Report

Female genital mutilation in Sudan and Somalia

The Country of Origin Information Centre (Landinfo) is an independent body that collects and analyses information on current human rights situations and issues in foreign countries. It provides the Norwegian Directorate of Immigration (Utlendingsdirektoratet – UDI), Norway's Immigration Appeals Board (Utlendingsnemnda – UNE) and the Norwegian Ministry of Labour and Social Inclusion (Arbeids- og inkluderingsdepartementet – AID) with the information they need to perform their functions.

The reports produced by Landinfo are based on information from both public and non-public sources. The information is collected and analysed in accordance with source criticism standards. When, for whatever reason, a source does not wish to be named in a public report, the name is kept confidential.

Landinfo's reports are not intended to suggest what Norwegian immigration authorities should do in individual cases; nor do they express official Norwegian views on the issues and countries analysed in them.

© Landinfo 2008

The material in this report is covered by copyright law. Any reproduction or publication of this report or any extract thereof other than as permitted by current Norwegian copyright law requires the explicit written consent of Landinfo.

For information on all of the reports published by Landinfo, please contact:

Landinfo
Country of Origin Information Centre

Storgata 33A
P.O. Box 8108 Dep
NO-0032 Oslo
Norway

Tel: +47 23 30 94 70
Fax: +47 23 30 90 00
E-mail: mail@landinfo.no
Website: www.landinfo.no

FGM **Eng (2).doc**

SUMMARY

Female Genital Mutilation (FGM) is very common in Somalia and Sudan. More than 90 percent of girls in Somalia and in Northern Sudan are subjected to the most severe form, i.e. infibulation. Factors such as religion, tradition and sexuality are used to explain and justify the practice of genital mutilation. While awareness campaigns and other efforts towards its eradication encourage changes to the practice, these have come about only at a very slow pace. Although women are accountable for upholding the practice, men carry a great responsibility. In societies where socio-economic security is provided for women primarily through the institution of marriage, the requirement that women must be virgins to be considered eligible for marriage contributes to a continuation of the practice of FGM.

SAMMENDRAG

Kjønnslemlestelse av kvinner er svært utbredt i både Somalia og Sudan. Over 90 prosent av alle jenter i Somalia utsettes for den mest omfattende formen, det vil si infibulering, og i Nord-Sudan er andelen tilsvarende. Denne praksisen begrunnes med religion, tradisjon og seksualmoral, og på tross av opplysningsvirksomhet og holdningskampanjer skjer endringer svært langsomt. Praksisen er først og fremst et kvinneanliggende, men menn bærer et betydelig ansvar. Krav om at kvinnen skal være jomfru for å være en akseptabel ekteskapskandidat i samfunn hvor ekteskapet er det sosiale og økonomiske sikkerhetsnettet for kvinner, bidrar i sterk grad til at praksisen opprettholdes.

CONTENTS

1. Introduction 7

2. Genital mutilation in Sudan 8

2.1 Incidence rate and types of mutilation 9

2.2 Justifying genital mutilation in Sudan 11

2.2.1 Genital mutilation – who decides? 11

2.3 When is genital mutilation performed? 11

2.4 Reinfibulation 12

2.5 Who performs genital mutilation? 12

2.6 Attitudes towards genital mutilation 13

2.7 Protection against genital mutilation 14

2.7.1 Legislation against genital mutilation 14

2.7.2 Enforcement of legislation 15

2.7.3 Social sanctions against uncircumcised women and/or parents? 15

2.8 Threats against activists 15

3. Female genital mutilation in Somalia 16

3.1 Incidence rate and types of mutilation 16

3.2 Justifying genital mutilation in Somalia 16

3.3 When is genital mutilation performed? 16

3.4 Reinfibulation 16

3.5 Who performs genital mutilation? 17

3.6 Attitudes towards genital mutilation 17

3.7 Protection against genital mutilation 19

3.7.1 Legislation against genital mutilation 19

3.7.2 Social sanctions against uncircumcised women and/or parents? 19

4. References 21

1. INTRODUCTION

The Norwegian term *kjønnslemlestelse* (genital mutilation) used in this report is normally referred to as female genital mutilation (FGM) in English. This terminology is incorporated into Norwegian laws, and applied by the World Health Organisation and various human rights organisations.

However, it is important to note that women affected by genital mutilation do not uniformly regard it as mutilation, and may react negatively to being referred to as "damaged" (Almroth 2005; lecture by Barre, March 2008). In dialogue with these women it is important to avoid further stigmatization. Applying what we perceive as appropriate or correct terminology can easily create additional barriers detrimental to the fight against FGM. Using the term circumcision in such contexts is therefore the most appropriate (lecture by Barre, March 2008).

