



FGM/C in Ethiopia:

Country Profile Update
June 2023

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Introduction

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Orchid Project merged with 28 Too Many on 1 April 2022. Combining forces provides an opportunity to draw on the unique strengths and experiences of both organisations, ultimately enhancing the movement to end FGM/C.

Orchid Project is a non-governmental organisation catalysing the global movement to end FGM/C, a human-rights violation that harms the lives of girls, women and their communities. Orchid Project partners with pioneering grassroots organisations around the world and shares knowledge and best practice to accelerate change. Orchid Project also advocates among governments and global leaders to ensure work to end FGM/C is prioritised.

28 Too Many brought an established research-and-evidence function to Orchid Project, helping it provide the high-quality evidence and best practice needed to guide policy- and decision-making as well as donor investments in the anti-FGM/C sector. This evidence and research, coupled with Orchid Project's existing programming, advocacy and movement-building efforts, will strengthen the capacity of organisations and activists globally and support them to bring an end to FGM/C by 2030.

Use of this Country Profile Update

This update is intended to be used in conjunction with and as a supplement to the report **Country Profile: FGM in Ethiopia** published by 28 Too Many (part of Orchid Project) in 2013, which may be downloaded at <https://www.fgmcri.org/country/ethiopia/>.

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Please note the use of a photograph of any girl or woman in this Country Profile Update does not imply that she has, nor has not, undergone FGM/C.

List of Abbreviations

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 2016' refers to Central Statistical Agency/CSA/Ethiopia and ICF (2016) *Ethiopia Demographic and Health Survey 2016*. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF. Available at <https://dhsprogram.com/pubs/pdf/FR328/FR328.pdf>.

'DHS 2011' refers to Central Statistical Agency/Ethiopia and ICF International (2012) *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia: Central Statistical Agency and ICF International. Available at <https://dhsprogram.com/pubs/pdf/FR255/FR255.pdf>.

'DHS 2005' refers to Central Statistical Agency/Ethiopia and ORC Macro (2006) *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia: Central Statistical Agency/Ethiopia and ORC Macro. Available at [https://dhsprogram.com/pubs/pdf/FR179/FR179\[23June2011\].pdf](https://dhsprogram.com/pubs/pdf/FR179/FR179[23June2011].pdf).

'DHS 2000' refers to Central Statistical Authority/Ethiopia and ORC Macro (2001) *Ethiopia Demographic and Health Survey 2000*. Addis Ababa, Ethiopia: Central Statistical Authority/Ethiopia and ORC Macro. Available at <https://dhsprogram.com/pubs/pdf/FR118/FR118.pdf>.

All cited texts in this Country Profile Update were accessed from January to June 2023, unless otherwise noted.

AIDS	Acquired Immunodeficiency Syndrome
DHS	Demographic and Health Surveys
FGM/C	female genital mutilation/cutting
GBV	gender-based violence
HIV	Human Immunodeficiency Virus
IDP	internally displaced person
INGO	international non-governmental organisation
IPV	intimate-partner violence
MICS	Multiple Indicator Cluster Survey
NGO	non-governmental organisation
SDGs	Sustainable Development Goals
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNJP	UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation
WHO	World Health Organization

A Note on Data

Statistics on the prevalence of FGM/C are compiled regularly through large-scale household surveys in developing countries, predominantly the **Demographic and Health Survey (DHS)** and the **Multiple Indicator Cluster Survey (MICS)**. For Ethiopia, the main surveys are the DHS 2000, the DHS 2005, the DHS 2011 and the DHS 2016. Unfortunately, the most recent survey conducted in Ethiopia (the DHS 2019) did not include data on FGM/C.

DHS reports do not use World Health Organization FGM/C typology. The categories of FGM/C used in the DHS surveys for Ethiopia are 'cut, flesh removed', 'nicked, no flesh removed', 'sewn closed' (infibulation/Type 3) and 'don't know/missing'.

UNICEF highlights that self-reported data on FGM/C needs to be treated with caution since women may be unwilling to disclose having undergone FGM/C due to the sensitivity of the subject or its illegal nature in some countries. In addition, they may be unaware that they have been cut or the extent of the cutting, especially if it was carried out at a young age.

Measuring the FGM/C statuses of girls aged under 14, who have most recently undergone FGM/C or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end the practice. Alternatively, responses to questions about FGM/C of girls can indicate the effect of laws criminalising the practice or a shift in societal attitudes toward it, which may make it harder for mothers to report that FGM/C was carried out, as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM/C after the age of 14.

As for any dataset, it is also important to note that some results of these surveys may be based on relatively small numbers of women, particularly when the data is further broken down by, for example, location or age. Therefore, in some cases, the trends observed should be interpreted with caution. It should be made clear that any limitations of the data used in this report do not mean that the data are not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and Orchid Project has, accordingly, taken that approach when researching and writing this Country Profile Update.

Executive Summary

This Country Profile Update provides comprehensive information on the most recent trends and data on female genital mutilation/cutting (FGM/C) in Ethiopia. It includes an analysis of the current political situation, legal frameworks and programmes to make recommendations on how to move toward eradicating the practice. This report serves as an update to **28 Too Many's 2013 Country Profile**. Its purpose is to equip activists, practitioners, development partners and research organisations with the most up-to-date information to inform decision-making on policy and practice in the Ethiopian context.

Ethiopia is the fastest growing economy in Africa,¹ but ranks 175 out of 191 countries ('low development') on the UNDP's **Human Development Index**,² as this growth has not trickled down to the country's most vulnerable.

Prime Minister Abiy Ahmed replaced Prime Minister Desalegn upon his resignation in February 2018 and was officially elected in July 2021.³

Ethiopia has experienced much **political and cultural turmoil** throughout its history, most recently in the northern Tigray region from 2020 to 2022, during which the Ethiopia Human Rights Commission and the Office of the United Nations High Commissioner for Human Rights⁴ found evidence of violations of international humanitarian/refugee laws and war crimes.⁵ Additionally, in January 2023, violence erupted over a new synod, formed in a split from the Ethiopian Orthodox Church, the leaders of which synod pushed to exercise their faith in the Oromo language.⁶

Crises and instability have negative impacts on the rights of women and girls, on their decision-making powers and on the overall development of a country, due to, for example, school closures, war crimes such as rape, disruptions to health services and aid, and general economic and social instability.

Progress was initially made under Prime Minister Abiy Ahmed toward realising the constitutionally envisaged **freedom of the press**. The repressive Broadcasting Service Proclamation was repealed in 2021 and a New Media Law introduced with the aim of reducing unlawful arrests and detentions of journalists.⁷ Sadly, Reporters Without Borders notes, 'Most of the recent press freedom gains have been lost since Ethiopia became embroiled in ethnic conflicts and a civil war.'⁸ It appears that new legislation against misinformation and the Tigray conflict in northern Ethiopia gave government agencies and media authorities permission to begin repressing the media once again.⁹ Reports on the actual numbers of journalists arrested since then vary, but there are numerous specific examples of arrests and violence.¹⁰ Access to the internet has also been restricted.¹¹ Partly due to these restrictions, radio remains the most commonly accessed medium¹² and is therefore still the most effective means (in terms of mass media) of reaching the Ethiopian population with messaging about FGM/C and related issues. If restrictions continue, the Ethiopian people's health and welfare will be significantly disadvantaged.

Statistics on the prevalence of FGM/C in Ethiopia were compiled through **Demographic and Health Surveys (DHS)** in 2000, 2005, 2011 and 2016.

The prevalence of FGM/C in Ethiopia appears to be decreasing. According to DHS reports, it has reduced from 79.9% of women aged 15–49 in 2000 to 74.3% in 2005 and to 65.2% in 2016.¹³

However, one concern is that the population of Ethiopia is growing, resulting in an increase in the number of girls at risk.

Orchid Project's estimate of 33 million girls and women at risk in Ethiopia as of 2016 is the largest absolute number of girls/women in eastern and southern Africa and the third-highest globally, after Indonesia and Egypt.

FGM/C prevalence is significantly higher in the eastern regions of Ethiopia (Somali and Affar) and lowest in the northern region of Tigray. However, taking **population density** into account, more than 60% of the women and girls affected by FGM/C live in the Oromiya (nine million) and Amhara (seven million) regions. The largest reductions in prevalence between 2000 and 2016 occurred in Dire Dawa (95.1% to 75.3%), Amhara (79.7% to 61.7%) and Addis Ababa (79.8% to 54%). The region that changed the least is Somali (99.7% to 98.5%).¹⁴

17.5% of women and 11.1% of men who have heard of FGM/C (aged 15–49) believe that the practice should continue. 79.3% of women and 86.7% of men believe that it should not.¹⁵ However, small-scale studies using indirect **methods of questioning** found that, while both men and women report low levels of support for FGM/C when asked directly, when they are asked indirectly, the amount of support is revealed to be significantly higher.¹⁶

These studies emphasise the need for improved survey techniques when researching matters that may be sensitive, taboo or illegal.

Unfortunately, not practising FGM/C still has **negative consequences for girls and women** in certain Ethiopian communities, especially where FGM/C is linked to marriageability and chastity. Many of these girls and women are motivated to undergo FGM/C to avoid those consequences.¹⁷

Ethnic identity and conformity is a strong driver of FGM/C in Ethiopia.

It affects the prevalence of FGM/C and the belief that it should continue. Ethnicity is strongly associated with religious affiliation and, therefore, **the mistaken belief that FGM/C is required by the major religions**. Nationally, 23.6% of women and 16.8% of men aged 15–49 believe that FGM/C is a requirement of their religion. This belief is most common among Muslim men and women.¹⁸ The strongest **levels of support for FGM/C** are among Affar, Somali and Sidama women and Affar, Somali and Amhara men.¹⁹ In the Affar region, where the majority of the population is Affar and Muslim, there are indications of a **change in the severity of cutting** that has been attributed to messaging from Muslim religious leaders and information about the health risks of FGM/C, showing the importance of engaging religious leaders in programming.²⁰

Interventions to address social and cultural norms that drive FGM/C must be tailored to the specific beliefs and practices of each ethnic group. Programmers and activists must understand the severity of social consequences for abandoning the practice. Programming should be directed at **FGM/C hotspots** in the country, where, in most cases, religious beliefs are strong drivers of the practice. It is critical to engage religious leaders in these areas to educate and shift beliefs.

Most girls in Ethiopia are **cut before the age of five**.²¹ 73% of Ethiopian women aged 15–49 who have undergone FGM/C report having had flesh removed. 2.6% report being cut, but having no flesh removed, and 6.5% report being ‘sewn closed’ (infibulation). 17.9% do not know what **type of FGM/C** they have undergone.²² Women and girls who are infibulated are predominantly from the Somali and Affar ethnic groups (75.6% and 71% of women aged 15–49, respectively). Muslim women are more likely to be infibulated than women of other faiths.²³

In terms of **the law**, FGM/C is illegal in Ethiopia under Articles 565 to 570 of The Criminal Code of the Federal Democratic Republic of Ethiopia (2004).²⁴ Accordingly, the Government and UNICEF developed in 2019 a *National Costed Roadmap to End Child Marriage and FGM 2020–2024*, which aims to eliminate FGM/C and early marriage before 2025 by empowering girls and their families; engaging with communities (including faith leaders); enhancing systems, accountability and services across sectors; creating and strengthening enabling environments; and increasing data-and-evidence generation and use.²⁵ **Medicalised FGM/C** was banned in January 2017 by the Ministry of Health, although it has not been criminalised.²⁶ If the Government is to further create an enabling environment for the eradication of FGM/C, however, enforcement of the law and access to legal services must be improved.²⁷

Ethiopia has made some progress toward the **Sustainable Development Goals** in terms of health and well-being. It ranks 125th out of the 144 countries on the Gender Equality Index and currently has a ‘Very Poor’ rating.²⁸ This means that conditions for women in Ethiopia are more challenging than for women across the wider continent. The prevalence of FGM/C in Ethiopia is well above the average for sub-Saharan African, but when the Horn of Africa is considered, the prevalence in Ethiopia is lower than in most of its neighbouring countries. Unfortunately, the COVID-19 pandemic has had a devastating effect on gender equality, closing schools, putting up to ten million girls at risk of early marriage and increasing their risks of FGM/C.²⁹ The maternal mortality ratio has also increased. On a positive note, the infant mortality rate has dropped, and, three years before the Millennium Development Goals’ deadline in 2015, Ethiopia reached its target for under-five mortality.

There are numerous **international and local non-governmental organisations** working to eradicate FGM/C, using a variety of strategies including national and regional advocacy, engaging with the ethnic drivers of the practice, addressing patriarchal gender norms that perpetuate FGM/C, promoting education about FGM/C through digital media and traditional outlets, and engaging with religious leaders. A comprehensive overview of these approaches, with examples from active organisations, is included in this report.

This report calls for the following actions:

- **increase** financial resources for the response to FGM/C in Ethiopia, prioritising a multi-sectoral and multi-faceted response to accelerate progress;
- **target** geographic hotspots;
- **gather and make available** sub-regional data;
- **engage with** the unique drivers and contextual factors associated with the practice in each community;
- **improve** research methods, using indirect approaches to explore attitudes and beliefs about FGM/C;
- **reduce** the social-exclusion risk for uncut women and girls by engaging men and boys, religious leaders and influential community members;
- **integrate** FGM/C awareness-raising, community dialogues, and skills training in relation to girls' rights and agency; and
- **strengthen and increase** economic opportunities for women and girls.



**Part 1:
Update on Situation
and Trends**

Political Conditions

Ethiopia is the fastest growing economy in Africa, currently growing at a rate of 5.6% per year.³⁰ However, Ethiopia is categorised as having 'low development' by the United Nations Development Programme (UNDP) and ranks 175th out of 191 countries on its Human Development Index.³¹

Prime Minister Abiy Ahmed replaced Prime Minister Desalegn when he resigned in February 2018. Elections were scheduled for 2020, but delayed due to the COVID-19 pandemic. In July 2021, Prime Minister Abiy Ahmed's party won 410 out of 436 parliamentary seats, providing him with a significant majority and a five-year term in office.³²

Violence and Instability

Ethiopia has experienced **radical political changes** in recent history. Ethiopia is situated in the Horn of Africa, which has been politically unstable for many years. The late Emperor Haile Selassie was ousted from power in 1974 by the Derg, a pro-Soviet socialist regime, which led to 17 years of civil war until the Derg were overthrown in 1991.³³ The country has had conflict with Somalia and Eritrea, which was annexed from Ethiopia in 1993.

More recent conflict erupted in the Tigray region in November 2020. A ceasefire was announced in March 2022 between the **Tigray People's Liberation Front** and the Government to allow for humanitarian access.³⁴ As of 2 November 2022, the ceasefire was formalised in a 'permanent cessation of hostilities' facilitated by the African Union.³⁵

A joint **investigation into the Tigrayn conflict** was conducted by the Ethiopia Human Rights Commission and the Office of the United Nations High Commissioner for Human Rights between 16 May and 15 August 2021.³⁶ Looking into alleged human-rights violations and abuses, and violations of international humanitarian law and refugee law, investigators found various violations and 'reasonable grounds to believe that, in several instances, these violations amount to war crimes and crimes against humanity'.³⁷ The final report states that, 'We also have reasonable grounds to believe that the Federal Government is using starvation as a method of warfare.' It calls on the Government to 'immediately restore basic services and ensure full and unfettered humanitarian access'.³⁸

Aid has been slow to reach Tigray because many areas are inaccessible by road, and there are strict controls on certain access routes and approval processes required for humanitarian flights. Despite these challenges, aid started to reach people in Tigray in December 2022. The UN reported that 20 organisations delivered to Tigray over 100,000 tonnes of food and ten tonnes of non-food items, including medical supplies.³⁹

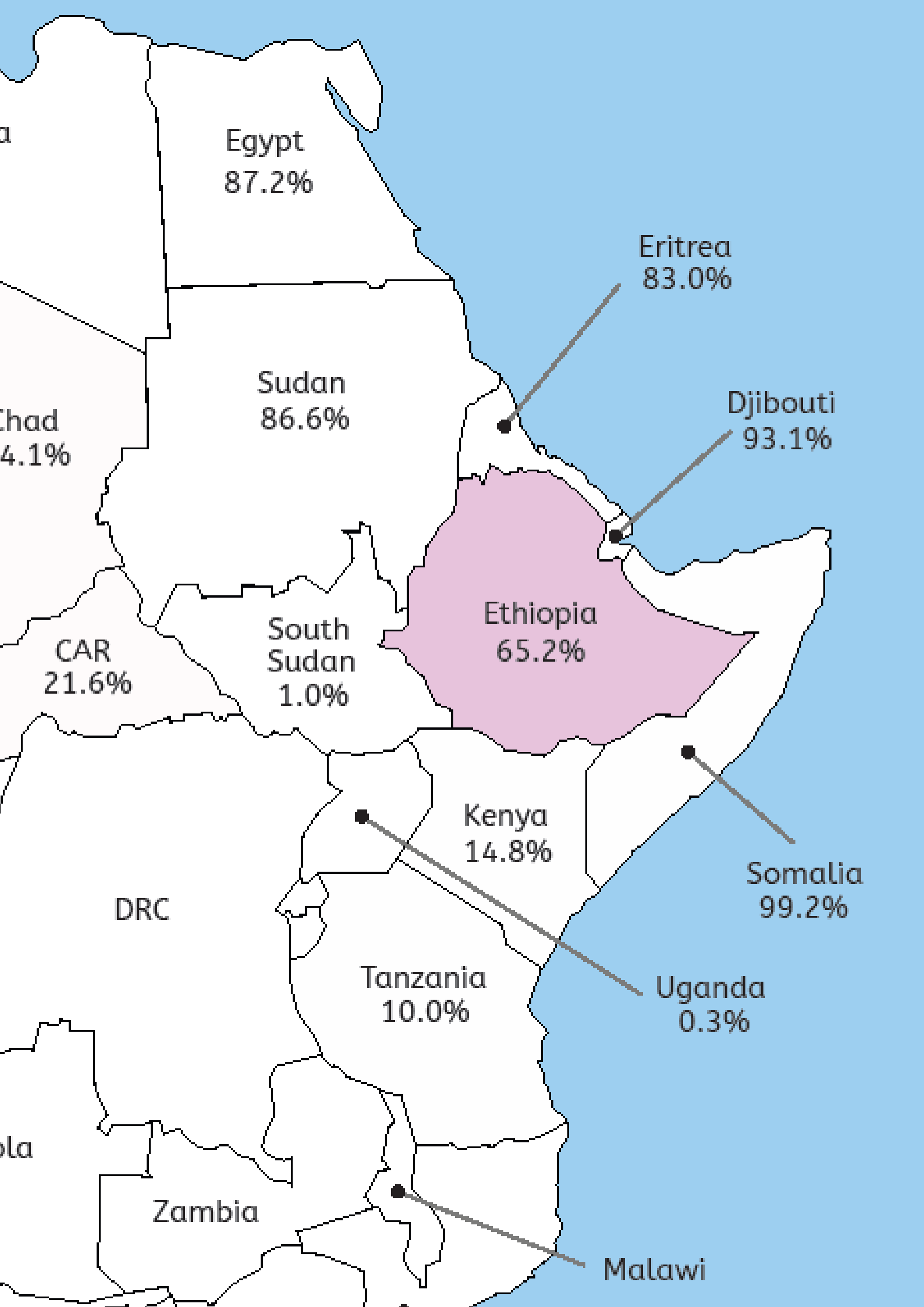
In January 2023, leaders of the **Ethiopian Orthodox Church** formed a new synod and expressed a desire to practise their faith in languages other than Amharic. The new synod was formed in the Oromiya region and the push was specifically to have more opportunities to exercise their faith in the Oromo language.⁴⁰ The split led to unrest in Addis Ababa and in the Oromiya region, which led to the deaths of at least ten people. Social media was blocked and planned rallies postponed indefinitely after the Government became involved. Prime Minister Abiy Ahmed is a Protestant Christian but also an ethnic Oromo and was accused of siding with the new synod. The Church came to an agreement to resolve the dispute that allows the use of the Oromo language in services.

