

A woman with dark, braided hair is shown in profile, looking towards the left. She is wearing a vibrant orange and yellow garment with intricate white and gold beaded patterns. She is holding a young child in a green sweater. The background is a blurred wooden structure.

COUNTRY PROFILE:
FGM IN ETHIOPIA

OCTOBER 2013

 **28 TOOMANY**
FGM...
let's end it.



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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 in the world 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 being carried out in unhygienic conditions. Longer term impacts include menstrual and urinary retention, fistula (incontinence), pregnancy and birth complications. Links are also made to higher prenatal death and HIV. FGM also has profound psychological impact.

This Ethiopia Profile shows FGM in 15-49 year olds has decreased by 16%, from 73% (NCTPE, 1997) to 57% (EGLDAM, 2007). The national DHS survey showed a reduction of 5.6% prevalence over 5 years: 79.9% (2000) to 74.3% (2005), however, the survey was not repeated in the latest DHS published in 2011.

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, with the highest adoption being 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%). FGM in Ethiopia is associated with other harmful traditional practices, and is linked with low female literacy rates; inequality of women's status, early marriage and poor economic/political

opportunity.

FGM has been in existence for over 2000 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 (Wilson, 2012/3) shows some of that thinking. Most families whose girls have FGM do so because those around them sustain and promote the practice. Important influencers such as parents, grandparents, community leaders and in some cases religious leaders support FGM and 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.

I worked in Ethiopia in 2011, and visited FGM projects, hospitals, schools and NGOs. I was pleased to visit the Addis Ababa Fistula Hospital and their Rehabilitation Centre, Desta Mender, and spoke with Dr Catherine Hamlin, the hospital founder and their CEO. I remember hearing the moving stories of the women in the hospital. Many had been abandoned by their husbands and families because of incontinence and smell resulting from the fistula and they felt deep shame and isolation.

During my research in Ethiopia I heard this story from Muna, from the Afar area of Ethiopia. Muna had FGM Type III on the seventh day of her life. After marriage at age 10 she had her second child at age 15 years. At full term, her labour lasted twelve 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 but 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; media; 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 help bring about change in more and more communities until eventually FGM is eradicated.

Whilst there is still much to be done and many challenges ahead, I am pleased that this profile confirms that 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 woman does not cut her daughter; then as a mother that daughter does not cut her own daughter; and as a grandmother, that she will not cut her granddaughter/others in the community, and 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 Country Profiles on each of the 28 countries in Africa as a resource tool to the FGM and development sector, government, media and academia. With your partnership, we can make these useful and often accessed reports which share good practice. We are pleased to launch this report on Ethiopia to complement our earlier Country Profiles on Kenya and Uganda, and thank all who contributed to it.

Dr Ann-Marie Wilson
28 Too Many Executive Director

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



BACKGROUND

28 Too Many is an anti-female genital mutilation (FGM) charity, created to end 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, where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We hope to build an information base including providing detailed Country Profiles for each country practising FGM in Africa and the diaspora, and develop a network of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

PURPOSE

The prime purpose of this Country Profile is to provide improved 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 profile the current situation. As organisations send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. Whilst there are numerous challenges to overcome before FGM is eradicated in Ethiopia, many programmes are making positive active change and government legislation offers a useful base platform for deterring FGM practice.

USE OF THIS COUNTRY PROFILE

Extracts from this publication may be freely reproduced, provided the due acknowledgement is given to the source and 28 Too Many. 28 Too Many invites comments on the content, suggestions on how it could be improved as an information tool, and seeks updates on the data and contacts details. Please contact us on info@28toomany.org. The information provided in this report is

based on available data and may not reflect all changes to NGOs and charitable organisations that have taken place since the introduction in 2009 of The Proclamation to Provide for the Registration and Regulation of Charities and Societies (CSP).

ACKNOWLEDGEMENTS

28 Too Many is extremely grateful for all who have assisted us in accessing information to produce this Country Profile. We thank you, as it would not have been possible without your assistance and collaboration. 28 Too Many carried out all its work as a result of donations, and is an independent objective voice not being affiliated to 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.

THE TEAM

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

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Ann-Marie Wilson founded 28 Too Many and is its Executive Director. She published her paper this year on ‘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’ in the Journal of Gender Studies.

Rooted Support Ltd through its Director Nich Bull in the report’s design, www.rootedsupport.co.uk.

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

Photograph on front cover: Diqoo, a Borana woman – El Dima Ethiopia © www.lafforgue.com.

LIST OF ABBREVIATIONS

AIDS - Acquired Immunodeficiency Syndrome

ARP - Alternative Rites of Passage

CBO - Community-Based Organisation

CC - Community Conversations

CEDAW - Convention on the Elimination of Discrimination Against Women

CFES - Covenant for Ethiopia Support

CRC - Convention on the Rights of the Child

CSP - Charities and Societies Proclamation

CSW - Commission on the Status of Women

DHS - Demographic Health Survey

EGLDAM - Ethiopian Association to Eliminate Harmful Traditional Practices

EIASC - Ethiopian Islamic Affairs Supreme Council

EPRDF - Ethiopian People’s Revolutionary Democratic Front

EPRDP - Ethiopian People’s Revolutionary Democratic Party

EWLA - Ethiopian Women Lawyers Association

FAO - Food and Agricultural Organisation

FBO - Faith-Based Organisation

FGC - Female Genital Cutting

FGM - Female Genital Mutilation

GBV - Gender-Based Violence

GDP – Gross Domestic Product

GER - Gross Enrolment Rate

HEWs - Health Service Extension Workers

HIV - Human Immunodeficiency Virus

HMIS - Health Management Information System

HTP - Harmful Traditional Practices

IAC - Inter-African Committee on Traditional Practices

IEC – Information, Education and Communication

ICESR - International Covenant on Economic, Social and Cultural Rights

INGO – International Non-Governmental Organisation

IFRI – International Forestry Resources and Institutions

LGBT – Lesbian, Gay, Bisexual and Transgender

MDG - Millennium Development Goal

MICS - Multiple Indicator Cluster Surveys

MoE – Ministry of Education

NCTPE - National Committee for Traditional Practices in Ethiopia

NER – Net Enrolment Rate

NGO - Non-Governmental Organisation

ODWaCE - Organisation for the Development of Women and Children Ethiopia

OECD - Organisation for Economic Co-operation and Development

OWDA - Ogaden Welfare and Development Association

PHCU - Primary Health Care Units

PMC - Population Media Centre

PSNP - Productive Safety Net Programme

PTSD - Post Traumatic Stress Disorder

RWB - Reporters Without Borders, also Reporters Sans Frontières

SIGI - Social Institutions and Gender Index

SNNPR - South Nations Nationalities and Peoples Region

STI- Sexually Transmitted Infection

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

WFP – World Food Programme

WHO - World Health Organisation

WMS - Welfare Monitoring Survey

EXECUTIVE SUMMARY

This Country Profile provides a detailed, comprehensive analysis of FGM in Ethiopia. It summarises the research on FGM and provides information on the political, anthropological and sociological context for FGM. It also includes an analysis of the current situation in Ethiopia and 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 practice to create positive, enduring change.

It is calculated that 23.8 million girls and women in Ethiopia have undergone FGM. This is one of the highest national numbers in Africa, second only to Egypt (UNICEF, 2013) but the most recent data indicates that attitudes are changing and FGM is declining in Ethiopia.

According to the Demographic Health Survey (DHS), the estimated prevalence of FGM in girls and women (15-49 years) is 74.3% (DHS, 2005). This has decreased from 79.9% in 2000 (DHS, 2000), therefore showing a 5.6% decrease over 5 years. Other data (the NCTPE/EGLDAM survey) shows a decrease from 73% in 1997 to 57% in 2007, a 16% decrease over 10 years but it should be noted that there are significant regional differences in the decline in prevalence. It is also noteworthy that while the proportion of girls under the age of 15 with FGM in 2011 is estimated to be 23% (WMS), the proportion of women with one or more daughters under the age of 15 with FGM in 2000 and 2005 was, respectively, 51.9% and 37.7% (DHS). Although some caution must be exercised with drawing conclusions from different data sets, if this trend is confirmed by subsequent surveys this is a significant decline. FGM is widespread across Ethiopia and is carried out in the majority of regions and ethnic groups. FGM is most prevalent, depending on which statistics are used for reference in the Afar region, in the north east of Ethiopia, where the rate of FGM is 91.6% (DHS, 2005) or 87.4% (EGLDAM, 2007); in the Somali region, in the south east bordering Somalia, where the rate is 97.3% (DHS, 2005) or 70.7% (EGLDAM, 2007); and Dire Dawa, where the rate is 92.3% (DHS, 2005). The prevalence rate is lowest in Gambela, a small region in western Ethiopia, with a rate of 27.1% (DHS, 2005) and Tigray in the north, with a rate of 29.3% (DHS, 2005) or 21.1% (EGLDAM, 2007). The prevalence among ethnic Somalis is high regardless of national context, with the prevalence among ethnic Somalis in Ethiopia (and Kenya) being similar to that of Somalia rather than the national rates for Ethiopia (and Kenya).

Ethiopia has a large number of distinct ethnic groups with differing concepts of identity.

Of 66 of Ethiopia's largest ethnic groups (of 82 in total) 46 carry out FGM (EGLDAM, 2007). FGM is therefore practised by over half of Ethiopia's ethnic groups. The Oromo, Amhara, Somali and Tigray are all significant practising ethnic groups. The Afar are also noteworthy given the high prevalence of FGM within the Afar region, the severity of the type of FGM (Type III infibulation), and the age at which girls are cut (often in infancy up to 8 days old).

Of those women who have undergone FGM, 8% have experienced Type III infibulation, and 92% Types I or II. Type III infibulation is most prevalent in Afar and Somali, but is also carried out to a lesser extent in Harari and Dire Dawa and other regions. There is a reported trend in areas where Type III infibulation is traditionally carried out, for some to adopt a less invasive form of FGM.

The age at which FGM is performed in Ethiopia depends upon the ethnic group, type of FGM adopted and region. More than 52.5% of girls who undergo FGM do so before the age of 1 year (DHS, 2000). In the north, FGM tends to be carried out straight after birth whereas in the south, where FGM is more closely associated with marriage, it is performed later. Due to the diversity of ethnic groups that practise FGM, the reasons also can vary. For the Dassanach, for example, it is a marker of cultural identity, whereas for the Somali and Afar it is a perceived religious requirement, needed to ensure chastity and to prevent rape.

FGM is practiced by both of the main religions in Ethiopia - Ethiopian Orthodox Christianity and Islam. Muslim groups are more likely to practice FGM than Christian groups, with the prevalence among Muslim communities being 65.1% and that among Orthodox Christians being 45%. The prevalence of FGM among Muslims is not only higher but is also changing more slowly (EGLDAM, 2007).

Although FGM is largely carried out by traditional practitioners, it is notable that according to the 2011 WMS survey, in Addis Ababa, health workers carried out over 20% of FGM on girls under 15 surveyed, and in SNNPR and the city of Harari the figure was over 10%. This may represent a trend towards the medicalisation of FGM within Ethiopia, particularly in urban areas. Education appears to play an important role in shifting normative expectations surrounding FGM and facilitates its abandonment (UNICEF, 2013). In Ethiopia, the prevalence of FGM decreases with the level of a woman's education. The data on the status of daughters in Ethiopia shows that 18.7% of women with secondary education have a daughter who has undergone FGM, compared to 41.3% with no education. According to the data on attitudes to FGM, the percentage of women who support the continuance of FGM is 4.7% for women with

secondary education or higher and 40.6% for women with no education.

Between 2000-2005, support for FGM has halved. In 2000 there was a recorded 60% support rate for FGM but by 2005 this had dropped dramatically to a 31% support rate (DHS). 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.

There are more than 82 local NGOs, CBOs, FBOs, international organisations (INGOs) and multilateral organisations working in Ethiopia on women's health issues. There have been strong social and political movements for the abolition of FGM, especially in urban areas, and the Ethiopian government has ensured a favourable legal and policy environment for change. The revised Criminal Code was passed in 2005 which specifically outlaws FGM and although there have been prosecutions, there is scope for greater and more effective law enforcement.

A range of initiatives and strategies have been used to end FGM. Among these are: health risk/harmful traditional practice approach; addressing the health complications of FGM; educating traditional excisors and offering alternative income; alternative rites of passage; religious-oriented approach; legal approach; human rights approach ('Community Conversations'); promotion of girls' education to oppose FGM; supporting girls escaping from FGM/child marriage and media influence. In Ethiopia, FGM is practised, to a varying degree, across almost the entire country. Due to the country's significant geographical, cultural, ethnic and religious diversity, strategies for eliminating FGM need to be both at a national level and a community level, with organisations needing to tailor anti-FGM initiatives and strategies to take into account the particular regional circumstances.

We propose measures relating to:

- Adopting culturally relevant programmes
- Sustainable funding
- Considering FGM within the Millennium Development Goals and post-MDG framework
- Facilitating access to education particularly for girls
- Improvements in access to health facilities and in managing health complications of FGM

- Dealing with the transition from Type III infibulation to Type I 'sunna' to ensure total abandonment
- Increased advocacy and lobbying
- Increased law enforcement
- Maintain effective media campaigns
- Encouraging FBOs to act as agents of change and be proactive on women's health issues.
- Increased networking and information sharing.

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' (UN Generally Assembly, 2009)

Female genital mutilation (sometimes called female genital cutting or female genital mutilation/cutting) is defined by the WHO as referring to 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. Between 100 and 140 million girls and women globally are estimated to have undergone FGM. Over 125 million girls and women alive today have had FGM in the 28 African countries and Yemen where FGM is practised (UNICEF, 2013) and 3 million girls are estimated to be at risk of undergoing FGM annually .

FGM occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and the Democratic Republic of Congo (DRC) in Central Africa. It also occurs in some countries in Asia and the Middle East and among diaspora communities in North America, Australasia, the Middle East and Europe. As with many ancient practices, FGM is carried out by communities as part of a past heritage and is often associated with cultural identity. Communities may not even question the

practice or may have long forgotten the original reasons for it occurring.

The WHO classifies FGM into four types:

Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
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 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). (The term 'appositioning' is used in preference to 'stitching' because stitching (with thorns or sutures) is only one way to create adhesion. Other common techniques include using herbal pastes and often include tying the legs together for healing.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation.

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour, with some communities considering that it ensures and preserves virginity, 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 considered 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 scripts require the practice, participants in the practice sometimes 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 (UNICEF, 2005). 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; cysts; infertility; an increased risk of childbirth complications and newborn deaths, and the need for later surgeries. For example, a Type III infibulation needs to be cut open later to allow for sexual intercourse and childbirth (WHO, 2013).

The eradication of FGM is pertinent to the achievement of a number of millennium development goals (MDGs): MDG 1 – eradicate extreme poverty and hunger; MDG 2 – achieve universal primary education; MDG 3 - promote gender equality and empower women; MDG 4 - reduce child mortality; MDG 5 - reduce maternal mortality and MDG 6 - combat HIV/AIDS, malaria and other diseases. The post-MDG agenda is currently under discussion and it is hoped that it will include renewed efforts to improve the lives of women. In Ethiopia, the estimated prevalence of FGM in girls and women (15-49 years) is 74.3% (DHS, 2005), and this is a decrease of 5.6% over five years (from 79.9% in 2000). Other data (the NCTPE/EGLDAM surveys) shows a decrease from 73% in 1997 to 57% in 2007; a 16% decrease over 10 years. 23.8 million women and girls in Ethiopia have undergone FGM, and this is the second highest rate in Africa, second only to Egypt (UNICEF, 2013). FGM is widespread across Ethiopia and is carried out in the majority of regions and ethnic groups, with the highest prevalence in the Afar region at a rate of 91.6% (DHS, 2005) or 87.4% (EGLDAM, 2007). As well, the Somali region has a rate of 97.3% (DHS, 2005) or 70.7% (EGLDAM, 2007). The region with the lowest rate is Gambela, with a rate of 27.1% (DHS, 2005).

FGM is practised by over half of Ethiopia's ethnic groups. Significant practising ethnic groups include the Oromo, Afar, Amhara, Somali and Tigray peoples. FGM customs are different along geographical divides associated with ethnic groups. More than 52.5% of girls who undergo

FGM do so before the age of 1 year (DHS, 2000). In northern Ethiopia, FGM tends to be carried out straight after birth whereas in the south, where FGM is more closely associated with marriage, it is performed during adolescence. FGM is, for many groups, a part of cultural identity, and, for the Somali and Afar, it is a perceived religious requirement and a means to ensure virginity. Although FGM is largely carried out by traditional practitioners, a recent study may indicate a trend towards medicalisation in some regions.

Between 2000 and 2005 support for FGM has halved. In 2000 there was a recorded 60% support rate for FGM but by 2005 this had dropped dramatically to a 31% support rate, according to the DHS. A range of initiatives and strategies have been used to combat FGM, including human rights approach referred to as 'Community Conversations'. The revised Criminal Code was passed in 2005 which specifically outlaws FGM.

The vision of 28 Too Many is a world where every woman is safe, healthy and lives free from FGM. A key strategic objective is to provide detailed, comprehensive Country Profiles for each of the 28 countries in Africa where FGM is practised. The Country Profiles provide research on the situation regarding FGM in each country, as well as providing more general information relating to the political, anthropological and sociological environments in the country to provide a contextual background within which FGM occurs. It also offers some analysis 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 Country Profile provides a sound knowledge base from which to determine the models of sustainable change necessary to shift attitude and behaviour and bring about a world free of FGM.

