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Country of Origin Information Centre

Report

Somalia

Female Genital Mutilation

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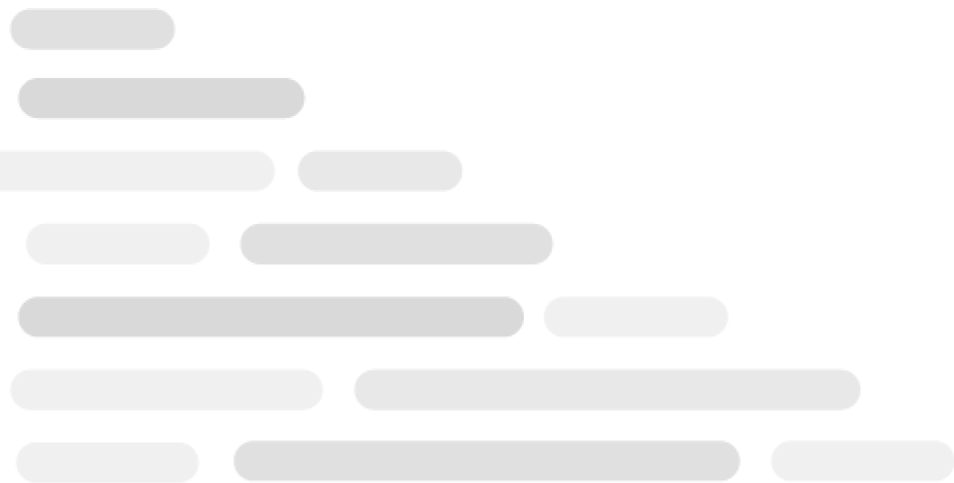

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Summary

Female genital mutilation (FGM) is a nearly universal practice in Somalia. According to numbers from the latest Health and Demographic Survey of 2020, there is no indication of the practice abating. However, some have departed from infibulation in favour of (somewhat) less intrusive operations. Female genital cutting is still viewed as a culturally significant custom and a condition for making a good marriage.

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1 Introduction

This report provides a brief description of the extent of female genital mutilation (FGM) in Somalia and local justifications for and practices related to carrying out the procedure. The report then explains some key developments in terms of prevalence, the type of FGM and support for the intervention in the population. Finally, the possible consequences of not being circumcised in Somalia are outlined as well as how the Somali diaspora in the West relates to the practice today.

In this report, we use the term female genital mutilation, or the abbreviation FGM, when we refer to the practice as a whole. This term is used by the World Health Organization (WHO), in Norwegian legislation and by human rights organisations. We also use the term circumcision, which corresponds to the Somali term *gudniin*, when we refer to local justifications for the custom and people who are circumcised.[1]

1.1 Sources

After many years of demand, a major statistical study was published in 2020, *The Somali Health and Demographic Survey 2020* (SHDS 2020), with updated figures on the prevalence and extent of FGM in Somalia. SHDS 2020 also highlights development over time compared with previous and similar studies. In addition to the quantitative studies, there is research literature and studies conducted by various aid organisations who use qualitative methods and thus provide a more complete picture of the local justifications and practical considerations in connection with performing FGM.

Landinfo has also been in contact with resource persons who work with or have researched FGM in Somalia and elsewhere.

2 Prevalence

FGM is almost universal in Somalia. The latest figures come from the comprehensive health and demographics study SHDS 2020,[2] where more than 99

[1] For more on the discussion around the use of the term, see Johnsdotter & Johansen (2020, p. 8-11).

[2] The study is based on interviews and self-reporting from a sample of 14,651 women in all regions in Somalia, with the exception of Lower Shabelle, Middle Juba and Bay, where interviews were not conducted for security reasons (SHDS 2020). Landinfo does not see any reason to believe that the prevalence of FGM in these regions differs from the prevalence elsewhere in Somalia. In UNICEF'S MICS study from 2006, for example, it was found that over 99 % of girls and women in southern Somalia between the ages of 15-49 had been circumcised (UNICEF 2006, p. 138).

% of respondents between the ages of 15 and 49 reported being circumcised (SHDS 2020, p. 213).

The numerical data in the survey is not organised geographically at administrative levels and thus does not say anything about variations at the federal state and regional level. However, in previous major quantitative surveys with figures on FGM – UNICEF's *Multiple Indicator Cluster Survey* (MICS) from 2006 and 2011 – it was found that there was little variation in the prevalence of FGM between Southern Somalia (99 %), Somaliland (99 %) and Puntland (98 %) (UNICEF 2006; 2011; 2014). In light of the persistently high occurrence of FGM in Somalia, there is no reason to believe that the geographical variation has changed significantly today.

