

28 TOO MANY

FGM...
let's end it.



**COUNTRY PROFILE:
FGM IN SOMALIA AND
SOMALILAND**

March 2019



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Preface for Somalia

By Gloria Mugarura

Founder & Executive Director, Hope in Life International Somalia

In the nine years since I set up Hope in Life International Somalia (*HILI*), I have experienced both suffering and joy as we provide support to some of the most vulnerable women and children in Mogadishu and surrounding areas. Without question, one of the toughest challenges we continue to face is the cutting of young girls in the name of culture and religion. I see FGM destroying young girls' lives, over and over, and we need to address this challenge as a matter of urgency.

I am proud that, standing together with government partners and inspiring young activists such as Ifrah Ahmed, we can now work in partnership and provide vital platforms on which to share knowledge and work out how to tackle these problems. We do, however, need good-quality background information and data on FGM in Somalia to support us.



I therefore welcome this report by 28 Too Many and the effort that has been made to provide detailed information that can be used to both educate and inform the conversations at international and local levels. 28 Too Many has brought an important focus on some of the real issues and challenges we face in the work to end FGM in Somalia, including the continuing support amongst religious leaders for the sunna cut and the urgent need to pass a comprehensive national law banning all types of FGM. 28 Too Many has also highlighted some of the incredible work being done by civil society across the region, and we are grateful for the positive way in which our efforts are portrayed.

As we progress our work and plans for the year ahead, please share this important new report with your colleagues and networks. I look forward to working further with 28 Too Many on future campaigns to end FGM across Somalia.

Preface for Somaliland

By Dr Mariam Dahir

Medical Doctor, Health System Specialist and Chair of the Youth Anti-FGM Network in Hargeisa

Despite the fight to end FGM and abandon all types of cutting across Somaliland, prevalence remains one of the highest in the region. As community organisations work hard to raise awareness and educate community members, the Government has a major role to play and must show a stronger commitment to supporting civil-society actors, such as the many amazing activists that have been doing great work within the community for years and now the emerging power and energy of young people, who are passionate to make change and stop harmful traditions such as FGM.

I am proud of and support the Youth Anti-FGM Somaliland movement, a leading youth network to end FGM in Somaliland in one generation through the education of young men and women who will save the next generation. Their motto is 'FGM is not my religion'.



We can see that awareness-raising is having a positive effect. Studies suggest that some families living in urban settings are leaving their girls uncut, while other communities have moved away from Type III FGM to practising the sunna type (a small incision of the clitoris with one or two stitches). But sunna is still a painful violation of girls' bodies, and the recent *fatwa* permitting it makes efforts to end FGM difficult – we need parliament to pass a law ensuring zero tolerance to all types of cutting.

When I hear women share their experiences of the day they were cut, their weddings, childbirth, it shows the importance of banning this practice once and for all.

We should all stand against FGM; it has caused death to many and left others suffering throughout their lives. Let's help girls to enjoy their body intact and no longer be victims.

~ Dr Mariam A Dahir

Also lacking is evidence-based information and up-to-date data on Somaliland to support this vital work. Studies carried out by organisations are usually based on their own projects, and there has been no new, nationwide research on FGM. This means uncoordinated interventions and wasted resources. Moving forward, we should have regular, quality, national studies to support the work; in the meantime, the information and resources produced by 28 Too Many are important to inform campaigns, the public and decision-makers and to shape interventions. 28 Too Many has done an amazing exercise to collect this evidence-based information, and I encourage you to read this report and use it to shape thoughts and actions with the aim of improving efforts to achieve zero tolerance to FGM across Somaliland.

Foreword

In a region where 98% of women and girls have been subjected to the most severe Type III (Pharaonic) FGM, the challenges to ending the practice remain huge. We are all shocked and deeply saddened when we read that young girls are still dying from FGM in Somalia and Somaliland. Difficult issues still need to be overcome, including the ongoing support, particularly from influential religious leaders, of FGM labelled as 'sunnah', the dangers of increasing medicalisation, the continuing absence of national laws banning FGM and the lack of new data to inform programmes.

But in this Country Profile we also want to bring attention to the progress that is being made in the face of these challenges, including the increased collaboration between government departments and civil society, more open discussion, particularly with religious leaders and men, the use of media as an advocacy tool, the move away from the most severe form of cutting, and the amazing growth of youth activism across the region.

I am constantly inspired by the passion and commitment to this campaign of so many Somali FGM survivors and activists of all ages, from Ifrah Ahmed in Somalia and Dr Edna Adan Ismail in Somaliland, to so many friends and colleagues across the diaspora. We have had the honour of connecting with some of the amazing community organisations in the region while working on this report, and their determination to address these difficult issues is humbling. There are some very important activities taking place, such as those around community dialogue, and these need to continue and receive adequate funding to reach right across the region until a position of zero tolerance to FGM is achieved.

The drafting of new national laws banning FGM in both Somalia and Somaliland is welcomed, and 28 Too Many's recent research on the law and FGM has shown the importance of any new legislation being comprehensive, accessible to all and easy to understand. Adequate training must be put in place to successfully implement and enforce the new laws, and communities must be appropriately sensitised both before and after enactment.

Much work is still to be done, therefore, but as we publish this new Country Profile on FGM in Somalia and Somaliland, I leave you with the very true words of Dr Edna Adan, who once said about FGM:

*It's a battle that needs to be fought
by both men and women – and
communities and governments –
together.*

Dr Ann-Marie Wilson
Founder and Executive Director
28 Too Many



Information on Country Profiles

Background

28 Too Many is an international research organisation created to end FGM in the 28 African countries where it is mainly practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable influencers and in-country anti-FGM campaigners and organisations to make sustainable change to end FGM. We are building a global information base, which includes detailed country profiles for each country practising FGM. Our objective is to encourage all those working in the anti-FGM sector to share knowledge, skills and resources. We also campaign and advocate internationally to bring change and support community programmes to end FGM.

Theory of Change

28 Too Many effects change by:

1. Collating and Interpreting Data (Research)

We present data in a number of ways, primarily through Country Profile Reports and Thematic Papers, with additional research products as required. To support our aims, we make this research available globally.

2. Influencing Influencers (Top-Down Approach)

Using the data we have collated, we engage influencers, encouraging them to advocate for change (of policy, legislation, etc) within their spheres of influence.

3. Equipping Local Organisations (Bottom-Up Approach)

Based on our research, we develop and distribute advocacy materials and training tools that local organisations can use to bring effective change at a community level. We also support community organisations by highlighting their work and sharing examples of best practice through both our research products and global communications.

Ultimately change happens when policy and legislation (top-down) aligns with community action and education (bottom-up). Our approach is to play a catalytic role in both and to base our interventions on solid, evidence-based research.

Purpose

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Somalia and Somaliland, many programmes are making positive, active change.

Use of This Country Profile

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool and seek updates on the data and contact details.

When referencing this report, please use: **28 Too Many (2019) Country Profile: FGM in Somalia and Somaliland. Available at <http://www.28toomany.org/Somalia/>.**

Acknowledgements

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, as it would not have been possible without their collaboration. We particularly extend our thanks to those community groups and activists who have given us their time and shared their knowledge so that we may report on some of the very important progress being made in both Somalia and Somaliland.

28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations and individuals that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

For more information, please contact us on info@28toomany.org.

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Cover: Free Wind 2014 (2010) *Unidentified Somali in the streets of the city of Hargeysa. City in Somalia, capital of unrecognized state of Somaliland. Much of the population lives in poverty.* Shutterstock ID 185473601.

Please note the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CEDAW	Convention on the Elimination of Discrimination Against Women Committee on the Elimination of Discrimination Against Women
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
ICU	Islamic Courts Union
IDP	internally displaced person
INGO	international non-governmental organisation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
MOLSA	Ministry of Labour and Social Affairs
MOWDAFA	Ministry of Women's Development and Family Affairs (Puntland)
MOWHRD	Federal Ministry of Women and Human Rights Development
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
PPP	purchasing power parity
SDGs	Sustainable Development Goals 2015-2030
SNM	Somali National Movement
TFG	Transnational Federal Government
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNJP	UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting
UNSOM	UN Assistance Mission in Somalia
US	United States of America
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'S-MICS 2006' refers to:

UNICEF Somalia (2006) *Somalia: Multiple Indicator Cluster Survey 2006*. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS3/Eastern%20and%20Southern%20Africa/Somalia/2006/Final/Somalia%202006%20MICS_English.pdf.

'SNE-MICS 2011' refers to:

UNICEF Somalia and Ministry of Planning and International Cooperation (2014) *Northeast Zone Multiple Indicator Cluster Survey 2011, Final Report*. Nairobi, Kenya: UNICEF, Somalia and Ministry of Planning and International Cooperation. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS4/Eastern%20and%20Southern%20Africa/Somalia%20%28Northeast%20Zone%29/2011/Final/Somalia%20%28Northeast%20Zone%29%202011%20MICS_English.pdf.

'SL-MICS 2011' refers to:

UNICEF Somalia and Somaliland Ministry of Planning and National Development (2014) *Somaliland Multiple Indicator Cluster Survey 2011, Final Report*. Nairobi, Kenya: UNICEF, Somalia and Somaliland Ministry of Planning and National Development, Somaliland. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS4/Eastern%20and%20Southern%20Africa/Somalia%20%28Somaliland%29/2011/Final/Somalia%20%28Somaliland%29%202011%20MICS_English.pdf.

'EAUH' refers to:

Edna Adan Ismail, Amal Ahmed Ali, Abdirahman Saeed Mohamed, Thomas Kraemer, Sarah Winfield (2016) *Female Genital Mutilation Survey in Somaliland, Second Cohort (2006–2013)*. Hargeisa: Edna Adan University Hospital. Available at <https://www.28toomany.org/country/somaliland/>.

All cited texts in this Country Profile were accessed between November 2018 and March 2019, unless otherwise noted.

A Note on Data

Statistics on the prevalence of female genital mutilation (FGM) are regularly compiled through large-scale household surveys in developing countries, predominantly the Demographic and Health Survey (DHS) and the Multiple Indicator Cluster Survey (MICS). For Somalia and Somaliland, MICS reports were published in 2006 and 2011. Previous reports published in 2000, 1997 and 1996 did not include any data on FGM. To date, there have been no DHS reports published in relation to Somalia or Somaliland.

The **2006 MICS report (S-MICS 2006)** covered the whole of the Somalia/Somaliland region, and the data can be broken down into three zones: North-East (Puntland), North-West (also referred to as Somaliland) and South/Central.

By the time of data collection for the 2011 reports, the South/Central Zone had become too dangerous to survey, and no data was collected. In 2011 MICS published two separate reports – one on the **North-East Zone of Somalia (SNE-MICS 2011)** and one on **Somaliland (SL-MICS 2011)**. The 2011 data is comparable with the data from the equivalent zones in the 2006 report.

In MICS surveys, FGM data is self-reported, meaning that it is not gathered via physical examinations. In general, UNICEF¹ emphasises that self-reported data on FGM ‘needs to be treated with caution’ since women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

Measuring the FGM status of girls, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses may indicate the effect of shifts in governmental or societal attitudes towards the continuation of the practice, which may make it harder for mothers to report that FGM was carried out, as they may fear implicating themselves. Additionally, unless they are adjusted, these figures will not take into account the fact that girls may still be vulnerable to FGM after the age of 14. It is not possible to compare the available data for daughters (aged 0–14) of respondents in 2006 and 2011, as the 2006 survey reports the percentage of women with at least one living daughter who has had FGM, whereas the 2011 surveys report the prevalence of FGM among all daughters of respondents. It is also worthwhile noting that, in the MICS data, only women who had heard of FGM were eligible to answer questions about their daughter’s FGM statuses; however, since almost 100% of women had heard of FGM, that data is practically representative of all daughters.

Carrying out demographic surveys in the Somalia/Somaliland region is particularly challenging. In addition to the danger presented by civil unrest, a lack of recent population-census data means there are challenges both in selecting a representative sample of people and in extrapolating survey results to the population as a whole. The region also has a large nomadic population, who typically exhibit seasonal patterns in their places of residence and whose location may not be fully accounted for if the census information was gathered at a different time to the MICS survey data. These challenges may have an effect on the trends and patterns seen in the resulting data.

As for any dataset, it is also important to note that some results of these surveys may be based on relatively small numbers of women, particularly when the data is further broken down by, for example, location, age or ethnicity. Therefore, in some cases, the trends observed should be treated with caution. This point is particularly important for Somalia and Somaliland, where the additional challenges of data-taking and interpretation described above may also contribute to uncertainty in the data.

A further important source of data for this country profile is the ***Female Genital Mutilation Survey in Somaliland (Second Cohort) (EAUH)***. This report presents data gathered at the Edna Adan University Hospital in Hargeisa, Somaliland and compares two cohorts of women: those who gave birth at the hospital between 2002 and 2006, and those who gave birth at the hospital between 2006 and 2013. The data on FGM prevalence among these women is based on a physical examination during a routine antenatal appointment, unless the FGM status was unclear, in which case the woman was directly asked. The data is, therefore, somewhat exempt from the known issues with self-reporting. The dataset is limited to pregnant women visiting the hospital, and, as a result, the women surveyed were predominantly between the ages of 20 and 34. Since the data was gathered at one hospital, the demographic of the women may not precisely reflect that of women across Somaliland as a whole. However, it is an important source of data and offers many insights.

This report also references ***Empowering communities to collectively abandon FGM/C in Somaliland (Baseline research report, 2016)*** produced by the **Orchid Project** on behalf of **ActionAid**. The research on which the report is based was gathered in two regions of Somaliland: Maroodi Jeex and Togdheer. In total, more than 2,000 women, men, boys, girls and opinion formers, such as religious leaders and teachers, were surveyed. As a result the report is able to provide important information on the views of men in Somaliland regarding FGM, as well as extensive data related to children. It should be noted that census data was not used to re-scale the survey results to reflect the true demographic of the region. Thus, the results can only be considered to reflect the views and experiences of those community members surveyed, not the region as a whole. In practice, of course, the two may be similar, but caution should be taken when interpreting the data. The data on FGM prevalence is self-reported and therefore subject to the usual notes of caution.

Around 2,000 women aged 15–49 were surveyed for a report by the **NAFIS Network (*Assessment of the Prevalence, Perception & Attitude of Female Genital Mutilation in Somaliland*)** at 19 Mother and Child Health Centres across all six regions of Somaliland. In addition, qualitative information was collected using focus-group discussions with men, women, boys and girls, including traditional cutters. Interviews were conducted with religious leaders and government workers. Again, it should be noted that census data was not used to re-scale the survey results and they can therefore not be considered to reflect the views and experiences of the region as a whole.

It should be made clear that any limitations of the data sources used in this report do not mean that the data is not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and 28 Too Many has accordingly taken that approach when researching and writing this country profile.

1 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.24. Available at http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf.

Executive Summary

Female genital mutilation (FGM) is defined by the World Health Organization (WHO)¹ as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM has been recognised as a harmful practice and a violation of the human rights of girls and women.

Carrying out **demographic surveys** in the Somalia/Somaliland² region, such as the Multiple Indicator Cluster Surveys (MICS) used extensively in this report, is particularly challenging. In addition to the danger presented by civil unrest, a lack of recent population-census data means there are challenges both in selecting a representative sample of people and in extrapolating survey results to the population as a whole. The region's large nomadic and displaced populations may also affect the trends and patterns seen in data.

One important factor discussed extensively in this Country Profile is the lack of understanding and agreement about **types of FGM**. One study in Puntland and Somaliland³ found that the majority of respondents divided FGM into 'Pharaonic', which is infibulation or Type III FGM according to the WHO classifications, and 'sunna'. Sunna may or may not involving stitching, but in many cases even more severe types of FGM are being labelled 'sunna'.⁴ Sunna is believed by many Somalis to cause no health problems and to be condoned, even required, by Sharia law. Further misunderstandings surround the use of specific **terminology** such as 'abandonment' and 'FGM' itself, both of which are commonly believed to refer only to Type III FGM.

Therefore, researchers in Somalia and Somaliland need to take extra care to examine and define the terminology being used; otherwise, such misunderstandings will contribute to the distribution of imprecise data and inaccurate interpretations.

In general, however, these limitations do not mean that the available data is not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions.

In Somalia, **the prevalence of FGM among women (aged 15–49)** has remained consistent for some time. In 2006 in South/Central Somalia, the prevalence was 99.2%. In 2011 in the North-East Zone of Somalia (Puntland), it was 98%.⁵ In Somaliland, FGM prevalence has increased from 94.4% in 2006 to 99.1% in 2011.⁶ However, due to the challenges of data collection, further data would be required to confirm that there has been a genuine upward trend in cutting, particularly as anecdotal evidence from activists in both Somalia and Somaliland suggests that there has been a recent decline in some, usually more urban, areas.

Trends in relation to the **prevalence of FGM among girls (aged 0–14)** are unclear, as survey questions differed between the 2006 and 2011 MIC surveys. However, the **age of cutting** appears to have risen from seven or eight (among women surveyed)⁷ to between 10 and 14 (among the majority of girls)⁸.

Traditional cutters are the most commonly used **practitioner**, although medicalised FGM is on the rise as more families take their daughters to medical professionals to be cut, mistakenly believing that this makes the procedure safer. In fact, activists are concerned that medicalised FGM can be even more dangerous as health professionals may cut deeper under anaesthesia, leading to more pain and a greater risk of infections later on.

Type III (Pharaonic) FGM is overwhelmingly the **most common type of FGM** self-reported by women, although the prevalence of this type appears to be declining. In 2011, 85% of women who had undergone FGM had experienced Type III in the North-East Zone of Somalia (Puntland) and Somaliland, a drop from more than 90% in 2006. The MICS data suggests that this trend is being driven by the younger cohorts of women being less likely to have experienced Type III.⁹ The NAFIS Network reports that the vast majority of women surveyed, 92.8%, wished for their daughters to undergo the sunna form of FGM.¹⁰

Along with 'tradition', 'religious beliefs' is the most common **reason given for the continuation of FGM** in the region – in particular, the continuation of the sunna form of FGM. In Somaliland, about one-third of women believe that the practice should be continued, while in the North-East Zone of Somalia (Puntland), around half of women support the practice. The level of support was highest in South/Central Somalia, at 79.5%.¹¹

In general, women make the decisions regarding FGM, and in only about 8% of households surveyed by the Orchid Project were **men and boys** also involved. However, 'they are influential in creating the social climate within which decision-making about cutting takes place', as only 4% of unmarried men surveyed preferred to marry a girl who has not undergone FGM.¹² Men who attended focus groups seemed caught between their concern about the impact of Pharaonic FGM on women and girls and their feeling that FGM is necessary as 'evidence of virginity'.¹³ Civil-society groups and activists report that the most successful way to approach FGM in discussions with Somali men is to talk about human rights in the first instance, then progress to health issues. This inevitably leads on to the impacts of FGM on both health and their relationships with women.

Conflict and drought have displaced an estimated 1.1 million people in the region.¹⁴ Women and children make up 70–80% of **internally displaced persons (IDPs)**.¹⁵ Violence against women is reportedly common in camps for IDPs, and a 'legal vacuum' created by the lack of a formal justice system in the camps leaves affected women with little recourse or support. This also makes the collection of reliable data on gender-based violence within the camps (which includes FGM) a huge challenge.

There is little data available on the **prevalence of FGM in the Somali diaspora**; however, stories of Somali girls being brought to the region to be cut have emerged of late.

Both Somalia and Somaliland are currently drafting and consulting on **new laws to ban FGM**. Civil society and Somali activists are working closely with government ministries to ensure the laws will be comprehensive, and advocacy work continues with religious leaders to move towards a position of zero tolerance to all types of FGM. This will take time and is requiring a step-by-step approach, but the commitment of the anti-FGM network will ensure that all women and girls will ultimately be protected under future national laws.

Civil society recognises the importance of sensitising all practising clans and communities to the content and meaning of new anti-FGM laws, both before and after their enactment. Community organisations and activists are best placed to undertake this advocacy work, with the support of governments, local law enforcement and judiciary, who will also require sufficient training to implement and enforce the legislation.

Although neither Somalia or Somaliland reached its targets under the Millennium Development Goals, both governments have created extensive **development plans** in relation to education and

healthcare. These line up with the Sustainable Development Goals and recognise the importance of women and children's healthcare, role models for girls, fully qualified and female teachers, and girls' education.

This Country Profile identifies the great progress that has been made to bring discussions on the harms of FGM into the public domain in both Somalia and Somaliland. Joint working between government departments and civil society, between community organisations themselves as they forge anti-FGM networks, and between activists and the communities in which they work is demonstrating **the power of collaboration** to tackle some of the difficult issues still to be overcome across the region. These challenges include the continuing support for the sunna cut and the belief that it is a religious requirement, and the continued lack of national legislation criminalising and punishing the practice of FGM.

Civil-society organisations are spearheading activities that promote community dialogue around FGM, and this Country Profile includes some case studies of successful work being done with religious leaders and men, in particular. Many organisations are also working with health workers and in schools to raise awareness of the harms of FGM, and 28 Too Many has been pleased to report on the growth of youth networks across the region and the importance of facilitating peer-to-peer dialogue in ending the practice.

One exciting aspect of these activities is the use of different types of **media**. Radio is an effective way to reach isolated communities with anti-FGM messages, and, particularly among young people in urban areas, social media is on the rise and showing great potential for future campaigning and discussion. This report profiles the dynamic work of Ifrah Foundation in partnership with the Global Media Campaign to equip religious leaders and other stakeholders to advocate for an end to FGM.

With greater support and funding, the work that is currently being undertaken to end FGM in Somalia and Somaliland will continue to grow, extending to hard-to-reach areas, helping to build necessary infrastructure and networks, and bringing widespread awareness to the fact that ***all FGM, however it is practised, is harmful to women and girls***. This message needs to be an integral part of government policy and advocacy initiatives in Somalia and Somaliland moving forward.

While difficult challenges remain, including the seemingly impossible task of overcoming social norms, **the total abandonment of FGM will be achieved as part of culture-wide changes to the way that women are viewed, treated and empowered in Somalia and Somaliland**.

- 1 World Health Organization (2015) *Female Genital Mutilation*. Available at http://www.who.int/topics/female_genital_mutilation/en/.
- 2 **For the purposes of the analysis in this Country Profile, the Federal Republic of Somalia is taken to comprise five federal States, including Puntland, but excluding Somaliland.**
- 3 Abdi A. Gele, Bente P. Bø and Johanne Sundby (2013) 'Attitudes toward Female Circumcision among Men and Women in Two Districts in Somalia: Is It Time to Rethink Our Eradication Strategy in Somalia?', *Obstetrics and Gynecology International*, 2013. Available at <https://www.hindawi.com/journals/ogi/2013/312734/>.
- 4 Sheena Crawford and Sagal Ali (2015) *Situational Analysis of FGM/C Stakeholders and Interventions in Somalia*, p.42. Available at <https://orchidproject.org/wp-content/uploads/2015/02/Situational-Analysis-of-FGMC-Stakeholders-and-Interventions-in-Somalia1.pdf>.
- 5 - UNICEF Somalia (2006) *Somalia: Multiple Indicator Cluster Survey 2006*, p.138. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS3/Eastern%20and%20Southern%20Africa/Somalia/2006/Final/Somalia%202006%20MICS_English.pdf.
- UNICEF Somalia and Ministry of Planning and International Cooperation (2014) *Northeast Zone Multiple Indicator Cluster Survey 2011, Final Report*, p.103. Nairobi, Kenya: UNICEF, Somalia and Ministry of Planning and International Cooperation. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS4/Eastern%20and%20Southern%20Africa/Somalia%20%28Northeast%20Zone%29/2011/Final/Somalia%20%28Northeast%20Zone%29%202011%20MICS_English.pdf.
- 6 UNICEF Somalia and Somaliland Ministry of Planning and National Development (2014) *Somaliland Multiple Indicator Cluster Survey 2011, Final Report*, p.100. Nairobi, Kenya: UNICEF, Somalia and Somaliland Ministry of Planning and National Development, Somaliland. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS4/Eastern%20and%20Southern%20Africa/Somalia%20%28Somaliland%29/2011/Final/Somalia%20%28Somaliland%29%202011%20MICS_English.pdf.
- 7 Edna Adan Ismail, Amal Ahmed Ali, Abdirahman Saeed Mohamed, Thomas Kraemer, Sarah Winfield (2016) *Female Genital Mutilation Survey in Somaliland, Second Cohort (2006–2013)*, p.31. Hargeisa: Edna Adan University Hospital. Available at <https://www.28toomany.org/country/somaliland/>.
- 8 - UNICEF Somalia and Ministry of Planning and International Cooperation (2014) *Northeast Zone Multiple Indicator Cluster Survey 2011, Final Report*, p.104. Nairobi, Kenya: UNICEF, Somalia and Ministry of Planning and International Cooperation.
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- UNICEF Somalia and Somaliland Ministry of Planning and National Development (2014) *Somaliland Multiple Indicator Cluster Survey 2011, Final Report*, p.100. Nairobi, Kenya: UNICEF, Somalia and Somaliland Ministry of Planning and National Development, Somaliland.
- 10 NAFIS Network (2014) *Assessment of the Prevalence, Perception and Attitude of Female Genital Mutilation in Somaliland*, p.24. Available at <https://nafisnetwork.net/wp-content/uploads/2018/10/FGM-Research-Report-2014-1.pdf>.
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- 13 *Ibid.*, p.12.
- 14 US Department of State (2013) *Somalia 2013 Human Rights Report*, p.20. Available at <https://photos.state.gov/libraries/somalia/323250/pdfs/somalia-human-rights-report-2013.pdf>.
- 15 UNDP Somalia (2014) *Gender in Somalia: Brief II*, p.10. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/Gender%20in%20Somalia%20Brief%202.pdf>.

Introduction

It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practised it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.

~ The General Assembly of the United Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)² as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence (GBV) and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.³

History of FGM

FGM has been practised for over 2,000 years.⁴ Although it has obscure origins, there has been anthropological and historical research conducted into how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, when infibulations were referred to as 'Pharaonic circumcision'.⁵ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young women, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'⁶. There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves.

FGM is practised across a range of cultures and it is likely that the practice arose independently among different peoples,⁷ aided by slave raids from Sudan for Egyptian concubines and the trading of maids through the Red Sea to the Persian Gulf⁸.

Global Prevalence and Practices

FGM has been reported in 28 countries in Africa, mainly along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices, FGM

is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

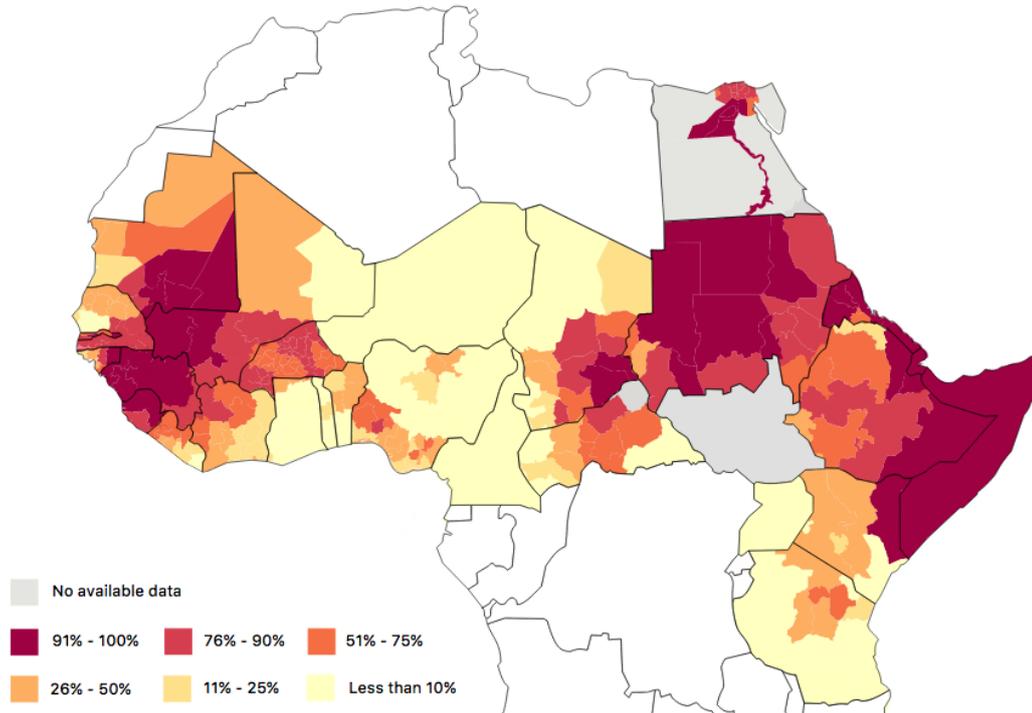


Figure 1: Prevalence of FGM in Africa (@ 28 Too Many)⁹

The WHO¹⁰ classifies FGM into four types:

Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 1: Types of FGM as classified by the WHO

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious texts require the practice, practitioners often believe it has religious support. Girls and women will often

be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.¹¹ Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.¹²



*Children in the Torfiq
District, East Mogadishu*

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, community-based organisations, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

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- 4 Alison T. Slack (1988) 'Female Circumcision: A Critical Approach', *Human Rights Quarterly*, Vol. 10, pp.439.
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- 6 Lightfoot-Klein cited in Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1, p.4. Available at <http://dx.doi.org/10.1080/09589236.2012.681182>.
- 7 *Ibid.*
- 8 Mackie cited in Ann-Marie Wilson, *op. cit.*
- 9 **Click for source document:** Burkina Faso: DHS 2010; Benin: DHS 2011-12; Cameroon: DHS 2004; CAR: MICS 2010; Chad: EDS-MICS 2014-15; Côte d'Ivoire: DHS 2011-12; Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Ghana: MICS 2011; Guinea: DHS 2012; Guinea-Bissau: MICS 2014; Kenya: DHS 2014; Liberia: DHS 2013; Mali: DHS 2012-13; Mauritania: MICS 2015; Niger: DHS 2012; Nigeria: DHS 2013; Senegal DHS-Cont 2015; Sierra Leone: DHS 2013; Somalia: MICS 2006; Sudan: MICS 2014; Tanzania: DHS 2015-16; The Gambia: DHS 2013; Togo: DHS 2013-14; Uganda: DHS 2011.
- 10 World Health Organization (2016) *WHO guidelines on the management of health complications from female genital mutilation*, pp.2-4. Available at <http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/> (accessed 18 June 2017).
- 11 *Ibid.*, p.1.
- 12 World Health Organization (2016), *op. cit.*, p.vii.

Image p.18: AMISOM Public Information (2011) *Civilian and street life behind the front line*. Available at <https://flic.kr/p/avGiwh> (public domain).

General Statistics

This section highlights a number of indicators of Somalia and Somaliland's context and development status.

Population

Sources differ, but likely around 15 million (11–12 million in Somalia; 4–5 million in Somaliland)

Growth rate: 2.08% (2018 est.)

Median age: 18.1 years

Human Development Index Rank: no reliable data

Age of Suffrage, Consent and Marriage

Age of Suffrage: 18 (Somalia); 16 (Somaliland)

Age of Consent: 18¹

Age of Marriage: 18²

Health

Life expectancy at birth (years): 52.8

Infant mortality rate (per 1,000 live births): 85 deaths³

Maternal mortality rate: 732 deaths/100,000 live births (2015)⁴

Fertility rate, total (births per woman): 5.8 (2017 est.)

HIV/AIDS – adult prevalence: 0.1% (2017 est.)

– people living with HIV/AIDS: 11,000 (2017 est.)

(country comparison to the world: 72)

– deaths: <1,000 (2017 est.)

GDP (in US dollars)

GDP (official exchange rate): \$7.382 billion (2017 est.)

GDP per capita (PPP): data not available

GDP (real growth rate): 1.8% (2017 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 40% (female – 36.2%; male – 43.8%)⁵

Urbanisation

Urban population: 45% (2018)

Rate of urbanisation: 4.23% annually (2015–2020 est.)

Religions

Sunni Muslim (Islam) (official, according to the 2012 Transitional Federal Charter)

Ethnic Groups

Somali – 85%, Bantu and other non-Somali – 15% (including 30,000 Arabs)

Languages

Somali (official, according to the 2012 Transitional Federal Charter), Arabic (official, according to the 2012 Transitional Federal Charter), Italian and English

THE SOMALI DIASPORA

Somali people have migrated throughout the world, and communities can be found in many countries, including the UK (particularly in London), Canada (in the province of Ontario), the United States (in the state of Minnesota), Australia (particularly in the state of Victoria), the Middle East and in neighbouring African countries such as Kenya and Ethiopia.

There is no accurate data on the number of Somali girls in the diaspora who are still subjected to FGM either within their communities, back in Somalia itself or elsewhere, but multiple stories have emerged of late as the media begins to focus in on the issue.

In some communities, such as in the UK, there are many Somali FGM survivors who have become leading activists, advocating passionately for an end to FGM and providing vital support services to other survivors and their families. Those affected by FGM in diaspora communities can often feel marginalised, and these leading Somali campaigners therefore work with governments and leading agencies to ensure that their voices are heard. In the UK, both Somali men and women are working closely with their communities to break down the myths surrounding FGM and ensure that girls are no longer at risk.

Whenever I speak to Somali men in the coffee shops – whether they have just arrived from Mogadishu or live in the UK – I tell them that this sunna cut, it is not religious, it is not in the Quran, the Prophet Mohammed never cut his daughters; it is cultural. When they understand this, then they have the power to stop it.

*~ Abade Ahmed, Somali activist, Men Speak Out
(interview with 28 Too Many, 2019)*

Recently, there have been suspected cases of FGM of children with Somali-born parents reported in both the UK and Australia. One case in the UK was dismissed because of a lack of evidence, causing members of the Somali community in Bristol, while labelling FGM 'barbaric', to report feeling intimidated.⁶ However, in a recent, landmark case for Queensland, Australia, a mother was convicted of taking her two daughters, aged 12 and nine at the time (2015), to Somalia, where FGM was performed on them at their grandmother's house. When the girls returned to Australia, after their mother extended the trip to let their wounds heal, the girls' step-sister reported the matter to child safety services. The girls themselves then told their story to police. At the time of writing, sentencing has yet to take place.⁷

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 - 2 Girls Not Brides (2002-2018) *Child Marriage Around The World: Somalia*. Available at <https://www.girlsnotbrides.org/child-marriage/somalia/>.
 - 3 Countdown to 2030 (2015) *A Decade of Tracking Progress for Maternal, Newborn and Child Survival The 2015 Report: Somalia*. Available at http://countdown2030.org/documents/2015Report/Somalia_2015.pdf.
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 - 5 UNFPA (2016) *Educational Characteristics of the Somali People*, p.7. Available at http://www.analyticalreports.org/pdf/UNFPA_PESS_Vol_3.pdf.
 - 6 Alex Ballinger (2018) 'Bristol Somali community condemn "barbaric" FGM but fear abuse and harassment after case collapses', *BristolLive*, 27 February. Available at <https://www.bristolpost.co.uk/news/bristol-news/bristol-somali-community-condemn-barbaric-1272901>.
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Political Background – Somalia

Historical

The Federal Republic of Somalia, located in the Horn of Africa, is the easternmost country of Africa and has the longest coastline of any country on Africa's mainland. It has an estimated population of 11–12 million.¹ Historically, its position between sub-Saharan Africa, Arabia and South Asia has made it one of the most important trading countries in the region.

