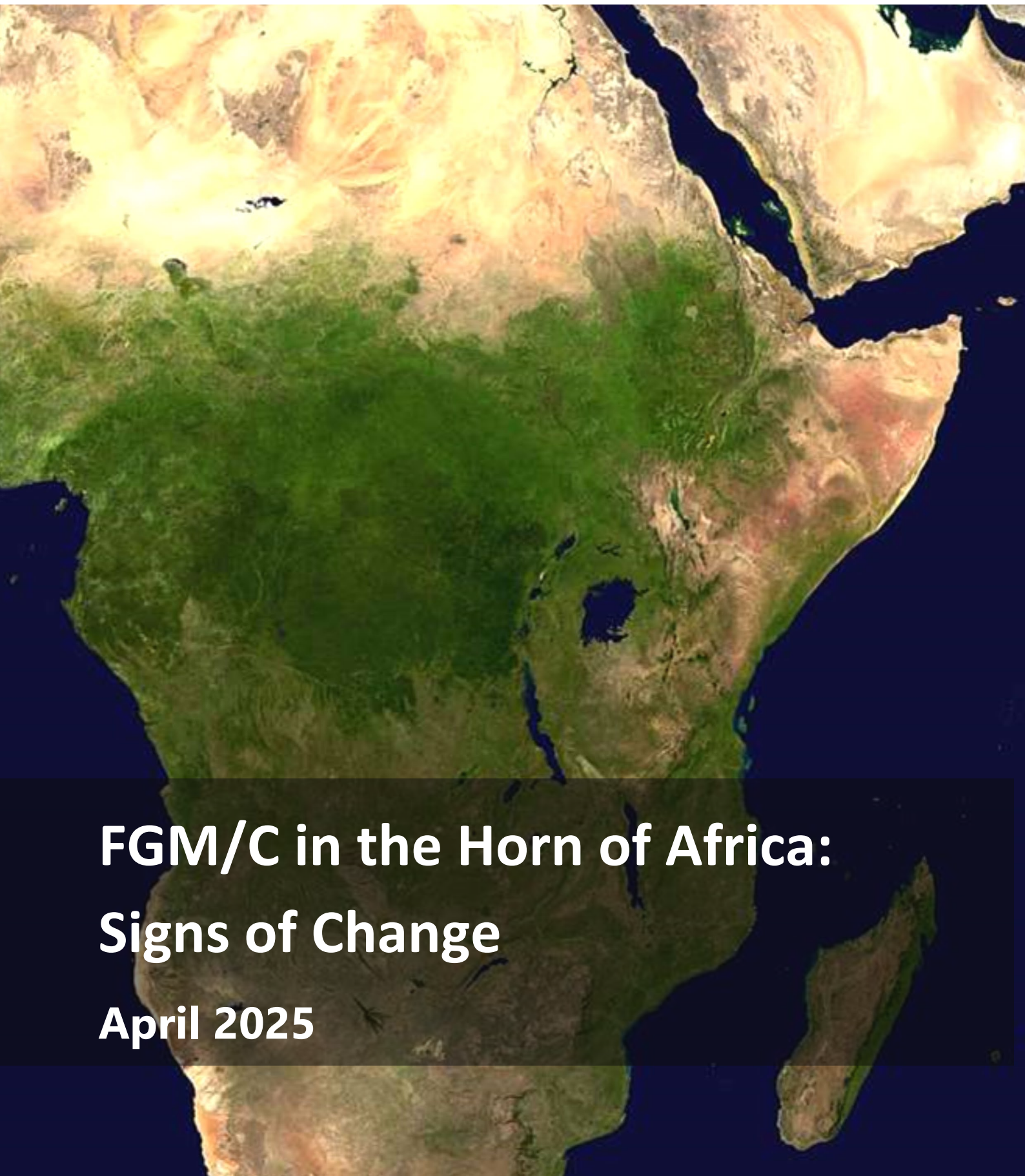
ORCHID PROJECT

WORKING TOGETHER TO END
FEMALE GENITAL CUTTING

END FGM/C NETWORK AFRICA



FGM/C in the Horn of Africa: Signs of Change

April 2025

About Orchid Project

Orchid Project is a UK- and Kenya-based non-governmental organisation (*NGO*) catalysing the global movement to end female genital mutilation/cutting (*FGM/C*). Its strategy for 2023 to 2028 focuses on three objectives:

1. to undertake research, generate evidence and curate knowledge to better equip those working to end FGM/C;
2. to facilitate capacity-strengthening of partners, through learning and knowledge-sharing, to improve programme designs and impacts for the movement to end FGM/C; and
3. to steer global and regional policies, actions and funding toward ending FGM/C.

Orchid Project's aim to expedite the building of a knowledge base for researchers and activists is being fulfilled in the **FGM/C Research Initiative**.

End FGM/C Network, Africa

End FGM/C Network, Africa is an African-led initiative, providing a unified voice to influence decision-makers and drive coordinated advocacy to end Female Genital Mutilation/Cutting across Africa. It is a network of civil-society organisations dedicated to creating a sustainable movement to end FGM/C across the continent, similar to regional networks in Asia, North America and Europe.

All cited texts in this document were accessed between July and December 2024, unless otherwise noted.