RESEARCH METHODOLOGY

We strive to remain objective in the information we provide in our Country Profiles, while maintaining the position that FGM is an inherent violation of human rights and needs to be ended. Our intent is to avoid victimising language and passing judgement on cultural practices, while focusing on the statistics behind FGM and the progress of anti-FGM programmes. We generally use the term FGM in our non-community research, as opposed to alternatives such as female circumcision or female genital cutting (FGC), to emphasise the gravity of the practice, following the approach of the WHO. The information in this document comes from reports available online, as well as scholarly articles and general literature on FGM. We provide a comprehensive overview of each country's current socio-economic, cultural, religious, and political conditions and the current state of FGM. Moreover, we focus on the rights, education, health and safety of girls and women. Our Country Profiles summarise past and current work on the elimination of FGM in Africa and document progress already made to end FGM.

Since the early 1990s, data on FGM has been collected through a separate module of the Demographic and Health Surveys (DHS) implemented by ICE International (formerly Macro International). The FGM module has yielded a rich base of data. In some countries, data have also been collected through the Multiple Indicator Cluster Surveys (MICS) using a module similar to that of DHS. The MICS FGM module has been adjusted to the DHS module and was implemented during the third round of surveys (MICS-3) in 2005-6. In Ethiopia DHS surveys were carried out in 2000, 2005 and 2011 (the latter did not cover FGM), and there has also been a country-wide baseline and follow-up surveys on harmful traditional practices (HTP) carried out by the Ethiopian Association to Eliminate Harmful Traditional Practices (EGLDAM).

INTRODUCTION TO FGM

See Introduction above for details of types of FGM.

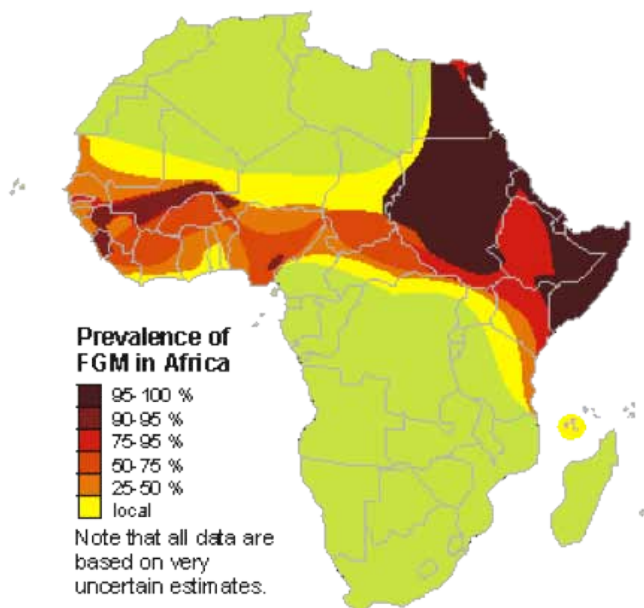
HISTORY OF FGM

FGM has been practised for over 2000 years (Slack, 1988). Although it has obscure origins, there has been anthropological and historical research on 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, with infibulations being referred to as 'Pharaonic circumcision' (Slack, 1988). Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders; as a custom amongst stone-age people in Equatorial Africa; or as 'an outgrowth of human sacrificial practices, or some early attempt at population control' (Lightfoot-Klein, 1983).

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 wide range of cultures and it is likely that the practice arose independently amongst different peoples (Lightfoot-Klein, 1983), aided by Egyptian slave raids from Sudan for concubines and maids, and traded through the Red Sea to the Persian Gulf (Mackie, 1996) (Sources referred to by Wilson, 2012/2013).

FGM – GLOBAL PREVALENCE

FGM has been reported in 28 countries in Africa, as well as in some countries in Asia and the Middle East and among certain migrant communities in North America, Australasia, the Middle East and Europe.



Prevalence of FGM in Africa (Afril News)

NATIONAL STATISTICS

GENERAL STATISTICS

All statistics are taken from the World Factbook unless otherwise indicated.

POPULATION

93,877,025 (July 2013 est.)

Median age: 17.5 years

Growth rate: 2.9% (2013 est.)

HUMAN DEVELOPMENT INDEX

Rank: 173 out of 186 in 2012 (UNDP)

HEALTH

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

Infant mortality rate (per 1,000 live births): 58.28 deaths; country comparison to the world: 29 (2013 est.)

Maternal mortality rate 350 deaths/100,000 live births (2010); country comparison to the world: 32

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

HIV– adult prevalence rate: 1.5% (DHS, 2011)

HIV – prevalence among women: 1.9%

HIV – prevalence among men: 1.0%

LITERACY (AGE 15 AND OVER THAT CAN READ AND WRITE)

Total population: 39% (2007 est.) (World Factbook)

Female: 38.4%; male: 65% (DHS, 2011)

Urban female: 69%; rural female 29%; urban male: 90%; rural male 59.8% (DHS, 2011)

Total youth (15-24 years): 55%

Female youth (15-24 years): 47%; male youth: 63% (2007) (World Bank)

MARRIAGE

Girls aged 15-19 who are married, divorced, separated or widowed: 21.6% (DHS, 2011)

Married girls or women who share their husband with at least one other wife: 10.5% (DHS, 2011)

GDP

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

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

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

URBANISATION

Urban population: 17% of total population (2010)

Rate of urbanisation: 3.57% annual rate of change (2010-15 est.)

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 (Afar) 1.7%, Gamo 1.5%, Gedeo 1.3%, other 11.3% (2007 Census)

RELIGIONS

Christian, 62.8%, Ethiopian Orthodox 43.5%, Protestant 18.6%, Catholic 0.7%, Muslim 33.9%, Animist 2.6%, Other 0.7% (2007 Census)

LANGUAGES

Oromo (official regional) 33.8%, Amharic (official) 29.3%, Somali 6.2%, Tigrayan (official regional) 5.9%, Sidamo 4%, Wolaytta 2.2%, Guragegna 2%, Afar 1.7%, Hadiyya 1.7%, Gamo 1.5%, other 11.7%, English (official) (major foreign language taught in schools), Arabic (official) (2007 census).

MILLENNIUM DEVELOPMENT GOALS

The eradication of FGM is pertinent to a number of the UN's eight Millennium Development Goals (MDGs).



GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

According to the World Food Programme (WFP), the scale of food insecurity and malnutrition in Ethiopia remains serious, with 23 million people having 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 (WFP, 2011). This MDG is relevant given the correlation between food insecurity and education, and education and FGM respectively. Education (particularly primary education) for rural populations is a key factor in fighting food insecurity (Burchi and Muro, 2007). Education is also important in tackling FGM, as discussed in FGM and Education. This illustrates the links between MDGs and the key role education can play in combating not only FGM but 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 the target to ensure that by 2015 all boys and girls complete a full course of primary schooling. This is relevant as the chances of girls undergoing FGM are reduced if they complete their schooling. See section on FGM and Education.

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 section on FGM and Education.

GOAL 4: REDUCE CHILD MORTALITY

FGM has a negative impact on child mortality.

A 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. See section on Women's Health and Infant Mortality.

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, it is also associated with an increased risk of childbirth complications. See section on Women's Health and Infant Mortality.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

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

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 (UN website). The focus of the UN CSW 58 is on the challenges and achievements in the implementation of the MDGs for women and girls, including the access and participation of women and girls to education. The UN is also conducting the MY World survey in which citizens across the globe can vote offline and online (including using mobile technologies) on which six development issues most impact their lives. These results will be collected up until 2015 and will influence the post-2015 agenda (Myworld2015.org).

Coinciding with this survey is 'The World We Want' platform, an online space where people can participate in discussions on the UN's sixteen 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 (Harper, 2013). 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.

NATIONAL STATISTICS RELATING TO FGM

Statistics on the prevalence of FGM are compiled through large scale household surveys in developing countries – the Demographic Health Survey (DHS) and the Multiple Cluster Indicator Survey (MICS).

The principal statistics relating to FGM in Ethiopia are as follows:

- A country-wide baseline survey on harmful traditional practices (HTP) carried out by the National Committee for Traditional Practices in Ethiopia (NCTPE) in 1997, and a follow-up survey 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.
- The Ethiopian DHS of 2000 and 2005 and the Welfare Monitoring Survey (WMS) of 2011, conducted by the Central Statistics Agency. The 2011 DHS did not cover FGM.

These surveys have different methodological approaches and therefore comparisons between them should be treated with some caution, particularly comparing data on the status of

daughters with the prevalence of FGM in girls under the age of 15 (see caution below).

Ethiopia is classified as a Group 2 country, according to the UNICEF classification, with a moderately high FGM prevalence. Group 2 countries have a prevalence of between 51% and 80% (UNICEF, 2013).

The estimated prevalence of FGM in girls and women (15-49 years) is 74.3% (DHS, 2005). This has decreased from 79.9% in 2000 (DHS, 2000), therefore showing a 5.6% decrease over 5 years. The NCTPE/EGLDAM data show a decrease from 73% in 1997 to 57% in 2007, showing a 16% decrease over 10 years. UNICEF calculates that 23.8 million women and girls in Ethiopia have undergone FGM. In terms of numbers, this is one of the highest numbers of girls and women who have undergone FGM in Africa, second only to Egypt (UNICEF, 2013).

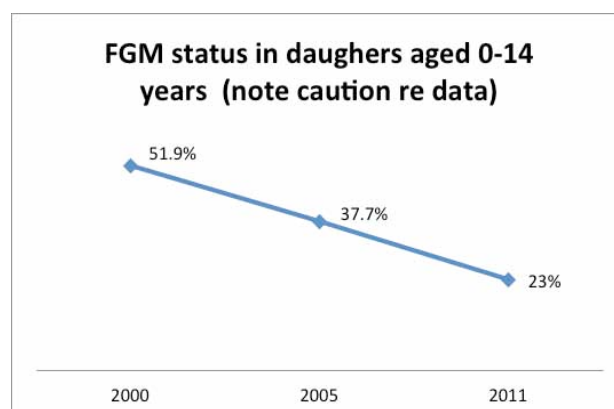
2000	2005
79.9%	74.3%
Prevalence of FGM in women and girls aged 15-49 (%) (DHS, 2000 and 2005)	

1997	2007
73%	57%
Prevalence of FGM in women (%) (NCTPE, 1997; EGLDAM, 2007), these are the adjusted figures, some sources refer to unadjusted figures of 61% and 46%	

The DHS data does not directly measure the FGM status of girls aged 0-14 years, however, pre-2010, the DHS surveys asked women whether they had a least one daughter with FGM. This data cannot be used to accurately estimate the prevalence of girls under the age of 15 (UNICEF, 2013). From 2010, the DHS methodology changed so that women are asked the FGM status of all their daughters under 15 years. The WMS data records the FGM status of girls aged 0-14 years. Measuring the FGM status of this age group who have most recently undergone FGM or are at most imminent risk of undergoing FGM gives an indicator of the impact of recent efforts to end FGM. These figures (unless they are adjusted) do not take into account the

fact that these girls may still be vulnerable to FGM after the age of 14 years.

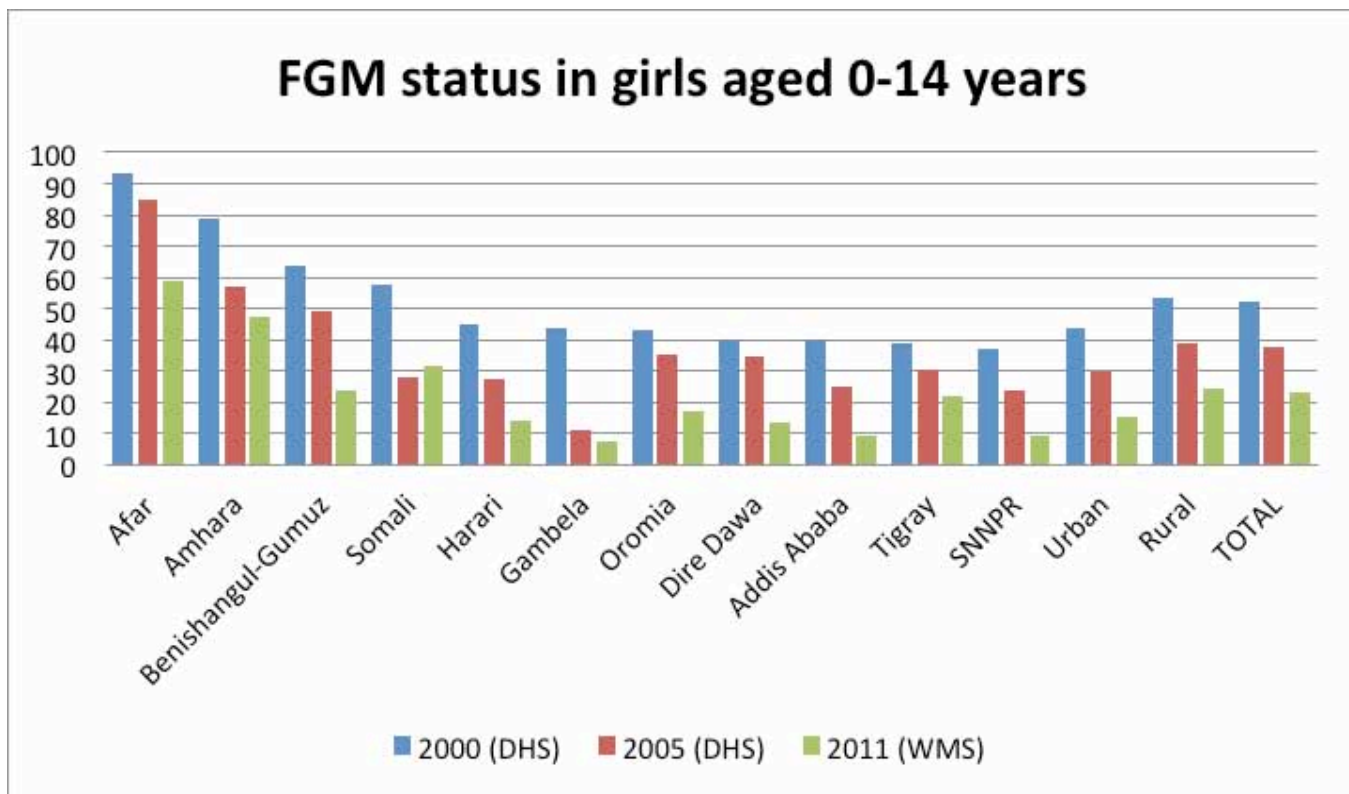
With this caution regarding the problems with drawing conclusions from this data and comparing the different datasets, it is nevertheless noteworthy that whereas the proportion of women with one or more daughters under the age of 15 with FGM in 2000 and 2005 were, respectively, 51.9% and 37.7% (DHS, 2000 and 2005), the proportion of girls under the age of 15 with FGM in 2011 is estimated to be 23% (WMS, 2011).



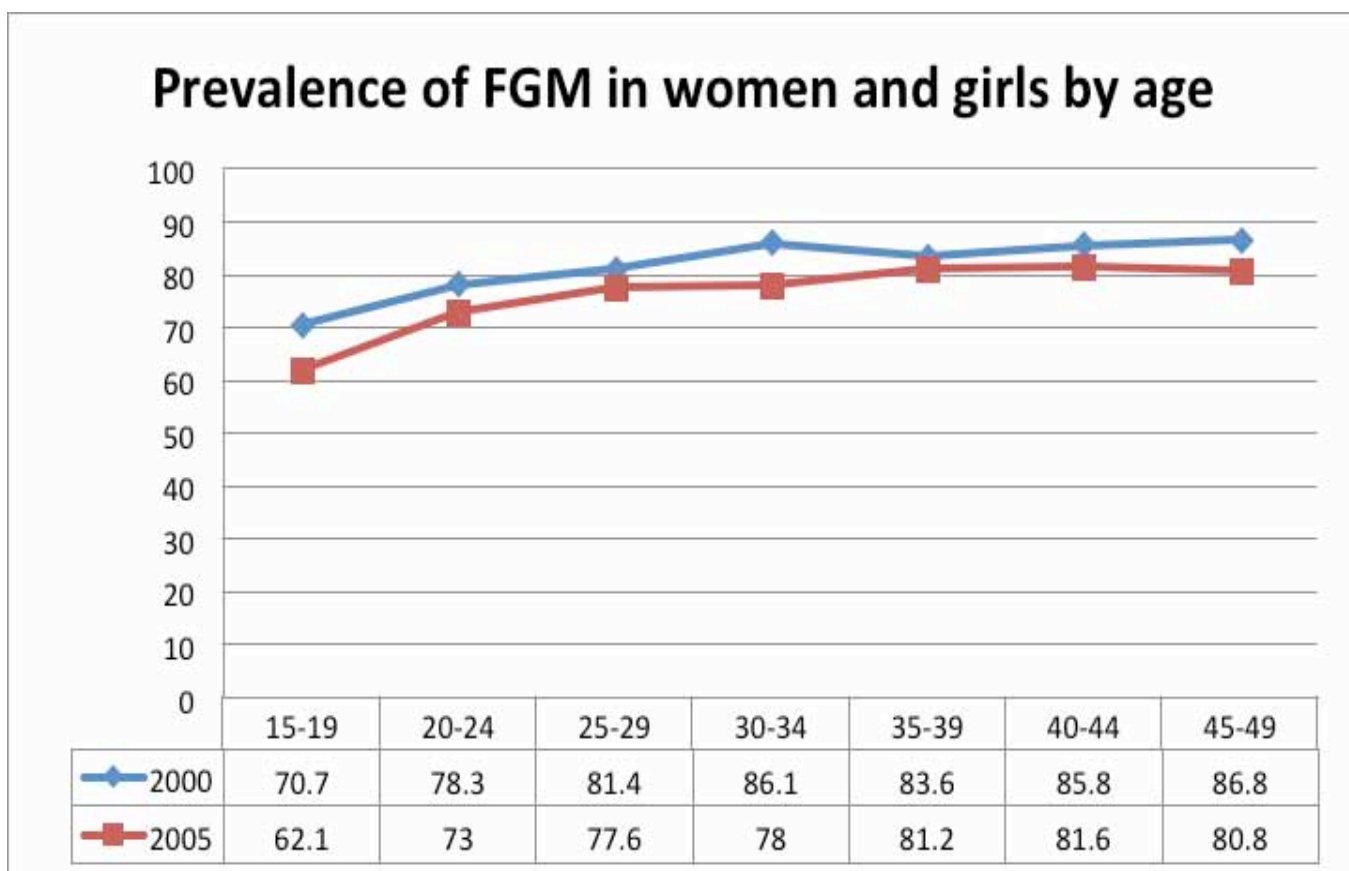
FGM in girls aged 0-14 years (DHS, 2000 and 2005*; WMS 2011) * DHS data measures % of women with at least one daughter with FGM. ** WMS data measures % of girls aged 0-14 years with FGM.**

Region	2000 (DHS)	2005 (DHS)	2011 (WMS)
Afar	93.6	85.1	59.8
Amhara	78.5	56.8	47.2
Benishangul-Gumuz	63.8	49.3	23.7
Somali	57.7	28.1	31.7
Harari	44.8	27.1	14.1
Gambela	43.4	11.0	7.4
Oromia	43.2	34.9	17.3
Dire Dawa	39.9	34.3	13.4
Addis Ababa	39.8	25.1	9.2
Tigray	39.0	30.2	22.1
SNNP	37.0	23.5	9.4
Urban	43.8	30.0	15.0
Rural	53.2	38.7	24.0
TOTAL	51.9	37.7	23

FGM in girls under the age of 15 by region (DHS, 2000 and 2005; WMS 2011)



FGM in girls aged 0-14 years by region (%) (DHS, 2000 and 2005; WMS 2011)



Prevalence of FGM by age (%) (DHS, 2000 and 2005)

Prevalence of FGM in Ethiopia by Education

Education	2000	2005
No education	80.4	77.3
Primary	78.4	70.8
Secondary and higher	78.2	64.0

Prevalence of FGM by education (%) (DHS, 2000 and 2005)

Prevalence of FGM in Ethiopia by Place of Residence

The prevalence of FGM is slightly higher in rural as opposed to urban areas.

