

## **Accelerating Change towards Zero Tolerance to Female Genital Mutilation/Cutting: Effects of Community Dialogues on FGM/C and Child Marriage‡**

### **Mid-Term Review of the NCA/SCI Joint Programme 2016-2018**

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## Executive Summary

Women and girls face extreme forms of violations in Somalia; common among them is Female Genital Mutilation/Cutting (FGM/C). National statistics estimates over 97% of girls aged 15 to 19 years have undergone FGM/C. To accelerate change towards reduction in tolerance of FGM/C, Norwegian Church Aid (NCA) and Save the Children International (SCI) jointly implemented a 4-year (2016 - 2020) programme in Garbaharey and Belethawa districts in Gedo, Jubaland and Bosaso, Qardo, Garowe and Eyl districts in Puntland, Somalia. The project focussed on addressing social norms perpetuating FGM/C and CEFM through various initiatives such as advocacy for legal and policy framework, community level sensitization and discussions, and providing medical and psychological supports to the girls facing health problems due to FGM/C. This study explores progress of the joint programme results from 2016 to 2018. Additionally, it tests the effects achieved by community level discussions – labelled Community Dialogue Sessions.

The study employed a mixed methodology combining quantitative, qualitative and participatory methods which included the reflective methodology. In the quantitative methodology, this study included five sample groups in each of the 18 communities sampled at the baseline including individuals participating in community level discussions (first group). Second group were individuals not participating in community level discussions but matching individuals in the first group. The third and fourth groups were those in the network of the first and second group. Fifth group were random sample of community members. In total, 1258 respondents were involved at baseline of whom 1168 were traced and re-surveyed at midline. In the qualitative method, a total of 31 Key Informant Interviews and 24 Focus Group Discussions were conducted. The FGD participants were members of the Community Dialogue (CD) sessions drawn from each target district and included the women, men, girls in schools, boys in schools, community and religious leaders' groups. The KII targeted the community and religious leaders, health workers, police, parliamentarians and Ministry of Women.

Despite wide (70%) support for child marriage in the study area, we find low prevalence of child marriage (1% at baseline and 6% at midline) among female children aged between 10 and 17 years. The community however perceives child marriage as a widespread practice, completely opposite of the reality. Using two-wave panel data, this study finds nearly universal FGM/C prevalence (93% in 2016 and 97% in 2018) among girls aged 15 to 19 years. The midline FGM/C prevalence was comparable to the rates observed almost a decade ago among girls of a similar age. Within a two-year period, the study recorded 38% incidents rates (newly circumcised) with 65% of the new FGM/C incidents done between age 5 and 10 years. All uncircumcised girls aged above 15 years underwent FGM/C during the two-year window. Mother and grandmothers were the main decision makers as to whether a girl would undergo FGM/C or not and also determined which type of cut to be performed on her.

Nearly all respondents were aware of negative health consequences of FGM/C. However, the health effects were largely associated with the Pharaonic type of FGM/C, with significant portion of the community perceiving the Sunnah type of FGM as less harmful or not harmful at all. Awareness of negative health consequences of FGM/C was the dominant driver of the two shifts in FGM/C practice: shift in FGM/C types being performed and medicalization of FGM/C. Six out of every ten new FGM/C cases were performed by health professionals especially in urban areas. Similarly, 60% of new FGM/C incidents were of Sunna Saker type while 10% were of Pharaonic type.

This study suffered from FGM/C terminology and translation challenges which could explain trends in FGM/C opinion. In the baseline, only key segments of the questionnaire were translated and not the entire questionnaire as was the case during the midline survey. At the baseline survey, the terminology used to refer to FGM/C was synonymous with only the Pharaonic type of FGM/C and thus did not encompass all FGM/C types. Despite these challenges, results show support for FGM/C abandonment is relatively low with only 29% supporting abandonment and committing not to subject their daughters to FGM/C in future. The few who commit to FGM/C abandonment might not however last for long to as positive deviants. For instance, only 15% of those who indicated not planning to cut their daughters still held their commitment not cut their uncut daughters at midline, the rest had either subjected their daughters to the cut contrary to what they indicated at baseline or had changed their minds and were now planning to subject their daughters to the cut, especially the Sunnah type.

This study revealed that FGM/C is practiced based on religious, gender relations and cultural justifications. Sunnah FGM/C type is justified as a mandatory religious practise by 71% of the community. Although religious leaders disagreed with the notion that Sunnah FGM/C being compulsory religious practice, they all supported a fatwa that prohibits only Pharaonic FGM/C. Religious leaders had not taken a common stand prohibiting FGM/C in totality, either they supported Sunnah FGM/C publicly or dismissed the FGM/C discussion as a non-important women issue. The few religious leaders who were for complete abandonment of FGM/C had not come out publicly to air their views. On the other hand Pharaonic type though on the decline was justified as part of the Somali culture and traditions. As a gender relations issue, FGM/C was justified as means to assure virginity, marriageability and taming women's sexual desires. Deviation from the norm would result in significant social costs such as failure to get a marriage partner and ridicule.

We also assessed the effects of continued participation in CD sessions that had started 4-5 months prior to baseline. The CD sessions were held periodically by congregating select members from different communities to inform about health and socio-emotional consequences of FGM/C. Other than informing them, CD sessions provided space for community members to openly discuss and reflect on FGM/C. These CD participants would then deliver these messages and take actions to end FGM/C practices in their respective communities. Using intention-to-treat estimates, results show no significant change in FGM/C practice due to continued participation in CD sessions among the participants as well as those in their immediate networks in opinion on FGM/C practise. However, community dialogues raised awareness on negative consequences of FGM/C which has led to a change in FGM/C type practiced and medicalization but not support for total abandonment

NCA, SCI and other actors needs to advocate for total abandonment of all forms of FGM/C. The actors should streamline their messages to conform to total abandonment to avoid the risk of silently endorsing the Sunnah type of FGM/C. Additionally the joint programme should explore successful strategies for buy in from top religious leaders. Enable the existing religious leaders who have a stand on FGM/C abandonment to come out and publicly declare their stand. Furthermore, CD sessions should be strengthened to enable critical reflection by the wider community not just a unidirectional information dissemination platform by just a segment (already converted) of the community segment.

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## **List of Abbreviations**

|         |   |
|---------|---|
| CD      | Community Dialogues                                       |
| CEC     | Community Education Committee                             |
| CEFM    | Child Early and Forced Marriage                           |
| CHC     | Child Health Committee                                    |
| CWC     | Child Welfare Committee                                   |
| FGD     | Focus Group Discussion                                    |
| FGM/C   | Female Genital Mutilation and Cutting                     |
| GBV     | Gender Based Violence                                     |
| IPV     | Intimate Partner Violence                                 |
| ITT     | Intention to Treat  |
| KII     | Key Informant Interview                                   |
| MICS    | Multiple Indicator Cluster Survey                         |
| NCA     | Norwegian Church Aid                                      |
| NGO     | Non-Governmental Organization                             |
| pp      | Percentage Points   |
| SCI     | Save the Children (International)                         |
| SEDHURO | Social-Economic Development and Human Rights Organization |
| TASS    | Tadamun Social Society                                    |
| ToC     | Theory of Change  |
| UNFPA   | United Nations Population Fund                            |
| UNICEF  | United Nations Children's Fund                            |
| WHO     | World Health Organization                                 |

## 1. Background and Interventions

### 1.1 Context

Somalia is considered one of the worst place for women and girls. According to the United Nations Development Programme (UNDP), Somalia had the fourth highest gender inequality in 2012 [1]. In Somalia, women are more likely to suffer from exclusion in key dimensions such as health, empowerment and labour market participation. Other than exclusion, women and girls are prone to most extreme forms of violations. Female genital mutilation/cutting (FGM/C) and child, early and forced marriage (CEFM) are two of the extreme forms of violation of child rights, which are prevalent in Somalia. Rates of child marriage, before the age of 18 years, has progressively reduced from an average of 46% in 2006 to 10%-13% in 2016 [2].

FGM/C on the other hand remains widespread and deeply entrenched social convention that has been practiced in Somalia. Multiple Indicator Cluster Survey (MICS) show the share of girls aged 15 to 19 who have undergone FGM/C averaged 97% to 99% in 2011, similar to estimates of 2006 [3]. Despite the absence in FGM/C changes, it masks changes in types of FGM/C practiced. World Health Organization classify FGM/C in to four types ranging from clitoridectomy (Type I), excision (Type II), infibulation (Type III) and other non-medical procedures on female genitalia (Type IV). In local terms, FGM/C practiced exists in two dominant forms: Pharaonic (infibulation) and Sunnah. The latter is loosely classified into two: Sunnah Sakeer (clitoridectomy) and Sunnah Kabeer (excision), however, exact definition of what Sunnah FGM/C entails is unclear [4, 5]. The MICS 2011 data show that the rate of women being sewn closed decline from 90% to 80% from older cohort (45-49 years) to younger cohort (15-19 years) in Puntland. This rate is static in South Central Somalia (80% and 78%). While Pharaonic FGM/C has declined, Sunnah types of FGM/C continue to rise [6].

Approval for FGM/C remains significant, however, estimates of persons supporting FGM/C in the country is plagued by what community understand to consist FGM/C. For instance, community members perceive FGM/C to mean Pharaonic type and do not consider Sunnah as a type of FGM/C. The few women in MICS 2006 (33%) and 2011 (37%) who indicate to support discontinuation of FGM/C was therefore likely over-estimated. Several studies document strong resistance towards full abandonment of the practice, instead the community support discontinuation of Pharaonic circumcision and support for the continuation of Sunnah circumcision is widespread [7, 8].

Somalia's constitution prohibits circumcision of girls but currently there no national legislation that expressly criminalizes and punishes the practice of FGM/C [5, 9]. Puntland region have FGM/C policy and a draft bill under consideration. During the 2018 International Day of Zero Tolerance for FGM/C, a fatwa (religious ban) was issued in Somaliland that forbids and punishes only the Pharaonic circumcision. A contested 2013 fatwa in Puntland called for total abandonment of all types of FGM/C [10]. International and local civic organizations viewed the 2018 fatwa as legitimizing the Sunnah type of FGM/C from a religious angle. Similarly, there is no express legal framework that protects children from early child marriage.

A number of initiatives in Somalia that are trying to address child protection concerns including harmful practices by working with the government at national policy levels as well as with communities through various approaches. Norwegian Church Aid (NCA) and Save the Children International (SCI) have been implementing a joint FGM/CEFM project titled *Accelerating Change towards Zero Tolerance to FGM/C in Somalia* funded by Norad which was under review and the findings are documented in this report.

## 1.2 Interventions

The NCA/SCI FGM/C Joint programme was launched in Somalia in 2014 based on learnings from a similar strategic partnership between NCA/SCI in Ethiopia. The programme is in the 2<sup>nd</sup> phase of implementation and covers six locations namely Garbaharrey, Belet Hawa (Gedo region in Jubaland state), Garowe, Eyl, Bosaso and Qardho (in Puntland state). Both NCA and SCI work through local partners namely Tadamun Social Society (TASS - SCI partner; working in Bosaso and Qardo), KAALO Aid for Development (NCA partner working in Garowe and Eyl) and Social-Economic Development and Human Rights Organization (SEDHURO - NCA Partner working in Gedo). NCA also implements certain components of the project directly in Gedo region. Targeted beneficiaries of the project included members of various community groups such as men, women, youth, children, community and religious leaders; as well as local community structure such as community education committees (CEC), child welfare committees (CWC), community health committees (CHC), and professionals such as teachers, health workers among others.

The overall goal of the joint programme was to contribute towards elimination of CEFM and all forms of FGM/C in targeted communities through realization of four key outcomes which are:

- ✓ Dominant social norms transformed to protect girls and women from HPs-FGM/C & CEFM
- ✓ Communities and faith actors commit to end Female Genital Mutilation (FGM/C) and Child Early & Forced Marriage (CEFM)
- ✓ Laws, policies and budgets to end FGM/C are improved and implemented
- ✓ Women and children exposed to HPs have accessed adequate and appropriate support services (Medical and Psychosocial support)

The programme employs various approaches towards realization of the intended change. Some of these approaches include Community conversations on monthly basis with different community groups, use of media to educate communities on various topics on FGM/C, engaging religious and community leaders as gate keepers and key influencers given their social standing; engaging men and boys as agents of change; Capacity building (trainings) of various groups and networks; advocacy on development and enactment of laws and policies, mass awareness campaigns & marking of calendar events (FGM/C day, IWD, DAC, 16 days of Activism, etc); Community mobilization towards girls' education and provision of Medical and psychosocial support to survivor with FGM/C related complications. The community conversations sessions were held periodically (quarterly or monthly) which provided community members a platform to discuss and learn about the harmful effects of FGM/C and CEFM practices and possibly take action to end FGM/CEFM practices in their respective communities.

The programme was guided by a Theory of Change which stipulated various pathways that were to be followed to realize the intended change as shown below.

**Figure 1: Programme’s Theory of Change**

| IF  | THEN  | RESULT   |
|---|---|--|
| Mobilize and build the capacity of community actors (women, men boys and girls, community leaders, government officials, local authorities & community groups) and Religious leaders to break the silence and acceptance of GBV | These actors will be able to act to end GBV and advocate for the rights of girls and women.   | Dominant social norms transformed to protect girls and women from HPs-FGM/C & CEFM   |
| Support Rights holders and Duty Bearers to participate in community dialogues on FGM abandonment and facilitate theological reflections on FGM for religious leaders  | Religious leaders would have an important role in changing religious dogma on FGM and have the potential to advocate and influence communities to abandon FGM as evidenced by community declarations leading to FGM free communities. | Communities and faith actors commit to end FGM and CEFM  |
| Faith actors receive knowledge and understand the need of laws/policies supporting eradication of GBV/HPs   | Awareness creation for norm change, support and enforcement of Laws/policies would contribute to reduced incidents of GBV in Somalia  | Laws, policies and budgets to end FGM/C are improved and implemented   |
| Make GBV (FGM-CEFM) survivors <u>aware</u> of psychosocial and medical services available<br>Facilitate skills training for GBV (FGM) survivors<br>Support out of school girls to have access to education                      | They will develop self-reliance which will lead to reduced vulnerability to GBV (FGM) and improved quality of life for survivors.<br>They will be empowered to make informed decisions and the risk of early child marriage reduced   | Women and children exposed to HPs have accessed adequate and appropriate support services (Medical and Psychosocial support) |

This midline review, other than tracking the project indicators, assesses the effects of the community conversations on transforming social norms that perpetuate harmful practices through building knowledge and capacity of targeted individuals as agents of change, who were expected to promote zero tolerance towards FGM/CEFM in their respective communities.

## **2. Methodology**

### **2.1 Study Design**

This Mid-term review used a mixed methods approach combining quantitative, qualitative and participatory method that included the reflective methodology. Triangulation of data from all sources was undertaken to arrive at the findings.

Survey was used to gather data on opinion, awareness and attitudes of different sample of community members on FGM/C. For comparative analysis, a panel survey was used to compare between the Mid-term and baseline findings. The Reflective study was used to review the validity of the Theory of Change. At baseline, qualitative study was not conducted but it was important during the Mid-term Review as Focus Group discussions and Key informant interviews was used to collect in depth information and collective responses to explain and support the survey.

