

Empowering communities to collectively abandon FGM/C in Somaliland

Baseline Research Report



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Cover image by Katy Newell-Jones: Data collection in Somaliland

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ABBREVIATIONS

AAIS	ActionAid International Somaliland
ACPO	Association of Chief Police Officers
Alla Amin	Alla Amin Women Organisation
CCBRS	Comprehensive Community Based Rehabilitation in Somaliland
CPS	Community Perspectives Study
CSO	Civil Society Organisation
DHS	Demographics and Health Surveys
DRR	Disaster Risk Reduction
EAUH	Edna Adan University Hospital
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation / Cutting
HAVOYOCO	Hargeisa Voluntary Youth Committee
Horumar	Horumar - News and information service about Somalia
IDP	Internally Displaced Person
INGO	International non-governmental organisation
MCH	Mother and Child Health
MEL	Monitoring, evaluation and learning
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
Mol	Ministry of Interior
MoJ	Ministry of Justice
MoLSA	Ministry of Labour and Social Affairs
MoP	Ministry of Planning
MoRA	Ministry of Religious Affairs
MoY	Ministry of Youth
NAFIS	Network Against FGM/C in Somaliland
Nagaad	Nagaad Network
NGO	Non-governmental organisation
NRC	Norwegian Refugee Council
ODK	Open Data Kit
SAVE	Save the Children
SDG	Sustainable Development Goals
SFHA	Somaliland Family Health Association
SOWDA	Somaliland Women Development Association
SRHS	Sexual and Reproductive Health Services
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
VAWG	Violence against women and girls
WAAPO	Women Action for Advocacy & Progress Organization
WASH	Water Sanitation and Health
WHO	World Health Organisation
ZT	Zero Tolerance

EXECUTIVE SUMMARY

This research informs the baseline of a 4-year project (2015-2018), *Empowering communities to collectively abandon FGM/C in Somaliland*, implemented by ActionAid International Somaliland (AAIS) in partnership with Women Action for Advocacy & Progress Organization (WAAPO) and Somaliland Women Development Association (SOWDA).

The research took place in 25 communities in two regions of Somaliland, Maroodi Jeex and Togdheer. A participatory, holistic approach was adopted involving 2,132 women, men, boys, girls, religious leaders, health workers, teachers, law enforcers, community leaders, parliamentarians, civil society organisations, national and international agencies. Participants were consulted through a community survey, using mobile data devices, focus group discussions and key informant interviews. This approach is in line with a social norms-based approach which recognises the impact of different stakeholders in decision-making at the individual, household and community levels.

This research distinguishes between three types of female genital cut commonly used in Somaliland (table 4A); the pharaonic (WHO FGM type III), the intermediate or sunna 2 (type II) and the sunna (type I). The use of terminology around female genital cutting is fluid with many considering the terms FGM and FGM/C relate only to the pharaonic cut.

The research shows that overall prevalence rate among community women in Maroodi Jeex and Togdheer remains high at 99.4%, with 80% having undergone the pharaonic cut. There is evidence of a change away from the pharaonic cut to the intermediate and sunna cuts, with only 34% of girls aged 12-14 years having 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 and many religious leaders and some community leaders calling for midwives and nurses to be trained to perform the cut safely and hygienically.

There are significant differences between urban and rural communities, with changes taking place at a faster rate in urban communities. This includes trends towards abandonment as well as increases in medicalisation.

The principle reason for cutting to continue is that it is a deeply embedded cultural practice, closely linked to proof of virginity for marriage (types II and III) and Islamic law (type I). Most religious leaders oppose the intermediate and pharaonic cuts as harmful, non-Islamic practices but support the sunna cut as honourable under Islamic law.

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

Communication about female genital cutting at household and community levels is low, with just 22% of community members having spoken to others about FGM/C in the last year. Only 16% of community members said that FGM/C had been raised in public meetings. Less than half of religious leaders have participated in private discussions (47%) or spoken in public meetings (45%) on FGM/C. The majority (93%) of community leaders in urban communities have spoken publicly about FGM/C, compared to just 31% from rural communities. Other opinion formers are less actively engaged with 59% of health workers, 38% of teachers and 22% of law enforcers having spoken in public meetings on FGM/C. Only a third of teachers have spoken about female cutting in schools, despite schools in other countries where considerable progress has been made towards abandonment of FGM/C providing important places for young people to learn and talk about the issues around female cutting.

Decision-making in relation to female cutting is primarily the responsibility of women, with women facing difficult decisions, wanting their daughters to be socially acceptable and able to marry, yet also wanting them not to suffer the kinds of health complications experienced by themselves and other women in their community. Whilst men and boys are only involved in the decision-making process in 8% of households, they are influential in creating the social climate within which decision-making about cutting takes place. Overall, only 4% of unmarried men would prefer to marry a girl who has not been cut and only 2% of men would prefer their sons to marry an uncut girl. Where cutting is required as proof of virginity this favours the intermediate or pharaonic cuts which include partial or complete closure of the vaginal orifice with stitching. Boys and men also showed concern about the harmful health impact of cutting and focus group discussions provided a forum for them to explore the decision-making dilemmas associated with FGM/C.

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

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

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

1. INTRODUCTION

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

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

The specific project outcomes are:

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

The project takes a multi-pronged approach to addressing FGM/C.

The project's *theory of change* asserts that if communities are more informed about FGM/C and have space to discuss the associated social, health and religious implications, and if there is an enabling environment for change which includes public support from religious leaders and policies enshrined in law that prohibit the practice, then this will lead them to collectively choose to abandon it. This shift will be more sustainable if led by a coordinated movement of national CSOs. Recognising that social changes of this kind take time, the project will bring about fundamental attitudinal changes which will lay the foundation for behaviour change over the longer term.

Structure of this report

The following sections of this report describe the overall aims of the research (section 2), the context in which it takes place (section 3, including the background literature review), the terminology used (section 4) and the methodological approach to the research (section 5). Section 6 presents a summary of the data collected.

Section 7 of the report presents the key findings, structured around the different stakeholder groups involved: communities (women and girls, men and boys); opinion formers (religious leaders, community leaders etc.). It also covers the policies and laws relating to FGM/C in Somaliland.

Section 8 provides a detailed analysis of the findings according to key themes that emerged through the research. Section 9 provides further analysis in terms of the implications of the findings for the project's implementation and its monitoring, evaluation and learning. Section 10 concludes the research report, summarising the issues that have emerged through the research.

2. RESEARCH AIMS

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

It was agreed to focus on robust quantitative and qualitative data collection in communities in the two target regions of Maroodi Jeex and Togdheer, where the project *Empowering communities to collectively abandon FGM/C in Somaliland* is being implemented by AAIS.

This would provide (a) current data on prevalence rates which can contribute to the dialogue around national advocacy initiatives and (b) sound data against which progress can be monitored against the specific project outcomes and indicators of the AAIS project.

2.1 Baseline research objectives

1. Provide detailed contextual information / situational analysis on attitudes, knowledge and behaviours of communities and stakeholders in Somaliland relating to FGM/C to help refine the project theory of change, activities and objectives
2. Gather data from a representative sample of women and men on FGM/C 'prevalence rates' from at least 25 communities in 2 regions, to inform national advocacy initiatives
3. Gather relevant baseline data for key project indicators to enable changes in beneficiaries' lives to be measured over the course of the project and in relation to a control group
4. Provide training to project staff and enumerators on data collection and research ethics
5. Develop recommendations for the on-going project monitoring, learning and final impact assessment.

3. THE CONTEXT OF FGM/C IN SOMALILAND

3.1. Review of published data on FGM/C (2006-2016)

Current data on FGM/C in Somaliland comes from four primary sources; the *Multiple Indicator Cluster Surveys* (MICS) carried out in 2006¹ and 2011², the *Female Genital Mutilation Surveys in Somaliland* carried out at the Edna Adan University Hospital (EAUH) in Hargeisa, Somaliland, carried out from 2002-2006 (first survey³) and 2006-2013 (second survey, *forthcoming*), a *Community Perspectives Study* (CPS) carried out by Crawford and Ali in 2015⁴ which provide an indicative snapshot on community perspectives on FGM/C, and the *Assessment of prevalence, perception and attitude of FGM in Somaliland* (2014)⁵ carried out by the Network Against FGM/C in Somaliland (NAFIS).

The MICS 2006 and 2011 interviewed girls and women, aged 15-49 years. Data was gathered of (a) their knowledge, experience and opinions (b) their own experience of being cut/uncut and (c) their daughters' experiences of being cut/uncut. Prevalence was assessed by self-reporting with the questions distinguishing clearly between the different types of cut, asking specifically whether they were sewn closed. The structure of the questions was instructive when devising the questions for this research. The latter of the MICS indicated that 99.1% of girls and women are cut in Somalia, with 84% of these undergoing the pharaonic cut. There was evidence of a possible change in the support for FGM/C with 65% of women and girls supporting the continuation of cutting in MICS 2006, but 69% thinking it should not continue in MICS 2011.

The EAUH surveys (2002-2006 and 2006-2013) are an on-going activity carried out by the Edna Adan University Hospital which involves collecting data from all girls and women attending the antenatal and maternity departments of the hospital. Assessment of whether girls and women have been cut takes place as part of the standard assessment process and is recorded by the health workers caring for the girl or woman. Patients are also asked about their age when they were cut, who performed the cut, where, and their intentions in relation to cutting any daughters they might have in the future. The way that EAUH has embedded their surveys into the standard practice of the hospital means that the data base is constantly being updated, providing a valuable source of information on practices and trends in relation to FGM/C in Somaliland. The first EAUH survey indicated that 97% of girls and women had undergone FGM/C with 99% of these having undergone the pharaonic types of cut (WHO FGM type III). The average age of being cut was 8 years, with 84% being performed by traditional cutters or Traditional Birth Attendants (TBAs). 62% of girls and women interviewed said that they would have their own daughters cut, with 92% saying this would be using the sunna cut only. The second EAUH survey (2006-2013) found that 98% of girls and women have been cut with 82% having undergone the pharaonic cut (WHO type III). This suggests there has been no change in the overall prevalence rate, although there has been a shift in the type of cut away from the pharaonic towards the sunna in the last 10 years in Somaliland.

The Community Perspectives Study (CPS) carried out by Crawford and Ali in 2015, supported by UNFPA and UNICEF was an in-depth study carried out across Somaliland, Puntland and South Central Somalia, with the intention of *gaining a greater understanding of existing interventions towards FGM/C, and to identify gaps....to strengthen the current interventions and inform future programming*. The research took a participatory, girl and women-centred approach, consulting with 93 people at institutional levels and 215 community members, both women and men. This study provides valuable

1 www.childinfo.org/files/MICS3_Somalia_FinalReport_2006_eng.pdf

2 www.unicef.org/somalia/SOM_resources_somalilandmics4_finalreport.pdf

3 <http://ednahospitalfoundation.org/wp-content/uploads/2014/10/female-genital-mutilation.pdf>

4 Crawford S and Ali S (2015) *Situational Analysis of FGM/C stakeholders and interventions in Somalia* UNFPA-UNICEF

5 NAFIS Network (2015) *Assessment of prevalence, perception and attitude of female genital mutilation*.

insights into the multiple interpretations of terms like Zero Tolerance, FGM, sunna and cutting as well as evidence of medicalisation and the need for further research into the role of men and boys in relation to FGM/C.

The assessment of prevalence, perception and attitudes of FGM in Somaliland (2014) carried out by NAFIS used a descriptive cross-sectional survey approach, supported by focus group discussions and key informant interviews and took place across all six regions of Somaliland, interviewing 1986 women. The prevalence rate of FGM/C was found to be 99.8% with 82.3% undergoing the pharaonic cut. The average age of cutting was 8 years. 99.5% of the cutting was performed by traditional circumcisers in rural areas with 95.7% in urban areas, the remainder being done by health workers. This study highlights the lack of consistency in the use of terms relating to female genital cutting. It includes focus group discussions with men and religious leaders. The report records that most religious leaders are in favour of girls undergoing the sunna cut. It also documents the strong preferences of most men for their sons to marry cut girls, indicating that an uncut girl would be 'haram', unclean, and marriage with such a girl would not be possible. The NAFIS report also investigated the decision-making process around female cutting, reporting that women, particularly mothers, are the principle decision makers with the fathers being involved in less than 20% of the households and taking responsibility for the decision less than 2% of the time.

The Landinfo report on female genital mutilation on Sudan and Somalia (2008)⁶ discusses the role of FGM/C in women's lives and concludes that

'Although women are accountable for upholding the practice, men carry a great responsibility. In societies where socioeconomic security is provided for women primarily through the institution of marriage, the requirement that women must be virgins to be considered eligible for marriage contributes to a continuation of the practice of FGM.' Landinfo (2008)

To date the Demographics and Health Surveys (DHS) have not included data on FGM/C in Somalia or Somaliland.

Respondent groups

The MICS surveys (2006 & 2011) for Somalia and the EAUH surveys for Somaliland are alike in having spoken only to 'adult' women above 15 years old. The EAUH surveys interviewed women presenting at the maternity hospital in Hargeisa who come from throughout Somaliland, while the women surveyed in MICS came from across Somalia.

Unlike various comparable DHS surveys in other practising countries, men surveyed in the MICS (2006 & 2011) in Somalia were not asked about their knowledge and attitude towards FGM/C or their expectations for its continuation. Anecdotally it is known that Somali men have strong opinions about FGM/C, and this baseline survey represents an opportunity to gain some robust data about the attitudes of men in Maroodi Jeex and Togdheer.

While there is 'daughter data' based upon questions asked to mothers in the MICS (2006 & 2011) data, there is no existing data direct from girls themselves, about their FGM/C status and attitudes, or from boys about their knowledge and beliefs.

Other key community stakeholders have also not been surveyed, specifically: religious leaders, health workers, teachers and law enforcers. These groups are especially relevant because religion is one of the three main reasons given for cutting in Somaliland, medicalisation of the practice is also reported to be increasing, in other contexts teachers are vital in providing a forum for young people to discuss FGM/C in a safe environment, and the introduction/strengthening of legal structures is widely viewed as a crucial stage in the abandonment of FGM/C.

⁶ http://www.landinfo.no/asset/764/1/764_1.pdf

Prevalence and type of 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 bore signs of FGM/C, 82.2% of whom had experienced WHO type III.

MICS 2006 and 2011 also asked questions about daughters and FGM/C. In 2006, 46% of daughters had been cut, 60% of whom had experienced the WHO type III. MICS 2011 found that 28% of daughters had undergone FGM/C, 12% of whom had been sewn closed. This data could indicate a decrease in the proportion of girls being cut from 2006 to 2011. However, the figures cannot be compared with data for women aged 15- 49 as they do not represent the final FGM/C status for the daughters of women surveyed.

EAUH found in its first survey (2002-2006) that 62% of women interviewed said they would have their daughters cut. In the second survey (2006-2013) 81% of women interviewed intend to have their own daughters cut, with 75% of them choosing 'sunna'. These figures suggest that there is an increase in the proportion of girls and women undergoing sunna and a corresponding decrease in the incidence of type III. However, Crawford and Ali (2015) draw attention to the differences in understanding of what sunna actually means, saying,

'in all regions in Somalia, the term Sunnah circumcision, can refer to WHO Type I, Type II or Type III FGM/C. Sunnah is used in the communities to refer to any type of circumcision which people believe is required/sanctioned by Islam' Crawford and Ali (2015, p4)

The term 'sunna', therefore, may not always mean type I cutting (see section 4). Crawford and Ali's Community Perspectives Study also reported the emergence of a new, intermediate form of infibulation, involving less stitching than the traditional pharaonic cut. These differences in perceptions as to what is and is not FGM/C bring additional levels of uncertainty to interpreting data.

Reasons why FGM/C takes place

The EAUH surveys asked women why they thought they were cut and why they would cut their daughters. A significant proportion of the women (55% in the first survey, 20% in the second) did not know why they had been cut. This was followed by religious then traditional/cultural reasons. When it came to why they would cut their daughters, traditional/cultural reasons were cited most frequently, followed by religious reasons, then 'don't know'.

Continuation of FGM/C

MICS in 2006 found that 65% of women had supported the continuation of the practice, while MICS 2011 found that 69% of women believed the practice should be discontinued. This may reflect a genuine change in attitudes which influences decision-making and future surveys will show whether this apparent attitudinal shift is in fact reflected in declining prevalence rates.

3.2. Legal status of FGM/C in Somaliland

Somalia and Somaliland currently lack a legislative structure on FGM/C. This is recognised by the EAUH (2013) and identified by Crawford and Ali (2015) as a key stepping stone towards abandonment stating 'zero tolerance is government policy through the lead ministries in each of the zones, and in the health ministries. However, it is not well-understood, regulated or communicated' (p6).

The first move to introduce legislation on FGM/C in Somalia was in 2012 when a Provisional Constitutional decree was introduced stating that the circumcision of girls is prohibited⁷. However, the decree does not specify the penalty, the person who would be considered responsible or the process to secure a ruling when girls or women undergo FGM/C.

In 2014, the newly elected President of Puntland, a region of Somalia adjacent to Somaliland, was reported to have enacted a new law against FGM and a religious fatwa was reported to have been issued by Islamic Scholars stating FGM had no basis in Islam⁸. However, the status of these is unsure and the impact limited.

In Somaliland, AAIS continues to work with the Ministry of Labour and Social Affairs and the Ministry of Religious Affairs to prepare a draft of FGM/C policy to be presented to and endorsed by the cabinet. There is agreement between these Ministries on the proposed policy in relation to WHO FGM types II and III (see table 4A). However, there is no agreement on the sunna cut (WHO FGM type I). The Ministry of Religious Affairs currently supports the banning of all types of cut except the sunna cut, whereas the Ministry of Labour and Social Affairs are in favour Zero Tolerance, which would ban all types of female genital cutting, including the sunna cut.

3.3. Gaps in existing knowledge

Given the very high FGM/C prevalence rate in Somaliland overall, and the slow pace of change (UNICEF 2013⁹), the most significant gaps in existing knowledge and data are around people's understanding of cutting as a tradition and a social norm, i.e. why they cut, why they believe they are cut, what is expected of them, by whom and what they expect others in their 'reference group'¹⁰ to do.

MICS and EAUH surveys both show that women are *not* universally in favour of the continuation of FGM/C, yet almost all of them are cut themselves and many of them intend to cut their own daughters. This baseline research is an opportunity to attempt to better understand the drivers around continuation of FGM/C, to both inform programming and monitor its impact, in target and non-target communities.

Crawford and Ali (2015) interviewed some men about their attitudes, however, the numbers involved are relatively small and they identify the need for more research data from men and boys about their knowledge, attitudes and beliefs around FGM/C in Somaliland. In many other countries, where data is collected through the DHS, men (aged 15-49) are asked their opinion about the practice and its continuation. Given that FGM/C is identified as a pre-requisite for marriage, the attitudes and expectations of men and boys are an important factor in understanding the drivers in relation to the continuation of the practice.

Religion is often given as a reason for cutting in Somaliland. As elsewhere, although FGM/C is not mandated by Islam in the Qur'an, some religious leaders and scholars interpret a weak *hadith* as suggesting that FGM/C is 'sunnah'. There is therefore a need for this baseline to better understand the religious drivers around FGM/C in Somaliland, both by asking respondents about their understanding of FGM/C and religion, and by talking with religious leaders to understand their positions, which may diverge. To conform to religious expectations, some families choose the 'sunnah' form of cutting as opposed to the more extreme 'pharaonic', believing it to be a more religious and less damaging option.

7 ActionAid Multi-country paper (2014) / Guardian www.theguardian.com/global-development/2012/aug/17/female-genital-mutilation-banned-somalia

8 <https://horseedmedia.net/2014/03/11/puntland-bans-fgm/>

9 UNICEF *Female Genital Mutilation / Cutting: A statistical overview and exploration of the dynamics of change 2013*

10 'Reference group' are people that matter to an individual's choices. As defined in Alexander-Scott, M. Bell, E. and Holden, J. (2016) DFID *Guidance Note: Shifting Social Norms to Tackle Violence Against Women and Girls (VAWG)*. London: VAWG Helpdesk

According to the WHO¹¹, globally 17% of FGM/C is performed by health workers. In Somaliland, EAUH (2013) found that 4.3% of FGM/C was undertaken by medical professionals. It is suggested by Crawford and Ali (2015) that this proportion is set to rise partly as 'a conscious strategy to reduce the harm caused by FGM/C' and partly as a result of the 'economically better off / educated better' believing that medical FGM/C is less damaging. Shell-Duncan (2001)¹² explores this dilemma thoughtfully at both a policy and family level. This baseline research is an opportunity to explore the attitudes and perceptions of health workers in urban and rural communities as to their perception of their role in relation to FGM/C; whether they see themselves as potentially providing a 'safer service' to girls and women by adopting the role of cutters or if they support the abandonment of the practice in all its forms.

11 www.who.int/reproductivehealth/topics/fgm/zero-tolerance-day/en/

12 Shell-Duncan B (2001) The Medicalization of female 'circumcision': harm reduction or promotion of a dangerous practice? *Social Science & Medicine* p1013-1028

4. TERMINOLOGY

As indicated by Crawford and Ali (2015), the terminology used in relation to female genital cutting in Somaliland is complex.

With Somaliland being predominantly Sunni Muslim, from the Shafi'i school of thought, female genital cutting is considered by most to be subject to guidance, called a 'Hadith' (or 'Sunnah') under Sharia law. If a hadith is '*obligatory*' then under Islamic law community members should abide by it. If it is '*honourable*' it is preferred, if '*not required*' then religious leaders will advise against. The term sunna is used both in a generic sense to mean Islamic guidance and also is the name given to the process young girls go through. The sunna, as defined by religious clerics in Somaliland, usually, but not always, equates to WHO FGM type I (table 4A). In this research the term 'sunna cut' is used in recognition that even in its mildest form, blood is drawn from the girl's genital area.

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

This research project used self-reporting to collect data on the type of cut a girl or woman underwent and also explored expectations and intentions of men and women. The research team decided that it was important to distinguish between three types of cut (table 4A).

Table 4A: Classification of types of female genital cutting as used in AAIS research (linked to WHO classification)	
Sunna (no stitches) WHO type I	Partial or complete removal of the clitoris (clitoridectomy), requiring no stitching. Often described as removing the tip of the clitoris in Somaliland.
Sunna 2 / intermediate cut 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.
Pharaonic cut WHO type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and re-stitching the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation), requiring 4-7 stitches and resulting in only a very small vaginal orifice.

There are differences among clerics about the precise nature of Islamic guidance on female genital cutting. The majority view in Somaliland is that the pharaonic cut is considered non-Islamic and therefore, on the whole, not supported by religious leaders and defined as 'not required' under Islamic law. The sunna cut, however, is regarded within the Shafi'i school of thought as subject to guidance, with the predominant thinking that it is considered 'honourable' or preferred, rather than obligatory. (See section7.2.4.)

In recent years, the intermediate cut, which is not as severe as the pharaonic cut, has risen in popularity in Somaliland. It requires two or three stitches and partially closes the vaginal orifice. In order to sound more acceptable than the pharaonic cut, this intermediate form is being called 'sunna' or 'sunna 2'. However, it is not considered to be Islamic by most religious leaders.

'... the Pharaonic cut is nothing at all to do with Islam. You can tell by the name that it pre-dates Islam. The Pharaonic cut is culturally normal, practised by the society in Somaliland. Islam has always spoken out against the Pharaonic cut. It is about history and social attitudes.... The sunna type 2 has moved a bit from the Pharaonic but it is still not Islamic.'
Mohamed Ibrahim Jama, Head of Department of Islamic Propagation, Ministry of Religious Affairs (MoRA)

An additional complication arises as many in Somaliland see the terms FGM and FGM/C as relating only to the pharaonic cut, with the sunna not being perceived as a cut. Responses were only recorded as the sunna cut by enumerators when no stitching was involved. Statements such as 'we have stopped cutting' need careful unpicking as many, including community leaders, teachers, lawyers and health workers support anti-FGM campaigns at the same time as their daughters are undergoing the sunna cut.

5. RESEARCH APPROACH

5.1. Overall approach

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

- a) provide baseline data for key project indicators against which progress can be measured
- b) inform the project theory of change and activities
- c) provide data on prevalence and attitudes in relation to FGM/C which can contribute to the debate around national advocacy initiatives.

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

5.2. Methodology

Further detail on the methodology and the research tools are available in appendix B.

5.2.1. *Capacity building*

Capacity building workshops took place on ethical research for AAIS staff and their partners, Somaliland Women Development Association (SOWDA) and Women Action for Advocacy and Progress Organization (WAAPO). The workshops were participatory and provided opportunities for the project team to gain skills in random selection of participants, consent, coercion and confidentiality and sensitive interviewing of community members which are all relevant in facilitating community-based activities and data collection for monitoring, evaluation and learning (MEL) purposes throughout the project (appendix C).

5.2.2 *Data collection tools*

A mixed methodology was adopted to gather quantitative data on the prevalence of FGM/C and quantitative and qualitative data relating to the project outcomes and indicators. The latter feeds into the on-going project monitoring, learning and evaluation processes.

Three data collection approaches were used. A community survey was carried out in 25 communities using mobile data collection tools, supplemented by key informant interviews and focus group discussions at community and national levels. The former enabled data to be collected from a wide range of community members whereas the latter enabled participants to engage in conversations and to explore the knowledge, attitudes and behaviours of themselves, and others. This approach is in line with a social norms-based approach which recognises the impact of different stakeholders in decision-making at the individual, household and community level.

Survey questionnaires were developed for the different stakeholder groups using Open Data Kit (ODK) software. The questions began with background data (age, education etc.), then asked general questions about female genital cutting in their community: how widely it was practised, whether they talked to others about FGM/C, whether the community expected girls to be cut, what their intentions were, what kind of girl they would prefer their sons to marry, whether they would cut any daughters in the future. Women were invited to answer additional questions about whether or not they had been cut, when, by whom, with what complications. Finally, all were asked about their understanding of the legal

status of FGM/C in Somaliland, the Islamic guidance on the different types of cuts, whether they know of organisations working to reduce cutting, whether they were involved in these activities and how they would like to see female genital cutting taking place, or not, in their community in the future. Opinion formers were also asked how they saw their role in relation to FGM/C and what support or guidance, if any, they provided (appendix B) The questionnaires were available on mobile data devices (tablets). The enumerators were able to access the questions in both English and Somali. All interviews took place in Somali. The questionnaires used cascading questions, with consent sought frequently and participants able to stop the interview or miss out particular questions. The interviews took between 10 and 40 minutes, depending on the stakeholder group and the experience of the participant. Data from the questionnaires were uploaded daily from the tablets to the AAIS server.

