

# SITUATIONAL ANALYSIS OF FGM/C STAKEHOLDERS AND INTERVENTIONS IN SOMALIA

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## Acknowledgements

The consultants would like to thank all of the contributors to the Situational Analysis on Female Genital Mutilation (FGM/C).

### Research Team

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### Organisations

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### UNFPA-UNICEF Joint Programme on FGM/C

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### Participants

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## Executive summary

The global movement to end FGM/C has gained strength rapidly over the last three years. Until recently, FGM/C was considered to be a taboo issue in Somalia. It was often avoided, even in health programmes concerned with maternal and neonatal, and sexual and reproductive, health and well-being. With estimates of FGM/C prevalence of up to 98% amongst women in all zones of Somalia, FGM/C was so much a part of normal life, so much a part of cultural practice and such a deeply embedded social norm, that it was possible to work for women's health and well-being without challenging FGM/C or specifically addressing the trauma it causes. FGM/C is a social issue, but it has often been ignored. For example, in Somalia, whilst issues such as fistula were addressed, the major underlying cause – FGM/C – remains a gap.

The overall aim of the Situational Analysis is for government, donors and the UN to gain a greater understanding of existing interventions towards ending FGM/C, and to identify gaps so as to be able to strengthen the current interventions and inform future programming. There are two parts to the report: **Part 1, “The Silence is Broken”**, is the overall report, which amalgamates key findings from a Participatory Community Perspectives Study (CPS) into analysis of the institutional policy and practice environments at the zonal level. **Part 2, The CPS**, is a report on views and opinions about FGM/C – both of the people who are the focus of end-FGM/C activities in the zones, and of those people who work to carry out those activities

The framework for the enquiry was simple and girl and women-centred, and involved enquiry on a number of topics: a) what FGM/C means in Somalia, and how it is changing; b) what people see as the advantages and disadvantages of FGM/C; c) what is happening and what needs to happen for FGM/C to end; and d) what are the existing structures, mechanisms, systems and interventions aimed at ending FGM/C. From these, further analysis led to identification of key issues and recommendations for future work. In total, 93 people were consulted at institutional levels (local through to central) and 215 people (old and young, female and male) in different interest groups in the communities. Consultations took place in Somaliland (Hargeisa and Borema), Puntland (Garowe and Bossaso) and South Central (Mogadishu).

### Findings

**The Enabling Environment:** There is **no overarching law or policy across the three zones on ending all forms of FGM/C**. However, the zones are united in commitment to ending FGM/C in the shortest time possible; A policy has been approved in Puntland and policies have been drafted for both Somaliland and the Federal Government. **The government position is zero tolerance:** banning of all forms of FGM/C. In each of zones, there are three key ministries primarily concerned with end-FGM/C activities: 1) The ministry concerned with women: the Ministry of Labour and Social Affairs (MOLSA) in Somaliland, the Ministry of Women's Development and Family Affairs (MOWDAFA) in Puntland, and the Ministry of Women and Human Rights Development in South Central (MOWHRD). These are the **lead ministries**; 2) The Ministry for Religious Affairs and Endowment (all zones); and 3) The Ministry of Health (MOH) (all zones). There are **FGM/C Task Forces in the three zones**, government-owned and established with UNFPA-UNICEF Joint Programme on ending FGM/C (UNJP) support. In Somaliland and South Central, the Task Forces are now a part of a broader Gender-Based Violence (GBV) Working Group. In all zones, there have been considerable achievements, including prohibition of FGM/C in the draft Somalia Constitution (2012), a total abandonment policy has been passed and a draft bill is being developed in

Puntland, and a draft total abandonment policy has been developed in Somaliland and by the Federal Government. The government authorities **note key major challenges** in their end FGM/C work. These include: **Lack of long-term funding, lack of solid evidence-base; inability to reach isolated, rural areas and areas in conflict; lack of regulatory powers, lack of consensus amongst religious scholars and lack of a solid evidence-base on which to base policy and programming.**

In recent years, the major intervention has been the **UNFPA-UNICEF Joint Programme on FGM/C (UNJP)**. This programme aims to: strengthen the enabling environments; develop and employ communications strategies to reach a wide audience with end-FGM/C information; and give direct support to a number of CSO partner organisations. The UNJP has generated real commitment towards ending FGM/C and has brought together a range of actors at all levels. But it faces challenges: funding is insecure and short-term (has been in one-year tranches to partners); choice of partners has been limited to “known” organisations, M&E has been weak and un-standardised, with little impact information and understanding generated, and coordination with Somalia desks in Nairobi is not always easy – because of distance. A wide range of different approaches are employed by UNJP partner organisations. These approaches range from the full community-development approaches taken by TASS, Relief Development Initiative, PUNCHAID in Puntland, through to small-scale end-FGM/C “add-ons” (such as training session or community conversation on Harmful Traditional practices) used by organisations whose main focus is elsewhere. Somaliland also have strong partners working on the same, for example IRADA and the Youth Peer Network

From the experiences of government, the UNJP and civil society organisations in Somalia and elsewhere we have gained understanding on **what works to end FGM/C**. FGM/C is about power and politics: it is about the way that people construct individual and social identities, about what it means to be a girl or a woman, and what is expected of girls, women, boys and men in society. To end FGM/C entirely requires not just the end of a single, social norm, but much wider, more fundamental, social change. A holistic approach is needed to: build the enabling environment and promote take-up of obligations; catalyse engagement and develop communications systems, advocacy and lobbying to “crowd-in” actors, and to model focused action for change. Systematic monitoring and evaluation in different contexts is needed to learn exactly what works, where, when, why and how, and to identify possibilities of, and needs for, successful scale-up, replication and adaptation of successful models.

To be able to do this successfully in Somalia, key issues need to be addressed.

**Limited reliable evidence-base:** Current statistics indicate a high prevalence of FGM/C in Somalia, at around 97.9% for women 15–49 years old (Population Reference Bureau, 2014). However, FGM/C is thought to be decreasing in urban areas, and Type III may be decreasing, even if rates remain high. There are not yet adequate baselines on which to base an understanding of change (or lack thereof) in prevalence and incidence.

**In Somalia there are different understandings of what “FGM/C” is:** The term FGM/C is interpreted in Somalia to refer to only one type of FGM/C, which is Pharaonic FGM/C (Type III, with removal of the clitoris, inner and outer labia, and infibulation). However, in all regions in Somalia, the term *Sunnah* circumcision, can refer to Type I, Type II or Type III FGM/C. “*Sunnah*” is used in the communities to refer to any type of circumcision which people believe is required/sanctioned by Islam. This wide interpretation differs from the use of the term *Sunnah* circumcision by other Muslim populations (and by the UN and WHO) who use it to refer only to Type I FGM/C. In the communities, two variations of Type III FGM/C were reported: a form of infibulation, which involves less stitching and which is known locally as

*Sunnah Kabiir* (greater Sunnah) and, Fadumo Hagoog, a form of Type III FGM/C, which involves excision but no stitching. There are also reports of a form of Type III in which there is infibulation, but no cutting. Women's and girls' self-reporting of the type of FGM/C they have undergone is often not accurate. The expanded information gained in the CPS, on the way FGM/C is changing, is new and of importance also in other countries.

**Multiple interpretations of “zero tolerance”:** The misinterpretation of FGM/C by local populations poses a problem. The issue appears to have arisen because numbers of NGOs, since the 1990s, have encouraged people to give up Pharaonic FGM/C, but some have said (and continue to say, in contravention of government policy) that Sunnah types can continue. This allows communities to claim they have “given up FGM/C” when, in fact, they have not.

**Limited understanding on how and why change happens:** There is very little research about, or understanding of, how knowledge and change are internalised in relation to FGM/C. The prevailing view is that social norm change has to be ‘triggered’ and that a ‘tipping point’ has to be reached in order for the norm to be dropped (changed). To date, work in Somalia has acknowledged the need to change public opinion on FGM/C, but there is little background research or evidence to help us understand exactly what makes change happen, in any given context.

**The role of men and boys:** More research is needed to gain a clearer understanding of the roles that men and boys can play in ending FGM/C, and what needs to be done to ensure their greater involvement. More space needs to be given to understanding the feelings of young men: they are forced to cause extreme pain to their wives, and to create/penetrate an open wound. These are hardly circumstances which can lead to ongoing and deep, respectful communication between men and women. Initiatives have been supported on male engagement in South Central, Somaliland and Puntland on their leading role in mobilising men and other opinion leaders against the practice. These needs to be made more systemic, and strengthened.

**Sexual practice and sexual pleasure:** In the context of FGM/C, this has not been addressed systematically. Within Islam, women as well as men have the right to enjoy sexual relationships within their marriage. Sex is a rights issue and we need to understand better the effects and impacts that FGM/C has, not only on physical relationships between people, but also on emotional ones. In Somalia, there is a good deal of anecdotal evidence that FGM/C causes sexual problems.

**Support for girls and young women who have undergone FGM/C:** There is little in-depth understanding of the contexts in which FGM/C is no longer carried out. We need to know more on the changes that occur when FGM/C stops. What has to be in place so that girls and their families can most benefit from the end of FGM/C? How can you girls deal with the trauma of FGM/C?

**Medicalisation:** Has both been used as a conscious strategy to reduce the harm caused by FGM/C and has been a recourse of the economically better off/better educated in the belief that medical FGM/C is less damaging. The development of an anti-medicalisation strategy in Puntland, and now in Somaliland, is positive. Nevertheless, medicalisation is reported to be increasing in all zones. Health staff in all zones claimed that: a) they do everything they can to dissuade women from re-infibulation after birthing, b) they repair and reconstruct as much as possible, and c) they do not carry out FGM/C themselves. This is not the understanding gained from communities during the Situational Analysis. As yet, there is no money for implementation of any anti-medicalisation strategies.

**Monitoring and Evaluation:** Community-based organisations have yet not been linked to a user-friendly testing, modelling and evaluation approach. We are not able to say with certainty what approaches work best, in which contexts, and why. We do not know the relative merits of different community-level approaches, and we do not know what combination of

components is best. There is need for more action-research, simple, user-friendly M&E systems and stronger M&E and greater M&E capacities amongst civil society organisations

### **Recommendations**

There are **recommendations for action** to strengthen work in four, main areas: **research, promoting zero tolerance, anti-medicalisation, and strengthening the work of the UNJP**. Recommendations are based on opportunities to gain synergies from the global movement to end FGM/C (The Girl Generation) and other components of the DFID-Funded African led movement Towards Ending FGM/C in Africa and Beyond programme.

**Support the development of National Plans of Action and full adoption of zero tolerance:** All stakeholders need to work together to develop coherent and mutually supporting, national plans of action, inclusive of the most vulnerable girls and women.

**Encourage full understanding of zero tolerance; support embedding of zero tolerance throughout policy:** Zero tolerance is government policy through the lead ministries in each of the zones, and in the health ministries. However, it is not well-understood, regulated or communicated. Government needs support in this to ensure a consistent message on zero tolerance.

**Encourage development of regulatory structures, mechanisms and systems, within government,** to ensure adherence to zero policy.

**Strengthen the implementation of policy and encourage the end of medicalisation of FGM/C:** supporting government in development and operationalisation of policy and embedding anti-medicalisation in all medical and para-medical training. Embedding end-FGM/C in all health sector planning and practice.

**Support the clarification of all roles and responsibilities amongst all actors who need to be involved in ending FGM/C in Somalia:** Internationally, nationally and throughout—and across—the zones, at all levels, there is need for increased clarity regarding roles and responsibilities better communication and greater coordination. This is both in terms of development of structures, mechanisms and systems, and in the promotion of improved communication between people (men, women, girl, and boys).

**Be pro-active in shaping the research agenda: ensure that research carried out under the FGM/C shows good fit to national and zonal identified needs:** Amongst other areas, research into the following will be highly valuable: Understanding more the where, when, what, how etc. of FGM/C in Somalia (within and across zonal boundaries, and across country borders); Internalising knowledge: what makes people turn away from FGM/C and to give up FGM/C forever?; What happens, in families and in communities, when people give up FGM/C?; How can support for “survivors” best be offered?; How can the attitudes of men and boys change so as to support ending FGM/C?; and Sexual practices and sexual pleasure. Develop monitoring, evaluation and learning approaches. The HMIS needs to be strengthened, and include FGM/C indicators and systems for sharing information across zones, and country borders, need to be developed and institutionalised.

**Support Somalia in becoming a model UNJP country:** The UNJP needs to develop a stronger and bolder, strategic portfolio of community led and owned-based work, inter-locked with enabling level interventions. This means : Continuing to support a holistic approach, with full attention to building synergies between enabling, catalysing and focused action; Expanding the range of community-level partners and providing mentoring where needed; Ensuring all partners are united under a government-approved Theory of Change and strategic approach; With partners, developing simple, user-friendly monitoring and evaluation systems (qualitative and quantitative) and strengthening the capacity of partners to use these effectively; Building protocols and processes to ensure that community-level learning is fed through the levels to inform higher level planning; Continuing to support critical pathways to ending FGM/C (e.g. anti-medicalisation , work through religious organisations, strengthening



youth engagement at all levels and greater involvement of midwifery schools and associations); Exploring and modelling a range of inter-dependent approaches: supporting and advising government on how this can be achieved; Supporting the establishment and work of FGM/C focal points at all levels; and Ensuring that innovative research and learning, generated in Somalia, is used to inform UN programming in other countries.

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## List of abbreviations

AIDS	Auto-immune Deficiency Syndrome
ANPPCAN	African Network for Protection and Perfection of Children Against Neglect
CCBRs	Comprehensive Community-Based Rehabilitation in Somaliland
CEFM	Child, Early and Forced Marriage
CHWs	Community Health Workers
CPS	Community Perspectives Study
CSO	Civil society organisation
DFID	Department for International Development (UK)
EPI	Expanded Program on Immunization
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
FGS	Federal Government of Somalia
GBV	Gender-Based Violence
HIV	Human Immuno-deficiency Virus
HMIS	Health Management Information System
HPA	Health Poverty Action (NGO)
HTPs	Harmful Traditional Practices
IDPs	Internally Displaced Persons
MIS	Management Information System
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MORA	Ministry of Religious Affairs
NGO	Non-Governmental Organisation
PIGDs	Participatory Interest Group Discussions
RDI	Relief Development Initiative
SPL	Somali Peace Line
TASS	Tadamun Social Society

TBA	Traditional Birth Attendant
ToR	Terms of Reference
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	United Nations Joint Programme on FGM/C: Accelerating Change
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
YWCA	Young Women's Christian Association

## **PART 1 – “The Silence is Broken” - A Situational Analysis of FGM/C Stakeholders and Interventions in Somalia**

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Now, as the Minister for Women's Development and Family Affairs in Puntland has said: "The silence is broken"<sup>3</sup>. It is now not only strong women's organisations—which have long worked for the empowerment of women in Somalia—which are openly talking about FGM/C, but also highly committed government officials, religious organisations, numerous different types of CSOs, and men, women, girls and boys in their own communities.

Much of the opening of the agenda can be attributed to the United Nations Joint Programme (UNJP), which has globally supported national governments and NGOs, and ignited donor commitment to working to end FGM/C. It is also the increased stability and security within much of Somalia, which has opened up possibilities for greater focus on the fundamental rights of girls and women. As one UNICEF staff member said about the previous lack of development work to end FGM/C: "You cannot talk about FGM/C when people are hungry"<sup>4</sup>.

## **1.2 Aim and objectives**

### **1.2.1 Aim**

The overall aim of the Situational Analysis is to allow the Department for International Development (DFID) and the UNJP to gain a greater understanding of existing interventions towards ending FGM/C, and to identify gaps so as to be able to strengthen the current interventions and inform future programming.

### **1.2.2 Objectives**

The following objectives were identified in the Terms of Reference (ToR's):

- Enable government to prioritise specific elements for FGM/C prevention;
- Guide government policy and strategies to tackle FGM/C at the zonal level;
- Identify existing major FGM/C interventions and implementing partners;
- Examine the effectiveness of collaboration between key partners in FGM/C in order to strengthen coordination;
- Identify lessons learnt and best practices to be incorporated into the next phase of implementation;
- Identify challenges faced in the previous phase of implementation, with a view of addressing in the next phase; and
- Identify further areas for research.

## **1.3 Contents of the report**

### **1.3.1 Two stand-alone documents**

There are two parts to the report.

**Part 1**, "The Silence is Broken", is the overall report, which amalgamates key findings from a CPS into analysis of the institutional policy and practice environments at the zonal level

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<sup>3</sup> Fieldwork for the Situational Analysis, consultations

<sup>4</sup> Fieldwork for the Situational Analysis, consultations



Section 2 of the overall report sets out the approach and method used in the Situational Analysis. Section 3 identifies the institutional set-up which supports end-FGM/C interventions. In Section 4, we outline key current interventions and assess their achievements and challenges. Section 5 sets out the key issues and emerging challenges which require immediate attention if end-FGM/C activities are to achieve sustainable success. Section 6 outlines key recommendations to DFID to inform future programming. Annexes are appended at the end of Part 2.

**Part 2**, The CPS, is a report of the study which was undertaken to gain greater understanding of the views and opinions—both of the people who are the focus of end-FGM/C activities in the zones, and of those people who work to carry out those activities.

Each of the two parts of this report has been written as a stand-alone document. Those readers who require only an overall picture of FGM/C in Somalia, with inclusion of key aspects of the CPS data, will find this information in Part 1. Readers who require more on the community perspective are directed to Part 2.

## 2 Approach and method

### 2.1 Approach

The principal **focus** of the Situational Analysis of FGM/C interventions and stakeholders in Somalia was on gaining a greater understanding of the existing enabling environments, in the three zones, which are designed to support work towards ending FGM/C. This entailed identification of achievements to date, analysis of challenges and identification of emerging opportunities, at both policy and practice levels, in all three zones.

The **scope of work** given in the ToR was to:

- Analyse the enabling environment to allow a greater understanding of who is facilitating policy dialogue and what are the barriers to further policy engagement;
- Identify the major efforts, both in policy and community engagement, to promote abandonment of FGM/C which have been implemented in all three zones of Somalia since 2007; identify the number of communities declaring abandonment; and include an analysis of the role of men in these major abandonment efforts;
- Review selected anti-FGM/C activities in one district in Somaliland, in Gedo district of South Central Somalia and in one district of Puntland, and document what worked well, what did not work well and what needs to be strengthened;
- Identify key knowledge gaps that may require research to improve understanding of the practice and/or activities to promote its abandonment and management; and
- Analyse existing coordination mechanisms and recommend how to best strengthen coordination roles, implementation structures and procedures across the three zones, to allow for more effective delivery of anti-FGM/C programmes.

The approach taken to fulfilling this scope of work was based on our **understanding of FGM/C** (see Annex B, The Approach Paper) and a set of **guiding principles**:

- 1) Because FGM/C is a rights issue and is highly sensitive, the importance of maintaining an ethical and respectful approach, during all enquiry, is crucial;
- 2) Do no harm. We paid particular attention to this in communities, and particularly in consultation with young people;
- 3) We used a participatory approach throughout; we used tools and methods which encouraged people to share, but ensured they were aware of their freedom not to disclose any information that they did not wish to share;
- 4) Ownership: all information and understanding gained belongs to the people who shared it – and they need to be fully aware of how it will be used; and
- 5) We provided opportunities for consultants and research assistants to reflect and gain support if they were affected by any of the issues which arose during consultations/ community enquiry etc.

Working with these principles, we divided the study into two distinct parts:

- A study of the institutional set-up towards ending FGM/C, including interventions carried out by governments, international and national organisations; and

- A “quick and dirty snap-shot<sup>5</sup>” CPS, to gather and assess the views and opinions regarding FGM/C of people living and working in the three zones.

The purpose of the CPS was to complement the institutional consultations, by giving the perspectives of the people who are the focus of anti-FGM/C activities in Somalia.

## 2.2 Method

### 2.2.1 The study team

The study team comprised:

- an international team leader;
  - a national consultant; and
  - four local research assistants per each zone (Somaliland, Puntland and South Central Somalia).
- 1) The **international consultant** took overall responsibility for design of the Situational Analysis, She was largely responsible for the literature review and design of the CPS, initial training on participatory methods, design of the reporting structure and of the final documents;
  - 2) The **national consultant** continued the participatory training for the study team in the second and third zone and supervised the research assistants in conducting the Participatory Interest Group Discussions (PIGDs). The international and national consultants worked together on the design of the CPS questions, synthesis and analysis of findings, and on providing recommendations. The national consultant also carried out all the institutional consultations in the South Central Somalia zone (to which the international consultant did not travel); and
  - 3) The community research was facilitated by Benadir University in all of the three zones in Somalia, in partnership with Amoud University in Somaliland and East Africa University in Puntland. The partner universities and Benadir University provided a team of four local research assistants, in each zone, to carry out the field work. The research teams consisted of two females and two males who were responsible for conducting consultations with single sex groups. In each zone, local NGO's that had implemented anti-FGM/C activities assisted the research team in engaging local communities and scheduling consultations with community members as well as local stakeholders. Consultations were organised by the ANPPCAN and CCBRS, TASS in Puntland and SPL in South Central Somalia.

### 2.2.2 Framework for analysis

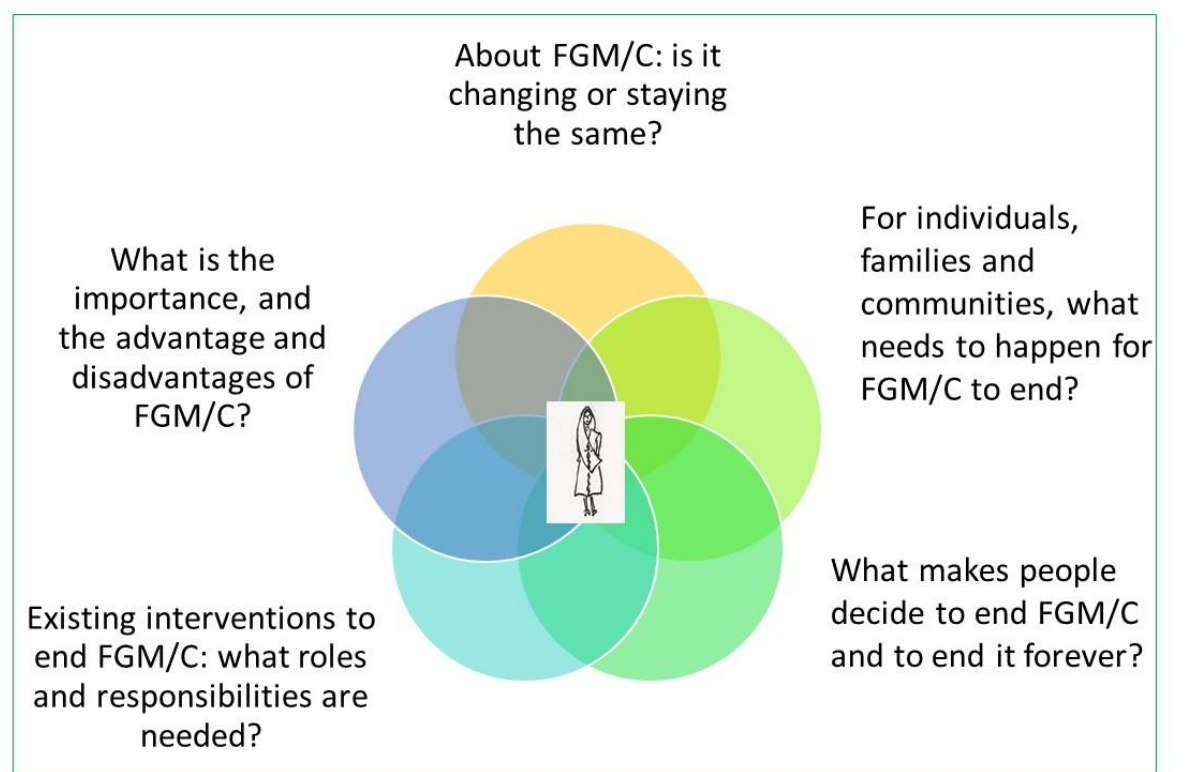
The framework for consultations and analysis was designed to be simple and easy to use. Two basic checklists of questions were developed: one which covered the institutional environment, and one which was appropriate to the CPS. However there was considerable

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<sup>5</sup> The implications of this are that, whilst rigorous in its methods and use of the guiding principles, participants in the CPS were not statistically sampled, the consultation process was not fully piloted etc. However, the teams carrying out the study were trained; enquiry and reporting methods were standardised etc.

overlap between the two sets of questions, both of which firmly placed girls at the centre. The CPS framework for consultations is represented diagrammatically in Figure 2, below:

**Figure 2 The community perspectives question framework**



The five topic areas also formed the basis for organisation and analysis of the data. The CPS report follows this format.

The institutional checklist also covered the five topic areas in Figure 2, with the addition of questions to encourage institutions and organisations to assess their own strengths, achievements and challenges. In all institutional consultations participants were asked to identify their five, key priorities for greater success in end-FGM/C work.

### 2.2.3 Process

About a week was spent in each of the zones. All consultations, whether for the CPS or with government, NGOs or other organisations, were participatory. Whenever appropriate, in group consultations, the research team used two active participatory tools: “Bricks and Termites” and “Spokes” (see Annexe 3 for the fieldwork guide).

**A total of 93 people were consulted in group and in-depth interviews with organisations and individuals involved in end-FGM/C efforts.** In the group consultations held with community activists, NGO staff, or committee members, men and women—of various ages—sat together, or there were various age groups. The interest groups consulted were: government officials, health workers, NGO staff, local activists and child protection working group members, FGM/C taskforce members and gender-based violence working group members.

**For the CPS, researchers consulted a total of 215 people in PIGDs<sup>6</sup>.** The PIGDs had an average of six to eight participants but in some instances groups there were more participants. The PIGDs were usually single sex groups, of people of similar ages. The only exception to this was a PIGD composed of a mix of younger and older men, which was held in an internally displaced persons (IDPs) camp in Garowe, Puntland. The different types of interest groups consulted in PIGDs were: men, women, young men and young women. Only one PIGD—in Borema, Somaliland—included young children, who were accompanied by their mothers. In-depth discussions were also held with a number of people from these groups. One in-depth interview was held with two young girls in Borema<sup>7</sup>.

The fieldwork was conducted in two phases: firstly, during Ramadhan 2014, in Somaliland and Puntland, and secondly, after the end of Ramadhan ‘Eid break, in South Central Somalia. The consultants then worked individually and together, in Nairobi, to analyse findings and make a presentation to DFID and other relevant stakeholders. The report integrates comments from the participants.