	2000	2005
Urban	79.8	68.5
Rural	79.9	75.5

Prevalence of FGM by place of residence (%) (DHS, 2000 and 2005)

Prevalence of FGM in Ethiopia by Household Wealth

The DHS 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.

Wealth Index Quintile	2005
Lowest	73.0
Second	75.9
Middle	75.4
Fourth	77.6
Highest	70.6

Prevalence of FGM by household wealth (%) (DHS2005)

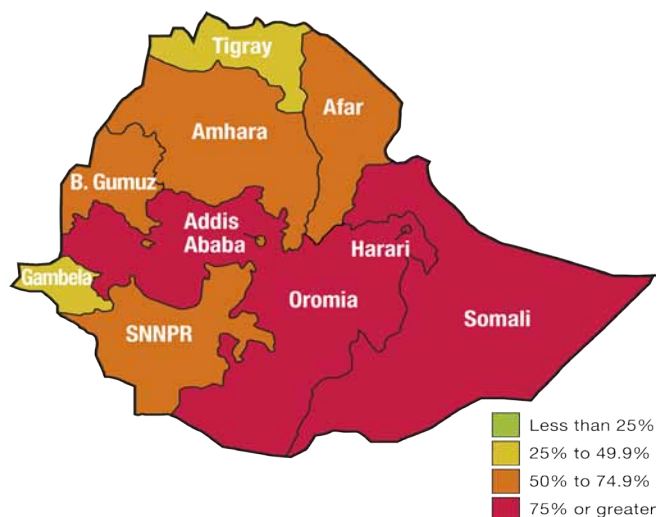
REGIONAL STATISTICS

FGM is widespread across Ethiopia and is carried out in the majority of regions and by most ethnic groups (see further FGM by Ethnicity).

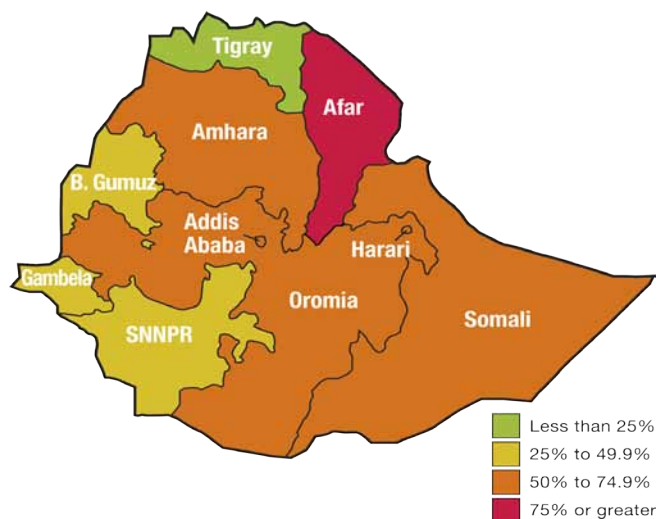
FGM is most prevalent, depending on which statistics you refer to, in the Afar region, in the north east of Ethiopia, where the rate of FGM is 91.6% (DHS, 2005) or 87.4% (EGLDAM, 2007); in the Somali region, in the south west bordering Somalia, where the rate is 97.3 (DHS, 2005) or

70.7% (EGLDAM, 2007); and the city of Dire Dawa, where the rate is 92.3% (DHS, 2005). The prevalence rate is lowest in Gambela, a small region in western Ethiopia, with a rate of 27.1% (DHS, 2005) and Tigray in the north, with a rate of 29.3% (DHS, 2005) or 21.1% (EGLDAM, 2007).

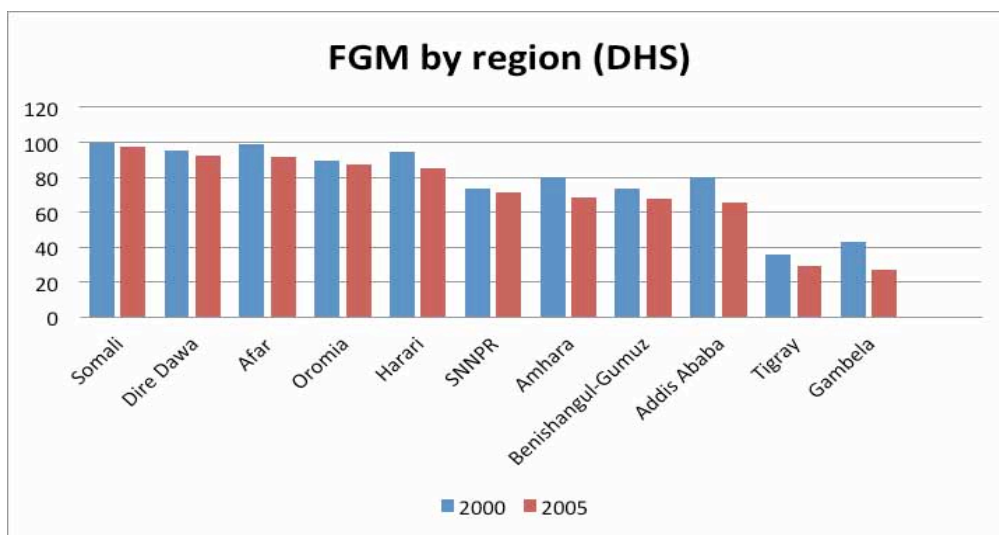
There are notable differences between regions in the decline of prevalence, although the DHS and EGLDAM data are not entirely consistent. The DHS data shows the greatest decline in Gambela, Addis Ababa and Amhara and the least in Somalia, Oromia and SNNPR. The NCTPA/EGLDAM data shows the greatest decline in Tigray, Oromia and Amhara and an increase in prevalence in Somali and the lowest decline in Afar and Benishangul-Gumuz.



FGM by region (DHS, 2005)



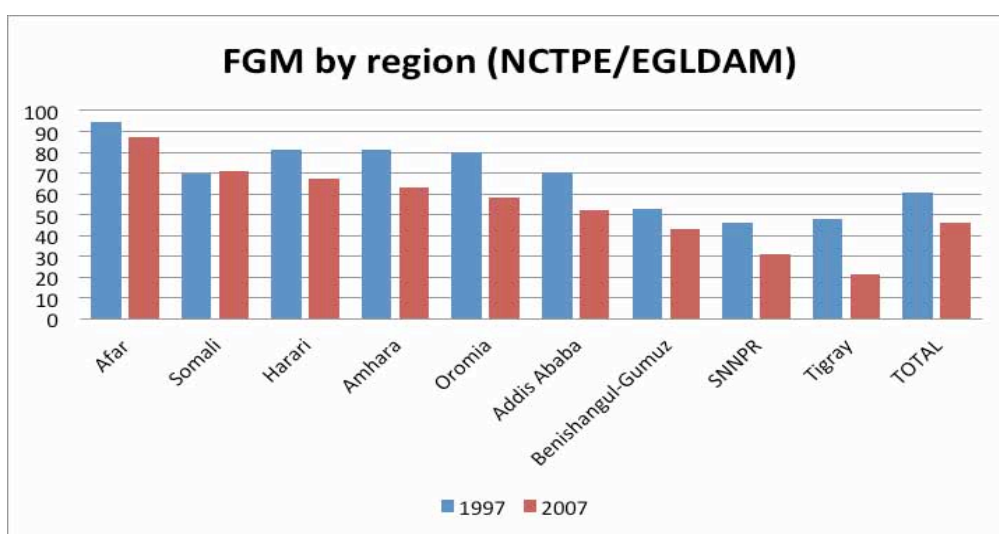
FGM by region (EGLDAM, 2007)



Women aged 15-49 who have undergone FGM by region (%) (DHS, 2000 and 2005)

Region	% of women with FGM (2000)	% of women with FGM (2005)	% decline
Somali	99.7	97.3	-2.4
Dire Dawa	95.1	92.3	-2.8
Afar	98.6	91.6	-7.0
Oromia	89.8	87.2	-2.6
Harari	94.3	85.1	-9.2
SNNPR	73.5	71.0	-2.5
Amhara	79.7	68.5	-11.2
Benishangul-Gumuz	73.7	67.6	-6.1
Addis Ababa	79.8	65.7	-14.1
Tigray	35.7	29.3	-6.4
Gambela	42.9	27.1	-15.8
TOTAL	79.9	74.3	-5.6

Women aged 15-49 who have undergone FGM by region (%) (DHS, 2000 and 2005)

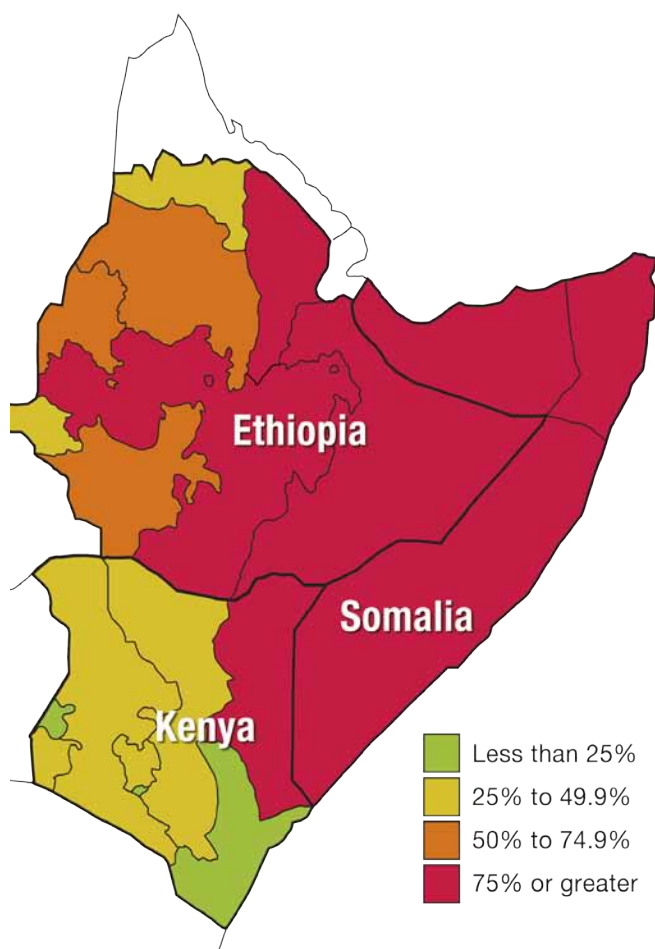


Women who have undergone FGM by region (%) (NCTPA, 1998; EGLDAM, 2007)

Region	% of women with FGM (1997)	% of women with FGM (2007)	% decline/increase
Afar	94.5	87.4	-7.1
Somali	69.7	70.7	1.0
Harari	81.2	67.2	-14.0
Amhara	81.1	62.9	-18.2
Oromia	79.8	58.5	-21.3
Addis Ababa	70.2	52.2	-18
Benishangul-Gumuz	52.9	43.3	-9.6
SNNPR	46.3	30.8	-15.5
Tigray	48.1	21.1	-27
TOTAL	60.6	45.8	-14.8
Gambela	42.9	27.1	-15.8
TOTAL	79.9	74.3	-5.6

Women who have undergone FGM by region (%) (NCTPA, 1998; EGLDAM, 2007)

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



Variations in prevalence of FGM within and across national borders (adapted from PRB 2010, and based on data from Ethiopia DHS 2005, Somalia MICS 2006 and Kenya DHS 2008-09)

POLITICAL BACKGROUND

HISTORICAL

Ethiopia was ruled by an ancient monarchy and remained free from colonial rule, apart from a brief Italian occupation from 1936-41. In 1974 the last emperor Haile Salisse was overthrown in a military coup lead by the socialist regime, the Derg 'committee'. This period of totalitarianism was known as 'Red Terror' and 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 Democratic Front (EPRDF). In 1994 a constitution was adopted and multi-party elections were first held in 1995.

Ethiopia has experienced on-going 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, with over a million people crossing the borders and the challenging conditions of refugee camps (Fransen and Kuschminder, 2009).

CURRENT POLITICAL CONDITIONS

Meles Zenawi, of the Ethiopian People's Revolutionary Democratic Party (EPRDF), 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 (EGLDAM, 2007). In reality, there is very little academic freedom and an intolerance of opposition to the government (Fransen and Kuschminder, 2009). 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 (Human Rights Report, 2012).

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, local authorities face challenges to coordinate among offices and implement changes due to leadership, human and financial resource issues.

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 to 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 professionals 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 169 out of 179 (UNDP) 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 (FAO) of the UN estimates that 44% of the county's population were undernourished in 2009. Ethiopia experienced catastrophic famines in 1973, 1977-78, 1983-84 and 1993. The famine of 1983-84 was the most severe, leaving around 300,000 people in the Tigray and other areas of Northern Ethiopia dead, with over a million mortalities in total. One of government's techniques to overcome famine has been a policy of resettlement, known as 'villagisation'. This involved the relocation of rural citizens into government made villages and these were 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 critique of the programme, from the national and international community (Fransen and Kuschminder, 2009).

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



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

or more and make up 99% of the population (EGLDAM, 2007) (see general statistics above). Political regions are constructed along ethno-linguistic lines. Whilst this division of Ethiopia gives different 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 (Fransen and Kuschminder, 2009). Ethiopia also 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 (Fransen and Kuschminder, 2009).

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' (Lake and Rothchild, 1998). Resource scarcity often results in forced migration and this increases contact and competition between differently identifying groups (Tache and Oba, 2009). These tensions are heightened when conflicts arise between groups who have a history of conflict over grazing land rights. The government's decentralisation attempts have re-ignited hostile relations between ethnic groups because of superimposed administrative borders over pre-established resource borders, interfering with traditional group interactions (Tache and Oba, 2009). 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 (Tache and Oba, 2009).

In Western Ethiopia there are on-going ethnic clashes in the Gambela region, between the indigenous people from the area: the Anuak (21.1% of the Gambela population) and more recently arrived Ethiopians, referred to as 'highlanders'. In Southern Ethiopia, there is a long standing 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 are an ethnic group that has remained independent until the 19th century and have since been subject to suppression, looting of their resources, and a division of their people by region and religion. Until 1991 the Oromo people did not have equal rights to the Amhara and 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.

COUNTRYWIDE TABOOS AND MORES

Ethiopia has a patriarchal society and there are moral and cultural restrictions on women and their behaviour. As in other African countries, sex and sexuality are taboo subjects in Ethiopian culture. A woman who discusses sexuality openly could be labeled 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' (Human Rights Report, 2012).

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 reported experiencing forced sex (Human Rights Report, 2012). There is a societal stigma and prevalent discrimination against persons with HIV/AIDS (Human Rights Report,

2012). There is a severe stigma against LGBT persons as same-sex sexual activity is illegal and punishable by imprisonment.

