GENDER & ADOLESCENCE: GLOBAL EVIDENCE

Exploring the diversity of FGM/C practices in Ethiopia

Drivers, experiences and opportunities for social norm change

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January 2022

Acknowledgements

The authors wish to thank reviewers from FCDO London and FCDO Addis Ababa for very helpful peer review comments.

We also thank Kathryn O'Neill for copyediting and Cheikh Sy for layout and design.

Suggested citation

Presler-Marshall, E., Jones, N., Oakley, E., Dutton, R., Baird, S., Yadete, W. and Gebeyehu, Y. (2022) Exploring the diversity of FGM/ C practices in Ethiopia. Drivers, experiences and opportunities for social norm change. London: Gender and Adolescence: Global Evidence

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1 Introduction

Female genital mutilation/cutting (FGM/C) – defined as all procedures involving injury to or removal of the external female genitalia for non-medical reasons – is practised in 29 African countries, including Ethiopia, and in parts of Asia and the Middle East (UNFPA, 2020). Due to its large population (115 million in 2020) and its high national incidence rate (65%), Ethiopia has the world's second largest total number of women and girls who have experienced FGM/C (behind Egypt) (28 Too Many, 2021). The most recent Demographic and Health Survey (DHS), conducted in 2016, highlights Ethiopia's regional diversity but also its slow but steady progress towards eliminating FGM/C (CSA and ICF, 2017). Although it notes that progress has accelerated in recent years (especially among younger women), it cautions that apparent progress may be due to under-reporting due to criminalisation of the practice in 2005.

This report draws on research conducted by the Gender and Adolescence: Global Evidence (GAGE) programme. It explores the diversity of practices and the ways in which current policy and programming efforts are contributing to change, as well as identifying where there are still blockages in shifting practices and norms around FGM/C. Critically, our findings suggest that mechanistic awareness-raising efforts are falling flat in the communities in which FGM/C is most embedded, and that future progress depends on more strategic and context-tailored efforts to address the intersecting age and gender norms that underpin the practice.

2 Background

Ethiopia has a national policy environment that is favourable to eliminating FGM/C. The practice is criminalised and the government has a costed strategy for elimination by the year 2025 (28 Too Many, 2018; Government of Ethiopia, 2019). However, in several regions (especially Afar and Somali), there is a disconnect between national and regional laws; moreover, laws are rarely enforced, because many local officials value the social norm of FGM/C more than they value the law prohibiting it. Arrests – much less prosecutions and convictions – are extremely rare. The charity, 28 Too Many, (2018) reports that in 2016 there was only one conviction for FGM/C in Ethiopia.

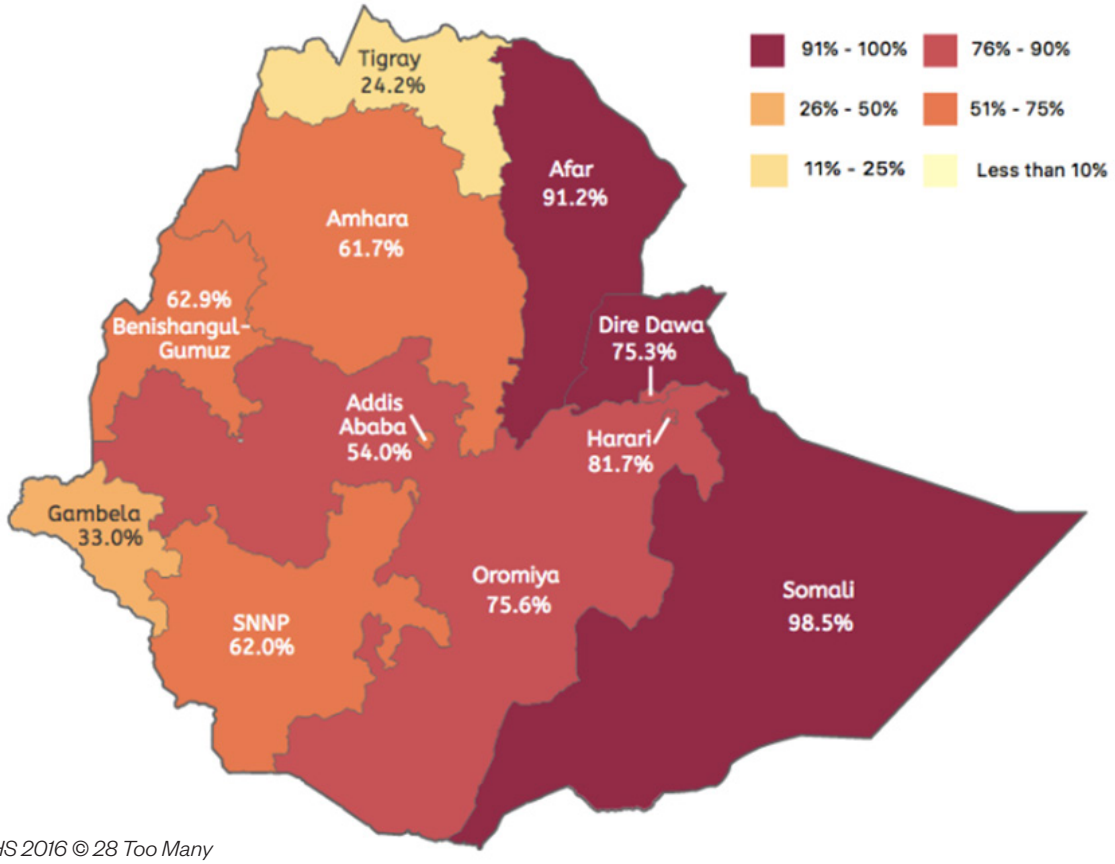
The prevalence rate of FGM/C in Ethiopia – 65% among women aged 15–49 – belies considerable regional diversity (see Figure 1) (CSA and ICF, 2017). The practice is most common in Somali region (99%) and least common in Tigray (24%). The age at which girls undergo the practice and what form it takes (see Box 1) are also highly variable. In some regions (e.g. Amhara), it is carried out soon after birth, whereas in others (e.g. Afar) it takes place in early childhood, and in others still (e.g. Oromia), it is common for girls to undergo the practice as late as early to mid-adolescence. In some regions (e.g. Amhara), it is most common for girls to be subjected 'only' to clitoridectomies; in others (e.g. Afar), most girls have historically been infibulated. Notably, the DHS found that of girls aged 15–19 who reported having been cut, 25% either did not know – or declined to report – what type they underwent (CSA and ICF, 2017).

