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When Culture Harms

- A Case Study on Female Genital Mutilation in Ethiopia and Reverberations Felt in a Wider Context from a Political and Ethical Perspective

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Abstract

Title: When culture harms - a case study on Female Genital Mutilation in Ethiopia and reverberations felt in a wider context from a political and ethical perspective.

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Purpose and Questions: The purpose with this thesis is to explore why female genital mutilation (FGM) persist in Ethiopia, and secondly to explore reverberations felt in a wider context from a political and ethical perspective. The aim of this paper is not to argue that traditional female genital mutilation ought to be legalized, but to highlight the double standards of moral involved. Following questions were used as guidance to fulfil the purpose: how is the situation for women and what is the status of FGM in Ethiopia?; are there legal framework mechanisms in place?; what are the attitudes on the biggest challenges in the struggle against FGM and what are the way’s forward?; and what readings can be made with regards to the ‘phenomenon’ of genital alterations in a wider context from a political and ethical perspective?

Method: This thesis is a case study of the phenomenon genital mutilation. It has elements of a field study with comparative elements, in terms of the ‘phenomenon’ of genital alterations. The material consists of data from fieldwork conducted in Ethiopia as well as data from literature review.

Results: The paper presents an alternative point of view on previously not so well understood relations on the subject matter. Ethiopia is a poor and highly traditional country, where women lack behind in most areas. The legal provisions in the Criminal Code against FGM are not strong enough, or in place. The Criminal Code only restricts the practice and doesn’t explicitly outlaw it. The country is also democratically crippled, and NGOs has been constrained (indirectly) in their work on FGM. Ethnicity and culture, rather than religion, seem to be the most decisive factors for the practice in Ethiopia. However, it seems as though the veil of silence has been partially lifted. There seem to be awareness in some segments of the population, however much more work is needed towards the total elimination of the practice. Awareness on the harm as well as implementation and adherence to the law, and thus change takes time. Western cultural norms however seem to prevail over other cultural norms, and various forms of genital alterations undertaken due to individual non-medical reasons might create skewed attitudes and have a negative impact on the struggle against FGM, from a wider perspective.

Keywords: law, policy, genital mutilation, circumcision and culture
Preface

Some words of acknowledgment are undoubtedly in place. This paper more or less took its first steps after Olof Palme’s memorial funds financial support, and hence during fieldwork conducted in Ethiopia, which would have been hard to achieve without this support. The idea for this project grew in the summer of 2011, before an internship at the Embassy of Sweden in South Africa took off. During this period I also developed the concept paper for this project further (when I came into contact with the concept MMC). It is with great passion I have worked with this project, not only for the fact that it is a thesis within my Master’s but also due to the fact that I see myself as torch bearer for vulnerable people, and as the great Africa ‘freak’ that I am, I also highly value working with democracy and human rights issues. Not because I think Africa needs to be rescued and developed as the West, but I rather enjoy working with ‘true meanings’ in life. It is important to emphasise that it is not my intention to debate for the legalization of FGM but rather to show the double standards of moral involved. Many thanks to my friends from ASH, for all your support and inputs. Also many thanks go to Lee at GT Guest House, an all the wonderful people I met, thanks for all your friendship and support, it has been a life experience hard to forget. Many thanks also go to friends in Sweden as well as in Ethiopia, for without your help my research would have been a struggle. My great appreciation also goes to all the people in Ethiopia – this proud and strong people with a unique history and a promulgating future. I would like to thank all who supported me in my work, interviewees, KMG, Amref and Egldam. Many thanks to Hans Bengtsson at Halmstad University, you taught me that hard work indeed gets you somewhere in the end. I am also most grateful to my supervisor Thomas Knoll, thank you for all your support and for giving me important points to ponder. I would like to express my gratitude to all those who supported me in this endeavour. Of course I would also like to thank my family for all your support (during all my field trips this last couple of years). Writing a paper like this is an arduous and ‘risky’ task, and I hope I haven’t stepped on anyone’s toes by making some of the concluding remarks, they are however my personal views, and thus comes without any apologies. It is my hope that this thesis will provide insights into the issue of harmful traditional practices and stimulate to debate on ways and means of eradicating FGM, but also serve as an active approach to the eradication of all forms of violence and suppression of and against women and children. Special thanks go to my dear friend, which I am most grateful to. Thank you for being my special ‘driving force’, for all your support and words of inspiration.

Amesegunahlun!

Yours Sincerely, Petra Spencer

1 June 2012, Halmstad
Abbreviations and Acronyms:

Amref  African Medical and Research Foundation
AU    African Union
BLS   Baseline Survey
CEDAW Convention on the Elimination of Discrimination against Women
DHS   Demography and Health Survey
Egldam Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (the former National Committee on Harmful Traditional Practices in Ethiopia)
FC    Female Circumcision
FGC   Female Genital Cutting
FGD   Focus Group Discussion
FGM   Female Genital Mutilation
FUS   Follow-Up Survey
GAD   Gender and Development
GID   Gender in Development
GO    Governmental Organisation
HIV   Human Immunodeficiency Virus
HTP   Harmful Traditional Practices
IAC   Inter-African Committee on Traditional Practices
IEC   Information Education Communication
IGO   Intergovernmental Organisation
KMG   Kembatti Mentti Gezzimma
MC    Male Circumcision
MOH   Ministry of Health
MMC   Medical Male Circumcision
NCTPE National Committee for Traditional Practices in Ethiopia (Egldam)
NGO   Non-Governmental Organisation
NORAD Norwegian Agency for Development
PEPFAR The United States President’s Emergency Plan for Aids Relief
PO    Police Official
PP    Public Prosecutor
RISK  Swedish National Association for Ending FGM
SIDA  Swedish International Development Agency
SNNP(R) Southern Nations, Nationalities and Peoples (Region)
TBA   Traditional Birth Attendant
UN    United Nations
UNFPA United Nations Fund for Population Activities
UNICEF United Nations Children’s Fund
USAID United States of America Agency for International Development
WHO   World Health Organization

Definition of Concepts:

Genital alterations  Genital/ intimate surgery
Kebele             Administrative subdivision within a Woreda
Roll’s Royce Vagina Genital/ intimate surgery for aesthetical appeal
Woreda              Administrative division within a region; a district
Beauty-FGM         Harmful traditional practices VS harmful modern practices
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1. Prelude

This paper develops some explanations for the occurrence of female genital mutilation as well as it develops some of the distinctive motives that should be important future calls for eradication of the harmful practice, from a political as well as ethical perspective. The thrust of this paper is based on how the experiences of bodily integrity and cultural norms are shaped and challenged by socio-economical and political changes, and especially why an harmful practice such as FGM persist in Ethiopia even though there is legal provisions for its eradication.

Over the past few decades, there has been growing concern about the practice of female genital mutilation (FGM). The World Health Organization (WHO) defines FGM as ‘partial or total removal of the female external genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons’ (WHO, 2012). According to WHO, approximately 100-140 million girls and women worldwide have undergone some form of FGM, and it is also estimated that about 3 million girls undergo this procedure each year. FGM is practiced in about 28 countries in Africa and the Middle East, and it is estimated that a majority of women in Ethiopia have been subjected to the harmful practice (ibid, Johnsdotter, 2005). In addition, FGM is also practiced among immigrants residing in countries where the practice is outlawed, and other forms of genital alterations even overlap prohibited forms of FGM (Johnsdotter, 2002, 2009).

‘Without progress in the situation of women, there can be no true social development. Human rights are not worthy of the name if they exclude the female half of humanity. The struggle for women’s equality is part of the struggle for a better world for all human beings and all societies’ (Boutros Boutros-Ghali)

In some parts of the text it is not possible to be consistent with the concepts of female genital mutilation/ or circumcision, especially not since the very use of the concepts is a side-track to the problem. However, the term ‘mutilation’ (and FGM) seems to be more correct to use rather than the term ‘circumcision’ (or FC and FGC).

1. 1 Research Problem

Ethiopia is a unique traditional society where the cradle of human kind lies, but it is also a country in which FGM affects the majority of women and children. Even though the country adopted a law as a way to eradicate the harmful practice in 2005, the prevalence remains high. A majority of the population confess to Christianity, live in poverty and is uneducated. It is argued that FGM mostly occurs in Muslim societies, however more than half of the population in Ethiopia confess to Christianity (Graham, 2010:31).
Since Ethiopia also is crippled democratically, citizens and various organizations risk being silenced in their struggle against harmful practices that violates basic human rights, such as FGM (Freedom House, TI, ICNL, 2012).

FGM is prevalent and affects all but very few ethnic groups in Ethiopia. The majority of girls and women affected risk having their clitoris cut off (Kitaw et al. 2008:100). Even though Article 35, in the Constitution of the Democratic Republic of Ethiopia (8 December 1994), and the Criminal Code prohibits or restricts FGM the prevalence remains high with approximately 74%4 of women and girls are affected (WHO, 2012). Pursuant to Article 35 in the Constitution women gained the right to protection by the state from harmful customs. In 2004, the Ethiopian Government modified the country’s Criminal Code by making FGM a criminal act (proclamation no 414/2004). Even though there are legal provisions adopted its effectiveness needs to be questioned since the practice persist and the prevalence remain high.

While advocating for laws that restricts or outlaws FGM may be effective, care must be taken to ensure that legislation does not drive harmful practices underground, possibly occurring under disguise. Even though anti-FGM laws (assumed that they actually are implemented) have some disadvantages it provides a backup to NGOs and other on their work by empowering them with legal support and the support of their governments. Even though Ethiopia has adopted a Criminal Code in 2005 restricting FGM, it can be difficult to find the right balance between enforcement, community education and dialogue as a way to combat the practice, especially when the country is highly traditional. There is of course also the challenge with a policy process in terms of if there is a clarity of the policy’s goals, or enough information and strategic planning in place, which according to Theodoulou and Kofinis (2004:183ff) can impede on an effective implementation of a policy.

Although human rights are regarded as universally applicable, the values on which they are based can be traced to a specifically European history and tradition of thought (Malmström in Schlyter et al, 2009:105). In countries where the practice of FGM is performed, states have adopted policies that prohibit the practice even when the laws do not reflect what the majority of the population wants. This clearly makes one wonder about challenges, in terms of the ownership and adherence to existing policies and law.

New norms and ideals are now challenging the old Western tradition of thought, and as a side-track in this case study on FGM in Ethiopia, the link to other forms of genital alterations will be made, in relation to policies and laws that exists in this area. It becomes necessary to address these issues in a wider perspective, not least because of new influential forms of intimate surgery but also due to claimed bio-medical procedures and benefits thereafter.

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3 In Transparency International (TI) Ethiopia ranks as 120 out of 183 in 2011 (183 as worst possible, lands on a score of 2.7/10), and its status by Freedom House is ‘not free’.

4 In Ethiopia about 57-74%4 of women and children are affected by the harmful traditional practice often referred to as female genital mutilation. WHO and Egldam states different numbers. See ‘extent of the problem’ and the chapter on FGM in Ethiopia on why the prevalence differs.
However, whilst an adult is quite free to submit herself to a ritual or a tradition, a child, having no formed judgment and which doesn’t consent, but simply is forced to undergo the mutilation (which in this case also is irrevocable) and is totally vulnerable.

At the same time as there is an on-going struggle against FGM, male circumcision (MC) is wide spread in Ethiopia and medical male circumcision (MMC) is also being scaled up as a way claimed to combat HIV and Aids. This scale up takes place even though PEPFAR’s HIV guidance is suppose to prioritize voluntary medical male circumcision in settings where male circumcision prevalence is low and HIV prevalence is high, which are not the case in Ethiopia (UNAIDS, 2011). How one practice be overlooked and advocated for while at the same time the practice of the female ‘circumcision’ or ‘mutilation’ is trying to be eradicated can be quite a arduous and risky task, and should therefore be dealt with carefully, especially in a traditional setting, according to the author of this paper. As MC is widespread in Ethiopia, and since the majority confess to Christianity, it is quite clear that FGM not only occur in only Muslim societies. Perhaps there is also a link between (M)MC and FGM when it comes to attitudes on the two practices, where the latter might have a negative impact on the first.

Female genital mutilation is a cultural engagement. It has been a tradition for thousands of years, but recent, more modern forms of intimate-surgical procedure is requested due to Western ideals and norms of beauty. Girls subjected to genital mutilation is always seen as defenceless victims, although she herself asked for the surgery, meanwhile women seeking intimate surgery expresses their personal freedom. The question here arises to what kind of outcomes a policy process, such as laws against FGM can come to have in a wider context, and thus how can we interpret the law without discriminate certain ethnic groups.

Social conflicts in several African countries resulted in an increasing number of African migrants to the West. It is argued that with the influx of migrants, from communities that practice FGM, healthcare professionals increasingly have to deal with this group of people without appropriate knowledge to meet their particular needs. The same problems seem to be true for the legislative. According to Johnsdotter (2009:13) intimate genital alteration is taking of in an increased speed, in Sweden and other Western countries, and as this happens, various ‘cultural’ activities, such as genital alterations, might clash with exiting laws and policy.

Question arises to why FGM continues to be prevalent in Ethiopia, even after major policy interventions, such as the enactment of the law against the harmful practice. The question also arises to what implications policy interventions and laws in this area can have in a wider perspective.

5 92% of Ethiopian men aged 15-49 are circumcised. Ethiopia has a relatively low prevalence rate with about 1,5% of people aged 15-49 infected with HIV (DHS, 2011).
6 Sometimes the reader might find (M)MC; as synonym to both medical male and male circumcision since MC tend to shift towards MMC. It could also be the case that it is easier to decrease the harmful practice in Christian rather than Muslim societies due to the adherence to the Koran, or just simply the fact the MC is widespread, no matter of religious adherence, and this can have negative attitude impacts.
7 Meanwhile, the procedure of male circumcision is legal to conduct and more or less unquestioned.
8 According to WHO (2012), FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.
1. 2 Purpose and Research Questions

The purpose with this thesis is to undertake the some what arduous and risky task of exploring why female genital mutilation persist in Ethiopia, with regards to the legal framework in place. This is undertaken in relation towards the ambiguous notion of bodily integrity and cultural norms, in a wider context from a political and ethical perspective.

The analysis shows thus also (but not primarily) to reveal how intricately interwoven traditional circumcision is with ‘Western’ forms of intimate surgery, and how some cultural norms seem to prevail over other. The aim of this paper is not to argue that traditional female genital mutilation ought to be legalized, but to highlight the double standards of moral involved.

In order to carry out the purpose with this thesis following Research Questions was used as guidance, (the first RQ however was mainly necessary in order to fulfil the overall purpose):

RQ 1. In Ethiopia, how is the situation for women and what is the status of female genital mutilation?

RQ 2. In Ethiopia, are there legal framework mechanisms in place?  

RQ 3. In Ethiopia, what are the attitudes on the biggest challenges in the struggle against FGM and what are the way’s forward?

RQ 4. What readings can be made with regards to the ‘phenomenon’ of genital alterations in a wider context and from a political and ethical perspective?

1. 3 Previous Research

Previous research will appear frequently in this paper as parts of connection to what’s been researched already as well as in the background chapter and also form part of the actual analysis. Much of this research is currently in the forefront, especially when concerning various forms of policy interventions in the genital area. According to the author of this paper, what is lacking in the discourse on FGM is the link to definitions, policy and laws and thus challenges in relation to various forms of alterations in the genital area. It is important to have in mind that policy interventions in the area of genital alterations can come to have unintended consequences (on a macro level), such as the risk of increased gender-based violence (GBV), stigmatization of women and discrimination of certain ethnic groups. Male circumcision could also affect attitudes negatively concerning female mutilation, and hence making it harder to work with attitude, knowledge and behavioural changes (AKB).

Kitaw et al. (2010:99ff) claims that urban women are not less likely to undergo FGM in Ethiopia, neither less likely if they are Christians.

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9 In terms of a legal framework in place and implemented, and implementation challenges with law enforcement.
Further they claim that this implies that religious obligation cannot be the only driving force for the continuation of the practice. Further underlying factors they mention are e.g. adherence to local custom or tradition (ibid). This can further include (but is not directly mentioned), the widespread practice of male circumcision.

According to Missialidis and Gebre-Medhin (2000:137) most girls in Ethiopia undergo some form of FGM. They argue that the predominant types are clitoridectomy and excision, but they also discuss that infibulation is practiced by some ethnic groups in the southeast. There is an international crusade to combat the harmful practice, but they claim that systematic data on incidence is lacking. To reduce and control female sexuality was mentioned as the main reason why FGM has been conducted in Ethiopia. Female virginity is judged as a prerequisite for marriage, and it is generally thought that virginity and sexual chastity are impossible to maintain without FGM. Missialidis and Gebre-Medhin (ibid) also stated in their paper that if men openly stated a preference to marry women who were uncircumcised, FGM would probably cease. The practice of FGM is upheld by a complex set of factors. They claim (ibid) however that evidence of change in knowledge, attitude, and practice is visible. In Ethiopia, it is argued that there has been a decline in the practice of infibulation, and this is a sign of communal recognition of the harmful effects on the health of women. Although these changes do not go far enough, and advocacy for Sunnah or other so-called lesser types of FGM has been condemned, it shows that FGM is amenable to external influence (ibid).

Misganaw (2009:47f) claim that the reasons for the persistence of the practice are the belief in socio-cultural reasons, religious requirements and economic concerns. Social pressure from the community and loss of social acceptance for uncircumcised girls and family, and difficulties in getting married was mentioned. Economic reasons was mentioned in terms of that the practice can form part of circumcisers livelihood, but other health related reasons was also mentioned in relation towards this such as protection against rape and that FGM is required as a way to stay ‘sexually healthy’. FGM conducted due to aesthetic value was also mentioned (ibid). Misganaw (ibid) also claims that in Ethiopia, there is legal enforcement mechanism challenges, and that compared to before FGM has now become a closed door practice. Nevertheless, Misganaw argues that there has been some progress, e.g. in terms of ‘less severe’ types of the practice.

Renshaw (2006:284) argues that there is no medical necessity for the foreskin of a baby or teenage boys to be removed in 99.9% of cases. Renshaw further argues that for infants or puberty girls there is absolutely no medical necessity for the clitoris or vagina to be cut or stitched closed. As Renshaw (2006:283) argues, male circumcision after delivery can have devastating effects, and there seem to be a tendency towards a practice of male circumcision because of a certain culture, a culture where father’s wants their sons to look like them. Aldeeb (1995:311) argues that there is no need to distinguish between male and female forms of circumcision, as he sees both as mutilation of healthy sexual organs.

Aldeeb (ibid) also claim that the debate on male circumcision is taboo in Western and Arab countries for different reasons, such as that circumcision constitutes a lucrative industry and also that there is a fear of being considered anti-semitic.
Dekkers et al. (2005:180) also regard both male and female mutilation as invasive interventions in the external genital organs for which (in most cases), there is no medical indication. According to Dekkers et al. (ibid) a minimal female ‘circumcision’ in the form of a small ‘nick’ incision may be less mutilating than a standard male circumcision.

Bikoo (2007:43) claims that social conflicts in several African countries resulted in an increasing number of African migrants to the West. It is argued that with the influx of migrants, from communities that practice FGM, healthcare professionals increasingly have to deal with this group of people without appropriate knowledge to meet their particular needs (ibid). The same problems seem to be true for the legislative. With the influx of many Somalis to Sweden in the beginning of the 1990s, there was a revival of attention paid to FGM (Johnsdotter, 2009:11ff). Johnsdotter claims that most African immigrants in Sweden originates from Somalia, Eritrea or Ethiopia. It is claimed that more than 18,000 immigrants in Sweden originates from Ethiopia, or Eritrea (and Eritrea used to be under Ethiopian territory).

Sweden was the first western country to pass a specific law in 1982 against female genital mutilation (Essén and Johnsdotter, 2004:611). Already in the preamble to the Act on the prohibition on FGM in Sweden a discussion arose on the law and comments were expressed that it was not entirely clear on what could be classified as FGM and the age neutrality of it. The Swedish legislature chose to ignore the objections and banned all forms of female circumcision/ or mutilation, either the woman had consented to the surgery or not (ibid).

Essén and Johnsdotter (ibid) argues that there is a general acceptance of cosmetic labio operations for non-medical reasons, but at the same time the society rejects the possibility of re- infibulation after delivery, and claims that this is a sign of institutionalized racism. As argued by Essén and Johnsdotter (2004:613), as long as the legislation in Sweden does not make distinction between adults, minor or motives, the official stand violates legal principles of all citizens equality before the law. According to Essén and Johnsdotter (2004: 2002), traditions rooted in culture, such as FGM, are often also confused with religious requirements.

Berhane et al (2001:1536) argues that the resistant traditional practice of FGM requires a more transitional approach until it is possible to abolish it altogether. They claim that in the future discourse on the bad practice of genital mutilation the success of abolishing the former tradition of nail extraction in Ethiopia could be used as an entry point when advocating change with regard to other harmful traditional practices, such as FGM. Another example of a quick abandonment of an harmful traditional practice is the old Asian practice of foot-binding (Essén and Johnsdotter, 2004:612). According to Berhane et al. (2001:1538), communities needs to be encouraged to learn more about its problems and to take informed action to alleviate deep-rooted female health problems through joint achievements by governments and NGOs, locally available resources, and by introducing appropriate technology to boost the economic and social independence of women.

10 The majority immigrated during the 1970s or 80s as political refugees, following a slow but steady inflow from the 1950s to mid-1980s. In the late 1980s, about 1,000 arrived each year. Since then there has been an influx of about 200 persons a year from each country (ibid).
This puts forward an assumption that cultures will evolve ‘naturally’ in a positive way if they are not plagued with poverty and inequality. Missialidis and Gebre-Medhin (ibid) claims however that society acts as a mechanism supporting the roles of men and women in a vicious circle, where Ethiopians at large, both women and men, are caught in a vicious circle of erroneous expectations and a mute consensus that maintains FGM. (See also chapter 5 for which also form part of previous research).