HARMFUL TRADITIONAL PRACTICES (HTP)

Below is a selection of customs practised in Ethiopia for health and cultural 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 finger nails of women prior to weddings and then dipping the nail beds in spices
- Shaking women violently to cause placental delivery
- Throat piercing using hot iron rods to remove the placenta
- Tonsillectomy
- Uvulectomy

(Assefa et al, 2005; Mladonova, 2007)

SOCIOLOGICAL BACKGROUND

ROLE OF WOMEN



Woman, South West Ethiopia, © Kimberly McKinnon

Ethiopia was ranked 64 out of 86 in the 2012 OECD Social Institutions and Gender Index (SIGI). Women face equality challenges in the following areas:

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 (SIGI). The median age at first marriage is 17.1 (DHS, 2011). Boyden, Pankhurst and Tafere (2013) 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 in 2011 was recorded as 6 years older, 23.1. In rural areas, the median age of marriage for women is much lower at 16 years of age. There are also regional differences, with the median age of marriage for women being lower in northern Ethiopia, notably in the Amhara and Tigray areas. The median age of first marriage increases with education levels (Boyden, Pankhurst and Tafere, 2013). Young motherhood is a main cause of Ethiopia's high rates of maternal mortality (SIGI).

MARRIAGE TRADITIONS

In Northern Ethiopia marriage is traditionally based around a dowry system, although more

recently 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 (Boyden, Pankhurst and Tafere, 2013). Polygamy is a cultural norm among the Oromo and some Southern peoples, although restricted to older and successful men (Boyden, Pankhurst and Tafere, 2013). Polygamy is illegal however the 2005 DHS estimates 6.5% of marriages as being polygamous. 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 (Fransen and Kuschminder, 2009). 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 only 1.4% of marriages in the Tigray region happening by abduction and 2.4% in the Amhara. The national average is 7.8% (Boyden, Pankhurst and Tafere, 2013).

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 and not keeping the house properly. The constitution guarantees equal rights in matters of inheritance; in practice property is usually passed to sons.

RESTRICTED PHYSICAL INTEGRITY

Domestic violence and sexual harassment are illegal but not effectively enforced. WHO reports that 70% of Ethiopian women suffered physical violence from their husband or partner at some point, and over 50% had suffered physical violence in the preceding 12 months (2009). 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. 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 the strong link between the fact that women face the majority of HTPs and the highly patriarchal nature of Ethiopian society. Women who support FGM are 1.7 times more likely to believe it is acceptable for a husband to beat his wife if she leaves the house without telling him (UNICEF, 2005). Women who do not believe that FGM is acceptable are 0.8 times as likely to believe that it is acceptable for a husband to beat his wife if she leaves the house without telling him. This suggests the connection between levels of support for FGM and views on wife-beating (UNICEF, 2005).

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). 80.4% of men are employed, compared to 37.6% of women. In urban areas this drops to 39% for women and 63% for men (DHS, 2011). The IFRI show 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, 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 2005 DHS, 60% of employed women received no pay.

Under the 1995 Constitution, women are to have 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 reports that 20% of widows reported being dispossessed of their land. Ethiopian women also have limited access to bank loans. There are several notable differences across Ethiopia in relation to property rights of women as outlined below (EGLDAM, 2007):

- 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 1/8 of the property is divided among spouses.
- In the Amhara Region, in theory, wives are entitled to half of the common property, but in practise 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 the husband dies, otherwise her parents must return the bride price received at her wedding.
- In the Oromia a woman cannot own any property.

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 out of the home, for example, an older daughter may have to substitute for the mother in caring for her younger children (EGLDAM, 2007). 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, for instance, in feeding and in the utilisation of health services, and in 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 (Human Rights Report, 2012). 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 is practised by remote tribes. As of 2010, approximately 150,000 children have been reported to be living on the streets and there are an estimated 5.4 million orphans. Child labour remains a serious problem in both rural and urban areas (Human Rights Report, 2012).

HEALTHCARE SYSTEM

Ethiopia's healthcare system is arranged in a four-tier system: Primary Health Care Units (PHCU), district hospitals, zonal hospitals and specialised hospitals (WHO, 2013). 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 about 60-80% of the country's health problems. These are usually the result of poor nutrition, and lack of access to health services (EGLDAM, 2007). Utilisation of healthcare services for the country is currently only 0.32 per capita (WHO, 2011a).

A survey carried out in 2004 shows that the main reason for not using the national health service for those living in rural areas 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 disproportionately more available in urban areas, whilst in rural areas access varies from limited to non-existent. Boydon, Pankhurst and Tafere (2013) highlight that better access to healthcare facilities for those in or near urban areas may contribute to influencing attitudes towards FGM as female health extension workers (HEWs) have mandates to address issues of reproductive health. This presents opportunities to raise awareness of the harms of FGM.

The same survey also highlighted the second most important reason for not using healthcare services was because there was 'no need'. 47% of the population live below the poverty line most cannot afford healthcare (EGLDAM, 2007). In addition, existing health posts are often understaffed and under-funded and provide poor service. There is a shortage of trained health staff in Ethiopia and these personnel are unevenly distributed. A poor skill set 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' (Fransen and Kuschminder, 2009). It is posited that many Ethiopian medical doctors migrate to work in Europe and North America, which results in a lack of skilled medical staff in Ethiopia. The out-migration of Ethiopian medical staff is estimated at 25.6%. In general, the emigration rate of tertiary educated individuals is estimated at 17%. This, combined with relatively low education levels, and few highly-educated professionals, leads to a substantial shortage of a skilled work force in Ethiopia.

WHO reports that the expansion of healthcare facilities has enhanced 'noticeable physical access to health services' with emphasis on primary healthcare units, including health centres and health posts (2011). In its effort to expand primary healthcare at the grass roots level, the government is training and deploying at community health posts health extension workers (HEWs) whose main function is health promotion. The government designed a new Health Management Information System (HMIS) 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. Greenwood (2011) notes that Ethiopia has successfully navigated a long-standing divide in the field of global health between vertical solutions (combating single diseases such as malaria and HIV/AIDS) versus a more horizontal approach, such as expanding infrastructure or training additional health workers.

As of the last WHO report in 2006, 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 6 inpatient facilities. There is only one residential facility in the country for the chronically mentally ill and several

others which 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 (Oumer, undated). 3% and 2% of the training of nurses and doctors, respectively, is focused 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 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 15-49 years (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 recommendation of 1:5,000.

Type of health facility	No. of women aged 15-49 years per health facility
Hospitals	135,007
Health centres (inc. hospitals)	24,194
Other government basic care centres (inc. hospitals and health centres)	2,678

Number of women aged 15-49 years per type of health facility (Addis Ababa Fistula Hospital)

The Addis Ababa Fistula Hospital notes that their 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 ante-natal care and only 12.4% receive any form of childbirth attendance from a skilled attendant. This too is uneven with only 1% of the poorest women giving birth with a trained birth attendant (Addis Ababa Fistula Hospital). In the

remote Afar region, which has a high prevalence of Type III infibulation, 83.3% of women gave birth to their youngest child at home and 92.5% were assisted by untrained TBAs (UNFPA/UNICEF Joint Programme Annual Report, 2012).

Contraception is only used by 15% of the population, compared to an average of 24% across Africa. Only 12% of the population make four or more ante-natal visits, compared to 43% of the population on average across Africa. Further, only 10% of births are attended by skilled health personnel, compared to an average of 48% of births across Africa. Less than 1% of births amongst those in the poorest 20% of the population are attended by skilled health personnel and only 3% of births in rural areas. 45% of births in urban areas are attended by skilled personnel.

EDUCATION

The 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 region. 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. Primary education 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 (Human Rights Report, 2012). In 2009/10, the Gross Enrolment Rate (GER) for primary schools reached 95.9% (93% for female and 98.7% for male). The general literacy rate, however, remains very low, at 39% (World Factbook, 2007).

Gender	Boys	Girls	Both
2004/05	73.2	63.6	68.5
2005/06	81.7	73.2	77.5
2006/07	82.6	75.5	79.1
2007/08	86.0	80.7	83.4
2008/09	84.6	81.3	83.0
2009/10	89.3	86.5	87.9

Primary School (1-8) Trend of Net Enrolment Rate (NER) by Gender and Year (MoE, 2008/09)

Access to education has improved dramatically over the last two decades, mainly since the end of the civil war in 1991, with approximately 3 million pupils in primary school in 1994/95 increasing to 15.5 million in 2008/09 (One Living Proof, 2011). The 2010 MDG's report indicates that Ethiopia is on track to achieve universal primary education. This has been achieved through abolishing school fees, increasing expenditure on school construction and maintenance, and training thousands of new teachers, changing instruction to children's mother tongue and the gradual decentralisation of the education system. UNESCO supports this, highlighting that the free-fee policy in 2005 has been regarded as successful overall. Support by donor agencies is a large source of primary school funding in Ethiopia. Cost-sharing (i.e. contribution 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 regarding cleaning; maintenance; repairs; furniture and catering (UNESCO, 2010). 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 (One Living Proof, 2011) 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 20.3% among women and 52.5% among men (DHS, 2011)).



School in Addis Ababa © 28 Too Many

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 amongst the nobility (EGLDAM, 2007). 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 GER was 90.7% for girls and 96.7% for boys (One Living Proof, 2011; MDGs Country Report, 2010). 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 7 million people since 2005. Combined, along with other broader societal changes, this has meant that women’s and girl’s aspirations are changing. With more girls in school the age of marriage is rising.

RELIGION

Religion is central to Ethiopian society. It is one of the oldest Christian states in the world, with the Ethiopian Orthodox Church dating back to the 4th century. Ethiopia has historical ties with the 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
<i>Ethiopian Orthodox</i>	<i>43.5</i>
<i>Protestant</i>	<i>18.6</i>
<i>Catholic</i>	<i>0.7</i>
Muslim	33.9
Animist	2.6
Other	0.7

Religious composition of population (Census, 2007)

Region	Christian	Ethiopian Orthodox	Protestant	Catholic	Muslim	Animist	Other
Addis Ababa	83.0	<i>74.7</i>	<i>7.8</i>	<i>0.48</i>	<i>16.2</i>	-	<i>0.8</i>
Afar	<i>4.7</i>	<i>3.9</i>	<i>0.7</i>	<i>0.1</i>	95.3	-	-
Amhara	82.7	<i>82.5</i>	<i>0.2</i>	-	<i>17.2</i>	-	<i>0.1</i>
Benishangul-Gumuz	46.5	<i>33.0</i>	<i>13.5</i>	-	<i>45.4</i>	<i>7.1</i>	-
Dire Dawa	<i>28.8</i>	<i>25.7</i>	<i>2.8</i>	<i>0.4</i>	70.9	-	<i>0.3</i>
Gambela	90.2	<i>16.8</i>	<i>70.0</i>	<i>3.4</i>	<i>4.9</i>	<i>3.8</i>	<i>1.1</i>
Harari	<i>30.8</i>	<i>27.1</i>	<i>3.4</i>	<i>0.3</i>	69.0	-	<i>1.1</i>
Oromia	48.2	<i>30.5</i>	<i>17.7</i>	-	<i>47.5</i>	<i>3.3</i>	<i>1.1</i>
Somali	<i>0.6</i>	<i>0.6</i>	-	-	98.4	-	<i>1.0</i>
SNPPR	77.8	<i>19.9</i>	<i>55.5</i>	<i>2.4</i>	<i>14.1</i>	<i>6.6</i>	<i>1.5</i>
Tigray	96.1	<i>95.6</i>	<i>0.1</i>	<i>0.4</i>	<i>4.0</i>	-	-

Religious composition by region, with majority populations highlighted (%) (Census, 2007)

Ethiopian Orthodox Christianity is predominant in the northern highland regions of Tigray and Amhara and also present in Oromia. Islam is most widely practised in the Afar, Somali and Oromia regions. Established Protestant churches are strongest in SNPPR, Gambela and parts of Oromia. Most Muslims living in Ethiopia are Sunni, and the majority of these are Sufi (Religious Freedom Report, 2012). There are also a number of ‘Felasha’ Jews, who are 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

Freedom of religion was given 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 the government’s respect for religious freedom during that year, with some Muslims accusing the government of interference in Islamic Affairs (Religious Freedom Report, 2012). 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 (EIU ViewsWire, 2004). Whilst 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 and have blamed these groups for exacerbating tensions between Christians and Muslims, and within the Muslim community. The government, the EIASC and civil society groups attempted to address extremism and potential sectarian violence through training and workshops. 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 (Religious Freedom Report, 2012).

MEDIA

PRESS FREEDOM

Media is governed under the 1995 Constitution of Ethiopia, as well as the Press Freedom Bill of 1992. In practise, however, the political climate is 'hostile to media independence and self-censorship is very common' (Reporters Without Borders, 2012). Ethiopia is ranked 137th out of 179 countries by the Reporters without Borders 2013 World Press Freedom Index. 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'. On 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' (Press Reference, undated).

In 2012, problems included restrictions in print media, as well as censorship of information and actions related to politically motivated trials and convictions of opposition political figures, activists, journalists and bloggers. Moreover, several newspapers were closed and weekly circulation of the remaining newspapers decreased. 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 blocked foreign news sites including the Washington Post and Al Jazeera for reporting on Ethiopia's human rights (Human Rights Report, 2012).

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 Amharic newspaper); *Daily Monitor*; *Ethiopian Herald* (government); *Ethiopian Reporter* (independent); *Yeroo*, *Jimma Times*

WEEKLIES

There are approximately 150 non-daily newspapers including:

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

TRENDS IN MEDIA

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, according to 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 (Human Rights Report, 2012).

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 (Pressreference). As of June 2012, there were 960,331 Internet users, with a 1.1% penetration rate, while the government estimates that 4% of individuals subscribed to Internet access. Ethiopia has the second lowest Internet penetration rate in sub-Saharan Africa. Efforts to improve access are hampered by the rural makeup of Ethiopia. Recently attempts have been made to improve Internet access by laying 4,000 kilometres of fibre-

optic cable along highways. Exposure and use of media remains low in Ethiopia, with radio being the most commonly used type of media. Men have greater access to media (DHS, 2011).

Gender	Female	Male
Reads a newspaper at least once a week	4.7	10.9
Watches television at least once a week	15.9	21.0
Listens to the radio at least once a week	22.2	37.9
All three media at least once a week	1.7	53.0
No media at least once a week	68.2	54.0

Exposure to mass media (%) (DHS, 2011)

FGM PRACTICES IN ETHIOPIA

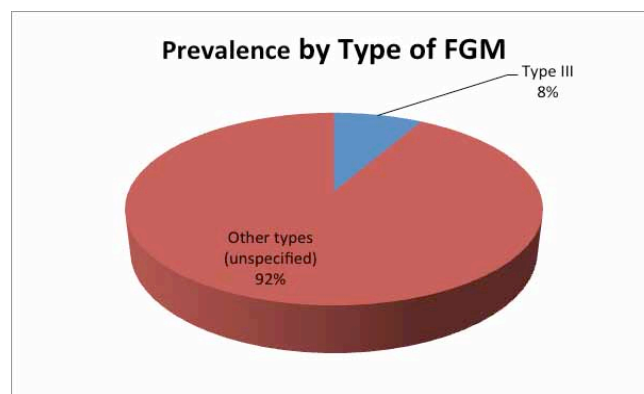
TYPE OF FGM

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 (EGLDAM, 2007). See note on terminology generally in Research Methodology above.

Prevalence of FGM in Ethiopia by type

The following data from the DHS 2005 shows the prevalence of FGM by type of FGM performed, as a total and according to other characteristics. Of those women who have undergone FGM, 8% have experienced Type III infibulation, and 92% Types I or II. Type III infibulation is most prevalent in Afar and Somali, but is also carried out to a lesser extent in Harari and Dire Dawa and other regions.

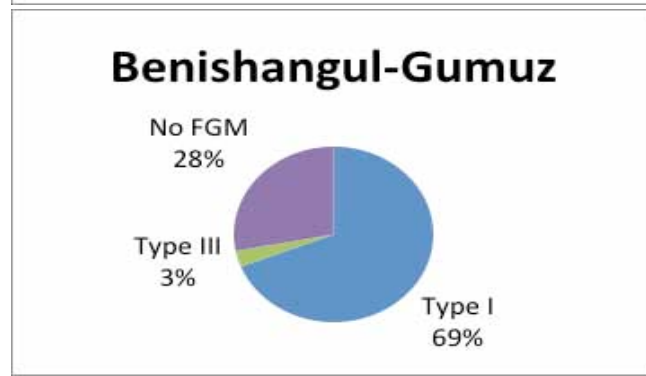
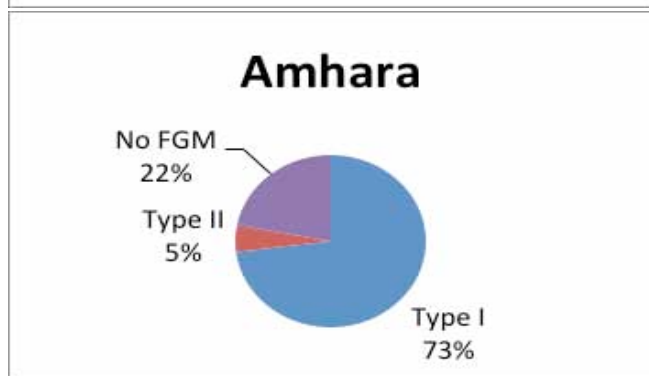
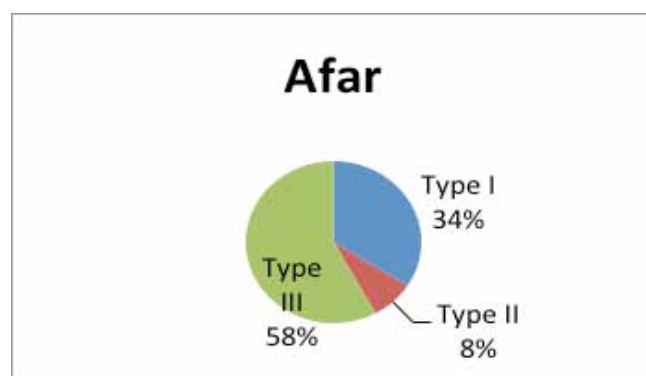
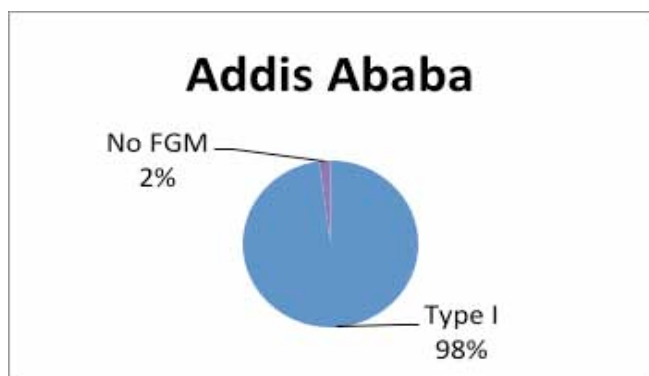
It should be noted that there is a reported trend in areas where Type III infibulation is traditionally carried out, for some to turn to a less invasive form of FGM (Berggrav, Talle and Tefferi, 2009).