Genital mutilation is a collective term for the variety of procedures in which the external female genitals are removed completely or partly, or other lasting damage is inflicted.[1] The procedure is mainly carried out by so-called excisors or circumcisers with no medical qualifications. Girls who do not experience chronic pain, serious bleeding or blood poisoning after the procedure often suffer complications during pregnancy, experience great pain during sexual intercourse, and suffer other gynaecological problems and traumas later in life. It is of course difficult for young girls to understand that their closest family allow this to be inflicted upon them. The tradition is upheld for fear that the child will not be accepted for marriage and that she will be ostracised, which can have serious social consequences. Genital mutilation is also a manner in which men exercise control over women's sexual lives. There are a number of other predisposing factors for genital mutilation, as outlined in Landinfo's 2007 report called "Kvinnelig kjønnslemlestelse i Vest-Afrika" (Female genital mutilation in West Africa) (Landinfo 2007).

---

[1] In 1997, the World Health Organisation (WHO) classified four categories of genital mutilation, type V follows on CEF (Landinfo 2007):
I. Clitoridectomy: Partial or complete removal of the clitoris and/or the prepuce.
II. Clitoridectomy: Partial or complete removal of the clitoris and the labia minora, with or without excision of the labia majora.
III. Infibulation: Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). Before the woman can have sexual intercourse, the vaginal orifice must be expanded, and before birth the vaginal orifice must be completely opened. This form is also referred to as *pharaonic.* Resealing after birth is known as *reinfibulation.*
IV. Other types of genital mutilation: Most other forms of genital mutilation are grouped into type IV. This relates to pricking, piercing and incising; burning or cauterising all or parts of the clitoris and the surrounding area; scraping in the area surrounding the vaginal orifice (known as *angurya* cuts); cutting the vagina (*gishiri* cuts); placing corrosive substances or herbs into the vagina to create bleeding for the purpose of tightening or narrowing it; and other procedures that cause damage to the sexual organs.
V. Symbolic genital mutilation: Pricks or small cuts in the clitoris in order to induce drops of blood, where the purpose is symbolic as opposed to creating lasting harm to the genitals (Landinfo 2007).

Removal of the clitoris (type II procedure) accounts for approximately 80 percent of all surgical procedures in Africa. Between 80 and 90 percent of Somali and Sudanese women have undergone infibulation (or a type III procedure).

However, this form of genital mutilation only accounts for 15 percent of the cases in Africa as a whole. Ethnic Somalis in Kenya and Ethiopia also practice infibulation. (World Bank & UNFPA 2004).

In general, the occurrence of genital mutilation throughout Africa varies greatly; from an approximate 5 percent incidence rate in the Democratic Republic of the Congo to the estimated 98 percent in Somalia (World Bank & UNFPA 2004).

2. GENITAL MUTILATION IN SUDAN

Research into the phenomena of genital mutilation in Sudan has a long tradition (Almroth 2005). Sudanese doctors have been involved in research and study efforts since the 1960s, but it was not until the 1970s that anti-FGM activities gathered strength. Towards the end of the 1970s, both the Sudan Family Planning Association and the Sudan Society of Obstetrics and Gynaecology adopted recommendations with a view to abolishing genital mutilation. In the wake of this, several voluntary organisations were established. Currently there is a number of government and voluntary organisations working towards the elimination of FGM. But despite these long term efforts, genital mutilation continues to be widespread in Sudan. Whereas a few positive changes have been observed, these relate primarily to a transition from infibulation to clitoridectomy (Almroth et al. 2001), and not eradication.

2.1 INCIDENCE RATE AND TYPES OF MUTILATION

It is estimated that 89 percent of North Sudanese women between the ages of 15-49 have been subjected to genital mutilation (Unicef 2000; SNCTP 2000). A demographic and health survey conducted among 5 860 women in Sudan between 1996 and 2000 by Save the Children in Sweden and the Sudan National Committee on Traditional Practices (SNCTP) showed that 91 percent of the rural female population and 89 percent of the urban female population had been subjected to genital mutilation.[2] According to the coordinator for the Sudanese network against genital mutilation, Dr. Nahid Jabrallah, a national strategy against genital mutilation has been drawn up. Starting in 2008, the ten-year strategy seeks full elimination and a zero-incidence rate by 2018 (interview May 2008).[3]

It is mainly infibulation (khifad firuni is the Sudanese-Arabic term) that is performed, and an estimated 74 percent of Sudanese women are infibulated. This entails partial or complete removal of all external sexual organs, and surgical closure

[2] Household Health Survey (1999) estimated an incidence rate of 69.4%. Other estimates show significant variation, and serve as reminder that figures and statistics are often used as tools for political ends.