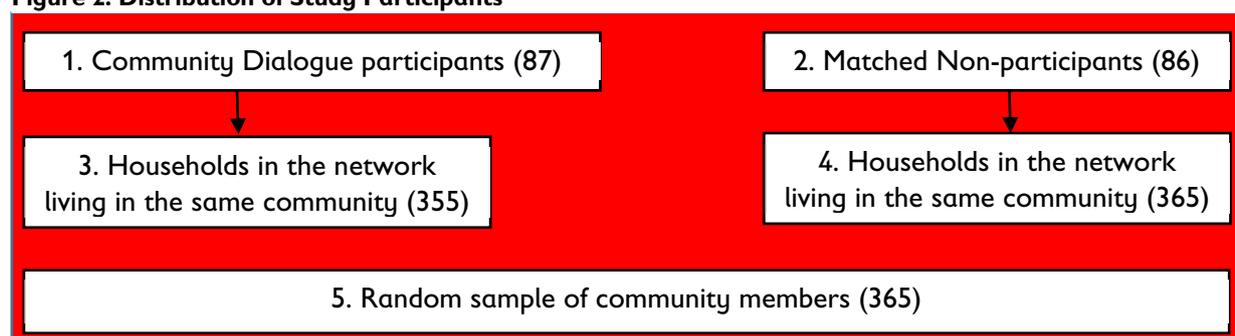
The survey included five different sample groups. The first sample group is the individuals who are directly participating in the community dialogue sessions and act as the agents of change in their communities (henceforth referred to as CD participants). The second group consist of individuals (from the same communities) who are of similar characteristics to the CD participants, hence referred to as potential CD participants. Comparison between these two groups (CD participants and potential CD participants) provides the effects of continuous participation in community dialogues on the participants. These CD participants, other than gaining from the sessions themselves, were also expected to deliver the change messages in their respective communities. Their activities as ‘agents of change’ create spill over effects on others to create a community wide change. We assumed that households in the immediate network of the CD participants are more likely to be the ones affected by the intervention after the CD participants themselves. To assess the spill-over effects at community level, we identified households in the network of CD participants and potential CD participants with whom they were likely to discuss about issues such as FGM/C or early marriage. Finally, to assess the level of selection bias for these samples from the general population and generate general trend, we include a random sample from the same communities.

### **2.2 Data Collection and Sampling**

#### **2.2.1 Quantitative**

For sampling of the respondents, the study used multi-stage cluster sampling. At the first stage, 18 communities was sampled from the project sites in six districts of Somalia- viz. Beletwaha and Garbaherey (from Gedo region), Eyl, Garowe, Bossaso and Gardo (from Puntland). As described above, this study involved five different sample groups. In each community, five persons already participating in CD sessions were chosen to be included in the study (first group). The project staff then identified five other matching individuals who they would have included in the project CD sessions if more resources were available (second group). The third and fourth groups were those in the network of the first and second group. These network sample were identified during the baseline survey of the first and second group. At the end of the baseline survey, both the potential and actual CD participants were asked to give six names each of people in their community with whom they talk to about issues on FGM/C or early marriage and/or people who come to them for advice on these issues. Four out of these six individuals were selected randomly as third and fourth sample groups respectively. The enumerators drew the fifth group, general population sample, 20 per community, after surveying all the four groups by random walk method.

**Figure 2: Distribution of Study Participants**



In total, the study achieved a sample of 1258 respondents at baseline conducted between September and October 2016. Subsequent follow-up conducted in October and November 2018 successfully traced 1168 (92.8%) of the baseline sample in all the five study groups. Attrition disproportionately affected the potential CD participants compared to other study groups; attrition was least among CD participants themselves.

**Table 1: Sample Distribution at Baseline and Midline**

| Sample group                        | Baseline     | Midline      | Successful follow up | Attrition rate (%) |
|-------------------------------------|--------------|--------------|----------------------|--------------------|
| CD Participant                      | 87           | 83           | 95.4                 | 4.6                |
| Potential CD participant            | 86           | 77           | 89.5                 | 10.5               |
| Network of CD participant           | 355          | 331          | 93.2                 | 6.8                |
| Network of potential CD participant | 365          | 334          | 91.5                 | 8.5                |
| Random sample                       | 365          | 343          | 94.0                 | 6.0                |
| <b>Total</b>                        | <b>1,258</b> | <b>1,168</b> | <b>92.8</b>          | <b>7.2</b>         |

In addition to the questions on knowledge and attitudes towards FGM/C and early marriage, the survey instrument covered aspects of household wealth, demography, women empowerment, participation in social programmes. In order to assess their FGM/C and early marriage practices, we included a ‘daughter roster’ that included all the <18 years old daughters of the respondents irrespective of them living in the same household or not. At baseline, the study tool only translated key parts of study tool, however at midline the entire tool was translated into Somali and distinguished the different types of FGM/C.

### 2.2.2 Qualitative

For qualitative data collection, purposive sampling was used to identify respondents for interviews. Purposive sampling was used to identify key informants and participants for the focus group discussions in the sampled districts of Belethwa, Eyl, Ufayn (Bosaso) and Qardho. The selection of respondents of the Focus Group discussions was based on the members of the 6 community dialogues groups per each of the 4 target location that included the men, women, boys, girls, community leaders and religious leaders. The Key Informant Interviews targeted the community leaders, religious leaders, teachers, police, parliamentarians and the 2 representatives each from the Ministry of Women in Puntland and Jubaland. NCA/SCI field staff and partners conducted the qualitative data collection. In total 24 FGDs (six for each of the 4 locations) and 32 KIIs were conducted as districted below.

**Table 2: Qualitative Sample Distribution**

| FGD Category      | Total | KII Category                             | Total |
|-------------------|-------|--|-------|
| Women             | 4     | Community leaders                        | 4     |
| Girls (school)    | 4     | Religious leaders (Female, Male)         | 8     |
| Boys(school)      | 4     | Teachers                                 | 8     |
| Men               | 4     | Health workers                           | 4     |
| Community leaders | 4     | Police                                   | 4     |
| Religious leaders | 4     | Parliamentarians/Ministry representative | 4     |

### 2.3 Analysis Design and Identification Strategy

In this study, we focus on estimating direct and spill over effects of continued participation in CD sessions using intention-to-treat (ITT) as shown in the equation below. As shown earlier, the study traced 93% of baseline sample. While the attrition rate was considerably low in general, there was differential attrition rate between the study arms. For instance, attrition among potential CD participants was 6-percentage points higher compared to CD participants. Comparison with random sample shows little difference in attrition rate with the first four sample groups. We also find higher attrition among those in the poorer wealth quantile and those drawn from Eyl and Garbaherey districts. Since some baseline characteristics predicted the likelihood of attrition, we adjust our effect estimates using inverse probability weights. This included initial estimation of a probability that a respondent remains in the follow-up survey conditional on his/her individual level characteristics and using these probabilities as weights.

$$Y_{it} = \beta_0 + \beta_1 CD + \beta_2 CD_{net} + \beta_3 PCD + \beta_4 PCD_{net} + \beta_5 (midline) + \beta_6 (CD \times midline) + \beta_7 (CD_{net} \times midline) + \beta_8 (PCD \times midline) + \beta_9 (PCD_{net} \times midline) + \beta_{10} X_{it}$$

Where  $Y_{it}$  is the outcome for participant  $i$  at time  $t$ . And  $t=0$  if follow= Baseline and  $t=1$  if follow= Midline.  $CD$  and  $PCD$  are dummies indicating whether the respondent is a CD participant or potential CD participant respectively.  $CD_{net}$  and  $PCD_{net}$  are network dummies showing whether respondent was in a network of CD participant or potential CD participant respectively.  $midline$  is follow-up dummy taking the value of 0 if the period is baseline and 1 if the period is at midline.  $X_{it}$  are characteristics associated with outcome  $Y_{it}$ . Regression coefficients are  $\beta_i$  where  $\beta_0$  is the baseline mean for random sample,  $\beta_1$  to  $\beta_4$  are the baseline differences between the random sample and the other four sample groups.  $\beta_5$  shows midline growth in outcome from values observed in baseline.  $\beta_6$  to  $\beta_9$  are the growth experienced by the other four sample groups over and above the growth registered by the random sample. The coefficients of interest in this study are  $\beta_6$  and  $\beta_7$  which are the effects of CD participant and CD participant network respectively. Qualitative data was recorded, translated and transcribed for analysis. Thematic analysis on the qualitative data to develop recurrent themes and results presented as verbatim.

### 2.4 Ethical Consideration

Informed consent was sought from the participants before the survey and qualitative study in both phases of data collection. Data generated from the surveys were used for research purposes only and other than the researchers, other persons did not have access to data. The community dialogue participation was voluntary, though the participants selected were mobilized and encouraged to attend all the group sessions. To establish the state of CEFM and FGM/C we did not include children who are the actual subjects, but rather interviewed adults to provide information about their children. Enumerators involved in the study were trained in child safeguarding and ascribed to uphold practices that safeguards children according to the SCI Child Safeguarding policy. Data collection teams were trained on ethical considerations as well.

## 2.5 Study Limitation

FGM/C practice in the study area is classified into Pharaonic (Type III), Sunnah Kabeer (Type II) and Sunnah Sakeer (Type I). Despite the distinction, the community members perceive FGM/C terminology to be synonymous with Pharaonic circumcision while they do not consider Sunnah as a type of FGM/C [5, 6]. Furthermore there seems to be varied definition of what Sunnah type of FGM/C between religious leaders and other community members, where the former describe it as Type IV while the latter as either Type I or Type II. The baseline study did not distinguish the different types of FGM/C in the survey instrument as a local term for circumcision [*gudninka*] was used to refer to all the FGM/C related questions in the survey questionnaire. While the study intended to encompass all types of FGM/C, it is likely that some of the respondents may have understood to only imply Pharaonic type of FGM/C. Therefore, the baseline community opinion on FGM/C could be potentially not all inclusive of all types of FGM/C. In the midline survey, however, the study further clarified this ambiguity to distinguish between FGM/C as meaning all types of cut (*gudniinka hablaha/gabdaha*) and the other types, that is, Pharaonic, Sunnah Kabeer and Sunnah Sakeer, instead of just *gudninka*. Furthermore, the study also translated the entire data collection tool to Somali taking into account local definition of terminologies as opposed to just the main segment as was the case in the baseline survey.

**Figure 3: FGM/C Terminology in the Study Area versus WHO Classification**

| WHO Types | Gudninka hablaha/gabdaha |                   | Gudninka  |                   | Sunnah    |                   | Local FGM/C Type           |
|-----------|--------------------------|-------------------|-----------|-------------------|-----------|-------------------|----------------------------|
|           | Community                | Religious leaders | Community | Religious leaders | Community | Religious leaders |                            |
| Type I    | X                        | X                 |           |                   | X         |                   | Sunnah Sakeer              |
| Type II   | X                        | X                 |           |                   | X         |                   | Sunnah Kabeer              |
| Type III  | X                        | X                 | X         | X                 |           |                   | Pharaonic                  |
| Type IV   | X                        | X                 |           |                   |           | X                 | Sunnah (Religious leaders) |

Another major limitation is with regards to the use of self-report data. This study relied on self-reported information to establish the prevalence and incident's rate of FGM/C and child marriage. Being a deeply held social norm, some of respondents might have not revealed the actual type of FGM/C they had their daughter undergo. It is known that FGM/C and female sexuality is a topic that the community would rather not talk about in the study area, especially to unknown persons or of the opposite sex. Being perceived as a women issue, male caregivers are likely not to have an accurate picture of what procedure was done to their daughter. To counter this limitation, this study involved mostly female respondents (66%) and female enumerators. Concerted efforts were made to ensure gender congruence between interviewer and the respondent. Furthermore, due to the different description and local terminologies used to define the different types of FGM/C, data collection teams were trained on these terminologies.

### 3. Findings

This section presents descriptive analysis of the trends between baseline and midline and effects of Community Dialogue in terms of the subsections of; opinion and statements on FGM/C practice in the target communities, probability of stopping/eliminating FGM/C, and findings related to child marriage.

#### 3.1 Background Characteristics of the Study Groups

More than half of the participants were female across the five study groups. Female respondents in the networks of CD participant as those in the network of potential CD participant were disproportionately many compared to other study arms. While there was difference in gender composition in study participants, the proportion of female-headed households were similar, averaging at around 40%. About two third of respondents were married and mostly aged between age of 25 to 50 years, however, the CD participants were slightly older compared to other four arms of the study. Most of the groups had some literacy levels with over half of respondents able to read and write in any language. Nevertheless, CD participants were more educated compared to their counterparts. Household sizes were different among the study groups and on average, the households had five household members but those in the network of potential CD participants had one member less. In terms of household wealth status, results show CD participants were wealthier. The FGD participants were members of CD sessions. While the results show some imbalance among the study groups, the imbalance do not depict any systematic variation between any group and the random sample.

**Table 3: Baseline Background Characteristics of the Study Groups**

| Characteristic                       | CD Participant | Potential CD participant | Network of  |                       | Random sample | F-test <sup>§</sup> |
|--------------------------------------|----------------|--------------------------|-------------|-----------------------|---------------|---------------------|
|                                      |                |                          | Participant | Potential participant |               |                     |
| Female respondent (%)                | 65             | 68                       | 77          | 72                    | 66            | 401.3***            |
| Female household head (%)            | 40             | 35                       | 43          | 37                    | 42            | 0.775               |
| Respondent is married (%)            | 66             | 73                       | 67          | 62                    | 61            | 3.229               |
| Respondent age (%)                   | < 25           | 17                       | 21          | 17                    | 22            | 1.083               |
|                                      | 25 – 50        | 55                       | 64          | 71                    | 66            | 4.615               |
|                                      | > 50           | 28                       | 16          | 12                    | 12            | 4.93                |
| Respondent education level (%)       | None           | 36                       | 52          | 53                    | 52            | 3.52                |
|                                      | Primary        | 30                       | 22          | 25                    | 25            | 0.996               |
|                                      | Post-primary   | 34                       | 26          | 21                    | 23            | 1.397               |
| Respondent can read and write (%)    | 69             | 58                       | 53          | 54                    | 58            | 2.689               |
| Average household size               | 5              | 5                        | 5           | 4                     | 4             | 37.95***            |
| Households without income earner (%) | 34             | 38                       | 41          | 44                    | 44            | 1.843               |
| Household wealth quantile (%)        | Lower          | 23                       | 35          | 33                    | 34            | 5.588**             |
|                                      | Middle         | 35                       | 30          | 35                    | 36            | 9.477**             |
|                                      | Upper          | 42                       | 35          | 32                    | 30            | 43.42***            |

<sup>§</sup> First four groups compared against random sample. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

### 3.2 Prevalence of FGM/C

The overall objective of the project is to contribute towards the elimination all forms of FGM/C in targeted communities. To measure the progress of this objective, the study sought to find out the circumcision history of the respondents' daughters who are less than 18 years old at baseline. At midline, the study explored the circumcision history of respondent's daughters who were uncut at baseline. This allows us not only assess prevalence of the practice but also document new FGM/C incidents in the two-year period. Results show prevalence of FGM/C among children below the age of 18 increased from an average of 50% at baseline to 68% at midline. We show at midline, the rates of FGM/C among girls aged above 15 to 19 years was comparable to the rates observed in 2011 (97% [MICS 2011] and 97% at 2019 midline up from 93% at 2016 baseline). Among girls 5 to 15 years, **Table 4** shows FGM/C prevalence increased by 10-pp from 60% at baseline to 70% at midline. Qualitative interview also confirmed only a few respondents indicated knowledge of parents who are not practicing FGM/C across the four locations. Some religious leaders said they had heard from radio. A female FGD notes that she knew one family in Belethawa town who do not cut their daughters.

