Assessment of
the Prevalence,
Perception & Attitude of

FEMALE GENITAL MUTILATION

In Somaliland

2014

MoLSA

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ABBREVIATIONS AND ACRONYMS

BBC	-	British Broadcasting Corporation
CBO	-	Community Based Organization
CCBRS	-	Comprehensive Community Based Rehabilitation in Somaliland
FGD	-	Focus Group Discussion
FGM/C	-	Female Genital Mutilation / Cutting
GBV	-	Gender Based Violence
HH	-	Household
INGO	-	International Non-Governmental Organization
KII	-	Key Informant Interview
KNH	-	Kindernothilfe (German NGO)
MCHC	-	Mother and Child Health Centre
MOH	-	Ministry of Health
NAFIS	-	Network against FGM/C in Somaliland
NAGAAD	-	Umbrella of Women Organizations in Somaliland
NGO	-	Non-Governmental Organization
SCF	-	Save the Children Fund
UNDP	-	United Nations Development Program
UNICEF	-	United Nations Children's Fund
WHO	-	World Health Organization
MOE	-	Ministry of Education
MORA	-	Ministry of Region Affairs
MOLSA	-	Ministry of labour and Social Affairs
SNMA	-	Somaliland Nursing and Midwifery Association
SMA	-	Somaliland Doctors Association

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EXECUTIVE SUMMARY

Female genital mutilation (FGM/C) is all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for nontherapeutic/medical reasons. It is an ancient tradition in large parts of Africa and is now practised in 30 countries in western, eastern, and north-eastern Africa, parts of the Middle East[and Asia, and within some immigrant communities in Europe, North America and Australia.This study looked at the prevalence, perception and attitude towards abandonment of FGM/C in Somaliland.

Descriptive cross-sectional survey was conducted between March to June 2014 on women of reproductive age. Quantitative data was collected through questionnaire from 1,986 females of reproductive age (15-49) from 19 MCHs from all the six regions of Somaliland to ascertain the prevalence of FGM/C. Data triangulation was done by collecting qualitative information through interview schedules using Focus group discussions from women, men, females and male youths and traditional circumcisers. Key informant interviews were conducted with religious leaders, MoLSA, MoH, MoE (gender department), SLNMA, SMA and Somaliland parliament (Health Caucus). Secondary data was collected through desk reviews of the previous reports from other intuitions that have implemented FGM/C interventions. Content and SPSS analysis were conducted for qualitative and quantitative data respectively.

On the prevalence, out of 1,986 women interviewed, the rate of FGM/C was 99.8%. 4 (0.2%) of the women from urban areas were not cut. The study shows that rural/pastoral circumcision stands at 100%. The average FGM/C performance age is eight years. Pharaonic type is performed at 82.3% in rural areas while 80.7% in urban areas. Sunna circumcision is not clearly understood by the respondents. In rural areas, 99.5% of cutting is done by the traditional circumcisers while at 95.7% in urban areas. In this study, 2/3 of the women support Sunna to be performed in the health facilities for their daughters. The study further established that the mothers are the ones who lead the decision for cutting their daughters, at 75% in the rural and 68% in the urban. Both parents decision is 19% in the rural and 14% in the urban. In both set ups fathers only make decision at 2%.

FGM/C is perceived by the community to be performed as a fulfilment of Islamic religious requirement as found at 20% and cultural obligation at 66%. It is a good practice that enhances marriage perspectives; protect girls from rape and immoral behaviour and “increase husbands’ pleasure”, wanting to save their daughters and the family from insults and discrimination within the community. Family and the opinion leaders of the community especially of religious leaders

influence

the need to perform FGM/C. The study established that there had been allot of awareness created through NAFIF NETWORK and its activities; urban community was well informed about FGM/C and its impacts to the females but not rural community: the health providers also lacked training and guidelines on the management of FGM/C complications, concerted efforts of interventions among the partners was also missing.

As per future trends, 90.5% of people interviewed think it is impossible to eradicate the practice. They were perplexed by the idea of untouched women. Results indicate a positive perspective where 90.5% of the women interviewed at MCHCs wanted their daughters to be cut while 9.3% have decided to abandon FGM/C. Some of the religious leaders interviewed admitted their daughters were not cut. This indicates a positive acceptance and change in the NAFIS Network interventions towards FGM/C abandonment with 90% of mothers also accepting Sunna type of FGM/C from the pharaonic type. Majority of the youths also wants FGM/C eradicated.

Most respondents acknowledge eradication will take slow pace;the younger generation and the religious said they will be effective role models of change. The six religious leaders interviewed recognized pharaonic type of FGM/C to have no religious basis. They are committed to campaign for eradication through religious platforms in the mosques.The respondents have a positive attitude towards FGM/C eradication and report a possibility with full involvement of the circumcisers in the NAFIS and its partners anti FGM/C program activities, passing and enforcement of the anti FGM/C law in full support from the religious and other community leaders. They realize that change is gradual.

The study concludes that NAFIS NETWORK with the support from the Somaliland government and the donor funders have implemented recommendable recognized interventions for the last 9 years towards eradication of FGM/C in Somaliland with 9.3% opting for eradication and majority of the population opting for Sunna cutting. However, the study recognizes that issues of culture and religion take slow pace to tackle and more concerted efforts are still required for program success.

Therefore, the study recommends for the passing of the anti FGM/C policy, full dialogue, workshops, advocacy and support from the government, religious and community leaders as role models of zero tolerance FGM/C; needs assessment and in-service training of health workers on post FGM/C complications management, integration of FGM/C programs in all the educational curriculums within the country and requests all the intuitions, local, governmental, NGOs and any other stakeholders involved in community interventions to join hands to lobby for eradication of

FGM/C

in Somaliland in order to uphold the women's right to health and prevent them from complications caused by FGM/C.

CHAPTER ONE
INTRODUCTION

1.1.Background of the study

Female genital mutilation or cutting (FGM/C) is a traditional practice that involves the partial or total removal of or other injury to the female genital organs for cultural or other non-therapeutic reasons. FGM/C is practiced in more than 28 countries in Africa and in immigrant communities in a number of countries including Australia, Canada, France, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. The practice of FGM/C is rooted in religious, cultural, personal and societal beliefs within a frame of psycho-sexual and social reasons such as control of women's sexuality and family honour which is enforced by community mechanisms. (WHO, UNICEF, UNFPA, 1997)

According to WHO (2008),FGM/C is recognized as a harmful practice which violates human rights. It is prohibited by law in several African and Western countries. The current classifications describes four types of FGM/C. Type 1, clitoridectomy, involves partial or total removal of the clitoris and/or the prepuce. Type 2, excision, involves partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Type 3, infibulation, involves narrowing of the vaginal orifice with creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris. Type 4 involves all other harmful procedures of female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

There is great variation in prevalence, reflecting ethnicity, tradition, and socio-demographic factors. Countries with very high prevalence, over 70%, include Egypt, Ethiopia, Mali, Eritrea and Somalia (Yoder and Khan, 2007). According to a 2013 UNICEF report, Egypt has the world's highest total number with 27.2 million women having undergone FGM/C, while Somalia has the highest prevalence rate of FGM/C at 98%. Estimates about the prevalence of FGM/C vary by source

FGM/C is associated with several health risks such as severe pain, bleeding, shock, difficulty in passing urine and feces, and infections. Caesarean section, blood loss, low birth weight and increased perinatal mortality are associated birth risks. Several psychological, social, and sexual

conseque

nces such as anxiety, depression, memory loss, loss of libido, and dyspareunia (Chalmers and Hashi, 2000; Talle, 2007)

Efforts to abandon the practice of FGM/C in Africa have used several different approaches, including those based on human rights frameworks, a health risk approach, training health workers as change agents, and the use of comprehensive social development approaches (UNICEF, 2005b). Although there are indications of the effectiveness of some anti-FGM/C interventions in achieving changes in knowledge, beliefs, attitudes, behaviors and practices related to FGM/C, systematic appraisal of the evidence is lacking. Further, much research has used observational designs that make it difficult to draw causal inferences, thus hampering valid conclusions about the effects of these interventions.

1.2.Problem Statement

NAFIS and the member organizations have been implementing the anti FGM/C programs since 2006. In support, in 2011 the government of Somaliland drafted a National policy for the abandonment of FGM/C and its Intervention Action Plan. In August 2013, NAFIS conducted a situation analysis and the report indicated that 90% of the girls predicted continuity of FGM/C but with no clear indication on their liking for it. Despite the above, FGM/C in Somaliland still prevails with greater percentage of girls developing infections post cutting, great psychological, psychosocial impact, intense traumatic experience at a marital stage, and intra partum and postpartum complications both to the mother and the fetus. Unfortunately, there is lack of evident based research which has been conducted before on the prevalence of FGM/C in Somaliland that can enhance FGM/C policy enactment and implementation that would encourage effective eradication interventions by the anti FGM/C stakeholders. The purpose of this study therefore, was to assess the prevalence, perception and the attitude towards the future trends of FGM/C in six regions of Somaliland (Awdal, MaroodiJeeh, Sahil, Togdheer, Sool and Sanaag).

1.3.Objectives of the study

1.3.1.Broad objective

The purpose of this study was to assess the prevalence, perception and attitude of female genital mutilation/cutting in Somaliland

1.3.2.Specific objectives

The specific objectives of the study were:

1. To establish the prevalence rate of FGM/C in Somaliland
2. Todetermine the perception of FGM/C in Somaliland
3. To understand the Attitude towards future trends and discontinuity perspectives of FGM/C in Somaliland;

1.4.Research Questions

1.4.1. Main Research Question

The main research question of the study was what are the prevalence, perception and attitude of FGM/C in Somaliland?

1.4.2. The specific Research Question

1. What is the prevalence rate of FGM/C in Somaliland?
2. What is the perception of FGM/C in Somaliland?
3. What is the Attitude towards future trends and discontinuity perspectives of FGM/C in Somaliland?

*1.5*Justification

This study would contribute the insight of FGM/C to the Somaliland communities particularly women, girls and families in the pastoral communities that suffer the consequences of FGM/C. It would also enhance the review, amendment and passing of effective sustainable anti FGM/C policy and appropriate legislation towards eradication of FGM/C in this country. The study would encourage sound and appropriate gender based FGM/C interventions with clear mandate of abandoning all forms of FGM/C by all the stakeholders. It would also contribute to new knowledge of prevalence, perception and attitude of FGM/C in the body of research.

CHPTER TWO
LITERATURE REVIEW

2.0 Introduction

This chapter contains literatures reviewed from international and national scholars who have done similar studies on FGM/Cutting. The review is documented according to the specific objectives. Summary of the literature review is done and a conceptual framework which informed the basis of the investigation is also established as follows:

2.1.Prevalence of FGM/C

WHO estimates that between 100 million and 140 million women and girls worldwide have been subjected to FGM/C. Three million girls and women a year are at risk of mutilation - approximately 8000 girls per day. Anecdotal evidence and case studies show that FGM/C is now being encountered in various European countries as well. Prevalence rates in Africa vary between countries. Countries with high prevalence rates (> 85%) are for example Somalia, Egypt and Mali. Low prevalence rates (< 30%) are found in for example Senegal, Central African Republic and Nigeria (WHO, 2009)

Prevalence rates also vary within countries and regions; the decisive criteria being ethnicity. For example, of the 23 percent of Yemeni women who have undergone FGM/C procedures, the figure rises to 69% in the sparsely-populated Red Sea and Aden coastal regions, compared with 15 percent in the heavily-populated highlands and five percent in plateau and desert regions (DHS Survey 1997).

According to Amnesty International (2010), a study done on the prevalence of FGM/C among Iraq's Kurdish communities showed that many Iraqi women and girls are subjected to harmful traditional practices, including forced and early marriage. Female genital mutilation is reported to be widely practiced in Kurdish areas. The Iraqi authorities are aware of such practices but do little to stop them. This report recommends the banning of this practice.