FGM/C is slowly becoming less common over time. Whereas 75% of women over the age of 35 reported having undergone FGM/C, only 47% of girls aged 15–19 had (CSA and ICF, 2017). Again, there is considerable regional diversity, with adolescent girls in Afar (92%) far more likely to have been cut than their peers in Amhara (51%) and Oromia (46%) (see Figure 2).[1,2] The government

1 Regional figures for girls aged 15–19 were calculated by the authors and should be interpreted with caution due to sample size.

2 The DHS reports that on a national basis, 28% of girls aged 10–14 have undergone FGM/C according to their mothers. However, given that many girls are subject to FGM/C in early and mid-adolescence, this relatively low figure should be taken with considerable caution, as it does not include girls who are likely to undergo the practice soon.

Figure 1: FGM/C prevalence rate, by region, for all women aged 15–49



Source: DHS 2016 © 28 Too Many

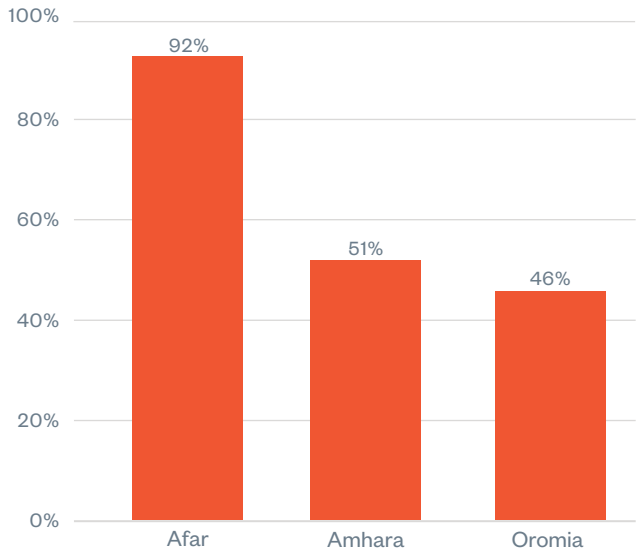
Box 1: Types of FGM/C

The World Health Organisation (2020) delineates four major types of FGM/C

- Type 1, often called clitoridectomy, consists of the partial or total removal of the clitoris and/or the clitoral hood.
- Type 2 consists of the partial or total removal of the clitoris and labia minora, with or without the removal of the labia majora.
- Type 3 is infibulation and involves the narrowing of the vaginal opening—sometimes with stitching.
- Type 4 is all other harmful procedures (e.g. scraping or pricking) to the female genitals for non-medical reasons.

recognises infibulation as the type of FGM/C that is of 'greatest concern' and accordingly tracks the proportion of girls and women who have been 'sewn shut' versus 'cut/no flesh removed' and 'cut/flesh removed' (ibid.: 317). There is no evidence in the most recent DHS, however, that infibulation is being abandoned faster than other types of FGM/C. Indeed, on national basis, adolescent girls aged 15–19 are slightly more likely to report this type of FGM/C than adult women a decade older (7.4% versus 5.7%).

Figure 2: Proportion of adolescent girls aged 15–19 who report having undergone FGM/C, by region



Source: CSA and ICF, 2017

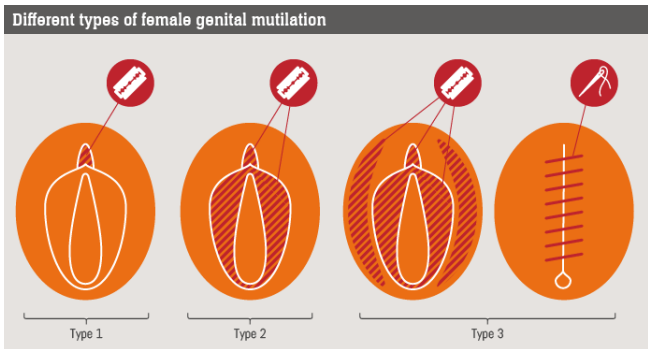
3 Methods

This report draws on mixed-methods research undertaken by GAGE in rural and urban sites in three regions of Ethiopia: Afar (Zone 5), Amhara (South Gondar) and Oromia (East Hararghe), and Dire Dawa City Administration. Baseline data was collected in late 2017/early 2018; midline data was collected two years later, in late 2019/early 2020. GAGE's quantitative sample, which includes 7,526 adolescents in two age cohorts (older adolescents, aged 17–19, and younger adolescents, aged 12–14), deliberately oversampled those recognised as being at risk of being 'left behind' by the Sustainable Development Goals – including out-of-school adolescents, married adolescents and adolescents with disabilities. The qualitative sample of 388 core adolescents (plus their caregivers, siblings, peers, service providers and community key informants) was selected from the larger quantitative sample.

The DHS found that many girls do not know what type of FGM/C they have undergone, and our baseline research found that it was common for adults to frame FGM/C as having been 'eliminated' when it has actually just shifted to Type 1. For these reasons, our midline tools included graphics to elicit more accurate responses to questions about which type of FGM/C girls had undergone (see Figure 3). These graphics allowed us to distinguish between Type 1, Type 2 and Type 3. Type 4 FGM/C (other) is very rarely practised in Ethiopia.

It should be noted that although there are longstanding debates about whether moves to Type 1 FGM/C constitute progress in areas where Types 2 and 3 have been common, with international actors predominantly on the side of 'no' (Kimani and Shell-Duncan, 2018), most study participants strongly believe that Type 1 FGM/C is the least invasive. They accordingly consider moves away from Types 2 and 3 as progress.

Figure 3: FGM/C picture card



Source: Grun, 2015

4 Findings

Echoing the 2016 DHS findings, our research underscores the importance of recognising and embracing the diversity that surrounds FGM/C in Ethiopia. Across regions and communities, girls are cut at different ages and in different ways. Some girls undergo the practice soon after birth and others in adolescence. While girls are increasingly likely to experience Type 1 FGM/C, some girls – including in the Afar communities in the GAGE study – are still infibulated. Furthermore, while the drivers of FGM/C are, at the highest level, shared across the study locations, differences in how drivers are embedded in regionally variable religious beliefs and cultural practices are stark and speak to a need for carefully tailored elimination strategies. For example, in predominantly Muslim communities, including in Oromia and Afar, there are widespread misconceptions that FGM/C is religiously mandated. This is less common in areas that are primarily Ethiopian Orthodox (including Amhara). Similarly, in communities in Oromia where FGM/C is seen as a marker of maturity, and is actively sought by adolescent girls, emphasising risks without addressing perceived benefits is especially unlikely to result in progress given the nature of peer pressure. Regional variation in capacity is also notable. Health extension services, girls' clubs and gender-focused NGOs are more common and stronger in South Gondar than in East Hararghe and Afar. Because of the diversity that surrounds FGM/C in Ethiopia – especially at the regional level – our findings are organised here by region. Specific research locations have been anonymised in order to protect respondents.