**Table 4: Changes in Prevalence of FGM/C**

| % circumcised by Age    | CD Participant |           | Potential CD participant |            | Network of CD Participant |           | Network of Potential CD participant |           | Random sample |           | Average    |           |
|-------------------------|----------------|-----------|--------------------------|------------|---------------------------|-----------|-------------------------------------|-----------|---------------|-----------|------------|-----------|
|                         | B              | M         | B                        | M          | B                         | M         | B                                   | M         | B             | M         | B          | M         |
| 0 – 4                   | 11             | 16        | 0                        | 0          | 3                         | 15        | 5                                   | 24        | 4             | 18        | 4          | 17        |
| 5 – 10                  | 23             | 41        | 49                       | 54         | 36                        | 50        | 32                                  | 48        | 41            | 55        | 36         | 50        |
| 11 – 15                 | 91             | 100       | 94                       | 100        | 96                        | 97        | 90                                  | 92        | 87            | 95        | 92         | 95        |
| 16 – 17                 | 63             | 100       | 100                      | 100        | 97                        | 100       | 88                                  | 100       | 96            | 100       | 91         | 100       |
| <b>Average (&lt;18)</b> | <b>53</b>      | <b>72</b> | <b>58</b>                | <b>68</b>  | <b>52</b>                 | <b>67</b> | <b>49</b>                           | <b>69</b> | <b>45</b>     | <b>65</b> | <b>50</b>  | <b>68</b> |
| <b>Average (5-15)</b>   | <b>62</b>      | <b>68</b> | <b>68</b>                | <b>73</b>  | <b>61</b>                 | <b>71</b> | <b>58</b>                           | <b>68</b> | <b>59</b>     | <b>70</b> | <b>60*</b> | <b>70</b> |
| <b>Average (15-19)</b>  | <b>77</b>      | <b>92</b> | <b>100</b>               | <b>100</b> | <b>99</b>                 | <b>98</b> | <b>92</b>                           | <b>99</b> | <b>96</b>     | <b>97</b> | <b>93</b>  | <b>97</b> |

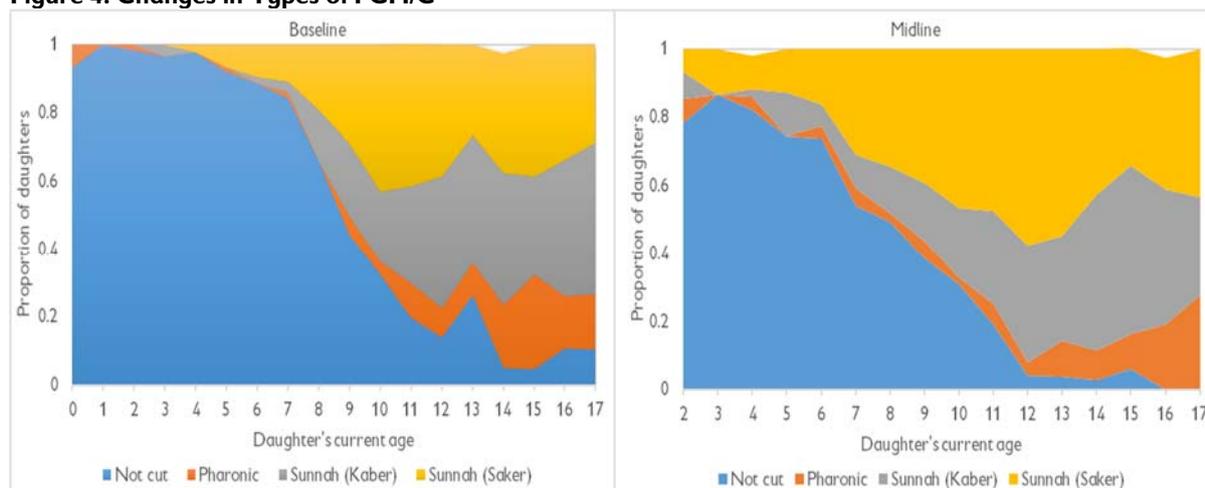
**B – Baseline; M – Midline; \* Revised from 59% due to attrition as at midline**

**Figure 4** shows FGM/C prevalence by daughter's current age, with the left showing prevalence at baseline and the right shows prevalence at midline composed of new FGM/C cases in addition to the baseline prevalence. The blue shade show the proportion of uncut girls decreases with age, orange coloration shows the declining prevalence of Pharaonic FGM/C with time. The grey and yellow colloration shows momentum both types of Sunnah have gained over time. In general, Sunnah Saker and Sunnah Kaber are the most common forms of FGM/C practiced in the study area. Only 6% of new FGM/C cases were Pharaonic, majority of the new incidents 28% were Sunnah Kaber while 65% were Sunnah Saker. The few pockets of the Pharaonic circumcision done among children under 10 were in Dawad and Badey clusters in Eyl district and, 1da August and Wadajir in Garowe district.

Despite the change in the type of FGM/C cut, the qualitative data revealed that there is a contradiction on what Sunnah type of FGM/C means. Religious leaders indicated that Sunnah is only one type, which does not require stitching while the Sunnah described by most of the respondents is both type I and II. The respondents indicated that Pharaonic type of FGM/C was still practiced in rural areas while Sunnah is mostly practiced in urban areas.

Although this study cannot verify the exact types done, it is plausible that respondents indicate their daughters have undergone Sunnah type while in reality they had them undergo types similar to the Pharaonic without the stitching. Another negative trend is that age of cutting daughters seems to be getting younger with time in addition to the fact that the few positive deviance (not cut until age of 15) were subjected to the cut within the two year widow.

**Figure 4: Changes in Types of FGM/C**



As described above prevalence among children below 18 years on average increased by 18-pp within the two year period. At midline, we found out that over a third (38%) of the 507 girls who were at baseline had undergone the cut (newly circumcised). Seven out of every ten new FGM/C incidents were done to girls aged between 5 and 10 years. Likelihood of being subjected to FGM/C among uncircumcised increased, nearly linearly, with a daughter's age. The few girls who had not undergone the cut beyond the age of 10 years were at higher risk of being subjected to the practice; in fact, all uncircumcised girls aged above 15 years underwent FGM/C during the two-year window.

**Table 5: FGM/C Incident Rate**

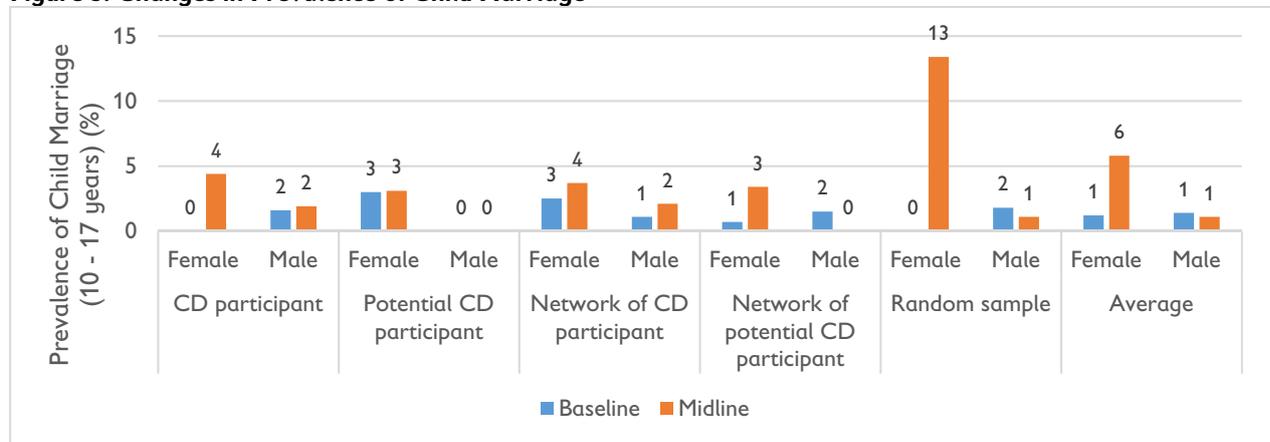
|   | CD Participant | Potential CD participant | Network of CD Participant | Network Potential participant of CD | Random sample | Average |    |
|---|----------------|--------------------------|---------------------------|-------------------------------------|---------------|---------|----|
| # girls uncircumcised at baseline                               | 39             | 28                       | 158                       | 138                                 | 144           | 507     |    |
| FGM/C new incident rate (%)                                     | 0 - 4          | 0                        | 15                        | 24                                  | 16            | 15      |    |
|   | 5 - 10         | 34                       | 34                        | 40                                  | 39            | 40      |    |
|   | 11 - 15        | 100                      | 100                       | 76                                  | 58            | 77      |    |
|   | 16 - 17        | 100                      | 0                         | 0                                   | 100           | 100     |    |
|   | Average        | 38                       | 27                        | 36                                  | 40            | 39      | 38 |
| FGM/C cases performed by health professional (%)                | Baseline       | 52                       | 43                        | 63                                  | 44            | 51      |    |
|   | Midline        | 72                       | 47                        | 58                                  | 47            | 84      | 63 |
| New FGM/C cases performed by health professional at midline (%) | 70             | 30                       | 58                        | 49                                  | 84            | 63      |    |
| Types of new FGM/C cases (%)                                    | Pharaonic      | 10                       | 0                         | 0                                   | 7             | 10      | 6  |
|   | Sunnah Kaber   | 10                       | 17                        | 26                                  | 36            | 29      | 28 |
|   | Sunnah Saker   | 80                       | 83                        | 74                                  | 55            | 60      | 65 |

Most (63%) of new FGM/C cases were performed by health professionals while the remainder (37%) were performed by traditional circumcisors and birth attendants. This shows continued trend to medicalizing FGM/C as compared to 51% of FGM/C cases performed by health professional at baseline. The exact prevalence of medicalized FGM/C however might be unclear as self-reported medicalized cutting may conflate trained health workers with community health extension workers, who are at times attached to health facilities.

### 3.3 Prevalence of Child Marriage

The second harmful traditional practice that this joint programme sought to address was to contribute towards elimination of CEFM. Available country statistics show prevalence of child marriage has been declining over the last decades. In this study, we estimate prevalence and incidents of child marriage from household roster listing all household members and exploring whether they had ever been married. In subsequent follow up, we explored if those who were not married from the onset of the study were now married. Reflective of other recent studies, this study shows low prevalence of child marriage (1% at baseline and 6% at midline) and few new incidents (5%) of child marriage among children aged between 10 and 17 years in the study area. Within the two year period, there were no newly married male children. The few cases of female child marriage was recorded as early as 13 years. There were relatively high number of new female child marriage in Garowe and Eyl districts (prevalence in both districts increased from 0% to 13%), compared to other districts. Compared to two years ago, age for age, rates of child marriage had slightly increased but not statistically significant different even among female children.

**Figure 5: Changes in Prevalence of Child Marriage**



### 3.4 Transformation of Dominant Social Norms Perpetuating FGM/C and CEFM

#### 3.4.1 Support for FGM/C Abandonment and Commitment not to Cut Daughters

This section presents the communities' opinion on FGM/C. As pointed out in the limitation section of this study, the baseline did not distinguish the different types of FGM/C but rather focused on FGM/C as a whole. The respondents might have translated it to mean the Pharaonic type only instead of all FGM/C types. During the midline survey, the questionnaires were translated to elicit views on all FGM/C types (Gudninka Hablaha) as well as some extra questions distinguishing Pharaonic and Sunnah types. This change in methodology might have affected findings between baseline and Midline.

At baseline, the study showed that 42% of the respondents supported FGM/C abandonment and committed not to cut their girls in future whereas at midline there was a decline of 13pp. Qualitative data revealed that the targeted community members have a misconception that Sunnah cut is not FGM/C while only Pharaonic is deemed as FGM/C. If not probed further, someone might be misled to believe that the targeted respondents do not practice FGM/C and support its total abandonment. Therefore, people who are supporting FGM/C could be overestimated and this could explain the decline in support for FGM/C abandonment between the baseline and midline.

The intention to circumcise daughters is considerably stronger at midline compared to baseline, with 61% revealing they would circumcise their daughters in future while 31% of respondents stated they would cut their daughters in future even when no one in their community was doing the practice. Furthermore, only 15% of respondents who indicated they were not planning to cut their daughters still held their commitment not cut their uncut daughters at midline, the vast majority (85%) had either already performed the cut on previously uncut daughters or were now planning to cut their uncut daughters. It was revealed that mothers and grandmothers are the decision makers on

*I know one family in the town who do not cut their daughters, but I know they will face challenges when the girls are about to get married as the community will view them badly or shame them for this” Female FGD participant Beletwyne*

whether a girl should be cut or not and which type of cut to be performed on her. The women respondents indicated that they would subject them to Sunnah type of FGM/C stating that it is good for their health, womanhood, religious requirement and reduction of sexual activeness among other reasons. Uncircumcised girls on the other hand risk being viewed as not a virgin, unclean, a prostitute, not marriage material, and is likely to suffer shame and stigma in the community among

other reasons. Pharaonic FGM/C, though declining, is practiced as a tradition and cultural heritage.

**Table 6: Changes in Opinion about FGM/C**

| Opinion questions   | Baseline (%) | Midline (%)     | Baseline and midline difference (pp) |                |
|---|--------------|-----------------|--------------------------------------|----------------|
| FGM/C should be stopped                                   | 61           | 39              | -0.229(0.104)*                       |                |
| FGM/C can be eliminated in the community                  | 68           | 47              | -0.213(0.078)**                      |                |
| FGM/C can be eliminated in the country                    | 65           | 41              | -0.237(0.084)**                      |                |
| Supports abandonment of FGM/C                             | 70           | 55              | -0.149(0.060)*                       |                |
| Would circumcise if have daughter in future               | 45           | 61              | 0.164(0.067)*                        |                |
| Would circumcise daughter even if no one practices        | -            | 31              | -                                    |                |
| Consistently not planning to circumcise uncut daughter    | -            | 15              | -                                    |                |
| Support FGM/C abandonment and commit not to cut in future | Male         | 45              | 32                                   | -0.130(0.068)  |
|   | Female       | 40              | 27                                   | -0.130(0.071)  |
|   | Average      | 42 <sup>§</sup> | 29                                   | -0.130(0.063)* |

Robust standard errors in parentheses \*\* p<0.05, \* p<0.1 <sup>§</sup> Reduces from 70% when we consider intention to cut

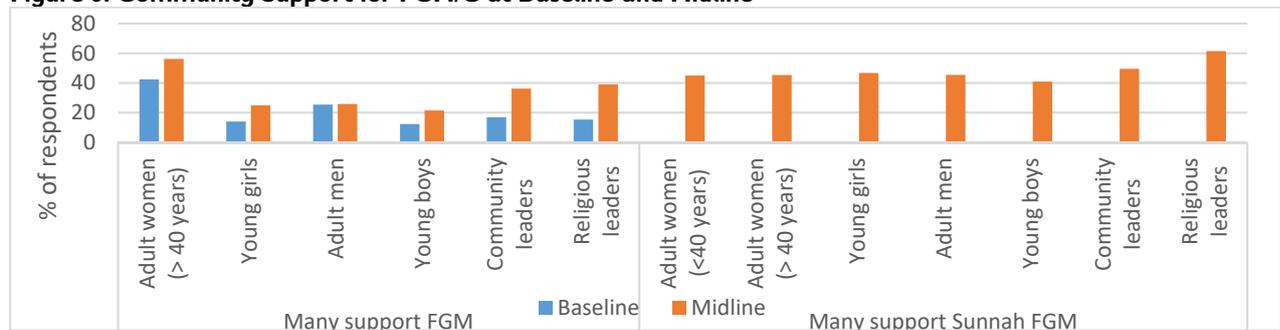
Abandonment of FGM/C requires not only changing individual’s attitude towards the practice but also their perception and observations that others in their community have also changed their perceptions and practice. Given that there has been decline in support for abandonment of FGM/C and that the practice is deemed less risky in terms health consequences compared to baseline values, it is useful to look at who they think are the groups supporting the FGM/C practice.