A report

from the Human Rights Watch (2010) indicates that while internationally recognized as a form of violence against women and girls, the tragedy is that female genital mutilation is perpetuated by mothers, aunts and other women who love and want the best for their children, who see the practice as ensuring that girls are marriageable, are conforming to the tenets of Islam, and are growing up to be respectable and respected members of Kurdish society

*2.2.*Perception and Knowledge of FGM/C

ACommunity-based cross-sectional house-to-house interviews conducted during 2008 among 858 females of reproductive age (15–49 years), in Kersa district, East Hararge, Oromia region, Ethiopia,198[60.3%]) women reported **t**he main reason of FGM/C was reduction of female sexual hyperactivity. Circumcision of daughters was reported by 288 (88.1%) respondents,and this showed a statistically signifcant association with the Christian religion (Yirga and Kassa. 2012)

Ahanour and Victor 2014 did an assessment of the perceptions of FGM/C among mothers at a primary healthcare centre in Lagos, Nigeria with a convenience sample of 95 mothers who completed the pre-tested, semi-structured questionnaires, findings showed that the mothers held ambivalent beliefs about the practice. Over half of the respondents (56.8%) perceived the practice of FGM/C as not being beneficial, 44.2% thought that uncircumcised girls will become promiscuous. Nearly a third (30.5%) believed that FGM/C promotes a woman's faithfulness to her husband. About a quarter (26.3%) reported that women who have undergone FGM/C are not at any risk of gynaecological complications. There was a significant relationship between the educational background of the mothers and the perception that uncircumcised girls will be promiscuous. These perceptions about FGM/C show that government at all levels should continue with educational efforts aimed at eradicating this practice.

Meanwhile, an exploratory study done on 8 women from Ethiopia, Somalia, Djibout and Eritria after immigrating to Sweeden revealed the women's feelings ambivalent; though they opposed FGM/C because of its negative effects on health, they acknowledged the practice's as positive cultural aspects. It emerged from the interviews that the role of FGM/C is to ensure virginity and protecting a family's honor, its roleis to avoid shame and enhance purity and social pressure experienced after immigration. FGM/C i s a symbol of the country of origin, and support for changing the tradition (Isman. E, Ekeus C and Berggren W., 2013)

2.3. Attitude towards the future trend of FGM/C

In a multi-country report, a study revealed that overall; the chance that a girl will be cut today is about one third lower than it was around three decades ago. Still, the pace of change is uneven, both within and among countries. The decline is particularly striking in some very low prevalence countries including Benin, Cameroon, Ghana and Togo. Among countries with higher prevalence, the most dramatic reductions in the practice of FGM/C have been found in Kenya and the United Republic of Tanzania. Thirty years ago, prevalence levels among adolescents in these two countries were three times higher than they are today. In the Central African Republic, Iraq, Liberia and Nigeria, prevalence has dropped by as much as half (UNICEF, 2010)

In other countries, however, FGM/C remains almost universal. This is true for Djibouti, Egypt, Guinea and Somalia, where the practice continues to affect more than 90 per cent of the female population. Even in some lower-prevalence countries such as Chad, Gambia and Guinea-Bissau, no noticeable decline has been found. Despite overall progress, if action against FGM/C is not accelerated, as many as 30 million more girls alive today may be cut in the next decade alone. And this number will continue to grow as the population of girls in affected countries rises(UNICEF, 2010)

Meanwhile, in a study where attitudes towards FGM/C were explored in household surveys, it was found that two thirds of women and almost two thirds of men living in the 29 countries think that the cutting of girls should stop. Even within practicing communities, in almost all of the countries surveyed, the share of girls and women who support the practice is substantially lower than the shares that have. The study further established that if public dialogues can be initiated, people may begin to see that social expectations about the practice are no longer valid. Finding ways to make hidden attitudes favoring the abandonment of FGM/C more visible and opening the practice up to public scrutiny in a respectful manner, as is being done in many programmes throughout Africa, can provide the spark for community-wide change (UNICEF/NYHQ 2013).

Somaliland is 100% Sunni Muslim. Anecdotic accounts indicate that the majority of the population are in favour of maintaining the practice on “traditional and religious” grounds, despite Islamic scholars in the country being divided on the subject. Most Somalilanders believe FGM/C is an

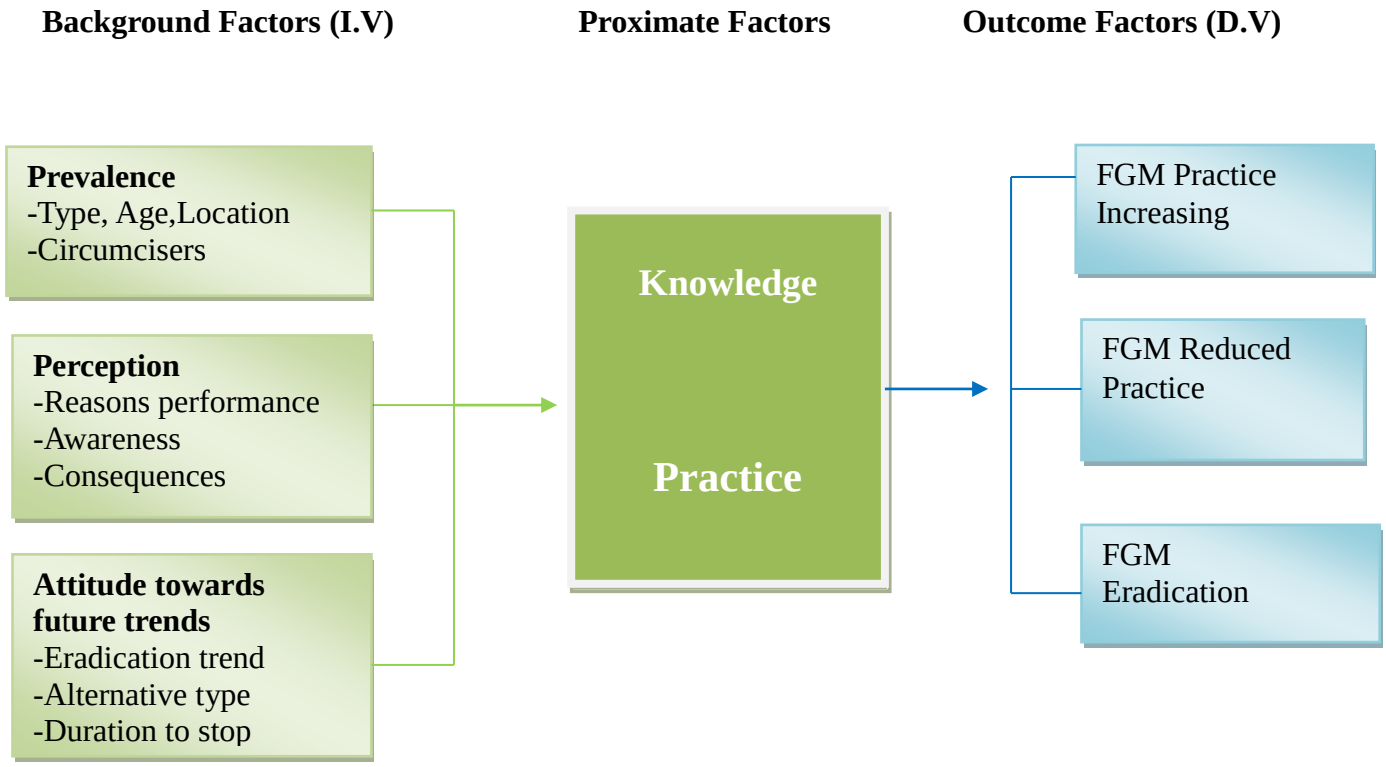
"Islamic
obligation." According to the Umm Attiah Hadith "circumcision is a Sunna (obligation) for men and a sign of respect for women." Although some religious leaders different position than this. Traditionalists on the other hand claim they inherited the practice from their ancestors who had been doing it for centuries.

Most countries in which FGM/C/ C is practiced are committed through their constitutions, national laws, policies and international charters to ensure that the basic rights of children are upheld. The Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, the Convention on the Elimination of All Forms of Discriminations against Women and other international instruments and standards, provide a global framework for the protection of the child. Civil strife, conflict and the breakdown of social and political institutions, drastically affected Somali authorities' obligations to fulfil and uphold children's rights. Where government structures are lacking however, parents, families, communities and clan leaders must ensure that children grow up in a safe and supportive environment (Dories,at www.desertflowerfoundation.org)

2.4. Summary of literature review

Scholars have mostly done studies in other countries including Somalia as a whole but no studies have been specifically done in Somaliland to ascertain the prevalence, perception and attitude towards the future trend and discontinuity of FGM/C in Somaliland. Many scholars applied surveys with quantitative method of data collection. The mixed method of data collection have little been applied. This study intends to assess the the prevalence rate, perception and attitudes towards eradication of FGM/C in Somaliland using a descriptive survey study design and a mixed method of data collection.

2.5. Conceptual framework



CHAPTER THREE
METHODOLOGY

3.1. Study Design:

Descriptive cross-sectional survey was conducted between March to June 2014

3.2. Study area:

The study was conducted in all the Somaliland six regions including Awdal, MaroodiJeeh, Sahil, Togdheer, Sool and Sanaag

3.3.Study Population*:*

A total number of 1,986 females of reproductive age (15-49) were interviewed. To verify the information, data triangulation was done by interviewing 212 additional participants both for KII and FGDs as shown below.

Table 1: FGD and KII participants

Key Informant Interviews (KII) 13	FOCUS Group Discussions (FGDs) 25
Religious leaders	Women
Ministry of Labour and Social Affairs	Men
Ministry Endowment and Islamic Affairs	Female youth
Ministry of Health	Women youth
Ministry of education (gender department)	Circumcisers
Somaliland Nursing and Midwifery Association	
Somaliland Medical Association	
Somaliland Parliament (Health Caucus).	

3.4.Sample and Sampling technique

The study adopted probability sample with multistage sampling technique forQuantitative information. Non probability sample with purposive sampling technique was done for qualitativeinformation

3.5. Data Collection Methods and tools

This study adopted a mixed data collection method. Quantitative data was collected by use of questionnaires and qualitative through interview schedules inform of Key Informant Interview and Focus Group Discussions

3.6. Data collection Procedures

Quantitative data was collected through questionnaires from 1,986 females of reproductive age (15-49) from 19 MCHs from all the six regions of Somaliland toascertain the prevalence of FGM/C.
Data triangulation was done by collecting qualitative information through interview schedules.a total of 25 focus group discussions were conducted from women, men, females and male youths, and traditional circumcisers. In addition, 13 key informant interviews were conducted with religious leaders, MoLSA, MoRA, MoH, MoE (gender department),SLNMA, SLMA and Somaliland parliament (Health Caucus).

Finally, secondary data was collected through desk reviews of the previous reports from other intuitions that had implemented FGM/C interventions as indicated below. Thereports reviewed provide insight on the state of FGM/C in Somaliland

National Plan of Action for Children (NPAC) In Somaliland (Ministry of Labour and Social Affairs), 2014

The NPAC report primarily focuses on the development of a national or government backed plan for children in Somaliland and legal framework supporting the rights of children in Somaliland. It discusses Somaliland's complex Legal system (Customary law or Xeer Islamic Al-Shari'ah Law and Formal Statutory Law) that makes it difficult to define and or enforce Children's rights and protection. This has a huge impact on FGM/C in Somaliland, which majorly affects children (young girls aged 4-14). With focus on FGM/C, key findings from field survey data and consultations

indicated

98% prevalence of FGM/C across Somaliland. It also emphasizes the fact that FGM/C prevalence is majorly caused by ignorance of health risks, perverse cultural practices and weak law enforcement.

