COUNTRY PROFILE:

FGM IN ETHIOPIA

OCTOBER 2013

28 TOO MANY

FGM...
let's end it.

28 TOO MANY

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Contents

Foreword

In many sectors, benchmarking is increasingly used to enable organisations or countries to compare themselves to peers and good practice standards. The FGM sector is no different, and the 2012 UN resolution to end FGM could not have been adopted without evidence showing the extent of the practice and how it is changing.

Over 125 million women and girls alive today have experienced FGM in Africa and 30 million more girls will be affected over the next decade – one girl being cut every ten seconds. It also affects diaspora populations in Europe, North America, Australasia and some of the Middle East and Asia. FGM has no health benefits and has serious physical and mental health consequences. Immediate effects include bleeding, pain, and death, often due to its being carried out in unhygienic conditions. Longer-term impacts include menstrual and urinary retention, fistula, pregnancy and birth complications. Links have also been made to higher prenatal death and HIV. In addition, FGM has profound psychological impacts.

This Ethiopia Profile shows that over the five years from 2000 to 2005, the prevalence of FGM in the country (as measured in Demographic and Health Surveys) reduced from 79.9% to 74.3% – a decrease that is statistically significant.[1] Unfortunately, data on FGM was not provided for comparison in the 2011 survey. A 2007 survey by EGLDAM found FGM prevalence to be 57%. However, this result should not be directly compared with the DHS data.

Despite this progress, FGM remains a serious concern in Ethiopia and has affected 23.8 million women and girls, making it the second highest country in Africa by affected numbers. This is due to FGM being carried out across the majority of regions and ethnic groups, most frequently in Afar in the north-east (up to 91.6%), the Somali region in the south-east, bordering Somalia (up to 97.3%), and in Dire Dawa (92.3%).[2]

FGM in Ethiopia is associated with other harmful traditional practices and linked with low female literacy rates, inequality of women and men, early marriage and poor economic/political opportunities.

FGM has been in existence for over 2,000 years and is regarded as a customary rule of behaviour by practising communities (often referred to as a 'social norm'). Since I began working in this sector in 2005, major advances have been made in understanding how social norms operate, and my research paper, published this year,[3] shows some of that thinking. Most families whose girls undergo FGM adhere to the practice because those around them sustain and promote it. Important influencers such as parents, grandparents, community leaders and, in some cases, religious leaders support FGM. It is interwoven with social acceptability, marriageability and beliefs about what is normal and healthy. However, FGM is a human-rights violation, a severe form of violence against girls and women, and breaks several UN conventions.

Dr Catherine Hamlin, Founder of Addis Ababa Fistula Hospital (© 28 Too Many)

I worked in Ethiopia in 2011 and visited FGM projects, hospitals, schools and non-governmental organisations (*NGOs*). I was pleased to visit the Addis Ababa Fistula Hospital and its rehabilitation centre, Desta Mender, where I spoke with Dr Catherine Hamlin, the hospital founder and CEO. I

remember hearing the moving stories of women in the hospital. Many had been abandoned by their husbands and families because of incontinence and the smell resulting from the fistula, and they felt deep shame and isolation.

During my research in Ethiopia, I heard this story from Muna, a woman from the Afar area of Ethiopia. Muna had FGM Type III on the seventh day of her life. After marriage at age ten, she had her second child at 15. At full term, her labour lasted 12 days, and the baby was stillborn. She said, 'A week later, I could not walk and my urine flowed constantly.' She was treated with local remedies and advised to go to Addis Ababa for 'repair', but did not have the funds. Her husband left her, and she cared for her parents. In time, her fistula led to foot drop, and she says, 'I could no longer cut the wood from our land for money.' Soon after, her parents died. One day a pastor was taking one of his two daughters to a fistula clinic and wanted a stop-over. Muna says, 'The villagers sent them to me, as my room already smelled of urine. Later, to repay the thanks, they helped raise funds from an NGO for me to go myself. I can now enter church again, which I couldn't do before I got treatment. I now want to train as a nurse at the Hamlin Hospital. I do not want this to happen to my child.'

This story highlights why we all need to work together to end FGM: governments, NGOs, academics, the media and communities.

There is evidence that attitudes to FGM are changing, and many affected by FGM want the practice to end. With support and resources, we can build on this and bring about change in more and more communities until eventually FGM is eradicated.

While there is still much to be done and many challenges ahead, I am pleased that this profile confirms there has been progress in eradicating FGM in Ethiopia. I will be returning to Africa in early 2014, when 28 Too Many will be seeking partners, FGM advocates, research volunteers and donors to help end FGM across Africa and the diaspora. Our dream is that a women does not cut her daughter; then as a mother that daughter does not cut her own daughter; and as a grandmother, she will not cut her granddaughter/others in the community. Over three generations (36 years), major change can happen; over five generations (60 years), FGM could be eradicated. Meanwhile, 28 Too Many plans to create profiles on each of the 28 countries in Africa as a resource tool to the FGM and development sectors, governments, the media and academia. With your partnership, we can make these useful and often-accessed reports that share best practice. We are pleased to launch this report on Ethiopia to complement our earlier profiles on Kenya and Uganda, and thank all who contributed to it.

Dr Ann-Marie Wilson
28 Too Many Executive Director

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1 - Central Statistical Authority [Ethiopia] and ORC Macro (2001) *Ethiopia Demographic and Health Survey 2000*, p.33. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro. Available at https://dhsprogram.com/countries/Country-Main.cfm?ctry_id=65.
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2 DHS 2005, p.253.

3 Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1. Available at http://dx.doi.org/10.1080/09589236.2012.681182.

Information on Country Profiles

Background

28 Too Many is an international research organisation created to end female genital mutilation (*FGM*) in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework of knowledge and tools that enable in-country anti-FGM campaigners and organisations to be successful and make sustainable changes to end FGM. We hope to build an information base including detailed country profiles for each country practising FGM in Africa and the diaspora. Our objective is to encourage all those working in the anti-FGM sector to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes.

Purpose

The primary purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Ethiopia, many programmes are making positive, active change.

Use of This Country Profile

 We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: 28 Too Many (2013) *Country Profile: FGM in Ethiopia*, 2nd ed.) Available at **http://www.28toomany.org/Ethiopia/**.

Acknowledgements

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, as it would not have been possible without their collaboration.

28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

For more information, please contact us on **info@28toomany.org**.

The 2013 Team

Producing a Country Profile such as this is a collaborative process. We are very grateful to the following key contributors:

Katherine Allen is lead editor and a research intern for 28 Too Many. She is a DPhil (PhD) student in the history of medicine at the University of Oxford.

Daisy Marshall is research administrator for 28 Too Many. She is a third-year Applied Social Science degree student at Hull University.

Charlotte Morris is a research volunteer for 28 Too Many. She is a graduate of King's College, University of London and now works as a research assistant for the think tank 2020health, where she has contributed to a number of published reports including 'Personal Health Budgets: a revolution in personalization?' and 'Making Connections: a transatlantic exchange to support the adoption of digital health between the US's VHA and the UK's NHS'.

Johanna Waritay is research coordinator for 28 Too Many. Prior to this, she worked for 13 years as a lawyer at a leading international law firm in London. She has carried out research in three countries where FGM is practised.

Ann-Marie Wilson founded 28 Too Many and is the Executive Director. She published a paper this year in the *Journal of Gender Studies* entitled 'Can lessons be learnt from eradicating footbinding in China and applied to abandoning female genital mutilation in Somalia? A critical evaluation of the possibilities offered for developing strategies to expand current promising practice'.

Rooted Support Ltd donated time through its Director Nich Bull in the design and layout of the original version of this Country Profile, **www.rootedsupport.co.uk.**

We are grateful to the rest of the **28 Too Many Team** who have helped in many ways.

Subsequent Edits: The 2021 Team

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Cover: © Eric Lafforgue (http://www.ericlafforgue.com/) Diqoo, a Borana woman – El Dima Ethiopia.

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

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARP	alternative rite of passage
CBO	community-based organisation
CC	Community Conversation
CEDAW	Convention on the Elimination of Discrimination Against Women Committee on the Elimination of Discrimination Against Women
CRC	Convention on the Rights of the Child
CSP	Charities and Societies Proclamation
CSO	civil-society organisation
DHS	Demographic and Health Survey
EGLDAM	Ethiopian Association to Eliminate Harmful Traditional Practices
EWLA	Ethiopian Women Lawyers Association
FBO	faith-based organisation
FGC	female genital cutting
FGM	female genital mutilation
GDP	gross domestic product
HIV	Human Immunodeficiency Virus
HTP	harmful traditional practice
INGO	international non-governmental organisation
LGBTQ+	Lesbian, Gay, Bisexual, Transgender, Queer, Plus
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Surveys
NCTPE	National Committee for Traditional Practices in Ethiopia
NGO	non-governmental organisation
OECD	Organisation for Economic Co-operation and Development
SIGI	Social Institutions and Gender Index
SNNPR	South Nations Nationalities and Peoples Region
TBA	traditional birth attendant
UN	United Nations
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organisation
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WMS	Welfare Monitoring Survey

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

'DHS 2000' refers to:

Central Statistical Authority [Ethiopia] and ORC Macro (2001) *Ethiopia Demographic and Health Survey 2000*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro. Available at **https://dhsprogram.com/countries/Country-Main.cfm?ctry_id=65**.

'DHS 2005' refers to:

Central Statistical Agency [Ethiopia] and ORC Macro (2006) *Ethiopia Demographic and Health Survey 2005*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ORC Macro. Available at **https://dhsprogram.com/countries/Country-Main.cfm?ctry_id=65**.

'DHS 2011' refers to:

Central Statistical Agency [Ethiopia] and ICF International (2012) *Ethiopia Demographic and Health Survey 2011*. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Agency and ICF International. Available at **https://dhsprogram.com/countries/Country-Main.cfm?ctry_id=65**.

'EGLDAM' refers to:

- Ethiopian Association to Eliminate Harmful Traditional Practices (2008a) Old Beyond Imaginings: Ethiopia, Harmful Traditional Practices (2nd ed.)*
- F. Hailemeskel, Y. Kitaw and A. Dejene (2008b) Follow-Up National Survey on the Harmful Traditional Practices in Ethiopia. Addis Ababa: EGLDAM.*

Please note that neither of these documents was available online as at the date of Version 2 of this Country Profile.

'WMS' refers to:

Central Statistical agency and UNDP (2012) Ethiopian Welfare Monitoring Survey 2011 Summary Report. Central Statistical Agency Addis Ababa. Available at **https://catalog.ihsn.org/catalog/3124/related-materials**.

A Note on Data

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries – the Demographic and Health Survey (*DHS*) and the Multiple Cluster Indicator Survey (*MICS*). For Ethiopia, Demographic and Health Surveys were published in 2000 and 2005. (A later DHS survey conducted in 2011 did not cover FGM.) These surveys are referred to as DHS 2000 and DHS 2005 respectively throughout this report.

A country-wide baseline survey on harmful traditional practices was carried out by the National Committee for Traditional Practices in Ethiopia in 1997, and a follow-up survey was undertaken by the same organisation, now called the Ethiopian Association to Eliminate Harmful Traditional Practices, or *EGLDAM,* in 2007. Quantitative and qualitative methods were used to gather data from more than 65,000 people.

A Welfare Monitoring Survey (*WMS*) was conducted in 2011 by the Central Statistics Agency.

These surveys have different methodological approaches and, therefore, comparisons between them should be treated with some caution.

In DHS surveys, FGM data is self-reported, meaning that it is not based on physical examination. In general, UNICEF[1] emphasises that self-reported data on FGM 'needs to be treated with caution' since women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice. They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

Measuring the FGM status of girls, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses to questions about them may indicate the effect of laws criminalising the practice, or a shift in societal attitudes towards the continuation of the practice, which may make it harder for mothers to report that FGM 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 after the age of 14.

As for any dataset, it is 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, age or ethnicity. Therefore, in some cases the trends observed should be treated with caution. It should be made clear that any limitations of the data sources used in this report do not mean that the data is not useful; they simply mean that one should be careful about drawing 'hard and fast' conclusions, and 28 Too Many has accordingly taken that approach when researching and writing this country profile update.

1 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.24. Available at http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf.

Executive Summary

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

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

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

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

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

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

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (*FGM*) is defined by the World Health Organization (*WHO*)[10] as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence and has

been recognised as a harmful practice and a violation of the human rights of girls and women. Ethiopia has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights. A new **Criminal Code of 2005** specifically made FGM a crime, and some communities have passed by-laws outlawing it. According to the UNFPA, although the law may bring perpetrators to court, in practise, the guilty often receive a pardon.[11] The National Committee has, however, been working to improve the implementation and enforcement of the law.[12]

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

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

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

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

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

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

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

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

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

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

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

cut at a younger age, as it is believed the wounds heal more quickly and bleed less, and there is less pain for the girl.[22]

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

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

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

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

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

Primary **education** in Ethiopia is universal and free. Access to education has improved dramatically over the last two decades. Approximately three million pupils were in primary school in 1994/95, increasing to 15.5 million in 2008/09.[29] Literacy, however, remains very low, at 39%.[30] The 2010 Millennium Development Goals report[31] indicates that Ethiopia is on track to achieve universal primary education.

It is usually the case that a more highly educated woman is less likely to have her daughters undergo FGM. In Ethiopia, the prevalence of FGM decreases as the level of women's education increases: 64% of those aged 15–49 with a secondary or higher level of education have undergone

FGM, compared with 70.8% and 77.3% respectively of those with primary-school or no formal education. Among women with at least one living daughter, 18.7% of those who have a secondary or higher level of education have a daughter who has undergone FGM, compared with 24.7% of those who have a primary education and 41.3% who have no formal education.[32]

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

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

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

28 Too Many recommends:

- adopting culturally relevant programmes;
- providing sustainable funding to NGOs and INGOs;
- reflecting FGM in any post-millennium Development Goals strategies;
- including FGM in education;

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

1 EGLDAM.
2 Sonja Fransen and Katie Kuschminder (2009) *History of migration in Ethiopia: History, Current Trends and Future Prospects*. Paper Series: Migration and Development Country Profiles. Maastricht Graduate School of Governance. Available at http://mgsog.merit.unu.edu/ISacademie/docs/CR_ethiopia.pdf.
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23 -DHS 2000, p.33; DHS 2005, p.253.
24 EGLDAM.
25 Jo Boyden, Alula Pankhurst and Yisak Tafere (2013) *Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia*. Oxford: Young Lives. Available at: https://ora.ox.ac.uk/objects/uuid:e760844d-c7ce-46b8-9150-df9205e37633.
26 Reporters Without Borders (2012) *Ethiopia World Report*. Available at http://en.rsf.org/report-ethiopia,16.html.
27 DHS 2011, pp.42–43.
28 Boyden, Pankhurst and Tafere (2013), *op. cit.*
29 One (2011) *Ethiopia's Progress in Education*. Available at https://www.one.org/international/.
30 DHS 2011, pp.40–41.
31 Ministry of Finance and Economic Development (2010) *Ethiopia: 2010 MDGs Report – Trends and Prospects for Meeting MDGs by 2015*. Available at https://www.et.undp.org/content/dam/ethiopia/docs/2010%20Ethiopia%20MDG%20Report.pdf.
32 DHS 2005, pp.253 and 254.
33 *Reference unknown.*
34 Boyden, Pankhurst and Tafere (2013), *op. cit.*

Introduction

> *'It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.'*
>
> *~ The General Assembly of the United Nations*[1]

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (*FGM*) is defined by the World Health Organization (*WHO*)[2] as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.[3]

History of FGM

FGM has been practised for over 2,000 years.[4] Although it has obscure origins, there has been anthropological and historical research conducted into how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, when infibulations were referred to as 'Pharaonic circumcision'.[5] Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young women, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'[6]. There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves.

FGM is practised across a range of cultures and it is likely that the practice arose independently among different peoples[7], aided slave raids from Sudan for Egyptian concubines and the trading of maids through the Red Sea to the Persian Gulf[8].

Global Prevalence and Practices

FGM has been reported in 28 countries in Africa, mainly along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices,

FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

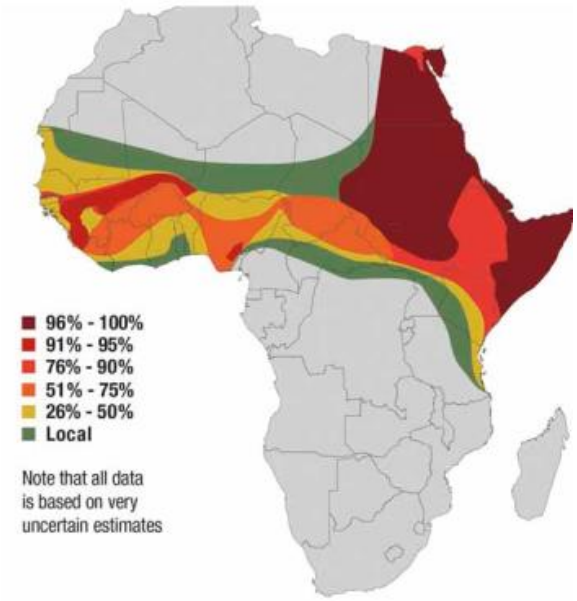

Figure 1: Prevalence of FGM in Africa (© 28 Too Many)[9]

The WHO[10] classifies FGM into four types:

Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 1: Types of FGM as classified by the WHO

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious texts require the practice, practitioners often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.[11] Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.[12]

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation, and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, community-based organisations, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local non-governmental organisations (*NGOs*) to be part of a greater voice to end FGM locally and internationally.

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1 UN General Assembly (2009) *The girl child: report of the Secretary-General*, p.17. Available at http://www.refworld.org/docid/4ac9ac552.html.
2 World Health Organization (2015) *Female Genital Mutilation*. Available at http://www.who.int/topics/female_genital_mutilation/en/.
3 UNICEF (2016) *Female Genital Mutilation/Cutting: A Global Concern*, p.2. Available at http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf (accessed June 2016).
4 Alison T. Slack (1988) 'Female Circumcision: A Critical Approach', *Human Rights Quarterly*, Vol. 10, pp.439.
5 *Ibid.*, p.444.
6 Lightfoot-Klein cited in Ann-Marie Wilson (2013) 'How the methods used to eliminate foot binding in China can be employed to eradicate female genital mutilation', *Journal of Gender Studies*, 22:1, p.4. Available at http://dx.doi.org/10.1080/09589236.2012.681182.
7 *Ibid*.
8 Mackie cited in Ann-Marie Wilson, *op. cit.*
9 *Afrol News* [no longer available online].
10 World Health Organization (2016) *WHO guidelines on the management of health complications from female genital mutilation*, pp.2-4. Available at http://www.who.int/reproductivehealth/topics/fgm/management-health-complications-fgm/en/ (accessed 18 June 2017).
11 *Ibid.*, p.1.
12 World Health Organization (2016), *op. cit.*, p.vii.

General National Statistics

This section highlights a number of indicators of Ethiopia's context and development status.

Population

93,877,025 (July 2013 est.)

Growth rate: 2.9% (2013 est.)

Median age: 17.5 years

Human Development Index

Rank: 173 out of 186 in 2012[1]

Health

Life expectancy at birth (years): 60 (2013 est.)

Infant mortality rate (per 1,000 live births): 58.3 deaths; world rank: 29 (2013 est.)

Maternal mortality rate: 350 deaths/100,000 live births; world rank: 32 (2010)

Fertility rate, total (births per woman): 5.31 (2013 est.)

HIV –adult prevalence: 1.5% (2012 est.) (women – 1.9% ; men – 1.0%)[2]

GDP (in US dollars)

GDP (official exchange rate): $41.91 billion (2012 est.)

GDP per capita (PPP): $1,200 (2012 est.)

GDP (real growth rate): 7% (2012 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 39% (female – 38.4%; male – 65%)[3]

Urban female: 69%; rural female: 29%

Urban male: 90%; rural male: 59.8%[4]

Youth (ages 15–24): 55% (female – 47%; male – 63%)[5]

Marriage

Girls aged 15–19 who are married, divorced, separated or widowed: 21.6%[6]

Married girls or women who share their husbands with at least one other wife: 10.5%[7]

Urbanisation

Urban population: 17% (2010)

Rate of urbanisation: 3.57% annually (2010–2015 est.)

Religions

Christian – 62.8% (Ethiopian Orthodox – 43.5%, Protestant – 18.6%, Catholic – 0.7%), Muslim – 33.9%, Animist – 2.6%, other – 0.7%[8]

Ethnic Groups

Oromo – 34.5%, Amhara/Amara– 26.9%, Somali/Somalie – 6.2%, Tigray/Tigrigna– 6.1%, Sidama – 4%, Gurage – 2.5%, Welaita – 2.3%, Hadiya 1.7%, Afar/Affar – 1.7%, Gamo 1.5%, Gedeo – 1.3%, other – 11.3%[9]

Languages

Oromo (official regional) – 33.8%, Amharic (official) – 29.3%, Somali – 6.2%, Tigrayan (official regional) – 5.9%, Sidamo – 4%, Wolaytta – 2.2%, Guragiegna – 2%, Afar – 1.7%, Hadiyya – 1.7%, Gamo – 1.5%, other – 11.7%, English (official) (major foreign language taught in schools), Arabic (official)[10]

Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2013) *The World Factbook: Ethiopia*. Available at https://www.cia.gov/the-world-factbook/countries/ethiopia/.

1 UNDP (2012) *Human Development Index*. Available at http://hdr.undp.org/en/content/human-development-index-hdi.
2 DHS 2011, p.234.
3 DHS 2011, pp.40–41.
4 *Ibid*.
5 The World Bank (2013) *Literacy Rate, Youth*. Available at https://data.worldbank.org/indicator/SE.ADT.1524.LT.ZS.
6 DHS, 2011, p.60.
7 DHS, 2011, p.61.
8 Central Statistical Authority, Addis Ababa (2007) *Population and Housing Census Report*. Previously available at www.csa.gov.et/.
9 *Ibid*.
10 *Ibid*.

Millennium Development Goals

The eradication of FGM is pertinent to six of the UN's eight Millennium Development Goals (*MDGs*). Throughout this report, the relevant MDGs are discussed within the scope of FGM.

The Millennium Development Goals

Goal 1: Eradicate Extreme Poverty and Hunger

According to the World Food Programme, the scale of food insecurity and malnutrition in Ethiopia remains serious. 23 million people have insufficient income to meet their food needs.

Ethiopia is prone to natural disasters, and weather-related shocks have exacerbated food insecurity. At least half of the highlands are degraded, and pastoral areas are over-grazed.[1] This MDG is relevant given the correlations between food insecurity and education, and education and FGM. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity.[2] Education is also important in tackling FGM, as discussed in Education and FGM. This illustrates the links between the MDGs and the key role education can play in combating not only FGM, but also another pressing development issue for Ethiopia, namely food insecurity.