[3] The network against genital mutilation encompasses 44 organisations that fight against genital mutilation. Nahid Jabrallah also represents the centre for children and women studies and is technical adviser for UNICEF projects related to genital mutilation and sexual assaults.

of the vaginal orifice (Unicef 2000; SNCTP 2000). Approximately 22 percent of the female population is subjected to a less extensive procedure called "sunna" (gata al-bazr is the Sudanese-Arabic term), while an estimated 2 percent are subjected to procedures in which elements from both the two aforementioned procedures are applied (Unicef 2000).

Religious affiliation is one of the factors determining which type of genital mutilation is to be performed. According to Unicef (2000), infibulation is most common among Muslim women (83 percent compared to 27 percent of Christians). Sunna is mainly practised by Christians (46 percent).

The incidence rate has remained constant for a number of years, apparently unaffected by information campaigns or other efforts to raise awareness about post-operative complications (Berggren et al. 2006; Almroth 2005).

Bearing in mind variations caused by religious or ethnic affiliation, the practice of genital mutilation – previously used mainly by (Arab) women in North Sudan and in particular in the Nile valley north of Khartoum – has spread to other Sudanese ethnic groups with no prior tradition for genital mutilation. This has in part been caused by the cultural influence spread by prestigious segments of the population (Berggren et al. 2006). South Sudanese migrants and refugees in North Sudan have, for instance, started practising genital mutilation, and the custom has gradually spread to various ethnic groups in the western and southern parts of the country. Coordinator for the network against genital mutilation, Nahid Jabrallah, confirmed this development when meeting with Landinfo in May 2008.[4] Migrants and internally displaced persons from South Sudan living in the north adopt a number of other northern cultural traits such as dress, skin discolouration etc. However, marriages between women from the south and northern Sudanese had only minor influence on genital mutilation practices, according to Jabrallah. Such marriages are uncommon due to racism among the north Sudanese (and primarily the Arabs of the Nile Valley).

The estimated incidence rate in Darfur is approximately 65 percent, while East Sudan averages at 87 percent (Unicef 2000).[5] However, there are no estimates available for South Sudan. In a meeting with Landinfo in May 2008, the local representative for MSF Belgium informed that small-scale surveys on the topic of genital mutilation were currently being conducted in groups from South Sudan. Few results were available as per yet.

---

[4] Dr Jabrallah also stated in the meeting with Landinfo in May 2008 that a number of Sudanese girls residing abroad are sent to Sudan to undergo genital mutilation. She also referred to examples of Sudanese people living in other Arab countries bringing persons that can perform genital mutilation to the country of residence.

[5] According to MSF Belgium, the prevalence of type III in Red Sea State was approximately 85%. MSF focuses particularly on the Beja groups in Red Sea State. The Beja normally perform genital mutilation during the first year of a girl's life. In the lower social stratum the practice is almost universal, but even here there is a tendency to shift from type III towards type I. While MSF is witnessing a change in attitudes through the project they are running to combat genital mutilation in Red Sea State, changes primarily entail transition from type III to type I (interview May 2008).

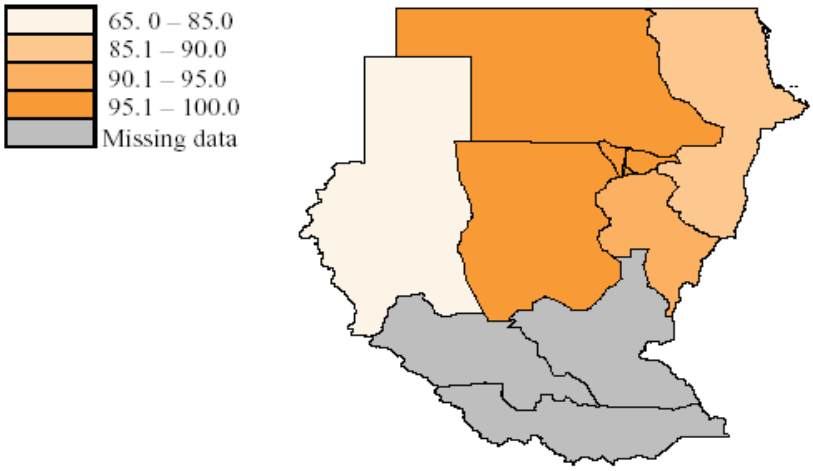

Figure 1, source: Unicef

2.2 JUSTIFYING GENITAL MUTILATION IN SUDAN

According to researchers and observers, marriage and sexuality are key reasons for the practice of genital mutilation:

