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Action Aid International Somaliland (AAIS) programme on FGM/C

Midterm Review

August 2018

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ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

Acknowledgements

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Contents

Executive summary

The AAIS MTR took place in July-September 2018. A mixed methods approach was used combining a desk review with a community survey of seven communities in Togdheer and Maroodhi Jeex which involved interviewing 436 community members and facilitating focus group discussions with 182 participants and interviews with 8 key informants at national level.

In the three years since the baseline assessment, the context of FGM/C has changed considerably in Somaliland resulting in significant changes, including the publication of a Fatwa by the Ministry of Religious Affairs which bans all types of FGM/C with stitches but which states that the sunna, drawing blood by pricking the genitals of girls and women, is obligatory. The AAIS project has both coincided with, and contributed to, creating a climate conducive to change in relation to FGM/C.

The MTR has found strong evidence that the AAIS approach of promoting community dialogue has contributed to a significant change in the attitudes and behaviours of community members in relation to FGM/C.

The overall prevalence of FGM/C remains at 98% in line with national statistics. However, FGM/C is being talked about more openly in all project communities surveyed. 91% of community members said FGM/C has been mentioned in public meetings in their community, an increase from 49% in 2016. The percentage of people who have spoken to someone about FGM/C in the last year has increased almost threefold from 22% to 64%, although people are still talking primarily to family, neighbours and friends with very few (3-8%) community members talking to teachers, health professionals, religious leaders or community leaders. There has been a threefold increase in the percentage of community members involved in activities to end FGM/C since the beginning of the project from 16% to 51%. The main activities are public meetings, campaigns and workshops, with an increase in the percentage of women involved in workshops increasing from 9% to 48%.

This project has also strengthened the network of organisations working to end FGM/C through targeted capacity building for AAIS's partner organisations SOWDA and WAAPO and also providing valuable funding to support the formation of the End-FGM/C working group with representation from CSOs and the line ministries.

The type of FGM/C which is being used is changing rapidly from WHO types I, II and III (partial or complete infibulation, requiring stitches and snipping the tip of the clitoris) to WHO type IV, the sunna, drawing blood by pricking. Women of all ages are experiencing fewer complications as a result of this positive change which has taken place in both urban and rural communities. The link between a girl's virginity, marriage and FGM/C has been weakened or in some communities ended. Men are embracing the change as they can see improvements in marital relationships and a decrease in the medical complications of their wives and daughters.

Support for the sunna remains extremely strong, and has possibly even increased since the publication of the Fatwa in February 2018. Somaliland now faces the challenge of abandoning the sunna in order to achieve total abandonment of FGM/C. The number of people supporting the abandonment of all types of FGM/C shows only a moderate increase from 5% (6% women and 3% men) to 14% (18% women and 6% men). The percentage of unmarried men preferring their future wives to be uncut has increased from just 4% to 14%. This increase is significant, however the vast majority of men would still prefer both their future wife (86%) and future daughters-in-law (91%) to have undergone FGM/C, although most (68%) would prefer them to have only undergone the sunna.

There is a draft anti-FGM/C law based on *zero tolerance,* although many people, including most religious leaders do not consider the sunna to be a form of FGM/C. There is an increase the in the cutting of girls and young women by health professionals, despite the dissemination of a draft anti-medicalisation strategy by the Ministry of Health. Neither of these documents are likely to be ratified by parliament until senior sheikhs within MORA are convinced that the sunna is a form of FGM/C and agree that the sunna should be abandoned. Currently, none of the senior sheikhs is prepared to say publicly that the sunna is a form of FGM/C and should be made illegal.

The abandonment of the sunna by whole communities will require more of the factors conducive to social norms change to be in place. A key factor will be the increased awareness of the place of FGM/C within the context of the rights of women and girls, and gender equality debate at both policy-making and community levels. A clear legislative framework in relation to FGM/C would also provide guidance and reduce some of the ambiguity in messages at national level around FGM/C. Equally important will be strong leadership committed to the abandonment of all types of cutting within communities to support collective decision-making.

The following key recommendations have been made as a result of the MTR.

- The development of an engagement strategy for the communities which have been most challenging to work with so that the success experienced in the communities surveyed can be extended to those harder to reach communities.
- Explicit and on-going clarification that FGM/C includes the sunna (WHO type IV) underpinned by a stronger rights-based approach, to challenge and encourage communities to see their end goal as the abandonment of all types of cutting and take strides towards achieving this.
- Role definition of health professionals in relation to FGM/C and greater involvement in community dialogue to reduce both the demand for medicalisation by community members and the willingness of health professionals to perform the sunna.
- Greater engagement of youth, especially young men, as future decision-makers on FGM/C as prospective husbands and fathers. Young men are currently, the least confident in speaking out on FGM/C and would benefit from specific activities to encourage them to be more actively involved in the movement towards total abandonment.

On-going community conversations and forums, as have been taking place in this project, have been shown to be an effective tool to promote open dialogue around FGM/C and bring about change. The remainder of the project should focus on the strategy of *zero tolerance* in line with the AAIS theory of change. This approach needs the active engagement of an even wider range of stakeholders, together with a greater focus on explicitly defining the sunna as a form of FGM/C explained through the agenda of the rights of girls and women to bodily integrity, freedom from violence and the right to unhindered access to education, and avoidance of unnecessary health risks.

The AAIS FGM/C project has just one year left, however, it will have brought about sustainable changes in the 35 target communities and have valuable lessons to share on effective strategies to bring about changes in social norms in Somaliland.

Abbreviations

AAIS	Action Aid International Somaliland
AAUK	Action Aid UK
CF	Community Facilitator
CR	Comic Relief
CSO	Civil Society Organisation
FFVWAG	Freedom from Violence against Women and Girls
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation / Cutting
IDP	Internally Displaced Person
KII	Key Informant Interview
MCH	Maternal and Child Health
MEL	Monitoring, evaluation and learning
MESFA	Ministry of Employment, Social and Family Affairs
MICS	Multiple Indicator Cluster Survey
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MOLSA	Ministry of Labour and Social Affairs
MORA	Ministry of Religious Affairs
MTR	Midterm Review
NAFIS	Network Against FGM/C in Somaliland
ODK	Open Data Kit
ONA	ONA platform for data collection
POTCAT	PC3 Organisational and Technical Capacity Assessment Tool
RL	Religious leader
SHG	Self Help Group
SOFHA	Somaliland Family Health Association
SOWDA	Somaliland Women Development Association
SRHS	Sexual and Reproductive Health Services
TBA	Traditional Birth Attendant
ToC	Theory of Change
ToR	Terms of Reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
VAWAG	Violence against women and girls
WAAPO	Women Action for Advocacy & Progress Organisation
WHO	World Health Organisation

Types of FGM/C in Somaliland

The range of types of FGM/C being used in Somaliland is complex and fluid as is the use of the term sunna.

With Somaliland being predominantly Sunni Muslim, from the Shafi'i school of thought, female genital cutting is considered by most to be subject to guidance, called a 'Hadith' (or 'sunna') under Sharia law. If a hadith is '*obligatory'* then under Islamic law community members should abide by it. If it is '*honourable'* it is optional and preferred, if '*not required*' then it is essentially banned and religious leaders will advise against.

The situation is further complicated as the term sunna is used both in a generic sense to mean Islamic guidance and also is the name given to the genital cutting (or touching) of girls and women which does not require stitching. In this report the term sunna is used to refer to this sunna cut. Religious clerics in Somaliland used to describe the sunna as either the snipping of the tip of the clitoris (WHO type I) or drawing blood by pricking (WHO type IV). The sunna by pricking is defined in the recent FATWA (February 2018) on FGM/C as obligatory.

All of the organisations involved in this project (AAUK, AAIS, SOWDA, WAAPO and Orchid Project) are committed to the abandonment of all types of FGM/C (table 1), expressed in the project outcomes and indicators as z*ero tolerance*.

Table 1: Summary of types of FGM/C being used in Somaliland, linked to WHO classification

WHO type I	Partial or complete removal of the clitoris (clitoridectomy), ***requiring no stitching*****.** In 2016/2017 most in Somaliland regarded the 'snipping' of the tip of the clitoris as a form of sunna. However, in the 2018 FATWA published by MORA it was described as non-Islamic and banned
WHO type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision), ***requiring 2 or 3 stitches to partially close the vaginal orifice*****.** Often referred to as the intermediate or sunna 2, described as non-Islamic and banned under the FATWA
WHO type III	Narrowing of the vaginal orifice, ***requiring 4-7 stitches and resulting in only a very small vaginal orifice.*** Usually referred to in Somaliland as the pharaonic cut, described as non-Islamic under the FATWA and banned
WHO type IV	Other genital touching including pricking, piercing, incising, scraping and cauterization. In 2018, the FATWA published by MORA defined the drawing of blood by the pricking of a girl's genitals as the sunna with no flesh being removed. It was also described as obligatory.

1. Introduction

1.1 A brief overview of FGM/C in Somaliland

Prevalence and current trends in FGM/C

Data from MICS (2006[1] & 2011[2]), Crawford and Ali (2015[3]), Edna Adan University Hospital (EAUH) (2014[4]), NAFIS (2015[5]) the AAIS baseline assessment (Newell-Jones 2016[6]) and the SOFHA baseline assessment (Newell-Jones 2017[7]) all indicate that Somaliland has an overall prevalence rate of around 99% of girls and women undergoing FGM/C.

MICS (2011) found that 99.1% of women responding had been cut, with 85% of them having been sewn closed, therefore experiencing the most extreme form of FGM/C, infibulation or pharaonic (WHO type III). EAUH found in its survey from 2002 – 2006 that 97% of women had been cut, and in the second survey from 2006 – 2013 that 98.4% of women participating in antenatal examinations had undergone FGM/C, 82.2% of whom had experienced the pharaonic cut. The results of the AAIS baseline assessment (Newell-Jones 2016) showed that, '*The overall prevalence rate among community women remains high at 99.4%, with 80% having undergone the pharaonic cut. There is evidence of a change, particularly in urban communities, away from the pharaonic cut to the intermediate and sunna cuts. Only 34% of girls aged 12-14 years have undergone the pharaonic cut compared to 96% of women aged over 25 years. Just 5% of girls and women are currently cut by health specialists. However, there is widespread evidence of increased medicalisation of cutting, with younger women more likely to have been cut by midwives, nurses or doctors. Many religious leaders and some community leaders are calling for midwives and nurses to be trained to perform the cut safely and hygienically.*'

MICS (2011), EAUH (1024) and Newell-Jones (2016 & 2017) all show that women in Somaliland are not universally in favour of the continuation of FGM/C. Virtually all are cut. Most suffer health consequences themselves and would prefer their daughters not to suffer the same. However, most feel that the community expects them to cut their daughters and consequently, the majority intend to cut their own daughters. This combination supports the understanding of FGM/C in Somaliland as a social norm, with individuals making decisions based on the perceived practices of others and their expectations.

Crawford and Ali (2015) identified the need for more research into the knowledge, attitudes and beliefs of men and boys around FGM/C in Somaliland. The AAIS baseline (Newell-Jones 2016) found that men were often not well-informed about the different types of cut being used in Somaliland and therefore are open to misinformation about what is happening to their daughters or sisters. This study also highlighted the decision-making dilemmas which many parents face, often not wanting to harm their daughters but also wanting to conform, in order to be able to demonstrate their daughter's virginity. Given that FGM/C is traditionally identified as a pre-requisite for marriage, the attitudes and expectations of men and boys are an important factor in understanding the drivers in relation to the continuation of the practice.

Appendix A provides a summary of the baseline assessment.

[1] www.childinfo.org/files/MICS3_Somalia_FinalReport_2006_eng.pdf
[2] www.unicef.org/somalia/SOM_resources_somalilandmics4_finalreport.pdf
[3] Crawford S and Ali S (2015) *Situational Analysis of FGM/C stakeholders and interventions in Somalia* UNFPA-UNICEF
[4] Ismail Edna Adan (2014) Female genital mutilation Survey in Somaliland (2014) http://ednahospitalfoundation.org/wp-content/uploads/2014/10/female-genital-mutilation.pdf
[5] NAFIS Network (2015) Assessment of prevalence, perception and attitude of female genital mutilation
[6] Newell-Jones K (2016) Empowering communities to collectively abandon FGM/C in Somaliland AAIS/ORCHID https://orchidproject.org/resource/empowering-communities-to-collectively-abandon-fgmc-in-somaliland/
[7] Newell-Jones K (2017) Female Genital Cutting in Somaliland: Baseline Assessment https://orchidproject.org/resource/sofha-female-genital-cutting-in-somaliland-baseline-assessment-by-orchid-project-supported-by-population-council-and-norad/

1.2 The AAIS Midterm Review

Orchid Project UK was invited to undertake the midterm review (MTR) of the 4-year project (2015-2019), *Empowering communities to collectively abandon FGM/C in Somaliland*, implemented by ActionAid International Somaliland (AAIS) in partnership with Women Action for Advocacy & Progress Organisation (WAAPO) and Somaliland Women Development Association (SOWDA). The full terms of reference are in appendix B.

This report presents the findings from the MTR, recognising the challenges faced in Somaliland over this period, including a severe drought in 2017-2018 and a change in government in November 2017. The changes in attitudes and behaviours are presented both in comparison with the baseline assessment from 2016 and also against the project indicators. Progress in the development and approval of a legal framework is reported against the challenging context of Somaliland.

The MTR also included an assessment of the effectiveness of some of the internal monitoring, reporting and evaluation systems (section 4.3).

Recommendations are presented for the remaining period of the project (section 6.1) and for future work (section 6.2).

The ***specific objectives*** for the AAIS MTR are to:

i. Review to what extent the project has progressed against its intended outcomes, provide data on specific indicators, and map and analyse progress (or lack of) against the project's theory of change

ii. Identify and document effective strategies for bringing about change in abandoning FGM/C, particularly at the community level, and provide recommendations on effective strategies on tackling by FGM/C by different community members

iii. To assess the progress at policy and national level in the abandonment of FGM/C

iv. Assess the level of coordination and capacity of CSOs in fighting against FGM/C

v. Suggest actionable recommendations for ActionAid and project partners to improve project implementation, including the collection and use of monitoring data, for the final two years

1.3 AAIS Theory of Change model

The theory of change model (appendix C), developed by AAIS in relation to FGM/C in Somaliland, is underpinned by a social norms approach based on community dialogue, leading to collective decision-making to abandon all forms of FGM/C.

AAIS place the focus on four key actors for change.

1. **Policy makers and parliamentarians** with a strong focus on the development of a robust legal structure underpinned by *Zero tolerance*
2. **Religious leaders** with a focus on the majority of religious leaders publicly opposing all types of cutting, including the drawing of blood by pricking (WHO type IV), the sunna
3. **Women and youth** which AAIS see as the principle decision-makers in relation to FGM/C
4. **NGOs and CSOs** working collaboratively, through networks such as NAFIS.

This model and the project indicators are based on a *zero tolerance* approach with the sunna being clearly defined as a form of FGM/C and the goal being to end all forms of cutting. See section 5.7 for a reflection on the theory of change model as a result of the MTR.

2. Methodology for the Midterm Review (MTR)

2.1 Overall approach

The MTR was carried out between June and September 2018 and involved a mixed methods approach drawing on documentation where available, supported by the collection of new data, both qualitative and quantitative.

A desk review of a selection of project documentation was undertaken which helped frame the areas to explore in greater depth during the 11-day visit to Somaliland. During this visit a community survey was carried out and a series of focus group discussions, key informant interviews and meetings with key stakeholders at national level in Hargeisa.

Progress against indicators and effective strategies for change (objectives i and ii) were explored using a combination of

- an examination of the types of data being collected to date through the AAIS MIS systems and tools
- a community survey in seven communities to assess changes at community level.

Progress on policy (objective iii) was explored through reports and documentation on policy development and KIIs with representatives from line ministries (MESFA, MORA, MOE, MOH).

Coordination and capacity building of CSOs (objective iv) was investigated by KIIs and FGDs with selected CSOs and reports on collaborative activities.

A review of the internal monitoring, evaluation and learning systems took place through collaborative meetings with the AAIS project team and the SOWDA and WAAPO project officers.

Actionable recommendations (objective v) have been drawn from the above and reflective discussions with key AAIS staff and partners involved in the project.

2.2 Community survey

A team of 7 community researchers participated in a two-day workshop on ethical community research in preparation for carrying out data collection over 5 days. The community researchers all had experience of interviewing community members and worked for AAIS, (2), SOWDA (2), WAAPO (1), NAFIS (1) and MOH (1). None was known in the communities surveyed. The questionnaire was available in both English and Somali. All interviews took place in Somali. Data was collected using mobile data devices and was uploaded daily onto the AAIS ONA platform.

Interviewees were selected randomly, using random number tables and other tools. Women and girls were accessed through a household survey, visits to health facilities, market places and schools. Men and boys were accessed through tea shops, households, workplaces, market places and schools. Teachers, health workers and religious leaders were identified at schools, health facilities and mosques as well as in the community.

Verbal informed consent was obtained before each interview began and on-going consent was also requested at intervals throughout each interview. Interviews took between 10 and 25 minutes.

Questions were asked under the following categories

- Background information
- Knowledge of FGM/C
- FGM/C in the community
- Personal questions for women only
- Religious status of FGM/C
- Commitment to abandonment
- Questions for teachers only
- Questions for health workers only
- Questions for religious leaders and community leaders

The questionnaire was based on the data obtained from the baseline and subsequent conversations. Most questions were multiple choice with the community researchers listening carefully to the interviewees and selecting 'best fit' responses. See appendix D for the list of questions. Data was able to be disaggregated by gender, age, community, rural/urban, role, education and marital status.