Goal 2: Achieve Universal Primary Education

The aim of this MDG is to provide universal primary education, with a target of, by 2015, all boys and girls completing a full course of primary schooling. The chances of girls undergoing FGM are reduced if they complete their schooling. See section on Education and FGM on page 62.

Goal 3: Promote Gender Equality and Empower Women

The aim is to eliminate all gender disparity in primary and secondary education by 2015. FGM is a manifestation of deeply entrenched gender inequality and constitutes an extreme form of discrimination against women. Moreover, there is a correlation between the level of a woman's education and her attitude towards FGM. See the section on Education and FGM on page 62.

Goal 4: Reduce Child Mortality

FGM has a negative impact on child mortality. A World Health Organization (*WHO*) multi-country study, in which over 28,000 women participated, has shown that death rates among newborn babies are higher to mothers who have had FGM.[3] See the section on Women's Health and Infant Mortality on page 66.

Goal 5: Improve Maternal Health

This MDG aims to reduce maternal mortality by 75% between 1990 and 2015. In addition to the immediate health consequences arising from FGM, the practice is also associated with an increased risk of childbirth complications. See section on Women's Health and Infant Mortality on page 66.

Goal 6: Combat HIV and AIDS, Malaria and Other Diseases

Although the correlation between HIV and FGM is not as direct as some research has claimed, there are a number of potential sources of HIV transmission associated with FGM and its consequences. See section on HIV and FGM on page 65.

Post-MDG Framework

As the MDGs are approaching their 2015 deadline, the UN is evaluating the current MDGs and exploring future goals. After 2015, the UN will continue its efforts to achieve a world of prosperity, equity, freedom, dignity and peace.

Currently, the UN is working with its partners on an ambitious post-2015 development agenda and striving for open and inclusive collaboration on this project.[4]

The focus of the UN Commission on the Status of Women (*CSW*) 58 is on the challenges and achievements in the implementation of the MDGs for women and girls, including the access to and participation in education by women and girls. The UN is also conducting the MY World survey, in which citizens across the globe can vote (offline and online) on which six development issues most impact their lives. These results will be collected up until 2015 and will influence the post-2015 agenda.[5]

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's 16 areas of focus for development.

On the issue of gender violence, there has been a growing call for the post-MDG agenda to include a distinct focus on ending violence against women.[6]

Though it is highly unlikely that FGM will be eliminated in Ethiopia by 2015, it is nonetheless encouraging that the MDGs have ensured a persistent focus on areas related to FGM (see above). The post-2015 agenda will undoubtedly provide renewed, if not stronger, efforts to improve women's lives. Additionally, the African Union's declaration of the years from 2010 to 2020 to be the decade for African Women will certainly assist in promoting gender equality and the eradication of gender violence in Ethiopia.

1 World Food Programme, 2011, Country Programme Ethiopia 200253 (2012-2015) *Executive Board Second Regular Session, Rome 12-17 November 2011, Agenda Item 8*. 6 September 2011.
2 Francesco Burchi, Pasquale De Muro (2007) *Education for Rural People and Food Security A Cross Country Analysis*. Food and Agriculture Organization.
3 WHO study group on female genital mutilation and obstetric outcome; Emily Banks, Olav Meirik, Tim Farley, Oluwole Akande, Heli Bathija, and Mohamed Ali (2006) 'Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries', *Lancet* 367(9525), pp.1835–1841. Available at https://pubmed.ncbi.nlm.nih.gov/16753486/.
4 United Nations (2014) [website]. Available at www.un.org.
5 United Nations (undated) *My World: The United Nations Global Survey for a Better World*. Available at http://www.myworld2015.org/.
6 Caroline Harper (2013) 'Gender, Violence and the Post-2015 Framework,' *Overseas Development Institute*, 24 January. Available at https://www.odi.org/comment/7220-gender-violence-and-post-2015-framework.

Political Background

Historical

Ethiopia has been largely ruled by an ancient monarchy and remained free from colonial rule, apart from a brief Italian occupation from 1936 to 1941.

In 1974 the last emperor Haile Salisse was overthrown in a military coup led by the socialist regime the Derg 'committee'. This period of totalitarianism was known as 'Red Terror'. Violence continued into the 1980s during periods of retaliation. The regime ended in 1991 through the efforts of a rebel coalition, the Ethiopian People's Revolutionary Democratic Front (*EPRDF*). In 1994 a constitution was adopted and multi-party elections were first held in 1995.

Ethiopia has experienced ongoing border conflicts, including a war with Eritrea in the 1990s, ending in a peace treaty in 2000. Warfare also occurred between Ethiopia and Somalia from 1977 to 1978 over the Ogaden region. Due to a series of regional conflicts, the Horn of Africa is now known internationally for its refugee crises: over a million people have crossed borders and there are challenging conditions in the refugee camps.[1]

Current Political Conditions

Meles Zenawi of the Ethiopian People's Revolutionary Democratic Party (*EFRDP*), was in power from the first elections in 1995 to his death in August 2012. His deputy, Hailemariam Desalegn, has become prime minister until the next elections in 2015.

Ethiopia is a federal republic and officially a democracy, although there have been widespread accusations of fraud and irregularities during elections and in the running of the Government.

The Constitution guarantees extensive human and political rights, including the right to engage in political activities and organise political parties.[2] In reality, there is very little academic freedom and an intolerance of opposition to the Government.[3] Human-rights issues relating to politics include allegations of torture, corrupt judiciary/administrative and police systems, infringement of citizens' privacy rights and restrictions to refugees' movement and freedom.[4]

Ethiopia has a decentralised government and operates under a policy of 'ethnic federalism' wherein there are nine national states and two city states, which have significant administrative authority over economic and social policies. Rural regions are divided into district councils called *woredas,* and city states are divided into village regions known as *kebeles*. As a result of rapid decentralisation, as well as a lack of leadership, human and financial resources, local authorities face challenges to coordinating among offices and implementing changes.

The Ethiopian Diaspora

There is a large Ethiopian diaspora living around the world, which has created numerous organisations, radio and television broadcasts, and media sites to connect Ethiopians within the diaspora and engage those in the diaspora with Ethiopia. For example, the Ethiopia North America Health Professionals Association brings together health professionals in the diaspora to offer

distance-learning specialised training for Ethiopian medical professionals, visiting surgical teams, and financial support for healthcare in Ethiopia. Members of the diaspora are also highly engaged in Ethiopian politics and were active in supporting the passing of the Ethiopia Democracy and Accountability Act of 2007 by testifying before the US Congress, circulating petitions in support of the bill and fundraising. During the 2005 elections, the diaspora supported opposition groups to the ERPDF, notably the Coalition for Unity and Democracy (*CUD*).

Politics and Food Security

Ethiopia remains one of the poorest countries in the world, ranking 173 out of 186 on the Human Development Index[5], and regularly faces famines, droughts, and political instability.

Food security is critical in Ethiopia and the Government's policy to overcome famine has been a source of much criticism. The Food and Agricultural Organisation of the UN estimates that 44% of the country's population were undernourished in 2009. Ethiopia experienced catastrophic famines in 1973, 1977/1978, 1983/1984 and 1993. The famine of 1983/1984 was the most severe, leaving around 300,000 people in the Tigray and other areas of northern Ethiopia dead. There were over a million mortalities in total.

One of Government's techniques to overcome famine has been a policy of resettlement, known as 'villagisation'. This involves the relocation of rural citizens into government-made villages which are highly monitored by the army. They aimed to move 2.2 million people from the chronically food-insecure highlands to the fertile agricultural lowlands within three years. The programme encompassed the Tigray, Oromia, Amhara, and SNNPR regions. Re-settlers received a plot of land, some start-up supplies, and eight months of food rations. The Government has hailed the programme as a success, but there has been widespread criticism of the programme from the national and international community.[6]

1 Sonja Fransen and Katie Kuschminder (2009) *History of migration in Ethiopia: History, Current Trends and Future Prospects*. Paper Series: Migration and Development Country Profiles. Maastricht Graduate School of Governance. Available at http://mgsog.merit.unu.edu/ISacademie/docs/CR_ethiopia.pdf.
2 EGLDAM.
3 Fransen and Kuschminder, *op. cit.*
4 US Department of State (2012) *Human Rights Report 2012*. Available at https://2009-2017.state.gov/j/drl/rls/hrrpt/2012humanrightsreport//index.htm#wrapper.
5 UNDP (2012) *Human Development Index*. Available at http://hdr.undp.org/en/content/human-development-index-hdi.
6 Fransen and Kuschminder, *op. cit.*

Anthropological Background

Ethiopia has a large number of distinct peoples with differing concepts of identity. The Government formally recognises 64 major ethnic groups, although the 1995 census recognised 82 ethnic groups, 51 of which had a population of 20,000 or more and made up 99% of the population (see General National Statistics above).[1]

Political regions are constructed along ethno-linguistic, rather than strictly geographic, lines. While this division of Ethiopia gives certain ethnic groups explicit political significance, none of the states are ethnically homogenous, which has encouraged much internal migration as ethnic groups move to their ethnic region.[2]

Ethiopia has a high number of immigrants. It has been recorded that there are 66,980 refugees from Sudan, 16, 576 from Somalia and 13, 078 from Eritrea.[3]

Women tend their livestock near Addis Ababa (© Martin Good/Shutterstock.com)

Clan and ethnic affiliations are important in Ethiopia, and tensions between ethnic groups are rife. Interethnic conflict is mainly attributed to food insecurity and 'collective fears of the future'.[4] Resource scarcity often results in forced migration, and this increases contact and competition between differently identifying groups.[5] These tensions are heightened when conflicts arise between groups who have histories of conflict over grazing-land rights.

The Government's decentralisation attempts have re-ignited hostile relations between ethnic groups because of administrative borders superimposed over pre-established resource borders, interfering with traditional group interactions.[6] Sceptics of the Government's federalisation policy infer that the State's involvement is aimed at pre-empting community support for armed groups by creating inter-community discord and, thus, discouraging these groups from building joint political alliances against the state.[7]

In western Ethiopia there are ongoing ethnic clashes in the Gambela region between the indigenous people from the area, the Anuak (21.1% of the Gambela population) and the newcomer Ethiopians, referred to as 'highlanders'.

In southern Ethiopia, there is a longstanding conflict between the Ethiopian Somali groups and the Borana people, a pastoralist group living in Oromia. Since the revolution of 1974, the Borana have united with the Ethiopian State against the Somali people in Ethiopia, mainly because of ongoing

inter-state conflicts between Ethiopia and Somalia. Today, the regional borders of the Oromia and Somali states are not marked on the ground, but follow the distribution of respective linguistic groups. The Oromo is an ethnic group that remained independent until the 19th century, and has since been subject to suppression, looting of its resources, and a division of its people by region and religion.

Until 1991 the Oromo people did not have equal rights to the Amhara; nor did several other ethnic groups. They were not permitted to display any manifestations of their culture or language, and were not allowed to enter politics or attend schools. Oromo people continue to report injustices against them by the Government, and, as noted above, continue to fight for independence.

FGM by Ethnicity

Out of 66 of Ethiopia's largest ethnic groups (there are 82 in total), 46 carry out FGM. In the two ethnic groups where the prevalence of FGM is highest, close to 100% of women have undergone FGM. Prevalence among ethnic groups varies considerably.

The Oromo, Amhara, Somali and Tigray are significant practising ethnic groups (i.e. the population of these groups accounts for more than 5% of the population). The Afar are also noteworthy, given the high prevalence of FGM within the Afar region, where that ethnic group mainly resides.

Girls in Harar (© Giovanni De Caro)

Afar

The Afar people are an ethnic group primarily residing in the Afar region of north-eastern Ethiopia, but also in Eritrea and Djibouti. They make up about 1.73% of the Ethiopian population, numbering around 1.3 million people.[8]

The Afar are traditionally **pastoralists**, raising goats, sheep, and cattle, and are somewhat isolated from mainstream Ethiopian society.

Afar people are predominantly **Muslim**, with a patrilineal clan structure and several semi-autonomous lineages. Lineages are inter-related in a number of ways, such as intermarriage and kin ties. These inter-relationships make Afar culture remarkably coherent.

Literacy rates in Afar are among the lowest in Ethiopia (20.3% for women and 52.5% for men) when compared to the national average of 38.4% for women and 66.5% for men aged 15–49.[9] Development infrastructure is minimal.

Gender roles are clearly defined: men make important decisions and own the majority of the resources, while women are expected to take care of children and small animals while fulfilling domestic duties. Women are the poorest and most marginalised cohort within the Afar communities.

Traditional social-control systems are cohesive and well organised, with elders and customary laws being assigned an *Afar-madaa* authority, and the *Finaa* institution being responsible for executing sanctions. These are seen as important parts of the Afar cultural heritage, which should be protected and used sustainably.[10]

The Afar people have one of the highest rates of FGM in Ethiopia. In the Afar region, the DHS surveys show a decline in the **FGM prevalence** among women aged 15–49 from 98.6% (2000) to 91.6% (2005).[11]

According to the DHS data, the percentage of women in Afar with one or more daughters under 15 years of age who have had FGM was 93.6% in 2000 and 85.1% in 2005.[12] In 2011, 59.8% of girls between the age of 0–14 living in Afar had undergone FGM. However, the WMS data should not be compared directly with the DHS data.[13]

65.6% of women in Afar who have heard of FGM still believe that the practice should be continued.[14]

According to one study, FGM accounts for the difference in mortality rates between men and women.[15]

The most common **type of FGM** among women in Afar is Type III, infibulation. According to DHS 2005, 63.2% of cut women have undergone Type III.[16]

Afar girls undergo FGM generally very soon after birth, within the first eight days. Many of the Afar believe that FGM prevents enlargement of the labia and consider the clitoris to be ugly. They also often believe that prayers and offerings by uncut women are not accepted by God. Further, for the Afar, infibulation ensures that women are virgins when they get married, which is something they value highly, and it forms part of marriage transactions.[17]

Amhara

The Amhara people make up 26.9% of the Ethiopian population,[18] number just under 20 million people and are the **second-largest ethnic group** in Ethiopia. Their language, Amharic, is the official language of Ethiopia. They live in the central highlands of Ethiopia and have inhabited this area for more than 2,000 years.

The predominant religion of the Amhara is **Ethiopian Orthodox Christian**.

In 2005, 68.5% of women (aged 15–49) living in the Amhara region had undergone **FGM**, compared to 79.7% in 2000.[19]

The EGLDAM 2007 survey found the prevalence to be 62.9%.[20] However, the latter figure should not be directly compared with the DHS data.

In 2011, 47.2% of girls aged 14 and under and living in the Amhara region had undergone FGM.[21] According to DHS data, the proportion of women with one or more daughters under 15 years of age

who had had FGM was 78.5% in 2000 and 56.8% in 2005.[22] (Note that the DHS and WMS figures should not be compared).

In 2005, 39% of Amhara women thought that FGM should continue.[23]

The most **common type of FGM** among the Amhara is reportedly Type I, and it is carried out as early as the eighth day after birth.

For the Amhara, there is a strong belief that FGM is a protective feature of childbirth.[24] Among Orthodox Christians in Amhara, FGM is also often justified by a belief that there are rare cases of girls being 'naturally circumcised', which has been referred to as 'a circumcision by Mary'.

Daasanach

The Daasanach, who number about 48,067 (0.07% of Ethiopia's entire population),[25] live on the semi-arid land where the Omo River delta enters Lake Turkana in the Omo valley. Environmentally, this is a hazardous place to live, with high temperatures, malarial mosquitos and frequent droughts. The area has also been known to flood severely, taking the lives of many Daasanach.

Cattle are essential to the Daasanach way of life, and members who lose their cattle through disease, drought or theft are forced to become *Dies* or 'poor people', an underclass – part of the tribe, but set apart due to their economic and cultural status. They then make their livelihood on Lake Turkana, where they fish and hunt, or cross tribal boundaries to join another group.

Building the huts and deconstructing them for migration is the responsibility of the female members of the tribe. The huts are semi-circular, single-room constructions made of sticks and branches. The women claim the right side of the hut for themselves.

Membership of the tribe is not governed entirely by ethnicity; anyone can join, male or female, provided they agree to male circumcision or FGM. Girls undergo **FGM** at the age of 10 or 12 years. FGM is related to marriageability: the payment of a girl's bride price depends on her having had FGM. Until girls are cut, they are called 'wild animals' or 'men', and it is believed that the clitoris needs to be removed for them to act like women. **Marriage** takes place soon after the girls undergo FGM.[26]

Oromo

The Oromo are the largest ethnic group in Ethiopia, numbering 25,489,024, and making up around 34.5% of the entire population.[27] They are mainly concentrated in the Oromia region, but, because of their large number, they can be found in nearly all regions of Ethiopia.

The Oromo view **aging** as positive, giving more respect to people as they grow older. Men adhere to the *gadaa* system, in which they move into a new age group every eight years, each being more respected than the last. Younger men are expected to fulfil physical tasks, whereas elders are revered as wise and ponder issues as they arise, giving advice where it is needed.

Gender roles are rigidly followed from the age of three. Girls are taught domestic tasks and cattle tending, while boys are taught hunting, farming, horse riding and survival techniques. The father is considered the head of the household, but the mother is responsible for the day-to-day lives of the family. Women are respected and **physical spousal abuse** is forbidden in Oromo law.[28]

The Oromo have their own traditional **religion**, but Islam and Christianity are also commonly practised.

In the Oromia region, 87.2% of women aged 15–49 have undergone **FGM**,[29] or 58.5% according to EGLDAM survey of 2007.[30] FGM is often carried out on infant girls as early as the eighth day after birth, but sometimes later.

Somali

The Somali people are an ethnic group living in the Horn of Africa. Around 4.6 million[31] of them live in the Somali Region of south-east Ethiopia, making up 6.2% of the Ethiopian population. There is internal pressure to remove Ethiopian rule from the Somali region, and there have been attempts to incorporate the region into Somalia.

The vast majority are **Sunni Muslims**, and less than 1% are Orthodox Christian.

Somali girls in traditional dress (© EcoPrint)

The Somali region has one of the highest **prevalences of FGM** in Ethiopia, measured in the DHS 2005 to be 97.3%.[32] The EGLDAM survey of 2007 measured prevalence to be 70.7%.[33]

The prevalence in girls is more encouraging: 28.1% of women have at least one daughter aged 0–14 who has been cut.[34] This is much lower than in other regions such as Afar (85.1%), although many of these girls may still be at risk of being cut. Clearly, however, it is a complex issue, since 74.3% of women in the Somali region who are aware of the practice believe that it should continue.[35] This is the highest level of **support** among women in any Ethiopian region, despite 60.9% of women recognising the harmful consequences of FGM.[36]

The most common **type of FGM** amongst the Somali people is Type III, infibulation. The DHS 2005 estimates that 83.8% of cut Somali women have undergone infibulation.[37]

FGM is carried out because there is a belief that it is not possible to rape a girl who has been infibulated, and it therefore preserves the 'sanctity' of women. Somali girls often stay outside the home and may spend the day working in the bush, herding animals. There is a concern that if FGM stops, women will not be protected from rape.

The prevalence of FGM among Somalis is high regardless of the national context in which they reside. The prevalence among ethnic Somalis in Ethiopia (and in Kenya) is very similar to that of Somalia itself, rather than the national prevalence for Ethiopia (or Kenya).

Tigray

Numbering around 4,483,892 and making up roughly 6.1% of the population,[38] the Tigray people mostly live in the northern highlands of Ethiopia's Tigray province, although a few live in the Amhara region and Eritrea. They speak Tigrinya, which descends from an ancient Semitic language called Ge'ez.

The vast majority of Tigray follow the **Ethiopian Orthodox Christian** religion; churches are built on hills and are an important part of Tigray culture.

Families, some consisting of eight or more children, are responsible for their own food supplies. Women often work between 12- and 16-hour days, fulfilling domestic duties and cultivating crops; children are usually expected to collect water.

Tigray **homes** blend in to the natural habitat and are made of a few timber poles, rocks and earth.

Marriage is monogamous and arranged by contracts under which the bride's family is expected to pay a dowry.

29.3% of women in Tigray province are affected by **FGM**, a decline from 35.7% in 2000.[39] The WMS found the prevalence in 2011 to be 22.1%.[40]

Types I and II are practised,[41] and cutting usually takes place when babies are eight days old.

FGM Rituals

The Afar

In Northern Ethiopia, in a region known as the Afar, infant girls are typically cut before the eighth day after birth. The procedure is considered a family affair and done privately, without any ritual.

After the girl has been cut, her labia majora is held together with thorns inserted horizontally, and a paste made from traditional herbs is applied to the wound. If the girl survives and the wound heals, the entrance to the vagina is sewn closed except for a tiny opening created by inserting a splinter of wood or corn.

On the girl's wedding night, the groom carries out de-infibulation using 'a double-edged dagger or any sharp instrument'.[42]

The Sidama

In Southern Ethiopia, it is more common for FGM to be celebrated as an event. Among the Sidama ethnic group, cutting is done after a wedding has taken place, but before marriage consummation at the home of the groom's mother. The bride's new mother-in-law is present to allow her to confirm the girl's virginity.

The bride sits on a stool, with her head and arms held back while her bridesmaid covers her eyes. Her legs are extended and opened wide to expose the vulva. Force must be used to hold her down, as the operation is carried out without any form of anaesthetic. The cutter starts with the excision of the clitoris. Depending on the type of FGM, she proceeds to cut the labia minora and in some cases also the labia majora.

The procedure is followed by a celebration. Female members of the bride's family are expected to bring fresh produce from an animal, usually butter or milk.[43] The bride then goes into a two-month seclusion period while she heals, during which she is fed buttermilk and meat at the expense of the groom's family.[44]

The Gurage

It is not common in Ethiopia for girls to undergo FGM as a group, but there are certain instances where FGM is carried out on girls over the age of seven and a number of girls undergo the procedure together. When cutting is done in this way, it is often followed by the giving of gifts by parents and relatives, such as clothes and jewellery. Performing FGM in this way has both a psychological advantage, as the girls can support each other, and an economic advantage for families, as the parents of the girls can girls can pay the cutter jointly.[45]

Among the Gurage people, boys and girls are circumcised/undergo FGM between the ages of eight and ten. A special caste of former hunters performs the ceremonies, and they are done as rites-of-passage ceremonies that involve a number of children. The girls undergo a 'a symbolic ritual abduction by the chief of a special caste and remain secluded for about a month in the bush, where they are taught a ritual language, kept secret from men and used at religious festivals'. Following the rite of passage, these children are considered age-mates and remain members of this group until marriage.[46]

> *In Amharic the traditionally accepted word for FGM which continues to be used is 'girzet'. In Tigray male and female circumcision is referred to as 'mknshab'. In the Afar the word 'selot' refers to FGM and in the Ormomia 'kitanaa' is used. These words do not convey the concept or perception of a 'mutilation' and distinctions based on the type of FGM are not evident in all local languages.*[47]

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Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on our website.