> *Marriage, or future marriage, and sexuality are central in the context of FGM, and the practice is often seen as a symbol of decency, dignity and fertility. The fact that adult women are repeatedly subjected to genitally mutilating operations when they undergo reinfibulation shows converge in the context of FGM, and much of the fundamental motives for the continuation of the practice are found in this interaction. (Almroth 2005:14)*

According to some sources, the custom also marks the first step in the transition from childhood to adulthood, although in social terms the girl remains a child until she enters marriage (SOAT 1999).

2.2.1 Genital mutilation – who decides?

Pressure in relation to genital mutilation generally originates from within the family. Sometimes family members other than the parents perform the genital mutilation. In particular this applies to girls living with their grandparents, and where one of the parents wants the procedure to be performed (Jabrallah, interview May 2008).

While the practice of genital mutilation is conditioned by social pressure, this pressure is applied from within and not from outside the family circle, according to Jabrallah. Nevertheless, such social pressure within the family does not exist independent from the general societal pressure experienced by women (statutory use of hijab, dress style etc.) It is, however, impolite to ask a woman over a certain age whether she has been subjected to genital mutilation.

2.3 WHEN IS GENITAL MUTILATION PERFORMED?

Studies undertaken in Sudan indicate that 86 percent of the female population had been subjected to genital mutilation prior to the age of ten. 74 percent were between the age of five and nine when the procedure was performed (SNCTP 2001). Normally, the procedure is performed throughout the months from April to July, during the school holidays (SOAT 1999). On occasion, women who have not already been subjected to genital mutilation are pressured into having the procedure performed prior to entering marriage (Jabrallah May 2008).

There are very few reports of genital mutilation performed on babies. The Beja tribe in East Sudan is an exception: here, genital mutilation is performed on infants up until they are two to three months old (SOAT 1999).

2.4 REINFIBULATION

Infibulated Sudanese women normally undergo reinfibulation after giving birth (the Sudanese-Arabic term is adal or al-adil, which in this context means to rectify and improve) (Almroth 2005; Berggren 2006). Studies from the early 1980s showed that 50-80 percent of the female respondents had been reinfibulated.

In 2002/2003, in-depth interviews of twelve women and ten men, all from the Khartoum district, were conducted. The respondents had different ethnic and social backgrounds. The interviews provide a certain insight into the reasons and attitudes governing this widespread practice (Berggren et al. 2006).

The significance of purification and tightening of the vaginal orifice after giving birth was central factor for the female respondents. Some of the women also referred to enhanced aesthetics of the sexual organs as an argument for reinfibulation.

Furthermore, the survey showed that the women had only very modest influence on the decision whether to be reinfibulated. They all felt strong pressure from their female counterparts, particularly from female relatives and mothers, and other older women in the local community. The survey does not cover the risks involved in resisting such social pressure. What it does show, however, is that the male respondents also suffered consequences from the practice. A number of them opined that it would have been better if their wifes had not been subjected to genital mutilation.

In a meeting with Landinfo in May 2008, the coordinator for the Sudanese network against genital mutilation, Dr Nahid Jabrallah, explained that reinfibulation is an extremely private affair. It had to be understood in a context where the level of information on sexuality was generally low and in which the topic was still very sensitive.

2.5 WHO PERFORMS GENITAL MUTILATION?

According to Unicef (2000), more than 60 percent of those performing genital mutilation are traditional midwifery assistants. Approximately 35 percent are midwives. Doctors account for less than one percent of those performing the procedure. Having learned their skill from mothers or other female relatives, local community members who perform circumcisions often practice as midwifery assistants (SOAT 1999).

Prior to the operation, a girl's mother or grandmother determines which kind of procedure the girl should be subjected to. Payment is made before, during and after the procedure in order to ensure the best possible service. The payment represents an important source of income for these women, a fact that further complicates the fight against FGM (SOAT 1999).

2.6 ATTITUDES TOWARDS GENITAL MUTILATION

An extensive demographic and health survey conducted among more than 5,000 women in 1989/90 (Unicef 2000) showed a varying degree of acceptance towards continuing the practice.