Baseline Report, Comprehensive Community Based Rehabilitation in Somaliland (CCBRS), 2013

The Baseline report commissioned by CCBRS basically assesses respondents' level of knowledge and attitude towards FGM/C. Overall findings indicated that on average, of the families with girls in their households (89.3% of those surveyed), two thirds (66.5%) of the girls were circumcised. A majority were circumcised by a traditional FGM/C practitioner, whilst only 6%, were circumcised by a health worker. Primary decisions makers for the girls on FGM/C were mothers. Further, it appeared that 59% of the community backed FGM/C. Only 23.5 % of respondents stated that they would be happy to marry an uncircumcised wife as opposed to a staggering 76.5%, who said they would never marry an uncircumcised girl.

However according to the report, it seems that in recent years, despite the shame (amongst 81% of respondents) associated with discussing FGM/C, increased education on the negative impact of FGM/C and its associated social and psychological problems, is slowly changing negative attitudes. This confirms that increased advocacy remains an important approach for FGM/C eradication.

Outpatient Perspectives on Problems and Needs Related to Female Genital mutilation/Cutting, 2013

This research study primarily explores female outpatients' perspective on problems related to FGM/C and their views on information, care and counselling. The study undertaken in Hargeisa, highlights MOLSA's recent attempt to begin to monitor and coordinate the development of FGM/C policies. It also highlights NAFIS' efforts to improve the coordination and efficiency of anti FGM/C efforts in Somaliland its eventual goal to totally eradicate FGM/C via its 'community education campaigns' or dialogues. The study further expounds on the role of NAFIS and its subsequent findings.

(SlNMA) Efforts, 2012

This report by Hamda Ali Abdillahi provides an overview on the SLNMA and UNICEF joint programme on integrated FGM/C Pilot project "Working together to abandon FGM/C" – from advocacy to influencing legislation. A key foundation for anti-FGM/C work is to raise the awareness of health care providers to FGM/C-related complications and to provide them with the skills and resources to manage these complications. The reports indicates that health care providers often encounter women with FGM/C-related complications yet they do not have the skills to treat and counsel these women, nor to prevent recurrence of FGM/C. There was limited training on the clinical management of FGM/C complications. Health care providers also need pre-service training, continuing education forums/special in-service training, treatment and counselling guidelines for all complications.

Summary Preliminary Multiple Indicator Cluster Survey, 2011

Essentially, survey results of women and children indicated that almost all women (99%) aged 15-49, had some form of female genital mutilation in 2011. Themost common form being: sewn closed (85 percent). Moreover, it also highlights areas of practice i.e., indicating that FGM/C practice appeared to differ slightly across regions, with certain regions like Togdheer for example, having the highest percentage (92%) of women who were sewn closed. The report further indicates that a majority of girls and women in Somaliland are most commonly subjected to the 'pharaonic' type of FGM/C, which is by far the most severe, involving infibulations.

Additionally, the survey also underscores: 'prevalence', level of acceptance/ attitude of FGM/C especially amongst victims, and their relation to age, education and economics. It reveals that FGM/C for example, is more prevalent amongst daughters aged 0 -14.29% of women thought it should be continued, while 69% wanted it discontinued. The percentage of women who believe it should stop was higher in urban areas, among those with secondary or higher education and those from the richest households. Finally, a higher proportion of younger women aged 15 – 19, thought FGM/C should continue compared to older women.

Edna

Adan Maternity and Teaching Hospital, 2009. Female Genital Mutilation Survey.

The study established that 79% women had no knowledge of FGM/C, 84% had been cut by old women and 1.9% performed by midwives . 11% of the women who had undergone FGM/C accepted it as part of their culture while (34%) as religion obligation. 55% of the respondents had no idea whatsoever whyFGM/C was being practiced or why they were being forced to undergo the practice. The study shows that this was the pioneer hospital in the awareness creation through anti FGM/C campaigns, it provides treatment of FGM/C has referral guidelines and has referral centre for all the FGM/C women in Somaliland since 2002 though faces challenges like simple medications as anesthesiawhich hampers effective management

Female Genital Mutilation/ Cutting, World Bank Report, 2004

This report essentially highlights the cost and prevalence of FGM/C/FGC in Somaliland and explores existing health, religious, cultural, economic and human rights perspectives of FGM/C/FGC. It captures responses from civil societies, communities, regional authorities and global partners. It further shares lessons learnt from FGM/C/FGC programs, which are meant to provide the basis for targeted and strategic follow-up initiatives that are meant to quicken its eradication. The assessment is also aimed at guiding the World Bank, UNFPA and their partners, in current and future anti-FGM/C/FGC initiatives.

Eradication of Female Genital Mutilation in Somalia - UNICEF

This online report uses six case studies to highlight Impact of FGM/C eradication efforts. These case studies ultimately reveal the level of FGM/C awareness in Somalia, which ranges from complete lack of awareness to minimal awareness with negligible behavioural change to total awareness and behavioural change. The report also showcases constraints faced by those seeking to end FGM/C. The report also indicates the identified target groups for successful FGM/C elimination (i.e. men, women, male youth, young girls and older women) as well as the need to reduce the supply and demand for FGM/C. This may mean finding alternative occupations for FGM/C practitioners.

3.7. Data Analysis

After collection**,** data was cleaned, organized and qualitative data was transcribed and analzed thematically through contents and presented in narative while quantitative data was analzed through Scientific Program of Social Studies (SPSS). The presentation was made in frequencies and percentages and presented in figures, pie charts and tables.

3.8. Ethical consideration

Study respondents were introduced to the study and the expected procedure. Consent forms were signed by all the study respondents; they were allowed to withdraw at any time they declined to participate in the study, privacy was maintained during data collection procedure and confidentiality of information was observed in all the stages and post data collection process.

CHAPTER FOUR
RESULTS AND DISCUSIONS

4.0Introduction

This study investigated the prevalence, perception and attitude of FGM/C in Somaliland. This was in the light of the high rate of FGM/C with girl child and women health complications post FGM/C. The qualitative data collected were analyzed thematically applying categorical and narrative analytical techniques while quantitative data was done SPSS analyses. This chapter presents the findings of the analyses in tables, pie charts and graphs form and reported in respect to furnishing evidence in the specific objectives of the study.

4.1. Prevalence of FGM/C

4.1.1. Prevalencerate

Out of 1986 respondents on the question: *"Have you undergone FGM/C, if so what type and at what age?"* The study established that1982 (99.8%) had been circumcised while 4 (0.2%) women living in urban areas had not been circumcised.1287 (100%) of respondents from rural areas had undergone FGM/C while 695 (99.4%) of respondents from urban areas had undergone FGM/C.

4.1.2. Types of FGM/C by area

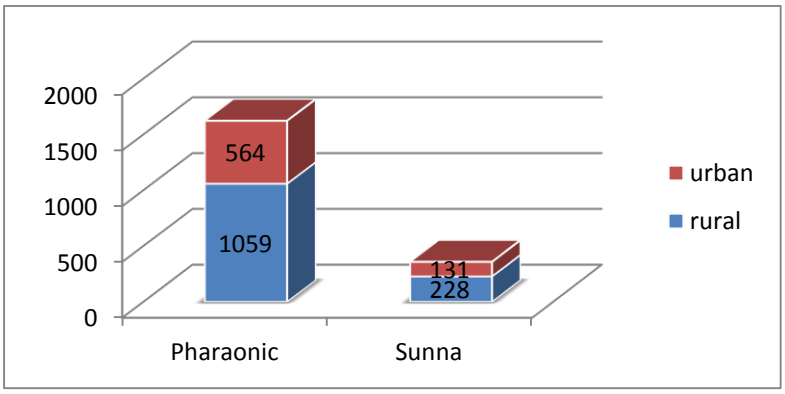


Figure 1: Types ofFGM/C by area

As shown above, out of the 1986 women who were done FGM/C, 1059 (53.3%) of the respondents had undergone Pharaonic type while 228 (11.5 %) had undergone Sunna type in rural areas. In urban settings correspondingly 564 (28.4%) women had undergone Pharaonic circumcision and 131

(6.6%)

women Sunna circumcision and 4 (0.2%) had not undergone any type of FGM/C.

4.1.3 **Types of FGM/C by area and performer**

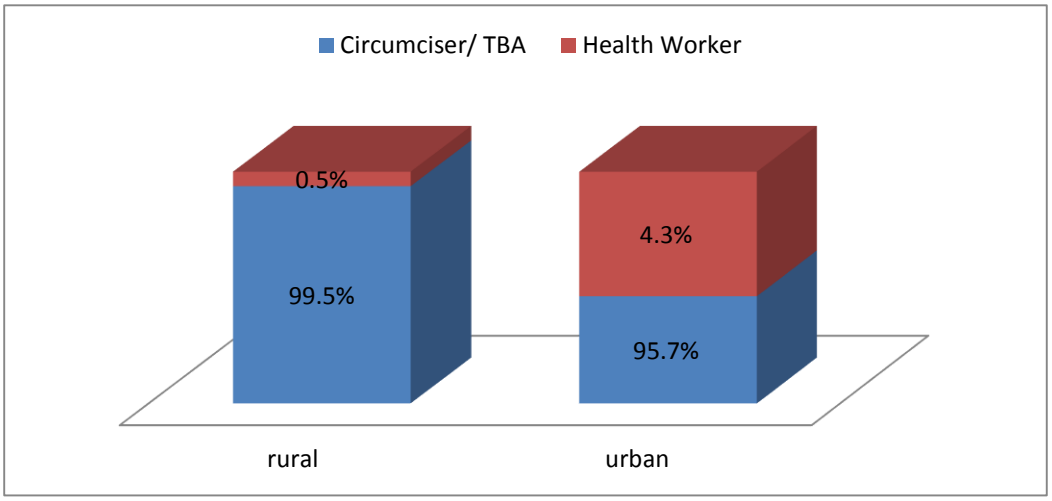


Fig 2: Types of FGM/C by area and performer

4.1.4. Age at whichFGM/Cwas Performed

At What age was FGM/C performed?			
	Average	Minimum	Maximum
Rural	8	2	14
Urban	9	6	12

Table 2.Age at which FGM/C was Performed

Performer of FGM/C

As shown below, most of the women (1917 (96.7%)) were circumcised by a traditional circumciser or a traditional birth attendant (TBA); 65(3.3%) reported that it was performed by health workers. The percentage is higher for rural respondents (99.5%) than for urban ones (95.7%)

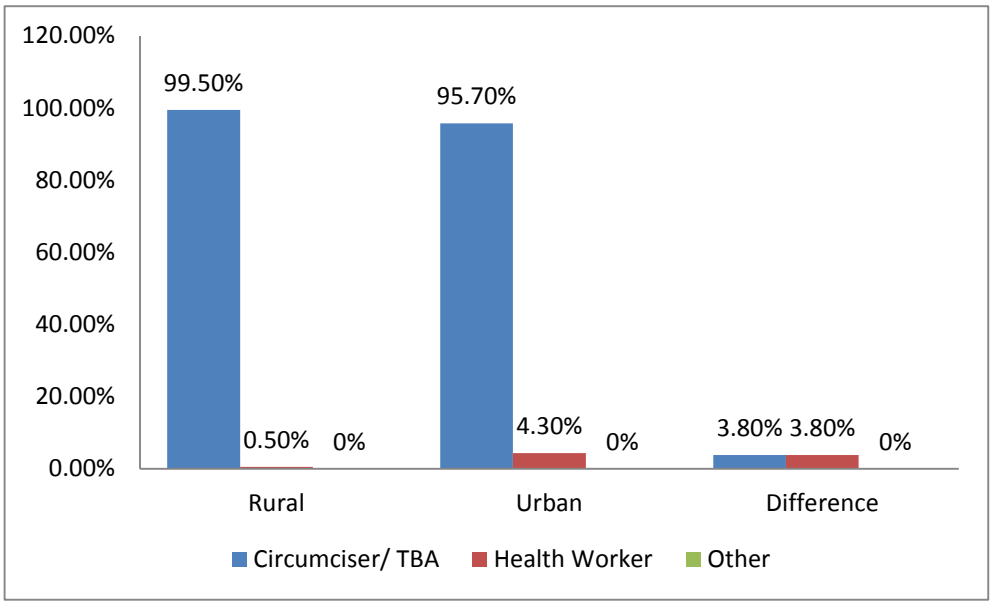


Figure 3: Performer ofFGM/C

*4.2.***Perception and Knowledge of FGM/***C*

Most participants in all FGD distinguished between two types: Pharaonic and Sunna. The Sunna FGM/C is again divided into several types, according to the degree of cutting and number of stitches.

