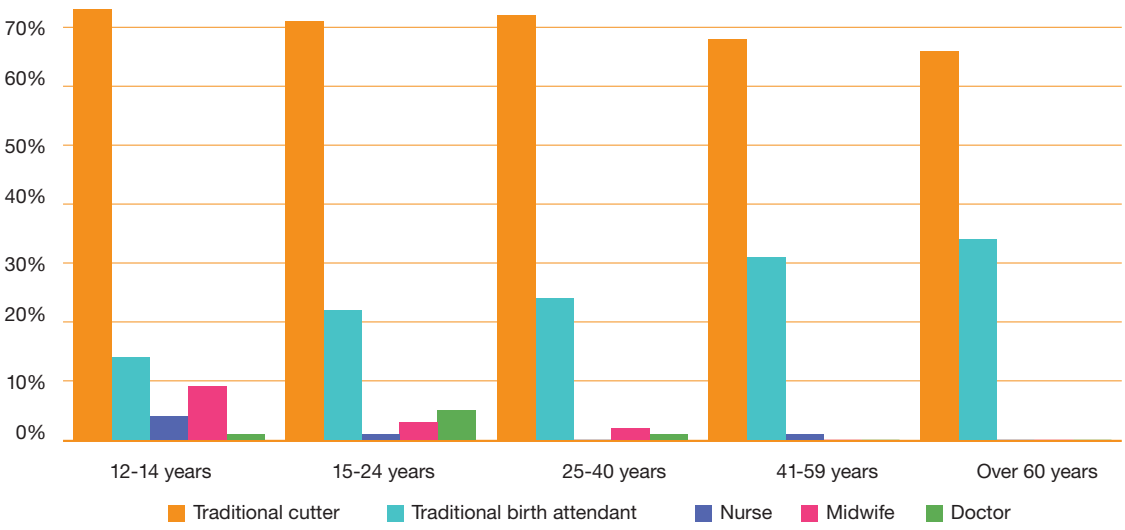
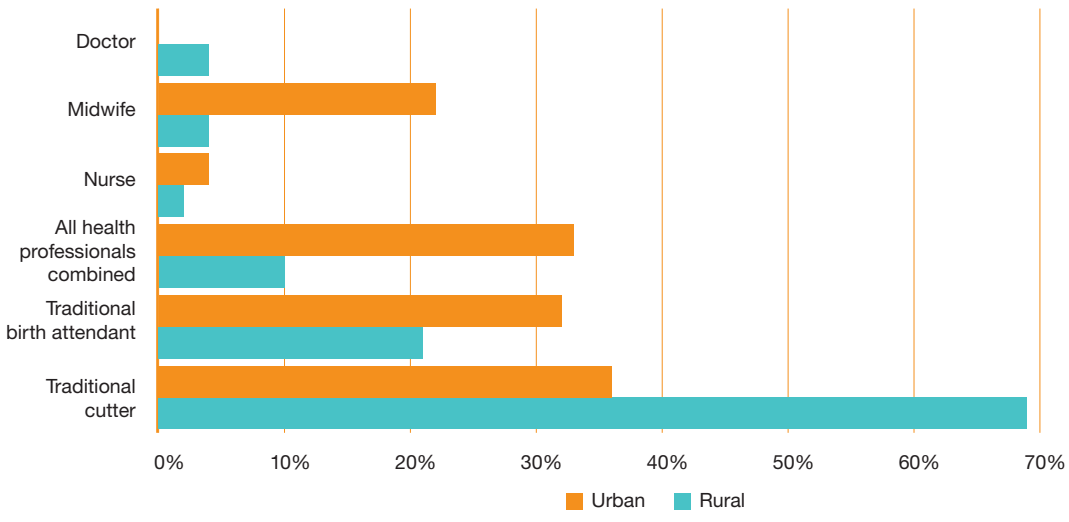


Chart 9: Type of cutter of community women by age



and midwives) (33%) exceeds the percentage carried out by traditional birth attendants (32%). This is in comparison to 5% of their mothers being cut by a health specialist (see chart 9).

Preferences for marriage

Although marriage is not stated as a reason for cutting their daughters as frequently as culture or religion, there is a strong preference (94%) for girls who are cut when it comes to selecting a future wife.

In focus group discussions, a strong preference for girls who have been cut was evident at the beginning of the discussions, when young men had not had an opportunity previously to discuss this. However, towards the end of the discussion most understood that there were advantages and disadvantages to marrying a cut girl. Some said they had changed their minds as a result of considering the health implications, which they knew about previously but had not made the link to their own future married life.

The preference for men to marry cut girls is also evident among married men and women where 80% say they would prefer their sons to marry a girl who had been cut. This preference is similar among men and women, rural and urban communities, and those over and under 25 years of age. In urban communities, among women and younger people more participants would allow their sons to decide, although these differences are minor.

Communication among the community about FGM/C

Female genital cutting is not a subject which people generally talk about in communities, with over three-quarters of community members in both rural and urban communities saying they have not spoken to anyone about it in the last year.

Of those who have spoken about FGM/C to someone, they are most likely to talk to family, usually of the same gender, friends and members of CSOs. Despite religious leaders being considered influential in decision-making, they are not a group with whom many conversations are taking place currently. Even fewer conversations are taking place with health workers and teachers.

Focus group participants reinforced this in both urban and rural communities:

"...we know only a little as it is never talked about with us"

Young man, Stadium, urban community

"Women cut is never talked about in public in this community. We do not talk about it even in our families it is not something we men talk about either"

Community men, Taysa, rural community

Towards the end of the focus group discussion in Ina afmadoobe, community women said that it was the very first time they had discussed female cutting with each other as a group. They were aware of changing their minds as they talked to each other and heard the views of others, and recognised the contradictions in some of their arguments.

The implications of a lack of communication between women and men about FGM/C emerged in the focus group discussions with separate men and women from the same community.

Implications of a lack of communication between women and men about FGM/C

In Ina afmadoobe, Togdheer, the men were adamant that they would not agree to their daughters undergoing anything except the sunna with no stitches, saying that when their daughters undergo the sunna *"there are no stitches, no complications and no harm, it is totally safe and simply purifies the woman ready for marriage."*

However, the women think that about two-thirds of the men would not accept the sunna with stitches and only about one-third would. *"We inform the father that the girl is going 'to be purified' and avoid giving any details at all. We know we are keeping a secret from the men about the details of their daughter's cut, because we 'know' that if she is not cut properly she will bring shame to the family".*

In Ina afmadoobe, all 32 women interviewed were cut, 25 (78%) with the pharaonic cut and with 7 with the intermediate cut. None had undergone the sunna cut with no stitches.

Only 16% of community members said that FGM/C is raised often in public meetings with 44% saying it was not raised. Two-thirds of people said that they felt able to speak about FGM/C in public meetings. This is in stark difference to less than a quarter who have spoken at all about FGM/C and suggests a willingness to engage, if the opportunity arose.