79 percent of the women in the age group 15-49 were in favour of upholding the custom. No major differences were recorded in the answers from urban or rural populations; 70 percent of the urban respondents were in favour, as were approximately 80 percent of the rural respondents. However, indicators such as level of education gave a far greater variation in attitudes toward FGM. 80 percent of the women who had primary or no schooling were in favour of upholding the practice. Meanwhile, only 40 percent of the women who held upper secondary or higher education shared this opinion.

Distribution with regard to type of procedure was fairly even: 48 percent believed that sunna was preferable (mainly Christian women), while 46 percent were in favour of infibulation.

The survey established that responses varied according to the respondents' regional belonging, religious affiliation and level of education

The lowest support for FGM was recorded among women from Darfur (67 percent) and Khartoum (68 percent), while stronger support could be found among women from central parts of the country (86 percent) and Kordofan (90 percent).

Urban Christian women with upper secondary/higher education were generally more critical to preserving the tradition than Muslim women with lower or no education.

An anonymous survey of 414 university students[6] in Khartoum in 2000 showed that approximately 56 percent of the respondents had been circumcised. Although more than 8 percent of the female students believed that genital mutilation was important in relation to marriage, almost 75 percent of the male students said that they preferred a non-circumcised wife (Herieka & Dhar 2003).

Meeting with Landinfo in May 2008, Dr Nahid Jabrallah made reference to the so-called Salima campaign. The campaign focuses on the female body being whole and healthy (salima is Arabic for "whole, intact"), and that no parts are redundant or in need of removal (meanwhile male circumcision is a religious requirement). When Jabrallah's own daughter was seven years old, she had arranged a party for her daughter's friends and their mothers in order to celebrate her daughter being whole, and not circumcised. She wanted it to be a marking of something positive, just like those who carry out genital mutilation do in order to celebrate the procedure.

[6] The questionnaire was distributed to 500 randomly selected students in July 2000.

2.7 PROTECTION AGAINST GENITAL MUTILATION

2.7.1 Legislation against genital mutilation

Sudan was the first African country to introduce legislation against genital mutilation. This happened in 1946, when infabulation was prohibited through a supplement to the penal code. Less severe procedures were permitted. The law was upheld as Sudan gained its independence in 1957, and provided for a fine and/or imprisonment up to seven years for practitioners of infibulation. In 1974, the maximum sentence was reduced to five years (SOAT 1999).

The current penal code, however, does not cover genital mutilation, although its provisions on "physical injury" might potentially cover genital mutilation (US Department of State 2001). Nahid Jabrallah told Landinfo in May 2008 that the authorities issued a decree in 2003, outlining that health personnel were not permitted to perform genital mutilation. Nor are they allowed to perform reinfibulation. However, lack of statutory prohibition makes it difficult to bring matters in before the courts.[7]

The network against genital mutilation is lobbying for statutory prohibition. At the request of the authorities, the network has drafted a legislative proposal. While the proposal is completed, the political process of getting it through the Council of Ministers and parliament has only just begun.

2.7.2 Enforcement of legislation

According to US authorities, there are reports that some practitioners have been arrested but no further information is available. Similarly, the outcome of a case from 1992 where FGM was evidently dealt with under the legislation on physical injury is not known (US State Department 2001). However, while meeting with Landinfo in May 2008, Nahid Jabrallah gave an example of how courts could be of use. A divorced woman discovered that her ex-husband planned to have their daughter subjected to genital mutilation. Assisted by the network against genital mutilation, she regained custody of her children due to the father's plans. The procedure was prevented.

2.7.3 Social sanctions against uncircumcised women and/or parents?

According to SOAT (1999), girls who have not undergone FGM are subjected to great social pressure. They are ridiculed and called ghalfa (uncircumcised) and nigisha (impure). Uncircumcised girls or women are often considered hypersexual (Berggren et al 2006), an undesirable or unattractive trait in the context of marriage. While the situation and position of women might vary according to regional and ethnic affiliation, none of these factors overrule the significance of the family itself. Dr Nahid Jabrallah claimed in the meeting with Landinfo in May 2008, that the stigma attached to women not having undergone genital mutilation is not as bad as it once was. However, marriage and family are the cornerstones of Sudanese society,

[7] Dr Jabrallah reported that there are also health personnel that are *for* genital mutilation, including an obstetrician that has written a book with some others in which she propagandises for genital mutilation, and claims that the so named sunna circumcision is in line with shari'a.

and in general, girls have no or few options and would find it difficult to survive without the support of the local community (Berggren et al. 2006). Girls and women are normally far less educated than men, and job opportunities for women, especially outside urban centres, are limited. Jabrallah believed that whereas pressure from a future spouse could occur, the actual decision whether to act on this pressure rested with the girl's family. Jabrallah indicated that girls are not forced to undergo genital mutilation in connection with marriage.