In the middle of the 19th century, British, French and Italian imperial powers competed for the opportunities it provided for further trade and development. In the 1880s the country was split between these three colonial powers, whose governments were only interested in developing the coastal areas; the interior of the country was left largely undisturbed.²

In 1887 Somaliland was claimed as a British Protectorate, and, in 1960, along with other countries being decolonised, it declared itself to be a sovereign state, independent of Somalia. Efforts were made to unite Somaliland and Somalia over the following two decades, but growing discontent with the military regime in Somalia led to the formation of the Somali National Movement (SNM) in Somaliland in 1981. War then broke out between the two states. Somali President Mohamed Said Barre was overthrown in 1991 by the SNM, who declared the 1960 agreement null and void and proclaimed the independence of the northern region, henceforth to be known as the Republic of Somaliland.^{3,4}

The UN has been in and out of Somalia providing support for many years. In 2013 UN Security Council Resolution 2102 established the **United Nations Assistance Mission in Somalia (UNSOM)** to contribute to peacebuilding across the country. Among its mandated functions, UNISOM 'is helping build the Federal Government's capacity to promote respect for human rights and women's empowerment, promote child protection, prevent conflict-related sexual and gender-based violence, and strengthen justice institutions . . .'⁵

In October of 2018, The Federal Republic of Somalia was elected to serve on the **United Nations' Human Rights Council**.

The Human Rights Council is an inter-governmental body within the United Nations system made up of 47 States responsible for the promotion and protection of all human rights around the globe.

Civil war and famine followed, particularly in the south between rival groups seeking control of the southern part of Somalia. Although peace and disarmament treaties were signed, fighting continued, and by 1995 UN peacekeeping troops had been pulled out.

In 1998 Puntland was declared a self-governing area by the militia group controlling that region, but, unlike Somaliland, the region did not seek total

independence from Somalia. Rather, it sought to remain a part of Somalia, but self-governing and autonomous and with an aim to reunite the different parts of Somalia to form a federal republic.

Talks continued, and by 2004 a Transnational Federal Government (TFG) was achieved. Abdullah Yusuf Ahmed was elected interim president for a five-year period, ruling from Kenya, as the Somali capital of Mogadishu was unsafe. Two years later the first meeting of the Government was held on Somali territory in Baydhabo, which was considered safer than the capital. In the same year, however, the Islamic Courts Union gained control of Mogadishu and challenged the TFG. The Islamic Courts Union changed its name to the Supreme Islamic Courts Council (SICC) and later

acknowledged its links with the militant al-Qaeda and al-Shabaab. Meanwhile, the TFG managed to push the SICC out of the capital, and in 2009 Yusuf was succeeded by a moderate Islamist, Sheikh Sharif Ahmed. In the same year, the TFG decided to adopt Sharia law throughout the country.

In 2012 the TFG's mandate expired and a provisional constitution was adopted by a constituent assembly in the House of the People (the lower of two parliamentary houses), which comprised mainly traditional elders and others put forward by a selection committee.

A new president, Hassan Sheikh Mohamud, who is regarded as moderate, was elected. His period in office was beset by further violence, such that he announced that elections planned for 2016 would not likely be held due to continuing threats by al-Shabaab.

Instead, electoral colleges were set up across the country, each comprising elders of Somalia's clans who would elect representatives to the House of the People. In addition, each of the federal states would select members for an Upper House. Despite further delays and difficulties, most MPs and members of the Upper House had been sworn in by the end of 2016, and in 2017 Mohamed Abdullahi Mohamed was confirmed as the new president. In January 2019, Abdullahi Deni was sworn in as Puntland's president, calling for 'forgiveness and collaboration' between the Puntland Government and the federal states.⁶

Current Political Conditions

Today, Somalia is a federal republic comprising six states, including Puntland and Somaliland, which Somalia and the international community continues not to recognise as a separate nation state. States are semi-autonomous, with their own police and security forces. The country is divided into 18 administrative regions, which further sub-divide into districts. Within the federal parliament's lower House of the People, 30% of seats are reserved for female representatives.⁷

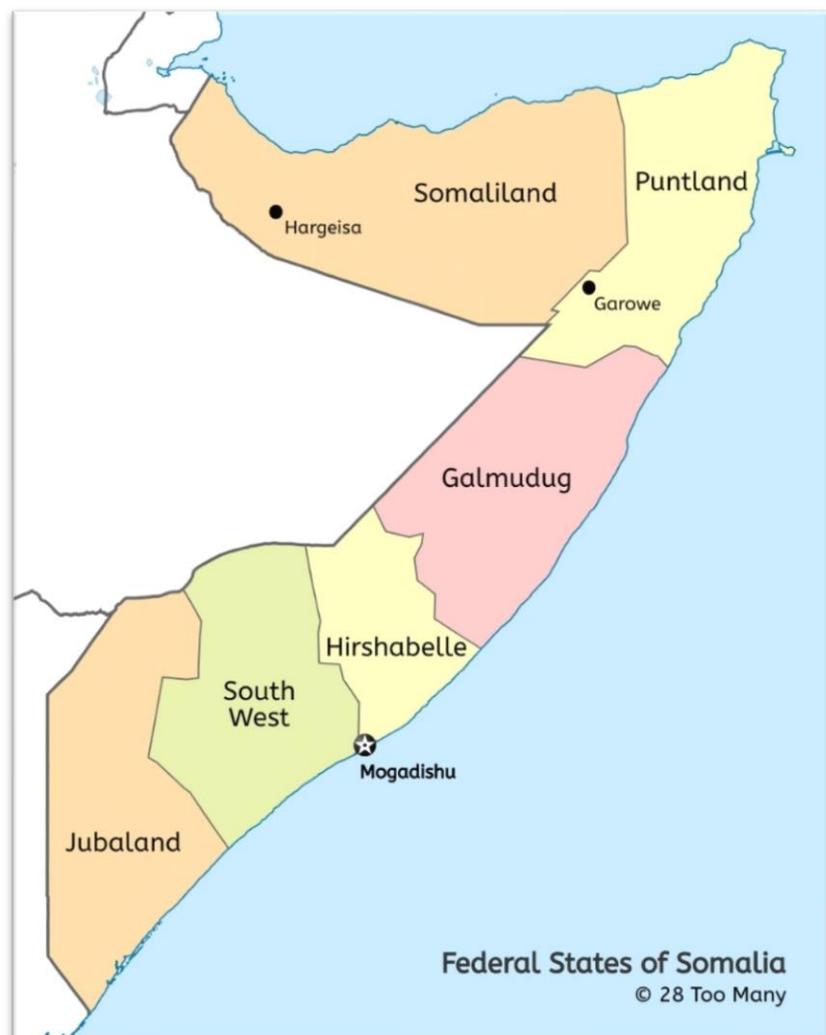


Figure 2: Federal states of Somalia

Current Economic Conditions

Somalia's economy is largely based on livestock agriculture and fishing and comprises mostly informal enterprises. It is estimated that 52.6% of the population lives below the international poverty line.⁸ Agriculture makes up some 40% of GDP. A large proportion of the population are nomads and semi-pastoralists, dependent on agricultural output and operating in the informal economy.

Other important sources of revenue are remittances from Somalis working outside of the country, and companies supporting the transfer of monies are strongly represented in the economy, as are companies in the telecommunications sector, which are present in most major cities.⁹

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- 1 Country Meters (2018) *Somalia*, 31 October. Available at <https://countrymeters.info/en/Somalia>.
 - 2 Encyclopaedia Britannica (2018) *Somalia*. Available at <https://www.britannica.com/place/Somalia/The-great-Somali-migrations#ref37749>.
 - 3 Encyclopaedia Britannica (2018) *Somalia*. Available at <https://www.britannica.com/place/Somalia/The-great-Somali-migrations#ref37749>.
 - 4 Presidency, Hargeisa, Somaliland (2013) *The recognition of Somaliland: A brief history*. Available at <http://recognition.somalilandgov.com/wp-content/uploads/2013/01/The-recognition-of-Somaliland-A-brief-history.pdf>.
 - 5 UNSOM (2019) *Mandate*. Available at <https://unsom.unmissions.org/mandate>.
 - 6 Garowe Online (2019) *Somalia: Puntland Inaugurates New President*, 27 January. Available at <https://www.garoweonline.com/en/news/puntland/somalia-puntland-inaugurates-new-president>.
 - 7 World Atlas (2018) *What Type Of Government Does Somalia Have?* Available at <https://www.worldatlas.com/articles/what-type-of-government-does-somalia-have.html>.
 - 8 Sustainable Development Solutions Network and Bertelsmann Stiftung (2018) *SDG Index and Dashboards Report 2018*. Available at <http://sdgindex.org/reports/2018/>.
 - 9 Countries of the World (2018) *Somalia Economy 2018*. Available at https://theodora.com/wfbcurrent/somalia/somalia_economy.html.

Political Background – Somaliland

Historical

The Republic of Somaliland declared independence from Somalia in 1991, but to date remains unrecognised as a separate nation state by the international community and Somalia.¹

Somaliland is located to the north-west of Somalia, bordering Djibouti, Ethiopia and Puntland, and has a lengthy coastline along the Gulf of Aden. It has a population of approximately 4–5 million.² As a part of the Somali region, historically its position between sub-Saharan Africa, Arabia and South Asia has made it one of the most important trading areas in the region. In the middle of the 19th century, British, French and Italian imperial powers competed for the opportunities Somalia provided for further trade and development. In the 1880s Somalia was split between these three colonial powers, whose governments were only interested in developing the coastal areas; the interior of the country was left largely undisturbed.³

In 1887 Somaliland was claimed as a British Protectorate, and, in 1960, along with other countries being decolonised, it declared itself to be a sovereign state, independent of Somalia. Efforts were made to unite Somaliland and Somalia over the following two decades, but growing discontent with the military regime in Somalia led to the formation of the Somali National Movement in Somaliland in 1981. War then broke out between the two states. Somali President Mohamed Said Barre was overthrown in 1991 by the SNM, who declared the 1960 agreement null and void and proclaimed the independence of the northern region, henceforth to be known as the Republic of Somaliland.^{4,5}

Development of a constitution for Somaliland began in 1993, and an interim constitution was introduced in 1997. The constitution was finally approved and put in place in May 2001, following a referendum in which it was endorsed by 98% of Somaliland's population. In 2003, Dahir Riyale Kahin became the first elected president of the Republic of Somaliland. The Government comprises two houses, each with 82 members. Members of the House of Representatives are directly elected by the people for five-year terms, and those of the House of Elders are honorary appointees.⁶

Current Political Conditions

Somaliland comprises six regions, each with its own elected regional council. Each region is divided into districts, with elected members, and beneath that there are village councils made up of local elders and appointees by the district councils.⁷

Current Economic Conditions

The economy of Somaliland is largely dependent on livestock agriculture (30%) and fisheries, and the wholesale and retail trade (20%).

It is estimated to have a diaspora of some 600,000, mostly living in Western Europe, the US and the Middle East. Remittances from this diaspora are estimated to contribute 35% of its GDP, which has mainly been used for start-up capital by small and medium-sized businesses.⁸ Nearly 40% of the rural population and 30% of those living in urban areas are living below the international poverty line.⁹

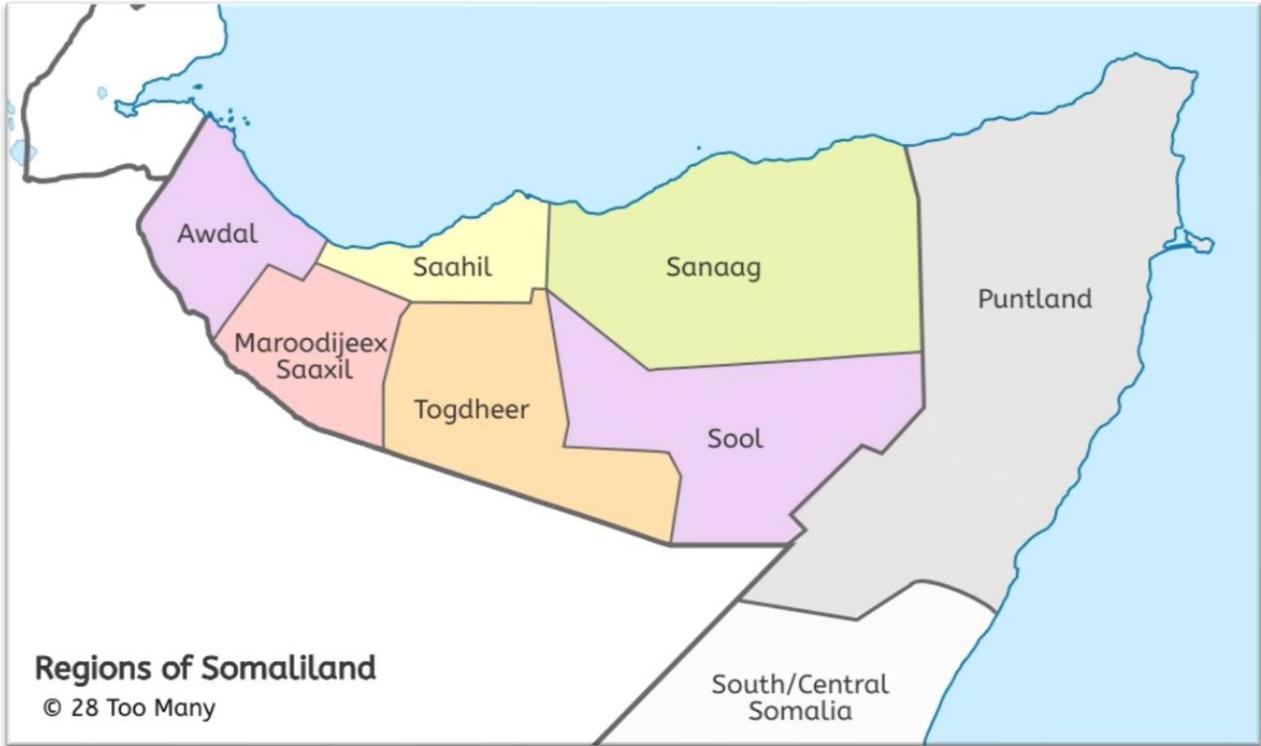


Figure 3: Regions of Somaliland

- 1 The World Bank (2014) *New World Bank GDP and Poverty Estimates for Somaliland*. Available at <http://www.worldbank.org/en/news/press-release/2014/01/29/new-world-bank-gdp-and-poverty-estimates-for-somaliland>.
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- 3 Encyclopaedia Britannica (2018) *Somalia*. Available at <https://www.britannica.com/place/Somalia/The-great-Somali-migrations#ref37749>.
- 4 *Ibid.*
- 5 Presidency, Hargeisa, Somaliland (2013) *The recognition of Somaliland: A brief history*. Available at <http://recognition.somalilandgov.com/wp-content/uploads/2013/01/The-recognition-of-Somaliland-A-brief-history.pdf>.
- 6 Somaliland Law (2007) *Somaliland Parliament*. Available at http://www.somalilandlaw.com/body_somaliland_parliament.html.
- 7 *Ibid.*
- 8 Unrepresented Nations & Peoples Organization, *op. cit.*
- 9 The World Bank, *op. cit.*

Anthropological Background

Somali is the national and official **language** of Somalia and Somaliland, although there are a number of dialects across the countries, which are classed as Northern, Benadir or Maay – Northern is the foundation of Somali; Benadir is spoken on the Benadir coast (from Adale to south of Merca and including Mogadishu, the capital city); and Maay is mainly spoken by the Digil and Mirifle (Rahanweyn) in the south of Somalia. Arabic is the second most common language. Somalis may also speak English and Italian, due to the countries’ colonial history.¹

Somalia has an estimated **population** of 11–12 million, and Somaliland has an estimated population of 4–5 million.

The central-African, Hamitic people who settled along Somalia’s rivers are the ancestors of the **Somali** people. Arab traders intermarrying and interacting with them brought Islam, patrilineal clan structures and other traditional practices. Somalis originally inhabited the northern parts of the region and now constitute the largest ethnic group in Somalia and Somaliland, making up about 85% of the region’s residents.²

Bantu and other non-Somali people groups make up about 15%. Non-Somali groups largely inhabit the southern regions of Somalia: the Bravanese, Benadiri, Bajuni, Ethiopians (mostly Oromos), Yemenis, Indians, Persians, Italians and Britons. Other groups include the Rer Hamar, Eyle, Galgala, Tumul, Yibir and Gaboye.³

Minority Group	Ethnic Origin	Estimated % of Total Population	Language	Clan Affiliation	Traditional Skill
Ashraf	Arabs from Saudi Arabia	0.5%	Mainly Maay	Rahaweyn	Farmers/pastorals
Bajuni	Kswahili from Kenya Coast	0.2%	Bajuni	No patron clans	Mainly fishing
Bantu	Communities in eastern and Central Africa	15%	Somali; Mushunguli	Some sub-clans in Lower Shabelle identify with the Digil and Mirifle in Lower Shabelle	Farmers; labourers
Boni		0.1%	Somali (Mahatiri)	No patron clan	Hunting
Brawan/ Bravanese	Arabs mainly from Yemen	0.5%	Baravenese	No patron clans	Business; fishing
Eyle	Sab	0.2%	Somali	Rahaweyn	Hunters/gatherers

Minority Group	Ethnic Origin	Estimated % of Total Population	Language	Clan Affiliation	Traditional Skill
Galgala	Samale	0.2%	Somali (Mahatiri)	Identify as Nuh Mohamud; clan patrons: Osman Mohamud/ Omar Mohamud sub-clans of Majetren	Wood crafters, pastorals
Gaheyle	Samale	0.1%	Somali (Mahatiri)	Warsenegeli (Darod)	Pastorals
Midgan/ Gaboye	Samale	0.5%	Somali	No patron clan	Shoemakers
Rer Hamar	Immigrants from Far East	0.5%	Somali	Some sub-clans have patron clans within Hawadle	Business, fishing
Tumal	Samale	0.5%			Blacksmiths
Yibir	Samale	0.5%			Hunters

Table 2: Minority Ethnic Groups in Somalia and Somaliland⁴

Clans

However, for the people of Somalia and Somaliland, ethnic identity is not as important as clan identity. World Atlas notes:

The clan structure has been woven deep into the country's society over an extended period of time and it remains the primary factor for identity in Somalia.⁵

Clan and sub-clan identities dictate social structures, practices, culture, law and politics. Traditionally, marriage took place within the same clan, although intermarriage to strengthen political alliances was not uncommon.

The major clans as are follows.

Isaaq

This clan constitutes 80% of the population of Somaliland and 22% of the entire region. Is it largely the Isaaq who have declared Somaliland independent from Somalia.

Hawiye

The Hawiye make up 25% of the region's population and largely inhabit South/Central Somalia (including Mogadishu). Some of its sub-clans are the Degodia, Ceyr, Murosade, Ajuran and Hawadle.

Darod

The autonomous region of Puntland was formed by the Darod, who make up 20% of the region's population. There are also Darod communities in Gedo and Kismayo. Its sub-clans are the Harti, Ogaden and Marehan.

Rahanweyn

The Rahanweyn make up 17% of the region's population and are often divided into the Digil Rahanweyn and the Mirifle Rahanweyn, both of which have numerous sub-clans.⁶

Dir

Inhabiting the north of Somalia and making up 7% of the region's population, this clan's sub-clans include the Akisho, Gurgure, Surre, Issa, Barsuug and Biimaal.

Ethnic and Clan Identities and FGM

It is not known to what extent ethnic and clan identities influence the practice of FGM in Somalia and Somaliland.

Internally Displaced Persons (IDPs)

Throughout the conflict in Somalia internally displaced women and girls have been particularly vulnerable to sexual violence. The extent of sexual and gender based violence . . . against displaced women and girls is difficult to assess but is believed to be widespread though largely underreported throughout south-central Somalia. Reliable data on SGBV is lacking.⁷

Conflict and drought have displaced an estimated 1.1 million people from Somalia and Somaliland, particularly from South/Central Somalia.⁸ Women and children make up 70–80% of IDPs.⁹

1,700 rapes and 800 other gender-based violence events, many by 'Government forces, allied militia and men wearing uniforms',¹⁰ were reported in 500 camps in Mogadishu in 2012.¹¹ Gang rape is also a problem, and many victims are children. Reports to the UN allege that girls and women are being forced to perform sex acts in exchange for goods and services.¹² One contributing factor to this may be that many IDP households are headed by women (for example, nearly 80% in Puntland¹³).

Because there is no formal justice system in IDP camps, victims are left in 'a legal vacuum'.¹⁴

FGM IN DADAAB REFUGEE CAMPS IN EASTERN KENYA



Women and girls in the Dadaab refugee camp

Over 800,000 Somalis have fled to neighbouring countries over the past five years, passing through refugee camps managed by UNHCR.¹⁵ Nearly a quarter of a million of these refugees are living in Dadaab, in eastern Kenya; some of them have been there for more than 20 years.¹⁶

Although Kenya has legislation prohibiting FGM and Garissa County has vowed to spend more on fighting FGM and gender inequality,¹⁷ cutting continues to be practised in the camps.

Brownkey Abdullahi is a young woman who was born in Dadaab to Somali parents and is a regular blogger from the camp. In an interview with ONE, an international campaigning and advocacy NGO, Brownkey says:

[I]n Dadaab it [FGM] seems normal. Many of our young girls go through FGM at an early age. I shed tears when I see a young lady under the age of eight undergoing FGM. Even when they go to school, they can't perform well because of the psychological and health complications. If they keep missing classes, they lag behind her classmates. Sometimes, when I see these girls and ask why they are not wearing school uniforms, they tell me that the doctor has advised them to get married so that the pain will stop.¹⁸

Another young woman, Rukia Hussein, born in Somalia but raised in Dadaab since she was five, now works as a GBV community worker in the camp. Rukia was trained under UNHCR's Engagement of Men in Accountable Practices programme, which stresses the importance of engaging with men and religious leaders in order to re-think belief systems and achieve behavioural change. 'There is very little a young woman like me can do to fight FGM alone, but I know there is hope,' says Rukia, but she does believe that, '[w]ith the support of stakeholders, FGM will be completely eradicated.'¹⁹

- 1 Accredited Language Services (2018) *Somali*. Available at <https://www.alsintl.com/resources/languages/Somali/>.
- 2 World Atlas (2018) *Ethnic Groups and Clans in Somalia*. Available at <https://www.worldatlas.com/articles/ethnic-groups-and-clans-in-somalia.html>.
- 3 UN Office for the Coordination of Humanitarian Affairs (2002) *A Study on Minorities in Somalia*. Available at <https://reliefweb.int/report/somalia/study-minorities-somalia>.
- 4 *Ibid.*, *op. cit.*
- 5 World Atlas, *op. cit.*
- 6 - World Atlas, *op. cit.*
- World Health Organization (2010) *Country Cooperation Strategy for WHO and Somalia 2010–2014*, pp.15–16. Available at http://applications.emro.who.int/docs/CCS_Somalia_2010_EN_14487.pdf.
- 7 UNDP Somalia (2014) *Gender in Somalia: Brief II*, p.10. Available at <https://reliefweb.int/sites/reliefweb.int/files/resources/Gender%20in%20Somalia%20Brief%202.pdf>.
- 8 US Department of State (2013) *Somalia 2013 Human Rights Report*, p.20. Available at <https://photos.state.gov/libraries/somalia/323250/pdfs/somalia-human-rights-report-2013.pdf>.
- 9 UNDP Somalia, *op. cit.*
- 10 US Department of State, *op. cit.*, p.4.
- 11 Omar Ahmed Fardale (2016) *Puntland Women, Trends and Statistics*. Puntland: Ministry of Women Development and Family Affairs, p.21. Available at <http://pl.statistics.so/wp-content/uploads/2017/03/Puntland-women-trends-and-statistics.pdf>.
- 12 US Department of State, *op. cit.*, p.21.
- 13 Omar Ahmed Fardale, *op. cit.*, p.4.
- 14 UNDP Somalia, *op. cit.*
- 15 UNHCR (2018) *Horn of Africa Somalia Situation*. Available at https://data2.unhcr.org/en/situations/horn#_ga=2.132270094.1407276910.1549019237-1385499894.1500483131.
- 16 UNHCR (2001–2019) *Dadaab Refugee Complex*. Available at <https://www.unhcr.org/ke/dadaab-refugee-complex>.
- 17 Burhan Salad (2018) 'Garissa steps up war on FGM, vows more spending', *Suna Times*, 13 March. Available at <http://sunatimes.com/articles/5276/Garissa-steps-up-war-on-FGM-vows-more-spending>.
- 18 Mustapha Dumbuya (2016) 'Meet Brownkey Abdullahi: Dadaab refugee camp's first female blogger', *ONE*, 10 October. Available at <https://www.one.org/us/blog/meet-brownkey-abdullahi-dadaab-refugee-camps-first-female-blogger/>.
- 19 Modesta Ndubi (2016) 'Dadaab Youth Determined to Fight FGM in her Community', *UNHCR Kenya*, 1 September. Available at <https://www.unhcr.org/ke/1711-meet-a-young-woman-determined-to-end-fgm-in-dadaab.html>.

Image p.31: Sadik Gulec (2011) *Unidentified woman & children live in the Dadaab refugee camp where thousands of Somalis wait for help because of hunger on August 15, 2011 in Dadaab*. Shutterstock ID 83490673.

Laws Relating to Women and Girls – Somalia

For the purposes of the legal analysis in this Country Profile, the **Federal Republic of Somalia** is taken to comprise five federal States, including **Puntland**, but excluding **Somaliland**. Somaliland has its own government, but its self-declared independence remains unrecognised by the United Nations, and Somalia continues to consider Somaliland a federal member state.

In 1998 Puntland was declared an autonomous state of the Federal Republic of Somalia. While Somalia has only recently started to review the situation in relation to FGM across the country, Puntland has made more progress in recent years towards ending FGM and its law and strategies form part of this section.

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on 28 Too Many's website.

International and Regional Treaties

Many of the international human-rights conventions and treaties related to the practice of FGM have been signed and ratified by Somalia. The ratification of these conventions places an obligation on the Government to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place, such as anti-FGM laws.

Somalia has ratified or signed up to the following conventions and treaties:^{1,2}

International

- **Convention on the Rights of the Child** (ratified 2015) – not bound by Articles 14, 20 and 21
- **International Covenant on Economic, Social and Cultural Rights** (acceded 1990)
- **International Covenant on Civil and Political Rights** (acceded 1990)
- **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** (acceded 1990)

Regional

- **African Charter on Human and Peoples' Rights (Banjul Charter)** (ratified 1985)
- **African Charter on the Rights and Welfare of the Child** (signed 1991 but not ratified)
- **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol)** (signed 2006 but not ratified)
- **Solemn Declaration on Gender Equality in Africa**, declared by the African Union (which includes Somalia)

Somalia has not signed the **Convention on the Elimination of All forms of Discrimination Against Women** (1979) (*CEDAW*). It is reported, however, that the Ministry of Women is reviewing the treaties still to be signed following Somalia's election to the UN's Human Rights Council.

National Laws in Somalia

The Constitution

Somalia's legal system is a mixture of civil law, Islamic law and customary law (referred to as *Xeer*). The Constitution of Somalia (2012)³ states at Article 4, 'After the Shari'ah, the Constitution of the Federal Republic of Somalia is the supreme law of the country.'

It protects human dignity and equality under Articles 10 and 11 respectively, and, most significantly in relation to FGM, sets out under Article 15(4) that:

*Circumcision of girls is a cruel and degrading customary practice,
and is tantamount to torture.
The circumcision of girls is prohibited.*

It does not, however, provide a detailed definition of 'circumcision of girls', and there is no article establishing a punishment for a breach of the Constitution. It does, however, provide for judicial review as a means to protect the supremacy of the Constitution and mandates the Human Rights Commission and Ombudsman to protect the Constitution.

Article 29(2) further provides, 'Every child⁴ has the right to be protected from mistreatment, neglect, abuse or degradation.'

Violence against women and other harmful practices are not specifically referred to in the Constitution.

Age of Suffrage, Consent and Marriage

Under Article 29(8) of the Constitution, a child is considered to be any person under the age of 18. The ages of suffrage, consent and marriage are 18, although a girl may be married at the age of 16 with parental consent.⁵

Laws Against FGM

There is currently no national legislation in Somalia that expressly criminalises and punishes the practice of FGM, and no penalties are set out for the practice or procurement of FGM.

The 1964 **Penal Code**, Law No. 05/1962⁶ (*the Penal Code*) is applicable to all jurisdictions in Somalia and makes it a criminal offence to cause 'hurt' to another that results in physical or mental illness. Under Articles 440(1–3), the penalty for causing 'hurt' to another is imprisonment for three months to three years. Where the hurt is deemed to be 'grievous', the penalty is imprisonment for three to seven years, rising to six to twelve years where the hurt is deemed to be 'very grievous' (i.e. 'loss of a limb, or a mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate'). There is, however, no evidence of the Penal Code being used to prosecute perpetrators of FGM in Somalia.

Medicalised FGM

An increase in medicalised FGM has been reported throughout Somalia, but there is no data available on the number of women and girls who have been cut by a health professional or in a medical setting. Some reports suggest that this increase is a result of families on higher incomes and with better education believing it will 'reduce the harm' of FGM.⁷

There is no legislation currently in place at the national level criminalising and punishing medicalisation of the practice, and no charges of malpractice have been brought against a health professional for performing FGM.

In Puntland, an inter-ministerial decree against FGM developed by the Ministry of Health and signed in 2014 states that there will be no medicalisation of FGM⁸ and that it has the authority to shut down clinics and hospitals that continue the practice, and arrest perpetrators. It also entitles the Government of Puntland to cancel the licences of medical professionals who practice FGM in their clinics, and doctors' associations have been asked to hold their members accountable for practising FGM by revoking their memberships. It is understood that this inter-ministerial policy is now being disseminated by stakeholders, but currently lacks an implementation plan and accountability framework.⁹

There have been instances where girls have bled to death or experienced adverse side effects following medicalised FGM, but it appears such cases were settled privately between the medical practitioners and the families, sometimes with the mediation of community elders. These cases were not reported publicly.

Cross-Border FGM

Somalia shares borders with countries where the prevalence of FGM and the existence and enforcement of anti-FGM laws vary, including Ethiopia and Kenya. There are many Somalis living in the border regions of Ethiopia and Kenya, and the absence of national legislation banning FGM in Somalia allows the practice to continue, as families move across borders to avoid prosecution. There is no accurate data on the number of girls who are taken across borders to be cut.

It is also reported that Somali women and girls from the Western diaspora (for example, in the USA, Australia, the UK and other European countries) are taken back to Somalia, to Djibouti or to countries in the Middle East for FGM because there is little risk of prosecution.

Government Work to End FGM in Somalia

The leading **government departments** responsible for work to end FGM in Somalia are the Federal Ministry of Women and Human Rights Development (*MOWHRD*) in South/Central Somalia and the Ministry of Women's Development and Family Affairs (*MOWDAFA*) in Puntland. In addition, across all zones, the Ministry for Religious Affairs and Endowment, Ministry of Health (*MOH*) and Ministry of Youth all contribute to the work to end FGM.

Although, since 2015, the MOWHRD and the MOH have co-chaired an FGM taskforce meeting to coordinate anti-FGM work¹⁰, there has been no evidence to date of a formal government strategy to end FGM. 28 Too Many has been informed that the initial scoping and drafting of a **National Action Plan to end FGM** in Somalia has now been completed by activist Ifrah Ahmed in partnership

with government ministries and key stakeholders, and, following consultation, implementation will be sought in 2019 (see details on the Ifrah Foundation on page 121).

It is not acceptable that in the 21st century FGM is continuing in Somalia. It should not be part of our culture. It is definitely not part of the Islamic religion.

~ Mahdi Mohammed Gulaid, the deputy prime minister of Somalia, 2018¹¹

The Government is generally supportive of the wide range of organisations working to end FGM in the region and has increasingly worked in partnership with them to tackle the issue, from the large INGOs such as UNICEF, Save the Children and Care International through to the smaller community-based organisations and individual activists.

HOPE IN LIFE INTERNATIONAL SOMALIA: EMPOWERING SOMALIA'S WOMEN AND CHILDREN

Advocacy work and providing a platform for women's voices are central to the anti-FGM activities of Mogadishu-based NGO Hope in Life International Somalia (*HILI*). Alongside core activities to improve nutrition and sanitation in the IDP camps of Karibu in Mogadishu and Dangwal in the outlying Abdul-Aziz district, HILI works with government and civil-society partners to provide two national platforms, in particular, on which FGM can be discussed:

- **The Somalia Women's Conference** – working with UN Women, this high-level platform brings together members of parliament, high-ranking officials and community and religious leaders.
- **The 100 Young Voices Somalia Conference** – working with partners such as the UNDP and Ifrah Foundation, enabling young people, both men and women, to discuss topics such as FGM and work together to propose solutions.



100 Young Voices: HILI facilitating dialogues on issues such as FGM (© HILI)

Regarding FGM, HILI recognises the importance of bringing together all key stakeholders and holding influential leaders to account by frequently challenging them to protect women and girls throughout Somalia.

Experience is showing that, once engaged, members of parliament and community leaders will support and participate in the anti-FGM advocacy work.

In 2015, it was reported that work had begun to initiate a **bill to criminalise FGM** across all of Somalia, and in 2016 the prime minister was successfully lobbied by campaigners to sign a petition calling for the passing of an anti-FGM bill.¹²

28 Too Many understands that the Government of Somalia has now formally instructed legal professionals to draft and consult on **national legislation that will ban all types of FGM**, and it is possible that the text will be placed before the president for approval by the end of 2019. The draft law is understood to be comprehensive, although definitions and exact content are not publicly available at the time of writing. The drafting of the law reportedly has support across all regions and government departments and the idea of zero-tolerance legislation in Somalia was first introduced to the public through a televised launch in December 2018. 28 Too Many, however, has received varying reports from civil society regarding public awareness of and sensitisation in relation to a new anti-FGM law being introduced in Somalia.

In March 2014, the president of **Puntland** approved an official government policy outlawing all forms of FGM. The policy aimed for 'total abandonment of FGM/C practices in the Puntland through effective Government FGM/C abandonment strategies and approaches for sustainable behaviour change at the family and at the society levels.'¹³ The strategy currently being disseminated includes generating reliable data on FGM, sensitising the community, working with religious leaders and health professionals, and utilising the media. However, there is no formal implementation plan as yet, and parliamentary legislation to support the work is still not in place.

Shortly before the Puntland policy was approved, In November 2013, 18 prominent religious leaders signed a *fatwa* (an Islamic law ruling) against FGM witnessed by various Puntland ministers.¹⁴ The *fatwa* had been drafted by a committee of seven members and justified the abandonment of all forms of FGM on health and religious grounds. To date, no criminal cases have been identified as arising from it.