Aspirations for the future of FGM/C

Community members were asked how they would like to see the future of FGM/C in their community. Overall 77% would prefer to see the abandonment of all except the sunna with just 5% aspiring to the abandonment of all forms of cutting. Age, education and rural/urban background were all significant factors. Those aged 15-24 years were most in favour of abandoning all types of cutting (16%) and the least likely to support maintaining all options.

Rural communities had fewer community members aspiring to abandonment of all types of cutting (3%) and more preferring to maintain all options (20%) compared to urban communities (7% and 16% respectively). Women are more open to change in FGM/C than men. Only 2% of men supported the abandonment of all types of cutting with 26% preferring to maintain all options including the pharaonic, compared to 6% of women preferring abandonment of all types of cutting and only 13% preferring to maintain all options.

The level of education of community members is a strong factor in their aspirations on FGM/C, with those attending further education being more than five times as likely to support the abandonment of all forms of cutting than those who did not attend school (16% as opposed to 3%). There is also a corresponding reduction in the support for maintaining all options, including the pharaonic. Of those who would like to see only the sunna cut in future, 55% would like to see health workers trained in safe cutting.

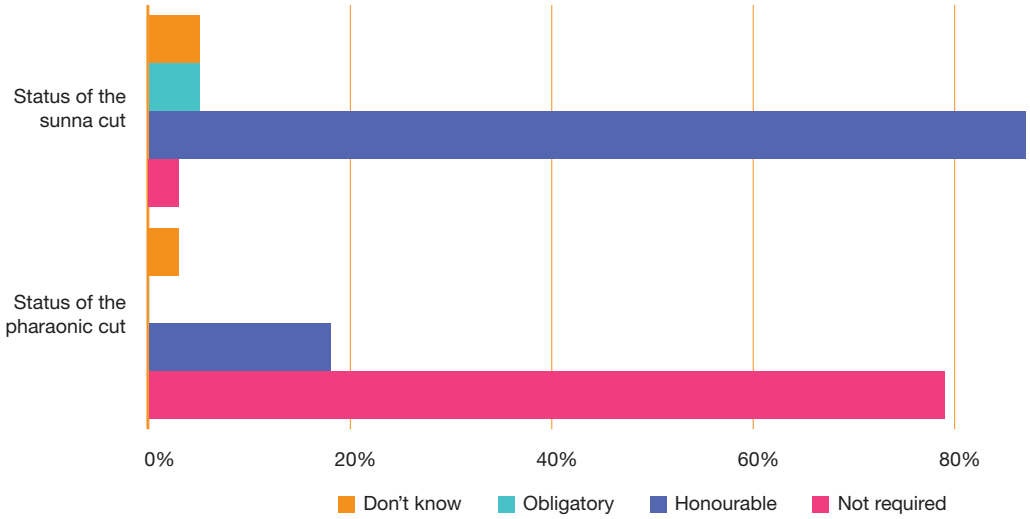
4.3 Opinion former perspectives

Religious leaders: knowledge, attitudes and behaviours on FGM/C

Religious leaders at community, district and national level were keen to participate in the research and to communicate their perspectives on female cutting. All felt that it is an important issue with over 90% considering that religious leaders should be involved in discussions at community level on FGM/C.

When asked about the position of female cutting under Islamic law, the difference in perception between the pharaonic and sunna cuts is crucial, with 87% of religious leaders describing the pharaonic cut as “not required” whereas on the sunna cut 79% consider it to be “honourable” (i.e. preferred) (see chart 9). Of the 18% who considered the pharaonic to be “honourable”, these tended to be older men (86% aged over 40) and from rural communities (86%), indicating rural religious leaders are more traditional in their interpretation of Islamic law than those from urban communities.

Chart 10: Religeous leaders’ perceptions of the Hadith in relation to the pharaonic and sunna cut



The view expressed by religious leaders in the community survey, that the pharaonic cut is seen as FGM/C, whereas the sunna cut is not, was also commonly expressed in focus group discussions by religious leaders and clearly articulated by the Ministry of Religious Affairs.

"FGM is against Sharia law. It is a violation of a woman...I talk regularly in the Mosque, whenever someone comes to talk to me I tell them that the sunna is acceptable but the pharaonic in any form is a cultural practice which goes against Islamic law."

Focus group discussion, Sheikh Fatxi Khadar Jaamac, Daami B

"Sunna is not harmful at all, it has a positive impact on the women's lives and on the community as a whole...If there are any stitches this would not be sunna so it would not be Islamic. "

Focus group discussion, Religious leader, Stadium

The community survey revealed that religious leaders are not particularly knowledgeable about the current legal status of FGM/C with only 8% aware that there are no laws in Somaliland on female cutting. Half of the religious leaders did not know the legal status of female cutting and a further 34% thought that the pharaonic cut was illegal. The remaining 5% thought that all cutting was illegal. However, they were more definite in wanting to see strengthening of the law on FGM/C (92%) with 11% supporting a law which only banned the pharaonic, 66% supporting the introduction of a law banning all cutting except the sunna and 16% supporting a law based on Zero Tolerance. Those supporting Zero Tolerance represented 8% of religious leaders from rural but 29% from urban communities, supporting the earlier observation that rural religious leaders are more traditional in their views on FGM/C.

The position of senior religious leaders on Zero Tolerance is seen by INGOs, CSOs, MoLSA and MoH as problematic, delaying the process of establishing a legal framework on FGM/C. All the senior religious leaders interviewed from MoRA would speak out publicly against all but the sunna cut – none would speak out against the sunna in public.

The views of the senior religious leaders interviewed about Zero Tolerance are illustrated below by a focus group discussion participant and a senior cleric from the Ministry of Religious Affairs.

"We are leading the way on stopping FGM, we are responsible for the reduction in FGM in our community, the religious leaders are leading the way, people forget this as they talk of Zero Tolerance. We oppose all types of cutting, we support only the sunna."

Religious leader, Qoryale, Togdheer

"If we think of two extremes of thought at the moment... on the one extreme is the pharaonic cut, which is harmful and cruel and non-Islamic. Then on the other extreme is the Zero Tolerance position. Zero Tolerance is an extreme position, of that there is no doubt. Zero Tolerance will restrain the fight against the pharaonic. It will entrench resistance and restrain people from change. It might even push people to more extreme actions. If you go to the extreme on either end you will push people on the other extreme. We [the Islamic leaders] are already fighting the pharaonic. At the moment the Islamic leaders are stopping the pharaonic. Those calling for Zero Tolerance are not stopping the cutting, they are polarising positions and slowing progress."

Mohamed Ibrahim Jama, Head of Department of Islamic Propagation, MoRA

Community leaders: knowledge, attitudes and behaviours on FGM/C

The community leaders interviewed held a wide range of roles including Mayor, Committee chairpersons, CSO committee members and members of community committees (for example education, health, security, women). Just under half (41%) were women. The men tended to be slightly older than the women with more of the men (66%) having attended school than the women (38%).

FGM/C is seen by community leaders overwhelmingly as a cultural issue (94%) with just 2% considering it primarily a rights issue and 4% a religious issue. Community leaders were familiar with the pharaonic and sunna types of cut, however, only 10% of the men were aware of the intermediate cut (sunna 2 with 2 stitches), compared to 52% of the women.