Sample size, locations and profile

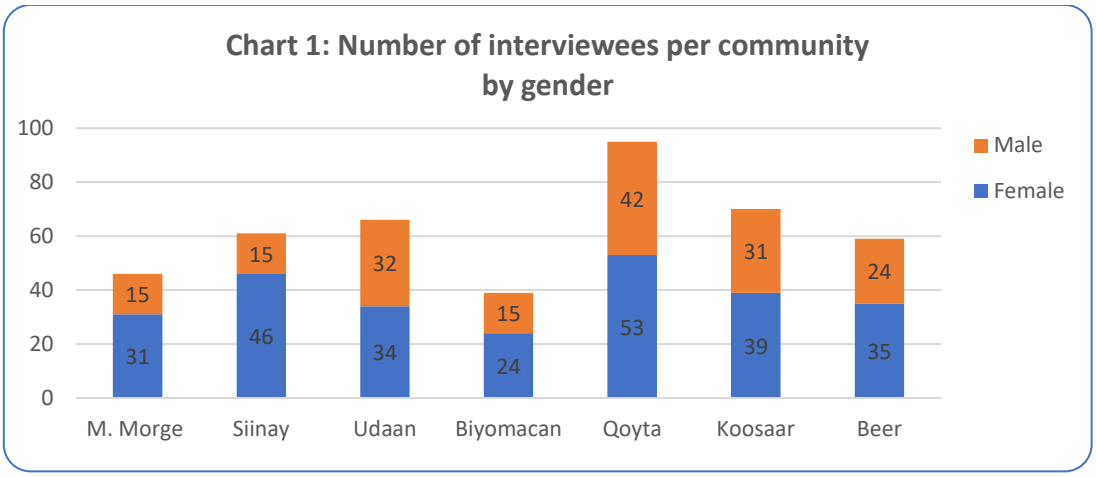
The community survey was carried out in 7 of the 35 target communities in which the FGM/C project is being implemented by the partner organisations SOWDA and WAAPO. They were selected to include rural and urban communities in Maroodi Jeex and Togdheer (table 2).

Table 2: MTR communities surveyed

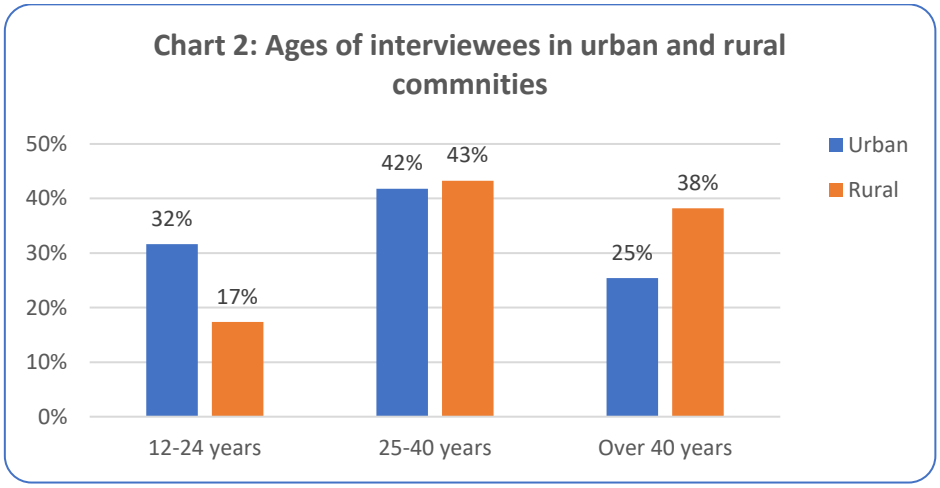
Communities	Urban	Rural
Maroodi Jeex	*Siinay (4)* *Mohamed Morge (5)*	*Biyomacan (3)* *Udaan (4.5)*
Togdheer	*Koosaar (4)*	*Beer (3)* *Qoyta (5)*

During the MTR planning process, each of the 35 communities was scored informally (on a scale of 1-5) on how much the project team felt that they had changed since the project began (see numbers in brackets in table above). Five of the seven communities selected were ranked in the top third, scoring 5 or 4.5. None of the seven communities rated the lowest was included in the community survey (see 3.1 for further explanation). Consequently, the seven communities surveyed for the MTR are not necessarily representative of the 35 target communities and so care should be taken when interpreting the results.

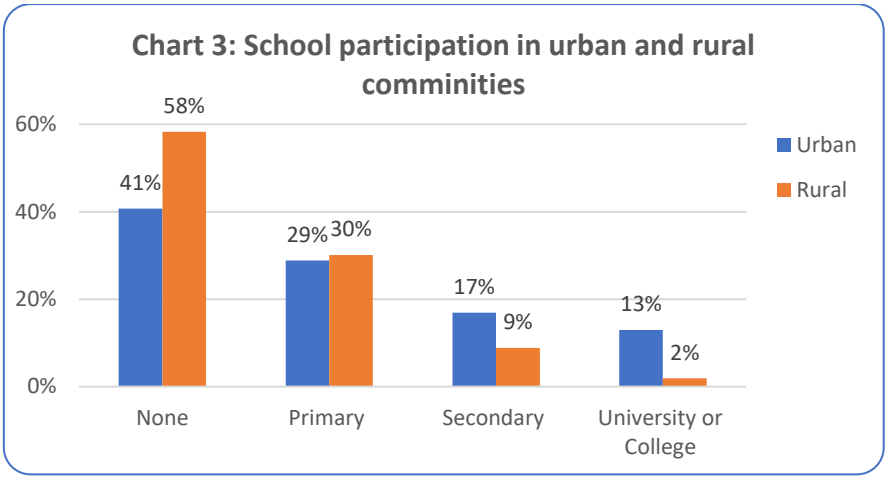
A total of 436 interviews took place, 60% with women (chart 1). The number of interviews per community varied between 39 and 95, depending on the size of community, the number of people available to be interviewed and the time available for interviewing.



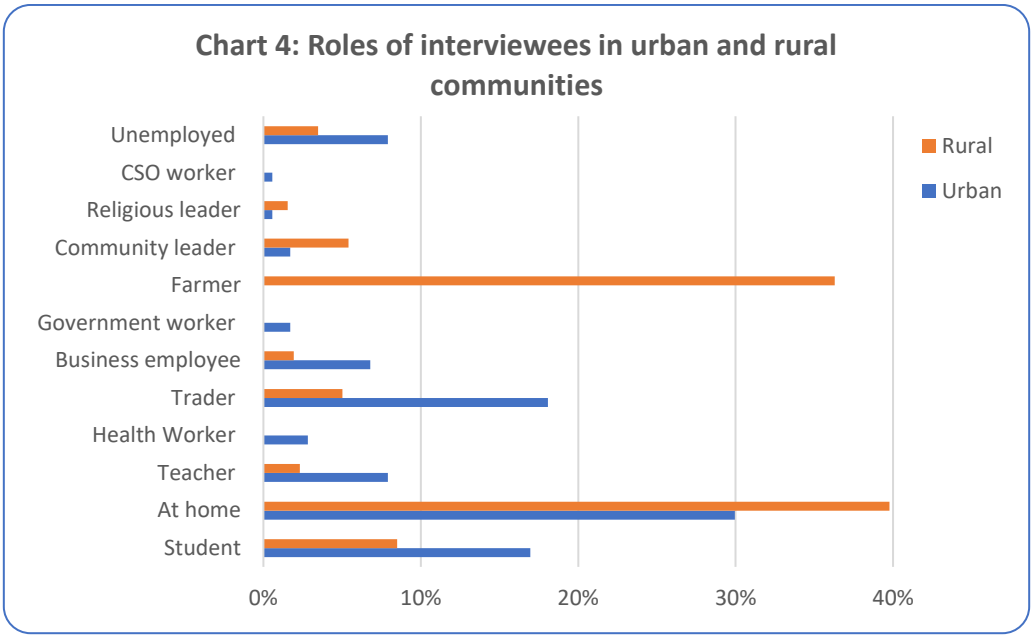
Overall, a quarter of the interviewees were young people (12-24 years), although only 5 (1%) were aged 12-14 years (see 3.2 for further explanation). Just over 40% of the interviewees were 25-40 years old. In rural communities, young people tended to be involved in farming activities away from their village and so fewer were available to be interviewed than in urban areas, where more were at school and in the market places (chart 2).



There is a marked difference in school participation between urban and rural areas with 58% of interviewees not having attended school in rural compared to 41% in urban communities (chart 3). Participation at secondary school and university or college is higher in urban than rural communities.



About a third of interviewees, mainly women, were based at home. In rural communities, farming, both agricultural and livestock, is the main livelihood, whereas in urban communities there are more opportunities for employment and trading (chart 4).



2.3 Focus Group Discussions (FGDs)

Focus group discussions (FGDs) and key informant interviews (KIIs) were facilitated by the consultant, with translation where necessary. They were semi-structured using a framework of key questions and took up to an hour.

Twenty five focus group discussions took place with a total of 182 participants (table 2). In each community FGDs took place with women and men separately. Where possible, additional FGDs took place with religious leaders, teachers, young men and young women. Most FGDs included religious leaders, community leaders and teachers. Two thirds of FGDs participants had been involved in AAIS project workshops and were active in activities to end FGM/C, as opposed to one third of interviewees in the community survey. Consequently, the views expressed in FGDs often represented an optimistic view of the extent to which attitudes and behaviours had changed across the community. However, they also provided valuable insights into attitudes and behaviours.

Table 3: Focus Group Discussions (FGDs)

Community	Stakeholder group	Number	Range age (years)	Average age (years)
Udaan	Women Men	9 10	30-80 34-70	45 54

Biyomacan	Women Men	11 7	26-70 30-60	53 49
Siinay	Women Men	9 8	17-85 20-70	41 35
Mohamed Morge	Women Men Teachers Youth (male) Youth (female)	12 9 2 4 5	19-50 19-85 25-26 15 13-17	38 40 26 15 15
Koosaar	Women Men Religious leaders Teachers Youth (female) Youth (male)	12 15 2 2 4 2	13-70 18-50 30-62 45-62 14-17 15	43 31 46 53 16 15
Beer	Women Men Youth (female) Youth (male)	17 12 5 2	20-70 20-67 14-18 15-17	38 46 16 16
Qoyta	Women Men Youth (female) Youth (male)	8 9 3 3	30-60 16-60 17-18 17-18	44 37 17 18

2.4 Key informant interviews (KIIs)

KIIs were used to obtain data through semi-structured conversations with key individuals in relation to FGM/C. They took place with representatives from the Ministry of Religious Affairs (MORA), including the Director General and two leading sheikhs and the Ministry of Employment, Social and Family Affairs (MESFA), including key stakeholders in the Department of Family and Social Affairs. The KIIs provided an opportunity for the positions of these ministries to be explored in depth.

KIIs also took place with health professionals in 3 of the communities.

2.5 Opinion formers – community leaders, teachers, health workers, religious leaders

Overall, a total of 101 opinion formers at community level (teachers, community leaders, religious leaders, health workers and government workers) were involved in the MTR. Half were interviewees in the community and half were participants in FGDs (table 3).

Table 3: Opinion formers involved in the MTR at community level

	Interviewees in community survey	**FGD & KII participants**	**Total**
Teachers	20	13	**33**
Community leaders	17	25	**42**
Religious leaders	5	9	**14**
Health workers	5	7	**9**
Government workers	3	0	**3**

3.0 Limitations

3.1 Selection of communities for the community survey

It was intended that the communities surveyed for the MTR would include a cross-section of those where the project team had seen most and least change in attitudes towards FGM/C. However, the communities selected by the project team included the three communities which the project team felt have changed their attitudes most in relation to FGM/C and did not include any of the seven communities where least progress had been made. The later tended to be those which have been affected most severely by the drought or have been least accessible to theproject teams due to security issues.

This limitation was identified after the community mobilisation had taken place and too late to change communities. The results should be interpreted with this in mind, recognising that they may imply a more positive picture than had a more representative cross-section of the 35 project communities been sampled.

3.2 Sample numbers of health workers, religious leaders, teachers and community leaders

The community data collection took place in 7 communities over 6 days with the team spending only 2-3 hours in each community. In some communities there were no health facilities and in other the schools were still shut from the holidays. A total of 101 opinion formers were involved (see table 3, section 2.2). Valuable insights have been able to be drawn from the discussions with these stakeholders, however, the sample size is too small to draw statistically valid conclusions.

3.3 Number of young people (aged 12-14 years) interviewed

Only 5 (1%) of interviewees were aged 12-14 years. Many of the schools were still closed following the school holidays. Young people were not encountered as part of the household survey and an alternative strategy was required to access this age range and obtain parental consent. The data from all young people 12-24 years was amalgamated for the purposes of data analysis.

Only 4 girls aged 12-14 years were interviewed which means it has not been possible to draw any conclusions about the changes in prevalence among this age group.

3.4 Availability of the Ministry of Health, Ministry of Education and Parliamentarians

The MOH and MOE are line ministries for FGM/C. Unfortunately, no-one was available from either ministry to be interviewed during the data collection period. However, the position of these ministries was obtained through detailed discussions and meetings the consultant had with key representatives from both ministries in December 2017 and June 2018 when facilitating knowledge sharing workshops on FGM/C in which representatives from MOH and MOE participated actively.

No parliamentarians were available to be interviewed during the data collection period.

3.5 Differences in the understanding of the term zero tolerance in relation to the types of FGM/C, particularly the sunna (drawing blood by pricking the clitoris)

Currently, in Somaliland there is widespread debate about what constitutes FGM/C. Most agree that the term FGM/C includes the pharaonic and intermediate cuts which involve stitching (WHO types II and III) and the removal of the end of the clitoris (WHO type I). The recent Fatwa on FGM/C has attempted to formalise a distinction between WHO types I, II & III which are declared as non-Islamic and the drawing of blood through pricking the clitoris, the sunna (WHO type IV) (appendix E).

This project is based on a goal of *zero tolerance* which includes all types of cutting. The community researchers were careful to check what people meant when they said they wanted to see the abandonment of all cutting, however, it is likely that there is some over reporting of the number of people opposing all types of FGM/C as they might not include the sunna as FGM/C.

4. Findings

This section presents the findings from the

The community survey, including the FGDs and KIIs, under the following headings

- Prevalence of FGM/C
- Speaking about FGM/C
- Religious status of FGM/C
- Legal status of FGM/C
- Expectations, intentions and preferences
- Abandonment of FGM/C
- Medicalisation of FGM/C
- Young unmarried men
- Involvement in activities to end FGM/C

Coordination and capacity building among CSOs

- Capacity building of partners WAAPO and SOWDA

- Contributions to the CSO network

Review of AAIS monitoring, evaluation and learning systems

- MEL systems
- Literacy and language

4.1. Community survey

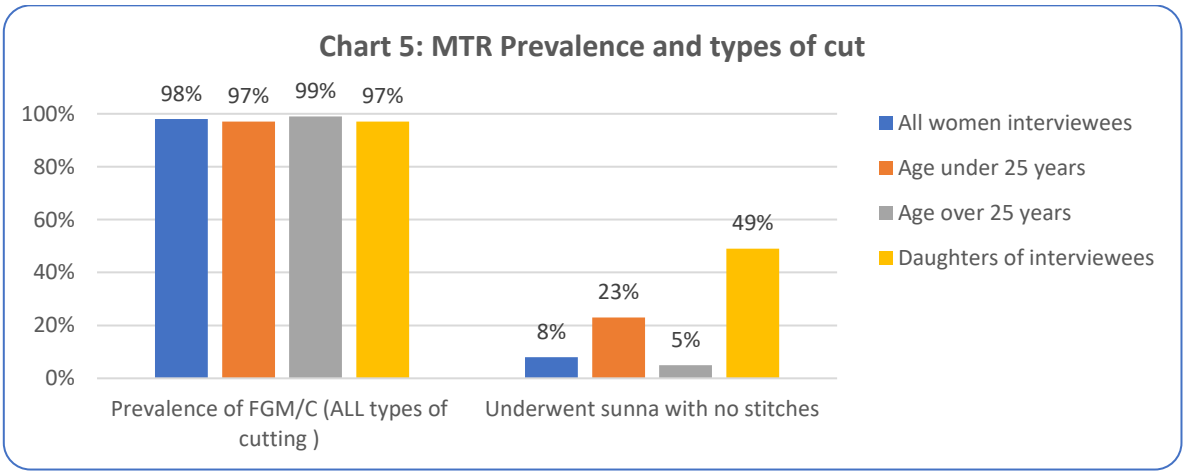
A comparison of the MTR and 2016 baseline data is included at the end of each section. Appendix G provides further comparison in relation to the project indicators.

Note: The communities surveyed in the MTR do not include those where the project team felt least progress had been made. The findings are likely to overestimate the overall changes. Nonetheless, the MTR data shows significant changes in attitudes and behaviours in relation to FGM/C in the 7 communities surveyed in the MTR.

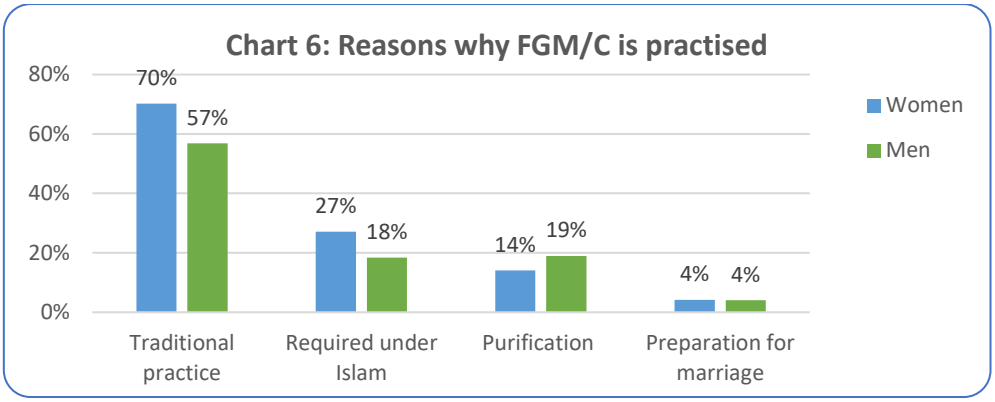
4.1.1 Prevalence of FGM/C and changes in the type of cut

The prevalence of FGM/C in the communities surveyed during MTR is 98% with 2% of women reporting that they had not undergone any form of cutting. This is in line with national statistics.

There is strong evidence of a move away from types of cutting which involve stitches towards the sunna with no stitches (chart 5). Only 5% of women over 25 years underwent the sunna with no stitches, compared to 23% of women under 25 years. Further evidence of the change comes from the reported type of cut which interviewees' daughters underwent. Almost half (49%) of women reported that their daughters underwent the sunna with no stitches.