## **2.3 Background to the study areas**

This sub-section gives a brief outline of the context of each of the study areas in Somaliland, Puntland and South Central Somalia.

### **2.3.1 Somaliland**

Somaliland is an autonomous territory in Somalia. The government of Somaliland seeks international recognition as a sovereign state and is not governed by the Federal Government of Somalia (FGS). The estimated population of Somaliland is 1.8 million. With the exception of low-intensity conflicts with neighbouring Puntland, over a border dispute in the Sanaag region, the Somaliland territory is relatively peaceful and stable.

During the Situational Analysis, consultations were carried out in homes, community centres and offices in Hargeisa and in Borama. The city of Hargeisa is the capital of Hargeisa District and Somaliland and has a population of 1.2 million. The estimated population of Borama is 39,100.

### **2.3.2 Puntland**

Puntland is a semi-autonomous state in the Federal Republic of Somalia that falls under the administration of the FGS. According to the government of Puntland, the population of the state is estimated to be 3.9 million. United Nations Development Programme (UNDP) population figures estimate the population at 2 million (UN Office for the Coordination of Humanitarian Affairs (UNOCHA), 2012). The stability and security of Puntland has increased significantly since the formation of the state in 1998. The principal security challenges include a border dispute with Somaliland in the Sanaag region and ongoing security threats in some districts from the terrorist organisation Al-Shabaab. The majority of the population is pastoral or agro-pastoral, with 52% of the population having nomadic livelihoods.

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<sup>6</sup> See Annex A for a breakdown of groups.

<sup>7</sup> For reasons of research ethics, consultations with children were only carried out by the Team Leader and National Consultants.

The consultation sites in Puntland were in Garowe and in Bosaso. Garowe is the capital of Garowe District and Puntland and has a population of approximately 57,300. Bosaso is the capital of Bosaso District in the Bari region. It is the most populous city in Puntland, with a population of 700,000.

### **2.3.3 South Central Somalia**

The South Central regions in Somalia are under the jurisdiction of the FGS but not all regions are fully government-controlled. The government, as at August 2014, had control of only five of the 11 regions. Other regions in South Central shift in and out of the control of the Islamist terrorist group, Al-Shabaab. The presence of the terrorist group also extends into government-controlled regions. In these regions, Al-Shabaab frequently orchestrates terror attacks, tyrannises local populations and assassinates prominent figures. Al-Shabaab also engages in high-intensity and low-level conflicts with government and African Union forces. The ongoing conflict has contributed to a high number of IDPs. The majority of the 1.1 million IDPs in Somalia reside in South Central Somalia and there are nearly 369,000 IDPs in Mogadishu (UN High Commissioner for Refugees (UNHCR), 2014). Recurring droughts, chronic food insecurity and famines are also drivers of displacement and instability in the region. Mogadishu is the capital of Somalia and of the Benadir region. The city has a population of approximately 1 million.

### 3 The enabling environment in Somalia

In this section we examine the environments in the three zones, in which end-FGM/C action is taking place. We outline the strengths and challenges faced by the key ministries, and we look at the major ways in which CSOs are engaging. In Section 4, we give examples of the work of key actors (UN and civil society) working to end FGM/C

#### 3.1 Overall law and policy and commitment

To date, there is no overarching law or policy across the three zones on ending all forms of FGM/C. However, the commitments made, by representatives of all the zones, at the Girl Summit on FGM/C and Child, Early and Forced Marriage (CEFM) in London, July 2014, unite the zones in a commitment to ending FGM/C in the shortest time possible.

Across the three zones, **the government position is zero tolerance**: the banning of all forms of FGM/C. The new, draft Constitution of the Somali Federal Republic states that: “Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.”<sup>8</sup> (Article 15, [4] Liberty and Security of the Person).

In Somaliland, the government has drafted a decree against all forms of FGM/C and has drafted a policy. The decree has yet to be adopted because of resistance from some sheikhs who wish to see the Sunnah form(s) of FGM/C remain legal. The policy has not yet been endorsed by the President and is encountering some resistance.

In Puntland, zero tolerance is the stated policy of all concerned ministries. The Ministry of Religious Affairs and Endowment in partnership with MOWDAFA has issued a *fatwa* against all forms of FGM/C. A total abandonment FGM/C policy has been endorsed by the President and a Bill is being updated.

#### 3.2 Overview of the government environment in the three zones

In each of zones, there are key ministries concerned with end-FGM/C activities:

- 1) The ministry concerned with women: the Ministry of Labour and Social Affairs (MOLSA) in Somaliland, the Ministry of Women’s Development and Family Affairs (MOWDAFA) in Puntland, and the Ministry of Women and Human Rights Development in South Central (MOWHRD). These are the **lead ministries**;
- 2) The Ministry for Religious Affairs and Endowment (all zones); and
- 3) The Ministry of Health (MOH) (all zones).
- 4) In partnership with the Ministry of Youth as well

The following tables give a “snap-shot” overview of the ways in which the key ministries in each of the zones are contributing towards ending FGM/C in Somalia. The tables outline the main **standpoints** taken by each of the ministries; the **approaches** they are using, or would

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<sup>8</sup> FGS, Mogadishu, 12 June 2012, Draft Constitution Technical Review Committee



like to use, in developing their policy and practice; their key **achievements** to date, and the **challenges** to working successfully to end FGM/C – as identified by the ministries themselves.

**Table 1: Somaliland: key government ministries**

Government draft decree against FGM/C	Standpoint	Policies/ strategies/approaches	Achievements	Challenges noted by ministry
<b>MOLSA</b>	Lead Ministry; strong support from Vice-Minister Shukri Harir Ismail “FGM/C is a social issue, not a health issue” Requests 50% of any donor funding to the three zones Zero tolerance Ready to work with the other ministries Wants to be able to regulate and oversee all work to end FGM/C	Supports the draft decree on FGM/C Takes a holistic approach: community-based, involving all sectors of community Involvement of women's organisations To increase outreach to isolated communities	Has set FGM/C high on political agenda Leads the Hargeisa Gender-Based Violence (GBV) Working Group and co-chairs with UNFPA the FGM Task Force, which covers FGM/C Supports wide communications strategy Active in drafting decree Has brought all relevant ministries and NGOs on board GBV working group is operating	No overall regulatory power in practice: donors may support NGOs which do not follow zero tolerance Lack of long-term donor funding (UNJP very short tranches) Difficulty of reaching rural populations Need more involvement from women's groups Donor funds to civil society should be coordinated through the ministry Need for oversight of all approaches and messages: standardisation needed
<b>Ministry of Religious Affairs (MORA)</b>	Minister Sheikh Khalil supports zero tolerance, but many of the sheikhs do not	The Minister is supportive of work towards a religious <i>fatwa</i> against FGM/C Wants to reach out to all sheikhs across Somaliland: awareness and education	Over his four-year tenure to date, the Minister has ensured MORA involvement in end-FGM/C UNICEF and UNFPA support in 2011 and 2013 to bring religious leaders together First Minister of MORA to know English: the Ministry is able to participate more widely	Backlash and lack of understanding amongst sheikhs in rural areas Lack of agreement within the ministry Low capacities within the ministry No transport to reach rural areas No funds
<b>MOH</b>	Director General of Health Osman Hussein is very supportive of zero tolerance, but acknowledges that some medical staff lack awareness and knowledge	Wants more integration and involvement with the other ministries Supports anti-medicalisation strategy Wants to embed end-FGM/C in midwifery strategy	Working with UNICEF and UNFPA (and MOLSA) on anti-medicalisation strategy. Working with the Somali Midwives and Nurses Association This is the first direct work on FGM/C by the MOH	Medicalisation is a real problem No funds to implement anti-medicalisation interventions properly Medical staff lack awareness on FGM/C – think it is “normal” Integrate better into end-FGM/C work Embed end-FGM/C in training for new Medical Institute Need to build health management information system (HMIS) on FGM/C and GBV

**Table 2: Puntland: key government ministries**

2011 Law banning the most extreme forms of FGM/C	Standpoint	Policies/ strategies/approaches	Achievements	Challenges noted by ministry
<b>Ministry of Women Development and Family Affairs</b>	Lead ministry Minister Anisa Hajimumin, and whole government, committed to zero tolerance President signed for eradication of FGM/C policy	Alternative livelihoods for cutters; training cutters to become advocates Communications and advocacy, including TV and radio Campaign through parliamentarians and female religious scholars Role models of un-cut girls Involvement of community Holistic inter-sectoral approach	Established a female cutters community networks as champions against FGM Works with Ministry of Justice and Ministry of Constitutions and Federal Affairs: providing funding for development of an act, Strong FGM/C taskforce is in place and functioning very well	Not enough reliable data for programming No long-term funding Lack of awareness of laws and understanding of consequences Need for more awareness and support from cabinet and parliament Difficulties of reaching the isolated, rural populations
<b>Ministry of Religious Affairs and Endowment</b>	Strongly supports zero tolerance FGM/C is against the teachings of Islam and cannot be supported in any of its forms It is a religious obligation to end FGM/C	Approach is to build awareness and capacities amongst all religious scholars so that they can work within their communities Production of religion-based communications materials	2013 <i>fatwa</i> banning all forms of FGM/C and saying it has no basis in Islam Production of communications materials on why FGM/C is contrary to Islamic teachings Work on law implementation Mobilisation of Quranic school teachers Involves women scholars in training	No funding for 2014: funding from UNJP was only for two to three months No funds for transport to reach isolated populations Need to expand the Task Force to include a greater range of people Funding needs to be in five-year cycles Set penalties, train law enforcement and ministry staff
<b>MOH</b>	Strong support for zero tolerance Lead on health aspects of FGM/C	Anti-medicalisation strategy at final draft stage Want to mainstream FGM/C issues in all training; “Practical” policy is to de-infibulate if women ask No set policy against re-infibulation but say they try to persuade women not to opt for re-infibulation (in guidelines)	Working as team on anti-medicalisation strategy Law requiring medical practitioner registration will assist anti-medicalisation FGM/C focal point in Ministry and through level UNICEF sending technical assistance from Nairobi on anti-medicalisation Communications campaigns: work with all community groups and house-to-house (in town) in the cutting season 82 MCH clinics in Puntland and there is at least one member of staff trained on FGM/C issues in each	No funding for implementation of the strategy Ministry believes about 80% of those carrying out FGM/C are TBAs Medicalisation is growing FGM/C needs to be in all training guidelines and staff curricula Staff need awareness to deal with FGM/C There are rural areas without health posts: therefore outside the system Many girls refuse de-infibulation before marriage Need to integrate FGM/C into existing and future health programmes

**Table 3: South Central: key government ministries**

The drafted new Constitution of Somalia bans all forms of FGM/C	Standpoint	Policies/strategies/approaches	Achievements	Challenges noted by ministry
<b>Ministry of Women and Human Rights Development</b>	Lead Ministry Supports zero tolerance Active in development of the new Constitution Believe Ministries of Education Justice, Religious Affairs should all work together to end FGM/C	Provision of alternative livelihood strategies for cutters Education and awareness raising Child Protection and GBV working groups: in which FGM/C is integrated Sexual Offences Bill is being drafted with the support of UNFPA and UNDP. See education of girls as crucial to ending FGM/C	Draft Constitution FGM/C is addressed under GBV initiatives (but there are no stand-alone FGM/C interventions) GBV Strategy and its operation is in place and has strong components of ending FGM/C practice across the country. Draft Action Plan on Sexual Violence in conflict is available in Mogadishu (but does not include FGM/C) GBV and Child Protection working groups are in place and functioning well	Needs: Better/new law on child protection Support for law enforcement to end FGM/C Investment in capacity-building for staff, human resources and technical training for staff (technical advisers, training for ministry) Support for implementation of action plan and work plan of Ministry Training for community and NGOs Equipment, facilities and institutional capacity-building
<b>Ministry of Religious Affairs and Endowment</b>	Minister Ridwan Hersi Mohammed strongly supports zero tolerance	Support all government initiatives on ending FGM/C Work to bring religious leaders together from all across the three zones Work with 'Ulama	Nov. 2014: sponsored three-day conference in Mogadishu to protect girls from FGM/C Good relations with religious groups across Somalia and feel able to coordinate across the three zones (current Minister is from Somaliland) Ready to work for a <i>fatwa</i> against all forms of FGM/C Organisation of Religious Scholars issued a well-received <i>fatwa</i> against Al-Shabaab (Ban on Type III FGM/C was reported to be issued by Shabaab )	Security is now better, but safety still an issue Reductions in donor support Need to provide training for 'Ulama Need more end-FGM/C religious programmes in the media Strengthen all communications: across the whole zone and country Develop programmes against FGM/C via lectures at mosques and Friday khutbahs (sermons) Set up an office in Ministry of Religion that can work on FGM/C issues
<b>MOH</b>	Delivered Somalia commitment to end all forms of FGM/C "soon", at the Girl Summit, London, 2014	Train midwives and nurses to work in outreach to end FGM/C – during regular family visits	Oversees midwifery and nursing schools (funded by UNFPA): human resource in ending FGM/C/prevention of medicalisation GAVI funded project to train 300 female health care workers (HCWs) and community health workers (CHWs) on Expanded Program on Immunization (EPI), nutrition and health promotion activities at the household level, including FGM/C. 100 trained so far. With UNFPA, produced a weekly message on GBV (including FGM/C) National TV	Insufficient resources: no long-term funding Some areas of the zone not under government control Years of conflict: severely damaged health infrastructure Need support to draft law and policies Need to develop more outreach with/for young people: integrate into school curricula Build capacities of all health personnel to deal with FGM/C issues

				FGM/C needs to be integrated into all health programming
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### 3.3 Key achievements

In all three zones, end-FGM/C work now receives the highest possible public endorsement, with commitments and support from presidents and the Somaliland First Lady. FGM/C is banned under the new draft Constitution (2012). The pledges made by representatives from all three zones, at the Girl Summit in London, July 2014, demonstrated a strong commitment which has been witnessed throughout the global community. Government in all zones is committed to ending FGM/C in the shortest time possible. Since 2009, and with the support of the UNJP (see Section 4), there has been significant progress in building the enabling environment to support end-FGM/C work.

In Somalia, FGM/C has long been recognised by women's organisations as a violation of women's rights. Now, in all zones, FGM/C continues to be seen as, primarily, a social issue (rather than a health issue) and this is evidenced by the choice of the "women's rights" ministries as the lead ministries. UNFPA strongly believes that it is equally a health and human right issue, which requires the greater involvement of key health practitioners for both prevention and treatment of related complications. However, a somewhat different approach to ending FGM/C is taken in each of the zones. In Somaliland and Puntland FGM/C has been a definite government priority since the inception of the UNJP. In Somaliland, FGM/C work is coordinated under the GBV working group and FGM taskforce. In South Central and Puntland Somalia, FGM/C is addressed under the GBV working group. There are series of FGM/C interventions led by both the government and NGOs within the working group. The FGM taskforce has just been established in Somaliland and in Puntland, work over recent years (supported by UNJP) has raised awareness of FGM total abandonment at both community and policy (upstream and downstream) levels. There is a draft total abandonment policy in place which needs to be endorsed with more advocacy to be done. In South Central Somalia, there are now wider media campaigns which is commendable. In Puntland, a *fatwa* has been issued against all forms of FGM/C. An anti-medicalisation strategy has been drafted. In Somaliland, a *fatwa* was drafted but this is currently stuck because of disagreement amongst certain sheikhs and 'ulema, who wish to see Sunnah FGM/C remain legal. Drafting of an anti-medicalisation strategy has begun recently. In Mogadishu, South Central Somalia, there is a draft action plan on Ending Sexual Violence in Conflict. The GBV working Group Strategy covers ending FGM/C. The three-day conference on FGM/C, held by the Ministry of Religious Affairs and Endowment, in November 2014, will move the agenda forward further.

There are GBV focal people at all levels of government. **However, the priority they give to FGM/C is not clear.**

### 3.4 Focus of the Task Forces and FGM/C "fatigue"

The taskforces in Puntland and Somaliland have been fully functioning over the last two to three years. South Central only established an FGM taskforce in late 2014 with an agreement of MOWHRD and MOH co- leading and to be technically supported by UNFPA and UNICEF. The Nairobi Task Force remains the national and is supporting the zonal groups. The need for funding and technical capacity strengthening of represented organizations is critical. There have been efforts also in harmonising community education, mobilization and advocacy messages to allow one voice on total abandonment. UNFPA received funds for FGM/C in 2011 from JHNP and has a clear plan which requires long term funding. Because the focus of the GBV working groups in Somaliland and South Central Somalia is GBV, rather than

FGM/C, there may be a danger that FGM/C is subsumed in the wider GBV agenda. Part of the issue with this is that, over the last year, UNICEF has received funding for GBV work, but not for FGM/C work. This has led to inevitable changes in perspectives and priorities (see Section 4, regarding the UNJP). There are both advantages and disadvantages in embedding FGM/C work under a GBV umbrella. The work of some of the working group members is outlined in Section 4, below. There are synergies to be gained from using a broad and deep “lens” to address the social norms change and social change needed to end FGM/C (as ending FGM/C requires increased gender equity and a shift in the way that women are conceptualised within society<sup>9</sup>). But there is also the danger that FGM/C may be “dropped” if it seems that donor funding is moving to other directions.

Another worrying factor is that whilst many of the women who have been activists against FGM/C over the decades are now in high positions – in government, medical services and organisations – they are becoming disillusioned. They are wary, and weary, of the regular changes in donor focus. As one woman said:

“No, I am not the FGM/C focal person anymore. I am now the GBV focal person, which means that I have twice as much work and half the resources!” (Personal communication, Situational Analysis consultations)

Many activists were pleased to learn that new funding may be available in Somalia through components of the DFID-funded Towards Ending FGM/C in Africa and Beyond programme, but they remained sceptical about how long the “new” interest, and new funding, would last.

## **3.5 Key challenges**

Many challenges were outlined by government in all three zones. Key concerns are discussed here. A deeper analysis of key issues is given in Section 5.

### **3.5.1 Lack of long-term funding**

In all zones, government and CSOs complained of the lack of long-term funding and stated that reliance on short-term tranches of money makes it impossible to achieve change in social norms and practices. In Somaliland and in Puntland some people consulted referred to the fact that they have no choice but to follow the donor “fashion”:

“Last year FGM/C, this year GBV. Next year what? (Personal communication, Situational Analysis consultations)

The lack of long-term funding has also meant that the value for money of certain initiatives – such as the development of policy and strategy – is *severely* compromised, as no funds are available to operationalise policy and strategy, or to monitor and evaluate its success (see, also, the following sections).

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<sup>9</sup> See, for example, Crawford, S. (2013) *Harmful Traditional Practices: Your Questions, Our Answers*, GADN, London



### **3.5.2 Limited evidence based information**

In all zones, the limitations of an evidence base and reliable statistical information pose huge problems in terms of targeting and programming (see Section 5, key issues and challenges).

### **3.5.3 Threats to reach isolated, rural areas, and areas in conflict**

Governments in all zones have very limited resources and means to reach isolated rural areas. People are well aware that, where FGM/C is decreasing, it is largely decreasing in urban areas. They feel powerless to reach many rural areas because they do not have transport, fuel or operational budgets. Nor do they have the personnel to reach out to all areas. There are still a number of areas where no health posts exist. However, it appears to be the ministries of religious affairs which feel most frustrated by this situation. They know that there is a huge need to reach out to the sheikhs and other religious teachers in all areas if FGM/C is to be ended. There is a mosque in every community, and the power of the sheikhs is considerable. They need to be convinced that FGM/C must end.

### **3.5.4 Lack of regulatory powers**

In all zones there is a real need for government to have stronger regulatory powers over all work carried out on FGM/C. At present, it is very difficult, if not impossible, for government to ensure that all CSOs follow the zero tolerance policy:

“Here it is only us, UNICEF and Health Poverty Action (HPA) that we can be sure of following the zero tolerance policy. Many of the rest are saying that Sunnah is acceptable. We do not have the regulatory powers to stop them, and you, the donors, keep giving them money without consulting us” (*Member of government, Situational Analysis consultations*)

## **4 Interventions to date**

In this section we discuss some of the key end-FGM/C interventions to date in Somalia, and assess achievements and improvement opportunities.

### **4.1 The United Nations Joint Programme on ending FGM/C (UNJP)**

#### **4.1.1 The global programme**

Globally, the UNJP has been the key driver in motivating the donor community, and national governments, to work towards the end of FGM/C

### Box 4.1 The UNJP

The UNJP is intended to be strategic and catalytic; holistic; based on a theoretical understanding of FGM/C as a social norm; human rights-based and culturally sensitive—preserving positive cultural values whilst working to eliminate harmful practices. The design of the programme acknowledges that ending FGM/C is a long-term objective. The specific objective of the programme is to: “Contribute to a 40% reduction of the practice of FGM/C amongst girls aged 0–15 years, with at least one country declared free of FGM/C by 2012”. Between 2007 and 2013, donors contributed a total of \$36,822,047 to the programme. By 2011 the programme was operational in 15 countries: Djibouti, Egypt, Ethiopia, Guinea, Guinea-Bissau, Kenya, Senegal and Sudan (beginning in 2008), Burkina Faso, Gambia, Uganda and Somalia (beginning in 2009) and Eritrea, Mali and Mauritania (beginning in 2011). In all countries, the programme has worked with national ownership and guidance (which has meant that national priorities for intervention have been followed).

In Somalia, as in the other target countries, the UNJP and its activities have been designed on the understanding that they need: to be **strategic and catalytic**: building on work that was already going on in programme countries, and working with national governments and strengthening existing efforts; to be **holistic**: working across sectors and levels (community, national, regional and global) to address FGM/C as a social, not only a medical, issue; to **address FGM/C as a social convention/norm**: working for collective, community-wide change in values and practices, not individual change; to be **based on human rights and culturally sensitive**: whilst recognising that FGM/C is valued by the cultures in which it is carried out, and must be addressed with sensitivity, FGM/C is an absolute violation of human rights. The desired **outcomes** for the programme have been: 1) A change in the social norm towards the abandonment of FGM/C at the national and community levels; 2) A strengthened global movement towards the abandonment of FGM/C in one generation.

There have been 10 expected **outputs**, covering the range of engagement thought necessary to end FGM/C: strengthening local commitment; enactment and enforcement of policy and law; communications and campaigns; building an evidence base; establishing partnerships and expanding the range of partners; working regionally; expanding understanding of “social norms theory”; tracking, monitoring and evaluating.

A 2013 evaluation found that, despite numerous successes, the programme has been over-ambitious in its objectives. It has helped to expand and accelerate existing change processes towards FGM/C abandonment at national, sub-national and community levels, and has contributed to strengthening the momentum for change at the global level. The evaluation noted the benefit of partnership and coordination between the UN agencies, but also noted that funds were not sufficient or regular enough to allow for fully effective community-level work at all times.

Source: UNFPA-UNICEF (2013)

#### 4.1.2 The UNJP in Somalia

Since 2009, the UNJP in Somalia has been involved in working to:

- Strengthen the enabling environments;
- Develop and employ communications strategies to reach a wide audience with end-FGM/C information; and
- Give direct support to a number of CSO partner organisations.

The UNJP has generated real commitment towards ending FGM/C and the achievements outlined in the previous sector were gained with UNJP support.

### 4.1.3 Challenges facing the UNJP

As elsewhere, the UNJP in all three zones of Somalia has faced a number of difficulties. Some of these difficulties relate to working in zones in a conflict or post-conflict state. Others are more structural. Key issues include:

- a) **Insecure funding:** During the first phase of the UNJP, funds did not reach the levels promised by donors. This means that, in Somalia as elsewhere, funding to partners has been short term and insecure—with funding gaps. It also means that interventions funded have tended to be small, or incomplete. For example, in Somaliland, funding supported development of the *fatwa*, but was not available to ensure that this could be pushed through to acceptance within the MORA<sup>10</sup>. The anti-medicalisation strategy in Puntland has been drafted, but there are insufficient funds to ensure operationalisation and full roll-out. Youth engagement innovations are grossly underfunded and same for the health institution such as midwifery schools and associations. All aspect of community led and owned, including male engagement towards total abandonment needs more meaningful and longer term resources.
- b) **Choice of partners to do community-based work:** Across all countries in which it works, the UNJP has tended to fund known partners which can be relied on for fund-dispersal, reporting and accountability. There is nothing wrong with this, but it does mean that the range of partners has been limited and there has been little/no regulation of their approaches and methods. The requirements of the UN funding mechanism mean, too, that smaller organisation may be excluded. In addition, the operation of partners is constrained by the one year funding tranches available to date—it is difficult to plan work for norm change when only one year's funding is secure.
- c) **Monitoring and evaluation:** This is under-developed throughout the UNJP. As the 2013 evaluation of UNJP showed<sup>11</sup>, nowhere is it possible to attribute a count-able reduction in FGM/C to UNJP interventions. The lack of a coherent approach to partner funding has diminished possibilities for lesson learning. The UNJP has not yet been able to establish a “modelling and testing” portfolio approach which would lead to greater knowledge about what works where, when, why and how. Indicators established at the UNJP Headquarters level are not well understood or used at country levels. The majority of country-level NGO partners monitor largely for activities and outputs, and do not evaluate outcomes and impacts. These issues are explored further in Section 5.
- d) **Planning and programming:** During the Situational Analysis, it was suggested by some partners that unified UNJP planning (between UNICEF and UNFPA) is still not as strong as it could be. In part, this is because of the heavy workloads of each organisation and the changing agenda from headquarters (UNICEF's 2014 focus being on GBV). Also, there has been a drop in FGM/C funding in 2014. It is to be hoped that this will improve as the TEF GMC in Africa and Beyond programme is put into operation.

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<sup>10</sup> However, at a meeting of the GBV Task Force on 15 July 2014 it was announced that UNICEF is making money available (presumably through the UNJP FGM/C funds) to hold a conference on FGM/C and religion and to invite scholars from Al Azhar and Mecca.

- e) **Coordination:** There appears to be good coordination with the Nairobi desks and the Nairobi-based Task Force. However, there are some inevitable challenges in coordinating from another country. There are also difficulties coordinating the stakeholders on consistent messages within the country and being able to support the line ministries on improving coordination.

The challenges outlined above indicate improvement opportunities for the coming phase. They do not indicate failings. Overall, the UNJP has done a great deal to stimulate commitment and work towards ending FGM/C in Somalia.

## **4.2 Organisations connected with UNJP and the Task Forces**

A wide range of different approaches are employed by partner organisations. These approaches range from the full community-development approaches taken by TASS, Relief Development Initiative, PUNCHAID in Puntland, COCO, IRADA through to small-scale end-FGM/C “add-ons” used by organisations whose main focus is elsewhere. Table 4, below, shows something of this range, with an outline of the Puntland FGM/C Task Force members.