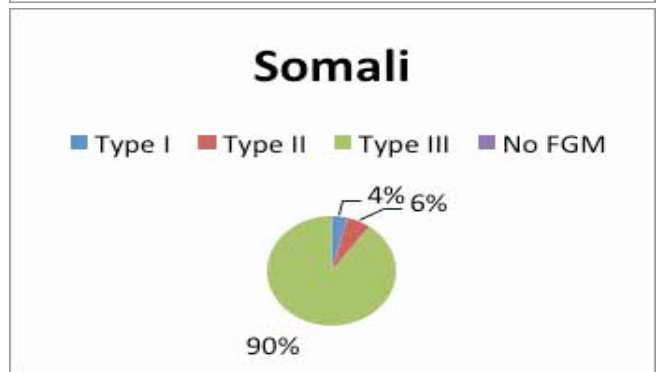
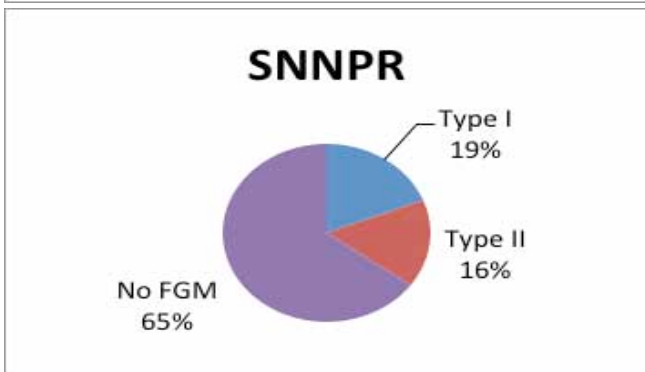
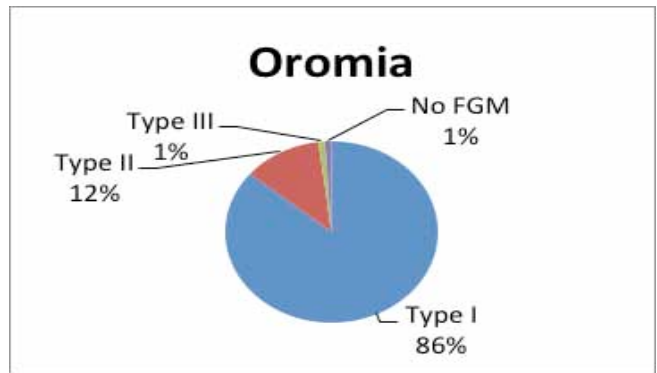
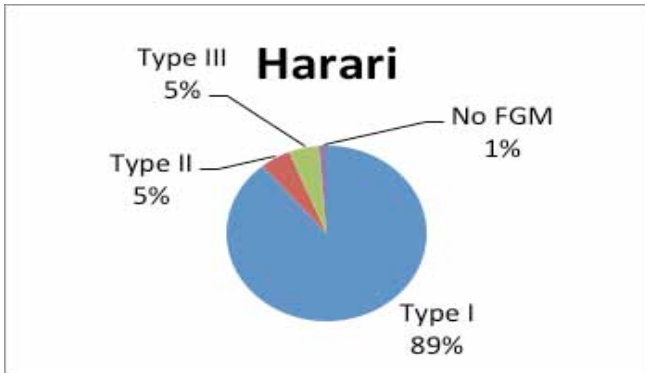


Prevalence of FGM by type among those women who have undergone FGM (DHS 2005)

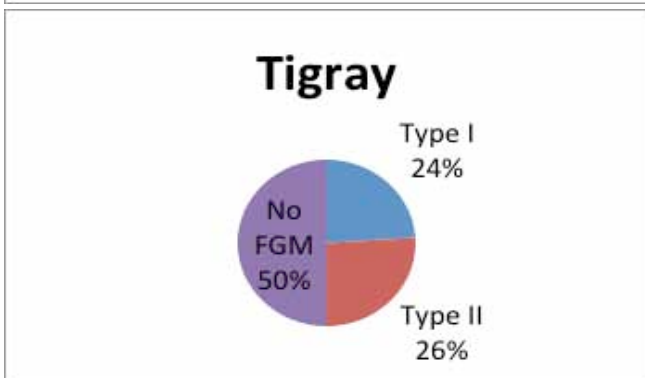
	% women with FGM (DHS, 2005)	% of cut women with Type III (DHS, 2005)	% women with FGM (EGLDAM, 2007)	% women with no FGM (EGLDAM, 2007)	% women Type I (EGLDAM, 2007)	% women Type II (EGLDAM, 2007)	% women Type III (EGLDAM, 2007)
Addis Ababa	65.7	0.8	98	2	98		
Afar	91.6	63.2	100	0	34	8	58
Amhara	68.5	0.6	78	22	73	5	0
Benishangul-Gumuz	67.6	3.2	72	28	69	0	3
Dire Dawa	92.3	13.2	Data unavailable				
Gambela	27.1	1.0	Data unavailable				
Harari	85.1	12.5	100	0	90	5	5
Oromia	87.2	2.5	99	1	86	12	1
SNNPR	71.0	0.6	35	65	19	16	0
Somali	97.3	83.8	100	0	4	6	90
Tigray	29.3	1.1	50	50	24	26	0

Prevalence of FGM by type and region (DHS, 2005) (EGLDAM, 2007, as estimated by focus group discussions)

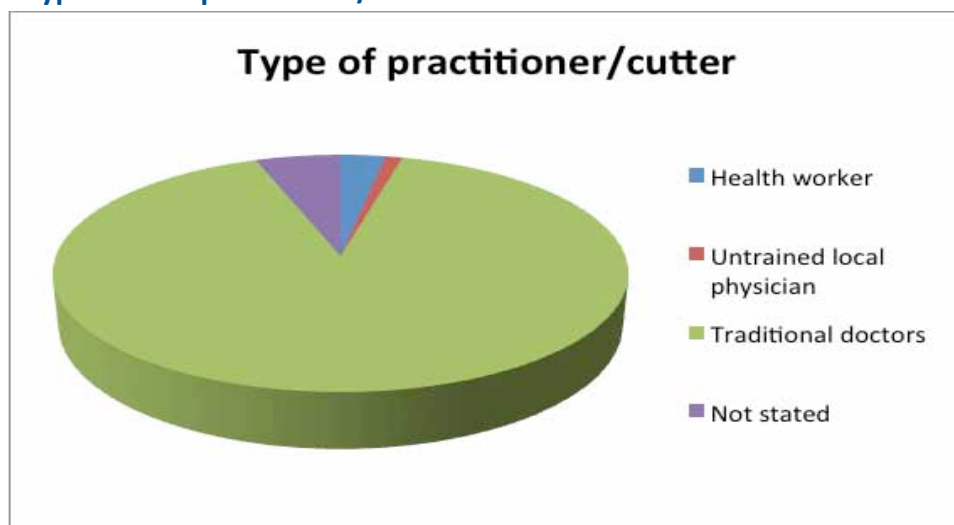




Prevalence of FGM by type and region (EGLDAM, 2007, as estimated by focus group discussions)



Type of FGM practitioner/cutter



Distribution of girls aged 0-14 years according to FGM practitioner by region (%) (WMS, 2011)

	Health worker	Untrained local physician	Traditional doctors	Other	Not stated
Tigray	0.8	0.3	95.3	0.3	3.2
Afar	3.4	0.5	93.4	-	2.7
Amhara	0.5	0.7	95.1	0.2	3.4
Oromia	3.0	0.9	89.1	0.1	6.8
Somali	4.1	1.9	91.3	0.1	2.6
Benshangul-Gumuz	0.2	0.6	95.8	-	3.4
SNNP	12.2	2.3	73.8	-	11.0
Gambela	4.2	-	87.5	-	8.2
Harari	11.6	3.6	76.9	-	7.9
Addis Ababa	22.1	5.7	44.2	0.3	27.6
Dire Dawa	3.2	-	89.1	-	7.7
TOTAL	2.9	1.1	90.3	0	5.5

Distribution of girls aged 0-14 years according to FGM practitioner by region (%) (WMS, 2011)

In Ethiopia, FGM is mainly carried out by traditional birth attendants (TBAs) or traditional ‘doctors’, normally old 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 (EGLDAM, 2007).

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, such as the chinasha among the Wolayta who are also involved in childbirth and rituals surrounding death. (Boyden, Pankhurst and Tafere, 2013). Whereas in other societies cutters are often afforded high status, the chinasa 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 carried out over 20% of FGM on girls under 15, and in SNNP and the city of Harari the figure was over 10%. UNICEF report that in 2000 92% of women had at least one daughter who had been cut by a traditional circumciser, 5.5% by a TBA and only 0.9% by a health worker (UNICEF, 2005). This may

represent a trend towards the medicalisation of FGM within Ethiopia, particularly in urban areas, although note the caution regarding statistics concerning daughters under National Statistics relating to FGM above.

Although medicalisation decreases the negative health effects of the procedure, 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 (UNICEF, 2005). 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 (Shell-Duncan et al, 2000). Furthermore, there is concern from older and more traditional members of communities that performing the surgery 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) (Christoffersen-Deb 2005).

FGM BY ETHNICITY

Out of 66 of Ethiopia's largest ethnic groups (of 82 in total) 46 carry out FGM. FGM is therefore practised by over half of Ethiopia's ethnic groups. In the two ethnic groups where prevalence of FGM is highest, 100% of women have undergone FGM. Prevalence among ethnic groups vary considerably with the lowest prevalence being 0% and the group with the highest being 100% (UNICEF, 2013). The Oromo, Amhara, Somali and Tigray are all significant practising ethnic groups (in terms of the population of these groups accounting 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 reside.



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 around 1.73% of the Ethiopian population, numbering around 1.3 million people (Census, 2007). The Afar are traditionally pastoralists, raising goats, sheep, and cattle, and 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 makes Afar society remarkably culturally coherent. Literacy rates in Afar are among the lowest in Ethiopia (20.3% for women

and 52.5% for men (DHS, 2011), compared to the national average of 38.4% for women and 65% for men (DHS, 2011). Gendered roles are clearly defined, with men making important decisions and owning the majority of the resources, while women are expected to take care of children and small animals whilst fulfilling domestic duties. Development infrastructure is minimal. Women are the poorest and most marginalised people 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's cultural heritage which should be protected and used sustainably (Norwegian Church Aid, 2009).

Afar facts and figures

Rate of FGM: 87.4% Type of FGM: Type III (63.2%) (DHS, 2005)

Age of FGM: > 8 days Women in favour of FGM: 65.5% (DHS, 2005)

Infant (below 1 year) mortality: 118/1,000 with 107/1,000 for males and 133/1,000 for female (estimated by Rohi-Weddu) (cf: 58.2/1,000 nationally*).

Child (below 5 years) mortality: 174/1,000 overall, 150/1,000 males and 206/1,000 females, meaning approx 1 in 5 girls die before the age of 5 years (cf: national average of 77/1,000).

Maternal mortality ratio, lifetime risk of maternal; death: 1 in 12, **compared to 1 in 67 nationally)

Male/female population: 55.8% men; 44.2% women (Census, 2007)

Physician density: 1 doctor per 86,660 people (cf: 1 doctor per 50,000 people nationally).

All statistics, unless otherwise indicated, are from: http://www.unicef.org/infobycountry/ethiopia_statistics.html#0

* World Factbook ** Referred to in Berggav, Talle and Tefferi, 2009, source unclear

The Afar people have one of the highest rates of FGM in Ethiopia. In 2007, 87.4% of women had undergone FGM (EGLDAM, 2007). This is compared to a rate of 94.5% 10 years before (NCTPE 2007). The DHS data shows a decline from 98.6% in 2000 to 91.6% (2005). Whilst this may seem like a significant decrease, the Afar region is still lagging behind other regions in percentage decrease. In 2011, 59.8% of girls living in the Afar region between the age of 0-14 had undergone FGM (WMS, 2011). This is compared to the proportion of women with one or more daughters under 15 years old with FGM of 93.6% in 2000 and 85.1% in 2005 (DHS, 2000 and 2005) (see caution relating to comparing this data in National Statistics relating to FGM above). 65.6% of Afar women still believed that FGM should be continued in 2005 (DHS, 2005). According to one study, FGM accounts for the biased mortality rates between men and women (Berggav, Talle and Tefferi, 2009) (see 'Male/female population' in inset box).

The most common type of FGM amongst the Afar is Type III, infibulation. According to DHS in 2005 63.2% of cut women had undergone Type III. Afar girls undergo FGM generally very soon after birth, within the first 8 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 uncircumcised 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 (EGLDAM, 2007).

Amhara

The Amhara people make up 26.9% of the Ethiopian population (Census, 2007), numbering 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 over 2000 years. The predominant religion of the Amhara is Ethiopian Orthodox Christian.

In 2005, 68.5% of women living in the Amhara region had undergone FGM, compared to 79.7% in 2000 (DHS, 2000 and 2005). This compares to 81.1% in 1997 and 62.9% in 2007 (NCTPA, 1998; EGLDAM, 2007). In 2011, 47.2% of girls living in the Amhara region between the age of 0-14 had undergone FGM (WMS, 2011). This is compared to the proportion of women with one or more daughters under 15 years old with FGM of 78.5% in 2000 and 56.8% in 2005 (DHS, 2000 and 2005) (see caution relating to comparing this data in National Statistics relating to FGM above). In 2005 only 39% of Amhara women thought that FGM should continue.

The most common type of FGM amongst the Amhara is Type I and it is carried out as early as the 8th day after birth. For the Amhara, there is a strong belief that FGM is a protective feature of childbirth (Boyden, Pankhurst and Tafere, 2013). Among Orthodox Christians in Amhara, FGM is also often justified by a belief that there have been rare cases of girls being 'naturally circumcised', which has been referred to as 'a circumcision by Mary'.

Daasanach

The Daasanach, numbering around 48,067, 0.07% of Ethiopia's entire population (Census, 2007) 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 marriagability with the payment of a girl's bride price depending 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 a woman. Marriage takes place soon after the girls undergo FGM (BBC, 2008).

Oromo

The Oromo are the largest ethnic group in Ethiopia, numbering 25,489,024 and making up around 34.39% of the entire population (Census, 2007); the Oromo 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 a positive, gaining more respect as they grow older, men adhere to the gadaa system in which they move into a new age group every 8 years, with 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, with girls being 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 (Ethnomed, 2003). The Oromo have their own traditional religion, but Islam and Christianity are also commonly practised. In Oromia region, 87.2% of women have undergone FGM (DHS, 2005), or 58.5% according to EGLDAM, 2007. FGM is sometimes carried out on infant girls as early as the 8th day after birth, but sometimes later (see FGM by Age for further details).

Somali

The Somali people are an ethnic group living in the Horn of Africa. Around 4.6 million (2007 Census) of them live in the Somali Region of South East Ethiopia, which makes up 6% 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.



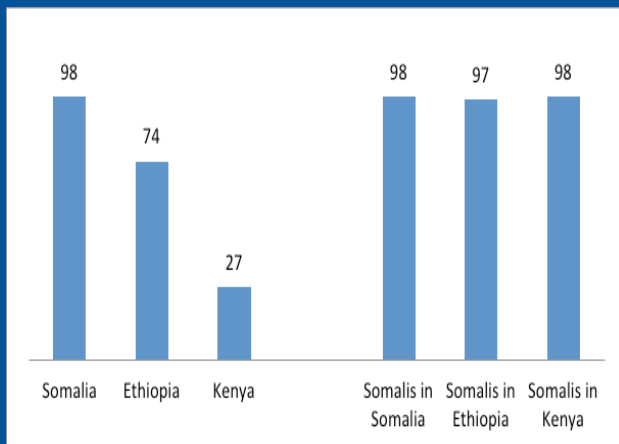
Somali girls in traditional dress ©EcoPrint

The Somali Region has one of the highest rates of FGM in Ethiopia, and in contrast to other regions of Ethiopia the rate has hardly changed over the last couple of decades. Depending on which statistics you use, the rate is 97.3% (DHS, 2005) or 70.7% (EGLDAM, 2007). However, in 2011 WMS report that only 31.7% of girls under the age of 15 had undergone FGM. This is in comparison to the proportion of women with one or more daughters under 15 years old with FGM of 57.7% in 2000 and 28.1% in 2005 (DHS) (see caution relating to comparing this data in National Statistics relating to FGM above). Yet 74.3% of Somali women believe FGM should continue (DHS, 2005), which is the highest percentage of women in any region in Ethiopia to think so. This is despite 60.9% knowing of the harmful consequences of FGM (EGLDAM, 2007).