The studies mentioned above are based on self-reporting and may be vulnerable to underreporting or overreporting, as the respondent is likely to respond with what she believes the interviewer or the surrounding community expects from her. However, the high occurrence of FGM is also supported by a clinical examination of 6,000 girls and women at Edna Aden Hospital in Hargeisa from 2006 to 2013, which found that 98 % of those examined had been circumcised (Ismail et al. 2016, p. 29).

2.1 FGM and social indicators

According to SHDS 2020, and as shown in Table 1 below, there is little variation in the prevalence of FGM across the social indicators of wealth, residence and level of education (SHDS 2020, p. 220).

However, the percentage of women who have reported having been circumcised is marginally lower in urban areas, in relatively wealthy families and amongst women with higher education. However, the study does not contain a multivariate analysis of the effect of a combination of factors, and thus cannot provide accurate figures for the prevalence of FGM amongst, e.g. highly educated middle class women in the cities.

According to a study based on focus groups and interviews with people who work with FGM in Somalia, it is only a small minority in Somalia – consisting of people with high education and some groups from the diaspora – who have moved away from all forms of FGM (Crawford & Ali 2015, p. 65).

Social indicators, especially levels of education and wealth, have greater significance for the type of FGM practised and the attitudes towards the practice (see chapters 4.2 and 4.3).

Table 1: FGM and social indicators

Social indicators	Prevalence of FGM
Residence	
- nomadic	99.7 %
- rural	99.3 %
- urban	98.8 %
Wealth quintile[3]	
- lowest	99.3 %
- second	99.5 %
- middle	99.1 %
- fourth	99.5 %
- highest	98.6 %
Education level	
- no education	99.3 %
- primary school	99.7 %
- "upper secondary"	97.7 %
- higher	96.3 %

The table was prepared by Landinfo based on data from SHDS 2020 (p. 220).

3 How, why and when FGM occurs

3.1 Types of female genital mutilation

WHO classifies female genital mutilation into four different types, ranging in scope from "symbolic" needle sticking to infibulation. The most widespread variants in Somalia are types I, II and III.

- Type I (Clitoridectomy): Partial or complete removal of the clitoris or the skin fold over the clitoris.
- Type II (Excision): Partial or complete removal of the clitoris and inner labia, with or without removal of tissue from the outer labia.
- Type III (Infibulation): Narrowing of the vaginal entrance through parts of the inner and/or outer labia being cut away and sewn or joined together so that a skin seal is formed that closes the vaginal entrance. Often, the clitoris is also partially or completely removed (WHO 2020).

[3] A quintile in this context is a sample divided into five equal parts. SHDS operates with "wealth quintile".

In Somalia, a distinction is made mainly between pharaonic circumcision (*gudniika fircooniga*), which in this report is referred to as infibulation, and sunna circumcision (*gudniika sunna*).

3.1.1 Infibulation (pharaonic circumcision)

Infibulation is the most extensive type of FGM – and the type most prevalent in Somalia. The procedure involves the removal of part or all of the external genitalia and a sewing of the vaginal opening with 4-7 stitches, with only a small opening for urine and menstrual blood (Newell-Jones 2016, p. 11).[4]

It is necessary for the vaginal opening to be opened again in connection with intercourse and childbirth, this is called defibulation. In northern Somalia it is common for this procedure to be performed surgically by an experienced woman before first intercourse, while in southern Somalia it is expected that the man himself will "open" the woman after marriage, in both a symbolic and physical sense. Further opening of the vaginal opening is necessary during delivery (Johansen 2017, p. 3; Crawford & Ali 2015, p. 77).

Defibulation can also be done in hospitals for medical reasons. However, this is very unusual in Somalia, and defibulation before marriage can give rise to suspicion of extramarital affairs (Swedish Migration Agency 2019, p. 34).

Reinfibulation is when the vaginal opening is sewn back together after being opened and is considered a form of FGM, see chapter 3.5.1.

3.1.2 Sunna circumcision

In Somalia, there is a widespread understanding that sunna circumcision is recommended in Islam (see chapter 3.2),[5] and that the procedure, unlike infibulation, is not harmful to health nor falls under the definition of FGM.