The enactment of the **Sexual Offences Act** in Puntland in 2016 further demonstrates a commitment to addressing harmful practices in the region.

For further information on the law, see ***Somalia: The Law and FGM***.

NO PROSECUTIONS AS SOMALI GIRLS CONTINUE TO DIE FROM FGM

While supporters of FGM continue to believe that the practice does no harm, there is overwhelming evidence internationally of the physical and psychological damage it inflicts on women and girls. This evidence is nowhere more apparent than in Somalia and Somaliland, where FGM prevalence is near universal, but, to date, there has been no legal framework to hold perpetrators of the practice to account and punish them under national laws.

The most tragic impact that society can witness is the loss of a girl following FGM. There are many cases that are never reported publicly in Somalia, but in recent years some deaths of young girls have reached mainstream media.

It is difficult to estimate the number of girls who die due to FGM per month or per day because they are [sworn] to secrecy, particularly in rural areas. We only get to hear of the few cases of those bold enough to seek medical treatment in towns. But from the stories we do hear, they could be in their dozens.

*~ Hawa Aden Mohamed of the Galkayo Education
Centre for Peace and Development¹⁵*

In July 2018 a 10-year-old girl called Deeqa Dahir Nuur underwent FGM in the village of Olol in the Galmudug state of central Somalia. The procedure severed a vein, and, after two days of bleeding heavily, Deeqa was taken to hospital in Dhusmareb, where she passed away due to the haemorrhaging and tetanus caused by dirty cutting tools. Her death was the most high-profile case reported to date in Somalia and brought widespread attention through the media to the dangers of FGM.

At the Media Training Academy held in Mogadishu later that month (see GMC profile in the Media section of this report), Attorney General Ahmed Ali Dahir publicly condemned the practice and pledged that the Somali Government would pursue legal action for Deeqa's case.

In September 2018, three more deaths were reported by local activists in Puntland: 10-year-old Aasiyo Abdi Warsame and her sister Khadijo (aged 11) both died from excessive bleeding as their mother was taking them to a health centre the day after they were cut;¹⁶ then another 10-year-old, Mumtaz Qorane, contracted tetanus and died three days later before medical help could reach her.¹⁷

These are just a few of the many young Somali lives lost to FGM, but the difficulty of locating the traditional cutters responsible after the procedure has taken place and the continued absence of national laws against FGM in the region remain huge challenges to seeking justice for these girls.

- 1 United Nations Human Rights Office of the High Commissioner (2014) *Status of Ratification Interactive Dashboard: Somalia*. Available at <http://indicators.ohchr.org/>.
- 2 **'Signed': a treaty is signed by countries following negotiation and agreement of its contents; 'ratified': once signed, most treaties and conventions must be ratified (i.e. approved through the standard national legislative procedure) to be legally effective in that country; 'acceded': when a country ratifies a treaty that has already been negotiated by other states.**
- 3 *Somalia's Constitution of 2012* (2012) Available at https://www.constituteproject.org/constitution/Somalia_2012.pdf.
- 4 **Article 29 (8) of the Somali Constitution (2012) defines 'child' as any person under 18 years of age.**
- 5 - Central Intelligence Agency (2018) *The World Factbook: Somalia*, 17 October. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/so.html>.
- Age of Consent (2018) *Age of Consent in Somalia*. Available at <https://www.ageofconsent.net/world/somalia>.
- Girls Not Brides (2002–2018) *Child Marriage Around The World: Somalia*. Available at <https://www.girlsnotbrides.org/child-marriage/somalia/>.
- 6 *Penal Code: Legislative Decree No. 5 of 16 December 1962* (1962) Available at http://www.somalilandlaw.com/Penal_Code_English.pdf.
- 7 Dr Sheena Crawford and Sagal Ali (2015) *Situational Analysis of FGM/C Stakeholders and Interventions in Somalia*. Available at <http://www.heart-resources.org>.
- 8 UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation (2017) *2016 Annual Report of the UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change*, p.62. Available at https://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA_UNICEF_FGM_16_Report_web.pdf.
- 9 Information supplied by the Population Council.
- 10 UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation, *op. cit.*
- 11 Mahdi Mohammed Gulaid cited in Kate Hodal (2018) 'Somalia under renewed scrutiny over FGM after two more young girls die', *The Guardian*, 17 September. Available at <https://www.theguardian.com/global-development/2018/sep/17/somalia-under-renewed-scrutiny-over-female-genital-mutilation-after-two-more-young-girls-die>.
- 12 - Goobjoog News (2015) *Somalia will soon ban FGM, Human Rights Minister says*, 17 August. Available at <http://goobjoog.com/english/somalia-will-soon-ban-fgm-human-rights-minister-says/>.
- A. Abdirahman (2015) 'Somalia to introduce law prohibiting Female Genital Mutilation', *Horseed Media*, 3 August. Available at <https://horseedmedia.net/2015/08/03/somalia-to-introduce-law-prohibiting-female-genital-mutilation/>.
- 13 UNICEF Somalia (2014) *Regional authority in Somalia introduces an official policy to end FGM/C*. Available at https://www.unicef.org/somalia/reallives_14437.html.
- 14 UNICEF Somalia (2013) *Important Religious Ruling against all forms of female circumcision signed in Puntland, North Eastern Somalia*. Available at https://www.unicef.org/somalia/reallives_13980.html.
- 15 Kate Hodal (2018) '10-year-old girl bleeds to death after female genital mutilation in Somalia', *The Guardian*, 20 July. Available at <https://www.theguardian.com/global-development/2018/jul/20/10-year-old-girl-death-fgm-female-genital-mutilation-somalia>.
- 16 Bukola Adebayo (2018) 'Two sisters die after undergoing FGM in Somalia, campaigner says', *CNN*, 14 September. Available at <https://edition.cnn.com/2018/09/13/africa/somali-fgm-victims-intl/index.html>.
- 17 Harun Maruf (2018) 'Third Girl Dies in Somalia After Genital Mutilation', *VOA News*, 17 September. Available at <https://www.voanews.com/a/third-girl-dies-in-somalia-after-genital-mutilation/4575084.html>.

Laws Relating to Women and Girls – Somaliland

In 1991 Somaliland declared independence from the Federal Republic of Somalia. Somaliland has its own political system, government, police force and currency,¹ but its self-declared independence remains unrecognised by the United Nations, and Somalia continues to consider Somaliland as a federal member state.

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on 28 Too Many's website.

International and Regional Treaties

Somaliland is not listed as a separate jurisdiction among the signatories to the international and regional treaties most relevant to protecting women and girls from FGM. However, Article 10(1) of the Constitution of Somaliland (2001)² confirmed compliance with all the treaties previously signed and ratified by the Federal Government of Somalia, 'provided that these do not conflict with the interests and concerns of the Republic of Somaliland'. The ratification of these conventions places an obligation on the Government to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place, such as anti-FGM laws.

Somaliland has committed to comply with the following conventions and treaties:^{3,4}

International

- **Convention on the Rights of the Child** (signed 2002, but not ratified)
- **International Covenant on Economic, Social and Cultural Rights** (acceded 1990)
- **International Covenant on Civil and Political Rights** (acceded 1990)
- **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** (acceded 1990)

While Somalia did not sign or ratify the **Universal Declaration of Human Rights**, Somaliland declares in Article 10(2) of its Constitution that 'the Republic of Somaliland recognises and shall act in conformity with United Nations Charter and with international law, and shall respect the Universal Declaration of Human Rights.'⁵

Regional

- **African Charter on Human and Peoples' Rights (Banjul Charter)** (ratified 1985)
- **African Charter on the Rights and Welfare of the Child** (signed 1991, but not ratified)

The status of the **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa** in Somaliland is unknown; it was signed by Somalia in 2006.

Somaliland has not signed the **Convention on the Elimination of All forms of Discrimination Against Women** (1979) (*CEDAW*).

National Laws in Somaliland

The Constitution

Somaliland's legal system is a mixture of civil law, Islamic (Sharia) law, and customary law. Sharia law takes precedence over all laws, and customary law also has a strong influence. This mixed system can lead to conflict and is not generally supportive of women's rights.⁶

Article 130(5) of the Constitution of Somaliland states:

All the laws [of the Federal Republic of Somalia] which were current and which did not conflict with the Islamic Sharia, individual rights and fundamental freedoms shall remain in force in the country of the Republic of Somaliland until the promulgation of laws which are in accord with the Constitution of the Republic of Somaliland.

The Constitution does not refer specifically to FGM. However, Article 36 sets out The Rights of Women and confirms that:

1. The rights, freedoms and duties laid down in the Constitution are to be enjoyed equally by men and women save for matters which are specifically ordained in Islamic Sharia.
2. The Government shall encourage, and shall legislate for, the right of women to be free of practices which are contrary to Sharia and which are injurious to their person and dignity.

Article 8 addresses Equality of Citizens and provides at (2) that 'programmes aimed at eradicating long lasting bad practices shall be a national obligation'.

Although the Constitution does not specifically address violence against women and girls, Article 24 states that everyone shall have the right to security of his person, that injury to the person is prohibited, and that crimes 'against human rights' such as torture and 'mutilation' shall have no limitation periods.⁷

Age of Suffrage, Consent and Marriage

The ages of consent and marriage are 18, although it is likely that, as in Somalia, a girl may be married at the age of 16 with parental consent.⁸

The age of suffrage is 16.⁹

Laws Against FGM

There is currently no legislation in Somaliland that expressly criminalises and punishes the practice or procurement of FGM.

The **Somali Penal Code**, Law No. 05/1962 of the Federal Republic of Somalia, as adopted by Somaliland, came into force on 2 April 1964 (the *Penal Code*).¹⁰ The Penal Code makes it a criminal offence to cause 'hurt' to another that results in physical or mental illness. Under Articles 440(1–3), the penalty for causing 'hurt' to another is imprisonment for three months to three years. Where the hurt is deemed to be 'grievous', the penalty is imprisonment for three to seven years, rising to six to twelve years where the hurt is deemed to be 'very grievous' (i.e. 'loss of a limb, or a

mutilation which renders the limb useless, or the loss of the use of an organ or of the capacity to procreate’).

In February 2018 the Ministry of Religious Affairs in Somaliland issued a *fatwa* (an Islamic law ruling) banning the most severe type of FGM, Type III (Infibulation). It stated that those who perform this type of FGM will face punishment and victims would be eligible for compensation (it did not, however, provide details of punishments or who would pay compensation and what amount).¹¹

There is no indication as to whether the prohibitions in the Constitution or *fatwa* cover only those who perform FGM or if they could also include those who plan, procure, aid or assist acts of FGM, or those who fail to report FGM that has already, or is due to, take place. There is also no evidence of the *fatwa* or the Penal Code being used to prosecute perpetrators of FGM.

Medicalised FGM

An increase of medicalised FGM has been reported in Somaliland, particularly in urban and semi-urban areas: a recent study by the Population Council¹² suggests that more nurses and midwives are now performing FGM (particularly those types referred to as sunna) at healthcare facilities or in private homes. There is no data, however, on the number of women and

The **Somaliland Nurses and Midwifery Association** is reportedly working closely with the UNFPA on the development of a draft policy intended to prohibit doctors, nurses, midwives and other healthcare workers from performing FGM under any circumstances. It is proposed that any of these medical professionals who violate the policy will have their licence revoked according to the Somaliland National Health Professions Commission’s guiding principles and by-laws.

girls who have undergone medicalised FGM in Somaliland. Anecdotal evidence also confirms that more families are taking their daughters to medical facilities and generally health workers are charging similar fees as the traditional birth attendants to perform FGM.

Current national legislation does not criminalise FGM carried out by a health professional or in a medical setting, nor have any cases of malpractice been identified against health professionals for performing FGM. As reported elsewhere in the region, there have been instances where girls have bled to death or experienced adverse side effects following medicalised FGM, but it appears that such cases are usually settled privately between the medical practitioners and the families, sometimes with the help of community elders to mediate. These cases are not reported publicly.

Cross-Border FGM

Somaliland shares borders with Somalia, Djibouti and Ethiopia, where FGM prevalence and the existence and enforcement of anti-FGM laws vary. The absence of any national legislation banning FGM in both Somaliland and Somalia gives families from neighbouring countries the opportunity to move across borders to avoid prosecution.

It has also been observed that Somali women and girls from the Western diaspora (for example, in the USA, Australia, the UK and other European countries) may be taken to Somaliland for FGM because there is less risk of being caught.

Government Work to End FGM in Somaliland

The leading government department responsible for gender issues, including work to end FGM in Somaliland, is the Ministry of Labour and Social Affairs (*MOLSA*). The Ministries of Health, of Justice and of Religion also have responsibility.

The Government has highlighted the challenge of ending FGM in several national documents in recent years, including in terms of improving reproductive health in a National Health Policy drafted by the Ministry of Health in 2011, which identified the need for policy to end FGM in the Somaliland National Development Plan for 2012–2016. As of 2016, however, the Government of Somaliland did not have an agreed national policy or strategy in place to end FGM. The UNJP in its 2016 report states that a draft policy is waiting to be taken to the Council of Ministers.¹³

In the run-up to the November 2017 presidential elections, it was reported that all three candidates publicly pledged to outlaw FGM. Musa Bihi Abdi, who went on to become president, stated:

*What is needed now is the political leadership to bring focus and clarity to this campaign led by Somaliland's hundreds of activists and campaigners. If I am elected president, I will do exactly that.*¹⁴

At the time of writing, 28 Too Many understands that a new anti-FGM bill has been drafted in Somaliland, which will criminalise and punish the practice of FGM. The draft bill is being driven by a task force that was set up in 2018, which includes civil-society representatives and organisations such as the Human Rights Centre. The bill has now entered the consultation stage with the Ministry of Social Affairs, and the challenge moving forward is to ensure it is comprehensive and bans all types of FGM (i.e. zero tolerance). To date, there has been immense pressure from religious leaders and supporters of the practice to only ban the most severe Type III (infibulation), but still permit the sunna cut (see also section of this report on Religion and FGM). The Ministry of Religious Affairs is now reportedly closer to modifying its position on sunna but needs to undertake further consultation with religious leaders.



Civil society organisations lobby for new anti-FGM bill in Somaliland (© NAFIS Network)

For further information on the law, see *Somaliland: The Law and FGM*.

- 1 BBC News (2017) *Somaliland Profile*. Available at <http://www.bbc.co.uk/news/world-africa-14115069>.
- 2 **The Constitution of the Republic of Somaliland was approved by referendum on 31 May 2001 (see http://www.icla.up.ac.za/images/constitutions/somaliland_constitution.pdf).**
- 3 United Nations Human Rights Office of the High Commissioner (2014) *Status of Ratification Interactive Dashboard: Somalia*. Available at <http://indicators.ohchr.org/>.
- 4 **'Signed': a treaty is signed by countries following negotiation and agreement of its contents; 'ratified': once signed, most treaties and conventions must be ratified (i.e. approved through the standard national legislative procedure) to be legally effective in that country; 'acceded': when a country ratifies a treaty that has already been negotiated by other states.**
- 5 **The Constitution of the Republic of Somaliland was approved by referendum on 31 May 2001 (see http://www.icla.up.ac.za/images/constitutions/somaliland_constitution.pdf).**
- 6 Maria Beata Tungaraza (2007; updated 2008) *Women's Human Rights in Somaliland*, p.54. Available at <http://www.progressio.org.uk/sites/default/files/Womens-human-rights-in-Somaliland.pdf>.
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- 8 - Central Intelligence Agency (2018) *The World Factbook: Somalia*, 17 October. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/so.html>.
- Age of Consent (2018) *Age of Consent in Somalia*. Available at <https://www.ageofconsent.net/world/somalia>.
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- 9 Saferworld and SONSAP (2018) *Somaliland decides: Domestic election observers' report on the 2017 presidential elections*, p.19. Available at <https://www.saferworld.org.uk/resources/publications/1174-somaliland-decided-the-domestic-election-observers-a-report-on-the-2017-presidential-election>.
- 10 *Penal Code: Legislative Decree No. 5 of 16 December 1962* (1962) Available at http://www.somalilandlaw.com/Penal_Code_English.pdf.
- 11 Nita Bhalla (2018) 'Somaliland issues fatwa banning female genital mutilation', *Reuters*, 8 February. Available at <https://www.reuters.com/article/us-somalia-fgm-fatwa/somaliland-issues-fatwa-banning-female-genital-mutilation-idUSKBN1FR2RA>.
- 12 R. A. Powell and M. Yussuf (2018) *Changes in FGM/C in Somaliland: Medical narrative driving shift in types of cutting*. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council. Available at http://www.popcouncil.org/uploads/pdfs/2018RH_FGMC-Somaliland.pdf.
- 13 UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation (2017) *2016 Annual Report of the UNFPA-UNICEF Joint Programme on FGM/C: Accelerating Change*, p.62. Available at https://reliefweb.int/sites/reliefweb.int/files/resources/UNFPA_UNICEF_FGM_16_Report_web.pdf.
- 14 Anna Davis (2017) 'Almost all Somaliland women have undergone female genital mutilation', *Evening Standard*, 10 November. Available at <https://www.standard.co.uk/news/world/almost-all-somaliland-women-have-undergone-female-genital-mutilation-a3687831.html>.

The Role of Women in Society

Somalia and Somaliland have been jointly ranked as one of the worst regions worldwide for women, second only to Afghanistan in terms of violence and exclusion of women.¹

As of 2012, the region has a Gender Inequality Index value of 0.766 (on a scale of 0 to 1, where 1 denotes complete inequality), which places it fourth-highest in terms of **gender inequality** globally, below Yemen, Mali and Papua New Guinea.²

The OECD Development Centre prescribed the region a Social Institutions and Gender Index value of 0.4594³ in 2014, placing its level of **gender discrimination** in social institutions into the category of 'Very High', the highest category⁴.

In 2012 a **constitution** was adopted in Somalia, of which many of the articles provide progressive laws surrounding Somali women and their rights. Article 11(1) states that 'all citizens, regardless of sex, religion, social or economic status, political opinion, clan, disability, occupation, birth or dialect shall have equal rights and duties before the law.'⁵ Article 27(5) states that 'women, the aged, the disabled and minorities who have long suffered discrimination [will] get the necessary support to realize their socio-economic rights.'⁶

Sharia and customary law (known as **Xeer**) are enacted concurrently with constitutional/civil law. Xeer and Sharia often take the place of the legal system for local-community and family-scale matters.⁷ Sharia law is usually administered by men.

In **Puntland**, the Government states that women have equal rights to men; however, it concedes that there may be cultural factors that hinder the realisation of this.⁸

At present, Somalia has not signed or ratified the **Convention on the Elimination of all forms of Discriminations against Women (CEDAW)**; neither does Somaliland recognise it.⁹ In 2017, the Somali Government claimed it was reviewing its stance on the CEDAW; however, it was receiving opposition from some conservative Islamic clerics.¹⁰

In July 2014 the governments of both Somalia and Puntland signed the **Girl Summit Charter on Ending FGM, Child, Early and Forced Marriage**.¹¹

Somalia's complex **clan system** is highly influenced by male elders and traditional values. In many parts of Somalia, there are vast divides between federal laws and clan-based traditional institutions. While Somalia has historically produced progressive laws giving women equal footing with men,¹² these traditional, clan-based systems continue to challenge the equality of the genders and the rights of women in Somalia.¹³

Women have, however, played roles in **conflict resolution and nation-building** following periods of conflict in the region. They are expected to be educated and married and to be homemakers, but many also own land and follow their own career aspirations.¹⁴

Physical Integrity

The OECD Development Centre prescribed Somalia and Somaliland (jointly) a **restricted physical integrity value** of 0.9905 in 2014, placing it in the ‘Very High’ category.¹⁵

*Violence against women cuts across all social and economic strata, and is deeply embedded in Somali culture.*¹⁶

Violence against women is a serious and pervasive issue in Somalia and Somaliland, where legislation and enforcement surrounding issues of domestic violence, sexual violence and rape are limited due to ongoing stigma and ingrained societal beliefs. There are higher rates of violence, accidental death, sexually transmitted diseases, mental health disorders and suicide among Somali women than among Somali men.¹⁷

It is understood that the majority of incidents of violence towards women go unreported to authorities, as there is a ‘culture of impunity’ surrounding violence against women. Cases of rape or violence against women are considered civil disputes and are often resolved through agreements between the clans of those involved. These usually consist of a monetary payment or a forced marriage.¹⁸

South/Central Somalia

Rape is illegal in South/Central Somalia under the Sexual Offences Bill that was passed in May 2018; an equivalent law has yet to be passed in Jubaland in the far south.¹⁹

*Rape and sexual violence against the displaced, particularly against members of rival clans and minority groups, are targeted strategies to weaken families and break down the social fabric of communities and societies.*²⁰

In November 2017, the Federal Ministry of Women and Human Rights Development and UNSOM held in Mogadishu a review of the **National Action Plan on Ending Sexual Violence in Conflict**.²¹

Puntland

A **sexual offences law** was passed in Puntland in November 2016.²² At the time of writing, two cases of gang rape involving young girls had been through the courts and charged under this legislation.²³

More than 20% of women in Puntland experienced some form of **violence (physical or sexual) during childhood**, compared to almost 30% of men. The percentage of women who experienced sexual violence as a child was greater than that of men.²⁴

Almost 25% of women in Puntland have experienced some form of **non-partner violence** (physical or sexual violence) during their life, in comparison to more than 35% of men.²⁵

48% of women in Puntland have experienced **intimate partner violence** (comprising physical, sexual or psychological harm by a current or former spouse or partner) since the age of 15. 40% of those

women experienced intimate partner violence in the form of physical violence, and about 30% in the form of sexual violence.²⁶

The actual prevalence of violence towards women is not known, due to the lack of reporting of incidents to authorities. Many women do not wish to report incidents to police, fearing that the associated stigma will harm their future careers or marriage prospects.²⁷ One study in Puntland revealed that only 3% of female respondents believe that incidents of GBV should be reported to the police, and most would prefer to report cases to local elders or parents.²⁸ Another factor contributing to the lack of reporting is the fact that many female victims of violence would wish to engage with a female police officer; however, there are very few women in the Puntland police force.²⁹

Somaliland

Somaliland, when it declared independence, adopted all the laws of Somalia that were current, including the Somali Penal Code. Although the **Constitution** does not specifically address violence against women and girls, Article 15 states that everyone shall have the right to security of his person, that injury to the person is prohibited, and that crimes 'against human rights' such as torture and 'mutilation' shall have no limitation periods.³⁰

A **Sexual Offences Bill** was approved by the House of Elders in April 2018 and is currently waiting assent.

Civil Liberties, Resources and Entitlements

The OECD Development Centre assigned Somalia and Somaliland (jointly) a restricted **civil liberties value** of 0.6093 ('High')³¹ in 2014.³²

Freedom of Movement and Access to Public Space

Ongoing conflict in the region has restricted freedom of movement and access to public spaces. Both men and women face forms of violence, and women particularly face sexual violence.³³

In general, Somali Islamic culture does not permit women to speak in public, especially when men are present. Reportedly, when women in Mogadishu and Garowe attempted to, they were openly opposed and ridiculed, causing other women to shy away from speaking, even when permitted to. On a more positive note, there have been other reports that women in Baidoa were 'recognised and respected in public events' and that 'even though they faced some opposition in parliament, their space in the public arena was uncontested.' This is perhaps the beginning of changes to come in other parts of the country.³⁴



Women's voices are beginning to be respected at public events

Women are reportedly concerned about insurgent groups, including al-Shabab militants, and the extreme interpretations of Sharia that they bring with them, especially the requirement for women to cover their faces, which is not customary in the region.³⁵

While there are no official restrictions on the rights of Somali women to leave or enter their countries, many individuals do not have the ability or the means to obtain a passport for international travel. Due to the high number of forgeries, many countries do not, or have not in the past, recognised Somali passports.³⁶ Since the introduction of electronic passports, more countries are recognising them as official travel documents, but may still have restrictions based on the date or place of issue.³⁷

Checkpoints exist at locations throughout Somalia, which are operated by the Government and guarded by the National Army, allies or clans. Some checkpoints are not under government control, but are patrolled by al-Shabaab or other militant groups. There have been reports of cases of violence, harassment, looting and extortion of individuals moving through certain checkpoints in the South/Central Zone, as well as at the border of Somaliland.³⁸

Sexuality

Sexuality is considered a taboo topic in Somalia and Somaliland, where individuals, both male and female, are prohibited by law to have same-sex sexual relationships or contact. Same-sex sexual contact is a crime, and those caught face up to three years' imprisonment.³⁹ Article 11(3) of the Constitution of Somalia does not provide protection from discrimination to LGBT persons.⁴⁰

There have been few widely-reported events of violence towards LGBT communities,⁴¹ likely because very few LGBT individuals will make their sexuality known due to the severe stigma surrounding same-sex relationships. However, reports of individuals being threatened with death by members of their communities or by armed gangs do exist.⁴² Many individuals who fear for their lives have escaped to neighbouring countries, usually to Kenya, where the situation for the LGBT community is improving.⁴³

In areas of Somalia where al-Shabaab insurgents are in control, those found to be LGBT may be publicly stoned or sentenced to death due to the militant group's prescription to strict Sharia.⁴⁴

Religion

According to the Somalia Constitution, no religion other than Islam may be practised in the country.⁴⁵ However, Article 11(3) states that 'the State must not discriminate against any person on the basis of . . . religion.'⁴⁶ Over 99% of the population of Somalia is Sunni Muslim, with small communities of Christian, Shia Muslim and Sufi individuals.⁴⁷ Those who convert from the Sunni Islamic faith face harassment from their communities or harsher punishment from al-Shabaab.⁴⁸

Somaliland also holds Islam as its state religion and bars individuals from converting to other faiths.⁴⁹

Female Representation in Government

The undeniable benefits of Somali women becoming more involved in politics include greater participation in nation-building, contributions to the end of FGM, opposition to extremism and associated violence,⁵⁰ and opposition of the ingrained societal and religious belief that it is immoral for women to vie for senior leadership positions.⁵¹



Many Somali women follow their career aspirations

South/Central Somalia

Traditionally, women's participation in Somali politics at all levels has been limited due to the impacts of conservative gender roles,⁵² security challenges and a patriarchal electoral system.⁵³ However, over the last few decades there has been an increase in women's representation in government and ongoing campaigning to further increase this presence.⁵⁴

Article 3(5) of the Constitution states that 'women must be included in all national

institutions, in an effective way, in particular all elected and appointed positions across the three branches of government and in national independent commissions.'⁵⁵

It is understood that the influence of clan leaders in elections is one of the main barriers to female representation in government.⁵⁶ The nature of the Somali election process means that the number of women elected into parliamentary positions is ultimately influenced by the 135 traditional elders involved in the electoral process, who select parliamentary members from within their clans.⁵⁷ The ingrained societal belief that women's intelligence and strength are inferior to those of men, combined with cultural norms barring women from seeking positions of leadership, are often upheld by clan leaders and so many do not support female candidates.⁵⁸ Female respondents to a 2016 study stated that some clan leaders in Baidoa, Somalia's second-most populous area, are becoming more accepting of women vying for leadership positions.⁵⁹

Other notable barriers to an increased female representation in government are limited finances for campaigning, social stigmas surrounding women vying for leadership positions, a lack of support from their communities, limited education and threats to the safety of campaigners.⁶⁰

The Constitution states that 30% of seats in both the upper and lower houses of parliament must be filled by women;⁶¹ however, this quota is not legally-binding,⁶² and so there is no absolute requirement for the Government to reach this quota.

In September 2016, a group of notable Somali men and women launched the All Women's Campaign in a bid to reach the 30% quota for women in government.⁶³ The campaign sought to achieve this goal by supporting women registering for electoral positions, setting up a database for female candidates and lobbying clan leaders to increase their support for female candidates within their clans.⁶⁴ Former President Hassan Sheikh Mohamud presided over the launch and gave his support to the campaign.⁶⁵

In 2012, 39 of the 275 parliamentary seats, constituting 14%, were held by women.⁶⁶ As of March 2017 women accounted for 24.7% of parliament members,⁶⁷ which, despite being below the quota, is a commendable achievement compared to previous years. As of March 2018, five members of the 25-member federal cabinet are women: the Ministers for Humanitarian and Disaster Management, Ports of Marine Transport, Women and Human Rights, Health and Social Care, and Youth and Sports.⁶⁸

Puntland

In 2008, a presidential decree ordered 30% of positions in leadership and governance be allocated to women; however, since the decree, no substantial effort appears to have been made to achieve this quota.⁶⁹

As of 2012, three of the 66 seats in the House of Representatives were held by women (members are selected by male clan elders). One female minister was in the 18-member cabinet.⁷⁰

As of 2014, 17.2% of positions in the Puntland Government were held by women.⁷¹

As of 2016, 12% of officials (of 600 positions in the parliament, cabinet, or higher judiciary committee or in the role of district councillor) were women:

- 14% of positions in the higher judiciary committee;
- 14% of district councillors; and
- 3% of parliament seats.⁷²

Somaliland

As of March 2017, there were four female ministers in the Somaliland Government.⁷³ Women have traditionally be excluded from the 82 seats in the House of Elders, but in 2012 a woman took a seat which had previously been occupied by her husband. In 2013, two women took seats in the 86-seat House of Representatives.⁷⁴

The challenges women face to becoming active in Somaliland political life are generally rooted in the patriarchal nature of political and clan systems and the lack of support for young women to pursue political careers. University College London's Barlett Development Planning Unit produced a document in 2015 that surveyed members of the Somaliland community regarding women in politics. They found a wide variation in respondents' level of support for female representation in government. However, there was resounding agreement among all respondents, male and female, that women could not stand for senior positions such as president, judge or imam.⁷⁵



Women casting their votes in Somaliland's 2017 presidential election

Employment

South/Central Somalia

Under Somali law, women are entitled to receive equal pay for work.⁷⁶ Somali women working in the private sector and public service and institutions are entitled to 14 weeks' paid maternity leave, (50% of their normal pay from their employer).⁷⁷ However, only 33% of employed women in South/Central Somalia are employed in the non-agricultural sector, so many employed women would not be receiving these benefits.⁷⁸

In al-Shabaab-controlled areas, women are discouraged from working and owning businesses.⁷⁹ In other areas, it is more common for women to own or manage businesses.

As of 2012, 74% of women in South/Central Somalia were unemployed, compared to 61% of men.⁸⁰ There are more young women who are neither working nor attending school (27%) than there are young men in the same position (15%).⁸¹

Puntland

41% of women and 57% of men are in the labour force in Puntland.⁸² 78% and 67% of those women and men, respectively, are employed in the agricultural, forestry and fishery industries.⁸³ 86% of women in Puntland are subsistence farmers.⁸⁴ 19% of civil service workers were women as of 2011.⁸⁵

The employment rates for women are lower than for men in all demographic groups (urban residents, rural residents, nomadic groups and IDPs). The group with the highest employment rate is the nomadic population, among whom 60–70% of men and women are employed.⁸⁶

The Puntland Government concedes that women may face certain challenges to engaging in business, such as 'limited financial resources, poor access to credit and other banking services, existing imbalanced gender roles and norms, gender discrimination, [and a] lack of access to proper knowledge, education and skills.'⁸⁷

Somaliland

80% of the population of Somaliland is unemployed and 55% of the population are nomads. As of 2014, an estimated 19% of civil service workers were women; however, most were cleaners or administrative workers.⁸⁸

Marriage and Divorce

It is estimated that 58% of women in Somalia and Somaliland are married. Marriage is the most common marital status for women over the age of 15.⁸⁹

Article 28(5) of the Constitution of Somalia states, 'No marriage shall be legal without the free consent of both the man and the woman, or if one or both of them have not reached the age of maturity.'⁹⁰

Despite this, early and forced marriages are common practices in the region. The S-MICS 2006 found that a quarter of women aged 15–19 are married – 7.7% before the age of 15 and 46% before the age of 18.⁹¹ World Vision found in 2014 that 16.8 million women worldwide were married

before the age of 18; 8% before the age of 15.⁹² The 2013 Human Rights Report for Somalia states that marriage with a young girl is being used as a military recruitment tool.⁹³

Early marriage is also common in Puntland, where:

- 12% of women aged 15–45 were married before they were 15;⁹⁴
- about 35% of women aged 20–49 were married before they were 18;⁹⁵
- women are more likely to be married at a young age if they are from poorer households; and⁹⁶
- 38% of women and 51% of men believe it is acceptable for a women to be married before she is 15.⁹⁷

In the event of a separation, the mother usually receives custody of male children up to the age of ten and female children up to the age of 15.⁹⁸

Family Planning

South/Central Somalia

The fertility rate in Somalia has declined;⁹⁹ however, there is a large unmet need for family planning.

Article 15(5) of the Constitution allows abortion only in ‘cases of necessity’ – generally where the mother’s life is at risk.¹⁰⁰ Abortion is at odds with Sharia.

Decisions regarding reproduction were often determined by a woman’s husband. Women had very limited ability to decide freely and responsibly the number, spacing, and timing of their children. Women had very limited information about and little, if any, access to contraception.¹⁰¹

A mere 1.5% of women aged 15–49 have access to a modern method of contraception. Obstetric and postpartum care, and delivery accompanied by a skilled birth attendant are rare. The maternal mortality ratio (MMR) is 732 deaths per 100,000 live births,¹⁰² ‘due to complications during labor that often involved anemia, FGM/C, and/or the lack of medical care.’¹⁰³

Puntland

11.4% of married women aged 15–49 have an unmet need for family planning (meaning that they do not use contraceptive methods but do not wish to have more children).¹⁰⁴

38.5% of live births in the two years prior to the 2011 MICS were attended by medical personnel – this is more common in urban areas and among younger mothers; however, 72.1% of women received no antenatal care.¹⁰⁵

Somaliland

The MMR in Somaliland dropped as the number of deliveries performed by a skilled attendant rose from 27% in 1999 to 41% in 2006.¹⁰⁶ In the two years prior to the 2011 MICS survey, 30.6% of births took place in healthcare facilities.¹⁰⁷

Expectations of Women in the Family Environment

In general, men are designated the head of a household,¹⁰⁸ and although women are expected to get an education, they are also expected to be homemakers,¹⁰⁹ supporting their husbands. However, up to 80% of IDP households are headed by women.¹¹⁰

Girls are expected to marry when they come of age, if not beforehand.¹¹¹

In April 2002, a UN independent expert on the region found that women and girls who had disobeyed their husbands had been detained in detention centres in Somaliland and Puntland, in conditions that were described as 'close to inhumane.'¹¹²

The OECD Development Centre has found that, since the civil war, women's autonomy and authority in the household has been increasing. 79% of women in 2002 made decisions or were consulted regarding the family budget; 81% regarding the education of their children; and 50% regarding selling household produce.¹¹³

Many Somali women in South/Central Somalia do not have an active or equal role in household decision-making, due to the patriarchal nature of most Somali families and households. Women are generally expected to stay at home and look after the children and livestock. Many women (or children) are also responsible for collecting water from scarce resources, often far from the home.¹¹⁴

In **Puntland**, although men head 80% of households, women are 'highly valued by society, and this was a driving force behind education of the community.'¹¹⁵

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- 15 OECD Development Centre (2014a), *op. cit.*
- 16 UNDP Somalia (2012), *op. cit.*, p.23.
- 17 *Ibid.*, p.51.
- 18 OECD Development Centre (2014a), *op. cit.*
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- 24 Ministry of Planning and International Cooperation, *op. cit.*, p.68.
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Image p.49: Free Wind 2014 (2010) *Somalis in the streets of the city of Hargeysa. City in Somalia, capital of unrecognized state of Somaliland. Much of the population lives in poverty*. Shutterstock ID 180309380.