The most common type of FGM amongst the

Somali people is Type III, infibulation. The 2005 DHS estimated that 83.8% of cut women had undergone infibulation and EGDAM (2007) estimate 100%. FGM is carried out because there is a belief that it is not possible to rape a girl who has been infibulated and that 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 their women will not be protected from rape.

The prevalence among Somalis is high regardless of national context, with the prevalence among ethnic Somalis in Ethiopia (and Kenya) being very similar to that of Somalia itself rather than the national rates for Ethiopia (and Kenya).



Prevalence among Somalis in Somalia, Ethiopia and Kenya (DHS and MICS, 2005-2009)

Tigray

Numbering around 4,483,892 and making up roughly 6.07% of the population (Census, 2007), 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 religion; churches are built on hills and are an important part of Tigray culture. Families, some consisting of 8 or more children are responsible for their own food supplies, women often work between 12 and 16 hour days fulfilling domestic duties and

FGM rituals

The Afar

The Afar, in Northern Ethiopia, infant girls are often cut up to the 8th day after birth. There is no ritual associated with either FGM or male circumcision and it is considered a family's private affair. After the procedure has been carried out the labia majora is held together with thorns inserted horizontally and a paste from a number of traditional herbs is applied to the wound. If the girl survives and the wound has healed, the entrance to the vagina is closed except for a tiny opening created by inserting a splinter of wood, or corn. On the wedding night, the groom will have to carry out de-infibulation using 'a double-edged dagger or any sharp instrument' (EGDAM, 2007).

The Sidama

In Southern Ethiopia it is also more common for FGM to be celebrated as an event. Among the Sidama, the cutting is done at the house of the mother-in-law, after the social part of the wedding arrangements have taken place, but before marriage consummation. This is to assure the mother-in-law of the girl's virginity and so is done in her presence. The girl sits on a stool, with her head and arms held back and her brides-maid covering her eyes with both hands. Her legs are extended and opened wide apart to expose the vulva. Force must be used to hold the girl down as the operation is carried out without any forms of anesthetic. The circumciser, sitting or squatting, faces the girls with the cutting instrument in her hand, starts with the excision of the clitoris and, depending on the type of FGM, proceeds to cut the labia minora, and in some cases also the labia majora. The procedure is followed by a celebration and female members of the bride's family are expected to bring a fresh produce from an animal, usually butter or milk. (EGDAM, 2007). The girl then goes into a two month seclusion period where she should be fed buttermilk and meat at the expense of the groom's family (Boyden, Pankhurst and Tafere, 2013).

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 through 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 (DHS, 2000 and 2005). This

The Gurage

Group FGM is not common in Ethiopia but there are certain cases where FGM is carried out on girls of seven years old or above and a number of girls undergo the procedure together, which is followed by the giving of gifts such as clothes and jewellery by the parents and relatives. This 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 pay the cutter jointly. (EGLDAM, 2007). Among the Gurage people, boys and girls are circumcised/have FGM between the ages of 8 and 10 in rites of passage ceremonies which involve a number of children and are performed by the special caste of former hunters. 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'. These children are then age-mates and remain members of this group until marriage (Boyden, Pankhurst and Tafere, 2013).

compared to figures of 48.1% in 1997 and 21.1% in 2007 (NCTPA, 1998; EGLDAM, 2007). Types I and II are practised (EGLDAM, 2007). Cutting usually takes place when female babies are eight days old.

The tables below show firstly, the prevalence of FGM by ethnic group in SNNPR from the EGLDAM baseline survey in 1997 and secondly, the prevalence by ethnic groups between baseline and follow-up surveys with a decrease of >20%.

Prevalence of FGM by ethnic group with decrease rate > 20% (EGLDAM, 1997 and 2007)(* SNNP)

Ethnic group	1997	2007	% decrease
Agew Awi	52.5	41.3	21.3
Agew Himira	100	60.4	39.6
Amhara	78.0	62.8	19.5
Aregoba	100	73.5	26.5
Bench*	19.5	10.0	48.7
Burji*	17.1	5.2	69.6
Daasanach *	100	79.9	20.1
Fedashi	71.4	52.6	26.3
Gamo*	29.6	13.5	54.4
Gedio*	16.7	3.9	76.6
Gidole/Derash*	12.6	0.0	100
Keffa*	68.7	49.7	27.7
Kemant	93.6	61.5	34.4
Kembata*	62.7	44.2	29.5
Kebena*	86.9	59.0	32.1
Komo*	40.7	19.7	51.6
Mao	25.0	18.0	28.0
Mello/Goffa*	81.3	52.0	36.0
Mocha Sheko*	14.1	3.8	73.0
Mosaye*	10.9	5.4	50.5
Oromo	80.3	58.5	27.1
Saho/Erobe	14.6	6.3	56.8
Sebatbet Gurage*	88.8	62.4	29.7
Sidama*	73.3	54.7	25.4
Sodo Gurage*	85.7	66.7	22.2
Tigraway	59.5	31.0	47.9
Tinbaro*	37.3	17.6	52.8
Wolita*	78.6	60.5	23.0
Woreji	100	76.0	24.0

Prevalence of FGM by Ethnic Group in SNNP (EGLDAM, 1997)

No FGM (>5%)	Intermediate Group			FGM Strong hold (75%)
	5-25%	25-49%	50-74%	
Dime (0), Dizi (2), Gewada (2), Hamer (4.9), Konso (0), Koyra (4), Mali (2) Me'en (0), Mejenger (0), Myangatom (0), Oyda (0), She (0), Suri (0), Tsamay (0). Yemsa (0). Zeysie (3)	Basketo (5) Bench (20) Burji (17) Dorze (5) Gedeo (17) Gidole (13) Mocha/Sheko (14) Mossiya (11) Sheko (5)	Ari (35) Gamo (30) Komo (45) Mao (25) Tinbaro (37)	Alaba (63) Goffa (73) Keffa (69) Kembata (63) Kulo/Dawro (74) Mareko (67) Sidama (73)	Daasanach (100) Hidaya (75) Kebena (87) Konta (87) Mello/Goffa (81) Sebatbet/Guragie (89) Siltie (82) Sodo/Guragie (86) Welaita (79)

REASONS FOR PRACTISING FGM

FGM is a social norm 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 considered necessary for a girl to become a woman. In the south of Ethiopia, FGM is sometimes performed as part of an initiation into womanhood ritual. FGM is often claimed to preserve a girl's virginity and protect her from promiscuity and immoral behavior. For many ethnic groups, an uncut girl is considered to be sexually promiscuous and not marriageable. 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 the follow-up survey in 2007, found the following key reasons for carrying out FGM by those who practise it. Of these, some were found across Ethiopia and others 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.

Suppressing women's sexuality: Amongst 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 husband: This was a reason given by a number of ethnic groups, although for slightly different reasons.

- Tigraway: FGM is considered necessary to avoid difficulty at penetration for males;
- Oromo and Goffa: to reduce insubordination;
- Daasanach, Gurage, Kebena: to discipline women and stop them being 'aynaewta' (too bold);
- Bure-wereda: to make it easier for men to have sex with someone who is a virgin.

To control women's emotions: To prevent her from breaking utensils, being wasteful, absent minded and 'aynaewta' (too bold).

To avoid being ostracised and stigmatised: An uncircumcised woman is despised and considered a shame to her family. They are often ostracised by the community. Oromo, Kebena and Kem ethnic groups referred to uncircumcised women as impure or 'polluted'.

For hygienic reasons: The uncircumcised vulva is considered dirty. It is believed to produce a foul smell by the Jebelawi and Oromo. The Jebelawi also believe it produces 'worms'. The Oromo believe that 'losing blood by circumcision may even wash out some diseases. Thus it [FGM] is advisable for girls who have certain diseases' (Boyden, Pankhurst and Tafere, 2013).

False beliefs surrounding sexuality and childbirth: Some ethnic groups believe that a woman who has not undergone FGM could become impenetrable, have deformities of the vaginal opening, will 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 with some groups believing 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 as a protective feature of childbirth (Boyden, Pankhurst and Tafere, 2013).

For aesthetic reasons: The Afar believe that FGM prevents enlargement of the labia and consider the clitoris ugly.

Religious requirement: Harari and Afar groups believe that prayers and offerings by uncircumcised women are not acceptable. The Jebelawi people believe that religion says ‘that which protrudes from the body is excessive and should be trimmed’, the Fadashi believe that it is demanded by the Qur’an 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 amongst the Afar, a nomadic community, which largely practises Type III infibulation. Amongst 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.

RELIGION AND FGM

As in other countries, 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 FGM and many agree it is not in the Qur’an. Within Christianity, the Bible does not mention FGM, meaning that Christians in Africa who practise FGM do so because of a cultural custom. 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 (Target, 2006).

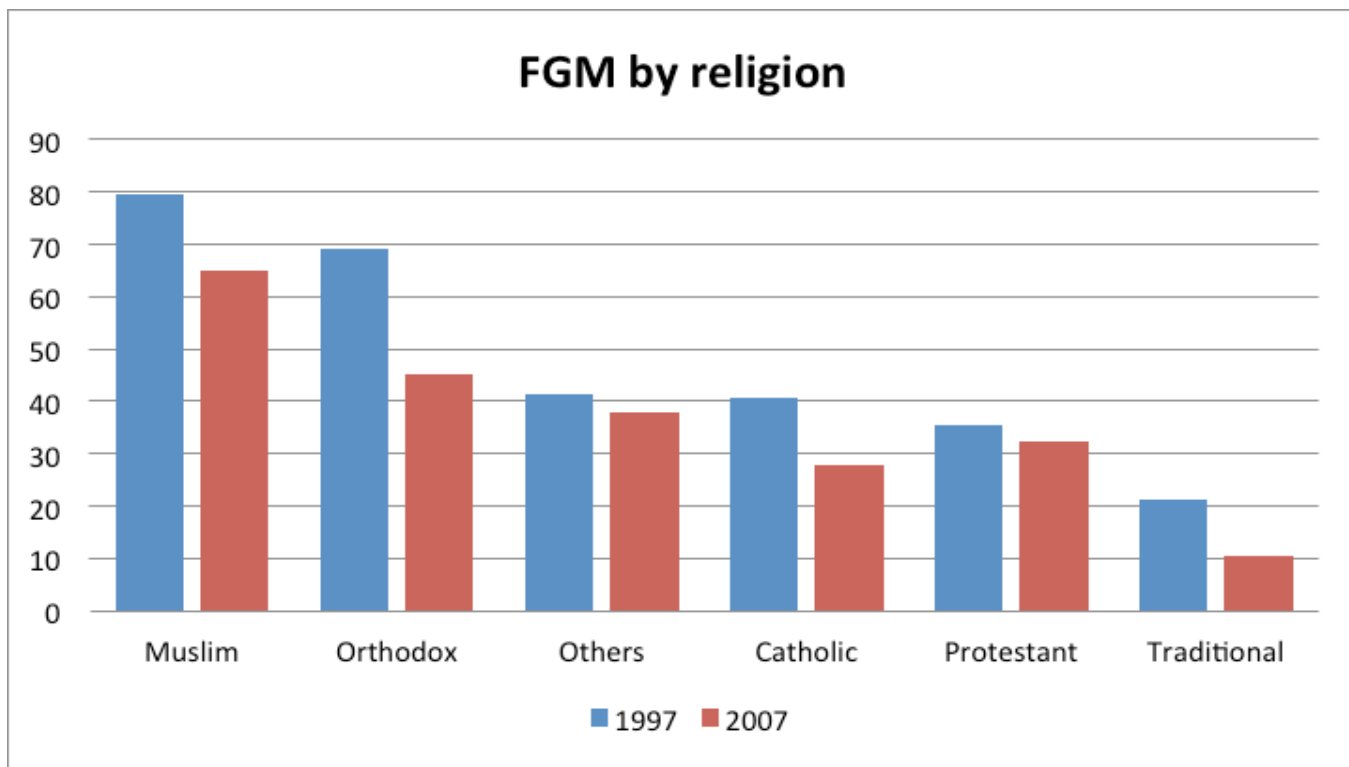
In Ethiopia, the role of religion in the practice of FGM is complex, and often intersects with ethnicity.

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 with the EGLDAM surveys recording a 65.1% prevalence rate among Muslim communities and a 45% prevalence rate among Orthodox Christians.

FGM and the Ethiopian Jews

Uniquely, Ethiopia was historically the only country where the Jewish community (the Ethiopian Jewish community called the Beta Israel, or known by the now derogatory term Felasha, meaning ‘stranger’ in Ge’ez) practised FGM. No other Jewish community, in either ancient, medieval or modern times, is known to have practised FGM and the practice of the Beta Israel can be seen as part of general Ethiopian culture, in which FGM is widespread as opposed to a relic of a long-lost Jewish tradition. The Beta Israel came from the Gondar province, Woggera, the Simien mountains, Walkait and the Shire region of Tigra (Cohen, 2005).

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 has largely abandoned FGM and women express no desire to continue the practice (Weil, 2009). 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 accepted that FGM was normative among Jewish people in Ethiopia, but that they now saw themselves as part of a Jewish society that does not practise FGM. Moreover, they expressed no signs of distress or nostalgia for the custom. The study found that approximately one third of participants showed evidence of genital scarring from FGM. The data suggest rapid cultural change as a function of the acceptance of a new identity (Belmaker, 2012).



Prevalence of FGM by religion (%) (NCTPA, 1998; EGLDAM, 2007)

	Muslim	Orthodox	Others	Catholic	Protestant	Traditional
1997	79.6	69.1	41.5	40.5	35.4	21.1
2007	65.1	45	37.9	27.8	32.3	10.3

Prevalence of FGM by religion (%) (NCTPA, 1998; EGLDAM, 2007)

The EGLDAM 2007 survey suggests that the prevalence of FGM among Muslims is not only higher but is also changing more slowly, than among Orthodox and other Christians, as the table above shows. UNICEF report that Muslim women are more likely to support the continuation of FGM than their Christian counterparts - that is, 76% of Muslim women in Ethiopia support the continuation of FGM as opposed to 58% of Christian women (UNICEF, 2005).

However, UNICEF found that FGM is higher among daughters of Christian women than among daughters of Muslim women. 45.3% of Muslim women 15-49 have at least one daughter who has been circumcised as opposed to 73.4% of Protestants and 67.1% of Catholics (UNICEF, 2005). The report notes although that this could be attributed to other factors such as ethnicity and the overall distribution of the various religious

groups within Ethiopia.

In Ethiopia, some believe that FGM is a requirement of their faith. Among some Muslim communities, FGM is believed to be a requirement of Sharia doctrine. One Muslim respondent in Addis Ababa in one study explained that, 'since it is Haram [sinful] to let the girls go uncircumcised, people still cut the genitals of the girls slightly'. Among 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 where FGM is Eve's punishment for eating fruit (Boyden, Pankhurst and Tafere, 2013).

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' and containing a declaration of zero tolerance of FGM. The Orthodox Church produced a similar statement on 13 October 2011, in which it stated that 'the prevention of FGM requires the strong involvement of the church leaders and men, and collaboration of the Ethiopian Orthodox Church with other partners. (Boyden, Pankhurst and Tafere, 2013).

UNFPA/UNICEF report 207 religious leaders have been sensitised about FGM/C and have 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 (UNFPA/UNICEF Joint Programme, Annual Report 2011).

WOMEN'S HEALTH & 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 causing fistula (incontinence) 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 (WHO, 2013). There are reports that women who have undergone FGM have reduced sexual desire, pain during intercourse, and less sexual satisfaction (Berg and Denison, 2011).

In relation to psychological issues surrounding FGM data suggests that following FGM, women were more likely to experience psychological disturbances (have a psychiatric diagnosis, suffer from anxiety, somatisation, phobia, and low self-esteem) (Berg and Denison, 2011). More research is needed to understand better the relationship between FGM and consequential psychological, social and sexual problems (Berg and Denison, 2011). 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 (PTSD). Among 79 circumcised girls studied in the Kurdistan region of northern Iraq, the study found rates of mental disorders up to seven times higher than among uncircumcised girls in the same region but comparable to rates among girls who had suffered early childhood abuse: 44% suffered PTSD, 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 (IRIN, 2012).

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 (WHO, 2006). The high incidence of postpartum haemorrhage is particularly concerning where health services are poor or inaccessible (WHO, 2008).

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 costs 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 years (WHO, 2011).

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 in those with Type I; 32% higher in those with Type II; and 55% higher in those with Type III. The study estimated that FGM leads to an extra one to two perinatal deaths per 100 deliveries (WHO, 2006).



A group of women in Awassa, Ethiopia © Kimberly McKinnon

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 of FGM 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 (see section below) 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 (UNFPA, 2013).

FGM AND EDUCATION

Education appears to play an important role in shifting normative expectations surrounding FGM and facilitates its abandonment (UNICEF, 2013).

According to UNICEF, lack of education is often associated with FGM, with the assumption that the educated women will be less likely to have their daughters cut. It is possible that while at school, girls have greater exposure to intervention programmes, media messages and international discourse surrounding FGM. They may also 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 (UNICEF, 2013).