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Introduction

For decades, the Horn of Africa has faced political instability of varying degrees, conflict and security challenges, and, more recently, problems related to climate change. This inevitably affected progress toward the abandonment of female genital mutilation/cutting (FGM/C) in the region, as there were many ***competing priorities*** *over the years.*

Traditionally, FGM/C was **a taboo subject**, not discussed in public spaces. Conflict and insecurity made it difficult for groups to gather and break this taboo in some parts of the region.

Figure 1: Distribution of Somali people across the Horn of Africa[1]

Families experienced financial hardship, food insecurity was a major concern, and, for many families, the risk of a daughter not marrying a husband who could take care of her, and thus the family not receiving her **dowry**, was too great to consider.

In addition, FGM/C is deeply embedded in the **social and cultural norms** of Somali people, who live beyond the borders of Somalia, across a significant portion of the Horn of Africa (see Figure 1).

It is widely recognised that FGM/C is **not a religious practice**; however, there are perceived connections between FGM/C and Islam because of messaging from prominent religious leaders in some parts of the region. The strong influence of religious leaders on all aspects of society has made it challenging for governments to pass **anti-FGM/C legislation** that is shaped around zero tolerance.

Classifying the **types of FGM/C** is complex. The types most commonly practised by Somali ethnic communities fall under three broad categories (see the following table).

Type of FGM/C	Description
Pharaonic cut (WHO Type 3/ infibulation)	Virtually closing the vaginal orifice by completely removing the labia and clitoris (infibulation); sealing the wound, usually with stitches, but sometimes with thorns; or leaving it to heal naturally.
Intermediate cut (WHO Type 2)	Partial closing of the vaginal orifice by removing the labia minora and the clitoris; sealing the wound, usually with two or three stitches or thorns; or leaving it to heal naturally.
WHO Type 1 ('snip') **WHO Type 4 ('prick')**	Removing of the tip of the clitoris, or drawing blood by pricking the clitoris, requiring no stitching or thorns to heal. (Usually referred to as *sunna*.)

Types of FGM/C practised in Somali ethnic communities (linked to the World Health Organization's [WHO's] classifications)