In this section, we asked respondents if many or almost all of the various community groups support FGM/C practice. Given the limitation described earlier in the local FGM/C being synonymous with Pharaonic type of FGM/C, the midline survey included a question addressing the support for Sunnah type of FGM/C. Indicative of general decline in support towards abandonment of FGM/C, results show increasing trend in proportion of persons deemed supportive of FGM/C especially adult women (increased by 14-pp), community leaders (increased by 19-pp) and religious leaders (increased by 24-pp). There was also a notable increase in perceived support for FGM/C by young boys. Some of the girls interviewed indicated that they believed FGM/C is not important to their lives, their family or community while some of the boys indicated that it is important for the girls to be cut when they are mature as it is critical for her marriage.

*“Fircooni is our culture. If a girl is not cut, she is considered useless”  
- A boy in a FGD.*

While the results depict a negative trend towards perceived FGM/C support in general, it was mostly linked to translation challenges during the baseline survey. At baseline, the survey instrument was not explicit of FGM/C in general but referred to just circumcise which was potentially interpreted as Pharaonic type while in midline the instrument was explicit of all types of FGM/C. Results show there is nearly uniform support for Sunnah among different groups of persons within the community, ranging from 40% among young boys to 61% among religious leaders. Summative, qualitative data shows zero tolerance concept has not been adopted and accepted by the community as Sunnah type of FGM/C was largely supported by community members across the study area.

**Figure 6: Community Support for FGM/C at Baseline and Midline**



Religious leaders were mentioned as the most influential actors in the campaign against FGM/C. However, it was revealed that community members are not aware of the religious leaders’ position on FGM/C. Some religious leaders expressed that it is women’s issue and perpetrated by women and thus women should be engaged in the campaign against FGM/C especially mothers and grandmothers. Respondents reported that religious leaders are divided in their support with some supporting total FGM/C abandonment while majority supporting Sunnah but both groups do not talk about this issue publicly.

*“People talk so much about FGM because it is something that is important to the society. Mobilization is always made in mosques aimed at promoting what is right and avoid what is wrong”. - Religious leader, Belethawa, Gedo*

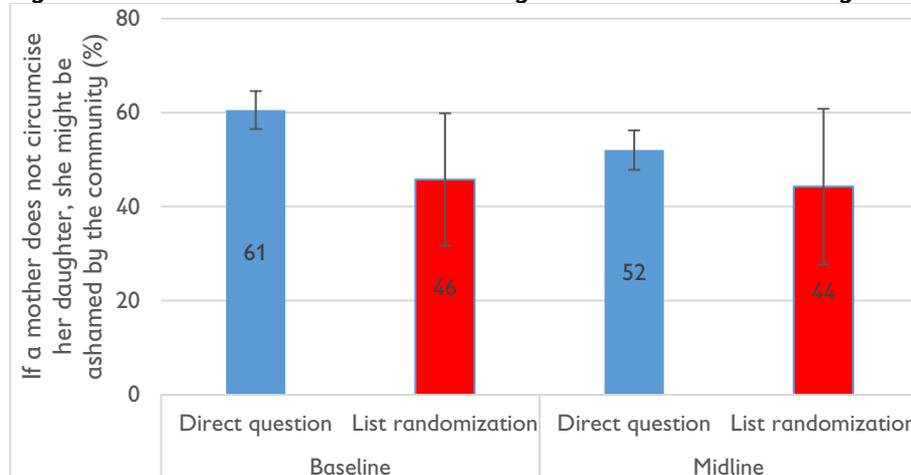
### 3.4.2 Social Costs of Uncircumcised Daughters and Social Desirability Bias

Another potential explanation for the mismatch between opinion and practice is social desirability bias among the respondents in answering the attitude question. List randomization is sometimes used to elicit the extent of response biases for sensitive issues. The basic idea of this data collection method is that the respondents are more likely to reflect their true opinion if asked to count the number of statements from a list of statements that they agree with instead of asking about the sensitive item directly. To measure the bias, the respondents are randomly divided into two groups where one group is asked about the statement directly as well as counting from a list of control statements. For the second group, the test statement is included in the list of statements to count.

The study conducted one list experiment at baseline and replicated the same experiment at midline survey. The item that was tested was intended to capture whether people over-report social cost to justify their FGM/C practices. As a proxy variable for ‘social cost’, the item that we tested is – “If a mother does not circumcise her daughter, she might be ashamed by the community”. If we ask this directly, 61% reported agreeing to the statement at baseline and 52% at midline. However, when measured indirectly through statement count, 46% give a positive opinion on this at baseline and 44% at midline. In other words, by asking directly the social cost of not doing FGM/C is over-reported by 15 percentage points at baseline and 8 percentage points at midline.

Despite this seemingly high over-reporting, the proportion of respondents who thought mothers will be ashamed through direct question was not statistically different from that estimated through list randomization. Furthermore, it appears the social desirability bias shrunk by half between baseline and midline survey. Over-reporting of social costs was predominantly among female respondents, respondents above 50 years, those drawn from lower socio-economic status households and respondents who thought most religious leaders support FGM/C.

**Figure 7: Social Costs of Uncircumcised Daughters and Social Desirability Bias**

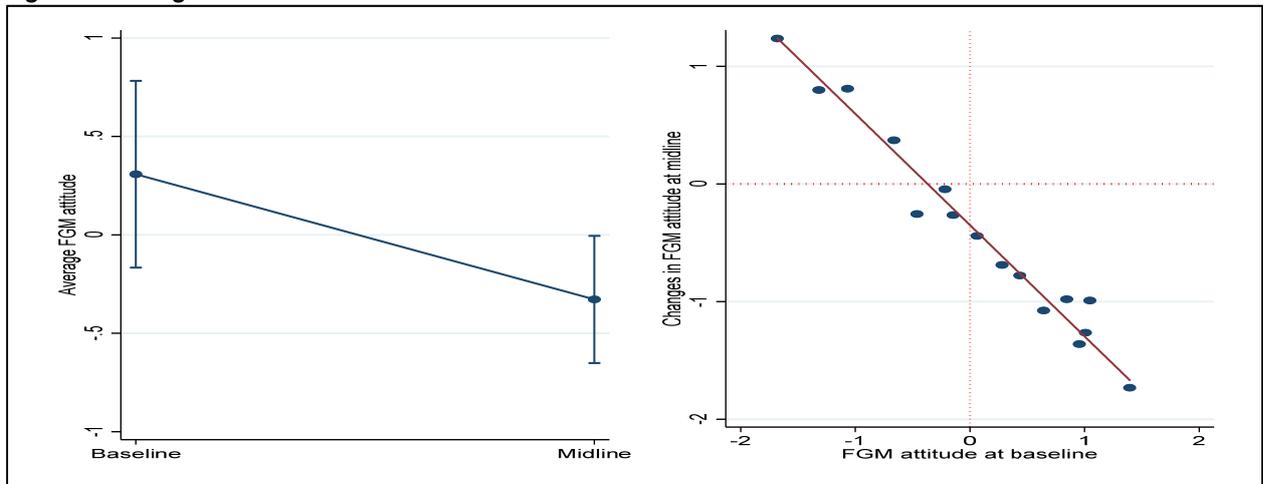


### 3.4.3 Determinants of Support for Stopping FGM/C

One challenge in analysing and interpreting results from these opinion questions is the multiplicity of indicators. One way to address this is to construct an opinion index from various indicators. We use the seven indicators, measured in baseline and midline, described above to construct an index of “supporting abandonment of FGM/C” by principal component analysis. Principle component analysis measures the latent attitude towards stopping FGM/C using the respondents’ answers to the opinion questions and create a standardized index with mean zero. Similar to the above-described statements, the composite index show the respondents became less supportive of abandonment of FGM/C. The support for FGM/C abandonment declined significantly by 0.64-deviation units from an average of 0.29 at baseline to -0.33 at midline.

Examining attitudinal changes show it varies by baseline levels, those with favourable attitudes towards stopping FGM/C witnessed the biggest decline in FGM/C attitude while there was some slight increase in support for stopping FGM/C among respondents who were initially against stopping FGM/C. The decline in attitude towards stopping FGM/C could partly be attributed two issues: first is with regards with the changes in FGM/C terminology between baseline and midline survey, at midline survey the tool was designed to reflect complete abandonment towards FGM/C relative to baseline which FGM/C statements used were potentially synonymous with Pharaonic type only and thus at midline the community adjusted their opinion to reflect the persistent favour in Sunnah type of FGM/C [7]. The second reason could be due to fact that at the midline survey, there was heated debates in the survey area about FGM/C, occasioned by FGM/C associated deaths of some girls [12].

Figure 8: Changes in General FGM/C Attitude



As shown in earlier sections, respondents in the study area have not become more supportive of abandonment of FGM/C in their community completely. Instead the community have progressively switched from supporting more severe forms of FGM/C to supporting less severe form of FGM/C. In this section we explore what factors predicted this trend. In addition, we explore if the same factors not only predict changes in attitude but observed attitudes at baseline and midline points. We see baseline attitude towards FGM/C abandonment was marginally predictive of midline attitudes, this could be linked to the difference in translation of FGM/C terminology used during the two surveys.

Results show awareness of health consequences was predictive of FGM/C attitude at baseline as well as change in FGM/C attitude but not at midline. More specifically, respondents who were more aware of FGM/C health consequences held more progressive attitude towards its abandonment at baseline.

**Table 7: Determinants of Support for Stopping FGM/C**

|  | Baseline FGM/C attitude | Midline FGM/C attitude |
|--|-------------------------|------------------------|
| Baseline FGM/C attitude  | -                       | 0.059(0.031)*          |
| FGM/C and Sunnah are different [1=Yes]                               | 0.085(0.052)            | 0.357(0.080)***        |
| Number of bad health consequences reported                           | 0.068(0.016)***         | 0.024(0.017)           |
| Female respondents [1=Yes]   | 0.096(0.077)            | 0.078(0.098)           |
| Respondent age (25-50)   | 0.017(0.061)            | -0.106(0.071)          |
| Respondent age (50+)   | -0.090(0.086)           | -0.014(0.098)          |
| Respondent education (primary)                                       | -0.075(0.060)           | 0.017(0.068)           |
| Respondent education (secondary+)                                    | -0.070(0.065)           | 0.015(0.076)           |
| Wealth index   | 0.036(0.031)            | 0.058(0.036)           |
| Progressive attitude towards IPV                                     | 0.173(0.051)***         | 0.150(0.060)**         |
| Discussed about stopping FGM/C                                       | 0.109(0.073)            | 0.309(0.077)***        |
| Took pledge for stopping FGM/C                                       | 0.411(0.071)***         | 0.189(0.072)***        |
| Received any information on FGM/C                                    | 0.351(0.054)***         | -0.097(0.061)          |
| Proportion of decision women are involved in                         | -0.090(0.083)           | -0.040(0.106)          |
| Proportion of decision women should be involved in                   | 0.837(0.133)***         | 0.043(0.171)           |
| Majority of community leaders support FGM/C [1=Yes]                  | -0.238(0.079)***        | -0.128(0.065)**        |
| Majority of religious leaders support FGM/C [1=Yes]                  | -0.393(0.082)***        | 0.134(0.064)**         |
| Constant   | -1.062(0.136)***        | -0.798(0.179)***       |
| Observations   | 1,126                   | 1,002                  |
| R-squared  | 0.381                   | 0.204                  |
| Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1 |                         |                        |

In terms of informational campaign against FGM/C, the study showed that mere receipt of anti-FGM/C messages or participating in anti-FGM/C discussions was not correlated with FGM/C attitudes. Majority of the respondents indicated that they had received information about FGM/C and its consequences and had heard about campaigns on zero tolerance to FGM/C. However, this has not translated to change in practice but rather, change in the type of cut. Concerns linger as to the whether the contents of the message disseminated could have been misinterpreted to mean condemning Pharaonic FGM/C and in effect silently endorse the Sunnah type of FGM/C [11].

*“Target the mothers if you want to eliminate FGM as they are the decision makers on whether a girl should be cut or which type.”*  
community leader in Eyl.

Mothers and grandmothers were the main decision makers as far as the practice of FGM/C for their daughters is concerned. As such they play a critical role as either accommodators or resisters of FGM/C practice. Results in this study show in households, women involvement in decision making increased over time, however, this increase did not accompany change FGM/C opinion or practice. While level of women involvement in household decision-making was not related to FGM/C attitude, there is some inconsistent evidence to show that respondents attitude (rather than practice) towards women involvement in decision-making was correlated with FGM/C attitude. Respondents who held progressive attitude towards FGM/C abandonment also had positive attitude towards involvement of women in household decision-making. We also find respondents who supported FGM/C abandonment were 15 to 17-pp more likely to have progressive attitude towards intimate partner violence (IPV), this is because both IPV and FGM/C are seen means of controlling women’s behaviour [13, 14].

Absence of statutory laws leaves customary and social conventions as the only way to deter FGM/C practice. Using social conventions, we find respondents who took a pledge in stopping FGM/C held more favourable attitude towards FGM/C abandonment. Reverse causality is however possible here, it is possible that those routing for FGM/C were more likely to take pledge to stop FGM/C. Community and religious leaders play a passive role behind FGM/C continuation through silent messaging. In this study, results show perception of community leaders level of FGM/C support negatively correlated with respondents' attitude towards FGM/C abandonment. Respondents who thought most community leaders supported FGM/C were less likely to themselves support FGM/C abandonment. Despite their potential role in FGM/C abandonment, religious leaders in the study area do not have a clear stand on FGM/C and disseminate at times conflicting message to the community about FGM/C. It is for this reason that perception of their support for FGM/C was not consistently correlated with respondents' attitude towards FGM/C abandonment.