In Ethiopia, the prevalence of FGM decreases with the level of a woman's education, with 64% of those having secondary education or higher having undergone FGM, compared with 70.8% and 77.3% respectively for women with primary or no education (DHS, 2005). This gap has, though not large, increased between 2000 and 2005.

Education	2000	2005
No education	80.4	77.3
Primary	78.4	70.8
Secondary and higher	78.2	64.0

Prevalence of FGM by education (%) (DHS, 2000 and 2005)

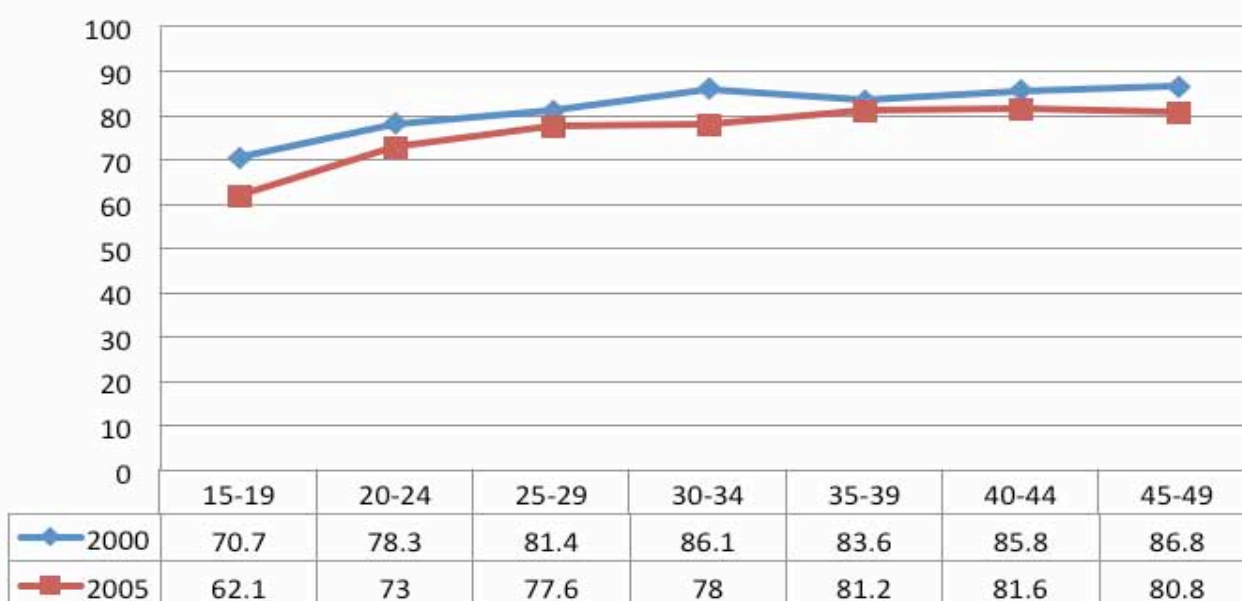
UNICEF highlights the importance of looking at the data of the status of daughters and the level of education of their mothers, given that FGM usually occurs before school leaving age and girls are not usually involved in the decision to undergo FGM. Generally the data from both high and low prevalence countries show that FGM is highest

in mothers of daughters with no education, and tends to decrease substantially as a mother's level of educational rises, suggesting that education appears to play an important role in shifting normative expectations surrounding FGM and facilitates its abandonment (UNICEF, 2013). This certainly appears to be the case in Ethiopia.

Looking at the data of the status of daughters in Ethiopia, 18.7% of women with secondary education have a daughter who has undergone FGM, compared with 24.7% of those with primary education and 41.3% with no education.

According to the data on attitudes to FGM, the percentage of women who support the continuance of FGM is 4.7% for women with secondary education or higher, 20.2% for women with primary education and 40.6% for women with no education (DHS, 2005) (see section on Attitudes). Education therefore appears to be playing an important key role in changing attitudes and practice in relation to FGM in Ethiopia.

Prevalence of FGM in women and girls by age



Prevalence of FGM by age (%) (DHS, 2000 and 2005)

FGM BY AGE

The estimated prevalence of FGM in girls and women by age is set out below. This data shows that the older a woman is, the more likely she is to have undergone FGM and, comparing the data for 2000 and 2005, there has been a decline in the rate of FGM.

The age at which FGM is performed in Ethiopia depends on the ethnic group, type of FGM and region. More than 52.5% of girls who undergo FGM do so before the age of 1 year (DHS, 2000).

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

Age at which FGM carried out

Age at which FGM carried out	% of daughters
<1	52.5
1-2	5.4
3-4	6.2
5-6	7.6
7-8	9.5
9-10	6.8
11-12	4.0
13-14	2.7
15+	4.7
Don't know/missing	0.6
Mean age	3.8

Distribution of daughter who has most recently had FGM according to age at time of FGM (%) (DHS, 2000)

Ethnic groups by age of FGM (EGLDAM, 2007), * This was the case where the survey was carried out in Assaita; the practice in other districts was 4 years+, **Variation among the Oromo (discussed below).

8 days or less	1-10 years	10 years+	Related to marriage	
			Just before	After
Afar*, Agew/Kamyr, Amhara, Argoba Kemant, Oromo (Region 3)**, Tigray	Jebelawi, Konta, Oromo**	Daasanach, Guragie (Mareko area), Hadiya Kembata, Konta, Ormo (Adala)**, Timbaro	Fadashi (at betrothal), Oromo (Arsi Negele)**, Goffa, Welaita, Arbore	Goffa, Sidama (before consummation)

study, children are being circumcised at a younger age as it is believed the wounds heal more quickly, there is less bleeding and less pain for the girl (Beggrav, Talle and Tefferi, 2009). 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 Tigray and Amhara regions neighbouring Afar and the Argoba, FGM is carried out as early as the 8th 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 (EGLDAM, 2007). 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 10 and in the east between the ages of 9-12 (Boyden, Pankhurst and Tafere, 2013). In Arsi (central Oromia) FGM is carried out a few days or weeks before a girl's wedding at the mother's home and is part of the engagement ceremony (EGLDAM, 2007). 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 (EGLDAM, 2007).

Amongst some of these ethnic groups where FGM is closely related to marriage and part of the preparation for marriage, FGM is performed before or after the wedding. This occurs, for example, amongst the Sidama, Fadashi and Goffa people (EGLDAM, 2007).

Although one report states that no FGM related to pregnancy has been reported in Ethiopia (EGLDAM, 2007), 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 (Boyden, Pankhurst and Tafere, 2013).

ATTITUDES AND KNOWLEDGE

RELATING TO FGM

Between 2000 and 2005, support for FGM has halved. In 2000 there was a recorded 60% support rate for FGM but by 2005 this had dropped dramatically to 31%, according to the DHS data. Similar results are seen from the EGLDAM data. 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.

EGLDAM notes that women seem to 'lag behind' male counterparts in their attitude towards the eradication of FGM. This 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 the practice in order to conform to a highly respected tradition and thus ensure their daughter's future marriage (EGLDAM, 2007). Today, negative attitudes towards FGM amongst women are becoming more common. The discourse around opposition to the practice amongst women is often based on women's and girl's own 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 (Boyden, Pankhurst and Tefera, 2013).

In urban areas of Ethiopia, whilst there may not always be a lower prevalence of FGM, 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 harmful consequences in rural areas. Boyden et al support this, arguing that ideas about modernity and interventions to counter 'harmful traditional practices' emanating from the state as well as from international and national non-government organisations have had a much greater impact in urban areas (Boyden, Pankhurst and Tefera, 2013).

It seems that in general, a change in attitudes towards FGM is happening much more quickly

than a change in behaviour among Ethiopians.

Background characteristic	% of women who support FGM (2000)	% of women who have heard of FGM (2005)	% of women who believe FGM should be continued (2005)
Age			
15-19	53.4	90.0	22.9
20-24	57.0	92.5	27.2
25-29	58.5	91.9	34.5
30-34	65.2	91.1	36.5
35-39	63.6	93.1	37.7
40-44	66.3	94.3	33.7
45-49	66.7	92.1	38.0
Residence			
Urban	31.0	97.8	10.4
Rural	66.1	90.5	36.3
Region			
Tigray	25.3	82.9	21.5
Afar	76.5	98.4	65.6
Amhara	60.3	88.9	39.0
Oromia	69.6	97.1	29.8
Somali	77.3	98.1	74.3
Benishangul-Gumuz	53.8	79.5	40.1
SNNP			
Gambela	26.8	44.6	21.0
Harari	51.3	99.8	21.6
Addis Ababa	16.2	99.5	5.6
Dire Dawa	45.5	99.8	13.8
Education			
No education	67.0	89.8	40.6
Primary	48.5	93.8	20.2
Secondary and higher	18.6	99.3	4.7
TOTAL	59.7	91.8	31.4

Distribution of women who have knowledge of FGM/support the continuance of FGM (%) (DHS, 2000 and 2005)

Region	Knowledge (of harmful effects of FGM)		Attitude (against FGM)	
	1997	2007	1997	2007
Tigray	48.1	85.7	56	82.5
Afar	27.4	76.3	26	73.2
Amhara	23.3	85	24	83.2
Oromia	18.2	88.6	17	83.7
Somali	51.3	60.9	24	54.6
Benishangul-Gumuz	36.5	83.2	31	81.6
SNNP	44.9	82.7	38	80.8
Gambela	27.3	49.6	27	49.2
Harari	44.2	74.8	46	67.4
Addis Ababa	60.5	92.8	65	91.4
Dire Dawa	-	83.4	-	81.1
TOTAL	33.6	82.7	30.7	79.9

Knowledge and attitude about FGM (%) (EGLDAM, 1997 and 2007)

HIV/AIDS AND FGM

The link between HIV and FGM is a complex and a contested issue amongst researchers. The 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 (WHO, 2006).

LAWS RELATING TO FGM

INTERNATIONAL & REGIONAL TREATIES

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)
- African Charter on Human and People's Rights (the 'Banjul Charter')
- The African Union declared the years from 2010 to 2020 to be the Decade for African

Women.

- 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 of states to develop policies and programmes to eliminate FGM as well as other forms of violence against women (UN, 2012).

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 that, '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 the numerous health consequences, as discussed in the section Women's Health and Infant Mortality above.

The African Charter on the Rights and Welfare of the Child requires members 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), 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 (Art 9.2).

Unless otherwise stated, all references in this sub-section are to Mgbako et al, 2010.

NATIONAL LAWS

Age of suffrage, consent and marriage

The legal age for marriage is 18, however, as discussed in the Role of Women above, this is weakly enforced. The minimum age for consensual sex is 18 years, however, 21.6% of girls aged 15-19 years have been married (DHS, 2011). 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 was passed in 2005, specifically making FGM a crime and aligning domestic law with the rights-orientated Constitution.

The Criminal Code 2005

The Criminal Code was passed in 2005. Article 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 3 months’ to 3 years’ imprisonment and a fine of no less than Birr 500 – 10,000 (approximately US\$ 27 – 528) or both imprisonment and fine. Article 569 focuses on Type III infibulation and provides that, ‘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.’ (UN/IAC, 2009)

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 (ADAA) has had a programme (see Interventions below), including 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 (Norwegian Church Aid, 2009).

Enforcement of the law

There was reported enforcement of the law in 2012, although the number is not clear from the UNICEF 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 awareness-raising tool (UNICEF Annual Report, 2012). In 2011, there were reported 8 legal actions. (UNICEF/UNFPA Joint Programme Annual Report, 2011).

In 2010, it was reported that nine cutters were

arrested in Afar, with seven being sentenced to between three to five years’ imprisonment. According to UNFPA, although the law may bring perpetrators to court, in practise, the guilty often receive a pardon (IRIN, 2010).

Challenges to law enforcement include:

- The fact that, according to EWLA, most people in rural areas do not see the police and courts as the place to go to resolve conflict (EGLDAM, 2007).
- Awareness of the law is very poor, even among law enforcement agencies (EGLDAM, 2007).
- Reluctance by some law enforcement officials to enforce fully the laws, with the police and courts promoting traditional arbitration and, where the case does go through the formal court system, with lenient punishments or pardons (IRIN, 2010 & EGLDAM, 2007) .
- FGM happens in secret where enforcement action is stronger (EGLDAM, 2007).

Interestingly, one report highlighted that advocacy and law enforcement have had a demonstrable effect on shifting values amongst those in positions of authority, including local government (Boyden, Pankhurst and Tafere, 2013).

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, has stated that the enforcement of the law is very weak and that there is a lack of connection between law making, policy and the enforcement

(Daily Monitor, 2007). Although there have been positive steps made to improve law enforcement, there is scope to improve further capacity and increase the level 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 (UNICEF/UNFPA Joint Programme, Annual Report, 2012).

The UNFPA/UNICEF Joint Programme in 2012 supported capacity building within the judicial system with the training of 150 people in law enforcement. In addition, 10,800 people being informed about the law by the Joint Programme (UNICEF/UNFPA Joint Programme Annual Report, 2012). In addition, EGLDAM, in cooperation with Ethiopian Women Lawyers Association (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 (UN/IAC, 2009).

Restrictions on NGOs

The government restricts the activities of 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 CSO law 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 (Human Rights Report, 2012). 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' (International Centre for Not-for Profit Law, 2009).

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 who prefer to use train-the-trainer models to reach more people (Human Rights Report, 2012).

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) (1974-91) (International Centre for Not-for Profit Law, 2009).

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 1973-74 and 1984-1985 famines, many more NGOs emerged with a focus on relief and humanitarian services. It was after the downfall of the Derg regime in 1991 that saw NGO numbers substantially increase.

There have been a large number of powerful campaigns and activities to prevent harmful traditional practices (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 (EGDLAM, 2007). 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 (EGDLAM, 2007), although campaigns have been strongest in urban areas, where

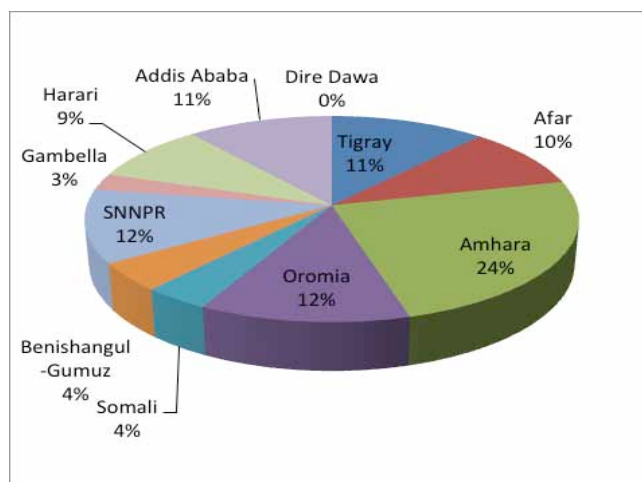
'government, media and NGO activity has been important' (Boyden, Pankhurst, Tafere, 2013).

GOVERNMENT POLICY AND SUPPORT

The Ethiopian government has ensured that 'a solid policy and a programmatic basis ha[s] been laid', with HTPs being included in all the major policy and legal plans across the country, including policies on women, on health, on education and on social policy (EGDLAM, 2007). 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 its major goals in its five year plan. In 2011 the ambitious Growth and Transformation Plan set progressive ambitious five year targets to almost eliminate FGM to 0.7% by 2014/15 (Boyden, Pankhurst and Taere, 2013). There has also been good collaboration between regional government and NGOs, e.g. between Women's Affairs Bureau and NGOs in Afar (Berggav, Talle and Tefferi, 2008).

OVERVIEW OF INTERVENTIONS

The following shows the number of NGOs involved in anti-HTP activities. What is noteworthy is the relative small number operating in Afar and Somali where the most severe form of FGM is prevalent.



Number of NGOs involved in anti-HTP activities, 2007 (EGDLAM, 2007)

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-oriented approach
- Legal approach
- ‘Community Conversations’
- Promotion of girls’ education to oppose FGM
- Supporting girls escaping from FGM/child marriage
- Media influence

1. Health risk/harmful traditional practice approach

The focus of anti-FGM work tends to focus on raising awareness of its harms and in Ethiopia this is ‘overwhelmingly the most important intervention’ in terms of numbers and extent of interventions (EGDLAM, 2007). Ethiopia also has a long history of ‘IEC’ (information, education and communication) 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 as well as films and social gatherings (EGDLAM, 2007).

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 and the Semera Health Sciences College in Afar (UNFPA/UNICEF Joint Programme, Annual report 2012).

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 fistula, the hospital also repairs damage to other childbirth injuries as a result of FGM, and also has hospitals in five regional towns (see International Organisations below for full profile). It also has a community called Desda Mender dedicated to the lifelong support of women whose fistulae are irreparable. In addition, the Afar Pastoralist Development Association (APDA) runs the Barbra May Maternity Hospital in Mille, Afar, in partnership with UNFPA/UNICEF, treating FGM-related complications (see National Organisations below for full profile).

There is, however, generally a need for more medical care, particularly in relation to women’s and maternal health, including treatment for the complications of FGM. The problem is especially acute in remote regions such as Afar (see Afar facts and figures on page 39 for health indicators), with one report recommending treatment for girls with complications from infibulations, for example, by training staff in health centres. Such treatment would also highlight the negative consequences of FGM and have a preventative effect (Berggav, Talle and Tefferi, 2008).

3. Educating traditional excisors and offering alternative income

Educating traditional excisors about the health risks and providing them with alternative means of income as an incentive to stop practising FGM is a further strategy used by organisations. For example, one organisation in Afar, the Covenant for Ethiopia Support (CFES), 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 FGM (UNICEF, 2005).