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FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Somalia and Somaliland. Other sections of this report give more detailed analyses of FGM prevalence set within anthropological and sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

None of the recent country-wide surveys for Somalia and Somaliland break down the prevalence of FGM according to respondents' **ethnicity** or **religion**, and there is no evidence from other sources to inform these criteria.

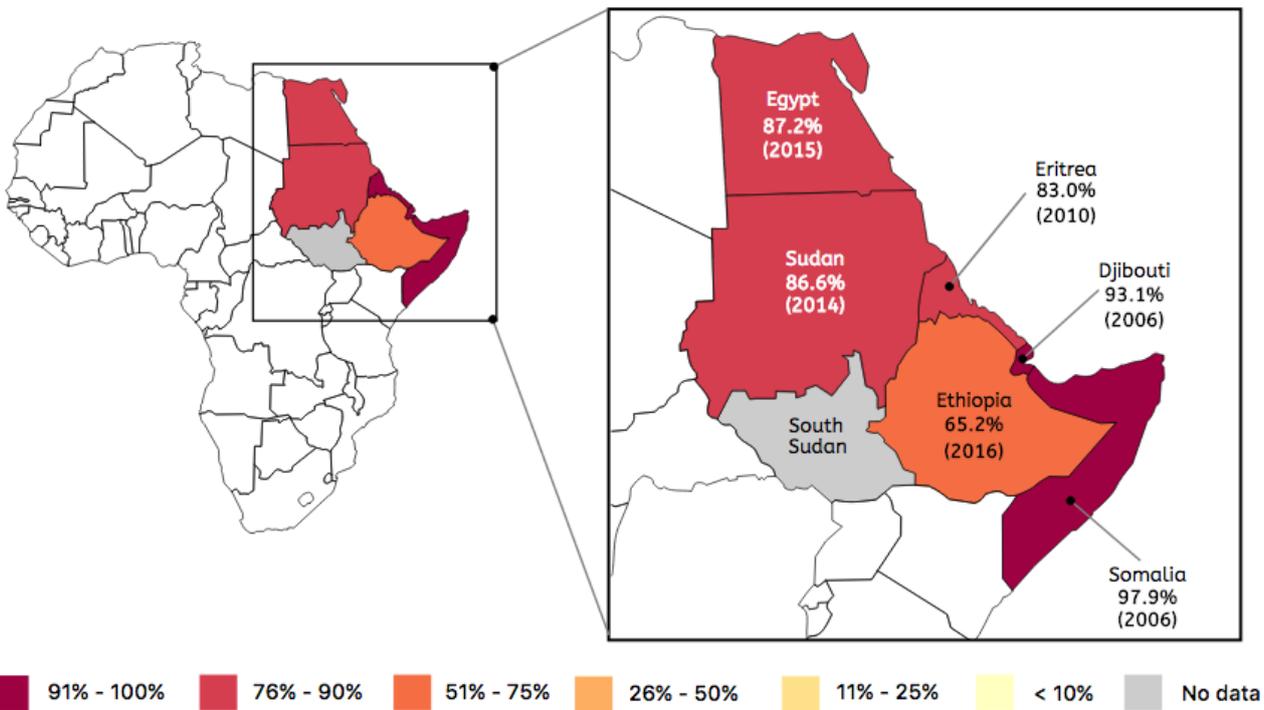


Figure 4: Prevalence of FGM in north-east Africa¹ (@28 Too Many)
Please note that the dates of these figures vary from 2006 to 2016

National Trends

Women (Ages 15–49)

Despite the MICS survey data, anecdotal evidence from activists in both Somalia and Somaliland suggests the opposite; that there has been a recent decline in some, usually more urban, areas.

Based on the MICS surveys, **Somalia and Somaliland are classified as ‘very high prevalence countries’**, having FGM prevalence of approximately 98% (Somalia) and 99.1% (Somaliland) among women aged 15–49.²

In **Somalia**, FGM prevalence has remained consistent for some time.

In **Somaliland**, the S-MICS 2006 and the SL-MICS 2011 indicate that the prevalence of FGM has increased from 94.4% to 99.1%; however, due to various challenges related to data collection, further data would be required to confirm that there has been a genuine upward trend in cutting.³

Year of Survey	Whole Region	North-East Zone of Somalia (Puntland)	South/Central Somalia	Somaliland
2006	97.9%	98.1%	99.2%	94.4%
2011	–	98.0%	–	99.1%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SL-MICS 2011; SNE-MICS 2011

Table 3: Prevalence of FGM among women in certain areas of the Somalia/Somaliland region

A study performed at the Edna Adan University Hospital (EAUH) in Hargeisa, Somaliland, in which data was collected in two stages, 2002–2006 and 2006–2013, found that the prevalence of FGM was 96.6% in 2002–2006 and 98.4% in 2006–2013. It should be noted that these figures are based on physical examinations of pregnant women, rather than on self-reporting, but they represent only the women visiting the hospital for antenatal appointments rather than the female population of Hargeisa as a whole.

According to the NAFIS Network report, 99.8% of the women surveyed had undergone FGM – 100% of those who lived in rural areas and 99.4% of those who lived in urban areas.⁴

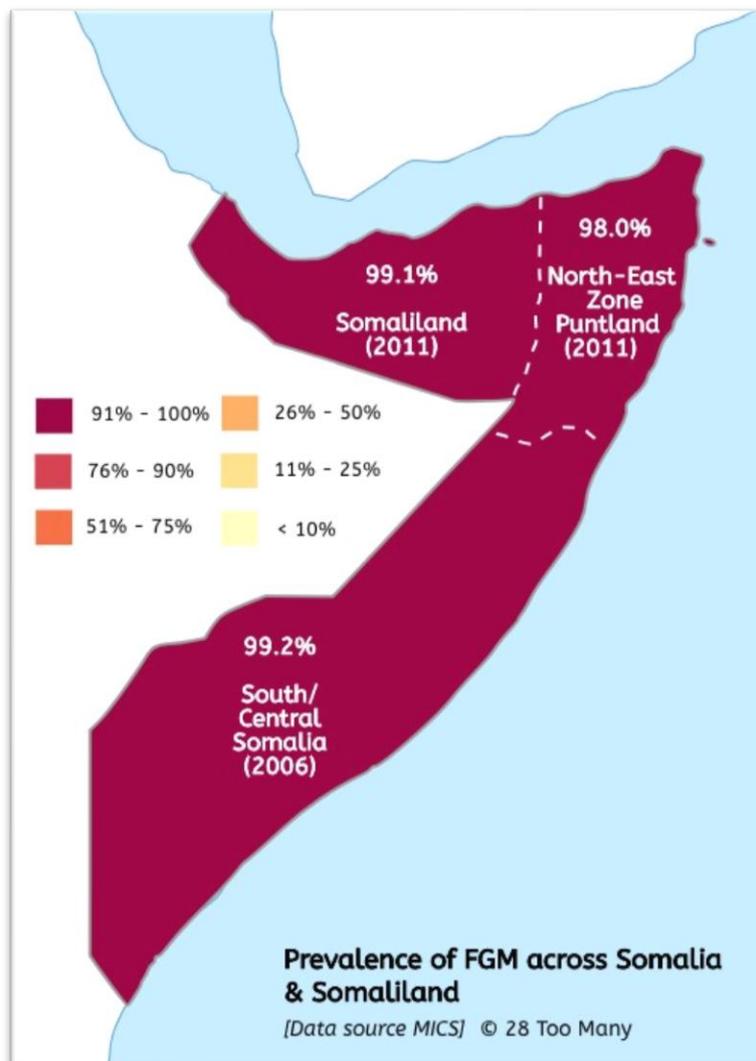


Figure 5: Prevalence of FGM across Somalia and Somaliland (@28 Too Many)⁵

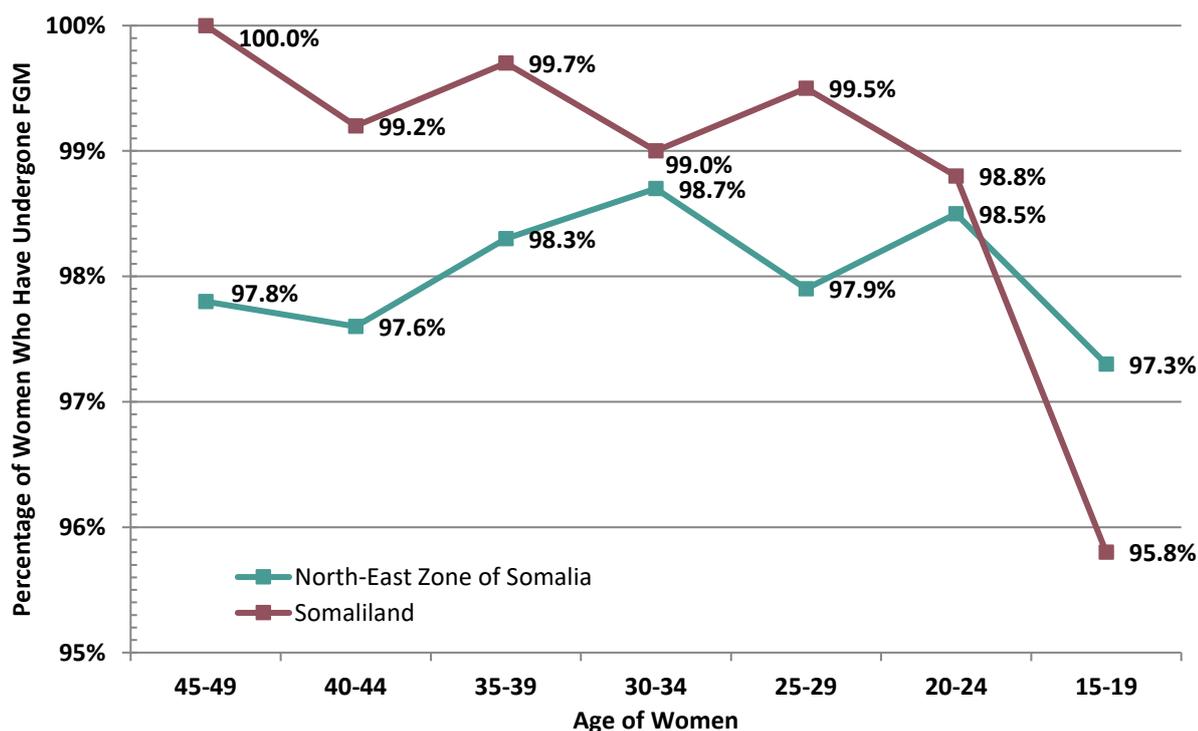


Figure 6: Prevalence of FGM in women of different age-groups (2011)⁶

The prevalence of FGM in both Somaliland and the North-East Zone of Somalia (Puntland) in 2011 appeared to be consistent across all age cohorts.

According to cutter Asha Ali Ibrahim, the **cutting season** in Somalia and Somaliland is from June to August.⁷

Daughters (Ages 0–14)

It is not possible to compare the available data for daughters (girls aged 0–14) in 2006 and 2011, as the 2006 survey shows the percentage of *women with at least one living daughter* who had undergone FGM, whereas the 2011 surveys show the percentage of *all daughters of the women surveyed* who had been cut.

The 2006 figures, therefore, could be expected to be higher than the 2011 figures, since women may have more than one daughter and they may not all have been cut. Table 4 shows that this is indeed the case; however, this is not an indicator that fewer daughters are being cut.

Year of Survey	Whole Region	North-East Zone of Somalia (Puntland)	South/Central Somalia	Somaliland
2006	46.0%	37.2%	47.6%	45.3%
2011	–	30.6%	–	27.7%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SL-MICS 2011; SNE-MICS 2011

Table 4: Percentage of women with at least one living daughter who has been cut (2006) and percentage of all daughters of all respondents who have been cut (2011)

The prevalence of FGM among daughters (see Table 4) appears to be much lower than it is among women; however, many of these girls may yet undergo FGM and the *figures for daughters and women should therefore not be directly compared*.

The NAFIS Network study found that 81% of women surveyed had daughters; of those women, 58.4% of them said that their daughters had been cut (75.3% of those living in rural areas and 27.1% of those living in urban areas). However, when those whose daughters had not yet been cut were asked if they planned to have them undergo FGM, 90.5% said that they were (88.9% of those living in rural areas and 91.5% of those living in urban areas). This supports the argument that, although the prevalence of FGM in daughters appears to be lower than in women, it is merely because many daughters are yet to be cut.⁸

Prevalence of FGM According to Place of Residence

Women (Ages 15–49)

There is very little variation between the prevalence of FGM in women aged 15–49 in urban and in rural areas (see Table 5), although the data suggests that prevalence is slightly higher among women who live in rural areas than among those who live in urban areas, especially in Somaliland. This is supported by the data present in ActionAid’s 2016 report, *Empowering Communities to Collectively Abandon FGM/C in Somalia*, which found that 98.7% of the women surveyed in urban areas and 99.8% of the women surveyed in rural areas had been cut.⁹ However, the differences between urban and rural are so small that no significant conclusions can be drawn and more study would be required to confirm whether this is a genuine trend.

Place of Residence	Whole Region (2006)	South/Central Somalia (2006)	North-East Zone of Somalia (Puntland) (2006)	Somaliland (2006)	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Urban	97.1%	99.1%	97.5%	93.5%	98.0%	98.7%
Rural	98.4%	99.4%	98.5%	95.4%	98.1%	99.6%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SNE-MICS 2011; SL-MICS 2011

Table 5: Prevalence of FGM (among women) according to area of residence

Daughters (Ages 0–14)

Overall, there is not a vast difference between the prevalence of FGM in daughters living in urban areas and the prevalence in those living in rural areas (see Table 6). However, according to the 2011 data, in contrast to other African countries and the data for women, daughters living in rural areas are slightly less likely to experience FGM than those living in urban areas. Again, it is important to note that the 2006 and 2011 figures cannot be directly compared with each other, as they are the result of different survey questions.

Place of Residence	Whole Region (2006)	South/Central Somalia (2006)	North-East Zone of Somalia (Puntland) (2006)	Somaliland (2006)	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Urban	47.7%	50.1%	37.1%	46.0%	33.0%	30.5%
Rural	45.0%	46.3%	37.2%	44.7%	26.2%	25.1%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SNE-MICS 2011; SL-MICS 2011

Table 6: Prevalence of FGM (among daughters) according to area of residence (PLEASE NOTE THAT 2006 and 2011 figures cannot be directly compared with each other)

Prevalence of FGM According to Economic Status

Women (Ages 15–49)

In 2006, survey data indicated a slight trend in the Somalia/Somaliland region as a whole towards a lower prevalence of FGM among wealthier women. This trend appears to be driven by Somaliland, as it had the greatest difference in FGM prevalence between wealth quintiles: 96.1% of the poorest quintile and 91.7% of the richest. In South/Central Somalia, FGM prevalence was fairly consistent across all wealth quintiles, and in the North-East Zone (Puntland) there was no obvious trend.

However, in the 2011 survey data for Somaliland, the trend was much less distinct; therefore, more data is required to fully understand the trends in FGM prevalence in relation to economic status.

Wealth Quintile	Whole Region (2006)	South/Central Somalia (2006)	North-East Zone of Somalia (Puntland) (2006)	Somaliland (2006)	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Poorest	98.4%	98.9%	100%	96.1%	98.2%	99.8%
Second	99.1%	99.7%	97.9%	97.1%	98.2%	99.5%
Middle	98.4%	99.3%	96.8%	96.5%	97.7%	99.5%
Fourth	97.5%	98.9%	99.0%	94.3%	98.1%	99.2%
Richest	96.2%	99.4%	97.3%	91.7%	97.9%	98.0%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SNE-MICS 2011; SL-MICS 2011

Table 7: Prevalence of FGM (among women) according to wealth quintile

Daughters (Ages 0–14)

Wealth Quintile	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Poorest	25.1%	22.0%
Second	28.7%	26.2%
Middle	29.6%	30.3%
Fourth	32.6%	29.2%
Richest	36.9%	32.5%

In contrast to women, girls in the richer wealth quintiles appear to be more likely to undergo FGM. This trend is most distinct in the North-East Zone (Puntland), although also very noticeable in the data for Somaliland. More research needs to be done to determine why this is the case.

Key: SNE-MICS 2011; SL-MICS 2011

Table 8: Prevalence of FGM (among daughters) according to wealth quintile

The **Somaliland Family Health Association**, as part of its current Mid-Term Review, is undertaking a new data analysis in partnership with the **Orchid Project**.

Though the sample size is small and not necessarily representative of the whole region, initial key findings shared with 28 Too Many suggest that no shift has been observed in overall FGM prevalence and it appears that young people have moved towards favouring sunna with stitches or ‘pricking’, but only a very small minority expressed support for total abandonment. Results of this survey are still being analysed, and the report will be published during 2019. It will include, for the first time, data on the prevalence of girls aged 5–15 in Somaliland.

Age of Cutting

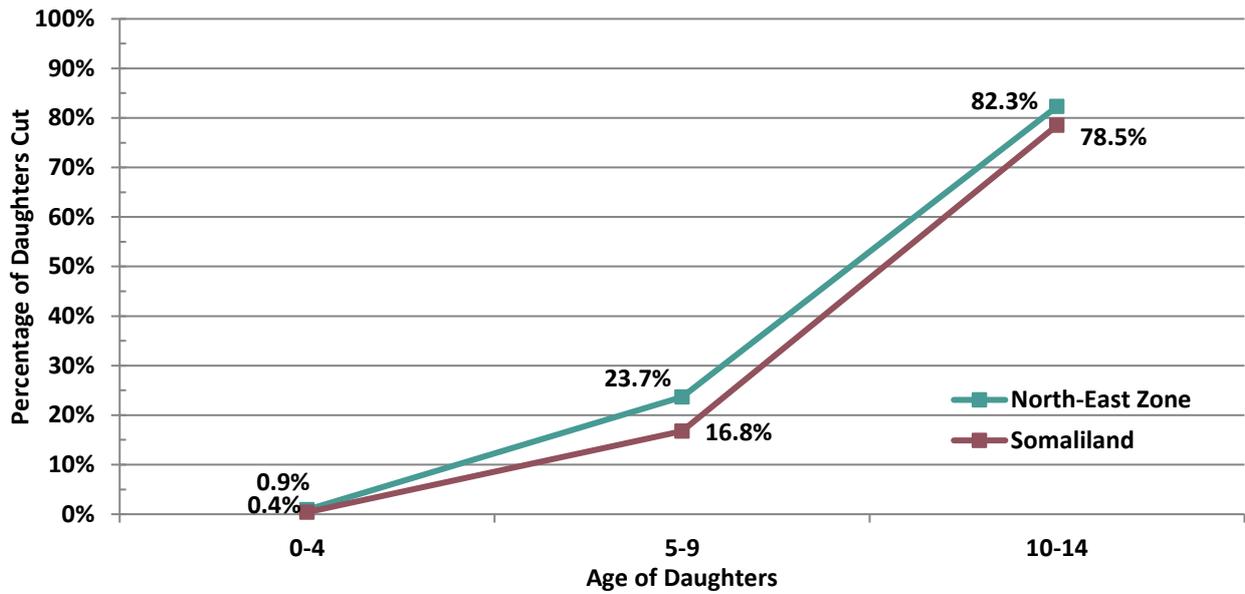
Women (Ages 15–49)

Data from the EAUH reveals that women in Somaliland were most commonly cut at seven or eight years of age (modal age = 7; mean age = 8) and that there has been no observable change over time to the average age of cutting among the women surveyed.¹⁰

Daughters (Ages 0–14)

The MICS data shown in Figure 7 indicates that the majority of girls (aged 0–14) are now cut between the ages of 10 and 14 (as opposed to seven or eight, as was the case for older women).¹¹ This suggests that the average age of cutting has risen over time. The survey by the EAUH, however, did not find an observable change in the average age of cutting for women. (It should be noted that the EAUH survey data includes female respondents down to the age of 12.)

News stories in recent years regarding deaths from FGM have involved Somali girls aged around 10 or 11, which does tie in with the trend suggested by the MICS data.



Key: SNE-MICS 2011; SL-MICS 2011

Figure 7: Prevalence of FGM (among daughters) according to age at time of survey¹²

Although the prevalence of FGM in women (aged 15–49) in Somaliland is higher than the prevalence in girls under 15, Figure 7 shows that this is because many younger girls are yet to be cut.

Types of FGM Practised and Practitioners

We are people who have a long history of circumcising girls. We moved from the Pharaonic to a milder form and further to the mildest form. I think if total abandonment is suggested, there is nobody who is going to accept it.

~ a 35-year-old woman

Data on the types of practitioners used in Somalia is unavailable; however, 28 Too Many understands from its research and conversations with activists that FGM is mostly performed by traditional cutters. Medicalised FGM, however, appears to be on the rise as more families, particularly in urban and semi-urban areas, take their daughters to healthcare centres to be cut.

The EAUH report found that in Somaliland, overwhelmingly, FGM is performed by traditional birth attendants or old women, and that there has been a recent shift towards the use of traditional birth attendants. This data, however, is only for respondents living in Hargeisa (the capital of Somaliland); additionally, it must be questioned how clearly defined the distinction between ‘traditional birth attendant’ and ‘old woman’ was to the survey participants.

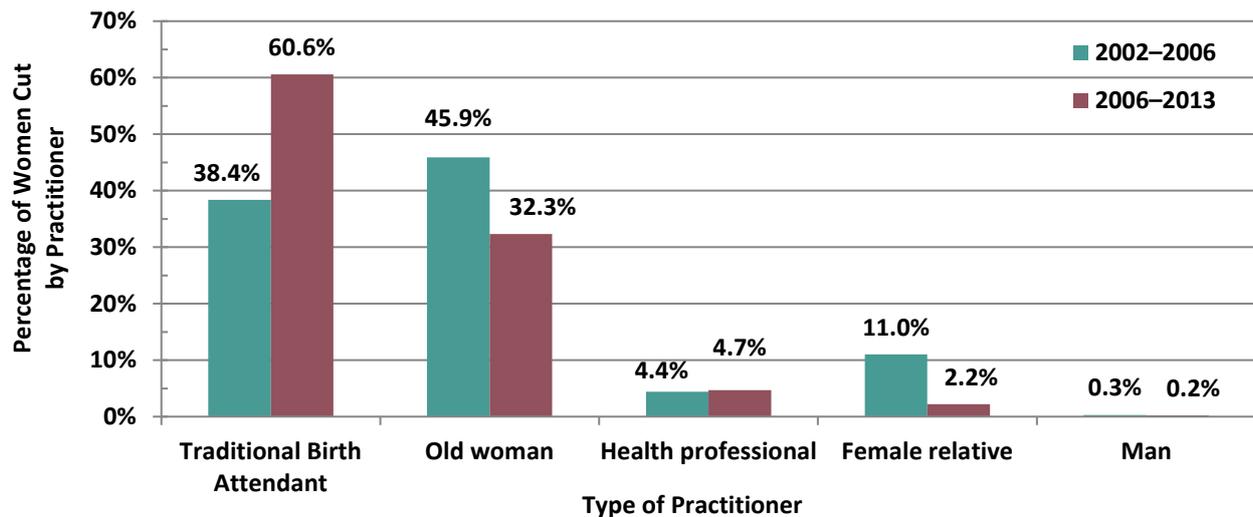


Figure 8: Percentages of women cut by type of practitioner (Somaliland)

ActionAid reports that 5% of women in Somaliland were cut by a health professional (a doctor, nurse or midwife) but that 14% of girls aged 12–14 were cut by a health professional, suggesting an increase in **medicalised FGM**.¹³

The NAFIS Network reports that, of the women surveyed who had undergone FGM, 99.5% of those who lived in rural areas and 95.7% of those who lived in urban areas were cut by traditional agents; the remainder were cut by a health worker. However, of the women surveyed who wished their daughters to undergo FGM, 75.6% of those living in rural areas and 60.9% of those living in urban areas wish for it to be performed in a health centre.¹⁴ This supports the observation that medicalised FGM is an increasing trend.

For detailed information about the medicalisation of FGM, please see 28 Too Many's report, which is available at <https://www.28toomany.org/thematic/medicalisation/>.



*CCBRS providing awareness training to traditional birth attendants and circumcisers in Somaliland
(© CCBRS)*

NAFIS NETWORK SURVEY OF CUTTERS IN SOMALILAND

In 2016 the NAFIS Network of NGOs conducted a mapping exercise and assessment of FGM cutters in Somaliland. 128 cutters were interviewed across three regions, of which more than half (56.3%) lived in urban areas, 14.9% in semi-urban areas, 18% in rural areas and 11% in IDP camps. It may be assumed the majority, if not all, were female, as the report refers to the skill being learnt from mothers, grandmothers and aunts. The age-range of cutters spanned from 25 to 83, with an average age of 52. Three-quarters (75.2%) were married and almost a fifth (18.4%) were widowed. More than two-thirds (64.8%) had never attended school; only 12.5% had attended secondary school or above.¹⁵

The study found that the practice is mostly passed down through generations of the same family. Some cutters are also traditional birth attendants, passing on the skill to their peers. 78% said they carried out both the sunna and Pharaonic types of FGM; many said they do not perform the Pharaonic type because of the harm it causes girls, citing kidney problems, 'too much' bleeding and infections.¹⁶

Among the descriptions of FGM and the reasons given for continuing it were that it 'gives beauty and purity to girls' and 'preserves the culture and long held traditional practice inherited from our ancestors'.¹⁷ NAFIS's analysis notes that, although 27.4% of cutters cited 'religious reward' as a reason for continuing the practice, none were able to cite a reference in the Quran or Hadith to support this belief.¹⁸ 92.5% of cutters interviewed said they were 'respected and valued for their services' and that they are received warmly when they visit villages.¹⁹

Conversely, nearly half (48.1%) reported that they began to have doubts about the requirement for FGM under Sharia law after they were exposed to media messages and teachings by religious scholars about the harm of FGM.²⁰ Unfortunately, this has not necessarily led to the elimination of FGM: rather, it has led to a reduction in the Pharaonic cut. For example, one cutter stated, 'One of the Sheiks told us that there is no sunna unclean or filthy part of a girl's body[,] so we only cut the smallest possible[,] not bigger than a single grain of wheat or sorghum.'²¹

42% said they continue the practice because it is their livelihood; 24% described it as their 'profession'; 21% said it is part of their heritage; and 8% believed it is a religious obligation. On average, a cutter performed FGM on 17 girls a month and had served an average of 813 families since they started their practice.²² Payment was approximately US\$35 for Pharaonic circumcision and US\$17 for sunna. Some also received non-cash benefits such as milk and meat.²³

Encouragingly, 17.2% of respondents said they have stopped performing FGM.²⁴ Reasons given for abandoning the practice include training and awareness of its harmful effects on girls; provision of income-generating alternatives; and harmful consequences to themselves, including arrest and imprisonment.²⁵ Many said they would be willing to give up the practice if they were given an alternative job or means of generating income: 'If we have to quit our profession . . . we have to be given skill training on our midwifery [so] . . . we would be able to apply [for] a permanent job in the government . . .'²⁶

The study concluded that there is a trend towards reduced Pharaonic FGM in favour of sunna, but not towards total abandonment. It was clear that practising FGM is a profitable livelihood, in particular carrying out Pharaonic FGM. On the positive side, there is greater awareness of the harm that FGM inflicts on girls and interest in pursuing an alternative livelihood if one were available.²⁷

An article reporting on a study conducted in Galkaayo (Puntland) and Hargeisa (Somaliland) from 2011 to 2012 discusses the difficulty in recording and reporting on the **types of FGM practised in the Somalia/Somaliland region**.²⁸

The majority of participants in the study divided FGM into ‘Pharaonic’, which is Type III under the WHO classifications (see page 17), and ‘sunna’. Additionally, there were two types of sunna mentioned by participants, both commonly believed to cause no health problems:

One is where a drop of blood is obtained from the clitoris, or the tip of the clitoris is incised, while the other type is called Kaatun [ring], which most commonly involves the removal of the prepuce. The clitoris is either removed totally or partially, and then two stitches are made.

~ a Somalian cutter

However, other participants reported sunna as being even more extreme and distinguished between Pharaonic and sunna simply by the amount of suturing required.

All the participants in the study supported the continuation of FGM, many stating that the move to abolish FGM ‘has no room in their culture’; for example:

In our culture there are no uncircumcised girls. Girls should be either circumcised with Pharaonic circumcision or the way the religion accepts [sunna].

~ a 40-year-old Somali man

The researchers concluded that the way FGM is categorised in surveys and discussions needs to be considered more closely – the failure to understand different interpretations of the types of FGM may cause incorrect conclusions.

A 2014/15 situational analysis²⁹ further elaborates on this subject and explains that in Somalia there are different understandings of what the term ‘FGM/C’ means:

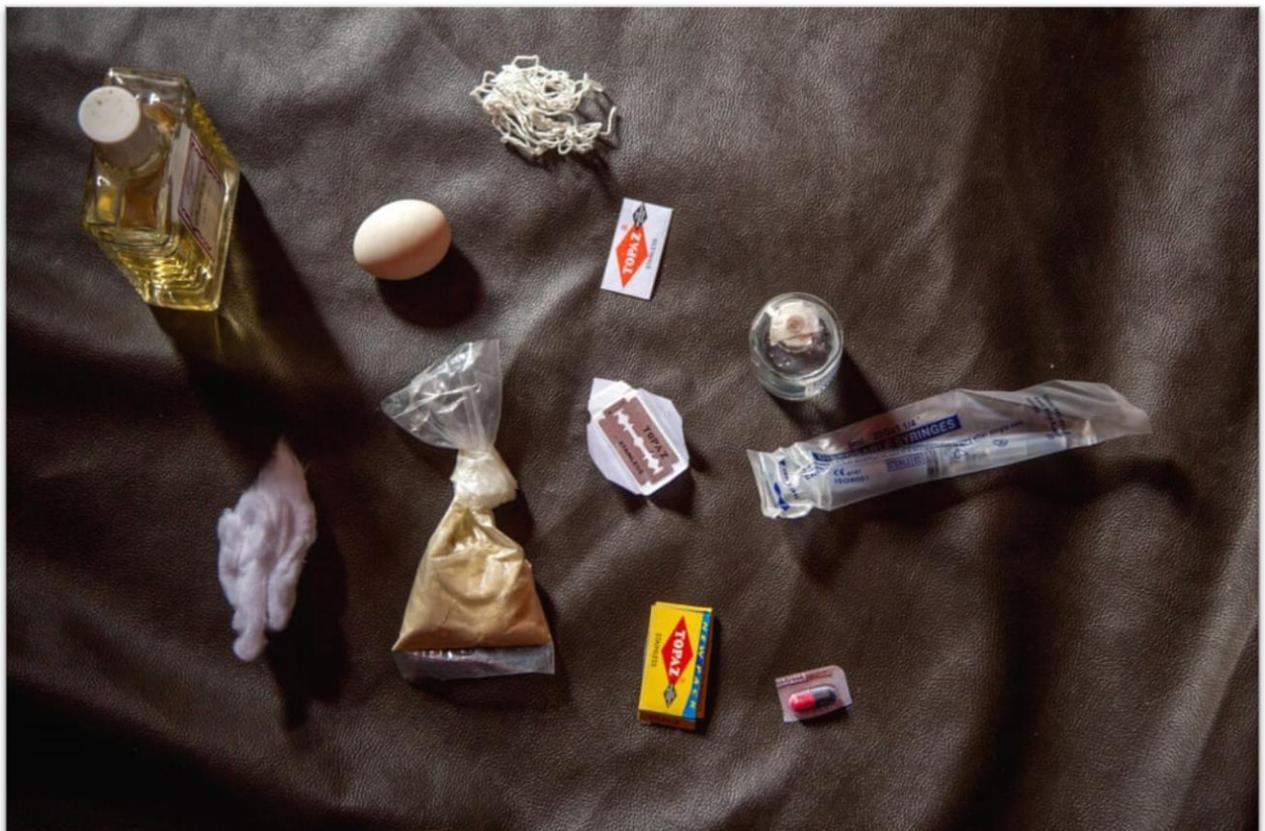
The term is interpreted in Somalia to refer to only one type of FGM/C, which is Pharaonic FGM/C (Type III, with removal of the clitoris, inner and outer labia, and infibulation). However, in all regions in Somalia, the term Sunnah circumcision can refer to Type I, Type II or Type III FGM/C. ‘Sunnah’ is used in the communities to refer to any type of circumcision which people believe is required/sanctioned by Islam. This wide interpretation differs from the use of the term Sunnah circumcision by other Muslim populations (and by the UN and WHO) who use it to refer only to Type I FGM/C.

In the communities, two variations of Type III FGM/C were reported: a form of infibulation, which involves less stitching and which is known locally as Sunnah Kabiir (greater Sunnah) and, Fadumo Hagoog, a form of Type III FGM/C, which involves excision but no stitching. There are also reports of a form of Type III in which there is infibulation, but no cutting.³⁰

The analysis notes the Government of Somalia's work since the 1980s towards the elimination of Type III forms of FGM, alongside encouragement by some NGOs to abandon only Pharaonic FGM. As a result, there is now a significant variation in the types of FGM/C that are labelled 'sunna', including very extreme forms. As doctors note, this is because

The population is not educated/nor consistent in their definitions of types of FGM/C and the cutters themselves are not even aware of what Sunnah (Type Ia or Type Ib) is and will often perform various forms of FGM/C that are more severe than Type I and claim that it is Sunnah to the parents.

~ Dr Habiba Ismail, Garowe Hospital, Puntland³¹



***Tools used by a Somali cutter to carry out FGM:
razors, kerosene to clean the wound, an egg used as glue to stop the bleeding,
a syringe and a numbing agent. A powder concoction that includes sugar and
crushed Ampicillin antibiotic capsules is deployed to stop excessive bleeding
and fight infection (© Georgina Goodwin/UNFPA)***

Women (Ages 15–49)

In 2006 and 2011, Type III (Pharaonic) FGM was overwhelmingly the most common type of FGM self-reported by women (see Table 9).