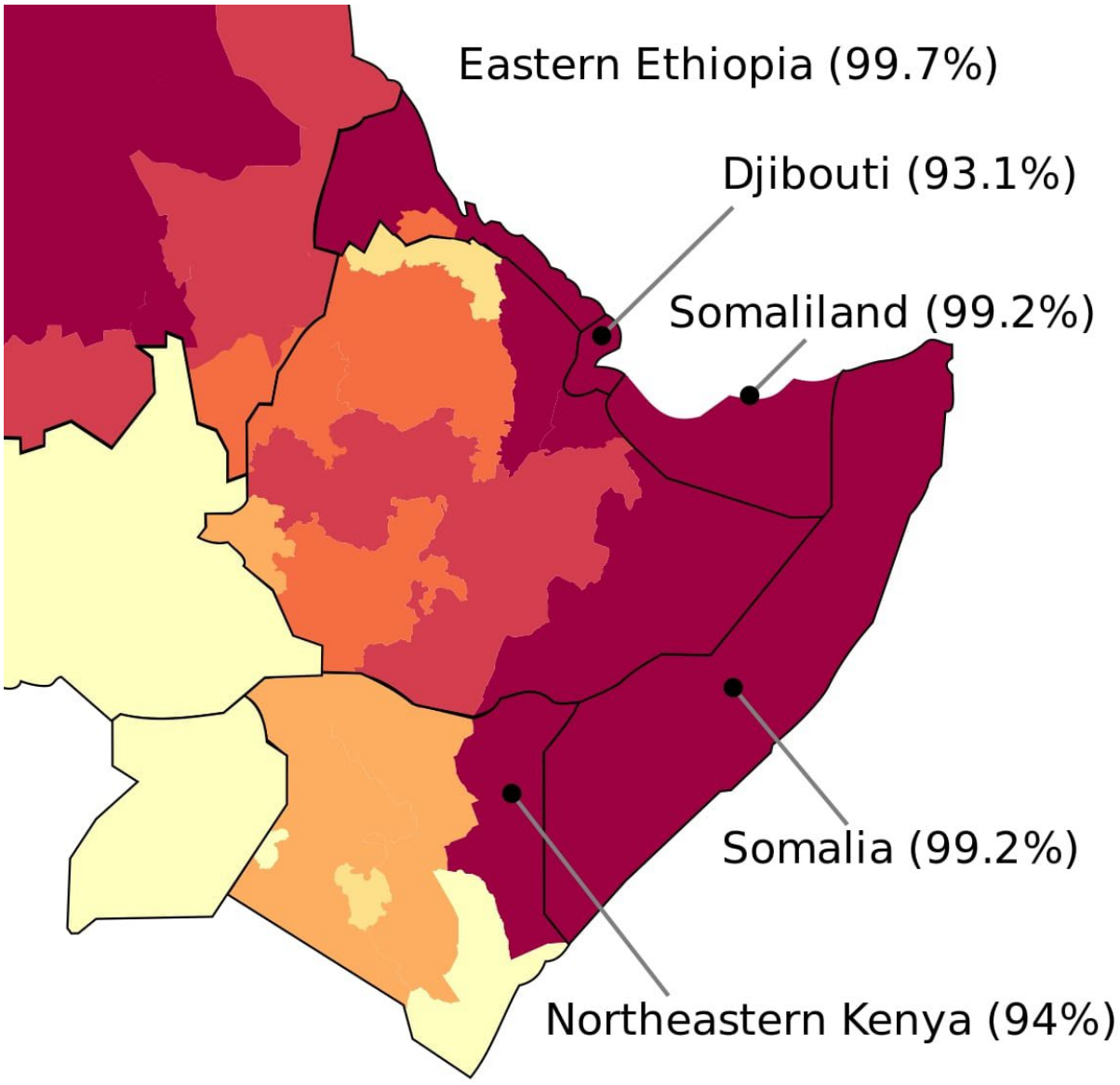

Figure 2: FGM/C prevalence in the Horn of Africa[2]
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National surveys, which focus primarily on whether or not a girl or woman has undergone FGM/C, not the type of cut, indicate that **prevalence across the Horn of Africa remains high**, at more than 90%. In many places, cutting is almost universal (for example, Somalia – see Figure 2).[3]

Despite the global headline message that there has been little or no change in FGM/C in Somali ethnic communities, **significant changes are happening at the sub-national level** and in the types of cutting practised, but data, evidence and evaluations of inter-ventions are limited.

This paper seeks to challenge the narrative that nothing is changing and no progress is being made in relation to FGM/C by exploring areas of change; documenting available evidence on how/why certain approaches work; outlining what we know does *not* work in this context; and discussing the unique contextual dilemmas and challenges to the goal of abandonment within the Horn of Africa.

This paper was developed through a collaborative process of knowledge sharing. The paper was first drafted as a briefing paper based on the available literature and Orchid Project's experience of working with partners in Somali ethnic communities in the Horn of Africa since 2012. The first draft served as the basis for a series of knowledge-sharing dialogues conducted between September 2024 and February 2025. The dialogues included Somali practitioners working with communities to create change in relation to FGM/C; policymakers and advocacy organisations working toward a more enabling environment for change; and researchers/ academics building the evidence base within the region. Each round of knowledge-sharing dialogues made contributions to the paper, and revisions were overseen by an advisory board comprised of practitioners, researchers and activists from across the region. This version of the paper includes contributions from all groups and is viewed by Orchid Project as a publication collaboratively produced and co-authored with a wide variety of stakeholders who offered their experiences and insights through the dialogue process.

Similarities and Differences Between Somali Ethnic Communities in the Horn of Africa

Somali ethnic communities live across borders within the Horn of Africa. They are prominent in Somalia, Somaliland, south-eastern Ethiopia (Somali region), north-eastern Kenya and Djibouti. There are a number of similarities between Somali ethnic communities that live across these borders, and it is important to consider the cultural practices and beliefs that transcend geographies. However, the experiences of Somalis in these different contexts varies.

- Conflict, fragility and instability in Somalia create unique circumstances for Somali people living in this context. Gathering in social groups can be challenging, and many civil-society organisations (*CSOs*) rely on radio and social media to share FGM/C campaigns.
- In Kenya and Ethiopia, Somali people are a minority and Islam is not the dominant religion. This contributes to the marginalisation of Somali people.
- There are laws that ban FGM/C in Kenya, Djibouti and Ethiopia and a policy framework for action on the issue in each country. However, there is no law in either Somalia or Somaliland, although an anti-FGM/C policy was recently passed in Somaliland (2024).

The below table lays out some of the primary similarities and differences that are helpful to consider in policymaking and programmatic responses concerning Somali ethnic communities.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Overall prevalence of FGM/C (national estimates)	14.8% (2022)[4]	65.2% (2016)[5]	99.2% (2020)[6]	99.2% (2020)[7]	93.1% (2007)[8]
Prevalence in Somali ethnic communities	94% (2014)[9]	99.7% (2016)[10]	99.2% (2020)[11]	99.2% (2020)[12]	Data not available

1. Legal/Policy Situation

Somalia and Somaliland have no laws that specifically ban FGM/C. Laws exist in Kenya, Ethiopia and Djibouti, although the law in Ethiopia does not clearly define 'FGM/C' and the laws in Djibouti and Ethiopia do not include measures against medicalised FGM/C. Somaliland recently passed an anti-FGM/C policy (2024).

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Anti-FGM/C law in place	✓	✓	X	X	✓
Anti-FGM/C law clearly defines 'FGM/C' and uses zero-tolerance framing	✓	X	X	X	✓
National FGM/C policy in place	✓	✓	X	✓	✓

2. Conflict and Security

There are conflicts and challenges with security across Somalia, the northern regions of Ethiopia and in areas that border Kenya. This conflict restricts the freedom to gather and discuss social issues and creates a heavy reliance on radio and social media to share messages/campaigns about FGM/C.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
High level of conflict, community meetings limited, fear of violence	X	✓ (north)	✓	X	X
Heavy reliance on campaigning by radio/social media	X	✓	✓	X	X

3. Government

There are strong government stances on FGM/C in Kenya, Ethiopia and Somaliland, but less so in Somalia, which is affected mainly by fragility.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Strong government with clear stance on FGM/C	✓	✓	X	✓	✓
National anti-FGM/C committee/body	✓	✓	X	✓	✓
Fragile or weak government	X	X	✓	X	X

