



Case study on ending female genital mutilation in the Federal Republic of Somalia

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Purpose of the case study

The purpose of this case study is to highlight a promising programme, service or approach that is supported by the UNFPA-UNICEF Joint Programme and is contributing to the elimination of female genital mutilation in Somalia. It provides an outline of the work that is being done, and an analysis of its successes and challenges. The information presented is based on a documentary review and interviews with those involved and available. Its intended audience includes those working in the areas of research, programmes and policy to eradicate FGM in Somalia, in the region, and elsewhere, such as UNICEF and UNFPA, regional institutions such as the African Union, governments, donors, NGOs, and academics.

The context of FGM in Somalia

Female genital mutilation (FGM) involves altering or injuring the female external genitalia for non-medical reasons. The practice poses serious risks to the health and wellbeing of girls and women and is widely recognised as a human rights violation. Nevertheless, it is estimated that at least 200 million girls and women alive today have undergone some form of FGM and a further 68 million are at risk of being cut by 2030.¹ Although rates of FGM are declining in most of the 31 countries where it is practiced, population growth rates in many settings mean that the absolute numbers of girls who will be cut will continue to grow if the practice continues at current levels. UNICEF is working in partnership with UNFPA and governments, donors and

civil society organisations to accelerate the abandonment of this harmful practice. The third phase of this Joint Programme to Eliminate FGM is currently underway (2018-2021).

FGM is a widespread practice in Somalia. The recent Somali Demographic and Health Survey (2020) showed a prevalence rate of 99%, including Type I, Type II, Type III and Type IIII.² The massive effort needed to reduce the practice is made more challenging by weak governmental authority amidst long-standing conflict, political instability and resource scarcity. Sexual and gender-based violence against women and girls, including gang rapes, forced marriages and FGM are considered significant concerns across all federal states.³ This reality is recognised in the prohibitions against FGM contained in federal legal and regulatory frameworks: Somalia's Provisional Constitution (2012: Article 15.4) declares female circumcision to be "a cruel and degrading customary practice...tantamount to torture", and prohibits it. The Penal Code, which is applicable in all regions of the country, provides for prison sentences for individuals who "ill-treat a member of the family or a person under the age of 14 years", and especially where "the act results in a serious or a very serious hurt" or death (Article 432, 1 and 2, Appendix 3). Moreover, FGM is specifically prohibited under the 2019 Somali Child Rights Bill. In theory, these instruments support the prosecution of the practice as the equivalent of actual or grievous bodily harm.

However, these and other mechanisms for child protection in Somalia are limited in their scope and effectiveness. There is currently no specific Cabinet-approved legislation against all forms of FGM. Other related provisions, such as those contained in the Sexual Offences Bill (introduced in 2016), have stalled at the review stage because of major opposition on religious and cultural grounds (although a similar bill

was passed in Puntland in 2016).⁴ A specific FGM Bill has been drafted and presented to the cabinet, but has yet to be endorsed, a process that will ultimately require the support of prominent religious leaders and institutions. These and other difficulties in developing and implementing laws and policies are expected to continue with the increase in Federal Member States and the recent resignation of the Prime Minister. The reality is that despite the federal government's efforts to strengthen child protection systems at all levels, governance and practice differ from region to region, and the practice of FGM is deeply embedded in social norms and practices within communities. Devising and implementing an effective policy framework in this context is extremely difficult, a problem that is exacerbated by ongoing cycles of displacement and conflict that impact longer-term approaches to programming, and a constant shifting of priorities, including in relation to harmful practices such as FGM.



In this context, the UNFPA-UNICEF Joint Programme was launched in Somalia in 2008 in a collaborative effort with the Ministry of Labour and Social Affairs and various non-governmental organizations. To date, work related to FGM has been integrated into wider programmatic efforts such as those aimed at combatting gender-based violence (GBV).

Promising approaches to combatting FGM

With support from UNICEF and UNFPA, a new national strategy is currently being developed to inform efforts to combat FGM. It will include the following key pillars:

The importance of a strong rights-based approach and high-level advocacy: human rights, women's rights, children's rights, and national policy and legislation.

Maximize the role of religious leaders, religious terminology, and religious and spiritual beliefs.

Address the medicalization of FGM and capitalize on the role of the MOH, the health sector, and health workers in the provision, prevention and treatment of FGM.

Change the narrative and re-focus the message on Zero Tolerance of FGM given that there has been no reduction in overall prevalence, although there has been a gradual shift away from Type III (infibulation - the most common type).