Semi-structured questions were compiled for each of the opinion former groups to use for *key informant interviews and focus group discussions* (appendix B). Key informant interviews and focus group discussions were facilitated by the consultant during the community visits and in Hargeisa with representatives from the Ministries of Labour and Social Affairs (MoLSA), Health (MoH) and Religious Affairs (MoRA), UN agencies, NGOs, CSOs and other national opinion formers. The selection of participants for key informant interviews was purposive, including primarily people with well-developed views and/or expertise on FGM/C in Somaliland.

5.2.3. Selection processes

A combination of purposive and random selection procedures was used. Purposive selection was used at the higher levels (selection of regions and communities) to ensure inclusion of a balance of urban and rural, target and non-target communities, and to use time efficiently. However, the selection of individuals to interview used robust techniques of random selection to ensure that the experiences, attitudes and beliefs expressed are a random representation of those in each target group within each selected community.

Table 5.2.3A below indicates the areas where purposive selection has been used in the design of the baseline research and the rationale for each decision.

Purposive selection	Basis of the decision
Restricting data collection to the regions of Maroodi Jeex and Togdheer	To gain maximum output from the resources and focus the research on obtaining baseline data relating to the project outcomes and indicators.
The balance of selected communities between Maroodi Jeex and Togdheer (15:10)	To reflect the balance of AAIS project communities across the 2 regions, slightly favouring Togdheer as AAIS felt that less was known about the more rural communities in Togdheer. There was a deliberate focus on obtaining data from a 'maximum range' of communities (large and small, urban and rural, accessible and less accessible, with and without NGO activity).
The balance of urban and rural communities (8:17)	To reflect the general balance between urban and rural in the AAIS project communities.
The balance of project and non-project communities selected (17:8)	To gain sound data from project communities to inform the impact assessment, whilst also enabling comparisons with non-project communities to be

	made.
The target groups selected (women and girls, men and boys, community leaders, religious leaders, health workers, teachers, law enforcers, parliamentarians)	To obtain data on all key stakeholder groups, including both community members and opinion formers.
The selection of national representatives including MoRA, MoLSA etc.	Selected on the basis of their role as opinion formers and also to obtain a cross-section of views on FGM/C.

5.2.4. Research team (see appendix B)

The research team consisted of eight enumerators, four female and four male, supported by the AAIS project team, the consultant and representatives from SOWDA and WAAPO, AAIS partner organisations. All enumerators were young people (aged 25-40 years) from Somaliland, with excellent communication skills and a specific interest in FGM/C. Five were trainees in midwifery, nursing or public health at the EAUH, two were previous enumerators with AAIS and one was from the Ministry of Labour and Social Affairs. Workshops were provided prior to the data collection to explore the concept of ethical research and to take the enumerators through the process of identifying respondents, interviewing them, recording their responses, saving and uploading the data to the AAIS ODK aggregate site. The workshops included community visits to test the research tools. The de-briefing sessions were invaluable in discussing differences in understanding of the questions, how to record the responses and in refining the tools.

5.2.5. Target communities

The research took place in 25 selected communities in Maroodi Jeex and Togdheer which represent a range in terms of large and small, urban and rural, accessible and less accessible, with and without NGO activity (Table 5.2.3B). Surveyed communities included 17 of the 35 project communities (communities which are part of the AAIS FGM/C abandonment project) and eight non-project communities (communities where AAIS has been active, although not specifically on the abandonment of FGM/C). The non-project communities were selected to provide a comparison both at the baseline and later if they are to be included in impact assessment activities.

Region	Urban communities		Rural communities		Total
	Project	Non-project	Project	Non-project	
Maroodi Jeex	3	2	7	3	15
Togdheer	2	1	5	2	10
Total	5	3	12	5	25

5.2.6. Stakeholder groups and target sample size

In each of the 25 communities surveyed, data was collected from *community members*: women and men, girls and boys (aged 12 and above) and *key opinion formers*: religious leaders, community leaders, teachers, health workers, law enforcers.

In each of the 25 communities the target for the community survey was 65-80 interviews with community members plus 12 opinion formers, giving an overall target of 1925-2300 interviews.

Key informant interviews and focus group discussions were planned with parliamentarians, representatives from Ministry of Labour and Social Affairs (MoLSA), Ministry of Religious Affairs (MoRA), Ministry of Health (MoH), UN agencies, representatives from INGOs, NGOs and CSOs.

All data can be disaggregated by age, gender, education, urban/rural, project/non-project. Age categories were those used by UNICEF (0-7, 8-14, 15-24, 25-40, 41-59, over 60).

5.2.7 The process of data collection

Data collection took place throughout March 2016 coordinated by the AAIS project team under the guidance of the lead consultant. Logistical support was provided by AAIS, community mobilisation and background to the target communities was provided by AAIS and their partner organisations SOWDA and WAAPO.

All the target communities were known by AAIS or their partners SOWDA or WAAPO. Community mobilisation took place prior to the data collection, engaging with the community leaders, women's coalition, religious leaders and other key community members explaining the purpose of the community survey, explaining that AAIS do not remunerate respondents and identifying suitable locations for the focus group discussions to take place.

The target for each community was 25-30 women, 10 girls (12-14 years approximately half from school and half from the household survey), 20-30 men, 10 boys (12-14 years approximately half from school and half from the household survey), 2 religious leaders, 4 community leaders (2 male, 2 female), 2 health workers, 2 law enforcers.

Focus group discussions took place in six communities facilitated by the consultant with the support of translators using the semi-structured framework of questions. They lasted between 45-75 minutes and had between 6 and 15 participants from a single stakeholder group (women, young women, young men, men, religious leaders, community leaders), in order to encourage free dialogue.

5.3. Quality assurance

Quality assurance measures included:

- *ethical issues* relating to consent, child protection, coercion, using accessible language and avoiding complex terms, confidentiality and data storage, checking quotations used from key informant interviewees
- *data collection issues* including purposive and random participant selection, piloting and refining of the tools, consistent and rigorous recording, supervision and support of the enumerator team
- *data analysis issues* including secure storage, confidentiality, triangulation of findings across stakeholder groups, focus group discussion and key informant interviews.

5.4. Limitations and constraints of the research

Time / resources

The number and type of key informant interviews and focus group discussions was limited to the three-week period during which the consultant was in Somaliland.

FGM/C terminology

Terms like FGM, sunna and cut are used in different ways by different stakeholders. These confusions exist in Somali as well as in English. The enumerators had to carefully check what each participant

meant.

For example,

- When enumerators asked whether someone would prefer their sons to marry cut or uncut girls, if a participant said 'uncut' this almost always meant not cut using the pharaonic cut. It was rare for this to mean they wanted their cut to marry a girl who has not undergone the sunna.
- In an early focus group discussion, a group of women said they had 'stopped cutting', however, when questioned carefully, most had moved from the pharaonic 4 stitches cut to what was called the sunna 2 with 2 stitches.
- At the Ministry of Religious Affairs, religious leaders stated that they oppose all forms of cutting, however, they regarded the sunna as honourable and did not define it as 'cutting'.

Care was taken to clarify the use of terms as much as possible in Somali, using terms like 'sunna with 2 stitches' and 'not touching in any way, even the sunna'. However, it is likely that the proportion of people who were opposed to all forms of cutting, including the sunna, is slightly over-estimated.

Severe drought

Somaliland has been suffering from a severe drought which affected the rural communities in particular in Maroodi Jeex. Young men in drought affected areas tended to be out with the livestock or preparing the ground for planting as soon as the rains arrive, the young women were away seeking water for the household, and other men left these communities in search of employment in the urban areas to support their families until the rains arrive. Consultation took place and most communities were keen to be included. The enumerators visited some of the more rural communities at different times of the day to reach a cross-section of ages of community members. Two remote communities in Maroodi Jeex, where the drought was particularly severe, were too preoccupied with the stresses of survival to take part in the survey. They were replaced by communities which were less affected by the drought.

Remuneration for AAIS partners

The initial plans included only a small remuneration for SOWDA and WAAPO in their role of mobilising the communities and supporting the research team during the data collection. Their support was invaluable and adjustments were made to the budget to enable this to be recognised and remuneration increased.

Remuneration for participants

Focus group discussion participants in communities were recompensed for their time, however, community members participating in the interviews did so on a voluntary basis. Enumerators took particular care to be considerate and efficient and the lack of remuneration did not appear to be a reason for anyone declining to participate.

The composition of the community focus group discussions

Initially the aim was for the community focus group discussion participants to be a cross-section of the community, however, this was not possible as those inviting the participants tended to invite those who had a higher status in the community. Consequently, the focus group discussion largely comprised opinion formers in the community, in the form of members of youth groups, women's groups or village water or security committee members. The result was often that there were some highly engaging discussions with people prepared to disagree with and question each other.

Participants changing their opinions during focus group discussions

In over half of the focus group discussions participants changed their minds about FGM/C as they discussed the questions among themselves. For example, in the focus group discussion with young men in Stadium when the unmarried men were first asked whether they would prefer to marry a cut or uncut girl they all they all responded that they would only marry a cut girl. As the focus group

discussion progressed they were discussing the impact of cutting and gradually they began to change their minds and towards the end were equally strongly saying they would only marry an uncut girl as they did not want their wife to have such health complications. Similar changes in opinion took place in focus group discussions with other stakeholder groups including lawyers, community women, and community men. Although several focus group discussion participants had attended workshops on FGM/C, the focus group discussions were, for many, the first time that people had actually discussed what they felt about FGM/C, the advantages and disadvantages, and been allowed to come to their own conclusions about what they felt.

Enumerators perceived in Togdheer as coming from Hargeisa

Initially when the data collection began in Togdheer the number of community members declining to be interviewed was higher than in Maroodi Jeex, with comments made about the enumerators, who all came from the Maroodi Jeex region, being 'outsiders'. The enumerators reflected on this in the debriefing session and adjusted their approach with positive results for the rest of the data collection.

Availability of some participant groups

A focus group was planned with parliamentarians from the Committee for Social Affairs. Unfortunately, they were not available during the data collection period which resulted in only one parliamentarian, who was not a member of this committee, being interviewed.

The law enforcers interviewed in the communities were all male. Efforts were made to identify female police officers, however, none were available during the community visits. However, the lawyers interviewed were all female.

6. DATA COLLECTED

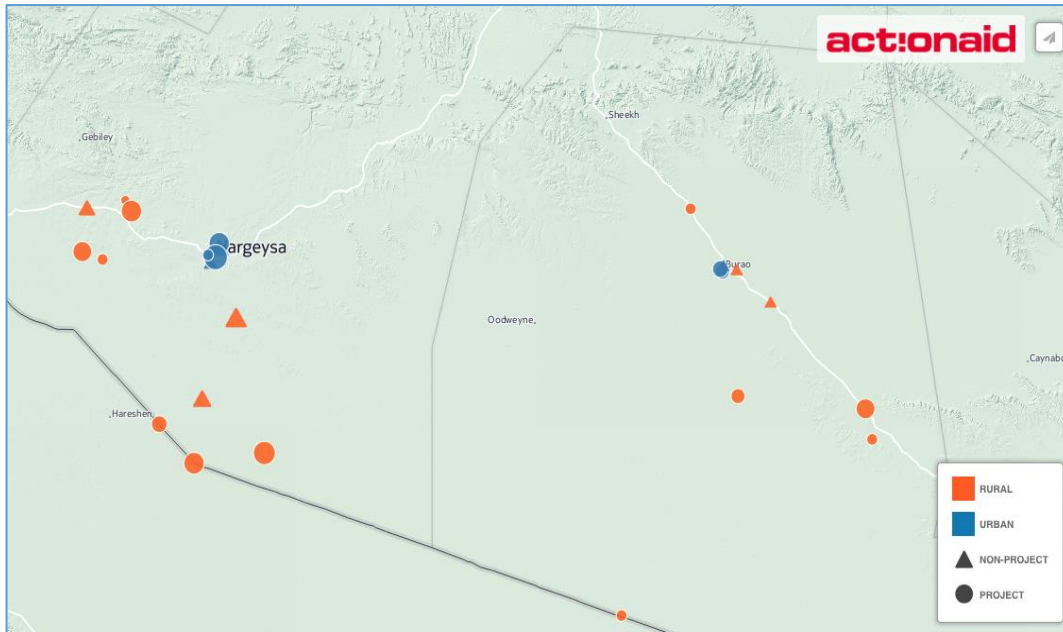
6.1. Community survey

The target for participants for the community survey was 2050, consisting of 1750 community members (25 women, 10 girls, 25 men and 10 boys per community) and 300 opinion formers (2 of each opinion forming groups; 12 per community). Table 6.1A shows the participants interviewed for each stakeholder group. The target was exceeded for community men and women (2060) but was too ambitious for the opinion formers as just 209 were identified. In some communities, for example, there were no law enforcers or health workers. Ten (5%) of the opinion formers, 129 (5%) of the women and girls and 174 (11%) of men and boys declined to be interviewed.

See map below for geographical location and appendix D for the participants per community.

Table 6.1A Community survey participants									
Stakeholder group	Women				Men				Total
	Declined	Project	Non-project	Total women	Declined	Project	Non-project	Total men	
Community members	129	713	286	1128	174	513	245	932	2060
Religious leaders	0	0	0	0	2	25	13	40	40
Health workers	0	14	4	18	0	17	4	21	39
Law enforcers	0	0	0	0	4	13	5	22	22
Teachers	0	6	1	7	1	34	12	47	54
Community leaders	0	17	4	21	3	21	9	33	54
sub-total opinion leaders	0	37	9	46	10	110	43	163	209
Total				1174				1086	2269

Map of the distribution of the 25 target communities. The size of shape indicates the sample size. This interactive map is also accessible [online](#) where more detail is available.

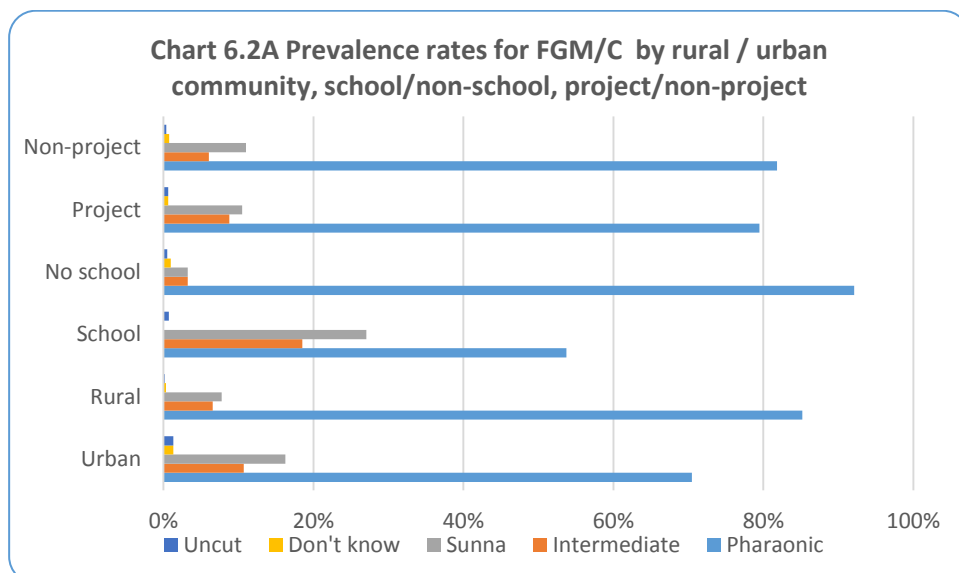


6.2. Project and non-project communities

The research included 17 communities which are part of the *Empowering Communities* project and also a control group of communities (8) which will not be involved in *Empowering Communities* activities.

The selection criteria for participants in all communities were identical. The profile of participants, in terms of age, educational background, gender balance and marital status was similar in project and non-project communities (appendix D).

Chart 6.2A shows the similarities in prevalence rates between project and non-project communities, compared to differences between urban/rural and school/non-school. The differences between project and non-project communities were not significant, in contrast, those between rural and urban communities and between women who had and had not attended school were significant.



However, project communities were one and a half times more likely to be aware of organisations working to reduce FGM/C than non-project communities (section 7.2.12), presumably due to the initial awareness raising in the first 3 months of the project. The implications for the project of this higher level of exposure are highlighted further in appendices E and F. The data set for the analysis of knowledge, attitudes and behaviours relating to FGM/C have included all 25 communities.

6.3. Key informant interviews and focus group discussions

A total of 23 key informant interviews took place lasting up to 75 minutes (table 6.3A).

Stakeholder group	Women	Men	Total
UN agencies		2	2
Parliamentarians	1		1
Civil servants			
<i>MoLSA</i>	1	2	3
<i>MoRA</i>		3	3
<i>MoH</i>	1		1
Health workers	3	4	7
NGO/CSO	3	2	5
Community member	1		1
Total	10	13	23

A total of 22 focus group discussions took place lasting up to 90 minutes (table 6.3B).

Stakeholder group	No. of focus group discussions	Women	Men	Total
Women	8	71	0	71
Men	5	0	31	31
Lawyers	1	3	1	4
Community / religious leaders	6	0	38	38
NGO/CSO	1	2	3	5
Health workers	1	4	0	4
Total	22	80	73	153

7. RESEARCH FINDINGS

The research findings are presented under four sections:

7.1 prevalence of FGM/C among girls and women, including the ages of girls and women being cut (section 7.1.1), the type of cut (7.1.2) and those who are performing the cutting (7.1.3).

7.2 communities' knowledge, attitudes and behaviours on FGM/C, including community perspectives on reasons for cutting (7.2.1), advantages and disadvantages of cutting (7.2.2), knowledge of types of cut (7.2.3), religious status and guidance (7.2.4), legal status of cutting (7.2.5), right to Freedom from Violence Against Women (7.2.6), expectations by the community and personal intentions to cut their daughters (7.2.7), preferences for marriage (7.2.8), decision-makers about whether a girl is cut and the type of cut (7.2.9), communication among the community about FGM/C (7.2.10), awareness of sexual and reproductive health services (SRHS) for girls after cutting (7.2.11), awareness of activities to reduce FGM/C in communities (7.2.12), involvement in anti-FGM/C activities (7.2.13), aspirations for the future (7.2.14)

This section relates primarily to project outcomes 1 and 2.

7.2.4 relates primarily to project outcome 3.

7.3 opinion former perspectives, including religious leaders (7.3.1), community leaders (7.3.2), law enforcers (7.3.3), health workers (7.3.4), teachers (7.3.5), parliamentarians (7.3.6), CSOs, NGOs and agencies (7.3.7)

7.3.1 relates primarily to project outcome 3

7.3.5 and 7.3.6 relate primarily to project outcomes 4 and 5

7.4 policies and laws relating to FGM/C

This section relates primarily to project outcome 4

7.1 Prevalence of FGM/C among girls and women

Of the 999 community women who participated in the community survey, 902 agreed to answer questions about whether they had undergone the sunna cut or another type of genital cutting. Only five of these were uncut, giving an overall prevalence rate of 99.4% (98.7% in urban and 99.8% in rural communities). All those who were not cut intended to cut their own daughters.

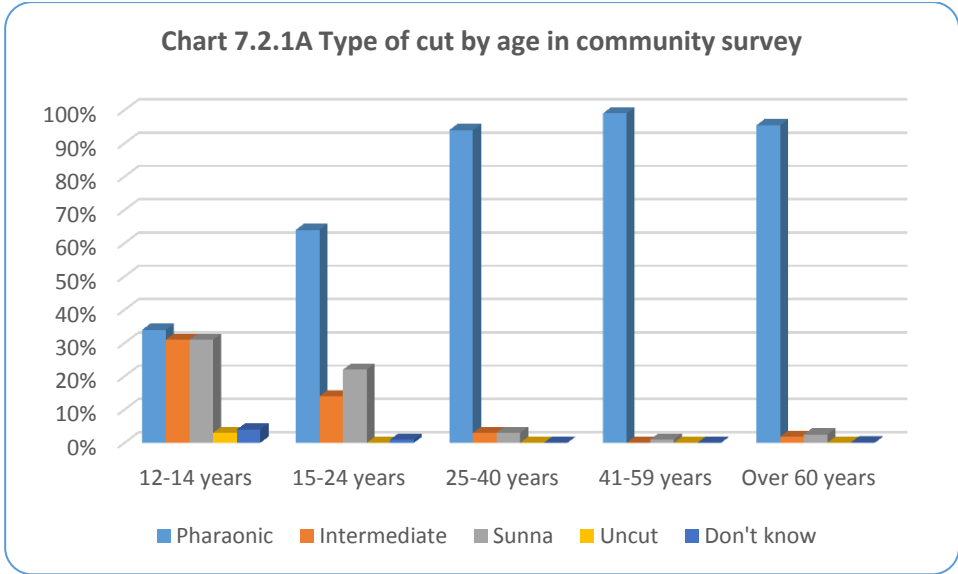
7.1.1 Age of being cut

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

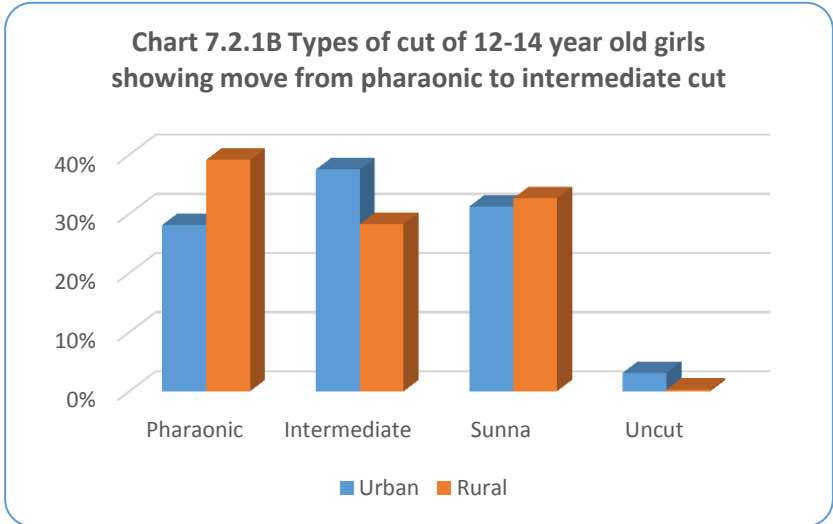
7.1.2 Types of cut among girls and women

There are three main types of female genital cut practised in Somaliland currently; the pharaonic, intermediate and sunna (table 3.4a, section 3.4). Responses were only recorded by enumerators as sunna when no stitching was involved.

Overall 80% of girls and women interviewed have undergone the pharaonic cut (type III). There is clear evidence of a trend away from the pharaonic cut (type III) towards the intermediate and sunna cuts (types I & II) with about a third of girls aged 12-14 years undergoing each of the pharaonic, intermediate and sunna cuts compared to 96% of women over 25 having undergone the pharaonic cut (chart 7.1.2A).

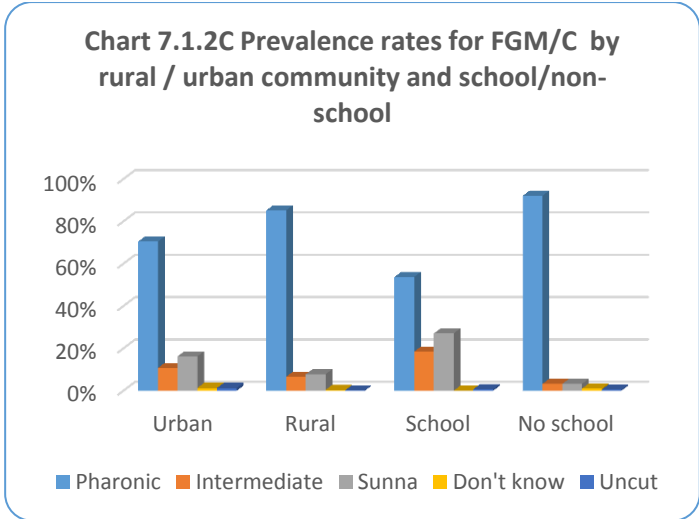


The move away from the pharaonic is stronger in urban than rural communities with only 26% of girls aged 12-14 in urban areas undergoing the pharaonic cut, compared to 38% of rural girls aged 12-14 (chart 7.1.2B).



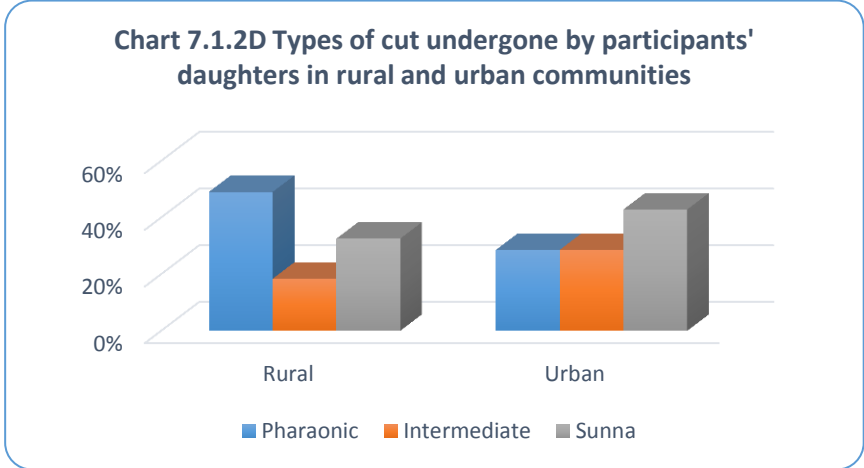
The trend away from the pharaonic cut is evident in the difference in the percentage of women needing to be cut open on their wedding night, with 97% of women over 25, compared to 85% of the married women aged 15-24.

There is a significant link between school attendance and the type of cut girls undergo. Overall 32% of the women interviewed had attended school with school attendance being higher among urban (43%) than rural (25%) girls and women. Girls and women who attended school, even just the first 2 years of primary school, were more likely to have undergone the intermediate or sunna cuts (chart 7.1.2C).



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

Further evidence of a trend away from the pharaonic cut and towards the sunna and intermediate cuts comes from the types of cut participants' daughters have undergone (chart 7.1.2D). Over 44% of participants' daughters had undergone the pharaonic cut compared to 80% of their mothers. This decrease is matched by corresponding increases in the intermediate and sunna cuts.