The Impact on FGM/C

Crises and instability have negative impacts on the rights of women and girls and on the overall development of a country. In the northern regions of Ethiopia, the two-year conflict in Tigray has resulted in school closures, disruption to health services and impeded access for humanitarian aid. In addition, human-rights bodies have found evidence of war crimes, including rape and the use of starvation. However, Tigray is one of the regions of Ethiopia that has the lowest rates of FGM/C.

Ethiopia's national economic growth has not trickled down to the most vulnerable, and income insecurity continues to be a challenge for many. Although FGM/C is not driven by poverty, it can be difficult for girls to challenge the practice in situations of poverty, as doing so risks a girl's own economic security by threatening her belonging within her family, community or wider society. Improving conditions for families, and girls in particular, can have an influence on individual and collective agency.

Figure 1 (following page): Prevalence of FGM/C in Ethiopia and surrounding countries



Freedom of Press and Media Access

Article 29 of the **Constitution of the Federal Democratic Republic of Ethiopia** guarantees '[f]reedom of the press and other mass media and freedom of artistic creativity', specifically '(a) Prohibition of any form of censorship' and '(b) Access to information of public interest.'⁴¹

Progress was initially made toward the materialisation of these freedoms under Prime Minister Abiy Ahmed. In 2007, a repressive Broadcasting Service Proclamation had been introduced, but it was repealed in 2021. The **New Media Law** was approved in February 2021, decriminalising defamation, requiring that charges be brought immediately before the court (without detention of the accused), and significantly reducing statutes of limitation. The aim of the working group that consulted on the drafting was to reduce the unlawful arrests and detentions of journalists, who were frequently held for long periods without charge and subject to human-rights violations.⁴²

Sadly, Reporters Without Borders reports, 'Most of the recent press freedom gains have been lost since Ethiopia became embroiled in ethnic conflicts and a civil war. Although a peace accord was signed in November 2022, journalists still fear reprisals.'⁴³

The Committee to Protect Journalists adds, 'Unfortunately, Ethiopia has rejoined the list of worst jailers of journalists in sub-Saharan Africa.'⁴⁴

*In 2023, Ethiopia was ranked 130th out of 180 countries in the **World Press Freedom Index**, which is much worse than its rank of 114th in 2022.*⁴⁵

It appears that **new legislation against hate speech and misinformation** introduced near the beginning of 2020 and the **Tigray conflict** in northern Ethiopia gave government agencies and the supposedly independent media-regulation authority permission to begin repressing the media once again. Both sides of the conflict began to employ propaganda, particularly through social media, restrict media access and even resort to physical violence in efforts to control the narrative surrounding the war.⁴⁶ Reports on the actual numbers of journalists arrested since then vary, but there are numerous specific examples available of reporters, and even a cameraman, being arrested and held without charge for long periods of time.⁴⁷

Various press-freedom and human-rights agencies recently signed an open letter⁴⁸ to the Government, expressing alarm about the continuing 'weaponization of **internet shutdowns**' across the country, but particularly in Tigray and Amhara. The letter states that,

Open, secure, reliable, and accessible internet is vital to exercising and protecting human rights, as well as ensuring safety during crises and conflicts.

It urges the prime minister to take the necessary action to ensure that Ethiopians have ‘unfettered access to the internet and digital communications platforms at all times.’

Unsurprisingly, given all these restrictions, **radio** remains the **most commonly accessed medium** in Ethiopia, although television is not far behind among women.⁴⁹

73.6% of Ethiopian women and 61.8% of Ethiopian men aged 15–49 do not have access on a weekly basis to any of the three main types of media listed in the DHS 2016 (**television, radio and newspaper**).⁵⁰ 85.5% of women (and 70.9% of men) living in rural areas and 95.5% of women (83.9% of men) in the lowest wealth quintile are not exposed to any of these media on a weekly basis.⁵¹ Women and men in the Somali region are the least likely to have access to different forms of media.⁵²

According to the DHS, only 5% of women and 13.1% of men (aged 15–49) had ever used the **internet** as of 2016.⁵³ As of 2023, 16.7% of the population has access, but only 5.1% use social media.

The Impact on FGM/C

A lack of access to the media and important messaging has a negative impact on efforts to change attitudes toward FGM/C. Increasing media infrastructure and distribution allows women and girls to be exposed to opposing ideas about FGM/C (and other harmful traditional practices) and to have better understandings of the risks and consequences associated with it, as well as their human rights.

It would seem that radio is still the most effective means (in terms of mass media) of reaching the Ethiopian population with messaging about FGM/C and related issues.

However, if journalists and broadcasters continue to be arrested, detained and persecuted, self-censorship will increase and media outlets will continue to shut down, restricting the flow of vital information across the country. The Government’s restrictions of internet access interfere with humanitarian aid and research and, if they continue, will significantly disadvantage the Ethiopian’s people’s health and welfare.

Laws Related to FGM/C

FGM/C is illegal in Ethiopia. Articles 565 to 570 of The Criminal Code of the Federal Democratic Republic of Ethiopia (2004) contain provisions against the practice.

Those provisions include:⁵⁴

- Article 565 – Female Circumcision;
- Article 566 – Infibulation of the Female Genitalia;
- Article 567 – Bodily Injuries Caused Through Other Harmful Traditional Practices;
- Article 568 – Transmission of Disease through Harmful Traditional Practices;
- Article 569 – Participation in Harmful Traditional Practices; and
- Article 570 – Incitement Against the Enforcement of Provisions Prohibiting Harmful Traditional Practices.

In support of this law, the Government of Ethiopia, in partnership with UNICEF, developed in August 2019 a ***National Costed Roadmap to End Child Marriage and FGM 2020–2024***. With this roadmap, Ethiopia has committed to eliminating FGM/C and early marriage by 2025.⁵⁵

The roadmap uses five pillar strategies to reach its goal, as follows:

1. empowering adolescent girls and their families;
2. community engagement (including faith and traditional leaders);
3. enhancing systems, accountability and services across sectors;
4. creating and strengthening an enabling environment; and
5. increasing data and evidence generation and use.

The *National Roadmap* builds on the *National Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia*, which was launched in 2013 by the Ministry of Women, Children and Youth Affairs (MOWCYA).⁵⁶ The strategic pillars of this former action plan were:

1. *prevention*, through improving community awareness;
2. *protection*, by strengthening and improving the legal and policy framework and ensuring effective law enforcement; and
3. *provision*, which included rehabilitative services and support for women and girls.

As part of the Government's efforts to eradicate FGM/C by 2025, **medicalised FGM/C** was banned in January 2017 by the Ministry of Health.⁵⁷ There is, however, no national legislation that explicitly criminalises health professionals performing the practice.

The Impact on FGM/C

The Government of Ethiopia has embedded legislation against FGM/C and committed to eradicating the practice by 2025, using the five pillars of the *National Roadmap*. However, according to the UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation (*UNJP*), enforcement of the law – in terms of arrests, convictions and sanctions – has been rare.⁵⁸ In addition, legal services are not widely available and thus not utilised.⁵⁹ If the legislation and policy frameworks are to create an enabling environment for the reduction of FGM/C, enforcement of the law and access to legal services must be improved.

National Statistics

Population as of December 2022:	122,145,944 ⁶⁰
Median age:	19.8 years ⁶¹
Growth rate:	2.42% (2023 est.) ⁶²
Population as of 2002:	69,158,904 ⁶³
Human Development Index rank:	173 out of 186 in 2013 ⁶⁴
	175 out of 191 in 2021 ⁶⁵
SDG Gender Index ranking:	125 out of 144 countries, with a score of 49.8 (2022) ⁶⁶
Infant mortality:	58.3 per 1,000 births (2013)
	39.1 per 1,000 births (2020) ⁶⁷
Maternal mortality:	350 per 100,000 (2010)
	401 per 100,000 (2020) ⁶⁸
Literacy (ages 15 and over):	39% (2011)
	51.8% (2020) ⁶⁹

The Impact on FGM/C

While progress has been made on some national indicators, such as the reduction in infant mortality and the improvement in literacy, in other areas, Ethiopia is stagnant or moving in the opposite direction; for example, the maternal mortality ratio increased between 2010 and 2020.

The main concern in terms of FGM/C is the increasing population. To gauge the success of interventions and progress toward national and global goals, the actual number of girls affected must be considered alongside the reduction in prevalence.

FGM/C: National and Regional Trends

The prevalence of FGM/C in Ethiopia appears to be decreasing. According to DHS reports, it has reduced from 79.9% of women aged 15–49 in 2000 to 74.3% in 2005 and to 65.2% in 2016 (Figure 2).⁷⁰

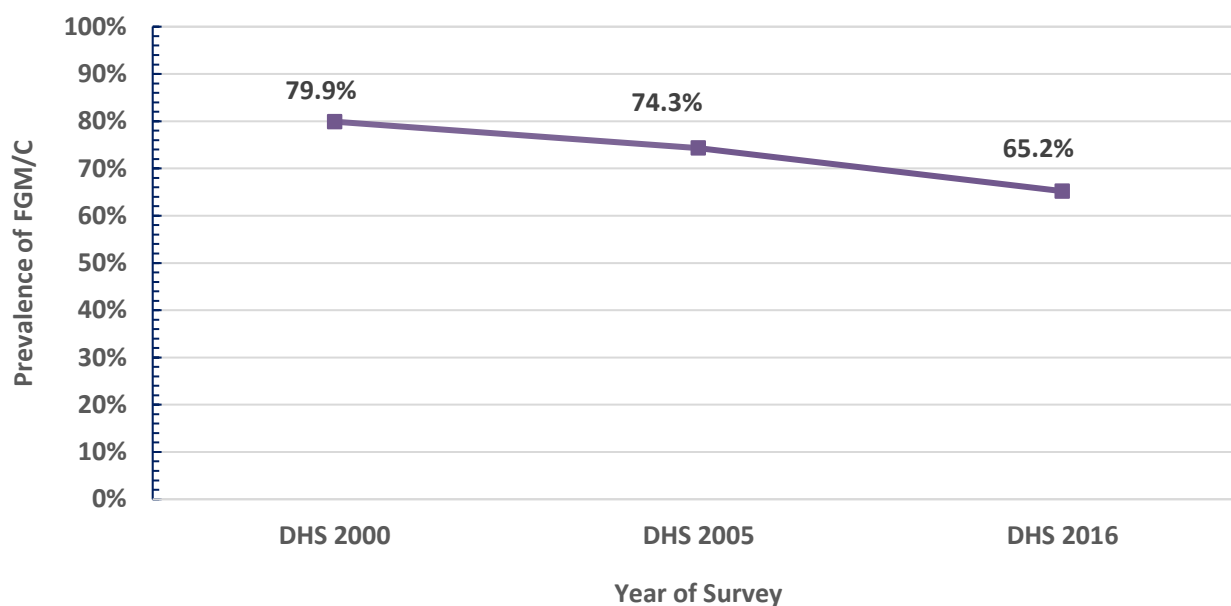


Figure 2: Prevalence over time of FGM/C among Ethiopian women aged 15–49⁷¹

Although the prevalence is decreasing, the population of Ethiopia is growing, resulting in an increase in the number of girls at risk.

The population grew from 65 million in 2000 to 102 million in 2016,⁷² which suggests that the number of women affected by FGM/C in Ethiopia increased from 26 million in 2000 to 33 million in 2016.⁷³

The drop in FGM/C prevalence is therefore being overcome by population growth, resulting in an increase in the number of girls and women at risk of FGM/C. The 2016 estimate of 33 million is the largest absolute number of girls and women in eastern and southern Africa and the third-highest globally, after Indonesia and Egypt.

FGM/C prevalence is not uniform across the country. It is significantly higher in the eastern regions of Ethiopia (Somali and Affar) and lowest in the northern region of Tigray. However, taking population density into account, more than 60% of the women and girls affected by FGM/C live in the Oromiya and Amhara regions.

Figure 3 below shows estimated numbers of women and girls affected by FGM/C in each region. Although prevalence is highest in Somali and Affar, seven million women and girls are affected in the Amhara region and nine million in Oromiya, compared to 790,000 in Affar and two million in Somali.⁷⁴

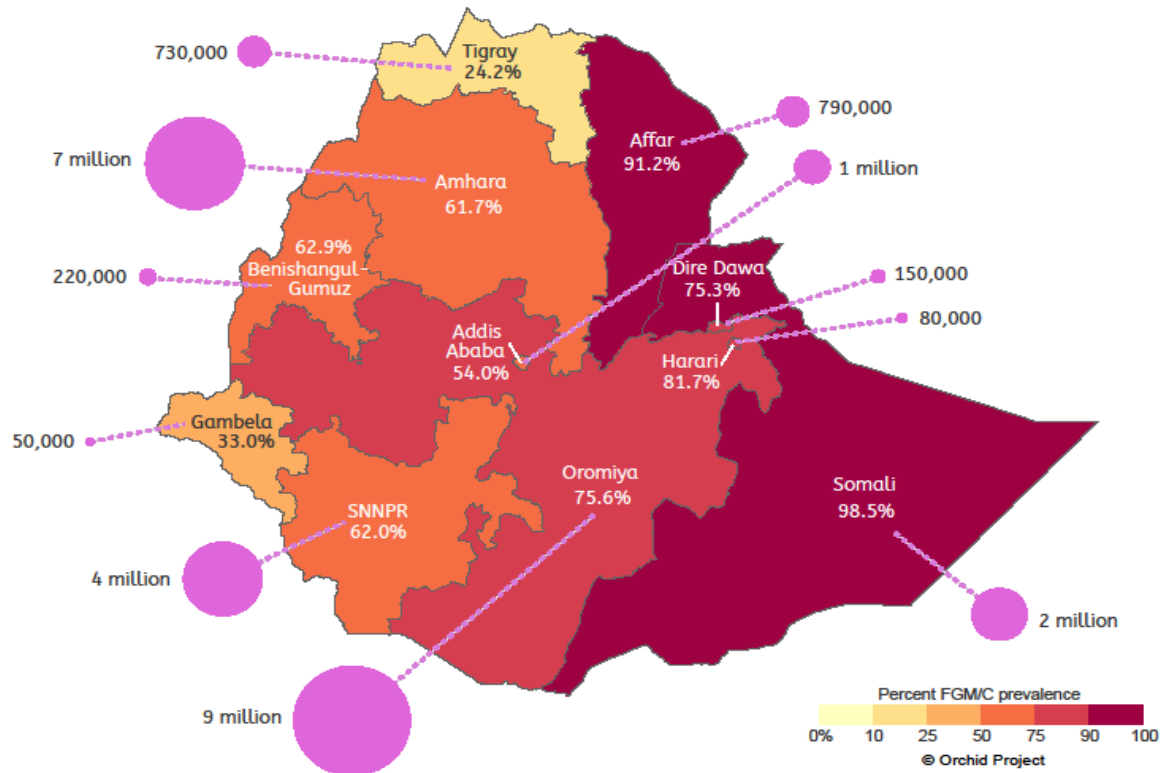


Figure 3: Prevalence of FGM/C in women and estimated number of girls and women affected by FGM/C in each region of Ethiopia⁷⁵

There were decreases in prevalence in all regions of Ethiopia between 2000 and 2016, some more substantial than others.

The largest reductions in prevalence occurred in Dire Dawa (95.1% to 75.3%), Amhara (79.7% to 61.7%) and Addis Ababa (79.8% to 54%). The region that changed the least is Somali (99.7% to 98.5%).⁷⁶

Between 2000 and 2016, Tigray, SNNPR, Oromiya, Dire Dawa, Harari, Addis Ababa, Amhara and Benishangul-Gumuz have all had decreases of more than 10% in the prevalence of women aged 15–49 who have undergone FGM/C. Prevalence in Affar dropped by about 7%, remaining high at 91.2%.⁷⁷

The regions of Ethiopia can be split, as follows, into three segments based on FGM/C prevalence.