Pharaonic circumcision is commonly defined as:

"major cuttings and infibulation" (Youth Female), or
"outer parts of the vagina are sutured together with a minimum of four thorns or stitches" (Youth Female).

Whereas the pharaonic type is considered as the norm: (male youth):

"Pharaonic is the real known circumcision which is undergone by the majority of the women".

However another male youth defined it as un-Islamic. He said:

"The severe pharaonic is done by people who are less obedient to follow the principles of Islam.

They circumcise girls by cutting many parts, then tying together the legs for a month or so that the operated parts can dry together." Several men declared that the "circumcision with infibulation is still done in rural and pastoral areas", and that they had heard "that recently it has been decreasing, in favour of Sunna, mainly in urban areas". Some men don't know much about it:

"We hear that FGM/C is very harmful when women get married" and: "The only type we are familiar with is circumcision with infibulation".

Concerning the Sunna type of FGM/C, it was defined as follows:Cutting of clitoris and two to three stitches;Cutting of clitoris but without stitches, just for bleeding;Cutting of clitoris and labia minora without suture.Cutting of clitoris and labia minora and suture like pharaonic (girl);More or less the same cutting like pharaonic but named Sunna (woman).
This shows clearly that the respondents in general don't know exactly what is meant by Sunna type FGM/C, and also that they ignore the difference between pharaonic and Sunna.
This is confirmed by the response of a woman:

"it is more or less the same cutting like in the pharaonic, but it is called Sunna".

On complications of FGM/C, most of the respondents were aware of the many problems caused by FGM/C include were bleeding, abdominal and back pain, irregular, painful and difficult menstruations, obstructed labour and still born children, transmission of infectious diseases including HIV/AIDS, anaemia, urinarycysts and fistula, vaginal tears during labour; damages of nerves, formation of warts,; psychological trauma and depression,tumours and fistulas,difficult deliveries, death at delivery and stillborn children.One respondent stated
"When I was circumcised (and infibulated), the thorns bent inside".

The answers were supported by men and women FGDs response who said that pharaonic circumcision had much more harmful effects than the Sunna type on women. They also said sexual problems due to FGM/C, as well as economic and social problems due to the cost of continuous medical treatments. Women and female youths proved to be more informed about health problems linked to FGM/C than male youths and men. The responses from the FGD of Youth Females in Borama showed rather high level of FGM/C knowledge of the participants as follows
"Infections, cysts and tumours, bleeding, menstruation problems, financial problems due to repeated visits at doctors, transmission of HIV/AIDS andmaternal death due to prolonged labour."

The participants in the women FGD in Borama proved to be particularly well informed and gave examples of various problems due to FGM/C and the links between them. These included:
Psychological problems start when the girl is "forcefully held for cutting". It continues into her marriage: she has the experience of pain in her mind, and her honeymoon ends in fear and fighting with her husband; they suffer from various and continuous health problems which often are not treated in time. They gave the example of a girl who had been circumcised with an unsterilized razor blade which made her body swell. Her parents thought that she was pregnant, hence ended up beating and torturing her. It took a long time until they brought her to a doctor who had to reopen her in order to remove blood and pus.

Others include continuous and often serious health problems which will also have financial implications on the family which has to spend a lot of money for doctors' bills and medicines.
It might also have a serious effect on the baby born by a mother who has undergone pharaonic circumcision: the delivery is stopped for some time at the pelvis, and the lack of oxygen would cause permanent mental deficiencies for the baby.An infibulated girl is more timid and less interactive and communicative than those who have been circumcised according to Sunna; they are also less able to compete with male youth in schools and etc. If a girl is raped, it is easier to prove it when she had been infibulated. This is often given as an advantage of pharaonic circumcision.

It is not astonishing that the responses from male youths are much less precise than female youths, but they had an idea of FGM/C problems:

"Many things go wrong from wedding to delivery"; "We have heard that there are many problems with 'fircooni[1]' and no complications with Sunna".

In one male youth FGD it was pointed out that FGM/C prevents girls from participating in running and other sports, and that it damages their (sexual) sensitivity. Also psychological effects were mentioned.Usually men are less well informed about possible complications, they just know that

"*There are problems, but (I) don't know precisely which kind". In one men's group it was mentioned that "also men are faced with a lot of complications, because it is difficult to penetrate a closed*

organ."

Men FGD in Lascadawo (Sahil) gave very detailed responses concerning complications, especially from pharaonic circumcision: They responded need of repeated medical assistance at deliveries, need of many costly treatments, girls miss school at least seven days per month, they are physically weak and cannot participate actively in household works, psychological effects, as continuous pain affects the brain and unsatisfactory sexual relations."

In one men FGD it was also mentioned that despite the fact that the Sunna type circumcision "does not cause complications and health problems, it might create another social problem, because it facilitates interaction of boys and girls. Infibulated girls are anxious and shy to mingle with boys". They gave the example of a 13 years old girl who ran away with a class mate, "due to undamaged sensitivity". In the men FGD in Adaadley District it was mentioned that "apart from health problems due to pharaonic circumcision it is also negatively affecting reproduction hence reducing population".

The negative effect is supported by KII. One Sh. mentioned it causes problems like reduction of birth rates". Religious leaders interviewed were not only aware of health complications and of the financial burden, but also the effects on the marital life of couples. Another Sh. mentioned

"Painful intercourse and sexual dysfunction, absence of sexual relaxation"

Asamong the negative effects of FGM/C, and a second Sh. said

"There is fear and anxiety among the married couples in their wedding night".

Religious leaders had a more sophisticated view of the whole issue than the FGD participants. According to a third Sheik,

"FGM/C *is in contradiction with the five Sharia principles of Islam and therefore it creates different perspectives from the religious sheikhs*."

The responses given in the KII showed that religious leaders were quite well informed and had spent time to reflect on it. They differentiated between the pharaonic type which was not allowed and the Sunna type, which was allowed under the condition that it was done by professional doctors and with modern medical equipment, "which does not exist in Somaliland". Another Sh. further said:

"According to the Islamic religion, both forms are unlawful. Men's circumcision is lawful, but it is favoured leaving the girls untouched."

Another *Sh*. clarified that:

"Pharaonic with severe cutting has serious consequences for the girl when getting pregnant and when giving birth. It is unlawful, as our religion forbids cutting of the human body". But according to him "the Sunna one which is very light is a good thing and it is lawful."

However, one Sh was doubtful and said:

"I heard that the Sunna type practised now is not as the way it should be. It is modified pharaonic. In Islam it is forbidden."

ASh. from Burao (Togdheer) said, *it is allowed to cut a very small part of the clitoris, but the girl may also be left untouched "because there is no bad thing in the human body and any harassment and injuries to human beings are not allowed in the Islamic religion."*

4.3.**Attitude towards the Existing Trends and discontinuity**

4.3.1 Respondents who have daughters and their position on circumcision

Four questions were used in this session: *"Do you have daughters?", "If yes, are your daughters circumcised?", "If no, will you circumcise your daughters?", "If yes, which type?", "Where will FGM/C be performed?"*

Those who have daughters

	Yes	No	NA	Total	Yes	No	NA
Rural	1059	228	0	1287	82%	18%	0%
Urban	564	131	0	695	81%	19%	0%
Difference	495	97	0	1982	1%	1%	0%

Table 3: participants with daughters

As shown in table 4 the majority of the respondents, that is 1623 (81%), reported that they have daughters, whereas 359 (18.1%) responded with "no" to the first question

Daughter(s) circumcised?

	Yes	No	NA	Total	Yes	No	NA
Rural	797	262	0	1059	75.3%	24.7%	0%
Urban	153	411	0	564	27.1%	72.9%	0%
Difference	644	149	0	1623	48.2%	48.2%	0%

Table 4: daughters circumcised?

More than half of those who had daughters (58.4%) said that their daughters had been circumcised? Among the 673 (41.6%) respondents said that FGM/C had not been performed on their daughters

Those who will have their daughters circumcised

	Yes	No	NA	Total	Yes	No	NA
Rural	233	29	0	262	88.9 %	11.1%	0%
Urban	376	34	1	411	91.5 %	8.3%	0.2%
Difference	143	5	1	673	2.6%	2.8%	0.2%

Table 5: those who will have their daughters circumcised

As per table 6, 90.5% of the respondents said they would have their daughters circumcised later while 63 (9.5%) respondents declined their daughters cutting; one respondent said that she did not know.

The type of FGM/Cthey wish to be performed on their daughters

	Pharaonic	Sunna	NA	Total	Pharaonic	Sunna	NA
Rural	25	207	2	234	10.7%	88.5%	0.8%
Urban	18	358	0	376	4.8%	95.2%	0%
Difference	7	151	2	610	5.9%	6.7%	0.8%

Table 6: Type, if FGM/C will be performed

As shown above, majority of the respondents (92.8%) clarified that they would choose the Sunna type, while only 7.2% said they would choose the pharaonic type.

As per table 8 below, the respondents would wish FGM/C of their daughter to be performed, 75.6% of rural respondents and 60.9% of urban respondents wanted it to be done in health centres, and 24% (rural) respectively 39% (urban) wanted their daughters to be circumcised at home.

Where will FGM/C be performed?

	At home	Circumciser's home	Health Centre	NA	Total	At home	Circumciser's home	Health Centre	NA
Rural	56	0	177	1	234	24%	0%	75.6%	0.4%
Urban	147	0	229	0	376	39.1%	0%	60.9%	0%
Difference	91	0	52	1	610	15.1%	0%	14.7%	0.4%

Table 7: whereFGM/C should be performed

Decision Makers

Household cutting decision makers

	Number				Percentage			
	Rural	Urban	NA	Total	Rural	Urban	NA	Difference
Mother	970	470	0		75%	68%	0%	7%
Father	22	14	0		2%	2%	0%	0%
Grandmother	27	79	0		2%	11%	0%	9%
Self	0	3	0		0%	0.4%	0%	0%
Aunt	15	17	0		1%	2%	0%	-1%
Both parents	241	98	0		19%	14%	0%	5%
Circumciser	0	0	0		0%	0%	0%	0%
Don't know	0	0	0		0%	0%	0%	0%
Grandfather	1	6	0		.0777%	0.86%	0%	1%
Uncle	4	3	0		.3108%	0.43%	0%	0%
Other	7	5	0		.2523%	0.712%	0%	0%
Sub-total	1287	695	0		100.0%	100.0%	0%	
Total	1982							

Table 8: Household FGM/C decision makers

In the above table, mothers are the majority while fathers are the minority decision makers in circumcision.

Reasons for FGM/C continuation

On FGM/C future perspective, most of the respondents, both men and women, the youths unanimously agreed that FGM/C is an established cultural norm in Somaliland. On further probe it came out that the practice is inherited from pharaonic times. One man pointed out that:

'It is inherited from Pharaoh and its being perpetuated out of ignorance".