2.8 THREATS AGAINST ACTIVISTS

In a meeting with Landinfo in May 2008, Dr Nahid Jabrallah informed that female activists working to combat genital mutilation, sexual violence etc., are subjected to pressure by the authorities. NGOs working with similar issues have problems getting registered with the authorities. There is also a well-organised campaign in favour of genital mutilation, with apparent access to extensive resources. The pro-FGM campaigners accuse the anti-FGM activists of having a hidden agenda, of being foreign agents or for unislamic behaviour etc. Although threats, pressure and smear campaigns were common, Jabrallah was not aware of any cases of violence towards activists.

3. FEMALE GENITAL MUTILATION IN SOMALIA

3.1 INCIDENCE RATE AND TYPES OF MUTILATION

Between 80 and 98 percent of all Somali women have been subjected to infibulation, i.e. partial or complete removal of all external sexual organs, and surgical closure of the vaginal orifice (World Bank & UNFPA 2004).

Some sources (meeting with COSPE 2007) claim to have observed a transition from infibulation to sunna in recent years, however it is difficult to ascertain with any degree of certainty how extensively patterns might have changed. Sunna is common among the Benadir population[8] in the coastal areas. In these population groups, the procedure is performed on newborns (ibid).

3.2 JUSTIFYING GENITAL MUTILATION IN SOMALIA

In Somalia, genital mutilation is not a rite of passage that marks the transition from child to adult. The practice is linked to tradition and notions about purity, virginity and control of unwanted sexuality.

[8] The Benadir population, consisting of a number of different groups, mainly lives in the coastal towns of Mogadishu, Merka and Brava, and is of Arabic, Asian and possibly Portuguese descent. The name Benadir refers to the coastal area at Mogadishu. The collective term Benadir in these minority groups, however, has a more recent origin. The Benadir members that live in Mogadishu are known as rer Hamar (the people from Hamar, i.e. Mogadishu). Benadir members from Merka are referred to as rer Merka, and Benadir members from the town Brava are called Barawas or rer Brava.

3.3 WHEN IS GENITAL MUTILATION PERFORMED?

Girls are subjected to the procedure when they are between five and eight years old.

A survey conducted in the Awdal district in North West Somalia (Somaliland) and the Mandera district in North East Kenya confirmed that genital mutilation is performed on girls between the age of 5 and 8 (World Bank & UNFPA 2004). The findings are supported by other surveys. According to local NGOs (ibid), all girls between the age of 6 and 8 have undergone infibulations prior to starting school in Puntland. According to COSPE (meeting 2007), girls in the Somali diaspora are much older when subjected to the procedure, possibly as late as in their twenties.

3.4 REINFIBULATION

There is very little information available on how widespread reinfibulation is among Somali women. Some sources claim that in general, women are reinfibulated after giving birth (US State Department 2001). Yet a study (Johansen 2002) conducted among Somali women in Norway showed that there was in fact no such firm basis to support the assumption that reinfibulation is common after giving birth or divorce. This view is also supported by other Somali sources (lecture by Barre March 2008).

According to Johansen (2002), however, there are rumours that certain clans practice reinfibulation. It is furthermore claimed that reinfibulation is only carried out after giving birth for the first time, and that it normally entails a partial reinfibulation only.

3.5 WHO PERFORMS GENITAL MUTILATION?

It is mainly traditional circumcisers, the so-called guddaay, who carry out the procedure. However, an increasing number of professional health workers perform genital mutilation (World Bank 2004). According to a World Bank survey (ibid), most members of the Professional Nursing Association in Mogadishu perform a more limited genital mutilation for a fee. They also oppose the activities of traditional circumcisers and the infibulation practice.