4. Marginalisation/Dominance of Somali Ethnic People in Each Context

In Ethiopia and Kenya, Somali ethnic people are a minority, which contributes to their marginalisation, whereas in Somalia and Somaliland they are a majority. However, anti-FGM/C campaigns are viewed by some people across the region as attacks on Somali culture.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Somali ethnic community seen as minority; under threat on several fronts	✓	✓	X	X	X
Anti-FGM/C movement seen as an attack on Somali culture	✓	✓	✓	✓	✓

5. Religious Diversity and Dominance and Active Involvement in Dialogue on FGM/C

Islam is the majority religion in Somalia and Somaliland. In Kenya and Ethiopia there is greater religious diversity. Across all countries, religious leaders have a strong influence on society, beliefs and practices.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Islam is a minority religion	✓	✓	X	X	X
Religious leaders speak out against all types of FGM/C	✓	✓	X	X	Unknown

6. Economic Development

Economic development is a difficulty for all countries in the Horn of Africa. There are widespread poverty and challenges for families and communities due to conflict and displacement. However, Somali ethnic communities tend to have higher levels of poverty and limited access to opportunities in Kenya and Ethiopia, largely due to marginalisation.

Characteristic	Kenya	Ethiopia	Somalia	Somaliland	Djibouti
Somali ethnic communities tend to have limited access to economic development opporutnities	✓	✓	X	X	Unknown
Somali-led organisations are prioritised for funding/resources	X	X	✓	✓	Unknown

Section 1: Areas of Change

This section explores areas where there have been changes over time – primarily:

- increased awareness of the health risks of FGM/C and the medicalisation of FGM/C;
- increased willingness of religious leaders to engage in dialogue around FGM/C;
- changes in the types of cutting (reductions in pharaonic cutting); and
- increased willingness from governments to engage in dialogue around FGM/C.

Awareness of Health Risks

There have been a number of campaigns in the Horn of Africa that used narratives of health consequences, and there is an increased willingness in communities to engage in discussion around FGM/C as the topic has become less taboo.

As awareness of FGM/C's health consequences has increased, there has been a medicalisation of the practice.[13] For many Somali ethnic communities, medicalised FGM/C offers a perceived protection from the risks of bleeding, infection and other complications.

> *Those who are educated take their daughters to hospital to do medicalised FGM/C so that their daughter is safe from pharaonic complications. The health workers do the sunna for the girls.*
>
> ~ Married man, Hargeisa, Somaliland[14]

The age of cutting has also reduced since 2011 from 10–14 to 5–8 years of age.[15] Reasons for this shift include the belief that, at a younger age, the child is less resistant and remembers the cutting less, reducing the harm from, or risk of, psychological trauma.[16]

Engagement of Religious Leaders

Before the Government of Somalia campaigned against FGM/C in 1988,[17] Somali religious leaders rarely spoke about the issue in public. It was considered taboo, and much social stigma foiled attempts to discuss it.

Since then, there has been pressure from local CSOs and international organisations to engage in dialogue about the perceived intersections of Islam and FGM/C and a growing openness among religious leaders to engage in these dialogues.

There have been attempts by Somali religious leaders to separate Islam from the practice of FGM/C. In 2014, a *fatwa* banning pharaonic cutting was issued in Puntland.[18] This was a significant step in the work to end FGM/C in the Horn of Africa, as it was the first time Somali religious leaders had spoken out about FGM/C and deemed pharaonic cutting (WHO's Type 3) to be cultural, not religious.

However, the fatwa did not include all types of cutting. 'Less severe' types of cutting (i.e. Types 1, 2 and 4) came to be referred to as *sunna* (non-obligatory, but recommended practices in Islam). Many activists who support the abandonment of FGM/C oppose this language. They argue that using religious language to describe FGM/C incorrectly aligns the practice with Islam.[19]

Following the fatwa, local religious leaders were found to be talking about FGM/C in Friday prayers – a significant shift away from the taboos and social stigmas that previously surrounded the issue.[20]

In 2018, in Somaliland, the Ministry of Religious Affairs issued a similar fatwa on FGM/C.[21] Once again, the intention was to separate the practice from Islam and to support the abandonment of the pharaonic cut, but to retain the 'less severe' types of cutting known as *sunna*.

This disentanglement of pharaonic cutting from Islam and the subsequent engagement of religious leaders at the local level has contributed positively to a change in the type of cutting that communities deemed necessary, and widespread acceptance of the change.

Change in Types of Cutting

The most widely celebrated change related to FGM/C in Somali ethnic communities in the Horn of Africa is the shift that has occurred in the types of cutting practised.

Many people in Somali ethnic communities report that FGM/C has been abandoned, yet national survey data indicate a prevalence of 99.2% among women aged 15–49. However, the percentage of those who practise pharaonic/Type 3 cutting has reduced: 46.2% of women aged 15–19 who have been cut have undergone Type 3 (2020), compared to 82.4% of women aged 45–49.[22]

National survey data classifies any type of cutting as FGM/C, whereas the understanding in many Somali ethnic communities of what constitutes FGM/C is very different. Many Somali define it as pharaonic cutting; thus, when asked whether or not they practise FGM/C, those who have not undergone this most severe type of cutting report that they have not undergone FGM/C:

I can say this is not even an FGM/C because FGM/C is the former infibulation, which was complicated. This one has nothing much. It is a mild Sunna form and I believe is good for the ladies and the current youth. It doesn't harm their body and health.

~ Woman, Hargeisa, Somaliland[23]

Government Engagement

Laws banning FGM/C have been in place in Kenya since 2001, in Ethiopia since 2005 and in Djibouti since 2009. In Eritrea, a proclamation banning FGM/C was published in 2007.

