



FEMALE GENITAL MUTILATION SURVEY IN SOMALILAND

Second Cohort

Edna Adan University Hospital
Hargeisa, Somaliland

2006 – 2013

By

Edna Adan Ismail, Amal Ahmed Ali, Abdirahman Saeed Mohamed,
Thomas Kraemer, Sarah Winfield

This report is an independent publication based on research commissioned and carried out by the Edna Adan University Hospital over a seven year period. It is the product of a collaborative effort involving members of hospital staff, students and volunteers. The report was published in partnership with Orchid Project in 2016.

For more information about the report, please contact:

Edna Adan Foundation
Email: ednafoundation@gmail.com
Tel: +44 (0)7736 932 030
www.ednahospital.org

© Edna Adan University Hospital, 2016
All rights reserved
First Edition

Graphic design by Olivia Comberti
Photos by Sarah Winfield

Acknowledgements

We wish to express our sincere thanks to **Orchid Project** for their guidance and support in facilitating the publication of this study.

In addition, we'd like to acknowledge the invaluable contributions made by members of staff and students who collected data and recorded findings on antenatal charts.

We are grateful also to the midwives and doctors who provided antenatal care and supervised students during their rotation in the department.

Finally, special thanks are reserved for the administrative staff who undertook the arduous and painstaking task of recording the collected data.

Contents

| | |
|---|-----------|
| Acknowledgements | 2 |
| What is Female Genital Mutilation? | 5 |
| Classification | 5 |
| Global prevalence | 6 |
| Studies on FGM/C | 7 |
| FGM/C in Somaliland | 8 |
| The Procedure | 10 |
| Instruments and methods..... | 10 |
| The operation | 11 |
| De-infibulation at the time of marriage | 13 |
| The Dangers of FGM/C | 13 |
| Complications | 14 |
| Reasons Given for FGM/C | 17 |
| Campaign to Eradicate FGM/C | 19 |
| The international campaign | 19 |
| The campaign in Somalia/Somaliland | 20 |
| Location of Study: The Edna Adan University Hospital | 22 |
| Health profile of the people of Somaliland..... | 23 |
| Services provided by the Hospital..... | 24 |
| Hospital objectives | 24 |
| The Hospital and FGM/C..... | 25 |
| The Study | 27 |
| Purpose of surveys..... | 27 |
| Methods of data collection | 27 |
| Questionnaire | 28 |

| | |
|---|-----------|
| Findings..... | 29 |
| 1. Age of women | 29 |
| 2. Prevalence of FGM/C | 29 |
| 3. Type of FGM/C | 30 |
| 4. Age at which FGM/C was performed | 31 |
| 5. Countries where FGM/C was performed | 32 |
| 6. Where FGM/C was performed: urban or rural areas..... | 33 |
| 7. Persons performing FGM/C | 34 |
| 8. Perceived reasons for having undergone FGM/C | 34 |
| 9. Number of women who would perform FGM/C on their daughters..... | 35 |
| 10. Type of FGM/C women would perform on their daughters | 36 |
| 11. Reasons given for performing FGM/C on their daughters..... | 37 |
| 12. Women’s level of education | 38 |
| 13. Women’s level of education compared with whether they underwent FGM/C | 39 |
| 14. How the decision to perform FGM/C on daughters varies with women’s education..... | 40 |
| 15. How the decision to perform FGM/C on their daughters differs between women with and without FGM/C | 42 |
| 16. How the reasons given for women’s own FGM/C varies with the reasons given for performing FGM/C on their daughters | 43 |
| Recommendations | 45 |
| Conclusion..... | 50 |

What is Female Genital Mutilation?

The World Health Organization (WHO) defines Female Genital Mutilation (FGM/C) as all procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons.¹ It is practised in more than 25 countries throughout Africa, the Middle East and Asia, and within diaspora populations across the world. FGM/C prevalence rates range from 5 to 99% and it is practised among all religious, ethnic, cultural, and socio-economic groups.

Also known as female circumcision (FC), or female genital cutting (FGC), FGM/C results in many health-related and potentially life threatening complications, as well as physical and psychological problems that do great harm to the wellbeing of women and children who have had it performed on them. Unlike male circumcision, FGM/C is not a religious obligation required by Islam, Christianity, Judaism, or any other religion.



Figure 1: Normal female genitalia

Classification

Procedures vary across the world but the WHO classifies FGM/C into four types.² These are:

Type I: Excision of the prepuce with or without excision of the clitoris



Figure 3: FGM/C Type I

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



Figure 2: FGM/C Type II

¹ World Health Organization, *Female Genital Mutilation - a teacher's guide*. WHO, Geneva, 2003

² World Health Organization, *Female Genital Mutilation - a teacher's guide*. WHO, Geneva, 2003.

² World Health Organization, *Female Genital Mutilation - a teacher's guide*. WHO, Geneva, 2003.

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



Figure 4: FGM/C Type III

Type IV: Unclassified, covering any other damage to the female genitalia including pricking, piercing, burning, cutting or the introduction of corrosive substances.³ It should be noted that Type IV is not practised in Somaliland.

Global prevalence

FGM/C is a widespread practice that is carried out on young girls between the ages of 5 and 10, and, in some countries, on grown women as well. It is estimated that up to 133 million women and girls globally have been subjected to some form of FGM/C with a further 30 million said to be at risk over the next ten years.⁴ In countries where either most or a large number of women have undergone the procedure, the medical complications that result place a heavy burden on health services.

In Asia, FGM/C is occasionally reported as being practised by a limited few in Oman, Saudi Arabia, United Arab Emirates, Yemen, and in certain communities in Indonesia, Malaysia, India, and Pakistan.⁵ However, it is reported to exist in many African countries. In some, it is performed on most or all women while in others it may be carried out only on women belonging to certain ethnic groups. These countries include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Democratic Republic of the Congo, Djibouti, Egypt, Eritrea, Gambia, Ghana, Guinea, Guinea-Bissau, Ivory Coast, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Somaliland, Sudan, Tanzania, Togo, and Uganda.⁶

³ It is noteworthy that a recent study in Somalia and Somaliland found a 'high level of variation in excision and divergence of local terms and interpretations from the WHO FGM/C types' listed above. The research suggests that *Sunna* is used in many communities to refer to 'any type of circumcision which people believe is required/sanctioned by Islam.' Two variations of Type III FGM/C were identified – *Sunna Kabiir* (less stitching) and *Fadumo Hagoog* (excision but no stitching) – and other increasingly radical forms labelled as *Sunna* have evolved into variations of Type II and Type III. – Crawford, S. & Ali, S. *Situational Analysis of FGM/C/C Stakeholders in Interventions in Somalia*. UNFPA-UNICEF, UK AID, London, p. 57.

⁴ United Nations Children's Fund, *Female Genital Mutilation/Cutting: What might the future hold?* UNICEF, New York, 2014.

⁵ United Nations Children's Fund, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York, 2013.

⁶ *Ibid*

In recent years, because of immigration and population movements, the practice has been emerging among refugee populations in Europe and North America where the treatment sought by women for medical complications as a result of FGM/C is a major source of anxiety among health care providers. This concern is reflected by the attention FGM/C receives from international health and human rights organisations as well as the world's media.

Studies on FGM/C

UNICEF is the leading agency providing data and resources on FGM/C in the 29 countries where the practice is currently measured. The 2013 statistical overview provided the most comprehensive review of available data to date, analysing prevalence and trends in the practice from more than 70 nationally representative surveys over a 20-year period.⁷ The report found that: more than 125 million women and girls have undergone FGM/C; 30 million girls are at risk of being cut in the next decade; social norms and expectations play a strong role in perpetuating the practice; FGM/C is becoming less common in slightly more than half of the 29 countries studied; and in most countries where FGM/C is practised, the majority of girls and women think it should end.

The report found that in Somalia: at least 80 per cent of girls are cut between the ages of 5 and 14, more than one in five girls have undergone infibulation; and there has been no significant change in prevalence. According to preliminary findings, the prevalence of FGM/C is 98% in the Northeast Zone and 99% in Somaliland, and the percentage of girls and women aged 15 to 49 who think the practice should continue is 58% in the Northeast Zone and 29% in Somaliland. Between 1995 and 2002 the Demographics and Health Surveys published data comprising questionnaires from 16 countries. Somaliland and Somalia, however, were not included.

Prior to this, the most comprehensive report was that of Yoder (2004).⁸ Some of the most accurate early data on FGM/C came from Fran Hosken, who, in 1982, compiled statistics from her many years of studying FGM/C in Africa.⁹ Other landmark studies include the research carried out in the early 1980s by the Somalia Academy of Arts and Sciences into the physical, psychological, and sociological aspects of FGM/C.

⁷ United Nations Children's Fund, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, UNICEF, New York, 2013.

⁸ Yoder, P. S., N. Abderrahim and A. Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A critical and comparative analysis*, DHS Comparative Reports No 7, ORC Macro, Calverton, MD, 2004.

⁹ Hosken, F. *The Hosken report: Genital and sexual mutilation of females*. Women's International Network News. Lexington, Massachusetts, 1982.

FGM/C in Somaliland

It has long been accepted that FGM/C is ubiquitous in Somaliland, but accurate data has been lacking. Anecdotal evidence suggests that the procedure is commonly performed on girls between the ages of 4 and 11 and that 95 to 100% of women have undergone the procedure, the majority of whom have been subjected to the most severe form.^{10 11 12} In 1999, Care International carried out a study in Somaliland which found FGM/C to be universal, with 91% undergoing Type III. In 2000, another study carried out by the WHO and UNICEF to investigate HIV prevalence also asked women about their FGM/C status. Of the 769 women participating in the research, 98% had undergone Type III FGM/C.¹³ In 2011, a study carried out by UNICEF in partnership with the Somaliland Ministry of National Planning and Development (MNPD) showed an FGM/C prevalence rate of 99.1% among girls and women between the ages of 15 and 49.¹⁴

The studies included in this report indicate that more than 98% of women receiving antenatal care at the Edna Adan Hospital have had FGM/C. In Somaliland the women refer to their procedure by two names, the **Sunna** and the **Pharaonic**. The Sunna correlates with Type I and II but also involves the stitching of the anterior part of the genitalia to varying extents. The Pharaonic correlates with Type III, which is also known as infibulation.

Many awareness campaigns (see p. 21) have been carried out in Somaliland over the past two decades, and, as a result, more Somalilanders are willing to discuss FGM/C openly and are increasingly concerned about the health risks associated with the procedure.

¹⁰ World Health Organization, *Traditional practices affecting the health of woman and children; female circumcision, childhood marriage, nutritional taboos etc.* WHO/EMRO Technical Publication; 1982, 2:1-360.

¹¹ *Female circumcision: female genital mutilation.* International Journal of Gynecology & Obstetrics 1992; 37:149.

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

¹³ World Health Organization. *HIV/AIDS ASSESSMENT: sero-prevalence survey.* Dr Adan Yusuf Abokor. ICD WHO UNICER. 2000.

¹⁴ UNICEF & Somaliland Ministry of National Planning and Development (MNPD). *Somaliland. Multiple Indicator Cluster Survey, 2011 – Somaliland, Final Report, 2014*, p. 100 (Sep 2014)



A home visit in Hargeisa

The Procedure

The day of FGM/C is considered an important event but is kept secret from the pre-menarche child, and sprung upon her once preparations have been made. Senior female members of the community, relatives, traditional birth attendants (TBAs) or, in some cases, health care workers, may be called upon to carry out the procedure.

No anaesthesia is used while this sensitive part of the female body is cut and manipulated. The exception to this is when the operation is performed by a health professional who has access to anaesthesia and the knowledge to make use of it.

The age at which FGM/C is performed varies from country to country and in accordance with the type of mutilation being carried out. The **Sunna** is generally performed at a very young age and may be carried out soon after birth, during the first week of life or any time before the menarche. In the case of **excision** and **infibulation**, when more tissue is removed entailing more manipulation, the child is older so that the tissues intended for excision are given a chance to grow. This gives the circumciser a better pinch or grip. According to the findings in our surveys, the average age at which excision and infibulation are performed in Somaliland is between 7 and 9.

Instruments and methods

Instruments

- Any sharp cutting instrument such as a knife, broken glass, or razor blade. In some cases, the circumciser may have acquired a medical instrument such as a scalpel, forceps, or scissors
- The instruments may be new or may have already been used for other purposes and/or on other persons
- Sterilisation is seldom known or performed by circumcisers.

Sutures

- Regular surgical catgut, silk, or cotton thread
- Domestic sewing thread
- Vegetable or nylon fibre pre-selected by the circumciser.

Needles

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

Approximating the wound

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

Condition of hands

No gloves are worn during the operation.

