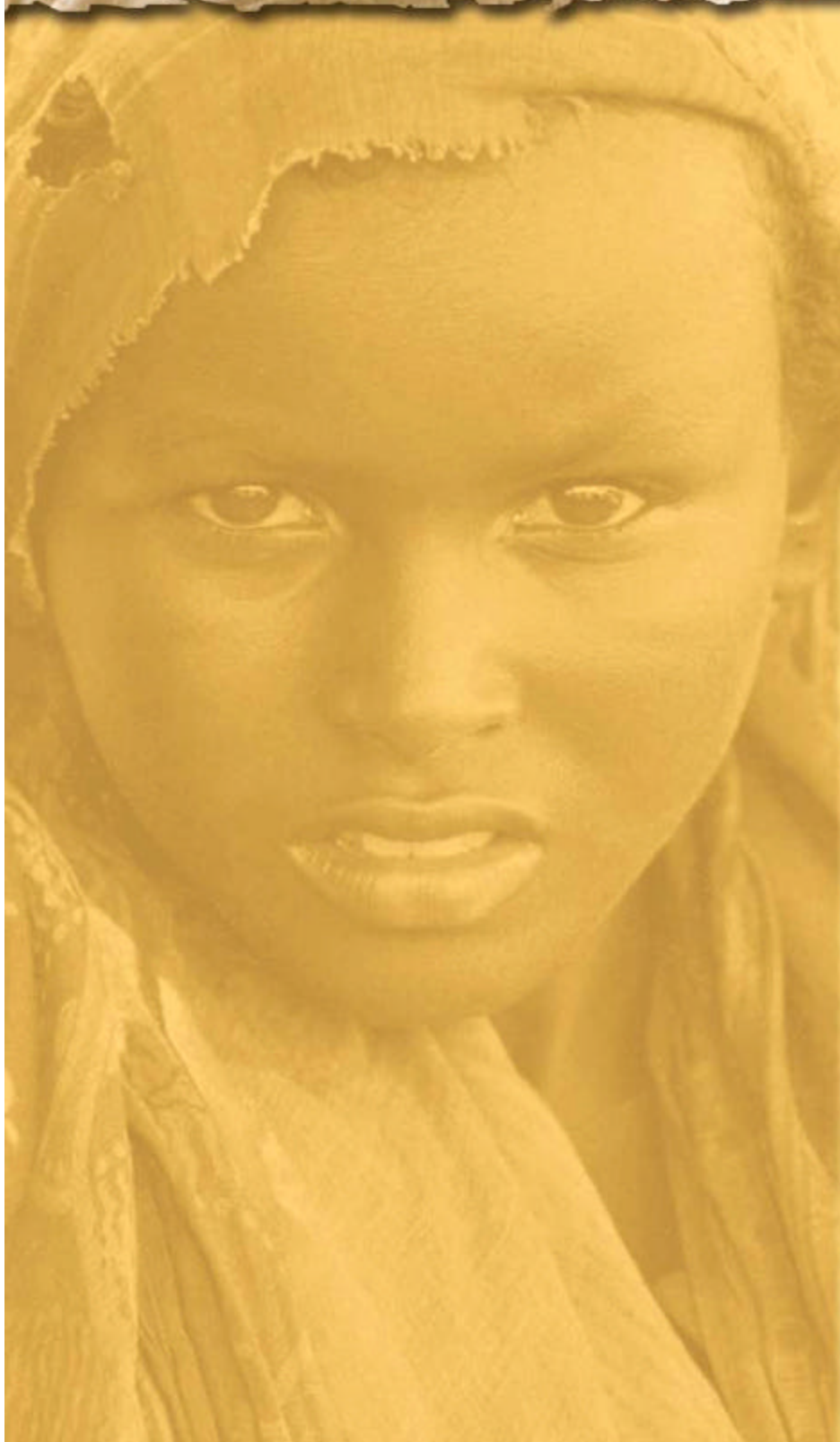




World Bank



FEMALE GENITAL MUTILATION/CUTTING IN SOMALIA





World Bank



UNFPA

**EXECUTIVE SUMMARY
FEMALE GENITAL MUTILATION/CUTTING IN SOMALIA**

March 2005

Foreword

The World Bank and the United Nations Population Fund (UNFPA) are pleased to present this assessment of female genital mutilation (FGM)/female genital cutting (FGC) programs in Somalia as a framework for intervention. The report resulted from consultations with various stakeholders in Nairobi and Somalia. It represents the first attempt in assessing the progress made towards the eradication of FGM/FGC in Somalia.

The report highlights the enormous cost and high prevalence of FGM/FGC in Somalia. It explores the health, religious, cultural, economic and human rights perspectives of FGM/FGC. It captures responses from Somalis, civil society, communities, regional authorities and global partners. Since FGM/FGC is deeply engrained, innovative traditional measures are required to initiate behavior change. The report examines ways of achieving such changes. The lessons learnt from FGM/FGC programs provide the basis for targeted and strategic follow-up initiatives to hasten its eradication.

The World Bank and UNFPA have actively supported the global fight against FGM/FGC, which undermines women's health and well-being. Both institutions believe that where FGM/FGC is universal, it should be integrated into reproductive health, education and social protection strategies.

Recommendations outlined here, particularly the six critical foundations necessary for the successful implementation of an FGM/FGC program, should be useful to those fighting against FGM/FGC. We hope the report will provide strategic and long-term interventions, which will ultimately eliminate FGM/FGC in Somalia.



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Executive Summary¹

Between 100 and 140 million women and girls have undergone mutilating operations on their external genitalia, suffering permanent and irreversible health damage. Every year, two million girls are subjected to mutilation, which traditional communities call “female circumcision” and the international community terms “female genital mutilation” (FGM), or “female genital cutting” (FGC). FGM/FGC inflicts serious physical, psychological and sexual complications on women and girls.

FGM/FGC has relentlessly been condemned by the U.N. and the international community. It was denounced by the U.N. in 1952, at a World Health Organization Regional meeting in Khartoum, in 1979, and in a 1984 conference in Senegal, which was attended by members from 20 African countries.

The 1993 Vienna U.N. Convention on Human Rights declared that:

“The World Conference supports all measures by the United Nations and its specialized agencies to ensure the effective protection and promotion of human rights of the girl child. The Conference urges States to repeal existing laws and regulations and remove customs and practices which discriminate against and cause harm to the girl child.”

The Platform of Action of the 1995 World Conference on Women also urged governments, international organizations and nongovernmental organizations to develop policies and programs to eliminate FGM/FGC and all forms of discrimination against the girl child.

It is estimated that 98 percent of Somali women and girls have undergone some form of genital mutilation. About 90 percent have been subjected to the most drastic form type III or Pharaonic circumcision (see definitions in section 2.2). Since the 1991 collapse of its central government, Somalia has lacked established institutions, infrastructure, human resources and a secure environment suitable for development programs.