- **High-prevalence regions:** Those regions with a prevalence greater than 85% at the beginning of the period 2000 to 2016 include Affar (98.6%), Oromiya (89.9%), Somali (99.7%), Harari (94.3%) and Dire Dawa (95.1%).⁷⁸ Of these high-prevalence regions, all have had a drop in prevalence, with the exception of the Somali region, where almost no change was recorded between 2000 and 2016.⁷⁹ Changes in prevalence in these high-prevalence regions are shown in Figure 4 below.

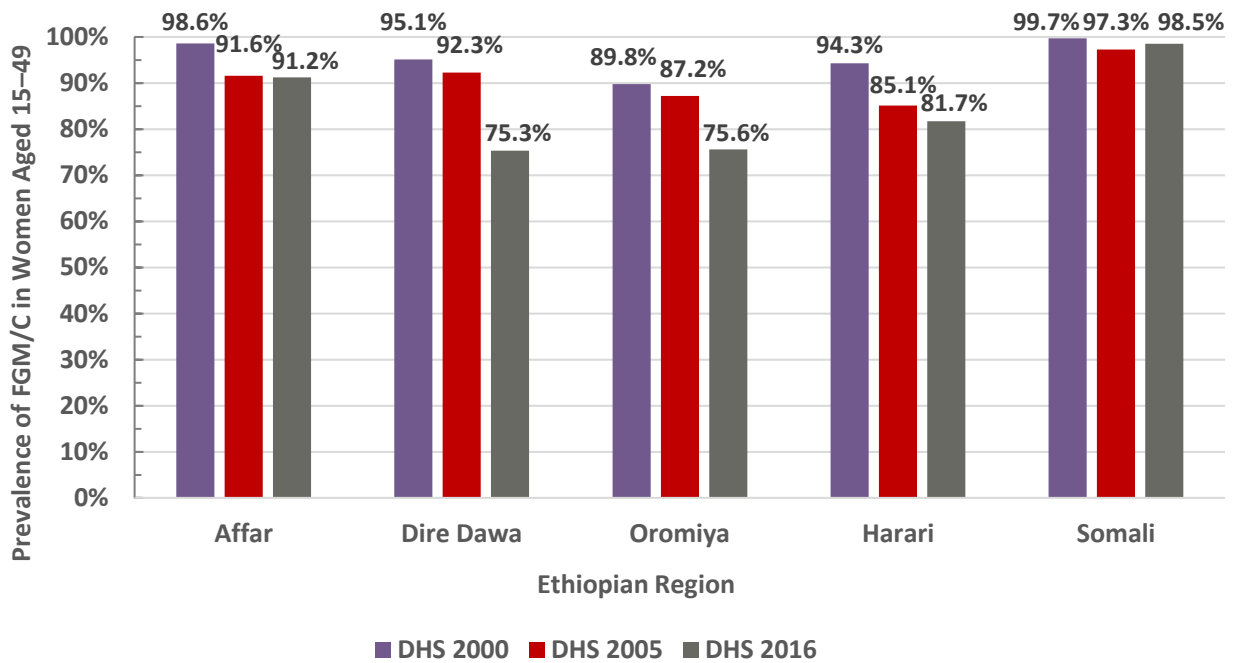


Figure 4: Change in prevalence of FGM/C over time (2000, 2005 and 2016) among Ethiopian women aged 15–49 in high-prevalence regions⁸⁰

- Mid-prevalence regions:** Those regions with a prevalence of between 50% and 85% at the beginning of the period 2000 to 2016 include Amhara (79.7%), Benishangul-Gumuz (73.7%), SNNPR (73.5%) and Addis Ababa (79.8%).⁸¹ Of these mid-prevalence regions, Addis Ababa has made the most progress.⁸² Changes in prevalence in these mid-prevalence regions are shown in Figure 5 below.

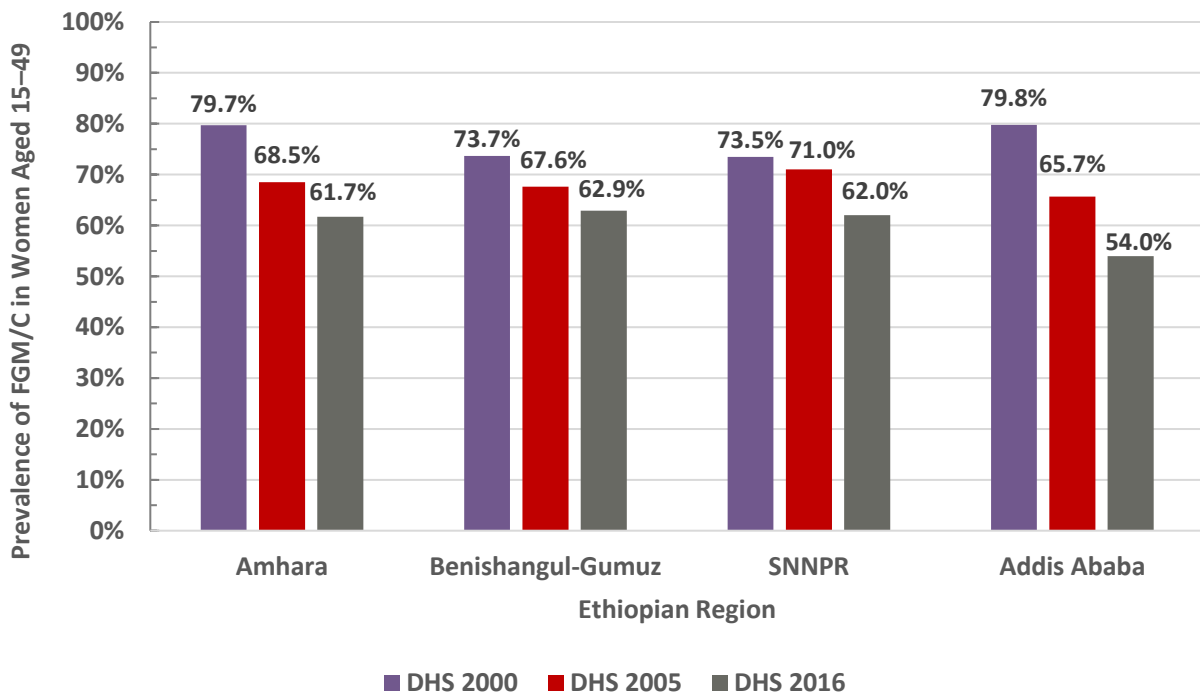


Figure 5: Change in prevalence of FGM/C over time (2000, 2005 and 2016) among Ethiopian women aged 15–49 in mid-prevalence regions⁸³

- **Lower-prevalence regions:** Regions with a prevalence below 50% at the beginning of the period 2000 to 2016 include Tigray (35.7%) and Gambela (42.9%).⁸⁴ Both regions have made progress in reducing prevalence.⁸⁵ Changes in prevalence in these lower-prevalence regions are shown in Figure 6 below.

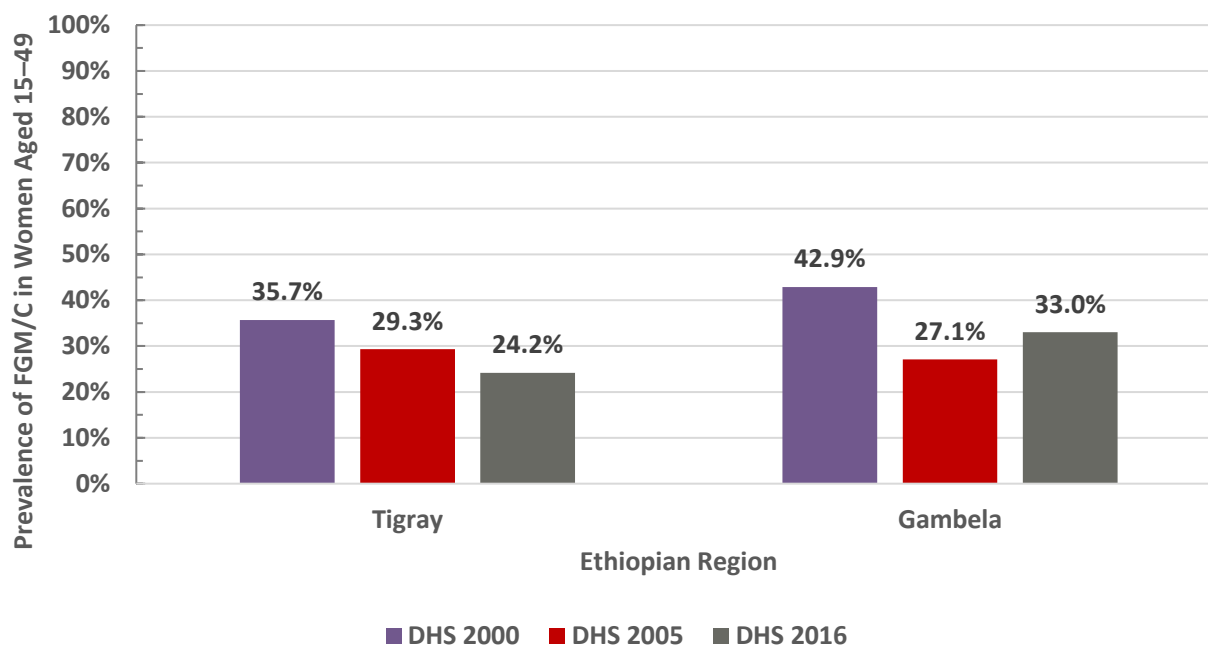


Figure 6: Change in prevalence of FGM/C over time (2000, 2005 and 2016) among Ethiopian women aged 15–49 in lower-prevalence regions⁸⁶

The prevalence of FGM/C in Gambela (among women aged 15–49) was 42.9% in 2000. This dropped to 27.1% in 2005, but then increased to 33% in 2016. However, the sample size in the DHS 2016 was extremely small ($n=22$), so it is not possible to draw conclusions from these variations. According to the UNHCR, 42.9% of the population in Gambela is made up of refugees and asylum seekers.⁸⁷ The vast majority of the refugees in Gambela are from South Sudan (92%).⁸⁸ The Nuer ethnic group, which practises FGM/C, are resident on both sides of the Ethiopia/South Sudan border in the Gambela region; thus, the fluctuation in prevalence may also be the result of incoming and outgoing refugees.

Girls Under the Age of 15

Of Ethiopian girls aged 0–14, those whose mothers are less educated are more likely to have undergone FGM/C. Girls in the Affar region or whose mothers are Affar are considerably more likely to have been cut (about 80%) than girls in other regions and of other ethnicities (less than 30%). Significantly, girls whose mothers have undergone FGM/C are far more likely to be cut (20.2%) than those whose mothers have not (4.1%).

Unusually, Orthodox girls are more likely to be cut (22.9%) than Muslim (12.8%) or protestant (10.8%) girls.⁸⁹

It is worth remembering that there may be significant under-reporting of girls' cutting by their mothers, as they may fear legal repercussions.

Age of Cutting

In Ethiopia, 48.6% of women aged 15–49 at the time of the DHS 2016 who had undergone FGM/C were cut before the age of five, a further 21.7% were cut between the ages of five and nine, and 18% between the ages of ten and 14. 5.9% were cut after the age of 15 (Figure 7).⁹⁰

In comparison, 10.6% of all girls aged 0–14 at the time of the DHS 2016 were cut before the age of five (three-quarters of those before the age of one), 3.7% were cut between the ages of five and nine, and 1% between the ages of ten and 14. 84.3% had not (or not yet) been cut (Figure 8).⁹¹

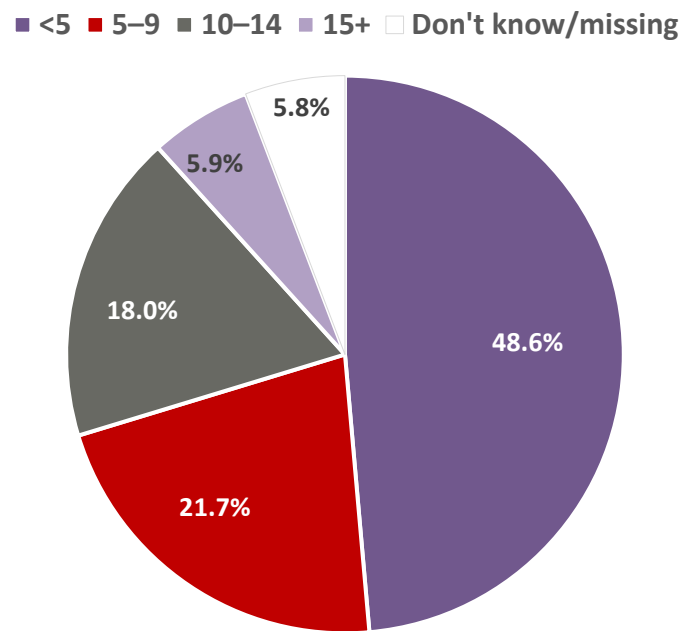


Figure 7: Percentage distribution of age of cutting of Ethiopian women aged 15–49 who have undergone FGM/C⁹²

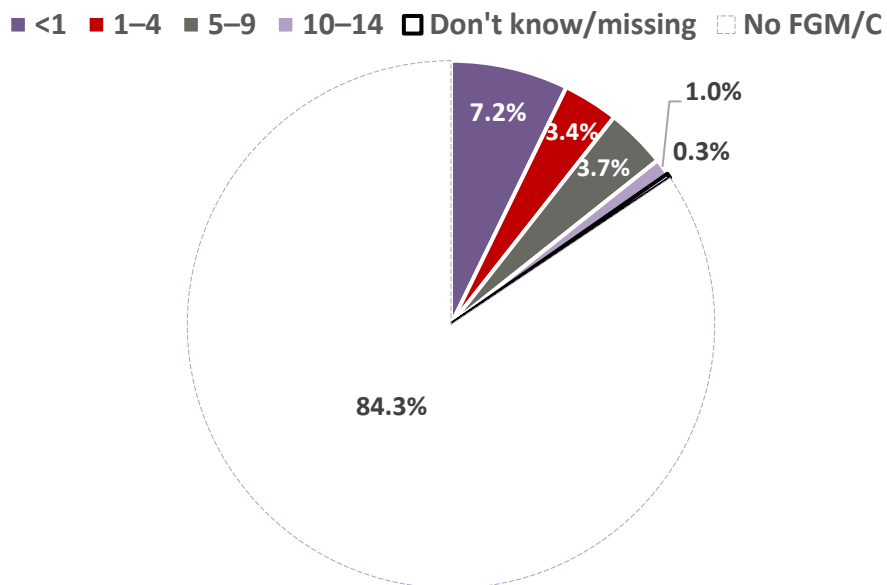


Figure 8: Age of cutting of Ethiopian girls aged 0–14⁹³

Both sets of statistics reveal that most cutting is performed before the age of five in Ethiopia, but about a fifth occurs between the ages of five and nine.

The age of cutting, however, varies according to the ethnic group a woman or girl belongs to, which region she lives in, and which religion she belongs to.

Studying the age of cutting (of women aged 15–49) according to each Ethiopian region reveals the age of risk for girls in each region.

Girls in Tigray, Affar and Amhara are most at risk shortly after birth. In Benishangul-Gumuz, girls are most at risk up to the age of one year. This means that programming in these areas should be targeted at pregnant women and young people who have not yet been pregnant.⁹⁴

Girls in Oromiya are at risk from birth until age 11, and in Dire Dawa girls are most at risk from birth to the age of ten.⁹⁵

In Gambela, girls are most at risk before the age of five and in Addis Ababa, until the age of four.⁹⁶

In Somali, girls are most at risk between the ages of eight and ten, and in Harari between the ages of seven and ten.⁹⁷

In summary, cutting before the age of five appears to be practised predominantly by the Tigray, the Affar and the Amhara and among people of Orthodox faith. Unusually, almost a quarter of Sidama women who have undergone FGM/C (23.5%) were cut after the age of 15, as were 29.2% of women who practise traditional religions.⁹⁸

These risk ranges give activists insight to help tailor programming in the different regions of Ethiopia.

Practitioners of FGM/C

In Ethiopia, girls aged 0–14 are predominantly cut by traditional circumcisers (95.3% of girls who have undergone FGM/C), but occasionally by traditional birth attendants (2.2%) or medical professionals (1.9%).⁹⁹

Medicalised FGM/C was banned by the Government of Ethiopia in 2017, making medical practitioners who conduct FGM/C subject to legal action.¹⁰⁰

However, in the SNNPR, 10% of girls and women who have undergone FGM/C were cut by health professionals, which is a vast difference from the country-wide rate.¹⁰¹

Additionally, a recent baseline study of three regions of Ethiopia, conducted by the Gender and Adolescence: Global Evidence (GAGE) programme, also found some evidence of medicalisation in the Amhara region.¹⁰²

Types of Cutting

73% of Ethiopian **women** aged 15–49 who have undergone FGM/C report having had flesh removed. 2.6% report being cut, but having no flesh removed, and 6.5% report being ‘sewn closed’ (infibulation, or Type 3 of WHO’s classifications). 17.9% do not know what type of FGM/C they have undergone (see Figure 9).¹⁰³

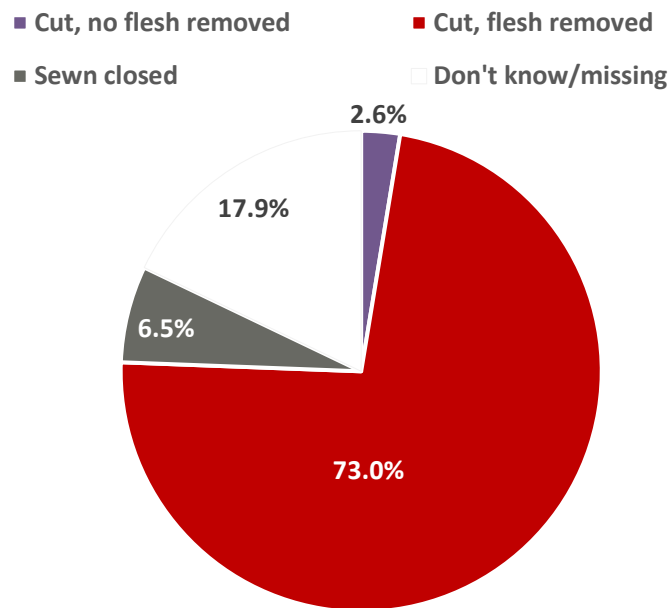


Figure 9: Types of cutting of Ethiopian women aged 15–49¹⁰⁴

According to their mothers, 9.3% of **girls** aged 0–14 who have undergone FGM/C have been ‘sewn closed’. 22.2% of Muslim girls who are cut are infibulated, compared to less than 5% of those whose mothers practise other religions. 24.2% of this cohort whose mothers are in the lowest quintile are infibulated. Additionally, going against the norm in African countries, 24.2% of this cohort who live in urban areas are infibulated, in comparison to 8.6% of those who live in rural areas.¹⁰⁵ As there is little difference in the prevalence of infibulation/Type 3 between Ethiopian women aged 15–49 who live in urban areas and those who live in rural areas, further research is needed into whether this difference is a statistical anomaly due to the low number of urban-dwelling girls surveyed ($n = 50$) or whether it is a genuine and developing problem.