The diverse reasons of FGM/C continuation were given during both household survey and FGD ccultural tradition, social acceptantes, pleasure, religious beliefs, augmentation of husband's preservation of virginity, prevent rape, prevent Improves fertility, elimination of dirty genitalia, adultery, protect them (and their mothers) from easy delivery humiliation and insults; Limitation of (girl's) It is a prerequisite for marriage; sexual desire To keep them at home and under control and to distinguish "our girls" from that of other cultures

In addition, household survey highlighted that an overwhelming majority (87.2%) of the respondents said they would do it either for cultural or for religious reasons.

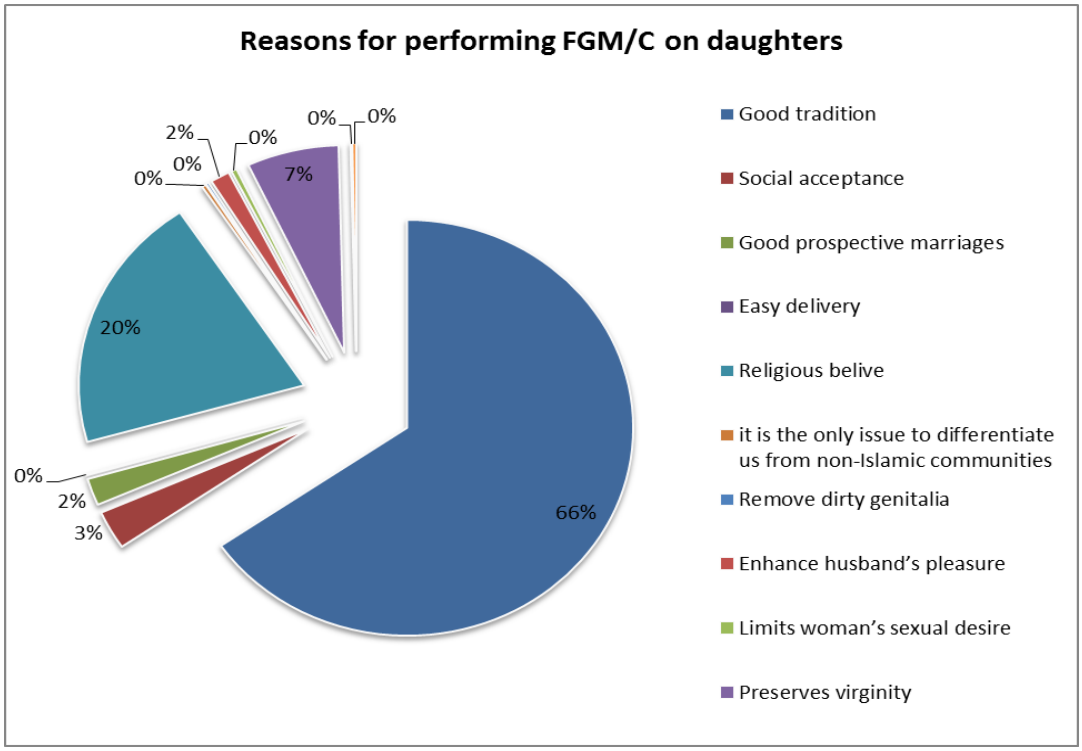


Figure 4: Reasons for performing FGM/C on daughters

Views from women FGD were that,

"In our culture if a woman is not mutilated and infibulated, she is not considered normal",

Whereas in another women in FGD it was pointed out that

"The dignity of the girls is created by Allah, and (it is) in their hearts".

One woman suggested that

"Men prefer infibulated girls"

and another one stated that

"Is good for health".

That's, it is performed in order to avoid the girl to be rejected after marriage, and because *"For circumcised girls fathers get more camels".*

According to responses from men's FGD the following came out from one of the participants *"Men prefer to marry a closed girl*".
It was also pointed out that;
"*When an infibulated girl is opened, men celebrate with gun fire".*

This question was of paramount interest for the religious leaders interviewed as key informants. Their responses mirrored the points of view of the four schools of Islamic thought, three of them confirming, circumcision as obligatory for boys as well as for girls, while the Abu Hanifa School was cited for its opinion that FGM/C is not obligatory but Sunna[2]. And if it is practised, the cut has to be small and it has to be assisted by doctors.

According to the views of all religious leaders interviewed as key informants, the *"Pharaonic circumcision" has no religious basis".*

But they voiced different opinions when it came to the question *whether according to the Islamic religion other forms of FGM/C are allowed or even a duty*.One Sheikh said that Sharia law does not allow the "extensive form of FGM/C"; any form of FGM/C must be practised according to Prophet Mohamed's order to UmmuAttiya Hadith. But according to another Sheikh .who had different opinion from the other sheikhs said that *no form of FGM/C is allowed by the religion,* He added:

"FGM/C is violation of (the person's) integrity and it's against the Islamic law."

On the other hand, a sheikh from Berbera (Sahil) pointed out that "it was (practised) for protection. It was believed, that if a girl is raped, she will not become pregnant. But we should know that FGM/C does not prevent them from anything, only faith". A sheikh from Burao (Togdheer) was equally clear: "According to the Islamic religion, FGM/C is a crime against the religion and it has no (religious) basis. So it must be abandoned." Two other religious leaders were less explicit about it. A sheikh from Borama (Awdal) said that all religious leaders agree that girls should not be left untouched, but that FGM/C must be done with assistance of medical doctors. Another Sheikh. saidthe Prophet Mohamed's advice to UmmuAttiya and explained that FGM/C is done *for protection and preparation for marriage: "According to the Islamic religion, it is lawful and a good thing, it is obligatory or Sunna."*

Religious views on FGM/C according to the four schools of Islamic jurisprudence:

The Shafi'i School considers female circumcision to be *wajib*(obligatory[3]); The Hanbali School considers female circumcision to be (honourable[4]) and therefore strongly recommended; the Maliki School considers female circumcision to be *Sunna, t*he Hanafi School considers female circumcision to be *Sunna*.

Knowledge and Opinions of Women Who Have Not Undergone FGM/C

The question "*Do you know women who are not cut*?" was followed by two probing ones: "*What do people think about them?"* and "*What do you think about them?"*

The general response was:

"I think this is impossible!" (Youth Female);	*"They must belong to non-Islamic communities!"* (Man);	*"It may happen in urban centres, but not in rural areas" (man).*

Majority of participants of all categories did not know any woman who had not undergone FGM/C. Some added that, as it was a very sensitive issue, people usually didn't talk about it. Among the boys, only three knew about one case each, among the Youth Females four were mentioned. The women knew about seven cases (four out of ten in Ceel Afweyn District!). The men did not know a single one, as "it was a women's issue". However, one man said that he had met a doctor who told him that his daughters were untouched, another one had heard of a girl who was married without

,

having undergone FGM/C.

Among the women the following examples were mentioned:

One of the women in the FGD said that she met one woman who was not cut,

"This woman was thrown out of the family house of her new husband on her wedding night and was immediately divorced after her new husband had realised that she was not touched."

Another woman mentioned that

"I have seen at Hargeisa maternity an 18 years old young woman in labour: she delivered without problems a healthy baby within ten minutes";

A female youth also mentioned that she saw a girl at University of Hargeisa who was not cut because her mother refused it. A participant in a female youth FGD gave the example of a small girl that had "*completely refused to be cut".*

The religious leaders of the KII were asked whether their daughters were cut. Those with daughters replied that they had undergone the Sunna type of FGM/C allowed by Islamic religion, with only very small cut. A respondent from Burao who has seven daughters said that; three of them had been cut according to Sunna, three had remained untouched and one is still very young.

Responses to the question *what people think about untouched girls* were more or less the same in all categories of respondents:

She must have no mother, or her mother neglected her; she will be considered as unclean and "haram", and she may not be allowed to slaughter or prepare food; she will face insults and discrimination; she will be returned by her husband and divorced; she follows imported norms contradicting Islam; she cannot be a Somali!It is a shame and scandal to our culture.

One of the participants in the Youth Female FGD elaborated that "an untouched woman who came from abroad said she did not know that FGM/C was practised in Muslim communities before she came to Somaliland. People never commented on her." Another woman said: "Knowledgeable people will think that she is a good girl".

Their own opinions were often similar if not identical to the one which they believe other people would have. Some wondered how one could know whether the girl is a virgin if she has not undergone FGM/C. A few men and boys guessed that "she must be very sensitive". One man went

as far as to presume that "she is behaving just like an animal!" Another one thought that one is not allowed to marry such a woman, and a third one wanted uncut women to "be expelled".

But there were also men who thought differently: "This is something new, but I have no problem with it", and: "It shows that the *anti-FGM/C campaign has a positive impact*".

Judgements of women were equally diverse. One woman saw it "as a normal thing," but the interviewer probed further to capture what would happen to her if people came to know about it. Another woman thought she could serve as a good example to abandonment of FGM/C, and a third one said that "the mother of the girl understood that FGM/C was not practiced."

Some responses from female and male youths however, showed a remarkable difference between what they believe and what other people thought of untouched girls. For instance one girl suggested that,

"this untouched lady should migrate to another place where people don't know her,"

While another one was afraid that she might be sent home and be divorced if the husband discovers that she is not cut, others saw it in a positive way. For example the girls from the discussion group in Erigavo think: She is a normal girl with a complete and healthy body; one should know why she has not been cut; her mother and her father have agreed not to practise FGM/C.

Youth males from the FGD in Burco had opposite views. Some said that they would be shocked on realizing uncut girl. Others suggested that an uncut girl could not be a Muslim, or that "she was in a rural area where there was no one to perform FGM/C". But others voiced positive opinion:

It shows that anti-FGM/C campaigns have had a positive impact;i would say this is something new to us, but I have no problem with it;i would welcome it.

Relatives Abroad and Their Way to Deal with FGM/C

Two questions were asked: "*Do you have relatives abroad?"* and *"Are their daughters cut?"*

Apart from one FGD of Youth Females without any relatives abroad, all other FGDs had participants with relatives abroad. The question concerning FGM/C being practised on their daughters solicited the following responses:

Most of them did not know, and they not that this was a too difficult question to be asked;
Some added that they expected/hoped that their relatives would get their daughters cut, as it was a

traditiona
l practice and/or religious order.The majority said that their relatives would come to Somaliland in order to practise Sunna circumcision, one man added: "but in a secretive way".
Some indicated that FGM/C was performed in their host countries.One Youth Female participant said that daughters of his relatives living abroad were brought to Ethiopia for FGM/C and that one of them was very shocked by the experience. In two women FGDs the participants mentioned two cases of relatives who don't practise FGM/C on their daughters.

The participants in FGD of youth females were the most explicit about the issue. Like in the other categories of respondents, there were some responses indicating that they did not know whether their relatives were practising FGM/C. According to most views, their relatives come to Somaliland for FGM/C. In one FGD a Youth Female said that she knew that her relatives don't practise FGM/C. In another FGD of female youths some said that their relatives come to Somaliland but without performing FGM/C on their daughters, and in a third FGD a Youth Female cited her uncle (living abroad) who had declared that he will not allow his daughters to be cut.

It was therefore, concluded that among the relatives of the participants in FGDs, the majority practise FGM/C, and that they come to Somaliland to have their daughters circumcised.

Attitude towards Marriage with an "Untouched" Girl

The questions were: "*Would you marry / allow your son or brother to marry an 'untouched' girl?"*

In three out of six persons from 1 FGDs composed of men, all participants declared that they would not allow their sons to marry an "untouched" girls, as it is a religious obligation, and as it is also part of the Somali culture. Moreover an "untouched" girl is considered to be unclean, and they were afraid of insults and negative comments from their relatives and friends. One man saw no objection to it: "she is a human being and a Muslim sister."