Despite a harsh and uncertain environment, a vibrant civil society has been born in Somalia. Hundreds of NGOs, including women and youth groups, are actively involved in assisting victims of war, displaced persons, ethnic minorities, orphans, returned refugees, drought-stricken nomads and rural communities. These civil society groups receive significant humanitarian and development assistance from U.N. agencies and 40 international NGOs² operating in Somalia. The Somalia Aid Coordination Body (SACB) was established to coordinate and facilitate information sharing among donor agencies, mostly based in Nairobi, Kenya. FGM/FGC eradication programs and activities are coordinated through the SACB FGM/FGC Task Force, which meets every month.

¹ This executive summary is based on the full version of the report, ‘Female Genital Mutilation/Cutting in Somalia’, which is on the World Bank’s Somalia web site at www.worldbank.org/afri/so.

² NOVIB Somalia, Somalia Human Rights Report, 2003.

This assessment is aimed at guiding the World Bank, UNFPA and other partners in current and future anti-FGM/FGC initiatives.

Lessons learnt and best practices

A successful anti-FGM/FGC movement must have the following six basic foundations:

- Strong and capable institutions implementing anti-FGM/FGC programs at the local, national and regional levels.
- A committed government which supports FGM/FGC eradication with positive policies, laws and resources.
- Institutionalization of FGM/FGC in national reproductive health, education/literacy and development programs.
- Trained staff that can recognize and manage the physical, sexual and psychological complications of FGM/FGC
- Coordination among governmental and nongovernmental agencies at the local, national, regional and international levels.
- An advocacy movement, which fosters a positive political and legal environment and increases support for programs and public education.

Program implementers must be competent and capable of designing, implementing and evaluating systematic and research-based anti-FGM/FGC interventions. They should target audiences and communities in accordance with their stages of new behavioral adoption.

Introduction

FGM/FGC is a traditional practice in which part of or the entire external female genitalia is removed. Some communities refer to it as female circumcision (FC). The severe effects of FGM/FGC on the health of girls and women have been widely documented. FGM/FGC results in complications at birth for both mother and child, sometimes leading to death³. The United Nations Children's Fund (UNICEF) estimates that FGM/FGC, which is a common practice in Somalia, covers 98 percent of the total female population⁴. The practice has strong repercussions on the health of women and on the social, political and economic fabric at the individual and community levels.

FGM/FGC eradication programs which started in the early 1980s, collapsed with the 1991 fall of the Somali government. Since then, international NGOs, Somali organizations and donor agencies have reinitiated program activities throughout Somalia. However, questions remain about the level of coverage, strategies, messages used, the overall effectiveness of projects and activities and what lessons learned and best practices have emerged.

This assessment of FGM/FGC eradication programs in Somalia, jointly initiated by the World Bank and United Nations Population Fund (UNFPA), aims at guiding current and future program efforts of both organizations. The two organizations have been actively involved in the global fight against FGM/FGC. The Bank believes that anti-FGM/FGC initiatives should be integrated into reproductive health, education, social protection and rural development strategies. UNFPA has made FGM/FGC eradication part of its mandate in implementing the 1994 International Conference on Population and Development (ICPD) Program of Action. UNFPA supports FGM/FGC eradication programs in most of the 28 African countries where FGM/FGC is practiced. Both institutions are members of the FGM/FGC Task Force of the Somali Aid Coordination Body (SACB)⁵. This joint assessment builds on their ongoing work in the areas of health and HIV/AIDS in Somalia.

1.1 The Assessment: Its Purpose and Objective

The purpose of the assessment was to undertake an appraisal of FGM/FGC programs and activities in Somalia. It was specifically expected to:

- Undertake an in-depth review of the FGM/FGC practice in Somalia, including responses from regional authorities⁶, communities, civil society and international partners.

³ World Bank. 'Ending female genital cutting: the Bank's role'.

⁴ World Vision. 2004. 'July update'.

⁵ SACB 2004. 'Somali Aid Coordination Body Handbook'.

⁶ The report uses the term "regions" to designate Northwest (Somaliland), Northeast (Puntland), and Central and Southern because of common usage and readability and is not an indication of any position on the part of the World Bank regarding this issue. The World Bank follows the United Nations in adhering to the principle of territorial integrity of Somalia and it therefore considers Somalia a single entity.

- Examine projects that are undertaken on FGM/FGC in Somalia by Somalis and the international community, and then extract best practices.
- Assess opportunities as well as constraints for engagement on FGM/FGC issues in Somalia.
- Recommend potential areas where the Bank and UNFPA may improve and/or engage to support the elimination of FGM/FGC in Somalia.

The study paid close attention to community-based mechanisms or approaches used in Somalia to address FGM/FGC and assess their success rates.

1.2 The World Bank in Somalia

The World Bank included Somalia as one of the four pilot countries in the Africa region for the Low-Income Countries under Stress (LICUS) initiative. The program seeks to provide proactive support through partnerships to countries with extremely weak policies, institutions and governance.

In June 2003, a joint World Bank/United Nations Development Program (UNDP) Country Re-engagement Note was formulated and endorsed by the Bank's Board of Directors. The strategy aims at laying the initial framework for long-term engagement in Somalia. It will also facilitate institutional and policy changes while improving basic social outcomes. The initiative focuses on four carefully selected areas of reform and uses key agents of change, particularly the private sector. The four identified strategic entry points for reengagement are: (a) support to macroeconomic data analysis and dialogue; (b) creating an enabling environment for the livestock and meat industry; (c) coordinated action plan to address HIV/AIDS; and (d) capacity building for skill development and centers of training. These are being implemented by U.N. agencies and international NGOs. The Bank is exploring support to FGM/FGC eradication activities.

1.3 UNFPA in Somalia

Since resuming its support to Somalia in early 1995, UNFPA has continued to expand its partnership and collaboration with relevant partners in executing different projects in core sectors. For instance:

- In 1995, UNFPA financed two reproductive health and family planning projects, which were executed by the World Health Organization (WHO) and the International Planned Parenthood Federation (IPPF). The projects' activities included rehabilitation of health facilities, provision of basic reproductive health and family planning services and training of health professionals and traditional birth attendants (TBAs).
- In 2003, UNFPA supported six core sector projects: four in reproductive health and HIV/AIDS, one in data collection and analysis and one in advocacy and capacity building. Integrated into UNFPA's reproductive health and advocacy programs are advocacy, creation of awareness and community dialogue, behavior change, HIV/AIDS and the eradication of FGM/FGC.