Women and girls who are infibulated are predominantly from the Somali and Affar ethnic groups (75.6% and 71% of women aged 15–49, respectively). Muslim women are more likely to be infibulated than women of other faiths.¹⁰⁶

Factors Affecting FGM/C Prevalence

Education

Education seems to be linked with FGM/C prevalence in Ethiopia.

Women (aged 15–49) who have secondary or higher levels of education are less likely to be cut (49.9% of those with a secondary level of education and 50.6% of women with a tertiary level) than women who have no formal education (72.9%) (see Figure 10).¹⁰⁷

In 2000, 80.4% of women who had no formal education had been cut. That reduced to 72.9% by 2016. Among women who have a tertiary level of education, 85.5% had been cut in 2000 and 50.6% in 2016.¹⁰⁸

A girl aged 0–14 is far less likely to be cut if her mother has a higher level of education. A girl whose mother has no formal education is the most at risk.¹⁰⁹

These figures may point to the influence of awareness campaigns within schools and the potential influence of these, but may also point to social desirability bias among those with higher levels of education, particularly those who have an understanding of the law against FGM/C and may not want to admit to being cut.

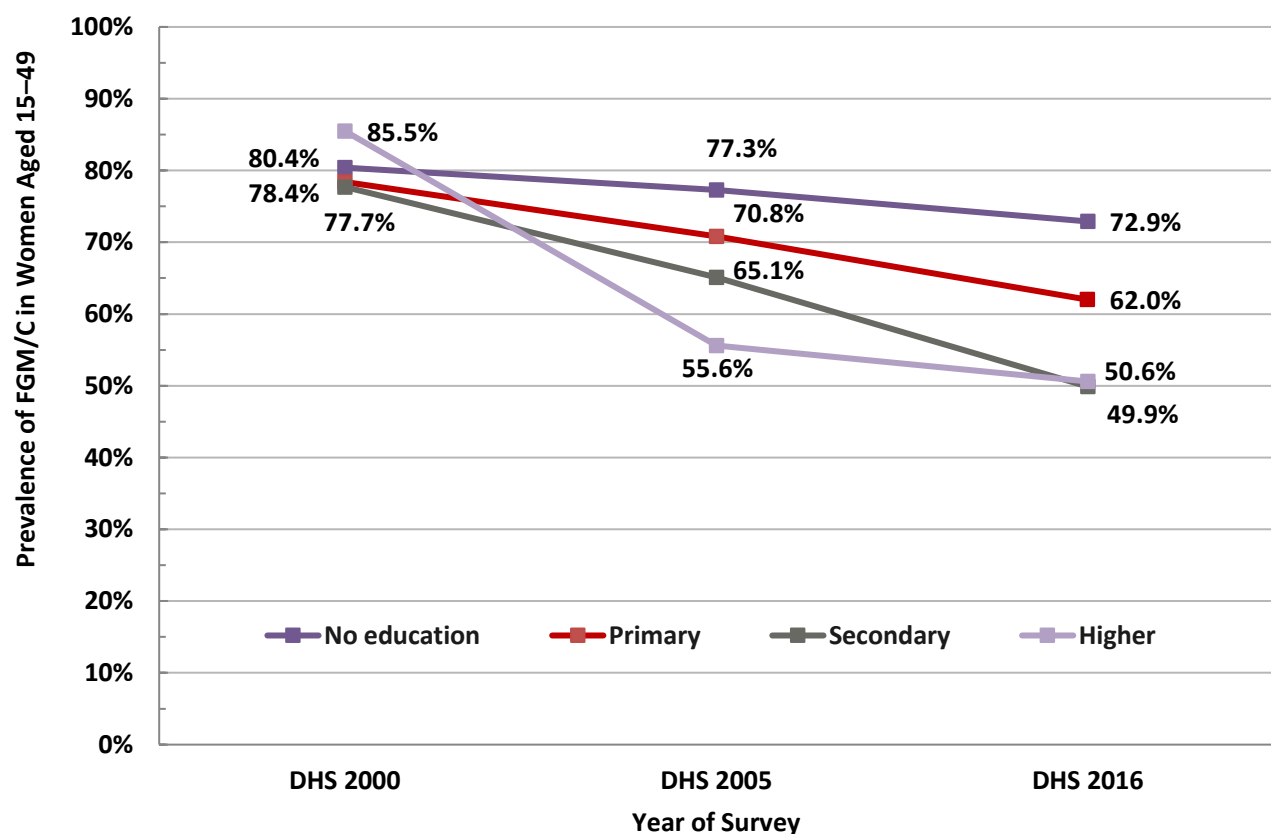


Figure 10: Changes over time (2000, 2005 and 2016) in prevalence of FGM/C in Ethiopian women aged 15–49, according to levels of education¹¹⁰

Place of Residence

There were decreases in FGM/C prevalence in women (aged 15–49) living in both urban and rural areas between 2000 and 2016 (see Figure 11). During that time, the prevalence in urban areas decreased more rapidly than the prevalence in rural areas. In 2000, the prevalence in urban and rural areas was the same (80%), but by 2016 the prevalence in urban areas had decreased to 53.9% while in rural areas it had decreased to 68.4%.¹¹¹

As with the relationship between FGM/C and education, this may point to the resources that have been invested in programming in urban areas, awareness campaigns that have targeted girls in schools, or social-desirability bias in urban populations.

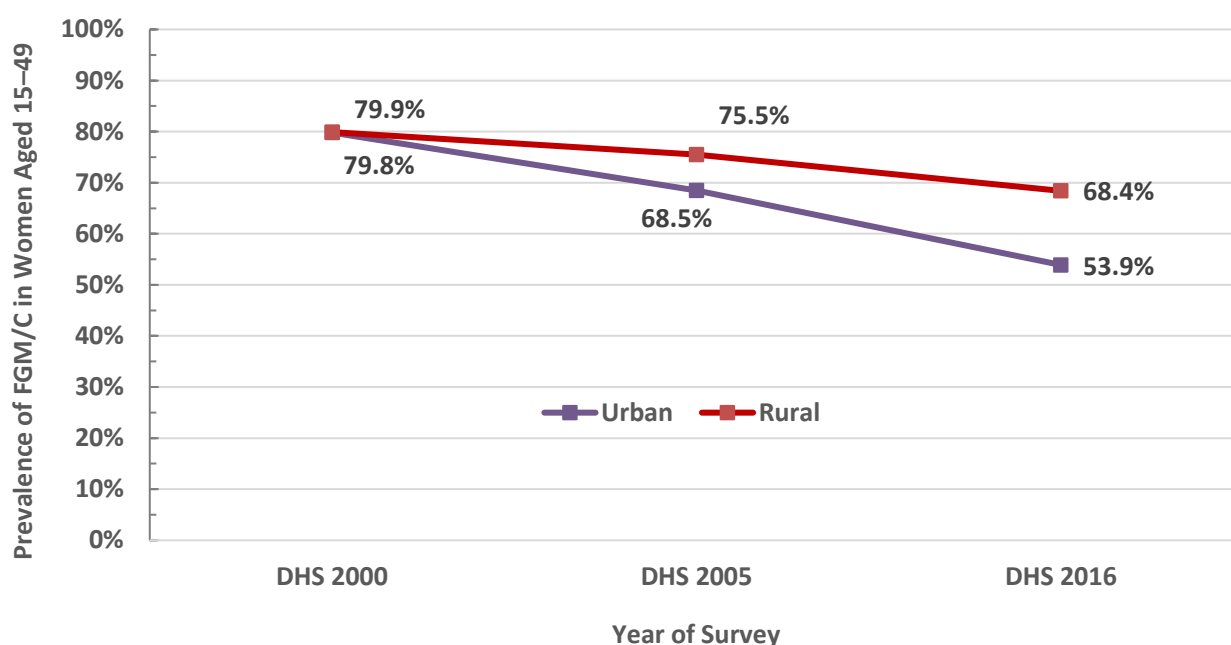


Figure 11: Changes over time (2000, 2005 and 2016) in prevalence of FGM/C in Ethiopian women aged 15–49, according to urban/rural residence¹¹²

Socio-Economic Status

The relationship between women’s wealth quintiles and the prevalence of FGM/C in Ethiopia is not a direct one (see Figure 12 below). The lowest prevalence of FGM/C among women aged 15–49 (56.7%) is in those in the highest wealth quintile, but, interestingly, the highest prevalence (71.4%) is in those in the middle quintile.

The gap between the lowest and highest prevalence according to wealth quintile is widening. In 2000, there was a gap of only 6.2 percentage points between the quintiles with the most and least FGM/C (76.7% of the middle quintile and 82.9% of the poorest quintile), but by 2016 the gap had widened to 14.7 percentage points (56.7% of the wealthiest quintile and 71.4% of the middle quintile). Prevalence in the middle quintiles has stayed quite static, while in the lowest and highest wealth quintiles the practice has become less common.¹¹³

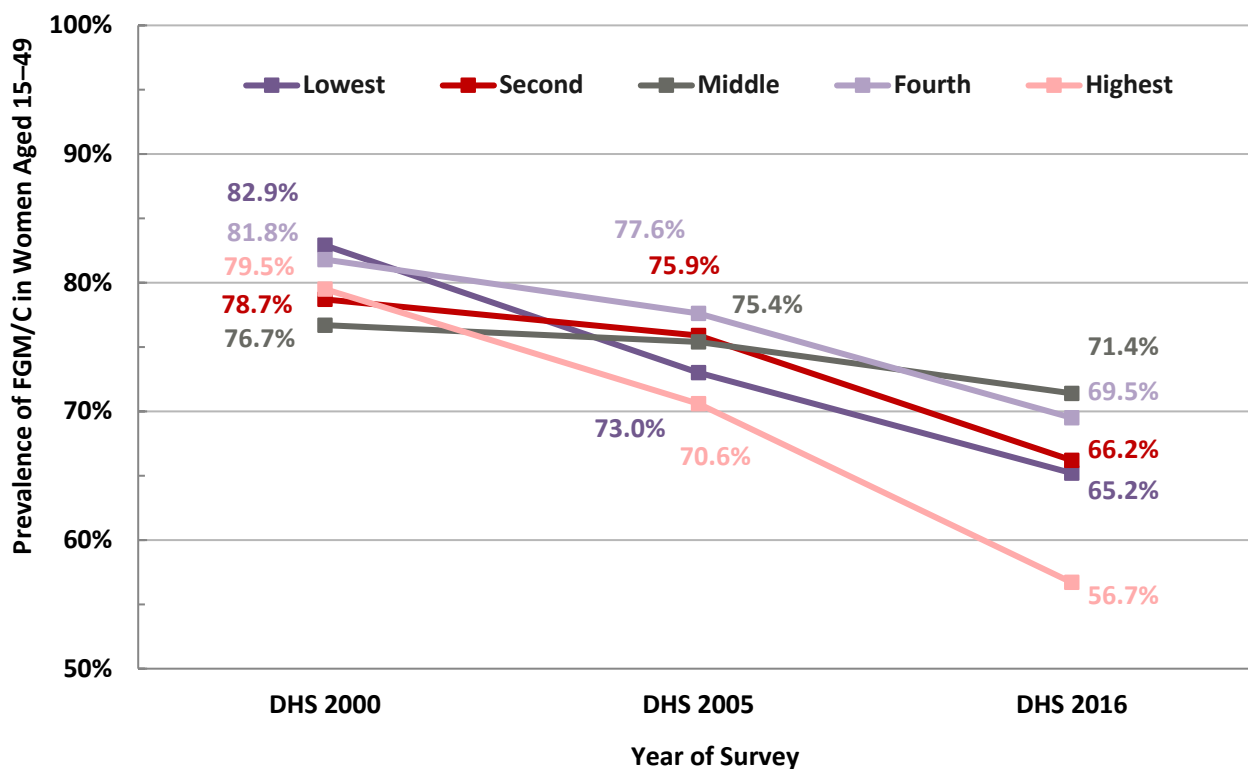


Figure 12: Changes over time (2000, 2005 and 2016) in prevalence of FGM/C in Ethiopian women aged 15–49, according to wealth quintile¹¹⁴

Ethnicity

Ethiopia has a population of just over 122 million.¹¹⁵ There are more than 90 distinct ethnic groups in the country and more than 80 different languages are spoken.¹¹⁶ The Oromo and Amhara ethnic groups make up 62% of the population (34.4% and 27% respectively).¹¹⁷ Other ethnic groups include the Somali, Tigray, Sidama, Gurage, Welaita, Affar, Hadiya and Gamo.¹¹⁸

Regions in Ethiopia are named for the predominant ethnic group that lives there. For example, the Oromo population lives primarily in the Oromiya region and speaks the Oromo language, the Amhara live primarily in the Amhara region, and the Somali live in the Somali region.

Social and cultural norms vary between ethnic groups, including the way FGM/C is practised.¹¹⁹ According to the DHS 2016, prevalence is highest among Somali and Affar women (aged 15–49), at 98.5% and 98.4% respectively. 92.3% of both Hadiya and Welaita women report undergoing FGM/C, as do 87.6% of Sidama women and 23% of Tigray women (see Figure 13).¹²⁰

As FGM/C practice varies so widely from ethnic group to ethnic group, hotspots of the practice occur in the country.

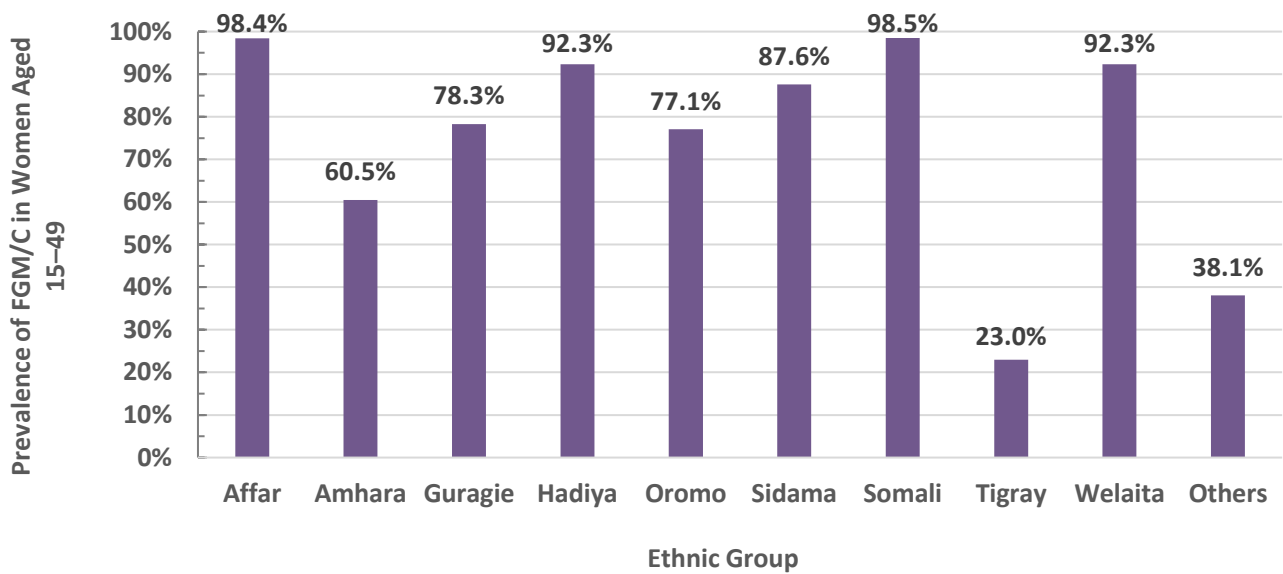


Figure 13: Prevalence of FGM/C in Ethiopian women aged 15–49, according to ethnic group¹²¹

Child Marriage and FGM/C

In Ethiopia, the Ethiopian Civil Code and Article 7 of the revised Ethiopian Family Code set the minimum age of marriage at 18 years for both men and women. However, the Affar and Somali regions do not have regional family laws containing this provision, meaning that child marriage is effectively still legal in those two regions.¹²²

Encouragingly, child marriage in Ethiopia has reduced: in 2000, 65% of women aged 20–49 were married by the age of 18; in 2016, 54.2% were married by the age of 18. Similarly, in 2000, 14.4% of girls aged 15–19 were married before the age of 15; whereas in 2016, that figure had reduced to 5.7%.¹²³

Most at risk of experiencing both child marriage and FGM/C are Affar girls (69% of women aged 18–49, although this statistic is based on only a small sample of women), those from rural areas (42%), those without formal educations (49%) and those in the second and middle wealth quintiles (45%). A girl’s risk of experiencing both child marriage and FGM/C is also influenced by her religious affiliation: 51% of Muslim girls, compared to 35% of protestant girls and 32% of Orthodox girls experience both.¹²⁴