In Somalia and Somaliland, there is no specific legislation banning FGM/C, despite efforts from policymakers and support from international non-governmental organisations over the last decade.

Somalia's Constitution of 2012 does refer to 'circumcision' in Article 15(4), stating, 'Circumcision of girls is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.'[24]

The Somalian Government spurred efforts to abandon FGM/C as early as 1988, due in part to advocacy from the Somali Women's Democratic Organisation, which was launched in 1977.[25] However, the Government often sits in tension between internationally-driven campaigns for zero tolerance and the nuanced realities in Somali ethnic communities. Bills and policies have been drafted in support of zero tolerance, but have not made it into law, in large part because of resistance from religious leaders.[26]

There is a growing openness within government ministries toward engaging in dialogues and working with religious leaders to move legislation forward. At the time of writing this paper, Galmudug state has successfully passed a zero-tolerance bill into law.[27]

FGM/C is about power and politics: it is about the way that people construct individual and social identities, about what it means to be a girl or a woman, and what is expected of girls, women, boys and men in society. To end FGM/C entirely requires not just the end of a single social norm, but much wider, more fundamental, social change.

Pivotal Moments

The movement against FGM/C in Somali ethnic communities has a long history, including a series of pivotal moments when progress was made toward change. The diagram below (Figure 3) outlines the most significant of these moments.

Figure 3: Pivotal moments in the fight against FGM/C in the Horn of Africa

Section 2: Available Evidence

Building on the areas of change outlined in Section 1, Section 2 explores the available evidence for particular interventions and seeks to identify either positive or negative influences on the effectiveness of interventions.

1. *Intervention*: COMMUNITY DIALOGUES ***Description*: Using a dialogic approach to engage community members in discussions about FGM/C.**	
Works best when: ▪ dialogues are conducted by local facilitators, using a non-judgemental approach, creating safe spaces for discussions of FGM/C and reconsideration of social norms;[28] ▪ potential changes are generated from within the community, not imposed from the outside.	**Does not work well when:** ▪ conducting large community gatherings or rallies to communicate anti-FGM/C messaging, as these can create risks for participants due to conflict and tension; ▪ dialogues focus exclusively on health risks, as this can influence a shift toward medicalised FGM/C and harm-reduction, not abandonment.[29]
2. *Intervention*: MEDIA AND TECHNOLOGY ***Description*: Using radio, social media, television and other mobile technology to share messaging on FGM/C.**	
Works best when: ▪ messages are developed specific to the audience(s); ▪ messaging is nuanced and includes health risks, human rights, psychological risks and bodily autonomy;	**Does not work well when:** ▪ the language used is judgemental and condemnatory or when extreme stories are used to bring about change; ▪ messaging focuses exclusively on health risks, as this can influence a shift toward medicalised FGM/C and harm-reduction, not abandonment.

▪ mobile applications for health are used to share information, report complications and receive support; ▪ positive stories of success and abandonment are included, as well as the voices of survivors; ▪ local and national celebrities talk openly about their experiences; e.g. Waris Dirie in *Desert Flower*.	
3. *Intervention*: ENGAGEMENT OF HEALTH WORKERS TO COUNSEL ***Description*: Training health workers to provide counselling on the harmful effects of FGM/C as a prevention strategy and to provide post-FGM/C care and support for survivors.**	
Works best when: ▪ linked with maternal/child healthcare such as antenatal care services targeting pregnant women; ▪ training is in person-centred counselling skills based on the WHO's initiative to train healthcare workers.[30]	**Does not work well when:** ▪ relying on the influence of health workers to shift social and cultural norms in the community. Health workers are not perceived to have 'cultural authority'.
4. *Intervention*: ENGAGEMENT OF MEN AND BOYS ***Description*: Involving men and boys in dialogues about FGM/C, breaking stigma for men to discuss issues such as cutting.**	
Works best when: ▪ dialogues are conducted by local facilitators, using a non-judgmental approach, creating safe spaces for discussions of FGM/C and reconsideration of social norms.[31]	**Does not work well when:** ▪ women are portrayed as the perpetrators and perpetuators of FGM/C and men as the rational voices of abandonment; ▪ engagement of men and boys reinforces patriarchal gender norms.

5. *Intervention*: **ENGAGEMENT OF RELIGIOUS LEADERS** *Description*: **Engaging in dialogue on FGM/C with religious leaders to delink the practice from Islam.**	
Works best when: ▪ engaging religious leaders in dialogues outside of a zero-tolerance framework, allowing for debate on definitions of FGM/C.	**Does not work well when:** ▪ dialogues are forced to conform to a zero-tolerance framework; ▪ dialogues are led by external facilitators who are perceived to be bringing an outside agenda.
6. *Intervention*: ENGAGEMENT OF THE GOVERNMENT ***Description*: Engaging government stakeholders in dialogues about FGM/C to influence legislation and policy.**	
Works best when: ▪ open dialogues are endorsed, outside of a zero-tolerance framework, allowing for debates on definitions of FGM/C (including all types); ▪ there is continued pressure from civil society to pass bills into law and to engage in dialogues about the formation of legislation.	**Does not work well when:** ▪ passing zero-tolerance legislation and enforcing legal consequences for cutting when zero-tolerance legislation is out of alignment with dominant social norms; ▪ consequences are promoted for health professionals who conduct FGM/C in medical settings or with medical equipment, as this risks driving the practice underground.
7. *Intervention*: ENGAGEMENT OF YOUTH ***Description*: Engaging youth in art, social media and other youth-friendly spaces to discuss FGM/C together.**	
Works best when: ▪ led by peer educators/uncut activists/survivors;	**Does not work well when:** ▪ utilising a youth-only focus that isolates the older generations and excludes them from dialogues/messaging;