The key reasons given for girls being cut show marked differences between community leaders in urban and rural communities. Traditional practice is cited more frequently in urban communities. FGM/C being required under Islamic law is considered more important in rural than urban areas and is slightly higher among men than women.

A third (35%) of community leaders consider purification and preparation for marriage to be primary reasons for girls to be cut. Purification and preparation for marriage are complex and often interlinked. These reasons include protection from rape which the community leaders consider to be a growing problem, especially in urban communities and which was mentioned in each of the focus group discussions with community leaders.

"...we have more and more sexual attack here in the urban communities and young women need protection from rape, from sexual attacks of all sorts. The girls need to have their virginity protected and this can be done with the pinching [sunna 2 cut]."

Community leader, Stadium, urban community

"It is meant to protect girls from men thieves when their parents are away."

Community leader, Salahlay, rural community

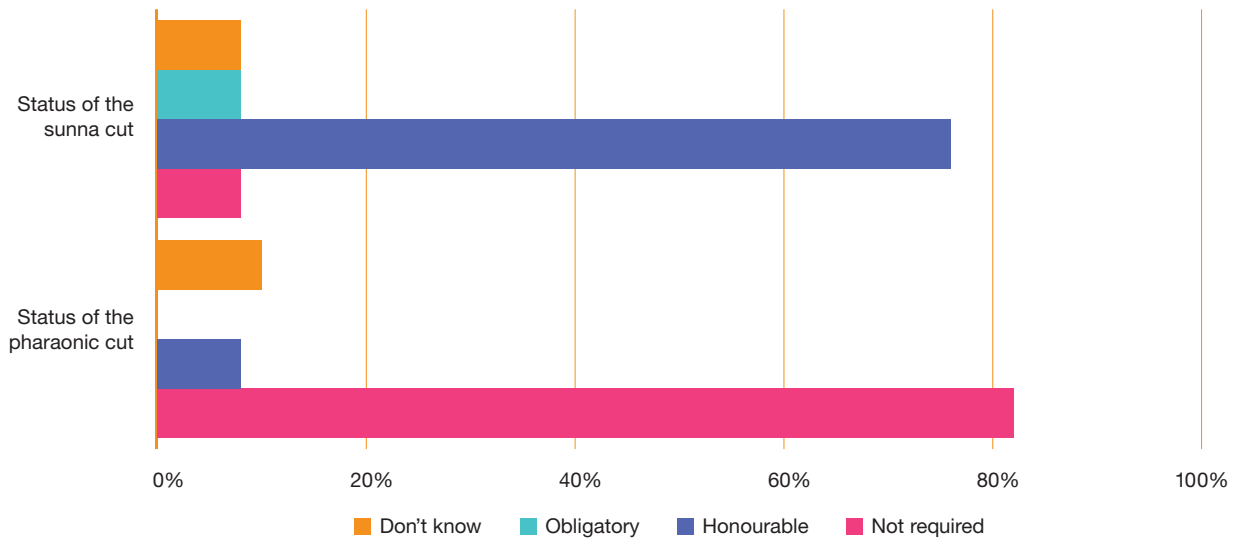
There was general agreement among community leaders that the pharaonic cut was not required under Islamic law but that the sunna cut was honourable (see chart 11). This was also the opinion expressed by community leaders in the focus group discussions in both rural and urban communities. 86% of community leaders felt that in their community the religious leaders strongly supported the sunna cut, with 14% considering that the religious leaders did not attempt to influence families' decisions.

Only half of the community leaders interviewed knew the legal status of FGM/C in Somaliland, however 88% would like to see a strengthening of the law. The majority (73%) would favour a law banning all except the sunna cut, with a further 14% favouring a law based on Zero Tolerance, banning all forms of cutting including the sunna. Views supporting Zero Tolerance were expressed more frequently in urban than rural communities and from female rather than male community leaders.

The majority of community leaders (82%) feel that their community expects parents to have their daughters cut. 64% of these say the community expects girls to undergo the sunna cut, 21% the intermediate cut and 14% the pharaonic cut. A similar percentage (84%) of community leaders intend cutting their daughters in the future, although with a greater tendency towards using the sunna (79%).

Community leaders, especially from urban communities, tended to underestimate the prevalence of FGM/C in their communities. The overwhelming majority (88%) of community leaders would like to see some changes in relation to FGM/C in their communities, with 92% of these wanting to see cutting continue but only in the sunna form.

Chart 11: Community leader's perceptions of the Hadith in relation to the Pharaonic and sunna cuts



There is a strong call from 79% of community leaders for health specialists (nurses, midwives and doctors) to perform the sunna cut, which is seen as a way of reducing the incidence of the pharaonic and intermediate cuts and ensuring the sunna is carried out safely and hygienically.

Law enforcers: knowledge, attitudes and behaviours on FGM/C

72% of the law enforcers were correct in their understanding of the legal position in relation to FGM/C, ie that there are no specific laws on FGM/C and that all forms of cutting are legal.
The majority (88%) of law enforcers interviewed would be in favour of the law on FGM/C being strengthened with 75% of these supporting a law permitting only the sunna, 12% banning just the pharaonic, one law enforcer (6%) supporting a law based on Zero Tolerance banning all forms of female cutting, and one holding no particular opinion.

The three legal aid lawyers were conversant with international human rights law and its relevance to female cutting. They were also able to articulately explain the commitment within the Somaliland constitution to international law.

"We also have the child's rights convention. FGM is against this convention. Children are not giving their consent to this practice. We also have Article 36 which supports women to have freedom from traditional harm and for their development to be promoted in society. We also have an article in our constitution which makes illegal anything that goes against Sharia law. This means that Pharaonic is against the law."

Legal Aid Lawyer

None of the lawyers had been asked for legal advice in relation to FGM/C despite their work on women's rights, including domestic violence. It was evident that they had not discussed female cutting previously, despite working closely together. Initially, they differed in their perception of what constitutes FGM/C. All considered the pharaonic cut to be FGM/C. Two of them also included the intermediate cut with two stitches. The other said:

"We must follow Sharia law - this mentions cutting a little bit... one stitch is sunna and fine because there are no health problems - it is not harmful."

After some discussion, in Somali, this lawyer changed her mind and concluded that only the sunna with no stiches should be permissible under Sharia law. The lawyer who initially described herself as supporting Zero Tolerance also changed her position. When questioned about how a Zero Tolerance law would be implemented, she was adamant it would not be right or possible to prosecute when a girl was "just given the sunna cut with no stitches and was playing the same day". So in when it came to the implementation she was unable to support Zero Tolerance.

The focus group discussion concluded with the lawyers reflecting on the process.

"This has helped me to change my mind as before I had not really heard anyone talk about it in a calm and reasonable way, about what ordinary people do, not just what damage happens."

"This is the first time we have thought about what we think rather than being told what we should think."