1.4 Method

Before launching the main study pilot activities were carried out in Sweden. The main objective of the pilot phase was to gain an overall insight about the phenomenon (genital alterations) in the study area and to develop the research instruments for the qualitative components of the study. During the pilot phase interviews were conducted with key-informants, such as people with Ethiopian origin and NGOs. The pilot phase of the project helped to focus on the local problems of the women and attitudes on FGM in general.

Following the pilot, data were collected using both qualitative and quantitative methods, however primarily through the use of ethnographic methods. The choice of a more ethnographic approach was essential since we are dealing with human culture. The research is first and foremost based on a case study design with comparative elements (of the phenomenon), as well as it includes element of a field study (fieldwork conducted in Ethiopia during three weeks in April). The thesis is of hermeneutic character, which means interpretation and understanding is in focus. The quantitative component is based upon official statistics.

This interdisciplinary case study (political science/ law/ social anthropology) is based upon that it is unique in the sense that the subject matter is previously not well documented, which Yin (2007: 61) describes as a typical feature in a ‘case study’. According to Yin (2007:54f, 145ff) a case study is often associated with qualitative methods, focusing on understanding and interpretation, delivering intensive and holistic descriptions of a phenomenon or entity. Yin (ibid) also argues that characteristic features in terms of empirism in a case study is deep-oriented data collection, the use of multiple sources which often is a combination of written sources and interviews, but sometimes with observations (triangulation). A case study is also characterized by being inductive and descriptive (ibid).

As Esaiasson (2009:121f) argues there are many variations of a ‘case study’. The choice of a case study design was based on the fact that there was a strong wish to explain the somewhat unique ‘phenomenon’ of genital alteration and its implications from a political and ethical perspective with a broad description. Ethiopia distinguishes herself as a traditional country as compared to Sweden, which is more secular. This is worth mentioning since we are dealing with a ‘phenomenon’, how it differs and challenges around it, from a political and ethical perspective.
Ethiopia is also worth to distinguish from other countries where the harmful practice is performed due to the fact that the second largest immigrant group in Sweden consist of people with Ethiopian origin, and hence since culture and policy in this area is explored with regards to the phenomenon of genital alteration in a wider perspective this seemed essential. Another underlying reason why Ethiopia is worth to distinguish is due to the fact that FGM is perceived as linked to religion, and Islam. In Ethiopia however the majority is Christian. As Esaiasson (ibid) argues, all conclusions require comparisons. It is important to emphasize that this is not a comparative study of Sweden and Ethiopia, in a classical sense, but comparative when it comes to the phenomenon.

A range of analytical methods or ‘tools’ can be employed in the analysis, this analytical tool is more a guidance map, it however enabled for the analysis of the problem and view the phenomenon from a macro-micro level, and from a subjective-objective perspective. It made it easier to relate to the theoretical framework. The aim of the analytical tool was simply to sharpen the focus of the analysis and to ensure a balanced approach, in a complex study area.

**Figure 1. Analytical Map for Guidance**

![Analytical Map for Guidance](image)

**Macroscopic level**

1. Macro-objective. Examples includes the society at large, law, bureaucracy. Nature of the issue; courses of action to deal with the issue; policy, problems and challenges for change? Theoretical explanations? (RQ 1,2,3 4)

2. Macro-subjective. Include: society, culture, norms. Nature of the issue to be dealt with; courses of action to deal with the issue; policy. problems and challenges for change? Theoretical explanations? (RQ 4)

**Microscopic level**

3. Micro-objective. Includes patterns of individual actors, interaction and bureaucratic structure. Nature of the issue; courses of action to deal with the issue; policy: Implementation problems and challenges for change? Theoretical explanations? (RQ 1, 2, 3, 4)

4. Micro-subjective. Include individuals, various facets of societal construction of reality, norms and values. Nature of the issue to be dealt with; action to deal with the issue; policy. Implementation problems and challenges for change? Theoretical explanations? (RQ 1,2 3, 4)

**Objective**

**Subjective perspective**

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**Note:** RQ = Research Question. RQ 1 can thus be analyzed both on a macro-micro level in terms of laws and patterns of behavior, as well as RQ 4 for example fit into the analysis of culture and norms in a wider perspective, thus ‘macro-subjective’. This should not be viewed as a strict way of analyzing, but mere a guidance tool for the author. This analytical tool is created by the author and consists of inputs from a sociological paradigm, tools for casual analyses and phases of a policy process. Major implementation challenges are clarity of policy goals; information intelligence; strategic planning. Macro-Micro: world systems, societies, groups, interaction and individual thought of action. Subjective-Objective: social construction of reality, norms and culture, varying elements include the state, family, work, world and religion, actors, action, interaction, bureaucratic structures and law (Ritzer 1992:387f). Arrows in middle means there are levels in between the levels and perspectives, as mentioned above.

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11 Largest ethnic immigrant group in Sweden is Somalis, but to travel there wasn’t an option at this moment.
1. 5 Material and Selection of Sources

The data collection is based upon a deep screening of previous research in terms of literature review (secondary sources) as well as fieldwork conducted in Ethiopia during three weeks in April 2012, in terms of participating and open observations and interviews (which are the primary sources). The literature review is based upon papers produced by leading academics on the subject matter such as Essén and Johnsdotter (Lund), Missailidis and Berhane (Ethiopia), as well as previous research reports produced by e.g. NORAD\textsuperscript{12} in cooperation with leading organisation in the study area, such as EGLDAM\textsuperscript{13}, to mention a few The literature review also includes reports by UN-organizations such as UNFPA and other governmental institutions as well as NGOs, as well as various other academic reports etc.

When interviewees were chosen considerations was taken to demographics (age, ethnicity, religion etc.), in order to gain a reliable and broad view of the issues studied. See appendix. The main criteria for the selection of interviewees was based upon their knowledge, expertise or background (demographics), but also availability and resources. Enumerators from various organizations, such as KMG,\textsuperscript{14} or people living in the villages in Ethiopia also helped to make the initial contacts. Sometimes initial interviews guided the choice of other interviewees (the snowball technique), in order to reach a range of different experiences and attitudes. Public officials, health practitioners, leaders, organizations and ‘ordinary’ women and men all served as informants.

Qualitative in-depth interviews (IDI) were done to obtain more insight into the problems of the women as they described them. Key informant interviews (II) were also conducted, and provided detailed information and opinions based on his or her knowledge of a particular issue. Focus group discussions (FGD) were used to explore the depth and nuances of opinions regarding the harmful practice female genital mutilation. Most of the IDIs, but also some of the FGD and II were conducted with the help of local enumerators who sometimes assisted with translation when needed. All interviews were conducted in an isolated place either in the household compound or in the surroundings to minimize interference and in order to maintain privacy.

Almost each IDI and FGDs took 1h to conduct. II did however often not require so much time since those questions often wasn’t as complex. Interviews were conducted using a interview guide.\textsuperscript{15} Participation in the study was voluntary and informed consent was obtained from all study participants. Concepts and categories were identified from the interviews. This part of the study enabled for more in-depth knowledge of the dimensions of the views and experiences of the interviewees themselves, rather than just rely on secondary sources. Quotes from the interviews are integrated in the thesis to elucidate the issues as brought forth in their own words.

\textsuperscript{12} Norwegian Agency for Development Cooperation.
\textsuperscript{13} The former National Committee on Traditional Practices in Ethiopia, Egldam (Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber). Egldam is a national umbrella organization. IAC is the global umbrella org. working on eradication of harmful traditional practices.
\textsuperscript{14} Also known as- Kembatti Mentti Gezzimma -Tope or Kembatta Women’s Self-Help Center. NGO in Ethiopia.
\textsuperscript{15} Based on Amrefs interview guide for their study in Afar. See Appendix.
1. 6 Limitations, Reliability and Validity

Since the sample is not as huge as when conducting research over a longer period of time or a study of more quantitative character (this study however is as mentioned inclusive of quantitative components as well) the results can be hard to generalize, however this is not always necessary in order to reach an understanding of the problem. A case study such as this enables strength of conceptual validity and identification of hypotheses. It also enables the analysis of complex causal relationships.

Ethiopia consists of nine (ethnic) regions and of 82 different ethnic (linguistic) groups\textsuperscript{16}, as well as various types of religious affiliations, which makes it harder to reach a deep understanding of the problem. Though it is very difficult to claim wide generalizability of results in a country where cultural and traditional practices vary, it might not be wrong to assume that the women’s and men’s situation in most areas of the country is not very different, especially not considering the general socio-economic development of Ethiopia as a whole. The similarity in perceived problems and attitudes from various groups of people, and co-linked with information from other sources indicate the validity of the interviewees responses to the questions.

The use of a qualitative more open approach and the use of a local (male) translator to obtain data may have obscured some negative impacts, as people in general might be shy or a tendency to give more favourable responses, a kind of social desirability bias or due to a taboo on sexual issues. This is a well-recognized problem when having to conduct interviews in a developing setting while keeping the procedures simple. The sample might have been small but any deficiency has however been compensated by integrating the statistics with the qualitative study. Interviewees concurred on many of the issues raised in this study, despite differences in their background. This indicates that issues, relevant to this study, are not always limited to particular settings.

Possible limitations might include interpretation of concepts such as good sexual health e.g. since perceptions and norms might differ in developing countries compared to Western countries. Other possible limitations might include the language barrier, and even with a good translator some narratives or important inputs risks being lost. The role of a researcher as a woman might have had a bad effect on men when discussing sexual and gender issues, especially since these are taboo in more traditional societies, such as Ethiopia. Another possible delimitation might be issues concerning the age of women when mutilation has taken place, in terms of problems related to what is perceived as a ‘normal’ vagina. However, since this was not the main purpose of this paper it is not a real limitation either but can be worth mentioning.

\textsuperscript{16} As mentioned Ethiopia consist of 82 different ethnic (linguistic) groups. Many in a urban setting understand English though.
1. 7 Disposition

It starts of with a preface, abbreviations and acronyms as well as an abstract, for clarification. It thereafter includes other usual features such an introductory; chapter 1 explains the purpose and research problem, as well as previous research, which enables to know what this study might contribute with. Chapter 1 also include method, material and a discussion on limits, validity and reliability. Chapter 2 explains the theoretical framework, which is needed in order to understand the problem. In order to understand the ‘phenomenon’ of FGM and other forms of genital alterations, classifications and definitions will be explained in chapter 3. Chapter 4-7 forms the basis for the empirical part. Both chapter 4-6 forms the basis for literature review, however chapter 4 is more of a background chapter on FGM and explains the origins of the practice and extent, legal treaties etc. Chapter 5 consist of a literature review on Ethiopia. Chapter 6 forms the basis for the primary sources in terms of the fieldwork conducted. Chapter 7 consist of concluding analysis and remarks. This thesis includes empiricism, but it also includes more normative philosophical parts in the end. Thereafter follows usual features such as bibliography and annexes.
2. Theoretical Framework

The theoretical connection here is a way to ‘anchor’ the paper in a scientific discussion, i.e. use and build on previous work of earlier scholars. According to Lindgren (2009:23) a theory can be an explanation or a way to view aspects of our surroundings – to categorize and reach understanding. It is against this background the theoretical framework should be understood, and hence various theories will be used in order to reach an understanding of the research problem. The theories are somewhat interwoven since they sometimes deal with the same issues. The theoretical connection is based upon that it is a study with case study design and of hermeneutic character, hence inductive reasoning. The reader should have the theoretical framework in mind when going through the text, especially chapter 4-7.

2.1 Culture

Interpretations and perspectives within ‘culture theory’ is what motivate the use of the connection to the theoretical framework and concepts on culture, rather than a culture theory. Culture is essential to include here as we are dealing with the analyses of humans. Human beings alone posses the on-going and developing mode of behavior that anthropologists call ‘culture’. For the purpose of this thesis it is essential to describe following definitions of culture, especially since harmful practices can be understood as cultural activities.

Culture is ‘the whole complex of distinctive spiritual, material, intellectual and emotional features that characterize a society or social group. It includes not only arts and letters, but also modes of life, the fundamental rights of the human being, value systems, traditions and believes’ (UNESCO). While defining the concept of culture various people use other terms such as belief, customs and tradition interchangeably. All these concepts have their own characteristics, however it is difficult to delineate a boundary between them.

Culture is the most important concept in the study of human kind, hence it is a very important concept in our understanding of harmful practices and if they are to be eradicated. Culture is a powerful human tool for survival, but it is a fragile phenomenon. It is constantly changing and easily lost because it exists more or less in our minds. Our written languages, and man-made things are merely the products of culture, and it is an integral part of every society. It is a learned pattern of behaviour and ways in which a person lives his or her life. Culture is essential for the existence of every society because it binds people together (Arvidsson, 2001:14ff). According to Lindgren (ibid:28) culture constitutes general mental state or behaviour, meaningful expressions and lived culture.

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17 By inductive reasoning the analysis is determined by empirical observations in which we detect patterns and regularities, formulate some tentative hypotheses to explore, and finally end up developing some general conclusions or theories (Esaiasson, ibid:124ff). Inductive reasoning, by its very nature, is more open-ended and exploratory, especially at the beginning. Some characteristic features of a case study in terms of relationship to the theoretical framework are that they often are regarded as suitable for the development of new concepts and theories, and are also suitable to identify causal mechanisms and describe causal complexity, as this study emphasizes on (ibid).
Culture is also a technical term emerged in the writing of anthropologists in the mid-19th Century. The concept of culture was first explicitly defined in 1871 by the British anthropologist Edward B. Taylor, as ‘that complex whole which includes knowledge, belief, art, moral, law, custom and any other capabilities and habits acquired by man as a member of society’ (Kitaw et al. 2008:41f). Culture is necessary in order to establish discipline in the society, it is however not only a means of communication between people, but also creates a feeling of belonging and togetherness among people in the society (Arvidsson, ibid).

There are other meanings and approaches to examine culture adopted by different anthropologists, however, all seem to agree that culture consists of the ‘learned’ ways of behaving and adapting, as contrasted to inherited. Culture is thus adaptive and flexible and adjusts to changes that occur in a given society. The gradual incorporations of change help us to ensure that the various aspects of culture evolve coherently and consistently. This gradual change or adaption takes place due to the various economic, environmental, political and other internal or external factors. It took thousands of years to reach the current stage in human culture. 18 Culture is learned and adaptive, thus also possible to change. Culture is something that a person learns from his family and surroundings, and is not ingrained in him from birth. It does not have any biological connection, directly, because even if a person is brought up in a culture different from that in which he was born, he imbibes the culture of the society where he grows up.

Changes in societies can be viewed as disrupting or destructing a part of a social, otherwise, functioning society. When it comes to viewing a specific culture as primitive or e.g. civilized there is always the case of outsider versus the insider’s point of view (Stier, 2009:36). When seen from a human rights perspective infibulation e.g. often is perceived as harmful, whereby ‘harmful’ implies negative health impacts. This is however a view which is subjective, reflecting a position of an outsider making a cross-cultural judgment. From the insiders point of view there is no ‘harmful’ culture. The society might tolerate specific ‘harm’ from that culture (or practice) because that specific culture has other meaningful contributions, which outweighs the harm (Kitaw et al. ibid:44f). We therefore carefully need to re-examine and rethinking the concept of culture before we are too quick to jump to any conclusions and make judgments.

Before reaching a ‘tipping point’19 where the positive aspects outweigh the negative, some imperatives are needed for people to abandon certain practices such as FGM. Attempts are sometimes made to change different cultures when they are perceived to be ‘harmful’, ‘savage’, ‘backward’ or ‘barbaric’. There are, of course, some parts of a culture that could be classified as harmful, depending on in which cultural perspective they are viewed.

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18 What’s noteworthy to mention is that the starting point of culture parallels the emergence of ancient hominid types, and ‘Lucy’ was also discovered in Ethiopia (human ancestor dating back > 3 million years. (Personal field notes, 2012-04-10). In the modern state, duties are increasingly deflected away from local or kin-based connections and towards the central state mechanism. Even nuclear family ties shrink as individuals become citizens of the state.

19 The Tipping Point is ‘the biography of an idea /.../ that the best way to understand the emergence of fashion trends /.../ mysterious changes that mark everyday life is to think of them as epidemics. Ideas and products and messages and behavoirs spread just like viruses do’ (Gladwell, 2000:7).
It becomes necessary to emphasize on the importance of viewing culture in terms of making rational motivated choices, both ‘primitive’ and so-called civilized forms of culture, which both thus can be understood as differences in learned patterns of social behavior etc. The viewpoint of cultural relativism is based on the deed for tolerance of ‘conventions’ (primitive, uncivilized behavior etc.), even though they may differ from one’s own. It emphasizes on that human’s must be understood within the framework for their culture (Stier, 2009:32).

2. 2 Human Motivation

The psychologist Abraham Maslow introduced the concept ‘a hierarchy of needs’, which often is presented as a pyramid, or as a stair, where the lowest levels represent basic needs and more complex needs are located at the top. These various levels of needs, for which can explain human motivation, is important to have in mind when we are discussing harmful practices, especially in a developing context where people might not even have food on their tables.

The hierarchy of needs suggests that people are motivated to fulfill basic needs before moving on to other, more advanced needs. Once the lower-level of needs, such as food and shelter, have been met, people can move on to the next level of needs, which are e.g. safety and security. As people progress up, needs become increasingly psychological and social. Soon, the need for friendship, love and intimacy become important. Further up the various levels, the need for personal esteem and feelings of accomplishment take priority. Maslow believed that these needs are similar to instincts and play a major role in motivating behaviour. Physiological, social, esteem and security needs are deficiency needs, meaning that these needs arise due to deprivation. Satisfying these lower-level needs is important in order to avoid unpleasant feelings or consequences. Maslow termed the highest-level as growth needs (Jerlang, 2008:27f). Growth needs do not stem from a lack of something, but rather also from a desire to grow as a person. See below figure for an understanding of the various levels.

![Figure 2. Maslow’s hierarchy of needs](image)

**Source:** Created with the help of Maslow’s hierarchy (pyramid) of needs, from (Jerlang, 2008:275f).

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20 First developed in his 1943 paper ‘A Theory of Human Motivation’ and his subsequent book called ‘Motivation and Personality’.
In the case of Ethiopia, which is a developing country, first priority might be to fight poverty, and hence not to fight harmful traditional practices. Depending on the viewer, harmful practices such as genital mutilation could be explained by all levels. The harmful practice could be conducted in terms of survival; as a way to be cared for when married away because families cannot take care of daughters, as well as the fact that circumcisers might need the income for their survival. And if girls are not circumcised they risk being discriminated in their communities, which makes them lack out on maybe both shelter, safety, family and friends. It might also occur due to reasons of self-actualization, in terms of aesthetical appeal.

2. 3 Rational Choices

According to Hay (2002:8) rational choice theory is the aggregation of individually rational behaviour which frequently produces collectively irrational outcomes. It is also explained as the narrow pursuit of self-interest, which also unfortunately ensures that public officials cannot be trusted to deliver collective welfare. Hay (ibid) argues that rational choice is the outcome if one seek to model political behaviour on the simplifying assumption that political actors are instrumental self-serving utility-maximisers.

This should be understood here as those cultural activities, such as harmful practices, might have meaningful contributions to maintaining a specific social structure and maybe even enhancing social integration, all which might outweigh the harm in it, especially when viewed from the outside. Before reaching a ‘tipping point’ where the positive aspects outweigh the negative, some socio-economics imperatives might be needed, if people seen as ‘selfish utility-maximisers’, are to abandon certain harmful traditional practices.

Rational choice theory as understand in relation to the practice of FGM can be seen as performed on the basis of socio-economic reasons, especially as a kind of social safety net, especially in more patriarchal societies. However, this ‘social safety net’ is different in the West, as compared to a developing setting, and that is why immigrants and others, not necessarily need to practice mutilation in order to ensure daughters futures. 21 This leads us on to the radical feminist explanations, which of course is intricately interwoven with theories on patriarchy and culture.

2. 4 Feminist Explanations

Radical feminism may provide a powerful framework for understanding sexual violence against women. Moreover, it is an important conceptual tool for understanding harmful practices in times of internal unrest or global change. Radical feminists focus mainly on the oppression in the private sphere, which manifests itself foremost in the form of domestic violence, male control over women in the family and male control over women's sexuality (Gemzöe, 2008:45ff).

21 FGM is surely not an act of cruelty but rather an act of love and surely in that specific moment it seemed rational for the people concerned.
According to Gemzöe (ibid) radical feminist theory can help us understand the inequality in the private sphere, but it also implies that the private sphere is no less political than the public sphere. It directs attention on the cultural degradation and devaluation of women. Radical feminist theory points out that the view on women that they are less worth than men is a corner stone in the patriarchy, which is imprinted right from the moment of birth. The organization between the sexes has a systematic character and manifests itself in all aspects of societies. This hierarchic system is found in politics, economics and in the family sphere (Gemzöe, 2008:77ff).

The politics of genital mutilation is designed to affirm the powers of males over female sexuality and reproduction The Afar people in Ethiopia have e.g. a legend explaining how infibulation (type III of FGM) started. According to this legend infibulation began in Egypt during the Pharaohnic period when Pharaohs required virgins, so mothers started to infibulate their daughters as a way to protect them. Another legend is that infibulation started in the 16th century as a means of protection against rape by the conquering Turks (Kitaw et al. 2008:44).

Patriarchy is often described as a social system in which male’s act as the primary authority figure. Hay (2002:72f) even discusses the patriarchal state, as it is intimately interwoven with the subordination of women. Hay discusses how feminists ‘invites’ the state to engage in the formal political regulation of the body, family, sexuality and personal relationships. He also argues that patriarchy is a set of social processes, which may vary from context to context (ibid, 250). Feminist explanations of women’s sexuality and reproductive control are found with Engels (1993) as well.