South Gondar (Amhara region)

In South Gondar, where FGM/C is traditionally practised soon after birth and most often takes the form of 'cut/flesh removed', our midline survey found substantial variation in incidence rates across cohorts. This seems to be because older girls, who reported on their own experiences, often did not know whether and when they had undergone FGM/C. Female caregivers reported on younger girls' experiences – and had better recall of relevant details. Of older girls, only 25% reported having been cut, and 70% of those were not able to say at what age. Of younger girls, female caregivers reported that 35% had experienced FGM/C, nearly all of them in infancy. Most caregivers (61%) of younger girls reported that their daughter took more than three days to recover from FGM/C; a minority (12%) reported that recovery took more than a week. Of all girls who had been cut, 79% had been cut by a traditional circumciser.

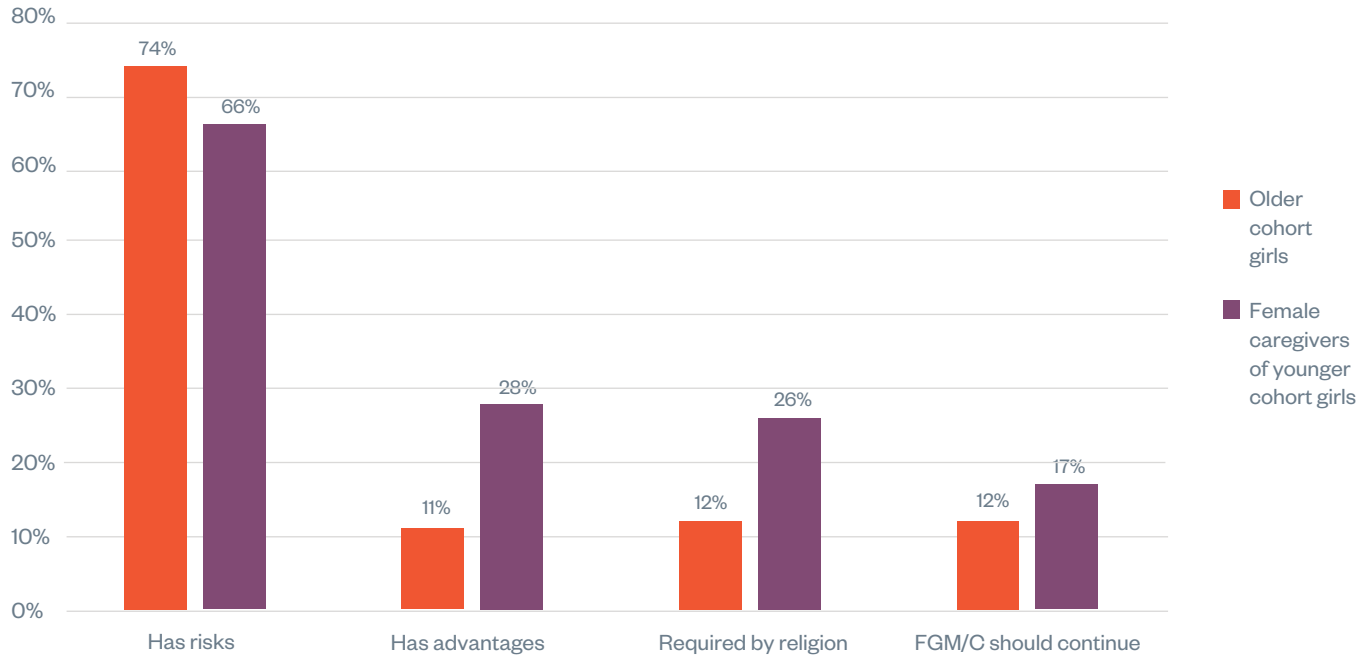
While older girls were not necessarily aware of if and when they had experienced FGM/C, a large majority (74%) were aware that the practice carries risks (see Figure 4). Girls identified difficulty in giving birth (42%) and infection (24%) as the primary risks of FGM/C. In our survey, only a small minority (11%) of older girls in South Gondar reported that FGM/C has any advantages, most commonly (5%) citing easier childbirth. Relatively few older girls reported that they believed FGM/C is required by religion (12%) or should continue (12%).

Most female caregivers of younger girls (66%) were also likely to identify that FGM/C entails risks (Figure 4). As well as citing difficulties during childbirth (44%) and the risk of infection (17%), 16% of caregivers reported that FGM/C can make sexual intercourse difficult. Female caregivers in South Gondar were relatively unlikely (28%) to report that FGM/C has advantages. Of those who did, the most common responses were easier sex (18%) and easier childbirth (12%). Our survey found that just over a quarter (26%) of female caregivers believe that FGM/C is required by religion; only 17% reported that the practice should continue.

In line with the DHS and government categorisation, our qualitative research found that in South Gondar, most FGM/C involves cutting with flesh removed; exactly *what* flesh is removed varies, and includes both Type 1 and Type 2 FGM/C. Of girls who undergo FGM/C, most undergo Type 1 (clitoridectomy). A *woreda*-level (district-level) key informant with the Bureau of Women, Children and Youth Affairs explained, *'They cut the tip of the clitoris.'* Other girls undergo Type 2, in which both the clitoris and labia minora are removed. A father from Community D reported, *'On both sides there is a black part that is believed to hamper penetration.'* A militia member from the same community clarified, *'They remove only the flesh on both sides of the sexual body.'*

With caveats, our qualitive research predominantly speaks to South Gondar's recent progress on eliminating FGM/C. Indeed, a large majority of participants reported that the practice has been *'totally abolished now'* (16-year-old girl, Community E). A woreda-level health official

Figure 4: Beliefs about FGM/C in South Gondar



added, *'I have never seen a case. Mothers discuss about circumcision when they give birth to boys, they never talk about circumcision for girls.'* Adults' responses suggested that progress has been especially rapid, even in the past five years, with younger daughters less likely to have experienced FGM/C than their older sisters. A father from Community D reported, *'My first child was circumcised. But two of my female children were not.'* A mother from Community C added, *'I circumcised my older children. I have two young girls but they are not circumcised.'* A principal from that same kebele (community) added that FGM/C has proven far easier to reduce than child marriage, because people see the risks of the former more clearly than the latter. He said, *'Progress is faster than that of child marriage in terms of its incidence.'*