Accelerate community education, awareness raising and engagement to change social norms.

Highlight the importance of documentation and regular M&E to demonstrate programmatic and advocacy impacts over time.

Currently programmatic efforts to end FGM are integrated into wider programmes that primarily focus on GBV, such as the Communities Care: Transforming Lives and Preventing Violence Programme (CC Programme). The CC programme was developed in response to the

significant experience and threat of GBV faced by women and girls. Its aim is to engage and support communities to tackle GBV by changing individual behaviours, collective practices and widely held beliefs that contribute to violence against women and girls and limit the ability of survivors to seek support and assistance. Its guiding premise is that sexual violence is a fundamental and unacceptable violation of human rights and that participation and partnership are the cornerstones of effective sexual violence prevention and response.⁵



The CC Programme began in Somalia in 2013. Over a 19-week period, trained local facilitators bring together diverse groups of community members of all ages with different partners across multiple sectors, such as health and education, to discuss and reflect on their shared values, beliefs and aspirations. Central to this approach is the provision of a platform for communities to identify their own priorities which ultimately informs the programme design in each respective location. In some communities, FGM was raised as a concern and hence it has been incorporated into the programme more broadly and is one of several other issues related to GBV that are addressed. As the programme progresses, communities identify their priority needs, building on these discussions and exploring the social norms in

their community that tolerate GBV, including FGM, and silence those who experience it. Dialogue is grounded in the everyday realities of women and girls in the community and stimulates discussion about what is relevant, what their priorities are and what is important in their particular context. It localizes shared ideals and values and enables community members to work together to identify the collective actions that are needed to transform harmful social norms and practices. Community dialogues have provided opportunities to discuss societal expectations and norms, health concerns related to FGM, as well as the roles and responsibilities of different people, including girls, boys, caregivers, teachers, religious leaders and authorities and the role of religion in keeping girls and women safe and protected. The CC Programme further supports the community to undertake these preventive actions, while also recognizing the need to build local capacity over the longer term.

When the CC Programme first began, discussions on sensitive issues, such as FGM and child marriage, were met with resistance. However, because the programme focuses on building relationships over time, rooted in community-led dialogue

and the local identification of needs, priorities and solutions, the approaches taken are contextually appropriate, locally owned and locally supported.⁶⁷

The Ministry of Labour and Social Affairs takes the official lead on prevention-related initiatives. Included in these efforts is working with 70 Community Based Child Protection Committees to raise awareness at the community level about FGM, particularly the health risks associated with the practice. Working with key stakeholders in both the formal and informal systems is essential to this work, and, in the future, efforts may include working directly with educators in the nonformal system, such as in the madrassas.

One-stop centers run by local and international organizations and the Ministry of Health have been important in providing legal aid and case management services to survivors of GBV, including FGM. Efforts have also been made by these groups to engage the traditional matrons/birth attendants who perform FGM on the health risks of the practice. Doing so has been challenging, given that these individuals perceive themselves as having few alternative means of earning a livelihood.



Embedding FGM into wider programming can be considered a promising practice in the Somalia context for several reasons:

This approach offers a less confrontational way of engaging communities and stakeholders on a very sensitive issue within the wider context of GBV.

Given that Somalia is a heavily resource-constrained environment, an integrated programming approach provides an opportunity to improve the appropriateness and sustainability of different interventions. By merging those programmes that have shorter funding timelines with others that have multi-year funding, it is possible to build rapport with communities over time, an essential prerequisite to meaningful and lasting engagement and change.

Integrated programming has allowed for wider multi-sector engagement and the enhancement of coordination across a range of different stakeholders, such as girls and boys, caregivers, elders, religious leaders, and service providers in the areas of health, education, police and others. This way of working is consistent with a 'systems strengthening' approach to child protection as opposed to an 'issue-based' approach, in which individual issues are addressed in isolation from each other and the broader social and economic context in which they are manifested.

Although FGM is largely perceived as a socio-cultural rather than a religious practice in Somalia, faith leaders play a significant role in shaping everyday life at the community level and can play a critical role in the elimination of FGM. While 99% of Somalis are Sunni Muslims, organizations working with religious leaders highlight the need to contextualize differences in federal and non-federal religious groupings in the development of advocacy and dialogue (depending on the type of Sunni Islam practiced).⁸ This differentiation has implications for how to engage various Imams and Sheikhs, both in terms of their secular beliefs and approaches to governance.