### 3.4.4 Community Support for CEFM Abandonment

In Somalia, rates of child marriage, before the age of 18 years, has silently reduced from an average of 46% in 2006 to 13% in 2013 and 10% in 2016 [2]. Despite this historical declining trend, respondents seems not to realize it. We explored what age respondents think most girls in their community get married and on average over a third (38% at baseline vs 45% at midline) of the respondents reported that most girls in their community get married before turning 18 years old. This shows there is consistent difference between perception and reality of child marriage in the community. When asked about their opinion on the right age for marriage, 14% of the respondents reported age below 18 years as the ideal marriage age for girls at both baseline and midline. While majority of respondents claimed to not to support marriage before age of 18 years, they mostly contradicted themselves to agree on marriage of a girl as soon as she reaches puberty (57% at baseline and 51% at midline). Therefore, support for child marriage should not be interpreted as a matter of age only but also perception that girls who have attained puberty can be married off. Considering these two indicators we find support for child marriage is quite widespread, as high as 70% of respondents support child marriage at baseline and 69% at midline. Using linear probability model, results show there were hardly any changes in opinion on child marriage among both male and female respondents.

*“The right marriage age for girls is the time she gets her menstruation period and it is not depending on the age” Religious Leader*

**Table 8: Changes in Opinion on Child Marriage**

|   | Baseline | Midline | Baseline and midline difference |
|---|----------|---------|---------------------------------|
| Thinks most girls in community get married before 18 years (%)                          | 38       | 45      | 0.064(0.157)                    |
| Right age of marriage for girls is below 18 years (%)                                   | 14       | 14      | 0.006(0.059)                    |
| Does not support marriage of boys or girls before age of 18 years (%)                   | Male     | 71      | -0.015(0.068)                   |
|   | Female   | 66      | 0.065(0.096)                    |
|   | Average  | 67      | 0.042(0.085)                    |
| Agrees to the statement – “a girl should be married as soon as she reaches puberty” (%) | 57       | 51      | -0.058(0.122)                   |
| Ideal age >=18 + no puberty marriage + not support marriage before 18                   | Male     | 27      | 0.030(0.062)                    |
|   | Female   | 32      | 0.024(0.139)                    |
|   | Average  | 30      | 0.008(0.114)                    |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Regarding community's preference in educating their children, it was revealed that some respondents indicated that they would educate their boys because girls would eventually get married. Others indicated that they would educate a girl because "if you educate a girl you educate a nation" and others further felt that early marriages have increased the rate of family separation hence many divorced teenage mothers with children. Two girls interviewed felt that marriage is more important than her education and the decision on whether to continue with her education or not lies with the husband and not her parents. Teachers interviewed explained that girls' enrolment is higher in lower grades while that of boys is higher in upper grades in some of the schools. One of reason for the drop in retention of girls is because of early marriage.

### 3.5 Communities and Faith Actors Commit to end FGM/C and CEFM

#### 3.5.1 Religious Leaders Supporting Implementation of Existing Fatwa

Majority of the respondents (71%) considered Sunnah type of FGM/C as a mandatory religious practise whereas only 7% viewed Pharaonic type of FGM/C as a religious requirement. It was revealed that FGM/C is not mentioned or supported in the Qur'an but there is a hadith (sayings of the prophet) that mentions it even though there is a contentious debate on whether it is an obligatory or optional practise. The religious leaders however agreed that the hadith clearly eliminates the severest form of FGM/C. It is with this backdrop that religious leaders support Sunnah type of FGM/C. This explains why the religious leaders have not taken a stand on zero tolerance and where Fatwas have been issued, they do not give a clear position. There is also a contradiction on what Sunnah type of cut means with Religious leaders explaining that Sunnah is only one type, therefore the different types of Sunnah (sakir and Kabir) defined by the community members are not recognized in Islam.

Less than half of respondents (33% at baseline and 46% at midline) thought FGM/C was a mandatory religious practice. Furthermore 61% of respondents indicate that most religious leaders in their communities support Sunnah FGM/C at midline. Respondents deemed religious leaders as not supportive of Pharaonic type of FGM/C. Separate interviews with 37 religious leaders from study indicated that FGM/C was an optional religious practice (89%) yet they all supported a fatwa that prohibits Pharaonic circumcision and not all types of FGM/C. The existing fatwa declared in Puntland upholds Sunnah type of FGM/C and not total abandonment.

*"Islam would never support anything that harms anybody's well-being."  
Religious leader in Belethawa.*

**Table 9: Religiosity of FGM/C**

| Opinion questions                                 | Baseline (%) | Midline (%) | Baseline and midline difference (pp) |
|---|--------------|-------------|--------------------------------------|
| FGM/C is a mandatory religious practice           | 33           | 46          | 0.133(0.091)                         |
| Pharaonic FGM/C is a mandatory religious practice | -            | 7           | -                                    |
| Sunnah FGM/C a mandatory religious practice       | -            | 71          | -                                    |

#### 3.5.2 Community Participation in FGM/C & CEFM Public Declarations

This study relied on self-reported participation among respondents to gauge level of participation in various program activities under this study. It is important to clarify that project activities had been operating for 4-5 months by the time of conducting the baseline survey. It is also possible that some of targeted participants in this project in a few communities have been reached by other similar intervention(s) by the same agencies under phase I of the same project or different project. Therefore, the midline results reflect the impacts of the continued participation in project activities over the rest of the phase II of this project. At baseline, results show participation of CD participants in project activities was significantly higher compared to the other arms of the study.

At midline, however, the other study arms, other than CD participants, registered significant growth in participation in the project interventions. By the time we conducted the midline survey, there was hardly any difference among study arms in terms of participation on interventions. This shows at baseline, the study suffered from self-selection, whereby the more convinced individuals are relatively more interested in such intervention. As time progressed by, implementation increased the likelihood of receiving the treatment. It is important to note that there might have been other similar initiatives and thus participation questions were not specific to the NCA/Save the Children programme.

While at baseline, CD participants were indeed more likely to be engaged in various discussions and pledges for stopping FGM/C; this advantage decreased with time and participation was nearly similar for any community member. Examining attendance records of the CD sessions reveal that participants did not consistently attend the sessions over time. Progressively new participants replaced the initial CD participants

**Table 10: Community Participation in Community Declarations against FGM/C and CEFM**

| % of respondents   | CD Participant |    | Potential CD participant |    | Network of  |    |                       |    | Random sample |    |
|--|----------------|----|--------------------------|----|-------------|----|-----------------------|----|---------------|----|
|  | B              | M  | B                        | M  | Participant |    | Potential participant |    | B             | M  |
|  |                |    |                          |    | B           | M  | B                     | M  |               |    |
| Discussed about stopping FGM/C in the last one year                                    | 88             | 78 | 55                       | 70 | 69          | 69 | 42                    | 63 | 50            | 71 |
| Took pledge for stopping FGM/C in the last one year                                    | 81             | 65 | 45                       | 57 | 60          | 59 | 42                    | 56 | 46            | 65 |
| Discussed about stopping CEFM in the last one year                                     | 65             | 62 | 39                       | 64 | 52          | 57 | 37                    | 55 | 41            | 63 |
| Took pledge for stopping CEFM in the last one year                                     | 61             | 59 | 34                       | 57 | 44          | 53 | 33                    | 49 | 35            | 60 |
| Received any FGM/C information in last two years                                       | 82             | 70 | 69                       | 63 | 79          | 60 | 55                    | 66 | 59            | 70 |
| Anyone in the community discussed with them about stopping FGM/C in the last one month | -              | 44 | -                        | 45 | -           | 29 | -                     | 41 | -             | 40 |
| Received any training on abandonment of FGM/C or CEFM                                  | 80             | 70 | 29                       | 55 | 47          | 43 | 21                    | 45 | 23            | 51 |
| Participated in community dialogue sessions  | -              | 63 | -                        | 46 | -           | 37 | -                     | 33 | -             | 41 |

**B – Baseline; M – Midline**

As described earlier, baseline survey happened 4-5 months after program initiation, and therefore reflective of treatment assignment, CD participants had higher participation at the baseline survey. It was intuitive that these CD participants maintain a higher level of participation relative to their peers during the study; however, as shown above, their participation did not differ compared to other study groups at the midline. An interesting finding was that 37% of CD participants at midline did not recall participating in CD sessions. As this was a panel survey, there is high possibility that the respondents interviewed at both baseline and midline are no longer members of the CD groups and thereby causing the variance between the findings at baseline and midline.

### 3.5.3 Knowledge on FGM/C Complications

As shown in Table 11, there was relatively high level of awareness in general on harmful health effects. Though not statistically different, the proportion of respondents aware of at least three negative FGM/C effects declined from 67% at baseline to 58% at midline. This is because most of the consequences mentioned were health related. Some of the effects listed in the Focus Group discussions included: child birth complications, severe pain, trauma, menstrual problems, infections, heavy bleeding, shock and death among others. Some of the female respondents indicated that they had personally experienced some of the complications including problems during sexual intercourse.

*“I no longer perform Pharaonic type on my clients, as I am more aware of the complications. I only perform Sunna and encourage my clients to accept that.” Traditional cutter, women FGD in Belethawa*

Negative health consequences were largely associated with Pharaonic type and not Sunnah as majority of the respondents continue to believe that Pharaonic type of FGM/C is the one that has adverse health effects on women and girls while Sunnah has no effects. The widely perceived link between Pharaonic and negative health effects unintentionally drives the shift to Sunnah type of FGM/C.

**Table 11: Awareness of Negative and Positive FGM/C Consequences**

| % of respondents                                 |                                   | Baseline | Midline | Baseline and midline difference (pp) |
|--|-----------------------------------|----------|---------|--------------------------------------|
| Aware of ≥3 harmful FGM/C effects                | Male                              | 72       | 56      | -0.153(0.089)                        |
|  | Female                            | 66       | 59      | -0.077(0.122)                        |
|  | Average                           | 67       | 58      | -0.099(0.111)                        |
| Negative FGM/C effects                           | Infectious disease transmission   | 57       | 38      | -0.195(0.016)***                     |
|  | Bleeding                          | 77       | 66      | -0.115(0.026)***                     |
|  | Health problems                   | 75       | 63      | -0.115(0.070)                        |
|  | Delivery difficulty               | 57       | 48      | -0.095(0.109)                        |
|  | Sexual feelings reduction         | 33       | 29      | -0.045(0.087)                        |
|  | Affects women health and welfare  | 15       | 24      | 0.086(0.064)                         |
|  | Sex penetration difficulty        | 18       | 22      | 0.036(0.078)                         |
| Aware of at least one positive FGM/C consequence |                                   | 5        | 12      | 0.062(0.037)                         |
| Positive FGM/C effects                           | FGM/C has no negative consequence | 2        | 8       | 0.053(0.029)                         |
|  | Maintain virginity                | 1        | 4       | 0.022(0.016)                         |
|  | Helps a girl become adult         | 1        | 2       | 0.004(0.007)                         |
|  | Reduce prostitution               | 2        | 2       | -0.002(0.009)                        |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

An unintended negative outcome of awareness on the health effects of FGM/C is medicalization especially in urban areas and those who are affluent. Most (63%) of new FGM/C cases were performed by health professionals. Health professional are performing FGM/C on girls with some of them defending themselves as “saving the girls’ lives”. A health worker interviewed indicated that sometimes they do a small cut on girls’ clitoris to satisfy the mothers who come to the health facility for FGM/C. Health workers claimed to engage them in discussions enlightening them on the health implications of FGM/C. However, it was revealed that the health effects discussed are on Pharaonic and not all types of FGM/C. This portrays the dilemma the health practitioners face between balancing their ethical values and dealing with the societies pressure.

*“If I don’t agree to cut the girls, the mothers will take them to a traditional cutter who will perform pharaonic cut and without my expertise, might harm the girls more. So, I do it for the girls.” Health professional in Qardho, Puntland.*

### 3.5.4 Knowledge on CEFM Consequences

Between baseline and midline, the study recorded an increase in awareness of the health effects of early child marriage among both female and male respondents at 83% at Midline compared to 66% at baseline. Commonly cited consequences of CEFM in this study were that the practice brings health problems to the teenage mother and weaker infants as a result of teenage motherhood. Consequences such as lost childhood, domestic violence and school dropout were also cited but to a lower extent especially at midline. Although the respondents deemed CEFM harmful, nearly all respondents were aware of at least one positive side of CEFM.

**Table 12: Awareness of Negative and Positive CEFM Consequences**

|   |                                   | Baseline | Midline | Baseline and midline difference |
|---|-----------------------------------|----------|---------|---------------------------------|
| Aware of any negative health consequences of CEFM | Male                              | 76       | 79      | 0.028(0.081)                    |
|   | Female                            | 62       | 85      | 0.224(0.114)                    |
|   | Average                           | 66       | 83      | 0.167(0.103)                    |
| Negative consequences of CEFM                     | Lost childhood                    | 33       | 19      | -0.145(0.073)                   |
|   | Domestic violence                 | 42       | 37      | -0.061(0.145)                   |
|   | Drop out school                   | 61       | 37      | -0.240(0.087)**                 |
|   | Will have weak/unhealthy children | 35       | 56      | 0.208(0.085)*                   |
|   | Leads to health problems          | 60       | 71      | 0.108(0.081)                    |
| Aware of any positive consequences of CEFM        | Male                              | 94       | 94      | 0.006(0.045)                    |
|   | Female                            | 96       | 93      | -0.037(0.037)                   |
|   | Average                           | 96       | 93      | -0.024(0.040)                   |
| Negative consequences of CEFM                     | Easy to find a husband            | 25       | 23      | -0.015(0.049)                   |
|   | Can start earning early           | 16       | 40      | 0.241(0.081)**                  |
|   | Reduce chance of making mistakes  | 53       | 54      | 0.017(0.081)                    |
|   | Produce children early            | 88       | 74      | -0.148(0.048)**                 |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

### 3.6 Laws and Policies to end FGM/C and CEFM

#### 3.6.1 FGM/C and CEFM Policies and Laws

Even though there are no FGM/C and CEFM laws in place, significant milestones have been made towards establishing a legal framework. In Puntland, an FGM/C policy is in place and an FGM/C bill has been tabled in parliament awaiting to be passed as law. In Jubaland, a FGM/C policy is under development by the Ministry of Women, Family Affairs and Human Rights with the support of NCA. There have been some challenges affecting the enactment of the FGM/C law with leaders divided between support for total abandonment and Sunnah. Somalia has ratified the convention on the Rights of the Child. However, there are no national legal framework to ensure enforcement.

#### 3.6.2 Perception of FGM/C and CEFM Legality and its Continuation

In the context of this study, there exists no statutory law expressly criminalizing the practice of FGM/C and CEFM. What exists is proposed bill that has been submitted to parliament for consideration. Despite the fact that there are no laws on FGM/C and CEFM in Somalia, the study measured the level of community awareness on legality of the harmful practices.

*“I recently heard of a bill against FGM, and I support anything that safeguards and protect the girls”, - police officer in Ufayn, Bari, Puntland*

At midterm we clarified the FGM/C terminologies to mean all types of cut, unlike before when community members perceived FGM/C to mean only Pharaonic. With this clarifications, majority of community members perceive Sunnah type as lawful while Pharaonic is not; thus 26-pp decline in the proportion of respondents who deemed FGM/C to be illegal in any of its form and should not be practiced. A similar margin of decline is reflected when a third variable "should FGM/C be continued or discontinued" is included. Therefore FGM/C is still widely perceived to be legal if it is the Sunnah type and people are reluctant to abandon the practice. On the other hand, majority of the respondents were aware that child marriage is illegal (60% at baseline to 55% at midline), however support for its abandonment is still low. In general, only 19% at baseline to 14% at midline thought that child marriage was illegal practice that should be abandoned.