Adolescents and adults agreed that awareness-raising about the deleterious health effects of FGM/C has been responsible for progress. Although a few adolescents believed that the law – and the threat of punishment – have brought about this recent change, adults strongly disagreed. A married girl from Community C reported, *'It is only because of the law that they are not cutting the girls.'* However, a woreda-level justice official argued that 'sanction and punishment cannot be a good solution' and that the only lasting change is that brought about by bringing about attitudinal change. Though progress has been slow, he continued that now, *'people genuinely believe that mutilation is not right'*. A father from Community D agreed, adding that even his mother, a former circumciser, believes that FGM/C should be abandoned. He said:

> *My mother was a cutter and she used to tell me that not being cut wouldn't hamper penetration in and of itself. It is even said that it exposes [the girl] to several risks, particularly if the blood is not cleaned well, it would hamper penetration in the future.*

Students' attitudes are 'enhanced' at school, where they learn about harmful traditional practices – including FGM/C – in the curriculum and in girls' clubs. An unmarried girl from Community D explained, *'They teach us at school about harmful traditional practices …They are working very hard to teach us about FGM.'* A female teacher from the same kebele added:

> *Lessons about the health risks of early marriage and FGM/C are given to students through Biology class [only for grades 5–8] and through environmental sciences [only for grades 1–4]. There are lessons about harmful traditional practices and their violation of children's and girls' rights in Civic Education classes given mainly to students in grades 5–8.*

A key informant from Women's Affairs in Community C, noted that although teaching adolescents about FGM/C is unlikely to prevent today's adolescent girls from undergoing FGM/C – given the weight of local norms and practices – educating adolescents has knock-on effects that cascade through families, thereby protecting younger relatives. She said:

> *When there is an educated person in the family, that person tells [the others] that FGM/C is a harmful traditional practice and they need to avoid it. That person convinces the family and stops them from doing it.*

Adults in South Gondar are targeted for awareness-raising about FGM/C through community discussions, including those led by health extension workers and religious leaders. A key informant from Community D commented that, *'Health extension workers are doing great in creating awareness about the health impacts of circumcision.'* A female teacher from Community C added:

> *Health extension workers are active in teaching about FGM … Starting from when they get pregnant, they have a follow-up with health extension workers. They teach them when to go for a check-up.*

Religious leaders are also working hard to shift mindsets about FGM/C; as a father from Community C noted, *'The priests tell us not to circumcise the girls.'* Religious leaders reported that they frame messages so as to resonate with local populations. An Ethiopian Orthodox priest explained that because *'Jesus was baptised with water, not circumcised,'* he is working to convince parents that the Bible does not call for FGM/C. A Muslim religious leader, while incorrectly reporting that the Qur'an calls for the clitoris to be cut, explained that because it is not possible for everyone to follow *'each rule and law provided by the book'*, he and his fellow sheiks (imams) in South Gondar have decided that the religious requirement for cutting the clitoris is one rule that should not be followed at all.

Future progress towards eliminating FGM/C in South Gondar requires that survey results and broader narratives about recent progress be viewed with considerable caution. First, due to respondents' concerns about the possible legal ramifications if they admit to FGM/C,

incidence rates are most likely considerably higher than reported – especially in more remote *kebeles*, which are rarely visited by *woreda*-level officials. Indeed, a *kebele* official from remote Community D contradicted members of his community and stated that he feels there has been little recent progress: *'There has been no change at all. Circumcision at infancy is still commonly carried out in our community.'* Several adolescents in that community – as well as more remote sub-kebeles of Community C – agreed with him. An unmarried adolescent girl from Community D reported, *'There is no girl who is not cut. It is only the children who are uncut.'* Alongside narratives about no progress on eliminating FGM/C, several adults admitted that the practice is moving underground, which makes it difficult to monitor. A child protection officer from Community C stated, *'There are FGM practices in the rural area, but they do it in hidden ways.'* A militia member from that community added, *'the practice of FGM/C is very difficult to sanction since it is practised by mothers/grandmothers in a very private and hidden manner.'*

Not all respondents agreed that mothers and grandmothers are solely to blame for the shift to hidden practices. On the one hand, some fathers are clearly champions working to protect their daughters from FGM/C – regardless of what the older women in their families would prefer. For instance, an adult male involved in community conversations about harmful traditional practices in Community E reported that when his mother-in-law had brought a traditional circumciser to their home – and put considerable pressure on his wife to allow them to perpetrate FGM/C on his newborn daughter before finally trying to cut the infant *'with force'* – he had kicked both of them out of his home in order to save his baby daughter. Other fathers were more culpable, though; a father from Community D, after first protesting that FGM/C had been eliminated, eventually confessed that mothers and fathers are involved:

> *There is no female genital mutilation … It is prohibited by the government … However, if their families [mother and father] have the skill, they circumcise their female children in a hidden way. … [His daughter] was circumcised by her mother … It was me that ordered my wife to circumcise our daughter.*

Across communities, respondents reported that girls in South Gondar are still at risk of FGM/C because while community members understand the risks, some – especially those in more remote communities – also believe that the practice confers benefits. For example, a key informant from the Women's Affairs Office in Community C noted that some families believe that FGM/C is essential for marriage. She said, *'The girl needs to get cut before getting married.'* This is due to beliefs (also noted by other respondents) that *'It will be difficult for a man to have sex with her if she is not circumcised'* (key informant, Community D) and because FGM/C helps her '*vulva to stretch'* to make childbirth easier (youth leader, Community C). A *woreda*-level justice official added that some people still associate FGM with taming girls' sexuality, believing that *'if a girl is not cut … she would become a slut'.*

Key informants at the *kebele* level, often after first protesting *'I have not come across those who circumcised girls'* (*kebele* official, Community F), sometimes expressed lackadaisical attitudes towards FGM/C and their role in eliminating it. As a health extension worker from Community E acknowledged: *'I don't give attention whether they are mutilated or not.'* Another key informant, a teacher from Community G, added that while there are high levels of awareness of the illegality of FGM/C, officials do not often engage with the issue: *'According to our criminal code of conduct, female genital mutilation is a criminal act … We are not seriously working on this aspect but we will have to address [it] in the near future.'* Field observations by GAGE researchers suggest that officials' lackadaisical attitudes towards awareness-raising and enforcement are primarily due to fatigue, because years of effort are yet to result in the hoped for elimination of FGM/C; but also due to fear of retaliation if they were to take action.