More families have started to use health personnel to carry out the procedures, wanting to avoid complications that often arise after infibulations. The World Bank (WB 2004) argue that the "medicalisation" of the procedure started as far back as at the time of Somalia's independence, when a Lebanese doctor started carrying out the procedures at the Martini hospital in Mogadishu.[9]

3.6 ATTITUDES TOWARDS GENITAL MUTILATION

Although the origins of genital mutilation are unclear, the population groups and communities practicing the custom are largely concurrent in their approach to the

---

[9] Terminology relating to FGM in Somalia:
Halalayn: Purification, a term that is also used about circumcision (all forms). The term signifies that those who are not circumcised are both physically and mentally impure and therefore must be cleansed.
Gudniin Fadumo: Fadumas's circumcision. The alleged circumcision of prophet Muhammad's daughter Fatima (Fadumo in Somalian), which refers to infibulation or pharaonic genital mutilation. However, there are no indications that any of the prophet's daughters were subjected to circumcision.
Gudniinka fircooniga ah: Pharaonic circumcision, i.e. infibulation or type III.

issue itself and in their justifications for continuing the practice. Justifications span from religious beliefs to ideas about purity, beauty and aesthetics.

In a study by World Health Organisation (WHO), covering 1,744 women aged between 15 and 49 in North East and North West Somalia, 90 percent of the women responded that they preferred that the custom be preserved (World Bank & UNFPA 2004). Another study carried out in the district of Awdal in North West Somalia (Somaliland) and among Somalians in the Mandera district of Kenya, showed that more than half[10] of the respondents wanted their daughters to be circumcised (ibid).

Furthermore, the study from the Awdal district showed that 36 percent of the respondents believed genital mutilation to have cultural and religious benefits. 42 percent did not share this view. Twelve percent believed that the custom prevented pre-marital sex and 16 percent were of the opinion that the custom promoted beauty.

Both studies highlight the fact that more than half of the rural and nomadic respondents believed that genital mutilation was a requirement in Islam. The percentage was lower among urban respondents.

The figures show that although many women understand that genital mutilation is harmful, they still believe that the custom should be preserved. This illustrates the complexity of the problems related to FGM. There is massive pressure on mothers (and other female family members) in societies where religion, tradition, ideals of purity, fear of stigmatisation and absence of networks beyond the family or clan, plays such a pervasive role. Whereas pressure itself is administered primarily by women, there is no doubt that the overall attitude towards FGM is strongly influenced by the requirements and ideals held by men (and society at large) towards virginity. With marriage and family representing the main pillars of society, even fear of exclusion or the mere prospect of exclusion contributes to pressurising those involved.

Awareness of the problems associated with genital mutilation and of the need to oppose the tradition is higher in urban than in rural populations.

Certain trends indicate a positive shift with regard to genital mutilation in Somalia. According to COSPE (meeting 2007), the custom is mainly a female affair and the young generation of men between 15 and 26 do not regard FGM to be a prerequisite for marriage. Somali sources claim that given that fact that men comply with the decisions women make, it should be possible for mothers to oppose FGM. However, the World Bank (World Bank & UNPFA 2004) and other Somali sources (lecture by Asha Barre 2008) emphasise that men carry major responsibility for the continuation of the practice. For a majority of the population, circumcision is a prerequisite for marriage. Prospective husbands pay a dowry and demand a circumcised wife. Fathers also play a key role – a daughter's chance to get married is poor unless she is circumcised and thus the father risks not getting a dowry.

3.7 PROTECTION AGAINST GENITAL MUTILATION

Families have limited means of preventing or impeding the genital mutilation of their daughters (meetings with UNICEF 2005 and COSPE 2007). If parents are absent or

[10] 73% lived in rural areas, 64% were nomads and 54% lived in urban dweelings/towns.

not looking after their daughters, other female family members might ensure that the procedure is carried out. According to COSPE (meeting 2007), some families choose the less severe procedure of sunna so as to protect their daughters from infibulation and in order to avoid that their daughters become victims of social stigmatisation (meetings with COSPE 2007 and UNICEF 2005).

The ritual following genital mutilation is an event marked by festivities. Hence it is generally known in the local communities if and when a girl has undergone the procedure. Those who have not been circumcised (e.g. girls that have lived in exile) can, according to COSPE, (ibid) hide the fact that they are uncircumcised until they get married.

3.7.1 Legislation against genital mutilation

There is no national legislation that prohibits FGM in present day Somalia, however the administration in Puntland[11] introduced legislation against genital mutilation in 1999. Awareness campaigns against genital mutilation, initiated in the early 1980s, were ended as the regime collapsed in 1991. In the years following the civil war, international and local organisations, including the National Committee Against FGM and Save Somali Women and Children (SSWC), resumed activities in other parts of the country. However, the actual value of these projects – their scope, effectiveness, strategies and lessons learnt – might questionable at times (World Bank & UNPFA 2004).