International and Regional Treaties[1]

Ethiopia has signed several international human rights conventions, which provide a strong basis for the characterisation of FGM as a violation of international human rights:

- Convention on the Elimination of Discrimination Against Women (*CEDAW*) (Protocol not signed);
- Convention on the Rights of the Child (*CRC*);
- International Covenant on Economic, Social and Cultural Rights (*ICESR*);
- African Charter on the Rights and Welfare of the Child;
- Maputo Protocol to the African Charter on Human and Peoples' Rights on the Rights of the Women in Africa (the 'Maputo Protocol') (signed but not ratified); and
- African Charter on Human and People's Rights (the 'Banjul Charter').

In December 2012 the UN passed an historic resolution, calling on countries to eliminate FGM, and in 2013 the 57th UN Commission on the Status of Women's agreed conclusions included a reference to the need for states to develop policies and programmes to eliminate FGM and other forms of violence against women.[2]

In addition, the African Union declared the years 2010 to 2020 to be the Decade for African Women.

The **CEDAW** and the **CRC** clearly prohibit traditional practices that discriminate against women and harm children. Article 2 of CEDAW directs 'State Parties . . . (f) To take all appropriate measures, customs and practices which constitute discrimination against women.' Additionally, Article 5 states, 'State Parties shall take all appropriate measures: (a) to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes . . .' Article 24(3) of the CRC states, 'State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.' In addition, Article 19(1) provides that 'State Parties shall take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury, or abuse.' Ethiopia ratified CEDAW in 1981 and CRC in 1991.

Under the **ICESCR**, FGM is a violation of the right to health. Article 12(2) provides that '[t]he steps to be taken by State Parties to the present Covenant to achieve the full realization of [the right to health] shall include those necessary for: (a) The provision for . . . healthy development of the child . . .' 'Health' is defined so as to include 'maturity, reproductive and sexual health'. FGM thus violates the convention due to its numerous health consequences, as discussed in the section Women's Health and Infant Mortality on page 66.

The African Charter on the Rights and Welfare of the Child requires member states of the African Union to abolish customs and practices harmful to the 'welfare, dignity, normal growth and development of the child and in particular: (a) those customs and practices discriminatory to the child on the grounds of sex or other status . . .'

The Maputo Protocol explicitly refers to FGM. Under Article 5, 'state parties shall prohibit and condemn . . . through legislative measures backed by sanctions, (b) all forms of female genital mutilation, scarification and para-medicalisation of female genital mutilation and all other practices in order to eradicate them.'

The Banjul Charter includes provisions related to the right to health (Article 16) and the right to physical integrity (Articles 4 and 5).

Ethiopia's Constitution endorses all international treaties ratified by Ethiopia as constituting part of the country's legal system (Article 9.2).

National Laws

Age of Suffrage, Consent and Marriage

The legal age for marriage is 18; however, as discussed in the Role of Women section below, this is weakly enforced. The minimum age for consensual sex is 18 years, yet 21.6% of girls aged 15–19 have been married.[3] The age of suffrage is also 18 years.

History of Anti-FGM Law

In the **1960 Penal Code**, there was a prohibition against torture and the cutting off of any body parts. This provision was interpreted by some as prohibiting FGM.

Articles 16 and 35 of the 1995 Constitution protect women from bodily harm and from harmful customary practices.

A new **Criminal Code** of 2005 specifically made FGM a crime and aligned domestic law with the rights-orientated Constitution.

The Criminal Code 2005

The Criminal Code was passed in 2005. **Articles 568 and 569** contain provisions on 'circumcision' (meaning, in this context, Types I and II FGM) and Type III infibulation, respectively. In **Article 568**, the penalty for Type I or II FGM is from three months' to three years' imprisonment and a fine of no less than Birr 500–10,000 (approximately US$27–528), or both imprisonment and a fine. **Article 569** focuses on Type III infibulation and provides, 'Anyone if engaged in stitching the genital part of a woman shall be punished by rigorous prison term of 3 to 5 years. If the practice causes physical or health injury notwithstanding the severe punishment provided in the Penal Code, the penalty will be rigorous prison term of 5 to 10 years.'[4]

By-Laws

Some communities have passed by-laws outlawing FGM. For example, in Siraro District, West Arsi Zone, Oromia, where the African Development Aid Association has had a programme (see Interventions and Attempts to Eradicate FGM on page 69) that includes raising awareness about the

national anti-FGM law, a number of communities have passed by-laws against FGM, and others are contemplating adopting the same approach.[5]

Enforcement of the Law

There was, reportedly, enforcement of the law in 2012, although the number of cases is not clear from UNICEF's Annual Report. In 2012, in the Afar region, a traditional cutter and the parents of six girls were arrested, tried and sentenced. The cutter received a six-month prison sentence and the parents were fined 500 Birr (US$27) each. This case received wide coverage on Ethiopian television, thus acting as a deterrent and an awareness-raising tool.[6]

In 2011, there were eight legal actions reported.[7]

In 2010, it was reported that nine cutters were arrested in Afar, seven of which were sentenced to between three and five years' imprisonment.

According to the UNFPA, although the law may bring perpetrators to court, in practise, the guilty often receive a pardon.[8]

Challenges to law enforcement include the following.

- According to the Ethiopian Women Lawyers Association (*EWLA*), most people in rural areas do not see the police and courts as the place to go to resolve conflict.[9]
- Awareness of the law is very poor, even among law enforcement agencies.[10]
- There is a reluctance by some law enforcement officials to fully enforce the laws. The police and courts often promote traditional arbitration, and, where the case does go through the formal court system, lenient punishments or pardons are given.[11]
- FGM often happens in secret where enforcement action is stronger.[12]

Interestingly, one report highlighted that advocacy and law enforcement have had a demonstrable effect on shifting values among those in positions of authority, including local government.[13]

> *'The anti-FGM/C law helped us a lot in the fight against FGM/C. But we don't see the enforcement of the law as the only option.'*
>
> *~ Head of the Women's Affairs Office of the local district in Afar*

Bogalech Gebre, the founder of KMG (Kembatti Mentti-Gezimma-Tope, which means 'women of Kembata working together'), has stated that enforcement of the law is very weak and that there is a lack of connection between law making, policy and enforcement.[14] Although there have been positive steps made to improve law enforcement, there is scope to improve further capacity and increase the number of prosecutions.

The National Committee has, however, been working to improve the implementation and enforcement of the law and has drafted an integrated and multi-sector strategy and action plan to effectively prevent and respond to violence against women and children, including FGM. A **National Coordination Body** located in the Ministry of Justice has the task of implementing the plan.[15]

The **UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation** (*UNJP*) in 2012 supported capacity-building within the judicial system by training 150 people in law enforcement. In addition, 10,800 people were informed about the law.[16]

EGLDAM, in cooperation with the **EWLA**, also trains legal bodies on application of the law and mobilises communities on the provisions of the law. Potential victims have reported to EWLA for legal protection.[17]

Restrictions on NGOs

The Government restricts the activities of civil-society organisations (*CSOs*) and NGOs under the **Charities and Societies Proclamation** (*CSP*). It is reported that humanitarian agencies had difficulty accessing the Somali Region conflict zones. In addition, the 'CSO law prohibits charities, societies, and associations (NGOs or CSOs) that receive more than 10 percent of their funding from foreign sources from engaging in activities that advance human and democratic rights or promote equality of nations, nationalities, peoples, genders, and religions; the rights of children and persons with disabilities; conflict resolution or reconciliation; or the efficiency of justice and law enforcement services.'

When the **CSP** came into effect, all organisations had to re-register, causing the UN High Commissioner for Human Rights to voice concern over Ethiopia's rapidly shrinking civil society space.[18] These restrictions may force the closure of NGOs, especially human-rights organisations. This is concerning, given that local sources of funding are very limited. The law has been described as 'one of the most controversial NGO laws in the world.'[19]

The '70/30' rule under the law caps administrative spending at 30% of an organisation's operating budget. The training of teachers, agricultural and health-extension workers and other government officials is defined as administrative costs under the rule, on the basis that training does not directly affect beneficiaries. This limits the number of training programmes that can be provided by development organisations that prefer to use train-the-trainer models to reach more people.[20]

1 ***Unless otherwise stated, all references in this sub-section are to*** Chi Mgbako, Meghna Saxena, Anna Cave and Helen Shin (2010) 'Penetrating the Silence in Sierra Leone: A Blueprint for the Eradication of Female Genital Mutilation', p.111, *Harvard Human Rights Journal*, 23(1).
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The Role of Women in Society

Woman in south-west Ethiopia
(© Kimberly McKinnon)

Ethiopia was ranked 64 out of 86 in the 2012 **OECD Social Institutions and Gender Index**.[1] Women face equality challenges in the areas discussed in this section.

Age at First Marriage

The legal age for marriage is 18; however, this is weakly enforced. Early marriage and marriage abduction are common (although decreasing) and are exacerbated by poor records of birth dates.[2] The median age at first marriage for women aged 15–49 is 16.5.[3]

Boyden, Pankhurst and Tafere[4] argue that early marriage in Ethiopia is 'clearly a gendered issue, given the considerable difference between men and women in age at marriage' – the median age of men at first marriage was recorded in 2011 as more than six years older, 23.1.

In rural areas, the median age of marriage of women (aged 25–49) is much lower, at 16.3 years, than for those in urban areas, at 18.1 years. There are other regional differences: the median age of marriage for women (aged 25–49) is lower in northern Ethiopia, notably in the Amhara, Afar and Tigray areas. The median age of first marriage increases with education levels.[5]

Young motherhood is a main cause of Ethiopia's high rates of maternal mortality.[6]

Marriage Traditions

In Northern Ethiopia, marriage is traditionally based around a **dowry** system, although in recent times payments are often limited and in the form of a gift from the groom's family to the bride's, usually clothing or jewellery. In the south, however, bride-wealth systems are common and traditionally involve cattle, iron bars and cash.[7]

Polygamy is a cultural norm among the Oromo and some southern peoples, although restricted to older and successful men.[8] Polygamy is illegal; however, the DHS 2011 estimates that 10.5% of women are in polygamous marriages.[9]

Marriage by abduction (*telfa*) has often been considered a legitimate form of marriage. Once the girl is taken, she is considered married, and the family cannot reverse the marriage.[10] This is more common in the southern region, at around 12.9%, and in 10.8% of Oromo marriages. It is much less common in northern Ethiopia, with 1.4% of marriages in the Tigray region happening by abduction and 2.4% in the Amhara. The national average is 7.8%.[11]

Family Code

The 2001 Family Code was enacted to guarantee the principle of gender equality, including women's equality in marriage and family relations. As noted above, in practice these equality rights are not effectively enforced. Children over the age of five are generally under the legal guardianship of the father, despite the Family Code. It is fairly common and relatively easy for a man to divorce a woman on the grounds of infertility, adultery, challenging male authority or not keeping the house properly. The constitution guarantees equal rights in matters of inheritance; however, in practice property is usually passed to sons.

Restricted Physical Integrity

Domestic violence and **sexual harassment** are illegal, but not effectively enforced. The WHO reports that 70.9% of women in Ethiopia have experienced physical and/or sexual violence by an intimate partner at some point and 53.7% have experienced this in the 12 months preceding the survey.[12]

Regarding **rape**, SIGI states, 'The 2005 Penal Code establishes new penalties for rape of between 5 and 20 years['] imprisonment. Formerly, men could avoid this charge if they married the victim (spousal rape is not considered a crime). The new Code repealed this provision, but fails to invalidate earlier marriages contracted on this basis.' [13]

Abortion is legal in cases of rape and incest, where the woman's health is in danger, and in cases of foetal impairment.

UNICEF asserts that there is a strong link between the fact that women face the majority of **harmful traditional practices** (*HTPs*) and the highly patriarchal nature of Ethiopian society. Ethiopian women who support FGM are 2.3 times more likely to believe it is acceptable for a husband to beat his wife in certain circumstances. This suggests a connection in Ethiopia between levels of support for FGM and views on domestic violence.[14]

Restricted Resources and Entitlements

The Ethiopian Labour Law 2003 and the Civil Service Regulations ban **discrimination in the labour market on the basis of sex**. In reality, women receive a much lower average wage than men. This is often because they hold low-paying jobs or work in the informal sector (mainly agriculture).

79.7% of men aged 15–49 are employed, compared to 37.6% of women. In urban areas, 49.9% of women and 76.6% of men are employed, and in rural areas, 33.8% of women and 80.7% of men are employed.[15]

However, the International Forestry Resources and Institutions shows that African women perform about 90% of the work of processing food crops and providing household water and fuel wood, 80% of the work of food storage and transport from farm to village, 90% of the work of hoeing and weeding, and 60% of the work of harvesting and marketing. The **gender-based division of labour** overburdens women with multiple productive and reproductive responsibilities. African women work far longer hours than men. According to the DHS 2011, a third of married women who are employed receive no pay.[16] Ethiopian women also have limited access to **bank loans**.

Under the 1995 Constitution, women are entitled to equal rights with men with respect to the use, transfer, administration and control of land. In reality, women have restricted **property rights**. The DHS 2005 records that 19.8% of widows report being dispossessed of their land.[17] There are several notable differences across Ethiopia in relation to property rights of women as outlined below:

- In the Afar (north-east Ethiopia), a woman may receive livestock as a wedding gift; she controls these but cannot sell them. Under Abukrate law, women have no inheritance rights, but under sharia law 1/8th of the property is divided among spouses.
- In the Amhara Region, in theory, wives are entitled to half of the common property, but in practice this does not occur.
- In the Gambela, women can only own trinkets and small animals. A woman herself may be inherited by her brother-in-law or next of kin when her husband dies. Otherwise, her parents must return the bride price received at her wedding.
- In the Oromia a women cannot own any property.[18]

Role of Children

The role of children in Ethiopian society is extremely varied and often unstable for the child. If one parent is missing, a child may have to take on adult responsibilities. When a mother has to take over a missing father's tasks outside of the home, for example, an older daughter may have to substitute for the mother in caring for her younger siblings.[19] This may mean that the daughter's developmental needs are neglected because of overwork or a lack of opportunity to attend school.

From childhood, boys are more exposed to the external world than girls, who are confined to the household. Girls are often chaperoned, sometimes by much younger boys, when they do leave the house. Boys are normally prioritised over girls in, for instance, the utilisation of health services and when it comes to investing in education. Moreover, in a traditional Ethiopian household, the husbands and sons are served with the best quality and the greatest quantity of food. The mother and daughters eat whatever is left over after the men have finished.

Child abuse is widespread in Ethiopia, and prosecution remains inconsistent. In 2012 'child friendly' benches were established specifically to hear cases involving violence against children and women. Trafficking and the sexual exploitation of children are punishable by up to fifteen years' imprisonment and a fine. However, girls as young as 11 have been recruited to work in brothels because they are favoured for being believed to be free of STIs. In the South Omo Valley, ritual and superstition-based **infanticide** has been practised by remote tribes.

As of 2010, approximately 150,000 children were reportedly living on the streets and there were an estimated 5.4 million **orphans**.

Child labour remains a serious problem in both rural and urban areas.[20]

1 OECD (2012a) *Social Institutions and Gender Index: 2012 SIGI: Understanding the Drivers of Gender Inequality*, p.13. Available at https://www.oecd.org/dev/50288699.pdf.
2 OECD (2012b) *Social Institutions and Gender Index [2012]: Ethiopia*. Available at https://www.genderindex.org/country/ethiopia/.
3 DHS 2011, pp.63–64.
4 Jo Boyden, Alula Pankhurst and Yisak Tafere (2013) *Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia*. Oxford: Young Lives. Available at: https://ora.ox.ac.uk/objects/uuid:e760844d-c7ce-46b8-9150-df9205e37633.
5 *Ibid*.
6 OECD (2012b), *op. cit.*
7 Boyden, Pankhurst and Tafere (2013), *op. cit.*
8 *Ibid*.
9 DHS 2011, p.61.
10 Sonja Fransen and Katie Kuschminder (2009) *History of migration in Ethiopia: History, Current Trends and Future Prospects*. Paper Series: Migration and Development Country Profiles. Maastricht Graduate School of Governance. Available at http://mgsog.merit.unu.edu/ISacademie/docs/CR_ethiopia.pdf.
11 Boyden, Pankhurst and Tafere (2013), *op. cit.*
12 World Health Organization/London School of Hygiene and Tropical Medicine (2010) *Preventing intimate partner and sexual violence against women: taking action and generating evidence*. Geneva, World Health Organization. Available at: https://www.who.int/violence_injury_prevention/publications/violence/9789241564007_eng.pdf.
13 OECD (2012b), *op. cit.*
14 UNICEF (2006) *Female Genital Mutilation/Cutting: A Statistical Exploration*, p.24. Available at https://www.unicef.org/gender/files/FGM-C_Statisitics.pdf.
15 DHS 2011, pp.45 and 47.
16 DHS 2011, p.246.
17 DHS 2005, p.251.
18 EGLDAM.
19 EGLDAM.
20 US Department of State (2012) *Human Rights Report 2012*. Available at https://2009-2017.state.gov/j/drl/rls/hrrpt/2012humanrightsreport//index.htm#wrapper.

FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Ethiopia. Other sections of this report give more detailed analyses of FGM prevalence and of efforts towards its abandonment, set within anthropological and sociological frameworks. For example, an analysis of the relationship between FGM and education may be found in the Education section.

According to the DHS 2005, **the prevalence of FGM among women aged 15–49 in Ethiopia is 74.3%**.[1] Ethiopia is therefore classified as a Group 2 country ('moderately high'), according to UNICEF's classifications.[2]

Prevalence has decreased from 79.9% in 2000, a statistically significant decrease of 5.6 percentage points over five years.[3]

The EGLDAM data shows a decrease from 73% in 1997 to 57% in 2007, a decrease of 16 percentage points over 10 years.[4]

UNICEF calculates that 23.8 million women and girls in Ethiopia have undergone FGM. In terms of absolute numbers, this is one of the highest numbers of girls and women who have undergone FGM in Africa, second only to Egypt.[5]

37.7% of women with at least one living daughter have a daughter who has undergone FGM.[6]

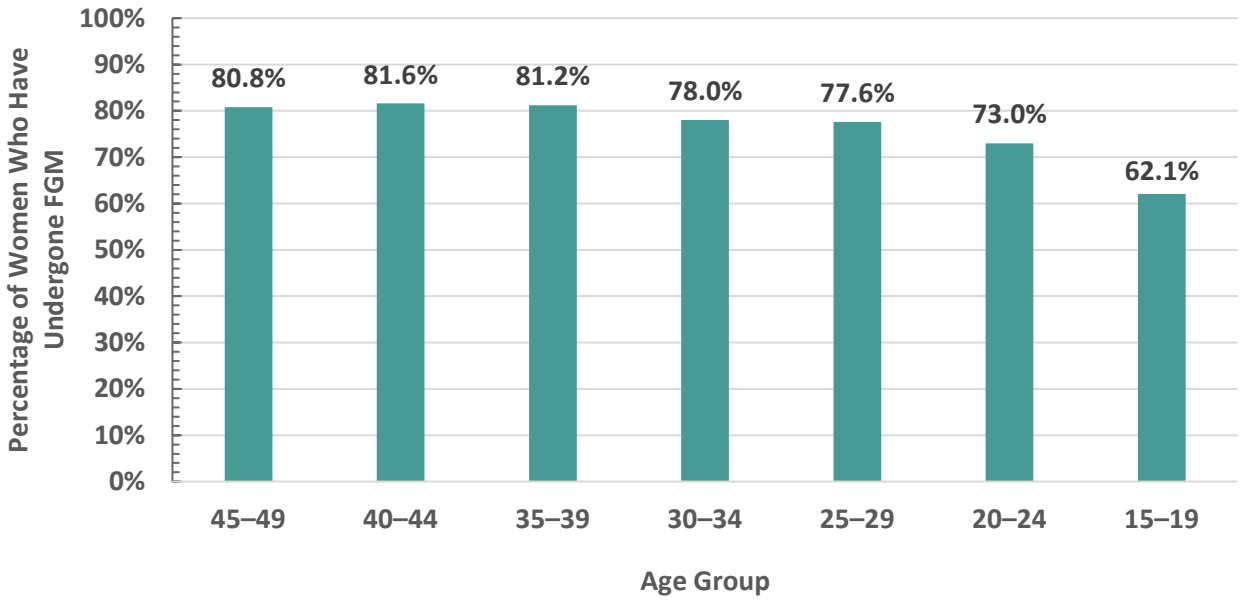


Figure 2: Prevalence of FGM in Ethiopian women aged 15–49, according to age cohorts[7]

The prevalence of FGM in Ethiopian women aged 15–49, broken down into age cohorts, is provided in Figure 2.[8] The data shows a general trend towards lower a prevalence in younger women, suggesting that the practice is declining. This is supported by the decrease in overall prevalence from 79.9% (in 2000) to 74.3% (in 2005).

Prevalence of FGM According to Place of Residence

Prevalence appears to be highest (among women aged 15–49) in the Somali, Dire Dawa and Afar regions and lowest in the Gambela and Tigray regions (Figure 3). However, only small numbers of women were surveyed in most regions, with the exception of Afar, Amhara and SNNP, and therefore no definitive conclusions can be reached in relation to the spread of FGM across the country. There does appear to be slightly more women who have been cut among those living in urban areas (68.5%) than among those living in rural areas (75.5%).[9]

Across most regions of Ethiopia, the DHS data suggests a decline in prevalence between 2000 and 2005. Again, because of the relatively low numbers of women sampled in some of these regions, these trends should be interpreted with caution. The numbers of women sampled in the Afar and Gambela regions are particularly small. The largest declines in prevalence are seen in Gambela, Addis Ababa and Amhara, and the smallest in Somalia, Oromia and SNPPR.[10]

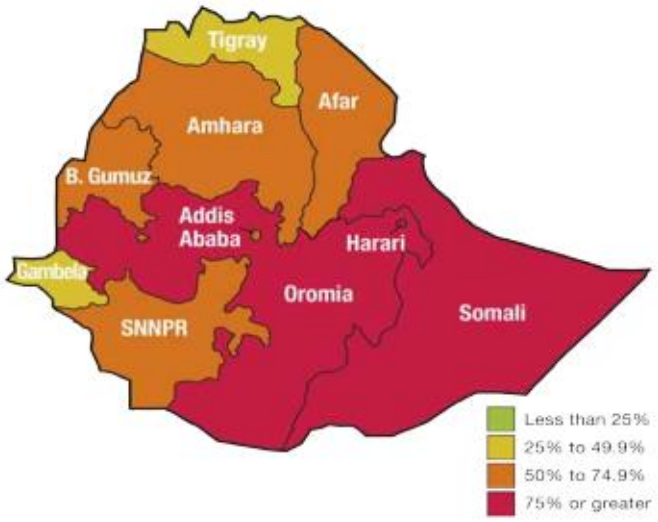


Figure 3: Prevalence of FGM among women aged 15–49, according to place of residence[11]

Figure 4 shows the variation of FGM across national borders. This is particularly important where there is a high interaction of communities across borders and much migration, as in Ethiopia.