**Table 4: Members of the Puntland FGM/C task force**

Name of organisation	Work field
PSA	Have worked on FGM/C for past three years with assistance from UNICEF. Majority of the work consists of increasing awareness FGM/C among IDPs and in communities in Bosaso as well as outreach to cutters. Their campaigns have reached up to 500 people. They have put signs up in the community as well. They stage dramas about FGM/C and the impact that it has on girls. They also have a magazine called Himilo with articles on FGM/C. They also have a Facebook page. The population of Bosaso is approximately 800,000 people.
TASS	The agency works across Puntland and one of its activities is child protection. Their awareness campaigns on FGM/C have reached up to 17,300 people. Through the work of TASS about eight girls were saved from Pharaonic FGM/C and eight cutters abandoned their work to become advocates/champions against FGM/C. They follow up with people that have stopped practice of FGM/C to see if they return to the practice. They hold a yearly child forum and work in every region of Puntland.
YESO (Youth Employment Solutions)	Puntland FGM Taskforce Secretary: Work in Bosaso on assisting youth with access to education and retention in school. In terms of their work on FGM/C they raise awareness of the issue with youth, they also hold live public debates. They distribute Joint UNFPA/UNICEF materials against FGM/C (these include hats, posters and signs). They also have a job placement programme for 'survivors' of FGM/C and hold a day of activism for women to talk about FGM/C.
Relief Development Initiative (RDI)	Based in Garowe: RDI with the support of UNFPA works on FGM/C awareness in Garowe and Sanaag region. They hold debates involving ulama, circumcisers and physicians, to raise awareness. They broadcast radio messages about FGM/C and conduct community consultations/forums on FGM/C. In Garowe they undertake outreach to raise awareness of FGM/C and reached approximately 1,200 people in 2014. In Sanaag they have reached up to 800 people. They use joint UNFPA/UNICEF materials on FGM/C as part of their outreach work. There are currently no funds to reach pastoral regions.
Galkayo Education Centre for Peace and Development	FGM/C is a major issue that this agency works on. They create booklets on FGM/C and distribute them to schools. They have also worked on training about 40 cutters to become TBAs and abandon FGM/C. Their training lasts 15 days. The majority of the agency's members were TBAs and also performed FGM/C. Currently they are waiting for medical instruments/UNICEF kit to be given to them so they can continue work. The cutters have said they would stop Pharaonic circumcision but not Sunnah.
Mudug Women and Child Development Organisation	This organisation only works in Galkayo and has three major achievements in their work on FGM/C: 1. They hold meetings with cutters to work on convincing them to stop; 2. They work on awareness raising on FGM/C; 3. They register FGM/C practitioners, and at this time they have 15 cutters in their registry and are coordinating this registry with the Ministry of Women's Development and Family Affairs. They meet with the cutters/cutters every three months. Their activities on FGM/C have been ongoing since 2000. From their observation the rate of Pharaonic circumcision has decreased but Sunnah continues.
Hormur Relief and Development Association	They established their organisation in 2012 and started FGM/C activities as volunteers in 2013. They work on raising awareness of FGM/C among parents and village leaders. They believe low-income populations need education, training and vocational training.
Timely Integrated Development Services	They have a field office in Garowe, Bosaso and Galkayo. They have worked on the prevention of FGM/C and in the past year trained media and held talk shows with elders, youth and community leaders.

The boxes below describe the work of some of the organisations which hosted the Situational Analysis fieldwork.

#### **Box 4.2      CCBRS**

CCBRS is based in Hargeisa, the capital of Somaliland, and works for increased advocacy and protection of all vulnerable and disadvantaged people through community-based and participatory approaches. CCBRS also has a sub-office in Burao, which coordinates a range of services in the region. The principal beneficiaries of CCBRS are IDPs, migrants, and urban and rural populations. The organisation offers three key services: a) capacity-building for service providers to address FGM/C, early marriage and GBV (they have trained 66 advocates and school staff); b) awareness and advocacy on GBV; c) service delivery and emergency medical referral. CCBRS has 16 IDP caseworkers who work with communities, and it has focal points in all IDP communities. Learning sessions are held with males and females and FGM/C and early marriage is discussed. In terms of service delivery they have provided emergency medical referrals, provided psychosocial support, legal aid/referrals for rape cases/domestic violence/GBV and have a case currently ongoing in the Supreme Court. From January until June 2014, CCBRS programmes have reached 1,464 people.

In Borema, CCBRS has been funded by UNICEF to work on anti-GBV interventions. Working closely with local police, lawyers and the Criminal Investigation Department, two case workers and two focal persons for the IDPs collect GBV cases. CCBRS advocates for victims of violence and helps them obtain legal aid. CCBRS workers say that, because of social beliefs that make it difficult to report the high levels of rape, FGM/C and other abuse against girls and women in the communities (35+ rapes cases were brought to them this year, and over half of these were children), they sometimes by-pass the authorities and refer directly to the “Baahikoob”. This is a one-stop shop in the hospital, where victims of violence can get treatment. Women may also be referred to the Borema Fistula Centre or Edna Hospital. However, there is no centre dealing specifically with the trauma caused by FGM/C, and no real help for survivors.

CCBRS operates a zero tolerance approach to FGM/C in all their community work and advocacy – in neighbourhood schools and IDP camps – and intensifies work in school holidays, when more cutting takes place. The Borema Coordinator says, however, that it is very difficult to get people to accept messages on zero tolerance. She has been working to end FGM/C since 1999, and believes there has been a reduction in the Pharaonic type—but Sunnah, in various forms, is still ubiquitous. The coordinator says that she has not received funding for FGM/C work for some time: “the money is now all about GBV”. This has left people somewhat confused; to what extent are we still focusing on FGM/C?”

Source: Fieldwork for the Situational Analysis, 2014



**Box 4.3 IIDA (Women's Development Organisation), Mogadishu**

IIDA is a non-profit organisation that was founded in 1991 in Mogadishu by a group of Somali women leaders to promote women's political, economic and social rights. Today, IIDA is operationally the largest grassroots movement in Somalia, and is represented in different regions of the country, such as Lower and Middle Shabelle, Banadir, Galgaduud, Bay and Bakool, and continues to work towards fostering sustainable development. IIDA works to promote peace and conflict resolution; ensure the integration of Somali women in all parts of Somali society; promote education for women and youth in order to increase their awareness on critical issues that affects their lives and to increase their potential as individuals and groups and to enhance women's economic self-sustenance and improvements in women's health. IIDA is a woman-led organisation working for women's empowerment and addressing the issues faced by women from minority backgrounds, who are often excluded from development interventions. IIDA is working with MPs in South Central Somalia to make sure that cross-cutting legislation on women is passed and that women, including women from minorities, are representatives in political positions. IIDA provides psychosocial support to rape victims, and work on HIV prevention and provision of contraception to ensure girls do not become pregnant (rape kit and dignity kit) and it provides legal aid for rape victims. Since its inception, IIDA has taken a zero tolerance approach to FGM/C. In the riverine areas of Southern Somalia, it has worked to provide women cutters with alternative livelihoods, through farming.

Source: Fieldwork for the Situational Analysis, 2014, and [www.facebook.com/pages/IIDA](http://www.facebook.com/pages/IIDA)

**Box 4.4 ANPPCAN**

ANPPCAN Somaliland was established in June 2008 by a group of volunteers concerned with the situation of children in Somaliland. ANPPCAN aims to be the national resource centre on child abuse and neglect. In Borema, ANPPCAN started the Women to Women project in 2012, funded by UNICEF (UNJP). The aim was to end FGM/C across a target population of 2,500 women. In the first year of operations four master trainers were trained by UNICEF. This was extended to training for another 15 trainers (10 in Borema and five in the village of Qulujeed, one hour from Borema). In turn, many more women were trained through a cascade model. The training capacitated people to conduct (a) home visits/door to door visits with the objective of orienting the mothers in these houses not only on FGM/C, but also on other health issues such as nutrition and malaria (b) school sessions on FGM/C; 1,500 children have been reached in this way, focusing on class 7 and 8, (c) Peer education/training, where they conduct discussions on FGM/C and give support to end it.

The project ran from 2012 to March 2013, but there has been no budget since then. ANPPCAN estimate that, out of the 2,500 women reached, perhaps 30% were convinced to abandon FGM/C. However, this was not based on a baseline. In group discussions for the Situational Analysis CPS, with women who had been part of the project, it was clear that some women are now against FGM/C. But most of these women understand FGM/C to refer only to Pharaonic FGM/C: one woman was presented as an "ex-cutter", but it turned out that she has only stopped doing Pharaonic FGM/C—she is still doing Sunnah. ANPPCAN staff feels that the project had been working well and was effective but there are now no activities because funding has stopped and there are no incentives for the trainers/educators. A community leader said that the College of Health Sciences now brings students and staff to do community extension twice a week, and that this works even better than the ANPPCAN programme did – because it gives people medical services and information, is free and does not involve incentives, and also helps build students' capacities.

Source: [www.anppcan.org](http://www.anppcan.org) and fieldwork for the Situational Analysis, 2014

**Box 4.5 TASS**

TASS was founded in 1992 and is one of the largest humanitarian and development organisations in Puntland. Its Head Office is in Bossaso. TASS has a broad remit, working for empowerment and education to improve the livelihoods, rights fulfilment and dignity of people in Puntland. TASS has been working on FGM/C abandonment with UNICEF for the last five years, and staffs says that there has been an impact in target locations. They say that, before TASS intervention, people did not dare to discuss FGM/C issues openly. Today, they say that there are a number of communities which have declared FGM/C abandonment. Also, a number of cutters have stopped cutting and a number of girls have been saved from FGM/C. In addition, some FGM/C survivors who were at risk have been given emergency medical support (numbers not provided).

To achieve these impacts, TASS has taken a wide approach. TASS holds a “girl child forum” every year, bringing together people from across Puntland. The organisation has staff in every region and staff work with the Ministry of Women’s Development and Family Affairs regional coordinators. TASS is also part of the child protection committee of Puntland, which has representatives from each region. It has been working on raising community awareness on FGM/C and training community champions. Similar to the Tostan model (developed in Senegal, and implemented in eight countries, including Somaliland where it has now stopped) TASS encourage a public declaration and promise of abandonment. TASS has developed radio talk shows on FGM/C, worked with religious leaders and health professionals to expose the risks of FGM/C, supported survivors, and worked for the empowerment of women and girls. The organisation is also active in attending FGM/C working group meetings and advocating for end-FGM/C policy and legislation through the government line ministries.

TASS awareness campaigns on FGM/C have reached more than 17,300 people. Through the work of TASS about eight girls have been saved from Pharaonic FGM/C and eight cutters have abandoned their work to become advocates/champions against FGM/C. TASS follows up with people that have stopped the practice of FGM/C to encourage them not to return to the practice. In outreach work, TASS use UNICEF materials on FGM/C and provide health referral services for women suffering from FGM/C related complications. One case was a 16 year old girl who had a vaginal cyst caused by FGM/C; she was sent to a physician by TASS staff and her condition improved significantly.

Source: Fieldwork for the Situational Analysis and TASS profile document

**Box 4.6 SPL**

SPL was established in 1995 and now operates in five regions across South Central Somalia (Banadir, Galguduud, Hiiraan, Lower and Middle Shabelle, Bay and Bakool). Its principal focus is on peace-building and human rights and it is an established UNICEF partner. The two population groups targeted for protection and peace-building activities by SPL are children and IDPs. Peace-building activities include conflict resolution using traditional (clan) and modern methods, holding awareness workshops and working to change the culture of violence within communities. To protect children, SPL works to combat violence and help improve safety in the community. Where needed, SPL trace families and reunite children with their parents.

Source: Situational Analysis consultations, 2014.

To change social norms and to effect wider social change, FGM/C needs to be tackled holistically and end-FGM/C approaches need to be embedded in all work relating to the development of girls and women. To this extent, the wide range of approaches employed by the numerous civil society organisations connected with work to end FGM/C, is positive. However, as we will discuss in Sections 5 and 6, below, there is now a real need to move beyond the “let a thousand flowers bloom” approach and to adopt a portfolio, learning approach to work to end FGM/C. To date, whilst the UNJP and its partners have greatly developed the global understanding of what is generally needed to effect social (norm) change, we have little real idea about what works where, when, why and how, and to what extent, positive changes that have been made will be sustained.

### 4.3 What works to end FGM/C?<sup>12</sup>

FGM/C is about power and politics: it is about the way that people construct individual and social identities, about what it means to be a girl or a woman, and what is expected of girls, women, boys and men in society. To end FGM/C requires not just the end of a single, social norm, but much wider, more fundamental, social change. To end FGM/C sustainably will require major shifts in how people think about themselves and their relationships with each other. FGM/C is complex, and highly context-related. Ending it requires greater gender equality and power-sharing between people of different age and sex, and full commitment by governments, CSOs and communities.

There is now wide acceptance that a holistic approach is needed in order to promote the social changes needed for an end to FGM/C and to work for the fulfilment of rights. A holistic approach will work, systematically, at all levels to:

**Build the enabling environment and promote take-up of obligations:** Develop the necessary laws, policy and regulatory structures; establish mechanisms and systems to implement the legal and policy framework; develop overall systems for monitoring and evaluation, and lesson learning, at all levels

**Catalyse engagement:** Develop communications systems, advocacy and lobbying to “crowd-in” actors, raise awareness and understanding amongst global, regional, national and local communities; put monitoring and evaluation and learning systems into operation, including systematic and in-depth research into areas of FGM/C, other harmful traditional practices (HTPs) and related issues, which are least understood.

**Model focused action for change:** Test and expand community-level models aimed at ending FGM/C. Monitor and evaluate in different contexts to learn exactly what works, where, when, why and how. Identify possibilities of, and needs for, successful scale-up, replication and adaptation of models to different contexts.

Because ending FGM/C is about social change and promoting human rights of women and girls, it requires work at all levels of society, and with the widest possible range of stakeholders (girls, boys, women and men, through to religious leaders, women’s organisations, politicians, global activists etc.). It is only when the three levels (enabling, catalytic and focused) are working in coordination that we can be hopeful that efforts to end FGM/C will be successful, and that gains made will be sustained over time. From experience to date and the evidence available, a number of characteristics are needed in a holistic approach to ending FGM/C. These are:

- Deep knowledge of the culture and context: a robust evidence base and full understanding of how power and gender relations work within the society;
- Effective partnerships between government and CSOs to promote social change;
- Active participation from all sorts of different actors at all levels of society, and from women, men, girls and boys within communities;
- Political empowerment: creating real opportunities for people, especially women, girls and poor people, to say what they think and to be heard by people in authority;

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<sup>12</sup> This sub-section draws on Crawford, S. 2013a and 2014, and 2013b.

- Economic empowerment: ensuring people, especially women, have opportunities to gain better livelihoods;
- Education, especially for girls and women – this might include formal / informal education, rights awareness, or life and livelihood skills;
- Increased access, especially for poor and vulnerable people, to all essential services, including health and education, social welfare and legal services; and
- Sound understanding of the importance of religion, faith and other belief systems: how they can support work to end HTPs, or how religious interpretations may be a barrier to ending HTPs.

At community level, a good understanding of the culture will help us to establish the best way to address HTPs in that particular context. Whatever the entry point, we know that working to increase and improve **communication** between men and women, girls and boys, is critical.

In contrast, we know that uncoordinated and unregulated small-scale, “scatter-gun” approaches are highly unlikely to bring about sustained change in social norms, and the end of FGM/C.

These considerations underpin the challenges and issues outlined in the next section.

## 5 Key issues and challenges

This section examines some of the key issues and challenges facing all actors working to end FGM/C in the three zones.

### 5.1 Research and understanding

Fieldwork and consultations for the Situational Analysis have shown that there are a number of crucial areas where more research is needed to build the evidence base which will facilitate policy and programme development and lead to effective programming

#### 5.1.1 Understanding prevalence: baseline facts

Current statistics indicate a high prevalence of FGM/C in Somalia, at around 97.9% for women 15–49 years old (Population Reference Bureau, 2014). In Somaliland, Puntland and South Central Somalia, the communities consulted said that nearly all households in their localities had women and girls who had undergone FGM/C. The few mothers who openly said they had not had their daughters undergo FGM/C were from communities that had been beneficiaries of anti-FGM/C activities carried out by ANPPCAN in Borama in Somaliland, TASS in Garowe in Puntland and SPL in Mogadishu, Somalia. During the Situational Analysis, there was not a single community consulted in which all households had completely abandoned FGM/C. This was equally true in communities which had seen anti-FGM/C interventions as in communities which had not. The only community in which the participants claimed that most families are abandoning FGM/C completely was in Borama, Somaliland, in a community that was targeted by CCBRS.

Many people consulted—in institutions and in communities—said, however, that FGM/C is decreasing, even if rates remain high. In consultations, people acknowledged that the decrease is highest amongst a minority of educated Somalis and the Somali diaspora from Western countries or the Middle East, and in urban areas. In isolated rural areas, FGM/C rates are believed to remain extremely high. There is a small number of riverine clans which do not carry out FGM/C.

In fact, there are not yet adequate baselines on which to base an understanding of change (or lack thereof) in prevalence and incidence. Incidence of FGM/C is, in any case, extremely hard to measure. The lack of reliable statistical data is further compounded by different understandings of what FGM/C actually refers to and what zero tolerance means (see below).

#### 5.1.2 Understanding of FGM/C and zero tolerance: lack of knowledge and facts

**In Somalia there are different understandings of what “FGM/C” is:** The term FGM is interpreted in Somalia to refer to only one type of FGM/C that is Pharaonic FGM/C (Type III, with removal of the clitoris, inner and outer labia, and infibulation). In the communities, *Gudniin*, the Somali term used for male and female circumcision, is the principal term used to refer to all forms of FGM/C. However, in all regions in Somalia, the term *Sunnah* circumcision, can refer to Type I, Type II or Type III FGM/C. “*Sunnah*” is used in the communities to refer to any type of circumcision which people believe is required/sanctioned by Islam. This wide

interpretation differs from the use of the term Sunnah circumcision by other Muslim populations (and by the UN and WHO) who use it to refer only to Type I FGM/C.

In the communities, two variations of Type III FGM/C were reported: a form of infibulation, which involves less stitching and which is known locally as *Sunnah Kabiir* (greater Sunnah) and, Fadumo Hagoog, a form of Type III FGM/C, which involves excision but no stitching. There are also reports of a form of Type III in which there is infibulation, but no cutting – the clitoris and inner labia being left intact and “sealed” beneath the infibulated labia majora. Women’s and girls’ self-reporting of the type of FGM/C they have undergone is often not accurate.

**Table 5: Local types of FGM/C**

Sunnah Saqiir	Sunnah Kabiir
<ul style="list-style-type: none"> <li>▪ <b>How Sunnah Saqiir is defined:</b></li> <li>▪ Partial or total removal of the clitoris and/or the prepuce</li> <li>▪ Type Ia: Removal of the clitoral hood or prepuce only</li> <li>▪ Type Ib: Removal of the clitoris with the prepuce</li> <li>▪ <b>What Sunnah Saqiir can also look like:</b></li> <li>▪ Type IIa: Removal of the labia minora only</li> <li>▪ Type IIb: Partial or total removal of the clitoris and the labia minora</li> <li>▪ Type IIc: Partial or total removal of the clitoris, labia majora and labia minora</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modified form of infibulation (Type IIIa or Type IIIb) that involves cutting of the labia major and/or labia minora, with or without excision of the clitoris</li> <li>▪ The upper portions of the outer labia or labia minora are stitched together</li> <li>▪ The stitching in Sunnah Kabiir leaves an opening that is larger than the significantly narrower vaginal introitus of women that have undergone Pharaonic infibulation.</li> </ul>
Pharaonic infibulation	Fadumo Hagoog
<ul style="list-style-type: none"> <li>▪ Narrowing of the vaginal opening with the creation of a covering seal by cutting, appositioning and stitching together the labia minora or the labia majora, with or without excision of the clitoris</li> <li>▪ Type IIIa: Removal and apposition of the labia minora</li> <li>▪ Type IIIb: Removal and apposition of the labia majora</li> </ul>	<ul style="list-style-type: none"> <li>▪ A form of Type III FGM/C that involves excision and sealing of the vagina but does not involve stitching. After excision, the legs of a girl are tied tightly together. The raw surfaces fuse together when the wound heals, forming a seal. In Somalia, a mixture of hot ashes and tree sap is often used to seal the wound.</li> </ul>

Note. WHO classifications of FGM/C are from “Eliminating Female Genital mutilation – An interagency statement,” by the WHO, 2008.

Since the 1980s, the Somali government had been working towards the elimination of Type III forms of FGM/C and activists believed that Type III FGM/C was beginning to decrease prior to the Somali civil war in 1991 (Warsame, 1989). Local populations were often encouraged to decrease the severity of FGM/C in Somalia, in the pre-civil war era, by abandoning infibulation and adopting Sunnah. There appears now to be a wide variation in the range and types of FGM/C that are now labelled Sunnah by the population.

According to Dr Habiba Ismail of Garowe Hospital the new forms of Sunnah may have evolved into variations of Type II and Type III because of the limited knowledge of the population and those people who carry out the cutting:

“The population is not educated/nor consistent in their definitions of types of FGM/C and the cutters themselves are not even aware of what Sunnah (Type Ia or Type Ib) is



and will often perform various forms of FGM/C that are more severe than Type I and claim that it is Sunnah to the parents.” (Dr Habiba Ismail, Garowe Hospital, Garowe, Puntland)

“[Some] Sunnah forms of FGM/C are essentially variations of Pharaonic FGM/C.” (Dr Habiba Ismail, Garowe Hospital, Garowe, Puntland)

The emergence of new terms and forms of FGM/C in Somalia has not yet been documented in any of the clinical or anthropological literature.

**So what is “zero tolerance”?:** The misinterpretation of FGM/C by local populations poses a problem for activists who make use of the term FGM/C to inform and educate the public. The issue appears to have arisen because numbers of NGOs, since the 1990s, have encouraged people to give up Pharaonic FGM/C, but some have said (and continue to say, in contravention of government policy) that Sunnah types can continue. This seems to have increased the innovative approach amongst the population – encouraging increasingly radical forms of cutting and mutilation to be labelled as Sunnah, but also allowing communities to claim they have “given up FGM/C” when, in fact, they have not. It also explains the enthusiasm with which community members introduced the research teams to women said to have stopped cutting. On consultation, these women were found only to have given up performing types of FGM/C which are fully recognised as Type III, Pharaonic.

### **5.1.3 Lack of understanding of why and how change happens and how it is sustained<sup>13</sup>**

There is very little research about, or understanding of, how knowledge and change are internalised in relation to FGM/C. This is true globally, not just in Somalia. The prevailing view is that social norm change has to be ‘triggered’ and that a ‘tipping point’ has to be reached in order for the norm to be dropped (changed)<sup>14</sup>. To date, work in Somalia has acknowledged the need to change public opinion on FGM/C, but there is little background research or evidence to help us understand exactly what makes change happen, in any given context. The relationship between change in social norms and values, and change in behaviour, and between these and broader social change, is not well understood. Box 5.1 below, about work that took place in Norway, illustrates the importance of gaining an understanding of what makes change happen.

As Lien and Schultz (2013) state: “In order to understand a paradigmatic shift of attitude from an ‘old’ to a ‘new’ packet of knowledge and meaning, we need to understand the internalisation processes that take place within individuals and the processes taking place between individuals and groups”.

The example above shows how it is NOT the message itself which, necessarily, triggers change (which is why the “knowledge leads to awareness and changes in behaviour” approach is too simplistic; if it worked, few people in the UK would smoke or have unprotected sex). The example shows that knowledge has to resonate with individuals and, in the case of FGM/C abandonment, may need to be linked to emotion, empathy and memory. Without

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<sup>13</sup> The following sub-sections develop ideas originally put forward by Sheena Crawford in a bid document submitted to DFID by HPI for the Research Component of the Towards Ending FGM/C in Africa and Beyond programme.

<sup>14</sup> See Mackie, G. (2000).

understanding how change is internalised we are hampered in attempts to make robust decisions on which approaches are most useful in work to end FGM/C.

## Individual versus collective change

### Box 5.1 Internalising knowledge for change

During a study conducted in Norway, an invited guest from an English organisation, an African Muslim, talked to a hundred Gambian women and men in Oslo about FGM/C for an hour, described the four different types of FGM/C, and explained the health consequences both short term and long term. There were several reactions to the lecture. One participant said: "... she called it FGM and told us horrible things." Another: "It is incredible that a grown up women can stand there and lie to us all." A key respondent who later became an activist said: "We thought it was a joke and laughed. We were all very happy that we had healed after circumcision, and did not suffer like the Somalis. We were in a state of denial. It was later, when I started to read the government's pamphlets that I understood that there were many things I did not know." Later, the researchers were told that most of the women did not believe in the information that was given during the first seminar. The information was heard and memorised, but it was not processed and internalised. Researchers present at the seminar noted how the women acted: looking around, fiddling with their hand bags, whispering to the next person and trying not to pay much attention to the information given.

Three months later, a second seminar was held, arranged by Gambians with an invited activist from the Gambia giving a lecture about the consequences of FGM/C. There were more than a hundred Gambians present in a lecture hall. A Gambian woman with a university degree, having lived in Europe for more than 20 years, told us that she would have cut her daughter if she had not attended this particular meeting. She said the following: "The Gambian woman, a doctor, asked whether she could show us some pictures of girls' genitalia. We protested, and this made her angry, but in the end, she managed to convince us to watch the slides of small Gambian girls suffering from conditions due to FGC. They had scars and cysts. Others had fistulas. We could see that the children were in pain. We were shocked. The Gambian doctor sang the secret songs from the circumcision ritual. That shocked us even more. The tension in the room was electric. There were tears in the eyes of every Gambian woman present. I got gooseflesh, all the hair on my body stood out. We realized that she herself had been there, that she herself had been circumcised. It was an emotionally strong discovery and experience. I understood, there and then, that this tradition is definitely wrong."

Source: Lien and Shultz (2013)

The UNJP programme has, to date, focused on collective change, rather than individual change. But we will need to understand more about the dynamics of change—within individuals, between individuals and families, between individuals, families and groups and between all of these and the wider community/society—to understand what drives people to stop FGM/C. In Somalia, as elsewhere, this means that we need deeper understanding of **power** and how power works within communities and wider society.

In some organisations working in Somalia (e.g. CCBRS and TASS) the process of developing an approach to collective, community-based change around FGM/C has somewhat obscured the gender politics of the issue. The focus has turned towards facilitating the empowerment of communities so that they can choose to renounce FGM/C, and away from the issue of women's empowerment—that is, strengthening and developing **all** aspects of women's autonomy, reducing women's vulnerability and increasing their resilience, and changing the gender relations of power<sup>15</sup>.

