EXECUTIVE SUMMARY

COUNTRY PROFILE:

FGM IN ETHIOPIA

OCTOBER 2013

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FGM...
let's end it.

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This Country Profile provides a detailed, comprehensive analysis of female genital mutilation (*FGM*) in Ethiopia. It summarises the research on FGM and provides information on the political, anthropological and sociological context for it. It also draws conclusions on how to improve anti-FGM programmes and accelerate the eradication of this harmful practice. Its purpose is to enable all those committed to ending FGM to shape their own policies and practices to create positive, enduring change.

Demographic and Health Surveys in relation to Ethiopia were published in 2000, 2005 and 2011 (the latter did not cover FGM). These surveys are referred to as DHS 2000, DHS 2005 and DHS 2011 throughout the report. A country-wide baseline survey was carried out by the Ethiopian Association to Eliminate Harmful Traditional Practices, or EGLDAM, in 1997, with a follow-up in 2007. These surveys have different methodological approaches and, therefore, comparisons between them should be treated with caution.

Ethiopia is a federal republic and officially a democracy. The **Constitution** guarantees extensive human and political rights.[1] In reality, there is very little academic freedom and an intolerance of opposition to the Government.[2] Ethiopia remains one of the poorest countries in the world and regularly faces famines, droughts, and political instability.

Clan and **ethnic affiliations** are important in Ethiopia. The country has a large number of distinct peoples with differing concepts of identity. The Government formally recognises 64 major ethnic groups, although the 1995 census recognised 82.[3] 46 of these carry out FGM. In the two ethnic groups where the prevalence of FGM is highest, close to 100% of women have undergone FGM. The Oromo, Amhara, Somali and Tigray are significant practising groups. The Afar are also noteworthy, given the high prevalence of FGM within the Afar region, where that ethnic group mainly resides.

The Government restricts the activities of civil-society organisations (*CSOs*) and non-governmental organisations (*NGOs*) under the **Charities and Societies Proclamation** (*CSP*). When the CSP came into effect, the UN High Commissioner for Human Rights voiced concern over Ethiopia's rapidly shrinking civil-society space.[4] These restrictions may force the closure of NGOs, which is concerning, given that local sources of funding are very limited. The law has been described as 'one of the most controversial NGO laws in the world.'[5]

Ethiopia was ranked 64 out of 86 in the 2012 OECD Social Institutions and Gender Index.[6] Women face several **equality** challenges, include early marriage and domestic violence. Young motherhood is a main cause of Ethiopia's high rates of maternal mortality.[7] Domestic violence and sexual harassment are illegal, but not effectively enforced.[8] UNICEF asserts that there is a strong link between the fact that women face the majority of harmful traditional practices (*HTPs*) and the highly patriarchal nature of Ethiopian society.[9]

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (*FGM*) is defined by the World Health Organization (*WHO*)[10] as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. Ethiopia has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights. A new **Criminal Code of 2005** specifically made FGM a crime, and some communities have passed by-laws outlawing it. According to the UNFPA, although the law may bring perpetrators to court, in practise, the guilty often receive a pardon.[11] The National Committee has, however, been working to improve the implementation and enforcement of the law.[12]

According to the DHS 2005, **the prevalence of FGM among women aged 15–49 in Ethiopia is 74.3%**.[13]

Prevalence has decreased from 79.9% in 2000, a statistically significant decrease of 5.6 percentage points over five years.[14]

The EGLDAM data shows a decrease from 73% in 1997 to 57% in 2007, a decrease of 16 percentage points over 10 years.[15]

The DHS data shows a general trend towards a lower prevalence in younger women, also suggesting that the practice is declining.[16]

UNICEF calculates that 23.8 million women and girls in Ethiopia have undergone FGM. In terms of absolute numbers, this is one of the highest numbers of girls and women who have undergone FGM in Africa, second only to Egypt.[17]

37.7% of women with at least one living daughter have a daughter who has undergone FGM.[18]

Prevalence appears to be highest (among women aged 15–49) in the Somali, Dire Dawa and Afar regions, and lowest in the Gambela and Tigray regions. However, only small numbers of women were surveyed in most regions, and therefore no definitive conclusions can be reached in relation to the spread of FGM across the country. There does appear to be slightly more women who have been cut among those living in urban areas (68.5%) than among those living in rural areas (75.5%).

FGM is less prevalent among women who are better educated. There is no strong trend in relation to women's levels of wealth and the likelihood that they have undergone FGM.

Of those Ethiopian women aged 15–49 who have undergone FGM, 6.1% have experienced Type III FGM/infibulation, or 'vagina sewn closed', and 93.9% other types. Type III appears to be most prevalent in the Somali and Afar regions.[19]

In Ethiopia, FGM is mainly carried out by **traditional birth attendants** (*TBAs*) or traditional 'doctors' – normally older women who are paid a small token in cash or kind for carrying out the process. They perform FGM under non-sterile conditions using a knife, razor blade or other sharp instrument.[20] Medicalised FGM is becoming a concern in urban areas.

The **age at which FGM is performed** in Ethiopia depends on the girl's ethnic group, the type of FGM she will have and the region in which she lives. More than half of girls who undergo FGM do so before the age of one year.[21] There is a divergence of practice between the north and the south: in the north, FGM tends to be carried out soon after birth, whereas in the south, where FGM is more closely associated with marriage, it is performed later. According to one study, children are being cut at a younger age, as it is believed the wounds heal more quickly and bleed less, and there is less pain for the girl.[22]

EGLDAM found that **reasons for FGM** include respect for tradition, cultural identity, the suppression of women's sexuality, religion and the prevention of rape.