According Engels, men’s patriarchal attempt to control women’s sexuality and reproduction followed the advent of private property. In his controversial analysis, Engels (1993) argues that gendered relations were balanced in primitive hunting societies. Engels argues that men were considerably advantaged in new agrarian settings. They accumulated wealth, and they wanted to ensure that their wealth passed to their legitimate offspring. Due to the long lapse between the sexual act and birth, and in the absence of biological knowledge or technological skills, the only way to assure paternity was to control the sexual behavior of women. The man took command and the woman was degraded and reduced to servitude. A woman thus became the slave of her man’s lust and a mere instrument for the production of children (ibid:120-121).

In short, women are seen as mere vessels in this intergenerational transmission of wealth and power, also within a capitalist system. Engels finds the salvation of women in their full labor force participation. Feminism is thus interwoven with patriarchy, and patriarchy runs through the concept of both culture and feminism.  

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22 The social radical feminist theory tries to combine the two; the public and private sphere. Liberal feminist theory also directs attention to the cultural degradation of women (Gemzöe, 2008:77ff).

23 Worth mentioning when discussing feminist explanations in terms of the harmful practice is Germain Greer. She is one of the world’s most renowned (back-lash) feminists. Greer is most interested in attacking double standards. Her stand- point is, more or less, that if Jews and Moslems are allowed to circumcise boys, why shouldn’t Ethiopians e.g. be allowed to do it to girls.

24 According to Engels (ibid:131), the process of industrialization and the ensuing accumulation of capital hasn’t been kind to women. In his view, the practice of monogamy and the equality it connotes is nothing
3. Classification and Definitions

FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (WHO, 2012). Law’s and definitions clash with both intimate surgery and male circumcision. The procedure of operations in the genitals nowadays can be interpreted as a global phenomenon, where it is not only Muslim cultures that undertake it but Christian dominated as well. The procedure has no health benefits for what so ever for girls and women. FGM is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women and children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman treatment, and the right to life when the procedure results in death.

3. 1 What is Female Genital Mutilation?

According to WHO (Feb, 2012), female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons (ibid).

WHO classifies FGM into four major types (for which could be divided up even more):

**Type 1**: Clitoridectomy: partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

**Type 2**: Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

**Type 3**: Infibulation: narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris.

**Type 4**: Other: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

The female clitoris is anatomically analogous to the male penis and plays a central role in women's sexuality. The equivalent of mutilation performed on a male would be to amputate it in various degrees of the penis.

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but a sham, because monogamy reveals the antagonism between the man and the woman expressed in the man's exclusive supremacy. Capitalistic marriages among the wealthy are merely a contract to preserve capital and to ensure its smooth and undiluted transmission across generations. It is argued that the bourgeois made sure that their capital remained intact through monitoring work relations and inheritance (ibid:135). Engel (ibid:134) argues that for women, marriage is like prostitution.
In its comparable extreme form the penis would be stitched together so as to make sexual intercourse and other bodily functions difficult (Kitaw et al. 2008:87).

3. 2 What is Male circumcision?

Aldeeb (2004:3) categorizes four forms of male circumcision:

**Type 1:** This type consists of cutting away in part or in totality the foreskin (prepuce) of the penis that extends beyond the glans.

**Type 2:** The circumciser takes firm grip of the foreskin with his left hand. Having determined the amount to be removed, he clamps a shield on it to protect the glans from injury.

The knife is then taken in the right hand and the foreskin is amputated with one sweep along the shield. This part of the operation is called the ‘milah’. It reveals the mucous membrane (inner lining of the foreskin), the edge of which is then grasped firmly between the thumbnail and index finger of each hand and is torn down the center as far as the corona. This second part is called ‘periah’. It is traditionally performed by the circumciser with his sharpened fingernails. This type is practiced mainly by the Jews.

**Type 3:** This type involves a complete peeling of the skin of the penis and sometimes the skin of the scrotum and pubis. It existed (and probably continues to exist) among some tribes of South Arabia. A similar practice has been described in black Africa, in the Namshi tribe.

**Type 4:** This type consists in a slitting open of the urinary tube from the scrotum to the glans, creating in this way an opening that looks like the female vagina, called sub-incision. This type of circumcision is still performed by the Australian aborigines.

3. 3 Harmful Traditional Practices – Harmful Modern Practices

Genital mutilation, medical male circumcision and designer vagina’s and Roll’s Royce vaginas … there are plenty of names for genital mutilation and alterations. What is clear though, from previous readings, is that some forms of male circumcision are as horrendous as traditional forms of female genital mutilation, as well as intimate surgery where the whole inner labia’s are removed might be more severe than a traditional ‘nick’ in the clitoris prepuce. In general a majority of men that has undergone circumcision seem to be complication free, which is obvious since equivalent parts to the female body is not cut away. A more appropriate analogy would be between clitoridectomy and penisdectomy. As mentioned above, according to WHO, FGM comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. In this respect, FGM could be viewed as a Western cultural practice as well, due to the practice of other non-medical forms of intimate surgery and genital piercing.
According to Johnsdotter, (in ‘the Beauty Bubble’\textsuperscript{25}, SVT, 2012) some forms of female genital alterations can be viewed in the same way as Western forms of intimate surgery. Often though, both male circumcision, claimed to be done due to bio-medical reasons, and so-called ‘intimate surgery’ is considered ‘normal’ even though if it is done for ‘beautification’, and often without health benefits. According to Johnsdotter (ibid) the area of genital alteration is wide and various practices might clash and be incoherent with existing laws, in Sweden (and elsewhere in Western countries).

If we are to broaden our view, and see the issue from a global perspective it is essential to explain the regulation and legal framework in place in Sweden (this wider perspective is essential since we have about 18, 000 Ethiopians living in Sweden). Sweden passed a specific law in 1982 against female genital mutilation.\textsuperscript{26} The Swedish law includes a prohibition of all operations on the external female genital organs, designed to mutilate them or produce other permanent changes in them. Such operations must not take place, regardless of consent (SR, 1981/82:172). The Swedish National Council on Medical Ethics\textsuperscript{27} has decided that intimate surgery do not conflict on the law against FGM, and they consider the practice as equal to plastic operations of the ears and breast. (Dnr 12/01, 2001-12-17). While Swedish law illegalizes FGM, it allows for male circumcision, in all age categories (SFS nr: 2001:499). The law’s in this area is also age neutral. The Swedish National Board of Health and Welfare has now engaged in reviewing existing laws and policy in this area (‘the Beauty Bubble’, SVT, 2012).

According to Essén and Johnsdotter (2004:613) clinicians are also facing women from the majority populations who may have low self-esteem due to trend-based ideas about what is ‘normal’ and beautiful in the genital area. They further argue that the relation of legislation to different changes of the female genitals needs to be sorted out, for a general application of the law inclusive of all people, regardless of ethnicity. What constitutes female genital mutilation can be quite contradictory, and how to combat the practise can also easily be quite an arduous and risky task, especially when the struggle is further complicated with new forms of genital alterations and policy. Important questions to be addressed here is to ask what happens when different aims clash, such as between MMC and FGM. An obvious challenge is how attitudes can come to be affected by the practice of these so called new and innovative forms of circumcision in the genital area, especially where there is an on-going struggle against FGM. Unintended consequences of policy interventions from e.g. MMC could be that the struggle against FGM is harder to overcome.\textsuperscript{28}

\textsuperscript{25} Authors translation. Original Swedish name is ‘Skönhetsbubblan’
\textsuperscript{26} Actually, Sweden was the first Western country to pass a specific law against FGM (Essén and Johnsdotter, 2004:611).
\textsuperscript{27} Original termed ‘Statens medicinsk-etiska råd’.
\textsuperscript{28} Regarding MMC and HIV: Women might risk being equally infected by HIV-positive men regardless of whether they are circumcised or not. The real risk for women is that the medical ‘knowledge’ of the protective effects of male circumcision may lead to neglect of other prevention measures (personal notes from South Africa during 2011/2012). There seem to be a general acceptance of cosmetic labio operations for non-medical reasons, but society seem to reject the possibility of ‘re- infibulation’ after delivery.
The procedure of genital alterations can nowadays be interpreted as a global phenomenon, where traditions rooted in culture often are confused with religious and medical requirements. There also seem to be a tendency towards a practice of male circumcision because of a certain culture, a culture where father’s wants their sons to look like them. It is obviously also a very lucrative industry, both for private practitioners as for traditional circumcisers. However, FGM often have more devastating outcomes, but both practices should however be viewed as violations of ones bodily integrity and personal autonomy. What interventions are allowed in the women's genitalia and on what grounds? 29

Plastic genital surgery is in Western countries regarded as normal, which clearly support ethnic discrimination. The law in this area is age neutral, which clearly makes things even more complicated. This is further complicated with issues of re-infibulation after childbirth, especially of women living in exile. Western legislation banning FGM, legislation created to protect migrant women and girls at risk of being subjected to the procedure, may unjustifiably penalize men and discriminate certain ethnic groups.

When it comes to genital alterations esthetical (sexual) and medical reasons seem to be accepted in general, but not cultural traditional or religious forms. What constitutes female genital mutilation can be quite contradictory, and how to combat the practise can also easily be forgotten or overshadowed. There are many explanations as on how to understand the customs of genital alterations. Should plastic genital surgery or piercing of genitals be legal while more traditional forms of circumcision be illegal, even though some traditional forms of female circumcision is milder than some forms of male circumcision and intimate surgery? While one group of people might view genital alterations as ‘sexual mutilation’, the other might view it as ‘sexual enhancement’. It could be quite controversial for immigrants living in exile in Sweden to embrace Swedish laws and policy in this area, especially when flawed.

At the same time as male circumcision is regarded as ‘normal’ African (adult) women are often viewed as oppressed victims in need of legislative support to protect themselves from harmful interference on their bodies, at the same time western women are regarded, even those who choose to undergo genital surgery of their inner labia’s for aesthetic appeal or piercing of the genitals, as rational and capable decision makers. Even Westerners is largely affected by culturally specific ideals of what is beautiful, in terms of piercing and cosmetic surgery, hence this should also be viewed as cultural traditions. It clearly clashes with WHO’s definitions for what constitutes female genital mutilation.

29 What role should the woman's age, motives and ethnicity play? How should a plastic surgeon react to react to a 18-year-old woman who wishes to undergo genital alterations if she has one Swedish and one African parent? Should the surgeon refuse an Ethiopian woman but not a Swedish woman? It should be easy to understand the controversy here when it comes to Sweden, not only due to the ethical aspects but legal as well. A balance between the Swedish law and the Swedish National Council on Medical Ethics on intimate surgery would clearly make it easier for surgeons, because the legislation in this area is not uniform. The legal text is not theoretically consistent on advice on so-called intimate surgery.
4. Background

In order for the reader to fully grasp and understand the research problem of this thesis it is now essential to introduce a background chapter on the origins, causes and consequences, as well as the extent of the practice and violations thereafter.

4.1 Origins of FGM and Common Justifications

Theories about the origin of the practice vary greatly, but often cultural or religious reasons are mentioned. However, traditions rooted in culture often are confused with religious requirements. Supporters of female genital alterations are quite quick to identify the double standards of moral at work here, pointing out that for example Western parents circumcise their newborns so that the sons will look like the fathers (Renshaw, 2006:283). Genital mutilation has also even been conducted as late as into the 20th century in the West, as a way to prevent ‘bad’ behaviours such as masturbation or prevent mental decease (ibid).

In Africa and the Middle East, FGM is thought to have taken root centuries ago. E.g. the Afar people in Ethiopia have a legend explaining on how infibulation (type III of FGM) started. According to this legend infibulation began in Egypt during the Pharaohnic period as a response to the King’s action. The Pharaohs of Egypt used to have sex with six or seven virgins daily, and mothers started to infibulate their daughters as a way to protect them (Kitaw et al. 2008:44). Evidence from Egyptian mummies suggests that a form of genital mutilation was routinely practised some 5000 years ago, and in ancient Rome, metal rings were passed through the labia of female slaves to prevent them from procreating (Kandela, 1999:1977f, Elchalal et al. 1997:643ff).

The United Kingdom in the 19th century allowed the surgical removal of the clitoris as an accepted technique for the management of epilepsy, sterilization and masturbation (Kandela, ibid). As discussed by Malmström (in Schlyter et al, 2009:105), although human rights are regarded as universally applicable, the values on which they are based can be traced to a specifically European history. In countries where the practice of FGM is performed, states (might) have adopted policies that prohibit the practice even when the laws do not reflect what the majority of the population wants.

According to WHO (February, 2012) the causes of female genital mutilation include a mix of cultural, religious and social factors within families and communities.

- Where FGM is a social convention, the social pressure to conform to what others do and have been doing is a strong motivation to perpetuate the practice;
- FGM is often considered a necessary part of raising a girl properly, and a way to prepare her for adulthood and marriage;

Another legend is that infibulation started in the 16th century as a means of protection against rape by the conquering Turks (Kitaw et al. 2008:44).
• The practice is often motivated by beliefs about what is considered proper sexual behaviour, linking procedures to premarital virginity and marital fidelity;
• The practice is in many communities believed to reduce a woman's libido and therefore believed to help her resist ‘illicit’ sexual acts. (When a vaginal opening is covered or narrowed (type III), the fear of the pain of opening it, and the fear that this will be found out, is expected to further discourage ‘illicit’ sexual intercourse among women with this type of FGM);
• Esthetical/ cleanliness: FGM is associated with cultural ideals of femininity and modesty, which include the notion that girls are ‘clean’ and ‘beautiful’ after removal of body parts that are considered ‘male’ or ‘unclean;
• Though no religious scripts prescribe the practice, practitioners often believe the practice has religious support;
• Religious leaders take varying positions with regard to FGM: some promote it, some consider it irrelevant to religion, and others contribute to its elimination;
• Local structures of power and authority, such as community leaders, religious leaders, circumcisers, and even some medical personnel can contribute to the maintenance;
• In most societies, FGM is considered a cultural tradition, which is often used as an argument for its continuation;
• In some societies, recent adoption of the practice is linked to copying the traditions of neighbouring groups, or when moving into areas where the local population practice FGM. Sometimes it has started as part of a wider religious or traditional revival movement.

According to WHO the practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths (TBA). More than 18% of all FGM is performed by health care providers, and this trend is apparently increasing.

4. 2. Poor health and emotional suffering

FGM has absolutely no health benefits. It harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls and women's bodies.

Short-term consequences can include:

• shock, severe pain;
• haemorrhage (bleeding);
• tetanus or sepsis (bacterial infection);
• urine retention;
• injury to nearby genital tissue or organs (can cause fistula)
Long-term consequences can include:

- injury to neighbouring organs;
- recurrent bladder and urinary tract infections;
- cysts;
- scarring and keloid formation;
- infertility;
- an increased risk of childbirth complications and newborn deaths;
- the need for later surgeries

FGM procedures that seals or narrows a vaginal opening (type III) needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening (deinfibulation) and closing procedures (reinfibulation), further increasing and repeats both immediate and long-term risks (WHO, February 2012, Kitaw et al.2008:114f).

4. 3 Extent of the problem

According to estimates by the WHO female genital mutilation (i.e. the traditional forms) affects some 140 million women and girls worldwide – and another 3 million girls risk being circumcised every year. FGM is mainly practised in 28 African states, and to some extent in some Asian and Middle Eastern countries. Procedures are mostly carried out on young girls sometime between infancy and at the age of 15, and occasionally on adult women. In Africa, about 92 million girls aged 10 years and above are estimated to have undergone the traditional harmful practice. (WHO, February 2012).

The global prevalence of FGM has been estimated from large-scale national surveys, asking women aged 15–49 years if they have themselves been cut. The prevalence varies considerably, both between and within regions and countries, with ethnicity as the most decisive factor. In seven countries the national prevalence is almost universal, (more than 85%); four countries have high prevalence (60–85%); medium prevalence (30–40%) is found in seven countries, and low prevalence, ranging from 0.6% to 28.2%, is found in the remaining nine countries (WHO, 2012). According to WHO (2008), FGM has been documented in some other countries as well, but no national estimates have been made. These countries include India, Indonesia, Iraq, Israel, Malaysia and the United Arab Emirates. There are anecdotal reports on FGM from several other countries as well, including Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka. Countries in which FGM is practiced only by migrant populations is not included (see appendix for global prevalence). FGM thus impact on countries of immigration as well, such as Sweden.

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31 In Amhara and Tigray most girls undergo it at the age of 4 day's and in more Souther parts at the age of 4 years or above (personal field notes, April 2012).
Occurrence and prevalence in Ethiopia is widespread, it affects all but very few ethnic groups, Muslims and Christians alike. According to the findings of the National Baseline Survey (1997) the prevalence of FGM in the country is about 73% \(^{32}\). The Demographic and Health Survey 2005 (DHS) indicates that 74 % of girls and women nationwide have been subjected to the harmful practice. The overall adjusted prevalence, in 2007, is claimed to be 57% (Kitaw et al.2008:97). WHO (2012) confirms the prevalence rate of 74.3% (in 2005).

4. 4 FGM is a violation of women’s, children’s and basic human rights

Major Human Rights treaties which are relevant to FGM, on a universal, regional and national level are as follows:

Rights of Children

- Article 5 of the Universal Declaration of Human Rights (prohibition of torture or inhuman or degrading treatment);
- Article 2 of the Convention on the Rights of the Child (CRC) (gender equality);
- Article 19 (1) of the CRC (prohibition of all forms of mental and physical violence and maltreatment);
- Article 24 (1) of the CRC (right to the highest attainable standard of health);
- Article 37(1) of the CRC (States must take effective and appropriate measures to abolish traditional practices prejudicial to the health of children)

Other treaties which FGM violates are:

- the African Charter on the Rights and Welfare of the Child, in which Article 21 stresses ‘appropriate measures can be taken in order to eradicate practices and customs which are prejudicial to the child’.

Rights of Women

- Article 5 (a) of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) calls for States to take ‘all appropriate measures 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 superiority of either of the sexes or on stereotyped roles for men and women’.
- UNs Declaration on the Elimination of Violence against Women. Article 1 includes the definition of FGM within its definition of the phrase violence against women. Article 4 provides that states should not invoke any custom, tradition or religious consideration to avoid their obligation to eliminate violence against women. \(^{33}\)

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\(^{32}\) Variations in prevalence based on the figure 73.6% is the weighted (by population size) population prevalence. The figure is lower due to the large number of non-FGM ethnic groups with small populations. Prevalence has substantially decreased in all regions except in Somali and Afar region (Kitaw et al., 2008:97). The 2005 Ethiopian DHS shows that the rate of FGM declined only 6% from 80% in 2000 to 74% in 2005.

\(^{33}\) The International community has also addressed the HR implications of harmful practices, such as FGM, at a series of international conferences, e.g. the Fourth World Conference on Women in Beijing 1995. Both African
National law’s and policies

Even though anti-FGM laws (assumed that they actually are implemented) have some disadvantages it provides a backup to NGOs and other on their work by empowering them with legal support and the support of their governments.

- The Constitution - as a signatory to the instruments of the Human Rights Convention and others, the Federal Democratic Republic of Ethiopia, through its 1995 Constitution, has declared that ‘the State shall enforce the right of women to eliminate the influences of harmful customs’ (Article 35).
- The Criminal Code of the Federal Democratic Republic of Ethiopia 2004 addresses FGM but doesn’t outlaw it explicitly, see below

Article 565 on Female Circumcision states that whoever circumcises a woman of any age, is punishable with simple imprisonment for not less than three months, or fine not less than five hundred Ethiopian Birr.

Article 566 on Infibulation of the Female Genitalia states that whoever infibulates the genitalia of a woman, is punishable with rigorous imprisonment from three years to five years. Where injury to body or health has resulted due to the act prescribed in sub-article one, subject to the provision of the Criminal Code which provides for a more severe penalty, the punishment shall be rigorous imprisonment from five years to ten years.

- The Family Law (2000) also confirms women’s rights and their equality with men

However, as a counter-approach, which indirectly affects FGM, is the restriction on NGOs. This law was mentioned by many interviewees as a huge obstacle in their work. In February 2009, the Government adopted the Proclamation to Provide for the Registration and Regulation of Charities and Societies (CSP), Ethiopia’s first comprehensive law governing the registration and regulation of NGOs.

The law is one of the most controversial NGO laws in the world. The Proclamation, among other things, restricts NGOs that receive more than 10% of their financing from foreign sources from engaging in essentially all human rights and advocacy activities (ICLN, 2012). The extent to which the CSP will affect civil society in Ethiopia has yet to be seen.

4. 5 Attention

The first documented actions to bring attention of FGM dates back to the early 18th century, when colonial administrators and missionaries in Burkina Faso, Kenya and Sudan attempted to stop the practise, however such actions provoked anger against ‘foreign intervention’. Later attempts to pass laws in the 1940s and 1950s, is claimed to have been made by the governments of Sudan and Egypt, which obviously were ineffective.
In the 1960s and 1970s, indigenous African activism against FGM developed in an increasing speed. Doctors, in mostly Sudan, Somalia and Nigeria, also began to document the harmful practice and its complications in medical journals. In 1979, WHO sponsored the first Seminar on Harmful Traditional Practices, in Sudan. Fran Hosken, the American journalist and feminist, presented her findings on FGM there (the Hosken Report, first comprehensive FGM report). In the 1980s African women continued to organize to address FGM, and the Mid Decade Conference on Women took place in Copenhagen. In 1984 the regional network Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) was formed. During the 1980s a position for a UN Special Rapporteur on Traditional Practices was established as well (Kitaw et al. 2008:128).

In 1997, WHO issued a joint statement with the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) against the practice of FGM. A new statement, with wider UN support, was then issued in February 2008 to support increased advocacy for the abandonment of FGM. The 2008 statement documents the evidence collected over the past decade about the practice. It highlights the increased recognition of the human rights and legal dimensions of the problem and provides data on the frequency and scope of FGM. It also summarizes research about why FGM continues, how to stop it, and its damaging effects on the health of women, girls and newborns. Since 1997, great efforts have been made to counteract FGM, through research, work within communities, and changes in public policy. WHO is particularly concerned about the increasing trend for medically trained personnel to perform FGM (WHO, February 2012). The UN-Assembly is currently under way with a new resolution against FGM (personal field notes).