<sup>15</sup> Also informed by Toubia, N. *personal communications*, consultations, 2014



### 5.1.4 Men and boys

More research is needed to gain a clearer understanding of the roles that men and boys can play in ending FGM/C, and what needs to be done to ensure their greater involvement. Fieldwork for the Situational Analysis supported findings from fieldwork carried out in 2012<sup>16</sup>: many men, especially younger men, are not in favour of Pharaonic FGM/C. Some younger men are against FGM/C altogether. Conversely, there are men who support many older women in believing in the value of FGM/C in maintaining the purity of girls. One older man also pointed out:

“We cannot satisfy a women who has not been cut”. (Older man, Garowe, Puntland)

There is, however, plenty of anecdotal evidence to suggest that young men, as well as women, are severely traumatised by the expectations placed on them regarding achieving penetration of their young brides who have been infibulated. Older women may claim:

“It takes a strong man to break down the door (*Older women, Boroma*)

and claim that woman want this. More space needs to be given to understanding the feelings of young men: they are forced to cause extreme pain to their wives, and to create/penetrate an open wound. These are hardly circumstances which can lead to ongoing and deep, respectful communication between men and women.

### 5.1.5 Sexual practice and sexual pleasure

Sexual practice and sexual pleasure, in the context of FGM/C, has not been addressed systematically. Within Islam, women as well as men have the right to enjoy sexual relationships within their marriage. Sex is a rights issue and we need to understand better the effects and impacts that FGM/C has, not only on physical relationships between people, but also on emotional ones. In Somalia, there is a good deal of anecdotal evidence that FGM/C causes sexual problems (see Part 2, the CPS). We need to know more about this and about individual and collective expectations in physical and emotional relationships. This will help to build appropriate and respectful initiatives to support girls and women who have undergone FGM/C.

### 5.1.6 Support for girls and young women who have undergone FGM/C

There is little in-depth understanding of the contexts in which FGM/C is no longer carried out<sup>17</sup>. We need to know more on the changes that occur when FGM/C stops. For example, do new life opportunities open up for girls, or does the end of FGM/C lead to new and different problems? What has to be in place so that girls and their families can most benefit from the end of FGM/C? There may, initially, be some disadvantages to face—such as a lack of social acceptance and marriageability. These risks need to be mitigated wherever possible<sup>18</sup>

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<sup>16</sup> Crawford, S. 2012, The Social Determinants of Health in Somalia, DFID-S

<sup>17</sup> Source: discussions with Nahid Toubia, Sudan. Also see, Johnsdotter (2007) and (2009) on Somali and Eritrean people in Sweden

<sup>18</sup> In Amhara, for example, in communities where girls are now not marrying early, they are staying in school until the end of primary education. But there is often no secondary school which they can attend. This means that they remain at home during adolescence. Parents fear that girls will “be led astray” and that they will have to find extra food to feed the family (End Child Marriage Programme, Independent Verification and Evaluation, Inception Report 2014).

More attention needs to be given to understanding the needs of girls and young women after they have undergone FGM/C. The physical and psychological trauma, may well not be recognised until first intercourse or birth—when women who have undergone Pharaonic FGM/C will be cut open to allow penetration or birth. Beyond trauma at the time of FGM/C and immediately after it, the pain and stigma of difficult urination, impeded menstruation, and fistula often go unattended. More effort is needed to support girls and young women, at the same time as working to end FGM/C. Otherwise, we are abandoning a cohort of girls who have been cut—and, in doing so, may be changing the dynamics of their futures for the worse.

## 5.2 Medicalisation

Medicalisation has both been used as a conscious strategy to reduce the harm caused by FGM/C and has been a recourse of the economically better off/better educated in the belief that medical FGM/C is less damaging. Medicalisation refers to performance of FGM/C by health care providers, rather than by traditional cutters. UN agencies, a number of national governments, and development workers have condemned the practice. It has been estimated that over 18% of women, globally, who have undergone FGM/C have had the procedure performed by a medical provider<sup>19</sup>. It is now widely acknowledged that medicalisation can never be an acceptable “first step” to ending FGM/C and is, in any case, unlikely to lead to abandonment<sup>20</sup>. Dr Abdelhadi El-Tahir, a physician who has campaigned against FGM/C for years, argues that medicalisation must be condemned as it “only validates the practice by providing the veneer of medicalization whilst ignoring the human rights violations”<sup>21</sup>.

The development of an anti-medicalisation strategy in Puntland, and now in Somaliland, is positive. Nevertheless, medicalisation is reported to be increasing in all zones. Communities consulted in Puntland and Somaliland indicated that the medicalisation of FGM/C was a trend, but in South Central Somalia it was considered to be widespread:

"Mogadishu practitioners of FGM/C openly advertise their services on street signs and there are “FGM clinics.” (*GBV and Child Protection Committee Member, Mogadishu, South Central Somalia*)

In South Central Somalia, the health care professionals who offered FGM/C as a clinical procedure differentiated themselves from TBAs by refusing to perform full infibulations:

"Most health workers (in clinical settings) do not do Pharaonic infibulation but they do Sunnah Kabiir. TBAs and midwives do Pharaonic infibulations.” (*Young woman, Mogadishu, South Central Somalia*)

Throughout Somalia, most FGM/C is carried out by TBAs, some of whom may have received some medical training. However, there is also a trend to towards seeking FGM/C in health clinics. One NGO, offering medical services in Somaliland, admits to telling clients that Sunnah will be carried out, but then “doing nothing”—as they say that clients do not know the difference. This is a dangerous approach, and one which does not necessarily convince the public. Although women may be unfamiliar with un-cut genitalia, fieldwork revealed that

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<sup>19</sup> UNAIDS, UNDP, UNFPA, UNICEF, UNHCR, INIFEM, WHO, FIGO, ICN, IOM, WCPT, WMA, MWIA (2010) Global Strategy to Stop Health-Care Providers From Performing Female Genital Mutilation, WHO, Geneva

<sup>20</sup> To resort to the much-used “parallel” with foot-binding, medicalisation is like binding only one foot—the lifetime damage is still done.

<sup>21</sup> Extracted from [www.prb.org](http://www.prb.org) (2014)

mothers may return their daughters to cutters for more radical cutting if they feel that the initial cutting is insufficient.

.Health staff in all zones claimed that: a) they do everything they can to dissuade women from re-infibulation after birthing, b) they repair and reconstruct as much as possible, and c) they do not carry out FGM/C themselves, this is not the understanding gained from communities during the Situational Analysis (see Part 2, the CPS, for further details). We understand that the demands made on medical staff, by women, wishing to be re-infibulated or to have modifications to their existing FGM/C, are high. It is also true that medical staff, themselves, are part of the system of social norms which perpetuate FGM/C. They, as much as anyone else, need to be convinced of the merit of ending FGM/C—many of them have, themselves, been cut, may be intending to cut their own daughters, or may feel pressurised by family and society into doing so. They need to be supported in refusing FGM/C:

### **Box 5.2 HCWs are also under pressure to cut**

“Every day, when I come to work, I am in fear for my two daughters. I hate leaving them. I do not want them to be cut—but my sister, my aunt and my mother-in-law all think it is necessary. Of course I try to get them to see why cutting is wrong. But they are adamant. My husband is weak, he will not stand up to his mother. Of course, he supports me when we are alone together, but I know he would never say anything directly to his mother if she insisted. I am scared that they will come round and snatch my daughters and do it. This isn’t a fantasy—it happens like that around here. Especially if they know that the mother doesn’t want it. They come when she is not at home and they take the girls off. They have been working on my daughters, telling them that they will be proper women if they are cut, promising them presents and a party and new dresses. The older one now comes to me and complains—she asks why she can’t be cut like everyone else, why won’t I let her fit in. Honestly, this is breaking the family apart. I don’t trust them. My poor daughters, they have no idea, no idea ...”

Source: Nurse, Hargeisa, in Crawford, S., 2011

In all zones, the MOH wishes to work through the colleges and Association of Midwives to promote greater understanding of anti-medicalisation. However, as yet, there is no money for implementation of any anti-medicalisation strategies

## **5.3 Monitoring and evaluation**

In this sub-section we outline some of the key issues which need to be addressed in developing approaches to monitoring and evaluation of end-FGM/C work.

### **5.3.1 What works, where and why?**

In spite of the valuable work done by the UNJP to improve evaluation and indicators, community-based organisations have yet not been linked to a user-friendly testing, modelling and evaluation approach. At the community level, we do not know enough about what works to end FGM/C and why, and what we think we know is based on assumptions and experience from other sectors and issues.

There is now a wealth of approaches to ending FGM/C, some of which have shown successes (for example, community development, community dialogue, working with early adopters/champions of change, safe spaces etc.) and some of which (for example

medicalisation, alternative income for providers of FGM/C services, very small-scale initiatives that do not reach inter-marrying communities, such as work with women khat sellers in Mogadishu) are either unethical and unacceptable, or unlikely to work<sup>22</sup>. Some programmes focus on FGM/C as a main issue, others address FGM/C only because it has relevance to their main goals and objectives (for example, when working more widely on community development, girls' education or GBV).

Neither in Somalia, nor anywhere else, are we able to say with certainty what approaches work best, in which contexts, and why. For example, public declarations of a commitment to end FGM/C have been shown to have had an effect in several countries in West Africa, with the backing of strong champions<sup>23</sup>. But do they have the same impact across the wide range of countries where FGM/C occurs, and in countries like Somalia, where public declaration does not have the same meaning and tradition? We suspect not, as making public promises has a different meaning in different societies. Public declaration may work well where FGM/C is a communal and public matter, less well in countries—like Somalia—where it is a family (at most, clan) matter. But we do not know for sure<sup>24</sup>.

Some organisations, notably Tostan in West Africa, firmly believe that a long term (three-year) community-development approach is needed to end FGM/C, and that FGM/C can only be addressed successfully as part of a wider programme of women's empowerment and community rights. Other organisations, for example the Young Women's Christian Association (YWCA) in Kenya, run shorter, FGM/C-centred awareness/education courses, focusing on the community and children in schools. There is considerably more evidence to suggest that longer-term approaches work better—but just how long, and covering what aspects of life, we cannot yet be sure.

As yet, we have very little data which can help us understand the relative merits of different community-level approaches (adherence to the four A's of human rights standards<sup>25</sup>, outcomes, impacts, value for money). Not only do we not know which components in wider approaches (such as Tostan's or TASS) are likely to be essential in ending FGM/C, and which desirable; we do not know what combination of components is best. We are not able to compare effectively between different approaches, and we cannot compare 'like with like' resourcing (time, money, person-input etc.).

### **5.3.2 Does a strong focus on one particular aspect work?**

We also do not yet know for sure whether a strong focus on one particular aspect of FGM/C prevention can work as a stand-alone approach. This is, however, unlikely, since we know that a holistic approach is needed to achieve social norm change and wider social change. Understanding more about this will be vital in Puntland, for example, where a major government strategy is to raise awareness amongst FGM/C practitioners and provide alternative livelihood opportunities for cutters, as part of a wider ending FGM/C strategy.

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<sup>22</sup> Though see Calder, R. *On Pensions for Grannies: where the provision of pensions to older women providing FGM/C services may have led to reduced incidence*

<sup>23</sup> Mackie, Melching

<sup>24</sup> In much of West Africa, promises made in public are serious and accountable. In some other countries, e.g. Somalia and Yemen, public promises may be mistrusted and FGM/C may be seen as a family issue, not a community/society-wide issue.

<sup>25</sup> These are standards which, though slightly different in each sector, regulate the provision of services designed to meet the requirements of human rights instruments. In essence, they are: Availability, Accessibility (including affordability), Acceptability of Quality, and Adaptability to different peoples and contexts.

Where organisations have experimented with providing alternative means of income for traditional cutters, they have not met with a great deal of success (see, for example, Senegal and Mali). Firstly, in many places, it is not only the money and gifts which cutters receive which are important to them, but also the status conferred upon them as cutters. Secondly, providing alternative incomes does nothing to reduce the inherent demand for cutting or the social belief that FGM/C is necessary. Encouraging existing cutters into other income generating activities may simply leave open a door for new cutters to start up. However, the Tostan programme, in Senegal, has shown the benefits of working with cutters in order to change their beliefs and mind-sets—in Kolda, ex-cutters have been vital community workers, campaigning against FGM/C, promoting diffusion of the commitment to end FGM/C and monitoring progress to end FGM/C in the communities.

More research is needed for fully understand the way that economic circumstances may influence efforts to end FGM/C. For example, Calder (2013) has suggested that the provision of pensions to grandmothers in Karamoja, Uganda, may contribute to reduction in the incidence of FGM/C<sup>26</sup>. The situation is likely to be different in different contexts and amongst different cultures.

### **5.3.3 Limited monitoring and evaluation capacity of smaller organisations**

Smaller NGOs and other community-based organisations do not often have the skills and resources to undertake rigorous monitoring and evaluation of impact and outcomes. Much of their monitoring and evaluation time is taken up with producing activity and output reports for funders. Increasingly, larger projects are being designed around target-orientated, performance indicators—designed to show process value for money. However, these indicators are often divorced from impacts and outcomes, and do not measure social change processes or progress towards rights fulfilment<sup>27</sup>.

There is a real opportunity with the UNJP in Somalia, to develop user-friendly monitoring and evaluation systems which can enable CSOs to gather and assess outcome and impact data. The culture of information-sharing is well-established in the zones—through the Task Forces—and can be expanded through the development of simple, standardised monitoring and evaluation systems. This would be a pioneering approach and would provide a model for FGM/C work, globally.

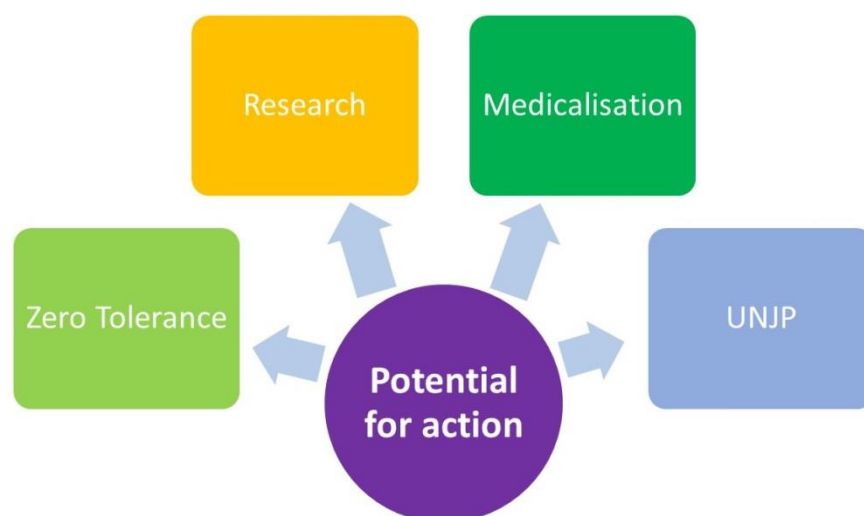
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<sup>26</sup> Calder, R. (2013) Grandmas, Pensions and FGM/C; Development Pathways Perspectives No. 7

<sup>27</sup> See, for example, “The Independent Verification and Evaluation of the Early Child Marriage Programme in Amhara”, Inception Report (IMC / GYA 2014).

## 6 Recommendations

**Figure 3** Areas for action



The recommendations we put forward here stem from the information and understanding gained through the Situational Analysis, and by the encouraging commitment towards ending FGM/C made at the London Girl Summit in July 2014, by representatives from the three zones. The recommendations are based on the following assumptions:

- 1) All future work to end FGM/C in Somalia can benefit from the broader, DFID-funded Towards Ending FGM/C in Africa and Beyond programme (2014–2017). It now seems highly likely that all three components of that programme will be operational in Somalia. This means that Somalia stands to benefit from increased participation in the global movement to end FGM/C, increased funding for research, monitoring and evaluation, and some increase of funding directly into the UNJP on FGM/C;
- 2) Donors need to strengthen their commitments to bi-lateral funding specifically for FGM/C in Somalia.
- 3) .

The recommendations are based on four key areas for action: **1) National Plans and zero tolerance; 2) Implementation of policy and stopping medicalisation of FGM/C; 3) Research monitoring and evaluation, and 4) Strengthening the UNJP Somalia so that it demonstrates a model approach**

- 1) **Support the development of National Plans of Action and full adoption of zero tolerance**
  - a) **Assist in the development of National Plans of Action:** All relevant stakeholders—including civil society partners in the FGM Task Forces at zonal and more local levels, to develop national plans of action to end FGM/C. It is important that there is coherence in these plans across the three zones. Approaches and focuses may be somewhat different in the different zones, but all planning needs to be: i) evidence-based; ii) inclusive of the poorest and most vulnerable people—especially girls and women in isolated areas and from amongst pastoralist groups;



iii) developed in such a way as to build information about, and understanding of, FGM/C in Somalia and end-FGM/C programme needs into the HMIS and d) based on a range of qualitative data. This will facilitate rigorous monitoring, evaluation and lesson learning (see also 4, below).

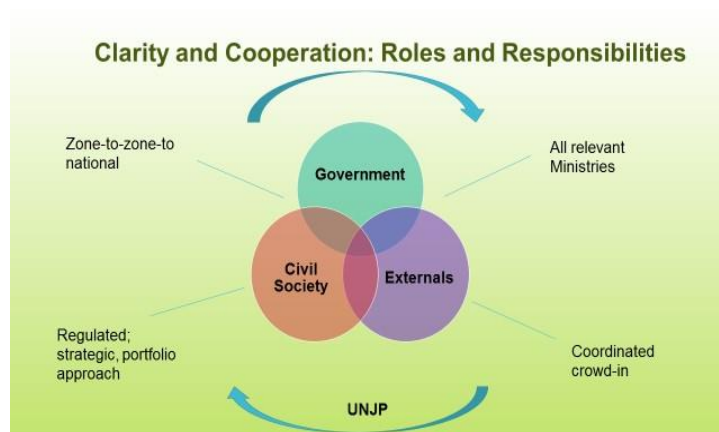
**b) Encourage full understanding of zero tolerance; support embedding of zero tolerance throughout policy:** At the London Girl Summit, in July 2014, FGS committed to ending FGM/C and all zones committed to working for zero tolerance. However, zero tolerance is currently not fully understood or accepted by all relevant stakeholders and communities, across the three zones (see Part 2, the CPS). Zero tolerance is government policy through the lead ministries in each of the zones, and in the health ministries. It is supported by a *fatwa*, and across the MORA in Puntland. But, despite full support from the Minister for Religious Affairs in Somaliland, not all officials within the ministry are in favour of it. Additionally, there is a lack of coherence in approaches and messages across civil society, with numerous organisations supporting the end of Pharaonic FGM/C, but tolerating Sunnah forms, and working for harm reduction rather than elimination. This has led to confusion amongst the population on what ending FGM/C really means. It has also led to a conviction, amongst some people in society, including some in government positions, that Sunnah FGM/C is a) allowable, b) desirable and c) too difficult to eliminate entirely (see Part 2, the CPS).

**c) Encourage the development of regulatory structures, mechanisms and systems, within government, to ensure adherence to zero policy:** Across the three zones, and particularly in Somaliland, there is frustration that CSOs are not presently fully regulated by government policy and strategy. In Somaliland, for example, the lead ministry noted that very few CSOs fully comply with delivery of zero tolerance messages, even though these organisations may be part of the government-coordinated GBV Working Group and FGM Task Force. It was also noted that the problem gets worse when donors directly fund CSOs, without ensuring that the approaches they fund are fully harmonised with government policy and strategy. DFID can support government in the development of regulatory structures, and use influence to ensure donor harmonisation—between donors, and with government.

**2) Strengthen the implementation of policy and encourage the end of medicalisation of FGM/C:** In addition to the supporting government in regulating civil society approaches, there are opportunities for donors to support existing anti-medicalisation work and to embed anti-medicalisation in all its future health programming. The CPS has shown that medicalisation of FGM/C is a serious issue across the three zones. To date, the UNJP has supported development of anti-medicalisation policy in Puntland and is beginning to support it in Somaliland, but there are no funds available to follow policy through into implementation. Neither are there plans to monitor and evaluate the impact of anti-medicalisation policy. Implementation will require, *inter alia*, development of curricula, training for all health care personnel (ideally, medical and non-medical staff), mentoring/coaching and on-the-job supervision; social contracts between health staff and clients, advocacy and awareness creation on all aspects of FGM/C (social and medical). Implementation of anti-medicalisation policy also needs to be inter-linked with social approaches to ending FGM/C.

- 3) **Support the clarification of all roles and responsibilities amongst all actors who need to be involved in ending FGM/C in Somalia:** Internationally, nationally and throughout—and across—the zones, at all levels, there is need for increased clarity regarding roles and responsibilities better communication and improved coordination. This is both in terms of development of structures, mechanisms and systems, and in the promotion of improved communication between people (men, women, girl, boys). The development of GBV Working Group and FGM Task Forces is positive – so long as the FGM/C agenda remains high.
- 4) More effort is needed in advocacy work to ensure that men and women, older and younger people, start to talk with each other more about FGM/C, and to challenge myths and misconceptions about the advantages of FGM/C. The structural approach to working closely with religious leaders needs to be continued and strengthened even further.

**Figure 4**      **Clarity and cooperation**



- 5) **Be pro-active in shaping the research agenda: ensure that research carried out under the FGM/C shows good fit to national and zonal identified needs:** The TEFGM/C research component is highly likely to offer valuable possibilities for developing an evidence base in Somalia which can increase effectiveness, sustainability and equity of all planning and intervention to end FGM/C, and ensure high value for money. This will require all stakeholders (government, civil society, the UNJP etc.) to be pro-active in identifying research needs and influencing partners in the TEFGM/C research component, so that the right kind of action-orientated research is carried out in an appropriate time-frame. The CPS has revealed that, amongst other areas, research into the following will be highly valuable:

- Understanding more the where, when, what, how etc. of FGM/C in Somalia (within and across zonal boundaries, and across country borders);
- Internalising knowledge: what makes people turn away from FGM/C and to give up FGM/C forever?;
- What happens, in families and in communities, when people give up FGM/C?;
- How can support for “survivors” best be offered?;
- How can the attitudes of men and boys change so as to support ending FGM/C?; and
- Sexual practices and sexual pleasure.



In addition, there is an urgent need to develop monitoring, evaluation and learning approaches. The HMIS needs to be strengthened to include indicators on FGM/C and systems for sharing information across zones, and country borders, need to be developed and institutionalised. As well as action research, user-friendly and participatory monitoring and evaluation is needed. Systems are needed to build this participatory monitoring and evaluation into improved MIS at district, zone and national levels, and to ensure that learning informs development of policy and practice.

## **6) Support Somalia in becoming a model UNJP country:**

UNICEF staff in South Central Somalia have described the current UNJP as “*Scattered inconsistent, short term and not coordinated*”. This means that the enormous efforts, and the progress, made by the UNJP are not being optimised. A change in strategy is needed.

It is unlikely that the TEFGM/C programme will lead to significant new investment in the UNJP in Somalia, though it is likely to ensure more reliable funding over longer payment cycles. The current funding cycle of one year is totally inadequate and cannot support value for money work to end FGM/C. A two-year cycle, preferably with a performance-related possibility of further funding, is a minimum requirement. If this can be ensured, there are several ways in which Somalia can become a model UNJP country:

- a) The UNJP needs to develop a strong, strategic portfolio of community-based work, inter-locked with enabling level interventions. This means:
  - i) Continuing to support a holistic approach, with full attention to building synergies between enabling, catalysing and focused action;
  - ii) Expanding the range of community-level partners and providing mentoring where needed;
  - iii) Ensuring all partners are united under a government-approved Theory of Change and strategic approach;
  - iv) With partners, developing simple, user-friendly monitoring and evaluation systems (qualitative and quantitative) and strengthening the capacity of partners to use these effectively;
  - v) Building protocols and processes to ensure that community-level learning is fed through the levels to inform higher level planning;
  - vi) Continuing to support critical pathways to ending FGM/C (e.g. anti-medicalisation and work through religious organisations);
  - vii) Exploring and modelling a range of inter-dependent approaches: supporting and advising government on how this can be achieved (e.g. supporting the Puntland authorities to link livelihoods for ex-FGM/C practitioners with other community-based and advocacy approaches, and the development and implementation of law and regulation);
  - viii) Supporting the establishment and work of FGM/C focal points at all levels; and

- ix) Ensuring that innovative research and learning, generated in Somalia, is used to inform UN programming in other countries.



## **PART 2 - Community Perspectives on FGM/C in Somalia**

Sagal Ali

Sheena Crawford (Dr)

## Executive Summary

The Community Perspectives Study (CPS) provides an overview and analysis of community views on the practice of FGM/C and local perceptions of efforts to end FGM/C in Somalia. FGM/C is defined as the partial or total removal of or other injury to the external female genitalia for cultural or other non-therapeutic purposes. According to the World Health Organization (WHO), there are four types of FGM/C: Type 1 is the partial or total removal of the clitoris and/or the prepuce. Type 2 is the partial or total removal of the clitoris, the labia minora and/or the labia majora. Type 3, infibulation, involves the narrowing of the vaginal opening with the creation of a covering seal by cutting and appositioning of the labia minora or the labia majora, with or without excision of the clitoris. Type 4 involves all other harmful procedures to the female genitalia for non-therapeutic purposes such as cauterisation, burning and scraping. All types of FGM/C were documented to occur in Somalia according to the results of the CPS.

The high rate of FGM/C in Somalia is driven by deeply entrenched cultural traditions, values and social norms. Local leaders, government institutions, international and local agencies, religious scholars and grassroots activists have attempted to promote the elimination of FGM/C with varying degrees of success. The purpose of the CPS was to investigate local perspectives and understand the role of men and women in ending, or putting up barriers with the aim of ending, FGM/C.

The methodology utilised in the CPS was a participatory assessment in which participatory stakeholder consultations were held with local communities, NGOs, health workers and local activists. Consultations were held in Somaliland, Puntland and the South Central zone with participants from urban, peri-urban and rural backgrounds as well as internally displaced populations. The participatory assessment was a 'snap-shot' study approach and did not include an in-depth analysis of FGM/C practices or a representative sample of all Somali populations. However, the study documented key issues and perspectives on FGM/C, many of which were found to exist in all of the consultation sites.