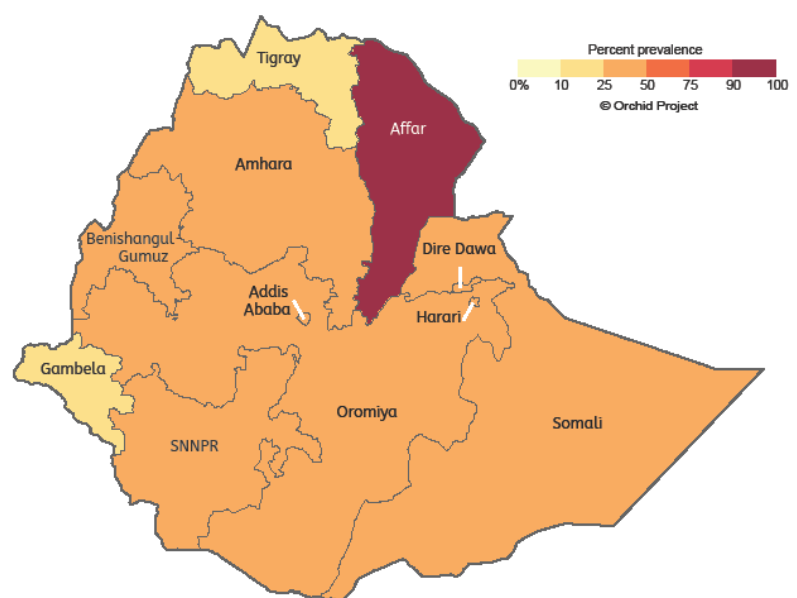
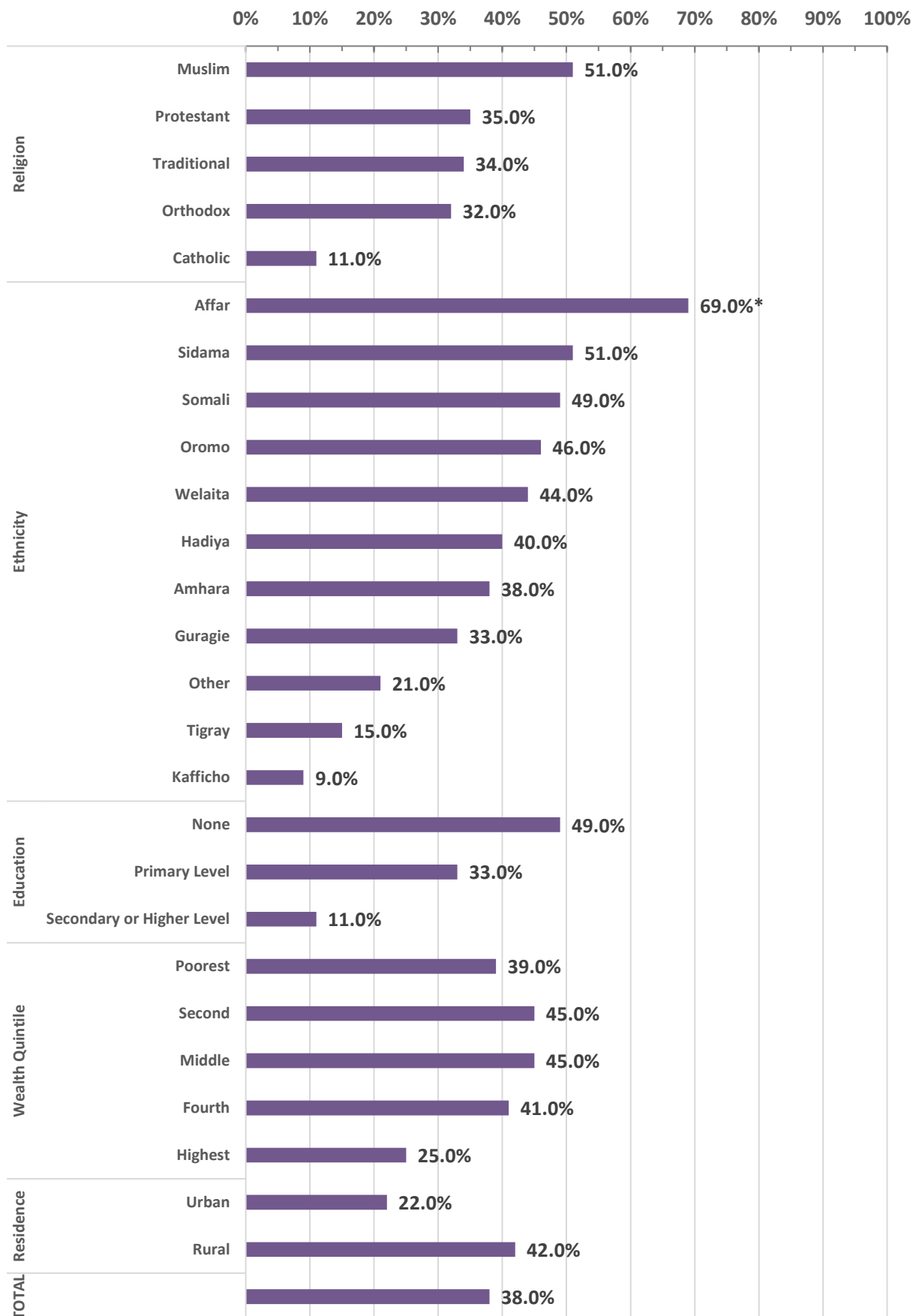


Figure 14: Percentage of women aged 18 to 49 who experienced both child marriage and FGM/C, according to region¹²⁵



***Statistic is based on only 25 to 49 unweighted cases**

Figure 15: Percentage of women aged 18 to 49 who experienced both child marriage and FGM/C¹²⁶

Cross-Border FGM/C

The UNJP estimates that a quarter of the 200 million girls affected by FGM/C worldwide are in the border areas of Ethiopia, Kenya, Somalia, Uganda and Tanzania.¹²⁷

A study conducted by the Anti-Female Genital Mutilation Board in Kenya and UNICEF found that 60% of respondents from Ethiopia travel to Kenya to undergo FGM/C.¹²⁸

In Ethiopia, ethnic identity is a key factor in the extent to which FGM/C is practised and the ways in which it is practised. It is, therefore, important to be aware of the ethnic groups that reside across the borders between countries. This is particularly relevant in relation to the Affar and Somali, who live in Ethiopia, Eritrea, Djibouti, Somalia and Kenya.

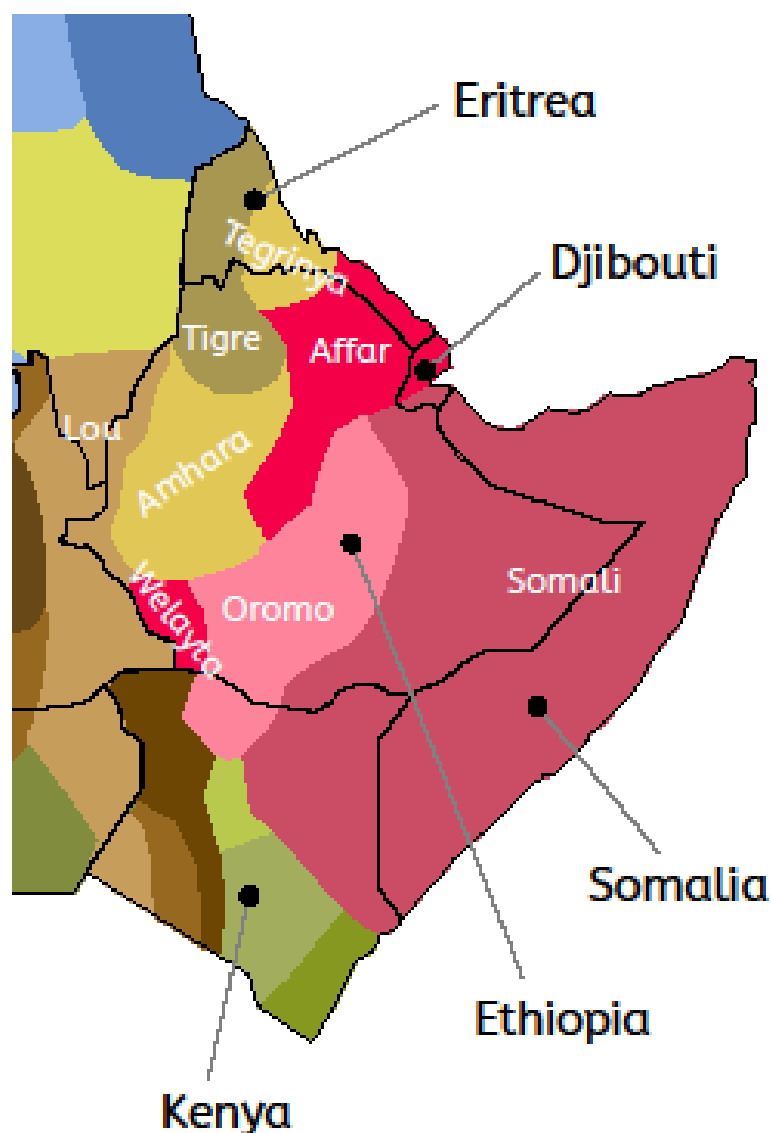


Figure 16: Cross-border residences of various ethnic groups¹²⁹

Somalia/Kenya/Ethiopia Borders

FGM/C prevalence is high on all three sides of the Somalia, Ethiopia and Kenya borders: 99.2% in Somalia,¹³⁰ 98.5% in the Somali region of Ethiopia¹³¹ and 97.5% in the north-east of Kenya.¹³²

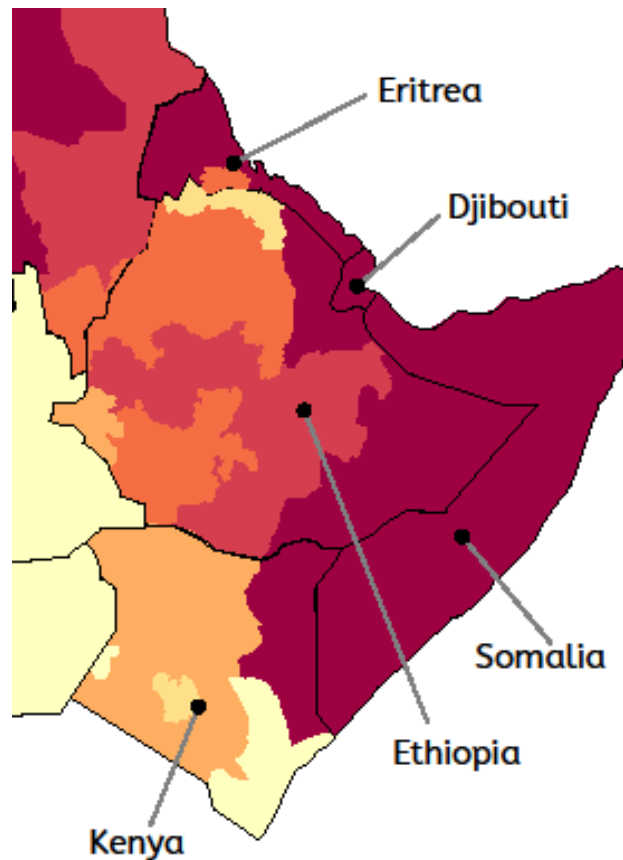


Figure 17: Prevalence of FGM/C among women aged 15–49 on all three sides of the Somalian, Kenyan and Ethiopian borders

56.1% of Somali women in Ethiopia (aged 15–49) who have heard of FGM/C believe that FGM/C is required by their religion (99.9% of Ethiopian Somali women have heard of FGM/C).¹³³

This is considerably lower than the 72% of *all* women in Somalia (aged 15–49) who believe that FGM/C is a requirement of their religion.¹³⁴

Interestingly, the belief that FGM/C is a requirement of one's religion is highest among Somali women in Kenya (82.3% of women aged 15–49 who have heard of FGM/C).¹³⁵ The Kenyan DHS 2014 includes a question on whether women feel that FGM/C is also required by their communities; 82.7% of this cohort feel that it is.¹³⁶

In Somalia, the pervasiveness of belief that FGM/C is required by one's religion differs according to women's wealth quintiles and levels of education. While 73.5% of women without a formal education believe that FGM/C is a requirement of their religion, 44.1% of women with a secondary

or higher level of education believe the same.¹³⁷ Similarly, 77.3% of women from the lowest wealth quintile believe that FGM/C is a requirement of their religion, while 58.8% of women from the highest wealth quintile hold this belief.¹³⁸ It is possible that similar ratios hold true among the Somali population in Ethiopia, but further research would be required to confirm or challenge this.

In Somalia, 76.4% of women believe that FGM/C should continue.¹³⁹ 52.2% of Somali women in Ethiopia hold this belief,¹⁴⁰ as do 81.2% of Somali women in Kenya.¹⁴¹ In Somalia, the levels of belief that it should be continued follow a similar pattern to the levels of belief that it is a religious requirement, when viewed in terms of women's levels of wealth and education.¹⁴²

Among Somali women in Ethiopia, 75.6% report undergoing pharaonic FGM/C (Type 3, or being 'sewn closed').¹⁴³ Interestingly, this is higher than the percentages of Somali women in both Somalia (64.2% of women aged 15–49¹⁴⁴) and Kenya (32.3%¹⁴⁵). A *fatwa* against pharaonic FGM/C was issued in Somaliland in 2018 by Islamic leaders.¹⁴⁶ It is probably too soon to know whether this will reduce the prevalence of pharaonic FGM/C in the Somali communities in Ethiopia.

Djibouti/Eritrea/Ethiopia Borders

The national prevalence of FGM/C among women aged 15–49 in Eritrea is 88.7%.¹⁴⁷ In Djibouti, it is 93.1%.¹⁴⁸ This high prevalence aligns with the prevalence in the bordering Affar region of Ethiopia, which is 91.2%.¹⁴⁹ The Affar ethnic group resides across these three borders.

The prevalence in the Tigray region, which borders Eritrea and Sudan, differs at 24.2%.¹⁵⁰ The Tigray people, who reside across the borders of Ethiopia and Eritrea, have much in common with the Tigrinya people of Ethiopia; in fact, they are often referred to as two sub-groups of a combined group, 'Tigray-Tigrinya'. While there are no accurate figures available on the prevalence of FGM/C among the Tigrinya in Eritrea, it is known that a very small percentage have experienced Type III.¹⁵¹ We can therefore hypothesise that cutting among the Tigrinya is also less prevalent, mirroring the practices of the Tigray in Ethiopia.

Understanding and Attitudes

Support for FGM/C

In Ethiopia, 92.7% of women and 93.7% of men aged 15–49 have heard of FGM/C.¹⁵²

*17.5% of women and 11.1% of men who have heard of FGM/C (aged 15–49) believe that the practice should continue. 79.3% of women and 86.7% of men believe that it should not.*¹⁵³

Support for FGM/C to continue is highest among women who have lower levels of formal education, those who are in the lowest wealth quintile, those who live in rural areas and those who are Muslim. Interestingly, support for FGM/C is lower among men than women in almost every demographic (see Figure 18). 22.9% of women who have undergone FGM/C believe the practice should continue, as opposed to 4.6% of women who have not been cut.¹⁵⁴

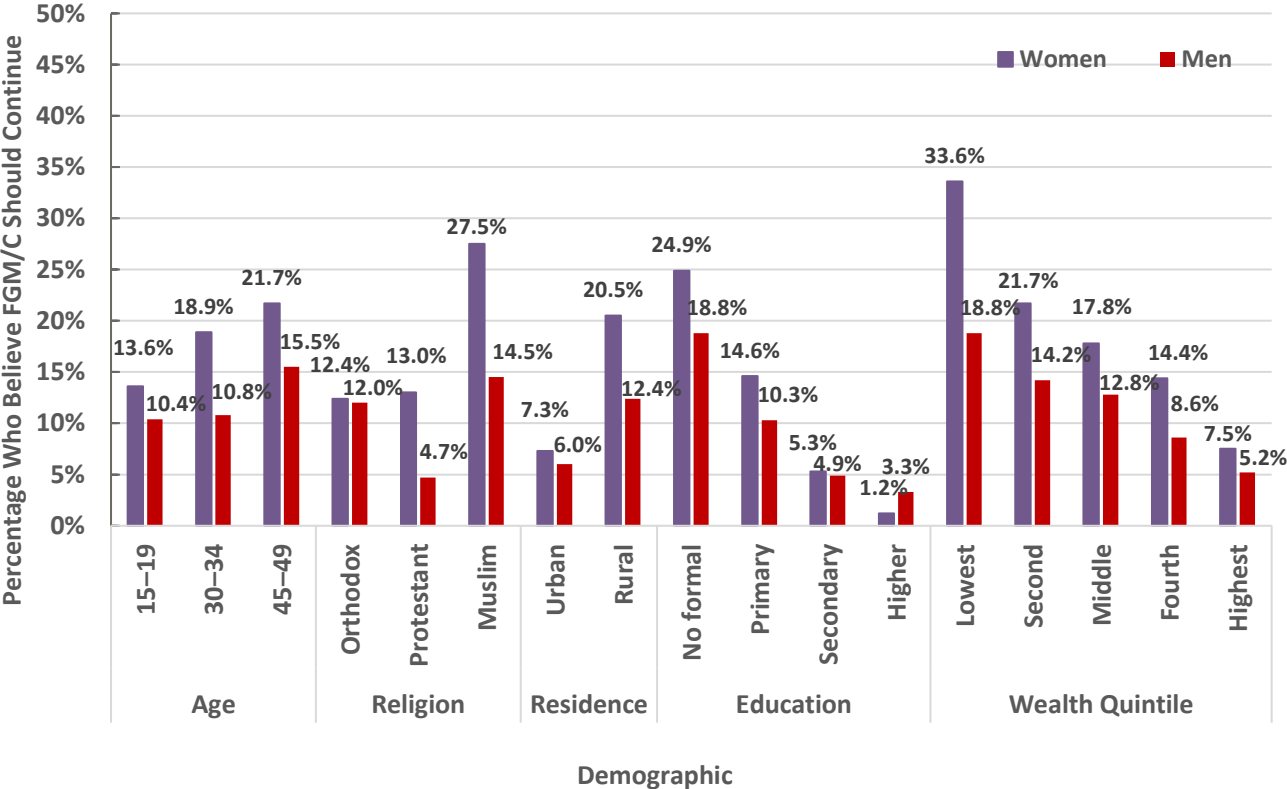


Figure 18: Of Ethiopian women aged 15–49 and men aged 15–59 who have heard of FGM/C, percentage who believe that it should continue, according to various demographics¹⁵⁵