Approaches and progress at both international and national levels includes:

- wider international involvement to stop FGM;
- the development of international monitoring bodies and resolutions that condemn the practice;
- revised legal frameworks and growing political support to end FGM (this includes a law against FGM in 22 African countries, and in several states in two other countries, as well as 12 industrialized countries with migrant populations from FGM practicing countries);
- in most countries, the prevalence of FGM has decreased, and an increasing number of women and men in practicing communities support ending its practice (WHO, 2012, Kitaw et al. 2008).

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36 The evolution of an idea on ‘women’s rights’ goes back to at least the 18th century, from e.g. Mary Wollstonecraft’s. The issue gained international prominence in the 1970s, when studies on underdevelopment issues, mainly in the UK explored the relationship between the sexes. Starting with the feminist movement through Women and Development (WAD), Women in Development (WID) to the current gender approach, some gains have been made in terms of health, education, employment and political representation. The various World Conferences on Women has helped focus national and international attention on gender issues. A turning point in gender issues and FGM came with the adoption of the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), in 1979. CEDAW was the culmination of a series of activities, which led to the formation of a UN Commission on the Status of Women (Kitaw et al. 2008:49f).
5. Ethiopia – A traditional Society

This chapter forms part of the literature review and is based on key facts such as an historical background of Ethiopia. This chapter is essential in order to understand the practice of harmful traditions, and hence why it can be hard to eradicate FGM. See Table 1. in chapter 7 as well for clarification of the analysis and results.

The chapter consist mainly of data from ‘Old beyond Imaginings’, a project about Ethiopia and harmful traditional practices’, by the NGO Egldam, with financial support from NORAD. The book project consists of findings and conclusions from a Baseline Survey (1998) and a Follow Up Survey (2007), conducted by researcher such as Yayehyirad Kitaw, Fisseha Haile Meskel and Amare Dejene. While the two Surveys conducted remains the core database, additional data and information from workshops and more recent studies (e.g. DHS 2000) have been integrated. 37

5. 1 An Overview

The Federal Democratic Republic of Ethiopia has a great number of ethnic groups, whose cultures are as rich and varied as their composition. Ethiopian had its Empire regime during 1137-1974. The country was severely restricted under the rule of the Derg (a military junta) during 1974-91. Ethiopia has since 1991 been ruled by the Prime Minister Meles Zenaw and his political party (ICNL, 2012). 38 The country has a rich conglomeration of different ethnic and linguistic communities, some calling her ‘a museum of people’, a miniature version of the continent. Her tradition has deep historical roots. Underlying traditions are so long-standing that they obviously have great force in the minds of the people, no doubt. Ethiopia is home to one of the most ancient settlements of the human race, dating back to over 3 million years and is one of the oldest Christian countries. The different ethnic groups residing in the country, as similar to linguistic, is said to be approximately 80. Ethiopia is clearly a huge despair for the compulsive classifier (Kitaw et al. 2008:11ff).

The recent regional divisions of the country were given the name of the dominant ethnic groups residing in them. For Tigray, Afar, Amhara, Oromiya and Somali regions the population of the major ethnic group makes up more than 75% of the population. The rest are multi-ethnic regions. Cross-border territorial claims still abound due to the complex settlement patterns. The country has 3000 years of state history. The size and borders of the state have frequently changed, but the country has withheld its sovereignty, more or less. In fact Ethiopia was the only country in Africa (however debated) that was not colonized, however, occupied/annexed by the Italians a shorter period of time before real independence was regained (ibid).

37 The main object of their book is stated to be to serve as reference material. It endeavors to facilitate understanding of the issues involved by giving the basic premises, the economic, social and legal factors on which the practices are or could be based. The hope is that the book will address ‘future leaders’ i.e. students, and that it to a certain degree serve current leaders (ibid). Egldam - former NCTPE.
38 Ethiopian People’s Revolutionary Democratic Front (EPRDF). Ethnic politics more or less (personal field notes).
Christianity was introduced in the 4th century, Islam in the 8th century and more recently the material and social culture of the industrial revolution. What’s important to have in mind is that Ethiopia is dominated by the Christian (Christian-orthodox) religion. Ethiopia presents a complex picture of ethnic cultures due to the influences and exchanges that have taken place among its ethnic groups at different historical periods. Most of the harmful traditional practices have no religious basis, even though some, e.g. FGM, tend to be associated with religion (Islam) in the popular mind (ibid).

Ethiopia is divided into nine autonomous regions and two sub-city administrations. However there have been a number of changes in the number and configurations of units at zonal and woreda levels (ibid). As of today the population is about 87 million (Freedom House, 2012). Ethiopia is one of the least urbanized countries in the world; however, this low proportion contributes to about 55% of the GDP (Kitaw et al. 17ff). Coupled with the low status of women and a steady population growth, this has important implications for harmful traditional practices (THP). The vast majority (75%) of the population carry the bunt of the HTP in the country. Marriage is universal and starts early. 41.7% of those aged 15-19 is married, compared with e.g. 0.5% for Sweden (ibid).

5. 2 Political reforms, economy, education and health

Arguably, the most important development in the country’s organization is the decentralization process towards weredas/ districts (Kitaw et al:19). The country faces a lot of challenges due to political, financial and human resources constraints. These decentralization phases (starting in 1991 and 2001) should be viewed against the background of the high centralized, autocratic and repressive system of the previous regimes and the wave of democratization that has been sweeping over Africa since 1989. Change in government has thus always been a traumatic experience in Ethiopia (ibid:20).

The Constitution of Ethiopia (enacted 1995) is said to guarantee human and political rights. Every individual has the right (at least theoretically) to engage in political activities. The rights of nations, nationalities and peoples to self-determination are recognized in the constitution. The Federal State is composed of nine regional states structured, essentially, on ethnic (linguistic) lines and with two autonomous administrations (sub-city’s, i.e. Addis Ababa and Dire Dawa).

The Constitution, while stipulating (Article 51.2) that the Federal Government shall ‘formulate the country’s policies in respect of overall economic and social development; it shall draw up and implement plans and strategies of development’, gives extensive power to the Regions. The regions exercise all powers not exclusively reserved to the federal government. This includes preparation and implementation of social and economic policies, strategies and plans (on the basis of the Federal frameworks); ensuring law and order within the state, and organization and administration of the police force etc.

39 Because of its position at the crossroads of Africa, Asia and the Mediterranean world, Ethiopia had early contacts with various civilizations, such as interaction with people from the Arabian Peninsula, and Middle East contact with Queen Saba e.g. (Egildam, 2008:14).
Similar powers are also given to Wereda Councils. The democratization and decentralization process is expected to facilitate focus on grass-root problems and ensure more responsible governance. However, the ethnic based regionalization could present some challenges to the grass-root efforts of HTP activists since politicization of the return to ‘tradition’ as a liberating strategy might put women on the loosing end (ibid:21).

Ethiopia was in the end of the 90s going through a major reform towards pluralism in politics and democracy in governing. What appeared like a very promising start stalled after the flawed 2005 election and its aftermath. Almost all opposition leaders were imprisoned and the press was muzzled. A gradual return to improved democratic process seems to be emerging. Overall, stability has proved elusive with internecine wars that were dominant between 1974 and 1991. 40

Ethiopia has a conflict prone legacy, which she shares with the Horn of Africa with an array of social, economic and political factors leading to intra-state conflicts often over-spilling to interstate conflicts. The region is also characterized by complex disasters related to periodic drought and famine leading to humanitarian and stability crises, massive internal and external displacement of people. The Horn is notorious for its several decades of conflicts, which seem to continue. Ethiopia is the linchpin of the region, what happens there impacts on the rest of the region (ibid:23). 41

Economic development is said to be critical for any acceptance of harmful practices.Any improvements in the lives of the poor are inconceivable unless there is economic development and growth in societies, as poverty means the denial of choices and opportunities. Almost all Ethiopians are poor, and about 45% are absolutely poor. 42 Ethiopia remains one of the poorest countries in the world, with only five countries in the world with less GDP. 43 Agriculture is the backbone of the economy. There have been some decrease in poverty rates, however, progress in addressing poverty has been disappointing as indicators are that poverty did not decline between 1990s and 2004 and may even have increased in urban areas. New economic policies in Ethiopia emphasizes the role of the private sector, reducing and redirecting the role of the state, which was dominant in the previous regime. (ibid: 24ff).

40 There was a brief respite of some of the advent of EPRDF but resumed in 1992 with the activities of the Oromo Liberation Front (OLF) in the Oromo region and growing problems in some other regions e.g. Somali and Gambella regions. There were also the Ethio-Eritrean war, 1998-2000, which remains unresolved and just recently also returned to conflict. Several wars has been fought between Ethiopia and Somalia, which has resulted in a tense regional situation over the last 15 and more and which escalated into open warfare at the end of 2006.
41 Thus Somalia, the epitome of failed states, has had problems with its neighbours from the dawn of its independence in 1960. The Somali State collapsed in 1991. Twenty years later or so, the banner of ‘Greater Somalia’ seem to be raised again by the Islamic Courts (replaced by Al-Shabab) which sort of overcame the divisions of former warlords, leading to intervention by Ethiopian forces alongside of the Transitional Government of Somalia. Ethiopian-Sudanese relationship has had its up and downs with each toying with dissident groups in the other camp to advance political agendas. The Ethio-Eritrean war led to tens of thousands deaths and a continuing ‘no war, no peace’ situation (what some have called pre-industrial war with post-industrial weapons) (ibid:23).
42 Less than $100 per annum. (For problems of definitions see UNAIDS, 2002), (Kitaw et al, 2008:26).
43 The Ethiopian GDP, 2006, was $858 compared to the highest, $72,855 for Luxembourg. The modern sector, industry in particular, is still at an infant stage, contributing only 10-15% of the GDP. Ethiopia has a registered GDP growth about 3.6% per annum (ibid:24f).
Ethiopia has a long history of traditional education, mostly religion oriented and limited to men. Still today many Ethiopians get their ‘education’ through church or koranic schools. Ethiopia has one of the least educated populations in the world, and 75% of primary school age children, primarily girls, are out of school. The adult literacy rate in 1994 was only 24% for females and 44% for men, however with great variations among regions (ibid:28).  

Important instruments when it comes to education in Ethiopia is the ‘Education Policy’ and the ‘Education Sector Development Program’ (ESDP). These policies aims at strengthening problem identification, developing and conserving the environment and promoting respect for HR and democracy, all very supportive in the struggle against harmful traditional practices. The target of the Education Policy is to reach universal primary education by 2015. The main thrust is also to improve quality and expand access with special emphasis on primary education in rural and badly served areas, as well as the promotion of education for girls. However, the literacy rate in Ethiopia has remained very low (ibid:29ff).

Health services play a major role in the struggle against HTP (such as FGM) as well, and most of the harmful effects thereafter are on health. Health institutions are expected to play a major role in ‘Information, Education and Communication’ (IEC) against harmful practices, such as FGM, especially in mitigating some of the harmful effects. The health status of the Ethiopian population is poor, the bunt of the problems born by women and children. Ethiopia had, in 2005, a maternal mortality rate of about 700 per 100,000 live births, and an infant mortality rate of about 103 per thousand live births or more and childhood mortality of 188 per thousand. Compared this to Norway e.g. who for instance had a child mortality rate in 2005 of about zero (ibid:32f).

Male circumcision is widespread, with a prevalence of 92% of Ethiopian men aged 15-49 being circumcised. Ethiopia has a relatively low prevalence rate of HIV, with about 1,5% of people aged 15-49 infected (DHS, 2011). Especially since circumcisers tend to use the same knife/razor blade/ stone when cutting many girls/or boy’s at the same time when doing this ‘ritual’ (Kitaw et al.ibid). A number of harmful practices, those that are ‘surgical’ in particular are suspected of possible transmission of HIV. Most harmful traditional practices, such as FGM, uvula cutting, tonsil scraping and milk tooth extraction, body image alterations have the potential for HIV transmission, especially when it involves group rituals (ibid:35).

Looking at the health situation of women, the Demographic Health Survey (DHS) highlights the fact that 27 per cent of women between the ages of 15 and 49 are severely malnourished.

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44 The literacy rate has gone down from higher levels in the 1980s, during the ‘literacy campaign period’. The literacy level varies greatly among regions, with less than 10% in Afar and Somali Regions. The reasons for disparity varies (ibid:28).

45 In 1997 the government of Ethiopia launched a five year Education Sector Development Program, the ESDP, within the framework of Education and Training Policy (ETP) and as a part of a twenty year education sector indicative plan.

46 Even early marriage and marriage by abduction can have an indirect role in the propagation of HIV as most of these marriages fail and most of the women end up in urban areas and as commercial sex workers. The FUS attempted to explore the linkage between HTP and HIV as perceived by participants in FGD, about half of the FGD indicated possible linkage with FGM, UC and MTE (ibid:35).
The maternal mortality rate for the period 1998-2004 remained one of the highest in the world at 673 per 100,000, while only 28 per cent of the women who gave birth in the five years preceding the survey had received antenatal care.  

Health services are limited, and only reached (in 2007 when the FUS were conducted) about 77% of the population, estimated at 73 million, compared to only reaching 53% in 1997. They are primarily government owned. (ibid:33f). More recently, the development of the health services has been extended through the employment of the so called Health Extension Program (HEP), with about 30,000 Health Extension Workers deployed. The importance of this in the effort to eliminate HTP can not be over emphasized (ibid:36). Worth mentioning, as a positive sign, is that the Global Public Health Conference was held in Ethiopia, April 2012 (personal field notes).

There are many reasons as to why changes are required in relation to gender equality and women’s empowerment, not least is it crucial in order to combat HTP. According to ECA (2009:9f) there is clear evidence that compared with men, women in Ethiopia are at a disadvantage in all respects and participate less in economic, political, social and cultural affairs. Data on federal government employees shows that women occupy only 18 per cent of all professional and scientific positions, and that the upper and middle-level positions in the civil service are overwhelmingly dominated by men. Only 22 per cent of elective positions in politics was held by women, and among the 28 ministers in place (in the year 2009), only 2 were women. According to ECA (ibid) there have been quite a few reviews and developments of laws and policies in Ethiopia addressing gender issues as a way to tackle them.  

5.3 Tradition and Gender in development

According to Kitaw et al. (ibid:47) the strength and sustainability of changes will depend on success on modifying and strengthening existing social organs. This is a complex task, because conflicting interests characterize every society. There are a number of harmful traditional practices in Ethiopia that are specifically directed at women, one of them is female genital mutilation. According to Kitaw et al. (ibid:48) a woman who is bleeding is considered unclean or polluted and is not allowed to join religious or social services. Understanding the gender bias is central to the understanding the issues of FGM, and measures required to combat them (ibid). Gender bias is a worldwide phenomenon, but is especially pervasive in the poorest parts of Africa. It ranges from the exclusion of women from development programs to wage discrimination and systematic violence against females.

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47 Maternal mortality rate ranges though, between 450 and 1,540 per 100,000 live births, according to various sources. The aggregated (male and female) infant and childhood mortality rates (under 5 years) are 116 and 171 per 1000 live births respectively (Kitaw et al, 2008:55).

48 The Constitution (Article 35) states that women have equal rights to men in all social, economic and political spheres. Several other policies are also in place that address gender issues, e.g. the National Policy on Ethiopian Women (1993); the National Population Policy (1993); the Ethiopian Education and Training Policy (1994); Developmental Social Welfare Policy (1996); the Cultural Policy (1997) e.g. (ibid).

49 There are a number of HTP in Ethiopia that are specifically directed at women, such as FGM, early marriage, marriage by abduction, shaking a woman after delivery, food discrimination, bleeding after expulsion of the placenta, massaging the abdomen in labor and drastic measures to enhance the expulsion of the placenta (ibid:48).
According to Kitaw et al. (ibid:51) such gender biases is tantamount to grossly unequal allocation of resources. Recognition and visibility of women has however evolved quickly in the last quarter century, and it heralded in an explosion of research, analyses and debates on women’s role in development. The term ‘gender’ was adopted for the analyses of the social implications of being feminine or masculine. This has led to locating women’s programs in special niches and the creation of special ministries, departments or divisions within GO, NGOs and IGOs, such as UN Women and in Ethiopia there is e.g. a Women’s Affairs Offices, as well as a National Action plan for Gender Equality. In Ethiopia there is a growing awareness of gender issues (ibid:51ff, personal field notes).

According to Kitaw et al. (bid:53) the majority of women in Ethiopia lag behind significantly when it comes to education, economic resources and work opportunities, to mention a few. Cultural values are also conveyed early, during a socialization process in childhood. It is further argued that cultural values encourage men to develop traits that translate into leadership and females into dependency and domesticity.

Kitaw et al (ibid) argues that in gender blind economic development it is assumed that men and women have equal access and control over resources. Therefore, as economies develop, ‘gender gaps’ develops and equal access to resources persist and may even grow. In the Human Development Index (HDI), women lagged behind men in every country on which there was data available. When development programs do not explicitly address gender, women might be discriminated further and hence also starts with a ‘handicap’ from the beginning (ibid).

Because of deep-rooted socio-cultural practices and, in general, low education status women have limited access to economic resources, which further aggravates their low social and economic base. In Ethiopia rural women are almost entirely confined to non-remunerated social reproduction, and rarely participate in ‘economic’ employment. This is to some extend true for urban Ethiopian women as well. In traditional Ethiopia education was restricted to boys, and even among the nobility girls were rarely educated (ibid:54f).

As mentioned, current statistics on maternal mortality in Ethiopia indicates that it is one of the highest in the world. Although relatively more boys than girls die in the world, in Ethiopia that is not the case. The female child mortality rate is 4% higher than for boys. Higher female mortality rates are also observed in the child-bearing ages (ibid:55).

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50 This led to what was originally called the Gender and Development approach (GAD), later adopted by the UN system as Gender in Development (GID), and to analysis of ‘gender relations’ rather than the more static concept of ‘women’s roles’. In the 1960s and 1970s WID programs had a ‘welfare orientation’, in terms of that they were programs ‘for’ women and responded mainly to women’s traditional roles. In the following decade greater emphasis were given to women’s ‘productive’ role and role as agents of change. The focus moved to political, social and psychological concerns and to the economic participation and contribution of women (ibid:50).

51 The national gender machinery is made up of the Ministry of Women’s Affairs at the federal level, Women’s Affairs Departments (WADs) at the ministerial or sectoral level, Bureaux of Women’s Affairs at the regional level and Offices of Women’s Affairs at the zone level (ECA, 2009:10).

52 According to the HDI (2011) Ethiopia ranked 0.363 on placed as 174 out of 187, compared to Sweden which ranks 10th place with a score of 0.904.
Kitaw et al. (ibid) argues that it is important to emphasize on the cultural gender valued roles and implications for morbidity and mortality difference between the sexes. In Ethiopia the disparity reflects the difference in child rearing (feeding and health service utilization), practices that favour boys. 53 Illiteracy remains high in Ethiopia, with an illiteracy rate of 77.2% for females and 54% for men, in 2005 (ibid:402). Available data indicates that the participation of females at all levels of education is lower than that of males (ibid:56). 54

Even though Ethiopia has a labour law (2003) and the civil service regulations ban discrimination on the basis of sex, women continue to face lower average wage than most men. In Ethiopia, women’s economic activity rate (63%) is much lower than men’s (at a rate of 82%), and even more so in urban areas (39% for women and 62% for men. Only 28% of total employed in the public sector was women).

Women are thus engaged in the informal sector more, with various tasks, such as into handicrafts, small trade, service work (maids), and shops and market sales workers. 55 All regions in Ethiopia record a higher rate of unemployment among women than men (ibid:57). Even in nursing, females are in minority in Ethiopia (ibid:66).

Kitaw et al. (ibid) argues that women are pushed out of productive work in the process of industrialization, and even the Green Revolution is claimed to be at the expense of women. Projects and programs (such as the social impact of reductions in public spending on health (as in former SAPs) often tend to fall on the poor, especially women (ibid:57). 56 In Ethiopia, it is claimed women can be working for 16 hours a day, and the women suffer from work stereotyping and gender distribution of labour. Girls tend to start taking care of the household at the age of 6 or 7, and women is claimed to carry the larger burden of labour both in and outside the household (ibid:58f).

In Ethiopia, women also suffer to a high extent of physical assaults. The country has one of the highest reports of gender based violence (GBV) in the world (ibid:59). 57 In Ethiopia GBV takes place under the pretext of culture and tradition and is thus condoned by the society. Sexual abuse, marriage by abduction, sexual harassment at police stations and at judiciary are claimed to be common forms of violence faced by women in Ethiopia. Tolerance remains enshrined in legal, policing and medical policies and practices, and where there have been significant legislative innovations and policies, these have not been implemented nor have they been budgeted for (ibid).

53 Among the developing world’s 900 million illiterate people women outnumber men by two to one. Girls constitute the majority of the 130 million children without access to primary school. (ibid:56).
54 In Ethiopia, the Gender Parity Index (GPI) in 2005/6 was 0.89, 0.74 and 0.58 for grades 1-4, 5-8 and 9-10 respectively, and GPI shows little improvement on previous years (ibid:56).
55 In 1994, 27% of total public sector staff was women. In 2000, 31% (out of 349,658) women were permanent employees. While women were 54% of those earning Birr 105-199 per month (Ethiopian currency), they were only 41%, 15% and 8% of those earning 500-999, 1000-1499 and over 1500 respectively. In Africa as a whole, women’s labour force participation has dropped the last two decades (ibid:57).
56 According to the International Food Policy Research Institute (FRI, in Kitaw et al, 2008:58), African women perform about 90% of e.g. processing food crops and the gender based division of labour overburdens women with multiple productive and reproductive responsibilities. African women work for far longer hours than men, and on the average their workday’s may be 50% longer.
57 Physical, sexual and psychological violence (Kitaw et al, 2008:59).
It is hoped that the modified Family Law will minimize some of the domestic and community-based violence (ibid, personal field notes).