The participatory consultations revealed that communities perceive FGM/C to be relatively prevalent and highest among rural populations. There were only a few rare instances of households that claimed to have completely abandoned FGM/C. The key findings and themes that emerged from the consultations included the following:

- **The rate of FGM/C remains high:** In all of the communities consulted the local populations expressed the position that although FGM/C remains prevalent they corroborated that the traditional form of Type 3 FGM/C was decreasing or decreasing in severity.
- **Misinterpretation of FGM/C is common:** The term FGM is principally interpreted in the Somali language to refer to only Type 3 FGM/C.
- **Local terms for and variations of FGM/C do not correlate well with WHO classifications:** The four WHO classifications of FGM/C are not suitable to use in identifying the variations of FGM/C in Somalia. For example, the local term Sunnah circumcision is used to refer to Type 1, Type 2 and Type 3 forms of FGM/C. Traditionally, Sunnah had referred only to Type 1 but in recent years other forms of FGM/C have been given the Sunnah label to circumvent local efforts to eliminate Type 3 FGM/C. Self-reporting from women on the form of FGM/C they have undergone is not accurate because of the high level of variation in excision and the divergence of local terms and interpretations from the WHO FGM/C types.
- **A new form of FGM/C has emerged:** An intermediate form of infibulation that involves less stitching was referred to in all communities consulted and was considered to be a less severe form of traditional infibulation. This modified form of Type 3 FGM/C is considered to have emerged as a response to previous government interventions that promoted the elimination of Type 3 but not Type 1 or Type 2 forms of FGM/C.

- **Medicalisation remains high:** In all three zones the principal group that carried out FGM/C were traditional birth attendants (TBAs) followed by semi-skilled health professionals, nurses and physicians in homes and in clinical settings.
- **Revision of FGM/C is a common practice:** Young girls were said to undergo revisions of their FGM/C if a family member did not consider the circumcision appropriate or severe enough. Women may also have their infibulation scars re-approximated after giving birth or even in instances of rape to restore a sense of normalcy, virginity or honour.
- **Miscommunication between men and women is high:** Although the overwhelming majority of men preferred women that were not infibulated the women were not aware of this. There is a general lack of awareness among both sexes of the preferences of men and women.
- **Zero tolerance for all forms of FGM/C is low:** Support by men, women and youth for zero tolerance was low and the majority of communities wanted to eliminate the Type 3 but not Type 1 form of FGM/C. There was a high level of stigma toward women and girls with no form of FGM/C.

The CPS highlighted the community attitudes and practices that are hindering efforts to eliminate FGM/C. The communities consulted indicated that cultural traditional, social pressures and marginalisation of women without FGM/C were the key barriers to local abandonment of FGM/C. The communities identified mothers and grandmothers as key decision makers and religious leaders as influential stakeholders that should be targeted in anti-FGM/C activities. Overall, there were no anti-FGM/C activities or interventions that were mentioned to have successfully eliminated FGM/C completely in any region in Somalia.

The CPS provided significant insight into emerging innovations and perspectives on FGM/C in Somalia. Some of the findings include new practices that have not yet been documented in the research literature. The results of the CPS indicate there is a need for additional in-depth, action-orientated research into FGM/C in Somalia. Although the CPS revealed relevant information on attitudes and practices towards FGM/C, there still remains a need for understanding why people abandon FGM/C completely, what support they require in maintaining their decision and how positive change can be sustained to end all forms of FGM/C across Somalia.

## 7 Introduction

### 7.1 Background

This participatory assessment, of community perspectives on Female Genital Mutilation/Cutting (FGM/C) was designed to support the Situational Analysis on FGM/C stakeholders and interventions in Somalia, commissioned by DFID Somalia. The Community Perspective Study (CPS) comprised three components:

1. Participatory stakeholder consultations in communities in Hargeisa and Borama in Somaliland, in Garowe and Bosaso in Puntland and Mogadishu in South Central Somalia.
2. Review, analysis and synthesis of existing data sources addressing FGM/C in Somalia; and
3. Recommendations to support DFID in fulfilling its objectives to identify key knowledge gaps that may require research to improve the understanding of the practice of FGM/C and activities that work to promote the abandonment and management of FGM/C.

The study also made use of consultations held, with local staff members of Non-Governmental Organizations (NGOs) and people in communities, during field visits to all of the three zones in Somalia. The CP Study has taken a “quick and dirty” snapshot approach to exploring community views on the practice of FGM/C and their perspectives on anti-FGM/C activities. This is not an in-depth study and it has not consulted a representative sample of citizens in Somalia. However, it has highlighted a number of major concerns, many of which are found to be common to all the areas where consultation took place. In working towards the elimination of FGM/C, these concerns may need further exploration and will need to be addressed in new planning.

### 7.2 Aim, Purpose and Objectives

The principal focus of the Situational Analysis on FGM/C interventions and stakeholders in Somalia was on engaging and holding consultations with institutional and governmental stakeholders. The purpose of the Community Perspectives Study was to complement the governmental and institutional consultations by giving the perspectives of the populations that are the target and/or beneficiaries of anti-FGM/C activities in Somalia.

### 7.3 Purpose

The purpose of the CP study was to investigate perspectives on FGM/C in Somaliland, Puntland and South Central and understand the role of men and women in ending, or putting up barriers towards ending, FGM/C.

#### 7.3.1 Specific Objectives

The following are the objectives which were addressed in the CPS:

- To assess how collective and individual change happens in communities where FGM/C is carried out
- To understand why specific individuals, families, groups and communities have abandoned FGM/C and where that choice is being sustained
- To determine what anti-FGM/C intervention approaches are equitable

## 8 Methodology

### 8.1 Method and Approach

The method used for the fieldwork part of the study was one of a **rapid, qualitative, participatory survey**.

#### 8.1.1 Study team

The study team comprised:

- an international team leader
- a national consultant
- four local research assistants per zone (Somaliland, Puntland and South Central)

#### 8.1.2 The approach

The international consultant was largely responsible for the literature review and design of the community perspectives study and initial training on participatory methods. The national consultant continued the participatory training for the study team in the second and third zone and supervised the research assistants in conducting the Participatory Interest Group Discussions (PIGD's). The international and national consultants worked together on synthesis and analysis of findings and on providing recommendations.

The community research was facilitated by Benadir University, in all of the three zones in Somalia, in partnership with Amoud University in Somaliland and East Africa University in Puntland. The partner universities and Benadir University provided a team of four local research assistants, in each zone, to carry out the field work. The research teams consisted of two females and two males who were responsible for conducting consultations with single sex groups. In each zone, local NGO's that had implemented anti-FGM/C activities assisted the research team in engaging local communities and scheduling consultations with community members as well as local stakeholders. Consultations were organized by the African Network for Protection and Perfection of Children Against Neglect (ANPPCAN) and Comprehensive Community Based Rehabilitation in Somaliland (CCBRS), Tadamun Social Society (TASS) in Puntland and Somali Peace Line (SPL) in South Central.

The approach used during fieldwork, and the fieldwork methods, were devised by the consultants during preparation days in Nairobi, Kenya and Hargeisa, Somaliland. The research assistants were taught two, simple, participatory tools for use during Participatory Interest Group Discussions (PIGDs). A fieldwork guide, containing explanations of the tools and a reporting format was shared. The tools and formats were designed by CR2 Social Development Ltd. and have been tested and used in a wide variety of settings (see Annex 3). They can be used with people from all backgrounds (government ministers through to the street-based children) and they are particularly useful with the poorest and most vulnerable people, people who are un-used to development interactions, and those who are non-literate.

#### 8.1.3 Process

The consultants drew up a set of open-ended questions on five topic areas, in Somali (See Annex 1). The questions were used as a guide to facilitate discussion during PIGDs and in-depth interviews, not as a questionnaire. The research assistants were trained in conducting PIGDs and became familiar with use of the methods and recording, and prepared for field work.



The International Consultant and National Consultant trained and accompanied the research team during fieldwork in Hargeisa District in Woqooyi Galbeed region and Borama District in Awdal region in Somaliland. The International and National Consultant trained the research assistants in Garowe. The National Consultant supervised the research assistants in conducting PIGDs in Garowe District in Nugaal region in Puntland. The research assistants also independently conducted two additional PIGDs in Bosaso District in Bari Region in Puntland. In South Central, the National Consultant trained the research assistants and supervised the fieldwork carried out in Mogadishu in Benadir region with participants from various districts across Mogadishu.

The research team held consultations over the course of two to three days per district. **The researchers consulted a total of 215 people in PIGDs** (See Annex 2 for breakdown of groups). The PIGDs had an average of 6 to 8 participants but in some instances groups had more participants. The PIGDs were usually single sex groups, of similar ages. The only exception to this was a PIGD composed of a mix of younger and older men which was held in an Internally Displaced Persons (IDP) camp in Garowe, Puntland. The different types of interest groups consulted in PIGDs were: men, women and youth. Only one PIGD in Borama, Somaliland, included young children who were accompanied by their mothers. In-depth discussions were also held with a number of people from these groups.

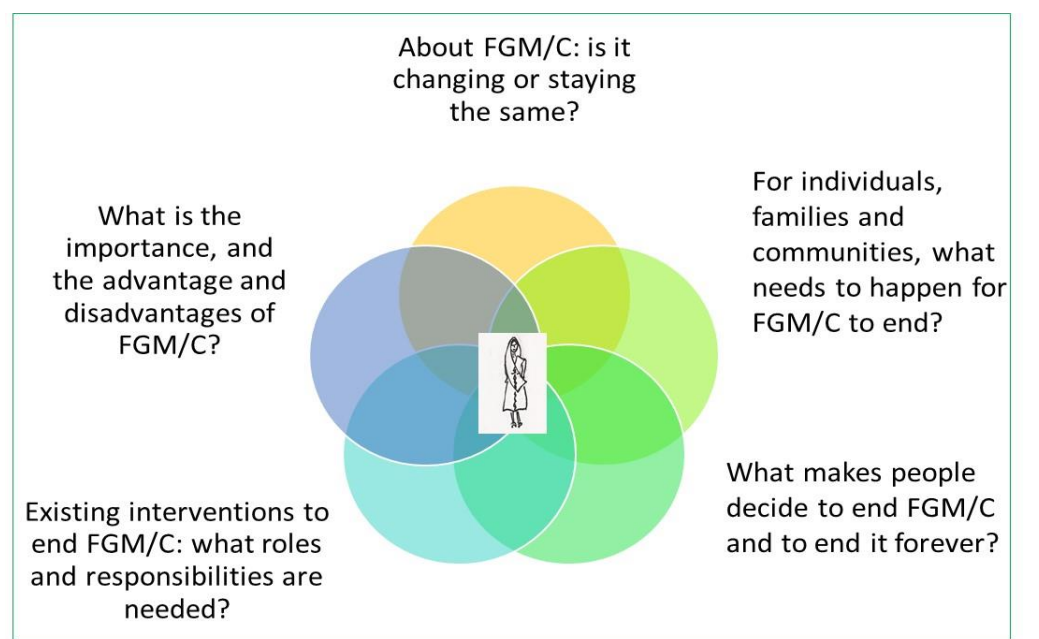
**Researchers also consulted a total of 93 people in group and in-depth interviews with organizations and individuals involved in anti-FGM/C efforts.** In the consultations held with community activists, NGO staff, or committee members, men and women sat together, or various age groups. The interest groups consulted were: health workers, NGO staff, local activists and child protection, FGM/C or gender based violence committee members.

Not all groups were consulted in each of the three zones of Somaliland, Puntland and South Central– but men, women and youth were consulted in all zones.

At the conclusion of consultations with interest groups in each zone, a consolidation workshop was held by the national consultant with the research assistants to discuss and consolidate the findings.

## 8.2 Framework for analysis

It was decided that, as the consultations were to provide a “snap-shot” on community perspectives on FGM/C, the framework for consultations and analysis would be kept simple and easy to use. For these reasons, a basic checklist of questions was developed, covering five, interlinked question areas. All questions were girl/woman-centred, rather than organization/institution-centred. Figure 1, below, shows the five question areas. The full checklist of questions (in English and Somali) are in Annex 1.

**Fig. 1: The Community Perspectives Question Topics**

The five topic areas also formed the basis for organization and analysis of the data. The report follows this format.

## 8.3 Limitations to the study and caveats

### 8.3.1 Indicative not representative

A qualitative, participatory study of this kind only provides a **snap-shot of the views of a section of the Somali public** on FGM/C. In this study, we aimed to hold consultations in communities in urban settings and among IDPs in Somaliland, Puntland and South Central. This means that the study gives an indication of the views of these selected communities. It does not, necessarily, indicate the views of the wider public. The study is also not an evaluation of the efficacy of the anti-FGM/C interventions implemented by local NGO's or the United Nations Joint Programme on FGM/C. Not all participants in PIGD's had been reached by NGO interventions or UN campaigns. The results are not objectively verifiable. In qualitative enquiry, there is no right or wrong answer. We created spaces, and used participatory methods, which encouraged people to be as free and open as possible and to give their true opinions. We used semi-structured, open-ended questioning which does not pre-suppose, or direct, the answer given. We were careful to facilitate the PIGDs so that even participants who would not normally raise their voices were able to participate. Where possible, we triangulated what people were telling us, so as to gain consensus opinions, not just the voice of the loudest individual.

The study does not claim to be representative of the views of all Somali groups throughout the country.

### 8.3.2 Public opinion versus statistical evidence

Public opinion rarely keeps pace with statistical findings. Also, owing to the lack of recent country-wide population statistics on FGM/C and FGM/C trends in Somalia, the community perspectives could not confirm or contradict existing statistics. People held views on FGM/C that were based on their own, immediate, experience and on local traditions. The perspectives

of the communities consulted in the PIGDs do not indicate awareness of general trends. Whilst people felt, overall, that the rates of specific types of FGM/C were decreasing or increasing, they felt this in comparison with their experiences, not because they have objective knowledge. As recommendations at the end of this report will show, addressing the need for further research on FGM/C in Somalia is necessary.

## **8.4 Background to the study areas**

This section gives a brief context outline on each of the study areas in Somaliland, Puntland and South Central.

### **8.4.1 Somaliland**

Somaliland is an autonomous territory in Somalia. The government of Somaliland seeks international recognition as a sovereign state and is not governed by the Federal Government of Somalia (FGS). The estimated population of Somaliland is 1.8 million. With the exception of low-intensity conflicts with neighbouring Puntland, over a border dispute in the Sanaag region, the Somaliland territory is relatively peaceful and stable.

Consultations were carried out in homes and community centres in Hargeisa and in Borama. The city of Hargeisa is the capital of Hargeisa District and Somaliland. The district is located in the Wooqoyi Galbeed region in north western Somalia. Hargeisa is a city with a population of 1.2 million. The community consulted in Hargeisa were internally displaced persons (IDPs) residing in an informal urban IDP settlement in Hargeisa. The population of the IDP camp is composed principally of pastoralists and agro-pastoralists who have been displaced by environmental and economic shocks. In Borama, the capital of Borama District in Awdal region in Somaliland, the PIGD's were carried out in two neighbourhoods in central Borama. The estimated population of Borama is 39,100.

### **8.4.2 Puntland**

Puntland is a semi-autonomous state in the Federal Republic of Somalia that falls under the administration of the FGS. According to the government of Puntland, the population of the state is estimated to be 3.9 million. UNDP population figures estimate the population at 2 million (UNOCHA, 2012). The stability and security of Puntland has increased significantly since the formation of the state in 1998. The principal security challenges include a border dispute with Somaliland in the Sanaag region and ongoing security threats in some districts from the terror organization Al Shabaab. The majority of the population is pastoral or agro-pastoral, with 52% of the population having nomadic livelihoods.

The consultation sites in Puntland were in Garowe and in Bosaso. The consultations in Garowe were held across Garowe and also in an IDP camp. Garowe is the capital of Garowe District and Puntland. It is located in the Nugal region in north-eastern Somalia. The population of Garowe is approximately 57,300. The IDP camp where consultations were held is a formal IDP settlement located on the outskirts of Garowe. The camp is managed by the Puntland government. The majority of the IDPs are from conflict-affected regions in South Central Somalia. Many of the IDPs are from riverine backgrounds and are ethnic Somali Bantu. The remainder of the population of the camp is composed of agro-pastoralists and pastoralists from local majority clans. They have lost their livelihoods because of drought and economic shocks.

Bosaso is the capital of Bosaso District in the Bari region. It is the most populous city in Puntland with a population of 700,000. The participants consulted in Bosaso are urban residents of low-income and lower middle-income backgrounds. The majority work in the commerce, fisheries and labour sectors.

### **8.4.3 South Central**

The South Central regions in Somalia are under the jurisdiction of the FGS but not all regions are fully government-controlled. The government, as of August 2014, had control of only five of the eleven regions. Other regions in South Central shift in and out of the control of the Islamic terrorist group, Al-Shabaab. The presence of the terror group also extends into government-controlled regions. In these regions, Al-Shabaab frequently orchestrates terror attacks, tyrannize local populations and assassinate prominent figures. Al-Shabaab also engages in high-intensity and low-level conflicts with government and African Union forces. The ongoing conflict has contributed to a high number of IDPs. The majority of the 1.1 million IDPs in Somalia reside in South Central and there are nearly 369,000 IDPs in Mogadishu (UNHCR, 2014). Recurring droughts, chronic food insecurity and famines are also drivers of displacement and instability in the region.

The communities consulted in South Central were principally non-IDPs from the city of Mogadishu and districts in the Benadir and Lower Shabelle region in south eastern Somalia. Mogadishu is the capital of Somalia and of the Benadir region. The city has a population of approximately 1 million.

In Mogadishu, for the security of all concerned, consultations were held in the offices of local NGO's. The individuals consulted in the PIGDs represented communities from the following districts in Mogadishu: Dayniile, Hamar-Jajab, Hamer-Weyne, Hodan, Howl-Wadag, Shibis, Wadajir, Warta Nabada (Wardhigley) and Yaqshid. Participants from the Lower Shabelle region were from Afgooye District. The participants in the PIGDs were principally low-income and lower middle-income urban residents. Additional consultations were also held with health workers and local NGO staff who served communities in the following regions in South Central: Benadir, Lower Shabelle, Middle Shabelle, Hiiraan and Galguduud.

## 9 Findings on FGM/C in Somalia

### 9.1 Shifts in Interpretations and Practices

This section reviews community discussions on the perceptions of and nature of FGM/C in Somalia:

#### Key Messages:

People consulted across Somalia, of all ages and backgrounds, believe that FGM/C rates remain high. Households that did not have their daughters undergo FGM/C were reported to be a small minority. The following key messages emerged from discussions:

- The acronym FGM is interpreted in Somalia to refer to only one type of FGM/C
- *Gudniin*, the Somali term used for male and female circumcision, was the principal term used to refer to all forms of FGM/C
- In all regions in Somalia, the term *Sunnah* circumcision, can refer to Type I, Type II or Type III FGM/C. This wide interpretation differs from the use of the term *Sunnah* circumcision by other Muslim populations (and by the UN and WHO) to refer only to Type I FGM/C
- Two variations of Type III FGM/C were reported: A form of infibulation, which involves less stitching, known locally as *Sunnah Kabiir* and, *Fadumo Hagoog*, a form of Type III FGM/C which involves excision but no stitching.
- Women's and girls' self-reporting of the type of FGM/C they have undergone is often not accurate

#### 9.1.1 Perceived prevalence of FGM/C

In Somaliland, Puntland and South Central the consulted communities said that nearly all households in their localities had women and girls who had undergone FGM/C. The responses of the communities consulted were reflective of current statistics which indicate a high prevalence of FGM/C in Somalia estimated to be 97.9% for women 15-49 years old (Population Reference Bureau, 2014). The few mothers who openly said they had not had their daughters undergo FGM/C were from communities that had been beneficiaries of anti-FGM/C activities by ANPPCAN in Borama in Somaliland, TASS in Garowe in Puntland and Somali Peace Line in Mogadishu, Somalia:

“There are some families that do not practice FGM but these are urban families that have been reached by anti-FGM/C advocacy workers.” (GBV Caseworker, TASS, Garowe, Puntland)

There was not a single community consulted in which all households had completely abandoned FGM/C. This was equally true in communities which had seen anti-FGM/C interventions as in communities which had not. The only community in which the participants claimed that most families are abandoning FGM/C completely was in Borama, Somaliland in a community that was targeted by CCBRS:

“The rate of all forms of FGM/C is decreasing.” (Older women, Borama, Somaliland)

The community members who were not the target of interventions and who were cited to have abandoned all forms of FGM/C were a minority of educated Somalis and Somali diaspora from Western countries or the Middle East:

“In the city of Bosaso almost everyone does FGM/C except for a few and these are principally the educated. There are those who have come from Arab countries long ago

and some of those who have come from the West who do not do it.” (Young man, Bosaso, Puntland)

### 9.1.2 Local terms for FGM/C

The local populations referred to FGM/C in the Somali language as *gudniin* which is translated as circumcision. *Gudniin* was the most common Somali term used to refer to all forms of FGM/C and is also the same term used to refer to the circumcision that boys undergo. Women who had not undergone FGM/C were referred to as being uncircumcised and during participatory group discussions, their genitalia was sometimes compared with those of an uncircumcised male:

“When a woman that is not circumcised is with a man it is just as if two foreskins come together and this is wrong.” (Older woman, Mogadishu, South Central)

“If [they] do not perform FGM the community understands there is something wrong like what they call *buuryo qab* (having a foreskin) and this means [the girl] has no value...” (Male IDP, Garowe, Puntland)

Men and women of all age groups in all of the study areas consistently used the same local terms for FGM/C. There were two main types of FGM/C that were universally known to all communities. The two most commonly cited types of FGM/C and their local names are the following:

1. **Sunnah:** Locals used the Islamic term Sunnah or Sunnah circumcision to refer to forms of FGM/C which they consider to have a religious justification. Sunnah is an Arabic term which is used to refer to Islamic practices derived from the words and actions of the Prophet Muhammad (pbuh). Sunnah practices are viewed by Muslims as optional and beneficial in Islam, but not compulsory (Al-Sabbagh, 1996). There were two types of the local Sunnah form of FGM/C most commonly mentioned in all three zones in Somalia. The types are known locally as Sunnah Kabiir which is translated as greater Sunnah, and Sunnah Saqiir, which is referred to as the lesser Sunnah. These are local Somali terms that make use of the Arabic and Islamic terms. The types of FGM/C known locally as Sunnah Kabiir and Sunnah Saqiir are not known to other Muslim populations and are unique to Somalia.
2. **Fircooni:** This type of FGM/C is pronounced fir’ooni. It is referred to across Somalia as *gudniin fircooni* in local dialects and Pharaonic infibulation or circumcision in English.

In Puntland and South Central Somalia another form of FGM/C was mentioned which was known locally as Fadumo Hagoog.

### 9.1.3 Local classifications and types of FGM/C

The current local terms and types of FGM/C in Somalia and their correlation to World Health Organization classifications of FGM/C are detailed in the table below:

**Table 1 Local types of FGM/C**

Sunnah Saqiir	Sunnah Kabiir
<ul style="list-style-type: none"> <li>▪ <b>How Sunnah Saqiir is defined:</b></li> <li>▪ Partial or total removal of the clitoris and/or the prepuce</li> </ul>	<ul style="list-style-type: none"> <li>▪ Modified form of infibulation (Type IIIa or Type IIIb) that involves cutting of the labia major and/or labia minora, with or without excision of the clitoris.</li> </ul>



<ul style="list-style-type: none"> <li>▪ Type Ia: Removal of the clitoral hood or prepuce only</li> <li>▪ Type Ib: Removal of the clitoris with the prepuce</li> <li>▪ <b>What Sunnah Saqiir can also look like:</b></li> <li>▪ Type IIa: Removal of the labia minora only</li> <li>▪ Type IIb: Partial or total removal of the clitoris and the labia minora</li> <li>▪ Type IIc: Partial or total removal of the clitoris, labia majora and labia minora</li> </ul>	<ul style="list-style-type: none"> <li>▪ The upper portions of the outer labia or labia minora are stitched together.</li> <li>▪ The stitching in Sunnah Kabiir leaves an opening that is larger than the significantly narrower vaginal introitus of women that have undergone Pharaonic infibulation.</li> </ul>
<b>Pharaonic Infibulation</b>	<b>Fadumo Hagoog</b>
<ul style="list-style-type: none"> <li>▪ Narrowing of the vaginal opening with the creation of a covering seal by cutting, appositioning and stitching together the labia minora or the labia majora, with or without excision of the clitoris</li> <li>▪ Type IIIa: Removal and apposition of the labia minora</li> <li>▪ Type IIIb: Removal and apposition of the labia majora</li> </ul>	<ul style="list-style-type: none"> <li>▪ A form of Type III FGM/C that involves excision and sealing of the vagina but does not involve stitching. After excision, the legs of a girl are tied tightly together. The raw surfaces fuse together when the wound heals, forming a seal. In Somalia, a mixture of hot ashes and tree sap is often used to seal the wound.</li> </ul>

Note. WHO classifications of FGM/C are from the “Eliminating Female Genital mutilation – An interagency statement,” by WHO, 2008.

### 9.1.4 Development of new terms and forms of FGM/C

Since the 1980's, the Somali government had been working towards the elimination of Type III forms of FGM/C and activists believed that Type III FGM/C was beginning to decrease prior to the Somali civil war in 1991 (Warsame, 1989). Local populations were often encouraged to decrease the severity of FGM/C in Somalia, in the pre-civil war era, by abandoning infibulation and adopting Sunnah. The definition of the Sunnah form of FGM/C historically has referred to Type Ia or Type Ib FGM/C. These forms of FGM/C have been validated by the following saying attributed to the Prophet Muhammad (pbuh):

“Do not cut too severely as that is better for a woman and more desirable for a husband.”

This saying has been viewed by several prominent religious scholars as questionable and misinterpreted (Al-Sabbagh, 1996). Despite religious edicts against FGM/C, religion remains one of the leading validations for “Sunnah” forms of FGM/C in Somalia. The types of FGM/C that have been labelled as Sunnah in Somalia often involve more extensive excision, or refer to a modified form of infibulation which involves less stitching than traditional Pharaonic infibulations. According to Dr Habiba Ismail, of Garowe Hospital, the new forms of Sunnah may have evolved into variations of Type II and Type III because of the limited knowledge of the population and those people who carry out the cutting:

“The population is not educated/nor consistent in their definitions of types of FGM/C and the cutters themselves are not even aware of what Sunnah (Type Ia or Type Ib) is and will often perform various forms of FGM/C that are more severe than Type I and claim that it is Sunnah to the parents.” (Dr Habiba Ismail, Garowe Hospital, Garowe, Puntland)

“[Some] Sunnah forms of FGM are essentially variations of Pharaonic FGM.” (Dr Habiba Ismail, Garowe Hospital, Garowe, Puntland)

The interpretations and trends in the forms of FGM/C, described by the communities consulted, are considered to be new developments that may have emerged since the outbreak of the

Somali civil war in 1991. The emergence of new terms and forms of FGM/C in Somalia has not yet been documented in any of the clinical or anthropological literature.