4. Alternative rites of passage

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'.

(Norwegian Church Aid, 2009)

For those ethnic groups where FGM is part of a rite of passage initiating girls into adulthood, one approach that has shown some success is Alternative Rites of Passage (ARPs). ARPs substitute the cutting part of the ceremonies with alternative rituals that preserve the cultural traditions while eliminating the cutting. ARPs have been implemented with varying degrees of success. The success of ARPs depends on the community practising FGM as part of a community ritual such as a rite of passage. In addition, ARPs will have limited impact unless they are accompanied by education which 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. (UNICEF, 2005). 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 have limited application overall. However, ARPs will be relevant for example where FGM is a rite associated with marriage, as happens more frequently in the South.

The African Development Aid Association (ADAA) has worked with Norwegian Church Aid in combating FGM in the Siraro District of West Arsi Zone of Oromia, where FGM is performed before marriage (a couple of days before the ceremony). Among the strategies used are alternative rites of passage (ARPs), including promoting positive parts of the culture (see National Organisations below for full profile).

5. Religious-oriented approach

A religious oriented approach refers to approaches which demonstrate that FGM is not compatible with the religion of a community, thereby leading to a change of attitude and behaviour. This approach has been used with both Christian and Muslim communities. Both the Orthodox Church and the Evangelical Churches Fellowship of Ethiopia have published declarations declaring in support of abandoning FGM (see further FGM and Religion above) and UNFPA/UNICEF report 207 religious leaders have been sensitised about FGM and have 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 (UNFPA/UNICEF Joint Programme, Annual Report 2011).

There have been some significant initiatives by

religious groups, including the Ethiopian Orthodox Church, and local and international NGOs and religious leaders are frequently important agents of change. For example, Ogaden Welfare and Development Association (OWDA) working in the Somali region has sensitising religious and held Model Family Award Ceremonies for girls and their families who have abandoned FGM, attended by influential religious leaders who publicly declare that FGM is contrary to Islam. 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 (see National Organisations below for full profile). Given the similarities with the practice of ethnic Somalis across the region, see commentary on the Population Council's religious-oriented approach in 28 Too Many's Kenya Report.

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, with the training of law enforcement officials and raising awareness of the law, a National Coordination Body located in the Ministry of Justice implementing a multi-sector plan to improve the implementation and enforcement of the law. Challenges remain in law enforcement, with law enforcement officials sometimes being 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 of FGM (derived from the social change theory behind foot-binding in China (Wilson, 2012/2013)). 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 (UNICEF, 2005).

In Ethiopia, this approach has been termed 'Community Conversations' and has been pioneered by KMG, initially in Kembatta, in partnership with UNDP. 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 (Norwegian Church Aid, 2009). 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 (UNICEF, 2010)

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 10 children's clubs, including girls clubs, gender clubs or child rights clubs, the aim of which is to raise the awareness of school children and the community to 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

(Berggav, Talle and Tefferi, 2008).

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 the girls and their families and their reintegration into the community. In isolation, however, safe houses are unlikely to have a significant impact in ending 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 as in other countries. However, in those regions and among those ethnic groups where FGM is carried out at a later age, such strategies may be relevant.

10. Media influence

There has been more discussion in the media concerning HTPs (Berggav, Talle and Tefferi, 2008). Moreover, there have been reported examples of FGM ‘stories’ receiving wide coverage. Radio has proved to be an important medium in Ethiopia (Berggav and Tefferi, 2010).

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 (UNFPA/UNICEF Joint Programme, Annual report 2012). There has also been international media interest in FGM in Ethiopia following Bogalech Gebre being awarded the King Baudouin Prize in May 2013.

Some NGOs adopt media broadcasts as part of their strategies, for example, by setting up

radio listening groups. The ‘highly professional’ Population Media Centre (PMC) has extensive research-based knowledge and experience which 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, newspapers (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.

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;
- 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;
- Encouraging local governance processes to become responsive to women’s and girls’ sexual and reproductive health rights amongst other initiatives and livelihood security.

A guiding principle of CARE is that communities and individuals have the right to decide issues for themselves and they have had particular success in their projects through their ability to build trust in the community and the community-based approach to their 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 (Berggav, Talle and Tefferi, 2009).

Hamlin International Fistula Hospital



Sign for Addis Ababa Fistula Hospital, © 28 Too Many

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) as a result of FGM. The hospital has treated more than 34,000 women for obstetric fistula. The hospital can accommodate up to 140 patients and four operations can be performed at the same time. 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 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 NCTPE (now EGLDAM) in a five dimensional approach to FGM abandonment in Ethiopia, focusing on health, gender, religion, human rights/ law and access to information. The intention of the project was to encourage abandonment of FGM through; closing knowledge gaps regarding FGM, 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 (SOWDO), Anti-FGC Mother's Association, Somali Women Self-Help Association (SOWSHA) and the African Development and Aid Association in order to encourage the project's sustainability (Population Reference Bureau, 2006).

Norwegian Church Aid (NCA)

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; 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. They partner with African Development Aid Association (ADAA), Covenant for Ethiopia Support (CFES), Rohi Weddu Pastoral Women Development Organization, Ethiopian Evangelical Church Mekane Yesus (EECMY), Kembatta Women's Self-Help Centre (KMG) Ethiopia, Ogaden Welfare Development Association (OWDA), Ethiopian Orthodox Church Development and Inter Church Aid Commission (EOCD/ICAC) and Professional Alliance for Development Ethiopia (PADET) (Norwegian Church Aid, 2009).

Population Media Centre (PMC)

Population Media Centre (PMC) is a non-profit, non-political non-governmental and non-religious organisation which specialises in media communication, including radio, theatre and creative art. From 2007-2010 they 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 a particular focus on the Afar and Somali regions and mainly includes radio serial drama in Amharic; 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 initiative in the Afar and Somali regions, in particular targeting religious leaders and young people.

PMC is praised as being a 'highly professional' organisation and adopting a 'research-based and culturally-sensitive approach' as well as the fact that they reach out to religious leaders and young people as key change agents and stakeholders on the national as well as regional and district levels. It was noted that this approach was expensive due to the high price of air time in Ethiopia. (Berggav, Talle and Tefferi, 2009)

Save the Children Norway-Ethiopia (SCN-E)

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 5 years (The Royal Norwegian Embassy, 2011). The partner organisations are Save the Children Norway-Ethiopia, CARE-Ethiopia, Population Media Centre, EGDLDAM, 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' (Berggav, Talle and Tefferi, 2009). The efforts of the first phase, from 2006-2010 were focused in the Afar and Somali, due to the high prevalence in the area and the severity of the cutting that is carried out, with infibulation prevalent. The second phase will concentrate on the Afar region, Amhara, Harari, Oromia, Somali and the SNNPR. See profiles of national organisations below for further details of the programmes.

The mid-term review of the Partnership suggests that their strategies from the first phase have been successful with one of their strengths being the simultaneous national, regional and community based work. They have observed progress in terms of awareness raising and coverage, as well as considerable commitment from regional leaders in the Afar and local key people (Berggav, Talle and Tefferi, 2009).

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

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

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

Public health: One of the major interventions of the Joint Programme 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 Joint Programme has trained medical personnel, as well as TBAs and Community Health Workers (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 communities move often in search of food and water. In 2011, the Joint Programme 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, as well as delivering 614 babies.

Education: The Joint Programme 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.

See also sections on National Laws and Media. The Joint Programme had a budget of US\$318,663 in 2012, of which 87% was utilised/implemented.

(UNFPA/UNICEF Joint Programme, Annual reports 2011 and 2012).

NATIONAL FGM NETWORK

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 that year when there were more than 46 governmental and non-governmental member organisations. The network had a seven member Executive Committee and was chaired by the Ministry of Women, Children, and Youth Affairs and EGLDAM serves as a secretariat. In addition, four regional networks were established in SNNPR, Somali, Amhara and Tigray. 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) 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 available on its website. The Network's objectives include:

- Raising awareness at grassroots level by conducting training, research and producing IEC materials.
- Increasing capacity of stakeholders/partners through programmes integration/mainstreaming, networking and collaboration by conducting forums in areas of common concern.
- Building 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.
- Networking strategy to strengthen the linkage with partners and stakeholders for better collaboration of efforts towards addressing issues of common concern.

Challenges/needs noted by the Network include:

- Need for strengthening the organisational capacity of EGLDAM with effective resource mobilisation and sustainability.
- Changes in donor’s funding policies, gradual decrease of financial sources.

Norwegian Church Aid note that the network is in the process of becoming strong, and that the network is focusing on:

- Formulating clear measurable goals for their 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.
- Strengthening local actors’ advocacy

capabilities.

(Norwegian Church Aid, 2009 and EGLDAM website).

LOCAL ORGANISATIONS

Afar Pastoralist Development Association (APDA)

The Afar Pastoralist Development Association (APDA) is a UNFPA/UNICEF Joint Programme 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 (UNFPA, 2013).

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 (UNFPA, 2013). 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 4 years to protect them from FGM, then the girls are followed up by their teachers (UNFPA/UNICEF Joint Programme, Annual Report, 2012).



Afar girl in Danakil Region © Cdkeyser

African Development Aid Association (ADAA) – Oromia Region

ADAA has worked with Norwegian Church Aid in combating FGM in the West Arsi Zone of Oromia. The prevalent type of FGM was 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, CBOs and local government offices (wereda offices). The strategies included information and awareness raising; alternative rites of passage (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 and others are contemplating doing so.
- Four public weddings, in which the couples announced the non-FGM status of the bride, were organised and widely publicised.

(Norwegian Church Aid, 2009)

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, 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 Harmful Traditional Practices (IAC) 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 were:

- Research, policy and law: As NCTPE, the organisation carried out a country-wide baseline survey carried out on the harmful traditional practices (HTP) in 1997, identifying

some 140 HTPs, and a follow-up survey by the same organisation (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 it 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, IAC and Norwegian Church Aid (Berggav, Talle and Tefferi, 2009).

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

The Ethiopian Orthodox Church Development and Inter Church Aid Commission (EOC-DICAC) is the development wing of the Ethiopian Orthodox Church and the oldest faith-based development organisation in Ethiopia and is viewed as a role model by other local organisations. They are 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 have included:

- 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 and 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 (IEC) 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.
- Working closely with local sector offices, schools, local administration, police and legal bodies to ensure local ownership and support.

(Norwegian Church Aid, 2009)

Kembatta Women's Self Help Center (KMG) – SNNPR and Oromia Regions

KMG was founded in 1997 by Dr Bogaletch Gebre and her sister Fikrte Gebre. Dr Gebre has been a pioneer in the empowerment of women and the fight against FGM and other HTPs for which she has received national and international recognition, including the 2012-13 King Baudouin African Development Prize. KMG aims to create an environment where the values and rights of women are recognised and where 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 has since expanded its focus to economic enfranchisement, education, reproductive health services, HIV/AIDS, environmental degradation, and small infrastructure development.

They estimate 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/AIDS. In 2002, in collaboration with UNDP, KMG piloted a framework of social mobilisation tool known as Community Capacity Enhancement through Community Conversation (CC). The Ethiopian government adopted these methodologies and in 2004 launched nationally where 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

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.

They began as general community forums but later specialised CCs 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/AIDS, HTPs, reproductive health and human rights, democracy and good governance. Each CC has facilitators.

CCs are held every 15 days for 1.5-3 hours, at times chosen by the participants. They start with 'introduction/reflection' sessions where 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 10 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 (Womankind website).

Challenges include:

- CCs pose a threat to existing power structures and community empowerment may lead to other power structures trying to derail CC. Key stakeholder involvement is required. KMG demonstrates how CC, 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 sufficient to justify rolling-out the project, more robust evaluation seems desirable.
- The need to take stock of adaptations of the programme to reflect ethnic diversity.
- Solve the dilemma of the need for educated facilitators versus the need for facilitators from within the community.
- Ensure quality, cost and capacity issues with scaling the programme up.

(Norwegian Church Aid, 2009)

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

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, poor women to be able 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 Ministry of Women, Children and Youth Affairs (MoWCYA), Ministry of Culture and Tourism and other NGOs and Civil Society Organizations (CSOs). On top of this ODWaCE is a member of national HTPs strategy and the national alliance to end child marriage. Both are organized MoWCYA. Based on this ODWaCE will continue to contribute its experiences and resources in the area of HTPs.

Currently ODWaCE focuses on the health and capacity building of women, enhancing educational attainment of children, repairing fistula victims and assisting them to be able to generate their own income as well as 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 (OWDA) (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. It has a staff of over 140 and partners with 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 at between 8 and 11 years. OWDA’s strategy for eradicating FGM has included:

- Sensitising religious leaders and information dissemination, 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 community conversations (CCs) being established, such a strategy aligning well with the Somali tradition of sharing information. There was a particular emphasis on the need to engage with the child’s 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.
- Change in number and attitude of cutters, with some publicly promising to abandon the practice and 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.
- Integration of anti-FGM message into health centre's maternal health care education programme.

Challenges include:

- Tendency for communities to focus on water and food security during discussions.
- Total abandonment of FGM is a challenge 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 a wave of infibulation.
- Lack of alternative sources of income for cutters.

- Promises given by community (especially in workshops) are not necessarily kept.

(Norwegian Church Aid, 2009)

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 their aims is to contribute to the abandonment of FGM and other HTPs. Their FGM project involves encouraging community dialogue, lobbying influential people and organising diffusion through a core group defined as 'community leaders'. They also organise radio-listening groups through Radio Fana and Tigray radio and produce information material. It operates in several zones in Afar and has wide coverage (Berggav, Talle and Tefferi, 2009). 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;
- Ensure 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);
- Establishing village anti-FGM committees and community dialogues. Consensus was reached to stop FGM in the district.

Achievements/challenges include:

- Facilitators from within the community are seen as key to the success of the programme and 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 agreeing to issue by-laws to prohibit FGM and prosecute parents who cut their daughters;
- An anti-FGM women's group was established and organised 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 (Norwegian Church Aid, 2009).

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 Bureau 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 (Berggav, Talle and Tefferi, 2009).

CHALLENGES FACED BY ANTI-FGM

ORGANISATIONS

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', leading to harm-reduction but not a change of social norms and eradication.
- FGM being undertaken secretly.
- Challenges in law enforcement, with law enforcement officials sometimes being reluctant to enforce the law and impose appropriate sanctions, and lack of capacity in the law enforcement sector.
- Lack of resources/capacity.
- Environmental challenges, with drought 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 to challenge traditional power systems dictating marriagability.
- Lack of resources to address health complications of FGM. Networks not yet harnessing the potential of shared resources and peer support. 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 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 a community level, with particular care being taken by organisations to tailor women's health and anti-FGM initiatives and strategies 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 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 a focal issue 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. Stopping FGM is connected to promoting the eradication of extreme poverty and hunger, the promotion of universal primary education, gender equality, reducing child mortality, improving maternal health and combating HIV/AIDS. Relating FGM to wider social crises is important when creating grant proposals and communicating anti-FGM initiatives to a wider audience because it highlights the need for funding anti-FGM programmes and research 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 focusing on violence against women and girls, including FGM. We hope that this momentum is continued and that violence against women, and FGM, are reflected in the post-MDGs agenda.

FGM AND EDUCATION

Education is a central issue in the elimination of FGM. The lack of basic education is a root cause for perpetuating 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 directly relates to issues surrounding child marriage. Anti-FGM programmes need to be focused 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 surrounding FGM. Given the recent trend towards medicalisation in some areas (Addis Ababa, SNNPR and Harari), this should also be addressed through education to 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. Lack of access to and utilisation of adequate health care generally is also 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 has been reportedly a trend towards the abandonment on Type III infibulations in Afar and Somali regions, towards the less invasive Type I ('sunna'). This does not lead to a change in social norms and effective abandonment, and Type I is still a human rights violation and causes 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 is essential to ensure that the 2006 Criminal Code is being effectively communicated to rural areas and that they are aware that national legislation has been put in place, that the law is being properly enforced and that the momentum gained by the change in law is sustained.

FGM AND THE LAW

With the passing of Ethiopia's Criminal Code in 2006, progress has been made to stop 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 relation to the receipt of foreign funds and caps on 'administrative' costs may hamper efforts to accelerate the decline of FGM.

FGM IN THE 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 regarding 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 and the role of Islamic leaders is vital in combating FGM in Afar and Somali regions. All faith groups and those of no 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 programme deliverables to communities.

COMMUNICATION AND COLLABORATIVE PROJECTS

There are a number of successful anti-FGM programmes currently operating in Ethiopia, with the majority of the progress beginning at the grassroots level. We recommend continued effort to communicate their work 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 strengthening of such networks of organisations working against FGM and more broadly on women's and girl's rights, integrating anti-FGM messages into other development programmes, sharing best practice, success stories, operations research, training manuals and support materials, advocacy tools, providing links/referrals to other organisations will all strengthen the fight against FGM.

APPENDIX - LIST OF INTERNATIONAL AND NATIONAL ORGANISATIONS CONTRIBUTING TO

WOMEN'S HEALTH ISSUES AND THE ABANDONMENT OF FGM

* denotes organisations that are members of the National FGM Network (see Interventions above), and the contact details for which can be found on their 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 Childrens 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*

Kembatta Women's Self-Help Centre (KMG) Ethiopia*

Menschen für Menschen (MfM)*

Ministry of Justice

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

Ministry of Culture and Tourism*

MUJEGUWA 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)*

UNICEF

United Nations Population Fund (UNFPA)*

World Health Organisation

Women Support Association (WSA)*

Women Support Association (WSA)

World Vision - Ethiopia (WVE)*

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