▪ utilising art and social media to engage youth in dialogue around FGM/C; ▪ creating youth-friendly spaces for dialogue; ▪ promoting intergenerational dialogue between youth and older generations.	▪ utilising a 'girl-empowerment' approach that does not address the family and community dynamics that perpetuate FGM/C, particularly the decision-making related to the practice, which is primarily done by mothers and grandmothers.
8. *Intervention*: ECONOMIC-EMPOWERMENT ACTIVITIES ***Description*: Utilising savings, access to loans, livelihoods and business opportunities to improve household income security.**	
Works best when: ▪ utilising self-help groups in which group members have peer psychosocial support and mobilise their own funds to increase access to savings, rotating loans, etc; ▪ reduces reliance on FGM/C for financial stability/economic support (e.g. dowries);[32] ▪ includes the acquisition of economic-empowerment skills.	**Does not work well when:** ▪ providing some traditional cutters with alternative sources of income to reduce the supply side of FGM/C. FGM/C is a deeply embedded social norm. Alternative cutters from across borders or within the community and/or medical professionals will step in to meet the demand, perpetuating the practice.[33]
9. *Intervention*: COALITION BUILDING/CAPACITY-BUILDING OF CSOs ***Description*: Strengthening/extending networks, developing coalitions, speaking with one voice, and sharing learning and skills, to collaborate and influence collectively, enhancing impact.**	
Works best when: ▪ civil society presses engagement in dialogues about the formation and passing of legislation;[34] ▪ peer education and mentorship schemes are embedded;	**Does not work well when:** ▪ when coalitions are seen to be aligned to 'Western' or 'liberal' agendas that undermine conservative values (i.e. rights of LGBTQ+ persons, abortion, etc.);

▪ sharing existing knowledge and the acquisition of new skills are focuses; ▪ coalitions support local, community-led FGM/C policy-making.	▪ when coalitions are not locally led, but are dominated by members from outside the region. This can be seen as cultural imperialism.
10. *Intervention*: ENGAGEMENT OF SCHOOLS AND TEACHERS ***Description*: Introducing school policies on FGM/C, afterschool clubs, additional curricula and training for teachers.**	
Works best when: ▪ headteachers are informed and committed to ending FGM/C; ▪ schools have access to school nurses to support girls; ▪ specific age-appropriate curriculum materials are available; ▪ training and support for teachers is provided; ▪ parents and elders in the community are actively engaged.	**Does not work well when:** ▪ teachers reinforce their own values and practices in relation to FGM/C; ▪ teachers lack the skills and knowledge to engage with students' queries about FGM/C.
11. *Intervention:* ALTERNATIVE RITES OF PASSAGE *(ARPs)* ***Description*: Initiating an alternative rite of passage for girls to transition from adolescence to womanhood without cutting.**	
ARPs are not appropriate for Somali ethnic communities.	**Does not work well when:** ▪ cutting is not considered a rite of passage. For example, the age of cutting in Somali ethnic communities is now between five and eight years. It is intended to protect 'purity' and chastity and reduce sexual desire. Cutting is done in private and not in public settings or with public ceremonies.

12. *Intervention:* **MEDICALISED FGM/C** *Description*: **Actively promoting harm reduction through medicalised FGM/C; e.g. through inclusion of 'less severe' forms (known as *sunna*) in the midwifery curriculum.**	
Medicalised FGM/C is contrary to a Zero-Tolerance, human-rights and bodily-integrity approach. **Sunna is a form of FGM/C.**	**Does not work well when:** ▪ performing FGM/C becomes an accepted part of a healthcare professional's role. This would embed it as an approved health practice, in direct opposition to the abandonment of all types of FGM/C.

Section 3: Dilemmas

In many situations where there is a movement to bring about social and behavioural change, there will be conflicting pressures and competing priorities, resulting in decision-making dilemmas at the individual, community, regional and national levels.

The situation faced by Somali ethnic communities in the Horn of Africa in relation to FGM/C is complex and challenging. Somali ethnic communities are often perceived as being particularly reluctant to change in relation to FGM/C. They face considerable international pressure to adopt zero tolerance to FGM/C, while often experiencing high levels of food insecurity, poverty, environmental crises and disease. Recognising these dilemmas, and supporting stakeholders in reconciling them, could lead to significant movement toward the abandonment of FGM/C.

This section explores some of the decision-making dilemmas related to FGM/C that are specific to Somali ethnic communities in the Horn of Africa.