In the study areas in all of the zones in Somalia, men consulted had no consistent knowledge or awareness of the most common forms of FGM/C. Although all female participatory groups were aware of all of the local variations and terms for Sunnah FGM/C, the male participants would often correlate Sunnah only with Type Ia or Type Ib forms of FGM/C.

### **9.1.5 Interpretation and use of the acronym FGM in the Somali language**

In addition to the Somali terms for various forms of FGM/C, the acronym FGM was widely used in all three zones of Somalia. According to the World Health Organization, FGM refers to all forms of cutting or mutilation of the female genitalia but this is not the case in Somalia (WHO, 2008). In all of the study areas the acronym FGM was used to refer to only one form of FGM/C and not to all types. FGM was often used interchangeably with Pharaonic infibulation. During participatory group discussions if the term FGM was used it, would elicit responses from participants on Pharaonic infibulation. When individuals who claimed to have abandoned FGM were asked to clarify further, they would say that they had only abandoned Pharaonic infibulation. In Puntland, a woman who had said she had abandoned FGM had difficulty accepting zero tolerance of all forms of FGM/C in her household:

“I cannot imagine leaving my daughter as she is, without at least a nick or small snip off of her clitoris.” (Older woman that claimed to abandon FGM/C, Garowe, Puntland)

This same perception of FGM to refer only to the full Pharaonic infibulation exists in Somaliland as well as South Central:

“I have abandoned FGM. I only now just perform Sunnah circumcision on girls.” (Older female cutter, Borama, Somaliland)

“I am against FGM! I have watched my daughter undergo Sunnah Kabiir and made sure the circumciser only did three stitches and did not do a full infibulation.” (Older woman, Mogadishu, Somalia)

The misinterpretation of FGM by local populations poses a problem for activists who make use of the term FGM/C to inform and educate the public. The issue appears to have arisen because numbers of NGOs, since the '90s, have encouraged people to give up Pharaonic FGM/C, but some have said (and continue to say) that Sunnah types can continue. This is in contravention with current government policy (Somalia and Somaliland) which requires zero-tolerance. This seems to have increased the innovative approach amongst the population – encouraging increasingly radical forms of cutting and mutilation to be labelled as Sunnah. It also explains the enthusiasm with which community members introduced the research teams to women said to have stopped cutting. On consultation, these women were found only to have given up performing types of FGM/C which are fully recognized as Type III, Pharaonic.

### **9.1.6 Reliability of self-reported FGM/C**

The women participating in the discussions in the community consultations said that there is a lack of reliability in self-reported forms of FGM/C. Women and girls are not always aware of the form of FGM/C they may have undergone:

“I cannot explain to you exactly what kind of the FGM/C I have had done to me.” (Young woman, Mogadishu, Somalia)



Additionally, although the classifications of the various types of FGM/C are generally consistent, the individuals who perform FGM/C are said to vary widely in their definitions and degree of excision or stitching when they perform excision or infibulations on girls or women:

“One patient had her labia minora and clitoris cut off and the [cutter] performed the FGM/C and claimed it was ‘Sunnah’ form of FGM/C.” (Dr Habiba Ismail, Garowe Hospital, Garowe, Puntland)

“Even the cutters themselves do not know the difference between Sunnah Saqiir and Sunnah Kabiir.” (Halima Abdi Sheikh, Somali Midwives Association, Mogadishu, Somalia)

The lack of awareness of types of FGM/C, as well as misinterpretation of the term FGM, indicates that self-reporting from women about the type of FGM/C that they, or their peers have undergone, is not always reliable.

## 9.2 Changes in the Types of FGM/C in Somalia

This section reviews community discussions on the perceived shifts in prevalence and frequency of the most common types of FGM/C in Somalia:

### Key Messages:

- The Sunnah and Pharaonic forms of FGM/C were reported to exist in all communities consulted.
- Sub-types of Sunnah were reported to exist in Somaliland, Puntland and South Central.
- In Somaliland and Puntland, there was a perception that infibulation was decreasing.
- In South Central, the communities perceived that less severe forms of infibulation were becoming more prevalent.
- Rural populations were considered to have the highest rates of Type III FGM/C.
- Fadumo Hagoog, a form of Type III FGM/C, was claimed to exist only in rural communities in Puntland and South Central.
- There are some rural populations that do not practice any form of infibulation but they were not considered to be the norm.

### 9.2.1 Most common types of FGM/C

The types of FGM/C that were said to exist in the study areas included the following:

**Table 2 Types of FGM/C reported in study areas**

Study area	Sunnah	Sunnah Kabiir	Sunnah Saqiir	Pharaonic	Fadumo Hagoog
Hargeisa, Somaliland	X			X	
Borama, Somaliland	X	X	X	X	
Bosaso, Puntland	X	X	X	X	
Garowe, Puntland	X	X	X	X	X
Mogadishu, South Central	X	X	X	X	X

### 9.2.2 Awareness of variations in “Sunnah”

All of the communities consulted in all three zones mentioned different sub-types of Sunnah except for one community in Hargeisa which mentioned only Sunnah and Pharaonic infibulation as two general types of FGM/C. Additionally, although young and older women were aware of and mentioned sub-types of Sunnah, the men consulted referred more often to Sunnah and Pharaonic infibulation as the two main types of FGM/C.

### 9.2.3 Fadumo Hagoog

In Puntland and South Central the type of FGM/C known as Fadumo Hagoog was said to exist, not specifically in the consulted communities but in rural localities. It was said to have been more common in the past:

“Fadumo Hagoog is only found in nomadic communities that may not have proper [tools] so they will not stitch girls up or they may use thorns if they have them.” (Child Protection Advocate, SPL, Mogadishu, South Central)

It was considered to be a far less common form of FGM/C and also considered by local populations to be the most severe form of infibulation because of the amount of time it took a girl to recover (as the wound is likely to be jagged and unprotected during healing).

### 9.2.4 Perceptions of prevalence

In Somaliland and Puntland, Pharaonic circumcision was believed to be decreasing. The type of FGM/C that was considered to be most commonly performed on young girls was Sunnah although there was no mention in Somaliland of whether or not modified forms of infibulation, with less stitching than Pharaonic infibulation, were becoming more common. In Puntland, the increase in Sunnah was attributed to Sunnah Saqiir, which involves excision, while rates of Sunnah Kabiir and Pharaonic infibulations were decreasing.

In Somaliland, Sunnah was considered to be the leading form of FGM/C to which young girls were subjected, but the rate of infibulation was considered to be higher among older girls and women:

“Sunnah has become more common in recent years. Women 12 years and older have Pharaonic infibulation while those that are 12 and under have Sunnah.” (Young male IDP, Hargeisa, Somaliland)

In South Central, variations of Type III infibulations were cited as the most common type of FGM/C followed by Sunnah forms that involved “only” excision. There were also generational differences cited in Mogadishu in types of FGM/C:

“Girls that are 10 and under have Sunnah most, while those that are 10 and above have Pharaonic infibulation.” (Young woman, Mogadishu, South Central)

### 9.2.5 Decrease in Pharaonic infibulation

In all of the study areas, Pharaonic infibulation was said to have decreased. In the areas where there were anti-FGM/C interventions the local NGO’s were said to have contributed to the decrease in “FGM” which is interpreted exclusively as Pharaonic infibulation. Also, increased awareness of religious edicts condemning Pharaonic infibulation, and knowledge of the health complications associated with Type III FGM/C, were cited as influencing the decrease:

“The rate of [Pharaonic infibulations] is decreasing because there is increased awareness of the dangers of FGM/C.” (Young woman, Borama, Somaliland)

“The population increasingly believes that the religion does not allow for Pharaonic infibulation.” (GBV Caseworker, TASS, Garowe, Puntland)

“The religious scholars do lectures on ending Pharaonic infibulation.” (Young woman, Mogadishu, South Central)

In Mogadishu, a new form of Type III FGM/C which involved less stitching was considered to have replaced the need for the traditional form of infibulation, thus leading to the decrease in Pharaonic infibulation:

“Circumcision has not decreased but what has changed is the way that they do it. Previously girls would be stitched eight times when they would be infibulated but now they will only do three stitches. The reason why this change happened is because the population benefited from advocacy and awareness campaigns and gained a greater understanding of religion.” (Young woman, Mogadishu, South Central)

In South Central one man described how the preferences of men for women without infibulation was also an influencing factor in driving down the rate of Pharaonic infibulation:

“After the civil war there was greater intermarriage with *Reer Xamar* which is a coastal ethnic group which does not practice Pharaonic FGM/C and when men saw that women with Sunnah had fewer complications/issues they came to prefer this and this contributed to driving down the rate of Pharaonic FGM/C. Men saw the pleasure of being with women that were Sunnah.” (GBV and CP Committee Member, Mogadishu, South Central)

The belief that Pharaonic infibulation is decreasing is a widely held belief in the study areas but in all three zones it was not considered to be decreasing in rural communities:

“The people who practice Pharaonic infibulation come from pastoral and agro-pastoral backgrounds.” (Young woman, Hargeisa, Somaliland)

Tradition and culture were cited as reasons why Pharaonic infibulation is higher in these communities. Additionally, Pharaonic infibulation was mentioned to be a more profitable livelihood in rural areas:

“In rural areas, Pharaonic infibulation can bring in up to \$50 but in urban areas it is cheaper...around \$15.” (GBV and CP Committee Member, Mogadishu, South Central)

In Somaliland and Puntland, some cutters in rural communities were said to receive livestock in exchange for their services.

## 9.2.6 Rural and urban differences in the prevalence of Type III FGM/C

In all of the communities consulted, the rural pastoral, agro-pastoral and riverine communities were frequently referred to as maintaining the most severe forms of Type III FGM/C known as infibulation or Pharaonic infibulation. Although urban residents did have their girls undergo infibulation it was most commonly considered to be highest among rural Somali traditions:

“Pharaonic infibulation is highest in IDP’s but especially among the agro-pastoral and pastoral IDP’s.” (GBV Caseworker, TASS, Garowe, Puntland)

Riverine populations including populations such as the Somali Bantu were mentioned to have the most severe forms of FGM/C:

“The Somali Bantu practice Pharaonic infibulation at high rates.” (Executive Committee Member, Somali Peace Line, Mogadishu, South Central)

Not all riverine communities have a high rate of Pharaonic infibulation. In Garowe, Puntland many of the IDP’s consulted originated from an ethnically Somali Bantu riverine community, at the Somalia-Ethiopia border, in which Pharaonic FGM/C was not a tradition. The community did, and does, practice Sunnah forms of FGM/C.

In some communities there was a fear that significant rural to urban migration would cause FGM/C rates to increase because rural populations are considered to maintain the practice of FGM/C more so than urban populations:

“When rural populations migrate into urban areas the FGM/C rates rise, especially if anti-FGM/C interventions have ended.” (Peer Advocate, ANPPCAN, Borama, Somaliland)

Another driver of the rate of Pharaonic infibulation is that in some communities girls will stay with relatives in rural areas so that they can be undergo FGM/C, or they may have relatives come from rural areas:

“There is family pressure for mothers and even fathers to continue FGM/C from grandmothers who come from rural areas...” (Peer Advocate, ANPPCAN, Borama, Somaliland)

Although the general consensus in all study areas was that rural populations practice FGM/C and infibulations at higher rates, there were some rural communities that were said not to carry out any form of infibulation. Some rural communities of the *Rahanweyn* clan of South Central were said never to have had any form of infibulation in their population, but their girls do undergo different types of Sunnah. There is also one riverine Somali Bantu population from the Ethiopia-Somalia border region, consulted in this study, that said their community abandoned Pharaonic infibulation for Sunnah approximately fifty to sixty years ago. The only other ethnic groups in Somalia, in which no form of Pharaonic FGM/C was documented, are the *Reer Xamar* and *Reer Baraawe* ethnic, coastal minorities. These principally urban coastal communities only have forms of FGM/C with excision but not infibulation. In community consultations, these groups that did not have their daughters undergo any form of infibulation, were considered to be rare and not the norm.

### 9.3 Changing Attitudes and Practices

This section discusses the way that FGM/C is carried out in Somalia and the changes in practices and attitudes:

#### Key Messages:

There were similar trends that were reported, by all communities consulted in Somalia, about the way that FGM/C is carried out and the attitudes of women and men towards FGM/C.

How FGM/C is carried out is similar across all zones:

- Traditional Birth Attendants (TBAs), midwives and cutters were reported to be the principal groups which carry out FGM/C in all zones in Somalia
- Young girls often undergo FGM/C in groups and are rewarded with a celebration

- FGM/C is medicalised and is carried out in hospitals, clinics and home visits

The revision of FGM/C was reported to be a common practice:

- Adult women revise or re-approximate their FGM/C scar by undergoing re-infibulation
- Young girls are sometimes sent back by their parents to have their FGM/C revised to a more severe form
- Rape victims were said to be coerced by their families into being re-infibulated. This is thought to restore the girl's and the family's honour
- Adult women who were not infibulated were reported to have undergone infibulations because of coercion, force or societal pressure

There was also significant miscommunication between men and women on FGM/C and infibulation:

- The majority of men consulted preferred women that were not infibulated
- Although men did not want women who were infibulated, they did not necessarily want women with no form of FGM/C
- Men believe that an infibulated woman will not enjoy sex. But they believe that a woman with Sunnah can have sexual pleasure
- Girls, women and some parents believe that women without infibulation are not marriageable
- There is little communication on FGM/C between men and women. There is little to no awareness between the sexes on "what women want" or "what men want".

### 9.3.1 Who carries out FGM/C

In study areas in Somaliland, Puntland and South Central the individuals that were said to carry out FGM/C were TBAs and women who worked only as cutters. Because of increasing medicalization of FGM/C, nurses, physicians and semi-skilled health professionals were also said to carry out FGM/C in health care settings and in house visits. When asked to carry out Sunnah FGM/C, some NGO health care providers only "pretend" to do so. They claim that, since the population is unfamiliar with the range of what normal genitalia may look like, they do not know that the girl has not been cut.

### 9.3.2 Where and how is it carried out

Girls undergo FGM/C either individually or in groups and it is most frequently mentioned that the site of the procedure is in a home. In rural Somaliland and Puntland young girls undergo FGM/C in groups, especially during the *xagaa* season when the nomadic people remain in one area and do not move around. Families in urban areas may even send their girls to undergo FGM/C in rural villages:

"Pharaonic infibulation is most common in *xagaa* season because the girls go to pastoral and agro-pastoral areas to be circumcised." (Older female IDP, Hargeisa, Somaliland)

In Mogadishu, the circumcision of girls in groups was also a common practice:

"When mothers want to circumcise their daughters they tell other women in the community and they all gather girls of similar age to have them circumcised at a home." Older woman, Mogadishu, South Central." (Older woman, Mogadishu, Somalia)

Once the girls have undergone FGM/C there may be a celebration hosted by all of the mothers. FGM/C is considered, in consultations in all of the zones, to be essentially a public milestone for girls and a time for celebration.

### 9.3.3 Medicalisation of FGM/C

When families have their daughters undergo FGM/C individually, they either choose to go to traditional cutters such as TBA's, traditional healers and midwives, or go to clinical settings. In Puntland, FGM/C was not mentioned to occur in clinical settings but nurses and other health professionals were said to visit homes. In Somaliland and South Central, there were some hospitals and clinics that offered FGM/C:

"Women can go to hospitals and clinics and get the type of FGM/C they want their daughter to have. The doctor will ask what form they want, but will also claim that doctors do not practice the most severe form (Pharaonic infibulation). They say they will infibulate to some degree if requested." Older woman, Mogadishu, South Central

In South Central, there was mention of local midwives using maternity kits, in a rural village outside Mogadishu, to perform FGM/C on girls:

"I have seen maternity kits distributed by a Western NGO to midwives. But these were used to perform FGM/C." (Child Protection Advocate, SPL, Mogadishu, South Central)

Communities consulted in Puntland and Somaliland indicated that the medicalization of FGM/C was a trend, but in South Central it was considered to be widespread:

"Mogadishu practitioners of FGM/C openly advertise their services on street signs and there are "FGM clinics." (GBV and CP Committee Member, Mogadishu, South Central)

In South Central, the health care professionals who offered FGM/C as a clinical procedure differentiated themselves from TBA's by refusing to perform full infibulations:

"Most health workers (in clinical settings) do not do Pharaonic infibulation but they do Sunnah Kabiir. TBA's and midwives do Pharaonic infibulations." (Young woman, Mogadishu, South Central)

### 9.3.4 Ages in which girls and women undergo FGM/C

Although the communities indicated that girls would undergo FGM/C between the ages of 6 to 10 years old, it was reported that older girls and adult women would undergo revisions or an initial FGM/C at later ages.

### 9.3.5 Revisions of FGM/C

The practice of revising FGM/C, on girls and adult women with or without their consent, was discussed in all three zones in Somalia. After girls undergo FGM/C their parents and/or relatives sometimes return them to revise (increase) the severity, or form, of FGM/C:

"Mothers sometimes keep taking their daughters back to have their FGM/C revised if they feel the infibulation is not tight enough." Older woman, Mogadishu, Somalia)

In one case, a young woman was forced to undergo a revision of her type of FGM/C, owing to the influence of her grandmother:



Case 1: A twenty year old woman in Mogadishu, who underwent Type I FGM/C at the age of six, was sent back by her mother to revise her FGM/C at the age of ten on the insistence of her grandmother. The young woman said, "When I was brought home with Sunnah circumcision my grandmother told my mother that it was shameful because I was open like a non-believer woman and she pressured my mother to take me back to be infibulated, which my mother did." The girl was forced into an arranged marriage at sixteen years old and suffered chronic pain and health complications due to the severity of the infibulation. After experiencing a difficult birth she believed she could not cope with giving birth again, or with sexual intercourse, and left her husband.

Source; *Fieldwork, CP Study, 2014*

Not all girls who had their FGM/C revised were coerced by parents or relatives. In some instances, the young girls themselves request to be infibulated so that they can conform to local custom:

"Pharaonic is so high [in Hiiraan region] that the young girls themselves ask to have Pharaonic infibulation." (Executive Committee Member, SPL, Mogadishu, Somalia)

A case of an adult woman who chose to be infibulated was also reported:

"There was an uncircumcised woman who came to give birth and during labour the people saw how large and unsightly her clitoris was and it increased in size while she was giving birth. It was shameless and she chose to be infibulated after she became a laughing stock." (Older woman, Mogadishu, Somalia)

In some instances women who previously did not have Type III FGM/C were infibulated shortly after giving birth by midwives and TBA's. This was sometimes without the women's consent or knowledge:

"I have known a woman who was Sunnah and went to give birth and was infibulated [without consent]." (Older woman, Hargeisa, Somaliland)

"Some of our girls who are Sunnah when they go to give birth outside of our community, they get infibulated." (Older woman, IDP, Garowe, Puntland)

Girls and women who are initially infibulated require their scar to be opened when they give birth. For some women, the scar is re-approximated at various stages in their life.

### 9.3.6 Re-infibulation and de-infibulation

Women and girls who undergo Type III FGM/C have a narrowed vaginal introitus which necessitates cutting of the vulvar scar tissue, to increase the size of the vaginal opening, before sexual intercourse and giving birth. The term de-infibulation refers to when a vertical incision is made on the vulvar scar tissue, along the infibulation (Ibe & Johnson-Agbakwu, 2011). Some women choose to be re-infibulated. This is a procedure in which the infibulation scar is re-approximated, partially or fully, so the vaginal introitus is as narrow as it had been in the initial infibulation (Ibe & Johnson-Agbakwu, 2011).

In the study areas in all three zones the de-infibulation of women was common and was reported to be carried out in the following circumstances:

- A woman may seek to be de-infibulated by a health care professional prior to the first night of marriage so that her husband does not rupture her scar, or cause tearing and vaginal lacerations, due to forceful penetration



- In some instances husbands use knives and cut along the infibulation scar rather than forcefully penetrating a woman with a narrow vaginal opening
- Some women will be de-infibulated while they are pregnant, or when they are giving birth, to prevent obstructed labour, fistulae and other Type III FGM/C-related birth complications

De-infibulation is recommended to young girls, prior to their wedding night, by some health providers. Or it may be recommended to treat health complications. Although girls and women may be advised to be opened in order to avoid possible negative health consequences, the de-infibulation of an unmarried virgin was viewed in study areas in South Central and Puntland as shameless. In Somaliland, it was reported that it was considered more socially acceptable than in other areas, for a girl to be de-infibulated to prepare for the wedding night.

Although women consulted associated numerous disadvantages and health complications with Type III FGM/C, it was said to be standard practice that women re-approximate their scar. Re-infibulation was reported to occur in all three zones in the following circumstances:

- After giving birth women often request to be re-infibulated – either partially or fully
- Some divorced women revise their infibulation scar so their vaginal opening is as narrow as that of a virgin – so as to make themselves marriageable
- The parents of female rape victims may have them re-infibulated
- In one Somali Bantu community in South Central, the women choose to be re-infibulated when their husband travels for extended periods– to prove to their husbands that they do not cheat on him whilst he is away

### ***Being closed feels normal***

One of the principal reasons stated for why many women choose to be re-infibulated is that the sensation of living with an opened scar, after living so many years with fused labia is felt to be uncomfortable and abnormal (see also Ibe & Johnson-Agbakwu, 2011).

"As health professionals, we want to leave women de-infibulated, but the majority of women want to be re-infibulated." (Halima Abdi Sheikh, Somali Midwives Association, Mogadishu, Somalia)

Women who come from the lowest socio-economic backgrounds in Somaliland and South Central were reported not to choose to re-infibulate. They are said not want to risk obstructed labour as they cannot readily access clinical care – because of distance and costs.

Victims of sexual violence are another group who were reported to undergo re-infibulation. Rape survivors are often forced, by their parents, to be re-infibulated. In Mogadishu, it was reported that parents would force rape victims to be re-infibulated so as to restore the honour of their daughter.

Regardless of the justification for re-infibulation, the communities consulted in all study areas claimed that there were health care workers who carry out the procedure in, and outwith clinical settings in all three zones.

### **9.3.7 Pleasure, pain and preference**

In all of the male interest groups consulted in the study areas, the men universally agreed that they did not prefer a woman that had Pharaonic infibulation. The principal reasons men gave for their preference for marrying women without infibulation are related to the sexual complications of FGM/C:

"On the wedding night there is no pleasure-only pain and sorrow." (Younger man, IDP, Hargeisa, Somaliland)

"Girls experience pain during sexual intercourse." (Younger man, Bosaso, Puntland)

Achieving successful penetration on the wedding night was a source of anxiety for some men. In the study areas in Somaliland, South Central and in Puntland the women and men said that the virility, strength and worth of a man is judged on his capability to penetrate an infibulated woman. In South Central, if a woman was de-infibulated by a health provider prior to the wedding night, and the community discovered this, the man would be viewed as weak. Some pharmacies in South Central market concoctions said to help increase the virility of men so they can avoid the embarrassment of failing to penetrate an infibulated woman. Other men use a knife to open the infibulation scars, rather than attempting to open the girl by penetration, but this is also considered to be a sign of weakness. A man who can successfully penetrate an infibulated woman is considered, by men and women, to be strong:

"Women need a strong man to break open that door!" (Older woman, Borama, Somaliland)

In a unique case, in Mogadishu, a young man sought the assistance of his mother-in-law:

Case 2: A child protection advocate working in Mogadishu reported the case of a young couple who had difficulty with sexual intercourse due to infibulation. The young man sought the assistance of his mother-in-law in possibly seeking out a health worker to de-infibulate the girl. The mother insisted that she would de-infibulate her daughter herself because she was said to have believed it would be shameless for the community to discover her son-in-law was weak. The attempt of the mother to de-infibulate the young woman led to the girl suffering from severe bleeding. She was hospitalized for three weeks.  
Source: *Fieldwork CP Study 2014*

Families in some communities are highly involved in guiding and observing newly married couples. In one village, in Bal'ad District, located outside of Mogadishu, it was reported that it was local custom for the families to demand to see if there was blood on the bed sheets of a newlywed couple, after their first night together, to verify the virginity of the wife. Men often expressed a preference for women who do not have infibulation. They believe that women who are not infibulated have less sexual dysfunction and higher libido than an infibulated woman:

"The libido of a woman with Sunnah is higher than that of a woman with Pharaonic infibulation." (Older male IDP, Hargeisa, Somaliland)

"Sunnah is better for pleasure and sexual intercourse." (Younger man, Garowe, Puntland)

The sexual dysfunction due to infibulation was believed to cause a strain in marital relations:

"The girl will hate marriage and marriage relations will become difficult." (Older man, Mogadishu, Somalia)

Marriage with girls with a Sunnah form of FGM/C with no infibulation is considered to have less conflict:

"The moral spirit of a girl [with Sunnah] and that of her household is high." (Older man, Mogadishu, Somalia)

Although men do not prefer women with infibulation, their preference is principally for women with some form of milder FGM/C that does not involve infibulation. They do not prefer women without any form of FGM/C. Some men expressed a fear that women who have no form of FGM/C have too much sexual desire:

"We cannot satisfy a woman that has not been cut." (Older man, Garowe, Puntland )

The majority of the male participants in interest group discussions did express a preference for women who were not infibulated, but female interest groups were generally not aware of this preference. In the female interest groups, they would often share stories that validated their beliefs that a woman who is not infibulated is not marriageable:

**Case 3:** In Garowe, Puntland, an older woman shared the story of an older man that had divorced his second wife because he was not comfortable with her type of FGM/C. His first wife had been infibulated but the second wife only had excision. According to the community, the man felt uncomfortable with how “open” the second wife was and subsequently divorced her. This story was shared widely in the community.

*Source: Fieldwork CP Study 2014*

Some fathers hold the belief that infibulation will ensure the marriageability of a daughter. In one case, a father feared his daughter would not be married if she was de-infibulated:

**Case 4:** A physician in a Mogadishu hospital reported that it was often difficult to convince families to have their daughters’ de-infibulated. Even when girls suffered from severe health complications the families would refuse the procedure: “I have had a [teenage] girl enter the hospital complaining of severe menstrual pain. When we did an ultrasound we saw that it would be necessary to de-infibulate the girl to open the vulvar scar and allow for a normal menstrual flow. When we informed her parents that we would need to de-infibulate their daughter the father was upset. He asked us who would marry his daughter if she was opened.”