The trend from the pharaonic towards the sunna is not always supported, even within the girl's family, as illustrated by the following account from a focus group discussion:

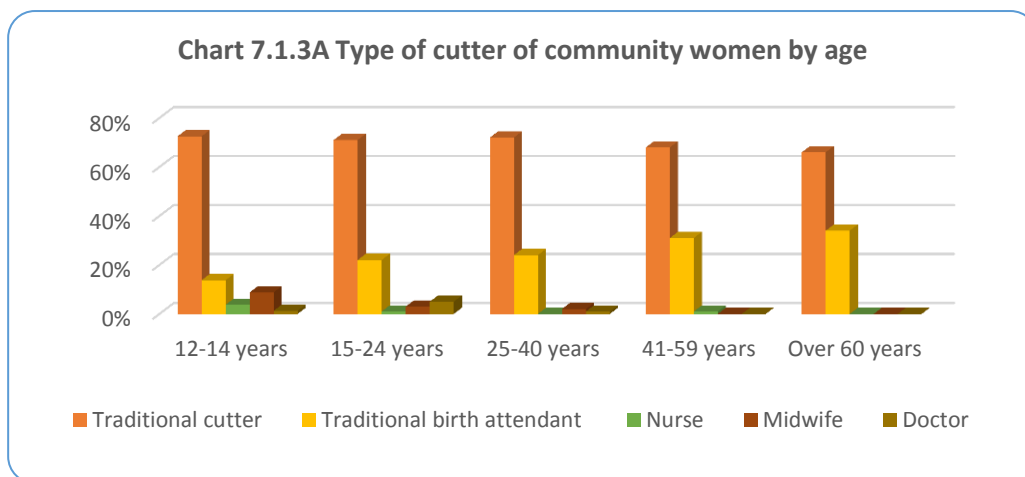
'My older sisters were cut and totally closed, every month their periods are extremely painful. They often get infections and end up in hospital. They miss time from school as well. I was cut, sunna with only 2 stitches, and am so much more healthy. But my younger sister is cut with the sunna with no stitches. She is more outgoing and rebellious and we all feel that this is because she has not been cut properly. Even in the house we call her names and mock her. We fear she will bring shame on the family and may never marry. When I marry I will have my daughters cut properly, sunna with 2 stitches, as this gives us the girls who are healthy and respect others.'

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

7.1.3 The people cutting girls and women

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

There is evidence of a recent increase in using health specialists to cut girls, accompanied by a decrease in the reliance on traditional birth attendants. Chart 7.1.3A shows a total of 14% of girls aged 12-14 years have been cut being by a health specialist with 9% being cut by a midwife. The proportion of women being cut by health specialists was significantly higher (11%) in urban than rural (2%) communities (see section 8.5).

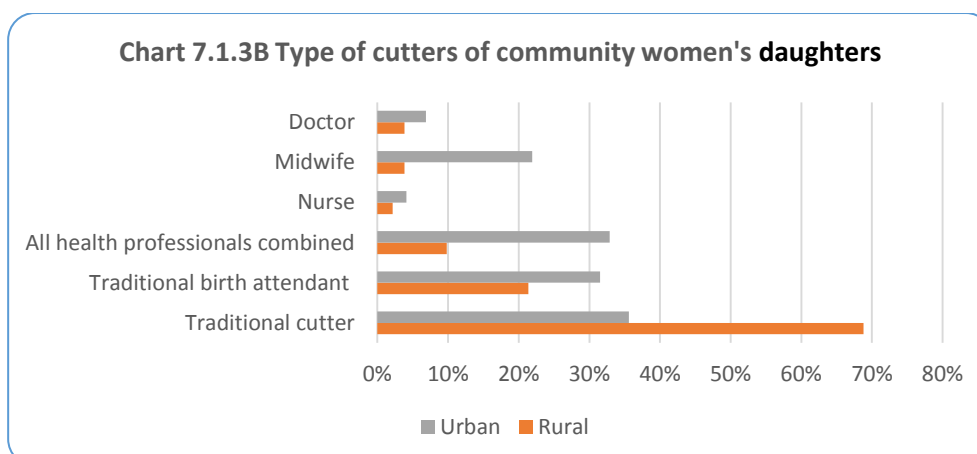


These changes are supported by further evidence of medicalisation of cutting from the focus group discussions and key informant interviews. For example, a grandmother in Stadium, Maroodi Jeex explained how she had taken her granddaughter to an MCH centre and asked for her to undergo the intermediate cut. The midwife initially refused but contacted her later and carried out the sunna cut at her home for \$10.

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

'...only the TBAs and traditional cutters, we do not have anyone else. It would be much better if it could be done at the MCHs safely and without so many complications.'

The medicalisation of cutting is evident from the types of people who participants report have cut their daughters (chart 7.1.3B). The change is most dramatic in urban communities where the percentage of daughters cut by health specialists (doctors, nurses and midwives) (33%) exceeds the percentage carried out by traditional birth attendants (32%). This is in comparison to 5% of their mothers being cut by a health specialist.

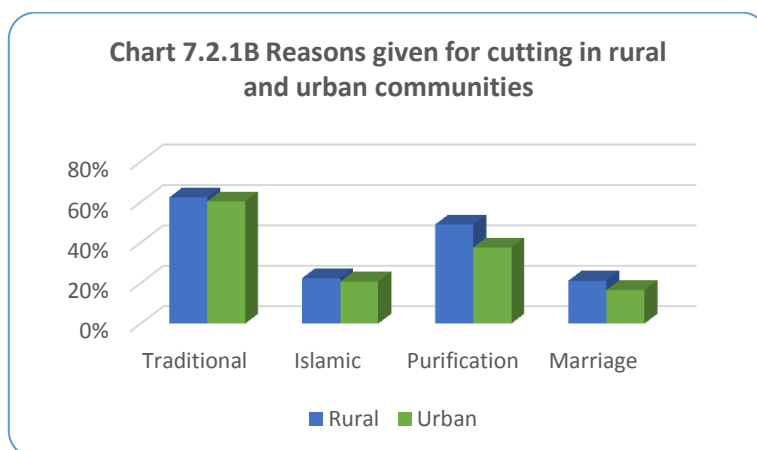
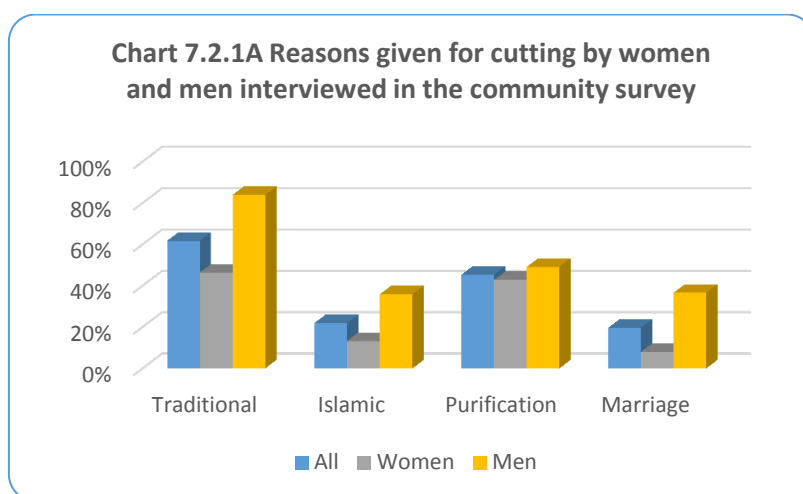


7.2 Communities' knowledge, attitudes and beliefs in relation to FGM/C

7.2.1. *Community perceptions about prevalence of, and reasons for, cutting*

The majority of community women (94%) and men (85%) interviewed said that female genital cutting takes place in their community, with 61% saying all girls and 22% saying most girls are cut. In urban communities more people felt that most, rather than all girls were being cut.

The reasons given for female genital cutting are complex with apparently contradictory evidence from the community survey and the discussions with individuals and groups. The strongest reason given is that cutting is a traditional practice (62%), which was stated most highly among men (84%). Religious reasons for cutting were cited less often, with 22% overall, and more important for men (36%) than women (13%) (chart 7.2.1A).



Purification, which comes from the Somali 'xalaalayn', is associated with reducing the sexual desire of girls, which in turn protects girls from sexual activity and the associated dangers of lack of virginity or pregnancy. The links between purification and marriage were made by women and men in the focus group discussions.

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

Community woman, Taysa, rural community

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

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

Community woman, Salahlay, rural community

'The reason why we keep the sunna is for marriage. We need the pinch and stitch as a way of proving that a girl is a virgin before she marries. So this is the main reason why it is still our practice.'

'Yes, the sunna has stiches as well, but only a small cut to remove some of the outside flesh and then you need 2 stitches to close it. The 2 stitches means she is closed enough to protect her virginity.'

Community women, Stadium, urban community

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

Community woman, Taysa, rural community

7.2.2. Advantages and disadvantages of cutting

Women in the community survey were asked about the advantages and disadvantages of being cut and uncut. Table 7.2.2A gives the most popular responses in each category.

Table 7.2.2A Women's responses on advantages/disadvantages of being cut and uncut	
<p>ADVANTAGES of being CUT</p> <ul style="list-style-type: none"> • socially accepted • proof of virginity • purified • able to marry • protected from rape and sexual advances • religious approval • positive for health • genital beauty 	<p>ADVANTAGES of being UNCUT</p> <ul style="list-style-type: none"> • no pain • no medical complications • no advantage, it is forbidden to leave girls without cutting • continues with education
<p>DISADVANTAGES of being CUT</p> <ul style="list-style-type: none"> • pain • menstruation problems • problems urinating • infections • back pain • kidney problems • cut on wedding night • relationship problems in marriage 	<p>DISADVANTAGES of being UNCUT</p> <ul style="list-style-type: none"> • social exclusion • would not be able to marry • increased sexual desire / activity (particularly before marriage) • not protected from rape or sexual advance • not Islamic, no longer a Muslim • ugly vaginal area

<ul style="list-style-type: none"> • medical complications through life • child birth problems • could die from the cutting 	<ul style="list-style-type: none"> • shame on the family • people abuse the young girl • illegal pregnancy (out of marriage)
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The advantages of being cut focus on social and religious acceptability, being seen as beautiful and able to marry. Protection from rape and sexual advances is also frequently cited as an advantage of girls being cut, although in discussion most agree that girls who have been cut are still vulnerable to rape.

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

Community woman, Salahlay, rural community

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

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

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

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

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

Young man, Stadium, urban community

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

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

Community member, Inaafmodoobe, rural community, Togdheer

7.2.3. Knowledge of types of cut

There are three main types of female genital cut practised in Somaliland currently; the pharaonic, intermediate and sunna (table 4A). Responses were only recorded as sunna by enumerators when no stitching was involved.

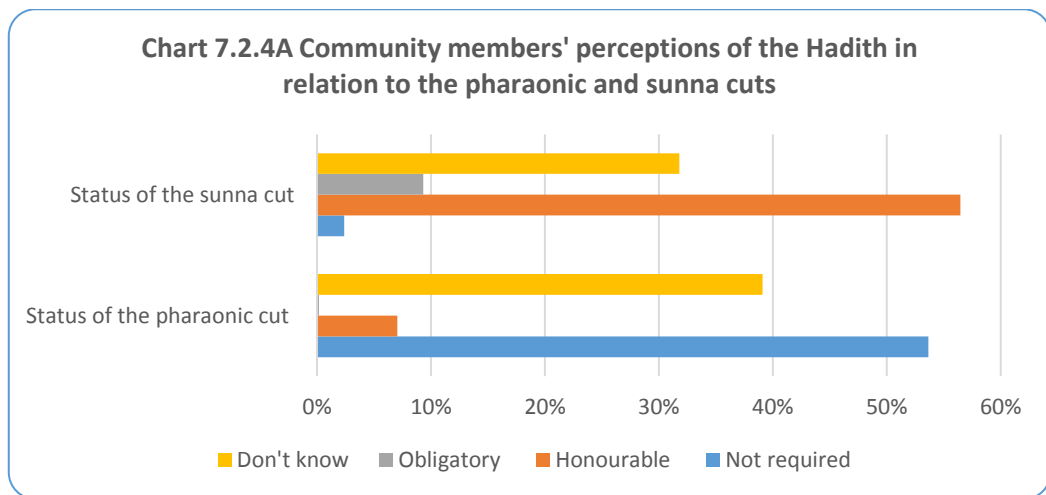
Almost 90% of women knew there were different types of cut, although only 77% of men were aware of this. Those who were unaware tended to be the youth (aged 12-14). Only 11% of men interviewed in the community survey were aware of the intermediate cut, or sunna 2. This was also clear in the focus group discussions where many of the men thought the decision was between either a cut which

required no stitches (the sunna) or the pharaonic cut. Greater awareness of the types of cut being practised would be beneficial if men are to be involved more in meaningful discussions with their wives about the cutting of their daughters (see communication among the community about FGM/C 7.2.10).

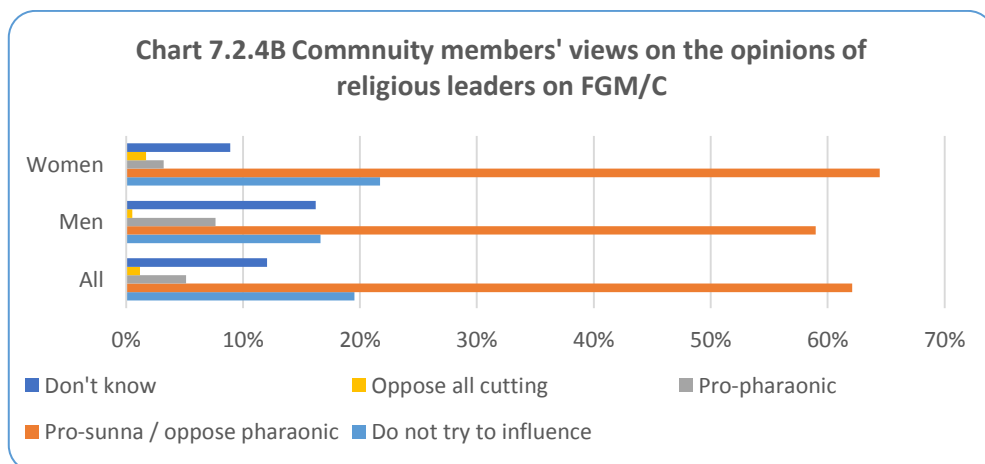
7.2.4. Religious status and guidance of female genital cutting

Under the Islamic Shafi'i school of thought, guidance is given in the form of hadiths which can be interpreted as *not required*, *honourable* or *obligatory*. If a hadith is obligatory then under Islamic law community members should abide by it. If it is honourable it is preferred, if not required then religious leaders will advise against. It is generally accepted that there is a hadith on female genital cutting.

Chart 7.2.4A shows how community members in the 25 selected communities interpreted the hadith on the pharaonic and sunna cuts. Of the two thirds who expressed an opinion, the difference in perception between the Islamic status of the pharaonic and sunna cuts is marked with the pharaonic perceived as not required, whereas the sunna cut is seen primarily as honourable with 9% considering it obligatory. There were no differences in opinions on the hadith between rural and urban communities or between community women and men.



The majority of community members, women (64%) and men (59%), see religious leaders as primarily supporting the sunna cut and opposing the pharaonic cut, with 1-2% opposing all forms of cutting including the sunna (chart 7.2.4B).



The following quotations are examples of how religious leaders are supporting the sunna with no stitches and opposing the pharaonic cut, which is seen as FGM and non-Islamic.

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

Community woman, Qoyale, Rural community, Togdheer

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

Community woman, Daami B, Urban community, Maroodi Jeex

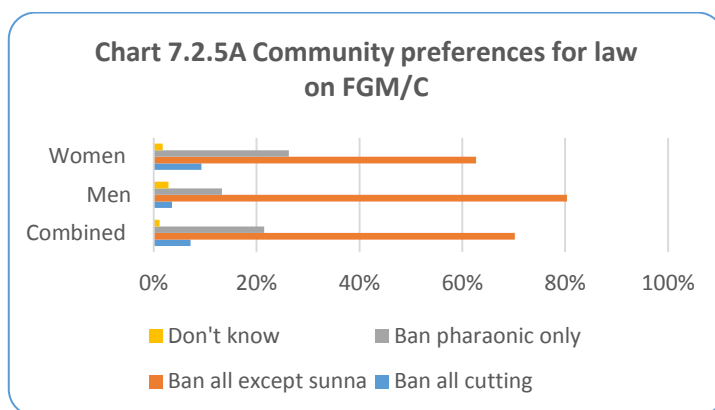
7.2.5. Legal status of legal cutting in Somaliland

There are no laws relating specifically to FGM/C in Somaliland currently, therefore all forms of female genital cutting are legal.

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

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

The most popular new law would be one which bans all forms of cutting except the sunna, favoured by 80% of men and 63% of women community members interviewed (chart 7.2.5A). Less than 10% of community members favoured a ban on all types of cutting.



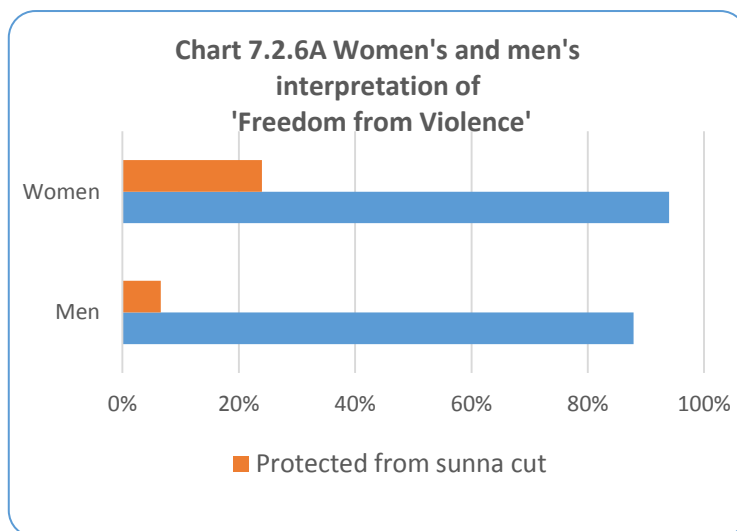
7.2.6. Right to Freedom from Violence Against Women and Girls (VAWG)

VAWG covers a broad spectrum of gender-based abuses including domestic violence, rape and physical and mental abuse. The UN definition of VAWG includes the threat of any VAWG as well as the acts themselves¹³.

62% of community women and 48% of community men interviewed were aware of the right of women and girls to freedom from violence. Youth aged 12-14 and those over 60 were less likely to be aware than those aged 15-59.

¹³ UN Women Defining Violence against Women and Girls <http://www.endvawnow.org/en/articles/295-defining-violence-against-women-and-girls.html>

In the community survey participants were specifically asked how they saw the right to freedom from VAWG in relation to FGM/C. The interpretation of the right to freedom from VAWG reflected the different attitude towards the pharaonic and sunna cuts (chart 7.2.6A). The majority of both women (94%) and men (88%) considered that freedom from VAWG should protect girls and women from undergoing the pharaonic cut. The connection between the right to freedom from VAWG and the sunna cut was made by only 24% of women and 7% of men (chart 7.2.6A). There was no difference between rural and urban communities.



There was some contradiction between people's understanding of the right to freedom from VAWG and their intended personal action. The majority of those women (70%) and men (79%) who said freedom from VAWG should protect girls and women from undergoing the sunna cut also said that they intend to cut their own daughters, with 8% saying they would use the pharaonic cut. It was clear from the research that community women and men have not previously had opportunities to discuss the links between concepts like VAWG and their own behaviour in relation to FGM/C. These apparent contradictions suggest that there are stronger driving forces towards continuing cutting (see decision-making dilemmas 8.8).

7.2.7.Expectations by the community and personal intentions to cut their daughters

Overall, 74% of community members think that people in their community expect them to cut their daughters. A higher percentage of women (84%) feel they are expected to cut their daughters than men (62%). The percentage of community members (84%) saying they intend to cut their daughters in future is slightly higher.

Charts 7.2.7A and 7.2.7B show the difference in expectations and intentions between community women and men, with men being less aware of the intermediate cut. Both men and women favour the sunna cut, with women in particular intending to use a lesser cut than they perceive the community to be expecting them to use.

Chart 7.2.7A Community women's expectations and intentions of cutting their daughters

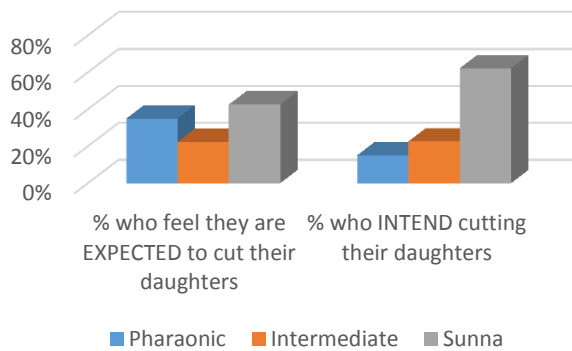
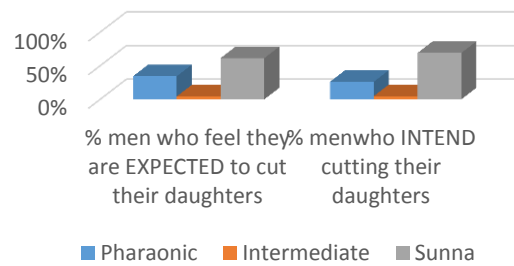


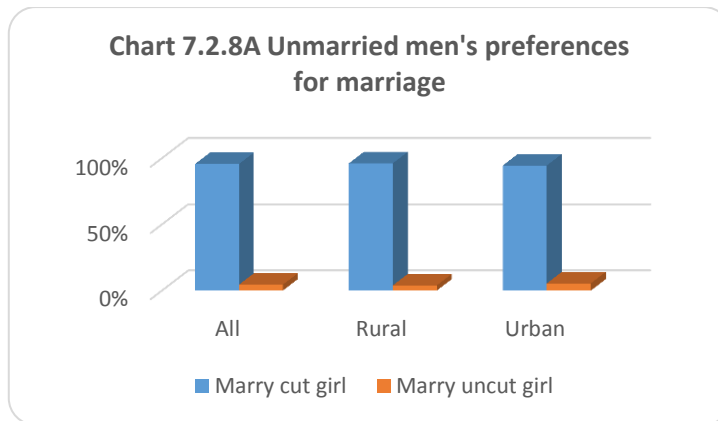
Chart 7.2.7B Community men's expectations and personal intentions of cutting their daughters



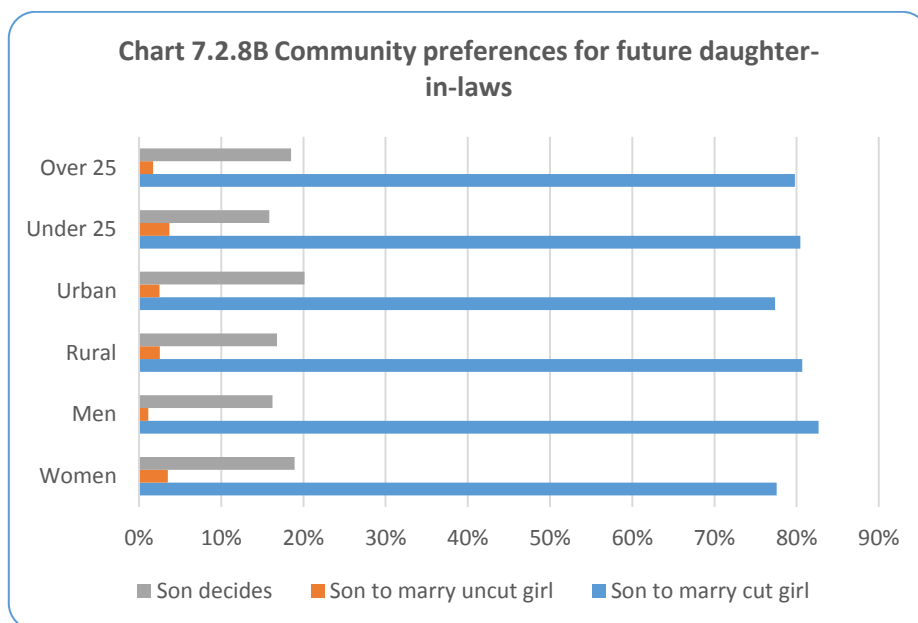
7.2.8. Preferences for marriage

Although marriage is not stated as a reason for cutting their daughters as frequently as culture or religion, there is a strong preference (94%) for girls who are cut when it comes to selecting a future wife. Chart 7.2.8A shows that unmarried men would prefer to marry a cut girl with only 6% urban and 5% rural unmarried men preferring an uncut girl.

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

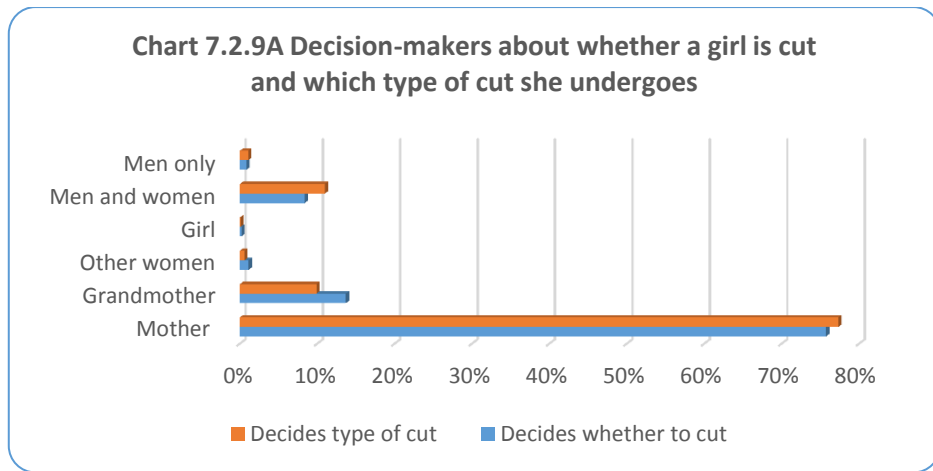


This preference for men to marry cut girls is also evident among married men and women when asked what kind of girl they would prefer their sons to marry. Chart 7.2.8B shows that 80% of participants would prefer their sons to marry a girl who has been cut. This preference is similar among men and women, rural and urban communities, and those over and under 25 years of age. In urban communities, among women and younger people more participants would allow their sons to decide, although these differences are minor.