Legal Aid Lawyers, Hargeisa

While law enforcers are overall reasonably well-informed, some would benefit from further information on female cutting and most would benefit from opportunities to discuss female cutting in safe spaces. They tend not to have spoken in public meetings on female cutting and are a group of opinion formers who are currently underutilised in changing attitudes.

Health workers: knowledge, attitudes and behaviours on FGM/C

The 39 health workers interviewed in the community survey included 33 health specialists (doctors, nurses, midwives, pharmacists and health officer) and six traditional birth attendant (TBAs).
The TBAs interviewed all came from Maroodi Jeex with 83% from rural communities. Those who attended school work in government hospitals or clinics, the others work in the community. None consider FGM/C to be a health issue, with opinions equally divided between FGM/C being a cultural, a religious and a rights issue. Half of them would agree to cut young girls or women if approached, half

would decline, none would report it. All would have their own daughters undergo the sunna cut with half using a traditional cutter and half using a doctor or midwife to carry out the cut.

The 33 health specialists (doctors, midwives, nurses, pharmacists and government health officer), 11 female and 21 male, were equally distributed across rural and urban communities, with 75% having continued to further education.

Four of the 33 health specialists interviewed (12%) have been approached to cut girls, half declined and half referred to another health specialist who they knew cut girls, none reported the approach. 70% would have their own daughters undergo the sunna cut, 3% would use the intermediate cut and 27% would not cut their daughters at all. Of those who would cut their daughters all would use a health specialist; 54% a midwife, 29% a nurse and 17% a doctor. 80% of health specialists would expect their son to marry a cut girl (sunna only).

In line with other opinion former groups, health workers perceive the pharaonic cut as “not required” under Islamic law but the sunna cut as “honourable”. Health workers are not well-informed about the legal status of FGM/C in Somaliland with 59% not knowing whether there are any laws and 38% believing that the pharaonic cut is illegal. 87% of them would like to see the legal position strengthened, with 13% supporting a law based on Zero Tolerance (including one TBA) and 64% supporting a law which permits only the sunna cut.

All health workers are well informed about the higher complications and health risks of the pharaonic cut compared to the sunna. And that the intermediate cut carries significantly higher health risks than the sunna, specifically problems relating to menstruation, infections, childbirth, urine retention, fistula and infertility.

When asked what they considered their responsibilities as a health worker in relation to FGM/C, 27% of health specialists and 43% of TBAs included providing a safe cutting service. Overall 38% of health workers also included providing education on the health risks of all types of cutting, despite the majority of indicating that their own daughters would undergo the sunna cut and they expect their sons to marry a girl who has undergone the sunna cut.

An FGM/C practitioner, aged 45, from an urban community explained how the type of cut requested by parents has changed in recent years.

"I used to cut only using the pharaonic but now my job is made easier as mainly now people want the sunna with two stitches. This means instead of removing both the labia major and minor I only scrape out most of the flesh from the inside and then sew with just two stiches. This is the sunna 2 which is what I do now. "

"I need the mother and grandmother there to hold down the girl whilst she is cut otherwise the girls scream and struggle and that is dangerous."

"I never have complications, because I am very careful, I use gloves and anaesthetic and the girls must take their medicine afterwards. [This is amoxicillin obtained from the hospital along with the gloves, needles and thread for stitching.] I give clear instructions on the taking of the medicine and follow up to make sure they are taking it."

FGM/C practitioner, urban community

An MCH midwife, aged 25, explained how she feels about colleagues who agree to cut girls.

"I feel under pressure to do it but will definitely not do it, ever. I am disappointed by my colleagues who do it, I leave the room as I cannot face seeing the damage they are doing. Most do the two stitches but I know some do the three or four stitches as well. They say they are doing a good service and saving the girls from future complications. They are proud of what they do."

A male nurse at an MCH in Togdheer explained how he sees FGM/C in his community

"There is a big problem with FGM in this community, it damages organs and is the cause of so many common problems in women, including pelvic pain, abdominal pain, fistula, difficulties giving birth especially for the first born. Most people who come here still do

the FGM, about 70% support it totally, only 30% oppose it."

"We raise awareness of the sunna, where just the tip of the clitoris is cut. We support and encourage the sunna only with no stitches, this gives no pain, no damage, no problems in delivery, no other organs are damaged and there are no complications at all."

He then went on to explain how he will approach a colleague at the MCH to carry out the sunna cut on his daughter,

"When my daughters are ready to be cut they will have the sunna only with no stitches. This is Islamic and is required. I want my daughters to be cut by a health worker in an MCH or hospital. MCH is best as they will do a home visit. They use clean materials, there is no infection. My wife is FGM and our daughters will be sunna only. I have already explained this to my wife, it is her decision but she will choose only the sunna."

Male nurse, urban MCH

The Ministry of Health (MoH) is opposed to all forms of female genital cutting, including the sunna cut and recognises the implications of an increase in medicalisation of FGM/C and the drivers which prompt health specialists to perform FGM/C. The Director of Hargeisa hospital made it clear that their first priority is to stop staff cutting girls and women on hospital premises. Staff found guilty of this are disciplined. However, he also recognised that staff may be carrying out cutting in their own time, in people's homes and that this is more difficult to police.

Edna Adan Ismail is a prominent proponent of the abandonment of all forms of cutting and also Founder and Director of Edna Adan University Hospital which carries out on-going research into FGM/C of patients attending the hospital. When interviewed, she explained the need for a review of existing strategies after limited change in the prevalence of FGM/C despite over 40 years of work to promote abandonment. She remains committed to abandonment of all forms of cutting but encourages policy makers to work with all stakeholders, especially religious leaders, to engage in genuine dialogue and to consider all options, including a law which bans all female genital cutting except the sunna cut.

Teachers: knowledge, attitudes and behaviours on FGM/C

When asked what, if any, role schools have in relation to FGM/C, the emphasis was on two areas, providing opportunities for girls to learn about FGM/C and educating girls on the traditions and maintaining them. Schools are perceived by a third of teachers to be places where opportunities should be provided for girls to learn about female cutting, with only 4% considering that the same opportunities should be available to boys.

34% of teachers had spoken about FGM/C at school. Female teachers are more likely to be having conversations about female cutting (72%), although most schools visited do not have any female teachers. 75% of male teachers have not talked about FGM/C at school at all. Classroom time and whole school time is rarely used to discuss FGM/C.

Just over half, (57%) of teachers were aware of the current legal status of female cutting and 87% would support a strengthening of the law. 70% would favour a law banning all except the sunna, with only 6% supporting a law based on Zero Tolerance.

Teachers tend to have more traditional views on FGM/C than other opinion formers. When asked about Islamic guidance on female cutting, 55% of teachers consider that the pharaonic cut is "not required" (55%). However, 30% consider it to be "honourable" (or preferred), the highest percentage of the opinion forming stakeholder groups, including traditional leaders. The sunna is fully supported with 85% considering it to be honourable with a further 8% considering it to be obligatory.