Linked to ongoing community level dialogue has been the identification of 'champions for change'. These 'champions' are usually identified in the course of community discussions and engagement both within the CC programme and through the work of the Community Based Child Protection Committees. Who these individuals are and why they are selected varies significantly from one context to another, but usually include elders, religious leaders, adolescents (girls and boys), mothers, fathers, local authorities and others.

Medicalization is described by government officials and agencies as increasing in parts of Somalia (including Somaliland), especially in urban centres, and amongst the diaspora. This challenge has highlighted the need to diversify messaging and approaches to combatting the practice, rather than the more historically-dominant method of focusing primarily on the health risks associated with traditional cutting techniques. The Ministry of Health works with midwifery training schools and there are modules on the anti-medicalization of FGM in the national midwifery curriculum.

Programme achievements

Community engagement and dialogue.

The importance of community engagement and dialogue cannot be underestimated as it ultimately forms the basis of genuine programme contextualization – a central theme to FGM programming in Somalia. The CC programme and work with Community Based Child Protection Committees have underscored the need to take a longer term view: to build relationships with communities over time, allowing for priorities and strategies to be articulated locally. This grounded means of understanding FGM and the essential role of the community in its eradication is believed to be one of the greatest successes of FGM programming in Somalia.

Adolescent engagement: Several government officials and service providers noted that the attitudes of adolescent boys towards FGM in urban areas are changing; a growing number appear to be expressing a preference for uncut girls who are able to be sexually fulfilled and vice versa. This changing (or at least more publicly shared) mindset was underscored as a potential entry point for further discussions with adolescents, a group that has to date been insufficiently involved. There is a general consensus amongst government actors and organizations working in Somalia that adolescent programming is lacking and should be a priority in coming years. Working through this lens is also believed to provide opportunities for furthering dialogue on FGM, effecting longer-term change in younger generations.

Multi-faceted and multisectoral approach.

Rather than seeing communities' issues and needs in isolation, including as they relate to FGM, a broader approach has been used to understand these practices in context and to address them as part of a wider 'systems strengthening' approach, which conceptualises drivers and needs within a framework of vulnerability. This integrated approach has allowed for a range of actors (depending on the specific needs and context) to work together to articulate appropriate strategies, including those from different sectors and well as those within the formal and informal child protection system (i.e., communities and service providers).

Collaboration and coordination with relevant national level ministries has ensured better resource utilisation, avoided duplication of work among partners and reduced a sense of competition. Critically, it has enabled stakeholders to deliver a shared message to communities on FGM as well as other wider child protection and welfare issues.



Challenges faced and future directions

Somalia has habitually experienced volatile periods of political, humanitarian and socio-economic upheaval and crisis. 2020 has been no different, with the country beset with multiple emergencies in addition to the impact of COVID-19 exacerbating existing tensions and deepening vulnerabilities. The COVID-19 pandemic has impacted on the socio-economic, cultural and political spheres of Somalia. This impact has also extended to FGM. Anecdotal evidence suggests that there may have been an increase in of FGM as a result of COVID-19, for example families taking advantage of school closures to carry out FGM so that girls can have time to recover from the ritual, which can take weeks. In addition, anecdotal evidence suggests that with the widespread loss of livelihoods associated with COVID-19, traditional practitioners that perform the cutting are increasingly soliciting 'work'.

Historical efforts and approaches to addressing FGM have been largely perceived by international agencies and national organizations as ineffective and there is a sense of fatigue in attempting to tackle the issue with little success. This weariness in part has led organizations to redirect their efforts to address needs perceived to be more pressing, such as those related to children associated with armed forces and armed groups, and to areas where they felt they could have a greater impact.

At the federal level, there have been efforts to develop and endorse the FGM Bill. One challenge in the past was that there were attempts at the government level (Cabinet) and among senior Sheikhs to change the content of the FGM Bill to continue to allow Type I cuts (Sunni). This bill was withdrawn as this outcome was perceived to be more detrimental

and difficult to reverse over the longer term. In general, while many, especially those in urban areas, feel that the more extreme forms of cutting are unacceptable, many are said to still condone Type I. An additional challenge widely cited by both government representatives and organizations is that the Sexual Violence Bill is also currently being presented and endorsed by government and has taken priority over the endorsement of the FGM Bill.⁹



Fear of stigma and being ostracized by family and the surrounding community remains a reality for many girls and women and families. Anecdotal evidence suggests uncut girls are less likely to be considered desirable for marriage and are often excluded from wider social events within the community. These social norms and beliefs need to be taken into account in programme design in each respective context and should inform dialogue and engagement with a range of community actors over time.