Although sunna circumcision is usually defined as type I in the WHO's typology, this does not necessarily coincide with how the procedure is practised in Somalia. Several studies have found that in practice sunna circumcision includes a wide range of FGM types, varying in severity from clitoridectomy (type I) to infibulation (type III). In recent times, for example, variants have been identified such as "big sunna" (*sunna kabir*) or "sunna 2", which means the removal of all or

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[4] Amongst nomadic communities in Puntland and Mogadishu, *fadumo hagoog* is also practised, an infibulation that involves removal of the external genitalia and the sealing of the vaginal opening without sewing. Instead, the girl's feet are bound together over time so that the wounds heal into each other and form scar tissue over the vaginal opening (Crawford & Ali 2014, p. 67, 69).

[5] The term *sunna* has clear associations with Islamic religious tradition and thus has connotations of "circumcision that is in line with Islam".

part of the clitoris, parts of the outer labia and partial sewing of the vaginal opening with 2-3 stitches (Crawford & Ali, p. 41-43; Newell-Jones 2016, p. 11).

The development of the more extensive sunna procedures may be due to little knowledge amongst circumcisers and the population as such. It may also be a strategy to both safeguard the traditional notion that the sewing together ensures virginity and simultaneously to get religious recognition of the procedure as "sunna" (Johansen 2006a, p. 55).

3.2 Reasons for performing FGM

Female circumcision has deep cultural roots throughout the Horn of Africa, and the background of the practice is varied and complex.

The practice is linked, amongst other things, to cultural notions of purity and aesthetics, where the clitoris is considered a "dirty" and "male" organ, and the infibulated vulva is considered the aesthetic and moral ideal (Johansen 2002, p. 235; Johansen 2006b, p. 522).

Female circumcision is also underpinned by strong social and moral norms about women's honour. The procedure is considered to suppress sexual drive and infibulation in particular is considered to guarantee virginity until marriage. Being circumcised is in many cases a necessary condition for being an acceptable marriage candidate, and many parents therefore fear that their daughters will have difficulties finding a spouse if they are not circumcised (Johansen 2019, p. 3; Crawford & Ali 2014, p. 79-80, 82; Newell-Jones 2016, 27-28).

There is also a widespread belief in Somalia that female circumcision is recommended in Islam (SHDS 2020, p. 210-211). The attitudes towards the practice amongst Islamic scholars in Somalia vary, but are mainly in support of less extensive forms of FGM. For example, a study from Somaliland showed that most scholars stated that they were opposed to infibulation, but supported sunna circumcision (Newell-Jones 2016, p. 72).

3.3 Who decides that FGM will be performed?

The prevalence of FGM in Somalia is nearly universal and is therefore a social convention that most people take for granted. In the vast majority of families, the most important choices related to the procedure will therefore not be about whether it should be performed, but rather the practical aspects of the procedure itself.

It is primarily mothers, grandmothers and other women who organise and decide what type of circumcision will be performed, while men are less involved in the process (Newell-Jones 2016, p. 76-77). Although the fathers are not always

consulted, the father's words will usually carry the most weight if he gets involved and, for example, disagrees that the procedure should be performed (Crawford & Ali 2015, p. 85).

Although many women understand that the custom is harmful, a majority still believe that it should be maintained (SHDS 2020, p. 223). This underscores that the problems surrounding FGM are complex and structural. In a society strongly characterised by tradition, ideals of purity, fear of stigmatisation and the absence of networks and support systems other than family and clan, the pressure on mothers and other female family members is strong. Although the pressure is primarily exerted by other women, it is rooted in society's demand for women's virginity before first marriage and the notion that circumcision is necessary to safeguard this. Since marriage and family are the foundation of Somali society, there is considerable social pressure in the fear that one's daughter will be excluded from this (Landinfo 2013, p. 10).

In Somalia, not performing any type of FGM would be a radical choice that goes against basic social norms. In order for parents to stand up against FGM of their daughter on their own initiative, they must have knowledge of and counter-arguments to the practice and enough robustness and resources to promote the counter-arguments to family, networks and local communities.

3.4 Who performs FGM?

Most female genital mutilation is performed by traditional female circumcisers (*guudaay*) and midwives who charge for the procedure (Crawford & Ali 2015, p. 46). Traditionally, circumcisers belonged to the occupational group *midgan*, and the profession was passed down from mother to daughter. Today, the profession is practiced by all clans and groups (Johansen 2006a, p. 56).