Between 2000 and 2005, **support for FGM** apparently halved. In 2000 there was a recorded 59.7% support rate for FGM, but by 2005 this had dropped dramatically to 31.4%, according to the DHS data.[23] Similar results are seen in the EGLDAM data.[24] Since the law against FGM under the new Criminal Code was introduced in 2005, it should be taken into account that awareness of this new law may have influenced either women's opinions or their willingness to admit supporting the practice. Future surveys may confirm or reverse this trend. Boyden, Pankhurst and Tefera argue that ideas about modernity and interventions to counter HTPs that emanate from the state as well as from INGOs and NGOs have a much greater impact in urban areas than in rural areas.[25]

The media is governed under the 1995 Constitution, as well as the Press Freedom Bill of 1992. In practice, however, the political climate is 'hostile to media independence and self-censorship is very common.'[26] Television is not widely watched and mainly only available in the capital. Ethiopia has the second lowest internet penetration rate in sub-Saharan Africa. Efforts to improve access are hampered by the country's rural makeup. Recently, attempts have been made to improve internet access by laying 4,000 kilometres of fibre-optic cable along highways. Radio is the most commonly used medium. Men generally have greater access to the media than women, as do people who are more educated. Overall, newspapers are much less popular than television and radio.[27]

Religion is central to Ethiopian society. It is one of the oldest Christian states in the world and has historical ties with all three Abrahamic religions. FGM predates the major religions and is not exclusive to one religious group. In Ethiopia, the role of religion in the practice of FGM is complex and often intersects with ethnicity. FGM is practised by both of the main religions – Ethiopian Orthodox Christianity and Islam. Muslim groups are more likely to practise FGM than Christian groups: the EGLDAM surveys record a 65.1% prevalence among Muslim communities and a 45% prevalence among Orthodox Christians. It is important to reiterate here that neither the Quran nor the Bible support the practice, and it has been soundly condemned by major Islamic and Christian leaders.

There have been some significant initiatives by religious groups. The Evangelical Churches Fellowship of Ethiopia announced a five-point declaration on 26 January 2010 in which they condemned FGM as unbiblical, barbaric and 'going against the divine principle of caring for the body, as well being unjust and degrading against women and depriving them of their basic rights'. The Ethiopian Orthodox Church produced a similar statement on 13 October 2011.[28]

Primary **education** in Ethiopia is universal and free. Access to education has improved dramatically over the last two decades. Approximately three million pupils were in primary school in 1994/95, increasing to 15.5 million in 2008/09.[29] Literacy, however, remains very low, at 39%.[30] The 2010

Millennium Development Goals report[31] indicates that Ethiopia is on track to achieve universal primary education.

It is usually the case that a more highly educated woman is less likely to have her daughters undergo FGM. In Ethiopia, the prevalence of FGM decreases as the level of women's education increases: 64% of those aged 15–49 with a secondary or higher level of education have undergone FGM, compared with 70.8% and 77.3% respectively of those with primary-school or no formal education. Among women with at least one living daughter, 18.7% of those who have a secondary or higher level of education have a daughter who has undergone FGM, compared with 24.7% of those who have a primary education and 41.3% who have no formal education.[32]

Ethiopia has a poor **healthcare** status; however, the Government is in the process of designing a social health insurance system. A survey carried out in 2004 shows that the main reason given by Ethiopians living in rural areas for not using the national health service was that it is 'too far'.[33] Boydon, Pankhurst and Tafere highlight that better access to healthcare facilities for those in or near urban areas may influence attitudes towards FGM, as female health extension workers have mandates to address issues of reproductive health.[34] This presents opportunities to raise awareness of the harms of FGM.

There are still many **challenges** anti-FGM initiatives face in Ethiopia:

- entrenched religious and cultural beliefs;
- the scale and geographical reach of FGM;
- the transition from infibulation to *sunna* cutting, leading to harm-reduction but not a change of social norms and eradication;
- FGM being undertaken secretly;
- challenges in law enforcement, as law enforcement officials are sometimes reluctant to enforce the law and impose appropriate sanctions, and there is a lack of capacity in the law enforcement sector;
- a lack of general resources/capacity;
- environmental challenges, with drought often disrupting anti-FGM activities for months;
- ethnic conflict disrupting anti-FGM activities in Oromia;
- fragmentation of interventions;
- propagation of myths unchallenged by poor literacy and limited media and internet access;
- non-equality of women and girls, and therefore an inability to challenge traditional power systems dictating marriageability;
- a lack of resources to address health complications resulting from FGM;
- activist networks not yet harnessing the potential of shared resources and peer support; and
- restrictions imposed on CSOs and NGOs on receiving more than 10% of their funding from foreign sources, in respect of activities that advance human rights or promote gender equality, and caps on 'administrative' spending.

Recommendations to further reduce FGM in Ethiopia

- Adopting culturally relevant programmes;
- providing sustainable funding to NGOs and INGOs;
- reflecting FGM in any post-millennium Development Goals strategies;
- including FGM in education;
- increasing the capacity of the healthcare system to provide care to survivors of FGM;
- ensure the total abandonment of FGM, rather than a transition from Type III to *sunna* cutting;
- continued advocacy, lobbying and training within federal and local governments, justice departments and law enforcement;
- continuing the momentum provided by the introduction of the anti -FGM law;
- making use of media that is appropriate to the region and people groups with which activists are working;
- involving and training faith-based organisations and faith leaders to dispel myths about FGM and religion; and
- continuing to improve networking and collaboration between anti-FGM organisations. 28 Too Many applauds the work that has been done thus far.

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