- UNFPA currently co-funds the five-year Well Women Media Project (*Sahan Saho*), which is broadcast over the BBC Somali service. It targets the Somali-speaking Horn of Africa (Somalia, Djibouti, North-eastern Kenya and Zone five in Ethiopia). Implemented by Health Unlimited, the program utilizes a drama and magazine format and disseminates messages on reproductive health, HIV/AIDS prevention, stigma reduction and elimination of FGM/FGC.

2.1 Background of FGM/FGC in Africa and in the Somali Context

2.1.2 Definition, Classifications and Terminologies

According to WHO, FGM/FGC comprises all procedures involving partial or total removal of the external genitalia or injury to the female sexual organs. This could be either for cultural, religious, or other non-therapeutic reasons. The WHO classifications of the different types of FGM/FGC practiced today are shown in box 1⁷.

Box 1. Types of FGM/FGC⁸	
Type I	Excision of the prepuce, with or without excision of part or the entire clitoris.
Type II	Excision of clitoris with partial or total excision of the labia minora.
Type III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation).
Type IV	Pricking, piercing or incising of the clitoris and/or labia. Stretching the clitoris and/or labia. Cauterization by burning of the clitoris and surrounding tissue. Scraping of tissue surrounding the vaginal orifice (<i>anguriya</i> cuts) or cutting of the vagina (<i>gishiri</i> cuts). Introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it. Any other procedures that fall under the above definition.

Type II or excision of the clitoris accounts for 80 percent of all operations in Africa. Among Somali and Sudanese women, 80 to 90 percent undergo type III or infibulation, which accounts for only 15 percent of cases in Africa. Ethnic Somalis in Kenya and Ethiopia practice infibulation which is also common among other ethnic groups in Ethiopia and Eritrea. At times, the tissue cut during infibulation is equated with that removed in simple vulvectomy, indicated in some lesions that are not amenable to conservative surgery, such as extensive micro-invasive cancer of the vulva⁹.

2.1.3 Prevalence of FGM/FGC

Prevalence of FGM/FGC in Africa varies from five percent in the Democratic Republic of Congo to 95 percent in Mali and 70 percent in Burkina Faso to 98 percent in

⁷ WHO, 2000. Fact Sheet No. 241, June.

⁸ No official definition of FGC was found, but rather references to it as synonymous with FGM/FGC.

⁹ Karim, Dr. Mahmoud, 1995. "Circumcision and Mutilations of Males and Females: Medical Aspects."

Somalia¹⁰. It should be noted that FGM/FGC is a difficult practice to monitor especially where it operates illegally and underground. However, it is useful to repeatedly measure the national and district-level prevalence rates to check whether the practice is decreasing, stagnating or increasing. Studies conducted in the Northeast (Puntland)¹¹ and Northwest (Somaliland)¹² reported a universal practice of FGM/FGC in both urban and rural areas.

Available data indicates that FGM/FGC does not respect status. A study conducted by the University of Nairobi, covering North East and North West Somalia, found the same universal practice with little or no difference in prevalence among different socio-economic groups, urban, rural or nomadic settlements¹³. It did not matter whether or not respondents were educated. There were insignificant variations related to social background such as education, settlement and income when it comes to FGM/FGC¹⁴.

2.1.4 Age and Type of FGM/FGC and Terminology in Somalia

In Somalia, FGM/C was traditionally performed in adolescence as initiation into womanhood. However, unlike other parts of Africa, circumcision in Somalia is no longer considered a rite of passage. Girls are now circumcised between the ages of five and eight, often within the privacy of their homes.

Box 2. Somali terminology for FGM/FGC

Gudniin: Circumcision (referring to all forms of FGM/FGC).

Halalayn: Purification, which also means circumcision (all forms). This name implies that the uncircumcised is perceived as unclean (physically and spiritually) and needs to be purified.

Guddaay: Circumciser.

Gudniin Fadumo: Faduma's circumcision (Prophet Mohamed's daughter's alleged circumcision that refers to infibulation or Pharaonic type. There is no evidence that any of the Prophet's daughters were circumcised, indicating erroneous legitimization of FGM/FGC for Somalis).

Gudniinka fircooniga ah: Pharaonic circumcision meaning infibulation or type III FGM/FGC.

¹⁰ UNICEF ESARO June, 1996. 'Female Genital Mutilation; Brainstroming Meeting'. Nairobi.

¹¹ Abubakar, 2001. Critical Reproductive Health Project.

¹² Ferguson and Odhiambo, 1999. "Safe Motherhood Baseline Survey." CARE Somaliland.

¹³ WHO, 2000. Fact Sheet No. 241, June.

¹⁴ Health Unlimited, 2003. "A Report on the Assessment of Level of Awareness in and Discussion on Issues of FGM/FGC, Safe Motherhood and STI/HIV/AIDS among Somali-Speaking Horn of Africa Community."

FGM/FGC: Infibulations or *gudniinka fircooniga ah* (a recent term-99 percent of people interviewed refer to it while discussing FGM/FGC).

Sunna: A variety of operations. These range from pricking the clitoral hood to the partial and total excision of clitoris. Part or complete removal of clitoris followed by sectional excision of labia and suturing two-thirds of the vulva. It also refers to various degrees of cuttings and total suturing of the vulva just as in normal infibulations. This is too general and devoid of the symbolic pricking of the clitoral hood implied by *Sunna* (following the Prophet's teachings). There is no clear evidence that Prophet Mohamed PBUH endorsed the practice. The term *Sunna* should therefore be eliminated from the program materials since it erroneously legitimizes FGM/FGC.

2.1.5 Health Consequences of FGM/FGC

Long-term consequences of FGM/FGC include cysts and abscesses, keloid scar formation, damage to the urethra resulting in urinary incontinence, pain during sexual intercourse, sexual dysfunction, menstrual pains, infections, bleeding, pain during circumcision and difficult childbirth¹⁵. If the operation is conducted in unhygienic surroundings and/or using shared instruments, the victims are exposed to deadly infections like tetanus and HIV/AIDS.

Somalia's rural and nomadic communities have recorded some of the most drastic forms of FGM/FGC. Lack of access to health facilities worsens the complications of FGM/FGC. Somali women undergo the 'three feminine pains': circumcision, wedding and labor¹⁶.

Most studies indicate that urban residents are more aware of the health complications from FGM/FGC than their rural or nomadic counterparts¹⁷. Nevertheless, most people associate FGM/FGC complications only with the Pharaonic circumcision (infibulation or type III FGM/FGC). This might be due to lack of clarity of messages or poor channels of communication¹⁸.

¹⁵ UNICEF Somalia/SACB Health Sector/UNIFEM. 'Symposium on the total eradication of Female Genital Mutilation'. 2001. Nairobi.

¹⁶ Saying learned when author of this assessment interviewed young married women in Allanfuto, Lower Shabelle, Somalia, 1988.