Decision-Making Dilemmas at the National Level

In March 2024, the WHO stated that the greater Horn of Africa region 'accounts for close to 22% of the global humanitarian caseload in 2024. It is one of the most vulnerable regions to climate change.'[35]

With increasingly limited resources, national and regional governments in the region are faced with intensely difficult choices between often-competing national priorities, including national security, poverty, food security, environmental crises, education and healthcare. Ending FGM/C is a long-term goal, whereas many of the other priorities, like food security and disease outbreaks, present more immediate needs and often result in the reallocation of funds to address them.[36] In addition, there is evidence that many forms of gender-based violence, including FGM/C, increase during times of crisis, potentially reversing any progress.[37]

There is commitment by governments in the region to support human rights, including the rights of women and children. However, Somali society has tended to be conservative, historically, and there is a reluctance to fully embrace what are seen as more liberal rights (for example, LGBTQ+ and trans rights). Governments want to control the speed and extent to which human-rights-based approaches are adopted, thereby limiting the extent of social change.

Campaigns to end FGM/C rely heavily on international support, which usually requires a commitment to zero tolerance and tends to report progress toward the abandonment of *all* types of FGM/C. This results in pressure to adopt a one-step change to total abandonment over a more step-wise approach, which some stakeholders feel would be more realistic in Somali ethnic communities, or an abandonment of the pharaonic cut while retaining other forms of cutting.[38]

Decision-Making Dilemmas for Professionals

Decision-making dilemmas for healthcare workers in relation to FGM/C are widely recognised at the individual, institutional and policy levels.[39] With medicalisation comes increased pressure to perform FGM/C, as it is perceived to reduce harm to girls and gives an additional opportunity for healthcare workers to secure income to support their families.

Conversely, there is increased pressure to support the total abandonment of all types of FGM/C from selected ministries, including ministries of health and anti-medicalisation policy enforcers.

There are recent initiatives to train healthcare workers to take on positive counselling roles supporting the abandonment of FGM/C, which have resulted in midwives and nurses feeling more informed and confident in their knowledge about cutting,[40] although the decision-making dilemma in relation to their own daughters remains.

Other professionals also face decision-making dilemmas arising from their roles in the community. Examples include the following.

- A school headteacher in Somaliland, who personally supported the abandonment of all types of FGM/C, introduced a school-wide policy opposing the pharaonic cut, but allowing other forms of cutting, because she knew many of the staff would not abandon these. She felt a step-wise approach would reduce the harm to girls, time taken off school to recover from FGM/C, and school dropout.[41]
- Law enforcers caught between pressures to report harm and enforce the law (if there is one – for example, in Kenya) or to engage families and communities in dialogue to support change through community awareness.
- The proportion of religious leaders publicly supporting abandonment of all types of FGM/C in Somaliland *dropped* from 24% to 14% following the fatwa in 2018, which stated that the 'less severe' cut (sunna) was obligatory.[42]

Decision-Making Dilemmas at the Household Level

It is widely recognised that parents and families are frequently caught between not wanting to harm their daughters by having them undergo FGM/C and wanting them to be socially acceptable both at school and in later life, as they marry, support their families and become active members of their communities.

The sanctions and benefits associated with social norms are not the only factors at work, but they can be highly influential in decision-making at the household level and have contributed toward both a movement away from pharaonic cut toward 'less severe' forms – snipping or pricking (i.e. harm reduction) and a shift toward cutting by healthcare workers rather than traditional cutters (medicalisation).

Parents and families may also be caught between wanting to abandon FGM/C and seeing it as a means of supporting the wider family through their daughters collecting higher dowries/bride-prices and by ensuring their social acceptance through marriage. This is especially common in contexts of high levels of poverty and food insecurity, which are often brought about by conflict or environmental crises.

There are reports of individuals who are influencers in their communities – for example, healthcare workers, teachers, law enforcers and community/religious leaders – caught between wanting to campaign for zero tolerance and adhering to the social norms surrounding FGM/C in their communities, fearing their daughters may be stigmatised and isolated at school and in the community.

Section 4: Challenges

This section explores challenges that are specific to Somali ethnic communities that impede the goal of abandonment in the region.

Historically, lack of knowledge about the health risks of FGM/C and the conservative nature of Somali culture have been seen as the greatest challenges to the abandonment of FGM/C by Somalis.[43]

The awareness-raising across Somali society that has taken place since the WHO typology was published in 1997 and the launch of the International Day of Zero Tolerance for FGM, in 2012, have resulted in an increase in knowledge of the consequences of cutting, an increase in dialogue about it and a shift away from the pharaonic cut (WHO Type 3) to sunna (WHO Types 1, 2 and 4), as outlined in Section 1 above.[44] Consequently, the challenges and barriers to the goal of abandonment in Somali ethnic communities have also changed.

Currently, challenges include the following.

Lack of Clarity on the Definition of 'FGM/C'

The WHO's definition includes 'all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.'[45] This definition underpins the UN's call for zero tolerance to FGM/C. Despite this apparent clarity, in many Somali ethnic communities there is both confusion and disagreement about what does and does not fall under the definition of 'FGM/C'.[46] There is a consensus that the pharaonic cut (WHO Type 3/infibulation) falls under the definition of 'FGM/C'. However, many consider that the 'prick' or 'snip', commonly referred to as *sunna*, is not FGM/C. This has led to multiple examples of people actively campaigning against FGM/C (pharaonic cutting), while arranging for their daughters to undergo 'less severe' forms (sunna). This ambiguity is conspicuous in the Somaliland fatwa on FGM/C published by the Ministry of Religious Affairs in February 2018, which strongly opposes all kinds of FGM/C except that described as the 'sunna' which it states is *waajib* ('obligatory').