Another respondent thought that if his son would marry an uncut girl, she could possibly get circumcised afterwards. From the FGD in Dila District seven men were of "no", as they considered FGM/C a religious duty, whereas two said they would allow their sons to marry an untouched girls, because they would be free from health complications due to FGM/C, and it would be possible to cut her later "in the slightest way".

Those who said "no" were mainly afraid of discrimination and insults from their friends and

relatives.

They also believed that the untouched girls were "haram" and not clean, and that it was against Islam to marry an untouched girl. One woman said that if her son would marry an untouched girl, she would get her cut after the marriage. In two FGDs majority of women said they would allow their sons to marry uncut girls. In Ceel Afweyn five out of six women voiced that opinion. One mother said she would see no problem if her son loved the girl. Also in Borama six women had no objection to their sons marrying untouched girls, because they consider them as being physically and mentally healthier than circumcised ones. One woman added that the untouched girls would be "safe from pain during marriage and child birth". Only one of the women in Borama did not want her son to marry an "open girl", considering him a "loser" if he would do it.

Majority of male youths asked whether they could envisage marrying an "untouched" girl, they declared that this was impossible, because of religious reasons, and that would be "haram". Some of those who answered "no" were also afraid of insults and negative comments from their relatives and friends. One said if he happens to marry an untouched girl, he would get her cut afterwards. Several of male youth who could consider marrying an untouched girl pointed out that according to Islam it was not an obligation to cut girls, and that "she is a Muslim with an integer body and there is nothing unlawful about her".

It was also mentioned that an untouched girl is healthier than a circumcised one – and if the need arises, she can always be circumcised later. In Borama all six boys in the FGD said that they saw no obstacle in marrying an untouched girl because: she is healthier and will suffer less complications linked to FGM/C, and therefore there would be less expenses for medical treatments; she will have no difficulties with child births; she will be able to share the pleasures of marriage with her partner.

Participants in female youths FGD from Borama the majority said they would not object to their brothers marrying untouched girls because they were lucky not to have been cut, they are healthier than other girls and they are complete in terms of their sensitive organs.

Attitudes towards future trend of FGM/C

The responses to the question "*Do you think FGM/C should continue to be practised?"* and to the sub-questions "*Why should it be done?*", "*Which type of FGM/C should be done*?" and "*Advantage of the type of FGM/C mentioned*" were ambiguous. It was not always clear whether they thought it would continue, or whether they wanted it to be continued. The overwhelming majority of the participants in FGDs agreed in predicting that FGM/C will/should continue to be practised "because it was their cultural tradition and also a religious duty". In some FGDs of female youths, the reason

given for its continuation was that if not cut they would not be accepted for marriage.

And one woman argued that "if you are against it, you will meet a lot of resistance by daughters, relatives, and the community in general." Another woman believes that "untouched girls will create problems in future".The views expressed by male youths in the FGDs in Erigavo showed the difficulty to distinguish between anticipation of the possible development and the wish that FGM/C should be continued or abandoned. One female youth out of seven wanted FGM/C to be stopped altogether, but the others thought that it would not be possible at present. In the women FGD in Borama two women out of seven wanted all forms of FGM/C stopped: "because at a workshop Sheikhs told us those girls born in Mekka are not touched. As Mekka is the centre of Islam, we have to follow them," and they added that it would also be for better health.

Also in another FGD in Mohamed Mooge two women out of 10 said that "girls should not be touched". In the men FGD in Yagoori, one man out of nine was sure that FGM/C could be stopped.

Nevertheless, nearly all were of the opinion that the pharaonic type would disappear. In the FGD of male youths in Ainabo seven participants out of ten were against the continuation of the pharaonic type of FGM/C. They were convinced that "FGM/C could be stopped through increased awareness building by medical doctors, especially focussing on rural areas." One man out of seven in the FGD in Adaadley district was convinced that it has to be stopped, because it is not allowed to perform a deed that causes acute harm to a person and "we know that girls who undergo FGM/C are missing important organs that could guarantee them enjoyment of their marriage life."

Only a few participants in the FGD thought that the pharaonic type should continue to be practised: the participants in the women FGD in Odweyne district believed that it will continue, and some men thought that pharaonic circumcision was good for protecting girls from rape, to control their behaviour and to reduce their (sexual) sensitivity.

The reasons given by women and female youths, men and male youths, for the belief that the Sunna type of FGM/C will be continued were as follows:

"A girl who is not cut is not halal" and "Sunna is based on religion and culture". (Women)

"It is not against religion and it gives no health problems." (Youth female). But the female youths of the FGD in Ainabo (all of them infibulated) didn't believe that Sunna will replace pharaonic circumcision: "It is only a lip service!"

Also some male youths were doubtful: "Since it is deeply rooted, it is not acceptable to say: Eliminate all types'', or wished Sunna to be maintained: "Sunna should be done because it is allowed by religion and because it causes fewer complications and less financial expenses". This opinion was also voiced by men: "Pharaonic should be replaced by Sunna, because it does not damage the girl's organs".

The religious leaders interviewed as key informants thought that FGM/C will continue, but that pharaonic circumcision will decrease (except in rural areas) and that performance of the Sunna type will increase. Only one sheikh in (Berbera) was not of the opinion that FGM/C would continue "because of increasing awareness – people are not as ignorant as before." All others were convinced that FGM/C should be continued in the Sunna form, because "it is legal and lawful and it must be encouraged. Pharaonic must be abandoned because it is unlawful" (Sheikh in Erigavo). Another Sheikhfrom Borama wanted Sunna to be continued with medical assistance. He was convinced that "if religious leaders – especially famous ones – preach one day in the mosques that it is forbidden, people will abandon it."

This opinion was shared by one Sheikh from Hargeisa: "If religious leaders agree on a common understanding of the Hadith and the quantity to be cut, both the girl's life and the religion will be protected." Most of the religious leaders did not agree with leaving girls completely untouched, also "because it was important to minimize their sexual desires." As mentioned in 3.2. 5 and elsewhere, there is no clear understanding of the different types of FGM/C.

Time Needed To Abolish FGM/C

The question asked was: "*How much time will it take to make people abandon FGM/C?*"

Responses ranged from "one year" to "never" or "many centuries". Participants of all categories distinguished between the times needed to overcome pharaonic circumcision and FGM/C in general. Female and male youths were convinced that it will not take more than two to seven years to abolish the pharaonic type "if it is pressed strategically". However, it will take much more time – up to 20 years – to eradicate the Sunna type, "because it is believed to be a religious obligation".

The responses of the women participating in FGDs showed much greater variations and reflected a more pessimistic view. The women of the FGD in Ceel Afweyn thought it would take more than 30 years "to stop Sunna which is similar to pharaonic". The participants in the women FGD in

Odweyne District thought it would never stop, and instead of leaving Sunna, people will opt for "fircooni". It would need a lot of anti-FGM/C campaigning to make it disappear in a foreseeable period of time. Only the women in Borama expressed a more optimistic view, they believed it could be stopped after four to ten years.

Most men's responses ranged from 30 to 100 years, and some thought that "Sunna could not be stopped at all because it was a religious obligation" (FGD of men inYagoori). As for the pharaonic type, they thought it could be stopped in a period from 5 to 30 years. Men in the FGD in Adaadley mentioned that the process could be accelerated if "religious leaders would preach that it is not a religious obligation, accompanied by medical doctors clarifying and educating people about health hazards."

The prevailing opinion in the KII was also less pessimistic. The religious leaders interviewed estimated that it will take less than 10 to 30-40 years. Another Sheikh was convinced that "if the senior religious leaders agree onaddressing it in one Friday preaches in the mosques, it will be enough to stop FGM/C." *"If suitable people address the FGM/C issue it will take about 20 years." But he saw a serious obstacle: "Religious scholars don't (want to) talk about FGM/C, because they see that it is dealt with by foreign organizations, and they think that foreigners have a hidden agenda."*

Participation in Awareness Building Measures / Discussions

The set of questions were: *"Have you participated in discussions / awareness building measures?", "By who were they organized?", "Do you remember the message and do you agree to it?"*

Two of the women circumcisers said that they participated in discussions organized by the village committee; the discussions highlighted and exposed the health risks posed by the FGM/C to women and the social consequence FGM/C leads to. On the other hand, less than half of the women had participated in such events, a few however even in several (in Mohamed Mooge). In Ceel Afweyn and Berbera more than half of the women had benefitted from awareness building measures. They were organized by Local MCHC and one hospital; regional office of MOH, Local and international NGOs: NAFIS, Candlelight (mentioned several times), NAGAAD, Red Crescent, SCF, Tostan and CCBRS.

Awareness building measures in MCHC, hospital and regional office of MOH were dealing with health effects of FGM/C. In LasAnod the only woman having participated in such an event said that she had attended a religious lecture on the position of Islam concerning FGM/C, and that additionally she had watched TV programs dealing with it.

In all men FGDs some few participants had had the opportunity to attend awareness building measures. They were mainly organized by local MCHC and also by a quite large range of NGOs, such as Candlelight, Red Crescent and HPA (Health Poverty Action). Some of those who had not benefitted from it said that they listened and watched radio and TV programs respectively, for example the radio serial *'Saxansaxo'* on BBC.

In four of six FGDs of female youths the participants said that they had participated in awareness building measures, organised by local MCHCs (mentioned twice), Red Crescent, Candlelight, SCF, CCBRS and YBM[5]. In the FGD of female youths in Sheikh six had an opportunity to attend events organized by four institutions. In Ainabo District none of the seven FGD female youths had participated in such an event, but they said that they had watched TV programs dealing with the issue.

Among the female youth in FGDs, only in one all participants gave a negative answer (Ainabo). In three cases the event was organized by MCHC, in one by a hospital. The NGO Candlelight was mentioned three times. In Adaadley one participant out of six told about a session with a medical doctor who had shown them a documentary dealing with complications caused by FGM/C and explained to them.

When asked whether they could remember the message and whether they would agree to it, most of their answers were related to health problems and complications. Also the position of Islam was mentioned by male youths: “make Sunna instead of pharaonic circumcision”, and by men: “stop fircooni circumcision”. A woman from the FGD remembered that they were told in a seminar organized by a sheikh: “Don’t do anything to the girls and leave them as they are born”. Another woman said: “After the awareness building in our village Jamalaye we agreed to leave pharaonic and practise Sunna.”

All agreed with the messages received, even if they were sometimes difficult to understand, as one man admitted: “First we did not agree, but after the religious leaders had talked about it, we agreed

to stop fircooni." One female youth participant explained that after the seminar all participants had agreed not only with the message, but also decided to carry out awareness building in their neighbourhood.

Persons/Institutions Best Suited To Stop FGM/C

Participants in the FGDs were asked two questions: "*Who would be best suited for stopping FGM/C?"* and "*What should they do?"* The respondents to these two questions were numerous and diverse. All categories showed preference for:

Religious leaders: to explain and publicize the religious point of view, mainly that FGM/C is not a religious duty, medical professionals like doctors and health workers: to deal with the health issues; Government, mainly Ministry of Health, but also Ministry of Religious Affairs[6]; Ministry of Justice (to make appropriate laws), Ministry of Labour and Social Affairs, Ministry of Education (to integrate the issue into the school curriculum); clan leaders and elders (to convince the communities).

Men and male youths also mentioned "intelligent people" and "knowledgeable people" who should take the lead in fighting FGM/C. Women and female youth want NGOs to play a leading role. Additionally, many others were mentioned, in order to establish broad and locally rooted movement teachers,Parents and grandmothers, Drama makers, poets and actors, organized groups at community level,Circumcisers.The women participating in the FGD in Borama defined the tasks of the different actors as follows the government should develop a policy and legislate a law on FGM/C; religious leaders should preach about it in the mosques on Fridays; media people should produce serials for TV and radio; youth groups should organize meetings and discussions in their neighbourhood.