The most commonly stated reason for cutting by both women and men is that FGM/C is a deeply held traditional practice (chart 6). A quarter of interviewees felt cutting was required under Islamic law with slightly fewer stating that cutting was carried out for purification purposes. Only 4% felt that FGM/C was performed in preparation for marriage. (Interviewees were able to give multiple answers to this question.) These findings were reflected in the FGDs where people emphasised that cutting with stitches was a traditional practice and that only the drawing of blood by pricking, the sunna was required under Islam.



Participants quoted two main reasons for the shift away from cutting with stitches, increased awareness of the adverse health consequences of cutting with stitches and the increased involvement in religious leaders in discussing FGM/C. These two factors are both important and are closely linked.

Women, in particular, sometimes expressed anger in FGDs at the health problems they and other women have suffered over many generations.

> *'We have felt sick all of our lives and now we have this awareness and we understand why. So many of the problems we have come from that one thing [FGM/C] and we are not going to let this happen to our daughters.'*
>
> Community woman, Mohamed Morge, urban community, Maroodhi Jeex

Both women and men explained that the change from the pharaonic to the sunna has been a gradual process. The first step was from the pharaonic to the intermediate with two stitches, then just one stitch and now the change is taking place to the sunna with no stitches. A teacher explains the positive impact of the change in the type of cut on girls' education.

> *'I have noticed at school, this term, that fewer girls are taking time to come back after the holidays. Before many girls would take some weeks to return after being cut. Now, with it being only the sunna they are back already. This I have noticed just this year. It is a good sign of the change [from pharaonic to sunna].'*
>
> Teacher, Beer, rural community, Togdheer

In the baseline assessment the majority of religious leaders opposed all types of cutting which required stitches. However, few were actively engaged in discussions with community members on FGM/C, so their message was not being heard. Since the release of the Fatwa, all religious leaders are involved in discussions in their communities on FGM/C and many seem to be taking a very active role. As influential people in the community their voice is powerful. The position of most religious leaders reflects that of the Fatwa and is summed up by the quote below which opposes both cutting with stitches and, equally forcefully, leaving a girl untouched.

> *'We do not allow our girls not to be harmed at all. Sharia law is against the pharaonic cut and also against not being touched. Both are as bad. If a girl is not touched the man will divorce her,'*
>
> *Religious leader, Beer, rural community, Togdheer*

So, the combination of increased awareness raising about the health consequences over the last 3 years, combined with a more recent active voice from religious leaders, is has led to a shift from the pharaonic cut to the sunna.

The commitment to the drawing of blood by pricking, called the sunna, remains strong with women and men talking of girls being proud to go to school having had 'a small bleed' from the sunna and continued stigmatisation of young girls who are not cut at all.

> *'We know if a girl has not been cut as we gather together the girls of the right age for the sunna and they are proud. If a girl is not cut she is bad, even I will call her names and the rest of the family, we will shame her to be cut.'*
>
> Community woman, Beer, rural community, Togdheer

The following example shows the different reactions to a girl not undergoing FGM/C.

'A young woman in our community has just been married and it was found she was not cut. The husband is happy with the wife but the whole family now is being isolated. She has verbal abuse, they call her 'baaro' which is very harsh. The family sell camel milk as a business and people are saying that this is unclean milk. If people can buy from others, they will and the business will suffer.'

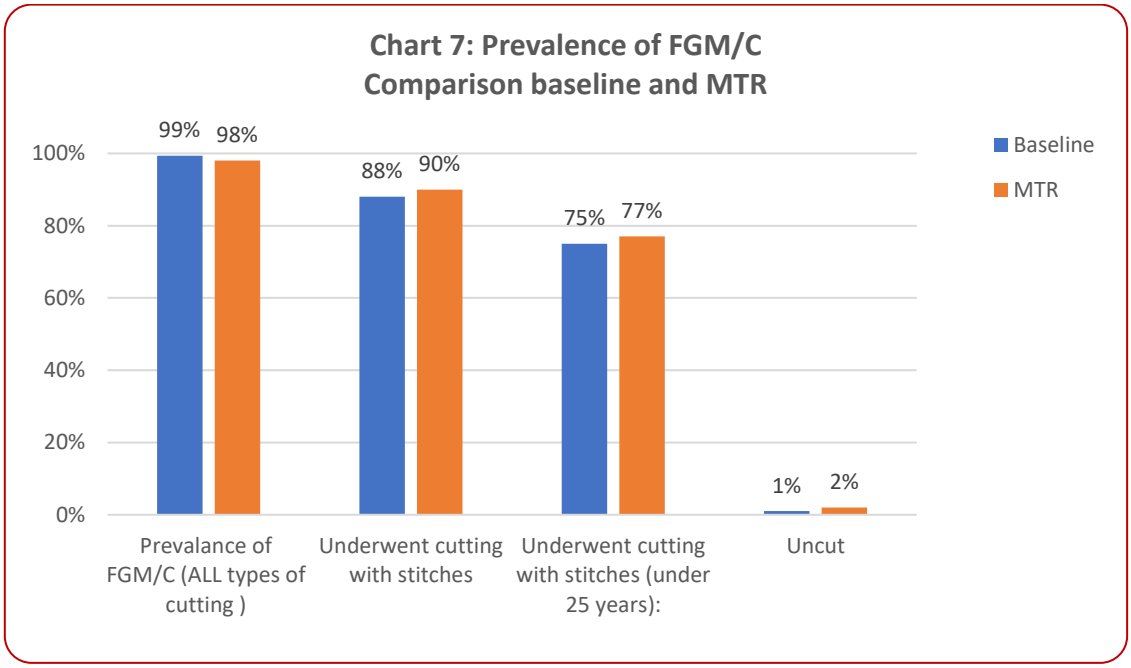
Community woman, Biyomacan, rural village, Maroodi Jeex

Conversely, there is some emergence of discrimination against girls who have been cut with stitches, who some see as less desirable as future wives and sexual partners.

> Sometimes they [young men] seem interested in you then ask what type of cut you have undergone and lose interest quickly if you say the pharaonic. It is like a light switching off.'
>
> Young women, Siinay, urban community, Togdheer

Summary and comparison of MTR with baseline assessment 2016

There have been no significant changes in the overall prevalence of FGM/C between the baseline in 2016 and the MTR (chart 7). The low numbers of girls interviewed aged 12-14 years mean that change in this age range could not be detected. Changes in prevalence usually require a much longer period to detect.



The FGDs revealed other changes in the last 2 years.

Firstly, the definition of the sunna appears to have narrowed slightly. In 2016, many, including senior sheikhs, were describing the sunna with no stitches as a snip, removing the tip of the clitoris (WHO type I) whilst others were describing it as drawing blood through pricking the clitoris (WHO type IV). Following the debate around the Fatwa the definition of the sunna has changed and most people, including sheikhs, now only include the pricking of the clitoris (WHO type IV) under the strict term of the sunna. This comes from the Islamic belief that women are made by Allah perfect, with no part of them requiring removing. However, there are still some variations with the pricking being described slightly differently in different communities. In most communities it is described as the lightest prick to draw blood, whereas in Qoyta it was described as 'an incision' rather than a prick and girls were proud only if they had a 'significant bleed'.

Secondly, the percentage of people who see the purpose of FGM/C to provide evidence of virginity has reduced from 20% in 2016 to just 4%. This change was explained by a young woman, as follows:

> 'Before, if a girl was not sewn she would be divorced but now it is different. The awareness of men was important. They know now that girls are not cut and sewn, so they are OK with the sunna only. Virginity is not linked to FGM/C anymore in our community.'

Young woman, Koosaar IDP camp, Burao, Togdheer

There was a belief expressed in several communities that girls who have only undergone the sunna actively seek sexual contact and need to be married younger, around 14-15 years, to avoid pregnancy outside marriage. When questioned about the impact of marrying younger on the dropout rate of girls from school, it was explained by a man in Biyomacan that *'early marriage and school can go together. A girl does not need to drop out of school when she marries, she can continue'*. It this is widespread it is clearly an unintended negative consequence of the move away from the most severe forms of FGM/C.

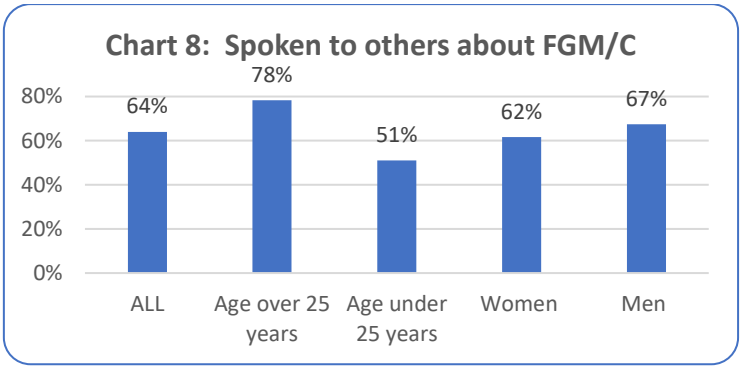
4.1.2 Speaking about FGM/C

The vast majority of people interviewed (91%) said FGM/C has been mentioned in public meetings in their community. This figure is consistent between communities, age groups and gender.

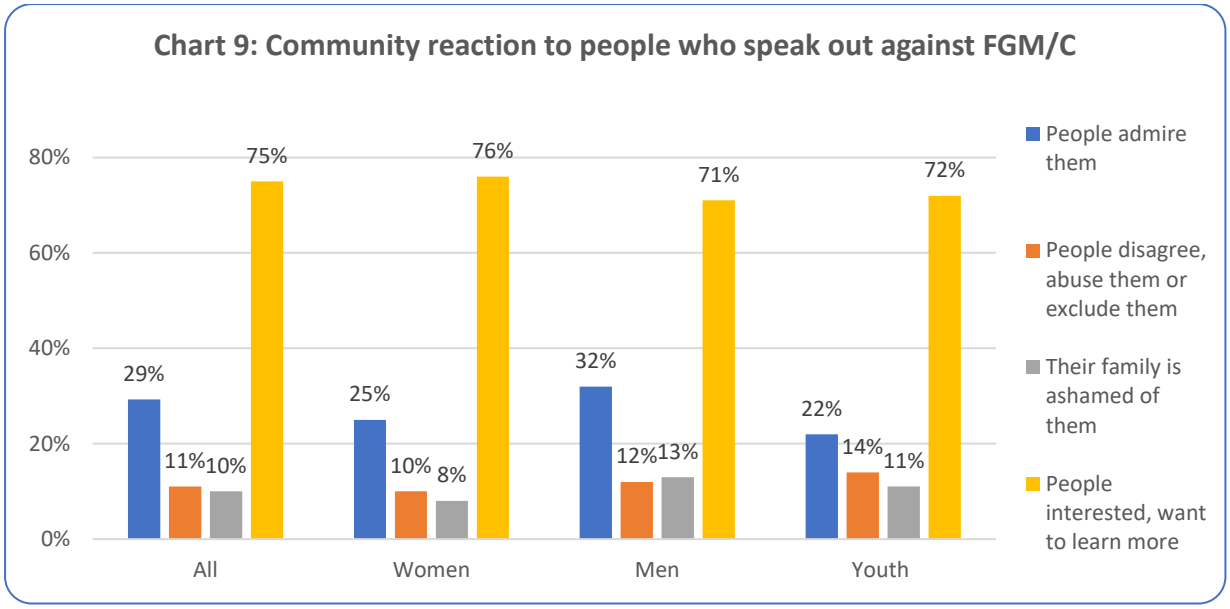
Overall, 64% of community members interviewed had spoken to others about FGM/C in the last year (chart 8). The figures varied between communities from 48% in Biyomacan to 78% in Koosaar. People over 25 years old are much more likely to talk to others about FGM/C than those under 25 years old (78% compared to 51%). About a third of people have spoken to family members, friends and neighbours.

> '*Nowadays the women talk more and more about the cutting. Even myself, I am hearing them in the market. One woman says I will cut, the other says you do not know the problems.*'
>
> Religious leader, Koorsaar, IDP camp, Togdheer

Few people are talking to opinion formers about FGM/C, for example 6-7% have spoken to a teacher, NGO/CSO worker or community leader and less than 5% to a health worker or religious leader. This suggests that people would prefer to talk to their peers than to a professional or community leader. Interestingly, 17% of men report having spoken to their wives, but only 3% of women say they have spoken to their husbands. The reason for this discrepancy is unclear, although it is clear that the vast majority of mothers and fathers are still not engaging in dialogue with each other about FGM/C.



When people speak out in public against FGM/C the most common reaction is people being interested and wanting to learn more (chart 9). However, about 10% feel the response is likely to be negative, either disagreeing, abusing or excluding them and the family being ashamed of them. (People were allowed to select more than one response to this question.) In FGDs people welcomed and supported those who spoke out against cutting with stitches. However, in more than half of the FGDs participants said that young girls and women who were not cut at all would be ridiculed and the family isolated. This distinction might be linked to the different responses in chart 9.

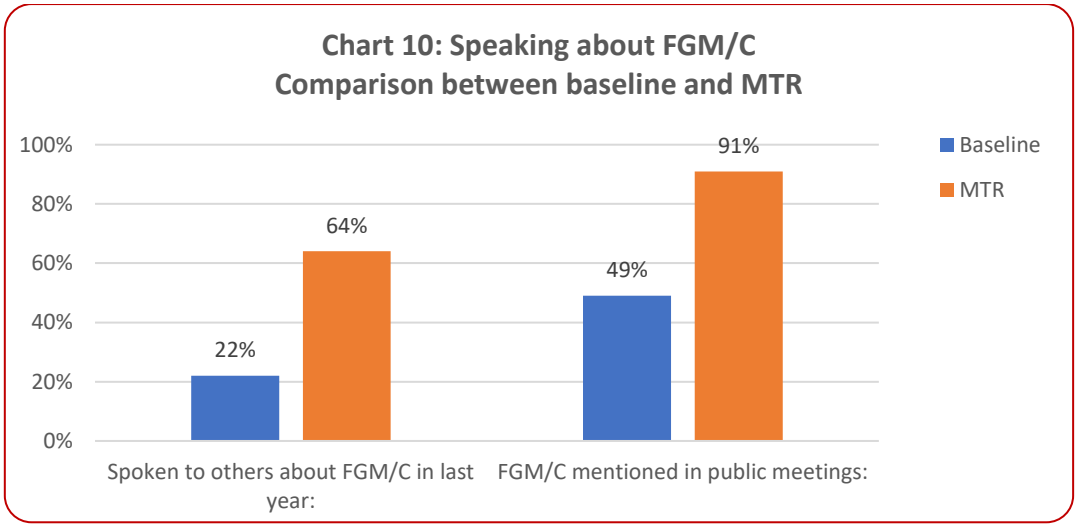


Understandably, young men, under 18, seemed not to have the same level of confidence in speaking about FGM/C as other community members. The young men in the FGDs could describe the pharaonic cut and some of the health risks and all felt strongly that it was wrong and should not take place. However, they lacked confidence in speaking publicly about such a sensitive issue. In discussion, they seemed unaware of it happening to anyone in their extended family or in their neighbourhood. This is not surprising as they are unlikely to be involved in discussions about FGM/C in their communities. The AAIS Programme manager, who was able to relate well to young men in Somali, made the same observation and felt the young men might need to have more opportunities to talk about the impact of FGM/C on their extended families, rather than just learn about it in a factual, anatomical manner. The sample size was quite small, however, when discussed among the project team all agreed that the project lacked specific activities for young men and that there would be some benefit in reviewing the approach to working with this stakeholder group.

Summary and comparison of MTR with baseline assessment 2016

The changes in when FGM/C is spoken about in communities and the response of others is one of most dramatic changes since the baseline assessment was carried out in 2016 (chart 10).

In FGDs, it was noticeable that most people, with the exception of young men, were not embarrassed to speak openly about FGM/C. Women, including young women, are talking about how they are managing their health problems and how they want things to be different for their daughters. Men are talking about the challenges they face in marriage relationships. Male teachers are talking about how they are talking to young girls about FGM/C. Many of these conversations are taking place independently of structured project activities. The impression given is that this is a sustainable change, rather than simply conversations taking place in workshops and facilitated community conversations.



The number of people who know that FGM/C has been raised in public meetings in their community has risen from 47% to 91% and is consistent across the seven communities surveyed. There has also been an increase in the extent to which it is raised, with 48% of interviewees saying it is raised '*often throughout the year*', an increase from 16% in 2016.

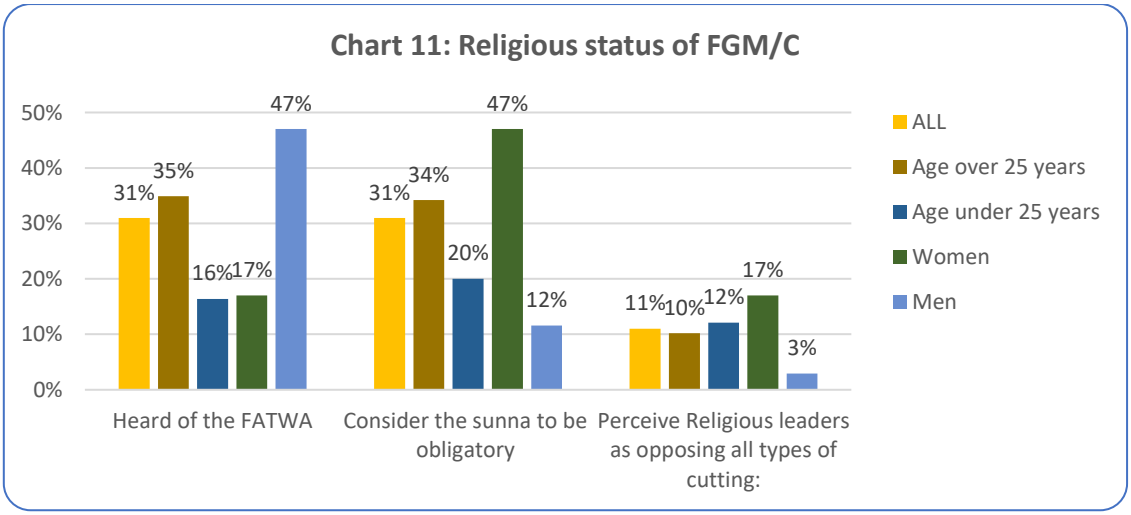
The percentage of people who have spoken to someone about FGM/C in the last year has increased almost threefold from 22% to 64%. People are still talking primarily to family, neighbours and friends with very few (3-8%) community members talking to teachers, health professionals, religious leaders or community leaders.