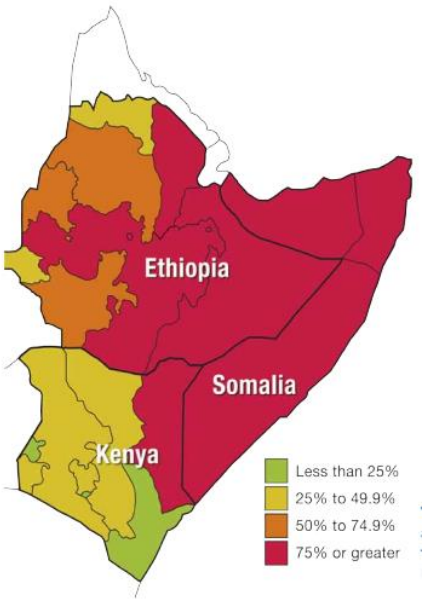


Figure 4: Variations in prevalence of FGM within and across national borders[12]

Prevalence in Relation to Education and Wealth

The DHS 2005 found that FGM prevalence among Ethiopian women aged 15–49 who have had no formal education is 77.3%; among those with a primary-level education, it is 70.8%; and among those with a secondary or higher level of education, it is 64%.[13] Therefore, FGM is less prevalent among women who are better educated.

The DHS 2005 also breaks down the population into quintiles from the richest to the poorest, using information such as household ownership of certain consumer items and dwelling characteristics. These figures are shown in Figure 5 below. There is no strong trend in relation to women's levels of wealth and the likelihood that they have undergone FGM.

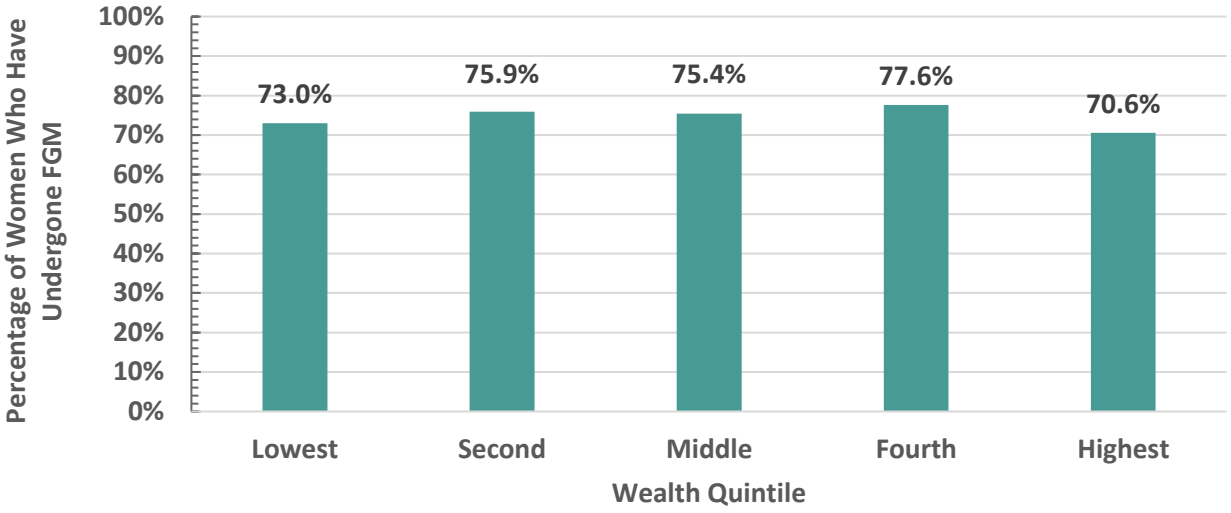


Figure 5: Prevalence of FGM among Ethiopian women aged 15–49, according to level of wealth[14]

Practitioners and Types of FGM

Of those Ethiopian women aged 15–49 who have undergone FGM, **6.1% have experienced Type III FGM/infibulation, or 'vagina sewn closed',** and 93.9% other types.

Type III appears to be most prevalent in the Somali and Afar regions.[15]

Reportedly, in areas where Type III has historically been practised, there is a trend to prefer types of FGM that are considered to be less invasive.[16] Further research would need to be conducted to confirm this.

In Ethiopia, **FGM is mainly carried out by traditional birth attendants** (*TBAs*) or traditional 'doctors' – normally older women who are paid a small token in cash or kind for carrying out the process. They perform FGM under non-sterile conditions using a knife, razor blade or other sharp instrument.[17]

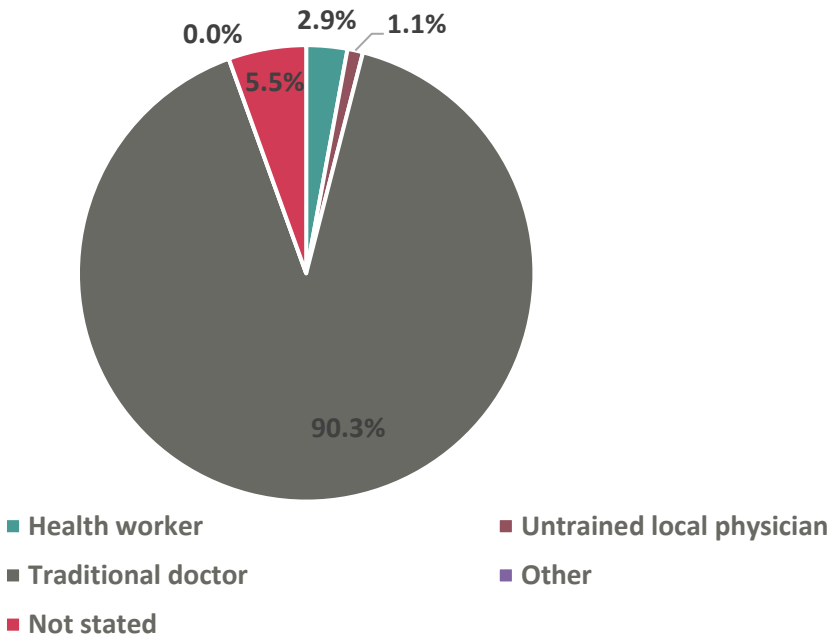


Figure 6: Of Ethiopian girls aged 0–14 who have undergone FGM, percentage cut by type of practitioners[18]

Another study found that, among some groups in southern Ethiopia where collective rites are more common, the role of performing both male circumcision and FGM is assigned to the caste group of specialist craftworkers such as potters, smiths and tanners. One example is the Chinasha among the Wolayta, who are also involved in childbirth and rituals surrounding death.[19] Whereas in other societies cutters are often afforded a high status, the Chinasha are considered 'outcasts' and looked down upon.

Although FGM is largely carried out by traditional practitioners, it is notable that, according to a 2011 survey, in Addis Ababa health workers carry out over 20% of FGM on girls under 15, and in SNNP and the city of Harari that figure was more than 10%.[20] In 2000, UNICEF reported that 92% of women had at least one daughter who had been cut by a traditional cutter, 5.5% by a TBA and only 0.9% by a health worker.[21] This may represent a trend towards the medicalisation of FGM within Ethiopia, particularly in urban areas, although note the caution regarding statistics concerning daughters in A Note on Data (page 8).

Medicalisation may decrease the negative health effects of FGM, but this has led to a misconception that FGM within a hospital/clinic setting is a benign and acceptable form of the practice. According to UNICEF and other NGOs, medicalisation obscures the human-rights issues surrounding FGM and prevents the development of effective and long-term solutions for ending it.[22] Moreover, medicalisation does not give protection from many of the long-term health consequences of FGM. Research has shown that changing the context of FGM or educating about the health consequences does not necessarily lessen the demand for it.[23]

There is concern from older and more traditional members of communities that performing FGM in a health facility with anaesthetic takes much of the meaning out of the ritual (i.e. the need for the strength to endure the pain).[24]

Age of Cutting

The age at which FGM is performed in Ethiopia depends on the girl's ethnic group, the type of FGM she will have and the region in which she lives. More than half of girls who undergo FGM do so before the age of one year.[25]

There is a divergence of practice between the north and the south: in the north, FGM tends to be carried out soon after birth, whereas in the south, where FGM is more closely associated with marriage, it is performed later.

According to one study, children are being cut at a younger age, as it is believed the wounds heal more quickly and bleed less, and there is less pain for the girl.[26] The young age at which girls are cut may pose a challenge, in some respects, in that women will not remember the event and may consider it is a natural process that they do not question.

In northern Ethiopia, in the Tigray and Amhara regions neighbouring Afar and the Argoba, FGM is carried out as early as the eighth day after birth.

Oromo people who live close to or in the Amhara region perform FGM when girls are a few days old, under the influence of Amhara culture.[27] However, FGM is carried out much later, sometimes just before marriage, in other parts of Oromia. For example, in parts of western Oromia FGM is carried out before the age of ten, and in the east it is carried out between the ages of nine and twelve.[28] In Arsi (central Oromia), FGM is carried out at the mother's home a few days or weeks before a girl's wedding and is part of the engagement ceremony.[29] There is therefore variation even within ethnic groups.

In the south, among the Somali, Harari and some practising ethnic groups in the SNNPR, FGM is carried out at a later age, which ranges from four years to over twenty years.[30]

In ethnic groups where FGM is closely related to marriage and part of the preparation for it, FGM is performed before or after the wedding. This occurs, for example, among the Sidama, Fadashi and Goffa people.[31]

Although one report states that no FGM related to pregnancy has been reported in Ethiopia,[32] another more recent report cites the example of an uncut woman in Amhara who, having been unable to give birth at home, went to hospital, where the doctors allegedly performed FGM to 'ensure a safe delivery'.[33]

1 DHS 2005, p.253.
2 UNICEF (2013*) Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. Available at http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf.
3 DHS 2000, p.33.
4 EGLDAM.
5 UNICEF (2013), *op. cit.*
6 DHS 2005, p.254.
7 DHS 2005, p.253.
8 DHS 2005, p.253.
9 DHS 2005, p.253.
10 - DHS 2000, p.33.
- DHS 2005, p.253.
11 DHS 2005, p.253.
12 Adapted from the Population Reference Bureau (2010) *Female Genital Mutilation/Cutting: Data and Trends Update 2010*. Available at https://www.prb.org/fgm2010/. Based on data from:
- DHS 2005.
- UNICEF Somalia (2006) *Somalia: Multiple Indicator Cluster Survey 2006*. Available at https://mics-surveys-prod.s3.amazonaws.com/MICS3/Eastern%20and%20Southern%20Africa/Somalia/2006/Final/Somalia%202006%20MICS_English.pdf.
- Kenya National Bureau of Statistics (KNBS) and ICF Macro (2010) *Kenya Demographic and Health Survey 2008-09*. Calverton, Maryland: KNBS and ICF Macro. Available at http://dhsprogram.com/what-we-do/survey/survey-display-115.cfm.
13 DHS 2005, p.253.
14 DHS 2005, p.253.
15 DHS 2005, p.253.
16 Marit Berggrav, Aud Talle and Hirut Tefferi (2009) *Prevention and Eradication of Female Genital Mutilation (FGM) and other Harmful Traditional Practices (HTPs) in Ethiopia: Save the Children Norway-Ethiopia and Partners Mid-Term Review (MTR) 25th November – 5th December 2008 – Final Report 02.02.09*. Available at https://www.scribd.com/document/46239901/DOCS-138374-V1-Projects-Against-Female-Genital-Mutilation-FMG-and-HTPs-in-Ethiopia-Final (accessed 25 February 2021).
17 EGLDAM.
18 EGLDAM.
19 Jo Boyden, Alula Pankhurst and Yisak Tafere (2013) *Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia*. Oxford: Young Lives. Available at: https://ora.ox.ac.uk/objects/uuid:e760844d-c7ce-46b8-9150-df9205e37633.
20 *Reference unknown.*
21 UNICEF (2005) *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*. Available at https://www.unicef-irc.org/publications/pdf/fgm_eng.pdf (accessed 25 March 2021).
22 *Ibid*.
23 Bettina Shell-Duncan, Walter Obungu Obiero and Leunita Auko Muruli (2000) 'Chapter 6: Women Without Choices: The Debate Over Medicalization of Female Genital Cutting and Its Impact on a Northern Kenyan Community', *Female Circumcision, Africa: Culture, Controversy, and Change*. Boulder, CO: Lynne Rienner Publishers.
24 Astrid Christoffersen-Deb (2005) 'Taming Tradition: Medicalized Female Genital Practices in Western Kenya', *Medical Anthropology Quarterly* 19(4), pp.402–418.
25 DHS 2000, p.34.
26 Berggrav, Talle and Tefferi (2009), *op. cit.*
27 EGLDAM.
28 Boyden, Pankhurst and Tafere (2013), *op. cit.*
29 EGLDAM.
30 *Ibid*.
31 *Ibid*.
32 *Ibid*.
33 Boyden, Pankhurst and Tafere (2013), *op. cit.*

Understanding and Attitudes

Countrywide Taboos and Mores

Ethiopia has a patriarchal society, and there are **moral and cultural restrictions** on women and their behaviours.

As in many other African countries, **sex and sexuality** are taboo subjects in Ethiopian culture. A woman who discusses sexuality openly could be labelled as 'immoral' or 'loose'.

Though illegal, **domestic violence and the discrimination of women** are endemic in Ethiopia. Cases of women and girls who have experience gender-based violence are under-reported due to 'cultural acceptance, shame, fear, or a victim's ignorance of legal protections'.[1]

It is also common for persons with **disabilities** to face discrimination. Women and girls with disabilities are more disadvantaged than men and are less likely to attend school because of their disabilities. Girls with disabilities experience physical and sexual abuse at a higher rate than girls without disabilities, and 33% of girls with disabilities report experiencing forced sex.[2]

There is a societal stigma and prevalent discrimination against persons with **HIV or AIDS**.[3]

There is also a severe stigma against **LGBTQ+** persons, as same-sex sexual activity is illegal and punishable by imprisonment.

Harmful Traditional Practices (HTPs)

Below is a selection of customs practised in Ethiopia for health and cultural/traditional reasons that are associated with taboos surrounding women and children.

- application of cow dung to the umbilical cord;
- body modification: eyelid incision, tattooing, cauterisation, tribal marks, etc.;
- child marriage and marriage by abduction (marriage by abduction, though illegal, continues in the regions of Amhara, Oromia, and SNNPR. These marriages normally result in forced sexual relationships and physical abuse);
- feeding fresh butter to new-borns;
- FGM;
- food taboos (no protein and restricted vitamins for pregnant women);
- forbidding food and fluids during diarrhoea;
- giving *Kosso* (Hagenia, African Redwood) to pregnant women;
- massaging the abdomen of a pregnant woman with butter during difficult labour;
- milk-teeth extraction;
- plucking the fingernails of women prior to weddings and then dipping the nailbeds in spices;
- shaking women violently to cause placental delivery;
- throat piercing using hot iron rods to remove the placenta;

- tonsillectomy; and
- uvulectomy.[4]

Knowledge of FGM

A widespread, correct understanding of FGM is a prerequisite to changing attitudes; thus, exposure to accurate information is essential. 91.8% of Ethiopian women aged 15–49 have heard of FGM. Women living in urban areas and those who have higher levels of education are more likely to have heard of it than their rural-dwelling or lesser educated counterparts.

Reasons for the Practise of FGM

FGM is a social norm and a tradition, often enforced by community pressure and the threat of stigma. Although every community in which FGM is found in Ethiopia will have different specifics around the practice, in every community in which it is practised it is a manifestation of deeply entrenched gender inequality.

FGM is usually considered necessary for a girl to become a woman. In the south of Ethiopia, FGM is sometimes performed as part of a ritual initiation into womanhood. FGM is often claimed to preserve a girl's virginity and protect her from promiscuity and immoral behaviour. For many ethnic groups, an uncut girl is considered to be sexually promiscuous and not suitable for marriage. Finally, FGM is sometimes associated with sexuality and the aesthetic appearance of the female body; uncut genitalia can be considered unclean or too masculine.

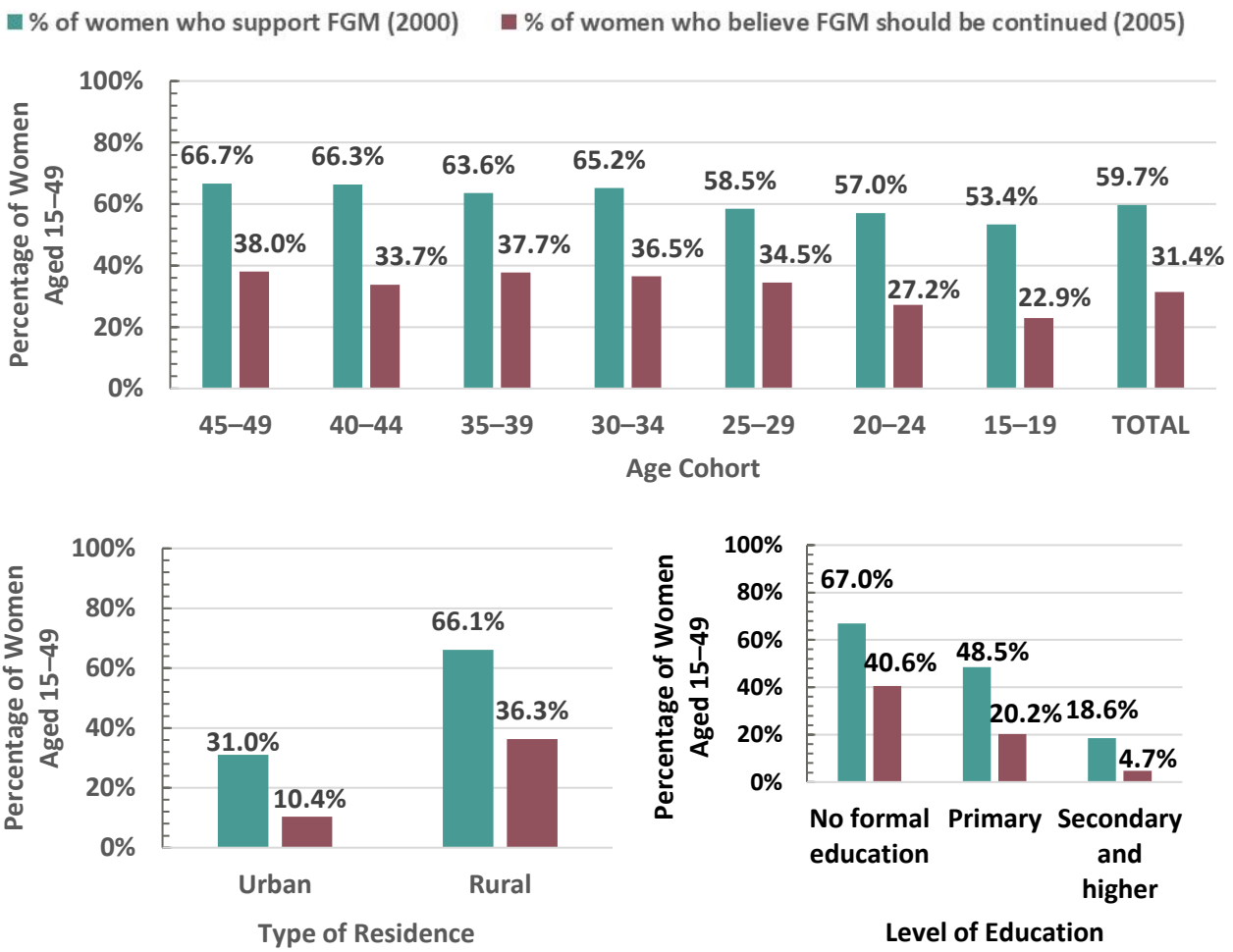
EGLDAM, in the focus groups it carried out as part of a follow-up survey in 2007, found the following key reasons for FGM.[5] Of these, some were found across Ethiopia and others were specific to particular ethnic groups:

- ***Respect for tradition/cultural identity.*** This was the most common reason articulated in the survey. For example, the Daasanach highlighted FGM as a mark of cultural identity. Those who are not cut are not considered part of the *Dimi* culture, and another Daasanach cannot marry them.
- ***Suppress women's sexuality.*** Among the Oromo, Amhara, Tigraway, Kulo/Dawro and other ethnic groups, FGM is considered necessary for preventing women from being too 'sexy' and too demanding on the husband for sex. FGM is also believed to prevent premarital sex and loss of virginity, which would bring disgrace to the family.
- ***Control by or sexual satisfaction of the husband.*** This was a reason given by a number of ethnic groups, although with slightly different explanations:
  - among the Tigraway, to *avoid difficulty at penetration* for men;
  - among the Oromo and Goffa, to *reduce insubordination*;
  - among the Daasanach, Gurage, Kebena, to *discipline women and stop them being* aynaewta *(too bold)*; and
  - in Bure-wereda, to *make it easier for men* to have sex with someone who is a virgin.
- ***Control women's emotions.*** To prevent her from breaking utensils, being wasteful, absent minded and *aynaewta* (too bold).

- ***Avoid being ostracised and stigmatised.*** Uncut women are despised and considered a shame to their families. They are often ostracised by the community. Oromo, Kebena and Kem ethnic groups refer to uncut women as impure or 'polluted'.
- ***Hygienic reasons.*** The uncut vulva is considered dirty. It is believed by the Jebelawi and Oromo to produce a foul smell. The Jebelawi also believe it produces 'worms'. The Oromo believe that 'losing blood by circumcision may even wash out some diseases. Thus [FGM] is advisable for girls who have certain diseases'.[6]
- ***False beliefs surrounding sexuality and childbirth.*** Some ethnic groups believe that a woman who has not undergone FGM may become impenetrable, have deformities of the vaginal opening, have problems such as thickness of the hymen and difficulties the first time she has sex. Some groups believe that FGM prevents difficulty during childbirth. It is believed that the clitoris hampers the progression of the child during delivery. Some groups believe that if the clitoris touches the baby's head the baby will suffer, or even die. The Amhara in particular make a strong link between FGM and protection during childbirth.[7]
- ***Aesthetic reasons***. The Afar believe that FGM prevents enlargement of the labia and consider the clitoris ugly.
- ***Religious requirement.*** The Harari and Afar groups believe that prayers and offerings by uncut women are not acceptable. The Jebelawi people believe that their religion says, '[T]hat which protrudes from the body is excessive and should be trimmed.' The Fadashi believe that it is demanded by the Quran, and the Keffa believe it is an insult to God to not have FGM. The Afar, Harari, Jebelawi and Fadashi are all Muslim.
- ***Prevention of rape.*** In many societies in Ethiopia, virginity is highly valued and forms part of marriage transactions. This was found to be the underlying reason among the Afar, a nomadic community that largely practises Type III/infibulation. Among the Somali it is believed that it is not possible to rape a girl who has been infibulated, and that it therefore preserves the sanctity of the woman. Somali girls often stay outside the home and may spend the day working in the bush, herding animals. There is a concern that if FGM stops, their women will not be protected from rape.