**Table 13: Perception of FGM/C and CEFM Legality and its Continuation**

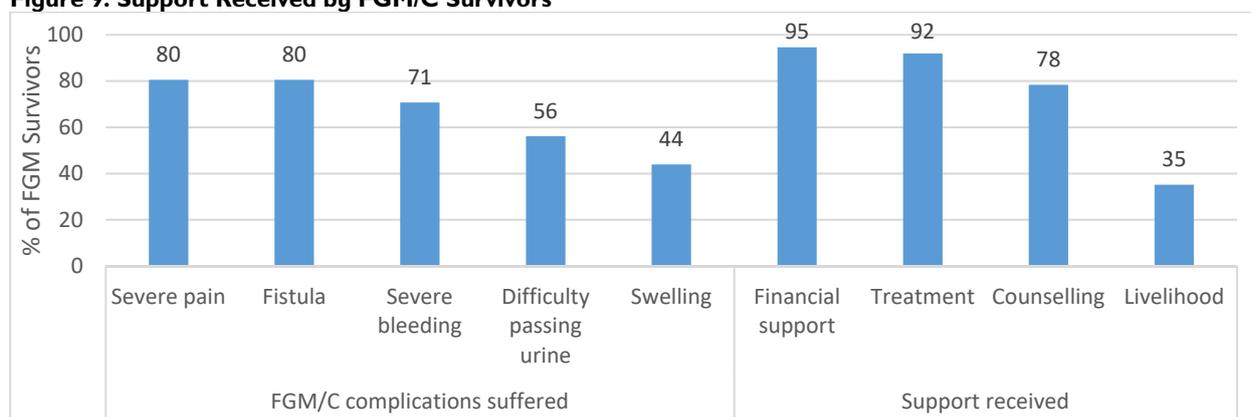
| Opinion questions  | Baseline (%) | Midline (%) | Baseline and midline difference (pp) |
|--|--------------|-------------|--------------------------------------|
| FGM/C is not permitted by law                                    | 62           | 31          | -0.317(0.051)***                     |
| Pharaonic circumcision is not permitted by law                   | -            | 81          | -                                    |
| Sunnah circumcision is not permitted by law                      | -            | 17          | -                                    |
| FGM/C is unlawful and should not be practiced                    | Male         | 42          | -0.264(0.039)***                     |
|  | Female       | 43          | -0.263(0.100)**                      |
|  | Average      | 43          | -0.264(0.082)**                      |
| FGM/C is unlawful, should not be practiced and should be stopped | Male         | 36          | -0.252(0.052)**                      |
|  | Female       | 34          | -0.231(0.088)**                      |
|  | Average      | 35          | -0.237(0.075)**                      |
| CEFM is unlawful (%)   | 60           | 55          | -0.050(0.044)                        |
| CEFM is unlawful and should not be practiced                     | Male         | 18          | -0.040(0.066)                        |
|  | Female       | 19          | -0.048(0.085)                        |
|  | Average      | 19          | -0.046(0.076)                        |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

### 3.7 FGM/C Survivors Access to Adequate and Appropriate Support Services

The study surveyed a sample of 42 FGM/C survivors (17 from Gedo, 16 from Nugal and 9 from Bari regions) who had sought care and support from NCA/SCI sponsored initiatives. These included 37 who were adults and the remainder slightly below the age of 18. The survivors indicated that they underwent FGM/C at the age bracket of 6-9 years. After the cut, they developed complications some within days of the cut, others within a year and have been struggling with the complication. Common complications reported include severe pain and bleeding, fistula, difficulty in passing urine and even swelling. It is important to note that all the survivors experienced more than one complication. The survivors sought help under the NCA/SCI sponsored project after getting information from friends, relatives and media. Support received included treatment, financial support and counselling. All survivors (100%) indicated that the support they received was beneficial and they all felt change in their situation after receiving the support and were satisfied with the support received.

**Figure 9: Support Received by FGM/C Survivors**



We did not collect data among girls because there are no reporting mechanisms in place for girls at risk to report and because of ethical considerations we could not interview girls aged between 5-15 years.

### 3.8 Effects of Community Dialogue Sessions

Drawn from Social Convention Theory, CD sessions provides space for community members to discuss and reflect the FGM/C and CEFM associated social, health and religious implications without fear. The space is necessary given that FGM/C is not a subject that people, especially of opposite gender, generally talk about in communities. In this study, CD sessions was seen as key entry points to increase awareness about the harmful consequences and create a network of other supporters of abandonment of these practices in their communities. These CD are thus an enabling environment to generate a collective support for discontinuation thus reduction in new incidents of both FGM/C and CEFM. From other contexts, evidence on effectiveness of CD sessions are mixed. For instance it was effective in Ethiopia [15] but not effective in Nigeria [16], Northern Kenya [17] and Somaliland [18, 7]. This section therefore tests effectiveness of CD sessions on opinion and practices of FGM/C.

#### 3.8.1 Effect of CD Sessions on Opinion on FGM/C

Findings in section 3.4.1 showed respondent's opinion towards FGM/C abandonment declined. Furthermore, more the respondents thought adult women, community and religious leaders and boys have become less supportive of FGM/C abandonment. This negative trend was largely driven by difference in interpretation of FGM/C terminology.

*Community attitudes will not change completely soon; it will take a long time... The key barriers to change is that FGM is an old culture that has been practiced for a long time"- health worker in Gedo*

FGM/C terminology used in the baseline was mostly interpreted to mean only the Pharaonic type at baseline, but this was expanded to encompass all FGM/C types at midline. Since there was significant limitation in definition of the FGM/C terminology between baseline and midline survey, the study could have measured different terms FGM/C terms. This was confirmed by the fact that FGM/C opinion at baseline predicted only 0.3% of the midline FGM/C opinion. As shown in **Table 14**, participants of community dialogue sessions did not accrue any FGM/C attitude change because of participation in CD. Because of the FGM/C terminology difference, the results here in are inconclusive of attitude change attributable to CD participation.

**Table 14: Effect of CD Sessions on Opinion on FGM/C**

|  | <b>Model1</b>    | <b>Model2</b>    | <b>Model3</b>    |
|--|------------------|------------------|------------------|
| Effect on CD participant   | -0.068(0.145)    | -0.188(0.145)    |                  |
| Effect on CD participant network                                     | -0.049(0.099)    | -0.135(0.102)    |                  |
| Effect of CD participation as intensity                              |                  |                  | 0.011(0.041)     |
| CD participant dummy   | 0.367(0.103)***  | 0.335(0.098)***  |                  |
| CD participant network dummy   | 0.150(0.072)**   | 0.141(0.069)**   |                  |
| Midline dummy  | -0.632(0.077)*** | -0.344(0.082)*** | -0.448(0.042)*** |
| CD participation intensity at baseline                               |                  |                  | 0.190(0.027)***  |
| Baseline mean (Random sample)  | 0.235(0.054)***  | -0.229(0.122)*   | -0.205(0.110)*   |
| Observations   | 2,332            | 2,128            | 2,124            |
| R-squared  | 0.110            | 0.173            | 0.204            |
| Covariates   | No               | Yes              | Yes              |
| CD participation as intensity  | No               | No               | Yes              |
| Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1 |                  |                  |                  |

### 3.8.2 Effect of CD Sessions on Awareness of FGM/C Health Consequences

Internalization of the health risks associated with FGM/C irrespective of type has long been seen as critical pathway to discontinuation of the practice, but recent studies have proven otherwise especially in Somalia where the practice is driven by social norms [7, 8, 11]. Despite baseline bias in terms of FGM/C terminology, results showed respondents who participated in more CD sessions were more aware of FGM/C health consequences. In this study, we find nine out of every ten respondents were aware of at least one negative FGM/C consequences while six out of every ten respondents could name at least three negative FGM/C effects.

Adverse consequences of FGM/C are widely associated with Pharaonic circumcision as community members do not associate Sunnah type of FGM/C with negative consequence. This points to a picture of near saturation of the knowledge on effects of Pharaonic type of FGM/C and not Sunnah. This study also revealed that increased awareness on health effects has not translated into support for total abandonment of FGM but led to medicalization of FGM/C as well as a shift to Sunnah type of FGM/C from Pharaonic FGM/C. Further results show no gender difference in knowledge about the harmful consequences of FGM/C.

*“I no longer perform Pharaonic type on my clients, as I am more aware of the complications. I only perform Sunna and encourage my clients to accept that.” Traditional cutter, women FGD in Belethawa*

**Table 15: Effect of CD Sessions on Awareness of FGM/C Health Consequences**

|  | Model1           | Model2          | Model3           |
|--|------------------|-----------------|------------------|
| Effect on CD participant   | 0.181(0.274)     | 0.138(0.289)    |                  |
| Effect on CD participant network                                     | 0.143(0.184)     | 0.097(0.187)    |                  |
| Effect of CD participation as intensity                              |                  |                 | 0.315(0.075)***  |
| CD participant dummy   | 0.216(0.186)     | 0.123(0.175)    |                  |
| CD participant network dummy   | 0.124(0.128)     | 0.095(0.124)    |                  |
| Midline dummy  | -0.516(0.123)*** | -0.148(0.135)   | -0.071(0.080)    |
| CD participation intensity at baseline                               |                  |                 | -0.219(0.048)*** |
| Baseline mean (Random sample)  | 3.271(0.089)***  | 2.480(0.199)*** | 2.507(0.184)***  |
| Observations   | 2,332            | 2,128           | 2,124            |
| R-squared  | 0.023            | 0.051           | 0.058            |
| Covariates   | No               | Yes             | Yes              |
| CD participation as intensity  | No               | No              | Yes              |
| Robust standard errors in parentheses *** p<0.01, ** p<0.05, * p<0.1 |                  |                 |                  |

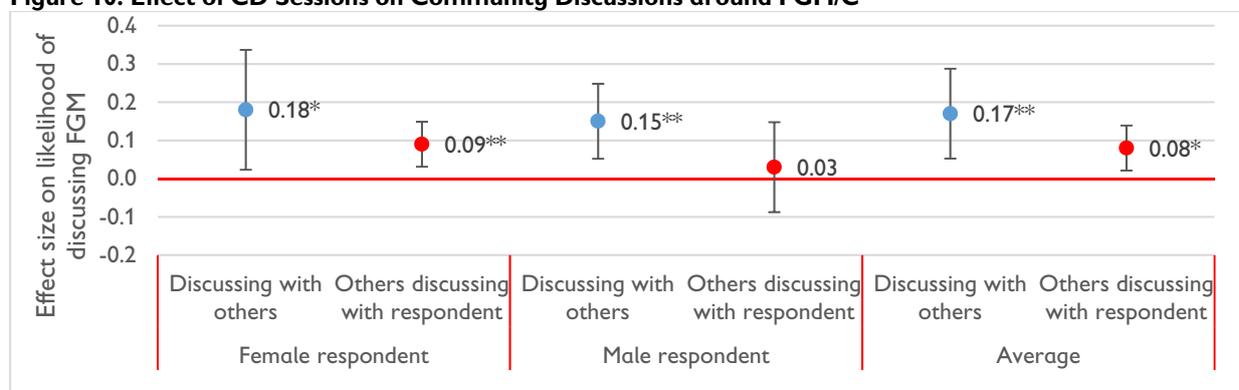
### 3.8.3 Effect of CD Sessions on Community Discussions around FGM/C

FGM/C is not a subject which people generally talk about in Somali communities, both in public and private, especially among persons of opposite gender [6, 19, 20]. The CD sessions were designed as a safe space where people can openly discuss and reflect about FGM/C. As such it was hypothesized that after CD sessions this will break communication barriers and stimulate community-wide discussions on issues that were rarely discussed especially among people of opposite sex. We explored if the respondents discussed FGM/C related issues with their networks after participating in CD sessions. In addition, on a self-report whether the CD participants themselves received information on FGM/C from other community members.

*“Before these meetings I was ashamed of speaking about FGM; but when I saw men discussing with us on our private issues I learnt that FGM is an issue for everyone”- CD participant*

Results show high level of community discussion on FGM/C; 76% of community members participating in CD sessions had discussed FGM/C with someone in the last one month. There was increased likelihood of persons participating in more anti-FGM/C activities discussing FGM/C information with other community members by 17pp, especially if the person participating in anti-FGM/C activities was a woman. When women participate in anti-FGM/C activities, they were more likely to discuss FGM/C issues with other community members as compared to their male counterparts. Discussants from the CD participants noted that unlike in the past when talking about FGM/C was a taboo, they expressed that they can openly discuss FGM/C in public. This is a milestone as men are also coming out to discuss the campaign and women can speak in public without fear of stigmatization. Although this was a significant milestone, evidence show anti-FGM/C discussions were mostly unidirectional, that is, the change agents (CD participants) were yet to get other community members to get on to their course. This was so because we do not see any increase in the likelihood of CD participants receiving any information from other community members other than just fellow CD participants.

**Figure 10: Effect of CD Sessions on Community Discussions around FGM/C**



### 3.8.4 Effect of CD Sessions on Community and Religious Leaders Support for FGM/C

Literature posits that greater success of the interventions geared towards stopping FGM/C if it secures religious and community leaders' commitment to halting FGM/C [21]. In the study setting, common reason behind continuation of FGM/C, especially Sunnah, is the perception that it is mandatory religious practice and a cultural issue. In nearly a similar study among Somali refugees in Kenya, the intervention failed to achieve desired changes about FGM/C opinion and practice due to failure to get congruence with religious and community leaders and by extension the wider community [17]. Although CD groups were organized separately for leaders, youths and women, once in a while, community and religious leaders attended and engaged various CD session groups. Therefore consistent attendance by CD participants increased the likelihood that they might be exposed to leaders who support FGM/C abandonment, this potentially reduce perceived social sanctions from leaders towards the practice. In this study, we found CD was effective in reducing respondent's view on level of FGM/C support by community leaders and not religious leaders only when we consider CD participation intensity. The number of respondents who thought most community leaders support FGM/C reduced by 6-percentage points because of continued participation in CD sessions. The absence of effect for perceived religious leaders support for FGM/C is linked to absence of a common stand on FGM/C within the religious community.