4.1.3 Religious status of FGM/C

Chart 11 shows the responses to three questions on the religious perceptions of FGM/C.

Overall, 31% of community members have heard of the recent Fatwa on FGM/C and a similar percentage think the sunna is obligatory. People over 25 years old are more likely to have heard of the Fatwa and more likely to think the sunna is obligatory compared to younger people. The difference between women and men is even more marked with only 17% of women having heard of the Fatwa compared to 47% of men and with 47% of women considering the sunna to be obligatory compared to just 3% of men.

Overall, 11% of community members perceive religious leaders as opposing all types of cutting. There are significant differences between communities with less than 5% in Koosaar, Beer, Qoyta and Udaan to 38% in Siinay, which suggests that the religious leaders in Siinay are particularly active. Only 3% of men but 17% of women think religious leaders support the abandonment of all types of cutting. This is consistent with more men having heard of the recent Fatwa which states that the sunna is obligatory.



The majority (81%) of religious leaders interviewed had spoken in public about FGM/C with 62% seeing their role as informing the community about the Fatwa. All publicly opposed all cutting which involves stitches but

supported the drawing of blood by pricking, called the sunna. When asked about their personal opinion 5% said they would like to see the abandonment of all types of cutting including the sunna.

In FGDs, all religious leaders were aware of the Fatwa. Most religious leaders interpreted the Fatwa as saying the sunna was obligatory, although a minority argued that the word sunna itself means optional and so that was how they were interpreting it (see types of FGM/C p 3). Most of these went on to say that the sunna was honourable and that they supported it, although they were keen to point out that the sunna should be no more than a drawing of blood through pricking.

The opinion of many religious leaders is summed up below

> *'FGM/C has no basis in our religion, it is a health issue. Allah created women as perfect human beings with no part needing removing. The pharaonic cutting comes from Egypt and is not a good understanding of God. The sunna is better if you do, but you can choose to do or to leave. But remember it is just the lightest prick to draw blood.'*
>
> Religious leader, Udaan, rural community, Maroodi Jeex

Religious leaders in FGDs see a strong role for men in the move to abandon cutting with stitches.

> *'Men have a role to play. We have to empower the men who are the cause of this thing by rejecting women who were not cut. Men have a role to say 'no, you will not cut our daughter' to their wives. In Europe women have the right to say no, but here in Somaliland men should learn to say no.'*
>
> Religious leader, Koosaar, IDP camp, Togdheer

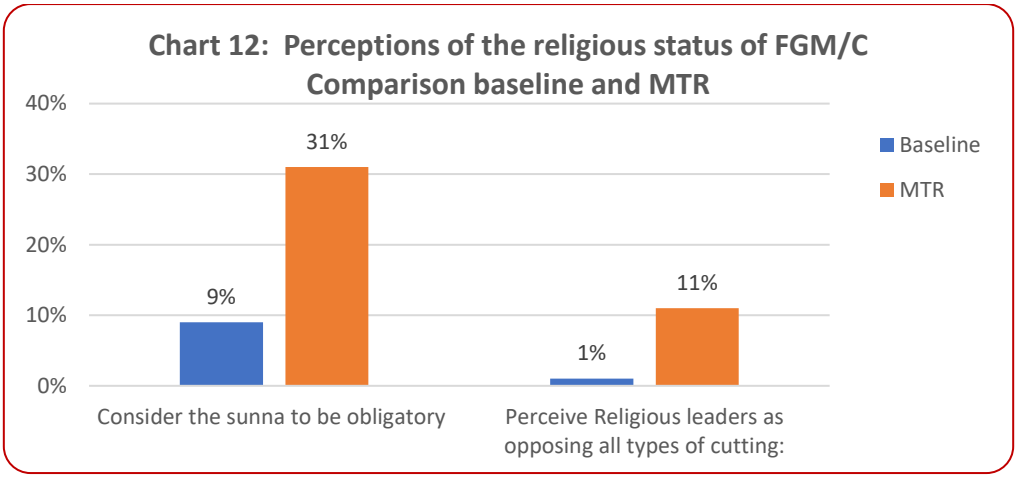
Summary and comparison of MTR with baseline assessment 2016

In 2016, none of the senior sheikhs would speak publicly in favour of the abandonment of all types of cutting. This remains the case now, although some, including the Director General of MORA, says in meetings that their own daughters have not undergone the sunna and remain uncut. None is prepared to say publicly that the sunna is a form of FGM/C and should be made illegal.

In 2016, at a community level, 45% of religious leaders had spoken in public on FGM/C. This figure is now 81% in the communities surveyed in the MTR. However, in the baseline assessment, 24% said they would support the abandonment of all types of cutting. Currently, just 5% of religious leaders at community level support the abandonment of all types of cutting. It appears clarification of the status of the sunna through the Fatwa has resulted in an actual decrease in the number of religious leaders supporting the abandonment of all types of cutting. If this change in attitude is replicated across Somaliland, this would represent a hardening of opinion of religious leaders in favour of the sunna and against a *zero tolerance* approach to FGM/C.

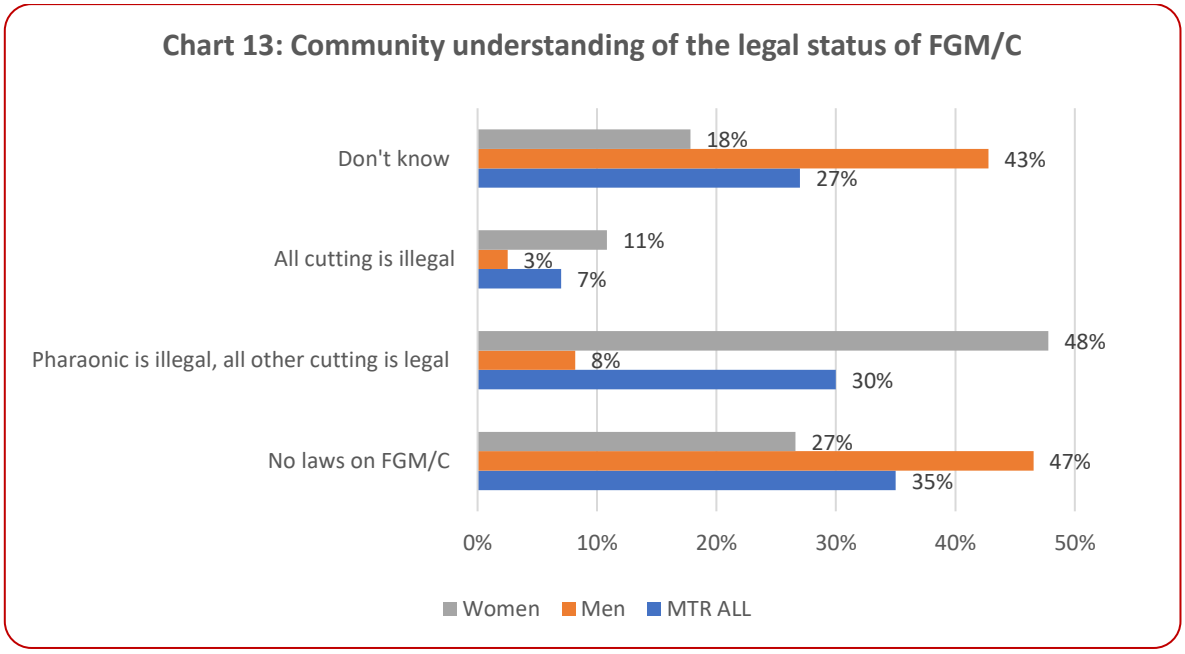
Since 2016, people have begun to hear about the Fatwa and religious leaders are talking more in public about FGM/C. This has resulted in an increase in the percentage of community members who now think that the sunna is obligatory to 31% (chart 12). Set alongside the gradual change from the pharaonic cut to the intermediate and then to the sunna, this is likely to be a barrier to a further change to the abandonment of the sunna.

There is also an increase in the percentage of community members who think that religious leaders are opposed to all types of cutting from 1% to 11%, although people may not be including the sunna as a type of cutting.



4.1.4 Legal status of FGM/C

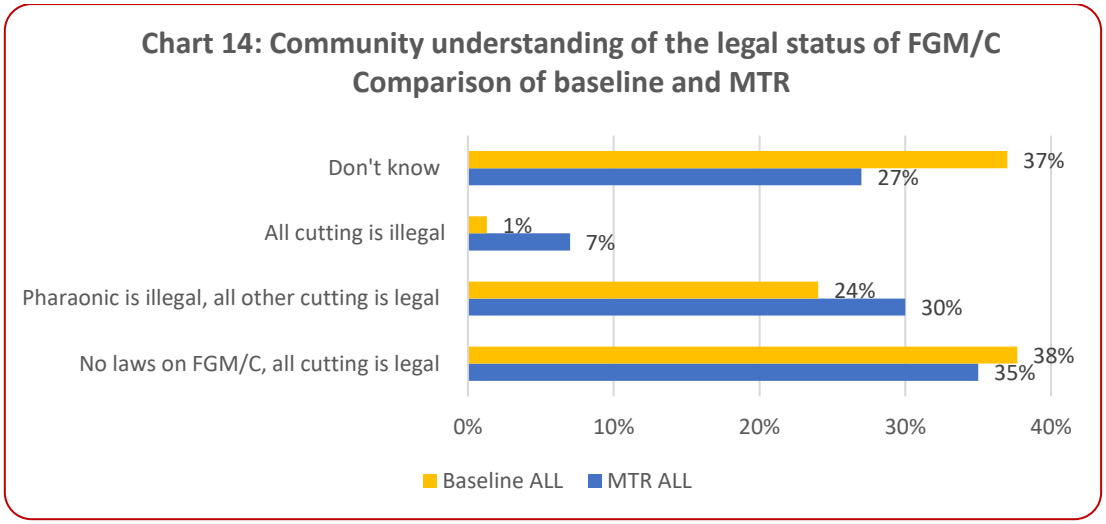
Less than a third of community members are aware of the legal status of FGM/C (chart 13). Men tend to either know that there is no law or not know the legal situation. Almost half of women think that the pharaonic is illegal but that all other cutting is legal. These figures are consistent across age groups and in rural and urban communities selected for the MTR.



In the FGDs, participants talked about having gained knowledge through the AAIS workshops about the health risks of FGM/C but not about its legal status. In two communities, when the men were asked about the legal status of FGM/C they showed copies of the Fatwa and described it as 'the new law'.

Summary and comparison of MTR with baseline assessment 2016

There has been relatively little change in the knowledge at community level of the legal status of FGM/C over the last 3 years (chart 14). Fewer people feel they do not know and more think that the pharaonic is illegal but all other cutting is legal. Overall, only a third of community members have an accurate understanding of the legal status of FGM/C. It is unclear the extent to which the legal status of FGM/C has been discussed in community conversations.



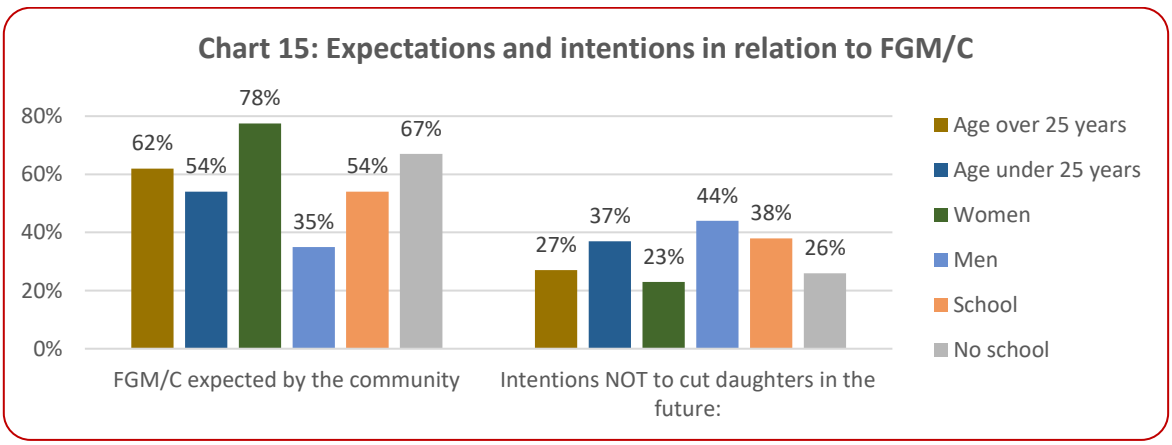
4.1.5 Expectations, intentions and preferences

Expectations and intentions are linked in social norms theory, with decision-making around social norms being influenced by the expectations of society. In the communities surveyed for the MTR, community members were asked about whether they felt their community had specific expectations of them in terms of cutting their daughters and their own intentions for the future in terms of cutting their daughters and also selecting a wife or daughter-in-law in future.

Overall, 61% of people interviewed felt that they were expected by the community to cut their daughters. However, only half as many (30%) intend to cut their daughters in the future, suggesting that people are now considering breaking away from the expectations within their community. There is a wide variation between communities with no significant difference between rural and urban communities.

Women and men experience different levels of expectation. Twice as many women (78%) experienced this pressure than men (35%) resulting in only 23% of women saying they intend not to cut their daughters at all, compared to 44% of men (chart 15). It appears that, in line with social norms theory, that women are subject to greater pressure to cut than men and consequently more of them intend to cut their daughters, in order to avoid the negative sanctions of not being cut.

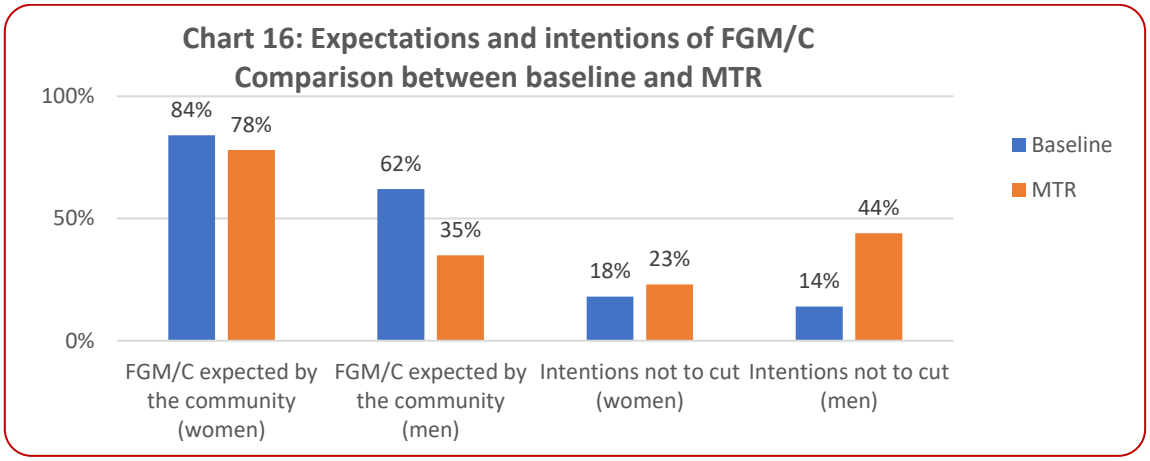
Younger people felt less pressure and are less likely to cut their daughters than older people. Participation in school also seems to be a factor with those not attending school feeling greater pressure to cut and fewer not intending to cut their daughters compared to those who have gone to school (chart 15). This is unlikely to be linked to FGM/C being talked about at school, as most will have gone to school at a time when FGM/C was hardly ever raised at school. It is more likely that those who have attended school are more likely to be able to read leaflets or posters, and more likely to be invited to workshops or become active members of community groups and through this process become more aware of the issues relating to FGM/C.



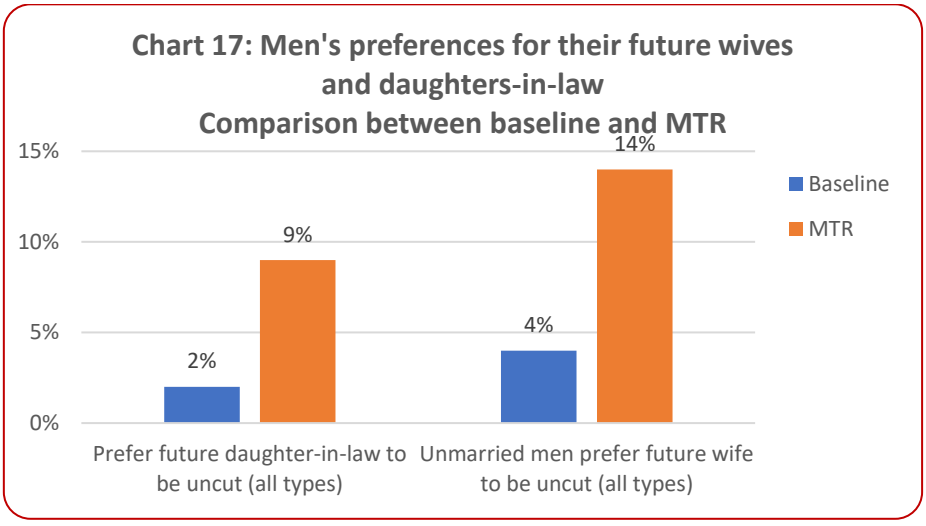
9% of men would prefer any future daughter-in-law to be uncut, with only 3% preferring her to have undergone a cut with stitches. 14% of unmarried men would prefer to marry an uncut girl with none preferring to marry a girl who has undergone a cut with stitches.

Summary and comparison of MTR with baseline assessment 2016

There has been a decrease from 74% to 61%, in the percentage of community members feeling they are expected to cut their daughters. This decrease has been greater for men (62% to 35%) than for women (84% to 78%). This change is also reflected in an increase in the percentage of men not intending to cut their daughters from 14% in the baseline to 44% in the MTR. However, most men also stated in the FGDs that their wife will make the decision with regards to the cutting of their daughter, although many said they will try and influence her decision.



The percentage of men preferring their daughter-in-law not to have undergone any form of cutting, including the sunna has increased from the baseline to the MTR from 2% to 9%. A similar increase is seen in the preferences of unmarried men for their future wives from 4% to 14% (chart 17). These changes are significant, however, the vast majority of men would still prefer both their future wife (86%) and future daughters-in-law (91%) to have undergone FGM/C, although most (68%) would prefer them to have only undergone the sunna.