Support for FGM

Between 2000 and 2005, support for FGM apparently halved (Figures 7 and 8). In 2000 there was a recorded 59.7% support rate for FGM, but by 2005 this had dropped dramatically to 31.4%, according to the DHS data.[8] Similar results are seen in the EGLDAM data.[9] Since the law against FGM under the new Criminal Code was introduced in 2005, it should be taken into account that awareness of this new law may have influenced either women's opinions or their willingness to *admit* supporting the practice. Future surveys may confirm or reverse this trend.



Figures 7 and 8: Percentages of Ethiopian women who support the continuation of FGM, by background characteristic, DHS 2000 and 2005[10]

However, the EGLDAM data also shows a marked increase in the level of awareness of the harmful effects of FGM, from 33.6% in 1997 to 82.7% in 2007 (Figure 9).

EGLDAM notes that women seem to 'lag behind' men in their attitude towards the eradication of FGM. This perhaps reflects the different gender roles within Ethiopian society, as men have better access to information and mothers are responsible for making sure their daughters undergo this highly respected tradition, thus ensuring their daughters' future marriages.[11] Today, negative attitudes towards FGM among women are becoming more common. The discourse around opposition to the practice among women is often based on women's and girls' personal experiences. For example, those who have suffered during childbirth or know others who have died during the procedure are keen to prevent their children from going through the same experience.[12]

In urban areas of Ethiopia, while there may not always be a lower prevalence, attitudes towards FGM are generally more negative than in rural areas. EGLDAM suggest this is due to a lack of information and low awareness of its harmful consequences in rural areas.[13] Boyden, Pankhurst and Tefera support this, arguing that ideas about modernity and interventions to counter HTPs that emanate from the state as well as from INGOs and NGOs have had a much greater impact in urban areas.[14]

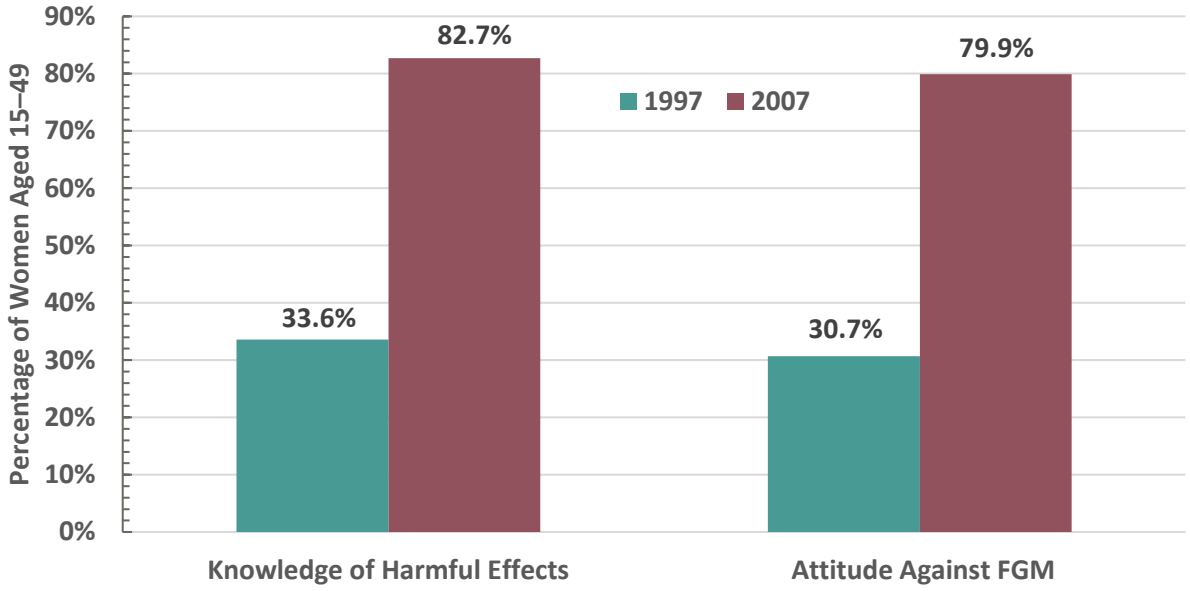


Figure 9: Percentages of Ethiopian women who have knowledge of harmful effects of FGM and those who are against FGM, EGLDAM 1997 and 2007[15]

1 US Department of State (2012) *Human Rights Report 2012*. Available at https://2009-2017.state.gov/j/drl/rls/hrrpt/2012humanrightsreport//index.htm#wrapper.
2 *Ibid*.
3 *Ibid*.
4 Dawit Assefa, Eshetu Wassie, Masresha Getahun, Misganaw Berhaneselassie, and Atsinaf Melaku (2005) *Module: Harmful Traditional Practices*. Ethiopian Public Health Training Initiative, Awassa College.
5 EGLDAM.
6 Jo Boyden, Alula Pankhurst and Yisak Tafere (2013) *Harmful Traditional Practices and Child Protection: Contested Understandings and Practices of Female Child Marriage and Circumcision in Ethiopia*. Oxford: Young Lives. Available at: https://ora.ox.ac.uk/objects/uuid:e760844d-c7ce-46b8-9150-df9205e37633.
7 Boyden, Pankhurst and Tafere (2013), *op. cit.*
8 - DHS 2000, p.33.
- DHS 2005, p.253.
9 EGLDAM.
10 - DHS 2000, p.33.
- DHS 2005, p.253.
11 EGLDAM.
12 Boyden, Pankhurst and Tafere (2013), *op. cit.*
13 EGLDAM.
14 Boyden, Pankhurst and Tafere (2013), *op. cit.*
15 EGLDAM.

Media

> *By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.*
>
> *~ Former UN Secretary General, Kofi Annan*[1]

Press Freedom

The media is governed under the 1995 Constitution of Ethiopia, as well as the Press Freedom Bill of 1992. In practice, however, the political climate is 'hostile to media independence and self-censorship is very common.'[2]

Ethiopia is ranked 137 out of 179 countries by the Reporters without Borders 2013 World Press Freedom Index.[3] This is a drop of ten places because of its 'repressive application of the 2009 anti-terrorist law and the continued detention of several journalists.'

Regarding press freedom, Press Reference states,

> The absence of a free media tradition in Ethiopia has resulted in lack of adequate provisions for developing independent, professional journalism. Also lacking is a professional board or other mechanism to determine whether press content fits the press bill's criteria for press responsibility and for the taking of lawful measures. Thus most press offenses are considered by authorities as criminal, and not civic in nature.[4]

In 2012, problems included restrictions on print media, as well as the censorship of information related to politically motivated trials/convictions of political figures, activists, journalists and bloggers. Moreover, several newspapers were closed and the weekly circulations of other newspapers restricted.

The law prohibits religious groups and foreigners from owning broadcast stations. In addition, the Government restricted internet access and blocked several websites including blogs, opposition websites and (temporarily) foreign news sites including the *Washington Post* and *Al Jazeera* for reporting on Ethiopia's human rights situation.[5]

Main Newspapers in Ethiopia

Due to high levels of poverty and low literacy levels, newspapers are mainly distributed in the capital and serve only a small population.

Dailies

- *Awramba Times*
- *Addis Zemen* (government-owned, Amharic)
- *Daily Monitor*

- *Ethiopian Herald* (government-owned)
- *Ethiopian Reporter* (independent
- Yeroo Times
- *Jimma Times*

Weeklies

There are approximately 150 non-daily newspapers, including:

- *Addis Fortune* (independent)
- *Berissa* (government-owned)
- *Al-alem* (government-owned)
- *Capital Ethiopia* (business)
- *Democracia* (Ethiopian People's Revolution Party newspaper)
- *Ethiopian Review* (opinion journal)
- *Feteh* (independent – currently closed)

Media Exposure

The Government controls the only **television** network that broadcasts nationally. The Ethiopian Broadcasting Corporation is the single network and has three regional stations. Television is not widely watched and mainly only available in the capital. Broadcasts are carried out in a variety of languages, in accordance with press freedom laws.

Radio is both private- and state-operated. State-*run Ethiopian Radio* has the largest reach, followed by *Fana Radio.* There are three private FM stations in Addis Ababa and approximately 13 regional community stations.[6] Radio Ethiopia claims to have reached 50% of the landmass and 75% of the population with a good signal, making it the most influential news source in the country. However, frequency coverage does not reflect the station's actual availability to listeners, due to a lack of radio receivers.[7]

As of June 2012, there were 960,331 **internet** users, with a 1.1% penetration rate, while the Government estimates that 4% of individuals subscribe to internet access. Ethiopia has the second lowest internet penetration rate in sub-Saharan Africa. Efforts to improve access are hampered by the country's rural makeup. Recently, attempts have been made to improve internet access by laying 4,000 kilometres of fibre-optic cable along highways.

The level of exposure to the media remains low in Ethiopia. Radio is the most commonly used medium (Figure 10). Men generally have greater access to the media than women, as do people who are more educated: those with a secondary or higher level of education are far more likely than others to watch television or listen to the radio. Overall, newspapers are much less popular than television and radio.[8]

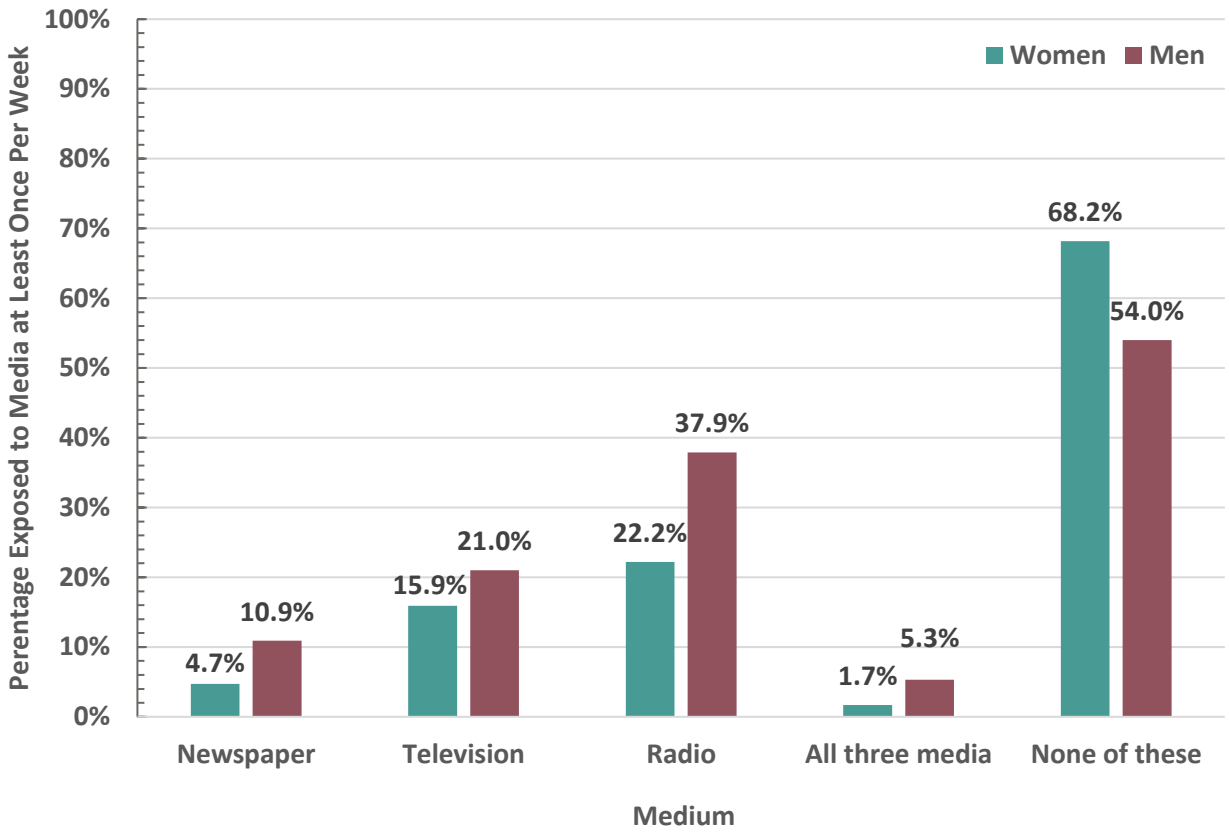


Figure 10: Percentages of Ethiopian men/women aged 15–49 who are exposed to certain forms of media at least once per week[9]

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8 DHS 2011, pp.42–43.

9 DHS 2011, pp.42–43.

Religion

Religion is central to Ethiopian society. It is one of the oldest Christian states in the world – the Ethiopian Orthodox Church dates back to the 4th century. Ethiopia has historical ties with all three Abrahamic religions. The most prevalent religions are Orthodox Ethiopian Christianity and Islam.

The Government's 2007 census showed the religious composition of the country to be as follows:

Religion	% of Total Population
Christian	62.8%
Ethiopian Orthodox	43.5%
Protestant	18.6%
Catholic	0.7%
Muslim	33.9%
Animist	2.6%
Other	0.7%

Table 2: Religious affiliations of Ethiopian population[1]

Ethiopian Orthodox Christianity is predominant in the northern highland regions of Tigray and Amhara and also present in Oromia. Islam is most frequently practised in the Afar, Somali and Oromia regions. Established Protestant churches are largest in SNPPR, Gambela and parts of Oromia.

Most Muslims living in Ethiopia are Sunni, and the majority of these are Sufi.[2] There are also a number of Jews living in the Gondar region in the north, although most emigrated to Israel in the 1980s and 1990s.

Orthodox Ethiopian festival
(© Clive Chilvers/Shutterstock.com)

FGM and the Ethiopian Jews

Uniquely, Ethiopia was historically the only country where the Jewish community practised FGM. (The Ethiopian Jewish community is called the *Beta Israel*, or sometimes by the term *Felasha*, meaning 'stranger' in Ge'ez, but that is now considered derogatory). The Beta Israel came from the Gondar province, Woggera, the Simien mountains, Walkait and the Shire region of Tigra.[3]

No other Jewish community, in ancient, medieval or modern times, is known to have practised FGM. Practise by the Beta Israel can therefore be seen as stemming from general Ethiopian culture, in which FGM is widespread, as opposed to being a relic of a long-lost Jewish tradition.

The Beta Israel moved en masse to Israel from 1984 under Israel's Law of Return, which guarantees citizenship to all Jewish individuals. That move was largely completed by 1991, although the migration of the *Felasha Mura* (Ethiopians who claim links to descendants of Jewish heritage who converted to Christianity generations ago) ceased only in August 2013.

Since migrating to Israel, the Beta Israel have largely abandoned FGM, and women express no desire to continue the practice.[4] One study refers to the 'the dramatic and total cessation of this custom among this community after immigration to Israel' (this study was rare in that it combined anthropological interviewing techniques and physical gynaecological examinations). The participants in the study accept that FGM was normative among Jewish people in Ethiopia, but they now saw themselves as part of a Jewish society that does not practise FGM. Moreover, they express no signs of distress or nostalgia for the custom. The study found that approximately one-third of participants show evidence of genital scarring from FGM. This suggests that rapid cultural change can occur as a function of the acceptance of a new identity.[5]

Freedom of religion was granted in the 1995 Ethiopian Constitution, although in reality this is not always practised in certain regions. The 2012 Religious Freedom Report states that the Government generally respects religious freedom, but there was a decline in its respect for religious freedom during that year, and some Muslims accused the Government of interference in Islamic Affairs.[6]

The Ethiopian state has traditionally associated itself with Orthodox Christianity, although the post-1991 administration made progress in establishing official recognition and 'official parity of esteem' between Christians and Muslims.[7] While Christians and Muslims have a history of peacefully co-existing in Ethiopia, in recent decades there has been growing tension and a number of violent outbreaks. The Ethiopian Islamic Affairs Supreme Council (*EIASC*) expresses concern about the increasing influence some allegedly Saudi-funded Salafist groups have in the Muslim community. It has blamed these groups for exacerbating tensions between Christians and Muslims and within the Muslim community. In 2011 there were several incidents involving riots and arrests at mosques, and claims that the Government has been withholding religious freedoms. There is also tension between some members of the Orthodox Church and Protestant churches.

The Government, the EIASC and civil-society groups are attempting to address extremism and potential sectarian violence through training and workshops.[8]

Religion and FGM

FGM predates the major religions and is not exclusive to one religious group. FGM has been justified under Islam, yet many Muslims do not practise it and many agree it is not in the Quran.

The Christian Bible does not mention FGM, meaning that Christians in Africa who practise FGM do so because of cultural custom.

Faith-based organisations (*FBOs*) are involved in the eradication of FGM. In 2006, Target sponsored a conference between Muslim scholars from many nations; they deemed FGM to be against the Islamic faith as it is a harmful attack on women.[9]

In Ethiopia, the role of religion in the practice of FGM is complex and often intersects with ethnicity.

FGM is practised by both of the main religions in Ethiopia – Ethiopian Orthodox Christianity and Islam. Muslim groups are more likely to practise FGM than Christian groups: the EGLDAM surveys record a 65.1% prevalence among Muslim communities and a 45% prevalence among Orthodox Christians.

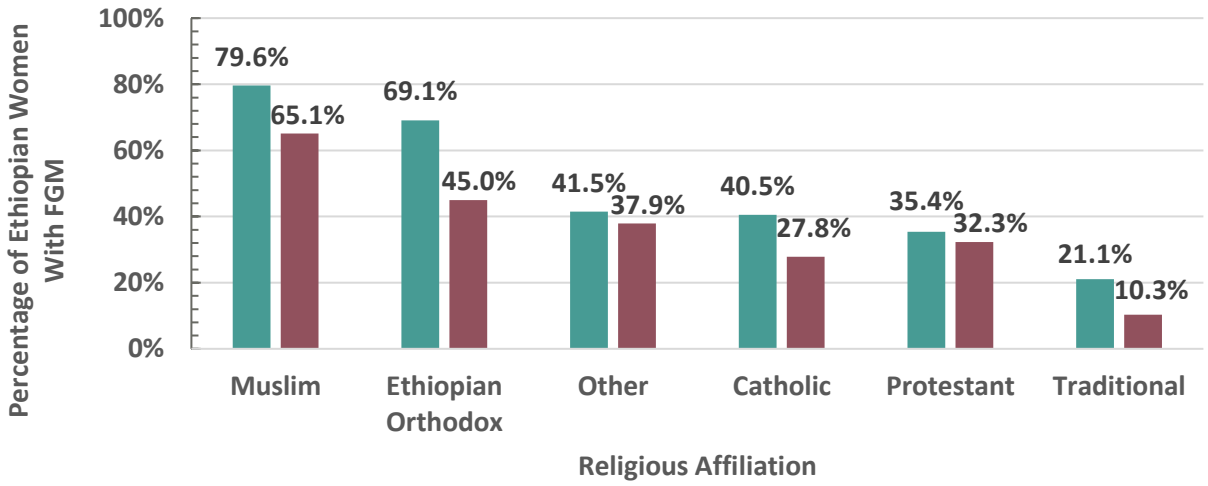

Figure 11: Prevalence of FGM among Ethiopian women, according to religious affiliation[10]

The EGLDAM surveys suggest that the prevalence of FGM among Muslims is not only higher, but also is changing more slowly than prevalence among Ethiopian Orthodox and other Christians, as Figure 11 shows.

UNICEF reports that, in Ethiopia, Muslim women are more likely to support the continuation of FGM than their Christian counterparts: that is, 76% of Muslim women support its continuation as opposed to 58% of Christian women.[11] However, UNICEF found that FGM is more common among daughters of Christian women than among daughters of Muslim women. 45.3% of Muslim women aged 15–49 have at least one daughter who has been cut, as opposed to 73.4% of Protestants and 67.1% of Catholics. The report notes, however, that this result could be attributed to other factors, such as ethnicity and the overall distribution of the various religious groups within Ethiopia.[12]

In Ethiopia, some believe that FGM is a requirement of their faith. In some Muslim communities, FGM is believed to be a requirement of Sharia law. One Muslim respondent in Addis Ababa explained that, 'since it is Haram [sinful] to let the girls go uncircumcised, people still cut the genitals of the girls slightly.' Among Ethiopian Orthodox Christians in Amhara, a justification for

performing FGM is that there have been rare cases of girls being 'naturally circumcised', which has been referred to as 'a circumcision by Mary'. There are also theological rationales for FGM such as adaptations of the story of Adam and Eve wherein FGM is Eve's punishment for eating the forbidden fruit.[13] It is important to reiterate here that neither the Quran nor the Bible support the practice, and it has been soundly condemned by major Islamic and Christian leaders.

There have been some significant initiatives by religious groups, including the Ethiopian Orthodox Church, and NGOs. The Evangelical Churches Fellowship of Ethiopia announced a five-point declaration on 26 January 2010, in which they condemned FGM as unbiblical, barbaric and 'going against the divine principle of caring for the body, as well being unjust and degrading against women and depriving them of their basic rights'. The declaration also contains a policy of zero tolerance of FGM.

The Ethiopian Orthodox Church produced a similar document on 13 October 2011, which stated:

> *[T]he prevention of FGM requires the strong involvement of the church leaders and men, and collaboration of the Ethiopian Orthodox Church with other partners.*[14]

UNFPA/UNICEF report that 207 religious leaders have been sensitised about FGM and have expressed their commitment to work towards its total abandonment. In addition, 150 leading clerics representing five FBOs – the Ethiopian Orthodox Church, the Ethiopian Islamic Supreme Council, the Ethiopian Catholic Church, the Evangelical Churches Fellowship of Ethiopia and the Ethiopian Seventh Day Adventist Church – agreed to admonish anyone who carries it out.[15]

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Education

The Ethiopian education system is structured following the Government's decentralised arrangement:

1. school;
2. zone or *woreda*;
3. region; and
4. federal.