38% of teachers have spoken in public about FGM/C, which is higher than the percentage of teachers who have spoken in school. Of these all describe the sunna cut as honourable and intend their daughters to undergo the sunna cut. 95% (19 of 20 teachers) would like the law strengthened, with 85% banning all but the sunna and 10% preferring a law which only bans the pharaonic cut.

Finally, of the 53 teachers surveyed 94% (50) would like to see a future with the sunna cut only in their community, with 4% (two) supporting the status quo and just one teacher supporting Zero Tolerance.

Considering how influential schools are in communities and their role in countries where the prevalence has been reduced, teachers would seem to be a key target group for attitudinal change. However, support would be required in providing them with safe spaces to discuss the issues around female cutting and to change their own perspectives before increasing the dialogue with pupils.

Parliamentarians: knowledge, attitudes and behaviours on FGM/C

It was not possible to interview any members of the Committee for Social Affairs. However, Baar Saeed Farah, the only female parliamentarian in Somaliland, who is a member of a permanent committee which liaises across all ministries, agreed to be interviewed.

Mrs. Saeed sees female cutting not as a religious but as a health issue. She is knowledgeable on the health risks and complications of FGM/C for women and girls and has met many constituents who have experienced life-changing complications as a result of being cut.

Following the Djibouti talks in 2015, Mrs Saeed is confident that the senior religious leaders in Somaliland do not consider cutting to be part of Islamic law, including the sunna cut.

> **"When we met with the religious leaders it was agreed that there are no body parts of a woman that need removing or are superfluous and that she is made as a perfect human being. The religious leaders agreed this. In fact, they totally and utterly prohibit any cutting at all. 90% of religious scholars believe this, only 10% are misguided and believe differently."**
>
> Baar Saeed Farah, Parliamentarian

Mrs Saeed is a strong supporter of Zero Tolerance and sees the role of parliamentarians as making policy and law for Somaliland to eradicate FGM/C. She feels significant progress has already been made in urban areas and stresses the importance of bringing about changes in the rural areas.

CSOs, NGOs and agencies

There has been considerable attention on FGM/C in recent years in Somaliland which has led to an increasing number of organisations and agencies incorporating it into their community work. Networks have been established to draw together CSOs and NGOs to coordinate activity and to support those for whom FGM/C is not the primary purpose of their work.

A series of interviews and discussions took place with representative from seven CSOs and two UN agencies to gain an overview of their perspectives.

The seven CSOs, actively involved in activities to reduce FGM/C, which were interviewed as part of the research all had experience of different approaches which have evolved from their experiences. All are focusing currently on approaches which address the *"demand"* by community members for their daughters to be cut (ie their desire to have their daughters cut), rather than attempting to reduce the 'supply' of cutters (ie persuading those who have been cutting to stop).

Comprehensive Community Based Rehabilitation in Somaliland (CCBRS) explored the use of paying traditional cutters to stop cutting, an approach aimed at reducing the 'supply' of cutters. However, they no longer use this approach as they found that other cutters are recruited to replace those who say they have stopped cutting.

NAFIS takes an approach aimed at "manipulating the decision-making process" and therefore focuses on the women, the traditional cutter and the girl. Other CSOs, Candlelight, CCBRS, Nagaad, Somaliland Family Health Association SOFHA, SOWDA and WAAPO take a more holistic approach, working with as wide a range of stakeholders as possible, including men and religious leaders.

The CSO workers interviewed were all asked which types of people are not cutting their daughters in Somaliland. All agreed that there are very few families in which girls do not undergo any form of cutting. The following groups were identified as most likely not to cut their daughters: people from the diaspora, some religious Sheikhs, educated intellectual /professional women, INGO workers, some CSO workers and some female teachers.

Opinions among CSO staff varied as to whether it was better to aim for Zero Tolerance or take a more gradual approach.

5. Key themes

5.1 Role of religion and religious leaders

There is agreement among religious leaders interviewed, both at community level (87%) and senior clerics from MoRA (100%), that the pharaonic cut is a harmful traditional practice which is non-Islamic and that the intermediate cut, often called sunna 2, which involves stitches, is also non-Islamic and not supported.

Religious leaders draw a distinction between the sunna cut, which is supported (ie considered either honourable or obligatory) by 92% of religious leaders, and other forms of cutting. Most religious leaders in Somaliland would classify the sunna cut as "doing no harm". This is on the basis that under the Shafi'i school of thought the sunna cut is considered honourable and therefore, as Islamic law specifically states that no harm should be done to women and girls, the sunna cut does no harm.

The overall position of religious leaders on female cutting is well understood by two thirds of community members and three quarters of community leaders, teachers and law enforcers who see religious leaders in communities as opposing the pharaonic and supporting the sunna cut (chart 12). This does however, leave a significant proportion of the community not aware of the guidance from their religious leaders.

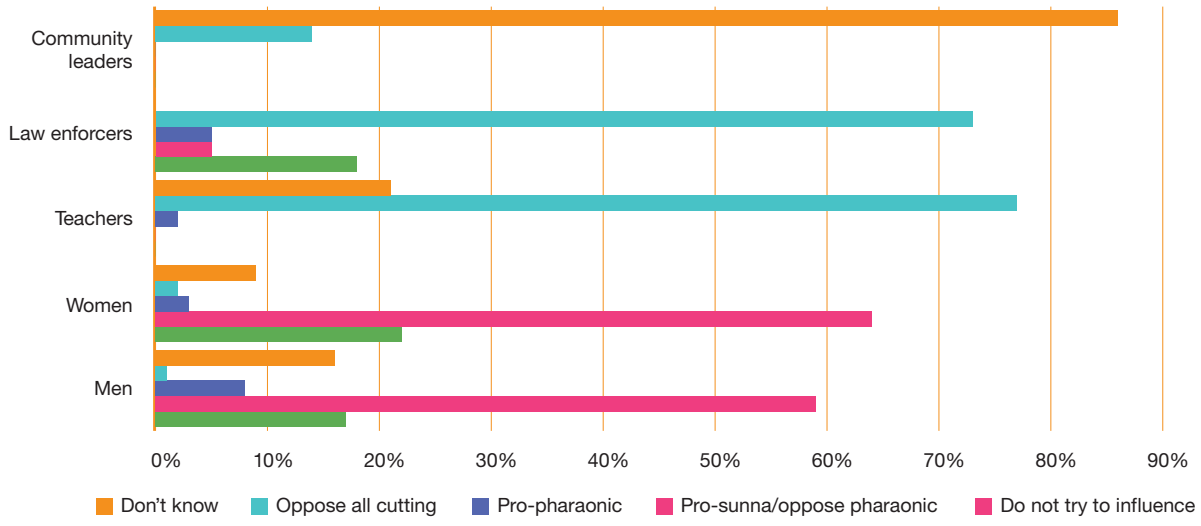
MoRA and two-thirds of religious leaders support a law which bans all except the sunna cut, however this requires a clear definition of what the sunna does, and does not, entail. The clearest definition appears to be that the sunna should never require stitching and the girl should be active and playing the same day. These are not sufficiently clear to be engrained in law. Another point of difference is that many religious leaders would like to see health specialists trained to perform the sunna cut, safely and officially, as part of their role.