The **ethnic group** that a woman or man belongs to appears to have a strong influence on whether or not they believe the practice should continue (see Figure 19). The strongest levels of support are among Affar (68.3%), Somali (51.4%) and Sidama (27.8%) women (aged 15–49) and among Affar (43.3%), Somali (33.4%) and Amhara (15.8%) men (aged 15–59).¹⁵⁶

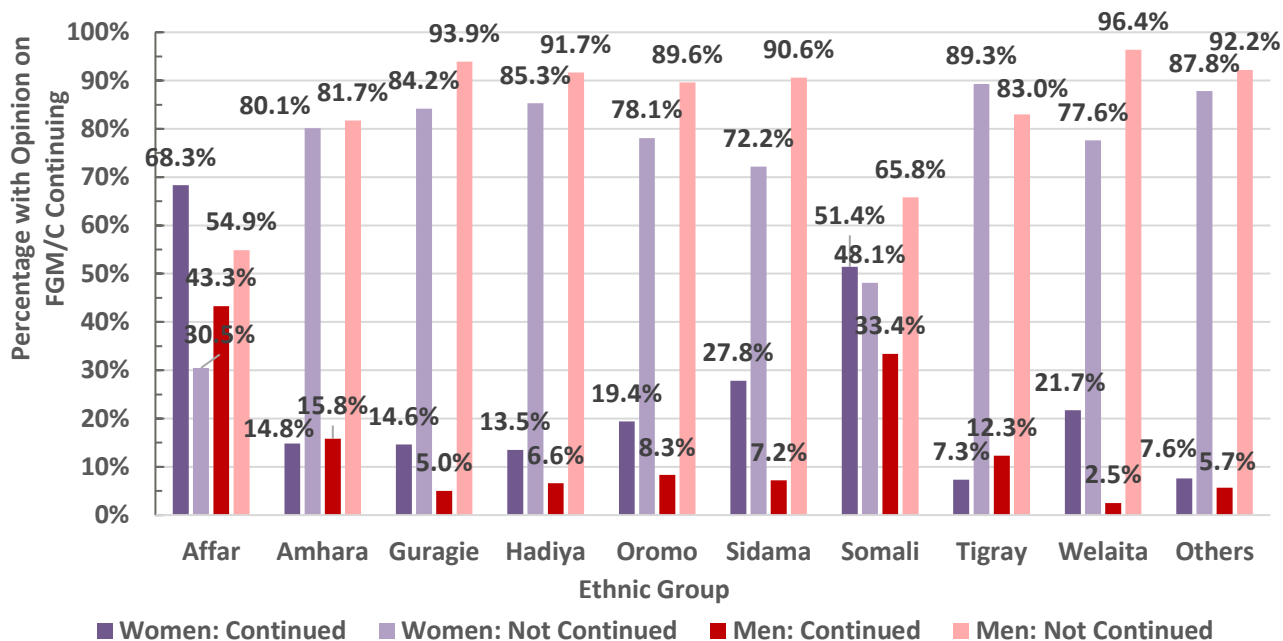


Figure 19: Of Ethiopian women aged 15–49 and men aged 15–59 who have heard of FGM/C, percentage who believe that it should continue or not continue, according to ethnic group¹⁵⁷

A study conducted in two zones of a rural south-central region in 2018 used **indirect-questioning methods** (known as ‘unmatched count technique’) to explore hidden support for FGM/C.¹⁵⁸ Researchers found differences between the results of direct questioning about support for FGM/C and the results of indirect methods of questioning.

Both men and women report low levels of support for FGM/C when asked directly (7.7%), but when asked indirectly, the amount of support is significantly higher (22.4%).¹⁵⁹ This is particularly true for educated men and women (5% gave support for continuing FGM/C when asked directly and 23.8% when asked indirectly), which may point to one result of education – people who have been taught that FGM/C is damaging, illegal, etc. will hide their ‘true’ views about it. Elder men hold the strongest views in support of FGM/C continuation (45%), but are most likely to conceal those views when asked directly.¹⁶⁰

Although this study was only conducted in two communities, it points to the importance of using indirect methods in surveys on FGM/C. It also speaks to the influence of social desirability bias on responses to surveys, particularly among those who are most educated and influential in their communities.

A similar study was conducted in the Affar region in 2018, also using an indirect-questioning method to explore beliefs and attitudes about FGM/C. It found that support for FGM/C was underreported by ten percentage points when direct questioning methods were used.¹⁶¹

Both studies reveal the need for improved survey techniques when researching matters that may be sensitive, taboo or illegal. Researchers and programmers should use a degree of caution when interpreting survey results, especially when direct questioning methods are used.

Beliefs About FGM/C

Unfortunately, not practising FGM/C still has negative consequences for girls and women in certain Ethiopian communities. Many of these girls and women are motivated to undergo FGM/C to avoid those consequences.¹⁶²

In many parts of the country, FGM/C is linked with **marriageability** and with norms related to the **chastity** and respectability of girls (even when cutting is done at a young age).¹⁶³

In the Oromiya region, FGM/C is strongly linked to marriage and **motherhood** – so much so, some girls beg their parents to have them cut to increase their likelihoods of marriage and pregnancy, even if their parents want to stop the practice.¹⁶⁴

In the Affar region, FGM/C is more closely tied to **religious belief** and the belief that FGM/C is required by Islam. However, there are indications of a change in the severity of cutting. A qualitative study conducted by GAGE in 2022 included the following statement from a research participant:

In previous times, we used to cut them deep. We even take some part from the side and then we sew it. But now we have learnt that this will have a problem at the time of giving birth. So we cut only the part called *haram* [forbidden by Islamic law].¹⁶⁵

This change was attributed by research participants to messaging from Muslim religious leaders and information about the health risks of FGM/C.¹⁶⁶

Understanding Religious Beliefs and FGM/C

Nationally, 23.6% of women and 16.8% of men aged 15–49 believe that FGM/C is a requirement of their religion. This belief is most common among Muslim men and women (24.9% and 40.9% respectively), but is also present in adherents to other religions (see Figure 20). Both men and women are less likely to believe it is a requirement of their religion if they are better educated, are in a higher wealth quintile and live in an urban area.¹⁶⁷

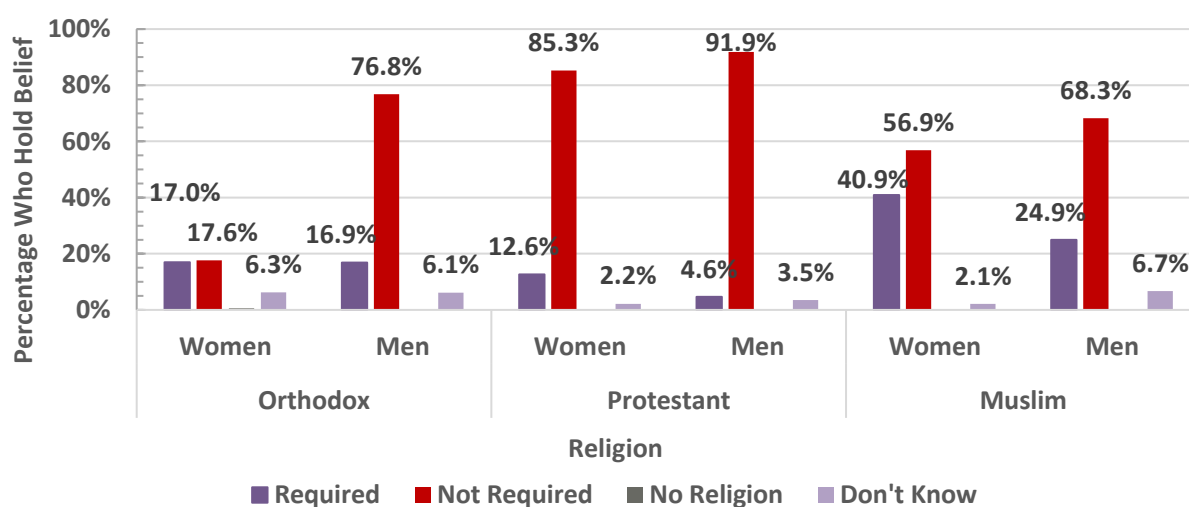


Figure 20: Percentage distribution of Ethiopian women (aged 15–49) and men (aged 15–59), according to belief whether or not FGM/C is required by their religion¹⁶⁸

Ethiopia consists of nine regional states. Three of these states have majority Muslim populations (Affar, Somali and Harari); three have majority Orthodox populations (Tigray, Amhara and Addis Ababa); and two have majority protestant populations (SNNPR and Gambela). Table 1 below shows the predominant religion and the prevalence of FGM/C in each region surveyed by the DHS.

Region	Predominant Religion(s)	Prevalence of FGM/C in 2016
<i>High-Prevalence Regions (more than 85% as at the year 2000)</i>		
Somali	98.5% Muslim	98.5%
Affar	89.1% Muslim	91.2%
Harari	71.1% Muslim	81.7%
Oromiya	51.8% Muslim 22.1% Orthodox 23.0% protestant	75.6%
Dire Dawa	67.8% Muslim	75.3%
<i>Mid-Prevalence Regions (50–84% as at the year 2000)</i>		
Benishangul-Gumuz	45.3% Muslim 33.3% Orthodox	62.9%
SNNPR	67.1% protestant	62.0%
Amhara	84.1% Orthodox	61.7%
Addis Ababa	76.0% Orthodox	54.0%
<i>Lower-Prevalence Regions (less than 49% as at the year 2000)</i>		
Gambela	58.1% Protestant	33.0%
Tigray	95.1% Orthodox	24.2%

Table 1: Predominant religion(s) and prevalence of FGM/C in regions of Ethiopia¹⁶⁹

As with other aspects of FGM/C in Ethiopia, there are strong relationships between ethnicity, religious belief and FGM/C. 74.6% of Affar women (aged 15–49), 56.1% of Somali women, 28% of Oromo women and 23.2% of Sidama women believe FGM/C to be required by their religions.¹⁷⁰ These same ethnic groups also have high numbers of women who believe that FGM/C should continue. This means that there are ‘hotspots’ of the belief that FGM/C is required by the major religions, most commonly in Affar, Oromiya, Somali, Harari and Dire Dawa.

Interventions in these areas must, therefore, engage with religious leaders and messaging about FGM/C to detach its practice from religion.

The Impact on FGM/C and Programme Design

Social pressures, often linked to ethnic identity, marriageability and belonging, are strong drivers of FGM/C in Ethiopia. Differences between ethnic identities create variations in how FGM/C is practised – what types of cutting are done, at what age and in which parts of the country.

The consequences of not practising FGM/C are strongly embedded in people’s belief systems; for example, beliefs that FGM/C will control sexual desire, support social conformity, and assist conception and the ability to have children.¹⁷¹

A study conducted in Muslim communities in Fafan and Arsi found that people believe not practising FGM/C carries a high social risk, including sanctions from the community.¹⁷² In a study among Somali women, not undergoing FGM/C created a risk that a woman would be seen as infidel/unfaithful or non-Muslim.¹⁷³

Interventions to address social and cultural norms that drive FGM/C must be tailored to the specific beliefs and practices of each ethnic group. Programmers and activists must understand the severity of social consequences for abandoning the practice. Programming should be directed at FGM/C hotspots in the country, where, in most cases, religious beliefs are strong drivers of the practice. It is critical to engage religious leaders in these areas to educate and shift beliefs.

In a striking example of this necessity, a grandmother from the Affar region, who was interviewed in the GAGE qualitative study, said:

*We will never accept what the government law is saying. We can change the practice only if we hear it from religious leaders. We do not stop because of meetings.*¹⁷⁴

Sustainable Development Goals

The **2030 Agenda for Sustainable Development** was adopted by all UN member states in 2015, following on from the Millennium Development Goals.

17 **Sustainable Development Goals** (the *SDGs*) make up a call to action for countries to work together to end poverty, improve health, reduce inequality and promote economic growth, while taking care of the environment.¹⁷⁵

The fifth SDG is specifically focused on gender equality, but there are a number of indicators throughout the SDGs that relate to gender. Equal Measures 2030 brought these indicators together to form the **Gender Equality Index (GEI)**, a broader measure of gender empowerment. Ethiopia ranks **125** out of the 144 countries on the GEI.¹⁷⁶

Using a 0–100 scoring system, the GEI rates countries as ‘Very Good (90–100), ‘Good’ (80–89), ‘Fair’ (70–79), ‘Poor’ (60–69) or ‘Very Poor’ (59 and below).

*While much of sub-Saharan Africa falls within the ‘Very Poor’ category, **Ethiopia, at 49.8, scores slightly below the West African average (51.1).** This means that, by comparison, conditions for women in Ethiopia are more challenging than for women across the wider continent. However, Ethiopia has made some progress since 2015, moving from a score of 48.5 to 49.8.*

Region/Country	Score (2022) ¹⁷⁷
Global average	65.7 (‘Poor’)
Sub-Saharan Africa	51.1 (‘Very Poor’)
Horn of Africa ¹⁷⁸	49.7 (‘Very Poor’)
East and Central Africa ¹⁷⁹	49.8 (‘Very Poor’)
East Africa ¹⁸⁰	52.4 (‘Very Poor’)
Ethiopia	49.8 (‘Very Poor’)

Table 2: Selected results from the 2022 Gender Equality Index¹⁸¹

SDG 5: Gender Equality

The fifth Sustainable Development Goal (*SDG5*) aims to 'achieve gender equality and empower all women and girls'.¹⁸² Within *SDG5*, there is a specific target for FGM/C (Target 5.3), which aims to 'eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation'.¹⁸³

Across sub-Saharan Africa, the average percentage of girls and women aged 15–49 who had undergone FGM/C as of 2015 was 29.4%.¹⁸⁴ By 2020, this had reduced to 24.8%. At the last review in 2016, the rate of FGM/C in Ethiopia was 65.2%, well above the average for sub-Saharan Africa.¹⁸⁵

However, when prevalence in the Horn of Africa region is considered, the prevalence in Ethiopia is lower than in most of its neighbouring countries, as shown in the table below.

Region/Country	Prevalence of FGM/C	Year Data Collected
Ethiopia	65.2%	2016
Djibouti	94.4%	2012
Eritrea	83.0%	2010
Somalia	99.2%	2020
Sudan	86.6%	2014
Kenya	14.8%	2022 ¹⁸⁶

Table 3: FGM/C Prevalence in Ethiopia and neighbouring countries¹⁸⁷

According to Cambridge University Press's *Sustainable Development Report 2021*, the COVID-19 pandemic has had a devastating impact on gender equality. The demand for women's unpaid labour has increased, as well as rates of gender-based violence (*GBV*) and, particularly, intimate-partner violence (*IPV*). Economic shocks, school closures and interruptions to reproductive-health services have put up to ten million girls at risk of early marriage.¹⁸⁸

There are also reports of an increased incidence of FGM/C as a result of the pandemic.¹⁸⁹ School closures and increased time at home have meant that girls have longer periods to heal after cutting and, in some places, have created opportunities for cutters to go door to door to carry out FGM/C.¹⁹⁰

SDG 4: Education

The fourth SDG is related to education and aims to 'ensure inclusive and equitable quality education and promote lifelong learning opportunities for all'.¹⁹¹

Progress toward the SDG targets on education was slow before the COVID-19 pandemic, but has been further set back by it. The pandemic is projected to have an impact on minimum reading and numeracy levels, causing an estimated 300 million children worldwide to fall behind minimum proficiency.¹⁹²

*The prevalence of FGM/C and levels of education appear to be linked in Ethiopia. Prevalence is highest among women aged 15–49 with no formal educations and lowest among those with higher levels (secondary and tertiary).*¹⁹³

The primary-school enrolment rate for girls increased from 51% in 2003 to 95% in 2016. However, only 53% of girls actually complete primary school, and only 25% go on to secondary school.¹⁹⁴

Girls face a number of challenges to attending school in Ethiopia: early pregnancy, gender norms in relation to household labour, the prioritisation of boys' education, and child marriage.¹⁹⁵ The DHS 2016 found that 58.3% of women aged 25–49 in Ethiopia were married before the age of 18.¹⁹⁶ In terms of the absolute number of girls who are married before the age of 18, Ethiopia has the fourth highest number globally – an estimated 2.2 million.¹⁹⁷

There is a significant divide in access to quality education between wealth quintiles and in urban versus rural areas. In 2015, the Affar region had one of the lowest rates of primary school enrolment, with an estimated 65% of children out of school.¹⁹⁸

SDG 3: Good Health and Well-Being

SDG3 aims to 'ensure healthy lives and promote well-being at all ages'. Target 3.1 aims to 'reduce the global maternal mortality ratio to less than 70 per 100,000 live births' by 2030.¹⁹⁹

Globally, there has been substantial progress made toward this goal. The maternal mortality ratio was reduced by 38% percent between 2000 and 2017, from 342 to 211 deaths per 100,000 live births worldwide. However, sub-Saharan Africa and Southern Asia account for about 86% of maternal deaths globally.

When it comes to health and well-being, Ethiopia is making progress.