¹⁷ Health Unlimited, 2003. "A Report on the Assessment of Level of Awareness in and Discussion on Issues of FGM/FGC, Safe Motherhood and STI/HIV/AIDS among Somali-Speaking Horn of Africa Community."

¹⁸ Kaphle, Shanti, 2000. "Report of Qualitative Research on the Communication Channels in Use in Somalia." UNICEF-Somalia.

2.1.6 Reasons for Practicing FGM/FGC and the Mental Map Guiding the Assessment¹⁹

FGM/FGC is so deeply embedded in society that its elimination requires a clear understanding of the cultural perceptions, and beliefs it feeds on. Since culture is the body of learned beliefs, customs, traditions, values, preferences and codes of behavior commonly shared among members of a particular community, it becomes the mirror and filter for information and reality. It is the mental map for community survival. Every community member is thus bound by culture. Unquestioningly, men, women, young, old, powerful and powerless, are influenced by it. They share similar mental maps, at times varying and evolving according to education, life experiences, exposure to mass media and other cultures²⁰.

Although the origins of FGM/FGC remain blurred, communities that practice it share similar mental maps. They have compelling reasons for eliminating the clitoris and other external genitalia. All reasons, as indicated in figure 1, fit into an elaborate mental map. The reasons range from spiritual to religious, sociological to hygienic, aesthetic to sexual.

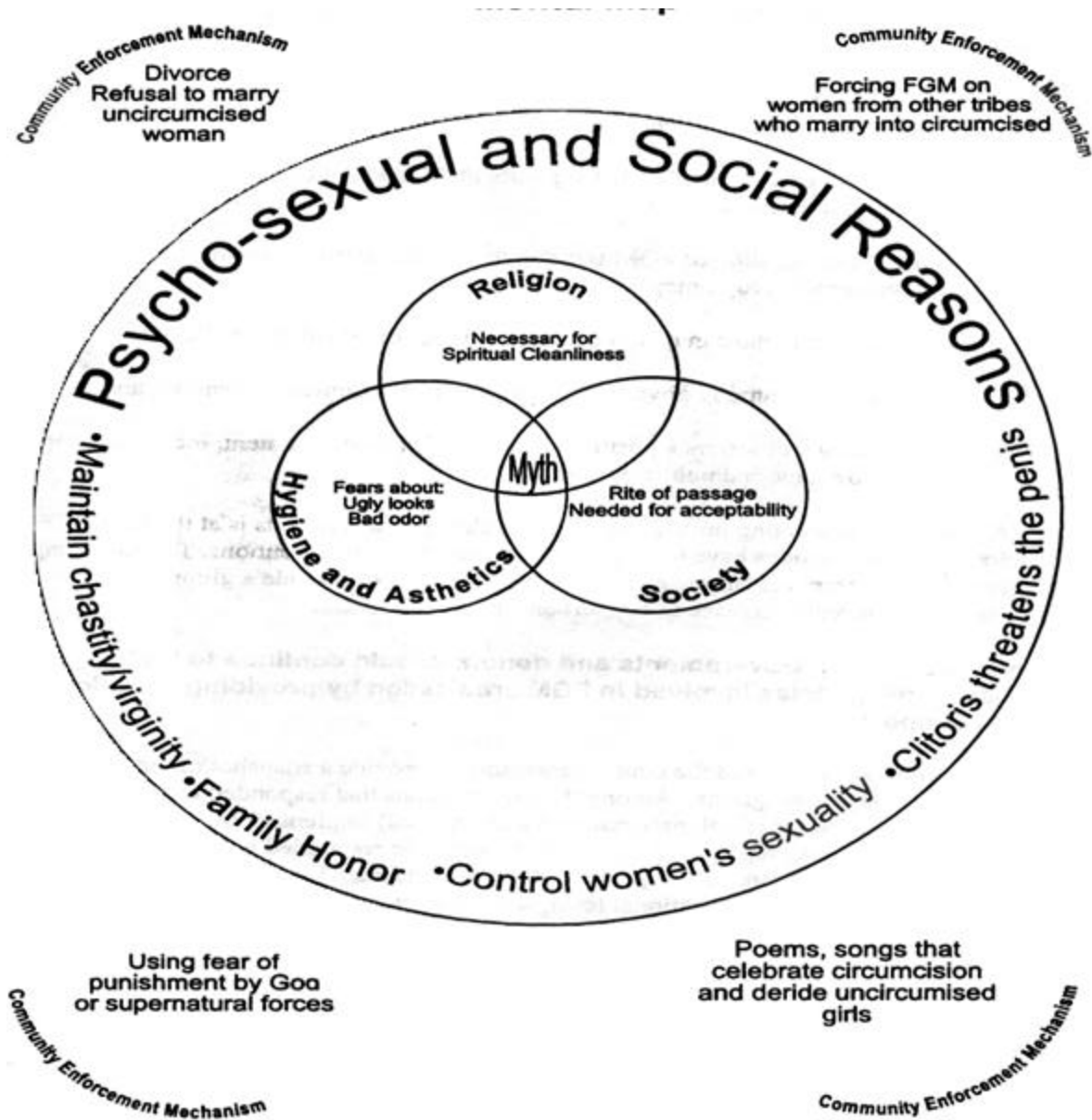
Once educated people discard these beliefs, complicated psychosexual reasons emerge focusing on dangers that may befall the girl, her family, potential husband and society, if the genitalia are not eliminated. A young woman's sexuality is therefore to be controlled to save her from becoming oversexed, losing her virginity, disgracing families or failing to get married. A woman is also a cause of mistrust to a potential husband and a threat to the existence of the entire community.

There are community enforcement mechanisms that compel communities to continue the practice of FGM as indicated in figure 1.

¹⁹ Excerpt from "Female Genital Mutilation: Programs to Date: What Works and What Doesn't." Mohamud, Ali, and Yinger, 1999. Department of Women's Health, WHO.

²⁰ Crane, Beth, and Asha Mohamud. *Communication for Change. A Curriculum for Health Workers and Program Planners*. Program for Appropriate Technology in Health (PATH).