At a community level 16% of religious leaders interviewed would support a law opposing all types of cutting including the sunna. However, the concept of Zero Tolerance is not publicly supported by senior religious leaders.

Almost all religious leaders (90%) consider that their involvement is important in relation to female genital cutting. Almost half see their role being to speak out against the pharaonic cut and educate the community that there are no religious grounds for FGM/C (which in their view does not refer to the sunna cut). However, less than half have spoken in public or are actively involved in activities to reduce FGM/C in their communities and only 4% of community members have spoken to a religious leader about FGM/C.

Bearing in mind how influential religious leaders are in communities and their position on the pharaonic and the intermediate cuts, it could be beneficial to support them in increasing their involvement in

Chart 12: Community members' and opinion formers' views on the attitude of religious leaders on FGM/C



discussions and public speaking about female cutting. Their involvement could encourage people away from the pharaonic, towards the sunna, rather than the intermediate. Although at present it is unlikely to support abandonment of the sunna.

5.2 Medicalisation of FGM/C

The term medicalisation of FGM/C is used to describe the involvement of trained health specialists, particularly midwives, doctors and nurses in the cutting of girls and women.

Although only 5% of the women surveyed were cut by a health specialist, evidence of a drive towards increased medicalisation of cutting is present throughout the research (table 1).

There are opposing schools of thought in relation to the medicalisation of FGM/C. Senior clerics from MoRA suggest that training health specialists to cut girls safely using the sunna cut, without stitches, would reduce the damage done and speed the process of abandoning the pharaonic cut. It could unite the religious leaders and those favouring a stepwise approach towards abandonment and prioritising a reduction in health complications arising from the pharaonic and the intermediate cuts.

The MoH has recognised the drive towards medicalisation of FGM/C and has adopted two strategies, drafting an anti-medicalisation of FGM/C policy and undertaking training workshops for MCH staff. Anti-medicalisation of FGM/C is already included in the midwifery and nursing curricula of some teaching hospitals, including Edna Adan University Hospital. CSO and NGO workers in favour of Zero Tolerance oppose the involvement of health specialists as this would legitimise the sunna cut, setting it apart from the pharaonic and intermediate cuts, rather than opposing all forms of cutting. Abdirahman Saeed Mohamed, Researcher and Data Analyst at Edna Adan University Hospital, explains, *"…if we train health workers and perhaps set up special rooms in MCHs then we shall be legitimising female cutting in the community which will be counterproductive to stopping the female cut. In addition, training of health workers to perform the female cut will also bring about the challenge of supervision and quality control of the TBAs who are not part of the mainstream health sector and yet they are close and most trusted by communities in the rural areas."*

Table 1: Evidence of the drive towards medicalisation of FGM/C

1. Young women (12-14 years) interviewed were more likely to have been cut by a health specialist (14%) than older girls and women (4%)
2. The percentage of participants' daughters being cut by a health specialist is 33% in urban and 10% in rural communities
3. 55% of community men and women in favour of only the sunna would like to see health workers trained to cut their daughters safely
4. In focus group discussions community women describe how they have taken their daughters to MCHs to be cut or arranged for a health professional to come to the village to cut girls
5. 75% of community leaders in favour of only the sunna in future, would prefer girls from their community to be cut by a health specialist
6. Half of TBAs interviewed would use a health professional to cut their own daughters
7. All health specialists (doctors, midwives and nurses) who said they will have their daughters cut, will ask a health specialist to perform the cut
8. Health workers in government hospitals and MCHs have spoken about having cut young girls themselves, or know colleagues who do so
9. 27% of health specialists and 43% of TBAs included providing a safe cutting service in the responsibilities of health facilities
10. Community religious leaders and senior clerics from MoRA would welcome the open involvement of health workers in the cutting of girls and women

5.3 Communication and conversations

Dialogue and exchange of knowledge and views is an important element in the process of changing attitudes. Only 22% of community members interviewed have spoken to anyone about FGM/C in the last year. A young man in Stadium, an urban community said, *"...we know only a little as it is never talked about with us"*. This is reinforced by the view that FGM/C is a women's issue only, hence not a subject young men need to know about. Without knowledge and an opportunity to be included in discussions about FGM/C, most of these young men will be unlikely to engage with FGM/C as an important issue in their community.

Of those community members who have spoken about FGM/C, the most common people to talk to are family members (39%), usually of the same gender, friends (31%) and members of CSOs (22%). Very few conversations are taking place with key opinion formers like religious leaders (4%), health workers (3%) and teachers (1%).

The focus group discussions demonstrated the potential value of encouraging conversations about FGM/C. They were, for many participants, the first opportunity to talk about FGM/C where they could openly exchange views. Those who had attended public meetings or workshops said they were told what to do and how to think in these, rather than invited to talk about what FGM/C meant to them and their families. During several focus group discussions, very real dilemmas were exposed between social expectations and the requirement of proof of virginity for marriage on the one hand and reducing the medical complications and staying within Islamic law on the other hand.

In almost all of the 22 focus group discussions, at least one participant, and often many more, changed their views in some way about FGM/C as a result of hearing other people's views or having their own views challenged. This included groups of men, women, community leaders, health workers, religious leaders and also women's rights lawyers, one of whom said, *"This is the first time we have thought about what 'we' think rather than being told what we should think… this has helped me to change my mind as before I had not really heard anyone talk about it in a calm and reasonable way".*

One way that women and men deal with the decision-making dilemmas they face in relation to female cutting, is the careful and deliberate use of unspecific terms and phrases. Women in one focus group discussion said, *"We inform the father that the girl is going 'to be purified' and avoid giving any details at all"*. Men, from the same community, said of the same conversations, that they would be, *"very general, along the lines of just agreeing that my daughters would be purified… I know this to mean the sunna with no stitches"*. Following these conversations, the girls undergo the sunna 2 cut, with two stitches. The women can say they have *"told"* their husbands who have agreed, and the men can say they have *"checked"* that their daughters are only undergoing the sunna (with no stitches), approved under Islamic law. The women are, by their own admission, using unspecific language to deceive the men, or at least to avoid the dilemma they face of wanting to avoid harming their daughters but wanting them to be acceptable to men for marriage. However, the men are clearly complicit as they go on to talk about the need for proof of virginity prior to marriage, which means, in their culture, that a girl must be at least partially closed with stitches. It is clear from these discussions that neither the men nor the women lack knowledge about FGM/C, instead they lack the skills and opportunities to communicate openly and honestly on these difficult dilemmas.

Almost half (44%) of community members said that FGM/C was not raised at all in public meetings in their community. For this to change, opinion formers like teachers, health workers, law enforcers, community and religious leaders need to be pro-active in ensuring public meetings are taking place and in speaking at them. Currently, community leaders are the most active opinion formers in terms of public speaking, especially in urban communities. Perhaps surprisingly, a higher proportion of community members said they felt able to speak in public meetings (66%) than had actually spoken to anyone about FGM/C in the last year (22%). This might suggest a willingness to engage, although a reluctance to be the person who raises the topic. The experience of facilitating the focus group discussions would support this. Community members were often reticent at first, although were keen to share experiences and to take forward discussion into their communities, once the conversations were established.