The **infant mortality rate** has dropped from 58.3 per 1,000 births in 2013 to 39.1 per 1,000 births in 2020.²⁰⁰ Three years before the Millennium Development Goals' deadline in 2015, Ethiopia reached its target for **under-five mortality**. Under-five mortality decreased from 205 deaths per 1,000 live births in 1990 to 64 per 1,000 live births in 2013, a 69% reduction.²⁰¹

In 2005, the Government of Ethiopia invested in the **Health Service Extension Program (HSEP)** to extend services to rural and hard-to-reach areas. Traditional birth attendants (TBAs) were provided with training and supported with supervision by Health Extension Workers (HEWs).²⁰²

There is a strong preference for homebirths among Ethiopian women and a practice of using TBAs for home deliveries. However, the Government of Ethiopia has banned TBAs from conducting home deliveries, training them to instead refer women to health facilities where they can be assisted by HEWs. In practice, this doesn't always work, and many TBAs still support deliveries at home in line with women's wishes.²⁰³ Despite these efforts, the **maternal mortality ratio** has increased from 350 out of 100,000 births in 2010 to 401 out of 100,000 births in 2020.²⁰⁴

The Impact on FGM/C

Gender equality, access to education and good health and well-being are crucial factors in the elimination of FGM/C. Although Ethiopia has made progress on its composite score from Equal Measures, the progress has been slow and the country is still in the category of 'Very Poor' – below the average for sub-Saharan Africa.²⁰⁵ Gender equality and gender norms have strong influences on the likelihood that a girl will undergo FGM/C; therefore, progress toward more equitable norms can have positive impacts on prevalence.

In Ethiopia, access to education is not equal between children in different geographic regions and wealth quintiles and between girls and boys. Improving access to education and the rate that girls complete their educations can be linked to the prevalence of FGM/C; however, in Ethiopia a significant driver of school dropout is child marriage, as the DHS 2016 found that 58.3% of women aged 25–49 were married before the age of 18.²⁰⁶

FGM/C is known to have an impact on maternal health, increasing the likelihood of complications during and after delivery and of infant disability or death.²⁰⁷ It is important to improve the quality of maternal health services, and specifically for health workers to know how to respond to FGM/C-related complications during and after delivery, to improve maternal and infant health outcomes overall. While Ethiopia is making progress in terms of infant and under-five mortality, maternal mortality remains a concern.

For a summary of all 17 SDGs, please see our **Global Goals** document.

Gender Norms

Social norms define 'what is considered normal and acceptable behaviour' for members of a specific group.²⁰⁸ Gender norms are a subset of social norms, which define what is considered appropriate behaviour for women, men, girls and boys within specific societies.²⁰⁹

Gender Norms and Education

In Ethiopia, patriarchal gender norms create barriers to women and girls enjoying the same freedoms, rights, access to resources, opportunities and protections as men and boys.

A report from UNICEF and the Ministry of Women, Children and Youth, using the DHS survey data, found that, as of 2016, only 15% of women aged 20–49 years had completed secondary or higher education, compared to 23% of men. The percentages of women and men who complete secondary school are lower in rural areas than in urban areas, but women are less likely to complete secondary school regardless of where they live.²¹⁰

Literacy levels vary by geographical region in Ethiopia, the lowest being in Somali (80.3% illiteracy among girls aged 15–19), Affar (78.5%) and SNNPR (75.5%).²¹¹ Gender inequality in literacy is highest in Gambela and Somali.²¹²

Gender Norms and Unpaid Labour

In terms of the resource of time, women and girls are disadvantaged compared to men and boys. The average Ethiopian woman works 16 hours a day, sharing in agricultural tasks and the care of livestock while being responsible for household chores, collecting water, childcare and other domestic tasks.²¹³

Gender Norms and The Law

The Family Code in Ethiopia was revised in 2000 to give women more rights within marriage. This applied to the division of assets in the case of divorce as well as rights within a current marriage.

In 2003, the **community-based land-registration reform** was initiated, which created the possibility of spouses having joint ownership of land.²¹⁴

Ethiopia has created an enabling environment for gender equality by establishing the **National Action Plan for Gender Equality** in 2006.

In addition, Ethiopia is a signatory to many **international conventions related to gender equality**.²¹⁵

Gender Norms and Gender-Based Violence

*23.3% of Ethiopian women aged 15–49 have experienced some form of physical violence in their adult lives and 10.1% have experienced sexual violence in their entire lives.*²¹⁶

A woman's place of residence seems to have a little influence on the likelihood that she will experience physical or sexual violence. 23.9% of Ethiopian women living in rural areas report experiencing **physical violence** in their adult lives, compared to 20.9% of those living in urban areas. Education level, however, is a stronger determinant: 13.0% of Ethiopian women (aged 15–49) who have tertiary levels of education report physical violence during their adult lives, and 28.1% of those without formal educations report experiencing it.²¹⁷

Similarly, in terms of **sexual violence**, 7.3% of Ethiopian women (aged 15–49) who live in urban areas report experiencing sexual violence in their lifetimes, compared to 10.8% in rural areas. 4.7% of those with tertiary levels of education report experiencing sexual violence, compared to 13.2% of those with no formal educations. Additionally, women in the lowest three wealth quintiles are slightly more likely to experience sexual violence than those in the highest two quintiles.²¹⁸

33.8% of Ethiopian women aged 15–49 who have been married at any time have experienced **intimate partner violence (IPV)** committed by their current or most recent partners (in this case, IPV means emotional, physical or sexual violence).²¹⁹

The most commonly reported forms of **physical IPV** include 'slapped her' – 18.8%; 'pushed her, shook her, or threw something at her' – 12.4%; 'kicked her, dragged her, or beat her up' – 9.7%; and 'punched her with his fist or with something that could hurt her' – 8.1%.²²⁰

10.1% of this cohort of women report experiencing a form of **sexual IPV**, while 24.0% of this cohort of women report experiencing **emotional abuse**. 19.4% were insulted or made to feel bad about themselves; 13.7% were humiliated in front of others; and 7.9% were threatened with harm to themselves or their loved ones.²²¹

Ethiopian women over the age of 30 are generally more accepting of GBV/IPV than are younger women: 43–44% and 35–39% respectively hold the opinion that **wife-beating** is justified in certain given circumstances; 63.0% of all Ethiopian women aged 15–49 hold this belief.²²² Interestingly, this view is taken by significantly fewer Ethiopian men – 27.7% of those aged 15–49.²²³ Views on GBV also vary by region. The highest rates of acceptance are in SNNPR (47.6%), Affar (46.0%), Oromiya (45.9%) and Tigray (39.0%).²²⁴

*Less than half of Ethiopian women feel they have control over when they have sex.*²²⁵

58% of women aged 20–49 had their **first experience of sexual intercourse** by the age of 18 (21.6% by the age of 16), while only 16% of men in the same age-group had their first experience by the age of 18 (1.7% by the age of 16).²²⁶ 15.0% of female respondents aged 15–19 were sexually active in the four weeks prior to the DHS survey, while only 2.4% of male respondents in the same age group were.²²⁷

Gender Norms and Child Marriage

The prevalence of child marriage reduced in Ethiopia between 2000 and 2016; still, as of 2016, 11.3% of girls aged 15–17 were already married. Almost 30% of girls aged 15–17 in Affar were already married, however, as were almost 30% of girls from the poorest wealth quintile. That indicates a large variation in risk according to the area in which a girl lives and her level of poverty.²²⁸

*The incidence of child marriage is actually increasing among girls aged 15–17 in the poorest wealth quintile – from 21.4% in 2005 to 27.0% in 2016.*²²⁹

The Impact on FGM/C Programme Design

FGM/C is often motivated by patriarchal gender norms that attempt to control women’s sexualities and how they are accepted in society and within the family. Gender norms influence women’s decision-making powers, their access to resources, the division of labour and their experiences of GBV. In contexts where FGM/C is linked to child marriage, patriarchal gender norms strongly increase the likelihood that a girl will be cut to ‘prepare her’ for marriage.

The UNFPA and UNICEF work to eliminate FGM/C across 17 countries. These organisations recommend that FGM/C programming have a more explicit focus on the transformation of gender norms.²³⁰

Gender-transformative programming works to address the root causes of gender inequality and the power dynamics and structures that reinforce gender inequalities. According to a recent report by Orchid Project, ‘a gender-transformative approach is defined as one that actively examines, questions and changes harmful gender norms and power structures that give boys and men advantages over girls and women.’²³¹

Programmatic responses to FGM/C exist on a continuum from gender-discriminatory to gender-transformative, as shown in Figure 21.²³²

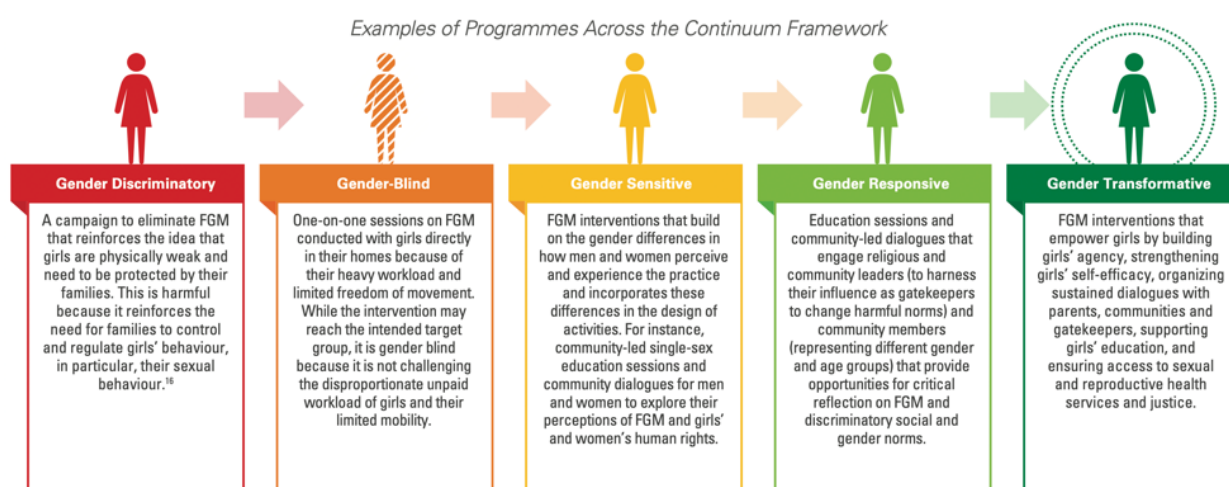


Figure 21: The Gender Equity Continuum²³³
(UNICEF; reproduced under Creative Commons Attribution–Non-Commercial 3.0 IGO)

Gender-transformative approaches to FGM/C include engaging men and boys to address patriarchal gender norms, and promoting intergenerational dialogue to shift gender norms accepted by both women and men. This can be done through critical dialogues on social acceptance, marriageability, sexual purity and positive masculinities, facilitated by local change-agents who promote alternative gender norms and opportunities for power-holders to consider and explore new norms.²³⁴

Multi-level approaches often shift gender norms most effectively. Promoting change at the levels of the individual, family and community, and at the regional and national levels, supports a true shift in gender norms that can be sustained over time.



Part 2:
Update on Responses
to FGM/C

Challenges

Part 1 of this report provided an update on the current situation and trends in Ethiopia, which have implications for the response to FGM/C and how activists focus interventions to reduce the prevalence of the practice.

The following is a summary of the current situation and trends in relation to FGM/C in Ethiopia.

A. Increasing Commitment

The Government of Ethiopia has committed to ambitious plans to eradicate FGM/C by 2025.²³⁵ Without increased financial commitment and acceleration of progress, however, even reaching the SDG 2030 targets will be impossible.

The Government of Ethiopia has worked to create an environment that enables the elimination of FGM/C, embedding FGM/C in its Criminal Code²³⁶ and creating a *National Costed Roadmap to End Child Marriage and FGM/C*.²³⁷ The Ethiopian Government is also signatory to international treaties and conventions to protect the rights of women and girls.²³⁸

Within the *National Costed Roadmap to End Child Marriage and FGM/C*, the Government committed to a 10% increase in budget allocation toward the elimination of these two practices.²³⁹

On 6 February 2023, UNICEF and the UNFPA issued a joint press release, calling for increased investment from the Government to implement the Roadmap and accelerate progress.²⁴⁰

Even if the Government increased resources to fulfill its commitments, a significant acceleration of progress is needed to eliminate FGM/C ahead of the 2030 target (SDG 5). Progress would have to be accelerated by more than seven times the current rate of decrease in prevalence (see Figure 22).²⁴¹

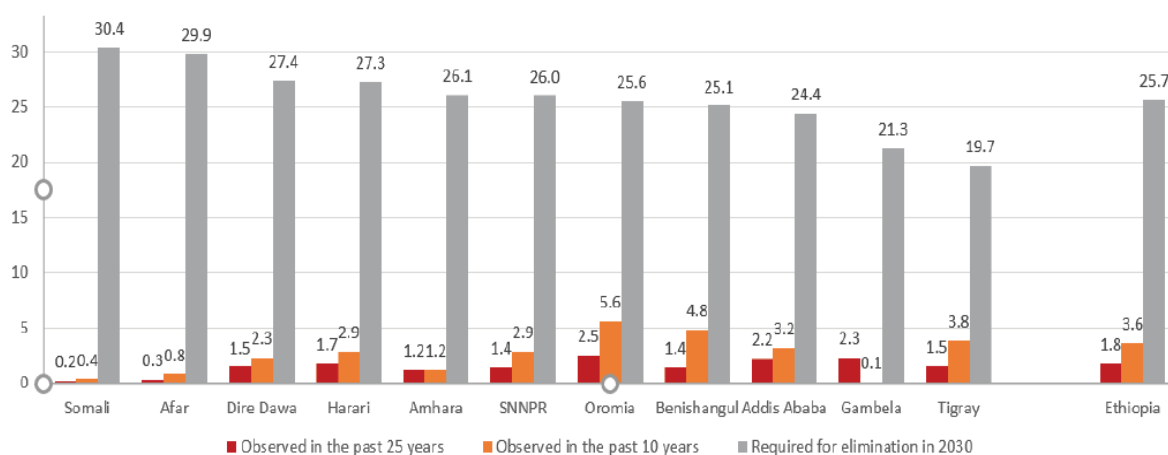


Figure 22: Average annual rate of reduction in the percentage of girls and women aged 15 to 19 years who have undergone FGM/C, observed and required for elimination by 2030, by region
Statistics: UNICEF, 2018

Figure © Ministry of Women, Children and Youth of the Federal Democratic Republic of Ethiopia²⁴²

B. Using Appropriate Population Data

As the population in Ethiopia is so large, regional-level data on FGM/C prevalence is insufficient to adequately target programming. Sub-regional data at the level of zones and woredas is needed to identify hotspots within hotspot regions and make the most effective use of available resources.

Although prevalence is decreasing, the population of Ethiopia in 2016 was 102,227,020,²⁴³ suggesting that approximately 33 million girls and women are affected by FGM/C in Ethiopia.²⁴⁴

This is the highest absolute number in East and Southern Africa and the third highest globally (after Indonesia and Egypt).

Although the prevalence of FGM/C is highest in the Somali and Affar regions, the population in those regions is smaller than in other regions that have a lower prevalence. It is estimated that seven million women and girls are affected in the Amhara region alone and nine million in the Oromiya region, compared to 790,000 in Affar and two million in Somali.²⁴⁵

In regions with large populations, it is critical to have data at the sub-regional level (zone or woreda) to effectively target programming. This was recommended in the *National Costed Roadmap to End Child Marriage and FGM/C*, but that level of data is not yet available.²⁴⁶

C. Underground FGM/C

In Ethiopia, the strong legal and policy frameworks and sustained efforts to raise awareness and create community-level sanctions against FGM/C may be driving the practice underground and increasing social desirability bias in research results. Innovative research methods must be validated at scale and used to explore respondents' 'true' beliefs and perspectives on FGM/C.

Responses to FGM/C in Ethiopia have focused on creating awareness: education in schools, girls' clubs where the harmful effects of the practice and the girls' human rights are discussed, and community campaigns. This has apparently led to a decrease in prevalence among women and girls with higher levels of education, in urban areas and in higher wealth quintiles.

However, research conducted in Oromiya²⁴⁷ and Afar,²⁴⁸ using indirect-questioning methods to explore attitudes and beliefs about FGM/C found that, when asked indirectly, respondents expressed higher levels of support for the practice than when they were asked directly. These studies were conducted with limited geographic scope (a small number of communities, in only one region); however, they point to a potential negative impact that awareness-raising campaigns and strong legal frameworks may have – pushing the practice underground and creating caution in discussions about FGM/C, particularly questions about people's attitudes and beliefs. More research is needed to explore how these indirect methods work at scale.

D. Cultural Norms

The practice of FGM/C in Ethiopia is deeply cultural and tied to marriageability and ethnic identity. Programming must respond to these ties in innovative ways, and the engagement of men and boys in programming is critical.

The practice of FGM/C in Ethiopia varies widely according to ethnic and religious affiliations and geographical location. This has created 'hotspots', where the prevalence is much higher than the national average and poses a programming challenge, as drivers differ between groups.²⁴⁹

What is clear from the data is that marriageability and ethnic belonging are the primary drivers of FGM/C in Ethiopia – so much so, some girls reportedly beg their parents to have them cut to ensure they can marry and have children alongside their peers.²⁵⁰ For many Ethiopian girls, being uncut brings significant social dangers. For some Muslim girls, being uncut equates to being an infidel/unfaithful or non-Muslim. For others, it means being unable to marry, which poses significant risks to economic security and community belonging.²⁵¹

It is critical that programming aim to reduce the social risks to uncut girls in Ethiopia, to create more opportunity for agency and decision-making. Working with men and boys to increase acceptance of uncut girls in marriage is a key programmatic area that needs further attention.

E. Economic Insecurity

Economic insecurity creates substantial risks for girls who go against cultural norms. These girls risk social exclusion, further economic insecurity and, in some contexts, death. Programming must support the economic empowerment of girls/women and increase opportunities for them to alleviate these risks.