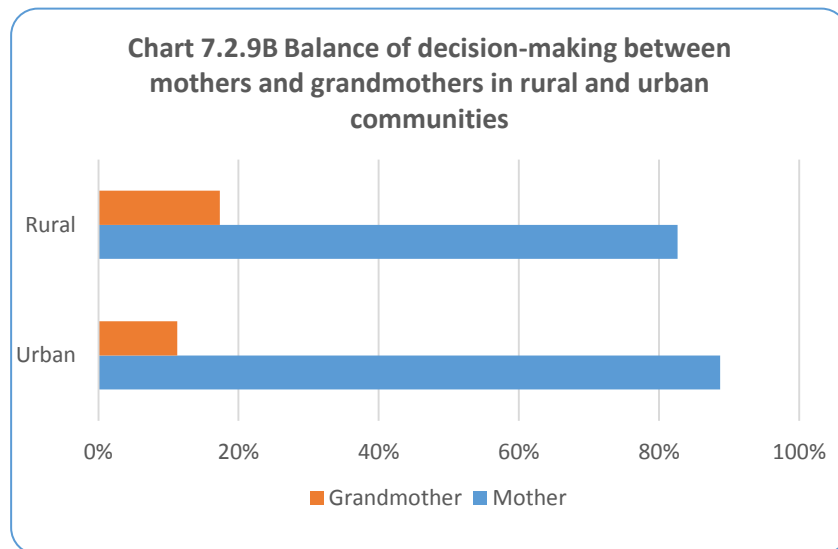


7.2.9. Decision-makers about whether a girl is cut and the type of cut she undergoes

Mothers are the principle decision-makers about whether a girl is cut and the type of cut she undergoes, taking the decision 76% of the time (chart 7.2.9A). Men and women deciding together happens in only 8% of families. Girls are reported to be involved in the decision-making process less than 0.5% of the time.



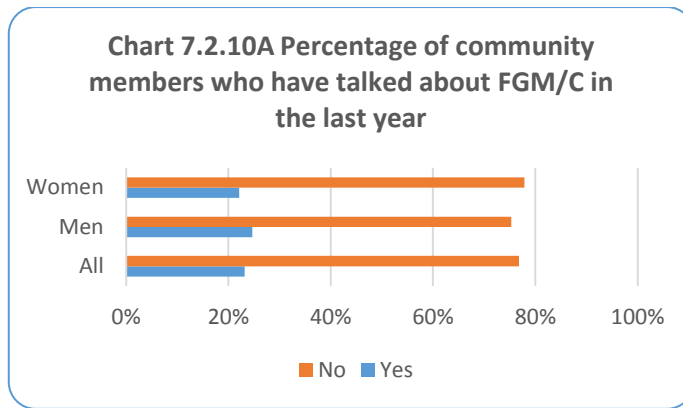
There a small difference in the balance in decision-making between mothers and grandmothers with grandmothers being more involved in rural (15%) than urban (10%) families (chart 7.2.9B). Linking this to the other data on types of cut, it is clear that where grandmothers are less involved, the type of cut is less likely to be the pharaonic.



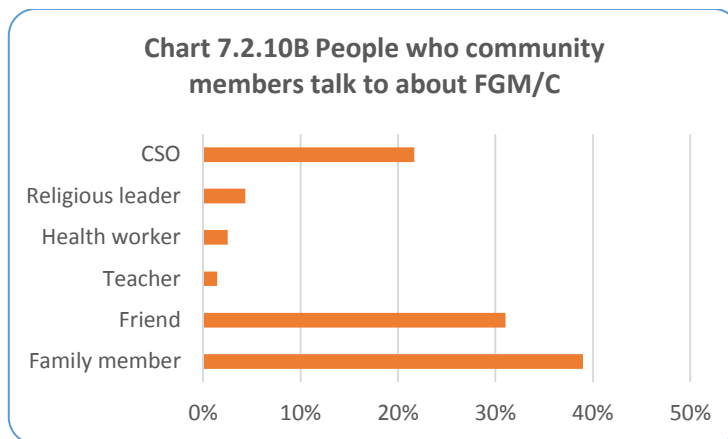
7.2.10. Communication among the community about FGM/C

Speaking individually about FGM/C

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



Of those who have spoken about FGM/C to someone, they are most likely to talk to family, usually of the same gender, friends and members of CSOs (chart 7.2.10B). Despite religious leaders being considered influential in decision-making they are not a group with whom many conversations are taking place currently. Even fewer conversations are taking place with health workers and teachers.



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

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

Young man, Stadium, urban community

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

Community men, Taysa, rural community

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

The implications of a lack of communication between women and men about FGM/C emerged in the focus group discussions with separate men and women from the same community (box 7.2.10A).

Box 7.2.10A

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

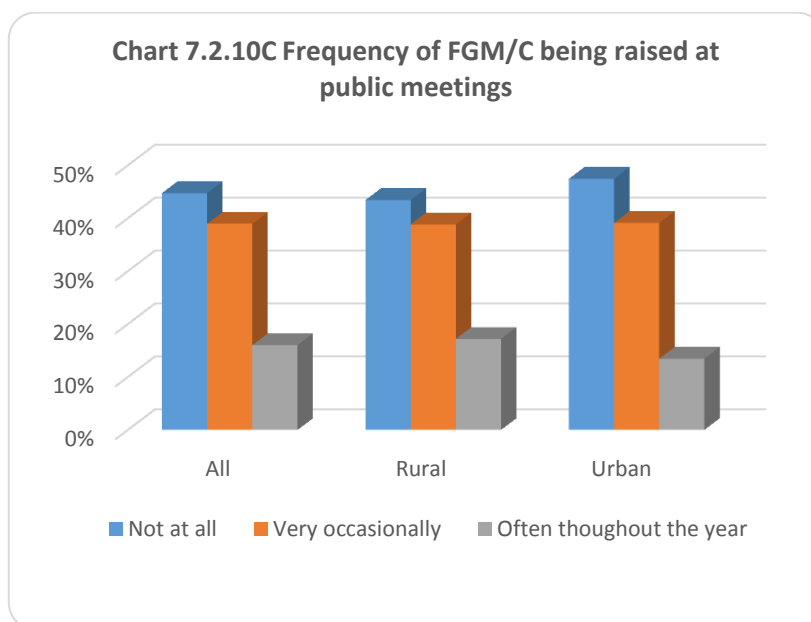
In Inaafmodoobe, Togdheer, the men were adamant that they would not agree to their daughters undergoing anything except the sunna with no stitches, saying that when their daughters undergo the sunna *'there are no stitches, no complications and no harm, it is totally safe and simply purifies the woman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

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

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

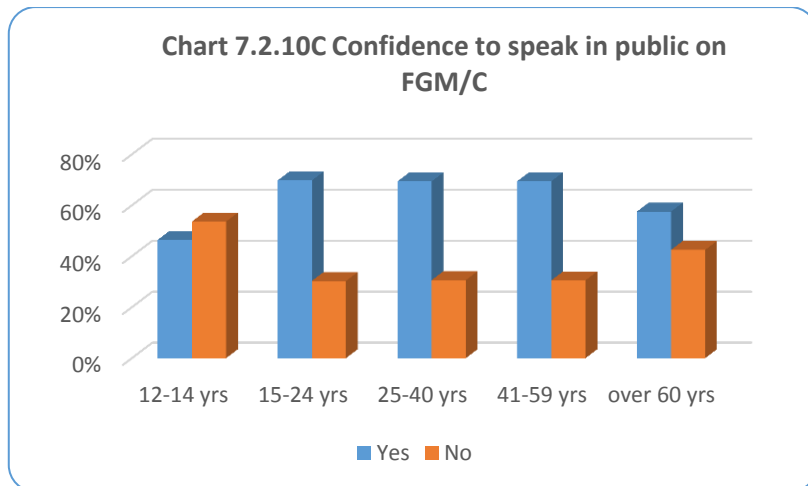
FGM/C being raised in public meetings

Only 16% of community members said that FGM/C is raised often in public meetings with 44% saying it was not raised at all (chart 7.2.10C).



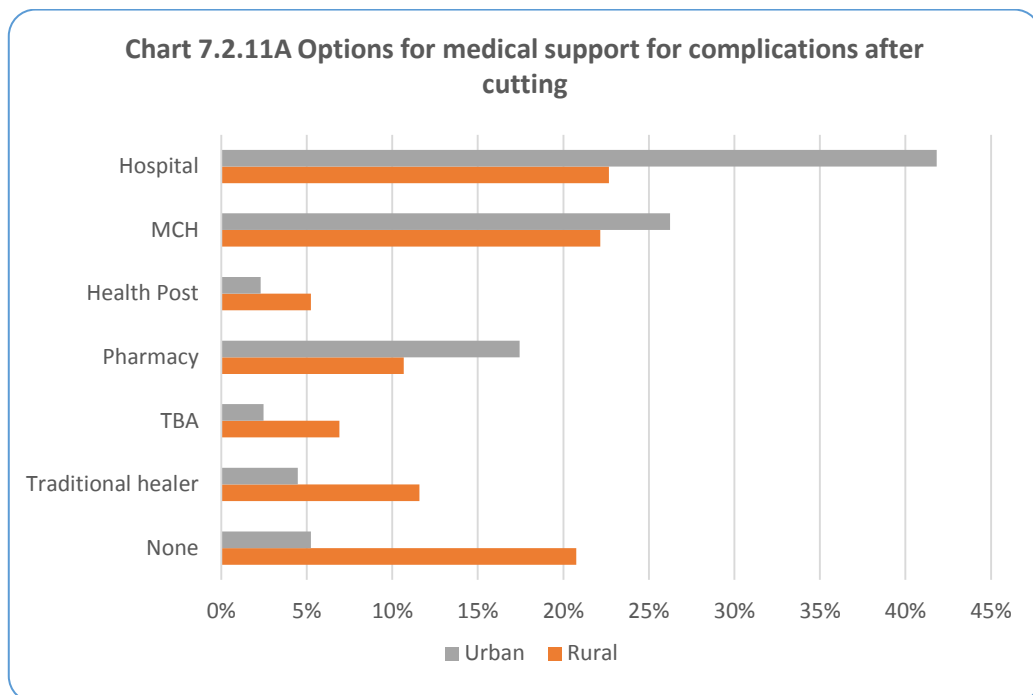
Confidence to speak in public on FGM/C

Two-thirds of people said that they felt able to speak about FGM/C in public meetings (chart 7.2.10C). This is in stark difference to less than a quarter who have spoken at all about FGM/C and suggests a willingness to engage, if the opportunity arose.



7.2.11. Awareness of sexual and reproductive health services (SRHS) for girls after cutting

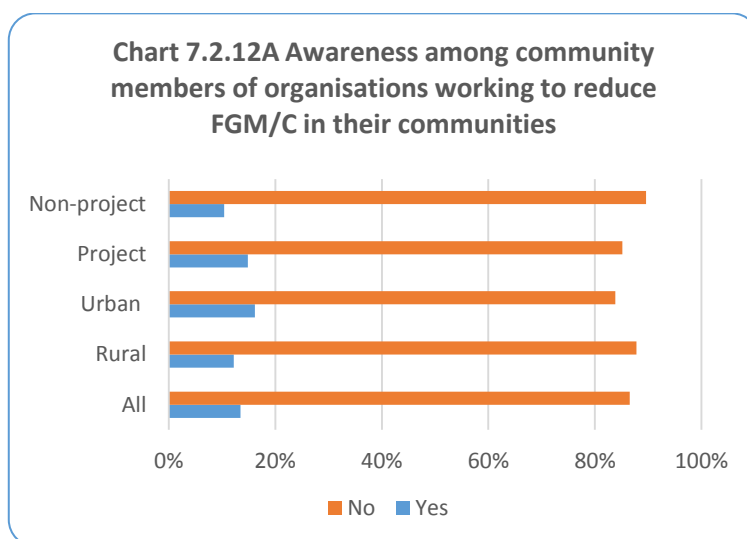
The range of medical options available to support girls after being cut is predictably greater in urban than rural areas, with 21% of participants from rural communities saying there is no health support available to girls (chart 7.2.11A).



Women explained the amount of preparation which takes place prior to cutting, saying ‘*the cutter woman has the anti-bleeding medications*’ and ‘*we buy the anti-haemorrhage medication before the cut*’. This was supported by an FGM practitioner in a focus group discussion who said ‘*I give clear instructions on the taking of the medicine and follow up to make sure they are taking it*’.

7.2.12. Awareness of anti-FGM/C activities

Only 13% of community members interviewed knew of organisations working to reduce FGM/C in their communities (chart 7.2.12A).



The following organisations were the most frequently named as working to reduce FGM/C.

Name	Number of responses	Name	Number of responses
ActionAid	16	Norwegian Refugee Council	8
Alla Amin	9	Samo Talis	5
CCBRS	43	Save the Children	9
Havoyoko	7	SOWDA	9
Horumar	9	WAAPO	16
Nagaad	7	World Vision	7
25 other local organisations were also mentioned by 1-3 participants			

The MoLSA Director of Social Affairs and several CSOs working on FGM/C suggest that the primary focus of initiatives to reduce FGM/C has been in urban communities and that greater emphasis needs to be placed on rural communities in the future.

‘Currently the focus is on the urban areas with the rural areas receiving a less sustained and supported programme of activities promoting movement towards abandonment’

Amal Ahmed, Executive Director of SFHA

7.2.13. Involvement in activities to reduce FGM/C in communities

Only 16% of community members report being involved in activities to reduce female cutting with the most active group being people aged 41-59 years (chart 7.2.13A). Surprisingly, a higher percentage of men (18%) than women (13%) have been involved in anti-FGM activities (chart 7.2.13B), with women tending to report having been involved in public meetings, whereas men have tended to be involved in workshops on FGM/C (chart 7.2.13C).

Chart 7.2.13A Percentage of community members involved in anti-FGM/C activities by age

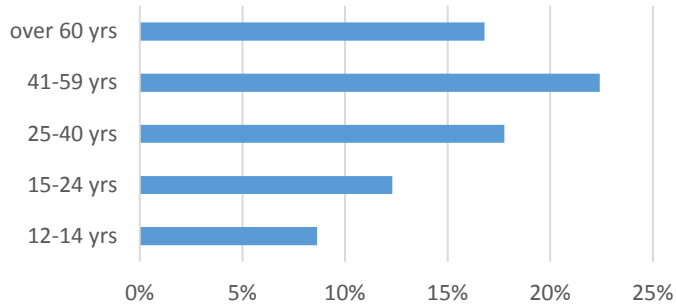


Chart 7.2.13B Percentage of community members involved in anti-FGM/C activities by urban/rural communities and by gender

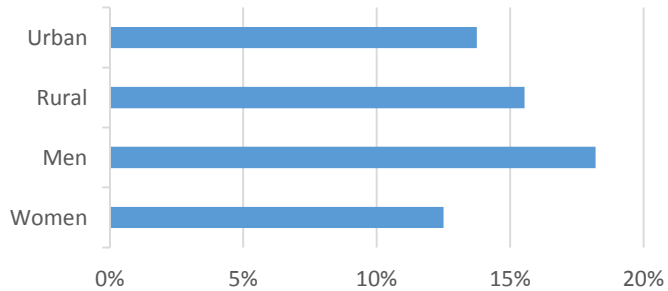
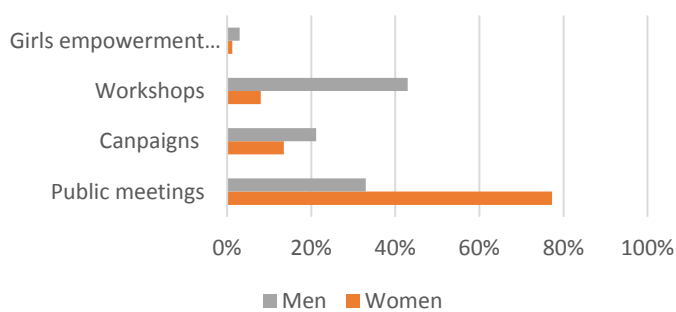


Chart 7.2.13C Types of anti-FGM activities in which community women and men have been involved



7.2.14. Aspirations for the future of FGM/C

Community members were asked how they would like to see the future of FGM/C in their community with three options; abandoning all forms of cutting, abandoning all except the sunna and maintaining all options as now. Overall 77% would prefer abandoning all except the sunna with just 5% aspiring to the abandonment of all forms of cutting. Age, education and rural/urban background were all significant factors. Those aged 15-24 years were most in favour of abandoning all types of cutting (16%) and the least likely to support maintaining all options (chart 7.2.14A).

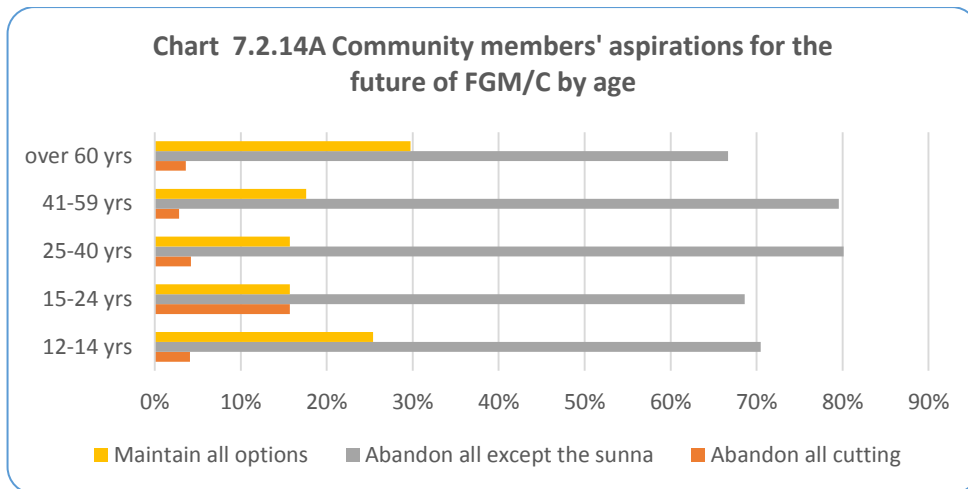
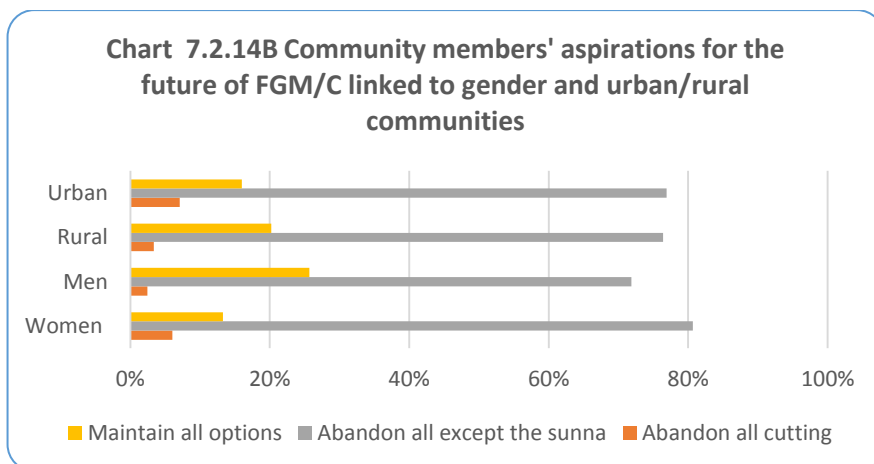
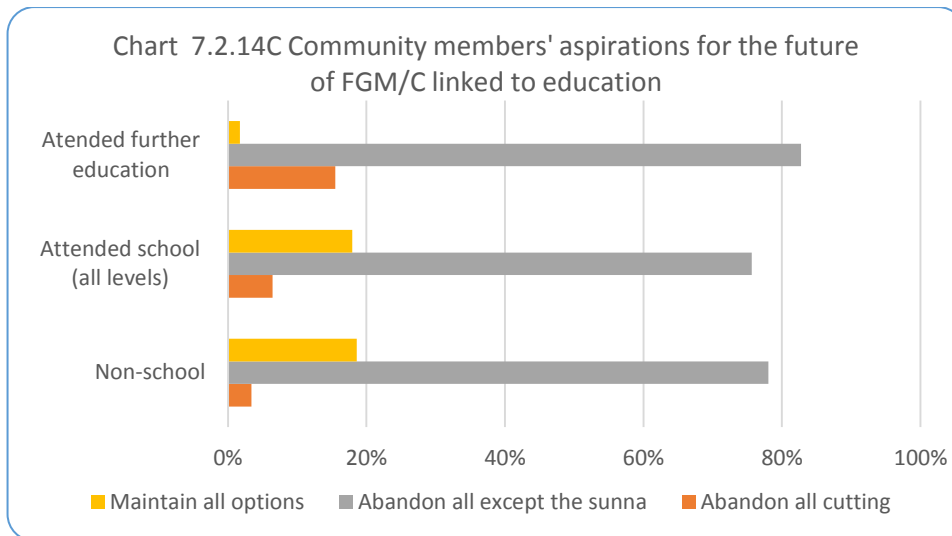


Chart 7.2.14B shows that rural communities had fewer community members aspiring to abandonment of all types of cutting (3%) and more preferring to maintain all options (20%) compared to urban communities (7% and 16% respectively). It also shows that women are more open to change in FGM/C than men. Only 2% of men supported the abandonment of all types of cutting with 26% preferring to maintain all options including the pharaonic, compared to 6% of women preferring abandonment of all types of cutting and only 13% preferring to maintain all options including the pharaonic cut. (Some women may be including the intermediate cut (sunna 2) under the category of sunna).



The level of education of community members is also a strong factor in their aspirations on FGM/C (chart 7.2.14C) with those attending further education being more than five times as likely to support the abandonment of all forms of cutting than those who did not attend school (16% as opposed to 3%). There is also a corresponding reduction in the support for maintaining all options, including the pharaonic.



Of those who would like to see only the sunna in future, 55% would like to see health workers trained in safe cutting.

7.3 Opinion former perspectives

In line with a social norms perspective information was gathered on the knowledge, attitudes and behaviours of seven key stakeholder groups with the potential to influence policy and decision-making in relation to female genital cutting in Somaliland: religious leaders, community leaders, law enforcers, health workers, teachers, parliamentarians and civil society and non-governmental organisations (CSOs, NGOs & INGOs).

The community survey, carried out in 25 communities included 199 interviews with opinion formers, using mobile data devices. This data was supplemented by evidence from 9 focus group discussions and 23 key informant interviews (section 6.3).

7.3.1 *Religious leaders: knowledge, attitudes and behaviours on FGM/C (Outcome 3)*

Evidence on the knowledge, attitudes and behaviours of religious leaders was gathered from three sources:

- interviews with 38 religious leaders as part of the community survey
- religious leaders participating in seven focus group discussions in communities
- key informant interviews with civil servants and religious scholars from the Ministry of Religious Affairs (MoRA)

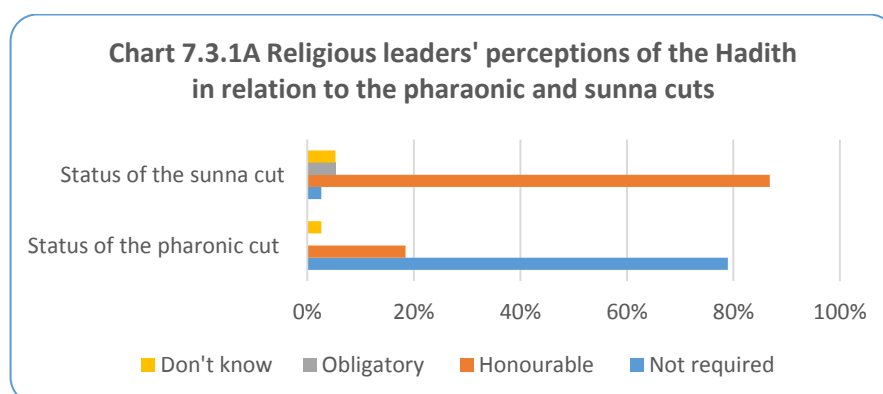
Table 7.3.1A summarises the profile of the community leaders interviewed in 25 communities during the community survey.

Characteristic	Number
Total	38
Communities sampled	25
Religious leaders based in rural communities	21
Religious leaders based in urban communities	13

Attended school	20 (53%)
Role	
Community Sheikh	10
Imam / Mosque prayer leader	14
Mufti / Scholar	1
Mu'adin / Caller for Prayer	2
Madrassa / Teacher	8
Dacci / Preacher	3
Age	
25-40	9
41-59	26
Over 60	3

Religious leaders at community, district and national level were keen to participate in the research and to communicate their perspectives on female cutting. All felt that it is an important issue with over 90% considering that religious leaders should be involved in discussions at community level on FGM/C. Half of all religious leaders surveyed are actively involved in community based health initiatives including 24% involved with FGM/C programmes, 26% with vaccination programmes, and 11% with child health programmes.

When asked about the position of female cutting under Islamic law, the difference in perception between the pharaonic and sunna cuts is crucial, with 87% of religious leaders describing the pharaonic cut as 'not required' whereas the opposite view is taken on the sunna cut where 79% consider it to be 'honourable'¹⁴ (i.e. preferred) (see chart7.3.1A). Of the 18% who considered the pharaonic to be 'honourable', these tended to be older men (86% aged over 40) and from rural communities (86%), indicating rural religious leaders are more traditional in their interpretation of Islamic law than those from urban communities.



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

'FGM is against Sharia law. It is a violation of a woman.....I talk regularly in the Mosque, whenever someone comes to talk to me I tell them that the sunna is acceptable but the

¹⁴ See section 4 for explanation of 'not required', 'honourable and 'obligatory'.

pharaonic in any form is a cultural practice which goes against Islamic law.'

Focus group discussion, Sheikh Fatxi Khadar Jaamac, Daami B

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

Focus group discussion, Religious leader, Stadium

'The Pharaonic cut is culturally normal, practised by the society in Somaliland. Islam has always spoken out against the Pharaonic cut. It is about history and social attitudes. It is also evidence of virginity which is a requirement for marriage.

The disadvantages to the Pharaonic cut are well known. I need not go into any detail but they are non-Islamic. I would never force my daughter to undergo this practice. The sunna type 2 has moved a bit from the Pharaonic but it is still not Islamic. Of that I am quite clear.