3.7.2 Social sanctions against uncircumcised women and/or parents?

The local community learns who has been subjected to FGM through the post-operative ceremonial markings. Girls who are not infibulated might experience harassment and teasing, and might encounter difficulties in becoming married (meeting with COSPE 2007).

[11] Puntland (North East Somalia) declared itself an autonomous entity in August 1998.

4. REFERENCES

Written sources

- ALMROTH, L et al. 2001. A community based study on the change of practice of female genital mutilation in a Sudanese village. International Journal of Gynaecology and Obstetrics, 74, 179-185.
- ALMROTH, L. 2005.Genital mutilation of girls in Sudan: Community- and hospital-based studies on female genital cutting and its sequelae. No date. Available from http://diss.kib.ki.se/2005/91-7140-236-5/ [retrieved on 12 March 2008]
- BERGGREN, V. et al. 2006. Being victims or beneficiaries? Perspectives on female genital cutting and reinfibulation in Sudan. African Journal of Reproductive Health. 10, 2.
- HERIEKA, E. & DHAR, J. 2003. Female genital mutilation in the Sudan: survey of the attitude of Khartoum university students towards this practice. Available at http://sti.bmj.com/cgi/content/abstract/79/3/220 [retrieved on 6 March 2008]
- GALLO, P.G. & ABDISAMED, M. 1985. Female circumcision in Somalia: Anthropological traits. Antropoligisher Anzeiger. 43 (4): 311-326.
- IRIN, 2003. SUDAN: Government to ban FGM. IRIN News, 3 September. Available at http://www.irinnews.org/report.aspx?reportid=45912 [retrieved on 6 March 2008]
- JOHANSEN, E.B. 2002. Pain as a counterpoint to culture: Toward an analysis of pain associated with infibulations among Somali immigrants in Norway. Medical Anthropology Quarterly. 16 (3):312-340.
- SNCTP, 2000. Summary on: Female Genital Mutilation (FGM) Psycho-socio-sexual Consequences & Attitude Change in Khartoum North & East Nile Provinces. Khartoum: Sudan National Committee on Traditional Practices. No date. Available at http://www.snctp.org/ [retrieved on 7 March 2008]
- SNCTP, 2002. Summary on: Female circumcision survey for girls in age group (4-10) in Greater Khartoum, Atbara, Elfasher and Elfula. Khartoum: Sudan National Committee On Traditional Practices. November. Available at http://www.snctp.org/ [retrieved on 7 March 2008]
- SNCTP, 2003. Summary on: A research study on: Knowledge attitude practice of adult population aged (15-49) years) towards FGM & HIV/AIDS among the internal displaced persons (IDPs) in Mayo farms (Khartoum state, Sudan). Khartoum: Sudan National Committee On Traditional Practices. Not dated. Available at http://www.snctp.org/ [retrieved on 7 March 2008]
- SOAT, 1999. Female genital mutilation in Sudan. London: Sudan Organisation Against Torture. No date. Available at http://www.soatsudan.org/public/othersources.asp [retrieved on 6 March 2008]
- UNICEF. No date. Sudan fgm/c country profile. New York: United Nations Children's Fund. Available at

http://www.childinfo.org/areas/fgmc/profiles/Sudan/Sudan%20FGC%20profile%20English.pdf [retrieved on 6 March 2008]

- US DEPARTMENT OF STATE, 2001. Sudan: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC). Washington DC: US Department of State. 1 June. Available at http://www.state.gov/g/wi/rls/rep/crfgm/10110.htm [retrieved on 6 March 2008]
- WORLD BANK & UNFPA. 2004. Somalia: Female Genital Mutilation/Cutting in Somalia. New York: World Bank & UN Population Fund. November. Available at http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTGENDER/0,,contentMDK:20275883~pagePK:148956~piPK:216618~theSitePK:336868,00.html [retrieved on 13 March 2008]

Lectures and Interviews

- Barre, A. Lecture in Oslo, 3 March 2008.
- Yaasin, H. Regional Coordinator, Cooperazione Per Lo Sviluppo Deipaesi Mergenti (COSPE). Interview, 27 March 2007.
- Elmi, A. H. Chairlady, Save Somali Women And Children (SSWC). Interview, 22 September 2005.
- Daloum , El Khidir. Programme Director, Save The Children, UK. Interview, 21 September 2005.
- Balslev-Olesen, C. Representative, UNICEF. Interview 21 September 2005.
- Jabrallah, N. Coordinator for the network against genital mutilation in Sudan. Interview, 3 May 2008.
- Daher, T. Head of Mission, Médecins sans Frontières (Belgia), Interview 4 May 2008.