Government, religious leaders and health professionals should cooperate in preparing awareness building programs and in implementing the measures at local level. It was also suggested that religious leaders and elders should focus their attention to rural and pastoral communities, and especially to parents and grandmothers, as they are the main people that can support and advocate

for FGM/C abandonment. Also the role of media was emphasized: they should produce documentaries on complications, give religious leaders the opportunity to publicise their point of view. Male and female youths should be trained to become as change agents for awareness building campaigns in their respective regions. Awareness building measures should be part of school education curriculum. Informal meetings should be organized in public places where people, especially women can attend. The girls of the FGD in MohamoudHaybe think that it is important to give victimized girls and women the opportunity to talk about their problems in public and through media. (This provoked a discussion with the interviewer who argued that victimized girls and women would not like to speak in public, especially not about such a delicate issue. The objection was countered by pointing out that there are educated women who are able to give them a voice).

All participants in FGDs opted for campaigns to be launched in order to fight FGM/C; only one woman was against it, she preferred to proceed step by step, according to the level of understanding of the people. Female and male youths wanted the campaigns to focus on grass root levels and local communities. All above mentioned people and institutions should participate in it. (It is not clear whether everybody understood clearly what was meant by "campaign" – some suggested that it was confused with "lobbying").

Specific Contribution of Religious Leaders to stop FGM/C

Two out of six religious leaders interviewed stated that it was important that they take the lead in it. Four Sheiks had attended discussions and workshops dealing with the issue of FGM/C, whereas two out of six sheiks had never had such an opportunity. All religious leaders were convinced that their contribution is essential, in clarifying the position of the religious leadership and in conveying the message that FGM/C is not allowed, that there is no basis in Islam for FGM/C, that "mutilation is not allowed in Islam" "They should address the community and declare that pharaonic circumcision is unlawful and should be condemned."

Organizations said FGM/C must be stopped completely, but this is very difficult, as society and religious leaders will oppose them. So it is very important to explain the complications and consequences."As a concrete approach it was suggested that the religious leaders should spread the message in mosques – especially during Friday prayers - in addressing public meetings, in speaking about it at all possible gatherings like weddings; it is important to go and build awareness in the rural areas. The religious leaders should deal with the negative social and health effects of FGM/C. Take the lead in campaigns also in order to have an impact, cooperation between all

religious leaders and with the Ministry of Religious Affairs was needed.

They were very confident that they will be successful, because people will listen to them. “If religious scholars work hard on the subject, people will abandon it. It only depends on the eagerness of the religious leaders”. On the effective channels of communication, media would be most appropriate for reaching the communities. Four of them mentioned the TV, but also mosques, public lectures, universities; public meetings at local level for dialogue and universities could play an important role. Some of us have attended worships and seminars for FGM/C and we agree for eradication.

Current Activities against FGM/C Practices

During the survey, the research team interviewed high officials in the governmental institutions including MOH, MOLSA, MOE and MOR, all of these miniseries except MOR said that they position them towards zero tolerance of FGM/C. During discussions the vice-minister of MOH mentioned that the health consequences and dangers of the FGM/C are in its national health policy book of March, on page 47. While the Planning Director of the MOLSA claimed that his ministry is the only ministry pushing and supporting actively against-FGM/C policies but he was concerned that if their policy draft against FGM/C is ratified by the parliament and given that the parliamentary elections were just around the corner, legislators were worried that this could make them less popular with the voters. To verify this allegation, the research team met with one Member of Parliament who did not refuse the MOLSA concern.

He clarified that FGM/C isn't a big concern to the parliamentarians as they don't consider it as a great danger to women's health. The MP also mentioned in his discussions that most of the MPs believe that FGM/C eradication is pushed by elite women and foreign organizations who exaggerate the health risks of women, he added that the total eradication of FGM/C can't and wouldn't happen as Sunna circumcision will remain in practice.

In addition, the Director of Gender Development mentioned in her discussions that one year ago the ministry created a committee of 15 members (all female) to address challenges faced by girls when it comes to their education, consequences and complications from the FGM/C.This committee meets monthly where they assign members to go to schools and encourage girls to continue with their education and carry out the messages of problems related to FGM/C to their young girls.

On the other hand, the only ministry that seems to be divided by this issue is the MOR. One senior official from the ministry said that although he personally believes in Zero tolerance towards FGM/C and he even decided to not circumcise his daughters, the ministry per se doesn't advocate for the Zero tolerance since the majority of religious scholars at the ministry do not support the position of the zero tolerance.

Apart from the governmental institutions the team also met with professional health associations including SNMA and SMA, both associations clarified that they stand for zero tolerance of FGM/C. The Director of SNMA highlighted that three years ago they added modules on FGM/C prevention and awareness in to nursing school, while one of the doctors in the SMA mentioned in his discussions that the medical professionals and its staff are for Zero tolerance of FGM/C.

CHPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. CONCLUSIONS

4.1.1. Prevalence of FGM/C

The current Somaliland FGM/C prevalence is 99.8%. 0.2% of uncut women were from urban areas; its 100% performed in rural setup by traditional circumcisers (TC) at 96.7% mostly between age 2 and 14 years. There is an improved trend from pharaonic type to medicalization. The decision makers is the mother, grandmother and occasionally both the parents.

4.1.2. Perceptionand Knowledge

FGM/C is perceived by the community to be performed as a fulfilment of Islamic religious requirement as found at 20% and cultural obligation at 66%. It is also perceived as good practice that enhances marriage perspectives, protect girls from rape and immoral behaviour and "increase husbands' pleasure", wanting to save their daughters and the family from insults and discrimination by not practising FGM/C. Family and the opinion leaders of the community especially of religious leaders influence the need to perform FGM/C.

Most of the respondents except men were well conversant with the FGM/C, its impact on health of the victims and the high health expenditure incurred post FGM/C. The anti FGM/C awareness campaigns were well conceived by especially the urban community though the rural community were not well conversant with the FGM/C information. However strong coordinated efforts among stakeholders was missing. Concerted researches in different aspect of FGM/C are also lacking.

4.1.3. Attitude towards future trends and discontinuity perspectives of FGM/C

There is a positive attitude and trend of eradicating FGM/C; 90.2% of women interviewed at MCHCs want their daughters to be cut, 9.3% have decided against it. 92.8% opted for Sunna with hope of abolishment of the pharaonic type. Religious leaders being optimistic and taking the lead in their contribution in abandoning FGM/C, though it may be a long term achievement.

5.2. RECOMMENDATIONS

The following three level recommendation sets are high-level in nature. Each recommendation outlines a course of action based on findings along with proposed actors. These recommendations should be seen as complementary to the more technical ones.

At Policy Level:

- ✓ There is great need for MOLSA to work closely with MORA in order to come into a consensus about FGM/C abandonment and give recommendations to the legislation to pass the drafted FGM/C policy that would be implemented by the government and all FGM/C reform actors which would criminalize all forms of FGM/C.

- ✓ NAFIS needs to organize high level campaigns with the legislators to effectively push for the passing of the anti FGM/C support

- ✓ FGM/Cimplementers needs to conduct country wide workshops to the religious, community, government and health institutions leaders and include all concepts of FGM/C including definition types and complications/consequences. They should also be motivated towards initiating effective lead initiatives for change by being role models of anti FGM/C eradication.

- ✓ Integrate FGM/C program in all levels of education curriculum and within the local and international NGO programmes to enhance FGM/C awareness and abandonment. Target youth institutors and youth groups in all the communities in Somaliland.

At Program Legislation Level:

All stakeholders will have to define appropriate cost effective and coordinated efforts of FGM/C

abandonment strategy, including the following suggestions:

There should be effective campaigns on anti FGM/C directed towards zero tolerance (IEC materials, Medias, train program leaders on FGM/C concepts, Islam position and Human rights.

- ✓ FGM/C education campaigns underscoring FGM/C in Islam, in Health and in human rights, led by religious, traditional leaders and health personnel with the involvement of community andgovernment institutions and also local NGOs, and civil societies.
- ✓ Prioritization for further research on different FGM/C perspectives should be advocated for especially on the aspect of the circumcisers engaged in FGM/C as a source of income generating activity.
- ✓ Similar survey needs to be conducted after 3 to 5 years using the same parameters and specifically target young girls in the households in different regions.
- ✓ NAFIS networks needs to organize for exchange visits programs to other countries like Kenya, Ethiopia, Sudan, and Eretria that have succeeded in reduction of FGM/C rate to borrow best practices, strategies and approaches implemented towards FGM/C eradication
- ✓

At Advocacy Level:

Due to the crucial role of religious leaders and other decision makers in the fight against FGM/C the research outlines the following recommendations:

- ✓ Encourage knowledgeable religious leaders directed by Ministry of endowment and Islamic affairs to elaborate the effects of FGM/C to the female's life and initiate effective straightforward measures towards FGM/C eradication.
- ✓ Draw experiences from the regions or Muslim countries succeeded in abandoning FGM/C. E.g. organize a high level conference of religious leaders, with like-minded guests from other African and Muslim countries, in order to present the anti-FGM/C concept of which religious scholars need to play a big role if FGM/C is to be abandoned. On this basis, elaborate a concept of awareness building measures for religious leaders at all levels, by outstanding religious leaders, in cooperation with health professionals

- ✓ Policy and decision makers need to be sensitized to take lead in the FGM/C elimination campaign programs in Somaliland.
- ✓ There is need of applicability of the following as community role models: girls or women not cut, fathers whose daughters are not cut and young men who prefer to marry untouched girls. Include them in lobbying and advocacy against FGM/C.
- ✓ NAFIS member organizations should be increased to enhance collective power and campaign against FGM/C eradication.

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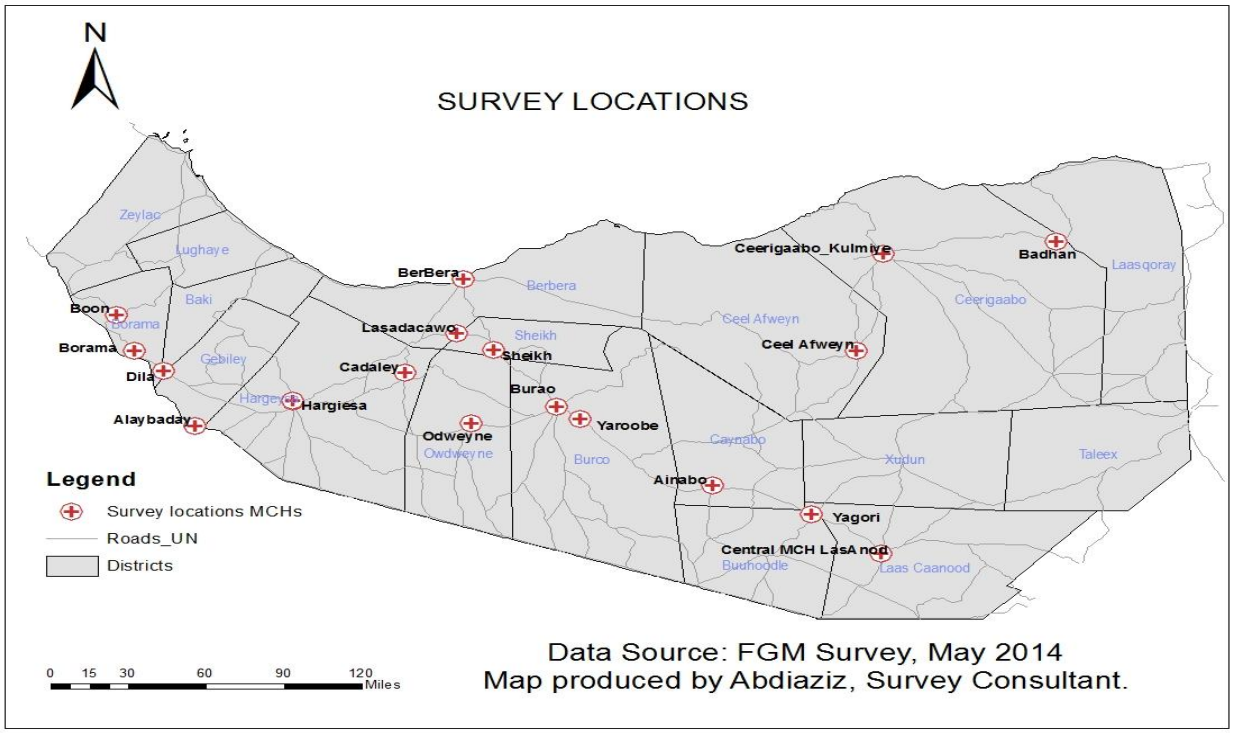
ANNEXES

Annex 1.MAP OF SURVEY AREAS



Annex 2:TOOLS

2 (a) ASSESSMENT OF THE PREVALENCE, PERCEPTION AND ATTITUDE OF FEMALE GENITAL MUTILATION IN SOMALILAND

QUESTIONNAIRE FOR MCH: FEMALES OF REPRODUCTIVE AGE

Demographic information

Number : **Region:** **District:** **Name of MCH:**

1. Age ……
2. Level of Education
3. Have you undergone FGM/C? Yes…..... No….....
4. What type of FGM/C were you done?
   A) Pharaonic……
   B) Sunna……
5. How old were you by then?
6. Who performed the FGM/C?
7. Where was the FGM/C performed?
8. Who in your household decide to perform FGM/C:
   ……..
9. Could you list any health complication you encountered due to FGM/C.....