*Source: Fieldwork CP Study, 2014*

While some fathers upheld the continuation of Pharaonic infibulation, there were other fathers who did not want their daughters to undergo infibulation. Cases of fathers refusing to have their daughters undergo Type III FGM/C were reported in Puntland and South Central. One father in Garowe and another in Mogadishu, had daughters infibulated without their knowledge, by the mother. This led the father from Puntland to divorce his wife. He was also reported to have asked his ex-wife to pay *diya* for his daughters. The practice of paying *diya*, which means blood money or ransom, is usually used to compensate a family or clan financially by the individual or clan that has committed a murder.

### 9.3.8 Lack of Communication: age and gender

The lack of consensus, communication and consultation between mothers and fathers is considered by some to contribute to the high rate of infibulation:

“Parents must communicate with another clearly about this issue. Quite often mothers will have it done without even consulting with fathers, or hiding it. The problem comes from mothers.” (Older male IDPs, Hargeisa, Somaliland)

The consultations indicated that the perceptions women and men have little or no mutual understanding of each other’s preferences. Men said more about how Pharaonic FGM/C harms women’s ability to feel sexual pleasure. In many ways, women seem resigned to the suffering caused by FGM/C:

“We are women, all our life is suffering. This is no different” (Older woman, Boroma, Somaliland)

## 9.4 The Drivers of FGM/C and Barriers to the Elimination of FGM/C

This section reviews community opinions on ending FGM/C, the barriers to zero tolerance for all forms of FGM/C and the drivers of FGM/C:

**Key Messages:**

The interest groups consulted were asked to describe their views on the elimination of FGM/C. Participants were also encouraged to discuss what they perceived as the advantages and disadvantages of FGM/C as well as their perceptions of the drivers of FGM/C. The following key messages emerged from discussions:

- All communities consulted believed there were more disadvantages to FGM/C than advantages
- Although the disadvantages of FGM/C were perceived to be greater, many respondents associated this with only Type III FGM/C and not all types
- Support by men, women and youth for zero tolerance towards all types of FGM/C was low in all zones in Somalia
- Many communities wanted to eliminate Pharaonic infibulation but not Sunnah
- Cultural traditions, social pressures and marginalization of women without FGM/C were stated as some of the key barriers to the elimination of FGM/C

### 9.4.1 Perceptions of advantages and disadvantages of FGM/C

Across Somalia, men and women view FGM/C as a tradition that has more disadvantages than advantages. Regardless of the age group or the gender, the table below shows the perceived disadvantages were consistently more numerous in different interest groups:

**Table 3 Perceptions of advantages and disadvantages of FGM/C**

Interest group	Advantages	Disadvantages
Male youth, Garowe, Puntland	<ul style="list-style-type: none"> <li>• Girl is viewed positively and not insulted by the community</li> <li>• Adherence to religion</li> <li>• Upholding culture</li> <li>• Beautification</li> <li>• Girl having more value</li> <li>• Better health</li> </ul>	<ul style="list-style-type: none"> <li>• Pain</li> <li>• Bleeding</li> <li>• Difficulty urinating</li> <li>• Menstrual complication</li> <li>• Difficult penetration and sexual intercourse</li> <li>• Need for medication to deal with FGM/C</li> <li>• Possibility of vaginal tearing/lacerations</li> <li>• Infection</li> <li>• Dizziness</li> <li>• Need for the girl to undergo surgery</li> </ul>
Female youth, Garowe, Puntland	<ul style="list-style-type: none"> <li>• There is no benefit</li> <li>• The culture maintains that girls with circumcision are better and more honourable</li> </ul>	<ul style="list-style-type: none"> <li>• Bleeding</li> <li>• Painful menstruation</li> <li>• Kidney pain</li> <li>• Giving birth is a major health risk due to the need to be cut open and sterile tools may not be available</li> </ul>
Older men, IDP, Hargeisa, Somaliland	<ul style="list-style-type: none"> <li>• Trust</li> <li>• Tradition and culture</li> <li>• Decreased libido</li> <li>• Virginity</li> <li>• Decrease in sexual desire preventing shameful actions</li> </ul>	<ul style="list-style-type: none"> <li>• Low libido</li> <li>• Pain</li> <li>• Difficult birth</li> <li>• On wedding night experiencing pain and sorrow</li> <li>• Infection</li> <li>• Restricted menstrual flow</li> <li>• Pain in kidneys</li> <li>• Bleeding</li> <li>• Difficult urinating</li> </ul>

		<ul style="list-style-type: none"> <li>• Vaginal cysts</li> <li>• Headaches and dizziness</li> <li>• Infertility</li> <li>• Vaginal tearing</li> </ul>
Older women, IDP, Hargeisa, Somaliland	<ul style="list-style-type: none"> <li>• Trust</li> <li>• Tradition and culture</li> <li>• Shyness in girls</li> <li>• Increases value and marriageability of a girl</li> <li>• Verifies virginity</li> </ul>	<ul style="list-style-type: none"> <li>• Infection</li> <li>• Period</li> <li>• Pain in kidneys</li> <li>• Bleeding</li> <li>• Women having vaginal lacerations and anal sphincter tears</li> <li>• Vaginal cysts</li> <li>• Infertility</li> <li>• Urinary tract infections</li> <li>• Mental health issues and psychological problems</li> </ul>

In all of the study areas the disadvantages of FGM/C are principally said to be associated with the complications of Type III FGM/C. The health disadvantages of Type III FGM/C that were listed by the community were often correlated with health outcomes documented in the medical literature (Simpson et al., 2012). Sunnah (Type I and Type II) were viewed as having fewer complications and were even viewed positively:

“Sunnah is happiness and health.” (Young woman, Mogadishu, South Central)

Even Sunnah Kabiir, which is a form of Type III FGM/C that leaves a larger vaginal introitus compared with the traditional Pharaonic infibulation, was considered not to have significant complications. Emphasis, by discussion participants, on the benefits of Sunnah Kabiir was on the fact that it has fewer stitches:

“They used to stitch girls up with eight stitches when they would circumcise girls but now they just stitch three times. This is what we call Sunnah Kabiir.” (Older woman, Mogadishu, South Central)

Although the interest groups cited greater disadvantages to FGM/C, this did not lead them to support the elimination of all types of FGM/C or Pharaonic infibulation.

#### 9.4.2 Views on the elimination of FGM/C

There were mixed opinions from the communities that had been reached by anti-FGM/C interventions, and those that had not, in Somaliland, Puntland and South Central. Some people support zero tolerance of all forms of FGM/C, some wish to see FGM/C continue in their communities. Some women and men support the elimination of FGM/C while others wanted to eliminate only some forms:

**Table 4 Male perspectives on the elimination or continuation of FGM/C**

Study area	Anti-FGM/C intervention	Young men	Old men
IDP camp, Hargeisa, Somaliland	No intervention	Eliminate Pharaonic and continue Sunnah	Eliminate Pharaonic only
Garowe, Puntland	TASS	Zero tolerance	Zero tolerance
IDP camp, Garowe, Puntland	TASS	Young and old men combined in one group supported zero tolerance with two men supporting elimination of Pharaonic infibulation only	
Bosaso, Puntland	No current intervention	Zero tolerance	Zero tolerance

Mogadishu, Somalia	SPL	Zero tolerance	Eliminate Pharaonic and continue Sunnah
Mogadishu, Somalia	SPL	Zero tolerance	Eliminate Pharaonic and continue Sunnah

**Table 5 Female perspectives on the elimination or continuation of FGM/C**

Study area	Anti-FGM/C intervention	Young women	Old women
IDP camp, Hargeisa, Somaliland	No intervention	Zero tolerance	Zero tolerance
Borama, Somaliland	CCBRS	Zero tolerance	Eliminate Pharaonic only
Borama, Somaliland	ANPPCAN		Zero tolerance
Garowe, Puntland	TASS	Zero tolerance	Consensus to end Sunnah Kabiir and Pharaonic; only 2 women wanted zero tolerance to all types
IDP camp, Garowe, Puntland	TASS	Eliminate Pharaonic and continue Sunnah	Eliminate Pharaonic and continue Sunnah
Mogadishu, Somalia	SPL	Eliminate Pharaonic and continue Sunnah	Eliminate Pharaonic and continue Sunnah
Mogadishu, Somalia	SPL	Eliminate Pharaonic and continue Sunnah	Eliminate Pharaonic and continue Sunnah

Overall, the communities consulted in Puntland and Somaliland were more likely to support zero tolerance for all forms of FGM/C in comparison with interest groups from South Central. The support of or condemnation of all forms of FGM/C by interest groups cannot necessarily be linked to the success or lack of success of the interventions of local NGOs.

Not all NGOs have ongoing, long-term interventions in the communities, due to lack of consistent funding. The participants in discussions were also from households that may not have been reached by campaigns. In one community in Borama, there were anti-FGM/C interventions that had been carried out over two years by TOSTAN and a local NGO, but the three-year programme was cut short by lack of funding and many households reverted to supporting FGM/C once the interventions ended.

There were many interest groups in all of the zones that wanted to eliminate Pharaonic infibulation but continue types of FGM/C that are locally referred to as Sunnah. In the female interest groups, support for the continuation of Sunnah could also indicate support for various forms of Sunnah and modified infibulation. Among male interest groups, their interpretation of Sunnah was only Type I or Type II FGM/C. All of the male interest groups said that they wanted to discontinue all forms of infibulation.

### 9.4.3 Barriers and challenges to the elimination of FGM/C

The communities consulted shared a number of barriers that advocates working to end FGM/C would encounter. The difference in the treatment of, and perception of, girls with and without FGM/C was considered to be one of the principal reasons why local populations consider FGM/C to be a tradition that will be difficult to eliminate:

**Table 6 Perceptions of women and girls with and without FGM/C**

With FGM/C	Without FGM/C
<ul style="list-style-type: none"> <li>High value in society</li> <li>Marriageable</li> <li>She will remain a virgin and honour herself and her family</li> </ul>	<ul style="list-style-type: none"> <li>Lower value</li> <li>Men may not marry uncut girls</li> <li>She will dishonour herself and her family</li> <li>Girls will be called prostitutes</li> </ul>



<ul style="list-style-type: none"> <li>• Sexual desire and libido will decrease and this will prevent promiscuity</li> <li>• Infibulated girls have a higher value in the culture and society</li> <li>• Feminine</li> <li>• Genitalia will be beautified</li> <li>• Clean</li> <li>• Pure</li> <li>• Pride</li> </ul>	<ul style="list-style-type: none"> <li>• Mothers fear they will be insulted and viewed negatively by the community if their daughter is not infibulated</li> <li>• Girls without circumcision will be taunted, isolated, stigmatized and bullied</li> <li>• Masculine</li> <li>• The large clitoris is ugly and unsightly</li> <li>• Dirty</li> <li>• Shameless</li> </ul>
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When asked to present the key challenges to ending FGM/C the communities consulted often discussed the difficulty of ending Pharaonic infibulation which remains the most prevalent form of FGM/C in Somalia (PRB, 2014). Infibulation is considered to increase the honour, value and marriageability of a girl more so than Sunnah types of FGM/C that involve only excision:

“We fear that girls with Sunnah will not be married and it would be better that they are infibulated.” (Older woman, IDP, Garowe, Puntland)

“[Sunnah circumcision] is like a house with an open door.” (Older male IDP, Hargeisa, Somaliland)

Infibulation was viewed as a form of protection and protection from sexual violence:

“Girls that are not infibulated can easily be sexually violated.” (Older female IDP, Hargeisa, Somaliland)

Even if mothers suffered from the severe complications of FGM/C they believed that infibulation would protect the virginity of girls:

“Families believe that FGM/C will maintain family honour and protect [their] daughter from having sex [outside marriage]. One mother said to Dr Habiba that she had her daughter undergo infibulation, despite all of the severe complications she herself suffered, because she thought that it would keep her daughter away from sex.” (Dr Habiba Ismail, Garowe Hospital, Puntland)

#### 9.4.4 Defying bans on FGM/C

Even with a ban or the threat of physical punishment, families are reported still to seek to have girls’ infibulated. According to communities consulted in South Central, the Islamic extremist group Al-Shabaab has attempted to bring an end to Pharaonic infibulation. In the regions they controlled, they were reported to have instituted a ban on Type III FGM/C with threats of physical punishment, such who infibulate girls, some of the cutters were reported to continue carrying out infibulations – by not referring to it as Pharaonic infibulations but as Sunnah. The Al-Shabaab ban on Type III FGM/C was mentioned by several participants but no government officials or Non-Governmental Organizations have been able to confirm these reports, due to the lack of access to the Al-Shabaab-held regions.

The pressure to conform to social expectations was cited as one of the driving forces behind the high prevalence of FGM/C, and especially the high rate of infibulation. Mothers, with daughters close in age, were reported to organize for their daughters to be cut in a group. They were also reported to speak frequently with one another about whether or not their daughters had undergone FGM/C. This tradition was said to occur in rural and urban settings, by communities consulted in South Central and Somaliland:

“I know of a mother who let her daughter join a group of girls who were being circumcised who were the daughters of her neighbours. She allowed her daughter to undergo the most extreme form of infibulation along with the other girls, and her daughter died of bleeding.



She deeply regretted her decision to follow the others.” (Older woman, Mogadishu, South Central)

“I am the only mother in my community who has not had her daughter circumcised. I feel embarrassed that she is this way. I plan to have her circumcised.” (Woman, Garowe, Puntland)

Even if parents did not disclose the status of the FGM/C of their child, the young girls would share that they had undergone FGM/C, because it was considered to be a source of pride. One father in Mogadishu had not had his daughter undergo any form of FGM/C and she was bullied in school when she disclosed this to her classmates. The bullying of his daughter was so severe that her classmates told her they would not eat with her and that her prayers would not be accepted by Allah. There were many instances mentioned of young girls who asked to undergo FGM/C because of peer pressure:

“Girls show off that they have [Pharaonic] infibulation.” (Older woman, Mogadishu, South Central)

“An 11 year old asked her mother please circumcise me because if you do not circumcise me the kids will insult me.” (Older woman, Mogadishu, South Central)

Young girls also request to undergo FGM/C because they expect presents and celebrations. Young girls and women without any form FGM/C, in some discussions in study areas, were often referred to as abnormal. They are thought to be of lower value and to have negative qualities. Disparaging terms are used to describe girls and women who have not undergone FGM/C:

“There is no difference between an uncircumcised girl and a dog.” (Older woman, Borama, Somaliland)

“When a girl is not circumcised we say that she has foreskin [like a male]. She is like a young girl that cannot take on the full responsibility of a woman. She will not be listened to, has no value among her people and will be viewed as a dirty person who is not pure and who may never be married.” (Younger man, Garowe, Puntland)

There was also a view held by some that a girl without FGM/C had to be purified and that the *haram* (forbidden) must be removed from her body to make her *halal* (permitted).

“We cannot stop. We must spill the dirty blood. We must clean [girls] of the forbidden and make them permitted.” (Older female IDP, Garowe, Puntland)

Beyond the social challenges the other barriers to the elimination of FGM/C that were mentioned in the participatory group discussions included the following:

- A general lack of long-term interventions, awareness raising and consultations on FGM/C
- The majority of the Somali population lives in rural and pastoral communities where the most extreme forms of FGM/C are prevalent and their migration across the region will always cause a resurgence in FGM/C rates if they are not reached by anti-FGM/C interventions
- Female ‘circumcision’ traditions are deeply ingrained in the culture and have been passed down for generations

- There is a lack of any incentive for cutters to stop FGM/C because it is considered to be a reliable source of employment and viable income stream
- Beliefs that the old traditions cannot be abandoned
- Lack of awareness of Islamic condemnations and edicts against FGM/C
- The general lack of knowledge on complications directly associated with FGM/C
- Normalisation of infibulation and health conditions associated with FGM/C

The activists and advocates working on anti-FGM/C activities and outreach also faced challenging environments, and sometimes strong pushback, from the households they encountered:

“The local populations are tired of people constantly talking about FGM/C and believe the [activists] benefit financially from them.” (Peer Advocate, ANPPCAN, Borama, Somaliland)

One physician explained that he would lose patients if he attempted to advise families to end the practice:

“As a doctor if I bring up with my patients that they must stop FGM/C they will just not return to my clinic.” (Physician, Mogadishu, South Central)

Workshop discussion sessions, that are one of the most common intervention activities organized by anti-FGM/C activists, were often viewed unfavourably in all of the zones:

“There is “workshop fatigue” especially among IDP’s who constantly have workshops held by humanitarian agencies on various issues in their camps, and many ask for their “rice” when NGO’s come in.” (GBV and CP Committee Member, Mogadishu, South Central)

Advocates who would reach out to households have a difficult time gaining the trust of families:

“People will insult you for talking to people [about FGM/C]....” (Child Protection Advocate, SPL, Mogadishu, Somalia)

“You cannot tell someone how to build their own house.” (Younger woman, Garowe, Puntland)

If anti-FGM/C campaigns were accepted by a community another issue mentioned was that the community would return to their previous practices:

“In our community FGM/C may come back if we do not continue anti-FGM/C advocacy.” Old women, CCBRS intervention site, Borama, Somaliland

Overall many of the communities viewed FGM/C as a tradition that would be difficult to eliminate completely. People frequently recommended that advocates push for a decrease in the severity of FGM/C rather than complete elimination.

## 9.5 Community Recommendations on Strategies to End FGM/C

This section reviews the recommendations of communities consulted on the key stakeholders and interventions they believe can end FGM/C and contribute to the elimination of FGM/C:

### Key Messages:

Interest groups were encouraged to share their views on how FGM/C can be eliminated and what has allowed those households that discontinue FGM/C to maintain their decision. The following views were discussed:

- Mothers and grandmothers were frequently mentioned as the key decision makers on whether or not to end FGM/C
- Religious leaders and scholars were also often considered to be influence the decisions of families to end FGM/C

Interest groups were also asked what resources and stakeholders should be mobilized to end FGM/C:

- All interest groups recommended that a diverse group of stakeholders are engaged
- Some of the PIGDs also recommended anti-FGM/C interventions during group discussions
- Overall, no stakeholder was mentioned by the PIGDs to have made full progress in ending FGM/C in any region in Somalia.

### 9.5.1 Decision-making on FGM/C

Women and men in all of the study areas were asked to identify what makes people decide to give up FGM/C in their family. Responses that were brought up in discussions in all three zones included the following:

- “The mother making the decision to end FGM/C.”
- “The mothers and fathers making a decision together.”
- “Understanding of the harmful consequences.”
- “Anti-FGM/C advocacy and awareness campaigns.”
- “The religious scholars always speaking about religious edicts [against FGM/C].”

Discussants also shared their opinions on what would allow some households to maintain their decision not to return to FGM/C again:

- “When they receive consistent sustained awareness and messaging to stop FGM this will allow people to sustain their decision.”
- “The reason why the mothers did not go back to it is because they recognized that their daughters that had not undergone FGM/C were much healthier than those girls that had undergone FGM/C.”
- “That the government strengthens regulations and laws against FGM/C.”
- “Religious scholars must constantly invest their efforts [in anti-FGM/C activities].”

In order to drive down FGM/C rates and positively influence decisions to end FGM/C, the communities said that the key decision makers were mothers. Grandmothers were also considered to play a highly influential role in the decisions of households. The fathers were not considered in most consultations to be the key decision makers on FGM/C, but were said to be critical in efforts to end FGM/C in a household. Often, discussants would recommend men influence the decision of women, because mothers were commonly viewed as the key decision-makers:

“Old men need to talk to mothers and tell them to not circumcise their daughters.”  
(Older woman, Garowe, Puntland)

“Men must convince their women to stop circumcision.” (Older man, Hargeisa, Somaliland)

When men were asked to elaborate further on other possible roles in ending FGM/C the roles that were often discussed were the following:

- Men should seek to marry women that do not have FGM/C.
- Men should work to protect women who are not just in their household but within their family, from undergoing FGM/C.

The other relevant stakeholders that were considered to play a key role in influencing and sustaining decisions to end FGM/C included the government, health care providers, NGO's, religious leaders and local community leaders.

### **9.5.2 What is needed to end FGM/C: Results of the Spokes activity**

In the spokes activity carried out with PIGDs, participants were asked what resources and stakeholders need to be mobilized, and what measures or interventions need to be implemented, to eliminate all forms of FGM/C in their communities. The interest groups principally recommended multi-sectoral approaches and harmonized efforts of diverse stakeholders involving both men and women. Participants were then asked to assess, as a group, how much of what they need is available at present. They were then asked to vote three times on the various recommendations they would prioritize and tally up their votes. They were allowed to allocate all of their votes to one, two or three unique recommendations. The prioritization of efforts and perceptions of progress on the elimination of FGM/C were the key areas in which the interest groups differed. The first example, below, shows what male youth from Garowe, Puntland, think:

The young men perceived that anti-FGM/C advocacy and awareness activities, campaigns targeting mothers and the media had made greater advances in efforts to end FGM/C in comparison with other stakeholders and measures. Advocacy and awareness campaigns promoting the elimination of FGM/C were viewed as the highest priority intervention by this interest group.

In Hargeisa, Somaliland, a group of female youth IDPs viewed other measures and stakeholders as having achieved significant progress in FGM/C elimination efforts in the spokes activity (Figure 2).

Health providers, religious leaders, local NGOs and international agencies were considered to be the key stakeholders that had made some progress in efforts against FGM/C. Nearly all votes in the group were allocated towards the prioritization of the role of religious leaders and scholars in the fight against FGM/C.

Older women, in Mogadishu, also said that health workers and religious leaders had advanced the anti-FGM/C agenda in addition to media and awareness raising efforts (Figure 3). Older women, in Mogadishu, recommended prioritizing an anti-FGM/C intervention which specifically targets cutters. They believed that providing income generation for cutters to establish new livelihoods should be the lead intervention in the push for the population to discontinue FGM/C. This was an intervention similar to that proposed by male youth in Garowe. The male youth proposed that providing skills training for cutters was an intervention that could support their transition into alternative livelihoods.

Overall, similar perceptions on progress and priority stakeholders and interventions emerged in many of the spokes activities across the three zones.

## **9.6 Conclusions from the Communities**

The CPS has revealed a significant amount of information and understanding on community attitudes and practices on FGM/C. Some of this information has not been fully understood before. The CPS shows that there is real need for further in-depth, action-orientated research into FGM/C in Somalia. Recommendations on this are included in part 1 of this report.

The confusions that have arisen because of the mis-match between earlier government policy, current government policy, and the practice of some NGOs – which condone Sunnah FGM/C, have led to innovation in the practice of FGM/C and belief, amongst much of the population, that Sunnah is acceptable and desirable.

Overall, there is a high level of congruence between what the communities think it will take to end FGM/C and the approaches taken by government. However, as yet there is little real knowledge or understanding on why people change, what support and maintenance this process of change needs, and how positive change can be sustained, so that FGM/C – of all forms – end forever. These issues were discussed in Part 1.

## Annex A Terms of Reference

### Background

Somalia is one of the world's most fragile states with alarming health indicators. Global data on FGM/C suggests that about 98% of women in Somalia have undergone Female Genital Mutilation (FGM/C). This practice has had evidence of physical, psychological and emotional damage, including health consequences such as pain and trauma as well as risks of haemorrhage and infection to the victims/survivors. There is evidence of increased risk of complications at childbirth putting mothers and new-borns at risk. It also has economic consequences for the affected families and communities and can prevent girls from accessing formal education and development.

FGM/C abandonment efforts started in Somalia before the collapse of Somalia, but until recently there was little work in Somalia to address the problems of FGM/C.

In 2007, UNFPA and UNICEF launched the Joint FGM/C Programme with the objective of reducing the practice of FGM/C among girls aged zero - 15 years by 40% and elimination of FGM/C in at least one community by 2012. The UNICEF and UNFPA programme was established as the main UN instrument to promote the acceleration of FGM/C abandonment. The Somalia Programme was initiated in 2009 in North East and North West Zones and there is anecdotal evidence that inroads have been made, even though the practice is a deeply embedded and closely held tradition.

More recently, efforts by the UN Joint Programme (UNJP) on FGM/C abandonment and work by civil society on the ground has led to an increase in awareness of the harmful practice of FGM/C through community education, policy dialogues and advocacy initiatives. This has resulted in advocacy being scaled up at different levels, including with religious leaders, and has led to the finalization of an acceptable rights based bill/legislation and policies denouncing the practice. The new Somali Constitution from 2012 outlaws all forms of FGM/C. The issuance of the religious decree ('Fatwa') by the Religious Leaders in Puntland is another milestone towards total abandonment of the practice.

Community dialogue has contributed to a positive behaviour change and over 100 communities have declared abandonment of the practice.

A communication for development strategy has been finalized and is being used to guide advocacy and dialogue sessions. Over 1,500 religious leaders have been trained towards advocating for FGM/C abandonment and they were actively involved in the advocacy campaign as champions. Public discussions on FGM/C in Somalia are no longer a taboo, community members and policy-makers including prominent Sheiks are actively advocating for the abandonment of the practice even in the Friday prayer sessions. The programme has engaged the media and FGM/C abandonment efforts were publicised by local and international media.

FGM/C has been included in the training curriculum of nurses and midwives. Service providers were trained in the management of FGM/C complications and the number of FGM/C survivors seeking medical and psychosocial services has increased. In addition, FGM/C prevention education has been incorporated in nine health facilities. With support from the Joint health and Nutrition Program, the FGM/C programme was expanded to Central South Somalia and 100 religious leaders were trained in facilitating dialogues on FGM/C abandonment and communities have made commitment to abandon FGM/C as a result.

To strengthen coordination of FGM/C activities, FGM/C task forces were formed in Nairobi and in the three zones. The Nairobi task force is composed of UN agencies, local and international NGOs implementing activities in Somalia. Most of these taskforces hold strategic discussions on FGM/C abandonment concerns during their coordination meetings held on quarterly basis under the leadership of the line Ministries.

In order to ensure a coherent approach, a better understanding of what is happening DFID and the UNJP want to commission a situational analysis to gain a greater understanding of existing interventions and identify the gaps to strengthen the current interventions.

## **Objectives**

- Enable government to prioritise specific elements for FGM/C prevention.
- Guide government policy and strategies to tackle FGM/C at the zonal level.
- Identify existing major FGM/C interventions and implementing partners.
- Examine the effectiveness of collaboration between key partners in FGM/C in order to strengthen coordination.
- Identify lessons learnt and best practices to be incorporated into the next phase of implementation.
- Identify challenges faced in the previous phase of implementation with a view of addressing in the next phase.
- Identify further areas for research.