5.4 Role of men

There is general agreement that in Somaliland women, mothers and grandmothers in particular, are the principle decision-makers about whether a girl is cut and the type of cut she undergoes. Results from the community survey indicate that these decisions

are made jointly by men and women in only 8% of families, in both urban and rural communities. In the focus group discussions men and women stressed that "the women look after the girls' issues and the men the boys'" with this being cited as evidence that men have little influence over FGM/C.

The role of men in FGM/C is the factor with most polarised views across the different stakeholder groups. These different perspectives are characterised by Pusparaj Mohanty from UN Women, who suggests men are *"failing to take responsibility for their role in FGM" whereas Ahmed Abdi Jamma from UNFPA feels that "the focus of efforts to reduce FGM must be on the grandmothers and mothers, this is where the attitudes need to change".*

Many would say that as men are not directly involved in the decision-making around FGM/C that they are not exerting influence on the process. However, their strong preferences for marriage with and for girls who have been cut is a substantial driving force towards cutting in a society where socioeconomic security for women comes primarily through marriage.

If it is accepted that proof of virginity, protection from rape and fear of one's daughter not being marriageable frame the way in which many women think about FGM/C, then the messages men are sending to the women in their community are likely to influence decision-making processes, even if men themselves are not actively involved in discussions. The move from the pharaonic cut to the intermediate could continue on the basis of reducing the health complications of women, whilst still providing proof of virginity etc. This process does not necessarily require men to become engaged in discussions about the type of cut their daughters are undergoing. However, the change from the intermediate cut (sunna 2 with stitches) to the sunna with no stiches, and further from the sunna to abandonment will require a change in the way marriageability is perceived. Such changes are as much about men's views as those of women, and so will require greater engagement from men in the community.

In focus group discussions in both urban and rural communities, men of all ages were keen to be involved in discussing FGM/C, although they were often unsure as to what action they could take. Young men in Stadium, Maroodi Jeex, who were founding members of a small CSO, were keen to take up the issue of FGM/C among other young men and women. Community men in Mohammed Ali, an urban community in Togdheer, concluded *"we as men should get involved more and we want… to change the thinking in our community"* and community men in Inaafomoode, a rural community in Togdheer said *"This is the first time we have ever discussed these things, the first time we understand what each other thinks. It is very useful and we can see now that we as men have a strong role to play and will discuss this in the future. Men need to be at the forefront of change here – we need to lead it in our community"*.

Men face a dilemma in how they are involved in FGM/C as traditionally decision-making about FGM/C is left to the women. It may be more culturally appropriate for men to change the messages they are sending to women about the importance of stitching as proof of virginity, than for men to become too involved in what traditionally is a women's decision-making process.

5.5 Driving forces and decision-making dilemmas

The debate around why female genital cutting takes place, or continues, is complex and fraught with contradictory drivers and decision-making dilemmas.

The most cited reason (62%) is that the pharaonic cut, as the name implies, is a pre-Islamic, traditional practice, believed to have originated with the Egyptian pharaohs and now deeply embedded in Somaliland culture. This is reflected in the comments of Nafisa Yusuf Mohamed, Executive Director of Nagaad, *"Most women believe in FGM, quite simply that…"* and Kaltun Sheikhassan, Executive Director of WAAPO, *"If you try to find an origin then you can look but you may not find it because it is not there… men, women, everyone just expects it to happen and it happens"*. So there is a deeply embedded cultural driver in favour of female genital cutting which is difficult to oppose through rationale argument. Religion is cited as a factor by 36% of men and 13% of women. In focus group discussions men, in particular, talked about following the guidance of their religious leaders. The religious leaders support primarily the sunna (with no stitches) and almost 80% of the community are aware of this.

Marriage was only cited by 20% of community members as a reason for cutting. However, marriage dominated the focus group discussions, was cited as a reason by all CSOs and NGOs interviewed and featured strongly in the community survey under advantages of being cut and disadvantages of not being cut. Protection from rape and sexual advances were quoted as reasons for cutting in the community survey and in focus group discussions, always with

implications for marriage. When explored in discussions, protection from rape was not about any physical barrier provided by the stitches after cutting, but about girls who have been cut being less sexually aware or responsive. The use of female cutting as a means of reducing the sexuality of women and consequently the danger of rape, is in line with the Landinfo report on FGM in Sudan and Somalia (2008) which states that FGM/C is *"a manner in which men exercise control over women's sexual lives"*.

This control is all the more difficult to challenge as it is conveyed through approval and marriage preferences, rather than explicitly. The following, from a woman in Qoyale, sums up the feelings of many mothers about cutting and marriage, *"It is simply not possible to live in this community without being cut, just not possible. Men need to see stitches to prove that their wife to be has not been with anyone else"*.
Interestingly, few if any, cite health as a reason for cutting, yet it is definitely a key driver for change. There is a high level of awareness of the complications from the cutting. Women, men, girls and to some extent, boys list them and give examples from their families or communities. People are aware of the health risks and costs to their families.

Decision-making dilemmas were also evident among women who knew from personal experience the health risks of cutting, yet also knew of the social exclusion of not being cut; and men who want to leave their wives to decide about cutting their daughters, yet also do not want to stand aside and see their daughters being harmed.

Community members do not appear to lack knowledge about female genital cutting, however they also do not appear to have had opportunities to discuss the decision-making dilemmas and to weigh up the options they face personally.

6. Recommendations for programme design

This section highlights the key findings from the research in relation to the design of the ActionAid project and of interventions aimed at supporting communities to abandon FGM/C more generally.

Seeing FGM/C in Somaliland as a spectrum of cuts with communities moving progressively from the pharaonic, intermediate and sunna towards abandonment

As with any attitudinal change, change is greatest when people are comfortable with the next step and it is seen as manageable. It is recommended that discussions with all stakeholders recognise this spectrum of cuts and that communities are encouraged to move along the spectrum towards abandonment, whilst keeping the ultimate goal of abandonment clearly in sight.

Recognising differences between rural and urban communities and planning accordingly

In urban communities, the change from pharaonic to intermediate cut already has momentum. As well as supporting this trend, programmes may be able to develop a core group of supporters for abandonment of all forms of female genital cutting. Social exclusion of uncut girls and women is likely to be lower where such a core group is vocal. Champions for abandonment could be identified from most stakeholder groups and a critical mass could be established, speeding up the process of attitudinal change. However, in rural communities, the priority might be to support the move from pharaonic to intermediate, and intermediate to sunna, whilst not losing sight of abandonment as the ultimate goal. Attempting to push towards Zero Tolerance might polarise opinions and be counter-productive at this stage in the process of change.

This research suggests that civil society efforts have thus far been focused in urban areas and a lack of effort in the rural areas of Somaliland. Civil society efforts need to be broader and reach "hard-to-reach" groups in order to have a sustainable impact.