Although nearly all cases of FGM/C in South Gondar are perpetrated by traditional cutters, a few respondents intimated that this may be shifting, and that the practice may be becoming more medicalised in response to the health messaging that has driven recent progress. An adolescent boy from Community D stated, *'It is not good to make female circumcision through traditional attendants. I heard that female circumcision should be made with the support of medical personnel.'* A mother in Community C added that FGM/C by medical personnel is not only safer, but kinder, as girls are given painkillers to keep them comfortable while they heal. She explained:

> *These days they will be cut in health centres … the clitoris and the side flesh … If it is cut in the health centre, it doesn't take long to heal … In the hospital they give*

painkillers and they apply ointments on the wound, that is why it recovers quickly.

East Hararghe (Oromia region)

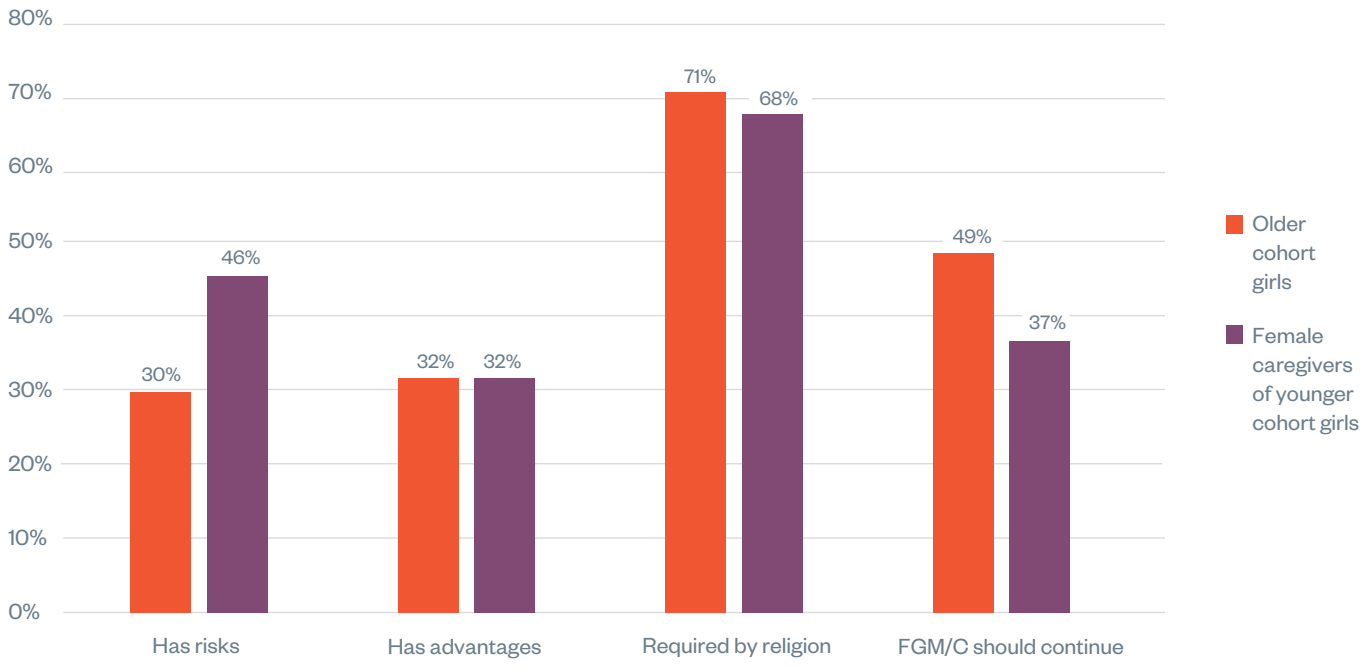
In East Hararghe, where girls undergo FGM/C from early childhood to mid-adolescence, our survey found that 89% of older girls admitted to having been cut – a significantly higher rate than that reported by the 2016 DHS for Oromia as a whole (76%). Two-thirds (65%) of female caregivers of younger girls reported that their daughters had already undergone the practice. Adolescent girls in our sample had been cut at an average age of 9.6 years, and 62% of older girls reported that they had wanted to be cut at the time it happened. Most older girls (86%) and caregivers of younger girls (73%) reported that recovery took at least three days. A minority of girls (30%) and caregivers (24%) reported that it took more than seven days. Of all girls who had been cut, 80% had been cut by a traditional circumciser.

Older girls in East Hararghe were far less likely than their peers from South Gondar to believe that FGM/C entails risks (see Figure 5); only 30% thought so. Infection (17%) and difficult childbirth (12%) were the most common risks identified by older girls. A similar proportion of girls (32%) believed that FGM/C has advantages, with the most common response being that it improved girls' behaviour (15%). A smaller proportion reported believing that FGM/C is necessary in order to attract a husband (5%). In East Hararghe, our survey found that 71% of older girls believe that FGM/C is required by religion, and 49% believe that it should continue.

Female caregivers of younger girls were markedly more likely to report that FGM/C carries risks than girls themselves (46%) (see Figure 5); they were equally likely to identify infection, difficult sex and difficult childbirth as risks of FGM/C (~22%). Around a third of female caregivers (32%) believe that FGM/C has advantages, most commonly citing improving girls' behaviour (23%) and attracting a husband (8%). In East Hararghe, our survey found that 68% of caregivers believe that FGM/C is required by religion and 37% believe that it should continue.

Our qualitative findings suggest that FGM/C practices in East Hararghe are quite diverse and perhaps becoming even more so in response to (increasingly limited) government efforts to reduce the incidence and shift the type of the practice. Girls experience FGM/C at different ages; although most undergo the practice between the ages of 9 and 12, some experience it before the age of 5, apparently because younger girls tend to be more compliant and also because it is easier to conceal the practice. A 10-year-old girl from Community I explained, *'Some are mutilated at a young age and others after growing up somewhat.'* A key informant from Community K added, *'They are circumcised when they are little, like 3 or 4 years. So I don't think they can make decisions at this time.'* Whereas respondents report that most girls

Figure 5: Beliefs about FGM/C in East Hararghe



experience 'only' Type 1, wherein just *'the top part of it [the clitoris]'* is cut (religious leader, Community K), and most adults report that suturing was *'abandoned a long time age, during the Derg regime'*[3] (key informant, Community J), a sizeable minority of girls undergo the removal of both the inner and outer labia (in addition to the clitoris) and a smaller minority are still infibulated. As a 15-year-old girl from Community J commented, *'They sew your body and it stays until you get married.'* In communities where leaders are still making some effort to reduce FGM/C, girls tend to undergo the practice individually (again, apparently to improve secrecy). A girls' club coordinator from Community K explained that in her community, *'They do it one by one. They don't circumcise at the same place. They take the girls to be circumcised at different times.'* In communities where leaders are not actively monitoring the practice, girls experience FGM/C together, alongside their peers.