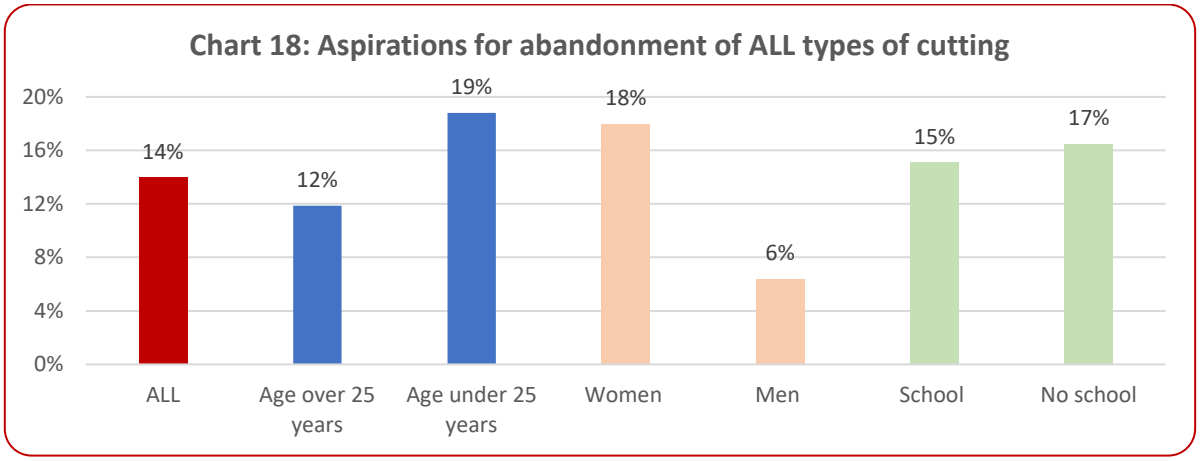


4.1.6 Abandonment of FGM/C

Overall in the community survey, 45% of community members would like to abandon all types of cutting which involved stitches, and 14% of community members would like to see the abandonment of all types of cutting. However, this must be seen in the light that none of the communities which AAIS, WAAPO and SOWDA have found particularly challenging to work in were included in the sample, so the results are likely to give an optimistic view of the change.

Younger people are more likely to want to see the abandonment of all types of cutting than those over 25 years old (19% compared to 12%) which is consistent with the way change has taken place in other countries.

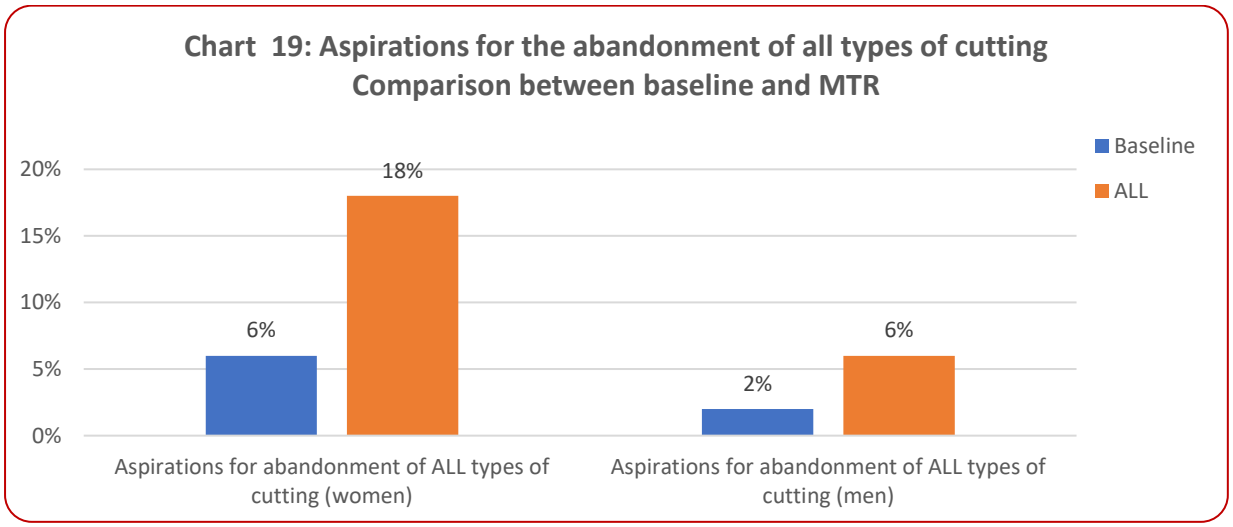
Chart 18 shows that women are three times more likely to support the abandonment of all types of cutting than men (18% compared to 6%). These figures are lower than those who do not intend to cut their daughters (chart 15), which possibly suggests that some people do not intend to cut their own daughters but equally, would like others to be allowed to choose to cut their daughters.



Summary and comparison of MTR with baseline assessment 2016

There has been an overall increase in the percentage of community members who support the abandonment of all types of cutting from 5% in 2016 to 14% in the communities sampled in the MTR. This change is most marked among women from 6% to 18% (chart 19). The corresponding increase for men is from 2% to 6%.

As in 2016, the majority of community members (84%) in all of the communities supported the abandonment of all cutting which requires stitches but did not support the abandonment of drawing blood by pricking, called the sunna in Somaliland.



4.1.7 Medicalisation of FGM/C

The percentage of women cut by health professionals (nurses, midwives and doctors) varies considerably between communities with a strong trend towards an increase in the medicalisation of cutting. Overall, 8% of women interviewed say they were cut by a health professional, with just 5% of women over 25 and 15% of women under 25 years old. When asked who cut their daughters 44% said their daughters were cut by a health professional.

In each of the 7 communities surveyed, both urban and rural, women explained how girls were being taken to MCHs to be cut or that midwives or nurses came to their houses to cut their daughters, nieces or granddaughters. Some communities talked of understanding that specific health professionals, often the older

ones, had been trained to perform FGM/C safely. In FGDs, the women who used health professionals were usually the first the speak. They were often the women's group leaders and keen to see more girls cut safely by health professionals. Most women said they pay $10 to have a girl cut by a health professional, although some said this service is free.

> *'This summer, just a few weeks ago, I had booked the traditional cutter to come to my house to cut my 3 nieces ages 8, 9 and 10. A friend told me that this could be done at the MCH. I went with no appointment, and they were done, with just the sunna, and we had medicine afterwards. The girls were all playing straight away and went to school the next day.'*
>
> Community facilitator, Siinay, urban community, Maroodi Jeex

In the FGDs, men were proud that the young girls in their communities were being cut by health professionals, often explaining that this is safer than previously when traditional cutters were being used. Several communities claimed to have stopped using traditional cutters and having sent them away when they approached the community.

Communities where the nearest health facility involves a long journey quote having their daughters cut by a nurse or midwife as one of the reasons why they want local MCH. In one community, Qoyta, a rural community in Togdheer, several women's groups have been actively supporting an end to all cutting involving stitches, and would like to hold a celebration to tell the world that they have 'abandoned FGM'. However, currently, they still strongly support the sunna performed by health professionals.

> *'….32 of our girls had the sunna this holiday, the younger ones went to the MCH for it and the midwife or nurse came to the home of the older ones. But many nurses and midwives have said they will not be able to do it again, they will refuse as they are not allowed to do it anymore. We will try to use our sheikhs to persuade them it is part of our religion……..We will not go back to the TBA as we can't trust her. She is unhygienic and we are still feeling the pain from all her cutting in the past. We only trust the nurses with their gloves, antiseptic, one blade and antibiotics which keep our girls healthy.'*
>
> *Community women, Qoyta, rural community, Togdheer*

The MOH has begun a programme of dissemination of its anti-FGM/C policy. There is evidence that this might be having both positive and negative effects. Most health professionals interviewed were more reluctant to talk about the decision-making dilemmas they face or to talk openly about cutting, than in the baseline assessment. Some who cut in the past, might be now refusing to perform the sunna. Others might be continuing to cut but unwilling to talk about it.

Only 4 health professionals were interviewed in the community survey which is not sufficient to draw any firm conclusions. However, in summary, one health worker said that the role of health workers in relation to FGM/C is '*to provide a safe cutting service to the community to reduce the harm of cutting being done by traditional cutters'*. She also said that her daughter would undergo the sunna. All of them said that they personally would not perform any type of FGM/C, however one said that if they were asked to cut a girl she would refer the mother to another health professional who does cut. Two of them said they knew of other health professionals who cut. Interestingly, all had heard of the freedom from violence against women and girls, although only one of them thought that FFV means girls should not undergo the sunna.

Two said they would like to see a law based on *Zero tolerance*, the others said they would like to see a law which banned all cutting which involves stitches but allows the sunna.

During a visit to a health professional a pharmacist said the following

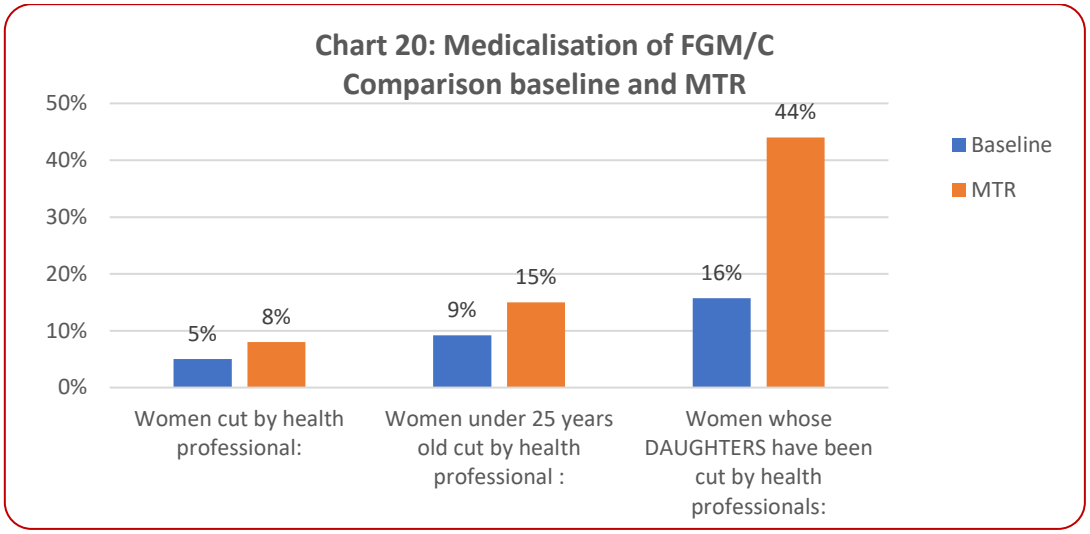
> *'Previously, we had the pharaonic but now after so much awareness we have only the sunna. Women bring their daughters here for the sunna and the midwife does it. I give them antibiotics afterwards. Then then go away to their homes fine. They are free to play straight away. My own daughters now are sunna only from now.*
>
> *Pharmacist, urban MCH, Togdheer*

The midwife at this MCH was interviewed and said that a previous midwife *'used to do the sunna, but she left before I came, I would never do FGM'.*

Summary and comparison of MTR with baseline assessment 2016

National statistics for medicalisation of FGM/C in Somaliland are in the region of 4-6%. The MTR data provides evidence of an increase in the medicalisation of FGM/C (chart 20). This is demonstrated by an overall increase from 5% to 8% since the baseline. Among young women, under 25 years old, the increase is from 9 to 15%. The most dramatic increase is in the reporting of women whose daughters have been cut by health professionals which has risen from 16% to 44%. These figures vary between communities but with both high and low rates in rural and urban communities.

These results are reflected by the accounts given in the FGDs by men, women, teachers, health professionals, community leaders and religious leaders (see examples above).



During the baseline assessment nurses and midwives talked openly about the dilemma they faced when asked to perform FGM/C, with many saying they tell parents they will only do the sunna and would like to be trained to do it more safely.

The dissemination of the anti-FGM/C policy by MOH to MCH staff appears to be having an effect on the health professionals, although it is not clear whether health professionals are changing their practice and no longer cutting, or that the practice of health professionals cutting is being driven underground.

On one hand, most community members are confident that they can have their daughters cut by a health professional. In all communities, women described in detail having taken their daughters to be cut by a health professional in the recent school holiday (July 2018).

On the other hand, health professionals are firm in saying they do not perform FGM/C and have been advised not to do so by MOH. However, they often say that their predecessor used to cut, or in one case a pharmacist said the midwife cuts.

4.1.8 Young unmarried men

Young unmarried men are described as key actors in the AAIS theory of change model as they are potential decision-makers, or influencers of decision-making in the future in relation to FGM/C

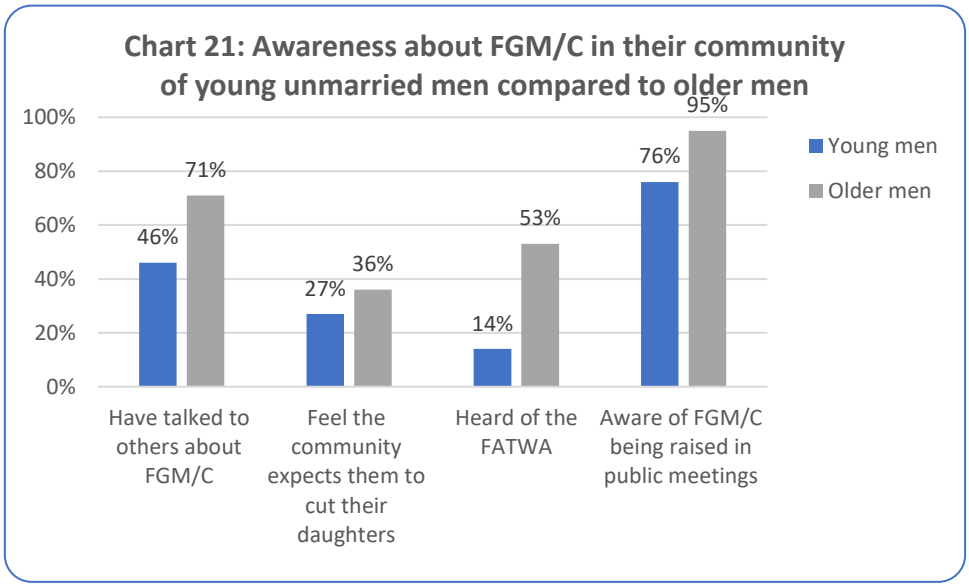
The young unmarried men in FGDs were keen to be involved in speaking about FGM/C but had limited awareness about the cutting of girls in their community or the role they could play. They could describe the pharaonic cut and some of the health risks and most felt strongly that it was wrong and should not take place. However, many were not aware of it happening to anyone in their extended family or in their neighbourhood and seemed to see it as something dreadful which happened 'elsewhere' and which should be stopped.

> *'We are on the Youth Forum and go to speak in our community to stop FGM/C. I know they cut everything and they don't need to, then they stitch to keep it together.'*

'It is a women's issue and we do not know what happens or what needs to be done to stop it……..I don't know anyone who has been through FGM/C, not my mother or sisters or anyone in my family.'

Young men, Beer, rural community, Togdheer

These observations were supported by the AAIS project manager, who was able to engage well with young men, in Somali. They were also supported by the community survey data (chart 21) which shows that young men are less likely to have talked to others, less likely to have heard of the Fatwa, less aware of FGM/C being spoken about in public meetings and fewer of them feel that their community expects them to cut their daughters in future.



When discussed in the project team meeting, it was agreed that young men often do not see the relevance of FGM/C to themselves. However, the team also felt strongly that young men should be encouraged to be involved as future decision-makers.

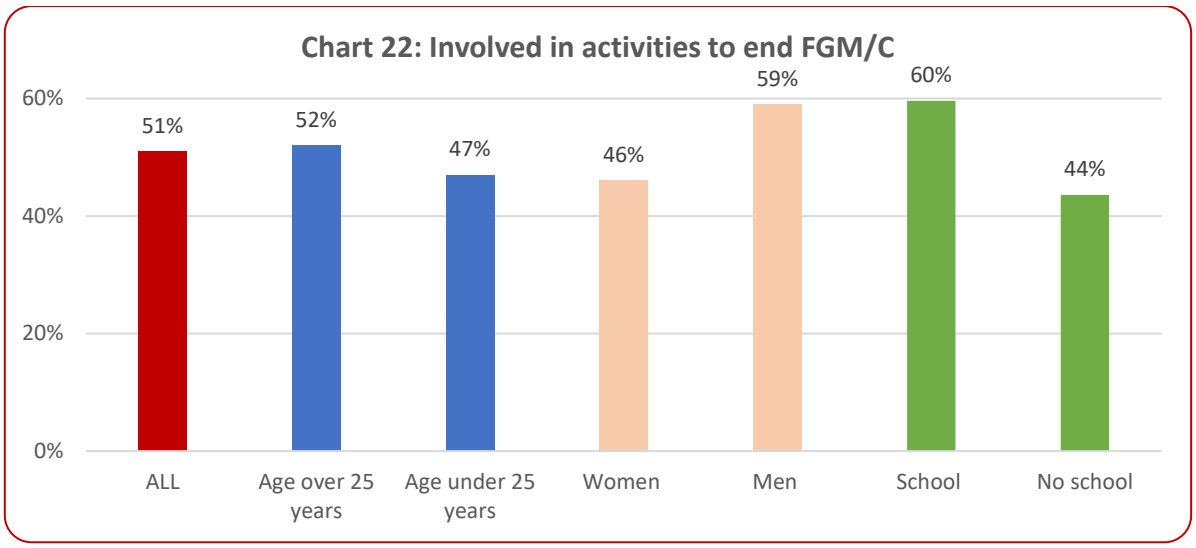
In the FGDs, men talked about the advantages of women not being cut in terms of their willingness to engage in sexual activities and improvements in marriage relationships. Almost all unmarried men wanted to marry girls who had undergone the sunna only. None wanted their future wives to have undergone cutting with stitches. These conversations suggest that young men do have opinions and preferences in relation to FGM/C and these preferences will influence decision-making, either explicitly or covertly.

Indeed, young girls report that young men have begun to ask them about the type of cut they have undergone when getting to know each other (see 4.1.1).

It seems clear that young men have a role to play in the abandonment of FGM/C and that the approach to working with this stakeholder group would benefit from being reviewed and adapted.