**Table 16: Effect of CD Sessions on Perceived Community and Religious Leaders Support for FGM/C**

|   | Community leaders support FGM/C |                 |                  | Religious leaders support FGM/C |                 |                 |
|---|---------------------------------|-----------------|------------------|---------------------------------|-----------------|-----------------|
|   | Model1                          | Model2          | Model3           | Model1                          | Model2          | Model3          |
| Effect on CD participant                | -0.081(0.075)                   | -0.076(0.075)   |                  | -0.015(0.071)                   | -0.023(0.070)   |                 |
| Effect on CD participant network        | -0.046(0.048)                   | -0.036(0.047)   |                  | -0.039(0.048)                   | -0.029(0.047)   |                 |
| Effect of CD participation as intensity |                                 |                 | -0.062(0.020)*** |                                 |                 | 0.025(0.020)    |
| CD participant dummy                    | 0.017(0.048)                    | 0.027(0.047)    |                  | -0.026(0.042)                   | -0.016(0.041)   |                 |
| CD participant network dummy            | -0.003(0.029)                   | -0.004(0.029)   |                  | 0.030(0.029)                    | 0.030(0.029)    |                 |
| Midline dummy                           | 0.195(0.036)***                 | 0.149(0.036)*** | 0.155(0.021)***  | 0.243(0.033)***                 | 0.180(0.034)*** | 0.167(0.020)*** |
| CD participation intensity at baseline  |                                 |                 | 0.051(0.011)***  |                                 |                 | 0.029(0.011)*** |
| Baseline mean (Random sample)           | 0.166(0.020)***                 | 0.253(0.048)*** | 0.253(0.047)***  | 0.150(0.019)***                 | 0.176(0.051)*** | 0.181(0.049)*** |
| Observations                            | 2,163                           | 2,163           | 2,159            | 2,177                           | 2,177           | 2,173           |
| R-squared                               | 0.057                           | 0.081           | 0.084            | 0.078                           | 0.102           | 0.109           |
| Covariates                              | No                              | Yes             | Yes              | No                              | Yes             | Yes             |
| CD participation as intensity           | No                              | No              | Yes              | No                              | No              | Yes             |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

### 3.8.5 Effect of CD Sessions on FGM/C and Child Marriage Practice

As demonstrated in earlier sections, there was hardly any change in community attitude towards FGM/C attributable to CD sessions. The CD sessions marginally increase participants' awareness on health consequences of FGM/C and stimulated unidirectional discussions about FGM/C in the community. The sessions were also effective in deconstructing the opinion that majority of community leaders support FGM/C practice. With these marginal changes, it is only intuitive that no changes in FGM/C practice in the community attributable to CD sessions. We examine if CD participants would circumcise less girls within the two-year period relative to other study arms. As shown below, those in treatment group (CD participant and those in CD participant network) and those in the control group registered nearly similar new FGM/C cases within the two-year period. Furthermore CD sessions did not offer any advantage in accelerating change away from Pharonic to Sunnah types of FGM/C. Like FGM/C, results show no difference in new incidents of child marriage between the five study arms. The absence of effect on new female child marriage incident rate was linked to the average low prevalence rates of female child marriage (1% at baseline and 6% at midline).

**Table 17: Effect of CD Sessions on FGM/C and CEFM Practice**

|                                     | Daughter is newly circumcised [1 = Yes] |                | Daughter [age 10 - 17] is newly married [1 = Yes] |               |
|-------------------------------------|---|----------------|---|---------------|
|                                     | Model1                                  | Model2         | Model1  | Model2        |
| Effect on CD participant            | -0.011(0.055)                           | -0.104(0.145)  | -0.094(0.083)                                     | -0.101(0.051) |
| Effect on CD participant network    | -0.035(0.088)                           | 0.042(0.058)   | -0.100(0.068)                                     | -0.075(0.050) |
| Potential CD participant            | -0.126(0.030)***                        | 0.009(0.096)   | -0.107(0.078)                                     | -0.100(0.079) |
| Network of potential CD participant | 0.004(0.060)                            | -0.012(0.086)  | -0.103(0.072)                                     | -0.094(0.051) |
| Base (Random sample)                | 0.394(0.041)***                         | 0.167(0.050)** | 0.138(0.072)                                      | -0.529(0.465) |
| Observations                        | 445                                     | 386            | 475   | 403           |
| R-squared                           | 0.004                                   | 0.286          | 0.031   | 0.094         |
| Covariates                          | No                                      | Yes            | No  | Yes           |

Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

### 3.8.6 Plausible Reasons for Absence of CD Effects on Opinion and Practice

**FGM/C Terminology:** The common assumption that the term “FGM/C” refers to all forms of female genital cutting is not true in the study area. During the baseline survey we translated FGM/C into the local Somali terms, gudniinka (circumcision). However, it turned out later that this in local term was just synonymous with gudniinka fircooniga (pharaonic circumcision) only and thus not explicit to encompass all types of FGM/C as intended for the study. Given that the Sunnah type of FGM/C in local terms is not considered as gudniinka, it is unlikely that respondents were initially referring to only pharaonic type of FGM/C. Since the CD sessions were conducted in the local language, it was likely that the participants referred to this gudniinka term and thus fall short of including all types of FGM/C. Such a phenomenon has been observed in a previous intervention in Hargeisa, Somaliland [11]. Since the baseline results show most respondents in the community were against gudniinka, it becomes an easy discussion topic as opposed to including the Sunnah type of FGM/C. This means it not only affects the discussion at CD sessions but also how the opinion on FGM/C was measured at baseline and midline.

**FGM/C Zero Tolerance:** Another conceptual ambiguity that lends itself to this study is the interpretation of zero tolerance to FGM/C. While the anti-FGM/C practitioners interpret it as being against all forms of FGM/C, the local community interpret it as abandonment of Pharaonic circumcision. In some cases, the community in this study consider undergoing Sunnah type of FGM/C equivalent to someone who has not been cut. Thus, a respondent claiming he/she intends "not circumcise" does not necessarily mean, she/he intends "not to carry out any sort of FGM/C" but could mean that he/she intends not do the severe form of FGM/C circumcision (pharaonic). This was confirmed by the fact that within two years respondents had their daughters undergo FGM/C irrespective of baseline intention not to circumcise their daughters. New FGM/C incident rate was similar among respondents who initially indicated that they were not planning to let their daughters undergo FGM/C and those who initially indicated that they were planning to circumcise their daughters. The ambiguity of zero tolerance not only emanates from the community but even at times from anti-FGM/C practitioners, some support the end of Pharaonic FGM/C, but tolerating Sunnah forms, and thus confusing the public on what ending FGM/C really means [5].

**Focus on FGM/C Health Risks:** FGM/C awareness campaigns often focus on the health complications; however, this is often biased towards Pharaonic type of FGM/C only. We do not rule out that CD sessions disproportionately focussed on this health risk approach but with bias towards Pharaonic. This does not promote FGM/C abandonment but implicitly endorses less severe forms of FGM/C, in this case the Sunnah type, which is often perceived devoid of medical complications and rarely mentioned. Given that FGM/C is enforced through social sanctions, the fear of one's daughter being socially ostracized or being divorced or not getting married off, outweighs health risks especially when these risks are less pronounced such as the case of Sunnah type FGM/C. Moreover, the increased awareness of the health effects of FGM/C has resulted to community shifting the practice or performing it under medical attention. The switch to less severe forms and medicalization as observed in this study is one of the unintended effect of anti-FGM/C efforts.

**Individual and Community Beliefs on Sunnah FGM/C:** Individual beliefs and experiences can act as a barrier or can facilitate change. Any new information is processed in conjunction with prior beliefs and lived experiences but if there is dissonance, prior beliefs might triumph over new information. In this study area, interpretation of what Sunnah type of FGM/C means was at times contradictory. For instance, while community members classify Sunnah into two types (Sunnah Kabeer - excision and Sunnah Sakeer – clitoridectomy), local religious leaders only consider it as one type which does not involve any cutting or sewing. Irrespective of their classification by religious leaders and other community members, Sunnah FG/C is not considered as FGM/C. Furthermore, it is deemed less harmful. The CD participants and their community believed Sunnah is less harmful or have lived to witness fewer effects of Sunnah relative to Pharaonic. Therefore, although the CD sessions were meant to enable community to critically reflect on FGM/C including Sunnah type of FGM/C, there was a likelihood that the discussions did not fully feature this individual and community beliefs and realities about Sunnah type of FGM/C. This is similar to observations in anti-FGM/C sensitization campaigns in Senegal, Burkina Faso, and Mali that found FGM/C continued as the community conversation participants were not convinced that what they were doing was harmful [22, 23]. A similar sensitization session among Somalis in Norway initially yielded the same results, the women participating in the session did not believe in the information that was given as they were still in denial stage for Sunnah FGM/C [24, 5].

**Structure of CD sessions and Intensity:** The CD sessions were organized into groupings of various segments of the community. For instance, there were different youth CD sessions, men CD sessions, children CD sessions, women CD sessions, religious leaders' CD sessions and community leaders' sessions. At the time of the study, the Community Dialogue was unstructured with no manual to manual to guide the facilitation process. In addition, the community facilitators did not have adequate skills to facilitate the dialogues. There was also inconsistency in participation which might be due to competing priorities of the communities and other factors beyond the control of the project.

NCA and SCI have now developed a new community conversation manual and have rolled out the new model that structures the conversation process. Staff and partners have been trained and are supporting the community facilitators to enhance their skills to be able to facilitate the community conversations effectively. In addition, measures have been put in place to motivate and follow up the Community conversation participants to consistently participate in the monthly forums. The new model will be assessed during the evaluation to establish the effectiveness of the new model.

### **3.9 Programmes' Theory of Change**

As indicated in section 1.2, the programme theory of change stipulates the pathways that the programme would follow to realize the intended outcomes. Despite the fact that the programme is still a long way towards realizing its overall goal on zero tolerance to all forms of FGM/C and child marriage, significant progress has been made. Community members are increasingly discussing FGM/C as an issue affecting them in the community; a topic that was previously regarded as a taboo particularly among the male counterparts. Secondly, there has been a shift in the type of FGM/C cut being practiced in the community; from the more severe (Pharaonic) to less severe (Sunnah type) due to increased awareness levels on the harmful effects of FGM/C.

There is still unsettled debate and misconceptions between religion and culture in which the continuity of FGM/C practice is embedded. The total buy-in of religious leaders and community leaders on zero tolerance anticipated by the TOC is largely lacking especially with senior leaders. Religious leaders have not made their stand known regarding FGM/C with majority supporting the Sunnah type of FGM/C as a religious requirement. Top level religious senior leaders are missing in high level FGM/C advocacy, with the programme engaging the lower level religious leaders in creating awareness but lacking endorsement on decisions and commitments especially from top level leaders.

The policy environment has gradually evolved in both Puntland and Jubbaland. A policy on FGM/C is in place and a bill in parliament awaiting ratification in Puntland. In Jubaland, FGM/C Policy is in draft stage. Survivors with FGM/C and related complications were supported to seek medical and psychosocial services; and registered improved health and well-being including economic empowerment. These among other milestones indicate progress towards in realization of the intended programme goal in line with the Programme's theory of change.

#### **3.9.1 Validity of the Programme TOC**

The Programme TOC was found to be valid but lacking in critical components that would enrich the programme towards realization of the intended results. The programme staff and partners held a reflective session where they critically reviewed the ToC pathways to establish its relevance and suggested the following components included in the programme moving forward:

- ❖ Media component needs to be strengthened
- ❖ Explore the use of female religious leaders
- ❖ Increase engagement of health professionals
- ❖ Educate communities on effects of Sunnah maybe from a human rights perspective
- ❖ Engage influential women professionals in the districts to advocate against FGM/C
- ❖ Explore adoption of women empowerment component, adult education
- ❖ Include Anti-medicalization messaging
- ❖ Engage law makers
- ❖ Adoption of harmonised individual declaration forms to enable follow-up

### **3.10 Lessons Learnt during Programme Implementation**

Based on experience gained through programme implementation overtime, a number of lessons have been learnt that need to be put into consideration for the success of future programming. First, engaging top influential Religious Leaders is critical towards influencing change. Given their moral standing and influence, their buy-in and support for zero tolerance to FGM/C would go a long way towards communities' change in beliefs, attitudes and practices. Secondly, given that one of the main reasons why FGM/C is practiced is to prepare girls for marriage, targeting men and boys and engaging them as change agents is critical towards change. In this study, the level of awareness on the negative effects of FGM/C among young men was found to be low with majority supporting continuation of the practice. Continuous sensitization and engaging them as role models to their peers will be crucial moving forward.

Thirdly, it is critical to strengthen anti FGM/C school interventions in schools. Providing safe spaces for children to learn and discuss about harmful practices and other forms of GBV among other issues affecting them is important. Using child friendly approaches in children conversations will make their engagement and learning interesting and meaningful. In addition, topics on FGM/C and early child marriage should be introduced in schools as part of the curriculum or life skills training package to equip children with knowledge, skills and values that are critical in life.

Government support and involvement in the project is very critical for community buy in, ownership and sustainability. Transforming social norms that promote harmful practices and other forms of GBV is one of the government's key priorities hence the need (for the government) to allocate sufficient resources and lead towards realization of this goal. It is therefore critical for the NCA/SC joint programme to involve the relevant government ministries in planning, implementation and coordination in operational areas.

Lastly, while having a legal framework in place is crucial, enforcement of the same is equally important. The policy environment in Somalia is gradually evolving, with some states having policies on FGM/C in place and a bill on FGM/C in parliament awaiting ratification (e.g. Puntland); while in Jubaland a policy on FGM/C is under development led by the Ministry of Gender, Family Affairs and Human Rights. Somalia has further ratified the convention on the rights of the child. However, enforcement remains a key challenge which if done, would go a long way towards protection of women and girls from harmful practices and other forms of Gender Based Violence.

#### 4. Conclusions

This research confirms that despite NCA and SCI interventions in the study area, FGM/C prevalence is still high, comparable to rates observed in the MICS 2011. In line with historical trend, this study documented change in the type of cut from the Pharaonic, which is considered the most severe to Sunnah which is considered less severe. Another shift accelerated by health concerns is the growth of FGM/C medicalization, where this study finds 63% of new FGM/C incidents are performed by health workers. The health workers claimed to perform the practice as a harm reduction strategy.

The study has revealed even though the prevalence of child marriage is low in the study area, community members are supportive of child marriage before the age of 18 (and as soon as a girl attains puberty). Although child marriage was deemed harmful, it was also deemed to have positive side such as ability to produce children early and avoid mistakes.

Support for FGM/C abandonment is still low, at midline only 29% of the respondents supported FGM/C abandonment and committed not to cut their girls in future. Most of respondents claim to support abandonment of FGM/C yet still plan to have their daughters go through FGM/C or had subjected their daughters to the cut already despite commitment not to cut at baseline.

Informational campaign against FGM/C managing to reach commitment level such as taking pledge to stop FGM/C shaped opinion on FGM/C but did not attain total commitment to abandon all types of FGM. This was due to miss interpretation of what FGM/C abandonment entailed; the community interpreted it as abandoning only the Pharaonic type and not the Sunnah type.

There is substantial awareness of FGM/C health effects. This is interpreted by the community along the lines of Pharaonic versus Sunnah FGM/C and not FGM/C in totality. Health awareness campaigns have not only silently endorsed the Sunnah FGM/C but also increased medicalization of FGM/C.

The study has also shown that it is more difficult to transform religious norms (as the case of Sunnah FGM/C and child marriage as soon as she reaches puberty) without the support of the influential religious leaders. The community members view Pharaonic FGM/C as cultural and have been able to move away from practicing it as a cultural norm. On the other hand, the Sunnah FGM/C is viewed as a mandatory religious practice by 71% of the population. Although the religious leaders have not taken a common stand on FGM/C, most of them are supporting Sunnah FGM/C. The few religious leaders who support total FGM/C abandonment, have not come out publicly on their stand. Therefore, without the support from the religious leaders, it will be difficult to achieve total abandonment of all forms of FGM/C including Sunnah type of FGM/C.

Mothers and grandmothers are the decision makers on whether a girl should be cut, they are facing the dilemma between subjecting their daughters and granddaughter to pain and protecting the integrity of the girls and securing their marriage prospects. This explains why there is lack of consistency between respondent's views on women empowerment (in terms of household decision making) and support for FGM/C abandonment. Support for FGM/C abandonment is not only a religious and a cultural issue but also within the wider gender relations, as support for abandonment was linked to individuals view on violence against women intimate partners.