While specific FGM/C practices across East Hararghe are diverse, the practice itself is nearly universal in GAGE research communities – despite the efforts of sheikhs to convince local communities that *'cutting kills wives' and daughters' feelings and emotions'* and assurances from *woreda*-level officials that *'if we see it and hear about it, we will put them in jail'* (key informant, Bureau of Women, Children and Youth Affairs). *'Everyone in the community does it,'* observed a 15-year-old married girl from Community K. *'It is our culture … It is also a principle of Sharia [law] too,'* added a key informant from a social court in Community I. Indeed, although most adults claimed recent progress in reducing FGM/C (almost exclusively relating to the type practised rather than its overall incidence), adolescent girls – who often freely admitted choosing to undergo FGM/C in order to maintain social status among their peers (see Box 2) – were more likely to report that the problem had become worse. As a 13-year-old girl from Community H explained, *'In the past, during our mothers' time, they were prohibited to practice circumcision … Now, it's open.'* A married 11-year-old girl from Community K confirmed this, noting that *'Previously it was forbidden, but now they allow it.'*

Although several married girls reported that they had never heard messages about the risks of FGM/C, others noted that they had, but had simply ignored them. Sometimes this was because social pressures to conform were too strong, but other times because messages were poorly framed. For example, a 17-year-old from Community H observed that health messaging about the possible risks of FGM/C to childbirth falls flat now that girls have access to surgical deliveries: *'You go to a health facility. You can deliver through an operation, for instance.'* Indeed, although several adults reported that

Box 2: 'I told my father to have me cut'

Adolescent girls in East Hararghe reported that FGM/C is painful. Whether they experience the practice alone or in a group, they are usually held down – with their hands tied and their eyes covered – while a traditional circumciser cuts their genitals with a razor blade. A 12-year-old girl from Community I recalled, *'They will tie your hand and leg together and also cover your eyes. They also hold your mouth hard so that you don't cry.'* A 14-year-old girl from Community H confirmed, *'They will cover your eyes and tie your hands together.'*

Most girls also agreed that they wanted to undergo FGM/C, despite having had discussions with teachers on *'how to abolish traditional practices like abduction, and girls' circumcision'* (girls' club member, Community K). A 10-year-old girl from Community J explained that: *'Daughters beg their families in order to get circumcised.'* A girl the same age from Community L added, *'They see it from their friends and ask parents to circumcise her.'* Several girls reported that their parents had insisted that they wait. As a 10-year-old girl from Community I explained, *'I told my father to have me cut, but he said that I have not yet reached [the age] for that.'*

Girls gave various reasons for wanting to undergo FGM/C. Some focused on how girls are pampered by their mothers in the days immediately after the procedure; not only are they excused from housework but they are fed special foods to help their bodies heal. A 12-year-old from Community I recalled that when she experienced FGM/C at the age of 10, *'They gave me milk and egg … They prepared for me rice and macaroni with sauce.'* A 14-year-old from Community H, who was 12 when she was cut, added that she not only got better food but was also given cash: *'We prepared food and chicken and then the people come and give you money.'* Other girls focused on how submitting to FGM/C allowed them to avoid the taunts of peers, and enabled them to join in shegoye (adolescent-only cultural dances). A 17-year-old girl from Community I explained, *'They have to be first circumcised. It is after circumcision that a girl attends* shegoye.' A married 11-year-old from Community K observed, *'There is an insult for girls who are not circumcised – they call her 'amara' … It is "the girl who gets married without being circumcised"'*

3 The Derg regime in Ethiopia lasted from 1974 to 1991.

fines and jail terms were succeeding in reducing FGM/C, others noted that fines, too, were often simply ignored. A woman from Community I explained:

> *They are telling us that circumcising girls is forbidden but it is taking place… The kebele administrator takes money from people who circumcise their girls. He takes (for instance) up to 200 birr (~$4)… The administrator stopped now. People don't even give him [the money] even if he asks now. They don't listen to him now. They do the circumcision freely.*

Girls' assertions that they 'choose' FGM/C must be placed in context to be understood. FGM/C in East Hararghe has long been held to be vital for marriage and motherhood. As a health extension worker from Community L reported, *'I didn't find girls who got married without being circumcised. It is shameful here not to be.'* The 25-year-old sister of a younger boy added that there are strong beliefs among the community that *'If the girl is not circumcised, she will not get pregnant.'* For others, the focus is on controlling girls' sexuality. A father from Community H explained the widespread belief that girls must undergo FGM/C before marriage in order to facilitate sexual intercourse, and to lower their sex drive:

> *We cannot marry them unless the circumcision is undertaken… During intercourse there is no way to insert the penis if the clitoris is not removed… The sexual desire of women who haven't had FGM is inflated… We are farmers and engage in tiresome activities of farming… We cannot handle another responsibility of satisfying our wives because their sexual desire is heightened if they are not circumcised.*

Where enforcement has been taken more seriously, parents have been willing to go to considerable lengths to hide FGM/C. Mothers do so actively, because they are culturally responsible for ensuring that daughters are cut; fathers tend to do so passively, because their role in FGM/C is to allow it to happen. A father from Community L explained:

> *Officials say a person who practised circumcision has to be brought before the law. They frightened us saying so. So the parents… made the girl sleep after they circumcised her… The father does not have information about the girls' circumcision. When the mother says the girl cannot go to school, the father will assume the girl is sick. The father does not investigate that. Mothers do this systematically. Later, the father hears that the girl is circumcised. But the father does not have any information when the girl is being circumcised.*

Several girls noted that parents today are active in ensuring that their daughters 'choose' to follow custom where FGM/C is concerned. A 17-year-old girl from Community I – ironically a member of a local militia group that works to reduce violence in the community – reported that any resistance would be futile: *'It cannot be stopped … If we are not interested to be circumcised, our parents beat [us] and force us to be circumcised … We cannot decide. It is our families who force us to be circumcised.'* A 14-year-old from Community H added that should a girl refuse to submit when she was younger, she would be forced to be cut during her honeymoon, when the pain would be far worse because she would also be having sex. The girl explained, *'If she married without, they will cut her during aruza [honeymoon] … If they cut you during aruza, the pain is huge. So it is better to have FGM long before getting married.'* Even members of the social court in Community I agreed: *'The government has a huge plan to prevent FGM … but her mother never accepts it because she considers it as a big shame culturally … They will not be willing to spare their girls from undergoing FGM.'*