4.1.9 Involvement in activities to end FGM/C

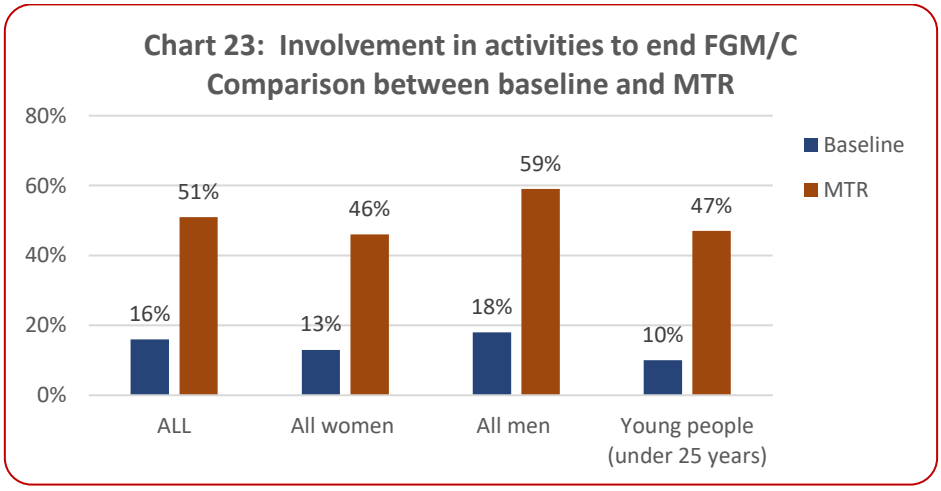
Just over half of the MTR interviewees reported that they are involved in activities to end FGM/C, with slightly more older people than those under 25 years. People who have attended school tended to be more likely to be involved than those who had not been to school (chart 22). Interestingly, although the project reached more women than men, a higher proportion of men (59%) than women (46%) now report that they are involved in activities to end FGM/C.



Almost all who been involved in activities to end FGM/C had participated in public meetings, two thirds had been involved in campaigns and half had attended workshops.

Summary and comparison of MTR with baseline assessment 2016

There has been a threefold increase in the percentage of people involved in activities to end FGM/C since the beginning of the project from 16% to 51% (chart 23). The main activities are public meetings, campaigns and workshops, with an increase in the percentage of women involved in workshops from 9% to 48%. In addition to attending organised events, women's group members in particular seem to be taking the initiative to reach out to other community members, visiting school, health clinics and talking to women's income generation groups, church groups etc.



4.2 Coordination and capacity building among CSOs

4.2.1 Capacity building of partner CSOs: SOWDA and WAAPO

Funds available for partner capacity building appear to have been used effectively. SOWDA and WAAPO project officers report that the following have helped to strengthen their respective organisations.

- Financial accountability and management, including Quickbooks
- Governance
- Strategic planning and policy development
- Project management and reporting
- Media

Capacity building was most effective when planned in collaboration, with SOWDA and WAAPO being consulted at all stages.

An organisational capacity development tool (PC3 POTCAT) has been used to assess the capacity of partners before, during and at the end of the project. This is a self-assessment tool which WAAPO and SOWDA complete under 13 categories (appendix F). It is reported that the PC3 POTCAT scores for both SOWDA and WAAPO have increased since the beginning of the project.

4.2.2 Contributions to the CSO network to end FGM/C in Somaliland

The AAIS project has contributed to the CSO network in three ways:

- Active participation in the monthly meetings of the working group on FGM/C with MESFA
- Funding the strategic activities undertaken by the CSOs actively working to end FGM/C
  A decision was taken early in the project to support the work of NAFIS in their role as the national agency engaging with government ministries involved in the development of policies on FGM/C. This decision has avoided replication and enabled NAFIS to extend its work. Key strategic meetings have taken place as a result of this strategy. In addition, NAFIS has been able to develop a manual *Guidelines on Mainstreaming FGM/C* and to disseminate this to a wide range of CSOs through workshops.
- Funding project implementation in 35 communities in Maroodi Jeex and Togdheer
  SOWDA and WAAPO have been able to extend their remit and capacity through this process.

During a review meeting with 6 key CSOs involved in anti-FGM/C activities AAIS was praised for bringing increased resources to the sector and for using these to strengthen the existing structures through which these organisations collaborate. They were also urged to play a more active and on-going role in supporting knowledge sharing and collaboration between CSOs. Specific suggestions included contributing to the strengthening of approaches to engage youth on FGM/C and active planning for the contribution of AAIS to the network after this project has finished.

4.3 Review of AAIS monitoring, evaluation and learning systems

4.3.1 MEL systems

The MEL systems were reviewed through an extremely positive collaborative meeting in which AAIS, SOWDA and WAAPO shared the achievements and challenges of the on-going monitoring data collection and interpretation. The discussion was open and reflective with positive suggestions for improvements being put forward by all.

Overall, the data collection and storage systems are well developed and have been designed to monitor the planned activities as well as to gather some information on changing attitudes. Most data is currently being collected using paper-based forms which community facilitators (CF) complete by hand. The forms are then copied by SOWDA and WAAPO during their monthly monitoring visits who then upload the data to the AAIS ONA platform.

Activities are taking place as planned and SOWDA and WAAPO are consciously completing the monitoring forms.

A number of areas for development were identified as follows:

1. SOWDA and WAAPO can only upload information when online which makes the process quite time consuming, especially when the internet connection is slow or erratic
   Recommendation: AAIS provide SOWDA and WAAPO with the access codes to submit data via the ODK Collect app which can be done offline, then data can be uploaded in one process when internet access is available.
   AAIS could consider providing SOWDA and WAAPO with tablets for this purpose.

2. SOWDA and WAAPO are unable to access the uploaded data and so are not able to review their own data submitted, identifying patterns etc.

Recommendation: AAIS provide SOWDA and WAAPO with brief training in how to access the AAIS ONA website online so they can review their monitoring data.
Specific time should be allocated in the project team meetings for further reflection on the data being collected and the implications for the project implementation.

3. The responses from the CFs on the monthly community conversations form have become quite repetitive and consequently are not very informative. The forms would benefit from review and amendment, where appropriate (suggestions included adding new categories for health workers and teachers, enabling data to be disaggregated by organisation (SOWDA/WAAPO) and school students by primary or secondary school, inclusion of space for quotations from community members, community leaders, religious leaders).
Recommendation: AAIS, SOWDA and WAAPO meet specifically to review the monitoring tools and amend appropriately.

4. Data for project years 1 and 2 has not been saved on the ONA platform, although quarterly reports have been submitted and saved.
Recommendation: An archive folder should be established on ONA to save project data for year 3 onwards.

5. The data being collected is primarily quantitative and does not tend to include case studies / stories.
Recommendation: A template should be developed for SOWDA and WAAPO to record brief case studies relevant to the project. These will be helpful in supporting the production of the quarterly reports.

6. The full-time post of AAIS M&E officer was vacant for several months. It is currently being filled part-time which has been extremely beneficial and the post is being advertised.
Recommendation: AAIS fill this full-time post as soon as possible.

7. Some of the statements in the AAIS reports gave an overly optimistic view of the changes taking place. For example, the Annual Report 2016-2017 outcome 4 includes the following two statements

   'The government line ministries (i.e. MOLSA/MORA) have the commitment and willingness to adopt and enforce the concept of zero tolerance.' This statement is true of MOLSA, however, it gives an overly optimistic view of the stance of MORA and is contradicted by the findings under indicators 3.2 and 3.3 of the MTR (section 5.2 and appendix F). The AAIS project manager has explained that he was referring to the personal position of the Director General of MORA and the previous Minister, not the official position of the Ministry (MORA).

   '…..and some communities are also committed to abandoning FGM/C.' There has been extremely positive progress made in the communities surveyed, which include those which have made most progress, however, this statement is contradicted by the findings of the MTR which found no evidence that any of the project communities are ready to abandon all types of cutting, including the sunna.

   The project team witnessed the dialogue between the consultant and community members and policy makers during the MTR and recognised the need for greater enquiry during monthly monitoring and evaluation visits and meetings with policy makers to ensure that an accurate account of change is recorded.

   For example, at Qoyta, the women's FGD began with the women saying they would like to have a public declaration of abandonment of FGM/C. This has been included in the AAIS reports. However, on closer enquiry, they have abandoned only cutting which involves stitches and spoke proudly of having recently taken 32 girls to the MCH to undergo the sunna.

   Deeper enquiry is particularly required at both national and community levels when someone says that FGM/C is being abandoned as many use the term FGM/C to refer only to cutting with stitches and do not include the sunna in their personal definition of FGM/C.

   Recommendation: Additional care should be taken to enquire fully into statements of change and to check out reports to ensure that the reports only include statements which can be substantiated.

4.3.2 Literacy and language

AAIS report that they have difficulty in identifying CFs with sufficient educational background, especially in the rural communities. An alternative approach would be to look at the literacy requirements for CFs and adapt

them to the skills and competencies of local community members. In this way the CFs might be able to further develop their literacy competency through the process of reporting, using simplified processes.

The community conversations manual is only available currently in English and written in a style which requires a high level of familiarity with formal English, which provides a challenge for the selection of CFs and their use of the manual.

For example, one sentence in the opening paragraph reads as follows: 'FGM/C is regarded as gross human rights violations, since it endangers the life, heath, and wellbeing of young girls. Although Somaliland Constitution and International Conventions are all enshrined the right to live, the right to heath, wellbeing, best interest of the child, the right to be free from torture, inhuman degrading, and right to protection, however, in Somaliland the practice is persistent and pervasive which is grounded in the local traditions and culture.'

Recommendations

- The text of the community facilitators manual should be reviewed, translated into Somali and adapted to suit the literacy levels of the CFs. This would involve, where appropriate, shorter sentences, more accessible vocabulary, more use of bullet points and more illustrations. Involvement of some CFs in this process would be beneficial.
- Other project documentation should also be reviewed with the language and literacy practices of the target audience in mind.

5 Analysis

5.1 Changing context of FGM/C in Somaliland since the baseline assessment in 2016

In the three years since the baseline assessment was carried out, the context of FGM/C has changed considerably in Somaliland. The AAIS project has both coincided with, and contributed to, creating a climate conducive to change in relation to FGM/C.

In 2017 UNFPA, in partnership with MOLSA, led a series of consultation workshops to develop national indicators for FGM/C which brought together ministries, NGOs and CSOs working to end FGM/C.

In November 2017, the general election brought about a change in government. During the election all presidential candidates declared their opposition to FGM/C and their intention to end the practice. The lead ministry for FGM/C has been restructured from the Ministry of Labour and Social Affairs (MOLSA) into the new Ministry of Employment, Social and Family Affairs (MESFA). There is a new female head of Social and Family Affairs, who is committed to ending FGM/C. There is also a new commitment to increasing women's participation in power with the target of 30% of parliamentarians being women in the forthcoming elections.

In December 2017 and June 2018, Knowledge Sharing Workshops funded by Population Council, facilitated by Orchid Project, brought together over 20 CSOs and line ministries to share research findings and good practice on FGM/C. Conferences on FGM/C bringing together youth from across Somaliland have also taken place in addition to the monthly FGM/C Working Group meetings, a conference for parliamentarians and other conferences hosted by different NGOs.

In contrast, the recent drought has impacted FGM/C in several ways. Firstly, at community level, the lack of water for basic hygiene and people's reduced immune systems from inadequate nutrition, leads to a slower rate of healing and an increased risk of infections among those who have been cut. Secondly, the drought has resulted in a decrease in the overall prioritisation of funds to activities to end FGM/C and, in the case of the AAIS project, the re-allocation of resources originally designated for anti-FGM/C related activities to providing emergency relief instead. Whilst these changes in funding priorities are understandable they have contributed to a decrease in the resources available to implement activities to end FGM/C.

Despite these challenges, the data collected for the MTR shows evidence of significant changes in attitudes and behaviours in the 7 communities surveyed.

5.2 Progress against the project indicators

The key achievements against the indicators are summarised in tables below relating to each target. A traffic light coding has been used green (good progress), orange (moderate or mixed progress), red (little or negative progress), white (data not available). Further detail for each indicator is contained in appendix F.

Care must be taken in their interpretation as the 7 communities surveyed include those that the project team felt had progressed most and not those which they felt had progressed least.

Overall, there has been good progress against 14 indicators, moderate or mixed progress against 4 indicators, little or negative progress against 2 indicators and data was not available for 4 indicators.

Target 1 Communities commit to abandon all forms of FGM/C

Progress towards target 1 indicators is good, although all communities show a continuing strong support for the continuation of the sunna and evidence of stigmatisation of families where a girl is uncut.

1.1 % of communities in which leaders state in public meetings that the community should abandon FGM
BASELINE - 20% of communities had at least one community leader who has spoken out against all forms of cutting including the sunna.
MTR - 57% of communities had at least one community leader who has spoken out against all forms of cutting including the sunna.
1.2 % men and women who think that people in their community expect them to cut their daughters
BASELINE - 74% community members thought that people in their community expect them to cut their daughters.
MTR - 61% community members thought that people in their community expect them to cut their daughters.
1.3 % men and women who say they intend to cut their daughters
BASELINE - 83% of community members intended to cut their daughters in future (pharaonic **19%**, intermediate **15%**, sunna **63%**).
MTR - 70% of community members intended to cut their daughters in future (pharaonic **5%**, intermediate **15%**, sunna **76%**).
1.4 The extent to which community members openly discuss FGM/C in public
BASELINE - 22% of community members have spoken to anyone about FGM/C in the last year **47%** reported that FGM/C has been raised in public meetings in their community
MTR - 64% of community members have spoken to anyone about FGM/C in the last year. **91%** reported that FGM/C has been raised in public meetings in their community.
1.5 The extent to which community members approve of FGM/C
BASELINE - 5% of community members (**6%** women, **3%** men) wanted to see the abandonment of all types of cutting, including the sunna. **18%** (**13%** of women and **26%** men) wanted to retain all forms of cutting, including the pharaonic
MTR - 14% of community members (**18%** women, **6%** men) wanted to see the abandonment of all types of cutting, including the sunna. **2%** (**2%** of women, **1%** men) want to retain all forms of cutting, including the pharaonic.

Narrative target 1

Of those surveyed more communities have at least one community leader who has spoken out in favour of abandoning all types of cutting (indicator 1.1). There is an overall reduction in both the percentage of community members who feel their community expects them to cut and also a major shift in this expectation away from the pharaonic to the sunna (indicator 1.2). There has been a reduction in the percentage of people who intend to cut their daughters and a further shift in the intended type if cut, away from the pharaonic towards the sunna (indicator 1.3). However, overall 70% of community members intend to cut their daughters in the future. There

has been considerable success in encouraging community members to openly discuss FGM/C (indicator 1.4) which was evident in the figures (i.e. an increase in the percentage of community members talking to others about FGM/C from 22% to 64% and an increase in the people saying FGM/C is spoken about in public meetings in their community from 47% to 91%). Finally, there has been an increase in the percentage of community members who would like to see the abandonment of all types of cutting from 5% to 14% (indicator 1.5).

These findings are fully supported by the FGDs where the change in the confidence in speaking about FGM/C was evident and participants were keen to explain the reasons behind the changes made and their resistance to further change. There are some contradictions in the figures, for example, 30% saying they do not intend to cut their daughters at all but only 14% wanting to see the end of all types of abandonment. This might be due to some meaning their daughters will only undergo the sunna when they say they will not cut at all.

Target 2 Women and youth are empowered to reject FGM/C

Progress against target 2 indicators is mainly good.

2.1 # of women and youth actively participating in groups/coalitions **BASELINE - 14%** of all women and youth had been involved in activities to end FGM/C. **MTR - 47%** of all women and youth had been involved in activities to end FGM/C
2.2 % women and girls with knowledge of their rights to freedom from violence and SRHS **BASELINE - 62%** of women are aware of the right of women and girls to Freedom from Violence. **24%** of women see Freedom from Violence as including protecting girls and women from the sunna cut. **15%** (**5%** of women and girls in urban communities and **21%** in rural communities) said there were no SRHS available to women and girls if they had complications following undergoing FGM/C. **MTR - 70%** of women are aware of the right of women and girls to Freedom from Violence, **65%** of women see Freedom from Violence as including protecting girls and women from the sunna cut. **60%** of girls and women (**91%** in rural, **43%** in urban communities) said there were no SRHS available to women and girls if they had complications following undergoing FGM/C.
2.3 Level of confidence of women and girls to discuss FGM/C in public safely and without fear of backlash **BASELINE - 66%** of women said they felt confident to speak out in public on FGM/C **25%** of women (**28%** in rural and **19%** in urban communities) felt that when people speak out on FGM/C that they are subjected to being ridiculed, called names, excluded socially or their families being embarrassed by their actions **MTR - 86%** of women said they felt confident to speak out in public on FGM/C **10%** of women (**9%** in rural and **12%** in urban communities) felt that when people speak out on FGM/C that they are subjected to being ridiculed, called names, excluded socially or their families being embarrassed by their actions.
2.4 Attitudes of boys and young men towards marrying girls/women who have undergone FGM/C **BASELINE - 96%** of unmarried men would prefer to marry a cut girl **MTR - 86%** of unmarried men would prefer to marry a cut girl
2.5 # of public engagements organised by youth forums to challenge FGM/C **BASELINE - 10%** of young people under 25 are engaged in activities on FGM/C. **MTR - 47%** of young people under 25 are engaged in activities on FGM/C.

Narrative target 2

There has been an increase in the involvement of women and youth in activities to end FGM/C, especially in their involvement in workshops (indicator 2.1). Women and young girls have been proactive in reaching out to their community, however, the young men seem lees informed and confident (see 4.1.8). Women and girls have greatly increased their confidence to safely discuss FGM/C in public and only 10% feel that they are subjected to a backlash when they do so (indicator 2.3). The increase in knowledge about their right of freedom from violence has increased only slightly, although more (65%) feel that FFV should protect girls and women from the sunna. An unexpected outcome is that there is an increase from 15% to 65% in the percentage of women and

girls who feel there are no SRHS available to support them if they have complications arising from FGM/C (indicator 2.2). This was particularly high in rural communities where there is often no MCH and people have to travel considerable distances to access health facilities. Attitudes towards marrying an uncut girl appear to be changing slowly with an increase from 4% to 14% of young would prefer to marry an uncut girl (indicator 2.4). And finally, young people are far more engaged in activities to end FGM/C, however, young men interviewed about this seemed unsure of their role or their intended outcomes (see 4.1.8).