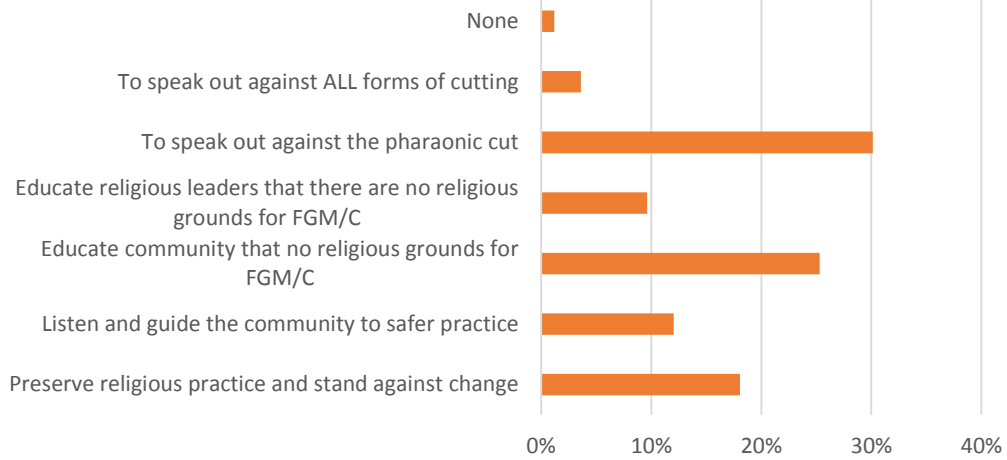
But the sunna, well that is Islamic, you must understand that Islam would never permit anything which brings harm to a woman, that would be non-Islamic. So the sunna does not harm at all if performed properly.'

Mohamed Ibrahim Jama, Head of Department of Islamic Propagation, Ministry of Religious Affairs (MoRA)

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

When asked about how they saw the role of religious leaders in relation to FGM/C, *speaking out against the pharaonic cut* and *educating the community that there are no religious grounds for FGM/C* were selected most frequently (see chart 7.3.1B). This was consistent across rural and urban communities and with older and younger religious leaders. The response *educating the community that there are no religious grounds for FGM/C* should be seen in the knowledge that most religious leaders use the term FGM/C to refer to any cutting which requires stitching. The high scores for these two options confirms the observation elsewhere that religious leaders strongly support a reduction in the incidence of all forms of cutting except the sunna.

Chart 7.3.1B Religious leaders' perceptions on their responsibilities in relation to FGM/C



47% of religious leaders interviewed in the community survey have participated in discussions on FGM/C. These tended to be the older and more educated religious leaders with 78% having attended school and 89% aged over 40. These discussions are with other religious leaders, families and communities. There is no difference between urban and rural communities.

A similar percentage (45%) of religious leaders from the community survey have spoken in public meetings in both rural and urban communities. However, there may be a difference in the message which they are communicating as in the urban communities half the religious leaders interviewed who had spoken in public would favour the introduction of a law based on Zero Tolerance, compared to less than 10% from rural communities.

In slight contrast to the results from the community survey, none of the religious leaders in the focus group discussions would support a law which banned the sunna, although all would speak out against all forms of cutting which required stitching.

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

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

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

Religious leader, Qoryale, Togdheer

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

Summary

Religious leaders draw a clear distinction between the sunna cut which 92% consider to be honourable or obligatory and the pharaonic (including all cutting which involves stitches) which is considered to be non-Islamic by 87%.

Zero Tolerance is not publicly supported by senior religious leaders, however, 16% of religious leaders from communities would support a law based on Zero Tolerance.

Religious leaders in rural communities are more likely to interpret Islamic law more strictly than those from urban communities, with more considering the sunna to be obligatory, rather than honourable or not required.

Less than half of religious leaders are involved in public discussions about female cutting. Bearing in mind how influential they are in communities and their position on the pharaonic and the sunna 2 cuts, it could be beneficial to support them in increasing their involvement in discussions and public speaking about female cutting. Their involvement could encourage people towards the sunna, rather than the sunna 2. Although at present it is unlikely to support abandonment of the sunna.

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

Evidence on the knowledge, attitudes and behaviours of community leaders was gathered from two sources:

- interviews with 51 community leaders, 21 women and 30 men
- community leaders participating in focus group discussions in six communities.

Table 7.3.2A summarises the profile of the community leaders interviewed in 24 communities during the community survey.

Table 7.3.2A Summary of community leaders interviewed			
Characteristic	Number of female community leaders	Number of male community leaders	Total
Total	21	30	51
Rural communities	15	21	36
Urban communities	6	9	15
Attended school	8 (38%)	20 (66%)	25 (55%)
Role			
Local authority	8	19	27 (53%)
CSO/NGO	10	0	10 (20%)
Community committee members	3	11	14 (27%)
Age			
25-40	12	7	19

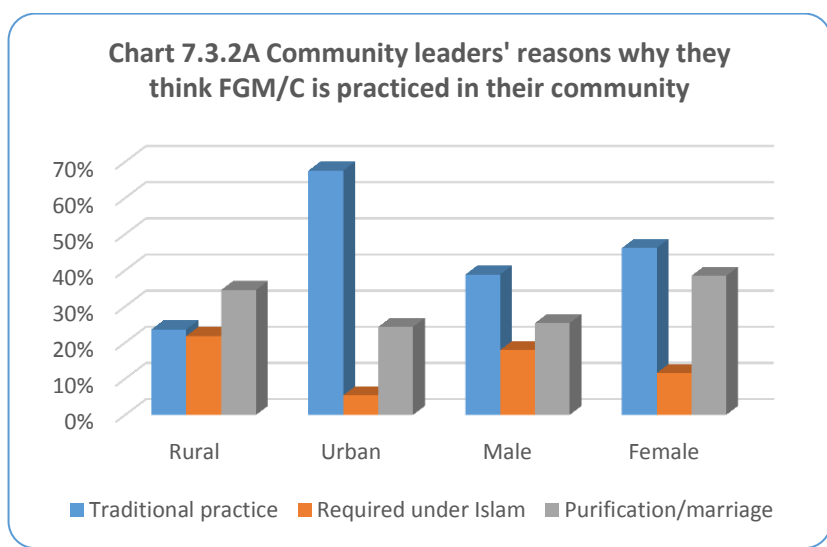
41-59	8	20	28
Over 60	1	3	4
Married	21	28	49 (96%)

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

The majority (82%) of community leaders were involved in health initiatives with 66% involved in anti-FGM/C, 33% child health, 25% maternal health and 33% vaccination programmes. FGM/C is seen by community leaders overwhelmingly as a cultural issue (94%) with just 2% considering it primarily a rights issue and 4% a religious issue. Community leaders were familiar with the pharaonic and sunna types of cut, however, only 10% of the men were aware of the intermediate cut (sunna 2 with 2 stitches), compared to 52% of the women.

The prevalence data from the communities indicates 99.4% of girls and women have been cut which is consistent across rural and urban communities. In urban communities only 60% of community leaders consider that all girls and women are being cut, with another 27% considering that most are cut. This may indicate that community leaders in urban communities are underestimating the widespread nature of female cutting in their communities.

The key reasons given for girls being cut show marked differences between community leaders in urban and rural communities (chart 7.3.2A). Traditional practice is cited more frequently in urban communities. FGM/C being required under Islamic law is considered more important in rural than urban areas and is slightly higher among men than women.



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

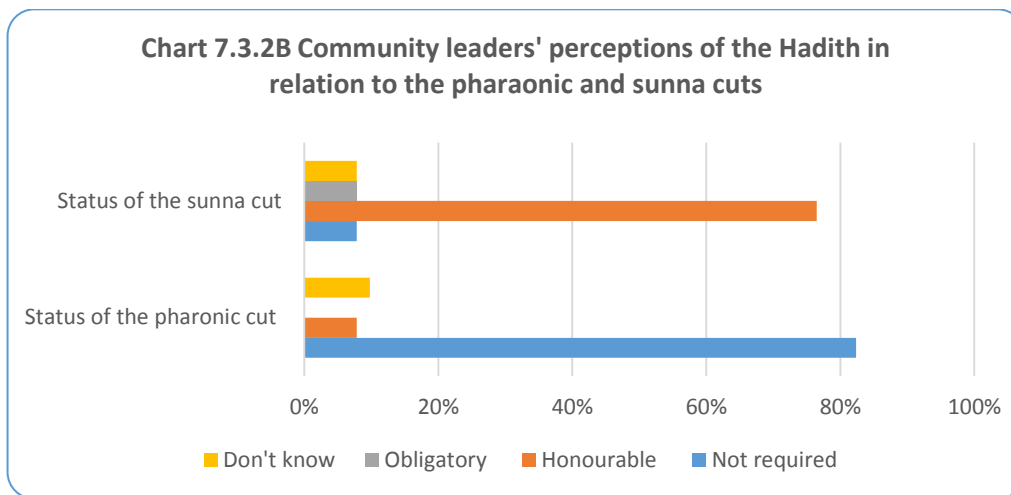
'...we have more and more sexual attack here in the urban communities and young women need protection from rape, from sexual attacks of all sorts. The girls need to have their virginity protected and this can be done with the pinching [sunna 2 cut].'

Community leader, Stadium, urban community

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

Community leader, Salahlay, rural community

There was general agreement among community leaders that the pharaonic cut was not required under Islamic law but that the sunna cut was honourable (see chart 7.3.2B). This was also the firmly held opinion expressed by community leaders in the focus group discussions in both rural and urban communities. 86% of community leaders felt that in their community the religious leaders strongly supported the sunna cut, with 14% considering that the religious leaders did not attempt to influence families' decisions.

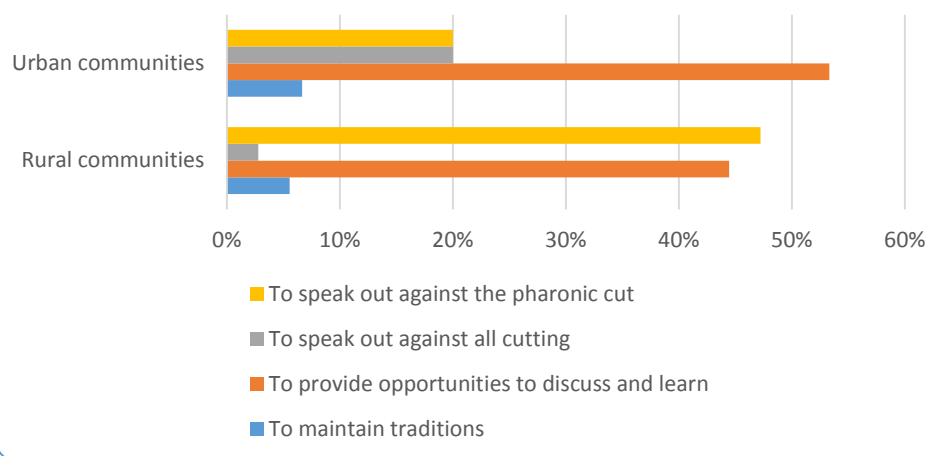


Only half of the community leaders interviewed knew the legal status of FGM/C in Somaliland, however 88% would like to see a strengthening of the law. The majority (73%) would favour a law banning all except the sunna cut, with a further 14% favouring a law based on zero tolerance, banning all forms of cutting including the sunna. Views supporting Zero Tolerance were expressed more frequently in urban than rural communities and from female rather than male community leaders. Community leaders were knowledgeable about the range of health facilities available to girls and women and almost all would refer girls and women with complications from being cut to medical facilities rather than to traditional healers or traditional birth attendants.

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

Community leaders' perceptions as to their responsibility in relation to female cutting provided further evidence of the differences between rural and urban communities. In rural communities almost half (47%) of community leaders saw their role as speaking out against the pharaonic cut, with just 3% speaking out against all forms of cutting and supporting Zero Tolerance. However, in urban communities only 20% saw their role as speaking out against just the pharaonic cut whilst the number speaking out in favour of abandonment of all forms of cutting was 20%.

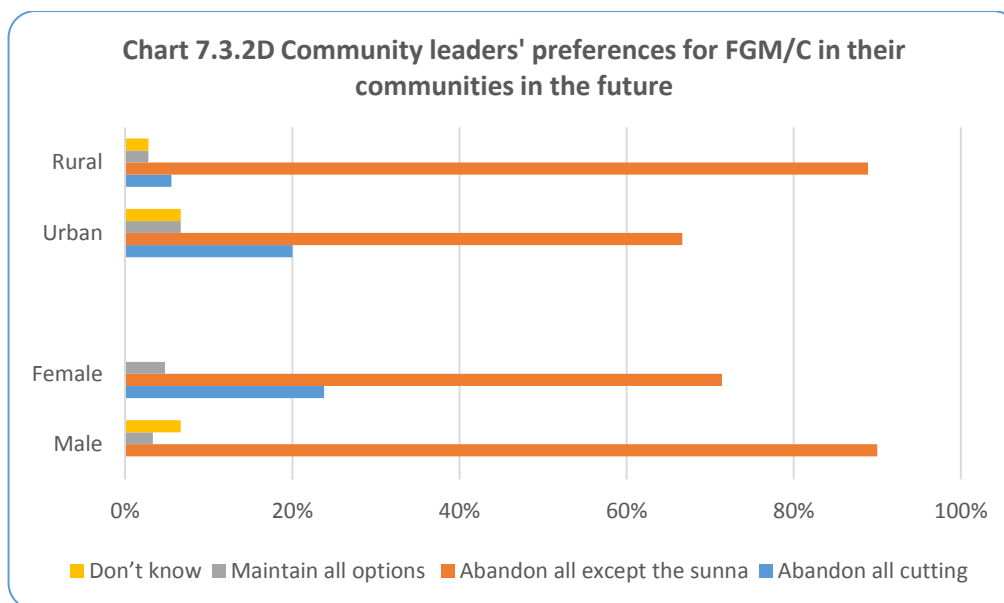
Chart 7.3.2C Community leaders' perceptions of their responsibilities in relation to FGM/C



There were marked differences in the percentage of community leaders from urban and rural communities who have spoken in public on female cutting with 93% of urban community leaders but only 31% of rural community leaders speaking. When this is combined with the more traditional attitude towards female cutting and the interpretation of Islamic law, this suggests that not only are there fewer rural community leaders speaking about female cutting but that the message will also be different, speaking out only against the pharaonic in rural communities and tending more towards sunna only or even zero tolerance in urban communities. Women community leaders are more likely to speak out with 86% overall doing so compared to 70% overall of male community leaders.

The overwhelming majority of community leaders would like to see changes in their communities in relation to female cutting, with 92% wanting to see cutting continue but only in the sunna form (i.e. for pharaonic and intermediate cuts to end). Of these, 79% (34 of 42) want to see the sunna performed by health workers. This is a view which is expressed equally strongly among rural and urban communities and more strongly among male than female community leaders. Such a change would represent a substantial shift towards the medicalisation of female cutting.

Overall, 10% of community leaders, all women, would like to see their communities abandon all types of cutting. As shown in chart 7.3.2D there is a marked difference between urban and rural communities with more community leaders wanting to see abandonment of all cutting in urban (20%) than rural (6%) communities.



In 73% (16 of 22) of communities where community leaders were interviewed they were aware of organisations which have been working in their communities to reduce female cutting. Urban communities appear to have had a greater involvement of larger INGOs including Save the Children, ActionAid and World Vision, whereas rural communities were more likely to have had contact with local CSOs like SOWDA, WAAPO, CCBRS, HAVO YOKO or Saxansaxo, a media publishing organisation.

Summary

The community leaders interviewed were drawn from a wide range of roles, with just under half (41%) being women. 82% of community leaders were engaged in health initiatives in their communities, with 66% involved in activities to reduce FGM/C.

Community leaders, especially from urban communities, tended to underestimate the prevalence of FGM/C in their communities. The overwhelming majority (88%) of community leaders would like to see some changes in relation to FGM/C in their communities, with 92% of these wanting to see cutting continue but only in the sunna form. There is a strong call from 79% of community leaders for health specialists (nurses, midwives and doctors) to perform the sunna cut, which is seen as a way of reducing the incidence of the pharaonic and intermediate cuts and ensuring the sunna is carried out safely and hygienically.

There was general agreement among all community leaders that the pharaonic cut was not required under Islamic law but that the sunna cut was honourable.

There were significant differences between the attitudes, beliefs and behaviours of community leaders from rural and urban communities, especially in relation to speaking out on FGM/C. Only 31% of rural community leaders speak out on FGM/C compared to 93% of urban community leaders.

Overall, 10% of community leaders would like to see their communities abandon all forms of cutting, with 20% in urban and 6% in rural communities.

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

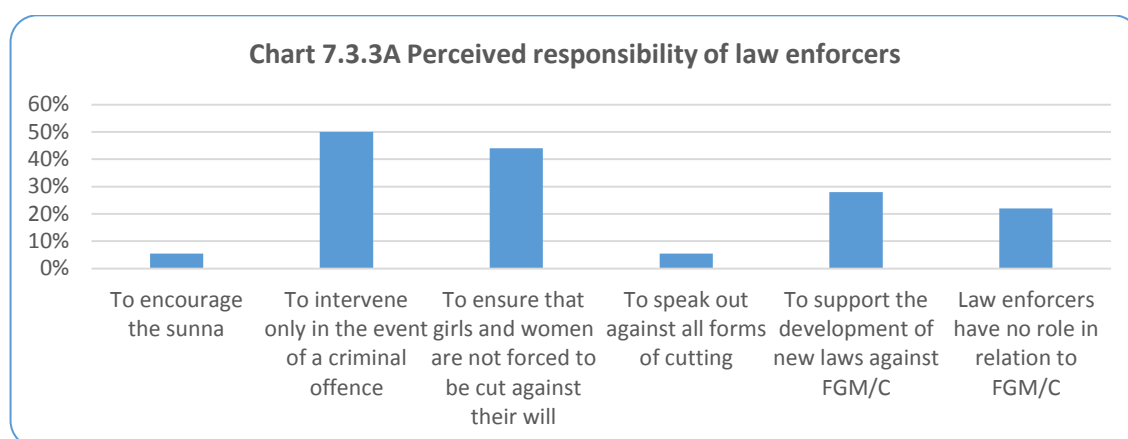
Evidence on the knowledge, attitudes and behaviours of law enforcers was gathered from two sources:

- interviews with 18 male law enforcers in 15 communities during the community survey
- a focus group discussion with three legal aid lawyers and the Legal Aid Director at the University of Hargeisa.

Table 7.3.3A summarises the profile of the law enforcers (all male) interviewed during the community survey.

Table 7.3.3A Summary of law enforcers interviewed	
Characteristic	Number
Total	18
Communities sampled	15 (8 rural, 7 urban)
Law enforcers based in rural community	8
Law enforcers based in urban community	10
Attended school	13 (72%)
Role	
Police officer	11
Police commander	3
Prosecutor	2
Local Council member	1
Local authority staff member	1
Worked in local community police station	16
Worked in local government	2
Age	
25-40	8
41-59	10

72% of the law enforcers were correct in their understanding of the legal position in relation to FGM/C, i.e. that there are no specific laws on FGM/C and that all forms of cutting are legal. The majority (83%) considered female cutting to be primarily a cultural issue, 11% considered it a religious issue and 6% a rights issue. When asked what they felt were their responsibilities as law enforcers, 22% felt they had no responsibility, although the most frequent options selected were to intervene only in the event of criminal assault (50%) and to ensure that girls and women are not forced to be cut against their will (chart 7.3.3A below).



The majority (88%) of law enforcers interviewed would be in favour of the law on FGM/C being strengthened with 75% of these supporting a law permitting only the sunna, 12% banning just the pharaonic, one law enforcer (6%) supporting a law based on Zero Tolerance banning all forms of female cutting, and one holding no particular opinion.

Only one law enforcer had been asked to intervene on a case relating to FGM/C. All participants were asked what they would do if a girl approached them for help if (a) she was being threatened with being cut against her will or (b) she had already been cut against her will. A third said that they would either do nothing or tell the girl that her parents know best. Half said that if the girl had not already been cut they would approach the parents to ask them to listen to their daughter. The remaining 28% would approach the family after the girl had been cut.

Two-thirds of the law enforcers consider that the pharaonic cut is 'not required' under Islamic law, and a similar proportion (66%) consider the sunna cut to be 'honourable'. In line with this, 72% of them perceive religious leaders as promoting the sunna cut.

Less than a quarter (22%) of the law enforcers had been involved in discussions or public meetings on FGM/C. These included Police Officers, a Police Commander and a local authority worker.

The three legal aid lawyers were aware that there is currently no law on FGM/C in Somaliland. They were conversant with international human rights law and its relevance to female cutting. They were also able to articulately explain the commitment within the Somaliland constitution to international law.

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

Legal Aid Lawyer

'FGM is a harmful practice which has no place in Sharia law. It is a serious crime under Sharia law and is no different from cutting any other organ of a woman, such as an arm, a wrist or an ear.'

Legal Aid Director, University of Hargeisa

None of the lawyers had been asked for legal advice in relation to FGM/C despite their work on women's rights, including domestic violence. It was evident that they had not discussed female cutting previously, despite working closely together. Initially, they differed in their perception of what constitutes FGM/C. All considered the pharaonic cut to be FGM/C. Two of them also included the intermediate cut with 2 stitches. The other said:

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

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

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

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

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

Summary

Over three quarters of law enforcers and lawyers support the strengthening of the law on female cutting, with at least 66% preferring a ban on all cutting except the sunna. Most are reasonably well-informed, although some would benefit from further information on female cutting and most would benefit from opportunities to discuss female cutting in safe spaces. They tend not to have spoken in public meetings on female cutting and are a group of opinion formers who are currently underutilised in changing attitudes.

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

Evidence on the knowledge, attitudes and behaviours of health workers was gathered from three sources:

- interviews with 39 health workers in 24 communities during the community survey
- a focus group discussion with health workers in an urban community in Maroodi Jeex
- key informant interviews with an auxiliary midwife in a rural government hospital, a male nurse in an urban MCH, Edna Adan Ismail and Abdirahman Saeed Mohamed from EAUH

Table 7.3.4A summarises the profile of the health workers interviewed in 24 communities during the community survey.

Table 7.3.4A Summary of health workers interviewed			
Characteristic	Number of female health workers	Number of male health workers	Total
Total	18	21	39
Working in rural communities	9	12	21
Working in urban communities	8	10	18
Level			
Community	5	18	23
District	11	3	14
Regional	1	0	1
National	0	1	1
Attended school	12 (71%)	18 (82%)	30 77%
Role			
TBA	6	0	6
Nurse	5	14	19
Midwife	1	0	7
Doctor	0	1	1

Health officer	0	1	1
Nutritionist	0	1	1
Pharmacist	0	4	4
Community	4	2	6
MCH	2	2	4
Government clinic	3	7	10
Government hospital	7	4	11
Private hospital	1	6	7
Private pharmacy	0	1	1
Age			
15-24	2 (1TBA)	5	7
25-40	11 (4 TBA)	13	24
41-59	4 (1TBA)	3	7
Over 60	0	1	1

The 39 health workers interviewed in the community survey included 33 health specialists (doctors, nurses, midwives, pharmacists and health officer) and 6 TBAs.

Traditional Birth Attendants (TBAs)

The TBAs interviewed all came from Maroodi Jeex with 83% from rural communities. Those who attended school work in government hospitals or clinics, the others work in the community. None consider FGM/C to be a health issue with opinions equally divided between FGM/C being a cultural, a religious and a rights issue. A third (2 of 6) of them are involved in activities in their communities to reduce FGM/C. Half of them would agree to cut young girls or women if approached, half would decline, none would report it. All would have their own daughters undergo the sunna cut with half using a traditional cutter and half using a doctor or midwife to carry out the cut.

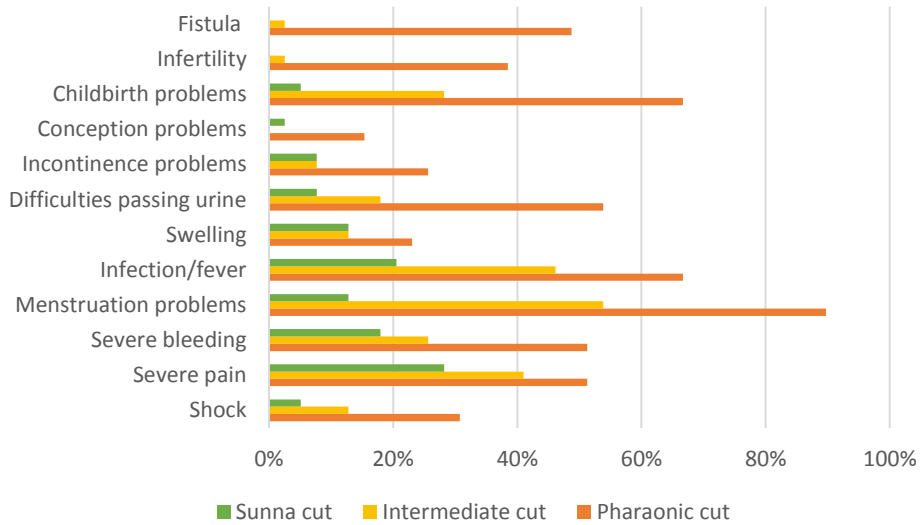
Health specialists (doctors, midwives, nurses, pharmacists and government health officer)

The 33 health specialists, 11 female and 21 male, were equally distributed across rural and urban communities, with 75% having continued to further education. 85% considered FGM/C to be a cultural issue with 15% considering it to be religious in nature. 73% are involved in health initiatives in their communities, with 41% of these being to reduce FGM/C. Four of the 33 health specialists interviewed (12%) have been approached to cut girls, half declined and half referred to another health specialist who they knew cut girls, none reported the approach. 70% would have their own daughters undergo the sunna cut, 3% would use the intermediate cut and 27% would not cut their daughters at all. Of those who would cut their daughters all would use a health specialist; 54% a midwife, 29% a nurse and 17% a doctor. 80% of health specialists would expect their son to marry a cut girl (sunna only).