Boy’s and girls are often treated differently, and in many societies in the world gender discrimination starts at birth. It is through these types of socialization that children internalize societal expectations and gender roles, including harmful traditional practices such as FGM 58. In some societies in Ethiopia the birth of a boy is celebrated to a higher extent, and a woman who gives birth to a boy is given better treatment and more respect. The sex preference can have a negative impact on how women perceive her position in society, and the gender inequality and discrimination might harm girls and women throughout their life cycle, directly or indirectly. 59 Kitaw et al (66f) argues that parents in Ethiopia often are forced to make choices as to which child that should go to school, and they often rather invest in their sons as they are ‘perceived’ to be the breadwinners.

Women’s access to economic resources in rural Ethiopia is complex, de jure-laws have had little or no impact on the majority of rural households. Until 1960, customary laws governed all personal matters in Ethiopia. 60 The 1960 Civil Code (recently amended) attempted to modernize the legal framework that governed social structures and relationships. Kitaw et al. (68f) argues that some customary laws persist and are still practiced across regions in Ethiopia (ibid:68f).

Women are disadvantaged in many areas such as literacy, education, health and political representation, and these factors diminish women’s development capacity and affects their health both directly and indirectly. This implies that it can be hard to make rational choices regarding harmful traditional practices, in relation to socio-economical concerns e.g. Poverty, particularly for women is far more than a lack of income.

5. 4 Female Genital Mutilation

As mentioned, data is based upon findings and conclusions from a Baseline Survey (1998) and a Follow Up Survey (2007), conducted by Egldam, sponsored by NORAD. While the two Surveys conducted remains the core database, additional data and information from workshops and more recent studies (e.g. DHS 2000) have been integrated. 61

Nationwide there seem to be a 10% decline of FGM between the two periods. The decline seems to hold true for all but Somali and Afar, and seem to be a long-term (secular) trend.

58 For example, boys are usually encouraged to play games that makes them stronger and they are often taught how to tackle problems, whereas girls play with toys or roles that revolve around beauty or household tasks (Kitaw et al, ibid:65). This is true for most societies and countries.

59 E.g. when a baby boy is received at birth he is ‘ululated’ seven times, compared with three for girls. Husbands and sons are also given the best quality of food and quantity. In some societies parents are more concerned about the illness of a son than they are of an illness of a girl (ibid).

60 Such as inheritance, wills, marriage, property division and child maintainance and custody. These laws found their authority in a varity of sources, e.g. Sharia Laws and Sharia courts for Muslims, Christian customary practices were codified in the Feteha-Negest, some sections in Oromo adhered to the Gada system etc. (ibid:68).

61 The data is also available at egldam-fgm.net.
The unadjusted prevalence of FGM in the follow-up survey (FUS) is 47% compared to 61% in the baseline survey (BLS). The adjusted prevalence was 57% compared to 73% in the BLS. Over all, there is an important (24%) decrease in the prevalence of FGM between BLS and FUS. The decrease is marked in Tigray (53%), SNNP (34% implying major changes in some ethnic groups, Oromia (27%) and Addis Ababa. The decrease in Amahara region is not negligible. On the other hand, there is almost no decrease in Afar (7%) and Somali (-1%), which are the strongholds for infilbulations (type III).

Occurrence and prevalence of FGM in Ethiopia is widespread, it affects all but very few ethnic groups, Muslims and Christians alike. According to the findings of the National Baseline Survey (1997) the prevalence of FGM in the country is about 73%\(^{62}\). The overall adjusted prevalence, in 2007, is claimed to be 57%.

(Kitaw et al. 2008:97). WHO (2012) indicates (2005) that 74.3 % of girls and women nationwide have been subjected to the harmful practice. \(^{63}\) It is not an easy task to establish whether has occurred or is occurring, both du to the fact that women might not know how to perceive their genitals as ‘normal’, or due to the sexual ‘taboo’. It is also claimed that women in some parts of Ethiopia is so ashamed of looking at their own genitals that they hardly have seen them (personal field notes).

Kitaw et al. (ibid:103f) argues that despite the fact that neither the Bible not the Koran put FGM among their religious requirements, FGM is considered a religious obligation in a number of countries. It is further argued that in countries such as Egypt Muslim women are more likely to undergo the procedure than Christian women, furthermore Muslim women are less likely than their Christian counterparts to oppose it. On the other hand, in Kenya which has a large Christian population, Muslim women are as likely as their counterpart to oppose the practice. In Ethiopia the dominant religion is Orthodox Christianity, followed closely by Islam. FGM is however prevalent in both religions, with slightly higher prevalence amongst Muslims (ibid).

In Ethiopia, 61.7% confessed to Christianity and 32.8% confessed to Islam, in 1994 (ibid:395, source: CSA 1998). This implies that religious obligations cannot be the only driving force for its continuation, but that there are other cultural and traditional factors to take into account as well. Following tables will be used to show upon of some factors of explanation. (For more and other information see chapters on classification, definition and background). FGM is prevalent in amongst both Orthodox Christians (69.1%) and Muslims (79.6%) and other religious groups, as is visible in below figure (ibid).

\(^{62}\) Variations in prevalence based on the figure 73.6% is the weighted (by population size) population prevalence. The figure is lower due to the large number of non-FGM ethnic groups with small populations. Prevalence has substantially decreased in all regions except in Somali and Afar region (Kitaw et al., 2008:97). The 2005 Ethiopian DHS shows that the rate of FGM declined only 6% from 80% in 2000 to 74% in 2005.

\(^{63}\) FGM is done on girls from the age of a couple of days up to about 15 years, and some sources claim that it is done even to grown ups, just before marriage. In Amhara and Tigray most girls undergo it at the age of 4 day’s and in more Soutner parts at the age of 4 years or above (personal field notes, April 2012).
Ethiopia has often been referred to as a mosaic of nationalities of the rich wealth and variety of its peoples and culture, especially as there are about 82 (linguistic) ethnic groups in Ethiopia. The practice is widespread and effect all but very few ethnic groups (ibid:102f). Those with higher than 75% are regarded as strong-holds, and these include e.g. the Agew and Kamyr ethnic groups.

The Shinasha and Agew/Awingi, even tough they have close ethnic proximity to above mentioned, they have reported much lower prevalence rate. At the other end of the spectrum are the ethnic groups that despite their close ties to ethnic groups with a high prevalence rate, do not practice any sort of genital mutilation. According to Kitaw et al. (ibid) there are 19 ethnic groups that are considered as free of the practice, mostly in SNNP region. Regions are based on ethnic lines, but there are huge intra-region differences as well.

In general education promotes a more open stand on tradition. Thus, women (and men) with no formal education are more likely to adhere to tradition compared to those with formal education. In Ethiopia however the prevalence of FGM does not show significant differences by level of education. The findings indicate that among woman who had no education, have had primary education, and have had secondary and higher education, the prevalence level was 80.4%, 78.4% and 78.2% respectively (Kitaw et al. ibid:105f). However, it is argued that the level of awareness of the impact of FGM, and the support for the eradication of the practice corresponds to the level of education (ibid:124). Findings from DHS also indicate that older, rural and less educated women are more likely to have at least one daughter that is mutilated (ibid).

Prevalence by age in the different regions in Ethiopia shows a complex picture due mostly to difference at age when the harmful practice is undertaken. For most regions there seems to be little difference in prevalence by age. However when viewing national prevalence due to age it is visible there has been a decrease in the practice (Kitaw et al. ibid:105). Urban women in Ethiopia is not substantially less likely to undergo FGM than rural women (ibid: 98f).

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64 FGM is often women’s ‘business’, even though it is often a decision by both parents (personal field notes).

65 The sources however are somewhat contradictory, but this might be due to attitudes and actual experiences etc.
In Ethiopia, five ethnic groups, i.e. Afar, Somali, Harari, Oromo, and to some extent the Berta Jebelawi practice infibulation. The predominant type of FGM countrywide is clitoridectomy (62%), followed by excision (19%) and infibulation (3%). A combination of type I and II occur in the regions of SNNP (54.4%), Tigray (91.8%) and Amhara (63.1%). No other type of FGM such as type IV has been documented (ibid:100). There seem to have occurred a shift towards abandoning infibulation to other forms of FGM among some ethnic groups. These include the Bertha (Jebelawi), Harari, and in a limited way, the Somali, Afar, and in parts of Oromia. They seem to have shifted towards the so-called Sunnah or type I. It is not fully known why this shift has emerged, more than opposition and campaigns, but sources claim that these are results of social movements and supported by religious and political leaders (ibid:126).

According to Kitaw et al. (ibid:121ff) awareness of the consequences of FGM is inversely proportional to the attitude towards eradication of the practice. Women that have a lower level of awareness might be less supportive of eradication of the practice. It is argued that the difference in awareness and attitude is a reflection of gender roles, difference in access to information and the status of women in the society, even though it is the mothers who bear the burden of making sure that their daughters undergo the practice. Among the regions with high prevalence levels (Afar, Somali, Amhara and Oromiya) resistance is higher. In Somali it is argued how the people have awareness of the harmful practice, but despite this the practice remains. This implies that awareness alone does not result in change of behaviour (ibid). See Appendices for further information on FGM, and variations due to setting, age.
6. Field work - Ethiopia

This chapter shows to reveal answers to the research questions through, mainly, the fieldwork conducted in Ethiopia. See Table 1. in chapter 7 as well for clarification of analysis and results.

6. 1 Knowledge, Attitude and Behaviour

According to Endale and Essaya in Ethiopia, FGM mostly occur due to cultural rather than religious reasons, and mostly in rural areas, as to their knowledge. They mentioned that it is a hot issue at the moment for the government and a lot of education is taken place. It was also mentioned that even though Ethiopia is a conservative country, it is more approved today for people to choose their life partner than compared to before. Thus, maybe also the requirement of marrying only a circumcised woman might have decreased. They themselves didn’t care whether a future wife was circumcised or not (II, 2012-02-29).

In general, most interviewed stated that sexual issues, hence also FGM still is sort of a taboo topic and were quite shy as well. Amongst youth there seem to be more open discussions. And especially in major cities such as Addis, people are more secular, hence tend to be more open. Most interviewees also tended to be unaware of the different types of FGM and that it still occurs. Most stated that if it occurs it occurs in regions such as Somali, Afar or northern parts. Majority stated that if it occurs, it mainly occurs in rural areas. All of the male interviewees stated that they prefer to marry uncircumcised women. Regarding questions as whether a women has undergone the procedure or not, or which type, it could be hard to get an answer due to the fact that many girls are mutilated as early as seven day’s, hence it can be difficult to know what a ‘normal’ vagina appears like (personal field notes, April 2012).

A majority of interviewees stated that there has been awareness raising campaigns through the media and NGOs, and seemed to be aware of the harmful practice, but especially of the most severe type ‘infibulation’ (personal field notes, April 2012).

What was obvious was that even though academics and health practitioners, that should be aware of the harmful traditional practice, not even they tended to have sufficient knowledge about the harmful practice. One interviewee (IDI, 2012-04-11) had written a Master’s thesis on FGM, but this did however not enable to open discussions with family members, nor did the interviewee have any knowledge whether e.g. the mother had undergone the procedure or not. Bad community responses were mentioned as a huge challenge, and the majority of interviewees stated that Ethiopian’s are aware of the harm, but that the practice is so deeply enrooted in their culture. Most interviewed mentioned that awareness on FGM tended to be raised in primary school, how early varied though (ibid).

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66 During April, 2012.
67 International students in Sweden with Ethiopian origin.
‘People don’t care if a girl is about to bleed to death’ (Wondimu Shanko, IDI, 2012-04-11).

One young woman was totally unaware of that FGM still occurred, (even though family constituted of doctors and nurses). According to this interviewee the Government is in total control, and this hinders the society. ‘There is no democracy’, she said (II, 2012-04-11).

When asking people about FGM and complications they tended to the answer ‘you don’t miss what you don’t know’. A common view expressed was that all types of female genital mutilation, in contrast to only infibulation, result in difficulties in labour. This is not the case since only the most severe type, when the vagina is stitched up, results in a sort of non existing passage for the baby. A common feature was that this lack of awareness on different types of FGM, which mainly has been brought from NGOs (personal field notes, April 2012).

Bissa (II, 2012-04-17) had her clitoris cut but thought now when she is pregnant will have a hard time getting her baby out. She mentioned that her mother actually has apologized for her ignorance, unawareness and for sticking to tradition (ibid).

‘FGM is not a problem in Addis, that is why people do not need to talk about it /…/ prefers to marry uncircumcised, but whatever destiny wants /…/ it does not matter if a girl would be either /…/ whatever God wants’ (II, 2012-04-13).

Grarbirak mentioned that accidently walked into a circumcision once, in the Amhara region. He said he asked them to stop but they didn’t, instead they went on with the procedure and told him that it was necessary otherwise the girl would be bad and behave disrespectful towards parents (IDI, 2012.04-14). Grarbirak also mentioned that he thought alcohol or egg was used afterwards to stop the bleeding. He also mentioned that FGM is performed as to make sure boys want to marry them.

‘Women are the ones that have the knowledge, but they don’t speak about it with men’ (ibid).

Grarbirak said that he has knowledge now, and has thus not let his daughter undergo the procedure. He also mentioned that some women don’t remember and hence know if they have undergone the procedure. He also mentioned that he didn’t know that his wife had been mutilated when they got married. FGM was said to occur more due to peer pressure from the community, for cultural reasons, and not due to religious or local leaders68 (ibid).

Hanna (IDI, 2012-04-14) was mutilated at the age of 40 days. She mentioned that NGOs teach them the harm with FGM; when giving birth. She also mentioned that she herself had no complications in labour, or otherwise. It appeared that she was unaware of the different types of the practice. According to Hanna the main reasons way it occurred was due to culture and community stigma. However, it was mentioned that FGM has stopped in her setting due awareness. She said she could be open about these issues with her husband, but not with her mother due to ‘disrespect’. She mentioned also that her husband would have married her even if she hadn’t undergone the procedure. She got married at the age of 14 (ibid).

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68 This man was Christian Orthodox. In Sululta most are Christian, but they it is a mixed society as well.
Askale (IDI, 2012-04-12) thought she underwent the procedure at the age of 2. She mentioned that FGM has stopped. She said it happened more before due to the fact that it is tradition, old habits, and they are hard to overcome. She revealed that she had let one of her daughters undergo the procedure, but not the younger ones since she now is more aware of the consequences.

Fatoma, (IDI, 2012-04-14) underwent the harmful procedure at the age of 8-10. She has six daughters, two have been mutilated. She argued that she gave in for peer pressure from the community. She mentioned that she can’t speak about this practice to her husband, but with her children she can. Fatoma also mentioned that it is illegal nowadays and that it results in complications when giving birth. She also mentioned that early marriage as a huge problem, as linked to harmful practices. She married at the age of 14.

Tsegay (IDI, 2012-04-14) was married at the age of 12. She stated that she thought she underwent the harmful practice at the age of 2, 3 years, but that she was to young to remember. She said that she can’t speak about these issues with her husband. Tesgay and her husband mentioned that they were grateful that people, such as myself, come and speak openly about these issues. Community stigma and hence not being able to marry was mentioned to have been the driving force for FGM before, but nowadays it was claimed to have stopped (ibid). Mekonnen, her husband (IDI, 2012-04-14) claimed he had no knowledge about FGM when they got married. He said he would have married her anyway but that his parents forced him to marry someone that had underwent the procedure. It was also mentioned that even though the Government have raised awareness about FGM at Kebele level, the community isn’t open about it (ibid).

In general police officials (PO) tended to state that FGM is a cultural practice and that they can’t really do anything about it. Some POs argued that the practice occurs ‘in the dark’, and that people seem to be aware of the harm and that it is illegal. It was argued that people don’t want to take action because it is their culture. Law enforcers tended to be somewhat unaware of the Criminal Code on FGM in general, however seemed to want to eradicate the practice.

A majority tended to be unaware of the high prevalence. Even health workers interviewed was unaware of the high prevalence of the harmful practice in their country. A judge was e.g. totally unaware that parents and not only circumcisers (there are various laws which can be applied) can be punished and sentenced to (short) time in prison, or that fee’s (in accordance with the Criminal Code) could be handed out along a prison sentence (personal field notes).

Dr. Morissanda Kuyateh from ‘the Inter-African Committee on traditional practices’ (IAC) mentioned that he thought that Sweden could have a problem with FGM. According to him the practice can also take place when people go back to Ethiopia, or other countries, for ‘vacation’, or that it can occur in the dark. He argued also that he thought midwifes, BA and others should receive more training on these issues in Sweden (II, 2012-04-21).

A former circumciser, Elina, explained that she use to mutilate girls due to her culture and tradition.

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69 In Sululta.
Elina’s mother had done it before her, and she claimed she thought she was helping people. She said she started when she was a young child, and that she didn’t have any clue about how many girls she had cut. She said she use to cut 4 girls a day, and earn 30 Ethiopian Birr (equivalent to approximately 12 SEK) per girl. She claimed that some girls asked for the procedure themselves, because boys wouldn’t marry them otherwise and they would be regarded as being dirty. Elina wasn’t sentenced to prison or handed a fee, even though the police found out. She said that her lack of knowledge saved her from sentence (and maybe POs lack of knowledge of legal instruments?). She stated that she stopped due to awareness of the harms. It was mentioned that the practice is decreasing in a very fast pace because people were and are dying due to the harmful effects. She said people are slowly beginning to understand the harm in the practice, especially due to the media (IDI, 2012-04-23).

‘Tell your masters to follow religious decrees about sex and don't follow new and don't generate new and novel theories about sex’ (II, e-mail, 2012-05-03).

Trying to pee for 2-3 hours while eating ‘injera’ (the traditional Ethiopian dish) can unfortunately be a daily tragedy women faces daily in Ethiopia (personal field notes, 2012-04-11).

Just briefly to mention attitudes in relation to the wider context, this was what a young woman argued: ‘if other countries do other forms of genital alterations there will be consequences in other countries, such as Ethiopia, and especially when we do these genital alterations due to individual selfish reasons /…/ both FGM and female genital alterations of more aesthetical forms are done based on cultural reasons’ (Aaryam, II, 2012-05-07).

6. 2 Culture and Politics

In general, the people encountered in Ethiopia tended to dislike the Prime Minister, which many argued had stayed in power too long, and (federal) governing was also mentioned as a problem.

While advocating for laws that restricts or outlaws FGM may be effective, care must be taken to ensure that legislation does not drive FGM underground, possibly occurring under disguise the practice. Even though anti-FGM laws (assumed that they actually are implemented) have some disadvantages it provides a backup to NGOs and others on their work by empowering them with legal support and the support of their governments.

Even though Ethiopia has adopted policies and a laws restricting FGM (as mentioned, the Criminal Code doesn’t explicitly outlaw the practice), it can be difficult to find the right balance between enforcement, community education and dialogue as a way to combat the practice. During the time of the fieldwork more questions appeared with regards to restrictions for NGOs in Ethiopia on democracy and HR-issues. The proclamation restricts NGOs that receive more than 10% of their financing from foreign sources from engaging in essentially all human rights and advocacy activities.

Wondimu Shanko (IDI, 2012-04-11) revealed that in Ethiopia there is a huge drop-off of public officials, with staff going over to working with NGOs that give them a higher salary.
According to Mr. Shanko the law is in place due to a conflict of interest and in order to keep Ethiopians from leaving public offices.

According to one NGO (II, 2012-04-11) there are two ways on how to register as an NGO; it is either that the organisation raises more, or less, than 10% of their funding from abroad. This particular NGO interviewed stated that they receive more than 10% from abroad so they are restricted in terms of HR issues, but it was claimed that they have found a way to work around the law.

‘we go around the law /…/ pass our reports further on to organizations that can speak up about HR and democracy issues’ (ibid).

Working around the law on restrictions on democracy and human rights concerns seem to work for other NGOs as well. Another interviewee stated that their organisation receive more than the majority of their funding from abroad so they cannot speak openly about HR but he said that they can do it in other ways more indirectly (II, 2012-04-12). 70 Organizations such as Amref do not need to abide to this law since they are an International organization, and hence the majority of their funds is derived from abroad. Amref has been successful in decreasing FGM in Afar region in Ethiopia (personal notes, 2012-04-12). Clinton Foundation, below, saw no problems with regards to this law.

‘we support the government /…/ there is no problem with regards to the law /…/ we are an international organization so we are not allowed to talk about HR, democracy…’ (Mr. Bejiga, Clinton Foundation, II, 2012-04-12).

According to Mr. Legesse from UNFPA coordination on the struggle against FGM has been an issue of concern, and mentioned that they have recommended Ministry of Women’s Affair to coordinate the struggle. He also mentioned that the Government now has the law enforcement mechanism in place. According to Mr. Legesse mapping is important, in terms of who is doing what. He also mentioned that there is a ‘national gap’, but that the Government is working on a National Action Plan on HTP, yet not developed though. It was mentioned that there was implementation problems with regards to the Criminal Code on FGM that came into force in 2005.

‘Legal provisions is not strong enough, the structure is not in palace’ (II, 2012-04-17).

Mr. Legesse mentioned that a PO confessed once during a training on HTP (organized by UNFPA), that practices such as FGM was deeply enrooted to him and his family and how difficult it can be to address issues such as these due to the legal versus social perspective, especially since his own family practiced HTP. Mr. Legesse also mentioned that he has experienced how sometimes health practitioners view rape victims as they asked for it. He also emphasized on social sensibility and to work with the ‘demand’ and not only the ‘supply-side’, in terms of communities as a whole and circumcisers, parents and their daughters.