Target 3 Religious leaders publicly denounce all types of FGM/C

Progress towards this target indicators is mixed with increased engagement of religious leaders since the baseline assessment but a stronger message in support of the sunna from religious leaders.

3.1 # of religious leaders involved in discussions on FGM/C
BASELINE - **47%** religious leaders have been involved in discussions on FGM/C.
MTR - **100%** religious leaders said they have been involved in discussions on FGM/C.
3.2 # of senior religious leaders who publicly speak out against all types of FGM/C
BASELINE - **0%** senior religious leaders would speak out against all forms of cutting in public.
24% community RLs said they would support a *Zero tolerance* law.
MTR - **0%** senior religious leaders publicly speak out against all forms of FGM/C.
0% community RLs said they would support a *Zero tolerance* law.
3.3 Level of understanding amongst religious leaders that sunna is a form of FGM/C not required by Islam
BASELINE - **5%** community religious leaders considered the sunna cut to be 'not required' under Islamic law and would support a *Zero tolerance* law.
1 of 4 regional/district level religious leaders interviewed also considered the sunna cut to be 'not required'.
MTR - **0%** community religious leaders considered the sunna cut to be 'not required' under Islamic law and would support a *Zero tolerance* law.
3.4 Perceptions of women and men in the community as to the stance of religious leaders on FGM/C
BASELINE - **1%** of community members think that religious leaders oppose all cutting including the sunna
MTR - **11%** of community members think that religious leaders oppose all cutting including the sunna

Narrative target 3

Religious leaders are now more actively involved in talking about FGM/C (indicator 3.1). Community members see religious leaders as now playing a stronger role in community dialogue in relation to FGM/C, with only 3% thinking that religious leaders are neutral in the debate. However, no religious leaders say they are publicly denouncing all types of FGM/C but instead see their role as informing the community about the Fatwa and supporting the sunna (indicator 3.2). Before the Fatwa was published some religious leaders were prepared to support the abandonment of all types of cutting. However, it is clear from the Fatwa that MORA does not currently support the abandonment of the sunna. Consequently, most if not all religious leaders now have adopted this as their stance in community dialogue (indicator 3.3). The result is that the stronger intervention of the religious leaders has three effects; firstly, to support the move from the pharaonic to the sunna cut, secondly, to clarify the definition of the sunna as drawing blood by pricking and not removing the tip of the clitoris or any other cutting which requires stitches. Both of these outcomes are in line with a harm reduction approach. The third impact is to actively support the continuation of the sunna, as either obligatory or optional, which is in direct opposition to the *zero tolerance* or *total abandonment* approach underpinning this project. Conversely, 11% of community members, primarily women think that religious leaders oppose all types of cutting. It is not clear whether this is from conversations before the Fatwa was released or that some religious leaders are opposing all types of cutting in private conversations.

Target 4 Policies and laws promoting zero tolerance against FGM/C progress through the legislative process

Progress against the indicators for this target are limited and uncertain.

4.1 % of parliamentarians with correct knowledge of women's rights under international and domestic law **BASELINE** – FGDs with parliamentarians did not take place **MTR** – No parliamentarians interviewed. A 2-day workshop took place for 30 House of Representatives in March 2018 on *International Legal Instruments on Rights of Women which included FGM/C.*
4.2 % of parliamentarians who are supportive of efforts to enact legislation eradicating FGM/C and 'strongly agree' that it should be passed **BASELINE** – One female parliamentarian interviewed. Others were invited but did not see FGM/C as a priority **MTR** – No parliamentarians interviewed
4.3 # of policies or law that have been passed through at least one stage further of the legislative process **BASELINE** - policy on FGM/C and anti-medicalisation policy based on *zero tolerance* in draft form. **MTR** – Draft policy translated to Somali. Fatwa on FGM/C published, bans cutting with stitches, states sunna is obligatory
4.4 Portrayal of women's rights issues (including FGM/C) in public debates by policy makers **BASELINE** – FGM/C raised on key dates like International *Zero tolerance* Day **MTR -** FGM/C is on the national agenda and has been the subject of a wide range of strategic events hosted by policy makers in 2018
4.5 Perceptions of women and men in community as to the legal status of FGM/C in Somaliland law **BASELINE** - **38%** of community members were correct in their understanding of the legal status of FGM/C **MTR** - **35%** of community members were correct in their understanding of the legal status of FGM/C

Narrative target 4

The positive change under target 4 is that FGM/C is firmly on the national agenda and is being talked about by policy makers and included in national events (indicator 4.4). It is being included as a component of violence against women and girls, and there are frequent references to FGM/C at national meetings and conferences. The financial support from the AAIS project has helped maintain the momentum for these strategic meetings.

No interviews took place with parliamentarians during the MTR and so it was not possible to assess their knowledge on FGM/C or their commitment to *zero tolerance* / *total abandonment*, since the publication of the Fatwa on FGM/C (indicators 4.1 & 4.2). However, 30 members of the House of Representatives participated in workshops on *International Legal Instruments on Rights of Women* in March 2018 which included a session on FGM/C.

The situation in Somaliland in terms of the development and approval of policies and laws is fluid and contested. There is little prospect of a policy or law promoting *zero tolerance* being approved by the cabinet or passing through Parliament during the life-time of this project (indicator 4.3). This is because there is currently no agreement as to the position of the sunna in future legislation. It is possible that the wording of the Fatwa is changed in the coming year to state that the sunna is optional rather than obligatory. However, this would still not be in line with a *zero tolerance* approach which bans all types of FGD/C.

However, as reported by AAIS, MORA produced a Fatwa on FGM/C (appendix D) in February 2018, which condemns all cutting which requires stitches. The Fatwa also states that the sunna (drawing blood by pricking the clitoris) is obligatory, hence it is in direct opposition to the concept of *zero tolerance*. The Fatwa is being disseminated widely and appears to be having some impact in terms of supporting the movement away from the pharaonic and intermediate types of cut and also in moving the definition of the sunna with no stitches away from cutting the tip of the clitoris (WHO type I) to the drawing of blood by pricking (WHO type IV). However, the Fatwa reinforces, rather than opposes, the use of the sunna.

There is widespread pressure on MORA to revise the Fatwa to define the sunna as optional, which might happen in the coming year. Several people within MORA, including the Director General, would welcome the ending of all types of cutting, including the sunna. However, the two senior Sheikhs (Head of Fatwa and Head of Research) who will be representing MORA in the negotiations with other government ministries, including MESFA, MOH and MOE, both see the sunna as obligatory.

If the Fatwa is revised to make the sunna optional, this still does not represent a *zero tolerance* approach as the sunna would not be defined as a form of FGM/C and parents would be free to choose whether or not their daughters would undergo it. The situation is further complicated by MORA and a range of CSOs being in favour of nurses and midwives being trained to perform the sunna so that it could be provided in a safe and hygienic manner, reducing the chances of infection or other complications.

MESFA are the lead ministry on FGM/C and they are committed to *zero tolerance*. There is an existing draft anti-FGM/C policy, from 2012, based on *zero tolerance* which has been translated into Somali. MOH has an existing draft anti-medicalisation policy, again based on *zero tolerance* and is carrying out a limited programme of awareness among health professionals. MORA will not approve either of these policies in their current form and are pushing for both to be amended to reflect the Fatwa.

The usual legislative route is for policies to be approved by the Cabinet, signed by the President and then presented to Parliament. Following the release of the Fatwa by MORA, a new series of consultations will take place in the coming year, involving all line ministries to try and develop a form of wording which all ministries can support. However, there are substantive differences between the stance taken by different ministries on whether drawing blood by pricking the clitoris (the sunna) is a form of FGM/C and the role of health professionals in the move towards abandonment.

The legislative framework and sharia law are closely linked in Somaliland with sharia law underpinning all legislation. The Fatwa produced on FGM/C is the first Fatwa produced in Somaliland, which is an indication of the importance placed on FGM/C by senior Sheikhs. It is unlikely that a law will be passed until key ministries, like MORA, MESFA, MOH and MOE agree on the wording.

With most of the recent focus being on the Fatwa rather than the law, there has been little change in the perceptions of community women and men on the legal status of FGM/C since the baseline in 2016 (indicator 4.5). Only a third of community members have an accurate understanding of the legal status and in the FGDs confusion and frustration were expressed, together with a call for a single, clear policy. Many who had heard of the Fatwa described it as 'law', rather than guidance from the senior sheikhs.

Target 5 Partners and Somaliland CSOs have greater capacity to drive forward nationally-led anti-FGM ***movement***

Progress against the indicators for this target is reported as being good, although precise data for 5.1, 5.2 and 5.3 is unknown.

5.1 # CSOs attending 75% of all meetings and actively contributing to coordination meetings **BASELINE** - not applicable **MTR** - Data not known
5.2 # of anti-FGM/C activities jointly delivered by CSOs **BASELINE** - not applicable **MTR** - Data not known
5.3 Partners average score on capacity scorecard assessment **BASELINE** - not applicable **MTR** - Assessments using the score cards were used at the beginning and midterm. Scores not known.
5.4 Anti-FGM information is integrated into awareness raising events and other programme activities **BASELINE** – Key CSOs integrating FGM/C into some programme activities **MTR** – Guidelines on Mainstreaming produced and disseminated to CSOs
5.5 Feedback on quality and usefulness of capacity building support received by partners

BASELINE - not applicable

MTR - Capacity building activities valued by WAAPO and SOWDA. PC3 POTCAT scores reportedly good, score not known.

Narrative on target 5

The AAIS project has provided a valuable injection of funds into the sector with a strong focus on collaborative working. The Ending-FGM/C working group, hosted by MESFA and funded by AAIS, meets monthly with a strong participation from CSOs. It was reported that all of those involved in the meetings were attending regularly and considered the meetings valuable (indicator 5.1). Several CSOs have talked about working in partnership with others, for example (a) NAFIS working with AAIS on the Mainstreaming Guidelines and dissemination, (b) SOFHA and SYS on youth engagement, (c) over 20 CSOs engaging in the Knowledge Sharing Workshops (indicator 5.2). The project partners SOWDA and WAAPO have gained through the capacity building activities (see section 4.1) and their capacity scores using POTCAT have reportedly increased, although the scores were not available (indicators 5.3 and 5.5). AAIS has supported NAFIS in producing guidelines on mainstreaming FGM/C which have been disseminated to other CSOs through workshops. Participant CSOs have welcomed this collaborative and sharing approach and benefited from the manual (indicator 5.4).

5.3 Least accessible communities

The communities selected to survey for the MTR were primarily those which have been most open to change. The MTR did not include those communities which have been most challenging to work in and which have been more resistant to change in relation to FGM/C.

Daami B, in Hargeisa, Maroodi Jeex, with high numbers of IDPs, was the most challenging urban community with sporadic violence posing security issues for the visiting WAAPO team. The project team felt that the data collection team might not be welcome and might be sent away, if it was included in the MTR without adequate preparation. A case study from Daami B was included in the 2016/2017 Annual Report of a young girl who is part of the Youth Forum persuading her mother not to cut a cousin of hers due to her young age (7 years old).

According to the project team, the five most challenging rural communities include four in Maroodi Jeex (Balicabane, Gumar and Salaxley in Baligubadle and Abaarso in Gabiliey) and one in Togdheer (Xajisalax in Odweyne). These are all remote communities which were strongly affected by the drought and benefitted from the drought relief activities. Crops failed completely and over 85% of the livestock died in the most drought affected areas. Community conversations were suspended for 6 months in rural communities to free funds for the drought relief programme which provided sugar, rice, flour, dates, cooking oil, water and dignity kits for the women. The SOWDA and WAAPO teams continued to engage and to raise the topic of FGM/C during their community visits. Understandably, however, the priority for the communities was to survive through the drought and subsequently to begin the process of rebuilding their lives and livelihoods.

It is not clear the extent to which attitudes or practices have changed in relation to FGM/C in these communities, although AAIS report that there have been positive changes. It would seem likely that with a reduction in the programme activities and the challenges faced from the drought, that less change would have taken place than in other communities. It will be important that some of these remote rural communities are included in the end of project assessment.

5.4 Community profiles

Brief summaries of each of the 7 communities surveyed are included in appendix 7 based on the FGDs and community data. Each community is unique and there is evidence of changing attitudes among men and women in all of the communities. In the baseline assessment there were clear differences between urban and rural communities with people being less informed and more traditional in their attitudes towards FGM/C in rural than urban communities. These difference no longer hold true among the communities surveyed and there are no overall differences between rural and urban communities in terms of their attitude towards FGM/C. Rural communities have less access to health facilities; however, small numbers of women are finding ways of gathering girls together to go to the hospitals and MCHs for their daughters to undergo the sunna.

In some communities, for example, Koorsaar and Qoyta, the women's groups are leading the change and influencing the attitudes of the men. The men, in turn, are supportive of the change and recognise that they

have a role to play. In other communities, like Mohamed Morge and Biyimacan, the men are more actively involved, wanting to influence change more directly.

The common themes are that all communities are moving gradually from the pharaonic to an intermediate cut with fewer stitches and then to the sunna. In half of the communities, Koosaar, Mohamed Morge, Qoyta and Udaan at least one community leader has spoken out against all forms of cutting.

5.5 Sexual activity of girls and women - unintended negative outcomes

Overall, the changes in the type of cut being used on girls and women has had positive effects on relationships within marriage. Men, in particular, report that women who have only undergone the sunna are more sexually active, leading to better marital relationships.

However, the MTR has also identified the emergence of a number of unintended negative outcomes from the difference in the sexual libido between young women who undergo FGM/C with stitches and those who are uncut or only undergo the sunna.

Firstly, there is evidence of stigmatisation of young women who have been cut with stitches as less desirable future wives and sexual partners. Men are increasingly saying they will ***only*** marry a girl who has only undergone the sunna. In addition, young women are reporting that they are being asked early in relationships which kind of cut they have undergone and that young men lose interest if they have undergone cutting with stitches. Whilst men's sexual experience is an important driver for change, this could leave young women who have undergone more harmful types of FGM/C discriminated against and with further reduced life chances.

Secondly, women and men reported a decrease in the age at which young women are being married (to 13-15 years) as a result of only undergoing the sunna. This increase in early marriage was explained on the basis that young women who undergo the sunna with no stitches are sexually aware at an early age, actively seeking sexual contact and therefore need to be married.

Finally, and perhaps more tentatively, with the widely held belief that girls and young women will in the future be more sexually active, this could lead to the assumption that when a young woman reports unwanted sexual advances or rape, that she is more likely to be blamed for being more sexually aware.

Although evidence for these traits is tentative at present, and would warrant further investigation, these suggest that greater emphasis on the rights of girls and women would be beneficial in the latter phase of the project.

5.6 Contribution analysis of the AAIS FGM/C project

It is always difficult to assess the extent to which the activities of a particular project are linked to specific changes. This is especially the case in relation to FGM/C in Somaliland where the issue is complex with multiple, interacting factors and a wide range of national and local initiatives taking place.

Activities to end FGM/C have been taking place in Somaliland for over 20 years with relatively little change in the practice until the last 3-5 years. Since the beginning of this project in 2015, the pace of change has increased. The AAIS project has contributed significantly to this change.

Strengthening the CSO network – contribution of AAIS project STRONG

At a strategic level, the project has contributed valuable resources to strengthening the national network, resulting in an active anti-FGM/C network, meeting monthly and contributing to the national debate. The role of NAFIS as the national agency linking CSOs, INGOs and line ministries responsible for FGM/C has been consolidated. There is an increased awareness of the range of activities taking place and collaboration between different organisations. Areas where further collaboration would be beneficial have been identified at both policy-making and programme implementation levels.

Publication of the Fatwa on FGM/C – contribution of AAIS – MODERATELY STRONG

NAFIS as the national agency, with active support from AAIS, led the drive from CSOs for MORA to produce a Fatwa on FGM/C. Pressure for the clarification of the position of MORA and senior sheikhs was also exerted by MESFA, MOH and MOE.

There is some critique around the lack of adequate consultation in this process, and also whether it would have been better to have delayed the publication of the Fatwa until it was agreed that the sunna would be described as optional, not mandatory. That said, the Fatwa has raised the issue of FGM/C on the national agenda and clarified that all cutting with stitches and removal of flesh, including snipping the tip of the clitoris, is strongly opposed across all government ministries, including MORA. AAIS has clearly contributed actively to this process which is clearly bringing about a reduction in the harm to girls and women of the most severe forms of FGM/C. Whether the Fatwa has also resulted in the sunna being even more deeply embedded in Somaliland culture is debatable and this has become the most pressing challenge in the movement to end all forms of FGM/C.

Changes at community level – contribution of AAIS and partners in target communities - STRONG

AAIS are to be commended on the way in which this project has contributed to changes in attitudes and behaviours in relation to FGM/C at community level, through the activities of the implementing partners, SOWDA and WAAPO. In the target communities, the approach of SOWDA and WAAPO is valued highly and has been a longer term engagement with the community than previous NGO initiatives on FGM/C. The changes taking place are being driven by community members and there are strong calls from communities for a continuation of the project.

The workshops and community conversations have clearly engaged large numbers of community members in the target communities in dialogue around FGM/C and have resulted in, not only increased awareness of the health risks of cutting, but also an increase in the extent to which community members are talking about FGM/C with each other. FGM/C is being taken on as an issue by women's groups, men's groups and youth forums, each reaching out into their community in ways which are likely to be sustainable beyond the end of this project. It is clear that FGM/C is a social norm in Somaliland, with individual decision-making dependent to a large extent on creating a climate in communities conducive to change. The value of the community conversations is significant in disseminating national policy changes and also in enabling communities to engage in dialogue and come to collective decisions about change. There are ways in which these community conversations can be enhanced, however, there is strong evidence that they have been effective in raising dialogue and bringing about actual changes in practices relating to FGM/C.

5.7 Implications for AAIS Theory of Change model

The AAIS theory of change model was introduced in section 1.3 and is included in full in appendix C.
Each of the four elements of AAIS's current theory of change model ***(1. policy makers and parliamentarians, 2. religious leaders, 3. women and youth 4. NGOs and CSOs*)** has contributed to the significant progress seen in the lifetime of this project.

It is recommended that AAIS and AAUK revisit the theory of change model in the light of the progress made to date, the MTR findings and also looking ahead at the next phase of change from the almost universal use of the sunna to the abandonment of all types of cutting. The model has served well in moving from a high prevalence of cutting with stitches to greater use of the sunna. Slightly different strategies might be required to support the move to abandon the sunna (WHO type IV).