The number of female genital mutilations performed by professional health workers, either at or outside a health institution, is increasing. In a study from Somaliland, 5 % of mothers reported having been circumcised by health professionals, while 33 % reported that their daughters had been circumcised by health professionals. The study found that the so-called medicalisation of FGM was most prevalent in urban areas, although an increase was also observed in rural areas (Newell-Jones 2015, p. 25). Although quantitative studies are unavailable, there is reason to believe that medicalisation is also increasing in other parts of Somalia (Crawford & Ali 2015, p. 46).

3.5 When is FGM performed?

Most girls are circumcised before the age of ten. In SHDS 2020, 73 % of circumcised girls/women between the ages of 15 and 19 stated that they were circumcised when they were 5–9 years old, while 25 % stated that they were 10–14 years old. Just under 1 per cent reported that they were under 5 or over 15 when the procedure took place (SHDS 2020, 221). The figures from SHDS are largely in line with the results from two larger quantitative studies conducted in Somaliland, which also concluded that the majority are circumcised before they are 10 years old (Ismail et al. 2017, p. 31; Newell- Jones 2016, p. 22).

In cases where the wounds have not healed properly or where they are otherwise not satisfied with the result, corrective interventions are sometimes performed during the first year after the procedure was carried out. There are also anecdotal reports of cases where a new procedure is done because the family wants a more extensive procedure than the original one (Johansen, email February 2021; Crawford & Ali 2015, p. 74).

Diplomats at Western embassies in Nairobi who work with FGM cases are aware of cases where girls from the diaspora have been subjected to FGM at an older age than is usual in Somalia (Special Envoy Heidi Bonvik, email February 2021).

3.5.1 Reinfibulation

Reinfibulation is when the vaginal opening is stitched back together after it has been partially or completely opened (defibulation) as a result of childbirth, intercourse or a surgical procedure.

There are no studies on the extent of reinfibulation in Somalia after giving birth and divorce. Ragnhild Elise B. Johansen, who has researched FGM in Somaliland and amongst Somalis in the diaspora, believes there is no basis for saying that reinfibulation systematically occurs after giving birth or divorce in Somalia, neither traditionally nor in modern times (Johansen 2002, footnote 14; Johansen 2017, p. 8). She points out that in a Somali context, infibulation is performed in order to "prove" virginity before marriage, and that there is consequently no point in reinfibulating a married woman after she has given birth (Johansen, email correspondence December 2021).[6]

However, there are examples of reinfibulation being performed on unmarried girls/women who have been subjected to sexual abuse, on the grounds that it restores the notion of virginity (Crawford & Ali 2015, p. 76). There are also anecdotal reports of cases where unmarried girls/young women from the diaspora

[6] Johansen (email correspondence, December 2021) points out that sources from Northern Somalia have claimed that reinfibulation is practiced in Southern Somalia and vice versa, but that these allegations cannot be substantiated by further investigation and that the procedure does not appear to be carried out systematically either in the north or in the south.

have been sent to Somalia to have a reinfibulation done (Johansen, interview January 2021).

4 Change over time

4.1 A very marginal decline in prevalence

In the years following UNICEF's extensive MICS studies in 2006 and 2011, there was cautious optimism that the prevalence of FGM in Somalia was on a decline, especially in urban areas (Crawford & Ali 2015, p. 4).

However, the results from the SHDS survey from 2020 (see Table 2) show that the overall prevalence of FGM is about the same as that found in the MICS surveys, and as is shown in Table 2, the decline in FGM amongst the youngest age groups is very marginal (SHDS 2020, p. 218). Landinfo believes there is reason to see the persistently high prevalence of FGM in connection with the political and humanitarian situation in the country, thirty years after the collapse of the state. While the authorities have very limited capacity to monitor FGM or enforce existing legislation (see chapter 5), the practice is considered by many to be both culturally meaningful and a prerequisite for a good marriage and thus access to the protection and resources family and clan networks provide (see chapters 3.2 and 3.3).

Table 2: Prevalence of FGM in different age groups

Age	Prevalence of FGM
15-19	98.8 %
20-24	98.6 %
25-29	99.5 %
30-34	99.7 %
35-39	99.4 %
40-44	99.6 %
45-49	99.8 %
Total	99.2 %

The table was prepared by Landinfo based on data from SHDS 2020.

4.2 Change to less extensive forms of FGM

Although infibulation is still the most widespread procedure, there has recently been a decline in the percentage of girls who are infibulated in favour of less extensive procedures.