Hands may or may not be washed and, in any case, wet fingers are slippery. Should the circumciser have difficulty in pinching the skin being removed, it is not unusual for him/her to wipe their hands on the thighs or clothes of the child or even on the sand of the ground in order to dry them and thus improve dexterity.

The circumciser allows his/her nails to grow as they are used as pincers during operations. Rings, amulets and other hand ornaments are rarely removed, as these items are not recognised by the traditional healer as sources of contamination.

Clothes and bedding

Since bleeding will occur and because there will be secretions for some days, the family usually makes use of an old mat or floor covering that can later be discarded. Sometimes sand is placed on the mat under the buttocks of the child in order to absorb blood and other secretions.

More affluent or educated families may be aware of the risks of infection and may use clean sheets and gauze pads to absorb blood and secretions from the wound.

The operation

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

Understandably, it is vital for the child to be held as still as possible in order to avoid inflicting cuts other than those intentionally being carried out for the purpose of infibulation. For this reason, adult helpers grab and pull apart the legs of the girl. Usually, two people take one leg each and hold down her hips; a third person holds back the head and torso.

To prevent kicks, the child's legs are held back by tying a rope to each of her ankles which is then tied to her thighs, thus keeping each leg in a tightly flexed position or what can roughly be described as a modified and forced Trendelenburg position.

If available, this is the stage at which a local anaesthetic would be used.

The element of speed and surprise is vital and the circumciser immediately grabs the clitoris by pinching it between her nails aiming to amputate it with a slash. The organ is then shown to the senior female relatives of the child who will decide whether the amount that has been removed is satisfactory or whether more is to be cut off.

After the clitoris has been satisfactorily amputated, and after female relatives have notified those waiting outside that the business in hand is progressing well, the circumciser can proceed with the total removal of the labia minora and the paring of the inner walls of the labia majora. Since the entire skin on the inner walls of the labia majora has to be removed all the way down to the perineum, this becomes a messy business. By now, the child is screaming, struggling, and bleeding profusely, which makes it difficult for the circumciser to hold with bare fingers and nails the slippery skin and parts that are to be cut or sutured together.

Quite often, the child faints allowing the circumciser to proceed calmly with the procedure.

It needs to be stressed here that it is important for the wound to heal, not only to protect the child from a repeat operation, but also to preserve the popularity of the circumciser who would otherwise acquire a bad reputation and thus lose future clients.

Having ensured that sufficient tissue has been removed to allow the desired fusion of the skin, the circumciser pulls together the opposite sides of the labia majora, ensuring that the raw edges where the skin has been removed are well approximated. The wound is now ready to be stitched or for thorns to be applied.

If a needle and thread are being used, close tight sutures will be placed to ensure that a flap of skin covers the vulva and extends from the mons veneris to the perineum, and which, after the wound heals, will form a bridge of scar tissue that will totally occlude the vaginal introitus.

A small hole with the diameter of a matchstick will be left unstitched in order to permit the flow of urine and vaginal secretions.

If thorns are being used, an equal number would be inserted into each side of the labia majora, and a string used to pull the thorns, and thus the raw edges of the labia majora, together. The string would be wound in the same way that sports shoes with hooks are laced.

If the procedure is being carried out by someone with knowledge of dressing wounds, they may apply regular medical disinfectants.

Once the stitching has been done, traditional circumcisers are known to break a raw egg over the wound, which is then sprinkled with whatever herbs, incense, sugar, or concoction that has been prepared according to the dictates of local custom or the

practice of the circumciser. This concoction, consisting of egg, herbs, incense, sugar, and the blood of the child, coagulate and form a crust over the sutures or strips of cloth holding the thorns together. One can only wonder why more girls do not develop infections after this rich culture medium for bacteria has been placed between the legs of the child. In order to prevent movement, the child's legs are bound together from the hips to her toes, and she is then made to lie on her side.

No dressing is used and the legs are tied together for a week, after which the bindings are loosened slightly and the child is allowed to take small steps. The leg bindings will be removed altogether after a further week.

To ensure that the urethra has not been accidentally closed, either by a blood clot or suture, the child is encouraged to urinate a few hours after the operation.

Whether sutures or thorns were inserted, these will be removed on the seventh day, but only after the circumciser is satisfied that the two sides of the labia majora have fused together and the remaining hole for urination is not wider than three to five millimetres in diameter.

De-infibulation at the time of marriage

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

The Dangers of FGM/C

FGM/C puts children at risk of life threatening complications at the time of the procedure as well as health problems that can remain with them for life. Girls may suffer bleeding during FGM/C or develop severe infections, both of which can lead to death if not treated promptly. Those who do not develop life-threatening medical complications may still suffer severe pain and trauma.

The procedure can also lead to the transmission of viral infections, such as hepatitis, which may cause chronic liver disease and even HIV. Women may suffer complications such as recurrent infections, pain, and obstruction associated with urination. Furthermore, women who have had FGM/C are at higher risk of painful menstruation and intercourse, pelvic infection, and difficulties in conceiving.

Retention of urine and recurrent infections often require repeated hospital admissions and some women are at risk of developing nephritis.

The development of cysts and keloids at the site of the scar is common, often causing embarrassment and marital problems, and usually requiring surgery for removal.

During pregnancy there are many further complications that may occur as a direct result of FGM/C. Labour may become prolonged or obstructed, obstetric haemorrhaging may occur, and, if early medical intervention is not provided, this may lead to the death of both baby and mother. The WHO asserts that, because of FGM/C, many women die in the process of giving birth.¹⁵ If the mother and baby survive there is the risk of damage to the vagina leading to the formation of fistulae in the bladder or bowel. The outcome is constant incontinence due to a vesico-vaginal or recto-vaginal fistula. Women in this condition are often rejected by their family and become social outcasts. During the 13 years that the Edna Adan Hospital has been functional, the fistulae of over 230 women have been surgically repaired.

Apart from the many physical complications, girls and women who have undergone FGM/C experience considerable psychological problems including depression, anxiety, and post-traumatic stress disorder. These issues are exacerbated at the time of marriage and often lead to increased distress and fear of intercourse.

If de-infibulation is performed the woman is again exposed to life threatening complications such as sepsis and bleeding, the transmission of chronic infections such as HIV and Hepatitis as well as damage to the urethra, if, as is common, the circumciser makes an error when performing the cut.

Complications

In light of the clumsy and unhygienic conditions in which FGM/C is usually performed, unsurprisingly, complications are commonplace and can be classified in the order in which they are likely to occur:

1. Immediate

- *Shock*
- *Fear*
- *Pain*
- *Haemorrhaging*
- *Other lacerations:* In addition to the intentional cuts on the clitoris, labia minora and majora, there may be accidental lacerations inflicted on the

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

child as a result of her struggles. These cuts may involve the vagina, urethra, anus, and thighs. As a result, a considerable number of children are taken to hospital for the control of haemorrhage, or for the repair of severe lacerations.

2. Within the first ten days

- *Infection:* Infection to the wound and septicaemia are often encountered and tetanus is not uncommon
- *Retention of urine (five possible causes):*
 - a) Post-traumatic oedema of the vulva resulting from the damage inflicted on the clitoris and labia impedes or obstructs the passage of urine through the swollen urethra
 - b) Obstruction of the urethra by a blood clot or by the thorns that were inserted to hold the sides of the labia majora together
 - c) Accidental suturing of the urethra itself
 - d) Over-tight application of the binds that were used to keep the thighs and legs together
 - e) Psychosomatic urine retention out of fear and pain
- *Failure to infibulate:* When the two sides of the labia majora fail to fuse, the child undergoes a repeat operation at a later date.

3. At the onset of menstruation

- *Dysmenorrhoea:* When the post-infibulation vaginal hole is too small there is a constant stagnation of menstrual blood and other vaginal secretions, causing bacteria to spread into the vaginal and uterine cavities. This is likely to increase the risk of chronic pelvic inflammation that might cause the severe abdominal cramps experienced by infibulated females during menstruation.
- *Recurrent urinary tract infection:* As the flap of skin obstructs the urethra after infibulation, urine does not jet out during micturition. Instead, it hits the flap of skin obstructing the vulva, is sprayed back into the vagina and then trickles out in drops. This obstruction also prevents proper vaginal hygiene and drainage and causes urinary stasis, which is likely to cause recurrent urinary tract infections.
- *Early de-infibulation:* Because the small artificial opening that had previously permitted the passage of urine becomes insufficient for the drainage of the more viscous consistency of menstrual bleeding, doctors often have to convince the parents of the need for the small vaginal opening to be enlarged to permit the flow of menstrual blood. Families often resist this due to fear that if the opening is too wide it may not be sufficient proof that their daughter is a virgin at the time of marriage. A medical certificate is often requested by the parents to explain the reason for the de-infibulation.

4. At the time of marriage

- *De-infibulation*: The infibulation opening that permitted the passage of urine and vaginal secretions does not allow for intercourse at the time of marriage. This requires that the husband makes a forcible penetration to burst the skin obstructing the entrance to the vagina. Alternatively, the opening has to be cut open with scissors or a knife to allow consummation of marriage.
- *Dyspareunia*: The scar tissue that surrounds the vaginal orifice may be rigid and inelastic and can cause pain during sexual intercourse.
- *Infertility*: Due to the constant stagnation of menstrual blood and other vaginal secretions that accumulate in the vaginal cavity, the resulting pelvic inflammation may obstruct the fallopian tubes. This blocks the normal travel of the ovum along the tubes, preventing it from becoming fertilized by the male spermatozoa.
- *Vulval keloids and dermal cysts*: Apart from their unsightly appearance, these may interfere with consummation of marriage or with childbirth during delivery.

5. During pregnancy

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

6. During labour and delivery

- *Caesarean*: Some women arrive at the hospital in labour with a very small infibulation opening. If the vagina is seen to be too rigid and scarred, and thought to be a possible cause of severe vaginal lacerations or third degree tears, it is likely that an elective caesarean section will take place. If keloids have formed and are too large, a caesarean section might be the best option for delivery
- *Prolonged second stage labour*: Because the vagina, perineum and labia have all been cut, leaving extensive scar formation, the vaginal canal becomes inelastic and the pelvic floor muscles rigid. This condition prevents the normal and gradual dilation of the vagina as well as the descent of the presenting part of the child during the second stage of labour.
- *Fetal complications*:
 - Large caput formation
 - Excessive moulding of the head
 - Intra-cranial haemorrhage
 - Hypoxia
 - Fetal distress

- Intrauterine death
- *Maternal complications:*
 - Obstructed labour
 - Extensive vaginal and perineal lacerations
 - Third degree tears
 - Uterine inertia
 - Uterine rupture
 - Impacted fetus
 - Maternal distress
 - Maternal death

7. Postnatal complications

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

8. Other complications

In recent years, since HIV/AIDS became a pandemic, the likelihood of transmission of the AIDS virus has been added to the long list of complications associated with FGM/C. The risk is increased because the traditional healers who perform circumcisions do not know the dangers of using unsterilized instruments that have previously been used on individuals who might have been carrying the AIDS virus.

Reasons Given for FGM/C

The reasons behind the practice of FGM/C are deeply entrenched within tradition and cultural heritage and are therefore complex and difficult to explain. Although motives vary between societies there are common themes. FGM/C is often erroneously believed to have a religious origin or to be a requirement of certain religions. However, this is not the case.



Girl in Hargeisa refugee camp

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

Campaign to Eradicate FGM/C

The international campaign

The international campaign against FGM/C has a long and difficult history. Advocacy and resistance started with individual health professionals from practising African countries working in their communities. Their efforts are to be commended as they worked in unreceptive environments with little support. However, there are few records of these efforts and the extent of their impact is unknown.

UN and NGO involvement

The United Nations and other humanitarian organisations consider FGM/C a violation of human rights.^{16 17} Although UN support for the eradication of FGM/C is now strong and active, it was slow in coming. Lack of knowledge on the subject first prevented UN agencies from addressing the issue. When awareness finally came about the extent of the practice and the serious health and psychological effects that result from it, it was recognised as a major human rights issue. Conferences were held, studies were commissioned, and discussions began. However, the mainly European representatives chairing these discussions did not understand the deep cultural ties that propagated the practice and were unprepared for the resistance of recently decolonised African nations who saw the attention placed on the issue as another intrusion. There were, however, exceptions. East African countries, including Somalia, where the most severe forms of FGM/C are practised and campaigns were already active, were more appreciative of UN involvement.

As early as 1979 the WHO recommended that the practice should be eradicated.¹⁸ After the first rounds of conferences in the 1980s there was a growing awareness of the sensitivities surrounding FGM/C, when even to talk about it was problematic. Abolition in the immediate future was therefore impossible. While mandates condemning female circumcision, as it was known then, were taken, in terms of field

¹⁶ Sullivan D., Toubia N. F. *Female Genital Mutilation and Human Rights*. Presented at the World Conference on Human Rights, Vienna, Austria, June 1993.