It is recommended that two areas are addressed,

- the role of health professionals in relation to FGM/C in the light of the increasing medicalisation of the practice
- the relationship between *zero tolerance* and harm reduction approaches to FGM/C.

The role of health professionals and the medicalisation of FGM/C

The issue of the medicalisation of FGM/C is complex and is one of the most contentious aspects of the future of FGM/C in Somaliland. Health professionals have two widely recognised roles, (1) providing advice and guidance on FGM/C from a health perspective and (2) providing on-going support to girls and women after following FGM/C. In addition, many stakeholders think that health professionals should also have a role in safely performing the sunna, the drawing blood by pricking a girl's genitals.

For clarification, all of the partner organisations involved in this project, AAUK, AAIS, SOWDA, WAAPO (and Orchid Project), oppose the medicalisation of FGM/C both in the short and long term, from a women's rights and VAWG perspective.

The MTR provides strong evidence that the performing of FGM/C by health professionals (nurses, midwives and doctors) is increasing in both urban and rural communities. The particular challenge in Somaliland is that some stakeholders see this as a positive change and others oppose it, just as strongly. Opinions differ among health professionals as well as among policy makers and in the wider community.

At government level, MESFA and MOH strongly oppose medicalisation, although some individuals within both these ministries support it. MOH have a draft anti-medicalisation of FGM/C policy which they have been disseminating through MCHs. Conversely, MORA see the involvement of nurses and midwives in performing the sunna as a positive move, reducing the immediate harm done to girls and the longer-term complications of FGM/C. They would like to see the introduction of safe cutting into the midwifery and nurse training curricula.

During the knowledge sharing workshops in December 2017 and June 2018 it was clear that opinions about medicalisation are divided among CSOs. Some see it as a safe stepping stone towards abandonment of all types of cutting whilst others see it as condoning the sunna and making it less likely it will be abandoned in the future. Many within MORA and some CSOs are calling for the training of nurses and midwives in safely performing the sunna. Most in MOE oppose medicalisation, however, some see it as a short-term way of reducing school absenteeism and drop out among girls.

The findings from the MTR indicate that at a community level, most people interviewed would like to have greater access to nurses and midwives for their daughters to undergo the sunna safely. Community members talk proudly of having taken their daughters to the MCH, or regret that the MCH or hospital is too far away and so they have to rely on the traditional cutter.

Opinions differ even among those who support *zero tolerance* as to whether total abandonment would be achieved more quickly by the involvement of health professionals in performing the sunna, or whether this would make the abandonment of the sunna much more difficult to achieve.

It is recommended that AAIS and partners, discuss the role of health professionals in relation to FGM/C and incorporate this in their theory of change model. The AAIS position on medicalisation needs to be explicit and linked to the updating of project activities (see recommendation 6.1.3). Health professionals would benefit from a supportive approach as they clarify their role and responsibilities in relation to FGM/C.

The relationship between zero tolerance and harm reduction approaches to FGM/C

Most projects working to end FGM/C adopt one of two approaches, *zero tolerance* or *harm reduction*.

A *zero tolerance* approach is based on upholding the rights of women and girls to bodily integrity and freedom from violence (FFV). It is linked to other rights in relation to education, health and life opportunities. All forms of FGM/C are opposed, irrespective of the degree or type of harm they cause.

A *harm reduction* approach is focused on reducing the severity of the type of cut being performed, in order to reduce the health consequences experienced by girls and women. The proponents of a harm reduction approach might actively support a less severe cut, like the sunna, to reduce the impact of a more severe cut, like the pharaonic.

The AAIS project was designed based on the concept of *zero tolerance* in relation to FGM/C, i.e. the total abandonment of all types of cutting. This is reflected in the theory of change model and the project outcomes and indicators.

Many in Somaliland, including most religious leaders, do not regard the the sunna, the drawing of blood by pricking of girls' genitals (WHO type IV), as a form of FGM/C. They argue that the sunna, if performed properly, does no harm and should not be included in the definition of FGM/C. This can result in people stating openly that they oppose FGM/C and believe in the total abandonment of FGM/C, yet also support the continuation of the sunna.

It is important, therefore, when adopting a *zero tolerance* approach, that AAIS and partners are explicit about their position by stating clearly that they view the sunna as form of FGM/C. This means avoiding talking of abandoning FGM/C, when what is meant is the abandonment of all types ***except*** the sunna.

Below are two examples of where the position of AAIS is not clear.

1. The AAIS community facilitator manual includes a table of types of FGM/C but does not include the drawing of blood by pricking, currently called the sunna. This could lead to community facilitators and

others reading the manual, concluding that AAIS does not consider that pricking is a form of FGM/C. Indeed, during the FGDs, at least one committed and conscientious community facilitator openly and proudly described how she had taken her nieces to an MCH in July 2018 to undergo the sunna. She clearly was not aware that this is not in line with the AAIS project definition of FGM/C.

It is recommended that the community facilitator manual is updated to include explicit mention of the sunna as a form of FGM/C by amending the table on page 23, and also that this information is disseminated to all project staff and volunteers.

2. The AAIS report on the workshop for Parliamentarians (March 2018) states (p12)
'The participants also discussed another landmark decision on FGM, the Ministry of Religion and Endowment announced a new Fatwa*, or religious edict, banning FGM. Similarly, the presenter a presented the various legal instruments on fight against FGM and he stated that FGM is a human rights violation, torture, an extreme form of violence and discrimination against girls and women.'*

   The suggestion here is that the Fatwa bans all types of cutting. As it only bans cutting with stitches, this statement is misleading.

The AAIS theory of change model is based on a zero tolerance approach. It is clear from discussion with the AAIS team that they recognise the sunna as a form of FGM/C. However, this needs to be communicated more clearly, if a *zero tolerance* approach is to be fully communicated, especially as most religious leaders are now speaking out more on FGM/C and most of them do not see the sunna as a form of FGM/C.

It is not necessary for project staff to criticise those who define FGM/C differently but it is important to state clearly the position of AAIS and be open to dialogue and exchange, in order to bring about change.

6 Recommendations - strategies for the remaining project period

6.1 Recommendations for the remaining project period

6.1.1 Development of an engagement strategy for the communities which have made least progress / been most challenging to work with

The key priority for the remaining period of the project should be on working with the 35 target communities. This might mean less AAIS time spent at a national level, where NAFIS is the lead agency, and more time visiting communities, reviewing MEL data and collection tools, and refining approaches.

The strategy of community dialogue has been shown to work in bringing about change and needs to be consolidated where it is working well and strengthened where it has yet to be well established. There have been significant challenges in working with some of the project communities including the remoteness, drought and conflict.

It is recommended that the project team continue to work with the 35 project communities and, as part of this, review the communities which have shown the least change, identify the specific challenges and share ideas for how to enhance the project activities in these communities. This could include inviting community members from nearby communities to engage with them, organising a youth forum and using drama to engage young people, having whole school event when parents, teachers, students, community leaders and religious leaders talk to each other about FGM/c or other ideas from the team.

A revised engagement strategy should be developed for the communities which have progressed least over the last 3 years and implemented for the remaining project period. This engagement strategy could be valuable for AAIS and other organisations in planning future initiatives after the end of this project.

6.1.2 Increased focus on collaborative reflection between AAIS, SOWDA and WAAPO

There are a number of recommendations to enhance the existing MIS and MEL systems in sections 4.3.1 and 4.3.2, including ensuring that SOWDA and WAAPO have access to the project data being collected on ONA and that opportunities are created for the whole project team to review progress and challenges in greater depth during their MEL meetings. Questions which could be addressed through this process include

- How can mothers and fathers be encouraged to talk more to each other about their intentions for the daughters?

- How can people be encouraged to talk to teachers, community leaders, religious leaders and health workers more about FGM/C?
- How widespread is the issue of increased early marriage linked to the move to the sunna with no stitches and how can it be addressed?

6.1.3 Clarification that FGM/C includes the sunna (WHO type IV) underpinned by a stronger rights-based approach

During the baseline, it was recognised that change in relation to FGM/C was likely to be a gradual and stepwise process in Somaliland due to the unique context and competing pressures. The strategy adopted was one of recognising the changes taking place in the type of cut being used as positive progress, whilst retaining an overall focus on the goal of total abandonment of all types of FGM/C.

In the early stages of the project a strong focus was placed on communicating the health consequences of FGM/C. After 3 years, women, in particular, are now more aware of the range of health problems which arise from being cut. This, combined with the religious leaders speaking out against cutting with stitches, but supporting the sunna, has resulted in a significant move away from the pharaonic and towards the sunna.

The project now finds itself in a challenging position. Under the existing approach, significant progress is being made which includes a reduction in the level of physical harm being experienced by girls and women. However, support for the sunna remains as strong, or has possibly even gained in strength with the Fatwa and most religious leaders supporting it, many not considering it to be a form of FGM/C and a third of those interviewed thinking it is obligatory under Islamic law (section 4.1.3, chart 12).

If the total abandonment of all types of FGM/C is to be achieved, then, (a) the sunna needs to be explicitly included as a form of FGM/C in the conversations with all stakeholders and (b) a stronger rights-based approach needs to be adopted. It is worth noting that the level of understanding about rights in general has increased in the last 3 years in Somaliland and that NGOs and CSOs are rapidly becoming familiar with the language of rights.

It is recommended that the team, for the remainder of the project, continue to recognise and celebrate the positive movement away from cutting with stitches, whilst strengthening these other two aspects.

Possible activities include

- Ensuring at national level that AAIS and partners clearly state that they see the sunna, however it is defined, as a distinct form of FGM/C, whenever it is mentioned and that dialogue around this is actively encouraged among all stakeholders. This will mean moving away from definitions of what is and is not involved in the sunna and whether it is obligatory or optional, towards discussion of the rights of women and girls to freedom from violence, bodily integrity, avoidance of unnecessary health risks, unhindered access to education etc.
- Amending the community facilitators manual to explicitly include the sunna (WHO type IV) as a form of FGM/C and disseminating this information to project staff and volunteers.
- Encouraging communities to see the abandonment of cutting with stitches as a stepping stone to total abandonment of all types of FGM/C. Where communities say they are ready to abandon cutting with stitches, this could involve celebrating this change whilst also encouraging dialogue around moving to abandoning the sunna.
- Encouraging the establishment of a network or support group(s) of people who recognise the sunna as a form of FGM/C and are working towards its abandonment. Note: This is different from people saying the sunna is optional and they will not do it themselves but they support others in choosing to do it.
- Once the first communities have abandoned all types of cutting, which may be after this project, they can be used as role models to encourage other communities to move directly from cutting with stitches to abandoning all forms of FGM/C.

6.1.4 Inclusion of more health professionals in AAIS Theory of Change model and in community dialogue

Currently, health professionals are being used in community forums as experts to provide information on the complications of cutting. However, they also face decision-making dilemmas as a result of being subject to contradictory pressures. At community level they are under increasing pressure to perform the sunna safely and hygienically. Simultaneously, they are receiving instructions not to perform FGM/C by MOH, through its

anti-medicalisation strategy, although criminalisation of the practice is unlikely to take place until the current policy impasse between MORA, MOH and MESFA has been resolved.

The role of health professionals and the medicalisation of cutting will need to be part of the dialogue if all types of FGM/C are to be abandoned and health professionals will need support in fulfilling their role in this process.

It is recommended that AAIS, SOWDA and WAAPO clarify their position on the medicalisation of FGM/C and include this in the revised theory of change model. This then will need to translate into activities project, for example

- Providing opportunities for non-judgemental dialogue among health professionals about the challenges they face could be useful in helping them clarify their role as one to support the abandonment of all types of cutting. It will be important for them to devise strategies to manage the pressures they face from the community to cut.
- Encouraging the sharing of good practice in the training of health professionals on FGM/C between different institutions in collaboration with MOH might further decrease the number of newly qualified nurses and midwives who are prepared to perform FGM/C.
- Including health professionals in community conversations with community members would enable the issues around medicalisation to be more fully explored at community level.

It is recognised that not all of these activities will be able to be incorporated into the final year of the project. However, a greater involvement of health professionals is recommended.

6.1.5 Greater engagement of youth, especially young men

Young men are potentially important stakeholders in the future of FGM/C, as identified in the AAIS theory of change model. In future, they will be making decisions about whether to marry an uncut or cut girl and influencing decision-making about whether and how their daughters are cut and who will be their future daughters-in-law. However, the MTR suggests that they are currently the least well-informed or engaged group in relation to FGM/C.

It is recommended that an increased focus is placed on developing activities specifically targeting young men (15-24 years). Currently the youth forums target boys and the community conversations attract mainly men over 25 years old. There are no activities specifically targeting young men. There are several CSOs in Somaliland focusing on youth engagement in relation to FGM/C, including The Girl Generation, who have funded 10 new projects on FGM/C in Somaliland in the last year. SOWDA and WAAPO have also both been developing strategies of working with youth.

In addition to these activities, the FGM/C CSO network could take the engagement of young men as one of its topics for the coming year.

6.1.6 Active collaboration with the CSO network

One of the strengths of the AAIS theory of change model is that is includes strengthening the CSO network. This network could provide a valuable forum for sharing the challenges faced by this project and for collaborative development of strategies to work with the stakeholder groups and communities which are hardest to engage. It is recommended that AAIS take an active role in enhancing the collaboration between network members to ensure the project leaves a strong self-sustaining network.

The AAIS project has already resulted in the development of a thoughtful and detailed *Guidelines to Mainstreaming* manual, written by NAFIS and supported by AAIS. This manual provides some excellent suggestions of how to embed FGM/C into a wide range of other community development activities. As a strategy, mainstreaming has both strengths and limitations. It can strengthen an existing movement, like the move away from cutting with stitches to the sunna. However, a more active intervention will probably be required in order to re-define the sunna as a form of FGM/C and reach the stage where some communities are abandoning all types of FGM/C and therefore acting as role models to other communities. It is recommended that NAFIS, supported by AAIS, specifically considers how the ideas within the mainstreaming manual can be used to promote the abandonment of all types of cutting.

6.1.7 Planning for the end of project review and project end

Planning for the end of project review should begin early in order to make most efficient use of available resources and to gain an accurate overview of change across the 35 communities. Communities surveyed should include some which have been more challenging, either through remoteness, drought or security issues.

Communities are calling for a continuation of the project and will need support in their planning for after the end of the project.

The project will have used a variety of strategies by the end of the project and a comparative review of the effectiveness of these could provide valuable information for other organisations planning initiatives.

6.2 Recommendations for future initiatives / programmes

6.2.1 Role definition of health professionals in collaboration with MOH

The current anti-medicalisation policy, drafted by MOH focuses, understandably, on clarifying what health professionals should not be doing in terms of FGM/C. It would also be useful for AAIS and NAFIS to work collaboratively with MOH to identify the skills which health professionals will require to manage the pressures they face to cut and also to clearly define their positive role in supporting the survivors of FGM/C. This might fit into a revised theory of change of AAIS, if health professionals were included as key stakeholders.

6.2.2 Organised diffusion on FGM/C between communities

All of the target communities where there has been substantial changes in relation to FGM/C said that when new people joined their community from surrounding areas they usually still used cutting with stitches and that the community needed to 'educate' them to change. They felt that they had the skills to reach out to other communities and support them in changing. One of the elements of the UNICEF Six Elements of Abandonment is organised diffusion, i.e. the structured and planned reaching out one community to another to engage them in dialogue and bring about change. This approach might be worth exploring within the CSO network as a possible model for future initiatives, using the most successful communities from this project and supporting them to move further towards total abandonment.

7 Conclusions

The MTR has found strong evidence that the AAIS approach of community dialogue has contributed to a significant change in the attitudes and behaviours of community members in relation to FGM/C. An equally important factor in bringing about change has been the publication of a Fatwa by MORA which bans all types of cutting ***except the sunna*** which it describes as obligatory.

The overall prevalence of FGM/C remains at 98%, however, FGM/C is being talked about openly in all project communities. Awareness of the health complications of cutting has increased and the link between a girl's virginity, marriage and FGM/C has been weakened or in some communities ended.

In practical terms, the type of FGM/C which is being used is changing rapidly from WHO types I, II and III (partial or complete infibulation, requiring stitches and snipping the tip of the clitoris) to WHO type IV, the sunna, drawing blood by pricking. Women of all ages are experiencing fewer complications as a result of this positive change which has taken place in both urban and rural communities. Men are embracing the change as they can see improvements in marital relationships and a decrease in the medical complications of their wives and daughters.

This project has also strengthened the network of organisations working to end FGM/C through targeted capacity building for AAIS's partner organisations SOWDA and WAAPO and also providing valuable funding to support monthly meetings for the End-FGM/C working group with representation from CSOs and the line ministries.

Somaliland now faces the challenge of abandoning the sunna in order to achieve total abandonment of FGM/C. There is evidence of a moderate increase in the commitment to the abandonment of all types of cutting since the baseline assessment in 2016. The percentage of community members in seven project communities who would like to see the abandonment of all types of cutting has increased from 5% (6% women and 3% men) to 14% (18% women and 6% men).

Somaliland appears to be in the process of making substantial change in relation to FGM/C in terms of harm reduction. There is an increase in the cutting of girls and young women by health professionals. There is a draft anti-FGM/C law based on *zero tolerance* and a draft anti-medicalisation strategy banning all health professionals from performing any type of FGM/C. However, these are highly unlikely to be ratified until senior sheikhs within MORA are convinced that the sunna is a form of FGM/C and agree that the sunna should be abandoned. The sunna is still supported widely.

The abandonment of the sunna by whole communities will require more of the factors conducive to social norms change to be in place. A key factor will be the increased awareness of the place of FGM/C within the context of the rights of women and girls, and gender equality debate at both policy-making and community levels. A clear legislative framework in relation to FGM/C would also provide guidance and reduce some of the ambiguity in messages at national level around FGM/C. Equally important will be strong leadership committed to the abandonment of all types of cutting within communities to support collective decision-making.

On-going community conversations and forums, as have been taking place in this project, have been shown to be an effective tool to promote open dialogue around FGM/C and bring about change. The remainder of the project should focus on the strategy of *zero tolerance* in line with the AAIS theory of change which needs a greater focus on explicitly defining the sunna as a form of FGM/C and the active engagement of an even wider range of stakeholders.