Key to understanding the difficulties involved in eliminating FGM/C in East Hararghe is the extent to which the issue has become tied to broader discourses about difficulties controlling girls. Adults and adolescents alike identified that girls are choosing to leave school, choosing to undergo FGM/C, choosing to dance *shegoye*, and choosing to marry as children. Narratives often involve girls' wilful disobedience and position parents as beleaguered, even as those same narratives ultimately highlight how girls deliver on parents' expectations. The positioning of girls as architects of their own bodies and lives has been so effective that parents are shielded from legal ramifications, allowing secrecy to fade away; it also means that government messaging becomes less germane over time, because emphasising the health risks of FGM/C rather than addressing its perceived social benefits has little resonance for adolescent girls who are interested in being pampered by their mothers and fitting in with their peers. Indeed, broader narratives about girls' 'wantonness' risk undermining recent progress towards the adoption of Type 1 FGM/C, as more and more adults – who are frustrated that girls (rather than parents) are choosing

marriage timing and partners – are now openly claiming that it would be best to return to more severe types so that girls do not *'become crazy'* (Women's Association officer, Community H). A grandmother, after first reporting that *'no girls are circumcised today'* (because she did not consider clitoridectomies to be FGM/C), then added: *'Girls do not listen to their families … They just go with boys … They go with boys to get married. In the past, we didn't go after boys unless we were asked for marriage because we were circumcised.'*

In East Hararghe, our research following the onset of the covid-19 pandemic suggests that school closures between March and November 2020 further complicated efforts to address FGM/C. For the relatively rare girls who do not 'choose' to be cut, teachers were important in protecting them against the practice. With schools closed, girls lost access to that support and to reporting chains. A community leader in Community J commented, *'There was a female teacher that used to register the names of parents who allowed girls to undergo FGM/C, but since there is no school, they cut girls and there is no one to question them.'*

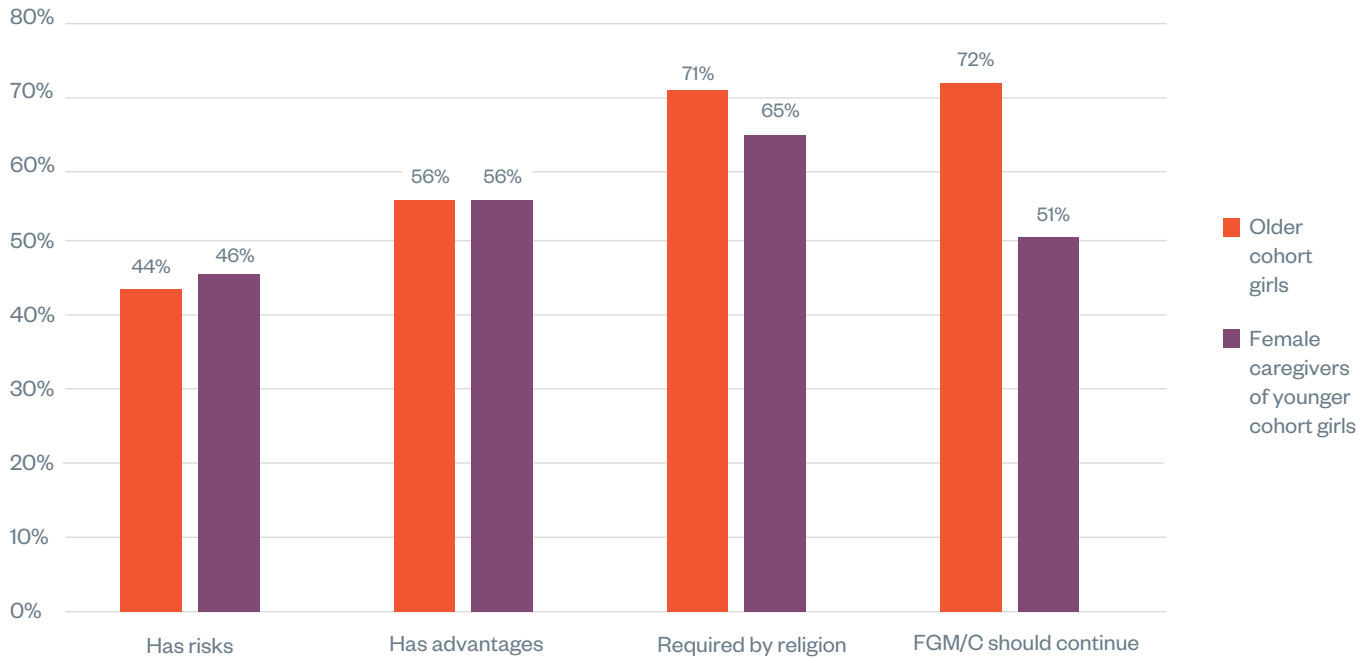
Zone 5 (Afar region)

In Zone 5, where FGM/C is most commonly undertaken in early childhood and takes the form of 'cut/flesh removed', there is again a mismatch in incidence rates across cohorts driven by the age at which girls undergo the practice. Among older girls, 84% reported having been cut. A significantly higher proportion of female caregivers of younger girls (92%) reported that their daughter had undergone FGM/C. Our survey found that across cohorts, the average age at which girls underwent FGM/C was 1.5 years. A large majority of caregivers (78%) reported that recovery took at least three days, while nearly a fifth (17%) reported that it took more than seven days. Of all girls who had been cut, 67% had been cut by a traditional circumciser.

In our survey, nearly half of older girls (44%) and female caregivers of younger girls (46%) believe that FGM/C entails risks (see Figure 6), typically mentioning difficulty during childbirth (34% among older girls, 39% among caregivers of younger girls). Girls also mentioned the risk of infection (23%), bleeding from the surgical site (18%), and difficulty having sex (14%); caregivers mentioned the risk of infection (17%) and difficulty having sex (14%). More than half of older girls and caregivers (56%) believe that FGM/C has advantages, with improving girls' behaviour the most commonly cited one (39% and 29% respectively). Both groups also believe that FGM/C makes childbirth easier (28% and 19% respectively). Our survey found that girls (71%) and caregivers (65%) believe that FGM/C is required by religion. Unsurprisingly, they also believe that it should continue (72% and 51% respectively).