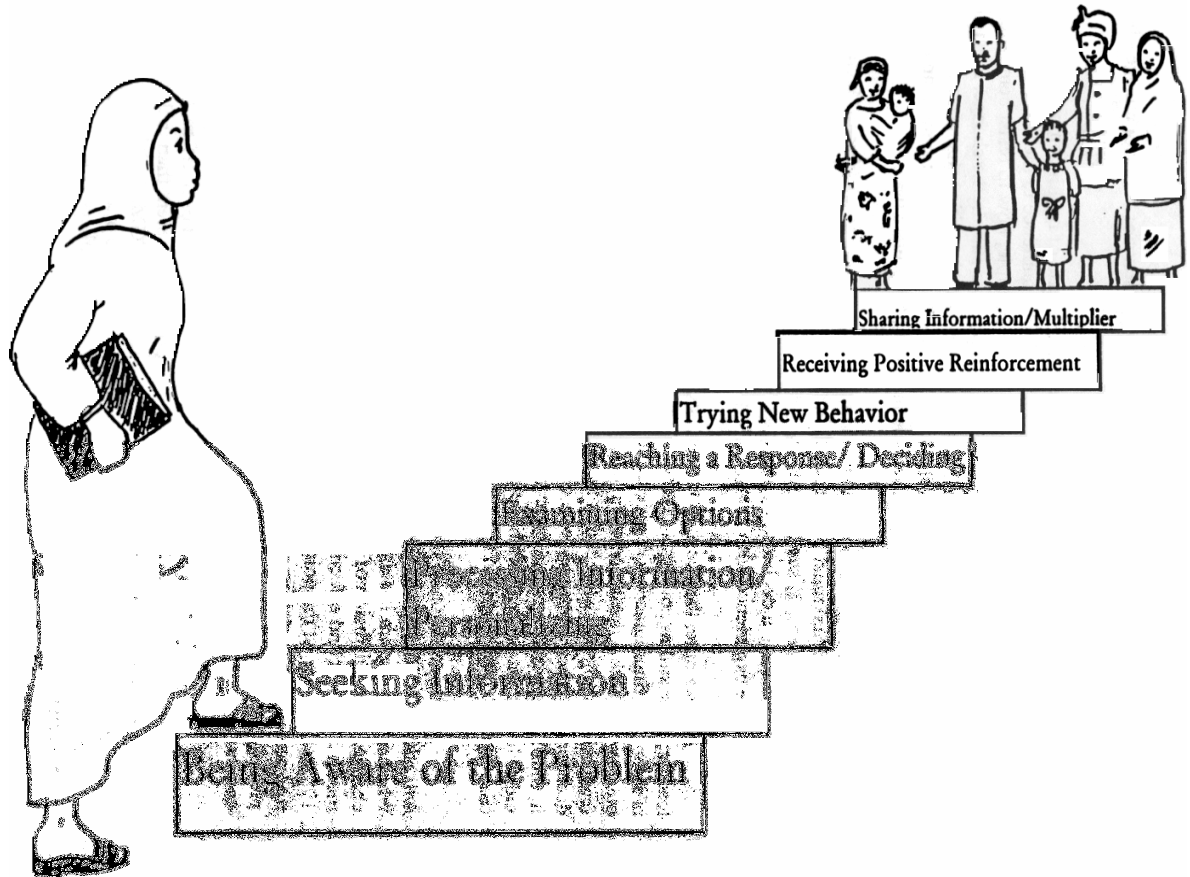
Figure 1. Why the Practice of FGM/FGC Continues – Mental Map²¹



²¹ Diagram from "Female Genital Mutilation: Programs to Date: What Works and What Doesn't." Mohamud, Ali, and Yinger, 1999. Department of Women's Health, WHO.

The decision by anyone to reject FGM/FGC encompasses changes at different levels as shown in figure 2.

Figure 2. Stages of Behavior Adoption and Change²²



Throughout the campaign close attention must be paid to the reception and absorption of messages. Communication strategies must merge the use of the media, community or interpersonal interventions to break into difficult groups such as grandparents, traditional leaders and circumcisers. Family and community pressures at times derail the determination to abandon FGM/FGC. This calls for communal decision making and consensus building.

²² Excerpt from "Female Genital Mutilation: Programs to Date: What Works and What Doesn't." Mohamud, Ali, and Yinger, 1999. Department of Women's Health, WHO.

3.1 Assessment Findings

Existence of strong, committed and capable institutions in the anti-FGM/FGC crusade is a major boost in the strategy against FGM/FGC. According to a NOVIB-Somalia human rights report²³, at least 40 international NGOs and hundreds of Somali civil society organizations operate in various parts of Somalia. With the support of U.N. and international NGOs, the Somali agencies are strengthening their networking and capacity building in management, fundraising, education, health, and environmental services.

Among the mechanisms enforcing the practice of FGM/C is the economic aspects of FGM/FGC. As shown in box 3 below (Economic Aspects of FGM/FGC), a father is intimately involved in marriage negotiations, he will not start negotiating until the deed is done.

Box 3. Economic Aspects of FGM/FGC: What factors Contribute to its Perpetration?

The Father and the Bride: Are girls circumcised because of bride price? Somalis pay varying amounts: camels, cows, goats, money, and guns for bride price according to their financial status and region. It is not easy to answer this question because bride price is paid in many other African communities where FGM/FGC is not practiced. However, in the Somali context, since marriage and bride price are linked and since being properly circumcised/infibulated is prerequisite to marriage, FGM/FGC and bride price become intertwined.

Fathers play a key role in the decision-making process leading to circumcision of daughters. They will not enter into marriage negotiations unless the girls are deemed marriageable. However, when asked about FGM/FGC, they often heap it on women as a women's affair. Can fathers agree to enter into marriage negotiations if their daughters are not circumcised? Since the issue is one of supply and demand, the answer probably lies with those demanding circumcision and paying the bride price—the future husbands.

The Groom and the Price: One of the most important achievements for a Somali man is to pay bride price, get married and start a family. Often his father and the family will contribute towards the bride price. On fulfilling his part of the bargain—paying the bride price, the groom and his family expect a young woman who is infibulated. Some Somali communities resort to inspection of the bride during the first day of marriage. Swift post-wedding night reactions could lead to divorce, digging a hole in front of the hut or onto the bedding (in Lower Shabelle) and actually demanding the bride price back. These actions are enough to shame any family and to teach them not to fall into the same trap. By linking circumcision/infibulation to the bride price, the groom is in charge of the demand for circumcision. The crucial question is what will it take to eliminate this

²³ NOVIB, 2003. "Somalia Human Rights Report."

demand?

The MYWO (Maendeleo ya Wanawake Organization) and PATH (Programme for Appropriate Technology) Project in Kenya explored this issue and registered some successes, which can provide some lessons for the Somali anti-FGM/FGC campaign. Their intervention targeted young men and explained the various aspects of the practice including its negative effects on women's sexuality and how that could affect their relationship. This led to many young men saying that they will not marry circumcised wives. However, the program thought it to be unethical since many of the marriageable pool of women at that time were already circumcised. Thus the program sought the following three responses from the young men:

- I will not require FGM/FGC as a pre-requisite for marriage.
- I will not circumcise my own daughters.
- I will fight circumcision of girls in my family.