¹⁷ *World Conference on Human Rights: the Vienna Declaration and Programme of Action*. WHO, June 1993, New York: United Nations.

¹⁸ *Traditional practices affecting the health of women and children; female circumcision, childhood marriage, nutritional taboos etc.* WHO/EMRO Technical Publication, 1982; 2: 1-360.

work, the UN chose to fund local efforts. These localised efforts focused on education and advocacy. Training was needed for health professionals dealing directly with the victims. Governments were lobbied to introduce policies against FGM/C, or, if such policies already existed, to be more proactive about implementing them. Efforts were made to educate the general public about FGM/C, which encouraged tentative steps towards change. In 1993 the World Health Assembly called for the abolition of the practice.^{19 20} As a consequence, many countries have strict laws prohibiting FGM/C, although, until recently, few have enforced them.

In recent years, with the support of the United Nations Joint Program (UNJP), efforts to encourage FGM/C abandonment have been accelerated. The objectives of the programme are to effect: 1) a change in social norms towards the abandonment of FGM/C at national and community levels; 2) a strengthened global movement towards the abandonment of FGM/C in one generation.²¹ Between 2007 and 2013 almost \$37 million was contributed to the programme, which, by 2011, had been rolled out across 15 countries with national direction and ownership in each.

Efforts towards accelerating FGM/C abandonment culminated in 2014 with the UK-hosted Girl Summit in London. The purpose of the gathering was to begin a dialogue that would spearhead a global movement. Following a major investment by the UK government's Department for International Development (DFID) this work was consolidated in part by the founding of the Girl Generation, a campaign designed to support initiatives across Africa and amplify the issue on the international stage. In parallel with this, a media spotlight on FGM/C has generated unprecedented levels of awareness in Europe and beyond.

Complete eradication has not been achieved; indeed, nothing close to it has been attained. More hopefully, though, in the countries where it is practised, FGM/C is now more openly discussed than ever before.

The campaign in Somalia/Somaliland

In March 1977, during the formation of the Somali Women's Democratic Organization (SWDO), Edna Adan Ismail was the first Somali to publicly denounce FGM/C, and went on to pioneer the campaign for its eradication in Somalia, Somaliland, and internationally.

¹⁹ *Female circumcision: female genital mutilation*. International Journal of Gynecology & Obstetrics. 1992; 37:149.

²⁰ *Female genital mutilation - World Health Assembly calls for the elimination of harmful traditional practices*. Press release of the 46th World Health Assembly. WHO, 12 May, 1993, Geneva.

²¹ See Crawford, S. & Ali, S. *Situational Analysis of FGM/C/C Stakeholders in Interventions in Somalia*. UNFPA-UNICEF, UK AID, London, p. 57.

In 1986 the Somalia government approved the campaign to eradicate FGM/C on health and religious grounds. With this approval, SWDO was able to accelerate the struggle, joining forces with the Italian Association for Women and Development (AIDOS) in 1987. In the intervening years, the effort continued until the overthrow of Siyad Barre in 1991 followed by the disintegration of the government in Somalia.

For almost 40 years, Edna has tirelessly campaigned against FGM/C and has spoken out in a variety of public forums.²² Thankfully, these efforts have borne fruit as human rights organisations are now joining forces with national initiatives in an effort to accelerate FGM/C abandonment. In 1987, Edna, who was by then employed by the WHO, was sent to Djibouti to launch the first campaign against FGM/C in that country. In 1997, UNICEF requested her assistance to obtain the approval of the government of Somaliland for a seminar to re-launch the FGM/C campaign. The seminar was held in Hargeisa and a national committee and regional task force was established to develop formal policies.

Among the most useful strategies deployed for the eradication of FGM/C in Somaliland is the inclusion of a module on FGM/C in the nursing training curriculum, produced by Edna in 2001. Now all training courses for nurses, midwives, laboratory technicians, pharmacists, and public health officers must include courses on the harmful effects of FGM/C on the health of women and children.

There are encouraging signs that awareness campaigns are having some effect. In 2003, a Save the Children publication on child rights in Somaliland found that most girls and boys, and some care givers, community leaders, and government officials, pointed to the harmful traditional practice of FGM/C as the most negative aspect of Somaliland society and culture.²³ Moreover, for some years now, FGM/C has been a stated government priority, coordinated under the Gender Based Violence (GBV) working group. This work has received high-level public endorsement, including commitments of support from the Somaliland President and First Lady, as well as the Minister of Religious Affairs, who publicly supports zero tolerance.

A draft bill to criminalise FGM/C in Somaliland received widespread support, including that of five government ministries. Yet, in spite of the position of the Minister of Religious Affairs, support from the Ministry has not been forthcoming. This is because, although religious leaders agree that Type III FGM/C is prohibited by

²² Conferences and events have included the 1979 WHO seminar in Khartoum where Edna was appointed as a temporary advisor on the mental and physical complications of FGM/C. Other occasions include the 1980 mid-decade conference for women in Copenhagen where a documentary was shown evidencing the medical dangers of FGM/C; in Lusaka in the same year as a UNICEF consultant; in Dakar in 1984 during a conference sponsored by WHO/EMRO when Edna co-founded and was elected Vice President of the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children; in 1986 in EMRO Egypt; and in 1987 in Addis Ababa, at which time the Organization of African Unity was lobbied to produce a resolution against FGM/C. In 1995, Edna raised the alarm about FGM/C during the Beijing Women's Conference when several First Ladies, including Hilary Clinton, Suzanne Mubarak, Nana Jerry Rowlings and Queen Nour of Jordan, were present.

²³ Lagu, M., *Child Rights situation Analysis in Somaliland*. Save the Children, July 2003.

Islam, reference to other types can be found in religious texts. For this reason, scholars are unwilling to support efforts to criminalise all forms of FGM/C and therefore the law remains in a state of limbo.

Nevertheless, progress has been made towards an environment more conducive to bringing the practice to an end. The Ministry of Labour and Social Affairs has established an FGM/C taskforce which is maturing, and the Somaliland Nursing and Midwifery Association (SLNMA) is exploring ways of curbing the increasing medicalisation of FGM/C. Other initiatives include the Network against FGM/C in Somaliland (NAFIS), an umbrella organisation comprising groups such as the African Network for Protection and Perfection of Children Against Neglect (ANPPCAN) and Comprehensive Community-Based Rehabilitation in Somaliland (CCCBRS). These organisations aim to increase advocacy and protect at-risk persons from FGM/C and other forms of gender-based violence through community-based and participatory initiatives. Caseworkers work within communities, especially IDP populations, to deliver educational programmes and emergency medical referral services.

One of the most active organisations working to end FGM/C is the Somaliland Family Health Association (SOFHA). Founded by Edna Adan Ismail, who also serves as President of the board, SOFHA is supported by the International Planned Parenthood Federation (IPPF). The working remit of the association concerns all areas of sexual and reproductive health. FGM/C-related issues are thus a core focus. A key activity is the provision of counselling services for new mothers on the perils of FGM/C, as well as offering women advice on de-infibulation and coping with complications that arise from the practice. Outreach work includes a school programme designed to accelerate FGM/C abandonment amongst the rising generation.

While education and the empowerment of women brought about by eradication campaigns are changing the views of Somalilanders on FGM/C, it is only through audits like these, that the rate of change can be accurately recorded and evaluated. In a society where the practice is almost universally accepted, change will occur slowly as long as people fear discrimination for choosing to break with tradition.

Having pioneered the campaign against FGM/C in Somaliland, the Edna Adan Hospital remains a major player in what is now a global movement. The following section provides information about the hospital and the vital role it has taken in this work.

Location of Study: The Edna Adan University Hospital

The Edna Adan Hospital (EAH) is situated in Hargeisa, the capital of Somaliland.

The hospital is a **non-profit charity** that was built by Edna Adan Ismail in order to address the key health problems that endanger the lives of women and children in

the Horn of Africa. It was established to provide quality care in Hargeisa which would expand to all areas of the country through the training of nurses and midwives in the best methods and technologies.

The construction of the hospital began on 1 January 1998 and the hospital opened for the first time on 9 March 2002 with 25 maternity beds. As the need increased, and personnel were trained, hospital services expanded to accommodate an additional eight paediatric, 16 medical and surgical beds, and several private rooms. Today the hospital has 65 beds and is a major referral institution for obstetrical, surgical, medical, and paediatric cases from a wide geographical area in the Horn of Africa.

With the opening of the Edna Adan University (EAU) in 2010, the level of training for health professionals has once again been increased. In 2012, the first 21 midwives graduated with a BSc degree. Today, over 900 students are enrolled on degree courses in nursing, midwifery, laboratory technology, pharmacology, and public health. EAU graduates are standard bearers for quality healthcare and provide a solid base of knowledge and professionalism in this struggling nation.

Health profile of the people of Somaliland

The health of the people of Somaliland is among the worst in Africa. Even before the civil war and the separation of the two Somali states, Somalia had one of the highest maternal and child mortality rates in the world.²⁴

According to a 2011 survey carried out by the Ministry of National Planning and Development (MNPD) in partnership with UNICEF, one in ten children growing up in Somaliland die before their fifth birthday.²⁵ Contributing factors include an unacceptably low level of immunization with only 2% of children receiving the recommended vaccines before their first birthday. Only 13% of children are exclusively breastfed and management of major causes of childhood mortality such as diarrhoea and pneumonia remains poor.²⁶

Maternal mortality rates are staggeringly high. Although recent accurate data are unavailable, a study in 2006 indicated that Somaliland women face a one in 15 risk of death due to pregnancy or childbirth-related complications such as puerperal sepsis, eclampsia, and obstructed labour.²⁷ Only about one in three women receive

²⁴ UNICEF. *The Progress of Nations, 1997* - 160 maternal deaths per 10,000 live births

²⁵ UNICEF & Somaliland Ministry of National Planning and Development (MNPD). *Somaliland. Multiple Indicator Cluster Survey, 2011 – Key findings*, p. 4 (Sep 2014)

²⁶ *Ibid*, p. 7-8

²⁷ “The maternal mortality rate in Somaliland was 1,044 per 100,000 in 1999, a ratio which listed Somaliland women among the highest-risk groups in the world. The rate dropped slightly, to 1,013, in the year 2006.” Somaliland Ministry of National Planning and Development (MNPD). *National Development Plan (2012-2016)*, p. 245 (Dec 2011)

antenatal care from a skilled birth attendant, and even fewer (15%) attend antenatal clinics the recommended four times during pregnancy. Whereas three quarters of all maternal deaths occur during delivery and the immediate post-partum period, barely more than half of women in Somaliland are attended by trained health workers during delivery.²⁸

Services provided by the Hospital

As the existing public maternal and gynaecological facilities were over-crowded, ill-equipped and under-staffed, the establishment of the Edna Adan Hospital has provided much needed reproductive health care for the growing population of Hargeisa and Somaliland as a whole. The hospital is run in accordance with international standards of maternal and infant care. With services and supervision carried out by highly qualified medical, midwifery, and nursing personnel, it is possible to provide patients with the type and quality of personalised care that women and their babies everywhere have a right to receive.

The **Maternal Mortality Rate (MMR)** of patients referred or admitted to the hospital from March 2002 to December 2014 is significantly lower than the national rate at 53 deaths out of the 16,097 women who were delivered, or referred to the hospital after being delivered elsewhere. This makes the MMR for the Edna Adan Hospital 330/100,000, which is about a fifth of the national average. The MMR has been steadily declining every year, and, with the continued training of personnel and provision of better equipment and supplies, we are confident that this can be reduced even further.

Hospital objectives

To make available a modern, well-equipped, and efficient health care facility that provides a much higher standard of patient care than that which was previously available to women and children in Somaliland.

- To establish a model health care institution, which provides not only good health care, but training and research opportunities to medical and paramedical personnel.
- To serve as an example to others, and thus encourage national and international investment in health services in order to improve the overall welfare of the nation.
- To provide 65 adult beds for obstetrical, neonatal, and general patient care, 16 cots and 3 premature incubators.

²⁸ UNICEF & Somaliland Ministry of National Planning and Development (MNPD). *Somaliland. Multiple Indicator Cluster Survey, 2011 – Key findings*, p. 12 (Sep 2014)

- To make antenatal and postnatal outpatient services available, as well as immunization for women and children.
- To make available laboratory facilities and a blood bank for emergencies.
- To provide ultrasound and visual monitoring facilities.
- To provide for gynaecological problems including management of infertility, as well as the diagnosis and treatment of sexually transmitted diseases, including HIV/AIDS and counselling where needed.
- To make available facilities for carrying out medical research, studies and counselling, with particular attention to the health problems associated with FGM/C as part of the comprehensive reproductive health services that are offered by the hospital.
- To carry out training programmes for health workers, with particular attention to the training of nurses and midwives in partnership with the Ministry of Health, UNICEF, and the WHO.