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70 It was mentioned that some NGOs have splitted due to this funding law (II, 2012-04-12).
Mr. Legesse emphasized on income generating activities, and mentioned that some NGOs have put in place economic options for circumcisers. It was also mentioned that some circumcise due to pride and not only due to economic issues.

According to Ministry of Justice (II, 2012-04-17) there is not strong linkage between the federal level and the regional levels, and hence there is no raw data on FGM since it do not come up to a higher level (if it even is reported). Mrs. Hebrit mentioned that work on law enforcement mechanisms is under way, and cooperation with the Ministry of Police. There was no data available at all at this office and (federal) level regarding FGM prosecutions. According to this office, they, NGOs (such as Egldam e.g.) and the Government together initiated the Criminal Code enacted in 2005 (ibid). Even before the Criminal Code, Article 35 in the Constitution prohibited FGM, she said. She also mentioned that the Criminal Code was developed due to the fact that the harmful practice clashed with the Constitution. 71

Ministry of Justice further stated that research is under way as on how regional courts, police, prosecutors and other law enforcers can follow up and adhere to the Criminal Code, as well as to enable easier access to data from a grass-root level. There has been a wish to create ‘victim friendly offices’ and national justice information-system mechanisms as well. The biggest challenge was claimed to be the lack of witnesses when trying to prosecute, and that it therefore would be practical with mandatory clinical examinations, as well as regional laws that fit the local context (ibid).

Women’s Affair in Kembata Tembaro Zone (KTZ, II, 2012-04-18) argued that Article 35 in the Constitution provided the framework to prosecute FGM offenders, so even before the Criminal Code was enacted in 2005 it was possible to prosecute the offenders. This has been evident in KTZ, where NGOs such as KMG helped bring justice to girls and women on the basis of the Constitution. Around 2005/2006 Women’s Affairs in Ethiopia became more independent and even got offices countrywide that addresses HTP, and this has helped enact the Law.

It was further mentioned that previous problems were faced from law enforcers because Women’s rights, as in KTZ, were not accepted before the instalment of the Criminal Code. Now that there has been awareness raising and empowerment campaigns GBV victims are better helped. In fact, in KTZ, locals ask for what they call ‘Dr. Bogge’s laws’. 72 Now more training has also been made with police officials and judges, and in this area at least three FGM cases has led to prosecutions since 2005. There is a emphasis on finding witnesses with regards to FGM. Judges are, at least in this area, evaluated after a case of FGM has been handled to them (ibid).

71 There are more cases of abductions on the Federal level. Regional district bureau’s has more information on FGM cases, as well as Women and Children protection units within sub city’s. This office drafted the Criminal Code enacted in 2005 (ibid).
72 Since their NGO KMG, and especially since the founder Dr. Bogaletch (driving force) made such a huge difference in decreasing HTP and especially GBV in the area of KTZ. Before KMGs work FGM prevalence was almost total, now it is < 3%. UNICEF conducted a survey in 2011 confirming this low prevalence rate. Women who can not afford lawyers e.g. are provided one with the help from KMG (personal notes from field work in KTZ).
Women’s Affairs (ibid) officials also expressed views on how law should force women to undergo clinical inspection in order to get a health certificate and hence bring cases to court easier. It was also mentioned that there were challenges in terms of economic issues, such as that poor families lacks funding and hence can’t even manage to report, or receive counselling, huge costs when if cases are brought to the federal level, resource and administrative issues. There is a huge challenge of bringing all cases to court, therefore a few is selected from each Kebele (ibid).

During a group discussion in KTZ, (FGD, 2012-04-18) it was mentioned that a FGM perpetrator was reported due to interventions with the help of both the NGO named KMG and the Police. Law enforcers were said to be committed and cooperate.

According to one PO (II, 2012-04-18) the harmful practice still occurs but it is hidden. In this police station there were no FGM cases, it was about one year ago since last one.  They and PP praised the work of and with the NGO KMG. They claimed that there is no problem in terms of adhering to the law since arrest were made even before due to Article 35 in the Constitution. They also confirmed what’s been stated before, that Women’s Affair and KMGs work has done a lot of good, but also that there is a problem in terms of finding witnesses. A motion has been put into place as to amend the state Criminal Code to become more Custom Law to fit into the local context and so they can decide more on these issues themselves (which can both help but also increase FGM, in other regions when local leaders, perhaps religious leaders are given more power) (II, 2012-04-18).

In Kera Police Station in Addis, PO working within the office for Women and Children’s Affair reported that there is no cases of the harmful practice in the city, and no cases has been reported for approximately ten years, nor do they receive any training on these issues (II, 2012-04-20).

Women and Children’s Affair (in Holeta) stated that with regards to the FGM front it has been quiet for about five years, due to different reasons; such as law and training and education of law enforcers, TBA and others. HUNDE was mentioned as a NGO, which has helped a lot in this area. Law enforcers were said to cooperate and coordinated from government level in the struggle against FGM. The ‘Geda system’ (sort of a CSO based on ethnicity, widespread in Oromia region) was mentioned as an improvement whit regards to FGM, because now they don’t circumcise every one in eight years, not even boys. This system is supported by the Ministry of Tourism and Culture, but it was emphasised that the government do not support HTP. It was mentioned that it might be an issue if a police is closely related to a girl at risk of FGM, and thus it can be an issue.

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73 About a year ago one FGM offender was given 5 years prison sentence. Police and KMG cooperate on these issues, and they confirmed that even before the Criminal Code arrest were made due to KMG (ibid).
74 Almost everyone, 90%, in KTZ were claimed to be Christians (personal field notes, 2012-04-18).
75 Chief Sergeant Yared Nagosi recommended another visit the Monday after, to interview a person that might have had more information on FGM, however following Monday permission wasn’t given for that interview due to another support letter was claimed to be needed.
Again the issue of enforcing the law was mentioned as problematic when it comes to witnesses, i.e. the lack of witnesses and that this is required (II, 2012-04-20).

‘I was one of the first to be happy when the law came /…/ even though it is in my culture I do not support it’ (PO77, II, 2012-04-20).

It was also mentioned that FGM occur, but in secrecy, but that police is given a lot of training, receive and raise awareness (pamphlets, face to face etc.), more recently. A huge challenge was mentioned that most locals are unaware that it is illegal.

‘People know it is harmful but they do not want to take action because it is their culture’ (PI, II, ibid).

Judges78 stated, as other have stated in other areas as well, that more cases of early marriage by abduction is reported than FGM. They said that people do not want to report. There was unawareness of the Criminal Code on FGM in terms of type of punishment and whom it is possible to prosecute and sentence. It was also stated the Criminal Code came recently and more time is needed to reassess whether there is any gaps (enacted in 2005).

One President of a Court (II, 2012-04-20) mentioned that locals probably are aware of the law, but that it is not much they can do because it is their culture. It was also emphasised however that law enforcers are not careless, they follow the law and are trying to teach society, and mentioned that more awareness raising, training as well as community approaches is needed. It was mentioned that this is a hot issue for the government.

‘locals probably know FGM is illegal but it is their culture /…/ what can we do about it…’ (ibid).

According to the University Police College (II, 2012-04-20) the Police in Ethiopia are mainly educated on GBV, and FGM more indirectly as it is communicated within GBV pillars. However, it was mentioned that they are under way with developing a new curricula.

Currently a draft resolution that Heads of States from AU has worked on regarding a Zero Tolerance on FGM has been handed in to the UN-assembly, and the result will be visible in 2012, according to IAC (II 2012-04-21). Dr. Kuyateh, from IAC, emphasised on the importance of a lead in this struggle on FGM from African Heads of State. It was also claimed that the Criminal Code came into force because of IACs work. 79

Abinet from Egldam (II 2012-04-23) stated following; ‘there has been problem with implementation of the legal framework /…/ the implementation process has been weak so that is why this new protocol is needed. To encourage countries to be more fierce /…/’

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76 In Holeta. One specific ‘Woreda’ here is e.g. responsible for eight ‘Kebeles’. It was also mentioned that girls are taken to the woods, so it is hard to find witnesses. An example was given when a circumciser was given 6 months in prison (ibid).
77 Oromiya Police Station in Holeta.
78 Walmaraa Holeta Court.
79 One can wonder why yet another ‘piece of paper’ is needed, why this document should be effective, more than other calls for eradication of FGM declarations.
He further stated that the legal framework already is in place that addresses the issue of FGM is the Constitution, the Criminal Code and the Family Law. Contrary to IAC, Egldam emphasised that the draft resolution on a Zero Tolerance on FGM is initiative from AU-states but from UN-member states as a whole. It was expressed that it has nothing to do with a wish that the struggle on FGM is lead from Africa, rather than the West.

Feven Hauddis from Hamlin Fistula Hospital (II, 2012-04-23) claims that people are aware that FGM is illegal due to the media. She mentioned that they only receive 1-2 FGM affected patients out of 3000 patients, a year. The lack of awareness however was visible as interviewees did not know about the practice in their country, the circumstances around it and that it occurred in this extent.

Sisay Alemayehy, from same hospital (II, 2012-04-23) mentioned that the Government has employed 36 000 extended health workers all over the country, that focus on general health issues but HTP such as FGM s well. As a way to adhere to the Criminal Code awareness raising is undertaken in the media, se said. According to Hamlin Fistula, the Government support hospitals such as theirs80 (which specialises in treatment of obstetric fistula). However there is no single specialized clinic that treats FGM patients.

The Ethiopian Human Rights Commission stated that the law regarding funding for NGOs in terms of HR constrains activities on FGM to a great extent. (II, 2012-04-23).

Misge Birara from Ministry of Women, Children and Youth (II 2012-04-23) (which cooperate with e.g. MOC, MOCT, various UN-organisations and NGOs on FGM) mentioned that the harmful practice falls under their table and their mandate.

‘to prevent any harmful practices against women, children and youth, whether it s modern or traditional’.

This man was the only interviewee that was fully aware of the law. It was mentioned that previously both abduction and FGM was considered as normal, but not nowadays. It was mentioned that the tools they have is first of all training and awareness raising, the other thing is the law. He also claimed that there is implementation problem with the regards to the law and also stated that;

‘punishment is not an option or preferable, teaching is the best medicine’ (ibid).

One example of when the law is not adhered to is when Elina, former circumciser (IDI, 2012-04-23), was caught by the police, but not prosecuted. She was unaware that it was illegal to practice FGM so the police, after sensitizing her, let her go due unawareness and ignorance. 81

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80 Hamlin Fistula climed that they asked patients from rural areas if FGM occurs, and that’s why they claimed that they thought is had ended almost. They have given them land for rehab centers etc. Hamlin Fistula focus on prevention, also in rural areas. They train midwife from rural areas as well and then they employ them in their home areas (personal field notes 2012-04-23).

81 However, she was caught at the same time as when the Criminal Code on FGM was being enacted.
6. 3 FGM and Male Circumcision

Regarding a possible link between the two procedures, in terms of skewed views when trying to combat one and increasing the other, many respondents has answered that ‘it is an interesting question which needs to be researched further’. And as mentioned before, even though MC is widespread, and HIV is relatively low, Ethiopia is one of the MMC scale-up countries. Western policy intervention such as FGM, can (according to the author of this paper) can have a negative impact on an already hard struggle against harmful traditional practices.

Most respondents agreed that FGM and MC are two different procedures, done due to different reasons and with different complications. However, some links were found. One interviewee, ‘C’ answered first that both practices are equally bad, but then that MC is traditional and good but FGM is ‘not a real problem’ even though FGM were said to be practiced (II, 2012-0410).

Wondimu Shanko (holds a Master in Public Health and degree thesis on FGM in Ethiopia, IDI, 2012-04-11) thought it was an interesting question whether there is a link between MC and FGM, one which needs to be researched further. According to Mr. Shanko there could be a confusion, or conflict of interest when FGM is trying to be eradicated but at the same time (M)MC is being scaled up. He argued that it might have a bad impact on the fight against FGM.

Alemayhu Bogale, within the MOH (II, 2012-04-11) also expressed his views regarding a possible positive link between the two procedures, especially since male circumcision is widespread in Ethiopia. He also confirmed what others have said, that it was an ‘interesting question, needs to be further researched’.

A man who didn’t see any link between the two practices was Ali Hassen at the NGO Egldam (II, 2012-04-11). He believed that men who undergo (M)MC is educated, and didn’t see a link either due to the fact that it occurs more often in hospitals and clinics.

‘Interesting question /…/ we need to be careful’ (Dr. Kassahuu from the NGO Amref, II, 2012-04-12). 82

Joa Soares (former country director at Amref, II, 2012-04-12) strongly emphasised that there can be a link between the two, in terms of that male circumcision can affect the attitudes on FGM in a negative sense. He expressed his views that this is un unexploited research area (a view shared by KMG, by Menbisha and founder Dr. Bogaletch, II, 2012-04-12).

According to Merratu Bejiga at Clinton Foundation (II, 2012-04-12) MMC is not needed due to the widespread practice of traditional male circumcision in Ethiopia. Regarding a possible link he responded that it is difficult to say if there is any connection, but mentioned that there is much awareness raised from governmental level.

82 He also said that it e.g. is only small part of the variety of different ethnic groups in the southern part of Ethiopia that practice FGM (three groups that do), but had no information on MC in these parts.
Mr. Bejiga stated that Clinton Foundation Ethiopia do not work on FGM related issues, as yet, even though they claim to work on HTP.  

Local attitudes (II, 2012-04-14) expressed confirmed a view that FGM is perceived as something bad, and that there has been a shift in attitudes and behaviour, and that MC has shifted to more MMC. ‘Teddy’ (II, 2012-04-14) revealed that he himself was circumcised at the age of 8, but he did not see any link towards the eradication of FGM and in terms of skewed views, even though he mentioned that both are deeply entrenched cultural traditions and that MC is widespread in Ethiopia. ‘Teddy’ mentioned that learnt about the harmful practice of FGM in primary school. He also revealed that his mother probably was a victim of FGM, but he wasn’t really sure due to the fact that sexual issues are a taboo topic.

‘Male circumcision is good because there is a bad organ on the top /…/ bad fluid comes out of the penis if it is not circumcised /…/ religious reasons require male circumcision’ (IDI, 2012-04-16).

This man also mentioned that the same religious requirements did not apply to FGM, but then mentioned that sometimes both religious and traditional reasons requires FGM. He said that he thought stigma could affect the attitudes on combating FGM, especially also when people are so accustomed to the two practices that often are deeply entrenched in their culture. A lot of campaigns have been undertaken in the media as a way to combat and sensitize the people in Ethiopia on FGM, he said. This man revealed that he was circumcised at the age of 17.

According to Mr. Legesse at UNFPA (II, 2012-04-17) the ethnic groups of e.g. Gambella practice neither MC nor FGM. Clearly there could be a possible link here in terms of when male circumcision is undertaken, that it spills over. This is however quite contradictory though due information from Izegaye Berhanu from KMG (II, 2012-04-18), who claimed that the FGM prevalence in KTZ nowadays is < 3%, but MC has an almost absolute coverage. Mr. Legesse revealed that he hadn’t thought about a possible link, but he also mentioned that even though FGM might be high MC prevalence can be low, and vice versa. He also mentioned that MC is widespread in Ethiopia.

Mr. Berhanu also explained how religious and local leaders, before KMG intervened, believed that both practices were good practices. He also mentioned that he thought the Bible encourage MC, not FGM though. He also claimed that everyone sees MC as necessary, good and required by religion. This view that the Bible, but also Koran encourage MC, was supported by a focus group discussion (FGD, 2012-04-18). It was also confirmed that this religious requirements did not apply to FGM, and that MC also is undertaken as a way to combat HIV.

83 Clinton Foundation Ethiopia has started talks with Hamlin Fistula Hospital on possible cooperation (ibid).
84 Before the NGO, KMG, was established in KTZ (1997) the FGM prevalence was almost 100% (ibid).
85 MMC is however a issue here, even though MC is widespread cause Ethiopia is one of the scale-up countries, according to various sources from e.g. UNAIDS and PEPFAR.
86 Most people in KTZ are Christian protestants (ibid).
87 All men in this FGD was circumcised at the age of 10-18 (ibid). Can the age when MC is undertaken affect views with regards to FGM, that if it occurs at a latter stage in their life they might get skewed views?
‘In every one out of eight years not even male circumcision takes place’ (Weyneshet Oda, Office of Women’s and Children’s Affairs, Walmaara, II, 2012-04-20).

In the ‘Geda system’ (which is widespread in the Oromia region), MC and FGM is practices and institutionalized. The Geda-system undertook circumcisions every year before, but this has now decreased. It was stated that Geda is supported by the MOCT. Another official, Alemu Worku (II, 2012-04-20) emphasized on that government don’t support Geda on FGM, nor that Geda support HTP is general. It was also mentioned that community members are given awareness and education of both MC, as well as MMC as a way to reduce HIV, and FGM, and to know the difference. It was argued also how the Bible supports MC. Mrs. Oda also mentioned that she perceived both male and female circumcision to be deep cultural traditions and how people can’t distinguish between the two, but that Women’s Affairs do their best as so people will gain awareness.

‘Locals do not understand the difference between male circumcision and female genital mutilation, why they can circumcise their boy’s but not their daughters’ (Tesfaye Welane, PO, II, interview 2012-04-20).

Derege Diriba (PI, ibid) mentioned that MC is required by the Bible but also by his culture. He explained how it could be a problem for him as a police official to explain the difference between the two practices of circumcision to the community. He also mentioned that he thought that biologically male circumcision is good, because tissue there needs to be removed due to health/medical reasons and due to the Bible. FGM was mentioned as bad from a health perspective.

‘As an Ethiopian myself…male circumcision is like law here /…/ they probably know FGM is illegal but it is their culture /…/ what can we do about it…’ (Tamirat Alemayehy, (President of Holeta court, II, 2012-04-20).

Mr. Alemayehu explained how deeply rooted the practice is in their culture, and also explained that it is required by the Bible. He emphasized on that it wasn’t a problem. And as for him, he said that he learnt about FGM in school so he is aware of the harm of the practice. However, he did say that he thought the community need education on these issues. This court, since it was established (unaware of date) only had one file on FGM. Mr. Alemayehu that there are no cases to handle since the practice is hidden.

Dr. Kuyateh from IAC (II, 2012-04-21) agreed on the view that there could be a link between the two since both are deeply enrooted in culture. However, he also stated that IAC train locals and create awareness of the difference between the two practices.

The view that the veil of silence on sexual issues has been partially lifted is confirmed by students, (currently living in Sweden. Interviews; 2012-02-29, 2012-05-07). All agreed that both practices are deeply entrenched in culture, and FGM can therefor be especially hard to combat. However, FGM is often not spoken about, but awareness is derived from the media.

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88 The Geda system is claimed to be like a civil society organisation (CSO), and is claimed to be based on ethnic and not religious groups. Geda is said to be a cultural system. Leaders are refered to as ‘Abageda’ (ibid).
89 Christian Ortodox.
6. 4 Coordination, Challenges and Ways Forward

‘People don’t care if a girl is about to bleed to death’ (Wondimu Shanko, IDI, 2012-04-11). Mr. Shanko stated that there are bad community responses in the struggle against FGM.

‘There is no democracy /…/ the government has a lot of spies and they control phones and the internet’ (Lee, II, 2012-04-11).

Democracy is lacking behind in Ethiopia. There is no freedom to right of information. The author of this paper also felt the issue of a fear of journalist when conducting the fieldwork. The Government even constrains NGOs (in terms of the right to raise their voices on HR, democracy issues; 10% funding law), this clearly affect the struggle on FGM as well. Most interviewees tended to dislike the Prime Minister, as some adored him. The Prime Minister’s wife though was claimed to work on HTP (personal field notes).

Mr. Bogale within MOH (II, 2012-04-11) stated that MOH and MOCT has the constitutional mandate on women’s issues, but the responsibility falls upon MOWCY; to implement and follow up. Mr. Bogale mentioned Egldam (the umbrella organisation, and national organisation in Ethiopia working on eradicating harmful traditional practices) as coordinating the fight against FGM. It was also mentioned that there is a broad network in place and they all cooperate in the struggle against the harmful practice.

A good example of a ‘best way’ to eradicate FGM in Ethiopia worth mentioning is the NGO named KMG (also a member of Egldam), and especially the passionate Dr. Bogaletch. Their work is work replicating in order to decrease FGM in other parts of the country, or in other parts of the world as well. A special emphasis should be placed on the founder here, especially since she seem to be the driving force, but also the special youth focus groups referred to as ‘CC-groups’. Before KMG started their work in Kembata Tembaro Zone the prevalence was almost 100%, now it is under 3%. This is also confirmed by a survey Unicef undertook recently (personal field notes).

Another ‘good’ example is the work of Egldam. In Afar region FGM is said to have decreased substantially, and this has been confirmed by other organisation such as UNFPA as well. Between 1997- 2008 the national prevalence is stated to have decreased with about 20%, down to 56%. Egldam is a national umbrella organisation working on eradicating HTP. Majority of all organisations interviewed agreed that Egldam has the lead in the (coordinated network) FGM struggle. One important thing Egldam (II, 2012-04-23) mentioned was that people believe in what local leaders preach or state, and that it therefore is crucial to work with these key entry-points. As many Ethiopians are illiterate, it is not hard understand why they might believe and engage in HTP. The FGM network, Egldam, is also chaired by the MOH. This shows that the Government is involved (ibid).

According to Ali Hassen from Egldam (II, 2012-04-11), the national prevalence on FGM can differ, and this is mainly due to region and ethnicity issues, people say ethnicity is same as language etc. Note the difference compared to 73, 74% from other sources in previous chapter. A BLS was undertaken in 1997, ten years later they did a FUS, that’s how it is been established that FGM has decreased with about 20%. Egldam work on five HTP. For more info visit egldam-fgm.net
The NGO Amref mentioned that they approach FGM more indirectly, through programs and projects aimed at other HTP. Indirect approaches tend to be a common character as an approach. Amref is a member of the network in the struggle to eradicate FGM, such as with various national and local organisations, and they get their funding from e.g. UN as well as Sida. However, it was mentioned that they are not so coordinated with UN in the struggle to eradicate FGM (II, 2012-4-12). However, UN conducted work in Afar on FGM, at the same time as Amref.