The Federal Ministry of Education is responsible for setting and maintaining national educational policies and standards. Regional educational bureaus formulate regional educational policy and strategies, as well as administering and managing places of education within their regions. They prepare the curriculum and resources for primary schools. The zones and Woreda Education Officers are responsible for establishing, planning and administering basic education services, including primary schools.

School in Addis Ababa (© 28 Too Many)

Education and the Development Goals

The two Millennium Development Goals most pertinent to the campaign to stop FGM are 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

Primary education in Ethiopia is universal and free. There are, however, not enough schools to accommodate Ethiopia's youth, and the cost of school supplies is often prohibitive for poor families. There is also a shortage of trained teachers.[1]

In 2009/10, the gross enrolment rate for primary schools reached 95.9% (93% for female and 98.7% for male).[2]

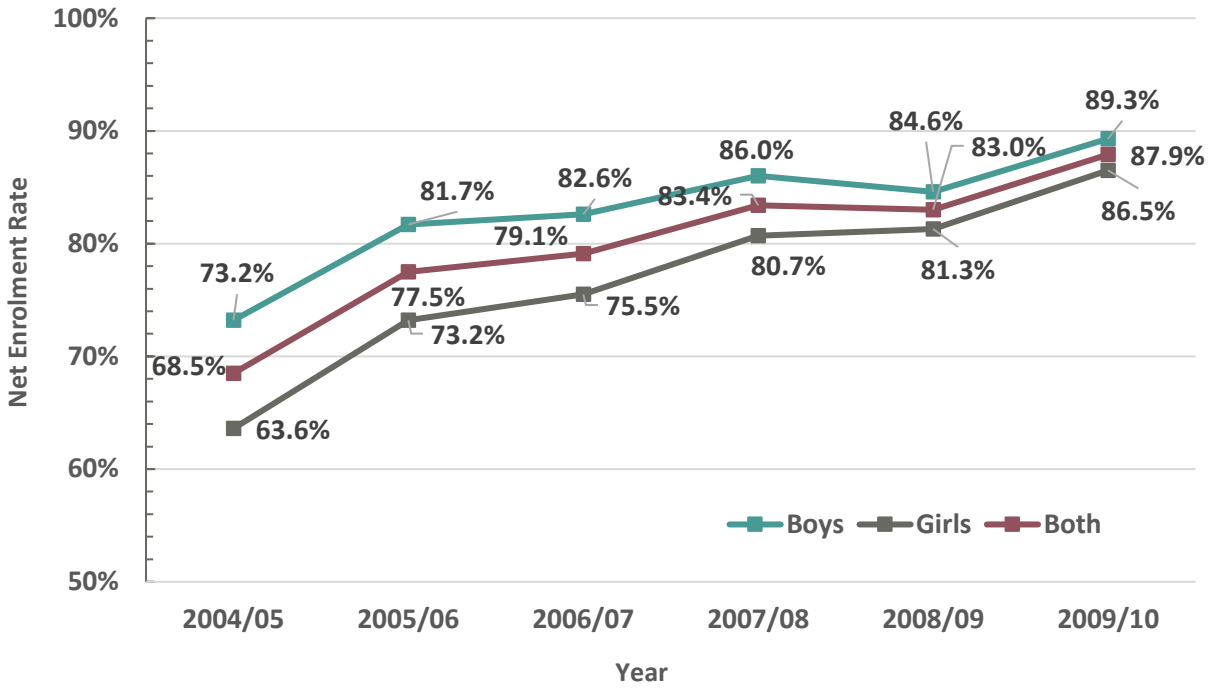

Figure 12: Primary school net enrolment rates by gender and year[3]

Access to education has improved dramatically over the last two decades, mainly since the end of the civil war in 1991. Approximately three million pupils were in primary school in 1994/95, increasing to 15.5 million in 2008/09.[4] Literacy, however, remains very low, at 39%.5

The 2010 MDGs report[6] indicates that Ethiopia is on track to achieve universal primary education. This has been achieved by abolishing school fees, increasing expenditure on school construction and maintenance, training thousands of new teachers, changing instruction to children's mother tongue, and a gradual decentralisation of the education system. UNESCO supports this, highlighting that the free-fee policy in 2005 is regarded as successful overall.

Support by donor agencies is a large source of primary-school funding in Ethiopia. Cost-sharing (i.e. contributions from local populations and parents) still exists on a large scale, although it often comes in the form of labour, due to poverty, and helps schools with cleaning, maintenance, repairs, furniture and catering.[7]

Secondary-school enrolment has grown more than fivefold since 1991. The two predominantly rural regions, Afar (northern Ethiopia) and Somali (southern Ethiopia), remain far behind the rest of the country, with net enrolment ratios of 24.4% and 31.6%, respectively,[8] and literacy rates that are the lowest in the country (Somali having 19.8% literacy among women and 51.2% literacy among men, and Afar having 20.3% literacy among women and 52.5% among men).[9]

Improvements in access to education have helped narrow the gender gap and have benefited the most disadvantaged. Traditionally, education had always been restricted to boys, even among the nobility.[10] Recently, a number of initiatives have been implemented, such as encouraging women's employment in the civil service, promoting gender-sensitive teaching methods and increasing the minimum marriage age to 18. In 2008/09, almost full gender parity was achieved: the gross enrolment rate was 90.7% for girls and 96.7% for boys.[11]

Progress in education in Ethiopia has coincided with substantial reductions in poverty and improvements in food security, health and nutrition. Most notably, the Productive Safety Net Programme (*PSNP*), the Government's flagship social protection and food security programme, has provided assistance to more than seven million people since 2005. All this and other, broader societal changes combined has meant that women's and girl's aspirations are changing. With more girls in school, the age of marriage is rising.

Education and FGM

According to UNICEF, a lack of education is often associated with FGM. It is usually the case that the more highly educated woman is less likely to have her daughters cut. Additionally, it is possible that, while at school, girls have greater exposure to intervention programmes, media messages and international discourse surrounding FGM. They may develop social ties with peers and mentors who oppose the practice, providing a reference group where no normative sanctions exist for not undergoing FGM. They may also have the opportunity to discuss new ideas in a conducive environment.[12]

In Ethiopia, the prevalence of FGM decreases as the level of women's education increases: 64% of those aged 15–49 with a secondary or higher level of education have undergone FGM, compared with 70.8% and 77.3% respectively of those with primary-school or no formal education.[13] These gaps, though not large, have increased since 2000.[14]

UNICEF highlights the importance of looking at the FGM status of daughters aged 0–14 in relation to the levels of education of their mothers, given that FGM usually occurs before school-leaving age and girls are not usually involved in the decision on undergoing FGM. Generally, the data from countries where FGM is frequently and infrequently practised that FGM is most common in daughters whose mothers have had no formal education. It tends to decrease substantially as mothers' levels of educational rise, suggesting that education plays an important role in shifting normative expectations surrounding FGM and facilitates its abandonment.[15] This certainly appears to be the case in Ethiopia.

Looking at this data for Ethiopia, among women with at least one living daughter, 18.7% of those who have a secondary or higher level of education have a daughter who has undergone FGM, compared with 24.7% of those who have a primary education and 41.3% who have no formal education.[16]

The percentage of Ethiopian women aged 15–49 who support the continuance of FGM is 4.7% of those with secondary or higher level of education, 20.2% of those with a primary education and 40.6% of those with no formal education.[17] Education, therefore, appears to be playing an important role in changing attitudes and practices in relation to FGM in Ethiopia.

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Healthcare

Ethiopia's healthcare system is arranged in a four-tier system: Primary Health Care Units (*PHCU*), district hospitals, zonal hospitals and specialised hospitals.[1] The Government is the main provider of healthcare and manages the majority of the country's 5,873 health stations, 600 health centres and 131 hospitals.

Ethiopia has a poor health status, mainly due to infectious and communicable diseases, which account for 60–80% of the country's health problems. These are usually the result of poor nutrition and lack of access to health services.[2] Utilisation of healthcare services for the country is currently only 0.32 per capita.[3]

A survey carried out in 2004 shows that the main reason given by Ethiopians living in rural areas for not using the national health service was that it is 'too far'. Health services in the country are limited in number, covering only about 77% of the population. (This has increased from 53% in 1997.) Healthcare facilities are disproportionally more available in urban areas, while in rural areas access varies from limited to non-existent.[4]

Boydon, Pankhurst and Tafere highlight that better access to healthcare facilities for those in or near urban areas may influence attitudes towards FGM, as female health extension workers have mandates to address issues of reproductive health.[5] This presents opportunities to raise awareness of the harms of FGM.

The same 2004 survey also found that the second-most given reason for not using healthcare services was that there was 'no need'.

47% of the population lives below the poverty line. Most people cannot afford healthcare.[6] In addition, existing health posts are often under-staffed, under-funded and provide poor service. There is a shortage of trained health staff in Ethiopia and these personnel are unevenly distributed. A poor skillset and high attrition of trained health professionals remains the major concern, impeding transfers of competency from urban to rural areas.

A further problem facing the Ethiopian healthcare system is that it is affected by a so-called 'medical brain drain'.[7] It is posited that many Ethiopian medical doctors emigrate to work in Europe and North America. The emigration of Ethiopian medical staff is estimated to be 25.6%. In general, the emigration rate of tertiary-educated individuals is estimated to be 17%. This, combined with relatively low education levels in general, and therefore few highly-educated professionals, leads to a substantial shortage of a skilled work force in Ethiopia.

The WHO reports that the expansion of healthcare facilities has enhanced 'noticeable physical access to health services', with emphasis on PHCUs, including health centres and health posts.[8] In its efforts to expand primary healthcare at the grassroots level, the Government is training and deploying at community health posts health extension workers, whose main function is health promotion. The Government has designed a new Health Management Information System and is preparing for its launch countrywide. In order to improve the resource flow to the health sector, the Government is in the process of designing a social health insurance system. Greenwood notes that Ethiopia has successfully navigated a longstanding divide in the field of global health between

vertical solutions (combating single diseases such as malaria and AIDS) and a more horizontal approach (such as expanding infrastructure or training additional health workers).[9]

As of the last WHO report in 2006,[10] Ethiopia was in the process of developing a national mental health policy. In 2004, only 1.7% of total expenditure on health was spent on mental health. The country has only one hospital dedicated to mental health, and this also acts as the national coordinator for mental health services. Ethiopia also has 53 psychiatric outpatient facilities and six inpatient facilities. There is only one residential facility in the country for the chronically mentally ill and several others that have mentally ill patients among their beneficiaries. The majority of mental-health-facility users are male, and all facilities lack special programmes for children and adolescents.[11] 3% and 2% of the training of nurses and doctors, respectively, is focussed on mental health. There are no mental health assessment and treatment protocols for primary health care workers. There are 0.02 psychiatrists and 0.03 psychiatric nurses per 100,000 head of population of the nation.

The Ministry of Health indicators highlight the plight of women in Ethiopia. In a population of 77 million people, there are 17,686,000 women aged between 15 and 49 (i.e. of reproductive age), served by just 163 obstetricians/gynaecologists, of which only 64 work in government institutions. This is a ratio of 1:276,343, compared with a ratio of 1:3,740 in the US. Midwife numbers are slightly better: there are 1,509 in total, of which 1,312 work for government institutions. The 1,312 government midwives for a population of 17,686,000 women of reproductive age gives a ratio of 1: 13,480, compared to the WHO's recommendation of 1:5,000.

The Addis Ababa Fistula Hospital's patients report that, on average, the nearest health facility is a two day walk from their homes. Only 41.5% of pregnant women attend any form of antenatal care, and only 12.4% receive any form of childbirth attendance from a skilled attendant. This too is unequal, with only 1% of the poorest women giving birth with a trained birth attendant.[12] In the remote Afar region, which has a high prevalence of Type III infibulation, 83.3% of women give birth to their youngest child at home and 92.5% are assisted by untrained TBAs.[13]

Modern contraceptives are used by 27.3% of the population. Only 19.1% of pregnant women have four or more antenatal visits. Furthermore, only 10% of births are attended by skilled health personnel. Less than 2% of births among those in the poorest 20% of the population are attended by skilled health personnel, and only 4% of births in rural areas. 50.8% of births in urban areas are attended by skilled personnel.[14]

HIV AND FGM

The link between HIV and FGM is a complex and a contested issue amongst researchers. A WHO multi-country study found that, although no studies link HIV/AIDS and FGM directly, haemorrhaging subsequent to the operation, bleeding during sexual intercourse as a result of lasting damage to the genital area and anal intercourse where infibulations prevent or impede vaginal intercourse are all potential sources of HIV transmission.[15]

Women's Health and Infant Mortality

Women's Health

There are numerous health concerns associated with FGM. Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue, such as fistula from cutting through the urethra. Long-term consequences can include recurrent bladder and urinary tract infections, cysts, infertility, an increased risk of childbirth complications and newborn deaths, and the need for later surgeries. For example, Type III/infibulation needs to be cut open later to allow for sexual intercourse and childbirth. There are reports that women who have undergone FGM have reduced sexual desire, pain during intercourse, and less sexual satisfaction.[16]

In relation to the psychological issues surrounding FGM, data suggests that, following FGM, women are more likely to experience psychological disturbances (have a psychiatric diagnosis, suffer from anxiety, somatisation, phobia, and low self-esteem).[17] More research is needed to understand better the relationship between FGM and consequential psychological, social and sexual problems.[18]

A recent study on FGM in Iraq showed that girls who have undergone FGM are more prone to mental disorders, including post-traumatic stress disorder. Among 79 girls studied in the Kurdistan region of northern Iraq, the study found rates of mental disorders up to seven times higher than among uncut girls in the same region, but comparable to rates among girls who had suffered early childhood abuse: 44% suffered post-traumatic stress disorder, 34% depression, 46% anxiety, and 37% somatic disturbances (symptoms unexplainable by physical illnesses). The girls studied were aged 8–14 and had not otherwise suffered a traumatic event.[19]

In relation to the increased risk of birth complications, a WHO multi-country study, in which over 28,000 women participated, confirmed that women who had undergone FGM had a significantly increased risk of adverse events during childbirth. Higher incidences of caesarean section and post-partum haemorrhage were found in the women with Type I, II and III FGM compared to uncut women, and the risk increased with the severity of the procedure. The consequences for women not giving birth in a hospital setting are likely to be even more severe.[20] The high prevalence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible.[21]

The Addis Ababa fistula hospital conducted a study that did not find a direct link between FGM and obstetric fistula. However, a WHO-sponsored study is examining the association between FGM and obstetric fistula. The pilot study indicated that there may be an association, but the final results are not expected until the end of 2013. In addition, a multi-country modelling study was set up to estimate the increased costs in obstetric care due to increased obstetric complications as a result of FGM. The annual cost was estimated to be US$3.7 million and ranged from 0.1 to 1% of government spending on health for women aged 15–45.[22]

Infant Mortality

The WHO also showed that death rates among newborn babies are higher to mothers who have had FGM. There was an increased need to resuscitate babies whose mothers had undergone FGM (66% higher in women with Type III). The death rate among babies during and immediately after birth was also much higher for those born to mothers with FGM: 15% higher for those with Type I;

32% higher for those with Type II; and 55% higher for those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries.[23]

CASE STUDY

Sadiya, aged 10, was just seven days old when she was infibulated. Infibulation, or Type III FGM, is the most severe form of FGM. Among the Afar , Type III is the most common type and is often carried out within days of birth. They have one of the highest rates of FGM in Ethiopia.

Sadiya found urination painful and difficult, and she would urinate drip by drip. Eventually a swelling occurred around the small opening left by the infibulation, which interrupted the limited flow of urine. Her mother took her via a long trip to the Barbra May Maternity Hospital in Mille, where the infibulation was opened and the swelling, which proved to be a cyst, was removed. Sadiya's mother has vowed that she will never again make a girl undergo FGM.[24]

A group of women in Awassa, Ethiopia
(© Kimberly McKinnon)

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Interventions and Attempts to Eradicate FGM

Background

Ethiopia has a long tradition of internal, informal, community-based organisations like the ***idir*** and ***iqub*** – self-help associations that operate at the local level and offer mutual socio-economic support to their members. **Formal civil society** – that is, organisations with legal personality – is a recent development. Civil society was slow to take root under the Ethiopian Empire regime (1137–1974). It was also severely restricted under the rule of the Derg (a military junta) (1974–1991).[1]

Modern civil-society organisations were first established as FBOs in the 1930s, and, beginning in the 1950s, welfare organisations like the Red Cross started to operate in Ethiopia. As a result of the 1973–1974 and 1984–1985 famines, many more NGOs emerged with a focus on relief and humanitarian services. After the downfall of the Derg regime in 1991, NGO numbers substantially increased.

There have been a large number of powerful **campaigns and activities to prevent HTPs** in Ethiopia in the last two decades, including FGM. Initially, the interventions were carried out by a small number of organisations, mainly the Ministry of Health, through the Family Health Department. In the 1990s, interest grew, and over 80 different organisations participated in activities against HTPs, with the main focus on FGM, uvula cutting, milk teeth extraction, early marriage and abduction.[2] There is now a large number of government and non-governmental organisations working on women's health issues.

Focus groups in the EGLDAM follow-up study highlighted that the public felt there are strong social and political movements for the abolition of FGM, although campaigns have been strongest in urban areas, where 'government, media and NGO activity has been important'.[3]

Government Policy and Support

The Ethiopian Government has ensured that 'a solid policy and a programmatic basis ha[s] been laid'. HTPs are included in all of the major policy and legal plans across the country, including those on women, health, education and social issues.[4] Other measures include the establishment of a **Women's Affairs Office** in 2005 (an inter-ministerial body set up to combat violence against women, including HTPs) and the identification of FGM by the Women's Affairs Office as one of the major goals in its five-year plan. In 2011, the **Growth and Transformation Plan** set progressive and ambitious five-year targets to reduce FGM to 0.7% by 2015.[5] There has also been good collaboration between regional governments and NGOs; for example, between Women's Affairs Office and NGOs in Afar.[6]

Overview of Interventions

Figure 13 shows the number of NGOs involved in anti-HTP activities. What is noteworthy is the relatively small number operating in the Afar and Somali regions, where the most severe form of FGM is prevalent.

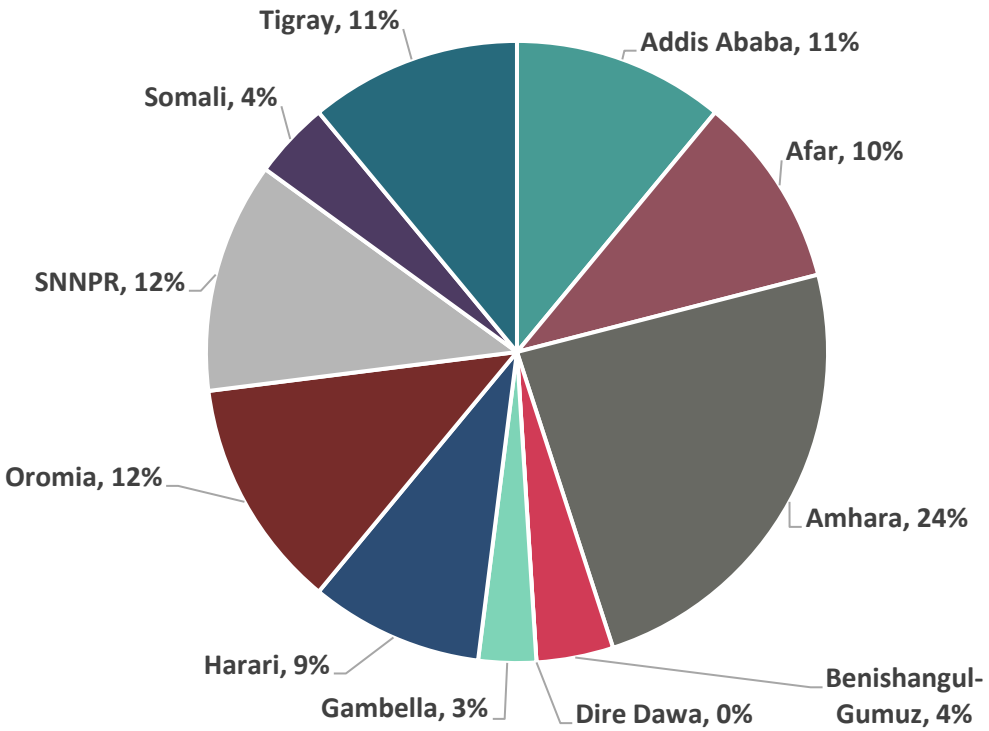

Figure 13: Areas in which NGOs are involved in anti-HTP activities (2007)[7]

A broad range of interventions and strategies have been used by different types of organisations to eradicate FGM. Often a combination of the interventions and strategies below are used:

- health risk/harmful traditional practice approach;
- addressing the health complications of FGM;
- educating traditional excisors and offering alternative income;
- alternative rites of passage;
- religious-orientated approach;
- legal approach;
- 'Community Conversations';
- promotion of girls' education to oppose FGM;
- supporting girls escaping from FGM/child marriage; and
- media influence.

1. Health Risk/Harmful Traditional Practice Approach

The focus of anti-FGM work tends to be on raising awareness of its harms and, in Ethiopia, this is 'overwhelmingly the most important intervention' in terms of numbers and extent of interventions.[8] Ethiopia also has a long history of information, education and communication (*IEC*) or health education activities. These are planned packages of intervention, which combine 'informational, education and motivational processes'. For example, EGLDAM has helped inform communities through the mass media, the sharing of information through communities, poster and leaflet campaigns, and films and social gatherings.[9]

2. Addressing the Health Complications of FGM

FGM is included in the National Reproductive Health Strategy (2006–2015) and is covered in the training of medical doctors, nurses and midwives at the Semera Health Sciences College in Afar.[10]

The pioneering Addis Ababa Fistula Hospital, founded in 1958, is the world's only medical centre dedicated exclusively to providing free obstetric fistula-repair surgery to women suffering from childbirth injuries. In addition to repairing obstetric fistulae, the hospital also repairs damage to childbirth injuries that are a result of FGM and supports a network of hospitals in five regional towns (see International Organisations below for a full profile). It also has a rehabilitation centre called Desda Mender, dedicated to long-term support of women whose fistulae are irreparable. In addition, the Afar Pastoralist Development Association runs the Barbra May Maternity Hospital in Mille, Afar, in partnership with UNFPA/UNICEF, treating FGM-related complications (see National Organisations below for a full profile).

There is still a need for more medical care, particularly in relation to women's health and specifically maternal health, including treatment for the complications of FGM. This need is especially acute in remote regions such as Afar. One report recommends treatment for girls with complications from infibulation by training staff in health centres. Such treatment would also highlight the negative consequences of FGM and have a preventative effect.[11]

3. Educating Traditional Excisors and Offering Alternative Income

Educating traditional excisors about the health risks of FGM and providing them with alternative means of income as an incentive to stop practising is a strategy used by a number of organisations. For example, one organisation in Afar, the Covenant for Ethiopia Support, has supported former excisors in receiving entrepreneurship training and establishing alternative-income activities. Some former excisors have pledged to stop cutting and are educating others to stop FGM.