The Hospital and FGM/C

The Edna Adan Hospital deals with the complications caused by FGM/C almost on a daily basis. Cases include children who have undergone the procedure hours and sometimes days before being brought to the hospital and who are still bleeding heavily or unable to pass urine. The severest case in recent years was one in which the child had been so badly cut that there was virtually no skin to suture together to stop the blood gushing from her body.

Common cases include newly married girls and women just de-infibulated and suffering from bleeding, infection, or extreme pain. Others may be in labour for protracted periods due to FGM/C scarring, preventing the birth canal from dilating properly. Some of these women fall victim to third degree lacerations and other postnatal complications.

Edna has been dealing with cases of this nature for more than 50 years as a midwife and has been engaged in a life-long struggle to bring this practice to an end. Not surprisingly, therefore, the Edna Adan Hospital is spearheading the campaign to abolish FGM/C in Somaliland. The hospital has become a repository of all information relating to FGM/C in the country and throughout the region. The auditing process began in 2002 for the purpose of acquiring baseline data about the prevalence of FGM/C. The surveys in this report represent the second data set to emerge from the initiative, which is the first of its kind in Somaliland.

As part of its efforts to accelerate FGM/C abandonment, the hospital holds educational seminars for special interest groups. At a patient level, counselling services are provided to victims of FGM/C and their families. Indeed, there is no other institution in the country better equipped with the experience, knowledge, facilities, and, above all, passion and dedication to tackle this issue.



Girl in Haud region

The Study

The current study is drawn from two surveys carried out on women attending the prenatal clinic at the Edna Adan Hospital in Hargeisa, Somaliland. The first cohort participated in the research between March 2002, when the hospital was opened, and August 2006, and the second between September 2006 and August 2013. These data were carefully recorded on the prenatal charts of each participant, collected, analysed, and compared to produce the findings recorded below.

The collected data indicate the prevalence of FGM/C in Somaliland, the procedures used, the ages at which it is performed, and information regarding those who carry it out. These data also provide fresh insights into the motives behind the practice, and serve as a predictor for the future. We believe the findings are a key factor in the ongoing campaign to abolish the practice, providing valuable data to inform and direct future efforts to eradicate the practice and measure their success. The collected data are also of interest to local communities, medical professionals, NGOs, international aid agencies, women's groups, and all those working to bring FGM/C to an end in Somaliland and beyond.

Purpose of surveys

- To obtain baseline data on the prevalence of FGM/C among women of childbearing age attending prenatal clinics.
- To identify the pervasiveness of each type of FGM/C.
- To record observed complications in pregnancy, labour, and delivery due to FGM/C.
- To collect data on the age when the procedure was performed, who performed it, and where.
- To find out why FGM/C persists; how women feel about it; whether they intend to put their daughters through it and why.
- To assess the degree of attitudinal change that has occurred following almost 40 years of campaigning.
- To use the findings to inform future efforts to eradicate the practice.

Methods of data collection

Physical examination

Examination of the vulva is carried out on all pregnant women attending the antenatal clinic. On occasion, it is not clear whether the patient has undergone any

form of FGM/C, hence the patient is asked directly. If the answer is 'no', the response is recorded as such; and, if 'yes', the rest of the questionnaire is completed.

Questionnaire

To ensure uniformity of data, a simple questionnaire was developed and printed on all antenatal cards. There were no differences between the first and second surveys in order to prevent any bias in the results:

**Edna Adan Maternity Hospital,
Pregnancy Record** Hospital Number: _____

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

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

History **Preveious Pregnancies**

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

Other problems with past pregnancies: _____

Curent Pregnancy

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

FGM: YES NO

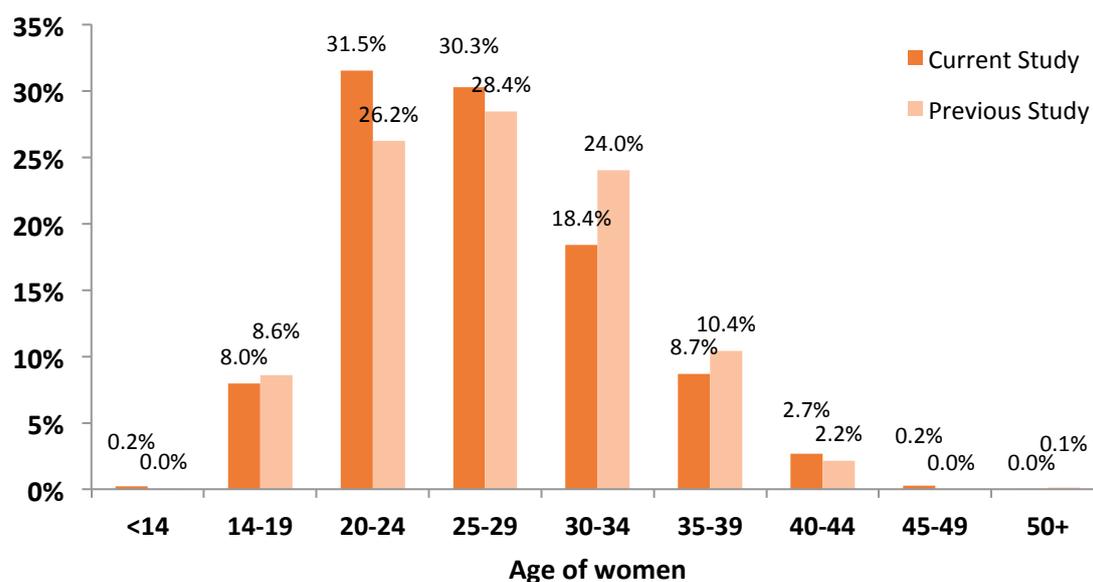
Where: _____ Age: _____ Type: _____
By whom: _____ Why: _____
Will you do it to your daughter YES NO Why: _____ Type: _____

Figure 5: Questionnaire example

Findings

1. Age of women

A total of 6,172 women participated in the second survey, 99.3% (6,131) of whom reported their age. The average age of participants was 26, with an age range between 12 and 50. The largest group (32.5% or 1,932) were aged between 20 and 24, followed by the group aged between 25 and 29 years (30.3% or 1,856).



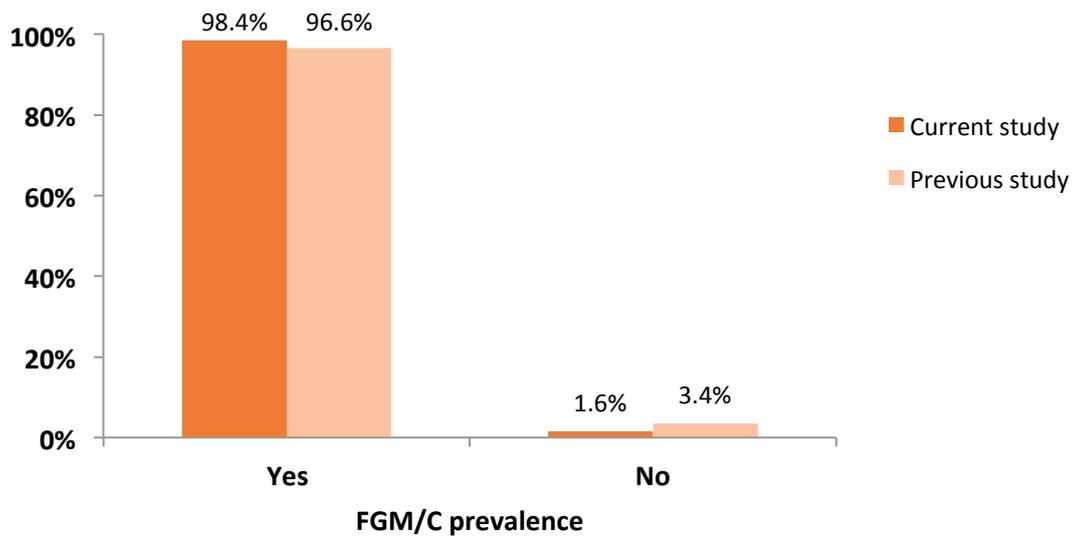
Findings in the previous study

Data analysis reveals that the age distribution of participants was similar in both survey cohorts; 20 to 24, and 25 to 29 being the most common age groups.

2. Prevalence of FGM/C

Data regarding the percentage of women who had undergone FGM/C was obtained from a sample population of 6,108 out of a total of 6,172 participants. The results were based on the physical examination of participating women during antenatal examinations. The survey revealed that 98.4% (6,011) of the cohort had undergone FGM/C. 1.6% (97) of participants bore no signs of FGM/C, and, when questioned, reported that they had not undergone the procedure.

Among the women surveyed, the records of 1% (64) were incomplete and it could not therefore be determined whether or not they had had FGM/C.



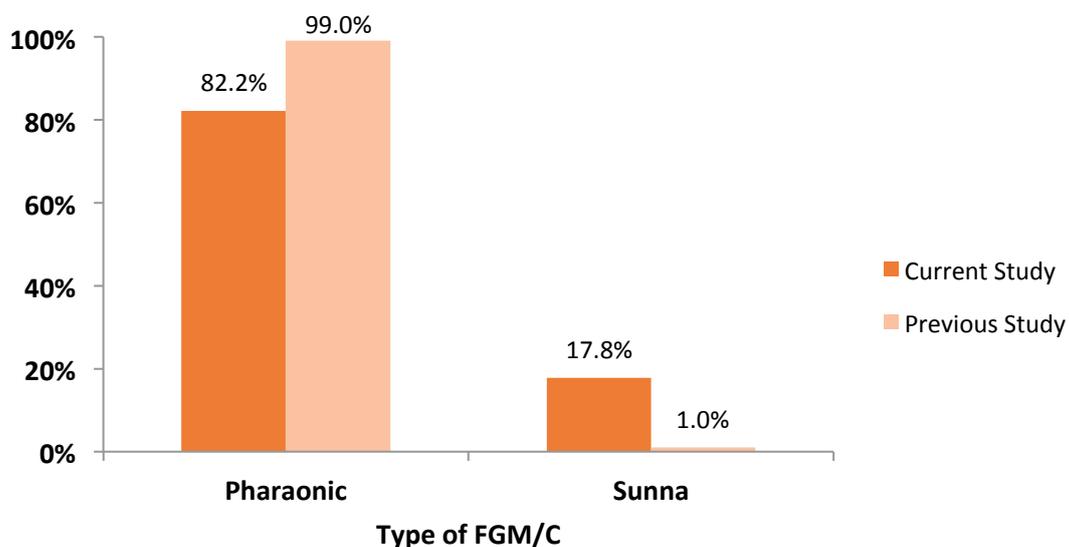
NB: Distribution does not include individuals whose records were incomplete (n=64 for current study, n=1 for previous study)

Findings in the previous study

The results of the current study are consistent with previous findings, with the majority of respondents in both the current (98.4%) and previous study (96.6%) having undergone FGM/C.

3. Type of FGM/C

Out of a total of 5,736 respondents, 82.2% of women (4,715) had undergone the most severe Pharaonic or Type III FGM/C in which all or part of the external genitalia is removed and the vulva approximated and stitched together. The remaining 17.8% (1,021) respondents had undergone Sunna or Type I FGM/C.



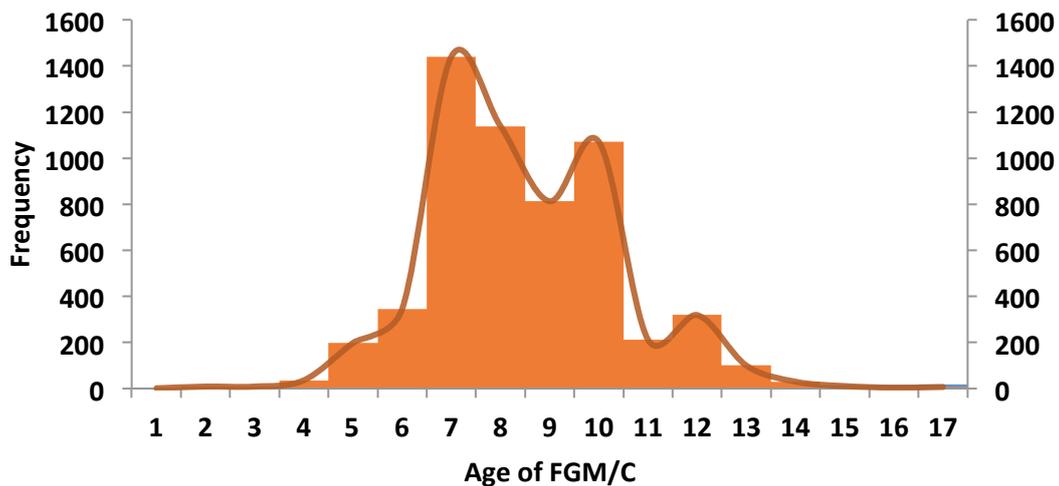
NB: Distribution doesn't reflect unreported cases (n=436 for current study, n=136 for previous study)

Findings in the previous study

In both the current and previous study the majority of participants had undergone the more severe Pharaonic type FGM/C (second survey: 82.2%; first survey: 99%). However, a comparison of findings reveals a shift away from the more severe Pharaonic type towards the Sunna type FGM/C, with a 16.8% increase.