The Circumcisers and the Fees: Both the traditional circumcisers and the health professionals who circumcise earn some income from the practice. It is a fact that as long as the demand is there from parents and husbands who want circumcised/infibulated brides, then the circumcisers will continue to provide the service. The demand for services and parents' willingness to pay is increasing the number of health providers who are willing to take the blade—a behavior which is condemned by WHO and other international agencies

Conclusion: While FGM/FGC and bride price are linked, it is possible to de-link them as has happened in other African countries so long as we address the demand side of the equation from various angles. Much centers on addressing and demystifying women's sexuality and the effect of FGM/FGC on women, men and families. Ultimately, elimination hinges on the decisions of future grooms.

3.1.2 Counseling and Treatment of FGM/FGC Complications

The key foundation to FGM/FGC eradication work is educating healthcare providers about the various complications arising from the practice. The medical professionals report numerous and serious complications (see section 2.5) that require immediate action.

Many women and girls suffer in silence. They need counseling services that are advertised and easily accessible, with appropriately trained professionals and referral lists. It is also crucial to integrate FGM/FGC education into pre-service training programs for nurses, doctors, and other health professionals. Preventing new trainees from taking the blade after graduation is an important and ethical step.

3.2 FGM/FGC Elimination in Somalia: Opportunities and Constraints

FGM/FGC poses an imminent threat to the health, happiness, and fundamental rights of Somali girls and women. Opportunities for engagement in the campaign fortunately outweigh the constraints. With a large pool of a committed network of fighters in form of organized women and youth groups, there is hope.

These networks are committed to addressing social and economic issues within their families and communities. Some of them already have significant capacities in organizational development, grant management, leadership skills, literacy, environmental protection, human rights, income generation, and support for pastoral communities. Specific population groups also present special opportunities for the final dismemberment of belief systems and mental maps that sustain FGM/FGC in Somalia and the Somali-speaking Horn of Africa.

3.2.1 Realizing the Potential in Youth

In 2000, Somalia had an estimated 3.2 million young people aged between 10 and 24 years. This number is projected to reach 7.2 million by 2025²⁴. These young people need to participate in formal and non-formal educational activities, social mobilization, and skill-building opportunities especially those geared towards eradicating FGM/FGC, preventing sexually transmitted infections and HIV/AIDS, protecting the environment, and improving reproductive health and gender equity and equality.

Consistent with global trends, young men in urban settings are more knowledgeable about sexuality. They do not condone FGM/FGC and doubt its religious basis. Generally, youth adopt new ideas more easily. Convincing them to move from their overwhelming support for *Sunna* is an achievable goal.

Girls in their formative years could be convinced to reject all forms of FGM/FGC, given their negative experiences. However, they need to be handled delicately to avoid psychological trauma and loss of self-esteem.

3.2.2 Harnessing the Potential of the Islamic Religion

Clerics present a huge opportunity for the fight against FGM/FGC. They can play a role in educating the public and declaring their stand against FGM/FGC. There is a need for:

- Identifying educated and moderate clerics for comprehensive training on all aspects of FGM/FGC i.e. health, sexuality, culture and tradition, human rights, gender, and the Islamic perspective on FGM/FGC.
- Religious Somali women are also ready for change. They are able to interpret the *hadiths* and other religious references, including Quranic verses, which support women's sexuality and freedom from artificial alterations of their bodies. Like the male clerics, they need empowerment and opportunities to network with other

²⁴ Population Reference Bureau 2000. 'The Worlds Youth 2000'. Washington D.C. USA.

moderate Muslim women from non-FGM/FGC-practicing countries. They should form their own anti-FGM/FGC network as well as work within the existing ones.

3.2.3 The Educated and Urbanized

Studies clearly show that there is no difference in the prevalence of FGM/FGC among various socio-economic categories. It is clear however that urban people, especially women, are more knowledgeable about the harmful effects of FGM/FGC. They also know that Islam does not sanction the practice.

Anti-FGM/FGC programs will benefit more by targeting those who are ready for change. Behavior change interventions should first target those who have already considered changing their behaviors or are weighing the options even if change was for the least forms.

3.2.4 Targeting Men: Fathers

More recent studies indicate that men and women share similar beliefs and values when it comes to FGM/FGC. However, although men expect all of their daughters to be circumcised to qualify for marriage, they are removed from the actual action and are often ignorant of its negative effects on women and girls.

Urbanized and educated men exposed to un-circumcising countries are more adaptable to change. Men are silent sufferers of the effect of FGM/FGC. Many suffer trauma to the penis and sexual health. Because of the culture of silence associated with sexuality and manhood, they are unable to voice their concerns or to break away from a belief system that ties trust in their wives and relationships with the practice of infibulation. Men disapproving of the practice should be encouraged to voice their rejection to, and make deliberate and informed decisions and to strengthen the behavior change communication interventions.

Men are currently marginalized in the fight against FGM/FGC, both as target audiences and change agents. It is important to establish and support male-led networks such as a concerned fathers' network, to spearhead some of the FGM/FGC eradication projects.

3.2.5 The Community Approach

Community-based interventions are critical in supporting national-level advocacy or behavior change programs. Although media can help in creating awareness and changing attitude, interpersonal communication is best suited for allowing people to critically examine their values, beliefs, norms, and practices.

The process must however be delicately moderated to steer communities from affirming the importance of harmful traditional practices. Conflict often arises on what space facilitators should be given to help bring about change without imposing outsider values

on communities. The facilitator's main goal is always to add fuel to the eradication of FGM/FGC.

It is important to clarify that sexual desires are controlled from the brain and involve multiple bodily processes: visual, hearing, fantasies, emotions, and touching. This will demystify beliefs that the genitalia control women's behavior. Showing and giving examples of millions of uncircumcised Muslim women brought up to be upright, respected and trusted by society, spouse and families add to the demystification.

To facilitate the process of community change, it is imperative to design a set of discussion guides or flipcharts dealing with the different dimensions. Each group should then go through every topic and issue. On reaching a positive response, they can then move on to the next topic. The last discussion should center on individual and group decision making then reach a consensus on the FGM/FGC practice.

It is only after a critical mass within each target group religious leaders, traditional leaders, women's groups, girls and boys has reached its own individual and group consensus, that it is appropriate to organize consensus building fora for diverse groups. After that the results can be widely publicized.

The last discussion should aim at building consensus among community members. Once that has been achieved, a public declaration against FGM/FGC in all its forms should be made. Successes such as these can spark other communities into action. However, the community-based projects should never take place within the areas of one sub-clan. They should be implemented in areas of different sub-clans so that one group is not labeled or ostracized.

Coordination and complementary programming should also be encouraged among the Somali non governmental organizations (NGOs) and community based organizations (CBOs). This will increase synergy, cross-fertilization, sharing of resources and will help eschew duplication of efforts and mixed messages.