Finding areas of agreement

Most religious leaders are further along the spectrum towards abandonment than most of their community members, as most oppose all forms of cutting except the sunna. However, much of the dialogue around FGM/C has focused on the areas of difference between INGOs, NGOs, CSOs and religious leaders which has led to tension between these groups. Considerable progress could be made from building on common ground, whilst still recognising the differences in relation to the sunna cut.

It is recommended that religious leaders are seen as positive agents of change in the direction of abandonment, rather than resistors to change. Conventional thinking suggests that the first step is to persuade senior clerics to support the abandonment of all forms of cutting and then to disseminate this information to communities. Adopting the language of abandonment, of encouraging religious leaders to describe the sunna cut as not required, rather than as honourable is likely to be a more effective strategy than a more confrontational one of expecting religious leaders to denounce all forms of cutting and support Zero Tolerance. This approach does not require religious leaders to deny that there is a hadith or guidance on female cutting, nor does it require them to state that the sunna cut is a form of FGM/C, however, it does require them to state clearly and publicly that the sunna cut is not required under Islam. The differences between these statements are subtle but could be crucial in influencing religious leaders to join the movement towards full abandonment.

The importance of dialogue in developing new understandings

Interventions, such as workshops and public meetings, usually include an element of providing new knowledge to community members and opinion formers. This research suggests that attitudes are more likely to be changed through opportunities for dialogue and exchange than "delivery" of information. For example, it would be more beneficial to facilitate community members discussing the implications and their options for change among themselves, than to lecture groups on the health risks which they are already familiar, even if they are not aware of the precise medical terminology. Theatre, drama, dance and song are more likely to change attitudes if they focus on difficult decisions faced by individuals in relation to female cutting than on teaching factual information.

During the course of this research many community members had their first ever opportunity to speak to each other openly, in a non-coercive and non-judgemental context, about FGM/C, leading people to share their experiences, opinions and dilemmas. This can be built upon to mobilise change.

New knowledge

The research indicates that there are some areas where increasing the level of knowledge could be beneficial. For example, men, on the whole, appear not to be aware of the intermediate cut and so are open to misunderstanding when hearing their daughters will be undergoing the "sunna 2" (intermediate cut). Increasing their knowledge might help them to have more meaningful conversations with their wives about the cutting of their daughters.

Building on changes

Change is happening in Somaliland around FGM/C, however, not necessarily the direct move from cutting to total abandonment. Both the increase in the use of the intermediate cut and the desire for an increase in the involvement of health workers as cutters are in direct response to increased awareness of the health risks related to the pharaonic cut. Eliminating the health risks to women and girls is an important outcome, but challenging the presumption of the sunna cut "doing no harm" and adopting a more rights-based approach will be necessary to create the environment that enables change from the intermediate and sunna cuts to total abandonment.

Zero Tolerance or step by step?

Overall, it would serve civil society in Somaliland well to consider the approach to Zero Tolerance, as it is not without controversy. This research suggests that Somaliland is quite some way from Zero Tolerance. Abandoning all forms of FGM/C must ultimately be the end goal. However, change often happens incrementally, and considering approaches which recognise the steps towards abandonment could be beneficial.

7. Conclusion

Despite the overall prevalence rate for FGM/C in Somaliland remaining stubbornly high at 99.4%, there is strong evidence from this research of a desire for change in relation to FGM/C among all stakeholder groups, including religious leaders, MoRA and senior clerics. Two-thirds of community members and opinion formers would like to see the law on female genital cutting strengthened. Only 18% of community members would like to maintain the existing situation in their community, with 82% in favour of change.

The picture looks less positive when measured against the goal of Zero Tolerance, with less than 10% of community members supporting the introduction of a law based on Zero Tolerance and only around 5% aspiring to an abandonment of all forms of cutting in their community. A key challenge for INGOs, CSOs, agencies and the government is how to keep Zero Tolerance in sight, yet recognise, support and value the steps communities are making.

If a law based on Zero Tolerance were introduced, communities would have to make a substantial change all at once. With such a high prevalence rate, female genital cutting being so deeply embedded into traditional culture and the added complexity of how female genital cutting fits within Islamic law in Somaliland, most stakeholders agree that progress needs to be incremental. The inclusion of the intermediate cut (sunna 2) has encouraged different stakeholder groups to clarify their position and helped define the steps towards abandonment.

This research identifies two ways in which the drive for change among community members is being manifested: first, a change in the type of cut, away from the pharaonic and towards the intermediate and sunna cuts and second, a change in the people who are performing the cutting, away from traditional cutters and towards health professionals.

The research shows that most community members, male and female, have not discussed FGM/C but respond positively when provided with opportunities to share their experience and explore new perspectives. Less than a quarter of community members have talked about FGM//C either publicly or privately in the last year. The decision-making dilemmas which households face in relation to FGM/C are complex with strong drivers and competing agendas, including the drive towards reducing the health risks faced by girls and women and the role of cutting in providing “proof” of virginity and suitability for marriage. The role of men and boys in FGM/C is contested, with women, specifically mothers and grandmothers, being named as those with responsibility for deciding whether, when and how their daughters are cut. However, the socioeconomic security of most women is intrinsically linked to marriage. Consequently, these decisions are influenced by the marriage preferences of men, indicating that men and boys have a significant role to play, albeit indirectly, in decision-making in relation to female genital cutting.

Opinion formers are keen to play a role in changing attitudes and behaviours in their communities. Some, including teachers, have played strong roles in influencing change in countries where there has been significant movement away from FGM/C, but in Somaliland lack the confidence and awareness to engage with community members and provide a forum for dialogue.

The focus group discussions demonstrated how opinions change through open dialogue in safe and supportive settings. The research has highlighted the complex nature of decision-making in relation to FGM/C and the significant dilemmas faced. Although there are some areas where greater knowledge could be beneficial, what community members lack on the whole is a safe and supportive environment in which to discuss these dilemmas, rather than factual information on which to base their decisions.

The evidence strongly suggests the adoption of an holistic approach towards overall abandonment. Opportunities should be provided for community members and leaders to engage in open dialogue in supportive environments, where the existing desire for change is recognised and they are facilitated in finding solutions to the challenging decision-making dilemmas they face in relation to FGM/C.

Abbreviation	Name
AAIS	ActionAid International Somaliland
CCBRS	Comprehensive Community Based Rehabilitation in Somaliland
CSO	Civil Society Organisation
EAUH	Edna Adan University Hospital
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation / Cutting
INGO	International Non-Governmental Organisation
MCH	Mother and Child Health
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
MoI	Ministry of Interior
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MoP	Ministry of Planning
MoRA	Ministry of Religious Affairs
MoY	Ministry of Youth
NAFIS	Network Against FGM/C in Somaliland
NGO	Non-Governmental Organisation
SFHA	Somaliland Family Health Association
SOWDA	Somaliland Women Development Association
SRHS	Sexual and Reproductive Health Services
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
VAWG	Violence Against Women and Girls
WAAPO	Women Action for Advocacy & Progress Organization
WHO	World Health Organisation

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January - May 2016