The lack of a consensus on what constitutes FGM/C is seen as a driver toward harm-reduction approaches (abandoning the pharaonic and intermediate cuts, but keeping other forms of cutting), rather than total abandonment or zero tolerance.

Lack of Consistent Anti-FGM/C Legal Framework in the Region

The situation in relation to the law and FGM/C is mixed across the Horn of Africa. Critical issues like age and consent have largely been resolved; however, the question of whether 'less severe' forms of cutting (particularly the WHO's Types 1 and 4) are included under the definition of 'FGM/C' remains the main barrier to obtaining support across government departments.

The lack of a consistent legal stance in relation to FGM/C across the Horn is seen by many as a major barrier to the goal of abandonment of the practice.

Perception and Stigmatisation of Girls and Human Rights

Traditionally, there was a feeling that, once a girl is cut, she no longer wants to study or be treated like a child, but feels ready for sex and so should be married to avoid unmarried pregnancies.

Girls who have not undergone FGM/C, or, more commonly, only undergone 'less severe' forms of cutting, are often perceived as being 'wild'; i.e. promiscuous, outspoken and uncontrollable. The perceived increase in unmarried pregnancies is mistakenly thought by many in the Horn of Africa to be caused by the decrease in the pharaonic cut.[47]

Secondly, the movement away from the pharaonic and intermediate cuts has resulted in an increase in the use of human-rights-based approaches to ending FGM/C. Human-rights approaches are often perceived as originating in the West and are linked with 'liberal Western culture', including LGBTQ+ and trans rights, which challenge the conservative values of Somali culture.[48]

Campaigns to End FGM/C Perceived as Attacks on Somali Culture

Some perceive campaigns to end FGM/C to be critical of Somali culture.

This may be exacerbated by the use of judgemental language, accusations that parents are ignorant and violent to their daughters, and descriptions of FGM/C as an abhorrent, 'primitive' practice.

Community elders often perceive themselves to be custodians of the culture and are reluctant to consider supporting change. Alternatively, they may consider the changes to be happening too quickly or the expectations to be too great, and instead prefer a more gradual approach.

Amirbahram Arabahmadi concludes:

> It is also important to emphasize that any strategy geared toward combatting FGM in the Horn of Africa should avoid policies that may be perceived by the people in that region as aggressive and insensitive toward their traditions and cultural protocols.[49]

In contrast, some activists, influencers and politicians are quite unrealistic about the speed of abandonment, claiming, for example, that a large proportion of the community has already abandoned FGM/C or that total abandonment is possible in a generation. Such attitudes fail to take into consideration the challenges and barriers to abandonment.

Reliance of Families on Dowries Linked to FGM/C

In times of extreme poverty due to environmental crises or conflict, there is some evidence that school participation by girls declines and FGM/C and child marriage increase. Parents may be primarily attempting to secure the futures of their daughters; however, dowries are valuable sources of income for families at such times.

FGM/C-Specific Programming/Integration of FGM/C Messaging

With increasing recognition of the interconnectedness of health and social issues, FGM/C is being closely linked to education, health and gender transformation. CSOs that have not previously included FGM/C in their programmes face the challenge of integrating FGM/C messaging into their social-development initiatives. Meanwhile, CSOs that have focused specifically on FGM/C face the challenge of widening their programmes to address poverty more directly, by establishing income-generating initiatives.

Setting Realistic, Measurable Goals

Local CSOs report that unrealistic assumptions about the speed of movement toward abandonment – for example, the eradication of all types of FGM/C in one generation – are unhelpful and can be counter-productive. Such assumptions can result in evaluations and measures of success being made purely on the scale of total abandonment (zero tolerance) and, therefore, the more nuanced changes that are taking place are missed.

Recognising small but significant changes would help generate the feeling that progress is being made toward the abandonment of FGM/C and that, therefore, all parts of society can embrace smaller victories.

Section 5: Next Steps

This paper seeks to challenge the dominant narrative that changes in the practice of FGM/C are not occurring in Somali ethnic communities; to highlight areas where there is change; and to explore what supports and hinders interventions.

However, the Horn of Africa region is complex. There are a number of decision-making dilemmas that occur in the national, professional and household arenas. The cultural context also presents specific challenges to the abandonment of FGM/C, particularly the lack of clarity around the definition of 'FGM/C', the lack of precise and consistent anti-FGM/C legislation, the standing and stigmatisation of girls/women, and the perception of campaigns against FGM/C as attacks on Somali culture.

This paper sets a foundation for a series of dialogues in which to further explore the evidence, dilemmas and context-specific challenges related to FGM/C-abandonment in the Horn of Africa. Dialogues between researchers, practitioners, policymakers and CSOs engaged in advocacy is crucial to identify a way forward for policies and programming.

The knowledge-sharing dialogue process that contributed to the production of this paper has also led to a resource for practitioners working with Somali ethnic communities on the issue of FGM/C, which is called ***Horn of Africa: Accelerating Change*** and can be accessed **here**. In addition, dialogues with academics and researchers have led to the identification of research priorities for the region. These are set out in a paper entitled ***Horn of Africa: Evidence of Change***, which can be accessed **here**.

If you are interested in participating in ongoing dialogues regarding evidence and strategies for change in the Horn of Africa, please reach out to Orchid Project to be added to our mailing list for quarterly dialogue and knowledge-sharing sessions: (**research@orchidproject.org**).

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