Even though Clinton Foundations in Ethiopia claimed to be working on HTP, they did not do any work towards eradicating FGM (not work on MC). Clinton Foundation have just started talks on cooperation though with Hamlin Fistula Hospital, and perhaps a results from these talks will be visible, in terms of eradicating the harmful practice of genital mutilation (II, 2012-04-12).

Hamlin Fistula however stated that they do indirect FGM approaches in terms of the nurses they train and which then are sent back to work in the remote areas where they came from (II 2012-04-23).

A common feature was that the ‘awareness’ on infibulation, that has been brought from mainly NGOs. Even when type I or II hade been undertaken, it was assumed that a baby couldn’t get delivered in labour without complications, in terms of a small passage. More and proper education thus seem to be needed in these community approaches (personal field notes).

Awareness raising and education was the catchwords with regards as how to best eradicate the harmful practice of FGM. Some ethnic groups were claimed not to practice FGM at all in Ethiopia. To focus on these groups could help in the struggle on eradicating FGM, however they might do other harmful practices such as tongue split practices (some undertake MC and some don’t, personal field notes).

‘Best way to stop FGM is more education from NGOs. Now they come and educate every 1-2 years /…/ I would like them to come every month or more to educate the community (Grarbirak, IDI, 2012-04-14).

One man even wanted Government to come and educate more daily. He learnt about the harmful practice at Kebel level, however he thought the Government should do more to in terms of awareness raising (IDI, 2012-04-14).

‘Tes’, a social worker, mentioned that orphanage girls are checked at hospitals before they are placed in a sheltering home. He also mentioned that Government train former circumcisers, at Kebele level, and even give hand them income generating activities as a way to combat the practice (II, 2012-04-13).

In general, both NGOs and Government was mentioned as having done a lot of good work, and locals tended to be quite open and helpful. In areas such as Kembata Tembaro Zone, in parts of Afar region, as well as towns such as Sululta e.g. FGM seemed to have decreased substantially. In Sululta e.g. FGM was mentioned to have occurred more 10-15 years ago or so (Grarbirak, IDI, 2012.04-14).
Fatoma, (IDI, 2012-04-14) mentioned that they learn about FGM at Kebele level, from local district leaders. Due to education FGM has decreased, but more education was said to be needed. She mentioned that early marriage was a huge problem, and as interlinked to FGM. She was married away at the age of 14.

Some girls even choose themselves to undergo the harmful practice of FGM, according to Mr. Legesse at UNFPA (II, 2012-04-17). A former circumciser also stated that some girls themselves ask for the procedure (IDI, 2012-04-23). UNFPA do various interventions in this area, in schools, amongst local political bodies etc. UNFPA, together with UNICEF is working in six districts in Afar. Regarding coordination he mentioned it is like when you prepare a sauce.

‘You need various ingredients /…/ joint efforts at all levels /…/ change take time, but change will come /…/ people will question their culture but give them space’ (ibid).

Mr. Legesse also mentioned that some districts have made a public declaration on eradication of FGM, and how they try to reach important leaders, such as clan or religious leaders. However he said it is also important to look at the local context, to look for various and different ‘entry points’. Clan leaders was mentioned to be one important entry point in Afar, but can also be the men and women in marriageable age. However, it was argued how UNFPA use a integrated approach, and that to approach religious leaders only, is not enough. It was mentioned that they have a ‘network’ in Afar, however coordination and mapping of who is doing what has been a problem. UNFPA was mentioned to work on FGM indirectly as well, in other parts of the country. Mr. Legesse emphasised on the importance of working with the ‘demand-side’, rather than just ‘supply’ in terms of circumcisers. He mentioned that some circumcisers even practice FGM due to status, and not due to financial incentives, even though he said income generating activities also is important (ibid).

It was mentioned (II, 2012-04-17) tat police cooperate on HR and gender issues with NGOs, and a new curriculum for women capacity building is under way in Ethiopia. One PO interviewed was that was unaware of FGM emphasised on that information from regional level doesn’t reach federal level (II 2012-04-17). Ministry of Justice (Women, Children and Youth’s Affair, II 2012-04-17) confirmed the weak linkage between federal and region level. They claimed to be under way with training to prosecutors and police, as a way to enable easier to access data from a grass-root level. There was a wish to create ‘victim friendly offices’ as well as a national justice system. It was also mentioned that it would be good to mandatory clinical examinations of victims, as well as regional laws that fit into the context more (ibid).

Amref, Egldam and UNFPA mentioned that some ethnic groups in southern parts of Ethiopia, especially around Omo valley, don’t practice FGM at all. See appendices and the sub-chapter specifically on FGM.

91 Fatoma is Muslim, this area Sululta is however mixed.
91 Working within Gender and Advocacy.
93 This is important for future researcher to have in mind, why it is not practiced there, in this diverse country that Ethiopia constitute.
‘I am proud to marry uncut and so is my husband’ (II, 2012-04-18).  

This slogan is used in wedding ceremonies in KTZ nowadays, after interventions from KMG. As a best way forward is clearly also to have dedicated and ambitious people such as Dr. Bogaletch from KMG. Girls in KTZ now have the power to say no to GBV and HTP. KMG raise awareness and teach girls how to become more empowered. A special approach they have is so-called CC-groups where uncut girls (50 people from each Kebel, in which half are of the opposite gender) and boys talk openly about various issues and this has helped a lot in these communities (ibid).

‘I feel like a human being again’ (Bekelech Hydamo, II 2012-04-18).

This was a statement from a woman who was grateful to KMG and Dr. Bogaletch help. This women has now become like a role model in her community, in which more women dare to speak out (ibid). Role models (women) seem to be one of the things lacking in Ethiopia. It was claimed that there is no family or peer pressure from community anymore and people are aware that it is illegal, due to the work of KMG (FGD, 2012-04-18).

Former circumcisers are welcomed back to the community, after a (possible rather short) prison sentence. They are sensitized and then welcomed back, and talk to the community about their experience (II, 2012-04-18). This community approach might be pragmatic, but maybe harsher sentence could discourage the practice.

Another organisations name that came up as doing good work on awareness raising was ‘HUNDE’ (II, 2012-04-20). The Geda system, which was mentioned previously, was mentioned by the Office of Women and Children’s Affairs (2012-04-20), in terms of doing good since they have abandoned FGM (and MC) every one in eight years.

In general POs tended to state that FGM is culture and that’s why it is difficult to combat, and due to the fact that it occurs in secrecy. PO tended to be somewhat unaware of the Criminal Code on FGM in general, however seemed to be wanting to eradicate the practice and emphasised on more awareness raising if the practice is to be eradicated. Some however thought locals were unaware the practice is illegal to conduct. If people don’t report to police there will be no cases that go to court either, one judge mentioned (personal field notes).

Dr. Kuyateh from IAC (African regional body working on HTP, similar to Egldam, II, 2012-04-21.) mentioned that they work on different pillars as on how to eradicate FGM, and they have since 2003 worked on a new policy document, in order to develop a common agenda to eliminate FGM, which they initiated in a meeting with people present from various organisations who claimed to fight FGM, such as Embassy’s, UN, African Heads of State. IAC recently handed in a draft resolution to the UN-Assembly on a Zero Tolerance on FGM IAC claimed to have well established relations with the Ethiopian government, and it was mentioned that the government is working hard to eradicate the harmful practice.

94 The first couple who got married with t-shirts stating this slogan got a honeymoon sponsored by KMG to the States (ibid).
95 Functions like a CSO, based on ethnicity and supported byt the Ministry of Tourism and Culture (ibid).
96 Advocacy; working law’s and policy; income generating activities; protection of victims and coordination of stakeholders (ibid).
It was mentioned that they have a different approach than e.g. UNICEF because they don’t consider children as the ‘property’ of parents. It was also mentioned that the International Day on Zero Tolerance on FGM (6 Feb) was initiated due to IAC’s work.

The government has employed about 36 000 so called extended health workers all over the country to work with general health issues, but this could help and function as a platform for advocacy in the struggle against harmful traditional practices such as FGM (II, 2012-04-23). Ethiopian Human Rights Commission fund and train (give technical support) to GO and NGOs. They thought that people are aware of the harm and the law, but that change takes time, due to tradition and culture. ‘It is cultural issues, only teaching doesn’t help. Society needs help, and society need to change in order to change the livelihoods’ (Adham Durri, II, 2012-04-23).

Ministry of Women, Children and Youth mentioned that the Prime Minister’s wife advocate against FGM (II 2012-04-23). This however seem to be a common feature amongst African Prime Minister’s and President’s wife’s in Africa (Mrs. Mubarak e.g.) If they really undertake hard work or just trying to make a empty statement remains to be seen.

Since a former circumciser can cut four girls a day, and earn 30 Ethiopian Birr (12SEK) per girl, this means that it is a great source of income. Due to media and NGOs a former circumciser said that people are slowly beginning to understand the harm and that it is illegal. Elina (former circumciser) mentioned that she thought that enrolment of people from rural areas into education centres specialized at HTP could be one away to combat FGM. She claimed she do community approaches today and talk about her experience with regards to the practice (IDI, 2012-04-23).

‘The biggest issue is poverty, not female genital mutilation’ (Tsegay and Mekonnen, IDI, 2012-04-14).
7. Concluding Analysis

The paper presents an alternative point of view on previously not so well understood relations on the subject matter. Ethiopia is highly traditional, where women lack behind in most areas, such as health and education. It is hard to fight FGM when most of the population live in poverty. The legal provisions in the Criminal Code against FGM are not strong enough, or in place. The Criminal Code enacted in 2005 only restricts FGM, and doesn’t explicitly outlaw the practice. Implementations challenges seem to be in insufficient training, information and clarity of goals. The country is democratically crippled, and NGOs has been constrained (indirectly) in their work on FGM. Ethnicity and culture, rather than religion, seem to be the most decisive factors for the practice in Ethiopia. There seem to have been great efforts in terms of advocacy in the struggle to eradicate the FGM in Ethiopia, and it seems as though the veil of silence on ‘sensitive’ issues has been partially lifted.

There seem to be awareness in some segments of the population, however much more work is needed towards the total elimination of FGM through joint coordinated efforts. Best practices, such as from KMG, should be highly recommended and replicated in the struggle against FGM. Awareness on the harm in the traditional practice as well as implementation and adherence to the law, and thus change takes time. However, Western cultural norms seem to prevail over other cultural norms. Various forms of genital alterations, undertaken due to individual non-medical reasons might create skewed attitudes and have a negative impact on the struggle against FGM, from a wider perspective. The legal framework in Sweden needs to be reviewed due to the fact that intimate surgery can be classified as a form of mutilation; hence Beauty-FGM.

Theories used should not necessarily always be understood as one is a more important explanation than the other; they are more or less interlinked. See below table.
Table 1. Clarification of Results

The purpose with this thesis was to undertake the arduous and somewhat risky task of exploring why female genital mutilation persist in Ethiopia with regards to the legal framework in place, in relation towards the ambiguous notion of bodily integrity and cultural norms in wider context from a political and ethical perspective (the ‘phenomenon’ of genital alterations)

<table>
<thead>
<tr>
<th>RQ 1. What is the status of females and FGM in Ethiopia?</th>
<th>RQ 2. Are there legal framework mechanisms in place?</th>
<th>RQ 3. What are the biggest challenges and what are the way’s forward?</th>
<th>RQ 4. What readings can be made with regards to the ‘phenomenon’ of genital alterations from a wider perspective?</th>
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<tbody>
<tr>
<td>Analysed and explained by various theories:</td>
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<tr>
<td>Rational Choice</td>
<td>Culture Theory</td>
<td>Human motivation</td>
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<td>Poverty: females lack behind in most areas, education,</td>
<td>No, a majority of those asked thought the Criminal</td>
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<td>Women are supressed</td>
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<td>health etc.</td>
<td>Code had implementation problems; or that the legal</td>
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<td>Sexually supressed</td>
<td>provisions was weak and needed to be revised</td>
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<tr>
<td>HTP, early marriages</td>
<td>Possible explanations: lack of awareness, clarity</td>
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<tr>
<td>100% of those asked preferred to marry uncircumcised</td>
<td>and willpower to adhere to law, due to;</td>
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<td>A majority mentioned a ‘taboo’ on sexual issues</td>
<td>Law enforcers engaged or aware of HTP;</td>
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<td>Lack of awareness</td>
<td>Democracy issues; NGOs constrained etc.</td>
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<td>Lack of coordination – No strong linkage between</td>
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<td>federal and regional levels</td>
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<td>Law restricting NGOs</td>
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<td>Implementation problems of Criminal Code</td>
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<td>Policy interventions such as MMC and others can</td>
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<td>Harmful traditional practices – harmful modern</td>
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<td>Insufficient, incompatible law’s and policy</td>
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<td></td>
<td>Self expression, Women use all options available</td>
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<td></td>
<td>A ‘phenomenon’ of Beauty-FGM</td>
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</table>

7. 1 FGM and women in traditional Ethiopia
RQ 1. In Ethiopia, how is the situation for women and what is the status of female genital mutilation?

Ethiopia is a traditional society where the majority is poor, and women carry the bulk of problems. All of those asked preferred to marry uncircumcised women, which is a good sign which might indicate that FGM has decreased due to the fact that young men nowadays are more entitled than before to choose their life partners themselves. However, FGM is still prevalent in a high rate (between 57-74%), and practiced in various ethnic and religious groups, both among Christians and Muslims. There are huge intra-state differences though, some strongholds of the practice is e.g. Somali and Afar regions (which are Muslim strongholds). Women lack behind in areas such as education, health, jobs and politics. Women gained more rights after the Criminal Code was enacted in 2005. There are many harmful traditional practices, not only FGM, but early marriages was mentioned a huge problem as well. Since Ethiopia is a traditional country sexual issues are more or less taboo, and thus there was lack of awareness regarding the practice and the law against it. Women’s Affairs offices countrywide, and some NGOs have done a lot of good work in relations to women’s status.

When first priority is to fight poverty, it is no wonder the struggle on FGM can lack behind. This can be explained by the theory on human motivation, and as some of the interviewees mentioned girls has even asked for the procedure themselves, As mentioned before, there is a legend explaining how infibulation started, when Pharaohs of Egypt used to have sex with six or seven virgins daily, and mothers started to infibulate their daughters as a way to protect them.

Radical feminist theory can explain the practice of FGM, when women are supressed by men as a way to control their sexuality. FGM was and can still be viewed as sexual suppression by men, which lies deep in their history and culture. It is sexual suppression, subjugation and exploitation, and mothers who still today believe they are watching out for the welfare of her daughters. Radical feminist (and the patriarchy) theory can be used as a way to understand the practice as well when women are subordinated to men, but it is also a form of sexual degradation and devaluation, especially when FGM is performed on the basis as to enhance men’s sexual pleasure, or as to ensure virginity etc.

Rational choice theory can be ascribed to FGM as when the practice is an act performed on the basis of socio-economic reasons, if we view individuals as ‘utility-maximisers’, especially if the practice is performed as a kind of social ‘safety net’. This safety net can e.g. to marry away daughter, and can thus look different in different countries, and that’s why some societies not necessarily need to practice mutilation as to ensure that girls can marry. As a former circumciser mentioned, it can be a great source of income. The prevalence of FGM may diminish if the ‘hints’ available on the prevalence decreases, and if there is open dialogue about sexuality, so that the community can take joint decisions on that FGM should not be maintained.
This is also a central theme of rational choice theory as the aggregation of individually rational behaviour often produce collectively irrational behaviour. The practice can be decreased when the tipping point is reached, when the positive outweighs the bad.

As a majority of the interviewees mentioned, sexual issues is sort of a taboo topic, and FGM is deeply enrooted in their culture. Thus, ‘culture’ enable us to gain an understanding of problems with change due to tradition. When FGM is openly debated, maybe the harmful practice can be eradicated easier.

7. 2 The Legal Framework

RQ 2. In Ethiopia, are there legal framework mechanisms in place?

The harmful practice of FGM persist, even with a legal framework, and there seem to be many reasons as due to why the practice persist. It is essential with a legal framework as law’s and policies make up a foundation, to e.g. the eradication of harmful practices. The Criminal Code enacted in 2005 however only restricts FGM, and doesn’t explicitly outlaw it. A majority of those asked stated they thought the Criminal Code had implementation problems; or that the legal provisions was weak and needed to be revised. Possible explanations for this can be lack of awareness, clarity of the goals with the law and thus willpower to adhere to it. The country is democratically crippled as well, and due to e.g. funding restrictions for NGOs organisations have been silenced and hence also hindered in the struggle on FGM. Neither was there a strong linkage between federal and regional level, which not only results in implementation challenges but also in lack of data on FGM.

There seem to be huge implementation problems of the Criminal Code, and other relevant policy documents for that matter, in terms of challenges such as resources; both human and economic constrains. Secondly, Ethiopia is a traditional society where FGM is deeply enroote in culture, where the population (both Muslim and Christians) value tradition. Last but not least, this is a developing country. Their first priority is, (and must?) be to fight poverty. What’s seems as a rational choice to parents, to mutilate their daughter’s, might not seem rational to us. Since it is a poor country where the majority is illiterate they also believe what they are told, from religious and local leaders sometimes, and they do what they perceive they have to do in order to survive on a day-to-day basis, so they might stick to their culture and traditions rather than adhere to new laws and policy. In a traditional setting, such as Ethiopia, feminist explanations and theories on the patriarchy can also be used as a way to understand why there is legal framework challenges. It implies the institutions of male rule and privilege, and entails female subordination. Law enforcers might neglect to abide to existing legal framework, and thus suppress women. In a traditional setting law enforcers might even themselves be involved into harmful traditional practices.

97 The Tipping Point is ‘the biography of an idea /.../ that the best way to understand the emergence of fashion trends /.../ mysterious changes that mark everyday life is to think of them as epidemics. Ideas and products and messages and behaviours spread just like viruses do’ (Gladwell, 2000:7).
7. 3 Challenges and Ways Forward

RQ 3. In Ethiopia, what are the attitudes on the biggest challenges in the struggle against FGM and what are the way’s forward?

As mentioned, the first obstacle might be poverty. Then, as mentioned, the legal framework is there, but it seems to have huge implementation problems. The majority of the people in traditional Ethiopia is poor, uneducated and thus many are illiterate and lacks knowledge. There are many challenges in the struggle to combat FGM. As some of the interviewees mentioned, a first priority is to fight poverty, not FGM. It was also mentioned during the interviews that the various stakeholders in the struggle on FGM seemed to be uncoordinated. Although human rights are regarded as universally applicable, the values on which they are based can be traced to a specifically European history and tradition of thought. In countries where the practice of FGM is performed, states have adopted policies that prohibit the practice even when the laws do not reflect what the majority of the population wants. This can imply challenges in terms of the ownership and adherence to laws and policy. It is a weak country democratically, which is visible e.g. through the restriction for NGOs. A huge obstacle in the struggle against FGM that was mentioned by many interviewees was the Regulation of Charities and Societies (CSP). The law is one of the most controversial NGO laws in the world. The Proclamation restricts NGOs that receive more than 10% of their financing from foreign sources from engaging in essentially all human rights and advocacy activities.

One major challenge as to eradicate the harmful practice might be that people perceive male circumcision, which is widespread in Ethiopia, as equivalent to female genital mutilation. One conclusion is that attitudes might be skewed in terms of that (uneducated) people in Ethiopia might be unaware of the difference between the two practices, and perhaps due to the fact that both are deeply enrooted in their culture. This can imply problems of effective implementations of laws against FGM. A majority of those asked agreed that there could be a link between the two practices, as discussed. (M)MC should also maybe not be used as ‘excuse’ as a way to fight HIV, especially not since Ethiopia has a relatively low HIV prevalence rate. Even so, Ethiopia is one of the MMC scale up countries. Intervention such as MMC and other types of genital alteration puts the focus on women as the ones either carrying the virus, which might increase GBV, or stigmatizes women as being ‘dirty’ or ‘ugly’ and hence something in the genital area needs to be removed. How one practice be overlooked and advocated for while at the same time the practice of the female ‘circumcision’ or ‘mutilation’ is trying to be eradicated can be quite an arduous and risky task, and should therefore be dealt with carefully according to the author of this paper.

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98 1,5% of people aged 15-49 are infected with HIV in Ethiopia (DHS, 2011).
99 Even though Ethiopia is more Christian than Muslim, and male circumcision is widespread, the prevalence rate between the two was almost the same. It is not quite established whether FGM mostly occur in Muslim societies. It could be easier to decrease the harmful practice in Christian rather than Muslim societies due to the adherence to the Koran, and/ or especially when people are illiterate.
FGM lies deep in Ethiopian culture and traditions. People need to be motivated enough, the positive need to outweigh the negative if it is to be eradicated. As mentioned during the interviews, it is important with economic incentives, in terms of income generating activities, especially for circumcisers. A husband might want to control his wife’s sexual urges, and a mother might want to mutilate her daughter due to community stigma or a fear of not being able to marry her away. Women are thus might risk being suppressed by both men and the wider society. Patriarchy theory drawn together with feminism, points it all in a politicized direction, making it all into a coherent cultural undertow.

All of those asked mentioned training and education (campaigns) as a best way to eradicate FGM. Community approaches was mentioned as well, as a way to combat stigma. The Global Public Health Conference (held Addis, April 2012), as well as former major FGM conference and the anti-FGM Draft Resolution to the UN-Assembly from African Heads of State, are all positive developments when it comes to women’s status, as well as the relatively newly installed Women’s Affairs offices. Maybe the FGM-resolution, if the UN-Assembly will enact it, will have a huge implication and spur the struggle against FGM in Ethiopia, and elsewhere. Change will surely come, but change takes time. Maybe an initiative from Heads of States from the AU will spur countries to be more motivated rather through ‘requests’ from the West.