Type of FGM	Whole Region (2006)	South/Central Somalia (2006)	North-East Zone of Somalia (Puntland) (2006)	Somaliland (2006)	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Flesh Removed	15.2%	21.0%	2.9%	5.7%	5.7%	8.6%
Nicked	1.3%	1.4%	1.7%	1.1%	1.4%	2.7%
Sewn Closed (Type III/Pharaonic)	79.3%	72.2%	93.2%	91.6%	86.7%	84.9%
Undetermined	4.2%	5.5%	2.1%	1.6%	4.2%	3.0%

Key: CALCULATED FROM THE S-MICS 2006 DATASET; SNE-MICS 2011; SL-MICS 2011

Table 9: Percentages of women with different types of FGM in the Somalia/Somaliland region

In 2006, in the North-East Zone of Somalia (Puntland) and Somaliland, more than 90% of women who had undergone FGM had undergone Type III (as opposed to 79.3% overall), but by 2011 this figure had dropped to about 85%. This is a substantial drop over the period.

Breaking down the data for the North-East Zone (Puntland) and Somaliland into age cohorts (see Tables 10 and 11) suggests that this trend is driven by the younger cohorts of women being less likely to have experienced Type III FGM and more likely to have had ‘flesh removed’.

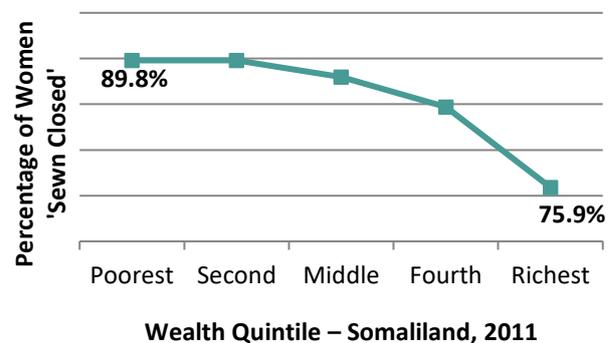
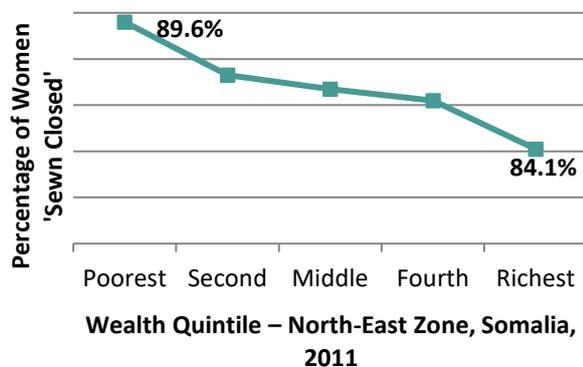
Type of FGM	Age Group of Women						
	15–19	20–24	25–29	30–34	35–39	40–44	45–49
None	2.7%	1.5%	2.1%	1.3%	1.7%	2.4%	2.2%
Flesh Removed	9.6%	6.0%	4.3%	4.4%	3.8%	4.4%	4.1%
Nicked	2.3%	1.8%	1.1%	1.4%	0.3%	0.9%	1.3%
Sewn Closed (Type III/Pharaonic)	79.7%	85.4%	89.0%	89.3%	90.2%	90.4%	89.5%
Undetermined	5.7%	5.3%	3.6%	3.6%	4.1%	2.0%	3.0%

Table 10: Percentage distribution of different types of FGM in women living in the North-East Zone of Somalia, according to age group³²

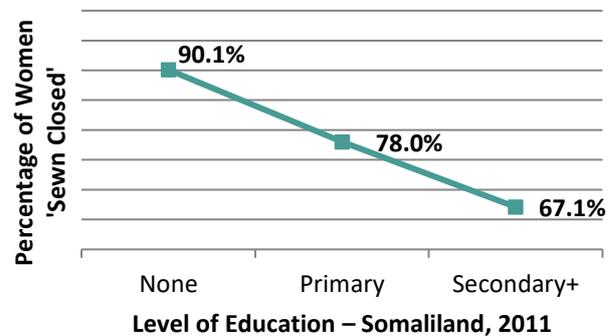
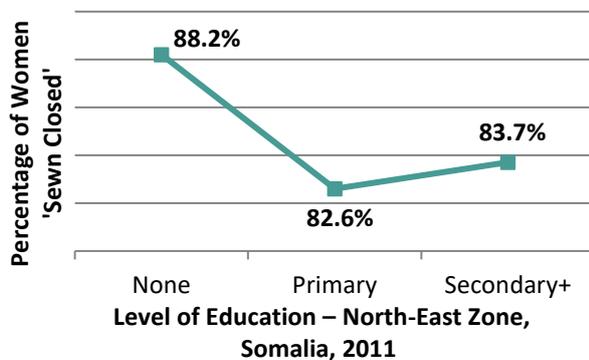
Type of FGM	Age Group of Women						
	15–19	20–24	25–29	30–34	35–39	40–44	45–49
None	1.5%	1.2%	0.5%	1.0%	0.3%	0.8%	0.0%
Flesh Removed	16.8%	11.6%	5.9%	3.3%	3.0%	3.0%	1.1%
Nicked	6.2%	3.7%	1.2%	0.7%	0.3%	0.4%	0.4%
Sewn Closed (Type III/ Pharaonic)	69.5%	78.3%	90.7%	94.4%	95.8%	95.9%	98.5%
Undetermined	5.9%	5.2%	1.8%	0.7%	0.6%	0.0%	0.0%

Table 11: Percentage distribution of different types of FGM in women living in Somaliland, according to age group³³

In 2011 in the North-East Zone of Somalia (Puntland) and Somaliland, there were differences in the percentages of women (aged 15–49) who experienced being ‘sewn closed’ (Type III FGM) between those who are richer and poorer and between those who have higher or lower levels of education: generally, the greater the levels of education and wealth, the lower the percentage who have been sewn closed, as shown below.



Figures 9(a) and (b): Percentage of women ‘sewn closed’ according to wealth quintile³⁴



Figures 10(a) and (b): Percentage of women ‘sewn closed’ according to level of education³⁵

However, as previously noted, the misunderstandings and changes in relation to what is considered sunna and what is considered Pharaonic means that this self-reported data should not be relied upon too heavily.

The data presented in the EAUH was obtained through physical examination and is, therefore, an unusual opportunity to separate the statistics on FGM type from the usual limitations of self-reporting. The cohort studied was only from that particular hospital (in Hargeisa) and is predominantly women between the ages of 20 and 34. However, it is in general agreement with the MICS data and does show a decrease in the prevalence of Pharaonic FGM between the two cohorts (the 2002–2006 study and the later 2006–2013 study).

ActionAid also reports that, overall, 80% of women and girls interviewed had undergone Pharaonic FGM (defined as ‘Cut clitoris and flesh removed from labia minor and/or major, sewn closed leaving very small vaginal orifice’). However, in girls aged 12–14, equal numbers (about 33%) had undergone ‘Pharaonic’, ‘Intermediate’ (defined as ‘Cut clitoris and some flesh removed, vaginal orifice sewn partially closed’) and ‘sunna’ (defined as ‘Clitoris nicked or tip removed (Clitoridectomy) no stitches required’) FGM. Of women over the age of 25, 96% have reportedly undergone Pharaonic FGM, so this would seem to confirm the trend away from the performance of Type III FGM.

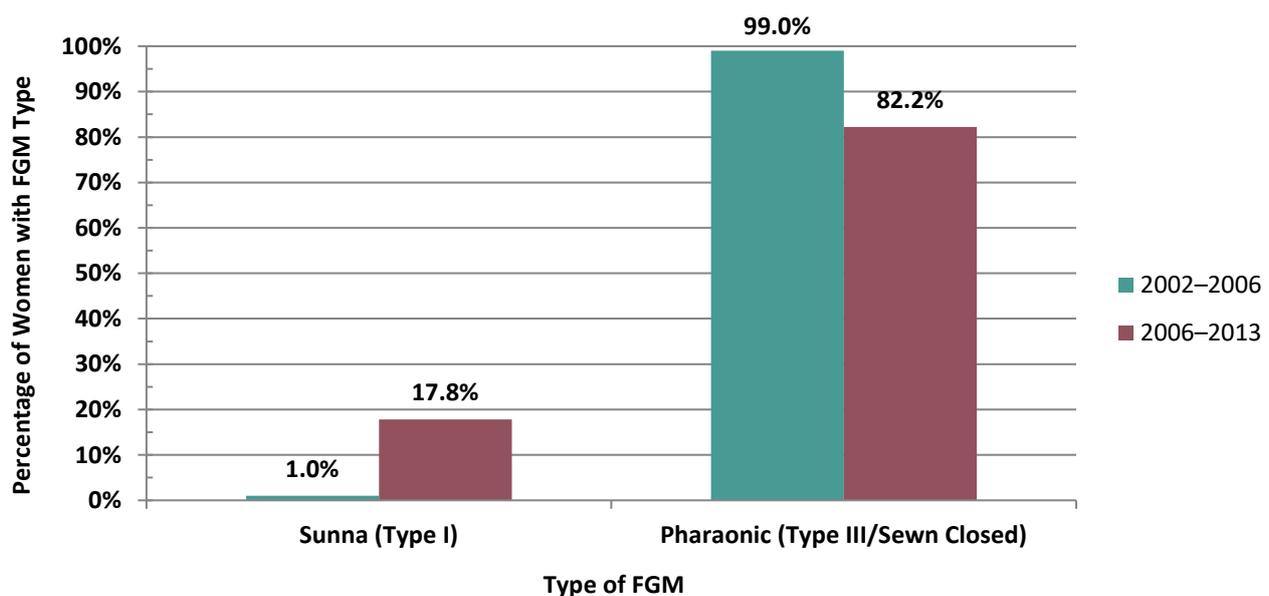


Figure 11: Comparison of two studies of different types of FGM found in women living in Hargeisa, Somaliland³⁶

The NAFIS Network reports that, of the 1,982 women surveyed who had undergone FGM, 564 of those living in urban areas had undergone Pharaonic FGM and 131 sunna. Of the women living in rural areas, 1,059 had undergone Pharaonic FGM and 228 sunna.³⁷

Daughters (Ages 0–14)

Type of FGM	North-East Zone of Somalia (Puntland) (2011)	Somaliland (2011)
Flesh Removed	4.7%	9.6%
Nicked	0.9%	3.3%
Sewn Closed (Type III/Pharaonic)	22.5%	11.6%
Undetermined	2.5%	3.2%

Key: SNE-MICS 2011; SL-MICS 2011

Table 12: Percentages of daughters with different types of FGM in the Somalia/Somaliland region

Again, the MICS data for 2006 and 2011 cannot be compared as the 2006 survey shows the percentage of women with at least one living daughter who had undergone FGM, whereas the 2011 surveys show the percentage of all daughters of all respondents, as discussed above.

As it was among women, ‘sewn closed’ was the most commonly reported type of FGM among daughters in 2011, although more so in the North-East Zone of Somalia (Puntland) than in Somaliland.

In contrast with the general trends, daughters of the women interviewed in the Maroodijeex/Saaxil and Awdal regions of Somaliland are more likely to have ‘flesh removed’ than they are to be ‘sewn closed’.³⁸ It would be worthwhile to research whether there are cultural or religious differences in these regions that may account for this difference.

The NAFIS Network reports that the vast majority of women surveyed, 92.8%, wished for their daughters to undergo the sunna form of FGM.³⁹

THE DATA AND INFORMATION GAP IN SOMALIA AND SOMALILAND

Throughout the course of this research, it has become very clear that there remains a huge gap in quality, up-to-date data on FGM for both Somalia and Somaliland. There have been no Demographic and Health Surveys undertaken, and MICS data is now eight years old for Somaliland and the North-East of Somalia (Puntland) and 13 years old for the region as a whole (see Note on Data on page 10). Reliable data is necessary to support the important work being undertaken to end FGM in the region.

Many NGOs and civil-society organisations have worked, often in partnership with others, to try to fill these information gaps themselves. As well as research reports produced at the international level by organisations such as UNICEF, ActionAid and the Population Council, many of the national anti-FGM networks and community-based organisations have had to invest vital funds in doing local surveys and producing research themselves to inform programmes. For example:

- **Action Youth in Development (AYID)** in Somaliland has reported to 28 Too Many the very poor availability of quality data on FGM and the lack of evidence-based knowledge to date on the drivers of the practice. AYID also notes that there is very limited and poor-quality monitoring and evaluation on FGM interventions in the region. Therefore, alongside its advocacy and awareness-raising activities within communities across all six regions of Somaliland, AYID tries to fill in some of this missing data and information by producing research to inform local programme managers and development partners. It has partnered with several organisations, including UNICEF, Oxfam, Mercy Corps, the Danish Refugee Council and the Girl Generation.
- **OpenStreetMap Somalia (OSM-Somalia)** is another important initiative that aims to rectify the lack of data. By mapping rural communities in northern Somalia, it provides local officials and community activists with detailed information that they can use to identify girls at risk of FGM and thus plan services and appropriate interventions. OSM-Somalia reports that, together with its advocacy work on FGM, the local collection, analysis and sharing of data has encouraged collaboration between law enforcement, the judicial system, women's and girls' protection committees, health services, community leaders, youth leaders and NGOs in applying reproductive health legislation and services.



AYID mobilises young people across Somaliland through its community development programmes, empowering women and youth in education, collaborating with universities, peacebuilding and preventing violence against women and FGM (© AYID)

- 1 **Click for source document:** Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Somalia: MICS 2006; Sudan: MICS 2014.
- 2 - UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, pp.26–27. Available at https://www.unicef.org/publications/index_69875.html.
 - S-MICS 2006, p.138
 - SL-MICS 2011, p.100.
 - SNE-MICS 2011, p.103.
- 3 *Ibid.*
- 4 NAFIS Network (2014) *Assessment of the Prevalence, Perception and Attitude of Female Genital Mutilation in Somaliland*, p.vii. Available at <https://nafisnetwork.net/wp-content/uploads/2018/10/FGM-Research-Report-2014-1.pdf>.
- 5 - Calculated from the S-MICS 2006 dataset.
 - SL-MICS 2011, p.100.
 - SNE-MICS 2011, p.103.
- 6 - SL-MICS 2011, p.100.
 - SNE-MICS 2011, p.103.
- 7 The Guardian (2017) *The curse of blades and powders: FGM in Somaliland – in pictures*, 11 August. Available at <https://www.theguardian.com/global-development/gallery/2017/aug/11/female-genital-mutilation-in-somaliland-in-pictures>.
- 8 NAFIS Network, *op. cit.*, pp.22 & 23.
- 9 Katy Newell-Jones (2018) *Empowering Communities to Collectively Abandon FGM/C in Somaliland*. ActionAid.
- 10 EAUH, p.31.
- 11 - SNE-MICS 2011, p.104.
 - SL-MICS 2011, p.101.
- 12 *Ibid.*
- 13 Katy Newell-Jones (2018) *Empowering Communities to Collectively Abandon FGM/C in Somaliland*. ActionAid.
- 14 NAFIS Network, *op. cit.*, pp.17 & 24.
- 15 NAFIS Network (2016) *Assessment & Mapping of FGM/C Circumcisers in Somaliland*, pp.18–19. Available at http://nafisnetwork.net/wp-content/uploads/2018/10/Assessment__Mapping_Circumcisers_in_Somaliland.pdf.
- 16 *Ibid.*, p.21.
- 17 *Ibid.*, p.26.
- 18 *Ibid.*, p.23.
- 19 *Ibid.*, p.28.
- 20 *Ibid.*, p.25.
- 21 *Ibid.*, p.25.
- 22 *Ibid.*, p.30.
- 23 *Ibid.*, p.30.
- 24 *Ibid.*, p.32.
- 25 *Ibid.*, pp.35–36.
- 26 *Ibid.*, p.39.
- 27 *Ibid.*, pp.42–44.
- 28 Abdi A. Gele, Bente P. Bø and Johanne Sundby (2013) 'Attitudes toward Female Circumcision among Men and Women in Two Districts in Somalia: Is It Time to Rethink Our Eradication Strategy in Somalia?', *Obstetrics and Gynecology International*, 2013. Available at <https://www.hindawi.com/journals/ogi/2013/312734/>.
- 29 Sheena Crawford and Sagal Ali (2015) *Situational Analysis of FGM/C Stakeholders and Interventions in Somalia*, pp.41–42. Available at <https://orchidproject.org/wp-content/uploads/2015/02/Situational-Analysis-of-FGMC-Stakeholders-and-Interventions-in-Somalia1.pdf>.
- 30 *Ibid.*
- 31 *Ibid.*, p.42.
- 32 SNE-MICS 2011, p.103.
- 33 SL-MICS 2011, p.100.
- 34 *Ibid.*
- 35 *Ibid.*
- 36 EAUH, p.30.
- 37 NAFIS Network (2014), *op. cit.*, pp.16–17.
- 38 SL-MICS 2011, p.101.
- 39 NAFIS Network (2014), *op. cit.*, p.24.

NGO Networks

When civil-society organisations come together, they can share vital experience and knowledge of best practice. They can also work as one to influence policy-makers to support and advance the protection of women and girls, particularly in relation to the efforts to end FGM.

There are several human-rights and anti-FGM networks operating across the region, including the NAFIS and Nagaad Networks in Somaliland. Below, we profile some of the work of the NAFIS Network.



*NAFIS Network
consultation meeting with
civil-society organisations
(© NAFIS Network)*

The Network Against Female Genital Mutilation in Somaliland (NAFIS Network)

Established in 2006 and based in Hargeisa, the NAFIS Network brings together 20 civil-society organisations working to end FGM across Somaliland. It provides a range of services, including capacity-building for member organisations through training and dialogue, awareness-raising and the sensitisation of government ministers and key religious and community leaders, community awareness-raising and support for FGM survivors. It also facilitates stakeholder meetings and undertakes research on FGM in Somaliland. The NAFIS Network is represented on the task force currently working to enact the new anti-FGM bill for Somaliland, which is in its consultation phase with government departments and stakeholders.



Current members of the NAFIS Network are as follows:

- Alkawnin Women Voluntary Organization (AWVO)
- Ayan women Development association (AYAN)
- Barwaaqo Voluntary Organization (BVO)
- Candlelight for Health Environment and Education (CLHE)
- Comprehensive Community Based Rehabilitation in Somaliland (CCBRS)
- Horn of Africa Voluntary Youth Committee (HAVAYOCO)

- Somaliland Health and Education Development Association (*SOHEADA*)
- Somaliland National Youth Organization (*SONYO*)
- Somaliland Women, Children and Disability
- Somaliland Women's Research and Action Group (*SOWRAG*)
- Somaliland Youth and Development Association (*SOYONDA*)
- Somali Red Crescent Society (*SRCS*)
- Taakulo Somaliland Community (*TASCO*)
- TAWAKAL
- Ubah Social Workers Organization (*USWO*)
- Voice of Somaliland Minority Women Organization (*VOSOMWO*)
- Women Action of Rights and Safety Network (*WARSAN*)
- Women Health and Education Development Organization (*WAHEDO*)
- Women Inter-Action Group (*WAIG*)
- Women Rehabilitation and Development Association (*WORDA*)

These member organisations often undertake anti-FGM activities as part of their wider human-rights work in Somaliland. FGM is often integrated into programmes around health and nutrition, livelihoods, education and environmental issues.

Candlelight, for example, focusses on environmental conservation, provision of quality education and awareness-raising around key health issues. Regarding FGM, it has been working with religious leaders in workshops to de-link FGM from Islam and discuss the health implications of the practice on women and girls. During a previous workshop in the Sheikh district of Somaliland, an influential video clip of Sheik Dirir clarifying the misconceptions around FGM and Islam was played to participants, who then drew up action plans committing to preach anti-FGM messages in their communities. Candlelight has also facilitated community dialogue in several rural villages and conducted sensitisation workshops for teachers in schools in the Sheikh district. Media has also been widely used, including a televised debate on FGM.

CCBRS and **TASCO** also provide sensitisation programmes for teachers and pupils in schools, and the **Somali Red Crescent Society** works extensively with the health sector and medical professionals on FGM advocacy and support.

NAFIS Network providing communication training to key stakeholders in Somaliland
(© NAFIS Network)



The Sustainable Development Goals

The eradication of FGM was pertinent to six of the UN's eight **Millennium Development Goals (MDGs)**, which reached their deadline in 2015. In September 2015 the UN adopted the **Sustainable Development Goals (SDGs)**, which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – **people, planet, prosperity, peace and partnership**.¹



Figure 12: The Sustainable Development Goals

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development*,² details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. **They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls.**

The SDGs go further than the MDGs and **make explicit reference to the elimination of FGM**. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.



Sustainable Development Goal 5: Achieve gender equality and empower all women and girls

Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality, such as **Goals 3 and 4** (for more detailed discussions in relation to these SDGs, see Education and Healthcare on pages 93 and 110).

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the **African Women's Decade**.³ This declaration will assist in promoting gender equality and the eradication of FGM and other forms of GBV in Somalia and Somaliland.

For more information on all 17 SDGs, please go to <http://17goals.org/>.



Supporting education for girls in Somalia and Somaliland is essential to reach SDG Goal 4

1 UN Department of Economic and Social Affairs (2015) *Transforming our world: the 2030 Agenda for Sustainable Development*. Available at <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

2 *Ibid.*

3 African Union (2011) *The African Women's Decade*, p.2. Available at <http://pages.au.int/carmma/documents/african-womens-decade>.

Image p.77: Free Wind 2014 (2010) *State University of Hargeisa, founded in 2000, more than 2,600 students, but higher education has short-term courses of improvement of qualification for teachers*. Shutterstock ID: 173086544.

**UNFPA-UNICEF JOINT PROGRAMME
'FEMALE GENITAL MUTILATION/CUTTING: ACCELERATING CHANGE'
TO ELIMINATE FGM IN SOMALIA**

The UNFPA-UNICEF Joint Programme (*UNJP*) has been working in sub-Saharan Africa since 2008. It now covers 17 countries, and Somalia was involved from the start. The programme works with a wide range of partners in each country – government, civil society, faith leaders, NGOs and community groups – using culturally sensitive approaches to raise the issue of FGM as a violation of women and girls' human rights. Aims include encouraging introduction and implementation of policy frameworks and legislation against the practice, as well as educating communities on the health implications and harm of continuing FGM. According to the performance report on Phase II of the programme (2014–2017), in 12 of the countries where it has been operating, more than 50% of women and girls have supported abandonment of the practice.¹

In Somalia the UNJP has worked with 369 communities across 30 districts in 21 regions covering South/Central Somalia, Puntland and Somaliland. An important aspect of the concept of 'abandonment' has been a widespread reduction in the most severe form of FGM, Type III/infibulation. UNJP task forces held many meetings with the various ministries responsible for women's health issues and religious affairs in order to introduce, coordinate and support implementation of initiatives aimed at taking out to communities knowledge and skills in relation to FGM.

Between 2014 and 2017 the programme delivered services to nearly 6,000 women and girls. Survivor-friendly training on FGM's health impacts was provided to staff at over 200 service-delivery points. It also contributed to a midwifery curriculum, integrated with neo- and post-natal care, and immunisation services, and delivered in four health centres across the region.

The programme has used a variety of methods to take out the anti-FGM message to communities. It has supported a girls' baseball team in Puntland, who chant and sing songs about the dangers of FGM during play,² and set up Child Rights Clubs in primary schools, which now have 1,500 members, where FGM and child marriage are discussed. Anti-FGM youth clubs have also been established in seven secondary schools and 12 universities.

Surveys have been undertaken to deepen understanding about the beliefs that underpin social norms in Somalia that relate to FGM and child marriage. One study developed radio shows about protection issues affecting girls and young women and their limited access to education and justice. Another survey looking at GBV suggested there is a link between social norms and behaviour change, and showed the importance of educating girls from a young age to challenge belief systems.³

In Phase III of the programme in Somalia (2018–2021), as in the other countries the UNJP supports, the emphasis will be on introducing budget lines, national response-systems and improved monitoring mechanisms at government level, in parallel with continued work to transform social norms through education projects with communities and local leaders, in order to achieve SDG 5.3.⁴

1 UNFPA-UNICEF (2017) *UNFPA-UNICEF Joint Programme on Female Genital Mutilation: Accelerating Change – Performance Analysis for Phase II*, p.1. Available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-UNICEF-Phase2Performance_2018_web_0.pdf.

2 UNFPA Somalia (2017) *Girls' basketball against FGM*, 3 October. Available at <https://somalia.unfpa.org/en/news/girls%E2%80%99-basketball-against-fgm>.

3 UNFPA-UNICEF, *op. cit.*, pp.91–94.

4 UNFPA (2018) *UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation*. Available at <https://www.unfpa.org/unfpa-unicef-joint-programme-eliminate-female-genital-mutilation>.

Understanding and Attitudes

A widespread, correct understanding of FGM is essential to change attitudes; accessible, accurate information is vital to the success of the work to end FGM.

FGM has always been a taboo subject in Somalia and Somaliland; it was never discussed in public and rarely among families and couples. Advocacy efforts by civil society and activists has done much to open up the dialogue in recent years, but challenges still remain. Education on sexual health and relationships is not mainstream, and even in diaspora communities Somalis can still be conservative about discussing intimate issues.

When I first started speaking out against FGM, many people in my community were critical, but things are changing. More people are speaking out against FGM in Somaliland.

~ Doctor Mariam Dahir¹

Knowledge of FGM

99.4% of women in the North-East Zone of Somalia (Puntland) and 99.8% of women in Somaliland have **heard of FGM**, making knowledge of it almost universal.² There is no comparable statistic available for the rest of Somalia, but it may be assumed that knowledge is equally widespread.

According to civil society, however, awareness of the harms of FGM is more widespread in urban areas, and 28 Too Many understands from the NAFIS Network in Somaliland that their members are being encouraged to take anti-FGM activities further into more remote rural areas.

ActionAid reports that only 38% of community members surveyed correctly understood the **legal status** of FGM in Somaliland. Correct understanding was more common among respondents who lived in urban areas (44%) than among those who lived in rural areas (38%), and more common among men (60%) than among women (28%). Encouragingly, 62% of those surveyed wanted to see anti-FGM laws strengthened.³

We know that this is a practice that is entrenched in traditional myths, which can only be effectively challenged through knowledge.

~ Hawa Aden Mohamed of the Galkayo Education
Centre for Peace and Development⁴

Reasons for Practising FGM and Its Perceived Benefits

ActionAid reports that the most common reason for practising FGM given by community leaders surveyed in urban communities of Somaliland was tradition, while community leaders surveyed in rural communities most commonly cited Sharia law. Other reasons included preparation for marriage and protection from rape.⁵

Of the women surveyed for the NAFIS Network study, the majority of women, 87.2%, said that FGM was performed for cultural and religious reasons – 60% said that it was a ‘good tradition’.⁶

UNFPA and the World Bank report that, in the Somalia/Somaliland region as a whole, support for FGM is the result of ‘religion, custom and tradition, preservation of virginity, hygienic reasons, fear of stigma[,] peer pressure and pleasure for husband.’ FGM was enforced through cultural practices such as the singing of songs ‘deriding the uncircumcised as dirty, foul smelling, and ugly, and praising the circumcised as a woman’ and demanding the return of the bride price if the woman is found to be uncut after marriage. Respondents made statements such as:

- ‘FGM/FGC is our tradition and stopping it will unleash the anger of God on us.’
- ‘FGM/FGC is a Sunna and we must do some cutting to purify the girl. It is sanctioned by Islam.’
- ‘The uncircumcised are dirty and foul smelling.’
- ‘Their genitals can grow to unseemly proportions dangling between the legs; FGM/FGC makes them look smooth and beautiful.’
- ‘They can become oversexed and can rape men – therefore, they cannot be trusted by either husband or family. They will engage in premarital and extramarital sex, bringing illegitimate children to the family.’
- ‘No one will marry an uncircumcised or uninfibulated woman – thus the parents have to circumcise.’⁷

FGM has destroyed so many young girls’ lives across Somalia. Everyone needs to face the truth that FGM does not make a woman more marriageable, faithful, clean; FGM only brings a lifetime of challenges for both wife and husband, physically and psychologically.

*~ Zubeda Dahir, Somali FGM survivor and activist
(interview with 28 Too Many, 2019)*

Belief that FGM is a religious requirement is a major factor in the practice of FGM in the Somalia/Somaliland region. Frequently, Pharaonic FGM is seen as being culturally inherited, while sunna is seen as being supported by religious teachings, honourable and more ‘healthy’⁸.

This belief combined with the lack of understanding of different forms of FGM is causing more extreme forms of FGM to be labelled ‘sunna’ and thus accepted. Therefore, although various commentators have reported a turn against Pharaonic (Type III) FGM in the public opinion, particularly in urban areas, it may be that its actual practice has not decreased as much as would at first appear.⁹

The Population Council has also noted confusion over the term ‘abandonment’ – many who report that they have abandoned FGM merely mean that they have abandoned Pharaonic FGM in favour of sunna.¹⁰

For more information on the Pharaonic and sunna forms of FGM, see page 66.

Other reasons for the practice include **aesthetic appeal** (some men say that ‘the smoothness of the scar is esthetically beautiful’); the **preservation of virginity and the family’s honour**, which are intrinsically linked; the **transition to womanhood** (women are said to undergo ‘three feminine pains’: FGM, the wedding and labour¹¹); **marriageability** (if a woman has not been cut, she can be forced to undergo FGM or easily divorced¹²); and **sexual enjoyment for men**.¹³

Support for FGM

The last available dataset for the whole of Somalia and Somaliland, the **S-MICS 2006**,¹⁴ reported that 64.5% of women (aged 15–49) in the entire region who had heard of FGM believed that the practice should continue, and 32.8% believed that it should not.

However, there were distinct **regional trends**. In Somaliland, about one-third of women believed that the practice should be continued, while in the North-East Zone of Somalia (Puntland), around half of women supported the practice. The level of support was highest in South/Central Somalia, at 79.5%.

Women who had had FGM were more likely to support its continuation (65.5%) than those who had not (18.5%); women living in urban areas were less likely to support its continuation (53.8%) than women living in rural areas (71.8%); and support for its continuation was highest among women who were less educated and less wealthy.

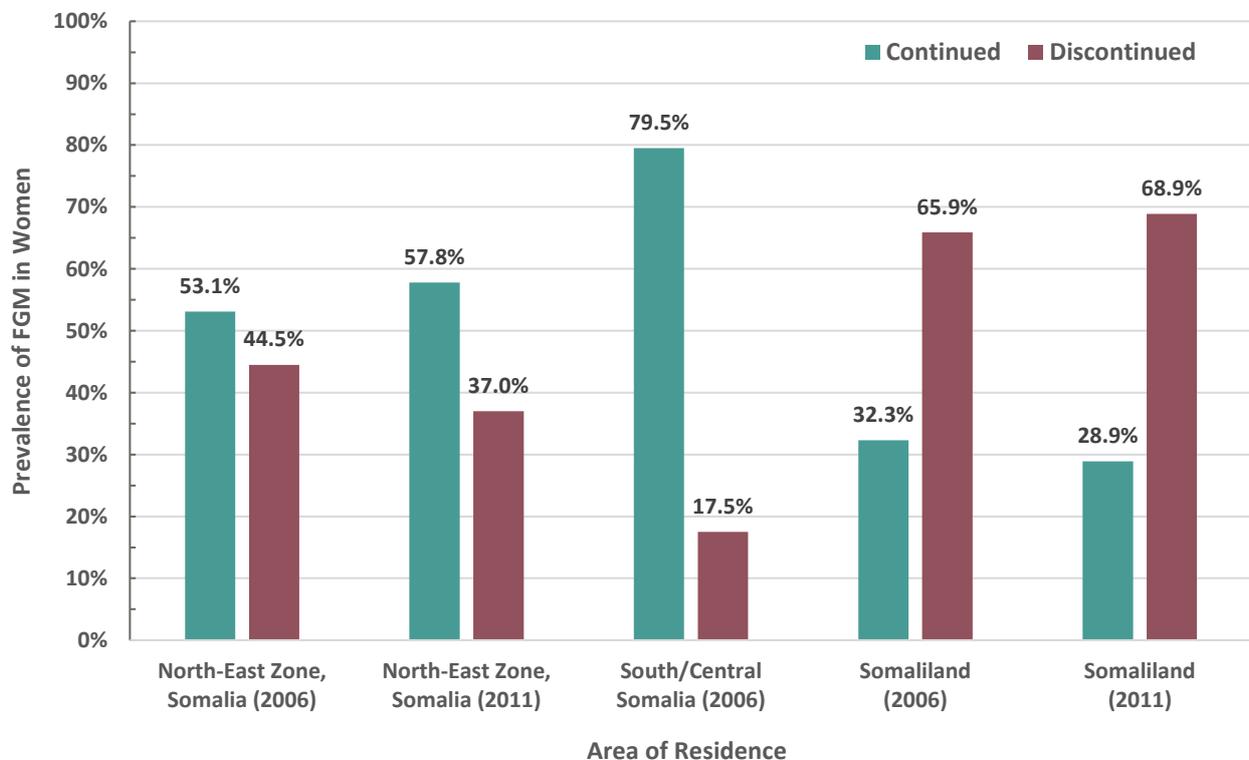


Figure 13: Women aged 15–49 who have heard of FGM and who believe that it should/should not be continued – comparison 2006 and 2011¹⁵

The **MICS surveys**¹⁶ reveal that attitudes have not greatly differed over time (see Figure 13): the data suggests a small increase in support for FGM in the North-East Zone of Somalia (Puntland) and a very slight decrease in Somaliland, but more data needs to be gathered to confirm this as a genuine trend.

In the **North-East Zone (Puntland)**, the strongest level of support for the continuation of FGM is in the Mudug region (61.1%) and the weakest is in the Nugal region (53.3%). This difference, however, is not because more women in Nugal stated that FGM should be discontinued, but because more women in that area responded 'Depends' or 'Don't know'. (Support for the *discontinuation* of FGM was roughly equal across the region, at 37%.) Once again, women who are less wealthy and live in rural areas are more likely to favour its continuation.

In **Somaliland**, the strongest level of support for its continuation is in Togdheer (33.9%) and Sanaag (33.4%), and the weakest is in Maroodijeex/Saaxil (25%). Again, women who are less educated and less wealthy are more likely to believe that FGM should be continued. However, the data suggests that, over time, support for the continuation of FGM among women in the poorer wealth quintiles has decreased.

Anecdotal evidence supplied to 28 Too Many during the course of this research also confirms that, although support for FGM is still high in some regions of Somaliland, mothers no longer want Type III FGM and are opting for Type I or sunna for their daughters.

The **EAUH** reports that the majority of mothers surveyed (83.2%) stated they would perform FGM on their daughters (16.8% said they would not). This is a higher percentage of women than the MICS reports as supporting the continuation of FGM; however, the EAUH data is limited to women of child-bearing age who are pregnant, so the demographics of the two surveys are different. It has also been noted during 28 Too Many's past research that, often, women may not support FGM but will still have their daughters cut because of social pressures. Women more commonly indicated that they would perform sunna instead of Pharaonic FGM on their daughters.¹⁷

THE IMPORTANCE OF DIALOGUE TO ENDING FGM

The Somaliland Family Health Association (SOFHA), in partnership with UK-based Orchid Project, undertakes Knowledge Sharing Workshops with key stakeholders in Somaliland to share best practice and discuss ideas around FGM. Their most recent workshop took place in Hargeisa at the end of February 2019 and brought together 28 participants, including community-based organisations and government representatives from the following ministries: Health, Education, National Planning and Development, Religious Affairs, Employment, and Social Affairs and Family.