4. Age at which FGM/C was performed

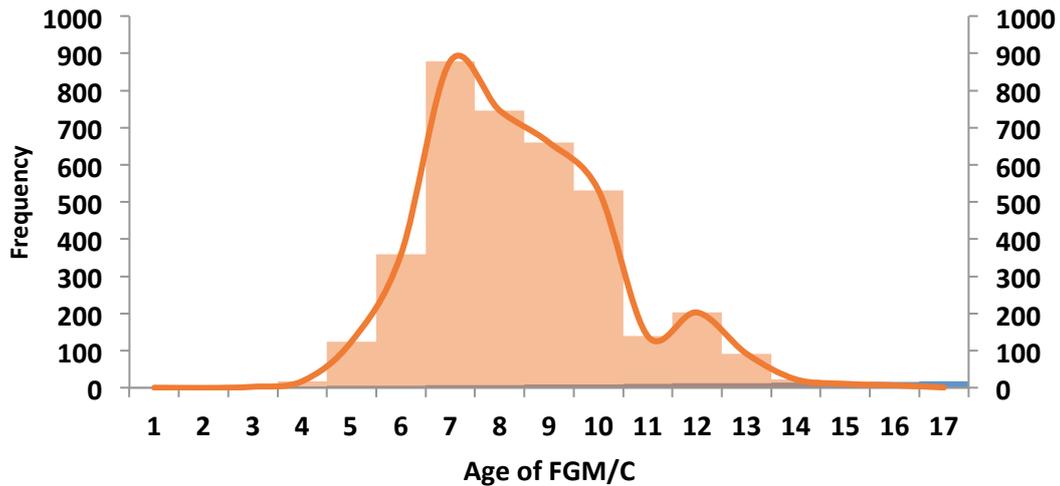
A total of 5,744 women reported the age at which they had undergone FGM/C, the mean being 8 years. 25.1% (1,440) of these women underwent FGM/C at age 7, which is the most common age when FGM/C is performed.



NB: Distribution does not reflect the number of individuals who did not respond (n=428)

Findings in the previous study

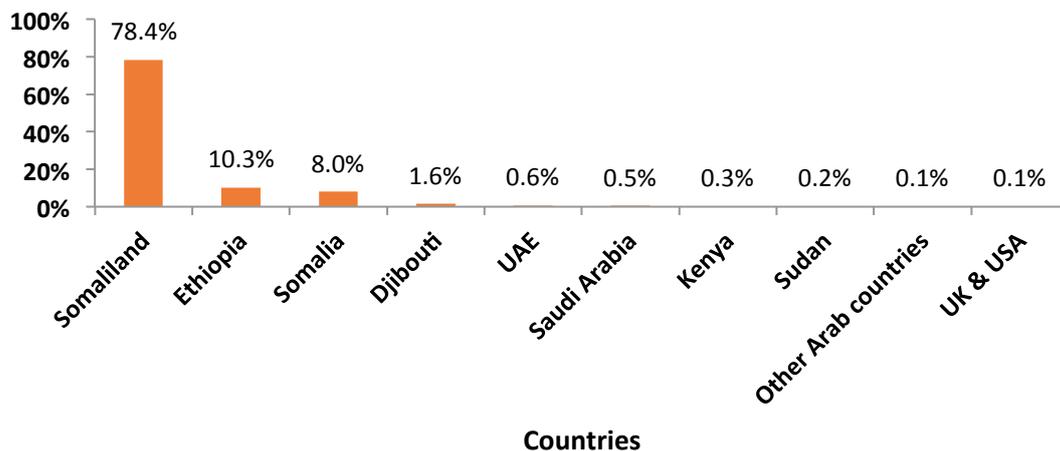
The findings of the current and previous studies are consistent, with the average age at which participants underwent FGM/C being 8 years, and the most common age 7 years.



N.B. Distribution does not reflect the number of individuals who did not respond (n=165)

5. Countries where FGM/C was performed

Out of a total of 5,692 respondents, 78.4% (4,461) of women reported having undergone FGM/C in Somaliland. Other highly represented countries included Ethiopia 10.3% (589) and Somalia 8% (453). FGM/C was reported as having also been performed in Bahrain, Djibouti, Kenya, Libya, Qatar, Saudi Arabia, Syria, Sudan, Tanzania, and the UK.

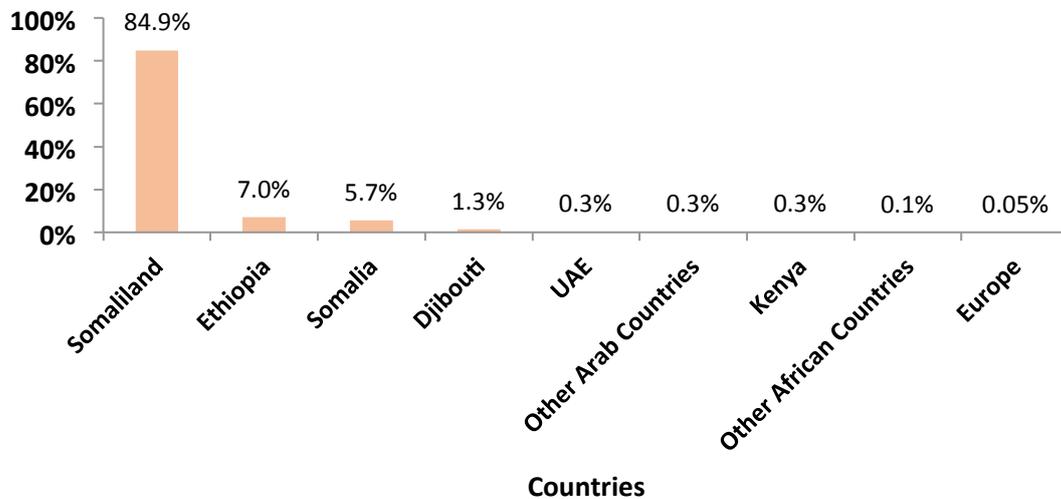


NB: Distribution does not reflect the number of individuals who did not respond (n=480)

Findings in the previous study

In both surveys the majority of women reported having undergone FGM/C in Somaliland (first survey: 84.9%; second survey: 78.4%). In both studies, in addition to

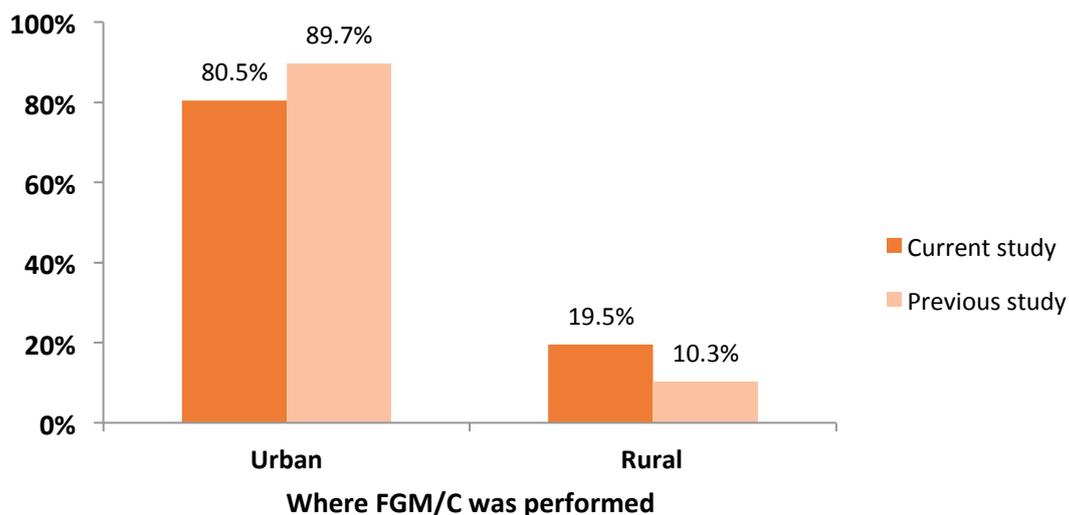
Somaliland, Ethiopia, Somalia, and Djibouti were the most highly represented countries.



N.B. Distribution does not reflect the number of individuals who did not respond (n=147)

6. Where FGM/C was performed: urban or rural areas

As for where FGM/C was carried out, among the second cohort, 80.5% (4,452) of participants indicated that it had happened in a town or urban location, compared with 19.5% (1,079) in a rural area.



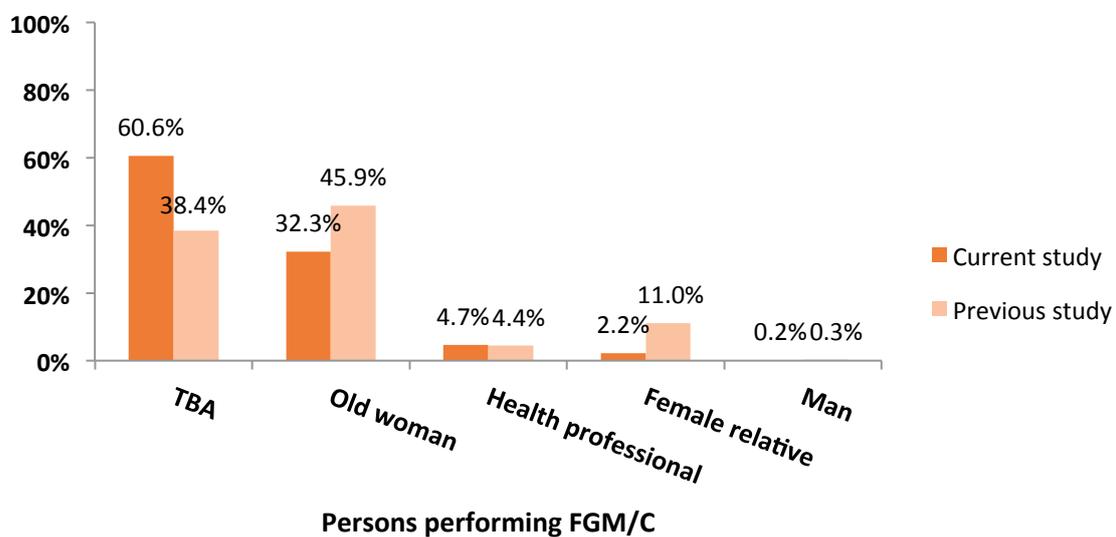
NB: Distribution does not reflect the number of individuals who did not respond (n=641 for current study, n=395 for previous study)

Findings in the previous study

Both the current study (80.5%) and previous study (89.7%) indicate that the majority of women surveyed underwent FGM/C in towns or urban areas.

7. Persons performing FGM/C

Of the 5,753 women who responded to this question, it was found that FGM/C was mostly performed by traditional birth attendants (60.6% or 3,486) and older women (32.3% or 1,861). Disappointingly, 4.7% of survey participants reported that trained medical personnel, including doctors and nurses, had performed FGM/C on them in hospitals.



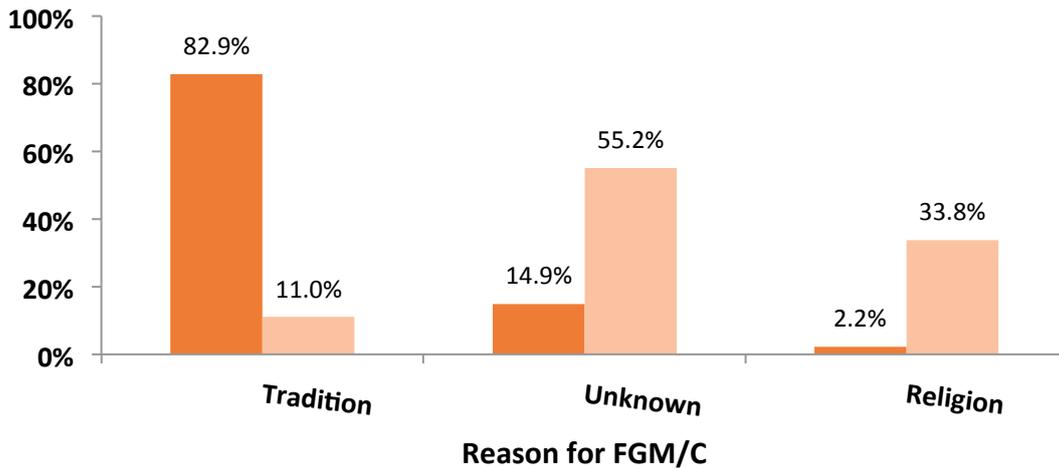
NB: Distribution does not reflect the number of individuals who did not respond (n=419 for current study, n=152 for previous study)

Findings in the previous study

Similar to the second study, the majority of FGM/C procedures in the first survey were performed by older women (45.9%) and TBAs (38.4%).