SHDS 2020 found that there has been a steady decline in the number of those infibulated (type III) from the age group 45–49 (82 %) to the age group 15–19 (46 %), and a corresponding increase in the proportion of sunna circumcisions (type I) from 8.5 % in the age group 45–49 to 37.2 % in the age group 15–19 (SHDS 2020, p. 220).[7] The unclear and varying definitions of sunna circumcision should not affect the results in SHDS 2020, as the various procedures are described in detail in the interview guide (SHDS 2020, p. 400).

The decrease in the proportion of infibulations is confirmed by the clinical study conducted at the Edna Adan Hospital in Hargeisa. The study found that the proportion of those infibulated amongst the examined girls/women decreased from 99 % during the period of 2002–2006 to 82 % during the period of 2006–2013 (Ismail et al. 2016, p. 30).

SHDS 2020 does not contain (published) data material that can say anything about in which population groups the decline in infibulation has been greatest. The study also shows that the type of FGM has a connection to level of education and to a lesser extent with one's socio-economic status. There is a lower proportion of those infibulated amongst the highly educated 27 %) than amongst those without education (70 %) and likewise amongst those in the highest economic quintile (51 %) than in the lowest (71 %) (SHDS 2020, p. 220). The fact that there is a decrease in infibulation amongst the highly educated and relatively wealthy may be due to increased knowledge of the continuing health problems resulting from the procedure and an increased social acceptance for (somewhat) less extensive procedures, such as sunna circumcision.

4.3 The majority of women state that FGM should continue

In SHDS 2020, 76 % of women asked stated that they believe that female circumcision should continue (SHDS 2020, p. 223). This is a higher proportion than in MICS 2006, where 65 % of the women stated the same (UNICEF 2006, p. 138).

The study shows that there is a connection between education and the desire to move away from FGM. Of the respondents with higher education, 44 % stated that female circumcision should continue, compared with 78 % of those without education. The connection between socio-economic status and the desire to end the practice was somewhat weaker, as 64 % in the highest quintile wanted to continue compared to 81 % in the lowest. Although the variations between age groups are small, the highest percentage (80 %) of those who want the practice to continue are in the lowest age range (15–19) (SHDS 2020, p. 223).

[7] The other respondents stated that they had type II or did not know which type they had (SHDS 2020, p. 220).

There are no studies that can say anything about why the proportion supporting FGM has apparently increased, but it is conceivable that it is related to the increase in less extensive forms of FGM.

5 Insufficient national legislation against FGM

There is no national legislation that explicitly prohibits or criminalises FGM in Somalia.[8] According to Article 440 of the Somali Penal Code, it is forbidden to harm another person, but no indictments in any FGM cases have been raised on the basis of this legal provision (28 Too Many 2018a, p. 5).[9]

In Puntland, a bill was presented to the state parliament in 2014 to ban FGM. However, the proposal was not adopted (28 Too Many 2018a, p. 5). Furthermore, religious leaders in the federal state issued a *fatwa*[10] banning FGM in 2013, and the federal state government issued a decree banning health workers from performing FGM in 2014. According to 28 Too Many (2018a, p. 5), none of these initiatives have led to FGM cases being brought to light or to consequences for health personnel who perform the procedure.

In Somaliland, the Ministry of Religion issued a fatwa in 2018 banning infibulation but did not ban sunna circumcision (28 Too Many 2018b, p. 3).

5.1 FGM in Al-Shabaab areas

According to a source Landinfo consulted in 2011, FGM was banned in all areas controlled by Al-Shabaab (Landinfo 2011, p. 11). A source consulted by the Swedish Migration Agency in Mogadishu in 2019 confirmed that the organisation had previously banned all forms of FGM, but that they now accepted sunna circumcision (Swedish Migration Agency 2019, p. 22-23).

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[8] In the provisional constitution of 2012, it is stated in Article 15, fourth paragraph, that female circumcision is prohibited. However, this ban has no practical significance, as it is not derived from laws with penal provisions (28 Too Many 2018a, p. 5). It is also worth noting that the Somali state is not present in all areas of Somalia, and that the Somali judiciary, like other civilian authorities, has very limited capacity.

[9] The death of ten-year-old Deeqa Dahir Nuur in Dhusmareb in 2018 as a result of complications after FGM attracted great national and international attention and was referred to by the media to be the first case in which Somali prosecuting authorities planned to bring an indictment in an FGM case (Batha 2018a). However, the charges were supposedly not brought because the parents would not cooperate with the authorities or identify the woman who performed the procedure (Batha 2018b).

[10] A fatwa is a statement on one or more matters based on Islamic legal practice. Note that a fatwa is a recommendation and not binding on anyone. The fact that fatwas are issued with contradictory arguments and conclusions is thus not a formal problem.