3.2.6 The Regional Media Approach

The best form of media for an orally active society like Somalia is obviously the radio. It is the most powerful and breaks across language and literacy barriers. Considering the power and acceptance of radio in Somalia, programs such as the *Sahan Saho*²⁵, should be utilized more fully. Well-produced programs and news events, can have a positive impact on communities in Somalia and the Horn of Africa. The programs should strive to give equal voice to all its target communities. The communities should also be able to identify with the voices, characters, dialect, testimonials or discussions on the program.

²⁵ Sahan Saho is a cross-border media program that was implemented in January 2004 by Health Unlimited and is broadcast over the BBC Somali Service. It targets Somali speaking Horn Africa and deals with sexual issues and reproductive health i.e. HIV/AIDS, FGM/FGC and stigma reduction.

3.2.7 Improved Monitoring and Evaluation

The crucial documentation and evaluation of anti-FGM/FGC activities can be done in tandem with systematic and long-term interventions. The current collection of baseline data for focused projects is a positive move that needs to be supported and encouraged. Program implementers must however bear in mind that reduction in prevalence will not show at the community level during a one- to two-year project. They will need qualitative, process-type assessments, indicators and project specific evaluations to guide interventions for the short term. The periodic Demographic Health Survey (DHS) and other national data can test cumulative effects of subsequent grants in the same project communities and national trends.

3.2.8 Drawing on the Somalis in the Diaspora

Drawing on the background, education, experiences and the language skills of the Somalis in the diaspora presents a unique potential for rebuilding Somalia and contributing to the eradication of FGM/FGC. Somalis in the various zones have limited foreign language skills and usually absorb limited knowledge from foreign consultants. Except for one or two leaders of the local women's and youth organizations, most members are barely literate in English and therefore will gain very little from courses conducted in English. This calls for rethinking the modalities of capacity building through international consultants, perhaps coupling Somalis with these consultants and later leaving the Somalis in charge. Capacity building can also be organized from within Somalia by offering consultancies to capable individuals from one NGO to provide technical assistance to others within the country where security allows. The cost of these consultancies would often be a fraction of foreign consultancies while at the same building local capacities.

Most Somalis in the diaspora have been exposed to outside cultures that do not circumcise. Positive role models that have stopped the practice should be sponsored to speak up and address their communities. Messages and voices from local Somalis who are against FGM/FGC could be distributed to the diaspora. Videotapes of anti-FGM/FGC program should also be distributed among them.

3.2.9 Constraints

There are major constraints in carrying out anti-FGM initiatives. Insecurity makes work in Somaliland, Puntland and Southern and Central Somalia a major challenge. Other problems, which hamper programming in Somalia, include inadequate actions by governmental and nongovernmental institutions, infrastructure, a banking system and dearth of qualified professionals.

4.1 Key Issues and Recommendations

4.1.2 Responses from International Partners and Civil Society Organizations

Coordinated by SACB, many international donors, including U.N. agencies, support the essential programs implemented in Somalia. Many of these agencies, such as UNICEF, UNFPA, WHO, Diakonia-Sweden, the European Union, Equality Now, NOVIB-Somalia, NPA(Norwegian People's Aid), NCA(Norwegian Church Aid), World Vision, CARE(Cooperative for Assistance and Relief Everywhere International), the Red Cross Society, Health Unlimited and UNIFEM (United Nations Women's Fund), support FGM/FGC eradication projects and activities. The World Bank is also interested in supporting FGM/FGC eradication.

Issue: FGM/FGC eradication activities mostly occur on a small scale, ad hoc and short-term basis. The full report noted that because FGM/FGC is a deeply entrenched practice, bringing about behavior change requires research and systematically designed and longer-term interventions. Many organizations are often given support for implementing activities like workshops, seminars, small research, study tours and sponsorship to a conference. Others are given one-year projects. With very few systematically and strategically designed, implemented and evaluated programs, this approach negatively affects the morale and effectiveness of implementing agencies thus affecting the desired objectives. Although FGM/FGC eradication activities of the donors are well coordinated in Nairobi, many partners note that coordination and joint programming is minimal in Somalia.

Recommendation 1: *International donors need to fundraise for and support long-term projects (of at least five years) with the possibility of committing and releasing funds on an annual basis pending satisfactory performance by the grantees.* Donors that have shorter country program periods can also plan five-year interventions with the caveat that multi-year support will be contingent on availability of funds. This approach will allow the grantor and grantees to have a vision and a plan for the program.

Recommendation 2: *International donors should develop a joint strategic framework for FGM/FGC eradication. They should support complementary components of the program to successfully cover all aspects of anti-FGM/FGC foundations.* Complementarities could be based on support for thematic areas such as counseling and treatment, research and evaluation of projects, mass media support, software development and regional or zonal programs. This will require donors to discuss joint framework, targeting use of current resources, roles, responsibilities and fundraising strategies for a more comprehensive and longer-term programming.

Recommendation 3: *International donors need to continue their coordination efforts at the international level while improving coordination and sharing of resources locally.* Many Somali women and youth NGOs implement anti-FGM/FGC programs either as umbrella organizations or as members of such umbrella networks. Despite this positive notion, not all member agencies of any given network may be involved in the FGM/FGC

work. What matters is that those involved remain committed and eventually make great progress in raising awareness about the harmfulness of FGM/FGC.

Issue: There is need to strengthen staff knowledge about the various dimensions of FGM/FGC and improve their technical capability to design, implement and evaluate anti-FGM/FGC programs. Agencies are adept in awareness-raising skills but lack behavior change, advocacy and participatory facilitation techniques. These skills are critical in bringing about social change at the community and national levels. Better understanding of the current successes and failures of the global anti-FGM/FGC movement will also assist organizations in understanding ineffective strategies, like that of offering alternative incomes to circumcisers. In some cases, confusion arises when members or staff from the same network, give different messages. Some support the total eradication of FGM/FGC while others encourage *Sunna*. This exposes lack of synergy in activists' efforts. Some field activists say that addressing FGM/FGC with HIV/AIDS prevention undermines the campaign.