Do you have a daughter: a) Yes b) No

10. If yes, was she circumcised? A)yes b) No
11. If no, Will you circumcise her? A)yes b) No
12. If yes, which type? A) pharaonic B) Sunna c) other_____
13. Where would you wish to be done FGM/C?
    .....
14. Why would you have FGM/C performed on your daughter?
    .....

THANK YOU VERY MUCH FOR TAKING PART IN THIS INTERVIEW TODAY!

2 (b)

ASSESSMENT OF THE PREVALENCE, PERCEPTION AND ATTITUDE OF FEMALE GENITAL MUTILATION IN SOMALILAND

INTERVIEW GUIDE

FOCUS GROUP DISCUSSION GUIDE

CAPITAL LETTERS INDICATE INSTRUCTIONS AND ARE NOT TO BE READ OUT!

NOTE-TAKER: PLEASE CAREFULLY OBSERVE AND RECORD FACIAL EXPRESSIONS AND BODY LANGUAGE (INCLUDING INTEREST, ENTHUSIASM, CONFUSION, BOREDOM, AGITATION, EMBARRASSMENT, AND LACK OF INTEREST ETC.).

NOTE-TAKER & MODERATOR:

ALTHOUGH WE DO NOT NEED AN ANSWER FOR EVERY QUESTION FROM EVERY PARTICIPANT (UNLESS OTHERWISE INSTRUCTED) WE DO NEED TO GET AN IDEA OF **GENERAL CONSENSUS** FROM THE GROUP. PLEASE RECORD WHETHER MOST OF THE GROUP AGREED WITH PARTICULAR OPINION OR NOT. RE-FOCUS PARTICIPANTS ON THE OBJECTIVES OF THE FOCUS GROUP IF THEY KEEP GOING OFF THE POINT.

GET RESPONDENTS TO INTRODUCE THEMSELVES AND TELL US A BIT ABOUT THEMSELVES.

INTRODUCTION

Good Morning/afternoon. My name is ……and this is …….We are conducting some work for NAFIS NETWORK and we wish to speak to members of the community on what they think about varios important issues that effect their communities. This information will give us a better understanding of the needs of your community.

Please give your honest opinions in this discussion today – there are no right or wrong answers and you do not have to agree with other people in the group. We would like you all to contribute to this discussion but please talk one at a time that we can record what you say and so that wo do not miss anything. Everything will be treated confidentially - no one will know who said what. We are having a number of these groups and we summarise the findings without making reference to any one's name.

We expect the discussion to take about 2, 5 hours.
Are there any questions?

Moderator's Name:
Observer's Name:
Note-Taker's Name:
Number of Participants:
Name of the village and region:
Type of Participants:

Youth Male, Youth Female, Men, Women
What is the name of your community?

1. Why is FGM/C practised?
2. Do you know the different types of FGM/C practised in Somaliland?
3. Do you know about complications from FGM/C?
   If yes: what kind of complications?
4. Do you think FGM/C should continue to be practised?
   If yes: Why should it be done?
      i. Which type of FGM/C should be done?
      ii. What is the advantage of the type of FGM/C mentioned?
   If no: Why should it be abandoned?
      iii. How could it be stopped?
5. How much time will it take to make people abandon FGM/C?

6. Do you know women who are not cut?
7. What do people think about them?
8. What do you think about them?
9. Do you have relatives living abroad?
10. Have their daughters been cut?

11. Would you marry "untouched" women? (Only for non-married men)

If yes: Why?

If no: Why not?

11.1. Would you allow your son to marry "untouched" women? (Only for women)

If yes: Why?

If no: Why not?

12 Have you participated in discussions / awareness building measures on FGM/C?

13 Who has organized the discussion / awareness building measures?

If yes: Do you remember the message?

Do you agree with it?

14 Who would be best suited for stopping FGM/C? (Religious leaders, elders, politicians, teachers, doctors/midwives/nurses)

15 What should they do to stop it?

16 Should there be campaigns against FGM/C?

17 Who should organize these campaigns?

THANK YOU VERY MUCH FOR TAKING PART IN THIS DISCUSSION TODAY.

2 (c)

ASSESSMENT OF THE PREVALENCE, PERCEPTION AND ATTITUDE OF FEMALE GENITAL MUTILATION IN SOMALILAND

Focus group discussions tools

FGM/C Practitioners /Circumcisers (FGDs)

Q1: In your opinion, why is FGM/C performed on girls? Do you agree with these reasons/justifications?

Q2. Which types of FGM/C do you perform on girls? If you do the Sunna type, explain how/what you actually do?

Q3: How many girls have you circumcised last month? Disaggregate by type

Q4: What challenges do you encounter when you are doing circumcisions? List as much challenges as you can.

Q5: Do you know about the complications resulting from FGM/C? If yes, what kind of complications?

Q6: Are you willing to stop circumcision of girls? If no, why?

Q7: Do you think FGM/C should continue to be practiced? If yes, why should it be done? Which type of FGM/C should be done? What is the advantage of the type of FGM/C you propose?

Q8: If you think FGM/C should discontinue, why should it be abandoned? How could it be stopped? How much time, do you think, will it take to make people abandon FGM/C?

Q9: Have you participated in discussions/Awareness building measures on FGM/C? If yes, do you remember the message? Do you agree with it?

Q10: Who organized the discussions/awareness building measures on FGM/C?

2(d)

ASSESSMENT OF THE PREVALENCE, PERCEPTION AND ATTITUDE OF FEMALE GENITAL MUTILATION IN SOMALILAND

Key Informant Interview Guide

Ministry of religion (Religious Leaders)

Q1: Why is FGM/C practiced?

Q2: In general, what is the attitude of the religious leaders towards FGM/C.? Is it positive or is it negative? Explain why?

Q3: Do you know the different types of FGM/C practiced in Somaliland? If yes: which one does religion is allowed and which one doesn't?

Q4: Do you know about social attitude complications from FGM/C? If yes: what kind of complications?

Q5: Do you think FGM/C should continue to be practiced? If yes: Why should it be done? If no: why should it be abandoned?, How could it be stopped?

Q6: How much time will it take to make people abandon FGM/C?

Q7: Did you cut your daughters?

Q8: How can religious leaders specifically take part in stopping FGM/C? What should they do to stop it?

Q9: what should they do to stop it?

Q10: How religious leaders are getting involved in activities or campaigns against FGM/C?

Q11: Have you participated in discussions/ awareness building measures on FGM/C?

Q12: Who has organized the discussions/awareness building measures? If yes: Do you remember the message? Do you agree with it?

Q13: Which channels of communication are very much available and accessed by the community?

Ministry of Education

Q1: In your opinion, why is FGM/C practiced?

Q2: - Do you see any advantages with FGM/C? Do you see any disadvantages? Why and why not?

Q3: If the respondent cannot see any advantages: When did you come to be against FGM/C? What made you come to this conclusion?

Q4: Do you know the different types of FGM/C practiced in Somaliland?

Q5: Do you know any uncut girls that are attending your school?

Q6: What do students think about them?

Q7: If yes, are there any social problems for the uncut girls inside the school?

Q8: Have you participated in discussions/Awareness building measures on FGM/C?

Q9: Who organized the discussions/awareness building measures on FGM/C? If yes: Do you remember the message? Do you agree with it?

Q10: Has your school ever organized discussions/Awareness building measures on FGM/C? If yes, what were the messages?

Q11: Which channels of communication are most available and can be accessed in the school?

12: What is according to you the most important factor to be able to cease FGM/C?

Q13: If you have a daughter, how do you perceive your own daughter's future concerning FGM/C?

Q14: How does your husband/wife perceive FGM/C? (For married ones)

Ministry of Labour and Social Affairs

Q1: Why is FGM/C practiced?

Q2. Do you know the different types of FGM/C practiced in Somaliland? Which types are allowed under the Somaliland law and which types are prohibited?

Q3: Does MOLSA have department that tracks and records FGM/C cases in the country? If so how many cases have you recorded for the last one year? Disaggregate by region and type

Q4: How many staffs are currently working in this department? Disaggregate by gender? What tools did the staff employ to record the FGM/C cases and complications?

Q5: Did the department staff receive any capacity building? What kind of capacity building? Who provide It.?

Q6: Does MOLSA/government have clear FGM/C policy?, what does the policy say about FGM/C practices?

Q7: what are the major challenges facing/hindering the department to implement their roles and duties? How can be addressed that challenges?

Q8: Do you know about social attitude complications from FGM/C? If yes: what kind of complications?

Q9: Have your staff participated in discussions/Awareness building measures on FGM/C?

Q10: Who organized the discussions/awareness building measures on FGM/C? If yes: Do you remember the message? Do you agree with it?

Q 11: Have MOLSA organized the discussions/awareness building measures on FGM/C? If yes: what was the message?

Q12: Which channels of communication are very much available and can be accessed in the country?

Ministry of Health and Health associations

Q1: Why do you think is FGM/C performed on girls?

Q2. What are the different types of FGM/C practiced in Somaliland? Please explain each type.

Q3: What are the health complications of each type of FGM/C?

Q4: Does your hospital/health facility provide any type of FGM/C services?

Q5: If yes how many girls were circumcised in the last 1 month?

Q6: If no, why don't you offer that service?

Q7: According to your experience, is there any difference between the health of circumcised women and uncircumcised women? If yes, what are the differences?

Q8: in your opinion, should girls be left untouched? If no, what type do you recommend? What are the advantages of doing the type you mentioned?

Q9: Have you participated in discussions/Awareness building measures on FGM/C? If yes, do you remember the message? Do you agree with it?

Q10: Who organized the discussions/awareness building measures on FGM/C? If yes: Do you remember the message? Do you agree with it?

Q11: Are you a member of the Doctors Association? If yes, what is the stand of the association on FGM/C?

The Health Caucus of the House of Representatives

Q1: Did the draft of the FGM/C Act reached the Health Caucus?

Q2: Is FGM/C a concern within your House?

Q3: Has the House ever held discussions on FGM/C?

Q4:Do you think that the FGM/C act will be passed by the House in the near future? Please explain why or why not? Challenges you anticipate.

Q5: What do you think could be done to eradicate FGM/C?

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