According to the same sources, the ban would have had little effect on the prevalence of FGM in the areas controlled by Al-Shabaab (Landinfo 2011, p. 11; Swedish Migration Agency 2019, p. 22-23).

6 Reactions against girls/women who are not circumcised

FGM is the norm in Somalia and is not a taboo subject amongst women (Johansen 2019, p. 8). As the neighbourhood/village girls in the same cohort are often circumcised at the same time, and the procedure is marked with a party, it is common for the local community to have some knowledge of which girls are circumcised and which not (Crawford & Ali 2015, p. 74).

Naturally, the various procedures are also a theme amongst young girls, both amongst those who have undergone the procedure and those who have not (yet). In a qualitative study examining attitudes to FGM in Somalia, several of the participants stated that young girls themselves asked to be circumcised so that they could be like their friends who were already circumcised. A father who did not want his daughter subjected to the procedure said that his daughter was bullied at school and that the other girls did not want to eat with her (Crawford & Ali 2015, p. 83).

There are no studies on the situation of uncircumcised adult women in Somalia and thus also not on the kind of reactions they are exposed to by their surrounding community. However, there are studies which, amongst other things, have examined the view of uncircumcised women in the Somali population. A study from Somaliland, where the participants were asked about societal and their own views on uncircumcised women, showed that negative characteristics, such as the woman being unclean and "un-Somali", were widespread (Nafis Network 2014, p. 29-30).[11] In a similar study, uncircumcised women were often referred to as "abnormal" and it was emphasised by the participants, amongst other things, that uncircumcised women are considered to have a lower value and to be shameless (Crawford & Ali 2015, p. 82-83). The term *kintir* means clitoris in Somali and is used along with *kinitrey* as a nickname for uncircumcised girls and women (Swedish Migration Agency 2019, p. 24).

There is also a widespread opinion that circumcision is a prerequisite for being able to marry and thus establish a family, see chapters 3.2 and 3.3. Being outside of marriage or being subjected to other social stigmatisation linked to not being

[11] The participants were first asked if they know (of) an uncircumcised woman, which only 14 out of 212 participants did. The study does not say anything about possible differences in attitudes towards uncircumcised women between those who know an uncircumcised woman and those who do not.

circumcised, can have serious consequences in a society such as Somali society, where networks are crucial in many contexts.

7 Change in practice and attitudes in connection with migration to the West

As far as Landinfo is aware, there is no mapping the prevalence of FGM amongst girls with Somali parents who have migrated to a Western country for a shorter or longer period and who have then returned to Somalia.

However, there is research literature that examines changes in the prevalence and attitudes of FGM amongst individuals and groups from areas where female genital mutilation is widespread and who have migrated to Western countries where female genital mutilation is prohibited. These studies look into possible causes of the changes in attitudes and behaviour of the migrant population regarding FGM.

In a knowledge summary of studies on FGM in diaspora environments, researchers Sara Johnsdotter and Birgitta Essén (2016) concluded that the prevalence of FGM is significantly reduced and in some cases completely ceases when migrating to Western countries. The authors pointed to possible explanations for the change in attitude and behaviour and showed, amongst other things, that migration leads to a "cultural reflection" on norms previously taken for granted and that the social cost of not implementing FGM disappears as attitudes change and the practice is less widespread amongst the diaspora. Distance also contributes to less pressure from the extended family in the home country.

However, there are also studies that point out that the decrease in cases of FGM in diaspora environments does not necessarily imply a corresponding fundamental change in attitude towards all forms of FGM. In a study on attitudes towards FGM amongst the Somali diaspora in Norway, the anthropologist Ragnhild Elise Johansen found that the opposition to FGM is not clear. While almost all participants in the study stated that they were opposed to infibulation, the majority accepted or supported sunna circumcision, and considered the procedure "normal" and non-harmful. Many also believed that the procedure is accepted in Islam (Johansen 2019, p. 11-12).

A recent study by Ragnhild Elise Johansen and Salma A. E. Ahmed (2021) found that attitudes towards FGM amongst women in the Somali diaspora in Norway are linked to their social network. Women who expressed fundamental opposition to all forms of FGM typically have ethnically diverse networks of like-minded people, while women who are ambivalent about or support the practice mainly relate to the transnational Somali diaspora. The study concludes that although the

vast majority have given up the practice in Norway, there is a real possibility that those who are ambivalent or supportive of FGM will resume the practice upon re-migration to Somalia or other countries where FGM is socially accepted.

8 References

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