8. Perceived reasons for having undergone FGM/C

Out of a total of 6,172 respondents, 5,778 reported perceived reasons for having been put through FGM/C. 82.9% (4,790) of the women surveyed thought it was for reasons of tradition and 2.2% (127) for religious reasons.



NB: Distribution does not reflect the number of individuals who did not respond (n=394 for current study, n=1,298 for previous study)

Findings in the previous study

The current study reveals a significant decline in the number of women who reported having undergone FGM/C for religious reasons (33.8% in the first survey compared with 2.2% in the second). By contrast, where 11% of women in the first survey perceived tradition as the motive for having been subjected to FGM/C, this proportion rose sharply to 82.9% among the second cohort.

9. Number of women who would perform FGM/C on their daughters

The majority of mothers, that is 83.2% (5,045), stated that they would perform FGM/C on their daughters, compared with 16.8% (1,021) who said they would not.

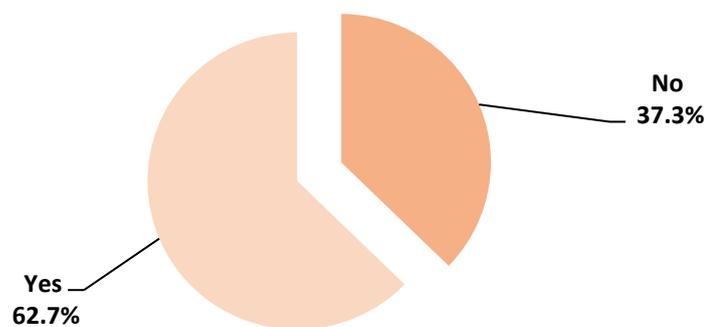


Women who would perform FGM/C on daughter

NB: Distribution does not reflect the number of individuals who did not respond (n=106)

Findings in the previous study

Among the first cohort of women surveyed, 62.7% stated that they would have FGM/C performed on their daughters, compared with 83.2% in the second. However, in the second study, more women indicated that they would perform the milder Sunna or Type I FGM/C on their daughters (see sample 10).

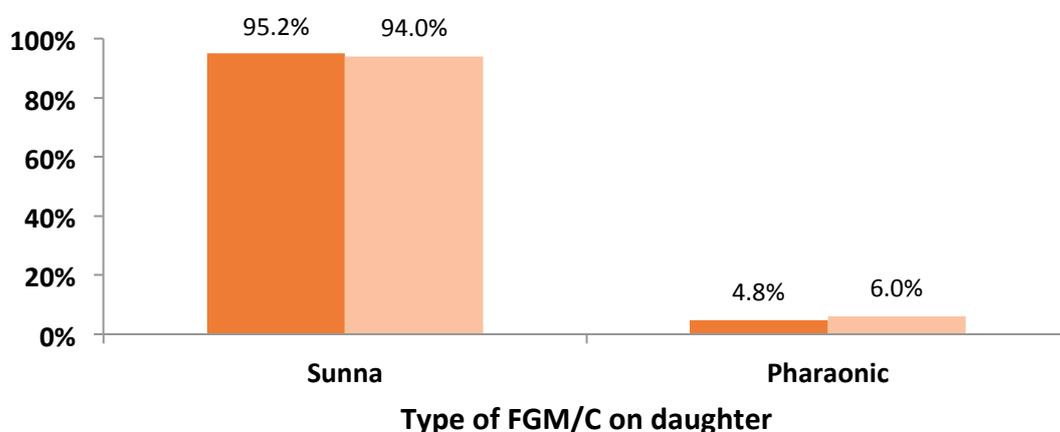


Women who would perform FGM/C on daughter

NB: Distribution does not reflect the number of individuals who did not respond (n=1,258)

10. Type of FGM/C women would perform on their daughters

A total of 4,861 women responded to the question about the type of FGM/C they would carry out on their daughters. 95.2% (4,626) of the total sample reported that they would perform Sunna or Type I FGM/C. 4.8% (235) said they would carry out Pharaonic Type III FGM/C, and 21.2% (1,311) declined to reveal which type they would favour.



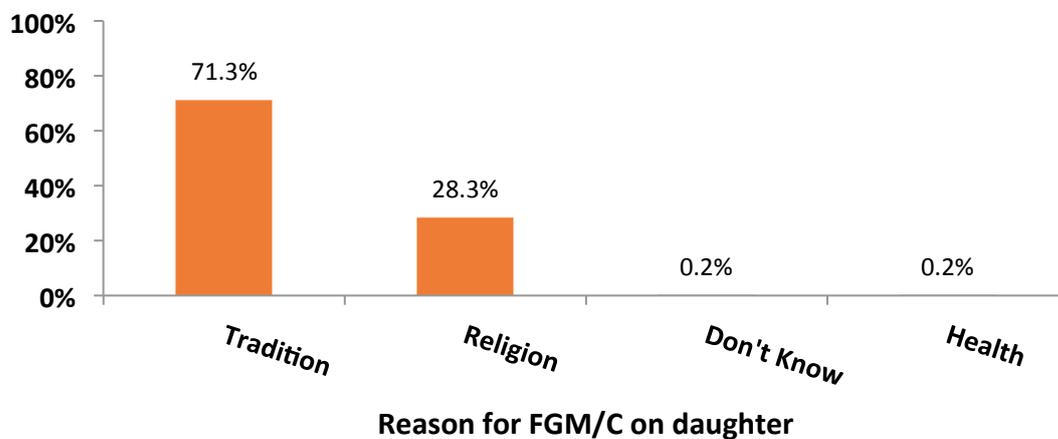
NB: Distribution does not reflect the number of individuals who did not respond (n=1,311 for current study, n=2,307 for previous study)

Findings in the previous study

It is noteworthy that Pharaonic Type III FGM/C has decreased as the favoured FGM/C type for mothers to perform on their daughters from 6% in the first survey to 4.8% in the second.

11. Reasons given for performing FGM/C on their daughters

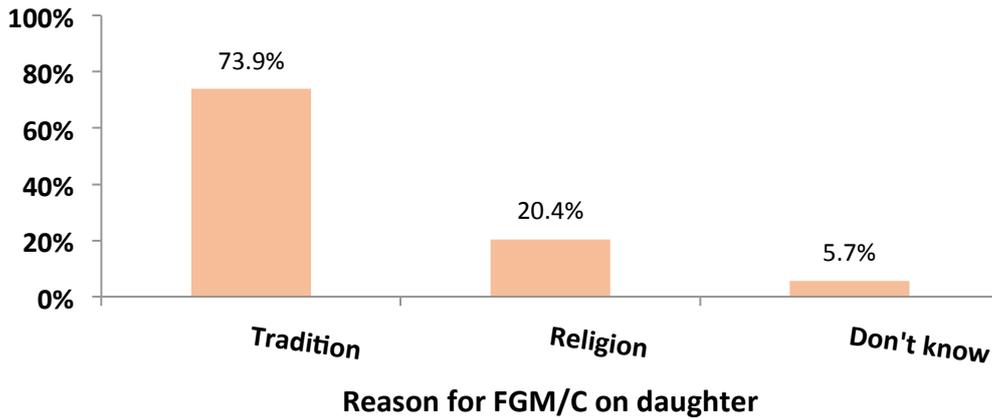
When questioned about why they would perform FGM/C on their daughters, 4,612 out of 6,172 women responded. 3,288 (71.3%) reported they would do it for reasons of tradition, and 1,305 (28.3%) for religious reasons. 25.3% (1,560) of survey participants did not respond.



NB: Distribution does not reflect the number of individuals who did not respond (n=1,560)

Findings in the previous study:

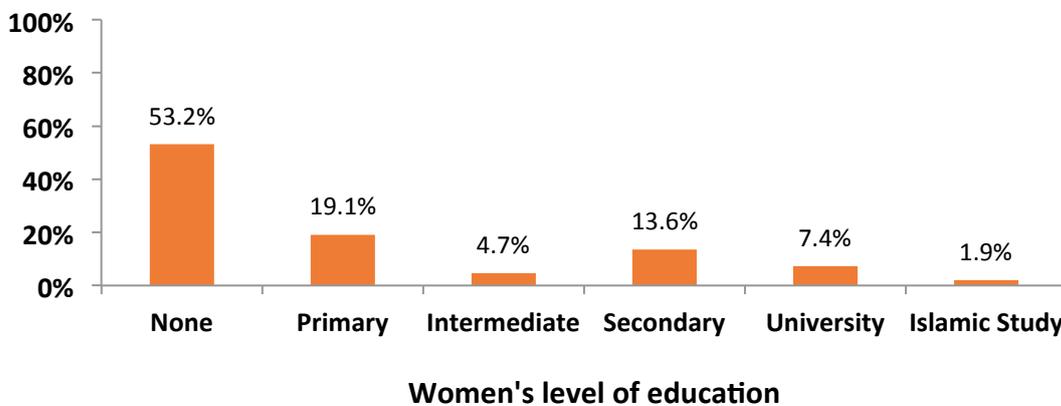
In both studies, a similar proportion of women stated that tradition would be the chief motive for carrying out FGM/C on their daughters (first survey: 71.3%, second survey: 73.9%). In the first survey, 20.4% of women said they would perform FGM/C on their daughters for religious reasons compared with 28.3% in the second. Among the second cohort of women, health was also stated as a reason for putting their daughters through FGM. However, the difference in sample size must also be taken into account.



NB: Distribution does not reflect the number of individuals who did not respond (n=3,561)

12. Women’s level of education

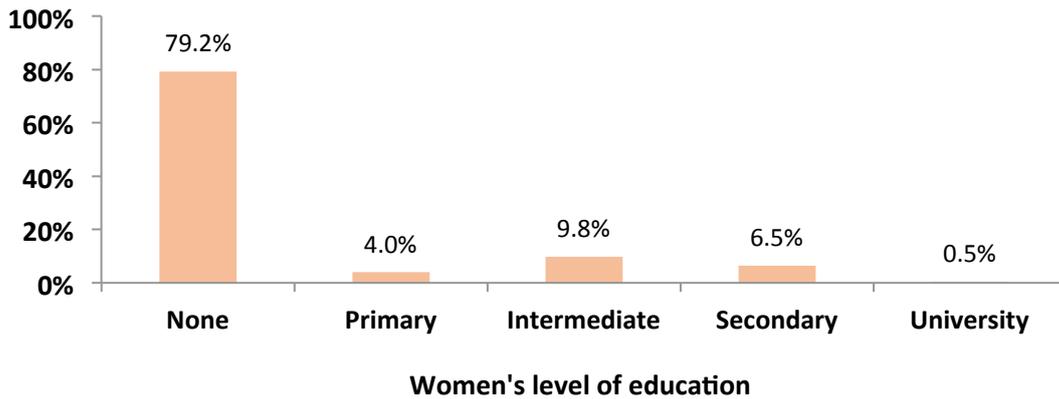
Out of the 5,775 women who responded, approximately half, 53.2% (3,072) had not received any education; 19.1% had had primary level schooling; 4.7% intermediate level education; 13.6% secondary education; 7.4% had received university level education; and 1.9% reported having attended an Islamic school.



NB: Distribution does not reflect the number of individuals who did not respond (n=397)

Findings in the previous study

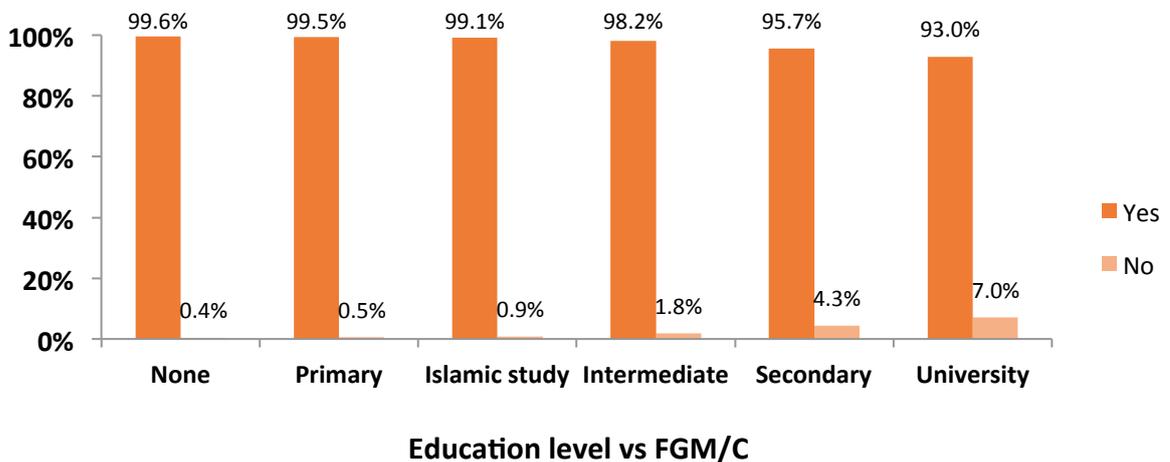
The second cohort of survey participants are better educated with 53.2% of respondents not having received any education compared with the 79.2% in the previous study. Also, a greater number reported having had a university education in the second group (7.4%) than the first group, among whom less than 1% had attended university.