All health workers (health specialists and TBAs)

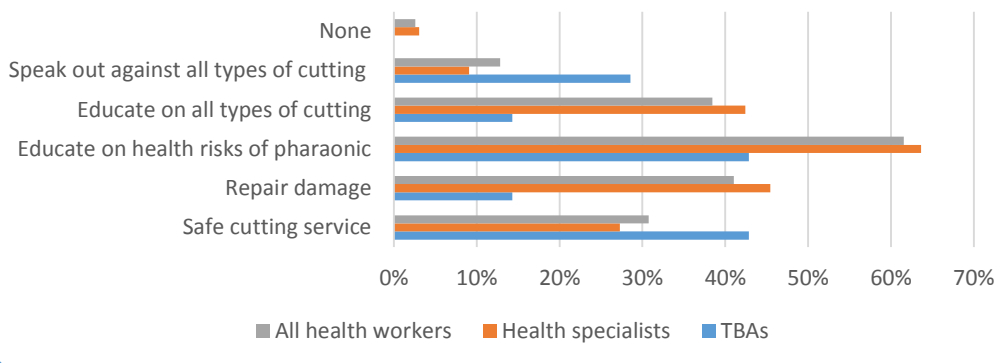
All health workers are well informed about the higher complications and health risks of the pharaonic cut compared to the sunna. Chart 7.3.4A indicates that the intermediate carries significantly higher health risks than the sunna, specifically problems relating to menstruation, infections, childbirth, urine retention, fistula and infertility.

Chart 7.3.4A Percentage of health workers reporting complications with pharaonic, intermediate and sunna cuts



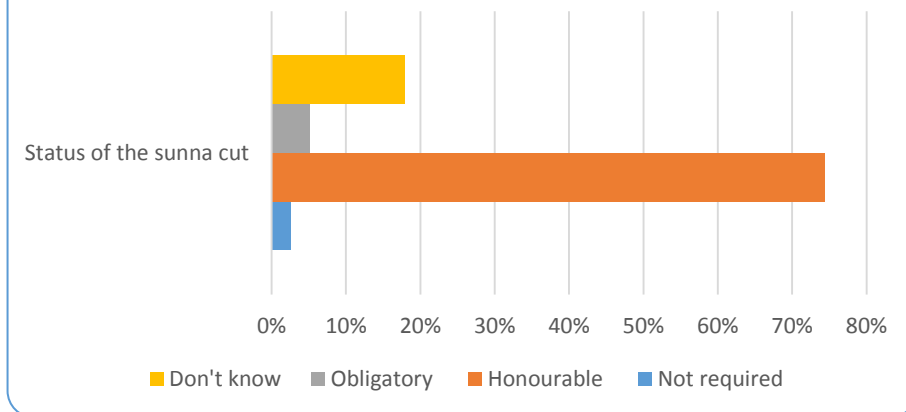
When asked what they considered their responsibilities as a health worker in relation to FGM/C, 27% of health specialists and 43% of TBAs included providing a safe cutting service (chart 7.3.4B). Overall 38% of health workers also included providing education on the health risks of all types of cutting, despite the majority of these indicating that their own daughters would undergo the sunna cut and they expect their sons to marry a girl who has undergone the sunna cut.

Chart 7.3.4B Health workers' perceptions on the responsibilities of schools



In line with other opinion former groups, health workers overwhelmingly perceive the pharaonic cut as 'not required' under Islamic law but the sunna cut as 'honourable' (chart 7.3.4C).

Chart 7.3.5C Health workers' perceptions of the Hadith in relation to the pharaonic and sunna cuts



Health workers are not well-informed about the legal status of FGM/C in Somaliland with 59% not knowing whether there are any laws and 38% believing that the pharaonic cut is illegal. 87% of them would like to see the legal position strengthened, with 13% supporting a law based on zero tolerance (including 1 TBA) and 64% supporting a law which permits only the sunna cut.

66% of health workers have had discussions about FGM/C with others, primarily with other health workers (60%), community members (36%) and families (13%).

59%, including equal numbers of female and male health workers, have spoken in public meetings on FGM/C. 52% report having sometimes had a negative response from the community. 65% of those who have spoken in public meetings support a law which permits only the sunna cut, 13% support a law based on Zero Tolerance.

During visits to health facilities and focus group discussions, individual health workers explained their role in relation to FGM/C. Their names and locations have been removed.

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

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

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

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

FGM/C practitioner, urban community

- At a government hospital in a rural community an auxiliary midwife explained how she had cut girls in order to avoid the kind of serious damage she experienced when she was cut.

'I was cut sadly before the community...changed from the Pharaonic type to the sunna type of cutting. I have suffered greatly all my life from the cutting and I do not want to see this happen'

to other people. Because of the cutting I have no children and can never have any grandchildren.

'...it [the sunna cut] is the best way the mother can treat her daughter. If she wants the sunna [type I or II] we will do it, but if she wants the totally closed type she must go somewhere else... We use anaesthetic for the 2 stitches sunna, but not for the sunna with no stitches. It is more healthy to do it here because we have the anaesthetic and use sterile equipment.'

'I feel a lot of happiness when I do this. I have experienced the FGM and have many problems and these girls will have none of them.'

'I need more training to do it better, all of us here need more training as we have never been trained for this thing.'

Auxiliary midwife

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

'I feel under pressure to do it but will definitely not do it, ever. I am disappointed by my colleagues who do it, I leave the room as I cannot face seeing the damage they are doing. Most do the 2 stitches but I know some do the 3 or 4 stitches as well. They say they are doing a good service and saving the girls from future complications. They are proud of what they do.'

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

'There is a big problem with FGM in this community, it damages organs and is the cause of so many common problems in women, including pelvic pain, abdominal pain, fistula, difficulties giving birth especially for the first born. Most people who come here still do the FGM, about 70% support it totally, only 30% oppose it.'

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

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

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

Male nurse, urban MCH

At the same MCH, three women waiting in the queue explained how they *'had invited one of the midwives from this MCH to our home to cut.....and were proud that we used the MCH as our daughters will not have any complications'*. Two of the women said their daughters had the sunna no stitches and one had the sunna with 2 stitches by MCH staff.

- Abdirahman Saeed Mohamed, Researcher and Data Analyst at Edna Adan University Hospital, explores some of the challenges if the cutting of girls using the sunna cut by health workers is formalised in Somaliland in order to reduce the serious harm of the pharaonic cut:

'There is big dilemma on the female cut. Religious leaders are advocating for the sunna cut based on Sharia law and if we train health workers and perhaps set up special rooms in MCHs then we shall be legitimising female cutting in the community which will be counterproductive to stopping the female cut. In addition, training of health workers to perform the female cut will also bring about the challenge of supervision and quality control of the TBAs who are not part of the'

mainstream health sector and yet they are close and most trusted by communities in the rural areas.'

Abdirahman Saeed Mohamed, Edna Adan University Hospital

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

Ministry of Health (MoH) position on FGM/C

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

The MoH FGM/C officer, Safia Dualeh is actively working against the involvement of health specialists in FGM/C, saying, *'We are working towards zero tolerance. We had meetings with staff from 13 MCHs in Hargeisa in 2015 to deliberate on how to stop and prevent FGM'*. These meetings were limited in scope through lack of funding and personnel.

Summary

Health workers are familiar with dealing with the complications of female cutting and are acutely aware of the associated health risks. They are in favour of a strengthening of the law in relation to female cutting with the majority supporting a law which bans all except the sunna cut with 13% supporting zero tolerance. Two thirds have had discussions about female cutting in the last year and 59% have spoken in public.

There is evidence of health workers being involved in cutting, although most say they would decline if asked to cut a girl. However, a third of health workers include providing a safe cutting service as one of the responsibilities of health facilities.

All TBAs and 83% of health specialists intend to have their own daughters cut in the future, with all health specialists and half the TBAs interviewed intending to approach a health professional to cut their daughters.

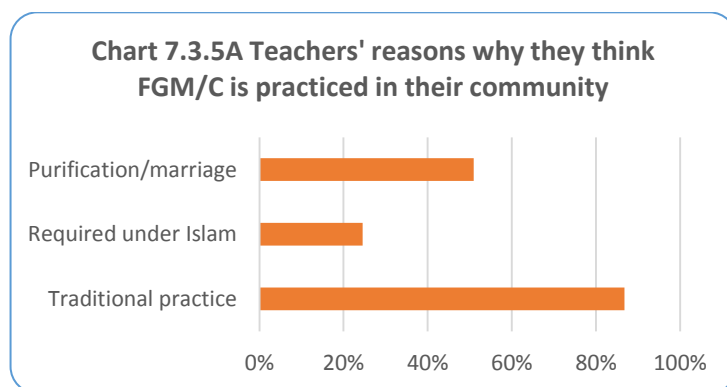
7.3.5 Teachers: knowledge, attitudes and behaviours on FGM/C

Table 7.3.5A summarises the profile of the 53 teachers interviewed in 24 communities during the community survey. Wherever female teachers were identified they were purposefully selected.

Table 7.3.5A Summary of teachers interviewed			
Characteristic	Number of female teachers	Number of male teachers	Total
Total	7	46	53
Rural communities	3	32	35
Urban communities	4	14	18

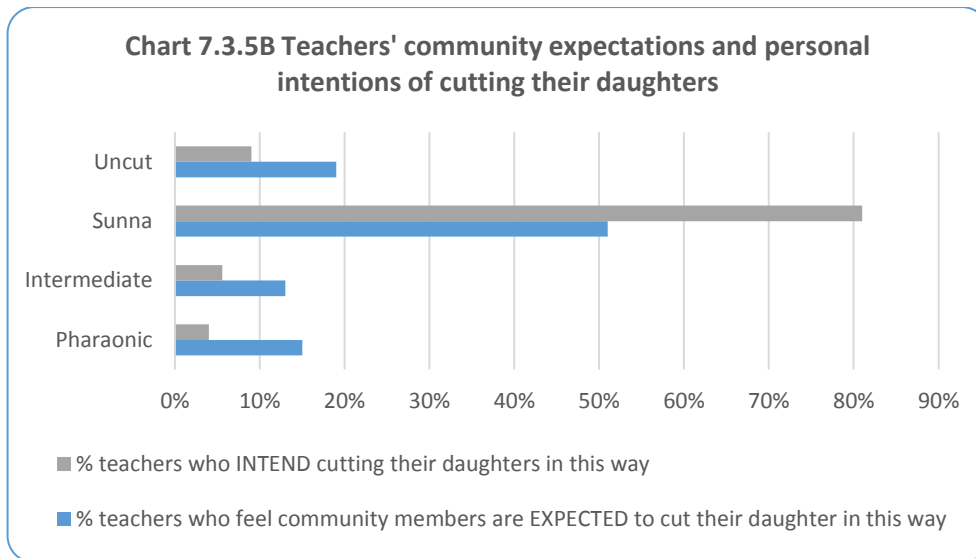
Attended school	7	37	44
Married	4	35	39
Role			
Volunteer	1	9	10
Qualified teacher	5	28	33
Headteacher	1	9	10
Primary school teacher	7	42	49
Secondary school teacher	0	4	4
Age			
15-24	3	3	6
25-40	2	23	25
41-59	2	20	22

All teachers said that FGM/C was practiced in their community, with 58% considering that it is practiced by all, 40% by most and just 2% by a few. The majority of teachers (89%) felt that FGM/C is a cultural issue, with just 4% considering it a religious issue and a further 4% a rights issue. The chart 7.3.5A below shows teachers' reasons why FGM/C is practised in their community. As with other categories of opinion leaders, traditional practice was the most commonly quoted reason, although issues relating to the purification of girls and preparation for marriage, which are closely linked were also considered important by over half of the teachers interviewed.



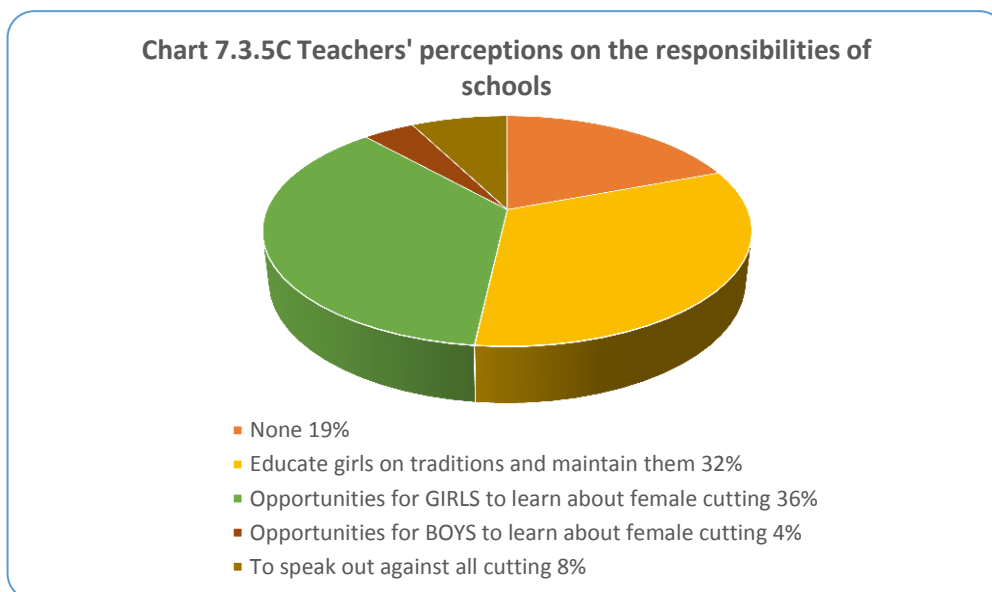
The pharaonic and sunna types of cut were familiar to 94% of teachers with only 23% knowing about the intermediate cut, including both male and female teachers. When asked who in their community is trying to stop FGM/C just under half (48%) said they did not know anyone who did not cut their daughters.

81% of teachers felt that within their community there was an expectation that parents would have their daughters cut. An even higher percentage, 91%, said they intend to cut their daughters in the future. As indicated in the chart 7.3.5B below, with both expectations and intentions, the sunna cut was the most popular. Only 9% of teachers currently do not intend to cut their daughters at all.



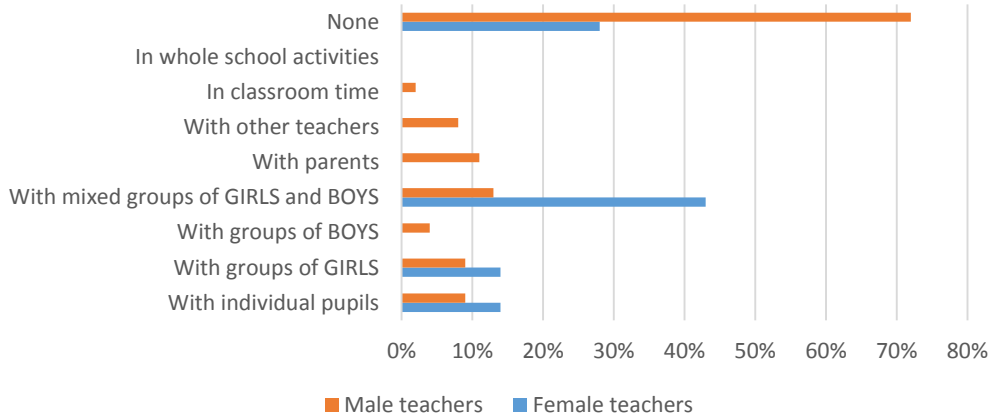
Ten male teachers were unmarried and all intend to marry a cut girl, nine with the sunna cut and one with the intermediate cut.

When asked what, if any, role schools have in relation to FGM/C, the emphasis was on two areas, providing opportunities for girls to learn about FGM/C and educating girls on the traditions and maintaining them. Only 4% felt schools have a responsibility to provide opportunities for boys to learn about FGM/C (see pie chart 7.3.5C below).



34% of teachers had spoken about FGM/C at school. Female teachers are more likely to be having conversations about female cutting (72%), although most schools visited do not have any female teachers. 75% of male teachers have not talked about FGM/C at school at all. The chart 7.3.5D below shows the types of conversations taking place. Classroom time and whole school time is rarely used to discuss FGM/C. Only 4 (8%) teachers have been asked for support in relation to FGM/C. If the girl had asked before she was cut the teacher was likely to approach the parents to ask them to listen to their daughter. If it was after she had been cut they were more likely to refer her for medical support.

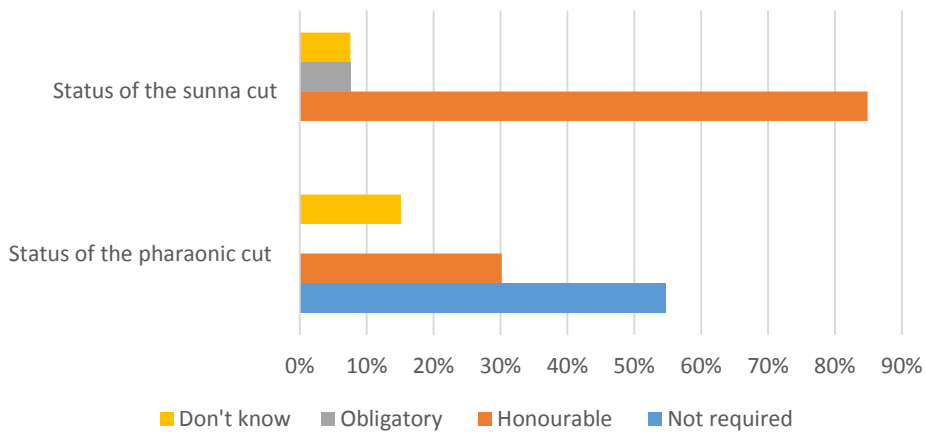
Chart 7.3.5D Conversations on FGM/C at school by teachers



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

When asked about Islamic guidance on female cutting, 55% of teachers consider that the pharaonic cut is 'not required' (55%), however, 30% consider it to be 'honourable' (or preferred). The sunna is fully supported with 85% considering it to be honourable with a further 8% considering it to be obligatory (chart 7.3.5E). This is reinforced by 72% of teachers considering religious leaders in their community support the sunna with an additional 21% saying their religious leaders do not attempt to influence families' decision-making on female cutting.

Chart 7.3.5E Teachers perceptions of the Hadith in relation to the pharaonic and sunna cuts



28% of teachers are aware of organisations which have been working towards the abandonment of FGM/C, mentioning SOWDA, CCBRS, Nagaad Network, Caritas, and Association of Chief Police Officers (ACPO). A higher percentage, 43%, have been involved in awareness-raising of some description, primarily workshops (18%) and public meetings (20%).

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

Finally, of the 53 teachers surveyed 94% (50) would like to see a future with the sunna cut only in their community, with 4% (2) supporting the status quo and just one teacher supporting Zero Tolerance.

Summary

Teachers tend to have more traditional views on FGM/C than other opinion formers with 30% of teachers considering the pharaonic cut to be honourable under Islamic law, the highest percentage of the opinion forming stakeholder groups, including traditional leaders.

Schools are perceived by a third of teachers to be places where opportunities should be provided for girls to learn about female cutting, with only 4% considering that the same opportunities should be available to boys. Although 87% of teachers would welcome a strengthening of the law on female cutting, the strongly favoured approach is a law which bans all except the sunna cut.

Fewer than half of teachers (43%) have been involved in awareness-raising about female cutting in their communities. A third of teachers have not spoken about female cutting at school. Female teachers are more likely to have conversations than their male colleagues, although many schools do not have any female teachers.

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

7.3.6 Parliamentarians: knowledge, attitudes and behaviours on FGM/C

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

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

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

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

Baar Saeed Farah, Parliamentarian

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

'...the Pharaonic has ceased completely in Hargeisa only the sunna is practised and only for 15% maximum. This is due to the high level of awareness and activity of the INGOs. They need to be encouraged to go out to the rural communities and not stay here in Hargeisa. The pastoralists in the rural areas they still do the practice.'

Baar Saeed Farah, Parliamentarian

The immediate priorities identified by Mrs Saeed were:

- changing attitudes in rural areas where FGM/C is going to be most difficult to eradicate

- securing funding to implement the new law, especially in rural areas, where fines and compensation should be introduced to provide additional funding for police time and travel
- supporting those who are cutting currently to find alternative sources of income, perhaps as policewomen to report those who still cut as they need an income to replace the one they would lose.

Mrs Saeed also stressed the need for severe penalties for those cutters who continue to practice a significant period after the introduction of a new law. She ended the interview saying:

'In 5 years' time I expect we will be close to 90% not cutting in Somaliland – even including the sunna.'

Baar Saeed Farah, Parliamentarian

The Parliamentary Committee on FGM/C is composed of 10 MPs, some of whom are associated with more than one ministry. It was not possible to interview other parliamentarians as only Mrs. Baar was available within the timescale of the baseline research. Consequently, it has not been possible to identify the percentage of parliamentarians with accurate knowledge of women's rights under international and domestic law (project indicator 4.1) or the percentage who are supportive of efforts to enact legislation eradicating FGM/C and 'strongly agree' that it should be passed (project indicator 4.2).

7.3.7 CSOs, NGOs and agencies

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

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

The 7 CSOs, actively involved in activities to reduce FGM/C, which were interviewed as part of the research all had experience of different approaches which have evolved from their experiences. All are focusing currently on approaches which address the 'demand' by community members for their daughters to be cut (i.e. their desire to have their daughters cut), rather than attempting to reduce the 'supply' of cutters (i.e. persuading those who have been cutting to stop).

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

NAFIS takes an approach which 'manipulates the decision-making process' and therefore focuses on the women, the traditional cutter and the girl. Other CSOs, Candlelight, CCBRS, Nagaad, SFHA, SOWDA and WAAPO take a more holistic approach, working with as wide a range of stakeholders as possible, including men and religious leaders.

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

Box 7.3.7A UN Women

Pusparaj Mohanty, Head of Sub Office Garowe, UN Women, considers that FGM/C is a cultural issue rather than a religious one and stressed the need for it to be seen as a rights issue saying, *'FGM is linked to poverty, to health, to education, to all of the major issues. When people side line FGM this is a false priority. It has inter-linkages with everything, ultimately to Quality of Life, even to the SDGs'*.

Mr Mohanty considers the pre-requisite of cutting prior to marriage as being *'a clear driving force'* and suggests men are *'failing to take responsibility for their role in FGM – shifting the blame to the women alone'*.

UN Women supports a Zero Tolerance approach on all forms of female genital cutting.

'We need to adopt ZT without compromise, although it might alienate some people, it is not something we should put on one side. If we aim for the sky then at least we might hit the top of a tree, but if we only aim for the top of the tree we might hit the ground. We need to have ZT clearly in our sights, even though we might end up making stepwise progress we still need to have ZT as our goal.'

Pusparaj Mohanty, Head of Sub Office Garowe, UN Women

Note: The views expressed here are those of Pusparaj Mohanty personally.

Box 7.3.7B United Nations Population Fund (UNFPA)

Ahmed Abdi Jamma, Youth and Gender Specialist, UNFPA has been actively involved in the policy and strategic discussions on FGM/C, including attending the workshops in Djibouti in December 2015 which brought together religious leaders from Somaliland and Egypt.

Although committed to the abandonment of FGM/C, Mr Jamma sees the concept of Zero Tolerance as unhelpful. Prior to its introduction INGOs were trying to promote change from the pharaonic to the sunna with the support of the religious leaders. But with the current prominence of Zero Tolerance in the debate the religious leaders are now seen to be opposing change, rather than promoting it.

He says, *'Religious leaders are at the forefront of the campaign against FGM, without them little progress will be made. They are the most trusted group of people at community level and people will not go against their guidance'*.

Mr Jamma does not see marriage as a significant factor and stresses the need to work with girls and women to change the practice.

Fathers, sons, brothers – none of these are involved or aware. FGM is a women's issue which is not really the concern of the men. The men know little or nothing about it, they do not speak about it, it is not something which they have anything to do with. It is possible that men could be made more aware of the issues around FGM, but the focus of efforts to reduce FGM must be on the grandmothers and mothers, this is where the attitudes need to change.

Ahmed Abdi Jamma, Youth and Gender Specialist, UNFPA

Note: The views expressed here are those of Ahmed Abdi Jamma personally.

Box 7.3.7C Candlelight

Candlelight is a CSO working on environment, education and health which incorporates FGM/C in its programmes building on the strong relationships established around practical projects, for example, providing water points in the village so girls didn't have to walk far to fetch water where they could be raped. Candlelight also works with circumcisers on alternative livelihoods, giving grants to establish small businesses.

Fardus Awil Jama, Executive Director, has seen attitudes change in recent years with conversations happening between women and men and village anti-FGM committees starting to oppose cutting.

Candlelight adopts a zero tolerance approach and is in close dialogue with religious leaders, some of whom now encourage families to choose not to cut their daughters i.e. accepting that the sunna is 'not required' under Islamic law.

'We now find some religious leaders are working with us, whereas before they stood against us...'

Fardus Awil Jama, Executive Director, Candlelight

Box 7.3.7D Comprehensive Community Based Rehabilitation in Somaliland (CCBRS)

CCBRS is CSO working in rural communities and with IDPs in Hargeisa and Togdheer taking a community-wide approach to FGM/C, establishing anti-FGM committees in communities consisting of parents, teachers, police, women's groups, youth, traditional and religious leaders. CCBRS consider marriageability to be a major factor in the continuation of FGM/C and have 'men-to-men' initiatives raising awareness and supporting men in becoming involved in decision making in relation to cutting their daughters.

CCBRS supports Zero Tolerance, although admits that this will take a considerable time, especially among rural and IDP communities. They see two key challenges, the support given to the sunna by religious leaders and the lack of alternative income for traditional cutters.

In the communities where CCBRS works, the religious leaders, without exception, believe there is a hadith for female genital cutting, although opinions differ on whether it is obligatory or not required. All religious leaders oppose the pharaonic cut and CCBRS use religious leaders to dissuade mothers from submitting their daughters to the pharaonic cut.

CCBRS have dismissed providing alternative means of support for cutters as *'there have been cases where the circumcisers in the community abandon the practice but they just train others in the community to carry out the cutting and take a portion of the money they make'*.

Box 7.3.7E Network Against FGM/C in Somaliland (NAFIS)

NAFIS is a networking organisation bringing together CSOs and NGOs with an interest in FGM/C. In 2014, NAFIS carried out research in collaboration with MoLSA which was a descriptive cross-sectional survey involving over 2,000 women across the 6 regions of Somaliland. Prevalence levels of 99.8% were found with slightly higher levels in rural than urban communities. Marked differences were found in the type of cut women had undergone in rural and urban areas with higher levels of the pharaonic cut in rural areas. The research covers a wide-range of issues relating to women's perceptions, with a wealth of quotes.

Abdirahman Osman Gaas, NAFIS Network Coordinator, considers FGM/C to be primarily a religious issue with a strong cultural basis. He stressed that female cutting is seen as

protecting girls from pre-marital sex and protecting marriageability.