Knowledge Sharing Workshop facilitated by SOFHA and the Orchid Project, February 2019, Hargeisa (© Orchid Project)

The SOFHA/Orchid workshops encourage non-judgemental dialogue and collaboration between the key stakeholders and, interestingly, reveal many of the complexities and differences between personal attitudes and organisational attitudes towards abandoning FGM. It appears that government ministries differ in their approach and in the messages they wish to convey to communities: while some, including the Ministry of Health, favour total abandonment of FGM, others, such as the Ministry of Religious Affairs, remain strongly in favour of abandoning Pharaonic and all cutting involving stitches, but maintain long-term support for sunna/‘pricking’, seeing it as an Islamic practice. The workshop did not reveal a clear majority for any of these possible paths forward.

Regarding personal attitudes to FGM, however, these workshops and the opportunities they give for open dialogue have a clear impact. Participants who begin the week supporting continuation of the sunna cut move to supporting total abandonment by the end. This corresponds to the outcomes of other organisations’ findings when applying the dialogue approach in both Somalia and Somaliland, and the importance of this strategy for the campaign’s progress across the region moving forward.

Men and FGM

ActionAid, through the Orchid Project's research, surveyed men and boys in the Maroodi Jeex and Togdheer regions of Somaliland, and, while the data reflects only the opinions of those surveyed (not the population of these regions as a whole), the report does provide some helpful insights.¹⁸

In general, women made the **decisions regarding FGM**, and in only about 8% of households surveyed were men and boys also involved. However, 'they are influential in creating the social climate within which decision-making about cutting takes place', as only 4% of unmarried men surveyed preferred to marry a girl who has not undergone FGM.¹⁹ Additionally, because FGM is often required as proof of virginity upon marriage, which in Somali culture means that a girl must be stitched partially closed, Pharaonic cuts were, in that sense, preferable. Without it, a girl may be considered *haram*.²⁰

FGM is a crime committed by the woman, against the women, for the men.

~ *Abade Ahmed, Somali activist, Men Speak Out*²¹

84% of men believed that FGM is a traditional practice, but religious **reasons for cutting** were a more important factor for men (36%) than for women (13%).²²

More men (60%) understood the **legal status of FGM** than women (28%). 3% of men, as opposed to 42% of women, believed that Pharaonic FGM was illegal. More women (67%) than men (55%) wanted to see the law strengthened, but less than 10% of community members favoured a complete ban. The majority of men (80%) and many women (63%) supported a ban on all types of FGM except sunna.²³

Likewise, only 2% of men supported the complete **abandonment of FGM**.

Men, in general do not speak about FGM. It remains a taboo ... Men here are the heads of the household and this means they can play an important role in ending FGM, if they chose to.

~ *Khadar, anti-FGM Ambassador trained by Candlelight, Somaliland*²⁴

Some respondents claimed that men are failing to take responsibility for their role in FGM.²⁵ One cause of this may be **confusion**. Men who attended focus groups seemed caught between their concern about the impact of Pharaonic FGM on women and girls and their feeling that FGM is necessary as 'evidence of virginity'.²⁶ However, there is evidence that, at least for some men, the underlying concern is their own pleasure during sexual intercourse, rather than the negative impact on women in and of itself, as revealed in the following quotes:

- 'We need this evidence of them being untouched. How else are we going to know whether she has been touched if she is not sewn? But we do not want a lady who is going to have health problems all her life and not be able to be a good wife' (a young Somali man from Stadium, an urban community).²⁷
- '[W]hen a man marries he wants an active wife and sex nowadays and that doesn't happen with an FGM girl. There is a problem here though which we need to resolve. I no longer support the pharaonic as it is a mistake[;] it damages our girls too much. The sunna will give us more pleasant experiences with our wives' (a rural community member from Inaafmodoobe).²⁸



Creating more opportunities for male activists to lead discussions with men on the harms of FGM is critical to the campaign in Somalia and Somaliland (© CCBRS)

In the community of Inaafmodoobe, Togdheer, the men stated emphatically that they would not consent to their daughters being cut in any way other than sunna without stitches; however, the women believed that about a third of men *would* accept sunna with stitches. Clearly there is a problematic **lack of communication between men and women** on the subject of FGM in general and types of cutting. A women in one focus group said, ‘We inform the father that the girl is going “to be purified” and avoid giving any details at all.’²⁹ Girls are then reportedly cut in what the report calls ‘sunna 2’ – a cut with two stitches, while their fathers believe that no stitching is involved. The use of unspecific phrases such as ‘purified’ allows this practice to continue (as does the idea of FGM providing ‘proof of virginity’).³⁰

The ActionAid report concludes, ‘It is clear from these discussions that neither the men nor the women lack knowledge about FGM/C[;] instead they lack the skills and opportunities to communicate openly and honestly on these difficult dilemmas.’³¹

This complex relationship between men and their attitudes to FGM can be seen through the stories often shared with Somali activists during their work (both in country and in the diaspora). While the ‘proof of virginity’ is so highly valued, the reality for many new husbands is a woman who is unable to have sex on their wedding night until she has been cut open again.

In the north of Somalia, it is reportedly quite acceptable for doctors to cut open the Type III FGM.

In South/Central Somalia it has always been a matter of honour that the husband reopens his wife; failure to do so not only causes great physical damage to the woman and psychological damage to both partners, it also brings great shame on the husband as he is labelled ‘weak’. This deeply affects the marriage right from the start, and marriage breakdowns are sadly very common.

On a positive note, in more than half of the focus-group discussions led by the Orchid Project, participants changed their minds about FGM simply by discussing it among themselves. For example, several young men in Stadium began by saying that they would only marry girls who have been cut, but by the end of the discussion were saying that they had changed their minds. These discussions were, for many attendees, the first time that they had discussed openly how they felt about FGM and been allowed to come to their own conclusions.³²

Civil society groups and activists report that the most successful way for them to approach FGM in discussions with Somali men is to talk about human rights in the first instance, then progress on to health issues. This will then inevitably lead on to the impacts of FGM on both health and their relationships with women.

After participating in focus groups, many men became eager to be involved in community discussions about FGM, but were unsure how to proceed.³³ This is an opportunity for activists, with adequate funding, to scale up and provide more training to men in both Somalia and Somaliland.

YOUTH NETWORKS TO END FGM

Across both Somalia and Somaliland, young activists are increasingly bringing discussion around sensitive topics like FGM into the public domain. As young Somalis become empowered to tackle FGM, such as the young women who have set up the **Solace for Somaliland Girls Foundation**, new opportunities emerge to grow networks that can share knowledge and widen the reach of the campaign to more young people.

Successful initiatives such as the **UNFPA Youth Peer (Y-PEER)** network, the **National Youth Organisation (SONYO Umbrella)** and the **Youth AntiFGM-Somaliland** movement have become important advocacy channels, improving understanding of the issues around FGM and mobilising young people to take action.

Social media, such as Facebook and Twitter, also provides an important platform for these young people to discuss FGM. The Youth AntiFGM-Somaliland activists, for example, play a key role in sharing knowledge and bringing the campaign into the heart of communities. They take the anti-FGM message into universities and, importantly, provide awareness-raising and training for young medical students in particular. They are also petitioning for the adoption of national legislation banning FGM in Somaliland.



Youth AntiFGM-Somaliland activists on Zero Tolerance Day 2019 (© Dr Mariam Dahir)

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- SL-MICS 2011, p.102.
- 3 Katy Newell-Jones (2018) *Empowering Communities to Collectively Abandon FGM/C in Somaliland*, p.13. ActionAid.
- 4 Kate Hodal (2018) '10-year-old girl bleeds to death after female genital mutilation in Somalia', *The Guardian*, 20 July. Available at <https://www.theguardian.com/global-development/2018/jul/20/10-year-old-girl-death-fgm-female-genital-mutilation-somalia>.
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- 8 R. A. Powell and M. Yussuf (2018) *Changes in FGM/C in Somaliland: Medical narrative driving shift in types of cutting*. Evidence to End FGM/C: Research to Help Women Thrive. New York: Population Council. Available at http://www.popcouncil.org/uploads/pdfs/2018RH_FGMC-Somaliland.pdf.
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- 13 - US Department of State (2001) *Somalia: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10109.htm>.
- World Bank and UNFPA (2004) *Female Genital Mutilation/Cutting in Somalia*. Available at http://siteresources.worldbank.org/INTSOMALIA/Data%20and%20Reference/20316684/FGM_Final_Report.pdf
- 14 S-MICS 2006, p.138.
- 15 - S-MICS 2006, p.138.
- SN-MICS 2011, p.105.
- SL-MICS 2011, p.102.
- 16 - SL-MICS 2011, p.102.
- SNE-MICS 2001, p.105.
- 17 EAUH, pp.35&36.
- 18 Katy Newell-Jones (2018) *Empowering Communities to Collectively Abandon FGM/C in Somaliland*, p.13. ActionAid.
- 19 *Ibid.*, p.4.
- 20 *Ibid.*, p.26. **Haram is a legal term for what is forbidden or inviolable under Islamic law.**
- 21 The Gathering Ground (2019) [website]. Available at <http://thegatheringground.co.uk/work/fgm/>.
- 22 *Ibid.*, p.12.
- 23 *Ibid.*, p.13.
- 24 Alice Rowsome (2017) 'Somaliland: "I convinced my sister not to do type III FGM on her daughter"', *The Guardian*, 30 March. Available at <https://www.theguardian.com/society/2017/mar/29/somaliland-i-convinced-my-sister-not-to-do-type-3-fgm-on-her-daughter>.
- 25 *Ibid.*, p.27.
- 26 *Ibid.*, p.12.
- 27 *Ibid.*, p.12.
- 28 *Ibid.*, p.13.
- 29 *Ibid.*, p.16.
- 30 *Ibid.*, pp.16 & 26.
- 31 *Ibid.*, p.26.
- 32 *Ibid.*, p.16.
- 33 *Ibid.*, p.27.

Religion

Islam is the major religion in Somalia and Somaliland, practised by over 99% of the population. Most align with the Sunni or Shaf'i schools of Islamic law.¹

Somalia

The Constitution of Somalia establishes Islam as the state religion and stipulates that all laws must comply with the general principles of Islamic Sharia. Article 17 reads:

1. Every person is free to practice his or her religion.
2. No religion other than Islam can be propagated in the Federal Republic of Somalia.²

While Article 17(2) is reportedly not enforced,³ members of religious minorities report abuse from other citizens and from agents of the state such as the military.⁴

Atheism is unrecognised, and it is taboo, perhaps even illegal, to convert to Islam from another faith.⁵ Blasphemy is outlawed and punishable by death.⁶

Non-Muslims do not have the right to hold the office of president.⁷

Puntland

The Constitution of Puntland restricts the 'propagation' of religions other than Islam (Article 6). Citizens are also prohibited from renouncing their faith from Islam (Article 24[2]).⁸

In November 2013, 18 high-ranking religious leaders signed a *fatwa* against all forms of FGM at an official ceremony held at the Puntland Ministry of Health. At the time, UNICEF noted:

One of the most influential groups in Puntland are the Somali Sheikhs and Imams. UNICEF has been engaging with them for five years and this had led to public declarations on FGM/C abandonment by more than 300 religious leaders in Puntland in 2011 and 2012.⁹

Somaliland

The Constitution of Somaliland states at Article 33: Freedom of Belief that:

1. Every person shall have the right to freedom of belief, and shall not be compelled to adopt another belief. Islamic Sharia does not accept that a Muslim person can renounce his beliefs.
2. The Mosque is a blessed place and deserves veneration. It is the place for preaching religion and for providing the nation guidance in spiritual and temporal matters and the preaching therein of matters which would divide the nation (sedition) is prohibited. The state shall be responsible for its general protection and any practicable support.

As does the Constitution of Somalia, it prohibits the promotion of religions other than Islam (Article 5), grounds the law in Sharia (Article 5), and requires the president, vice-president and members of the house of representatives (as well as their wives) to be Muslim (Article 82).¹⁰

In February 2018 the Ministry of Religious Affairs in Somaliland issued a *fatwa* banning the most severe type of FGM, Type III (Infibulation). It stated that those who perform this type of FGM will face punishment and victims would be eligible for compensation (it did not, however, provide details of punishments or who would pay compensation and what amount).¹¹

al-Shabaab

The terrorist group al-Shabaab ‘retains significant terrorist capacity’,¹² making threats against the lives of converts to Christianity and enforcing an extreme understanding of, and adherence to, Sharia law, including the wearing of *niqab* in public spaces. The group reportedly has ties with both al-Qaeda and ISIS. Although it has lost territory, in the areas the group controls it has established a ‘local government’, including taxation systems and court processes.¹³

It is not known whether the group enforces or encourages FGM.

Religion and FGM

No surveys have been carried out in relation to FGM **prevalence or practices within different religious groups** in the region. It is therefore necessary to rely on qualitative information regarding the relationship between religion and FGM in Somalia and Somaliland.

Religious leaders in Somalia and Somaliland have great influence and have traditionally been very conservative towards any proposal to ban FGM. In 2012 in Somaliland, for example, religious leaders objected to early attempts at an anti-FGM policy calling for zero tolerance, and it took several years for them to set out their position in the *fatwa* opposing Type III FGM and supporting the sunna cut (see below).



*Religious leaders meeting in Hargeisa to discuss FGM
(© Girl Generation)*

Activists in 2019 are now reporting a positive trend across both Somalia and Somaliland as some religious leaders are more willing to publicly discuss FGM and are beginning to speak out against the practice. It has been reported to 28 Too Many that in Somalia there is now a 50:50 split of opinion among religious leaders towards zero tolerance and the banning of all types of FGM.

CARE International is one organisation that has been running workshops with religious leaders in Somalia and Somaliland, where Islamic texts are examined and discussed in relation to harmful practices such as FGM, early marriage and forced marriage. After taking part in the seminars, Sheikh Mohammed Yusuf decided to talk to his congregation about the harmful impact of FGM on women and girls. Now, every Friday, he leads awareness-raising meetings, speaking about FGM and the rights of women in Islam. As a result, the taboo on speaking about FGM in public is starting to break in his community.¹⁴

To abandon FGM was inconceivable to us because we thought it was a religious obligation. After several workshops, seminars, and research, we started to change our perception of these customs and accepted that it could be subject to debate.

We were cautious. We really wanted to know if female circumcision was a religious obligation. It was then confirmed that FGM was harmful to women's health and that it was not at all obligatory in Islam.

~ Sheikh Mohammed Yusuf, cited on the Care website¹⁵

Six sheikhs have also formed a network to fight FGM, including Sheikh Almis Yahye Ibrahim, who is head of International Horn university in Hargeisa. To the 5,000 people who attend his mosque, he preaches about the harm caused by FGM. He also leads by example – none of his three daughters have been cut.¹⁶

INITIATIVE FOR RESEARCH AND DEVELOPMENT ACTION (IRADA)

IRADA has been working on anti-FGM programmes by reaching out to community groups and key influencers across six regions of Somaliland, including remote rural areas, over the last six years.

Its anti-FGM programmes specifically target religious leaders, traditional healers and birth attendants, and boys and girls in schools.

One of IRADA's important successes has been the establishment of an anti-FGM religious network through which, by training religious leaders on their responsibility to change social norms and promoting their role in the advocacy process, it has been made possible to explain to the wider community the religious teachings against FGM and GBV from the perspective of Islamic principles.

28 Too Many understands from IRADA that, in some cities, they are witnessing a drop in FGM prevalence as a result of their anti-FGM campaigning involving religious leaders.¹⁷

Sunna

Along with 'tradition', 'religious beliefs' is the most common reason given for the continuation of FGM in the region – in particular, the continuation of the sunna form of FGM (see page 66).

Sunna, unlike Pharaonic FGM (Type III/infibulation), is incorrectly believed by many people in the region to have no negative consequences to health and is considered to be honourable.¹⁸ Many men, in particular, do not understand that sunna often involves stitches.¹⁹ Of the people surveyed by ActionAid who expressed an opinion on the matter, 9% believed that sunna was an obligatory religious practice (as opposed to merely an honourable one). The majority of community members (64% of women and 59% of men) saw religious leaders as supporting sunna and opposing Pharaonic FGM.²⁰



CCBRBS training for religious leaders on FGM abandonment in Somaliland (© CCBRS)

There is confusion and disagreement about the different types of FGM and what exactly constitutes sunna. According to activists in Somaliland, sunna is now mainly considered by religious leaders to mean 'no cut/no stitch' (i.e. a form of 'pricking'), whereas some other sources have suggested that more extreme forms of FGM, which have not previously been considered sunna, are beginning to be practised under that label.²¹

The challenge remains across the whole region, as reported to 28 Too Many by the NAFIS Network in early 2019, to demonstrate that the sunna cut also does harm and has a negative impact on the health of women and girls, and, as such, should also be banned under Islamic rule and opposed by all religious leaders. The support of religious leaders is also critical to achieving enactment of the zero-tolerance laws against FGM currently in the drafting stage in both Somalia and Somaliland.

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- 20 *Ibid.*, p.13.
- 21 Sheena Crawford and Sagal Ali (2015) *Situational Analysis of FGM/C Stakeholders and Interventions in Somalia*, pp.41–42. Available at <https://orchidproject.org/wp-content/uploads/2015/02/Situational-Analysis-of-FGMC-Stakeholders-and-Interventions-in-Somalia1.pdf>.

Education – Somalia

Before 1991, education in Somalia was free and compulsory for children aged 6 to 13, but with the collapse of the state and prolonged civil war, Somali's education system broke down and most public schools were closed.¹

In 2012, the new Somali Federal Government was inaugurated in Mogadishu. Following this, a series of conferences with donor agencies were held, which resulted in funding under the Global Partnership for Education and the launch of the **Go-2-School** initiative, aimed at bringing into the education system by 2016 one million children and young people living in South/Central Somalia.²

Education Strategic Sector Plans were developed for 2013–2016 and 2018–2020. In 2017 the Somalia Federal Government adopted the **General Education Law**, which makes eight years of education compulsory.³

Since 2014, education in Somalia has been the responsibility of the Ministry of Education, Culture and Higher Education, headquartered in Mogadishu.⁴ Responsibility for Quranic schools, however, falls under the Ministry of Religion.⁵

In keeping with the 2017 General Education Law, the Education Sector Strategic Plan 2018–2020 requires eight years of compulsory education up to the age of 14. There are two **education cycles**: the 9–3 system is mainly used in private Arabic institutions and the 8–4 system by state-funded public schools (see Table 13).

The 9–3 System		The 8–4 System	
Early childhood care and education (including pre-school)	1–2 years	Kindergarten schools	1–2 years
Primary schools	9 years	Primary schools	8 years
Secondary schools	3 years	Secondary schools	4 years
Post-secondary institutes	2–4 years	Post-secondary institutes	2–4 years

Table 13: Education systems in Somalia⁶

Quranic education offers an alternative to state education, mainly serving rural areas, where access to state education is limited.

Technical and Vocational Education and Training (TVET) is available for young and unemployed people. Higher education degrees are generally of four years' duration.

In addition, there is an **Accelerated Basic Education (ABE)** system for children of primary-school age who are unable to participate in the formal education system (for example, children of internally displaced families and nomadic, pastoralist families). These institutions are often run by non-governmental organisations funded under the Global Partnership for Education.⁷

Literacy

Overall, literacy is less common in South/Central Somalia (38.3%) than it is in Somaliland (45.3%) and Puntland (42.9%). Only in the Sool and Sanaag regions, which are border areas contested by Puntland and Somaliland, is literacy less common than in South/Central Somalia, at 27.9%. Again, literacy among women is less common across all states. In South/Central Somalia, 34% of women are literate, compared to 42.5% of men (see Table 14).

State Average	Men	Women	Total
Jubaland	33.6%	25.6%	29.6%
Southwest	29.6%	23.1%	26.4%
Hirshabelle	23.1%	16.6%	20.0%
Galmadug	55.7%	47.4%	51.4%
Banadir	70.8%	57.3%	63.9%
TOTAL SOUTH/CENTRAL	42.5%	34.0%	38.3%
PUNTLAND	44.6%	41.2%	42.9%
CONTESTED REGIONS	28.3%	26.8%	27.6%

Table 14: Literacy of Somali people by state, 2015⁸

Education and the Development Goals

The two **Millennium Development Goals** most pertinent to the campaign to stop FGM were 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

Goal 4 of the **SDGs** is relevant to FGM in that it relates to education:

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills-training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

Enrolment, Access and Gender Parity

Early-years education has been identified as particularly under-resourced. There is limited data on enrolment rates, but the majority of children in early-years education are believed to be in Quranic preschools, for which there is not yet a national curriculum or framework (it is a politically sensitive area).⁹

The **gross primary-school enrolment ratio** for South/Central Somalia in 2015/2016 was 22.1% , and of the 454,000 enrolled students around 58% were male and 42% were female. The gross primary-school enrolment ratio for Puntland in 2014/2015 was 61%, and of the 151,000 students enrolled, 56% were male and 44% were female. There is a large urban-rural divide in primary enrolment: in South/Central, 88.3% of children living in urban areas are enrolled compared to 11.5% of children living in rural areas; in Puntland, 58.4% of children living in urban areas are enrolled compared to 41.6% of children living in rural areas.¹⁰

The **net attendance ratios for children in primary school**¹¹ (male – 18.5%/female – 15.2% in 2008–2012) compare unfavourably with neighbouring countries – for example, Kenya (72.4%/75%) and Ethiopia (64.3%/65.5%) – and are among the lowest in Africa.¹²

The **rate of children remaining in education until at least Grade 5** is 65% (of those who are enrolled) in South/Central Somalia and 56% in Puntland, with only a narrow disparity between boys and girls (see Table 15). There is also massive geographic disparity. Banadir (a densely populated, urban area) has the highest retention rate at 96.7% (where the retention of girls actually outstrips that of boys by 4.5 percentage points), and South West has the lowest at 47.2% (where the retention rate of girls lags behind boys by 6.3 percentage points).

State	Boys	Girls	Total
Jubaland	55.4%	44.8%	50.3%
South West	50.0%	43.7%	47.2%
Hirshabelle	58.8%	53.9%	56.5%
Galmadug	83.1%	82.0%	82.6%
Banadir	94.7%	99.2%	96.7%
TOTAL SOUTH/CENTRAL (2015/2016)	67.4%	62.1%	65.0%
PUNTLAND (2014/2015)	57.4%	54.2%	56.0%

Table 15: Primary school retention rates to Grade 5¹³

Uptake of **Accelerated Basic Education** remains low. Regulation for this type of education can be poor, with no standardisation of curriculum or compulsory teaching qualifications. This is the one sector of education, however, for which female enrolment is higher.¹⁴

Approximately 126,000 young people are enrolled in secondary education in South/Central Somalia and almost 15,000 in Puntland.¹⁵ The **gross secondary-school enrolment ratio** for South/Central Somalia in 2015/2016 was 12.9% (male – 14.6%/female –11%) and for Puntland in 2014/2015 was

14% (male – 17.6%/female –10.1%). The gap between young people living in rural and urban areas is wider in secondary than in primary: in South/Central Somalia, for example, only 1.3% of children enrolled in secondary education are resident in rural areas.¹⁶

It is estimated that 96% of young people in South/Central Somalia and 91% of young people in Puntland (aged 14–24) are not in any type of post-secondary learning institution. **TVET education** is largely funded and implemented by INGOs; the content and curriculum is non-standardised and does not deliver clear pathways to employment or meet the needs of the employment market.¹⁷

There are 44 **universities** in the region, but enrolment across all of them is low at 51,471 (as at 2013), and just under half of these are resident in South/Central Somalia. It has been suggested that the level of fees may be prohibitive, but there are also challenges relating to the lack of standards and guidance on curricula.¹⁸

IDPs, nomads/pastoralists, people in urban and poor communities and girls are the groups most vulnerable to **exclusion from education**. Gross school-enrolment rates among IDP children (in Somalia and Somaliland) are 16.6% at primary level and 12% at secondary level.¹⁹ The gross primary-education enrolment rate for nomadic/pastoralist children in Somalia and Somaliland is only 3.1% and at secondary level it is just 0.9%.²⁰



*Somali NGO Hope in Life International supporting girls' education at AlJazeera Primary School in Mogadishu – school dropout is discouraged by providing essential needs such as food, stationary and sanitary towels
(©HILI)*

There are only around 300 children with **Special Education Needs and Disability (SEND)** recorded as attending primary school in Somalia, and just 52 in secondary school, likely indicating that many disabled children are being excluded from education. There is a dire shortage of SEND facilities and specially trained teaching staff.

Child labour remains widespread, commonly in agricultural or household work, as well as child soldiers. Child-labour laws are poorly enforced, and, even when fines are administered, these are often so low, due to inflation, that they do not present a suitable deterrent. The legal working age is 15, but this leaves a one-year gap after children complete primary school (at 14), which makes them vulnerable to exploitation. Children dropping out of school are at increased risk of recruitment to non-state armed actors, such as terrorist groups like al-Shabaab.²¹

In May 2016, a new **national gender policy**, which includes an intention to improve women's and girls' participation in education, was approved by the council of ministers, but as at 2017 it had yet to be implemented.²²

Teaching Staff

Only 37.9% of teachers across all of Somalia, Somaliland and Puntland are qualified. This percentage is lowest in South/Central Somalia at 20.1% (compared with 39.2% in Somaliland and 62.6% in Puntland).²³ Only 8% of teachers in South/Central Somalia are paid by the Government, 47.3% are paid by 'private institutions' and 24.8% by communities (the remainder are paid by NGOs and undefined sources).²⁴

The average pupil-to-teacher ratio in 2015/2016 in South/Central Somalia was 35%, and in Puntland in 2014/2015 it was 32.6%.

Schools teaching children in two shifts a day is common to make limited resources stretch further, but 61.8% of schools in South/Central Somalia and 27.8% of schools in Puntland operate on a single-shift system. In South/Central Somalia, an average of one mathematics textbook is shared by 18 pupils.²⁵



Students at Hajjil Mohamud Hilowle Primary School in Mogadishu, built by the African Union Mission in Somalia

Spending on Education

The **National Development Plan** commits to increasing the national budget allocation to the education sector from 1% in 2016 to 12% in 2020, with a large percentage of this funding to be committed to primary-level education and the ABE programme.²⁶

In its Education Sector Strategic Plan 2018–2020, the Ministry of Education, Culture and Higher Education outlines the following vulnerabilities in the education system:

- a weak capacity to support education in emergency responses;
- vulnerabilities and reduced levels of resilience of learners and communities caused by high levels of inequity, particularly for those who are most disadvantaged; and
- risks of violence and attacks against education facilities, personnel and learners.²⁷

It outlines objectives and strategies for achieving improvement across all levels of education, as well as implementing an evaluation and monitoring process. Importantly, one of these aims is to 'attain gender equity and parity in education' (30% by 2020), indicated by 'the percentage of managerial positions occupied by women'.²⁸

Education and FGM

Education plays an important role in overcoming and changing attitudes that are still in favour of FGM. While at school, girls may have greater exposure to intervention programmes and discourse about the practice. In many countries, the longer a girl is in school, the less likely she is to undergo FGM or early marriage. Girls and women who are more highly educated are also more likely to understand their rights, support the abandonment of FGM and feel equipped to challenge social norms. There are many NGOs and community activists in Somalia, such as the Galkayo Education Center for Peace and Development and HILI, who are working to improve girls' education and taking FGM sensitisation activities into schools.

It's a challenge to educate a girl in Somalia, especially in central and southern Somalia. Many families prefer to marry them off at an early age after they have undergone FGM. The girl child has no space in Somalia because there's widespread child marriage perpetuated both through culture and religion.

*~ Chairwoman Nazlin Umar Rajput,
National Muslim Council of Kenya²⁹*

It is notable, then, that in the North-East Zone of Somalia (Puntland), daughters (aged 0–14) of mothers who have had a secondary- or higher-level education appear far more likely to be cut than those of mothers who have had less education (see Figure 14). Further research into why this is so would be useful.³⁰

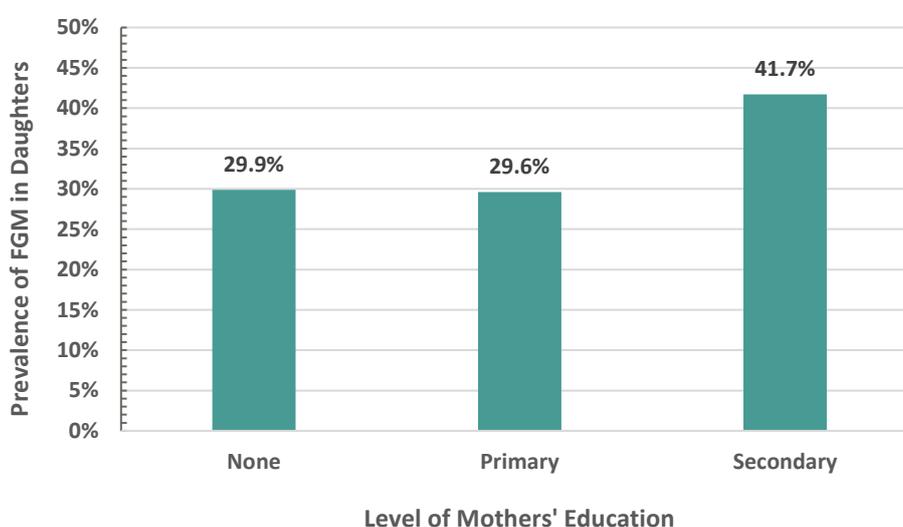


Figure 14: Prevalence of FGM among daughters aged 0–14 living in North-East Zone of Somalia (Puntland), according to their mothers' levels of education³¹

Among women aged 15–49, however, there is little difference between the percentages who have undergone FGM when broken down by their different levels of education (see Figure 15).³²

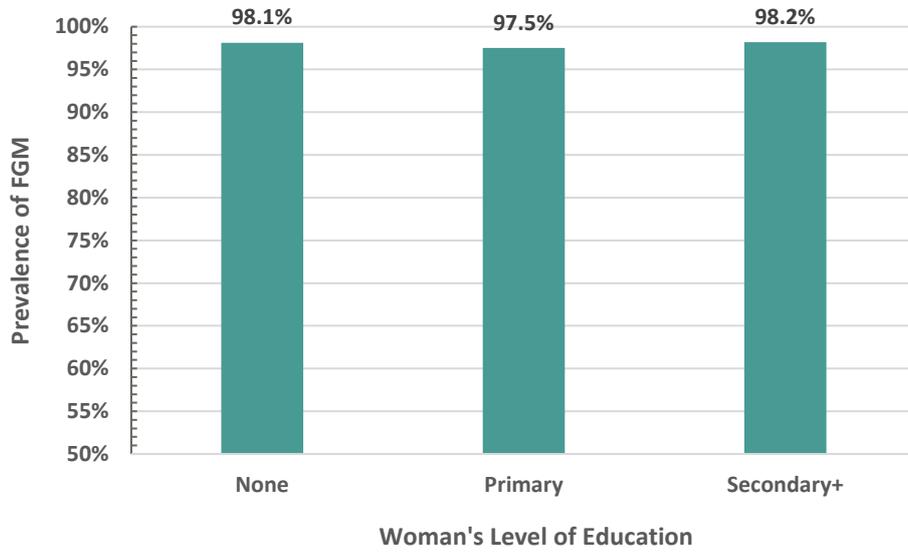


Figure 15: Prevalence of FGM among women aged 15–49 living in North-East Zone of Somalia (Puntland), according to their levels of education³³

- 1 Somalia Federal Republic Ministry of Human Development and Public Services Directorate of Education (2013/2014) *Interim Education Sector Strategic Plan 2013/2014 for 2015/2016 for South Central Zone*, p.5. Available at <https://www.globalpartnership.org/content/interim-education-sector-strategic-plan-20132014-20152016-somalia-south-central-zone>.
- 2 Somalia Federal Republic Ministry of Human Development and Public Services (2014) *Programme Document 2014–2016: Programme Implementation Grant – Global Partnership for Education*, pp.i–xii. Available at <https://www.globalpartnership.org/content/program-document-gpe-grant-somalia-federal-government-2014-2016>.
- 3 United States Department of Labor (2017) ‘Somalia’, *Child Labor and Forced Labor Reports* (Section II). Available at <https://www.dol.gov/agencies/ilab/resources/reports/child-labor/somalia>.
- 4 The Federal Government of Somalia Ministry of Education (2013) *About Us*. Available at <http://moesomalia.net>.
- 5 Somalia Federal Republic Ministry of Human Development and Public Services (2014), *op. cit.*
- 6 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017) *Education Sector Strategic Plan 2018–2020*. Available at <https://www.globalpartnership.org/content/education-sector-strategic-plan-2018-2020-somalia>.
- 7 Somalia Federal Republic Ministry of Human Development and Public Services (2014), *op. cit.*
- 8 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017), *op. cit.*, pp.29–30.
- 9 Somalia Federal Republic Ministry of Human Development and Public Services (2014), *op. cit.*, p.vii.
- 10 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017), *op. cit.*, pp.53–56.
- 11 **Percentage of children in the age group that officially corresponds to primary schooling who attend primary school.**
- 12 UNICEF (2013) ‘Somalia’, Kenya’ and ‘Ethiopia’, *Statistics*. Available at https://www.unicef.org/infobycountry/somalia_statistics.html, https://www.unicef.org/infobycountry/kenya_statistics.html and https://www.unicef.org/infobycountry/ethiopia_statistics.html.
- 13 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017), *op. cit.*, pp.58–59.
- 14 *Ibid.*, p.iv.
- 15 *Ibid.*, p.77.
- 16 *Ibid.*, pp.viii & 76–78.
- 17 *Ibid.*, p.113.
- 18 *Ibid.*, p.x.
- 19 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017), *op. cit.*, p.vi.
- 20 UNFPA (2016) *Educational Characteristics of the Somali People*, p.34. Available at http://www.analyticalreports.org/pdf/UNFPA_PESS_Vol_3.pdf.
- 21 United States Department of Labor, *op. cit.*
- 22 *Referenced article no longer available.*
- 23 Federal Government of Somalia Ministry of Education, Culture and Higher Education (2017), *op. cit.*, p.60.
- 24 *Ibid.*, p.61.
- 25 *Ibid.*, p.62–63.
- 26 *Ibid.*, p.xi.
- 27 *Ibid.*, p.35.
- 28 *Ibid.*, p.170.
- 29 Nazlin Umar Rajput cited in Doreen Ajiambo (2018) ‘For Many Somali Girls, Education Ends With a Brutal Ritual’, *Al-Fanar Media*, 2 March. Available at <https://www.al-fanarmedia.org/2018/03/many-somali-girls-education-ends-brutal-ritual/>.
- 30 SNE-MICS, p.104.
- 31 SNE-MICS, p.104.
- 32 SNE-MICS, p.103.
- 33 SNE-MICS, p.103.

Image p.97: AMISOM (2014) *2014_AMISOM_CIMIC_Schools_Visit-2*. Available at <https://flic.kr/p/mP8pM6>.
 CCL: <https://creativecommons.org/publicdomain/zero/1.0/>.