Key learning

One of the key lessons from the Somalia experience has been the value of taking a holistic approach to addressing FGM, both in terms of the framing of the issue as one that requires multi-sectoral collaboration, and the implementation of a broad range of programmatic approaches, for example, addressing the structural drivers of the practice as well as social norms. These combined efforts offer the most promise in terms of relevance and sustainability.

The need to contextualize approaches to addressing FGM is paramount. Although some efforts may be required at an overarching 'national' level, for example in policy and legislation (such as the FGM Bill), the Community Cares Programme has demonstrated that different regions and communities may have different approaches to how they engage in dialogue and with who. The flexibility of the model has ensured the programme is contextually relevant and appropriate and also increased a sense of ownership within families and communities.

Strongly linked to contextualization is the need to diversify approaches to FGM. In the past, programmes and messaging have been overly reliant on imported programmes insufficiently rooted in local realities or unable to adjust as necessary over time. Working with communities and supporting dialogue on sensitive issues requires taking an iterative approach that can be adapted over time.

Sources

[1] UNICEF (2016) Female Genital Mutilation/Cutting: A global concern. New York: UNICEF.

[2] Directorate of National Statistics, Federal Government of Somalia (2020) The Somali Health and Demographic Survey 2020. DNS: Mogadishu.

[3] Nyanduga, B.T. (2019) 'Situation of human rights in Somalia: report of the Independent Expert on the Situation of Human Rights in Somalia'. Report of the Independent Expert on the Situation of Human Rights in Somalia. <https://digitallibrary.un.org/record/3862632?ln=en>[4] UDHS (2006)

[4] Further information is available at: <https://reliefweb.int/report/somalia/puntland-passes-law-against-sexual-offences>

[5] Marsh, S.R.-H.M. (2016) 'The Communities Care Programme: changing social norms to end violence against women and girls in conflict-affected communities'. Gender and Development. 24(2):261–76.

[6] Perrin, N. et al (2019) 'Social norms and beliefs about gender based violence scale: a measure for use with gender based violence prevention programs in low-resource and humanitarian settings'. Conflict and Health. 13:6. <https://doi.org/10.1186/s13031-019-0189-x>

[7] An evaluation of the impact of the CC Programme in four districts in Mogadishu (Glass, N. et al (2018) 'Evaluating the Communities Care Program: best practice for rigorous research to evaluate gender based violence prevention and response programs in humanitarian settings'. Conflict and Health. 12:5. <https://dx.doi.org/10.1186%2Fs13031-018-0138-0>, showed men and women participants in the intervention district had statistically significant improvements in perceptions and expectations that support GBV and sexual violence-related social norms compared to the control district. In particular, participants reported a 14% reduction in norms that support husbands' right to use violence against their wives, a 22% reduction in the acceptance of violence as a means to protect family honour, and an 11% reduction in social norms that support negative responses among family and community members towards those who had experienced sexual violence. Importantly, participants in the CC Programme showed an increase in the belief in the helpfulness of different services, such as health, police, justice and elders.

[8] Such as Hanafi, Maliki, Shafi'i, Hanbali.

[9] In the Federal Government/Republic of Somalia, the Sexual Offences Bill has been under review since 2016 but has not been passed due to major opposition on religious and cultural grounds (although a similar bill was passed in Puntland in 2016). This Bill does not explicitly refer to FGM, however, there are draft FGM Bills for the Federal Government and for Puntland, both of which prohibit FGM as a human rights violation and provide specific punishments for perpetrators. These are currently under stakeholder consultation and parliamentary review. Puntland approved an official policy, as well as issuing a fatuwa, against all forms of FGM in 2014, but legislation has not been enacted, and the policy and fatuwa have not been widely disseminated or enforced at the community level. The progress of the FGM Bills and their ultimate approval by Cabinet appears to be stalled due to resistance to passing legislation against all forms of FGM (including what is termed 'Sunna' and viewed as a religious requirement), as well as contested wording in the drafts and the lack of mention of medicalization. In Somaliland, a 'Draft National Policy for the Abandonment of FGM' (FGM Policy) is under review, but as in the other regions it is unlikely to gain support from the Ministry of Religion because it includes all forms of FGM including 'Sunna'. There is a fatuwa against the Pharaonic type of FGM from the Ministry of Religion in Somaliland, but rather than being viewed as a deterrent to FGM, it is widely seen as a means of promoting the 'Sunna' cut.

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