Mr Gaas considers that it is too early to take a rights-based approach at a community level saying, *'many do not know their rights and have not had exposure to this way of thinking. It is not until we can all recognise that this is a violation against rights that we can take a rights argument to the community'*.

Following their recent strategic planning process, NAFIS are focussing on 'manipulating the decision-making process' which analyses where decisions about cutting girls are made, by whom and then develops strategies to engage with these processes.

Mr Gaas' priorities for action on FGM/C were:

- *Linking health complications and FGM – most women do not make these connections, if they did they would act differently.*
- *It is a multi-dimensional issue and needs to be a cross-cutting issue linked with livelihoods, WASH, DRR, agriculture. It fits with each of these and if communities have partners who are supporting their agriculture and it is working well then they will be more open to listening about FGM.*
- *Collaboration – networking and partnerships.*

Box 7.3.7F Nagaad Network

Nagaad Network is a networking organisation which collaborates with grass roots organisations with its strengths in (a) advocacy at government level and (b) bridging the gap between governmental and INGO levels and local CSO/NGO activity. Nagaad's programme covers a wide remit in relation to women's rights, of which FGM is a strong embedded element.

Nafisa Yusuf Mohamed, Executive Director of Nagaad says of FGM/C:

'It's quite clearly a health and social issue....It's difficult to say who is driving for the continuation because it is so engrained and accepted. Most women believe in FGM, quite simply that..... Young female intellectuals are the key people deciding not to cut, making decisions with their husbands. They have education and usually jobs and so their husbands respect them and they talk about important decisions together.... Possibly some health workers are also not cutting their daughters, or at least moving away from the pharaonic.

'It is also a gender issue. The father is responsible for the home and husband and wife together need to be making these decisions. They are not just women's issues at all. Not much is said about the role of men although some research Nagaad member organization (Alkowniin Organization) carried out in 2005 among men showed that they believe that FGM protects the girls, so that they can be married. So marrying a cut girl means they believe she's intact. If she is not cut they believe they do not have that guarantee.

'There are different interpretations from different scholars but essentially it should not be a religious issue although the religious leaders are strongly involved in keeping the sunna, though it is not clear what the sunna is, it is not defined. When we get in these conversations we find ourselves asking of MoRA for them to define the sunna as this is not clear at all. Is it cutting just the tip, or more?

'The only clear position is abandonment, no cutting at all, then it is clear. We keep talking but there is no clarity about what the sunna is.

'The term ZT makes people defensive, it feels like you are bringing criticism in from the outside, damning people's cultural tradition. It is not a helpful term at all. We should be

instead using the term 'abandonment' which is what we use in Somali.'

Box 7.3.7G Somaliland Family Health Association (SFHA)

SFHA provides a wide-ranging programme of interventions principally focus on women and child health and empowerment. SFHA is involved in advocacy, service delivery (in clinics and outreach) and counselling on women's health.

Amal Ahmed, Executive Director SFHA explained SFHA's position on FGM/C

'There is definitely a religious aspect. But, there are people now who have come to the realisation that the Pharaonic cut is definitely not required under Islam, however even knowing this they continue to cut their daughters. So although there is a religious dimension, the enduring reason is very much cultural.

Women in communities are the key people perpetuating the cutting. I have encountered many households where the man either doesn't know what is happening or actually opposes the cutting, however the women continue to practice it.

Marriageability is a major driving force with older women fearing that their daughters might not be able to be proved to be virgins and therefore unacceptable as wives. Cutting is also seen as a deterrent against rape which is increasing in urban areas.

The positive deviants at the moment are people who have lived elsewhere, from the diaspora. The other key group are the Sheiks and their families. Many of these no longer cut girls in their households, however placed in a formal setting they will continue to support the cutting as 'Sunnah'.

The use of judgemental terms like FGM is in itself a deterrent for change. Communities react strongly to the use of the term and close down from listening. They see FGM as yet another 'project', rather than something which they want to change within their own communities.

Zero Tolerance as an approach will not work. It is impractical and causing people to retrench, building barriers to progress rather than helping. Gradual stepwise change is far more practical. If the religious leaders can be supported in stating their opposition to the pharaonic, whilst retaining the sunna then this would be a positive step towards abandonment.

My priorities?

- *Holistic programmes which draw together different stakeholder groups into forums.*
- *Working with school as there have been virtually no programmes which focused on schools and teachers, despite education being disrupted considerably following cutting.*
- *Focusing on partnerships and consortia. This has begun to happen with the work of NAFIS and MoLSA, however it needs to be a core element of all programmes.*
- *However, currently the focus is on the urban areas with the rural areas receiving a less sustained and supported programme of activities promoting movement towards abandonment.*

Box 7.3.7H Somaliland Women Development Association (SOWDA)

SOWDA is committed to working on the concerns of destitute women and children, particularly focusing on providing livelihood programmes including water, health, education,

and economic empowerment. SOWDA is currently implementing an FGM project in 19 community sites.

SOWDA believes that FGM/C is a deeply rooted cultural practice that was established a long time ago and is deeply embedded. They do not see any form of cutting as justifiable under Islamic Law and feel that the practice of cutting has no position in Islam. They are in favour of the complete elimination of all forms of FGM/C and favour an approach which brings all types of people together to unite in efforts to abandonment.

Ibrahim Mohamed Ismail, SOWDA Executive Director, explains three key reasons why he feels communities continue to practice FGM/C:

- It is a cultural practice which having been adopted is now deeply embedded in Somaliland culture
- FGM/C is not a subject which is talked about and so existing practices are not discussed or challenged
- Religious leaders and traditional elders do not publicly speak against FGM/C.

Box 7.3.8J Women Action for Advocacy & Progress Organization (WAAPO)

WAAPO is a women's organisation focusing on women's rights, especially health, focussing on education, economic capacity building, reproductive health, gender based violence and FGM/C.

WAAPO considers FGM as a cultural issue, about attitudes in the community with the community believing that it is part of their historical culture.

Kaltun Sheik Hassan, Executive Director explains the driving force for the continuation of cutting:

'If you try to find an origin then you can look but you may not find it because it is not there. They, the community as a whole, men, women, everyone just expect it to happen and it happens. Challenging this deeply held practice is not going to be easy at all. Those who do not cut are usually women intellectuals who are strongly against FGM and a few men although not many and they are not very vocal. The role of men is not well considered; men are far more important in FGM than people think. We need also to be working with the Sheikhs, people in the communities listen to them and so we need the Sheikhs to come on board with us.'

Initially when WAAPO began working in communities the community leaders would not talk about issues like FGM/C, however now they talk openly about it.

Kaltun Sheik Hassan, Executive Director voices her frustrations about the policy making process

'We need Zero Tolerance as the Law. Policy makers are giving contradictory messages...If a new law is not Zero Tolerance how can I implement it? If it is supporting sunna then it is not supporting me... When the new law is passed [ZT] how can the MoRA accept and implement it as they still support the sunna? MoRA must shift their position to eradicate it.'

She also gave the following priorities for future action:

- National agencies should be supporting the local agencies as well as supporting the policy development process
- Policy and passing a law banning all types of cutting, with real punishments

- Implementation of the policy at community level, meeting and mobilising them
- Targeting the community committees, men especially, schools etc. All of these need to be fully involved in mobilisation
- Targeting the Health Post Centres as these are the places where the women take their daughters to have them cut
- Public Interest Prosecutions, developing some cases and taking them all the way to court.
- Establishing a monitoring committee to monitor the progress.

7.4 Policies and laws relating to FGM/C in Somaliland

Currently there is no approved policy and no laws in place in Somaliland on FGM/C.

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

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

Whilst these statements strongly oppose FGM/C, they do not define what actually constitutes FGM/C. This research confirms that most consider the sunna cut to be approved under Sharia law. As such article 36 sub-article 2 of the National Constitution would only relate to the pharaonic and intermediate cuts and not the sunna cut.

The usual process for developing new legislation in Somaliland is to draft policy which first passes through the cabinet for approval, before being signed by the President. A lead ministry is then selected, from the 23 ministries, and a task group established with representation from key ministries with expertise and influence.

The lead ministry on FGM/C strategy and policy development is the Ministry of Labour and Social Affairs (MoLSA). Seven other ministries are involved in the task group on FGM/C, namely, the Ministries of Religious Affairs (MoRA), Health (MoH), Education (MoE), Justice (MoJ), Interior (MoI), Planning (MoP) and Youth (MoY). All support Zero Tolerance with the exception of MoRA.

Work began on the drafting of a *National Policy for the Abandonment of Female Genital Mutilation* (FGM/C Policy) in 2009. UNFPA in collaboration with AAIS and others, had hoped to present the final policy to the cabinet in 2016, with the support of the First Lady. However, further discussion between ministries is required before the policy can be agreed and presented to cabinet.

The goal of the draft FGM/C Policy is *to accelerate total abandonment of FGM/C in the Republic of Somaliland.*

The FGM/C policy will:

- Document the current status of FGM/C in the Republic of Somaliland
- Identify existing gaps in FGM/C interventions
- Document promising interventions and good practice on FGM/C within Somaliland and in the region

- Make policy recommendations for FGM/C abandonment
- Provide an Action plan for FGM/C abandonment in Somaliland.

The content of the draft FGM/C policy is not yet ready for public distribution, although it has been shared with AAIS and the lead consultant for the research. The problem statement below indicates the strength of the government's commitment and also highlights some of the challenges.

Box 7.4A Problem Statement from the draft FGM/C Policy

For the past years, The Government of the Republic of Somaliland and its partners have been addressing FGM/C from a health perspective, through training of health professionals (particularly midwives) to mitigate maternal and child mortality, establishment of FGM/C trauma centres and health services addressing FGM/C complications. Despite these efforts, the Human rights aspect of FGM/C has been at a low key, with FGM/C abandonment campaign mainly targeting Religious leaders. Most of the FGM/C abandonment activities are being implemented in the urban centres. Yet very little is being done by implementing organizations among the rural and nomadic communities. Ironically, rural communities that are not being targeted are the major practicers [sic] of FGM/C.

The government and many civil society organizations have initiated different efforts and outreach programs in order to encourage communities to abandon the practice. Unfortunately, although there have been several efforts in the recent past to introduce legislation against FGM/C, Somaliland does not have a national law against FGM/C.

This implies that, despite the Government of Somaliland's willingness and commitment to protect and preserve the rights of women and girls from FGM/C, without an existing FGM/C law, through which it can be interpreted that a crime has been committed, protection will not be legally possible.

Moreover, the Republic of Somaliland does not have an FGM/C National policy or strategy for the eradication of this practice. It is therefore important to develop an FGM/C National policy, which will address the strategy for FGM/C abandonment, and in future lead to an "Act of Parliament." It is hoped that, the "Act of Parliament" will pave way to an FGM/C law, which will criminalize the practice.

An Anti-FGM/C Bill, grounded firmly in Zero Tolerance, has been drafted with cross-ministerial collaboration. The draft is understood to be in need of refinement through the consultation process.

The MoH is drafting policy on anti-medicalisation of FGM/C to be submitted for approval by the government, later in 2016. This will fit within the proposed FGM/C policy. Currently, the focus for health specialists is on training to safely open a woman who has undergone the pharaonic cut and the prohibition of re-infibulation (the re-closing of the vaginal orifice after childbirth). The draft policy does prohibit health care workers from performing FGM/C, however, it does not state that FGM/C includes the sunna cut. This research confirms that there is considerable pressure for health workers to take on the role of cutters in order to reduce the health risks (section 8.5).

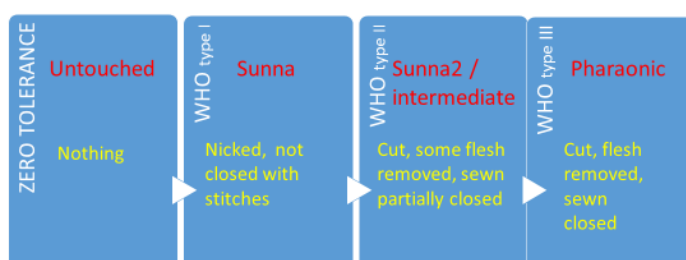
Another complicating factor is the progress of the bills on Quota (representation of women) and Sexual Offences, which currently does not include FGM/C. Both are well developed but have yet to be approved. UNFPA feel that priority should be given to these bills before pushing for the Anti-FGM Bill. UNFPA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

8 DISCUSSION OF KEY THEMES

8.1 Recognising the intermediate cut / sunna 2

Crawford and Ali (2015) recognised the increasing use of the intermediate cut as a form of FGM/C in Somaliland. They also highlighted the varied ways in which the term sunna is used, from only drawing blood to a cut removing flesh and involving stitching. The AAIS team and its partners, SOWDA and WAAPO noticed both of these features. Consequently, it was decided to include the intermediate cut in the community survey, especially with the women, to identify movement from the pharaonic to the intermediate cut which would not be recognised if only the terms pharaonic and sunna were included.

Chart 8.1A Types of female genital cutting in Somaliland



The inclusion of the intermediate cut was both challenging and positive.

Challenging, because only 10% of men were familiar with the intermediate cut, although this in itself demonstrated the lack of specificity in the conversations between women and men about female cutting (section 8.8). It was also challenging for the enumerators as they had to learn to question what participants meant when they responded 'sunna'.

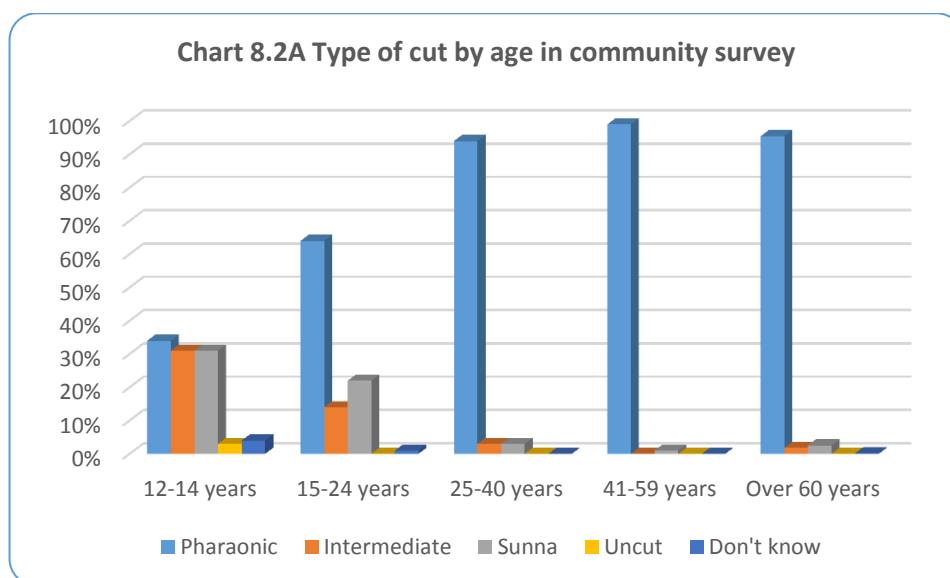
Positive, because it made the conversations extremely practical. Participants needed to be specific about the type of sunna cut to which they were referring. This made them think, question and discuss among themselves in focus group discussions. It helped people, including a group of women's rights lawyers (section 7.3.4), to discuss, and later agree on what they understand as the sunna cut. Religious leaders found it useful as a means of demonstrating their position and it helped clarify, in discussions with religious leaders, the type(s) of cut which they consider to be Islamic and those which they do not.

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

8.2 Prevalence of female genital cutting

The prevalence rate among community women in 25 communities across Maroodi Jeex and Togdheer was 99.4% (98.7% in urban and 99.8% in rural communities). This is in line with MICS 2011 (99.1%), research from Edna Adan University Hospital (2006-2009, 97%, 2009-2011 98%) and NAFIS 2014 (100% in rural and 99.8% in urban communities). There is a perception among policy-makers, NGOs and CSOs that a substantial proportion of the urban community have abandoned all forms of cutting (8.3). However, this is not borne out in this research. It may be that policy-makers are talking primarily to young, educated professionals who aspire not to cut their own daughters and that there will be a change in prevalence in the next 10-15 years as those daughters phase into datasets.

Although the prevalence rate remains stubbornly high, there is strong evidence of a significant change in the type of cut which girls and women are undergoing (chart 8.2A). Overall, 80% of girls and women interviewed had undergone the pharaonic cut, however, there has been an increase in the proportion of girls undergoing the intermediate and sunna cuts in recent years with equal numbers of 12-14 years old girls undergoing the 3 types of cut. This change has resulted in fewer girls requiring cutting open on their wedding night (and thus experiencing the trauma involved) as well as a reduction in the medical complications reported.



There is a danger that if progress is measured solely against the goals of Zero Tolerance or abandonment that significant changes in the type of cut are not valued. It may be that by recognising that female genital cutting is not a static practice, but rather an evolving one, that communities can be encouraged to embrace change more readily.

8.3 Differences between FGM/C in urban and rural communities

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

Urban communities have a higher concentration of CSOs working on social issues like FGM/C. Levels of school attendance are higher (45% in urban compared to 25% in rural communities), as are access to health facilities and access to information through the media. In addition, initiatives to raise awareness on FGM/C have taken place predominantly in the urban areas, with rural communities being more likely to have had short term interventions, if any.

The key differences identified are:

- the move away from the pharaonic to the intermediate and from the intermediate to the sunna is stronger in urban than rural communities (section 7.1.2)
- the percentage of girls and women cut by health specialists is higher in urban (11%) than rural communities (2%) communities (7.1.3)
- religious leaders are more likely to support the abandonment of all forms of cutting in urban (29%) than rural communities (8%) (7.3.1)
- religious leaders are more traditional in their interpretation of Islamic law with more considering the pharaonic cut to be honourable in rural communities (23%) than urban communities (15%) (7.3.1).
- community leaders are more likely to support abandonment of all forms of cutting in urban (20%) than rural (6%) communities (7.3.2)

- community leaders are more likely to speak in public about FGM/C in urban (93%) than rural (31%) communities (7.3.2)
- decisions about whether young men marry a cut or uncut girl are more likely to be left to the son in urban (20%) than rural communities (17%) (7.2.8)
- more community members aspire to the abandonment of all forms of cutting in urban (7%) than rural communities (3%) (7.2.14)

The differences between urban and rural communities are fully recognised by MoLSA. The Director of Social Affairs, Ms. Luul Aden, explained that MoLSA's understanding is that the prevalence of the pharaonic cut in urban areas has reduced to quite low levels and that the rural areas are the priority in the coming years.

The differences in attitudes and behaviours in relation to FGM/C between urban and rural communities have implications for both programme implementation and monitoring, evaluation and learning (MEL) processes.

In urban communities, the change from pharaonic to intermediate cut already has momentum. As well as supporting this trend, AAIS may be able to develop a core group of supporters for abandonment of all forms of female genital cutting. Social exclusion of uncut girls and women is likely to be lower where such a core group is vocal. Champions for abandonment could be identified from most stakeholder groups and a critical mass could be established speeding up the process of attitudinal change.

In rural communities, the priority might be to support the move from pharaonic to intermediate, and intermediate to sunna, whilst not losing sight of abandonment as the goal. Attempting to push towards abandonment might, as MoRA, several CSOs and Edna Adan, Director of Edna Adan University Hospital have suggested, polarise opinions and be counter-productive at this stage in the process of change.

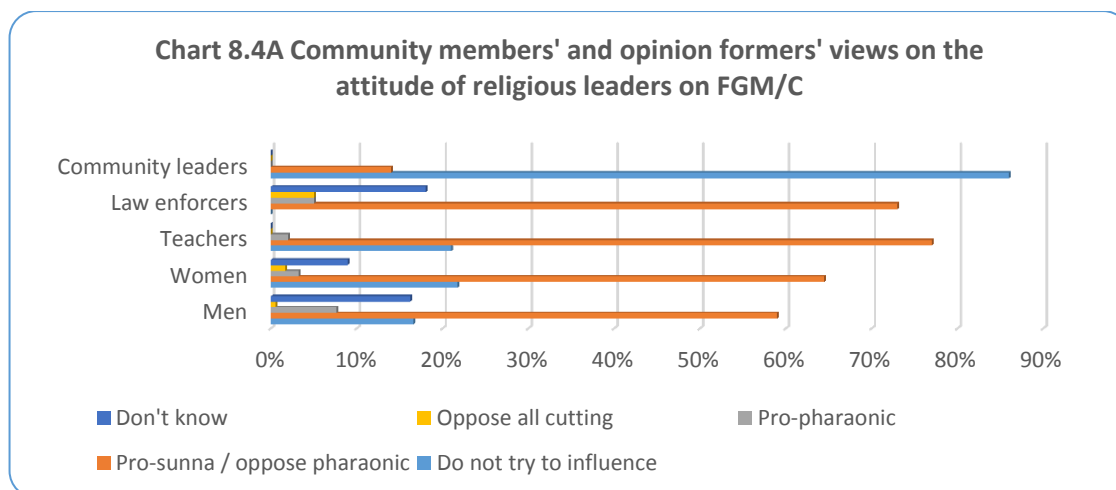
8.4 Role of religion and religious leaders

FGM/C is linked with religion and religious leaders in Somaliland as the leading school of Islamic thought is Shafi'i in which there is considered to be guidance (sunna) on female genital cutting.

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

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

The overall position of religious leaders on female cutting is well understood by two thirds of community members and three quarters of community leaders, teachers and law enforcers who see religious leaders in communities as opposing the pharaonic and supporting the sunna cut (chart 8.4A). This does however, leave a significant proportion of the community not aware of the guidance from their religious leaders.



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

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

'If we think of two the extremes of thought at the moment.....on the one extreme is the pharaonic cut, which is harmful and cruel and non-Islamic. Then on the other extreme is the Zero Tolerance position. Zero Tolerance is an extreme position, of that there is no doubt.....At the moment the Islamic leaders are stopping the pharaonic. Those calling for Zero Tolerance are not stopping the cutting, they are polarising positions and slowing progress.'

Mohamed Ibrahim Jama, Head of Department of Islamic Propagation, Ministry of Religious Affairs (MoRA)

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

Bearing in mind how influential religious leaders are in communities and their position on the pharaonic and the intermediate cuts, it could be beneficial to support them in increasing their involvement in discussions and public speaking about female cutting. Their involvement could encourage people away from the pharaonic, towards the sunna, rather than the intermediate. Although at present it is unlikely to support abandonment of the sunna.

8.4 Medicalisation of FGM/C

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

Although only 5% of the women surveyed were cut by a health specialist, evidence of a drive towards increased medicalisation of cutting is present throughout the research (table 8.5A).

Table 8.5A Evidence of the drive towards medicalisation of FGM/C

1. Young women (12-14 years) interviewed were more likely to have been cut by a health specialist (14%) than older girls and women (4%) (section 7.1.3)
2. The percentage of participants' daughters being cut by a health specialist is 33% in urban and 10% in rural communities (section 7.1.3)
3. 55% community men and women in favour of only the sunna, would like to see health workers trained to cut their daughters safely (section 7.2.14)
4. In focus group discussions community women describe how they have taken their daughters to MCHs for them to be cut or arranged for a health professional to come to the village to cut girls (section 7.1.3)
5. 75% community leaders in favour of only the sunna in future, would prefer the girls from their community to be cut by a health specialist (section 7.2.14)
6. Half of TBAs interviewed would use a health professional to cut their own daughters (section 7.3.5)
7. All health specialists (doctors, midwives and nurses) who said they will have their daughters cut, will ask a health specialist to perform the cut (section 7.3.5)
8. Health workers in government hospitals and MCHs have spoken about having cut young girls themselves, or know colleagues who do so (section 7.3.5)
9. 27% of health specialists and 43% of TBAs included providing a safe cutting service in the responsibilities of health facilities
10. Community religious leaders and senior clerics from MoRA would welcome the open involvement of health workers in the cutting of girls and women (sections 7.3.1)

There are opposing schools of thought in relation to the medicalisation of FGM/C.

The MoH has recognised the drive towards medicalisation of FGM/C and has adopted two strategies, drafting an anti-medicalisation of FGM/C policy and undertaking training workshops for MCH staff (section 7.3.4). Anti-medicalisation of FGM/C is already included in the midwifery and nursing curricula of some teaching hospitals, including Edna Adan University Hospital. CSO and NGO workers in favour of Zero Tolerance oppose the involvement of health specialists as this would legitimise the sunna cut, setting it apart from the pharaonic and intermediate cuts, rather than opposing all forms of cutting.

Abdirahman Saeed Mohamed, Researcher and Data Analyst at Edna Adan University Hospital, explains, '*....if we train health workers and perhaps set up special rooms in MCHs then we shall be legitimising female cutting in the community which will be counterproductive to stopping the female cut. In addition, training of health workers to perform the female cut will also bring about the challenge of supervision and quality control of the TBAs who are not part of the mainstream health sector and yet they are close and most trusted by communities in the rural areas.*'

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

Shell-Duncan (2001) suggests that '*medicalisation, if implemented as a harm-reduction strategy, may be a sound and compassionate approach to improving women's health in settings where abandonment*

of the practice of “circumcision” is not immediately attainable’. It may be that Somaliland is one such setting.

8.6 Communication and conversations

The extent to which community members and community leaders openly discuss FGM/C is included in the project indicators in recognition of the importance of dialogue and exchange of knowledge and views in the process of changing attitudes. This study incorporated the extent to which people are talking about female genital cutting both privately and publicly.

Among families and in schools FGM/C is hardly talked about. Only 22% of community members interviewed have spoken to anyone about FGM/C in the last year. The age range 12-14 years were the least likely to speak to others (5% for young women, 1.5% for young men). A young man in Stadium, an urban community said, ‘...we know only a little as it is never talked about with us’. This is reinforced by the view that FGM/C is a women’s issue only, hence not a subject young men need to know about. Without knowledge and an opportunity to be included in discussions about FGM/C, most of these young men will be unlikely to engage with FGM/C as an important issue in their community.

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

Few conversations are taking place in schools, with only a third of teachers saying they have had any conversations about FGM/C at school. There were no reports of any whole school time being allocated to FGM/C and only 1 of 47 teachers said they had discussed it in class time. In countries where substantial progress has been made in reducing the incidence of FGM/C, schools and teachers have been influential in promoting debate and bringing about change. In Somaliland currently schools and teachers are not considered agents of change. Abdirahman Osman Gaas, Network Coordinator from NAFIS, was just one of several voices who said, ‘Schools are not important currently as the subject is taboo and FGM/C cannot be spoken about in the education environment’.