Education – Somaliland

Before 1991, when Somaliland declared independence from Somalia, education was free and compulsory for children aged 6 to 13. However, like Somalia, the war through the 1980s severely damaged Somaliland's education infrastructure, and by 1991 only 46 primary schools remained.¹

Immense strides forward were made during the following two decades, and by 2008/2009 there were 627 primary schools and 68 secondary schools. The proportion of girls attending school also increased significantly over this period, so that gender parity index in primary education increased from 0.4 in 1995/2006 to 0.6 in 2008/2009. The first university in Somaliland was opened in 1998, and by 2011 each of the country's six regions had a university.² Also, in 2010, the president decreed that all primary education should be universal and free.

The Ministry of Education and Higher Education is responsible for all state education institutions, and the Ministry of Religion oversees Quranic schools.



Students at First School Sunshine of Hargeisa in Somaliland

Education Sector Plans (ESPs) were developed for 2012–2016 and 2018–2020, their implementation being supported by funding from the Global Partnership for Education.

In August 2018 the first comprehensive **National Education Law** came into force,³ covering primary to tertiary levels, and a **National Curriculum Framework** is in development.⁴ The **National Development Plan 2017–2021 (NDP)** states, 'Somaliland is striving forward on a path towards universal education that enables all citizens to have access to basic education irrespective of their gender, ability, ethnicity and social status.'⁵

The current ESP describes Somaliland’s **educational system** as being divided between formal and non-formal, the latter comprising Alternative Basic Education (ABE) for vulnerable groups such as nomads/pastoralists and older people who were unable to participate in formal schooling, Quranic schools, and those run by NGOs and private institutions.⁶ In addition, there are Early Child Development Centres for three-to-seven-year-olds. In April 2014 the Government announced that it would be piloting a programme to devolve the management of primary schools to district councils in order to strengthen delivery and take services ‘closer to the people’.⁷

Somaliland’s formal education system comprises eight years of primary school (four years lower and four years upper), followed by four years of secondary schooling and four years of university.

Technical Vocational Education Training is limited and has not been fully standardised into formal qualifications yet, although that is the long-term plan. It currently includes short or long courses provided by the Government, NGOs and the private sector.⁸

The official **medium of teaching** at primary level is Somali, but English is introduced from Grade 2 and is the language used at secondary level and above. Arabic is taught as a language subject and is the main medium of instruction in many private schools.⁹

Literacy

Overall literacy in Somaliland is at 45.3%, which is a higher percentage than in Somalia (38.3%) or Puntland (42.9%). Literacy among women is less common in Somaliland provinces, at 40.5%, than among men, at 50.2%.¹⁰

State Average	Men	Women	Total
SOMALILAND	50.2%	40.5%	45.3%
CONTESTED REGIONS	28.3%	26.8%	27.6%

Table 16: Literacy of men and women in Somaliland, 2015¹¹

According to the SL-MICS 2011, only 44.1% of young women aged 15–24 years are literate. Literacy is also lowest among those women in the bottom wealth quintile, at 14%, while 65% of women in the wealthiest quintile are literate.¹²

Education and the Development Goals

The two **Millennium Development Goals** most pertinent to the campaign to stop FGM were 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

Goal 4 of the **SDGs** is relevant to FGM in that it relates to education:

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and

men to receive equal skills-training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

Enrolment, Access and Gender Parity

Early-years education in Somaliland is largely underdeveloped. Most institutions are run by NGOs or the private sector; many of them deliver Quranic education and are managed under the Ministry of Religion. Fourteen state schools in Hargeisa, however, run early-education classes.¹³

The **gross primary-school enrolment ratio** in Somaliland in 2014/2015 was 43%; this varied between 60.8% in urban areas and 25.8% in rural areas. In the same year, girls comprised 42.6% of the primary-school population.¹⁴ Under the ESP 2012–2016, the gender parity index for primary-school attendance increased from 0.76 to 0.83.¹⁵

The rate of children remaining in education until at least Grade 5 in 2014/15 was 63%.¹⁶

Little data has been kept about **ABE** schools, but participation in them is believed to have dropped in recent years (from some 12,000 in 2011/2012 to 5,236 in 2014/2015). The age of ABE students has traditionally been between 15 and 45, with a higher proportion of women among them, seeking this second chance to obtain literacy and numeracy skills and move into formal education. The other main group that uses ABEs are IDPs.¹⁷

Eligibility to enter **secondary education** is determined by an examination at the end of Year 8. In 2014/2015 there were 29,334 male and 18,579 female secondary students, of which over half (55.6%) studied in government-managed schools. This is more than double the number of secondary students in 2012/2013 (14,837 male and 7,220 female). However, the **gross enrolment ratio** was only 21.3%, and **gender parity** at secondary level was 0.68.¹⁸

Also evident is a lower gender parity in government schools: girls make up 35.3% of students in government schools, but 43.1% in private schools. The NDP 2017–2021 suggests that this is because state schools are generally situated in the more disadvantaged parts of the country, where girls experience greater barriers to continuing their education.¹⁹

The NDP notes that 'school facilities have a significant impact on gender equity One of the key provisions to enable girls staying in schools is the availability of water (drinking but especially washing) and latrines.' Only 46% of primary schools (including Quranic) have any access to water, and drinking water is available in less than a third.²⁰ Early marriage is cited in the ESP as another reason for earlier school dropout rates among girls.²¹

TVET is very underdeveloped and under-resourced in all regions of Somaliland and there is little data about their enrolment rates, but it is estimated there are between 5,000 and 10,000 young people attending some type of TVET. TVET is an area of education that is seen as critical to development of the economy, however, as a way of giving young people the skills required to meet

the country's economic ambitions and reducing youth unemployment, which is estimated at a third of young people.²²

By 2016 the number of **universities** in Somaliland had reached 28, of which seven are government owned and spread across all regions of the state (the remainder are privately managed). Between 2013 and 2015, 33,863 students enrolled for higher education courses, of which 34% were female.²³



Access to education is limited for Somali girls growing up in IDP camps

IDPs, nomads/pastoralists, people in urban and poor communities and girls are the groups most vulnerable to **exclusion from education**. Gross school-enrolment rates among IDP children (in Somalia and Somaliland) are 16.6% at primary level and 12% at secondary level.²⁴ The gross primary-education enrolment rate for nomadic/pastoralist children in Somalia and Somaliland is only 3.1% and at secondary level it is just 0.9%.²⁵

Child labour remains widespread in Somaliland. 40–50% of children aged 5–14 are working, and this may account for low primary- and secondary-school enrolment.²⁶

Teaching Staff

Although the primary-school pupil-to-teacher ratio in 2014/2015 was 31:1, marginally down from 32:1 in 2011/2012,²⁷ in 2014/2015 only 39.2% of primary-school teachers were qualified.²⁸ There is a severe shortage of teachers in rural areas. Only 37.9% of teachers across all of Somalia, Somaliland and Puntland are qualified.²⁹ In Somaliland, only 14.3% of primary-school teachers in 2014/2015 were female, a point noted in the ESP as being a limitation on role models for female students.³⁰

At secondary level in 2014/2015, of 1,804 teachers only 78 were female – a mere 4.3%.³¹ Only 55% of teachers were qualified to diploma level or above, a fall from previous years.³² The pupil-to-teacher ratio in 2014/2015 was 22.1:1.³³

Interventions

Both the NDP 2017–2021 and the ESP 2018–2020 set out ambitious targets for improving access and quality of education services. The Government’s Vision Statement for the education sector is based on SDGs 3, 4, 9 and 13.³⁴

The NDP’s matrix for SDG3 is as follows:

1. By 2021, 70% of secondary school students are aware of reproductive and communicable health issues.
2. By 2021, 70% of all primary and secondary school students are aware of the negative health impacts of female genital mutilation.
3. By 2021, 5% of students in higher education courses will be enrolled in medicine, health and medical science courses.

Its priority interventions to achieve this are:

- implementing national health campaigns and awareness-raising programmes in schools;
- providing health-specific teacher guides, example lesson plans and added teaching resources;
- including reproductive issues, communicable diseases and female genital mutilation into health chapters within textbooks and curricula;
- expanding university infrastructure, facilities and human resources to accommodate more medicine, health and medical-science students; and
- reviewing the national curriculum to integrate cultural heritage and civic education.³⁵

In relation to SDG4, its matrix includes:

1. By 2021, female gross enrolment rate in primary education will increase to 52%.
2. By 2021, female gross enrolment rate in secondary education will increase to 28%.

Its priority interventions to achieve this are:

- investing into the infrastructure of new and existing education institutions, with an emphasis on clean water supply, latrines, green spaces and disability access;
- ensuring in-service and pre-service teacher-training programmes are linked to competency assessment, registration and certification;
- demanding side programs that include financial- and food-based incentives;
- implementing annual Go-2-School campaigns and other community awareness programmes for all educational levels;
- committing to increase the education budget incrementally from 7% to 20% with increased efficiency measures; and
- providing flexible non-formal and alternative educational programming for vulnerable population groups including women and those living in rural areas.³⁶

The NDP’s Risk and Mitigation Measures Matrix notes the ‘Gender-based inequalities, early marriage, FGM, unwillingness to employ females in school’. It places responsibility on the ministry of education, state ministers and the deputy minister to:

- provide gender-awareness and sensitisation at all trainings;
- introduce government quotas on the recruitment of female teachers and head masters at all levels of education, both public and private; and
- train teachers on positive reinforcement and discipline, paying particular attention to the girls in the classrooms.³⁷

Education and FGM

Most of the girls here drop out of school at the age of 11 to 12. When schools are closed they are taken by their parents and forced to undergo FGM. After the procedure, you will never see them again. They get married to old men and disappear forever.

~ Muna Omar, teacher, Istanbul Primary School in Somaliland

Education plays an important role in overcoming and changing attitudes that are still in favour of FGM. While at school, girls may have greater exposure to intervention programmes and discourse about the practice. In many countries, the longer a girl is in school, the less likely she is to undergo FGM or early marriage. Girls and women who are more highly educated are also more likely to understand their rights, support the abandonment of FGM and feel equipped to challenge social norms. There are many NGOs and community activists across Somaliland, such as TASCO and CCBRS (see below), who are working to improve girls' education and taking FGM sensitisation activities into schools.

It is notable, then, that in Somaliland, as in the North-East Zone of Somalia (Puntland), daughters (aged 0–14) of mothers who have had a secondary- or higher-level education are more likely to be cut than those of mothers who have had less education (see Figure 16). Further research into why this is so would be useful.

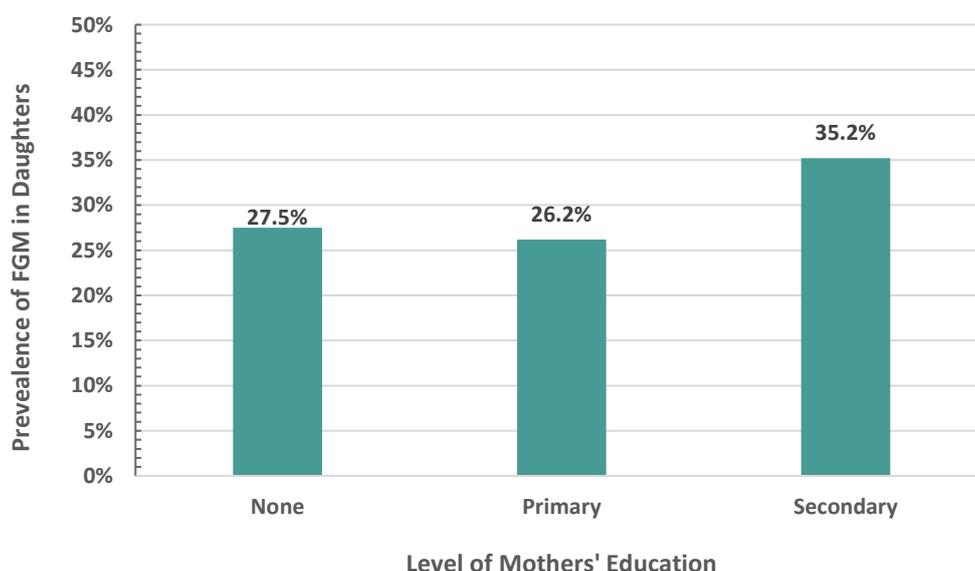


Figure 16: Prevalence of FGM among daughters aged 0–14 living in Somaliland, according to their mothers' levels of education³⁸

Among women aged 15–49, however, there appears to be a very slight trend towards a lower prevalence of FGM among women with a higher level of education (see Figure 17), although the practice is nearly universal across all levels of education.³⁹

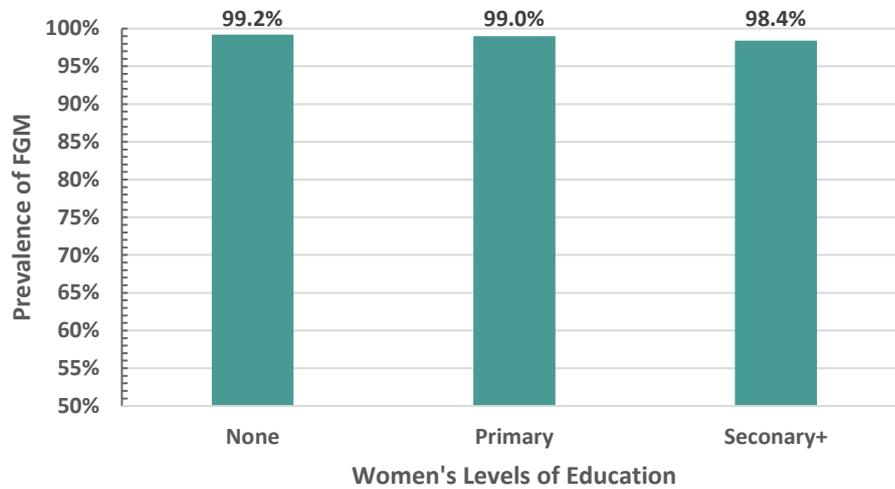


Figure 17: Prevalence of FGM among women aged 15–49 living in Somaliland, according to their levels of education⁴⁰

The EAUH studies also suggest a trend towards lower prevalence of FGM among women with higher levels of education (see Figure 18); however, the report acknowledges that in some education categories only small numbers of women were surveyed. This is particularly important for the prevalence of 23.8% observed in university-educated women for the period 2002–2006. Only 0.5% of women surveyed during this period had a university-level education, and more data would be needed to confirm this.⁴¹

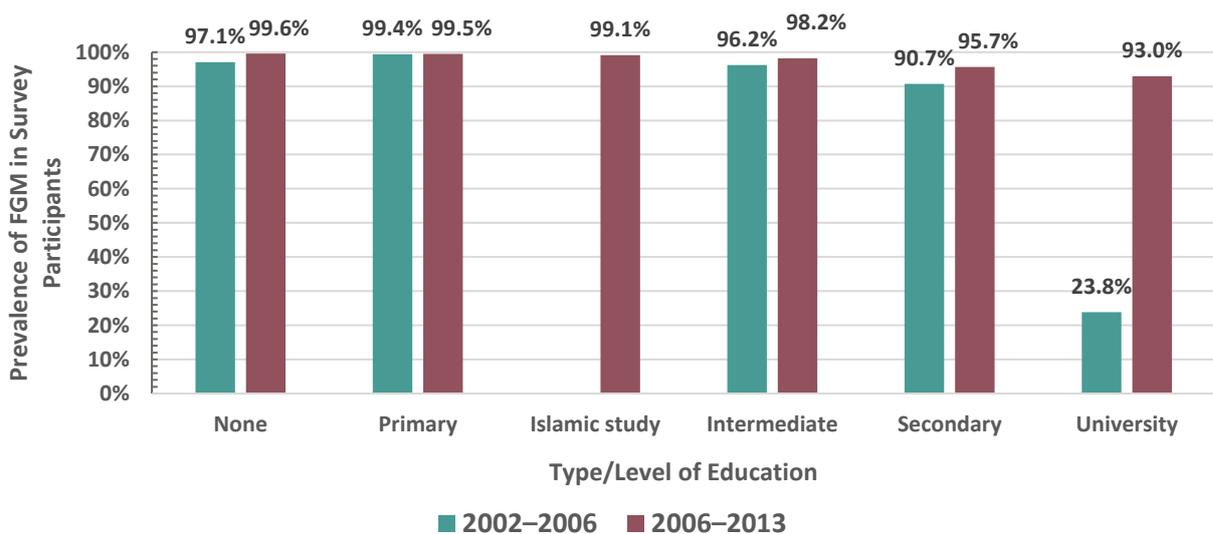


Figure 18: Prevalence of FGM among women in the EAUH studies, Hargeisa, according to their types/levels of education⁴²

COMPREHENSIVE COMMUNITY-BASED REHABILITATION IN SOMALILAND (CCBRS)



A school 'child rights club' run by CCBRS in Somaliland (© CCBRS)

CCBRS is an NGO that provides a wide range of awareness and advocacy services around GBV and FGM in Somaliland, as well as various community-based and medical-referral services for the more marginalised and vulnerable members of society. Its work is primarily focussed in four rural villages and six IDP camps in the Maroodijex Saaxil and Togdheer regions. It is also a member of the NAFIS Network of NGOs.

CCBRS works with all members of the community, including influential religious and community leaders and traditional elders, to enhance their knowledge and dispel misunderstandings around FGM and religion, so that they can go on to promote and support attitude and behaviour change around child protection and FGM. CCBRS also provides awareness training for medical professionals, traditional birth attendants and cutters, so they understand the harmful effects and complications caused by FGM.

Important work is also carried out with men and boys to improve awareness and knowledge.

In schools, CCBRS undertakes child-protection training with headteachers and their staff, to provide them with the knowledge and skills necessary to effectively and sensitively tackle the issue of FGM. Inter-school games and football tournaments are successfully used to disseminate anti-FGM messages among schoolchildren, as well as 'child rights clubs' for parents and students.

Youth engagement is a key focus, with CCBRS empowering young people to become peer educators and conduct anti-FGM activities in their schools and communities.



Spreading the anti-FGM message through football competitions in Somaliland (© CCBRS)

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Image p.101: Free Wind 2014 (2010) *Unidentified students at First school Sunshine of Hargeysa. In Somaliland, there are a number of primary and secondary schools, with the acute shortage of material resources and funds.* Shutterstock ID 180399248.

Image p.104: Stars Foundation/Kristen Buss (2010) AET - 2010 Education Award Recipient: Africa - Middle East. Available at <https://flic.kr/p/e6ws15>. CLL: <https://creativecommons.org/licenses/by-nc-nd/2.0/>.

Healthcare

Status of the Healthcare System

The healthcare system in the Somalia and Somaliland region suffered greatly during the years of civil war, leaving governments with many challenges to address to rebuild functioning health sectors. The ongoing lack of security, armed conflict, violence and poverty continue to curb access to healthcare and the provision of primary health services. There is a particular weakness in the field of reproductive health.¹

Despite this, there has been progress in recent years, particularly in Puntland and Somaliland, and a range of policies and programmes developed to address the public-health situation:

Somalia

- Somali Health Policy (2014)
- three Health Sector Strategic Plans (*HSSPs*) 2013–2016
- National Development Plan 2017–2019

Puntland

- Puntland Health Policy Framework 2012–2017
- Draft Health Financing Strategic Plan 2016–2017

Somaliland

- Somaliland Health Sector Strategic Plan 2013–2016
- Somaliland National Vision 2030 (within the pillar for Social Development)



Public hospital in the city of Borama

In addition to government strategies, various organisations have their own **strategies** in place for providing aid and healthcare to the region. These include UNICEF Somalia's Health Strategy Note 2018–2020, which highlights the need to strengthen the health system as a priority and meet specific needs of mothers and babies. UNICEF has also committed to working closely with the Ministry of Health, communities and other funding organisations to improve access to health services.²

NGOs provide the main **health services**, and there is a growing private health system, which is currently unregulated.³ 2014 estimates were that there were around 6,000 doctors, nurses and midwives in the entire region, a huge shortage compared to the target of 30,000 set for the achievement of the MDGs.⁴ More than 85% of professional skilled health workers are in urban administrative districts and regional headquarters.⁵

Somalia

Health services in Somalia are provided through the Essential Package of Health Services (*EPHS*) which provides four levels of service through ten programmes. The *EPHS* has not yet been fully implemented, due to a lack of funding, shortages of trained staff and medical supplies, and security issues.⁶

The Somalia National Health Policy includes detailed HSSPs. However, implementation of the plans has been inconsistent, with Puntland faring better than South/Central Somalia. A lack of professional staff, accountability and regulation has hindered progress.⁷

The **main health issues** in Somalia are communicable diseases, malnutrition and reproductive health issues, with one in 18 women in Somalia having a lifetime risk of death during pregnancy.⁸

Community-level services are provided by around 17 different types of providers, including female health workers, traditional birth attendants and community-health workers. Female community-health workers (*marwo caafimaad*) were introduced to extend the range of services to communities that previously had difficulty in accessing them. 200 female workers were trained initially, with a further 300 recruited in 2015, and there are plans to extend this to 8,000 or more.⁹

A study undertaken in 2018 by Save the Children found that many people in Somalia rely on traditional healers, home remedies and other untrained providers for health matters, particularly in rural areas. Often, this is due to the distance to a health centre, but also in some cases a lack of faith in the abilities of the health providers in public facilities.¹⁰

The report also notes that 90% of community-health workers have less than three years' experience and one-third of the community workers are volunteers or receive no salary for their work.¹¹

The 2016 Human Resources for Health policy focussed on increasing community-based healthcare in Somalia, including the female community-health workers' integration into the health network.¹²

UNICEF Somalia's Health Strategy Note 2018–2020 also recognises the benefits of community-based interventions, the strengthening of community workers and the use of integrated community case-management.¹³

Progress on healthcare overall has been slow and the strategies are not always updated when they run out (one exception is the Somali Human Resources for Health Development Policy 2016–2021). However, in 2018, work began between the WHO and the Somali Government on a roadmap to

develop universal health coverage throughout Somalia. The project is being led by the Ministry of Health together with various UN agencies and includes work on how Somalia can attain SDG3 (Good Health and Wellbeing). The Government of Japan is supporting the initial work to develop the roadmap.¹⁴

Puntland

The Health Policy Framework 2012–2017 for Puntland specifically includes measures designed to alleviate the problem of healthcare access for nomadic pastoralists, who make up around 50% of Puntland's population. Distance from health facilities and the need to care for livestock are both barriers to access to healthcare for the nomadic communities, and therefore it was agreed in the Framework to create a department dedicated to Nomadic Pastoralist Health Services within the Ministry of Health. In addition, mobile clinics and training Nomadic Lady Health Workers to complement Female Health Workers are stated as objectives of the framework.¹⁵

Because many districts are located in hard-to-reach, mountainous areas, the Framework also notes the need to establish maternal waiting homes that can be located near maternal and child health centres and used to prevent the need for late transportation of high-risk pregnant women from mountain areas. The policy also suggests quotas for midwifery schools, so that girls from remote areas can train to be midwives in return for guaranteeing they return to their native area to practise for a certain period of time.¹⁶

Somaliland

The Ministry of Health is responsible for healthcare in Somaliland. International development partners and international and local NGOs provide support through funding and technical advice. In addition, there are several Health Associations in Somaliland, including the Somaliland Medical Association and the Somaliland Midwifery and Nursing Association.¹⁷

A 2016 Health Facility Assessment found that there were 336 functional health facilities in Somaliland and 443 private health facilities and hospitals, as well as five medical institutes and six midwifery schools for the training of professional healthcare staff.¹⁸

As in South/Central Somalia, issues facing Somaliland are a high burden of communicable diseases, weak stewardship, a lack of sustainable funding, poor access to health services, an absence of data, a lack of coordination of external funding resources and a lack of qualified professional health staff.¹⁹

Healthcare Funding

Government funding for healthcare in the region in 2015 was very low, with no public budget or commitment to funding in Somalia and only around 3% of the annual budgets of Somaliland and Puntland dedicated to healthcare.

The majority of healthcare funding comes from donors. Often, this is through targeted programmes tackling diseases, rather than for the development of primary healthcare services.²⁰ Reliance on donor funding is unpredictable, as funds may be withdrawn and there is no guarantee of future funding once current commitments have run out. There is also a lack of harmonisation

between donor investment and national priorities, demonstrating a need for more local funding and better government–donor planning and consultation.²¹

The remaining expenditure on health is out-of-pocket payments, which are high and often only managed by patients with money from family at home and overseas. In fact, the majority of the population pays for private healthcare, but, although it is known that private health expenditure is high, there are no official figures available.

An example of recent funding is the three million Euros given to UNFPA Somalia by the Italian Government to be used for social and human development, including health, with an emphasis on reducing maternal mortality.²² The UN Migration Agency also announced the provision of health services to two South/Central Somali towns that had previously been void of such services due to ongoing conflict.²³ A further \$31 million of funding for health projects in Puntland is being provided by the German Government. It is allocated to two projects, one for health-system strengthening generally and the other for maternal and child health.²⁴



Maternity services at the Edna Adan Hospital in Hargeisa

Women's Health

Maternal healthcare comes under the EPHS framework for the provision of health services, which aims to reduce **maternal and child mortality**.²⁵ Additionally, the reduction of maternal, neonatal and child mortalities and the improvement of access to essential health services is one of the goals of the Somalia National Development Plan 2017–2019.²⁶

According to the WHO 2015 Strategic Review of the health sector, there are a total of 385 **maternal and child health centres**/general health centres in the region. Of these, 109 are in Somaliland, 79 in Puntland and 197 in South/Central Somalia. Additionally, there are 78 hospitals (23 in Somaliland, 8 in Puntland and 47 in South/Central Somalia).²⁷

Despite progress towards improving maternal and child mortality rates during the period of the MDGs, the **maternal mortality rate** remains among the highest globally, at 732 deaths per 100,000 live births.²⁸ A woman's chance of dying from pregnancy and childbirth is one in 18, and many deaths are from preventable causes. The lack of facilities (just over half of health facilities provide basic emergency obstetric care) and the low number of skilled birth attendants present at deliveries are important factors in this.²⁹ In addition, awareness of issues related to maternal and child mortality remains low, and even where women are better informed on such issues, their decisions about access to health services are often made by husbands and grandmothers.³⁰

The **Daryeel Dumar Hospital** opened in August 2017 in Mogadishu and provides maternity, pre- and post-natal care by female doctors to cater for women who would perhaps not have felt comfortable giving birth in a hospital with male doctors.³¹

In October 2018, the **First Lady Dr Hodan Said Isse**, ambassador for the Campaign for Accelerated Reduction of Maternal Mortality in Africa (*CARMMA*), led an event in Garowe, Puntland, to increase awareness of the problems of maternal and neonatal deaths in Somalia. The event also celebrated the expansion of Comprehensive Emergency Obstetric and Newborn Care service provision into remote areas as well as the graduation of 40 midwives from midwifery schools in Garowe and Bossaso.³²

In 2017 at the **Family Planning Summit in London**, the Government of Somalia renewed their 2015 commitment to address 'the barriers to accessing reproductive, maternal, neonatal and child health services'. Specifically they set targets to be achieved by 2020 to ensure that legal policy and strategic frameworks were in place for family planning and to increase access from 50% of facilities providing family planning services to 80%.³³

Puntland

In the North-East Zone of Somalia (Puntland), only 2.6% of married women are using a form of contraception. The unmet need for contraception among married women is 11.4%, the majority of this being for birth spacing.³⁴ However, a recent survey found that that unmet family-planning need in certain districts is much higher (for example, in Armo district it is 87%).³⁵

Around three-quarters of women aged 15–49 who gave birth in the two years prior to the 2011 MICS survey did not receive any antenatal care. For those who did receive care, this was mainly provided by medical doctors (19.5%).³⁶

12.7% of births take place in a health facility (9.2% of which are in public-sector facilities and 3.5% in private facilities). However, the majority of births still take place at home (84.3%). Women with higher levels of education and wealth are more likely to use health facilities, as are those in urban areas.³⁷

38.5% of women who had given birth in the two years prior to the 2011 MICS survey received assistance at birth from a skilled health professional (doctor/midwife/nurse). 55.7% were assisted by a traditional birth attendant.³⁸

Somaliland

In Somaliland, only 9.8% of married women aged 15–49 use a form of contraception. The unmet need for contraception in married women is 20.2%.³⁹

More than half of the women who had a live birth in the two years prior to the 2011 MICS survey did not receive antenatal care (57.9%). 31.7% received care from a doctor, nurse, midwife or auxiliary midwife.⁴⁰

30.6% of births take place in a health facility (18.8% in public sector facilities and 11.8% in the private sector). Women in urban areas and those with higher levels of education and wealth are more likely to give birth in a health facility. More than half of all deliveries in Somaliland occur at home (67.2%), and in the Sanaag region this is as high as 89.7%.⁴¹

44% of women who had given birth in the two years prior to the 2011 MICS survey received assistance at birth from a skilled health professional (doctor/midwife/nurse). 41% were assisted by a traditional birth attendant.⁴²

Health and The Development Goals

2015–2030 – Challenges and Opportunities

The MDGs have now been replaced by the **SDGs**, which have a deadline for achievement of 2030. The full set of SDGs is available at <http://17goals.org/>.

In addition to **Goal 5.3 (Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation)**, which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

Goal 3 (Ensure healthy lives and promote wellbeing for all at all ages) aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

While much progress was made in **Somalia** towards the end of the MDG period,⁴³ the country is still well behind on its health targets, particularly in regard to maternal and child health. A recent report based on 37 health criteria for the SDGs ranked Somalia among the bottom three countries.⁴⁴ In addition, the policy document for Somali Human Resources for Health recognises that the current health status in Somalia reflects a failure to meet the MDGs and a need to address health workforce gaps if there is to be meaningful progress towards achieving the SDGs.⁴⁵

Somaliland did not reach the majority of its MDG targets. Although it is not an official signatory of the SDGs, its National Development Plan 2017–2021 was drafted to fall into line with the SDG targets (including the reduction of FGM), which Saferworld notes ‘puts it ahead of most others when it comes to incorporating the SDGs in national planning processes.’⁴⁶

Healthcare and FGM

EDNA ADAN MATERNITY AND TEACHING HOSPITAL, HARGEISA

Dr Edna Adan Ismail has been a pioneering voice in the efforts to eradicate FGM in Somalia and Somaliland since the 1970s.

As an FGM survivor and trained nurse and midwife, Dr Adan has campaigned for the abandonment of FGM at both international and domestic levels and has taught FGM awareness to medical students in Mogadishu University and throughout Africa and Asia. She has also worked in Somaliland's Ministry of Family Welfare and Social Development and was Foreign Minister for Somaliland (2003–2006), and is most well-known for establishing the Edna Adan Maternity and Teaching Hospital in Hargeisa in 2002.

The Edna Adan Hospital (now a general hospital) is a centre of excellence for the treatment of complications caused by FGM, the provision of survivor support services and research on FGM across Somaliland. It is also ground-breaking in its auditing of FGM cases so as to build a baseline dataset upon which further analysis and research can be done to inform policy, services and teaching.

For further information see <https://www.ednahospital.org/>.



Dr Edna Adan Ismail, leading anti-FGM campaigner and founder of the Edna Adan Hospital in Hargeisa

Obstetric Fistula

Obstetric fistula is a condition caused by prolonged obstructed labour, which results in a hole between the vagina and the rectum or bladder.⁴⁷ Although FGM does not directly cause obstetric fistula, it can lead to complications in labour that in turn lead to obstetric fistula.

Obstetric fistula is common in Africa, accounting for the majority of the estimated 200 million women who are affected globally, and it is usually the result of poor maternal care or giving birth at a young age.

In Somalia, the combination of inadequate obstetric services, high rates of teenage marriage and motherhood, and widespread Type III FGM combine to make it a high-risk country for obstetric fistula.⁴⁸ It is a safe assumption that this is also the case in Somaliland.

The Borama Fistula Hospital in Somaliland, which provides care for women from all over Somaliland and Somalia, is the only hospital in the region that exclusively provides fistula treatment. Three full-time surgeons perform over 400 operations each year, and the hospital also provides training and rehabilitation for patients as well as training for community-health workers about obstetric fistulae.

The Somaliland Nursing and Midwifery Association, supported by UNFPA Somalia, ran a fistula campaign at the Borama Fistula Hospital in Somaliland in early 2018, providing surgery for sufferers.

In 2009, a fistula repair facility was also opened at the Edna Adan University Hospital. Both the Borama Fistula Hospital and the Edna Adan University Hospital have received help and funding from the Fistula Foundation. The Foundation also funds fistula surgeries and surgeon training in Hanano and Benadir Hospitals in Mogadishu.⁴⁹

In addition, in 2016 the NGO Physicians Across Continents undertook fistula surgery clinics at three hospitals (Daynile, Kismayo and Garowe General Hospitals), working with the Somali Ministry of Health and the UNFPA Somalia. The surgery clinic was accompanied by a campaign to educate women about the programme.⁵⁰ The Maato Kaal Centre in Garowe General Hospital, run by Muslim Aid, also provides support for survivors of FGM.⁵¹

On 15 January 2017, a fistula department was opened in Kaysaney Hospital in Mogadishu, which is managed by the Somali Red Crescent Society.⁵²

The NAFIS Network is also involved in providing health and support services to FGM survivors. At centres in the Awdal, Marodijeh and Togdheer regions, psychological counselling and medical referrals are provided, as well as surgery support. An FGM education module has been added to the curriculum of community health workers, and training provided to healthcare centres.⁵³

Support centres were also established in Hargeisa, Borama and Burao:

The support centers provided door to door household visits to raise awareness on FGM and more than 3470 households benefited. One thousand one hundred and eighty (1180) persons benefited from the monthly discussions on FGM issues offered by the support centers.⁵⁴



CCBRS, a member of the NAFIS Network, provides training to health workers in Somaliland (© CCBRS)

Medicalisation

Medicalisation refers to the performance of FGM by healthcare providers or in healthcare facilities, rather than by traditional cutters.

Activists from communities in Puntland and Somaliland have indicated that medicalised FGM is a growing trend, but in South/Central Somalia it is considered to be widespread: 'Mogadishu practitioners of FGM/C openly advertise their services on street signs and there are "FGM clinics."' ⁵⁵

28 Too Many understands that new data due in 2019 from the **Somaliland Family Health Association**, conducted as part of its current Mid-Term Review supported by the Orchid Project, is showing a rapid increase in medicalisation in Somaliland.

A study by the UNFPA also found that, although in most parts of the region traditional circumcisers carry out FGM, the number of professional health providers who cut girls is increasing:

This medicalisation of FGM/FGC started at the dawn of Somalia's independence when a Lebanese medical practitioner began circumcising girls in . . . Mogadishu under sterilized and anaesthetic conditions. He claimed to minimize damage and dangers associated with FGM/FGC. He conducted partial or total clitoridectomies without infibulations for those who demanded 'Sunnah' circumcision. Other health providers emulated him, spreading services to Mogadishu's elite. ⁵⁶

Activists and health professionals have rightly pointed out that medicalised FGM can actually cause greater harm to girls:

People who send their girls to hospital say that they are now able to have it without pain. But the practitioner will cut more. Therefore the expansion of medical services can be counter-productive. When the child is circumcised in the rural areas without anaesthetic, four people have to hold her down to control her, and then less may be cut.