## **Scope of work**

- Analyse the enabling environment to allow a greater understanding of who is facilitating policy dialogue and what are the barriers to further policy engagement.
- Identify the major efforts, both in policy and community engagement, to promote abandonment of FGM/C which have been implemented in all three zones of Somalia since 2007; the number of communities declaring abandonment and include an analysis of the role of men in these major abandonment efforts.
- Review selected anti-FGM/C activities in one district in Somaliland, in Gedo district of South Central and in one district of Puntland and document what worked well, what did not work well and what needs to be strengthened.
- Identify key knowledge gaps that may require research to improve understanding of the practice and/or activities to promote its abandonment and management.
- Analyse existing coordination mechanisms and recommend how to best strengthen coordination roles, implementation structures and procedures across the three zones to allow for more effective delivery of anti-FGM/C programmes.

## **Methodology**

Methodology to be provided by the consultant. But should include the following:

- Desk review of available documentation.
- Consultations with the members of the Technical Task Force on FGM.



- Consultations with regional Ministries of Health, Ministries of Justice, Ministry of Labour and Women's Affairs, Ministry of Religious Affairs, Ministry of Planning, Ministry of Higher Education and Culture, Ministry of Information.
- Meetings with local and international NGOs.
- Meetings with the managers of health facilities in key cities.
- FGDs at community, district and regional levels in the field with relevant stakeholders.

## **Requirements**

- Draft methodology and draft implementation plan to be submitted as part of the proposal for the selection process.
- Team to include Somali speakers; and members with extensive knowledge of Somalia and FGM/C issues (CVs of the key experts to be submitted as part of selection process).
- Team members with ability to travel to the northern and south central zones.
- Financial proposal, including costs related to travel and focus group meetings at the community level.
- Estimated time for implementation is about 3 months.
- Maximum number of team members to be 3 people.

## **Deliverables**

- Detailed methodology and implementation plan, including an outline for final report form to be provided as part of the inception report – (2 weeks from contract date)
- Draft report – (8 weeks from contract date for feedback)
- Final report – (2 weeks from contract date incorporating feedback)

## **Organisational requirements**

Consultants to be provided by HEART and supported at the field level by UNFPA, UNICEF and government Ministries.

## **Expertise**

- Consultants with minimum 6 years' experience in programme evaluation, advocacy, community development, communication skills (writing and spoken) and social sciences (sociology, anthropology, ethnography or any other related field).
- Knowledge of FGM/C is key.
- Consultants to have an understanding of the health sector in Somalia and experience of working in a fragile states with government.
- Consultants to have experience of conducting research in fragile states.
- Consultants to have proven expertise in conducting situational analyses.
- Familiarity with the socio-cultural context of Somalia and the cultural and religious sensitivity surrounding FGM/C.

## **Reporting**

- The work is commissioned by the FGM taskforce, comprising of representatives from the Health Authorities, UN agencies, donors and CSO. The consultants will report to the FGM Taskforce at both the Nairobi and zonal level. The consultants will report contractually to DFID.

## Supporting documents

- Baseline Survey Report on FGM/C Puntland
- Baseline Survey Report on FGM/C Somaliland
- Somalia RH strategy
- NCA – External evaluation of Somalia Programme Activities in Gedo, Puntland and Mogadishu
- SL National Policy for the Abandonment of FGM/C
- PL National Policy for the Abandonment of FGM/C (?)
- Evaluation of TOSTAN programme in SL
- ToR's of FGM Task Force

## Annex B Approach Paper

### Background

Somalia is one of the world's most fragile states with alarming health indicators. Global data on FGM/C suggests that about 98% of women in Somalia have undergone Female Genital Mutilation (FGM/C). This practice has had evidence of physical, psychological and emotional damage, including health consequences such as pain and trauma as well as risks of haemorrhage and infection to the victims/survivors. There is evidence of increased risk of complications at childbirth putting mothers and new-borns at risk. It also has economic consequences for the affected families and communities and can prevent girls from accessing formal education and development.

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More recently, efforts by the UN Joint Programme (UNJP) on FGM/C abandonment and work by civil society on the ground has led to an increase in awareness of the harmful practice of FGM/C through community education, policy dialogues and advocacy initiatives. This has resulted in advocacy being scaled up at different levels, including with religious leaders, and has led to the finalization of an acceptable rights based bill/legislation and policies denouncing the practice. The new Somali Constitution from 2012 outlaws all forms of FGM/C. The issuance of the religious decree ('Fatwa') by the Religious Leaders in Puntland is another milestone towards total abandonment of the practice.

Community dialogue has contributed to a positive behaviour change and over 100 communities have declared abandonment of the practice.

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FGM/C has been included in the training curriculum of nurses and midwives. Service providers were trained in the management of FGM/C complications and the number of FGM/C survivors seeking medical and psychosocial services has increased. In addition, FGM/C prevention education has been incorporated in nine health facilities. With support from the Joint health and Nutrition Program, the FGM/C programme was expanded to Central South Somalia and 100 religious leaders were trained in facilitating dialogues on FGM/C abandonment and communities have made commitment to abandon FGM/C as a result.

To strengthen coordination of FGM/C activities, FGM/C task forces were formed in Nairobi and in the three zones. The Nairobi task force is composed of UN agencies, local and international NGOs implementing activities in Somalia. Most of these taskforces hold strategic discussions on FGM/C abandonment concerns during their coordination meetings held on quarterly basis under the leadership of the line Ministries.

In order to ensure a coherent approach, a better understanding of what is happening DFID and the UNJP want to commission a situational analysis to gain a greater understanding of existing interventions and identify the gaps to strengthen the current interventions.

## **Objectives**

- Enable government to prioritise specific elements for FGM/C prevention.
- Guide government policy and strategies to tackle FGM/C at the zonal level.
- Identify existing major FGM/C interventions and implementing partners.
- Examine the effectiveness of collaboration between key partners in FGM/C in order to strengthen coordination.
- Identify lessons learnt and best practices to be incorporated into the next phase of implementation.
- Identify challenges faced in the previous phase of implementation with a view of addressing in the next phase.
- Identify further areas for research.

## **Scope of work**

- Analyse the enabling environment to allow a greater understanding of who is facilitating policy dialogue and what are the barriers to further policy engagement.
- Identify the major efforts, both in policy and community engagement, to promote abandonment of FGM/C which have been implemented in all three zones of Somalia since 2007; the number of communities declaring abandonment and include an analysis of the role of men in these major abandonment efforts.
- Review selected anti-FGM/C activities in one district in Somaliland, in Gedo district of South Central and in one district of Puntland and document what worked well, what did not work well and what needs to be strengthened.
- Identify key knowledge gaps that may require research to improve understanding of the practice and/or activities to promote its abandonment and management.
- Analyse existing coordination mechanisms and recommend how to best strengthen coordination roles, implementation structures and procedures across the three zones to allow for more effective delivery of anti-FGM programmes.

## **Methodology**

Methodology to be provided by the consultant. But should include the following:

- Desk review of available documentation.
- Consultations with the members of the Technical Task Force on FGM.
- Consultations with regional Ministries of Health, Ministries of Justice, Ministry of Labour and Women's Affairs, Ministry of Religious Affairs, Ministry of Planning, Ministry of Higher Education and Culture, Ministry of Information.
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- Consultants to have experience of conducting research in fragile states.
- Consultants to have proven expertise in conducting situational analyses.
- Familiarity with the socio-cultural context of Somalia and the cultural and religious sensitivity surrounding FGM/C.

### **Reporting**

- The work is commissioned by the FGM taskforce, comprising of representatives from the Health Authorities, UN agencies, donors and CSO. The consultants will report to the FGM Taskforce at both the Nairobi and zonal level. The consultants will report contractually to DFID.

### **Supporting documents**

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- Baseline Survey Report on FGM/C Somaliland

- Somalia RH strategy
- NCA – External evaluation of Somalia Programme Activities in Gedo, Puntland and Mogadishu
- SL National Policy for the Abandonment of FGM/C
- PL National Policy for the Abandonment of FGM/C (?)
- Evaluation of TOSTAN programme in SL
- ToR's of FGM Task Force
-

## Annex C Community consultation question areas in English and Somali

### Group 1

**Does FGM/C happen in your area/community (relate the answer to types of livelihood)**

- Gudniinka ma lagu sameeya goobta aad joogtid?

**What are the most common types?**

Noocee ayaa badi sameeyaa?

**Do most families here carry out FGM/C? Are there any people who don't?**

- Dhamaan qoysaskiina halkan dagan ma samaysaan gudniinka?
- Ma jiraan qoysas idinka mida oo aan samayn gudniinka?

**Is FGM/C changing – is there more, or less? Is the way that it is carried out changing? How? Why?**

- Isticmaalka gudniinku ma is badalay, ma sii badanayaa mise wuu sii yaraanayaa?
- Qaabka loo sameeyaa ma is badalay? Siduu isku badalay? Sababtumaxay tahay?

### Group 2

**Why is FGM/C important?**

- Muxuu gudniinku muhiim u yahay?

**What are the things that are good about FGM/C? What advantages does it bring a girl? Her family? And the community as a whole?**

- Waa maxay waxyaalaha uu ku fiican yahay gudniinku? waa maxay faa'iidada uu u leeyahay gabadha?, qoyskooda?, iyo bulshada oo dhan?

**What are the disadvantages? Do you think there are problems caused by FGM/C? What are they?**

- Waa maxay faa'iida darada uu lee yahay?, ma u malaynaysaa dhibaatooyin in uu keeno gudniinku?, maxayse yihiin?

### Group 3 questions

**What are the community interventions that are working to try to end FGM/C?**

- Ma jiraan hayado idin yimada oo idin ka wacyigeliya joojinta gudniinka?

**Have you had any other programmes which are concerned with your well-being? (Health, education, livelihoods etc.) Are they working well? Have you faced any problems? (what, why?)**

- Ma jiraan mashruucyo khuseeya?, ( sida caafimaadka, waxbarashada iyo noloshaada etc.), si fiican ma u shaqaynayaan?, wax dhibaato ah ma kala kulanteen?, maxay yihiin, sabatuse maxay tahay?

**Who do you trust in your community to make decisions about FGM/C? (whether it will continue or not) Why them and not ....?**

- Yaad aaminsatahay tahay in ay go'aan laga ka gaadhi karaan gudniinka? In la sii wado iyo in la joojo?

**Who do you trust to “take ownership” in promoting the end of FGM/C? (religious leaders, NGO, CBOs, government etc.)**

- Yaa qaadaya masuuliyada in korloogaado ama la horumariyo sidii loo joojin lahaa gudniinka? (sheekhyada, ururada bulshada, dawlada etc)

**Who will take the lead on this?**

- Yaa hogaamindoona arinkan?

**What are the roles of health providers in this (TBA's, traditional healers, clinic staff)?**

- Waa maxay kaalinta (shaqalaha caafimaadka) ay ku leeyihiin arintan?



#### **Group 4 questions**

**Who thinks FGM/ C should end? Does anyone think it should continue?**

- Yaa rabaa in gudniinka la joojiya?, Yaa rabaa in uu sii socondoono?

**What does the community need in order to start ending FGM/C (e.g Resource, education...)**

- Maxay u bahan tahay bulshadu si loo bilaabo in la joojiyo gudniinka?

**So, what needs to happen for FGM/C to be able to end? What are men's and boys' roles? What are women and girls' roles?**

- Hadaba, maxaa loo baahan yahay in la sameeyo si uu gudniinku u dabar go'?, waa maxay kaalinta ay ku leeyihiin inamada iyo ragu?, waa maxay kaalinta ay ku leeyihiin hablaha iyo dumarku?

**What are the major barriers/challenges to ending FGM/C?**

- Waa maxay waxyaalaha ugu waawayn ee ka hor iman kara in la joojiyo gudniinka?

#### **Group 5 questions**

**What is it that makes people decide to give up FGM/C in their family? What actually makes the difference and allows them to make that choice?**

- Maxaa keeni kara dadku in ay go'aan ka gaadhaan si ay uga joojaan gudniinka qoysaskooda?, maxaa keena is badelka dhabta oo inoo ogaalanaya in aan samayno doorasho?

**When people do decide to stop FGM/C, what allows them to stay stopped? Why don't they change their minds back again?**

Goorma ayay dadku go'aan ku gaadhi karaan in la joojo gudniinka, maxaa u ogolaanaya in la joojo, maxay u badali laa yihiin fikirkooda mar labaad?

## Annex D Breakdown of people consulted

**Table 1: Participatory Interest Group Discussions (215 people)**

Location	Type of participants	Number of participants in Group
Hargeisa, Somaliland	Older female IDPs group	6
	Youth female IDPs group	6
	Older male IDPs group	11
	Youth male IDPs group	6
Borama, Somaliland	Older female group and children	10 women and 14 children
	Youth female group	16
	Older male group and community leaders	7
	Older female group	8
Garowe, Puntland	Older female IDPs group	7
	Youth female IDPs group	11
	Male IDPs group	11 (mix of young and older men)
	Older female group	8
	Youth female group	6
	Older male group	6
	Youth male group	9
Bosaso, Puntland	Older male group	6
	Youth male group	6
Mogadishu, South Central	Older female group	8
	Youth female group	5
	Older male group	8
	Youth male group	8
	Older female group	8
	Youth female group	8
	Older male group	8
	Youth female group	8

**Table 2: Consultations with organizations and individuals involved in anti-FGM/C efforts (93 people)**

Somaliland	23 GBV Taskforce members; 8 NGO staff
Puntland	17 FGM Taskforce members; 2 NGO staff; 1 physician
South Central	10 GBV and CP Taskforce members; 23 NGO staff; 1 physician; 2 midwives

## Annex E Fieldwork Guide

### PARTICIPATORY TOOLS FOR THE COMMUNITY PERSPECTIVES STUDY

This document gives a reporting format and explains three tools which we can use to help people explore our question areas on: **Voice and Governance; Health Service Response, and Social Protection.**

With each group we consult, we will use **at least one of these tools**. It is possible we may use two tools with a group. We will **never use all three** (it takes too long)

#### 1. Reporting Sheet (USE THE SHEETS PROVIDED)

##### PIGD Reporting Sheet

Community Perspectives, Stakeholder Consultations Data Sheet Location:

Name of Researchers: ..... Date:.....

Tools used:.....

Total Number of Participants ..... Women.....Girls..... Men.....Boys.....

*This is the first stage analysis. It is helpful if the data sheet is completed as soon as possible after the PIGD takes place and involves the facilitator, and whoever else from the core team who may have been present.*

Topics covered during the PIGD	Key Issues Raised Relating to objectives of the
<i>Bullet point question areas covered during the PIGD when the groups are mixed (by age or sex) make sure you record if the issues raised are mainly by women or men, old or young, or shared across the sexes.</i>	<i>Review the data collected and against each main topic area discussed record key issues relating to the CPS objectives:</i> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Voice and Governance</li> <li><input checked="" type="checkbox"/> Health Service Response</li> <li><input checked="" type="checkbox"/> Social Protection</li> <li><input checked="" type="checkbox"/> Improvement suggestions.</li> </ul>

At the bottom of the data sheets for communities give a brief description of the backgrounds and age of the participants. E.g. if children – what age group; drop-out, orphan; victim of early child marriage; parent/guardian receives CHF support; etc...

#### 2. Bricks and Termites template (used on ground/flipchart during Participatory Interest Group Discussion)

**NOTE: IF PEOPLE DO NOT LIVE IN BRICK HOUSES, FIND SOMETHING ELSE TO REPRESENT OPPORTUNITIES/ HELPFUL THINGS AND BARRIERS/ CHALLENGES**

##### (OPPORTUNITIES AND BARRIERS)

The tool is used in conjunction with questions on the topic we want to understand. For example, “what are the barriers which stop you using the health centre?” “What is helping you

improve your children's health?" PIGD participants identify the key issues in terms of opportunities and barriers in relation to each of the questions.

Bricks	Termites

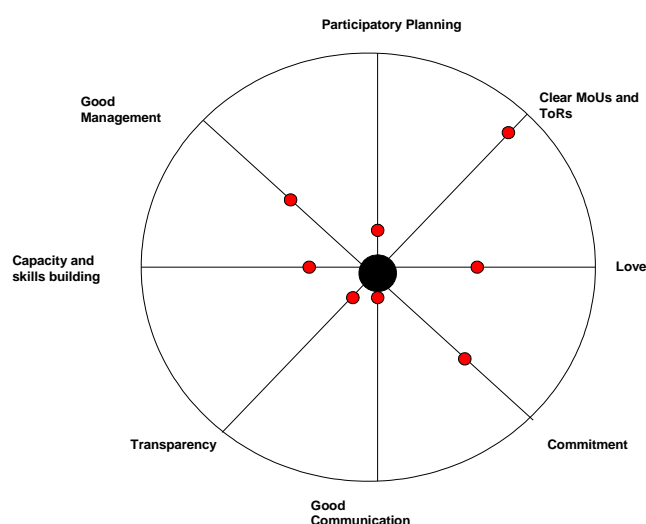
Sheena Crawford, Mary Ann Brocklesby, CR2 Social Development

### 3. Explanation of Spokes

#### Method

Spokes is a very simple activity which can be used to explore any number of different themes and topics. Following discussion on a topic, characteristics of an issue are agreed upon and symbols for these are arranged around the outside of a circle. These are then joined to a central point by lines drawn on the ground, or by sticks etc., to form a wheel. The centre represents "us", or "now", and the symbols around the edge of the wheel represent things we want to achieve. Participants are asked to discuss together and mark along each spoke where they think they are now, in relation to the things they want to achieve. It is important that participants do not try to give percentage values to the distances they are marking. The marks should show the value in spatial terms and show also the achievement of one issue relative to another. Participants generally find this a very accessible tool which gives them plenty of space to think and discuss with each other, whilst keeping their focus on the issues under discussion.

The example below shows a spokes wheel relating to goals around partnership and where participants felt they had reached in terms of achieving those goals:



Spokes allows for comparison between what we want to achieve or the ultimate goal of our activities, (the edge of the circle) and where we are now (the markers). A second set of markers can be used to show what the situation was like 5 years ago or even longer. In this way we are gaining people's opinions on what has changed over time, and the nature of that change. It also allows people to compare visually, and discuss, which characteristics they think are the most important.

## Annex F List of people consulted

### Breakdown of people consulted in Somaliland

#### International agencies, local organisations and institutions

Name	Agency
Dr Haydar Nasser	UNICEF
Safia Jibril Younis	UNICEF
Bahsan Said	UNFPA
Dr Abib Ahmed Hersi	CCBRS
Abdurahman Musa	ANPPCAN

#### Somaliland GBV working group

Name	Agency
Amina Hamud	WAAPO
Anab Farah Ahmed	Magan Hospital/NAFIS
Ali Abdirahman	Magan Hospital/NAFIS
Luul Aden Geddi	MOLSA
Huda Ali Hassan	CCBRS
Shukri Osman Saed	CCBRS
Domenica Constantini	Danish Refugee Council (Consultant)
Abdrisak Ali Yusuf	DRC GBV Liaison
Khadra Elmi	DRC (Consultant)
Raquja Yusuf Ibrahim	Somaliland Women Lawyers Assoc.
Nafisa Mohamoud Shirwa	Candlelight
Fadumo Shaib Odawa	WORDA
Hibo Mahad Mohamud	UNHCR
Salma A. Sheikh	Baahi Koob Cntr in Hargeisa Grp Hospital
Asha Abdi Roobleh	BKC (Baahi Koob Centre)
Fadumo Muse Yusuf	Somaliland Women Lawyers Assoc.
Abdishakur Aden Ahmed	MOLSA
Safia Younis Jibril	UNICEF
Fardawsa Hassan Obsiye	MOLSA
Naima Hussein Daud	MOLSA
Amina Mohamed Rodol	NAFIS
Rahma Mohamed Diriye	MOLSA
Rakia Ahmed Abdi	MOLSA

## Breakdown of people consulted in Puntland

### International agencies, local organisations and institutions

Name	Agency
Fatima Handulle	UNICEF
Mohamed Abdulkadir Farah	TASS
Dr Habiba Ismail	Garowe Hospital

### Puntland FGM Taskforce

Name	Agency
Fardewsu Yusuf Hersi	MOWDAFA
Naahid Abdirisak Ali	MMWCD
Asha Said Ali	HORDA
Mohamed Abdulkadir Farah	TASS
Cabduqani Mohamud Abdi	PSA
Abdirizak Izak Miro	TASS
Mustafa Abdulahi Abdi	YESO
Hamdi Ahmed Said	RDI
Abdirisak Omar Mohamed	TASS
Mohamed Ali Nur	MOWDAFA
Abdirizak Hassan	MOWDAFA
Hawa Yusuf Elmi	GECPD
Axmed Ciise Xusen	Punchad
Mohamed Said Nur	RDI
Sulekha Hassan	TIDES
Fadumo Jama Aden	Samofal
Maimun Mohamed Yusuf	KAALO

### Ministry of Women's Development and Family Affairs

Name
Anisa Haji Mumin
Abdirahman Mohamoud Hassan
Amino Mohamoud Nor
Safiyo Jamac Geyre
Luul Jaamac Nuur
Khadijo Cali Xashi
Abdijabar Rashid Mohamed
Abdirizak Hassan
Safia Hussein Muse

### Ministry of Justice and Religious Affairs and Rehabilitation

Name
Faisal Mohamed Mata
Farah Roble
Sheikh Cabdirizaak Xassan Aden
Ismail Hagi Abdi

**Ministry of Health**

Name
Abdirizak Hassan Isse
Ayaan Saud Ali
Mariam Said Mohamed
Sudi Hamid Isse
Hawa Abdi
Jihan Mohammed Salad
Faiza Abdalla Jama
Idris Abdulahi Mohamed

**FGM/C Anti-Medical Strategy Working Group**

Name	Agency
Asad Osman Abdi	TASS
Abdisalan M. Hersi	MOH
Habiibo Nuh Ismail	GGH
Siciid Cabdirashid Elmi	MOH
Hussein Hassan Samah	MOH
Abdisalan M. Hersi	MOH
Mohamed Salad Mohamed	MOH
Mohamoud Yusuf	MOJ
Mukhtar Abdi Ibrahim	MOJ
Khadro Abdinasir Mohamed	MOH
Faiza Abdalla Jama	MOH
Ayaan Omar Mohamed	MOH
Hawo Abdi Ducale	MOH
Fatuma F. Handulle	UNICEF
Ardo Said Mohamed	SOMDA
Jihan Mohamed Salad	MOH
Nasra Abdi Hassan	MOH



## Breakdown of people consulted in South Central Somalia

### International agencies, local organisations and institutions

Name	Agency
Mohamed Nur Yalahow	UNICEF
Zakaria Ibrahim	UNICEF
Abdifatah Mohamud Abdi	UNICEF
Abdullahi Shirwa	Somali Peace Line
Mohamed Abdi	Somali Peace Line
Ahmed Ibrahim	Somali Peace Line
Faisal Ahmed Mohamed	Somali Aid Foundation
Abdi A. Khalif	Somali Aid Foundation
Fatima Mohamud	Somali Aid Foundation
Hawo Osman Hussein	Somali Aid Foundation
Abdifatah Dahir Atto	Somali Aid Foundation
Abdisalan Shiine	Somali Aid Foundation
Deqa Yasin	IIDA
Halima Abdi Sheikh	Somali Midwives Association
Khadijo Farah Muhyedin	Somali Midwives Association

### Ministry of Health

Name
Ahmed Aden Ahmed
Abdihamid Ibrahim

### Ministry of Women and Human Rights Development

Name
Dr Mina Hassan Mohamed
Barlin Mohamed Ali
Mohamed Omar
Hon. Khadija Mohamed Diriye
Ahmed Abdi Omar
Sofia Mahdi

### Ministry of Religious Affairs and Endowment

Name
Ridwan Hersi Mohamed
Mohamed Khairow Adam

**South Central Child Protection Working Group members**

Name	Agency
Ilwad M. Ali	Elman Peace and Human Rights Cntr
Abdullahi Sheikh Abukar	SOHRA (Somali Human Rights Assoc)
Abdirahman Abdikadir	IRC
Mohamed Magow	INTERSOS
Abdifatah Mohamud Abdi	UNICEF
Aisha Abdi Ibrahim	IRC
Zakaria Abdi Mohamed	SFCC (Somali Family & Child Care)
Fardowso Mohamed Muse	American Refugee Council
Fatima Abdullahi Ahmed	Somali Women Development Centre
Abdulkadir Dakane	Save the Children
Mogadishu GBV Working group members	
NAME ORGANIZATION	
1 Isatu Kajue (Chair)	GBVWG National
2 Abdirahman Ibrahim Adan (co-chair)	COCO
3 Sahra Abbow Hassan	HAYAAN
4 Fardowso Hassan Ibrahim	COGWO
5 Farhia Nor Ahmed	MMD
6 Amina Abdi Osman	IIDA
7 Ahmed Ali Mohamed	SOGWE
8 Ahmed Sahal Abdulle	Somali-Aid
9 Amina Abdulkadir Arale	SWDC
10 Fadumo Aweys Hassan	IRC
11 Mohamed Mayow	KAHRO
12 Abdullahi Abdirahman Ali	SCWRW
13 Mohamed-Nor Mohamed Sheikh	IIDA
14 Abdikarim Nor Kulane	COCO
15 Fa'iza Ahmed Mohamed	ANPPCAN
16 Fadwo Hassan Jim'alle	HINNA
17 Nasro Abdullahi Hussein	OSPAD
18 Muna Ali Abdulahhi	UNICEF
19 Shamso Omar Dhaffe	UNHCR
20 Abass Mohamed Adan	UNHCR
21 Mohamed Abdi Ali	Ministry of Women & Human Rights
22 Mohamed Sa'id Shire	COSV
22 Mumin Moallim Mohamud	Elman
23 Alia Adan Abdi	HIWA
24 Hussein Yusuf Ali	Daljir
25 Yasmin Abdulkadir Mohamud	ARC
26 Mohamed-Nor Mohamed Sheikh	IIDA

**Somali Peace Line Child Protection Advocates**

Name
Fardowsa Abdirahman Ahmed
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Muna Salad Abukar
Amina Abdullahi Omar
Hassan Mohamed Dini
Farah Barre Abdulle
Abdikarin Ali Barre
Abdiwahid Sheik Abdullahi
Mustafa Mohamed Moalin
Ahmed Mohamed Ibrahim

**Breakdown of people consulted in Kenya****International agencies, local organisations and institutions**

Name	Agency
Karen Stephenson	DFID
Mercy Oduor	DFID
Charity Koronya	UNICEF
Isatu Kajue	UNFPA
Betty Oloo	WHO
Dr C.B. Uday Raj Naidu	Save the Children Somalia
Members present of 04.09.14	Nairobi based FGM Taskforce