In order to combat FGM an integrated holistic intervention is required, with focus on information, education and communication (IEC), in order to affect attitudes and thus behaviour. Clearly, considerations must be given to use all means necessary to promote women, but also youth empowerment, and equally important is to encourage men’s involvement in any endeavour related to improving women’s status. A special focus should be given to open up the taboo on ‘sensitive’ issues between the genders so an open discussion can take place. A good example of a ‘best practice’ is the one from the NGO KMG, and their youth groups called ‘CC-groups’. This is very crucial in traditional countries as Ethiopia as women and men live together in a complex socio-cultural context that favours the latter.

Education is crucial in the struggle against FGM, as it empowers people, and women in particular. At the same time however that education empowers women it changes the dynamics in households, and thus changes norms, especially also du to the fact that women are also the ones who inculcate cultural values in their children. Education is determinant in the struggle to eliminate harmful practices, thus it plays a major role in delaying the start of sexual activities, entry into marriage and the start of childbearing etc. Girls and women’s access to resources in terms of education e.g. in Ethiopia is lower than men’s, even though, the returns for society are might be greater from the education of women due to their dominant role in social reproduction. The more educated a woman is, the more likely she is to have opportunities and life choices and can avoid being oppressed and exploited.
7. 4 Globalization and FGM

RQ 4. What readings can be made with regards to the ‘phenomenon’ of genital alterations from a wider perspective (on a macro level, with regards to existing legal frameworks)?

Harmful traditional practices seem to have spilled over to harmful modern practices, in terms of new forms of genital alterations, such as medical male circumcision (MMC) e.g. which is a Western influence. A majority of those asked thought there was a link between MC and FGM. Male circumcision has also shifted to more of a ‘medical’ form. Policy interventions such as MMC and other forms of genital alterations can have unintended consequences. It might stigmatize and suppress women, since the practice put focus on them as the ones carrying the virus. This and other phenomenon of genital alterations might have an (bad) impact also on immigrants living in exile.

It might create new and/ or skewed norms of what is perceived as beautiful, or what it is that constitutes a medical or cultural activity. Western forms of genital alterations (both intimate surgery and piercing) is also a form of ‘mutilation’, according Swedish law, as well as WHO. In a globalized world, different ethnic groups live side by side, thus one might value what they perceive as sexual ‘mutilation’ and the other sexual ‘enhancement’. Both suffering and ideals are imperative components here as we are dealing with the phenomenon of genital alterations. What’s seems as a rational choice for one might be viewed differently by the other.

There could be possible reverberations felt in a Swedish setting. With the influx of many immigrants from Africa in the beginning of the 1990s, there was a revival of attention paid to FGM. Most African immigrants, in Sweden originate from Ethiopia e.g. 100 This might complicate the issue of genital alterations, especially since in Sweden it is accepted to do cosmetic surgery, but illegal with FGM. The Swedish law includes a prohibition of all operations on the external female genital organs, designed to mutilate them or produce other permanent changes in them. Such operations are illegal, regardless of whether consent to this operation has or has not been given. Law’s and definitions clearly clashes with both intimate surgery and male circumcision, and thus violates the legal principle of all citizens’ equality before the law.

What constitutes female genital mutilation can be quite contradictory, and hence how to combat the practise can also quite an arduous and risky task. As mentioned in from the interviews, IACs Executive Director Dr. Kuyateh argued that he thought that Sweden has a problem with FGM, that it a risk that it occur when people go back for ‘vacation’ to Ethiopia e.g. and thus that it might occur in the dark. Dr. Kuyateh should know, both as an Ethiopian himself, but also due to the fact that IAC is represented in Sweden by RISK.

This made my curiosity grow further. A minor undercover cell research was therefor undertaken. Could it be that people with false and ‘wrong’ agendas can receive ‘treatment’ in the genital area at private clinics in Sweden?

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100 Immigrants in Sweden originates primarily from East Africa: Somalia, Eritrea and Ethiopia. More than 18,000 of these originates from Ethiopia or Eritrea (Johnsdotter, 2009:13ff).
Is an operation where the inner labia’s are removed to be considered as a crime or ‘just’ a cosmetic alteration? All out of five clinics agreed to undertake genital alterations, even though it was claimed that it had to be done in a rush before going back to the country of origin (which was claimed to be Ethiopia), because a marriage was waiting in that home setting (investigating interviews by phone, 2012-05-14).  

Every fifth woman in Sweden is actually willing to undergo surgery to improve her appearance. Among the younger age group 15-29 years, as many as one in three claim to be willing to undergo a cosmetic surgery. Obviously it is another question how many people that actually would take the plunge and actually go through with a procedure. Compared to a Sifo poll that ‘Agenda’ ordered in 2009, we can also see an increase in the interest amongst females. The comparison shows that almost 515 000 women would consider a cosmetic surgery in 2009, that figure grew to almost 715 000 women 2011 (SVT, 2012).

‘if other countries do other forms of genital alterations there will be consequences in other countries, such as Ethiopia, and especially when we do these genital alterations due to individual selfish reasons /…/ both FGM and female genital alterations of more aesthetical forms are done based on cultural reasons’ (Aaryam, II, 2012-05-07).

Aaryam, a 24-year old Swedish student (2012-04-07) stated that she regarded both male circumcision and female forms of genital alterations as disgusting practices. However, it was not until recently she began to be aware of other forms of genital alterations, and especially from programs such as ‘the Beauty Bubble (SVT, 2012)’. Aaryam argued that both FGM and other more so-called designer vaginas are utterly bad practices. Aaryam also mentioned the importance of how classification and definitions are made, that it has to be done with caution. She compared FGM and designer vaginas with the discourse on honour related violence, which she meant stigmatized certain ethnic groups. Aaryam meant that focus also should be on violence that occurs in ‘normal’ Swedish homes (ibid).

A view opposing the belief that FGM constitutes human rights crime could be that of cultural relativity. This viewpoint is based on the deed for tolerance of ‘primitive’ and ‘uncivilized’ behaviour even though they may differ from one’s own. Human’s behaviour must be understood within the framework for their culture. It depends on who is raising the issue, where and the extent to which women themselves seek to normalize the practice.  

Everything is relative, depending on the inside versus the outside point of view. Harmful Traditional Practices might thus have shifted to Harmful Modern Practices, where women might not necessarily be suppressed by the patriarch but suffer from self-suppression.

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101 Undercover interview: undercover name was Aaryam Bogale; she grew up in Sweden, was born in Ethiopia. It was claimed that Aaryam was going back to Ethiopia for her wedding ceremony. It was claimed that the procedure needed to be done quickly, before the wedding that was claimed to take place in August, in Ethiopia with an Ethiopian man. All five clinics (Stockholm, Göteborg, Jönköping, Halmstad and Malmö) offered to help. One emphasised on the time span with regards to the wedding night. The clinics staff might have misunderstood, or been under stress or just suffered from a lack of knowledge. However, as working professionals in this area they all should be aware on the debate on the subject matter, and thus been somewhat sceptical?!

102 German Greer might be viewed as a cultural relativist as she is regarded as a back-lash feminist in terms of her defence of the harmful practice.
One of the world’s most renowned (back-lash) feminists, Germaine Greer is most interested in attacking double standards. Her standpoint is, more or less, that if Jews and Moslems are allowed to circumcise boys, why shouldn’t Ethiopians and Somalis be allowed to do it to girls. Academics such as Johnsdotter e.g. have another interpretation and do not defend the harmful practice as Greer, but instead mean that the practice is similar to cosmetic surgery, and discusses the issues around reinfibulation etc. Male genital mutilation is considered trivial; female genital mutilation however is often considered devastating even if it involves nothing more than ‘simply’ nicking the prepuce of the clitoris to provoke ritual bleeding.

The issues of intimate surgery linked to female genital mutilation were debated in the three part documentary series SVT broadcasted recently. Scholars such as Sara Johnsdotter, expert on FGM from Lund University, and Dr. Birgitta Essén (they have together produced research on the subject matter, and this is visible under previous research as well) participated in the program (SVT, 2 Juni 2012). Johnsdotter mentioned that it could problematic when a doctor faces a woman that wants to do a genital alteration and when she has one parent with Western origin and one with African origin, in terms of if she is to be regarded as a rational person with the right to bodily autonomy or a victim of patriarchy. Johnsdotter claimed that the procedure can be the same, but interpreted differently. Swedish National Board of Health and Welfare has now launched an investigation on the regulations in this area (ibid).

7. 5 Concluding Remarks

Women in Ethiopia are often uneducated and overburdened with work. Not only do they perform low paid jobs, or often non-remunerated work (at the market in the field), but they also have to take care of the (male-dominated) household. Leisure is probably a foreign concept for traditional Ethiopian women. On top of all this, Ethiopian women also have to endure harmful traditional practices. Western women have to endure harmful modern practices - well at least Western women have a choice, most of the time. It seems to be an issue of pressure and expectations, in a highly materialistic (‘religion’ of capitalism) setting, and thus rational decisions for one might result in a hysterical mass of irrational choices.

Eliminate poverty seem to be on the tongue for many activist and politicians, however, this type of approach rests on the assumption that cultures will evolve ‘naturally’ in a positive way if they are not plagued with poverty, which is often claimed to be the main cause of inequality. To eliminate poverty is essential to a high extent, sure, otherwise how are societies suppose to combat harmful practices such as FGM when they don’t even have food on their tables? However, genital mutilation (and inequality) occurs even where societies are not plagued with poverty.

Western feminist arguments often describe female genital mutilation as patriarchal control over women’s bodies and sexuality, and as a symbol of women’s subordination to men. This could be true also in a Western society, even though women alter their genitals by their own whim, as ‘logical’ thinking and independent women. Bodily integrity and personal autonomy, that is autonomy over the body should be a ‘prima facie’ principle in its own right.
However, it seems as though it is not possible, especially not in this globalized world where Western cultural norms seem to prevail over other religious or cultural norms. A lot of double standards of moral are involved here. Western parents might actually circumcised their newborns so that the sons will look like the fathers. As mentioned before, genital mutilation has also even been conducted as late as into the 20th century in the West, as a way to prevent ‘bad’ behaviours such as masturbation or prevent mental decease. This is important to remember, since people sometimes tend to judge before they reassess their own culture and background. Unfortunately (Western) women seem to be subjected to self-suppression as well, since women tend to agree to do these cosmetic genital alterations. In general, men also hypocrites since they tend to crave a woman who does these types of alterations. An important question though to ask here is why do men, and women, want baby looking vagina’s, so-called ‘Roll’s Royce vaginas’?

Have our moral values has been flushed away? Why else do women and men mutilate their genitals just because they perceive it to be beautiful? Women from the majority populations, in Sweden, might have low self-esteem due to trend-based ideas about what is ‘normal’ and beautiful in the genital area, and so might immigrant groups and these cultural norms might clash, or perhaps they are similar in some case. In any case, the relation of legislation to different changes of the female genitals needs to be sorted out, for a general application of the law that is inclusive of all people, regardless of their ethnic background.

Is the concept of ‘Beauty-FGM’ thus a result of post patriarchal neo patriarchy, or can it be explained in terms of female supremacism? Patriarchy ‘theory’ runs through feminism, and feminism implies moral license for women, and therefore women are often entitled to extra perks and ‘pampering’s’, such as cosmetic surgery e.g. Do men suppress women, or are women suppressing themselves when agreeing to do bodily alterations (and in who’s interest really?), or are women rational utility-maximizers exploiting all options available in this materialistic world? Thus women become capitalistic supremacists… The question is what happens when the thin line between intimate surgery for aesthetical appeal (influenced from the world of porn?!?) and FGM overlap each other. FGM, or intimate surgery remains some sick desire of girl-looking genitals, a form of paedophilia. Western interventions can have devastating effects, side effects that are harmful, in both a local context as well as on a global context, with regards to both laws as well as norms.

What we need to have in mind is that even Western cultural ideals and norms can have devastating effects, especially from an egocentric individualistic perspective, when we don’t think ‘out of the box’. Nor is FGM something that only occurs in Muslim societies. Especially when it comes to such a diverse country as Ethiopia (82 ethnic groups, where MC is widespread, and it is one of the poorest countries in the world), we need to integrate a more holistic approach, with emphasis on multicultural understanding. Future research should focus on whether FGM actually is more prevalent among Muslims or if it appear in Christian populations at similar rates, because at the moment this seem to be more of a claimed fact. I am not trying to make some dodgy moral statement, because it is as equally bad no matter how you look at it.

The term is often used by social anthropologist Sara Johnsdotter from Lund University.
Future research should however be more curious whether FGM, like honour killings is claimed, to be more ingrained into Islamic societies, especially with regards to prevalence of male circumcision. Future researcher should also focus on the link between MMC and FGM, as mentioned in this study. The aim of this paper was, as mentioned, not to argue that traditional female circumcision ought to be legalized, but more to highlight the double standards of moral involved, otherwise we might risk stigmatize certain ethnic groups further. Why western agencies like the WHO have defined FGM as an atrocity which must be stopped while ignoring comparable operation such as male circumcision, and the increasing practice of ‘Beauty-FGM’ is an interesting question which needs to be discussed further.
List of References:

Book literature:


Electronic Sources:


Journals and Articles:


**Other Official Documents and Publications:**


For information on interviewees see appendices.
## Appendix 1. Interviews Conducted

<table>
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<th>Method:</th>
<th>Target Group:</th>
<th>Number/Type of Interview:</th>
<th>Remarks:</th>
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<tr>
<td>FGD/IDI/II</td>
<td>Youths</td>
<td>10 II 3 IDI 1 FGD</td>
<td>100% of those asked preferred to marry uncircumcised</td>
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<td>SOCIO-DEMOGRAPHIC CHARACTERISTICS TO CONSIDER:</td>
<td>Health workers</td>
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<td></td>
</tr>
<tr>
<td>LITERACY</td>
<td>Public officials</td>
<td>17 II</td>
<td>A majority of those asked thought there was a link between MC and FGM</td>
</tr>
<tr>
<td>ETHNICITY</td>
<td>NGO or other Stakeholders</td>
<td>15 II</td>
<td>100% of asked mentioned education (advocacy, awareness raising) as a way to eradicate FGM</td>
</tr>
<tr>
<td>AGE</td>
<td>Men, Others</td>
<td>9 II 1 IDI</td>
<td>A majority of those asked thought the Criminal Code had implementation problems; or that the legal provisions was weak and needed to be revised</td>
</tr>
<tr>
<td>SEX</td>
<td>CIVILIAN STATUS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** II = Informant Interview; IDI = In-Depth Interview; FGD = Focus Group Discussions. Interview period (in total) from 29/1-14/5-2012. Youths = < 30 years of age. Men = > 30. 5/9 II on the category of others includes private plastic surgery clinics in Sweden.
Appendix 2. Interview Guide
(Stakeholders)

<table>
<thead>
<tr>
<th>Interview Form: (II, IDI or FGD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
</tr>
<tr>
<td>Commencing and Concluding Time:</td>
</tr>
</tbody>
</table>

Hello, my name is Petra Spencer, I am a Master student from Sweden conducting fieldwork on FGM for my degree thesis. You are an important stakeholder and I would appreciate if you could spare your valuable time to respond to some questions pertaining to FGM. Your response will be treated confidentially if you choose so, and we can stop at any time.

(General information)
Name: 
Profession: 
Interview took place: 
Age: 
Demographic area: 
Civilian status: 
Educated (literate): 
Religion: 
Ethnicity: 

(Organisational profile, i.e. if it is an organisation/office)
Organisations name: 
What are your strategies (target group etc.) to fight FGM: 

(Occurrence of the practice)
How common is the practice in this area, (why and how): 
From your experience, could you tell me the major reasons contributing to the persistence of FGM, despite interventions, such as the Criminal Code: 
Do you see any link between FGM and the widespread use of male circumcision: 
Activities against FGM by other stakeholders (coordination): 
Changes brought and challenges: 
Is the practice similar (magnitude) over the years: 
What is your suggestion or recommendation on how to reduce or eradicate FGM: 

* Various 'probe questions' were asked depending on the 'stakeholder', whether it was a health worker, NGO, public official, circumciser, youth, mothers or men that was interviewed. Questions were asked such as personal views on FGM, in relation towards marriage and if FGM is a taboo topic etc. When women were interviewed questions were asked on if they themselves had undergone the procedure, why, when, where and if they and done it to their daughters etc. Public officials were asked specific questions about the law as a way to establish how aware they were of it, and adherence to it.
### Appendix 3. Prevalence of FGM (%), by Regions in Ethiopia

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>On Self (15-49)</td>
<td>On Daughter</td>
<td></td>
</tr>
<tr>
<td>Tigray</td>
<td>48.1</td>
<td>35.7</td>
<td>39.0</td>
<td></td>
</tr>
<tr>
<td>Afar</td>
<td>94.5</td>
<td>98.6</td>
<td>96.6</td>
<td></td>
</tr>
<tr>
<td>Amhara</td>
<td>81.1</td>
<td>79.7</td>
<td>78.5</td>
<td></td>
</tr>
<tr>
<td>Oromiya</td>
<td>79.8</td>
<td>89.8</td>
<td>43.2</td>
<td></td>
</tr>
<tr>
<td>Somali</td>
<td>69.7</td>
<td>99.7</td>
<td>57.7</td>
<td></td>
</tr>
<tr>
<td>B/G</td>
<td>52.9</td>
<td>73.7</td>
<td>63.8</td>
<td></td>
</tr>
<tr>
<td>SNNP</td>
<td>46.3</td>
<td>73.5</td>
<td>37.0</td>
<td></td>
</tr>
<tr>
<td>Gambella</td>
<td>0.0</td>
<td>42.9</td>
<td>43.4</td>
<td></td>
</tr>
<tr>
<td>Harari</td>
<td>81.2</td>
<td>94.3</td>
<td>43.3</td>
<td></td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>70.2</td>
<td>79.8</td>
<td>39.9</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>60.6</td>
<td>79.9</td>
<td>51.9</td>
<td></td>
</tr>
</tbody>
</table>

**Source:** Kitaw et al. 2008:407

**Note:** The Survey is on all females. The results seem to be concordant except for notable differences in Gambella, which can be explained by that the Survey reports on the local ethnic groups only while DHS includes all inhabitants. DHS sample tend to be urban biased. Value put on girls in Gambella is not being based on being mutilated or not in terms of remain virginity, especially not since rape and abduction are punishable by stone killings.

*There are many intra-state differences; between and underlying factors to difference of the prevalence in Ethiopia. In Kitaw et al. (2008) there are plenty of tables and figures due to age, ethnicity etc. but too many to attach here. Available online at: egldam-fgm.net*
### Appendix 4. Global Documented FGM Prevalence

<table>
<thead>
<tr>
<th>Country</th>
<th>Year</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benin</td>
<td>2006</td>
<td>12.9</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>2006</td>
<td>72.5</td>
</tr>
<tr>
<td>Cameroon</td>
<td>2004</td>
<td>1.4</td>
</tr>
<tr>
<td>Central African Republic</td>
<td>2008</td>
<td>25.7</td>
</tr>
<tr>
<td>Chad</td>
<td>2004</td>
<td>44.9</td>
</tr>
<tr>
<td>Côte d’Ivoire</td>
<td>2006</td>
<td>36.4</td>
</tr>
<tr>
<td>Djibouti</td>
<td>2006</td>
<td>93.1</td>
</tr>
<tr>
<td>Egypt</td>
<td>2008</td>
<td>91.1</td>
</tr>
<tr>
<td>Eritrea</td>
<td>2002</td>
<td>88.7</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>2005</td>
<td>74.3</td>
</tr>
<tr>
<td>Gambia</td>
<td>2005/6</td>
<td>78.3</td>
</tr>
<tr>
<td>Ghana</td>
<td>2006</td>
<td>3.8</td>
</tr>
<tr>
<td>Guinea</td>
<td>2005</td>
<td>95.6</td>
</tr>
<tr>
<td>Guinea-Bissau</td>
<td>2006</td>
<td>44.5</td>
</tr>
<tr>
<td>Kenya</td>
<td>2008/9</td>
<td>27.1</td>
</tr>
<tr>
<td>Liberia</td>
<td>2007</td>
<td>58.2</td>
</tr>
<tr>
<td>Mali</td>
<td>2006</td>
<td>85.2</td>
</tr>
<tr>
<td>Mauritania</td>
<td>2007</td>
<td>72.2</td>
</tr>
<tr>
<td>Niger</td>
<td>2006</td>
<td>2.2</td>
</tr>
<tr>
<td>Nigeria</td>
<td>2008</td>
<td>29.6</td>
</tr>
<tr>
<td>Senegal</td>
<td>2005</td>
<td>28.2</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>2006</td>
<td>94</td>
</tr>
<tr>
<td>Somalia</td>
<td>2006</td>
<td>97.9</td>
</tr>
<tr>
<td>Sudan, northern (approximately 80% of total population in survey)</td>
<td>2000</td>
<td>90</td>
</tr>
<tr>
<td>Togo</td>
<td>2006</td>
<td>5.8</td>
</tr>
<tr>
<td>Uganda</td>
<td>2006</td>
<td>0.8</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>2004</td>
<td>14.6</td>
</tr>
<tr>
<td>Yemen</td>
<td>2003</td>
<td>38.2</td>
</tr>
</tbody>
</table>

**Source:** WHO, 2012.

**Note:** Documented FGM prevalence by % in Africa and Yemen (women aged 15-49). According to WHO (2008), FGM has been documented in some other countries as well, but no national estimates have been made. These countries include India, Indonesia, Iraq, Israel, Malaysia and the United Arab Emirates. There are anecdotal reports on FGM from several other countries as well, including Colombia, Democratic Republic of Congo, Oman, Peru and Sri Lanka. Countries in which FGM is practiced only by migrant populations is not included.