Although such initiatives may be successful in supporting excisors in ending their involvement in FGM, they do not change the social convention that creates the demand for their services. Such initiatives may complement approaches that address demand for FGM, but alone they do not have the elements necessary to end it.[12]

4. Alternative Rites of Passage

For those ethnic groups where FGM is part of a rite of passage to initiate girls into adulthood, one approach that has had some success is conducting alternative rites of passage (*ARPs*). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve cultural traditions while eliminating FGM. ARPs have been implemented with varying degrees of success.

The success of ARPs depends on the community practising FGM. In addition, ARPs will have limited impact unless they are accompanied by education that engages the whole community in collective reflection and leads to changes in the expectations of community members. The use of ARPs is further limited by the trend for communities to cut girls at a younger age and with less ritual.[13] Due to the fact that FGM, especially in the north of Ethiopia, is performed on girls at a young age with little or no ceremony, ARPs will likely have limited application in Ethiopia. However, ARPs will be relevant where FGM is a rite associated with marriage, as happens more frequently in the south.

The African Development Aid Association has worked with Norwegian Church Aid (*NCA*) to combat FGM in the Siraro District of West Arsi Zone of Oromia, where FGM is performed before marriage (a couple of days before the ceremony). ARPs are used in this context, and positive parts of the culture are emphasised to encourage engagement of the community (see National Organisations below for a full profile).

5. Religious-Orientated Approach

A religious-orientated approach refers to approaches that demonstrate that FGM is not compatible with the religion of a community, thereby leading to changes in attitudes and behaviours. This approach has been used with both Christian and Muslim communities. Both the Ethiopian Orthodox Church and the Evangelical Churches Fellowship of Ethiopia have published declarations in support of abandoning FGM (see Religion and FGM above). In a UNFPA/UNICEF programme, 207 religious leaders were sensitised about FGM and expressed their commitment to work for the total abandonment of the practice. In addition, 150 leading clerics representing five FBOs – the Ethiopian Orthodox Church, the Ethiopian Islamic Supreme Council, the Ethiopian Catholic Church, the Evangelical Churches Fellowship of Ethiopia and the Ethiopian Seventh Day Adventist Church – agreed to admonish anyone who carried out the procedure.[14]

CASE STUDY

Kasech is 50 years old and was an excisor for the last 25 years in Kozeba Peasant Association in Amhara. She is now an agent of change.

My mother was a circumciser and while she circumcised I watched and learned how to circumcise. Unfortunately, she died before I gave birth and I went to one circumciser for my daughter but she told me she was busy. I was disappointed[,] took the risk, and started circumcising my daughter. Since then I continued the practice. I circumcised all my 3 children, a boy and two girls. Now, since EOC-DICAC gave me training on the negative impact of FGM I have stopped the practice[.] I teach my neighbours and relatives.[15]

Religious groups and religious leaders are frequently important agents of change. For example, Ogaden Welfare and Development Association, working in the Somali region, has sensitised religious leaders and held Model Family Award Ceremonies for girls and their families who have abandoned FGM. These ceremonies are attended by influential religious leaders who publicly declare that FGM is contrary to Islam. Religious leaders have become key to the project, and regularly sensitise the community on the negative effects of FGM and the fact that it has no roots in Islam (see National Organisations below for a full profile).

6. Legal Approach

Although there has been some enforcement of the law, overall, the number of reported cases is low and challenges remain in law enforcement. There has been positive progress, however, with the training of law enforcement officials and raising awareness of the law. A National Coordination Body, located in the Ministry of Justice, implemented a multi-sector plan to improve the implementation and enforcement of the law. Law enforcement officials are sometimes reluctant to enforce the law and impose appropriate sanctions. There appears, therefore, to be scope for scaling up law-enforcement activities.

7. Human Rights Approach/Community Conversations

A human-rights approach acknowledges that FGM is a violation of women's and girls' human rights. This approach is sometimes used alongside other strategies to eradicate FGM based on the social abandonment theory (derived from the social change theory behind foot-binding in China).[16] The components of this theory include (i) a non-judgemental human rights approach; (ii) community awareness-raising of the harmfulness of the practice; (iii) a decision to abandon FGM that is a collective decision by the entire community; (iv) the requirement of community public affirmation of abandonment; (v) intercommunity diffusion of the decision; and (vi) a supportive change-enabling environment, including the commitment of the government. This approach was pioneered by Tostan in Senegal.[17]

In Ethiopia, this approach has been termed 'Community Conversations' and has been pioneered by KMG, initially in Kembatta, in partnership with the UNFPA. It has emerged as an important approach to eliminating FGM. Community Conversations (*CC*) promote changed and informed decision-making by creating opportunities for regular, open discussion of situations, values and behaviours relating to HIV and AIDS, initially, but then applied to other subjects such as FGM (see 'Community Conversations' inset box under KMG's profile in National Organisations section below). The Ethiopian Government adopted these methodologies and, in 2004, launched this approach nationally. KMG's model is also used by NGOs in their work against FGM around the country, and there appears to be at least qualitative evidence of its success.[18] However, in other cases where CCs have taken place outside of village communities, on a larger district or sub-district level, discussions did not lead to the necessary consensus to change social norms as the participants had no sense of shared ownership.[19]

8. Promotion of Girls' Education to Oppose FGM

Schools are involved in the fight against FGM and other HTPs. The Ministry of Education stipulates that every school is expected to have a minimum of ten children's clubs, including girls' clubs, gender clubs or child-rights clubs, the aim of which is to raise awareness among school children and the community on issues such as HTPs and FGM. One study has shown that students attending such clubs feel that they have a lot of support and opportunity to influence their communities.[20]

9. Supporting Girls Escaping from FGM/Child Marriage

There are organisations that aim to protect children from early marriage and/or FGM, as well as sometimes enabling young girls to continue their education. They can also facilitate the reconciliation of girls and their families and their reintegration into the community. In isolation, however, safe houses are unlikely to have a significant impact in the work against FGM.

Since FGM is carried out on the majority of girls before the age of one year, rescue homes specifically to protect girls from FGM are perhaps not as relevant in Ethiopia as in other countries. However, in those regions and among those ethnic groups where FGM is carried out at a later age, the strategy may be relevant.

10. Media Influence

There has been more discussion of late in the media concerning HTPs.[21] Moreover, there have been reported examples of FGM 'stories' receiving wide coverage. Radio has proved to be an important medium in Ethiopia.[22]

For example, in Afar, the International Day of Zero Tolerance of FGM in 2012 was celebrated in the presence of two ministers from the Ministry of Women, Children and Youth Affairs, high-level officials and heads of Islamic Affairs. Women (cut and uncut) gave testimonies and religious leaders declared that FGM was not a religious requirement. Due to national and regional media coverage, many outside Afar heard the speeches.[23] There has also been international media interest in FGM in Ethiopia as a result of Bogalech Gebre being awarded the King Baudouin Prize in May 2013.

Some NGOs adopt media broadcasts as part of their strategies; for example, setting up radio listening groups. The highly professional Population Media Centre has extensive research-based knowledge and experience that has led to the preparation and broadcast of radio shows, in particular in Afar and Somali (see further International Organisations below).

EGLDAM and the School of Journalism of Addis Ababa University have sensitised journalists from radio stations, TV stations and newspapers (both government and private). In 2009, sensitisation sessions were held for 80 journalists, and there has, as a result, been increasing coverage of FGM in the media.

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International Organisations

CARE – Ethiopia

CARE – Ethiopia has worked in Afar in primary healthcare since 1996. In 2003 it founded the CARE Awash FGM Elimination Project, an integrated comprehensive health project aimed at eliminating FGM. It has worked alongside the local Ministry of Health and Women's Affairs Office, Islamic leaders, village health communities and religious and community leaders.

CARE's strategy includes:

- facilitating community conversations;
- training traditional birth attendants and primary health workers;
- creative mass information campaigns as well as radio programmes and listening groups;
- supporting anti-FGM clubs/groups;
- targeting women via savings and credit groups;
- addressing education for marginalised girls; and
- encouraging local governance processes to become responsive to women's and girls' sexual and reproductive-health rights, among other initiatives and livelihood security.

A guiding principle of CARE is that communities and individuals have the right to decide issues for themselves, and its projects have had particular success because of its ability to build trust in the community and the community-based approach to its work. One concern of the project is the need to protect girls who have not undergone FGM, and the education of these girls is seen as key to sustainability. CARE's approach is very comprehensive, but it means it is expensive.[1]

Hamlin International Fistula Hospital

The Addis Ababa Fistula Hospital, founded in 1958, is the world's only medical centre dedicated exclusively to providing free obstetric fistula-repair surgery to women suffering from childbirth injuries. The founder, Catherine Hamlin, has been recognised by the UNFPA as a pioneer in fistula surgery. In addition to repairing obstetric fistula, the hospital also repairs damage to other childbirth injuries (to the vaginal openings, rectum and urethra) that are a result of FGM. The hospital has treated more than 34,000 women for obstetric fistula, can accommodate up to 140 patients and can perform four operations simultaneously. There is now a network of Hamlin Fistula Hospitals, with five fistula centres having been established in the regional towns of Bahir Dar (Amhara region), Mekelle (Tigray

Sign for Addis Ababa Fistula Hospital (© 28 Too Many)

region), Harar (Harar region, expected to also treat Somali women given the proximity to the Somali border), Yirgalem (SNNPR) and Metu (Oromia Region). The hospitals are funded mainly by private donors in Australia, the UK and the US. The largest of the dedicated support organisations is the Fistula Foundation, located in Santa Clara, California. Money is also provided by World Vision, UK-based Ethiopia Aid and the Australian Government.

IntraHealth International

IntraHealth International teamed up with the National Committee on Traditional Practice of Ethiopia (now EGLDAM) in a five-dimensional approach to FGM abandonment in Ethiopia, focussing on health, gender, religion, human rights/law and access to information. The intention of the project was to encourage abandonment of FGM by closing knowledge gaps, strengthening communication between the community and policy makers and empowering women. This programme was highlighted by the Population Reference Bureau as impressive in its range of activities and multi-faceted approach.

The project was introduced in eight communities with FGM rates of 90% and above within Harar, Oromia and Somali. It educated more than 4,200 community members on the five dimensions, with many more people being reached through local and national media. Influential elders, religious and political leaders helped to increase the programme's impact and audience by publicly condemning FGM. The programme set out to advocate FGM abandonment through national and regional sensitisation workshops, training of trainers (religious leaders), community-leader training, community mobilisation, public declarations of abandonment and the creation of a forum of religious leaders for advocacy. IntraHealth created links with Somali Women Development Organisation, Anti-FGC Mother's Association, Somali Women Self-Help Association and the African Development and Aid Association in order to encourage the project's sustainability.[2]

Norwegian Church Aid

Norwegian Church Aid (*NCA*) started working on HTPs in Ethiopia in 1999 and, through its partners, employs the following strategies: awareness-raising and advocacy; community mobilisation and campaigns; and organising and strengthening women's groups and integrating this approach with other thematic areas. NCA has undertaken awareness-raising and sensitisation through its Rural Development Programmes, national advocacy, sponsoring radio and TV documentaries, supporting the FGM Network and building the capacity of local organisations. NCA partners with African Development Aid Association, Covenant for Ethiopia Support, Rohi Weddu Pastoral Women Development Organization, Ethiopian Evangelical Church Mekane Yesus, Kembatti Mentti-Gezimma-Topee (*KMG*) Ethiopia, Ogaden Welfare Development Association, Ethiopian Orthodox Church Development and Inter Church Aid Commission and Professional Alliance for Development Ethiopia.[3]

Population Media Centre

Population Media Centre (*PMC*) is a non-profit, non-political, non-governmental and non-religious organisation that specialises in media communication, including radio, theatre and creative arts. From 2007 to 2010, PMC ran a project with Save the Children Ethiopia – Norway to improve 'the health of girls and women by addressing women's reproductive concerns, including harmful traditional practices and FGM'.

The project aims for national coverage and has a particular focus on the Afar and Somali regions. It mainly includes radio serial drama in Amharic and targeted radio broadcasts for Afar and Somali, as well as printed posters and leaflets, workshops and capacity building for religious leaders, young people and media practitioners. They have worked to develop strong links with anti-FGM initiatives in the Afar and Somali regions, in particular targeting religious leaders and young people.

PMC is praised for being a highly professional organisation and adopting a research-based and culturally sensitive approach. The organisation is also known for reaching out to religious leaders and young people as key change agents and stakeholders on the national, regional and district levels. It was noted that this approach was expensive due to the high price of air time in Ethiopia.[4]

Save the Children Norway – Ethiopia

In 2006, a four-year contract was signed with the Norwegian Embassy to coordinate a Strategic Partnership on FGM in Ethiopia. In 2011, this partnership was renewed for another five years. The partner organisations are Save the Children Norway-Ethiopia (*SCN–C*), CARE – Ethiopia, Population Media Centre, EGLDAM, the Afar Women's Affairs Bureau and Rohi-Weddu Pastoral Women Development Organization.

The main interventions carried out by the Partnership are 'community-based approaches, media communication and documentation'.[5] The efforts of the first phase, from 2006 to 2010, were focussed in the Afar and Somali regions, due to the high prevalence in the area and the severity of the cutting that is carried out. The second phase will concentrate on the Afar, Amhara, Harari, Oromia, Somali and SNNPR regions. See the profiles of national organisations below for further details of the programmes.

The mid-term review of the Partnership suggests that its strategies from the first phase have been successful. One of its strengths is the simultaneous national, regional and community-based work. It has observed progress in terms of awareness-raising and coverage, as well as considerable commitment from regional leaders in the Afar and local key people.[6]

The second phase will build on the encouraging results from the first phase by scaling up interventions and making FGM a national agenda.

UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting[7]

The UNFPA/UNICEF Joint Programme on Female Genital Mutilation/Cutting (*UNJP*), which aims to strengthen the momentum towards ending FGM, was founded in 2008. The UNJP has worked in partnership with other UN agencies, cooperation/development partners and leading NGOs to achieve this aim. By 2012, the UNJP implemented its 'novel, culturally sensitive human-rights based approach' in 15 countries: Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, The Gambia, Guinea Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, Sudan and Uganda.

Human-rights-based approach: The UNJP has introduced a human-rights-based approach (see Overview of Interventions above for further detail), with community-based interventions to build a consensus to abandon FGM. This has resulted in 234 community discussion-and-education sessions and 60 community declarations involving over 20,000 people in 2012.

Public health: One of the major interventions of the UNJP is strengthening the role of public health services in preventing FGM and mitigating its negative effects on girls' and women's health. In several districts in the remote Afar region, the UNJP has trained medical personnel, as well as TBAs and CHWs (collectively known as health extension workers) who work full time to integrate care for FGM-related complications into reproductive-health services. The extension workers undertake health-promotion activities to prevent FGM, as well as identifying women with FGM complications and treating them or referring them to health centres or hospitals. Extension workers provide health-promotion activities in schools and in house-to-house visits, which are helpful in a pastoralist community where people move often in search of food and water. In 2011, the UNJP, via the extension workers, provided counselling to 85,454 people; treatment, counselling and referral services to 52,004 mothers; antenatal check-ups to 725 women and postnatal check-ups to 841 women; and delivered 614 babies.

Education: The UNJP has also supported the introduction of awareness and prevention of FGM into the education system. For example, 20 elementary school teachers underwent training, facilitated by health and legal professionals, on the consequences of FGM and on law and policy, following which the issue was included in daily teaching sessions and the whole school mobilised.

The programme had a budget of US$318,663 in 2012, of which 87% was utilised/implemented.

National FGM Network[8]

EGLDAM, with the support of Norwegian Church Aid, established the National FGM Network. It was incepted in 2002 and officially launched in 2010. It was visited by 28 Too Many in 2010 when there were more than 46 governmental and non-governmental member organisations as members. The network had a seven-member Executive Committee and was chaired by the Ministry of Women, Children, and Youth Affairs with EGLDAM serving as a secretariat. In addition, four regional networks were established in SNNPR, Somali, Amhara and Tigray and the network holds national conferences in Addis Ababa. The objective of the FGM Network is (i) to mobilise actors in order to increase possibilities of making positive change and (ii) to increase coordinated participation of local civil society and international organisations to bring about broad social change through a collective voice and action. It also publishes a newsletter that is available on its website.

The Network's objectives include:

- raising awareness at the grassroots level by conducting training, researching and producing IEC materials;
- increasing the capacity of stakeholders/partners through programme integration/ mainstreaming, networking and collaborating, y conducting forums in areas of common concern;
- building the capacity of 200,000 students and youth (both in and out of school) for the dissemination of information and active participation in the fight against HTPs; and
- implementing a networking strategy to strengthen the links with partners and stakeholders for better collaboration of efforts towards addressing issues of common concern.

Challenges/needs noted by the network include:

- a need for strengthening the organisational capacity of EGLDAM with effective resource-mobilisation and sustainability;
- changes in donors' funding policies; and
- a gradual decrease of financial sources.

Norwegian Church Aid feels that the network is growing stronger and states that it is focussing on:

- formulating clear, measurable goals for its agenda;
- documenting outcomes of members' activities and the added value of the role of the network;
- increasing members' participation in the network;
- creating links at the grassroots level through local alliances and networks; and
- strengthening local actors' advocacy capabilities.

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3 Norwegian Church Aid (2009) *NCA Ethiopia and Partners engagement in Abandoning HTPs – FGM in Ethiopia: Review of 9 partners contribution (2002–2008)*. Available at https://www.norad.no/en/toolspublications/publications/ngo-evaluations/2011/nca-ethiopia-and-partners-engagement-in-abandoning-htps_fgm-in-ethiopia--review-of-9-partners-contribution-2002-2008/.

4 Berggrav, Talle and Tefferi (2009), *op. cit.*

5 Berggrav, Talle and Tefferi (2009), *op. cit.*

6 *Ibid*.

7 - UNJP (2013) *Joint Project on Female Mutilation/Cutting: Annual Report 2012*. Available at https://www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-annual-report-2012.
- UNJP (2011) *Accelerating Change: 2011 Annual Report*. Available at https://www.unfpa.org/publications/accelerating-change-2011-annual-report.

8 - Norwegian Church Aid (2009), *op. cit.*
- EGLDAM.

Local Organisations

Afar Pastoralist Development Association

The Afar Pastoralist Development Association (*APDA*) is a UNJP partner and runs the Barbra May Maternity Hospital in Mille, Afar. In addition to more routine obstetric services, the hospital treats FGM-related complications. The hospital treats up to 50 cases of urinary and obstetric complications relating to FGM every week.[1]

In addition, in areas where there are no government-supported health extension workers, APDA has trained and deployed women, from their respective communities, to provide outreach and health promotion messages about FGM.[2]

In 2012, APDA implemented a registration system for pregnant women, including their pre-, intra- and post-partum care. The system is designed with a follow-up mechanism: TBAs record births and follow-up on girls for the first four years, to protect them from FGM; then the girls are followed up by their teachers.[3]

Afar girl in Danakil Region (© Cdkeyser)

African Development Aid Association – Oromia Region[4]

The African Development Aid Association (*ADAA*) has worked with Norwegian Church Aid in combating FGM in the West Arsi Zone of Oromia. The most prevalent type of FGM in this region is Type I, which in Siraro District is often performed before marriage (a couple of days before the ceremony). The project targeted households and community, religious and traditional institutions, community-based organisations (*CBOs*) and local government offices (wereda offices). The strategies included information and awareness raising; ARPs, including promoting positive parts of the culture; involvement of religious and traditional leaders, which was noted as particularly important due to the belief that FGM is a religious and/or cultural requirement; positive deviance; the formation of anti-HTP associations, and promoting income-generating activities for FGM practitioners. Community conversations (*CCs*) have been a key behavioural-change tool used.

Highlights include:

- over 60,000 people have participated in CCs, which then go onto establish anti-HTP associations;
- strong collaboration with women's affairs officers and district (wereda) administration led to a strong sense of joint ownership;
- most communities have decided to stop HTPs, particularly FGM;

- community is well aware of anti-FGM legislation and some communities have passed by-laws outlawing FGM; others are contemplating doing so;
- four public weddings during which the couples announced the non-FGM status of the bride were organised and widely publicised.

EGLDAM (formerly NCTPE)

In accordance with the Civil Societies and Charities Law, the name and objectives of EGLDAM was changed to ODWaCE (see entry below).

Formerly the National Committee on Traditional Practice of Ethiopia (*NCTPE*), the Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (*EGLDAM*) was an NGO established in 1987 (initially it operated under the Ministry of Health). It became a chapter of the Inter-African Committee on Traditional Practices in 1997. Its mission was the promotion of beneficial traditional practices and the eradication of harmful practices. It had ten regional offices. It has set up an FGM network (see above).

Among its other strategies and achievements are the following.

- **Research, policy and law:** As the NCTPE, the organisation carried out a country-wide baseline survey on HTPs in 1997, identifying some 140 HTPs, and a follow-up survey (as EGLDAM) in 2007. The baseline survey was a useful advocacy tool for EGLDAM, with the Ministry of Women's Affairs, to bring the issue to the Ethiopian parliament. This has ultimately led to FGM being addressed in the Ethiopian Constitution and the passing of the revised Criminal Code in 2005. EGLDAM has also lobbied parliamentarians and regional council members.
- **Health system:** EGLDAM carried out capacity-building of the healthcare system in Amhara, Oromia, Tigray and SNNP, in partnership with Pathfinder International.
- **Education system:** Anti-HTP clubs have been established in most schools.
- **Religious/traditional leaders:** EGLDAM has provided training to traditional and religious leaders.
- **Legal system:** In collaboration with the Ministry of Justice, training of judges, prosecutors and police officers in Addis Ababa, Amhara, Oromia, Tigray and SNNPR.
- **Media:** Training of journalists (see Overview of Interventions above).
- **Capacity building:** Building the capacity of other organisations combating HTPs, by providing resources, personnel, training and materials.
- **Reaching communities via Women's Affairs Offices and Kebele and Peasant Associations:** Working through Women's Affairs Offices from regional to wereda (district) level to reach thousands of communities, disseminating information on HTPs. With UNICEF, EGLDAM has carried out grassroots activities in *kebele,* or wards (urban), and peasant associations (rural).