Recommendation 1: *There is need to upgrade the technical capacity of staff and volunteers of women and youth organizations in FGM/FGC eradication strategies, lessons learnt; behavior change communication (BCC); advocacy, skills; and participatory facilitation techniques. Skill building should also include counseling, conflict resolution and mediation. Assisting with individual and communal decision-making skills should also be part of the BCC training.*

Recommendation 2: *Anti-FGM/FGC activist organizations should organize consensus-building meetings for their own staff, volunteers and consultants. This should formulate an agreement on key messages related to the total eradication of FGM/FGC. Similar consensus-building meetings are also needed for members of the umbrella networks to unite their voices. It is important to train participants in all the dimensions of FGM/FGC, and dismantle their negative belief systems before involving them in the consensus-building exercise. The aim should be that all staff and volunteers would eventually support the no tolerance stance for all forms of FGM/FGC.*

Recommendation 3: *NGO leaders and activists should continue being role models. They should not circumcise their own daughters. They should persuade staff and volunteers in their own agencies to follow suit. Once they have recruited a sizeable mass of un-circumcising families, they should be encouraged to publicly declare their positions on radio and via other media. Communities should collectively decide when such a massive move of public declaration is feasible. When activists change their own behavior and declare their intentions publicly, their messages will be more convincing.*

Recommendation 4: *Anti-FGM/FGC implementers should weigh the options of linking FGM/FGC and HIV/AIDS prevention and awareness-raising programs. Integrating HIV/AIDS prevention into all reproductive health programs is important. More crucial is the message that: "circumcising multiple girls with the same blade may cause HIV and AIDS." The linkage between FGM/FGC and HIV/AIDS is replete with underlying fallacies. First, communities practice FGM/FGC in order to reduce women's sexuality.*

The community also believes that HIV and AIDS are fuelled by promiscuity. Religious leaders have even agitated for the burning of condoms, which are viewed as ‘instruments of promiscuity’. Therefore it is a major challenge for the reproductive health programs to advocate for FGM/FGC eradication, condom use and HIV and AIDS prevention in the same breathe. FGM/FGC eradication requires in-depth dialogue, debunking myths, providing accurate information about religion, the female anatomy and sexuality.

4.1.3 Responses from Regional Authorities

Meetings with representatives of the Ministries of Health in Northwest/Somaliland and Northeast/Puntland indicated that they were generally interested in the eradication of FGM/FGC. They perceived that current programs are important for improving the health of women and children. They identified their role as that of setting up policies and guidelines, coordination of program activities, quality control of messages and monitoring of activities.

Issue: Representatives from the Ministries of Health and other agencies complained that international donor agencies are likely to support NGOs and CBOs than government institutions. They deplored the lack of capacity and expertise of some of the agencies implementing HIV/AIDS prevention and FGM/FGC eradication activities. They reported that without the necessary oversight and technical quality control, many of these NGOs and CBOs would pass erroneous information to the communities.

Recommendation 1: *International-funding agencies should encourage the Ministries of Health and other governmental agencies to coordinate and supervise anti-FGM/FGC prevention activities by ensuring that NGO staff and volunteers pass scientifically correct and non-contradictory messages. The staff of regional authorities should also receive capacity building in the latest information, strategies, lessons learned and guidelines adopted by the global community.*

Recommendation 2: *International development and funding agencies should also assist staff of regional authorities to draft counseling and treatment guidelines for FGM/FGC survivors. They should also help draft policy and legal documents to protect the rights of young people. Legislative language should be incorporated into regional authorities’ constitutions. It can be drawn from the laws adopted by the other African countries or accessed from the Center for Reproductive Law and Policy in New York. Laws aimed at promoting gender equity and equality and remove customary laws and practices that impede women’s health, should also be drafted.*

4.1.4 Responses from Communities

Somalis use their oral tradition to narrate recent and past events and also retell stories and information. Lack of entertainment fora provides a fertile opportunity for the rapid spread of information given at workshops, seminars and other right channels. The social

upheavals of the last decade may have exposed Somalis to foreign cultures which might have facilitated social change in deeply held tradition.

Issues: Anti-FGM/FGC behavior change interventions need interpersonal channels of communication to support mass media or general public education methods. Traditional channels of communication are appropriate for reaching remote and nomadic communities. Participatory methods of community and social change that build on local conflict mediation and facilitation techniques may bring about behavior change.

Recommendation 1: Design participatory community-based interventions, as described in section 3.2.5. This should have traditional methods such as community dialogue and conflict mediation techniques to support mass media and other national interventions.

Recommendation 2: Develop appropriate software training packages for use in as many communities as possible (see the community approach, section 3.2.5).

Recommendation 3: Train competent facilitators to support national and community based initiatives. Facilitators should be comfortable supporting a no tolerance stance on FGM/FGC.

Recommendation 4: Initiate community-based interventions with a People living with HIV/AIDS (PLA) process, preferably in communities that already have development interventions such as water, sanitation, clinics and schools.

4.1.6 Examining Projects: Lessons Learnt and Best Practices

It has been clearly stated that a successful anti-FGM/FGC movement must have six basic foundations in place (see executive summary). Program implementers must be competent in designing, implementing and evaluating systematic and research-based anti-FGM/FGC interventions. They must also target audiences and communities according to stages attained in new behavior adoption.

Issues: An assessment of the six basic foundations in Somalia shows some having passed the halfway mark. Others are in their rudimentary stages. Program designs also lack systematic approaches, strategies, consistent messages and appropriate materials. They tend to focus on awareness raising and fall short of moving audiences along the continuum of behavior change. Most anti-FGM/FGC programs and activities reach only small numbers of audiences.

Recommendation 1: Anti-FGM/FGC implementers and donor agencies should build on the six critical foundations.

Recommendation 2: Anti-FGM/FGC programs should be research-based, designed systematically and with short- and long-term objectives. This means conducting appropriate baseline and end-line studies into programs, adopting systematic and theory-based strategies and developing appropriate action plans that address the coverage,

quality and cost of strategies and actions. Program implementers need to use a set of indicators to guide program focus and evaluation.

Recommendation 3: Program implementers must ensure consistency in the most crucial messages of the anti-FGM/FGC movement, while still respecting flexibility and innovation. This means that messages for the total eradication or lesser cut, the position of Islam, effects of FGM/FGC on women's sexuality and the rights violated by FGM/FGC, should all be consistently addressed by staff and volunteers.

Recommendation 4: Attractive, easy-to-use, research-based training and educational materials are needed to support local, regional and national programs. Building on the oral traditions, simple reading materials, cartoons and illustrated text can be developed into literacy programs.

Recommendation 5: While all communities and audiences need to be targeted with anti-FGM/FGC interventions, program implementers should base their campaigns on the most cost-effective and audience-selected strategies. They should prioritize key decision-makers in the fight against FGM/FGC. They should then recruit those most likely to change. It is only after impacting on those that easy to change that the programmers should shift focus on recalcitrant groups (i.e. nomadic and the uneducated).

Recommendation 6: Anti-FGM/FGC program implementers and donors should establish easily accessible treatment and counseling services for women suffering from FGM/FGC-related complications. They should empower those already engaged in counseling and build the capacity of medical doctors, nurses and lay counselors.

Recommendation 7: Anti-FGM/FGC program planners and donors should first develop the necessary software, implement it in demonstration-type projects and then scale it up based on lessons learned. The human rights networks, currently being established and strengthened by NOVIB-Somalia and the child rights defenders being strengthened by UNICEF (United Nations Children Funds), can be rapidly strengthened in FGM/FGC programming. Organizations involved in political dialogue and known to be members of political parties will not be the most appropriate ones for implementing anti-FGM/FGC programs. They may not solicit support from all religious, cultural and political groups.

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