Social exclusion in the context of economic insecurity is a risk not only to an individual's psychological well-being and identity, but also to their capacity to survive. In rural areas in Ethiopia and in regions affected by drought, famine and protracted, complex crises, maintaining marriageability is a survival strategy for women and girls.

Humanitarian and development organisations working in these contexts must prioritise the economic empowerment of girls/women, while increasing their awareness of their rights and skill-building to improve agency. Without alternative mechanisms for security (apart from marriage), it will be impossible to shift the belief that FGM/C is necessary.

Responses

The following section contains examples of the different types of responses that have been put in place in each of the priority areas. This is not an exhaustive list, but a snapshot of interventions that are having an impact on FGM/C in Ethiopia.

(For further details on organisations that are actively responding to FGM/C in Ethiopia, see our 2013 Ethiopia Country Profile, available [here](#).)

A. Increasing Commitment

❖ *Financial commitment needs to increase to reach the ambitious targets set by the Government of Ethiopia.*

Organization for the Development of Women and Children (ODWaCE)²⁵²

The Organization for the Development of Women and Children (ODWaCE) was formerly known as Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM) and before that was the National Committee on Traditional Practices in Ethiopia (NCTPE).

ODWaCE has conducted research on FGM/C and produced reports for implementing organisations and activists to use in their work. In the past, ODWaCE had a 'traditional practices officer' situated within government ministries, but this is no longer an active position.

Consortium of Reproductive Health Associations (CORHA)

The Consortium of Reproductive Health Associations (CORHA) is an umbrella organisation established in 1993. It was initially an association of foreign-policy organisations, but, after the International Conference on Population and Development, it switched its focus to reproductive health. It currently has a membership of 85 NGOs and CSOs. The overall mission of CORHA is to provide integrated and sustainable services in relation to sexual-and-reproductive health and rights (SRHR). For CORHA, the eradication of FGM/C is a key component of quality SRHR.

CORHA works to build member capacity (based on member needs), by coordinating, networking and knowledge sharing, and mobilise resources. CORHA hosts **Share-Net Ethiopia**, a knowledge platform for SRHR in Ethiopia.

As part of its capacity-building agenda, CORHA has established 'communities of practice'. FGM/C is situated within communities of practice on SRHR, child marriage and GBV.

CORHA coordinates advocacy efforts with the support of its members, engaging policymakers, civic and religious leaders and other influential community members to support an enabling environment for SRHR in Ethiopia.

UNFPA-UNICEF Joint Programme on the Elimination of FGM: Accelerating Change (UNJP)²⁵³

In 2021, FGM/C-prevention interventions were implemented by the UNJP and its partners in Amhara, Affar, Gambela, Oromiya, SNNPR, Sidama and Somali. Programmes included training-and-capacity support sessions with community-based organisations in partnership with the **Bureau of Women and Social Affairs**, which resulted in increased reporting of FGM/C cases and cooperation with government service-providers.

Communities in the Affar region made public declarations against FGM/C and adopted community bylaws to enforce social sanctions on those who practice cutting. These bylaws were supported by social-sanction committees composed of ten representatives (five women and five men).

The UNJP collaborated with **Girl Effect** in 2021 to develop a season of *Yegna*, a TV edutainment series that was broadcast in 2022. *Yegna* is aimed at youth and broadcast nationally in urban and rural communities to an audience of approximately ten million. The show focused on relationships, menstruation, puberty, violence and FGM/C.²⁵⁴

In addition to this, the UNJP supported the development of training manuals and job aids, providing technical support through the **Ministry of Health**, which were distributed through the **Health Child Programme**.

The **ACT Framework** is a framework for measuring social norms and behaviour change, which was developed by the UNJP and the Dornsife School of Public Health at Drexel University and published in 2021. The framework was piloted in Ethiopia and Guinea in 2021.

The UNJP had plans to engage in cross-border-FGM/C prevention through implementation of the **Action Plan to End Cross-Border FGM** adopted in 2019. The plan covers cross-border FGM/C in Ethiopia, Kenya, Somalia, Uganda and the United Republic of Tanzania. Unfortunately, implementation of this was delayed by the COVID-19 pandemic.

Ethiopian Women Lawyers Association²⁵⁵

The Ethiopian Women Lawyers Association works with the **UNFPA** to prevent sexual and gender-based violence and harmful traditional practices (*HTPs*). The project aims to raise awareness in communities about the rights of girls and boys in relation to sexual and gender-based violence and HTPs; to build the capacities of legal professionals (judges, police, social workers, prosecutors, counsellors, etc.); to support women and girls to represent themselves in court; and to scale access to free legal aid for survivors.

B. Using Appropriate Population Data

- ❖ *Sub-regional data is needed to effectively target programming, especially in regions with large populations.*

C. Underground FGM/C

- ❖ *Social desirability bias may be concealing true attitudes and beliefs about FGM/C.*

TaYA

Talent Youth Association, now known as TaYA, was founded in 2003 with the mission of building opportunities for youth to be self-reliant and healthy, so that they can grow in leadership and influence. TaYA works on programmes to promote sexual and reproductive health; youth engagement and employment; and the empowerment of women and girls, including girls' educations. One of its primary objectives is to provide youth activists with the skills and information they need to advocate for the issues that are important to them. TaYA produced guidelines for the Ministry of Health in Ethiopia on how to engage youth in health projects, including projects that focus on eradicating FGM/C.

TaYA implemented the 'Yes I Do' project, which is focused on FGM/C and child marriage in Oromiya, working as a consortium of two international NGOs and two local NGOs. TaYA's main contribution to the project was mobilising and equipping youth activists by taking them through skill-building workshops on advocacy and on the harmful effects of FGM/C and child marriage. Youth activists went on to organise coffee ceremonies with community elders to share their experience with these practices and to advocate for them to stop.

TaYA works in the following states: Oromiya, Amhara, SNNPR, Gambela, Benishangul Gumuz and Addis Ababa.

AMREF Ethiopia²⁵⁶

Amref Ethiopia is implementing a project called 'Power to You(th)', which aims to combat early marriage, unintended pregnancies and FGM/C. The project equips local community activists with skills and information on HTPs. These activists organise committees and campaigns in their own communities to work toward change.

D. Cultural Norms

❖ *FGM/C in Ethiopia is deeply cultural and tied to marriageability and ethnic identity.*

Norwegian Church Aid²⁵⁷

Between 2010 and 2016, Norwegian Church Aid worked with seven members of the **Inter-Religious Council of Ethiopia** to support abandonment of FGM/C and child marriage. Those members included the **Ethiopian Orthodox Tewahedo Church (EOTC)**, **Ethiopian Islamic Affairs Supreme Council (EIASC)**, **Ethiopian Catholic Church (ECC)**, **Evangelical Churches Fellowship of Ethiopia (ECFE)**, **Ethiopian Seventh Day Adventist Church (SDAC)**, **Ethiopian Evangelical Church Mekane Yesus (EECMY)** and **Kale Hiwot Church**.

NCA supported the Inter-Religious Council of Ethiopia members to engage with faith leaders, in national and regional initiatives as well as grassroots responses, across 47 woredas in ten zones of Amhara, Tigray, Oromiya, Somali, Affar and SNNPR.

At the national and regional levels, members created position statements on FGM/C and child marriage. Only two members did not create position statements – the Inter-Religious Council of Ethiopia and the Ethiopian Seventh Day Adventist Church – and the Ethiopian Muslim Development Agency statement did not include FGM/C.

At the local level, the approaches varied. They included organising forums for high-profile religious leaders, engaging former cutters as change agents, developing community sanctions against FGM/C and child marriage, and mobilising declarations of FGM/C abandonment and alternative rites of passage.

The approaches faced challenges in reducing FGM/C and child marriage. In some areas, religious leaders were hesitant to declare abandonment of FGM/C and were concerned about discrimination and shame for uncut girls. Alternative rites of passage did not adequately replace cutting, and the strong cultural pressure was difficult to mitigate.

Centre for Interfaith Action on Global Poverty (CIFA)

The Centre for Interfaith Action on Global Poverty (CIFA) worked with religious leaders in Ethiopia and Nigeria to pilot an intervention engaging them on FGM/C and child marriage. The project was piloted between 2010 and 2012 and reported that opposition to child marriage and FGM/C doubled among religious leaders following the pilot.²⁵⁸ The pilot included Orthodox faith leaders from the **Ethiopian Orthodox Tewahedo Church** and Muslim scholars (*ulamā*) selected through the **Ethiopian Islamic Affairs Council** in Amhara.

As a result of this work, CIFA produced a manual for training Orthodox faith leaders on FGM/C and child marriage. The manual is available at <https://jliflc.com/resources/the-faith-effect-a-facilitator-manual-to-train-ethiopian-orthodox-tewahedo-church-eotc-faith-leaders/>.

A similar manual was produced for Muslim faith leaders on the same topics, which is available at <https://www.rfp.org/sites/default/files/publications/Ethiopia%20-%20Muslim%20Faith%20Leader%20Training%20Manual.pdf>.

UNICEF²⁵⁹

The **UNICEF Luxembourg National Committee** supports the implementation of a programme to promote conversations in Affar and Somali communities in Ethiopia. This programme has been implemented in 64 kebeles across eight woredas (Gode, Danan, Kabridahar, Shaygosh, Wardher, Daratole, Fik and Hamaro).

Community conversations are conducted with groups of 40–50 community members, both women and men, together with government and clan leaders, community police officers, religious leaders and representatives from local schools. Community conversations often bring in former traditional cutters, where possible. Discussions last for two to three hours and take place bi-monthly.

Sheikh Mohammad Abdulah from the **Islamic Affairs Supreme Council** (a local faith-based organisation) said,

Our position plays a great role in facilitating these conversations and communicating with the community that FGM has no religious base. It can be difficult to change people's beliefs, especially religious ones, but, looking back, I can happily say that community conversations are among the greatest strategies that have helped us to enable our community to critically reflect on the wrong beliefs which perpetuate the practice and challenge the practice for the better.

Rohi Wedu Pastoral Women Development Organization²⁶⁰

Rohi Wedu Pastoral Women Development Organization (*Rohi Wedu*) works in the Affar region in partnership with UNICEF. Rohi Wedu facilitated community dialogues about FGM/C with community leaders and prominent figures from different clan groups. The project built in elements of social diffusion, as participating leaders were expected to share information with their communities following the dialogues. Rohi Wedu intentionally included Muslim religious leaders as community-dialogue facilitators because FGM/C is strongly linked to religious beliefs in the Affar region.

Harmee Education for Development Association (HEfDA)²⁶¹

Harmee Education for Development Association is an indigenous, non-governmental development organisation working to promote socio-economic development through the inclusion and full participation of women and people living with disabilities in agriculture, education and other development initiatives. As a core part of its mission, HEfDA works to promote the empowerment of women and their protection from harmful practices and GBV.

HEfDA uses the SASA! approach to promote more equitable relationships between men and women, and through this addresses harmful practices such as FGM/C, GBV and keeping girls out of school.

The organisation works in three woredas (Munessa, rural Akaki and Heban Arssi) in the Oromiya region and hopes to expand to selected districts in Arssi, West Arssi, East Shewa and Finfinne Zuria Oromia Special Zone in its next strategic plan.

Kembatti Mentti Gezimma-Toppe (KMG)²⁶²

Kembatti Mentti Gezimma-Toppe (KMG) is a national NGO committed to raising public awareness about the harmful effects of FGM/C in Kembatta Tembaro Zone, SNNPR. KMG uses public education campaigns and mobilises public pressure against FGM/C. As a strategy for creating change in attitudes, it has conducted public weddings of uncut women. KMG also uses community conversations embedded into savings-and-loans groups as a major component of its approach.

Unfortunately, the founder and director of KMG, Boglatech Gebre, passed away unexpectedly in 2019. This has disrupted the work of KMG, but a new director was appointed in 2022.

Afar Pastoralist Development Association²⁶³

The Afar Pastoralist Development Association (APDA) supports female extension workers to educate communities on the harmful effects of FGM/C. These extension workers have reached over 70,000 people with their messaging.

The APDA wants to build on the work of other organisations in the Affar region that are working with religious and clan leaders to effect change.

Population Media Centre²⁶⁴

Population Media Centre produce radio content on FGM/C in three languages (Amharic, Affar and Somali). The programmes use different formats. Some are talk shows featuring interviews promoting community conversations and raising awareness about FGM/C, and others are short plays and stories that integrate content on FGM/C with their narratives.

E. Economic Insecurity

❖ *Economic insecurity exacerbates the risks of social exclusion for uncut girls.*

Save the Children Ethiopia²⁶⁵

Save the Children Ethiopia is implementing a programme called 'Supporting women and girls in Ethiopia's lowlands to realise their rights, and live healthy and productive lives free from violence and abuse'. It is funded by **Irish Aid**. The programme is being implemented in two zones in the Affar region and two zones in the Somali region. The focus of the programme is economic empowerment, material support to help out-of-school girls return to school, leadership training through women and girls' clubs, support for survivors of GBV, and community engagement, which includes working with men and boys and clan and religious leaders in community conversations. Save the Children Ethiopia includes FGM/C as a component of GBV within its work.

From 2016 to 2019, Save the Children, in partnership with **Rohi Weddu Pastoral Women Development Organization**, also worked on a project called 'Cementing Changes towards Zero Tolerance to FGM' in the Somali and Harari regions of Ethiopia.²⁶⁶ This project established child-led school clubs to raise awareness about HTPs and provided material support for girls to remain in school.

Care Ethiopia

Care Ethiopia is integrating work on child marriage and FGM/C with its projects related to disaster preparedness, education, water and sanitation.²⁶⁷ Working with pastoralist households in Somali and Affar, Care Ethiopia promotes income-generation and women's empowerment as means of increasing women's agency and decision-making power, including decisions made around HTPs such as FGM/C.²⁶⁸

Un Enfant par la Main and ChildFund Ethiopia²⁶⁹

Un Enfant par La Main and ChildFund Ethiopia are working to end FGM/C in five villages in the Bassona Worana district of Ethiopia. The project raises awareness in community members, trains and builds capacity in schools and with religious leaders, works with traditional cutters to provide alternative income sources and supports the economic empowerment of women.

Siiqqee Women's Development Association (SWDA)²⁷⁰

The Siiqqee Women's Development Association (SWDA) works on economic empowerment for women through self-help groups in Ameya District, South West Shoa Zone; Guto Gidda Woreda and Nekemte town in East Wollega Zone; and Bokoji town in Arsi Zone. The SWDA integrates health education into self-help groups to promote awareness about child health issues and about the effects of HTPs, such as FGM/C.



Part 3:
Next Steps

Next Steps

As outlined above, there are five major challenges that programmatic and policy responses in Ethiopia must address. While there are a number of organisations working to reduce the prevalence of the practice and, ultimately, see it eradicated, the following aspects must be addressed to effectively reach these goals:

- **increase** financial resources for the response to FGM/C in Ethiopia, prioritising a multi-sectoral and multi-faceted response to accelerate progress;
- **target** geographic hotspots;
- **gather and make available** sub-regional data;
- **engage with** the unique drivers and contextual factors associated with the practice in each community;
- **improve** research methods, using indirect approaches to explore attitudes and beliefs about FGM/C;
- **reduce** the social-exclusion risk for uncut women and girls by engaging men and boys, religious leaders and influential community members;
- **integrate** FGM/C awareness-raising, community dialogues, and skills training in relation to girls' rights and agency; and
- **strengthen and increase** economic opportunities for women and girls.

Recommendations

Considering our findings, we recommend that:

- activists and non-governmental bodies put pressure on the Government of Ethiopia to increase resources per its commitment to accelerate progress toward eliminating FGM/C;
- researchers and implementing organisations contribute to improving the availability of sub-regional data, to inform the targeting of programming at the zone and woreda level;
- strategies such as community conversations and community dialogues continue to be employed, engaging influential community members, religious leaders, and men and boys alongside women and girls;
- support be given to research that uses indirect questioning methods to more accurately explore the beliefs and attitudes people hold about FGM/C; and
- programming on economic strengthening and the economic empowerment of women and girls be integrated with approaches to eliminating FGM/C, to increase the likelihood of girls/women developing agency and decision-making power and reduce their risks of social exclusion.

Call To Action

Government of Ethiopia

We call on the Government of Ethiopia to:

- **increase** resource allocation in line with the *National Costed Roadmap to End Child Marriage and FGM 2020–2024* to reach the 10% commitment and accelerate progress toward eradicating FGM/C in Ethiopia; and
- **provide support** for the collection of sub-regional data on FGM/C trends (for example, at the levels of zones and woredas).

Stakeholders

We call on stakeholders, including government bodies, non-governmental organisations and others in Ethiopia, to:

- **advocate** for the Government and external donors to allocate resources in line with the *National Costed Roadmap to End Child Marriage and FGM 2020–2024*;
- **advocate** for the allocation of resources to grassroots and other organisations that are engaged in the long-term work of changing attitudes and beliefs about FGM/C;
- **use available data** to target interventions at hotspots;
- **work to fill the gap** in sub-regional data through effective monitoring and evaluation of interventions;
- **prioritise programming** that, firstly, seeks to understand the unique drivers of FGM/C and the risks of social exclusion faced by uncut girls and, secondly, tailors programmes to respond accordingly; and
- **include in programming** economic strengthening and the economic empowerment of women and girls with the aim of increasing their agency and decision-making powers.

Donors

We call on donors to **help finance** the *National Costed Roadmap to End Child Marriage and FGM 2020–2024*, in partnership with the Government of Ethiopia, and actively support programmes and initiatives that:

- **aim to validate** indirect-questioning methods as an approach to uncovering people's true attitudes and beliefs about FGM/C; and
- **engage** with the unique ethnic and cultural drivers of the practice, while working to reduce the risks of social exclusion to women/girls and to improve opportunities for them to exercise their agency.

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