N.B. Distribution does not reflect the number of individuals who did not respond (n=1)

13. Women’s level of education compared with whether they underwent FGM/C

Analysis of women’s level of education in relation to whether they had undergone FGM/C reveals a trend toward women with higher levels of education being less likely to be subjected to FGM/C. This may indicate that one or both parents had received some form of education. The highest proportion of women who had not undergone FGM/C was among groups who had had secondary level (4.3%) and university level education (7%).

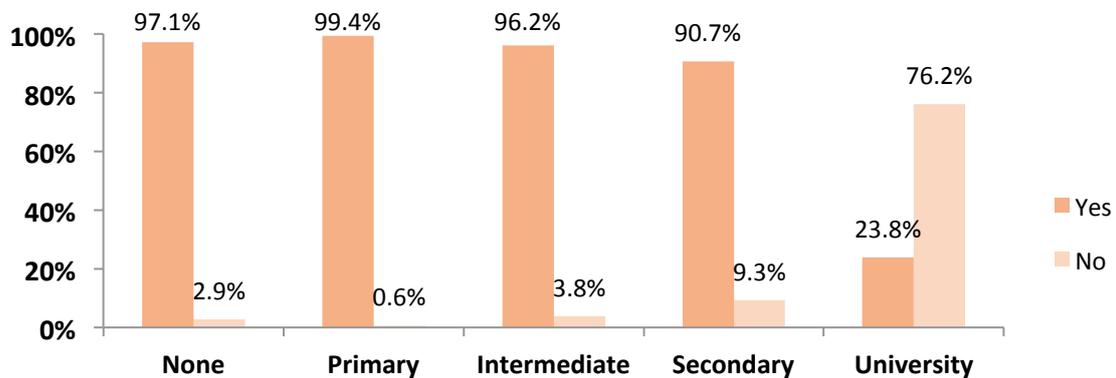


NB: Distribution does not reflect the number of individuals who did not respond (n=397)

Findings in the previous study

In both studies, women with a higher level of education were associated with lower levels of FGM/C. Among the second cohort, of the 53.2% of women who had not received an education only 0.4% had not undergone FGM/C, compared with 7% of those who attended university. In the first survey this difference was more

pronounced, as, of the 79.2% who had not received an education, 2.9% had not had FGM/C, compared with 76.2% of those who had attended university.

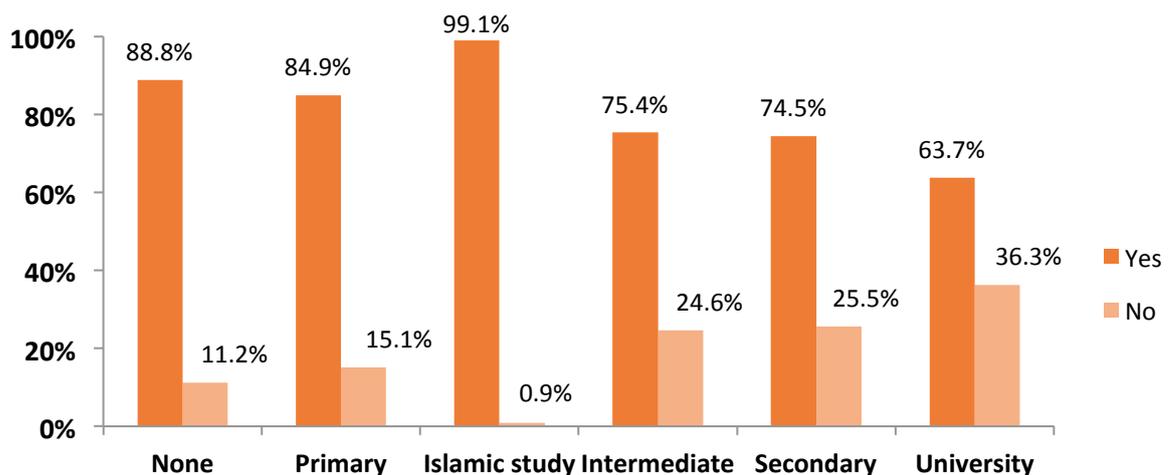


Education level vs FGM/C

N.B. Distribution does not reflect individuals who did not respond (n=1)

14. How the decision to perform FGM/C on daughters varies with women’s education

The graph below compares women’s level of education with their decision to carry out FGM/C on their daughters. Of the 53.2% of women who had received no education, 11.2% said they would not perform FGM/C on their daughters. It is striking that among the 13.6% who had had secondary level schooling, this proportion grew to 25.5%, and then 36.3% among the 7.4% who had attended university.



Education level vs FGM/C on daughter

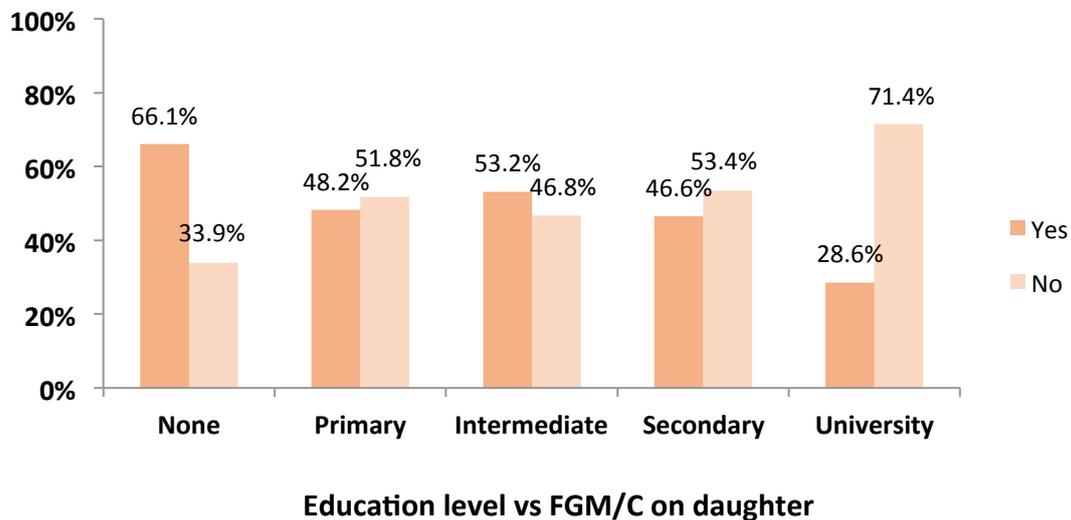
NB: Distribution does not reflect the number of individuals who did not respond (n=432)



Girl in Hargeisa refugee camp

Findings in the previous study:

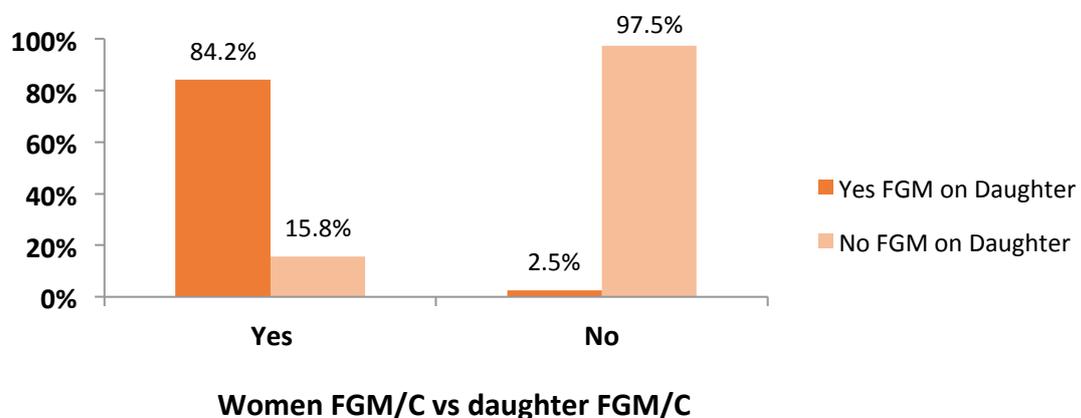
The findings of both surveys suggest that as women's levels of education go up, the tendency to carry out FGM/C on their daughters goes down. The trend appears more pronounced among the first cohort of women, but more consistent among the second.



N.B. Distribution does not reflect the number of individuals who did not respond (n=1,258)

15. How the decision to perform FGM/C on their daughters differs between women with and without FGM/C

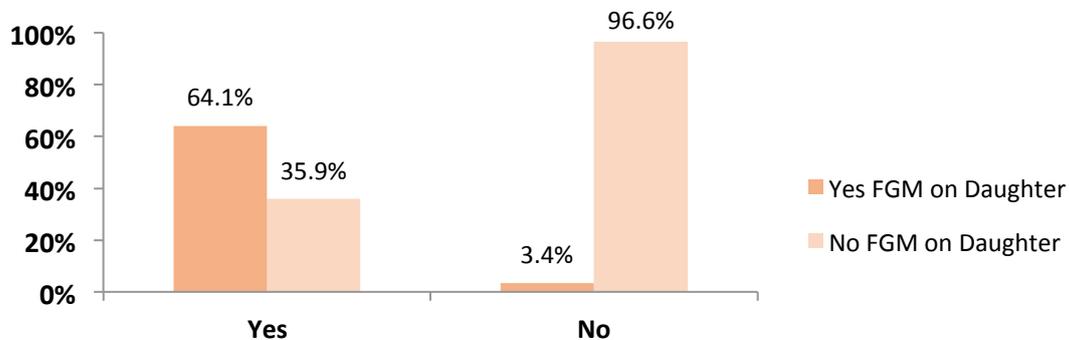
The response of survey participants on whether they would perform FGM/C on their daughters was compared with whether they themselves had undergone FGM/C. Of the 98.4% who had undergone FGM/C, 84.2% said they would perform FGM/C on their own daughters. By contrast, this proportion was reduced to 2.5% among women who had not had FGM/C.



N.B. Distribution does not reflect the number of individuals who did not respond (n=106)

Findings in the previous study:

The findings in both studies are consistent in that a higher proportion of women who had themselves undergone FGM/C expressed an intention to put their daughters through it. The vast majority of those who have not undergone FGM/C do not intend to subject their daughters to it.

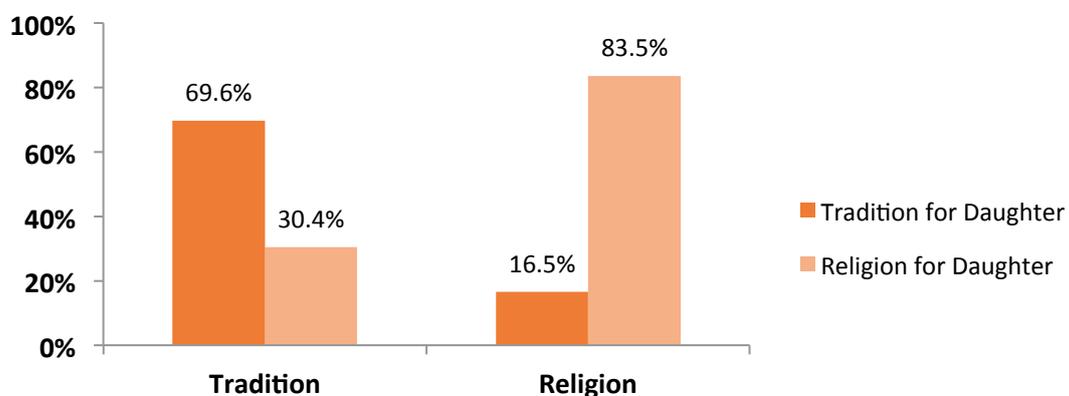


Women FGM/C vs daughter FGM/C

N.B. Distribution does not reflect the number of individuals who did not respond (n=1,258)

16. How the reasons given for women's own FGM/C varies with the reasons given for performing FGM/C on their daughters

The table below compares data on why survey participants thought they had undergone FGM/C with the reasons why they intend to perform FGM/C on their own daughters. The findings show some correlation between the two data sets as the majority of those who perceived that they were subjected to FGM/C for reasons of tradition or religion intend to put their own daughters through it for the same reasons.