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

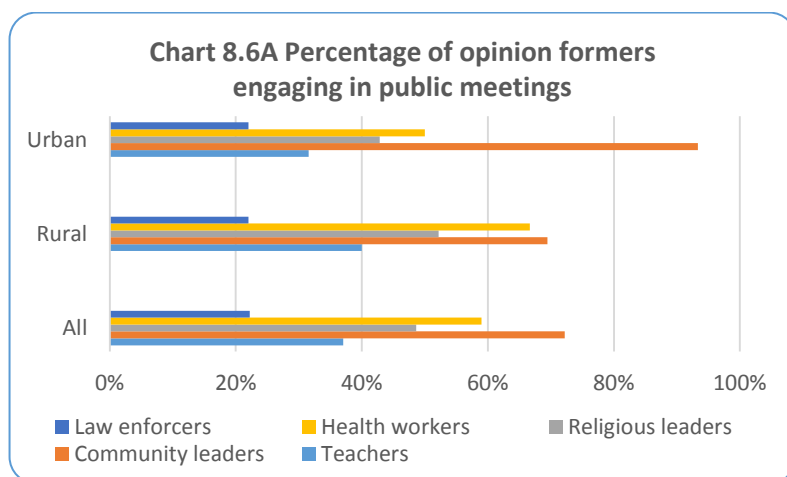
In almost all of the 22 focus group discussions, at least one participant, and often many more, changed their views in some way about FGM/C as a result of hearing other people’s views or having their own views challenged. This included groups of men, women, community leaders, health workers, religious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

One way that women and men deal with the decision-making dilemmas they face in relation to female cutting, is the careful and deliberate use of unspecific terms and phrases. Women in one focus group discussion said, ‘We inform the father that the girl is going ‘to be purified’ and avoid giving any details at all’. Men, from the same community, said of the same conversations, that they would be, ‘very general, along the lines of just agreeing that my daughters would be purified...I know this to mean the sunna with no stitches’(7.2.10). Following these conversations, the girls undergo the sunna 2 cut, with 2 stitches. The women can say they have ‘told’ their husbands who have agreed, and the men can say

they have ‘checked’ that their daughters are only undergoing the sunna (with no stitches), approved under Islamic law. The women are, by their own admission, using unspecific language to deceive the men, or at least to avoid the dilemma they face of wanting to avoid harming their daughters but wanting them to be acceptable to men for marriage. However, the men are clearly complicit as they go on to talk about the need for proof of virginity prior to marriage, which means, in their culture, that a girl must be at least partially closed with stitches.

It is clear from these discussions that neither the men nor the women lack knowledge about FGM/C, instead they lack the skills and opportunities to communicate openly and honestly on these difficult dilemmas.

Almost half (44%) of community members said that FGM/C was not raised at all in public meetings in their community. For this to change, opinion formers like teachers, health workers, law enforcers, community and religious leaders need to be more pro-active in ensuring public meetings are taking place and in speaking at them. Currently, it appears that community leaders are the most active opinion formers in terms of public speaking, especially in urban communities. Law enforcers and teachers are less active than health workers and religious leaders (chart 8.6A).



Perhaps surprisingly, a higher proportion of community members said they felt able to speak in public meetings (66%) than had actually spoken to anyone about FGM/C in the last year (22%). This might suggest a willingness to engage, although a reluctance to be the person who raises the topic. The experience of facilitating the focus group discussions would support this. Community members were often quite reticent at first, although were keen to share experiences and to take forward conversations into their communities, once the conversations were established.

8.7 Role of men

There is general agreement that in Somaliland women, mothers and grandmothers in particular, are the principle decision-makers about whether a girl is cut and the type of cut she undergoes (7.2.9). Results from the community survey indicate that these decisions are made jointly by men and women in only 8% of families, in both urban and rural communities. In the focus group discussions men and women stressed that *‘the women look after the girl’s issues and the men the boy’s’* with this being cited as evidence that men have little influence over FGM/C.

The role of men in FGM/C is the factor with most polarised views across the different stakeholder groups. These different perspectives¹⁵ are characterised by Pusparaj Mohanty from UN Women, who suggests men are *'failing to take responsibility for their role in FGM'* whereas Ahmed Abdi Jamma from UNFPA feels that *'the focus of efforts to reduce FGM must be on the grandmothers and mothers, this is where the attitudes need to change'* (7.3.7).

The CSO NAFIS are focusing on manipulating the existing decision-making process and so are focussing their interventions primarily on the mother, the grandmother and the traditional circumciser, in line with their research which shows that men are actually involved in the decision-making around FGM/C in less than 20% of households. Other CSOs take a different view and are attempting to draw men into the decision-making process, for example CCBRS which has developed a 'men-to-men' initiative (7.3.7).

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

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

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

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

8.8 Driving forces and decision-making dilemmas

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

¹⁵ These perspectives are personal views expressed in key informant interviews, not official views of UN Women or UNFPA.

The most cited reason (62%) is that the pharaonic cut, as the name implies, is a pre-Islamic, traditional practice, believed to have originated with the Egyptian pharaohs (FGM/C is thought to have first originated in the Nubian Empire covered the area now Sudan and Egypt) and now deeply embedded in Somaliland culture. This is reflected in the comments of Nafisa Yusuf Mohamed, Executive Director of Nagaad, *'Most women believe in FGM, quite simply that...'* and Kaltun Sheikhassan, Executive Director of WAAPO, *'If you try to find an origin then you can look but you may not find it because it is not there... men, women, everyone just expects it to happen and it happens'*. So there is a deeply embedded cultural driver in favour of female genital cutting which is difficult to oppose through rationale argument.

Religion is cited as a factor by 36% of men and 13% of women. In focus group discussions men, in particular, talked about following the guidance of their religious leaders. The religious leaders support primarily the sunna (with no stitches) and the community are on the whole aware of this, or at least 79% are (7.3.1).

Marriage, itself, was only cited by 20% of community members as a reason for cutting. Ahmed Abdi Jamma, Youth and Gender Specialist, UNFPA, does not consider marriage to be a significant factor and distances men from the process, stating that, *'The men do not want their daughters to be harmed but it is not their decision. The men also do not want a wife with no sexual desire either'*. However, marriage dominated the focus group discussions, was cited as a reason by all CSOs and NGOs interviewed and featured strongly in the community survey under advantages of being cut and disadvantages of not being cut. Protection from rape and sexual advances were quoted as reasons for female cutting in the community survey and in focus group discussions, always with implications for marriage. When explored in discussions, protection from rape was not about any physical barrier provided by the stitches after cutting, but about girls who have been cut being less sexually aware or responsive. The use of female cutting as a means of reducing the sexuality of women and consequently the danger of rape, is in line with the Landinfo report on FGM in Sudan and Somalia (2008) which states that FGM/C is 'a manner in which men exercise control over women's sexual lives'.

This control is all the more difficult to challenge as it is conveyed through approval and marriage preferences, rather than explicit. The following, from a woman in Qoyale, sums up the feelings of many mothers about cutting and marriage, *'It is simply not possible to live in this community without being cut, just not possible. Men need to see stitches to prove that their wife to be has not been with anyone else'*.

Interestingly, few if any, cite health as a reason for cutting, yet it is definitely a key driver for change. There is a high level of awareness of the complications arising from the cutting. Women, men, girls and even, to some extent, boys list them and give examples from their families or communities. People are aware of the health risks and costs to their families.

A young man in Inaafmodoobe, struggling with the dilemma around female genital cutting, said, *'firstly we move from the pharaonic because it is not Islamic and secondly we move away from it because of the health complications which our girls and women are suffering from.....but if you only do the sunna then this does not protect them from rape'*.

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

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

9 IMPLICATIONS FOR THE PROJECT

One of the objectives of the research was to provide baseline data for the project *Empowering communities to collectively abandon FGM/C in Somaliland*. This section highlights the key findings from the research in relation to the project outcomes and indicators.

Further data relating to the indicators is contained in appendix F. The numbers in brackets refer to the location in the findings section of this report (section 7). The percentages in section 7 refer to the combined data from project and non-project communities; this data is disaggregated by project/non-project communities in appendix F.

9.1 Project outcomes and indicators: baseline data

Outcome 1: Target communities commit to abandon all forms of FGM/C

Abandoning all forms of FGM/C, including the sunna cut, is an ambitious target.

In project communities, currently only 5% of community members would like to see all forms of cutting abandoned (appendix F & 7.2.14) and just 11% of community leaders, all of whom were women, have spoken out against all forms of cutting (appendix F & 7.3.2). In contrast, 66% of community leaders in 71% of communities have spoken out against all forms of cutting **except the sunna** (appendix F & 7.3.2).

70% of community members think that their community expects them to cut their daughters, indicating a strong social norm in favour of cutting. Almost half of these (47%) feel they are expected to use a cut which includes stitches (pharaonic 31%, intermediate 16%) (appendix F & 7.2.7).

Perhaps surprisingly, a higher percentage of community members (83%) intend to cut their daughters than feel their community expects them to, although only 33% intend to use a cut which includes stitches (18% pharaonic, 15% intermediate) (appendix F & 7.2.7).

Overall, people do not speak about FGM/C, with only 24% of community members in project communities having spoken to anyone about FGM/C in the last year. 49% of community members in project communities said FGM/C has been raised in public meetings (appendix F & 7.2.10).

In most of the focus group discussions, participants changed their minds on topics relating to FGM/C as a result of exchanging views with other participants. These shifts in position were all in the direction of abandonment; from pharaonic to intermediate, intermediate to sunna and occasionally from sunna to abandoning cutting altogether.

These findings highlight the challenge faced in encouraging target communities to abandon all forms of cutting. However, they also support the approach taken by the project team of engaging stakeholders in dialogue and providing opportunities for exchange and sharing of experiences in relation to FGM/C.

Outcome 2: Women and youth are empowered to reject FGM/C

Only 16% of women and youth in project communities have been involved in activities on FGM/C, mainly public meetings (appendix F & 7.2.13), indicating that women and youth are currently not engaged around FGM/C to any great extent. This is contrasted with 63% of women and girls saying they felt confident to speak out in public, yet clearly they do not have the opportunities to do so currently.

Almost two-thirds of women and girls support the right to Freedom from Violence Against Women and Girls (VAWG). However, in relation to female cutting, this is interpreted primarily as protecting girls from the pharaonic cut and not from the sunna cut (appendix F & 7.2.6).

The attitude of boys and men towards the type of girl they would prefer to marry or prefer their sons to marry presents a considerable challenge, with just 4% of unmarried men preferring to marry an uncut

girl and only 3% of married men preferring their sons to marry and uncut girl (appendix F & 7.2.8). However, once again these attitudes shifted quite considerably during focus group discussions as participants weighed up the advantages and disadvantages and shared opinions. In order to change women's expectation that it is necessary to cut their daughters, the marriage partner preferences of men need to change and be communicated to the women in their communities.

Outcome 3: Religious leaders publicly denounce all types of FGM/C

This outcome has two distinct elements, firstly, whether religious leaders oppose all forms of cutting and secondly, whether they speak out publicly on FGM/C.

None of the senior religious leaders interviewed would currently publicly speak in favour of Zero Tolerance and define the sunna cut as doing no harm (appendix F, 7.3.1, 8.4). Just 1 (of 22) religious leaders interviewed in the community survey described the sunna as 'not required' and 3 (of 11) religious leaders interviewed in the community survey said they would support a law banning all forms of cutting (appendix F & 7.3.1). By contrast 87% of religious leaders felt that the pharaonic is 'not required' and would strongly oppose it (7.3.1). This position is quite well understood by the community members, with two-thirds of them perceiving religious leaders as opposing the pharaonic cut and supporting the sunna cut (appendix F & 7.2.4).

Over a third (39%) of religious leaders have not been involved in any discussions on FGM/C (appendix F & 7.3.1). Over half (55%) have not spoken publicly on FGM/C (noting here that 76% of those who have spoken in public support the sunna cut (appendix F & 7.3.1)).

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

There are currently no specific approved policies or laws on FGM/C, although FGM/C is mentioned in the Gender Policy (2009) and the National Youth Policy 2010-2015).

A policy on FGM/C based on zero tolerance and a bill on FGM/C based on zero tolerance, are currently under development (appendix F & 7.4), both of which will incorporate anti-medicalisation of FGM/C.

All of these documents are in the early stages of development and face active opposition from influential stakeholder groups, for example, the religious leaders favouring the increased involvement of health specialists in the sunna cut, which would be outlawed under the anti-medicalisation bill and an FGM/C bill based on zero tolerance (appendix F & 7.4).

Only one parliamentarian was interviewed and so it was not possible to gauge the extent of the knowledge or commitment of parliamentarians towards abandonment of all forms of cutting (appendix F & 7.3.6).

Just over a third of community members are correct in their understanding of the current legal status of FGM/C (appendix F & 7.2.5).

Outcome 5: Partners and Somaliland CSOs have greater capacity to drive forward nationally-led anti-FGM/C movement

Two partners of AAIS, SOWDA and WAAPO, attended the capacity building workshops and were fully involved in the research process.

Seven CSOs were involved as participants in the baseline research, all of whom are integrating FGM/C into programmes and support the abandonment of all forms of cutting.

A review of the websites of 17 CSOs from the networks of NAFIS and Nagaad showed that only 2 (12%) give prominent coverage to FGM/C, a further 3 (18%) give good coverage but without a link on their front page and the remaining 12 (71%) have little or no coverage of FGM/C.

9.2 Recommendations for design, monitoring, evaluation and learning (MEL)

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

The project outcomes are based on abandonment of all types of cutting, which is unlikely to be met within the project period. However, there is already some momentum away from the pharaonic cut which, if built on, could result in considerably fewer health risks for girls and women and could help build momentum for change towards abandonment.

As with any attitudinal change, change is greatest when people are comfortable with the next step and when change is seen as manageable. The inclusion of the intermediate cut in this research has resulted in more explicit discussion of female cutting and consequently some changes in opinion about what is, and is not, acceptable. It also challenged religious leaders and others to be more specific about what they consider to be Islamic with the statement being made by most religious and community leaders that the intermediate cut is non-Islamic.

It is recommended that discussions with all stakeholders recognise this spectrum of cuts and that communities are encouraged to move along the spectrum towards abandonment, whilst keeping the ultimate goal of abandonment clearly in sight (outcomes 1 and 3).

In terms of monitoring change, it will be important to measure the increase in the proportion of community leaders (indicator 1.1) and religious leaders (outcome 3) speaking out against all forms of cutting as well as the number of communities where one or more is speaking out against all forms of cutting. It might also be worth measuring the number of communities and community leaders/ religious leaders who are speaking out against *all except the sunna cut* as this would represent a significant change from the baseline position where 80% of girls and women have undergone the pharaonic cut. Movement towards speaking out against all except the sunna cut should always be phrased as moving towards abandonment of all forms of cutting in order to maintain complete abandonment as the ultimate goal.

Finding areas of agreement

Most religious leaders are further along the spectrum towards abandonment than most of their community members, as most oppose all forms of cutting except the sunna. However, much of the dialogue around FGM/C has focused on the areas of difference between INGOs, NGOs, CSOs and religious leaders which has led to tension between these groups. Considerable progress could be made from building on common ground in the initial stages of the project, whilst still recognising the differences in relation to the sunna cut. Religious leaders are also facing decision-making dilemmas, with several reportedly not cutting their daughters, yet not necessarily stating this publicly.

It is recommended that religious leaders are seen within the project as positive agents of change in the direction of abandonment, rather than resisters to change. Conventional thinking suggests that the first step is to persuade senior clerics to support the abandonment of all forms of cutting and then to disseminate this information to communities. However, the research shows that community-based religious leaders were more likely to favour a law banning all forms of cutting than senior clerics, so it might be worth engaging some of these community-based clerics in dialogue with the senior clerics.

Adopting the language of abandonment, of encouraging religious leaders to describe the sunna cut as *not required*, rather than as *honourable* is likely to be a more effective strategy than a more confrontational one of expecting religious leaders to *denounce all forms of cutting* and *support Zero Tolerance*. This approach does not require religious leaders to deny that there is a hadith or guidance on female cutting, nor does it require them to state that the sunna cut is a form of FGM/C, however, it does require them to state clearly and publicly that the sunna cut is *not required* under Islam. The differences between these statements are subtle but could be crucial in influencing religious leaders to join the movement towards full abandonment. This approach has been adopted with some success by

the CSO Candlelight with the result that they are able to work closely with a few selected religious leaders with a shared agenda of the abandonment of all forms of cutting.

The importance of dialogue in developing new understandings

Interventions, such as workshops and public meetings, usually include an element of providing new knowledge to community members and opinion formers. This research suggests that attitudes are more likely to be changed through opportunities for dialogue and exchange than through the 'delivery' of information. This is supported by the large numbers of people who have not talked about FGM/C previously and also the feedback from the focus group discussions where many who had been to FGM/C workshops and public meetings still felt they had not had an opportunity previously to discuss FGM/C in relation to their own lives and decisions.

For example, the knowledge and awareness about the health complications of the different types of cuts is reasonably sound among most stakeholder groups, particularly among women. It would be more beneficial to facilitate community members in discussing the implications and their options for change among themselves, than to lecture groups on the health risks with which they are already familiar, even if they are not aware of the precise medical terminology. When devising theatre, drama, dance and song, these are more likely to change attitudes if they focus on difficult decisions faced by individuals in relation to female cutting than on teaching factual information.

New knowledge

The research indicates that there are some areas where increasing the level of knowledge could be beneficial. For example, men, on the whole, appear not to be aware of the intermediate cut and so are open to misunderstanding when hearing their daughters will be undergoing the 'sunna 2' (intermediate cut). Increasing their knowledge might help them to have more meaningful conversations with their wives about the cutting of their daughters. Another example is the understanding of the right to Freedom from Violence Against Women and Girls (VAWG) in relation to female cutting. Currently most see it as only referring to protection from the pharaonic cut and not to all forms of cutting.

Recognising the difference between rural and urban communities

Disaggregation of data by rural / urban community will be essential in order for changes not to be masked by the overall differences between urban and rural communities. It may also be beneficial to re-define some of the indicators to be applicable to take these differences into account.

For example, *Indicator 1.1 Percentage of communities in which leaders state in public meetings that the community should abandon FGM/C*. With rural communities being more traditional than urban ones it might be worth measuring the communities in which leaders publicly oppose the pharaonic and intermediate, as well as those where leaders oppose all forms of cutting. This will enable progress towards abandonment to be more readily demonstrated, whilst maintaining the overall goal of abandonment in sight.

Legislative progress (outcome 4)

It is recommended that the progress of development of all policy and bills is mapped against the stages identified in appendix F and section 7.4 (or a modification of these). This needs to be a strict process with evidence being requested of all progress, rather than word of mouth. The process of monitoring might in itself act as a prompt for progress. If FGM/C is included in the Sexual Offences Bill, which it is not currently, then this monitoring process should include this bill.

Legislative progress is extremely difficult to achieve and there might be some benefit in the process being delayed until such time as the MoRA and MoLSA are able to find a form of words which they can both support, for example, a policy which recognises that abandonment is the ultimate aim, with the pharaonic and intermediate cuts being recognised as non-Islamic. Such a delay should not be seen as a failure of the project, instead alternative means of demonstrating action and progress should be identified.

In order to assess the attitude of parliamentarians towards FGM/C (indicators 4.1 & 4.2), which was not achieved in this research, any workshops or seminars with Parliamentarians that take place should include brief pre and post-event knowledge assessment using a short questionnaire. Additionally, a brief survey tool could be developed based on the baseline questions for enacting FGM/C legislation. This could identify the level of support for (a) legislation on FGM/C which bans all forms of cutting, and (b) legislation on FGM/C which bans all forms of cutting *except* the sunna. This survey should be able to be completed by all members of the Parliamentary Committee for Social Affairs.

Outcome 4 also includes an indicator (4.4) on the portrayal of women's rights issues in public debates by policy makers. This indicator is likely to be important in demonstrating change at a policy level over the lifetime of the project, especially since measureable legislative progress might be limited. It is recommended that AAIS collect and date a range of public statements and communications made by policy makers on FGM/C for discourse analysis at mid-term and end of project. A series of scales could be developed based on the statements measuring movement from focusing exclusively on (a) health risks to a rights-based approach (b) eradicating the pharaonic to abandoning all types of cutting (c) telling people to stop cutting to using positive examples of champions of change (d) individual choice at the household level to collective community abandonment.

Outcome 5 assesses the capacity building of AAIS's partners and other CSOs in Somaliland. It is recommended that a skills and activity audit of key CSOs is undertaken at mid-term and end of project. In addition, a review of the inclusion of FGM/C in awareness-raising literature, workshop schedules and on their websites and Facebook pages could be carried out of (a) 7 focus CSOs and (b) a sample of CSOs from the NAFIS and Nagaad networks. A review of their activity schedules would identify the percentage of communities with which the 7 CSOs are actively working with that have included specific activities on reducing FGM/C (mid-term and end of project).

Random sampling

Careful attention was given to ensuring those interviewed in the community survey were a cross section of community members, selected at random across the target communities. It is important that the sampling at mid-term and end of project is also random and sampling is not biased towards those who have made significant changes in their attitudes or behaviours.

Project evaluation and learning questions

1 To what extent have girls, boys, women, men and community leaders been able to publicly discuss FGM/C, and has this translated into changes in attitudes and behaviour?

This baseline research has established that girls, boys, women, men and opinion formers currently discuss FGM/C to quite a limited extent and that once they begin to discuss the issues contradictory positions are revealed. It is recommended that data is kept on the ways and forums in which FGM/C is discussed as the project progresses and also to ask community members and opinion formers in what ways have they changed their views and behaviours on FGM/C over the course of the project. A most significant change type approach to evaluation might be useful in uncovering the ways in which attitudes and behaviours change over the course of the project.

2. What have been the enabling and disabling factors that have enabled community members to publicly challenge FGM/C and what have been the most effective strategies for mobilizing change?

This research suggests that:

- potentially enabling strategies would include (a) encouraging dialogue at household level between women and men (b) recognising the spectrum of cuts including the pharaonic, intermediate and sunna and (c) adopting an holistic approach - engaging the full range of stakeholders and opinion formers (including men, religious leaders, health workers and teachers in the dialogue (d) facilitating public forums providing community members with opportunities to openly discuss the decision-making dilemmas they face in relation to FGM/C

- potentially disabling factors could include (a) pushing for Zero Tolerance instead of supporting stepwise change towards abandonment (b) positioning religious and traditional leaders as resistant to change (c) actively supporting the medicalisation of the sunna cut as this would be likely to limit abandonment to the pharaonic and intermediate cuts only (d) working solely with the decision-makers (women and traditional cutters) without including other stakeholders
- change is happening in Somaliland around FGM/C, however, not necessarily the direct move from cutting to total abandonment that might be hoped for. Both the increase in the use of the intermediate cut and the desire for an increase in the involvement of health workers as cutters are in direct response to increased awareness of the health risks related to the pharaonic cut. Whilst eliminating the health risks to women and girls is an important outcome, challenging the presumption of the sunna cut 'doing no harm' and adopting a more rights-based approach will be necessary to create the environment that enables change from the intermediate and sunna cuts to total abandonment
- open dialogue and focus group discussions are vital. During the course of this baseline research many community members had their first ever opportunity to speak to each other openly, in a non-coercive and non-judgemental context, about FGM/C, leading people to share their experiences, opinions and dilemmas. This can be built upon to mobilise change.

3. What are the most effective strategies to influence religious leaders to publically denounce all forms of FGM/C and to what extent have any changes in religious leaders' attitudes influenced wider public opinion?

Senior religious leaders state that the pressure to support zero tolerance, i.e. to publicly denounce all forms of FGM/C, is pushing religious leaders away from engagement. The most effective strategies initially could be to engage in dialogue with the religious leaders and to build on areas of agreement to develop working relationships, whilst maintaining the overall goal of abandonment of all types of cutting. The research shows that religious leaders are currently more in favour of a move towards sunna (and away from pharaonic) than most community members surveyed. However, currently, most religious leaders in Somaliland seem to resolutely believe that the sunna cut must continue, as it is required by Islam.

Adopting the language of abandonment, of encouraging religious leaders to describe the sunna cut as *not required*, rather than as *honourable* is likely to be a more effective strategy than a more confrontational one of expecting religious leaders to *denounce all forms of cutting* and *support Zero Tolerance*. This approach does not require religious leaders to deny that there is a hadith or guidance on female cutting, nor does it require them to state that the sunna cut is a form of FGM/C, however, it does require them to state clearly and publicly that the sunna cut is *not required* under Islam. The differences between these statements are subtle but could be crucial in influencing religious leaders to join the movement towards full abandonment. This approach has been adopted with some success by the CSO Candlelight with the result that they are able to work closely with a few selected religious leaders with a shared agenda of the abandonment of all forms of cutting.

4 How sustainable are civil society efforts to effectively influence public opinion and policies and laws that promote zero tolerance against FGM/C?

This research suggests that civil society efforts have thus far been focused in urban areas and there has been a lack of effort in the rural areas of Somaliland. To be sustainable and make a real impact civil society efforts need to be broader and reach more people.

Overall, it would serve civil society in Somaliland well to consider the approach to zero tolerance, as it is not without controversy. This research suggests that Somaliland is quite some way from zero tolerance, and it could be preferable for groups working on FGM/C in the country to consider other approaches.

10 CONCLUSION

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

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

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

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

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

Policy making and legislation on FGM/C is at an early stage in Somaliland. There may be only limited progress towards establishing legislation on the statute book during the lifetime of the project, however, open public debate by policy makers on FGM/C could stimulate valuable dialogue at community and household level as well as inform emerging policy and legislation.

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

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

This research has significantly increased understanding of the attitudes, knowledge and expectations of men and boys in Somaliland, alongside increasing the evidence base around the shifting types of FGM/C in Somaliland and the increasing move towards medicalisation, providing data that will support the delivery of stronger programmes in the country.

As well as providing baseline data against which progress towards the project outcomes and indicators can be measured, this research has uncovered important contextual information about the knowledge, attitudes and behaviours of communities and stakeholders in Somaliland in relation to FGM/C. The evidence strongly suggests the adoption of an holistic approach towards overall abandonment, providing opportunities for community members and leaders to engage in open dialogue in supportive environments, recognising the existing desire for change and facilitating them in finding solutions to the challenging decision-making dilemmas they face in relation to FGM/C.