One study commented that EGLDAM is well-placed for lobbying and has developed good networks. However, the organisation is struggling to maintain itself at an optimum level and has inadequate staff capacity. It is supported by a number of donors, including Pathfinder, Inter-African Committee on Traditional Practices and Norwegian Church Aid.[5]

Ethiopian Orthodox Church Development and Inter-Church Aid Commission[6]

The Ethiopian Orthodox Church Development and Inter-Church Aid Commission (*EOCD–ICAC*) is the development wing of the Ethiopian Orthodox Church and the oldest faith-based development organisation in Ethiopia. It is viewed as a role model by other local organisations. EOC–DICAC is active in many regions of the country.

EOC–DICAC has worked with Norwegian Church Aid in combating FGM in Dahana district, Amhara.

Strategies and achievements include:

- establishing anti-HTP committees and school anti-HTP clubs;
- targeting excisors and survivors as agents of change and engaging former excisors in income-generation activities;
- involving religious leaders. Most of the Dahana district is Orthodox Christian. Clergymen are highly respected and influential and have played a major role in the community advocating against FGM;
- thousands of people have participated in training and workshops on HTPs;
- information, education and communication materials have been distributed;
- radio programmes and radio listening groups established in association with Amhara Mass Media Agency, enabling a larger proportion of the population to be addressed; and
- working closely with local sector offices, schools, local administration, police and legal bodies to ensure local ownership and support.

Kembatti Mentti-Gezimma-Topee Ethiopia – SNNPR and Oromia Regions

Kembatti Mentti-Gezimma-Topee (*KMG*) Ethiopia was founded in 1997 by Dr Bogaletch Gebre and her sister Fikrte Gebre. Dr Gebre is a pioneer in the empowerment of women and the fight against FGM and other HTPs, and has received national and international recognition, including the 2012/2013 King Baudouin African Development Prize. KMG aims to create an environment where the values and rights of women and their talents and wisdom are recognised. KMG operates in 24 districts in SNNP and Oromia, reaching out to more than 481,289 direct and 2,859,500 indirect beneficiaries, 70% of whom are women.

Initially, KMG's focus was on eliminating FGM and other HTPs, but it has since expanded its focus to economic enfranchisement, education, reproductive health services, HIV and AIDS, environmental degradation, and small infrastructure development.

KMG estimates that hundreds of thousands of girls have been spared FGM. In the areas of their work, young men now want to marry uncut girls and whole communities openly discuss these once-taboo subjects at open-air meetings once limited to only elders. Over 2,000 trained facilitators work among communities and every community keeps track of every uncut girl in its neighbourhood.

The organisation has also contributed to the national and international efforts to eliminate HTPs and control HIV and AIDS. In 2002, in collaboration with UNDP, KMG piloted a social mobilisation tool known as Community Capacity Enhancement though Community Conversation. The Ethiopian Government adopted these methodologies and in 2004 launched them nationally. KMG was contracted as a national co-coordinator and trainer during the start-up phase. KMG's model is also used by NGOs in their work against FGM around the country.

Annual 'Whole Body Healthy Life Celebration' events are an important off-shoot of the CCs. These events receive much publicity and are well attended. There are festivities, poetry sessions, drama and sporting events, with girls who have not undergone FGM being the focus.

Community Conversations Pioneered by KMG in Ethiopia

CCs promote changed and informed decision-making by creating opportunities for regular, open discussion of situations, values and behaviours relating to HIV and AIDS initially, which is then applied to other subjects, such as FGM.

The CCs began as general community forums, but later specialised for particular groups (e.g. uncut girls, the Fuga social group). Topics are guided by the manual developed by UNDP/KMG, but could vary depending on the local context. All programmes include HIV and AIDS, HTPs, reproductive health and human rights, democracy and good governance. Each CC has its own facilitators.

CCs are held every 15 days for 1.5–3 hours, at times chosen by the participants. They start with an introduction/reflection session during which the day's topic is raised. Participants then discuss the topic in groups. Quarterly meetings of all CC participants in the district also help to share experiences, best practice and coordinate activities. CCs are conducted for at least one year, after which the group 'graduates' and forms a ten-person committee to follow up on the decisions made by the CC, with little or no direct support from KMG.

There is substantial qualitative evidence that this approach has led to changes in knowledge, attitudes and practise, with reported results of abandonment of FGM. Womankind report that the project has enabled communities in Kembatta to abandon FGM, which reduced from 97% in 1998 to less than 4% by 2008. Over 175,000 girls have been protected from FGM.[7]

Challenges include the following.

- CCs pose a threat to existing power structures and community empowerment may lead to other power structures trying to derail CCs. Key stakeholder involvement is required. KMG demonstrates how CCs, if carried out well, can provide opportunities for local authorities to understand community consensus and decisions and integrate them into their plans.
- Fortnightly meetings may lead to 'conversation fatigue' before outcomes are realised, although this is not supported by all studies.
- Evidence for the effectiveness of CCs is largely qualitative, and, while it is sufficient to justify rolling-out the project, more robust evaluation seems desirable.
- Adaptations of the programme need to reflect ethnic diversity.
- There is a need to balance educated facilitators with facilitators from within the community.
- Ensuring quality, cost and capacity issues with scaling the programme up.[8]

Organization for the Development of Women and Children Ethiopia

The Organization for the Development of Women and Children (*ODWaCE*) is the former Ye Ethiopia Goji Limadawi Dirgitoch Aswogaji Mahiber/EGLDAM. ODWaCE focuses on the following core activities: health, education, life-skill training for women and children, assisting fistula victims and poor women to generate their own income, research and networking.

The role of ODWaCE with regard HTPs is to share its expertise and resources for government sector offices like the Ministry of Women, Children and Youth Affairs (*MoWCYA*), the Ministry of Culture and Tourism and other NGOs and CSOs. In addition to this, ODWaCE is a member of a national HTPs strategy and the national alliance to end child marriage. Both are organized by MoWCYA. Based on this, ODWaCE will continue to contribute its experience and resources in the area of HTPs.

Currently, ODWaCE focuses on the health and capacity-building of women, enhancing educational attainment of children, treating fistula victims and assisting them to be able to generate their own income, networking and research. ODWaCE is operating in more than five regions and produces a newsletter that is an informative publication focussing on health, education and life-skill training.

Ogaden Welfare and Development Association (Somali)

Ogaden Welfare and Development Association (*OWDA*), founded by a team of Ethiopian Somali in 1999, is a secular, non-political NGO. It engages in both emergency and development programmes, has a staff of over 140 and partners with the Government, UN agencies, embassies and INGOs. Its mission is to improve the living conditions of the most disadvantaged and vulnerable within the region; to empower women; to build the capacity of communities to withstand environmental shocks; and to prevent environmental degradation and conserve natural resources.

OWDA has had programmes to combat FGM in the Gode Zone in partnership with UNICEF and Norwegian Church Aid. The area has a very high prevalence of FGM, and mostly Type III/infibulation, with girls being cut between 8 and 11 years of age.

OWDA's strategy for eradicating FGM has included the following.

- Sensitising religious leaders, disseminating information and encouraging at least an abandonment of Type III/infibulation to the less severe Type I 'sunna'.
- Experience-sharing, with various members of the community. This led to CCs being established, which align well with the Somali tradition of sharing information. There was a particular emphasis on the need to engage with grandmothers as key influencers in the decision to get a girl cut.
- Model Family Award Ceremonies for girls and their families who have abandoned FGM, attended by influential community members, former cutters and influential religious leaders who publicly declare that FGM is contrary to Islam. These ceremonies have been important in persuading other families to abandon FGM.
- Workshops and training targeted at different sections of the community, and radio programmes.

Achievements include:

- breaking the taboo of FGM such that it is now widely discussed;
- religious leaders have become the key to the project, and regularly sensitise the community on the negative effect of FGM and the fact that it has no roots in Islam;
- a change in number and attitude of cutters, with some publicly promising to abandon the practice, becoming advocates against FGM and engaging in alternative livelihoods (some, however, have shifted to practising Type I 'sunna' FGM);
- reporting to law enforcement agencies has increased; and
- integration of anti-FGM message into health centres' maternal health care education programmes.

Challenges include:

- the tendency for communities to focus on water and food security during discussions;
- total abandonment of FGM, given that it is so deeply entrenched and the trend towards practising Type I 'sunna';
- religious leaders have differing views on total abandonment of FGM;
- fear, especially in rural areas, that girls who have not been infibulated will be raped (rape cases trigger waves of infibulation);
- the lack of alternative sources of income for cutters; and
- promises given by community (especially in workshops) not necessarily being kept.[9]

National FGM Network

See section above.

Rohi Weddu Pastoral Women Development Organization (Afar)

Rohi Weddu, which means 'saving life', is based in Afar and works with pastoralist communities, CBOs, traditional institutions, government and development partners for the socio-cultural transformation and economic empowerment of children and women. One of its aims is to contribute to the abandonment of FGM and other HTPs. Its FGM project involves encouraging community dialogue, lobbying influential people and organising diffusion through a core group defined as community leaders. Rohi Weddu also organises radio-listening groups through Radio Fana and Tigray radio and produces information material. It operates in several zones in Afar and has wide coverage.[10]

The organisation has adopted the following specific strategies:

- raising awareness and sensitisation on FGM and other HTPs among community leaders, traditional leaders and excisors;
- strengthening legal protection measures against FGM;
- ensuring sustainability by enabling communities to continue the prevention work on their own;

- training advocates for change from within the community (community leaders, religious leaders, former excisors and youth); and
- establishing village anti-FGM committees and community dialogues. Consensus was reached to stop FGM in the district.

Achievements/challenges include the following.

- Facilitators from within the community are seen as key to the success of the programme. According to one report, if care is taken in their selection and they are convinced on FGM abandonment, '70% of the job could be considered completed', as they will be so influential.
- Following community dialogues, consensus was reached to stop FGM in the district; however, some find it hard to accept abandonment.
- Communities do not always agree to issue by-laws to prohibit FGM and prosecute parents who cut their daughters.
- An anti-FGM women's group was established and organised an income-generation programme, with shops being successfully set up.
- Girls have been registered and are followed up to ensure they have not been cut.
- Most have abandoned Type III/infibulation, but some have merely changed to Type I 'sunna' FGM or continue to infibulate under the guise of 'sunna'.
- To ensure sustainability, such programmes need to extend to other districts.[11]

One of the strengths of Rohi Weddu is that it encourages communities to define and solve their own problems. Moreover, it has strengthened collaboration with stakeholders such as the Women's Affairs Office and the Regional Muslim Affairs Supreme Council. The organisation notes the empowerment of women in other ways in Afar – for example, women are starting to earn an income and girls are increasingly attending school – and hopes this will lead to a decline in FGM.[12]

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1 *Avoiding and mitigating the health consequence of FGM/C in Ethiopia*, 18 June. Available at http://www.unfpa.org/public/home/news/pid/14400.
2 *Ibid*.
3 UNJP (2013) *Joint Project on Female Mutilation/Cutting: Annual Report 2012*. Available at https://www.unfpa.org/publications/unfpa-unicef-joint-programme-female-genital-mutilationcutting-annual-report-2012.
4 Norwegian Church Aid (2009) *NCA Ethiopia and Partners engagement in Abandoning HTPs – FGM in Ethiopia: Review of 9 partners contribution (2002–2008)*. Available at https://www.norad.no/en/toolspublications/publications/ngo-evaluations/2011/nca-ethiopia-and-partners-engagement-in-abandoning-htps_fgm-in-ethiopia--review-of-9-partners-contribution-2002-2008/.
5 Marit Berggrav, Aud Talle and Hirut Tefferi (2009) *Prevention and Eradication of Female Genital Mutilation (FGM) and other Harmful Traditional Practices (HTPs) in Ethiopia: Save the Children Norway-Ethiopia and Partners Mid-Term Review (MTR) 25th November – 5th December 2008 – Final Report 02.02.09*. Available at https://www.scribd.com/document/46239901/DOCS-138374-V1-Projects-Against-Female-Genital-Mutilation-FMG-and-HTPs-in-Ethiopia-Final (accessed 25 February 2021).
6 Norwegian Church Aid (2009), *op. cit.*
7 *Womankind Worldwide* [website]. Available at https://www.womankind.org.uk/.
8 Norwegian Church Aid (2009), *op. cit.*
9 Norwegian Church Aid (2009), *op. cit.*
10 Berggrav, Talle and Tefferi (2009), *op. cit.*
11 Norwegian Church Aid (2009), *op. cit.*
12 Berggrav, Talle and Tefferi (2009), *op. cit.*

Challenges

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

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

Conclusions

28 Too Many recognises that each country where FGM exists requires individualised plans of action for elimination to be successful. We propose the following general conclusions, many of which are applicable within the wider scope of international policy and regulation, and some of which are specific to Ethiopia.

Adopting Culturally Relevant Programmes

Ethiopia is a country of significant geographical, cultural, ethnic and religious diversity. FGM is practised, to varying degrees, across much of the country. Strategies for eliminating FGM need to be at both the national level and the community level, with particular care being taken by organisations to tailor women's health and anti-FGM initiatives to take into account the particular regional circumstances.

Sustainable Funding

Programmes and research studies concerned with the elimination of FGM require sustainable funding in order to be effective. This is a challenge in Ethiopia, given both the wide geographical coverage of anti-FGM efforts that is essential to bring sustainable change and the other challenging development needs, such as food security.

Continued publicity of current FGM practices at a global level, particularly through the UN and the WHO, is crucial for ensuring that NGOs and charities are given support and resources long term.

Prioritising charitable aid and grant funding is inherently challenging, and programmes for ending FGM are given less attention than those related to the health and poverty crises. However, as discussed in this report, FGM is connected to these crises and directly relates to several of the MDGs.

FGM and the Millennium Development Goals

Considering FGM within the larger framework of the MDGs conveys the significant negative impact FGM makes on humanity. The abandonment of FGM is connected to the eradication of extreme poverty and hunger, universal primary education, gender equality, the reduction of child mortality, maternal health and the fight against HIV and AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience, because that will highlight the need for funding anti-FGM programmes and researching for broader social change.

There has been a momentum for change, with the UN global ban on FGM in December 2012 and the UN CSW 57 focussing on violence against women and girls, which includes FGM. We hope that this momentum is continued and that violence against women and FGM are reflected in the post-MDGs agenda.

Education and FGM

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause of the perpetuation of social stigmas surrounding FGM as they relate to health, sexuality and women's rights. FGM hinders girls' ability to obtain basic education and prevents them from pursuing higher education and employment opportunities. This lack of education also directly relates to issues surrounding child marriage.

Anti-FGM programmes need to be focussed on educating girls; however, educating boys and the wider community on FGM is equally important. Although access to education has improved and Ethiopia is making significant progress towards achieving universal primary education (MDG 2), the Afar and Somali regions, where FGM is prevalent and of the most severe type, lag behind the rest of the country.

FGM, Medical Care and Health Education

Health providers need to be better trained to manage complications resulting from FGM. Given the recent trend towards medicalisation in some areas (Addis Ababa, SNNPR and Harari), this should also be addressed through the education of health providers on the consequences of their role in FGM. Moreover, the authorities should prosecute health providers carrying out FGM.

There needs to be improved access to healthcare through the FGM complications referral programme to ensure women are receiving appropriate care quickly. The lack of access to and under-utilisation of adequate healthcare is generally an issue that needs to be addressed, particularly in more remote areas such as Afar. More resources are needed for sexual and reproductive health education, and more research and funding is needed on the psychological consequences of FGM.

Transition from Infibulation to Sunna

There has been harm reduction in that there is a reported trend towards the abandonment of Type III infibulations in Afar and Somali regions in favour of the less invasive Types I and II (*sunna*). This does not lead to a change in social norms and effective abandonment, however, and Types I and II are still human-rights violations and cause great harm. Therefore, an effective approach with all stakeholders to ensure the total abandonment of FGM is needed and not transition from one type to another.

FGM, Advocacy and Lobbying

Advocacy and lobbying are essential to ensure that the 2006 Criminal Code is being effectively communicated in rural areas. Residents need to be aware that national legislation has been put in place and that the law is being properly enforced. It is important that the momentum gained by the change in law be sustained.

FGM and the Law

With the passing of Ethiopia's Criminal Code in 2006, progress was been made towards stopping FGM. However, reports suggest that the law is not being implemented to the fullest extent. We welcome the capacity- building that has already taken place among those responsible for upholding the new law. We recommend that such capacity-building is increased to sustain the momentum already gained. The legal restrictions on the activities of NGOs, in respect of the receipt of foreign funds and caps on 'administrative' costs, may hamper efforts to accelerate the decline of FGM.

FGM and Media

Media has proven to be a useful tool against FGM and in advocating for women's rights. 28 Too Many supports the work that has been done with media on women's issues and encourages these projects to continue. Diverse forms of media should be used (including formal and informal media) to promote awareness of FGM and advocate for women's rights at a grassroots level.

FGM and Faith-Based Organisations

With over 80% of the population in Africa attending a faith building at least once a week, religious narratives are essential for personal understanding, family and society. Faith-based organisations are a major agent of change, and their international, regional, national and local presence and structures offer platforms for teaching, education, support and health provision in relation to issues such as FGM. They can also work with global bodies such as the UN and its agencies. The church, including the Ethiopian Orthodox Church, has been active in advocating against FGM. Existing religious structures should be used to sensitise the community about FGM. The role of Islamic leaders is vital in the Afar and Somali regions. All faith groups and those of no formal faith should be included in policy development and dialogue, as they have an important role to play in supporting the delivery of key messages and programmes to communities.

Communication and Collaborative Projects

There are a number of successful anti-FGM programmes currently operating in Ethiopia. The majority of the progress begins at the grassroots level. We recommend continued efforts to communicate the work of anti-FGM organisations more publicly and encourage collaborative projects. A coalition against FGM will be a stronger voice in terms of lobbying and will be more effective in obtaining sustainable funding and achieving programme success, and efforts in Ethiopia are headed in this direction.

We welcome the work already undertaken by the National FGM Network of Ethiopia. The fight against FGM will be intensified by the strengthening of such networks of organisations working against FGM and, more broadly, on women's and girls' rights; the integration of anti-FGM messages into other development programmes; sharing best practice and success stories; researching operations; publishing training manuals, support materials and advocacy tools; and providing links/referrals to other organisations.

APPENDIX I

List of International and National Organisations Contributing to Women's Health Issues and the Abandonment of FGM in Ethiopia (as at 2013)

Please note that this list was current as at October 2013; it has not been updated. Additionally, 28 Too Many does not claim that this is an exhaustive list; we recognise that there are many more organisations working on women's and children's issues and to eradicate FGM in Ethiopia.

* *Denotes organisations that are members of the National FGM Network (see Interventions and Attempts to Eradicate FGM above). Contact details can be found on its website: www.ODWaCE.org/our-partners.*

Afar Women Affairs Bureau

Aba Wolde-Tensae Gizaw Mothers and Children Welfare Association (*AWWA*)

Action Aid Ethiopia*

ADEHENO Integrated Rural Development Association*

Afar Mother and Child Care Organisation

Afar Pastoral Children's Development Association

Afar Pastoralist Development Organisation (*APDA*)

African Development Aid Association (*ADAA*)*

African Medical and Research Foundation (*AMREF*) – Ethiopia*

Alliance of Civil Societies of Tigray (*ACSOT*)*

Anti-FGC Mother's Association

Association for the Promotion of Indigenous Knowledge (*APIK*)*

Austrian Development Organisation

Beza Youth Health and Counseling Center (*BYHCC*)*

Birhan Integrated Community Development Organization (*BICDO*)*

Care – Ethiopia*

Christian Aid*

Concern Ethiopia*

Concern for Integrated Development (*CFID*)*

Consortium of Reproductive Health Association (*CORHA*)

Consortium of Christian Relief and Development Associations (*CCRDA*)*

Covenant for Ethiopia Support (*CFES*)

Dejazmach Wondyirad Primary School Harmful Traditional Practices Prevention Club*

Deutsche Gesellschaft für Technische Zusammenarbeit (*GTZ*)

Developing Families Together (*DFT*)*

Eshet Children and Youth Development Organization (*ECYDO*)*

Ethiopian Catholic Secretariat/Ethiopian Catholic Church (*ECS*)

Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (*EGLDAM*)*

Ethiopian Catholic Secretariat/Ethiopian Catholic Church (*ECS*)*

Ethiopian Evangelical Church Mekane Yesus (*EECMY*)

Ethiopian Midwives Association*

Ethiopian Muslims Development Agency (*EMDA*) *

Ethiopian Orthodox Church Development and Inter Church Aid Commission (*EOC-DICAC*)*

Ethiopian Women Lawyers Association (*EWLA*)*

Evangelical Churches Fellowship of Ethiopia (*ECFE*)*

Farm Africa

Generation in Action Development Association

German Foundation for World Population (*DSW*)*

Gondar Educational Media Centre

Gudina Tumsa Foundation

Hamlin Fistula Ethiopia*

Healing Hands of Joy

Health Poverty Action

HUNDEE – Oromo Grassroots Development Initiative*

Inter-African Committee on Traditional Practices (*IAC*) – Ethiopia*

Integrated Family Service Organization

Intra Health International – Ethiopia*

Kembatti Mentti-Gezimma-Topee (*KMG*) Ethiopia*

Menschen für Menschen (*MfM*)*

Ministry of Justice

Ministry of Women, Children and Youth Affairs (*MOWCYA*)*

Ministry of Culture and Tourism*

MUJEJEGUWA LOKA Women Development Association (MLWDA)*

National Women's Affairs Bureau

Nazareth Children Center and Integrated Development (*NACCID*)

Network of Ethiopian Women's Association

New Life Community Organisation (*NLCO*)*

Norwegian Church Aid – Ethiopia (*NCA-E*)*

Organization for the Development of Women and Children Ethiopia (*ODWaCE*)*

Ogaden Welfare Development Association (*OWDA*)*

Oxfam – Canada

Oxfam – UK

PACT – Ethiopia

Panos Ethiopia

Pathfinder International – Ethiopia (*PI-E*)*

Plan international – Ethiopia (*PIE*)*

Population Media Center (*PMC*)*

Professional Alliance for Development Ethiopia (*PADET*)

Radio Fana

Rohi Weddu Pastoral Women Development Organization*

Save the Children – Ethiopia (*SCN-E*) – Ethiopia

Save the Children – Sweden (*SCN-E*) – Ethiopia

Siiqqee Women's Development Association (*SWDA*)

SNNPR HIV/AIDS Forum of Civil Societies Consortium (*SHAFOCS*)*

Somali Women Development Organisation (*SOWDO*)

Somali Women Self-Help Association (*SOWSHA*)

Tamira Reproductive Health and Development Organization (*TRHaDO*)*

United Nations International Children's Emergency Fund (UNICEF)

United Nations Population Fund (*UNFPA*)*

World Health Organisation *(WHO)*

Women Support Association (*WSA*)*

World Vision – Ethiopia (*WVE*)*

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