~ Dr Xasan Ismail Yusuf ⁵⁷

All types of FGM, no matter where or by whom they are carried out, are harmful to women and girls.

For further information about the medicalisation of FGM, please see 28 Too Many's report, available at <https://www.28toomany.org/thematic/medicalisation/>.

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- 49 Fistula Foundation (2019) *Somalia*. Available at <https://www.fistulafoundation.org/countries-we-help/somalia/>.
- 50 Gele *et. al.*, *op. cit.*
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- 52 Somali Red Crescent Society (2017), *Annual Report 2017*, p.15.
- 53 NAFIS Network (2017) *Annual Report 2017*, pp.4 & 7. Available at <https://nafisnetwork.net/wp-content/uploads/2018/10/Annual-Report-2017.pdf>.
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- 56 World Bank and UNFPA (2004) *Female Genital Mutilation/Cutting in Somalia*, p.19. Available at http://siteresources.worldbank.org/INTSOMALIA/Data%20and%20Reference/20316684/FGM_Final_Report.pdf.
- 57 Dr Xasan Ismail Yusuf cited in Maggie Black (2003) *Somali children and youth: Challenging the past and building the future*.

Image p.110: Free Wind 2014 (2010) *Public hospital in the city of Borama in North-West Somalia. Located near the border with Ethiopia. The hospital has a poor funding*. Shutterstock ID 181193945.

Image p.113: Free Wind 2014 (2010) *The Edna Adan University Hospital. Is a non-profit charity that was built by Edna Adan Ismail who donated her UN pension and personal assets to build the hospital*. Shutterstock ID 175968782.

THE IFRAH FOUNDATION – ADVOCATING FOR AN END TO FGM ACROSS SOMALIA



Ifrah Ahmed of the Ifrah Foundation works closely with government, civil society and media partners to advocate for an end to FGM across Somalia (© Global Media Campaign)

The Ifrah Foundation, founded in 2010 by Somali FGM survivor Ifrah Ahmed, has been operational in Somalia since 2013. In this time Ifrah has become a powerful force in the movement to end FGM in Somalia and effects change through a focus on advocacy, awareness-raising and community empowerment and education.

Since being appointed gender advisor to the Somali Government in 2016, Ifrah has been working with many community, national and international partners on important activities, including:

- Scoping and drafting a **National Action Plan** to end FGM in Somalia. Following initial research and consultation with stakeholders (including focus groups with some 5,000 individuals), the Ifrah Foundation informs 28 Too Many that the focus across 2019 will be to bring together these key stakeholders and create a coalition that will agree and implement the National Action Plan.
- In July 2018 the Ifrah Foundation led the **first high-level conference on FGM** in Mogadishu, bringing together around 200 of Somalia's most influential actors, including government ministers, embassies and international agencies (such as DFID), religious and community leaders, the media and representatives from across civil-society organisations. The conference explored the following areas: the role of religious leaders in the work to end FGM, the status of government frameworks relevant to FGM and the current status of anti-FGM advocacy efforts both nationally and globally.
- The conference was followed by a successful **Media Campaign Academy** with religious leaders, in partnership with the Global Media Campaign (GMC) to End FGM. Supported and funded by international organisations such as the UNFPA, UNICEF and Save the Children, the Media Academy brought together 70 representatives from public and private media institutions to work with religious leaders and better understand the dangers of FGM and how to utilise that knowledge to increase awareness through the use of all types of media.

- In August 2018, Ifrah produced a short documentary film in partnership with the GMC called **Deeqa's Story**. This investigated the story of ten-year-old Deeqa Dahir, who bled to death after being cut in Somalia a few months previously. This very powerful film has had huge international coverage and significant local impact, reaching an East African audience estimated at 15 million. It has also promoted wide discussion on social media within Somalia, particularly among young Somali women.



Ifrah Ahmed planning a Media Campaign Academy with a colleague from the Global Media Campaign to end FGM (© Global Media Campaign)

28 Too Many understands from the Ifrah Foundation that the scoped National Action Plan, which should start to roll out across 2019, funding permitting, envisages legislative reform that will ban all types of FGM in Somalia, per the SDG of Zero Tolerance, by 2020. The National Action Plan subscribes to a systemic three-pillar model of change requiring consistent, combined and sustained action at the policy, media and community levels.

In partnership with the UNFPA and GMC, and following on from the widely-viewed Deeqa's Story, a further documentary film on the adverse effects of FGM on three more girls who have recently been cut in three regions of Somalia will be rolled out (entitled **This is My Story**, the film was launched at an event to mark Zero Tolerance Day in Mogadishu in February 2019).

At the time of writing, an Irish/Belgian feature film entitled **A Girl from Mogadishu** (written and directed by Mary McGuckian and starring Aja Naomi King, Barkhad Abdi, Martha Canga Antonio and Maryam Mursal), which is based on Ifrah Ahmed's life story, has just been completed and will also be released towards the end of the year.

Media

By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.

~ Former UN Secretary General, Kofi Annan¹

Major Media Outlets in Somalia and Somaliland

Radio is extremely popular in the region. The major radio stations are:

- Radio Mogadishu (government-run)
- Radio Shabelle (private)
- Radio Banaadir (private)
- Radio Simba (private)
- Radio Kulmive (private)

Reception for all of the above stations is limited to Mogadishu.

- Raedio Hargeisa, Somaliland (government-run)
- Radio Gaalkacyo, Puntland (state-run)²

Infoasaid's media landscape guide on Somalia notes that many radio and television stations in the region have 'well-established relationships' with NGOs and INGOs, and that radio is a particularly good way for activists to reach people in very rural areas or IDP camps.⁴

The most popular international radio stations are the Voice of America Somali Service and the British Broadcasting Corporation Somali Service.³

Other **web-based news publications** are as follows:

- *Dayniile* (English)
- *Jowhar* (English)
- *Mareeg* (English)
- *Hiiraan Online* (English)
- *Puntland Post*
- *Somaliland Sun*

Popular **television** stations include:

- Somali National Television (state-run, Mogadishu)
- Somaliland National TV (SLNTV) (government-run)
- Somali Broadcasting Corporation (SBC) (private, Puntland)
- Universal TV – London-based, satellite⁵

Press Freedom

Reporters Without Borders ranks Somalia and Somaliland
168 out of 179 countries
in its **2018 World Press Freedom Index**.⁶

Freedom Press categorises Somalia's press status as 'not free' and calls it 'one of the most dangerous countries in the world for journalists'. By way of example, it lists Daud Ali Omar, a producer for Radio Baidoa and Hindia Haji Mohamed, a reporter for Radio Mogadishu and Somali National TV, who in 2016 were both 'killed in retaliation for their work'.⁷

It does not appear that reporting on FGM in and of itself is particularly likely to spark retaliation in either Somalia or Somaliland.

Save the Children in Somalia has launched a publication that 'captures stories of hope and courage' from the communities in which they work. This beautiful booklet can be found at bit.ly/2WN4Pzw.

Access to Media

*Media matters in Somalia. The society arguably ranks among the most media literate in Africa. While much divides a deeply fractured, war-torn and now drought-stricken and famine-stricken country, an ancient love of poetry and a common language unite it. So, throughout recent history, has an avid consumption of news and information.*⁸

There are no obvious barriers to citizens accessing media and information in Somalia or Somaliland. However, men and women in al-Shabaab-controlled areas are not permitted to listen to foreign news broadcasts.⁹

In **Somalia**, the Constitution provides for freedom of media in all forms at Article 18,¹⁰ and there are no widely-known instances of the Somali Government restricting internet access to civilians. News is mostly accessed via foreign and local radio broadcasts, but many government-owned and independent print newspapers also exist.¹¹

The only FM radio station in **Somaliland** is government-owned, and independent FM stations are not permitted.¹² Citizens' access to social media was restricted for a period of four days during elections.¹³

Traditional Media: Television, Newspapers and Radio

There is no MICS data available for the whole of **Somalia**, but for women (aged 15–49) living in the North-East Zone (Puntland), radio is the most commonly accessed form of traditional media. Access to media in general is vastly more common in urban areas than in rural areas, and among wealthier and more highly educated women (see Figure 19). Newspapers and television are more commonly accessed by younger women than older women.¹⁴

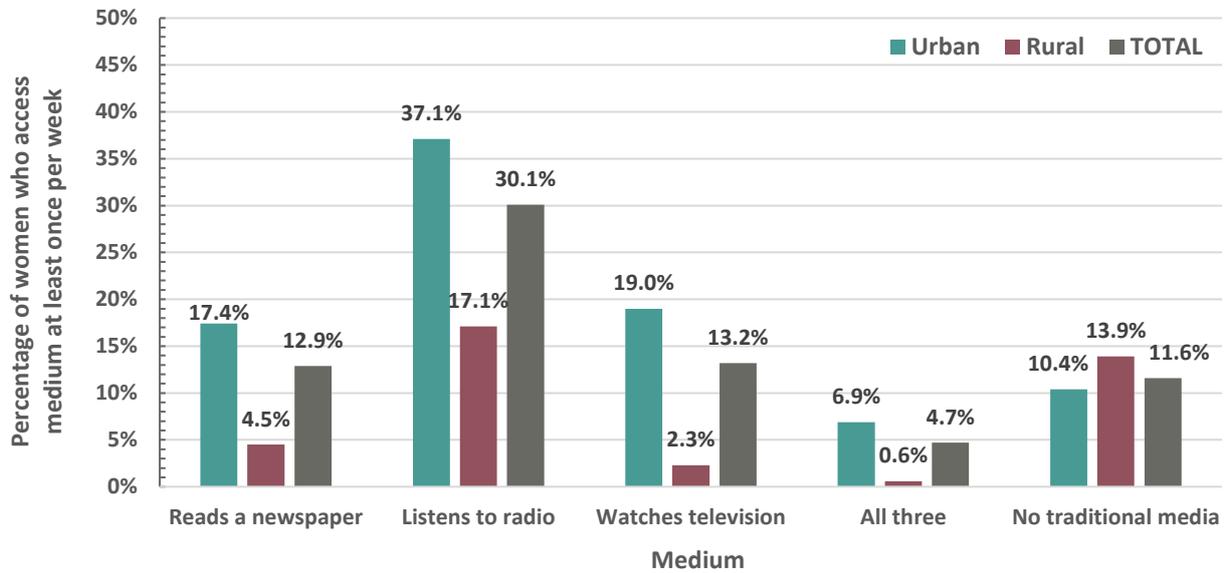


Figure 19: Percentages of women aged 15–49 who access at least one form of traditional media per week, by medium (North-East Somalia, 2011)¹⁵

Among women aged 15–49 living in **Somaliland**, television is the most commonly accessed form of traditional media (see Figure 20). Again, all forms of traditional media are more commonly accessed by women in urban areas and those who are wealthier and more highly educated. Radio is equally popular among women from all age cohorts, but younger women are more likely to read a newspaper or watch television.¹⁶

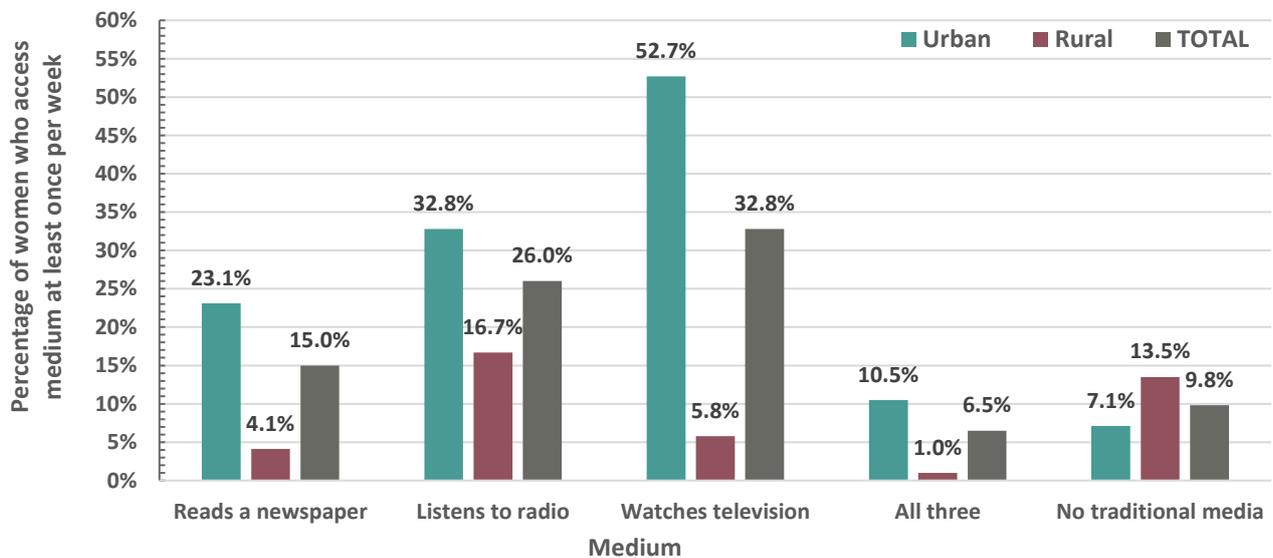


Figure 20: Percentages of women aged 15–49 who access at least one form of traditional media per week, by medium (Somaliland, 2011)¹⁷

Radio would appear to be the most effective medium for reaching people in rural areas of both Somalia and Somaliland with anti-FGM messages; however, television would also be useful in Somaliland.

The Internet and Social Media

Among women aged 15–24 living in the North-East Zone of **Somalia** (Puntland), 9.9% had used the internet during the 12 months prior to the MICS survey, and 7.7% had used the internet in the previous month. It is more common for women aged 15–19 to use it (9.4%) than women aged 20–24 (5.8%), and much more common for women living in urban areas to use it (11.3%) than women living in rural areas (0.8%). Women who are in the richest wealth quintile and who have received more than a secondary education are vastly more likely to use it than other women.¹⁸

Among women aged 15–24 living in **Somaliland**, 14.3% have used the internet during the 12 months prior to the MICS survey, and 12.2% use the internet at least once a month. In contrast to Somalia, it is slightly more common for women aged 20–24 to use it (13.5%) than women aged 15–19 (11.1%), yet much more common for women living in urban areas to use it (18.2%) than women living in rural areas (1.7%). Again, women who are in the richest wealth quintile and who have received more than a secondary education are vastly more likely to use it than other women.¹⁹

I have been posting many different articles about the work we are doing. Due to the sensitive nature of the topic, it has proved a good way for people to read about it in their own time, from the privacy of their phones and computer.

~ Mohamed, anti-FGM Ambassador trained by Candlelight, Somaliland²⁰

At present, it would appear that social media and the internet may not be a hugely effective medium for campaigning against FGM in poorer, rural areas of the region; however, it is useful for reaching wealthier and more educated women, and young people more generally in urban areas. As social media use is reportedly on the rise in Somalia and Somaliland, it is likely to prove to be an effective channel for anti-FGM advocacy in the future.

The Media and FGM

Multiple forms of media are being harnessed to aid anti-FGM work all over the world. Somalia and Somaliland are no exception. Activists can more effectively raise awareness about a variety of issues, even in the most remote parts of the region, where radio is popular. Social media, including Facebook and Twitter, as well as more traditional forms of media, can be used as a platform for discussions and break taboos, which in turn paves the way for education and change. Telling FGM survivors' stories is also an important work that is aided by media such as film and television.



NAFIS Network
@NAFIS_NETWORK

Media is very powerfull
to change the social
norms to end FGC through
awareness-raising, advocacy
and political action or
change.



*Using media to advocate for the enactment of the new anti-FGM law in Somaliland
(NAFIS Network Twitter, February 2019)*

Poetry is a national passion and the subject of endless debate.²¹

In its work around FGM and women's social and economic empowerment in Somalia and Somaliland, Care International has found poetry a powerful medium to convey the painful experiences of women which can then, in turn, be used to educate and advocate for an end to the practice. As Care explains, '[I]n Somalia, poetry and activism go hand in hand. Somali people are renowned poets, and in times of struggle poems are used to convey social and political messages.'²²

THE GLOBAL MEDIA CAMPAIGN TO END FGM

The Global Media Campaign to end FGM (GMC) has been working with partners in Somalia, such as the Ifrah Foundation, since 2016. Through its Media Training Academies, GMC empowers religious leaders, Somali journalists and activists to use all forms of media to educate communities on the harms of FGM, spread the message that it is not a religious obligation, and thus advocate for total abandonment across the region.

Two successful Media Training Academies have been held to date in Puntland (December 2017) and Mogadishu (July 2018), supported by UNICEF and Save the Children. By providing a space for honest conversation, debate and learning, in the presence of the relevant government ministries from both state and federal level, religious leaders, journalists and activists have been able to discuss challenging issues in relation to the campaign to end FGM, and build confidence to work together on awareness-raising campaigns in future.

*The learning and sharing in the academy was one of a kind. It's the first training that has ever equipped [me] as a religious leader [with] the relevant knowledge I need to use media in my FGM awareness raising. I am elated!*²³

The GMC also works with partners to produce documentaries and associated social media highlighting important stories on FGM in Somalia; for example, *Deeqa's Story*, in partnership with the Ifrah Foundation, investigates the death of 10-year-old Deeqa Dahir following FGM in 2018.

28 Too Many understands that the GMC aims for the media campaign work to accelerate across the period 2019–2021, building upon this trained network of journalists, religious leaders and activists who now have the skills to advocate for collective abandonment of FGM across Somalia, through the use of all forms of media.



Religious leaders, journalists and activists learning together at the GMC Media Training Academy to end FGM in Puntland, 2017 (© Global Media Campaign)

- 1 The late Kofi Annan cited in Adelokun Lateef Adekunle (2014) 'Finding Justification for the Practice of Peace Journalism: A Public Assessment of Media Roles towards Peace Promotion in Nigeria', *Journal of Mass Communication & Journalism*, 4(5), p.195. Available at <http://www.omicsgroup.org/journals/finding-justifications-for-the-practice-of-peace-journalism-a-public-assessment-of-media-roles-towards-peace-promotion-in-nigeria-2165-7912.1000193.pdf>.
- 2 BBC News (2017) *Somalia profile – Media*, 15 August. Available at <https://www.bbc.com/news/world-africa-14094550>.
- 3 Infoasaid (2012) 'Somalia Media and Telecoms Landscape Guide: Reports & Surveys', *Internews*. Available at <https://www.internews.org/resource/somalia-media-and-telecoms-landscape-guide>.
- 4 Infoasaid, *op. cit.*
- 5 BBC News (2017) *Somalia profile – Media*, 15 August. Available at <https://www.bbc.com/news/world-africa-14094550>.
- 6 Reporters Without Borders (2018) *2018 World Press Freedom Index*. Available at <https://rsf.org/en/ranking>.
- 7 Freedom House (2016) *Somalia: Freedom of the Press 2016*. Available at <https://freedomhouse.org/report/freedom-press/2016/somalia>.
- 8 The BBC World Service Trust cited in Infoasaid, *op. cit.*
- 9 US Department of State (2013) *Somalia 2013 Human Rights Report*, p.17. Available at <https://photos.state.gov/libraries/somalia/323250/pdfs/somalia-human-rights-report-2013.pdf>.
- 10 *Somalia's Constitution of 2012* (2012) Available at https://www.constituteproject.org/constitution/Somalia_2012.pdf.
- 11 *Ibid.*, p.18.
- 12 *Ibid.*, pp.15–16.
- 13 Human Rights Watch, *op. cit.*
- 14 SNE-MICS 2011, p.121.
- 15 SNE-MICS 2011, p.121.
- 16 SL-MICS 2011, p.114.
- 17 SL-MICS 2011, p.114.
- 18 SNE-MICS 2011, p.122.
- 19 SNE-MICS 2011, p.122.
- 20 Mohamed cited in Alice Rowsome (2017) 'Somaliland: "I convinced my sister not to do type III FGM on her daughter"', *The Guardian*, 30 March. Available at <https://www.theguardian.com/society/2017/mar/29/somaliland-i-convincing-my-sister-not-to-do-type-3-fgm-on-her-daughter>.
- 21 Infoasaid, *op. cit.*
- 22 Care (2018) *FGM: Was it a blessing when they cut me?*, 6 February. Available at <https://www.careinternational.org.uk/stories/fgm-was-it-blessing-when-they-cut-me>.
- 23 Confidential correspondence provided to 28 Too Many; used with permission.

Ending FGM: Challenges

Challenges faced by anti-FGM advocates fall into two categories.

Firstly, there are cultural challenges related to the structure of society in any country that must be negotiated or surmounted, such as traditions, beliefs and social norms that support the practice of FGM.

Secondly, there are practical challenges, such as how to deliver messages to all practising communities, how to enforce the law in a way that curbs FGM and prevents it being driven underground, and how to maintain a consistent, clear message about FGM when civil society is impacted by political unrest or natural disaster.

Cultural Challenges

In a region where FGM is such a deeply ingrained tradition that, for many, it is inconceivable that society could exist without it, changing opinions and social norms in favour of total abandonment of FGM could be considered an impossible undertaking. This research has shown, however, that progress is being made in both Somalia and Somaliland, and challenges that were once considered too difficult to overcome are now gradually being confronted. For instance, FGM used to be a taboo subject, never publicly discussed and certainly not opposed; now it is openly debated in Somali communities, on television and radio and across social media. Government ministries are generally supportive of NGOs and activists' work, which is not always the case in some other FGM-practising countries. Joint working and strong partnerships are evident across the region.

Challenges that remain, however, include the following.

Misunderstandings About Types of FGM and the Sunna Cut

There is a continuing lack of understanding and agreement on the types of FGM and their various labels in Somalia and Somaliland.

Support has moved away from the most severe Type III FGM (infibulation, or the Pharaonic cut) towards other types labelled 'sunna'. While sunna is considered 'the safe cut' by supporters of FGM, there is no universal definition in place as to what type of FGM this actually is; it is variably used to refer to practices from 'nicking' through to more severe types of FGM that still involve cutting and stitching.

Ultimately, all types of FGM are harmful to women and girls, and these misunderstandings need to be overcome for progress towards total abandonment to be achieved.

Enactment and Implementation of Comprehensive Anti-FGM Laws

The absence of national legislation banning all types of FGM is a challenge across the region. Both Somalia and Somaliland are now tackling this, with laws being drafted and consultation underway between governments, influential religious and community leaders and activists. The challenge for civil society is to ensure any new legislation is 'zero tolerance' and outlaws all types of FGM, taking a clear position that all forms, including sunna, are harmful to girls and women and a violation of their human rights.

The divide between the federal and clan-based legal systems also poses a number of challenges. The introduction of federal laws in future may not have the expected influence at a community level, especially in remote areas, if community leaders, elders and heads of clans do not actively uphold them.

Full understanding and acceptance of anti-FGM laws will therefore be essential to ensure that the practice is not pushed underground and potentially across borders to avoid prosecution.

Additionally, although violence against women is legislated against in constitutions and other laws, it is infrequently reported to police. As it is considered a civil dispute, most women would prefer to report incidents to their elders or parents, or female police officers, of which there are few, and it is likely that those affected by FGM would take the same position.



Working together with governments, community organisations and activists can overcome the challenge of implementing laws and policies that will protect women and girls from FGM in Somalia and Somaliland (© NAFIS Network)

FGM as a Religious Obligation

Although civil society work with religious leaders is shifting opinions and more religious leaders are gradually calling for the abandonment of all forms of cutting, many remain at the point of condemning Type III FGM, but still supporting the sunna cut, believing it is sanctioned by Islam. The 2012 *fatwa* in Somaliland, while a step forward, did not advocate for zero tolerance, and focussed advocacy work with religious leaders will need to continue to reach this point.

Involving Men and Boys

Men and boys, although they rarely directly make decisions about FGM, are 'influential in creating the social climate within which decision-making about cutting takes place'.¹ With surveys suggesting that a mere 4% of unmarried men prefer to marry uncut girls and see FGM as 'proof' of virginity, swaying opinions is a major challenge, but one which, if successful, has the potential to create lasting change.

The challenge of communication between men and women in relation to FGM also needs to be overcome. Women often use vague words like 'purification' to describe what they are sending their daughters to undergo, and often men do not always understand the severity of the practice, its long-term implications and the risks of severe complications and even death.

Practical Challenges

Gathering Reliable Data

Without reliable and consistent, evidence-based information and data, anti-FGM programmes and policies may be disjointed, misinformed, culturally insensitive, inappropriately funded and therefore less effective. Misunderstandings about religion and FGM and the different types of cutting will also continue without the support of accurate background knowledge.

Civil society therefore needs to be supported with quality research and data, undertaken on a regular basis and made accessible to all in the sector. However, while the international community remains divided on whether or not to recognise Somaliland's existence as an independent state, and while areas of the country remain affected by war and terrorism, this is a significant challenge.

Funding

As is the case in all countries where FGM is practised, getting enough targeted, long-term funding for advocacy work, as well as research, is difficult in Somalia and Somaliland. Much international aid is targeted at specific diseases rather than at building infrastructure and domestic services such as women's healthcare facilities. FGM is usually incorporated within wider healthcare and education programmes, but, in order to scale up successful initiatives, more funding needs to be specifically committed both in national budgets and donor initiatives.

Accessibility to Rural Areas

Anti-FGM programmes to date have mainly been focussed in urban and semi-urban areas, and it remains a challenge for organisations and activists to reach more remote rural communities with their work in Somalia and Somaliland. As well as the challenge of physical access to rural areas, civil society has previously been restricted by civil war across the region or having to divert efforts away from their programmes in rural areas to provide food and water in times of drought:

While people don't have enough food and water it is not sensible for us to talk about FGM with them.

~ Candlelight, Somaliland²

Civil society in both Somalia and Somaliland clearly recognises the importance of taking anti-FGM advocacy into remote rural areas, and it must therefore be supported and adequately funded to overcome this challenge and widen the reach of its programmes.

Girls' Education

Keeping girls in full-time education is an important part of tackling FGM and early marriage. However, enrolment and equity ratios in Somali schools are low, especially in secondary schools. Girls often cannot stay in school because appropriate facilities, such as drinking and washing water and latrines, are unavailable. Many NGOs, community organisations and activists are attempting to fill this gap and the Government's commitment to girls' education is essential to supporting the ongoing work to end FGM.

Alternative Forms of Livelihood

Traditional cutters in FGM-practising communities have stated that, in order for them to abandon the practice, they would need alternative ways to generate an income. This requires considerable extra funding and resources for both training and ongoing support, but it is possible.

Support for FGM Survivors

With FGM affecting nearly every woman and girl across Somalia and Somaliland, the challenge to provide universal healthcare and support is immense. Women and girls who have access to the main cities in the region may be able to seek the physical and psychological support they need through the few specialist facilities that are now in place, but, potentially, hundreds of thousands still remain without any support, which has a severe impact on their careers and families as well as their health and wellbeing.

1 Katy Newell-Jones (2018) *Empowering Communities to Collectively Abandon FGM/C in Somaliland*, p.4. ActionAid.

2 Candlelight cited in Alice Rowsome (2017) 'Somaliland: "I convinced my sister not to do type III FGM on her daughter"', *The Guardian*, 30 March. Available at <https://www.theguardian.com/society/2017/mar/29/somaliland-i-convinced-my-sister-not-to-do-type-3-fgm-on-her-daughter>.

Conclusions and Strategies for Moving Forward

FGM prevalence in Somalia and Somaliland remains the highest in the world. Available statistics, though dated, suggest there has been very little change over time. From qualitative and anecdotal information supplied during the course of this research, however, 28 Too Many recognises that important progress is being made in both Somalia and Somaliland to raise awareness of the harms of FGM and build on existing knowledge to shape the work being done in communities.

Government departments and ministries in both Somalia and Somaliland are developing important **working relationships** with civil society and activists to progress draft legislation and national policies to end FGM. It appears that the anti-FGM sector has support across all relevant government departments in the region, and continued joint working is to be encouraged to seek solutions to some of the very difficult challenges outlined above.

The absence of **national legislation** banning all types of FGM is recognised by all working in the sector as a huge challenge still to be overcome. Efforts to ban FGM to date have been hindered by parliamentarians who fear losing the support of influential religious leaders, but as civil society works more closely with government representatives, and as advocacy efforts are scaled up, the possibility of new laws being enacted is becoming a reality.

Ultimately, comprehensive, 'zero tolerance' laws are essential to the work to end FGM: they demonstrate a commitment by governments to ending the practice and show that all forms of the practice are harmful and unacceptable. In both countries, draft laws are now moving into consultation stages and, importantly, civil society continues to work closely with government departments and religious leaders, taking a step-by-step approach to ensuring that all key stakeholders move towards the position of banning all types of FGM.

It is now imperative that the public is sensitised to the proposed new laws. Community activists, in partnership with government agencies, are best placed to disseminate information on the meaning and content of new laws, both before and after enactment. Laws also need to be made accessible in all local languages, and members of both law enforcement and the judiciary need adequate training and resources to enforce them. Tribunals could also be encouraged to make sure that any future prosecutions relating to FGM are clearly reported in the media, including via community radio.

Advocacy work to end FGM requires long-term commitments to **funding** by both governments and donor organisations. Additionally, in order to support FGM survivors or girls at risk of FGM, safe-space providers, trainers, specialist healthcare facilities such as fistula departments and counselling services require consistent, long-term funding.

The absence of comprehensive, up-to-date and accurate **data** on FGM in the region needs to be urgently addressed to inform future policy and programmes. This will also require ongoing, targeted funding.

The inherent challenges to accurate data-gathering in the region have in part been attributed to misunderstandings about the **terminology used in relation to FGM**. Terms such as 'abandonment' and 'FGM' are often understood to refer only to Type III or Pharaonic FGM (infibulation).

Additionally, the term '**sunna**' means different things to different people. Various descriptions range from pricking to infibulation, bringing into question the apparent trend of decreasing Type III FGM in Somalia and Somaliland.

Informants described [sunna] as everything from a 'prick' to the clitoris to the same as infibulation. . . . This raises the question whether what we're finding is a real change in practice or only a change in terminology.¹

Regardless of the definition, sunna is considered by many right across the region as a 'good' form of FGM (as opposed to Pharaonic FGM). Many religious leaders, elders, and even, reportedly, some anti-FGM activists also support sunna and/or believe it is required by Sharia law. Community organisations and anti-FGM networks, therefore, will need to continue focussing on discussing sunna and educating influential leaders and communities that even 'mild' sunna is just as much a violation of human rights as the Pharaonic cut, also causes health problems in girls and women, and is not a religious requirement.

Misunderstandings also extend to **medicalised FGM**, which, it is clear from civil-society reports, is on the increase as families take their daughters to be cut in what they perceive to be a 'safer and cleaner' way. 28 Too Many understands that medicalised FGM can, in some cases, be extremely dangerous because health professionals can cut even deeper under anaesthetic than traditional cutters, causing more pain and a greater risk of infections in the long run. New national laws need to ensure that medical professionals are held to account and punished for practising FGM, and adequate training needs to be provided to all medical professionals on the health implications of FGM.

All FGM, however it is practised, is harmful to women and girls. This message needs to be an integral part of government policy and advocacy initiatives in Somalia and Somaliland moving forward.

This research has shown that there are many NGOs, community organisations and activists now working across the region on anti-FGM programmes. Advocacy work is often integrated into wider educational, social and economic programmes, but there are a range of creative and effective approaches being taken.

Implementing a '**community dialogue approach**' and providing facilitated and focussed discussions during which all members of the community have an opportunity to participate has proved successful in many FGM-practising countries, including Somalia and Somaliland. Civil society and community activists are proving that, by providing safe and non-judgmental environments in which participants can share their experiences, programmes are more likely to have an impact on the understanding of, and attitudes towards, FGM.

There has been encouraging progress made in reaching influencers in Somalia and Somaliland – including religious and community leaders – with advocacy messages and training that enable them to take their learning out to the wider community. It is vital to continue this. Many NGOs and



community organisations are now providing advocacy and training to health workers, school teachers and universities, too. This is vital work and needs to be scaled up to reach across all areas, both urban and rural. Healthcare workers, especially midwives, are in the ideal position to both gather data and spread messages about FGM to women and girls, as they are usually trusted and respected.

Activists have shared experience with 28 Too Many during the course of this research about their work with both **religious leaders and men** to break down the myths surrounding FGM, especially the ongoing belief that is a religious obligation sanctioned by Islam. As advocacy and knowledge is shared and understood, stories of success can be seen and this challenge can be overcome. As the Edna Adan University Hospital website notes,

FGM is thought of as a women’s issue. Somali men don’t generally think very much of it . . . They can be made aware of existing religious scholarly work available on the subject . . . If this group no longer feels that a girl must go through FGM in order to be suitable for marriage, then the stigma of being free of FGM can be alleviated and more families will have the freedom to abandon it.²

Community organisations and Somali activists standing at the forefront of the campaign is critical to successfully achieving the complete abandonment of FGM across the region, as they are able to circumvent the feeling that foreign activists and Western powers are attempting to impose their ideas and opinions on Somali people.

There are many examples of success to date, such as certain programmes at the local level that work with **traditional cutters** to provide alternative forms of income, encourage them to give up the practice, and then recruit them to the anti-FGM campaign. As a result of one programme in Borama, former cutters have abandoned cutting to open a restaurant, sell second-hand clothes and import vegetables.³

A further example is the powerful networks of **young people** right across the region who are becoming peer educators and using social media to advocate for change.

Almost any strategy to end FGM can be enhanced by the use of different forms of **media**. Media helps to create strong, cohesive and highly visible anti-FGM messages in both urban and rural areas. The popularity of radio in remote areas of the region creates an opportunity to reach isolated and nomadic people with messages about FGM, and social media and mobile technologies provide low-cost platforms for dialogue, especially among young people.

The UN notes that FGM in Somalia and Somaliland is about ‘power and politics’, ‘social identities’ and ‘what it means to be a girl or a woman’. Its situational analysis concludes that there is little data on **how and why change happens in Somali society**, but that to ‘end FGM/C entirely requires not just the end of a single, social norm, but much wider, more fundamental, social change.’⁴

In other words, the total abandonment of FGM will be achieved as part of culture-wide changes to the way that women are viewed, treated and empowered in Somalia and Somaliland.

1 Ingvild Lunde cited in Ingrid P. Nuse (2015) ‘Young Somali girls want modern circumcision’, *ScienceNordic*, 6 April. Available at <http://sciencenordic.com/young-somali-girls-want-modern-circumcision>.
 2 Edna Adan Hospital (2019) ‘Female Genital Mutilation’, *Mission*. Available at <https://www.ednahospital.org>.
 3 Maggie Black (2003) *Somali children and youth: Challenging the past and building the future*, pp.19 & 20.
 4 Dr Sheena Crawford and Sagal Ali (2015) *Situational Analysis of FGM/C Stakeholders and Interventions in Somalia*, pp.4–5. Available at <http://www.heart-resources.org>.



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