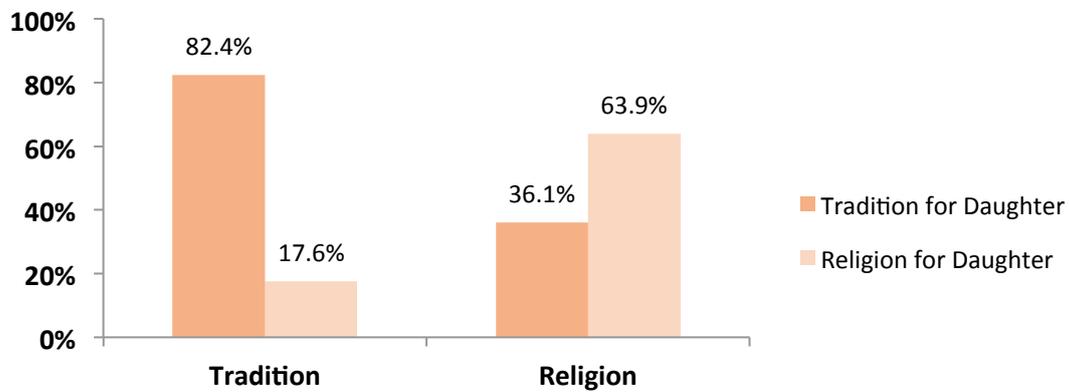


Reason for own FGM vs reason for daughter

NB: Distribution does not reflect individuals who did not respond (n=2,064)

Findings in the previous study:

Similarly, the first study indicated that the majority of women who thought they had undergone FGM/C for reasons of religion or tradition intend to perform FGM/C on their own daughters for the same reasons.



Reason for own FGM vs reason for daughter

N.B. Distribution does not reflect individuals who did not respond (n=3,825)

Recommendations

1. MEN MUST JOIN THE MOVEMENT

For too long FGM/C has been approached as a women's only issue when in fact it concerns the whole community. It is time for men to be brought into the picture, to step up, and speak out to protect their sisters and daughters from what is a violation of human rights.

EDUCATE: Men need to understand that male and female circumcision cannot be equated, as, unlike male circumcision when only the prepuce is removed, FGM/C entails the amputation of the clitoris and adjacent tissue which causes more severe consequences for a girl's health and wellbeing. Moreover, FGM/C can damage a woman's reproductive powers and cause major complications during childbirth, endangering both her life and that of her unborn child.

DE-STIGMATISE: As FGM/C is carried out chiefly to increase a girl's marriageability, the stigma of not undergoing the procedure could best be eliminated if men did not consider it a criterion for a suitable marriage mate. The trauma that FGM/C can create from a sexual relations perspective often negatively impacts upon a marriage. If more men were aware of this and the damage that the practice causes to a woman's health, both physical and psychological, perhaps the stigma could be reversed.

VIRGINITY: Men need to be convinced that it is the proper upbringing of girls that protects their virginity not the FGM/C that has been inflicted upon them.

2. ENGAGE THE YOUTH

If the cycle is to be broken among the next generation then campaigners need to focus their efforts on the youth, the parents of tomorrow. Both girls and boys need to be reached with the message that FGM/C is wrong on every level and must be abolished for the benefit of all. Mobile phone technology and social media channels need to be harnessed to communicate this message in a way that resonates with young people and enables them to share their views and experiences. The outreach work of SOFHA piloted in Hargeisa should be expanded to a national schools programme directed towards both teachers and pupils just as all who enrol at the Edna Adan University are taught about FGM/C.

GIRLS AND YOUNG WOMEN: Need to be approached directly to inform them of their condition and the choices before them. A frank and honest dialogue with this group at an early age can influence decisions regarding their own daughters in future years. The building of peer support networks can help raise awareness of the issues and mobilize youths towards the total abandonment of the practice.

TEACHERS: Educators play a critical role in shaping the development of young minds. Engaging them in the campaign and encouraging them to use their influence will

help reverse the social conditioning that has for too long allowed FGM/C to be carried out universally to the detriment of women and society as a whole.

3. RELIGIOUS LEADERS ARE KEY

More than any other group, religious leaders are looked up to and trusted for guidance and direction. They are therefore key agents of change. If they denounce FGM/C as a practice which compromises the sanctity of the body and is prohibited by Islam, this will go a long way towards convincing the general public of the need to abandon the practice.

UNDERSTAND: Existing scholarship on the illegality of FGM/C must be brought to the attention of the religious leaders. If they are sent to religious centres in Islamic countries for training they may learn from the experiences of communities which have abandoned the practice.

SUPPORT: Other initiatives designed to sensitize religious leaders have found that once this group understands the issue and the severity of the problem, they invariably become strong supporters of the movement to eradicate FGM/C.

ADVOCATE: Once religious leaders are on board their stance must be made public through weekly sermons in Mosques, on television, in radio broadcasts, and in religious schools and madrasas. Educational tools such as videos and other materials need to be developed and circulated in all areas of the country.

4. SENSITISE FRONT-LINE HEALTH PROFESSIONALS

FGM/C education needs to be included in the curriculum of all training programmes for health professionals. Sensitising front-line health workers through seminars and workshops will increase the number of persons in the field actively working against FGM/C.

ONE VOICE: FGM/C training must be uniform to increase impact and avoid mixed messages. Partners working against FGM/C need to coordinate training curricula to ensure a consistent and cohesive approach.

TOOLS: Training needs to include educational tools that health professionals can use to counsel, and, if possible, intervene in FGM/C. Such tools might include booklets, pamphlets, videos, and DVDs in the local languages of the targeted communities.

DATA: Informed and equipped health professionals can help collect data about the status of FGM/C in Somaliland as well as documenting approaches which are having an impact in specific communities.

5. TAKE THE ARGUMENT TO THE VILLAGES

Too often, the case against FGM/C is being communicated in conference halls and through international media outlets and channels that never reach the affected communities. For the campaign to be effective the message needs to be tailored to and targeted at local community level.

PARENTS (and especially mothers): As the primary decision makers on FGM/C, parents are the most important group to persuade. Contact needs to be consistent and continuous if progress is to be made.

BUSINESS PEOPLE AND PROFESSIONALS: As authority figures within the community, they generally have a higher level of education and concern for health and welfare. Educating them about FGM/C can affect the decisions they make in their own families and the advice they dispense in circles of influence.

DIASPORA: As FGM/C is less prevalent in diaspora communities, it would be wise to form networks of people who have abandoned the practice and are willing to share their reasoning with clan groups in Somaliland. In this way decision-makers and stakeholders would be exposed to the idea that women in Islamic and Somali communities overseas are valued without FGM/C.

6. USE MEDIA TO AMPLIFY THE MESSAGE

The campaign against FGM/C cannot be a sporadic or one-off annual event. This is a serious human rights and health violation issue that affects all women and girls in Somaliland. The message must have a strong and permanent presence through the use of billboards, print publications, traditional, and digital media. Mobile phone technology, the radio, television, websites, and social media should all be harnessed to reach out to communities as a whole. The contents of these materials should be executed sensitively and in a user-friendly way. Moreover, organisations working in the field must cooperate to ensure a more cohesive approach.

7. CHANGE THE DISCOURSE

While FGM/C is no longer a taboo subject, a donor-driven discourse is in danger of alienating the very communities it is directed towards. Increasingly, even the term FGM/C is associated with a western ideology, which, in itself, provokes resistance. Campaigners need to choose their language and arguments carefully. By using local terminology and reasoning appropriate to the context in which they are working, the message is more likely to be accepted.

8. RESEARCH

More research needs to be carried out on the subject of FGM/C in the Somali regions. Although these surveys furnish data on the prevalence, there remains a dearth of information regarding the practice. Possible research questions for future studies include:

- Of those who choose to subject their daughters to Type III FGM/C, why do they opt for the most severe type?
- Why do others choose a less invasive type?
- Can the reasons for choosing one type over another be used to influence families to opt for a less invasive procedure or to abandon the practice altogether?
- What about those who choose not to subject their daughters to FGM/C? How did they come to that decision? What challenges have they encountered?
- Is there a correlation between education and FGM/C, or parental income and FGM/C?
- Most Somalis have family members living abroad with whom they maintain strong ties. What is the attitude of Somalis in the diaspora towards FGM/C? Do they have any influence over their families in the homeland regarding FGM/C? Can these connections be harnessed to good effect?
- What ideas about women's sexuality are inherent in the practice of FGM/C? Are these notions discussed openly or concealed?
- What is the relationship between age and attitude to FGM/C? How do youths, male and female, feel about it? Can intensive education campaigns aimed at this group help to abolish the practice?
- What about health professionals? They are expected to be partners in the campaign to eradicate FGM/C but what are their personal views on the subject? Is FGM/C practised within their own families?
- What is the relationship between religion and FGM/C? Could a campaign focused on the religious position be more effective than one that stresses health complications or human rights violations?

9. MONITOR AND EVALUATE

To take full advantage of the collective effort and resources being invested in the campaign, the outcomes of different approaches must be carefully monitored, documented, measured, and evaluated to establish what is working and what is not. This can only be achieved through more cooperation between the organisations spearheading the work. Moving forwards, the government, religious leaders, health practitioners, and all other stakeholders must take a more aggressive approach.

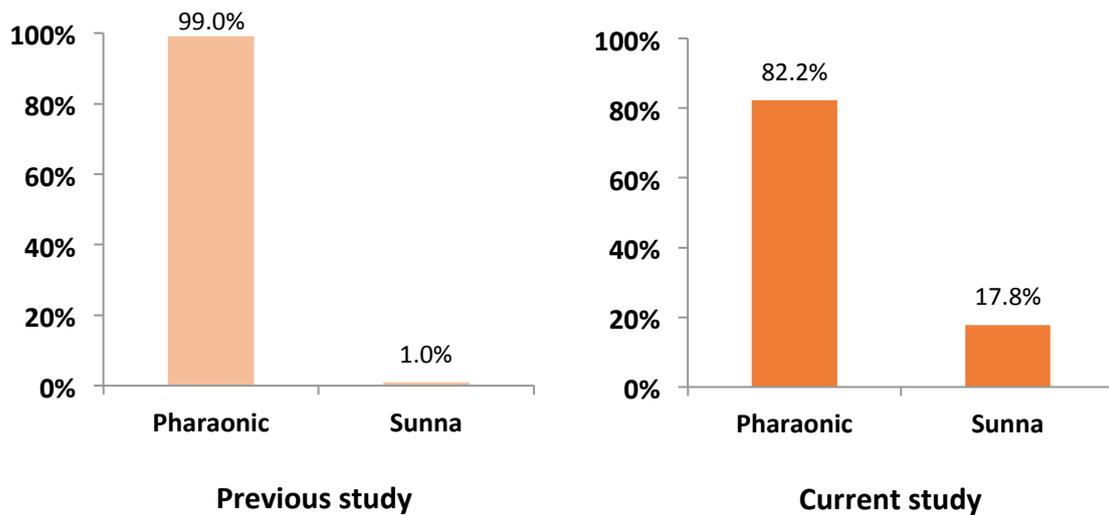
The recommendations outlined above show the need for a wide ranging, and all-encompassing approach in the fight to eradicate FGM/C. As the practice is so pervasive, all groups in society must be targeted simultaneously and continuously. No stone must be left unturned, nor any time wasted, if we are to see the end of this pernicious practice.



Girl in Haud region

Conclusion

After 14 years of educating the community about the harmful effects of FGM/C the progress made has been disappointingly slow. The only noteworthy change is the shift in the proportion of women undergoing Type III FGM/C to Type I. However, the practice remains as ubiquitous as ever.



Despite all efforts to inform the public that FGM/C goes against the tenets of Islam, the findings indicate that religion remains a key motive for subjecting girls to the practice. However, these data also suggest an inverse correlation between education and the propensity to carry out FGM/C, whereby the higher the level of a woman's education, the less inclined she is to have her daughter cut. Most encouragingly, women who have not had FGM/C are the least likely to put their own daughters through it. Thus, it is clear that once the cycle is broken, it is broken forever.

There is a definite need to improve, accelerate, and expand the campaign against FGM/C if we are to see more tangible results in the near future. Fathers and grandfathers as well as male religious and political leaders must join forces. There needs to be stronger participation and leadership shown by the many thousands in the diaspora. Resources must also be secured in order to accelerate the campaign among the nomadic populations and those living outside the major cities.



EDNA ADAN UNIVERSITY HOSPITAL
www.ednahospital.org