After participating in CD sessions, the participants disseminated information about FGM/C in their communities, this helped the community to be aware that there were some community leaders who were against FGM/C. While CD sessions did not reduce FGM/C rates, it was not directly linked to the two unintended consequences (shift to Sunnah types and increased FGM/C medicalization).

## 5. Recommendations

- Whereas the shift in the type of cut is a progress, the challenge remains for NCA, SCI and other actors to advocate for total abandonment of all forms of FGM/C. The actors should streamline their messages to conform to total abandonment to avoid the risk of silently endorsing the Sunnah type of FGM/C.
- There is a perception that FGM/C is decreasing, and more community members supported abandoned FGM/C; however, careful consideration shows community refer to only the Pharaonic type of FGM/C and not FGM/C in totality. NCA and SCI should maintain a clear translation reflecting the community understanding of FGM/C terminologies. Further efforts should focus on how to declassify FGM/C into one as opposed to two.
- It is important to structure the community dialogues to enable critical reflection by the wider community. NCA and SCI have already started the process by developing a new community conversation manual and rolling out the new model, which is anticipated to build communities' capacity to make appropriate decisions for lasting positive change.
- As discussions on the health consequence of FGM/C are leading to medicalization and shift to Sunnah types, the Joint program should explore other issues on FGM/C such as on Child Rights, what religion says about harming a person, etc. These discussions should feature in the newly structured CD sessions.
- Sensitization on the health consequence of FGM/C should raise awareness on all types of FGM/C including the Sunnah types. The health information should highlight the less salient health effects of the less severe form of FGM/C.
- Train health practitioners on anti-medicalization and support the Ministry of Health to implement the anti-medicalization policy.
- Young people (with focus on men and boys) should be targeted more to raise awareness consequences of all types of FGM/C while ensuring the tools that are used for engaging them are friendly.
- Explore successful strategies for buy in from top religious leaders. Enable the existing religious leaders who have a stand on FGM/C abandonment to come out and publicly declare their stand.
- There needs to be a strong political will for legislation and enforcement of laws and policies against FGM/C. NCA/SCI joint programme should work more on advocacy and influencing government to further political will, development of legislation and enforcement of laws. There should also be dissemination and awareness about laws in the community.
- Discussions around early child marriage should be enhanced. Most of the respondents said they rarely speak about it even when they come across cases. Awareness raising for parents and traditional elders is important. Focus should be given on the health consequence of child marriage.
- An in-depth study be conducted on prevalence of child marriage as there is a contradiction between the low prevalence of Child marriage and high community support.

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## 7. Annexes

### Annex 1. Programme Results Frame Summary

|   |         | Baseline | Midline | Endline |
|---|---------|----------|---------|---------|
| FGM/c prevalence amongst girls aged 5-15 years  | 5 – 10  | 36       | 50      |         |
|   | 11 – 15 | 92       | 95      |         |
|   | Average | 60       | 70      | 49      |
| CEFM Prevalence rates amongst girls 10-17 years   | 10 - 15 | 1        | 6       |         |
|   | 16 - 17 | 3        | 8       |         |
|   | Average | 1        | 6       | 3       |
| % of men and women who support abandonment of CEFM  | Male    | 27       | 24      |         |
|   | Female  | 32       | 34      |         |
|   | Average | 30       | 31      | 80      |
| % of men and women who support abandonment of FGM/C by committing not to cut their future daughters   | Male    | 45       | 32      |         |
|   | Female  | 40       | 27      |         |
|   | Average | 42       | 29      | 90      |
| Proportion of the religious leaders who are supporting the implementation of the existing Fatwa/declarations within the targets communities |         | 81       | 100     | 90      |
| % of community members that have participated in public declarations on FGM   | Male    | 51       | 60      |         |
|   | Female  | 49       | 60      |         |
|   | Average | 50       | 60      | 70      |
| % of individuals who have knowledge on FGM complications  | Male    | 72       | 56      |         |
|   | Female  | 66       | 59      |         |
|   | Average | 67       | 58      | 90      |
| Proxy for 2.2a % of respondents reporting to know any religious leader in their community talking about stopping FGM/C                      | Male    | 46       | 33      |         |
|   | Female  | 44       | 27      |         |
|   | Average | 45       | 29      |         |
| Proxy for 2.2c % of community members engaged in community dialogues on abandonment & zero tolerance FGM/c                                  | Male    | -        | 43      |         |
|   | Female  | -        | 39      |         |
|   | Average | -        | 40      |         |
| % of individuals who know that FGM is unlawful and should not be practiced  | Male    | 42       | 16      |         |
|   | Female  | 43       | 17      |         |
|   | Average | 43       | 17      | 70      |
| % of girls and women who have undergone FGM whose situation improved after receiving the services   |         | -        | 100     |         |

### Annex 2. Staff and Partners' Reflective Sessions Report Staff & Partners Reflective Session on the Programme

### Annex 3. Changes between Baseline and Midline per Study Group

|  | CD Participant |                  | Potential CD participant |                 | Network of CD Participant |                  | Network of Potential CD participant |                  | Random sample |                  |
|--|----------------|------------------|--------------------------|-----------------|---------------------------|------------------|-------------------------------------|------------------|---------------|------------------|
|  | B              | C                | B                        | C               | B                         | C                | B                                   | C                | B             | C                |
| FGM/C is a mandatory religious practice              | 0.297          | 0.101(0.114)     | 0.303                    | 0.191(0.104)    | 0.311                     | 0.077(0.085)     | 0.357                               | 0.146(0.082)     | 0.331         | 0.168(0.115)     |
| Pharonic circumcision a mandatory religious practice | -              | 0.039            | -                        | 0.042           | -                         | 0.071            | -                                   | 0.078            | -             | 0.073            |
| Sunna circumcision a mandatory religious practice    | -              | 0.659            | -                        | 0.691           | -                         | 0.703            | -                                   | 0.719            | -             | 0.720            |
| FGM/C is not permitted by law                        | 0.689          | -0.317(0.057)*** | 0.598                    | -0.284(0.098)** | 0.647                     | -0.330(0.063)*** | 0.590                               | -0.302(0.067)*** | 0.621         | -0.327(0.037)*** |
| Pharonic circumcision is not permitted by law        | -              | 0.868            | -                        | 0.831           | -                         | 0.828            | -                                   | 0.814            | -             | 0.789            |
| Sunna circumcision is not permitted by law           | -              | 0.144            | -                        | 0.207           | -                         | 0.181            | -                                   | 0.170            | -             | 0.168            |
| FGM/C should be stopped                              | 0.713          | -0.277(0.139)    | 0.625                    | -0.246(0.122)*  | 0.656                     | -0.274(0.117)*   | 0.594                               | -0.204(0.109)    | 0.576         | -0.195(0.106)    |
| FGM/C can be eliminated in the community             | 0.832          | -0.287(0.108)**  | 0.654                    | -0.106(0.145)   | 0.708                     | -0.248(0.083)**  | 0.675                               | -0.213(0.066)**  | 0.648         | -0.188(0.099)    |
| FGM/C can be eliminated in the country               | 0.796          | -0.289(0.118)*   | 0.560                    | -0.080(0.099)   | 0.671                     | -0.246(0.101)*   | 0.642                               | -0.245(0.068)**  | 0.635         | -0.245(0.105)*   |
| Supports abandonment of FGM/C                        | 0.738          | -0.084(0.029)**  | 0.791                    | -0.178(0.113)   | 0.758                     | -0.193(0.056)**  | 0.676                               | -0.127(0.059)*   | 0.657         | -0.137(0.093)    |
| Would circumcise if have daughter in future          | 0.333          | 0.198(0.109)     | 0.482                    | 0.131(0.134)    | 0.448                     | 0.152(0.074)*    | 0.460                               | 0.146(0.069)*    | 0.449         | 0.193(0.065)**   |
| Would circumcise daughter even if no one practices   | -              | 0.191            | -                        | 0.353           | -                         | 0.233            | -                                   | 0.337            | -             | 0.358            |
| FGM attitude in general                              | 0.602          | -0.700(0.199)**  | 0.269                    | -0.511(0.315)   | 0.385                     | -0.681(0.204)**  | 0.246                               | -0.610(0.169)**  | 0.235         | -0.632(0.206)**  |

B – Baseline mean; C – Changes at midline from baseline values; Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

|  | CD Participant                   |               | Potential CD participant |               | Network of CD Participant |               | Network of Potential CD participant |               | Random sample    |               |                  |
|--|----------------------------------|---------------|--------------------------|---------------|---------------------------|---------------|-------------------------------------|---------------|------------------|---------------|------------------|
|  | B                                | C             | B                        | C             | B                         | C             | B                                   | C             | B                | C             |                  |
| Aware of at least three harmful FGM effects    | 0.712                            | -0.037(0.090) | 0.722                    | -0.104(0.116) | 0.692                     | -0.094(0.135) | 0.652                               | -0.097(0.090) | 0.666            | -0.119(0.126) |                  |
| Negative FGM effects                           | Infectious disease transmission  | 0.674         | -0.311(0.065)***         | 0.645         | -0.232(0.051)***          | 0.596         | -0.218(0.045)***                    | 0.584         | -0.233(0.035)*** | 0.511         | -0.097(0.037)**  |
|  | Bleeding                         | 0.807         | -0.084(0.041)*           | 0.838         | -0.131(0.035)**           | 0.768         | -0.082(0.030)**                     | 0.740         | -0.092(0.042)*   | 0.791         | -0.173(0.042)*** |
|  | Health problems                  | 0.759         | -0.073(0.086)            | 0.708         | -0.076(0.098)             | 0.777         | -0.116(0.051)*                      | 0.706         | -0.080(0.090)    | 0.757         | -0.170(0.085)    |
|  | Delivery difficulty              | 0.558         | 0.091(0.111)             | 0.610         | -0.131(0.126)             | 0.572         | -0.036(0.133)                       | 0.580         | -0.172(0.099)    | 0.568         | -0.112(0.117)    |
|  | Sexual feelings reduction        | 0.338         | -0.087(0.058)            | 0.323         | 0.018(0.065)              | 0.332         | -0.048(0.109)                       | 0.331         | -0.023(0.083)    | 0.339         | -0.069(0.105)    |
|  | Affects women health and welfare | 0.135         | 0.096(0.046)*            | 0.182         | 0.137(0.094)              | 0.151         | 0.079(0.069)                        | 0.164         | 0.071(0.056)     | 0.144         | 0.095(0.086)     |
| Sex penetration difficulty                     | 0.217                            | 0.034(0.089)  | 0.209                    | 0.100(0.117)  | 0.199                     | 0.048(0.109)  | 0.185                               | 0.034(0.070)  | 0.161            | 0.010(0.060)  |                  |
| Aware of at least one positive FGM consequence | 0.025                            | 0.070(0.059)  | 0.042                    | 0.071(0.039)  | 0.068                     | 0.014(0.018)  | 0.052                               | 0.106(0.059)  | 0.051            | 0.060(0.037)  |                  |
| Positive FGM effects                           | FGM has no negative consequence  | 0.000         | 0.072(0.058)             | 0.012         | 0.048(0.035)              | 0.021         | 0.022(0.013)                        | 0.027         | 0.076(0.040)     | 0.026         | 0.055(0.034)     |
|  | Maintain virginity               | 0.025         | -0.014(0.022)            | 0.014         | 0.051(0.026)              | 0.013         | 0.005(0.022)                        | 0.017         | 0.035(0.031)     | 0.009         | 0.027(0.007)***  |
|  | Helps a girl become adult        | 0.000         | 0.000(0.000)             | 0.016         | 0.037(0.017)*             | 0.016         | -0.001(0.015)                       | 0.010         | 0.005(0.012)     | 0.009         | 0.003(0.006)     |
|  | Reduce prostitution              | 0.000         | 0.036(0.016)*            | 0.014         | 0.026(0.016)              | 0.037         | -0.026(0.012)*                      | 0.020         | -0.011(0.015)    | 0.009         | 0.015(0.013)     |

B – Baseline mean; C – Changes at midline from baseline values; Robust standard errors in parentheses \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

|  | CD Participant |                | Potential CD participant |                 | Network of CD Participant |                 | Network of Potential CD participant |                | Random sample |                |
|--|----------------|----------------|--------------------------|-----------------|---------------------------|-----------------|-------------------------------------|----------------|---------------|----------------|
|  | B              | C              | B                        | C               | B                         | C               | B                                   | C              | B             | C              |
| Many adult women support FGM/C               | 0.378          | 0.210(0.162)   | 0.350                    | 0.108(0.105)    | 0.377                     | 0.129(0.153)    | 0.395                               | 0.178(0.148)   | 0.423         | 0.134(0.130)   |
| Many young girls support FGM/C               | 0.109          | 0.108(0.095)   | 0.107                    | 0.197(0.091)*   | 0.159                     | 0.063(0.049)    | 0.162                               | 0.160(0.085)   | 0.138         | 0.111(0.077)   |
| Many adult men support FGM/C                 | 0.177          | 0.049(0.058)   | 0.141                    | 0.151(0.092)    | 0.238                     | 0.046(0.083)    | 0.229                               | 0.140(0.081)   | 0.251         | 0.009(0.073)   |
| Many young boys support FGM/C                | 0.062          | 0.138(0.061)*  | 0.057                    | 0.222(0.043)*** | 0.134                     | 0.086(0.068)    | 0.117                               | 0.205(0.087)*  | 0.121         | 0.097(0.094)   |
| Many community leaders support FGM/C         | 0.184          | 0.114(0.058)   | 0.129                    | 0.238(0.074)**  | 0.163                     | 0.149(0.069)*   | 0.165                               | 0.262(0.066)** | 0.166         | 0.195(0.071)** |
| Many religious leaders support FGM/C         | 0.124          | 0.228(0.075)** | 0.156                    | 0.256(0.082)**  | 0.181                     | 0.205(0.044)*** | 0.146                               | 0.290(0.086)** | 0.150         | 0.243(0.098)*  |
| Many women (>40 years) support Sunna FGM/C   | -              | 0.516          | -                        | 0.440           | -                         | 0.525           | -                                   | 0.506          | -             | 0.452          |
| Many women (18-40 years) support Sunna FGM/C | -              | 0.405          | -                        | 0.421           | -                         | 0.481           | -                                   | 0.477          | -             | 0.453          |
| Many young girls support Sunna FGM/C         | -              | 0.401          | -                        | 0.523           | -                         | 0.485           | -                                   | 0.562          | -             | 0.464          |
| Many adult men support Sunna FGM/C           | -              | 0.422          | -                        | 0.476           | -                         | 0.495           | -                                   | 0.515          | -             | 0.453          |
| Many young boys support Sunna FGM/C          | -              | 0.453          | -                        | 0.493           | -                         | 0.342           | -                                   | 0.526          | -             | 0.410          |
| Many community leaders support Sunna FGM/C   | -              | 0.551          | -                        | 0.541           | -                         | 0.534           | -                                   | 0.562          | -             | 0.491          |
| Many religious leaders support Sunna FGM/C   | -              | 0.651          | -                        | 0.695           | -                         | 0.640           | -                                   | 0.674          | -             | 0.613          |

## Annex 4. Changes between Baseline and Midline per Region