Participants in both individual and group interviews – sometimes after first reporting that FGM/C had been eliminated on the grounds that today's Type 1 does

Figure 6: Beliefs about FGM/C in Zone 5



not constitute 'real' FGM/C – agreed that the practice remains effectively universal. A 19-year-old girl from Community A noted, *'Up to now, there is no girl who is not circumcised … all girls are circumcised.'* A clan elder from the same *kebele* agreed that *'No girl can escape being uncircumcised.'* There is, however, more diversity of practice than might be expected given regional findings from the 2016 DHS. Although most girls undergo FGM/C *'immediately after they are born'* (17-year-old girl, Community A), others are *'circumcised after they grow up'* (15-year-old girl, Community B). A mother from Community A reported that the practice was most commonly performed between the ages of 7 and 9 years, while a girl from Community B reported that she and her friends had undergone FGM/C at age 12. Some girls experience FGM/C in groups, with *'mothers bringing their daughters and all are circumcised together'* (13-year-old girl, Community B); other girls undergo FGM/C 'in isolation' (mother, Community A). The person who does the cutting is also changing in communities closer to the district town (possibly due to greater concerns about being discovered by district officials). A mother from Community A explained, *'Previously, there were skilled elder women who made FGM, moving from home to home. However, now every mother practises FGM of her own daughter.'* In Community B, FGM/C is still practised by traditional cutters – women who also serve as traditional birth attendants and have seen their incomes drop as large public feasts celebrating girls' FGM/C have become smaller in scale in response to measures to end FGM/C.

Shifts in practices appear related to the recent adoption of Type 1 FGM/C – especially in more central kebeles, where uptake of education and oversight by woreda officials is more common. A mother from Community A explained:

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

Clan elders from that same community agreed that FGM/C is shifting from Type 3 to Type 1, and highlighted the role of religious leaders in driving this change. One elder explained that:

> *Currently people cut only the tip of the girl's clitoris, people stopped cutting the entire part of the inner of the girl's genital organ from three directions … Especially, the Sharia persons and religious leaders taught us to change the type of cutting and to use the 'sunna' type [Type 1].*

A justice official from Community A reported that authorities are endeavouring to make public messaging more effective by pairing it with practical support to encourage families to abandon the practice. He explained, *'We work with women doing it and give them alternative income opportunities. And we also organised a reward programme for champions who stopped doing it.'* Although one female teacher from Community A reported that *'officials are not properly implementing the law … I have never seen punishment,'* several female community leaders (one a health extension worker and one a police officer) added that their own near-death experiences during childbirth had led them to speak more openly against the practice. With the caveat that we found no clear evidence that fines were being implemented in Zone 5 for people who put their children through FGM/C, the health extension worker explained that she tried to use the idea to frighten her relatives into eschewing the practice*: 'I told my relatives if they try to practise it again, they would get imprisoned for 10 years, pay a 10,000 birr fine.'*

In more remote *kebeles*, even progress towards the adoption Type 1 FGM/C has been more mixed. On the one hand, some parents in Community B reported that Type 1 is now preferred over Type 3 *'due to the influence of individuals and institutions'* who teach and preach about the health risks of FGM/C and its lack of religious underpinnings (mother, Community B). As was the case in Community A, messaging from religious leaders – both in person and on the radio – has been especially important. A male community key informant explained that, *'Muslim leaders tell us it is contrary to the Sharia and only slight cutting is allowed.'* On the other hand, clan leaders in Community B insist there has been no change, and that *'what we are practising now is what we were practising previously'*. Indeed, while girls are not sewn shut with thread (or thorns), it appears that many are still effectively infibulated with scar tissue. A woreda-level health official explained, *'In Community B they remove all tissues then tie the leg.'* An adolescent girl clarified:

> *Those circumcised girls' legs will be tethered together using rope, to make the cut organ stick together and their organ will get narrower. They do not use any medical treatment to heal the wound, they use cultural*

> *treatment, and the wound will cure after a week or after two weeks … There is no sewing in our locality, the cut organ will be stitched up together with blood.*

Although several adults in Community B acknowledged that they know that FGM/C is illegal, clan leaders admitted that *'there is no sanction or punishment because all people in this community accept that female genital mutilation is normal.'*

Drivers of FGM/C in Zone 5 largely mirror those in East Hararghe. As a 17-year-old girl from Community A noted, *'girls have to be circumcised to get a husband'.* Boys added that this is because of beliefs that it is *'difficult to have sex with uncircumcised girls since the clitoris prevents the penis penetrating deep in the girl's vagina'* (14-year-old boy, Community B). Analogous arguments about controlling girls' sexuality were also widespread; an older boy from Community A explained the common belief that *'if girls are not circumcised, their sexual desire will be high'.* Critically, respondents added that while religious leaders may be preaching in favour of Type 1 FGM/C, they are also preaching that FGM/C is a religious mandate. A clan leader from Community B explained:

> *We are also told that a father who didn't circumcise his daughter is considered as lazy and we are also ordered not to get in the house of a man who didn't circumcise his daughter because having a daughter who is not circumcised is considered haram.*

A mother from Community A added, *'They taught us that it became a big sin if a female child died without being circumcised and also girls would misbehave and be disobedient to their parents unless they were circumcised.'*

A large majority of adolescents in Zone 5 professed strong support for continuation of the practice of FGM/C – at least in its Type 1 form. Indeed, although a married girl from Community B forcefully stated *'we do not want FGM/C because it is associated with pain',* several girls reported that they were glad they had been cut. A 15-year-old girl from Community B stated that she was happy to have complied with the religious mandate: *'I wouldn't be happy if I wasn't circumcised … Not being circumcised is haram.'* An older girl from Community A added that she was happy to not be teased about her genitals by her peers, saying, *'We are happy [to be cut] … They insult us by singing "their clitoris is longer like hala wolf".'* A mother from that same community emphasised how girls' preferences are shaped by social norms – as older girls who have not been cut are excluded by the community. She explained:

> *If a girl is not cut, she will be isolated by the people. So, the girls themselves agree to circumcision. They prepare themselves and ask the mother to do it. It is done based on family interest and the girl's willingness.*

Unsurprisingly, given widespread beliefs that FGM/C is required by religion, respondents in Zone 5 were nearly unanimous that future progress will depend more on religious leaders than on government messaging about the health risks and legal consequences. A religious leader in Community A explained, *'Though we know that female genital cutting harms our daughters, we are still practising it.'* A clan leader from Community B stated, *'We will never accept what the government law is saying.'* A grandmother from the same *kebele* agreed: *'We can change the practice only if we heard it from religious leaders. We do not stop because of meetings.'* Government officials, while noting that FGM/C *'is not given commitment and budget from the federal government like vaccine and nutrition'* (*woreda*-level health official), acknowledged their limited impact. A woreda-level official at the Bureau of Women, Children and Youth Affairs explained:

> *It becomes risky to speak about stopping FGM among rural communities and they are afraid to teach about FGM as a bad practice because it has been a long-held traditional practice … For instance, there is a midwife working at Community B and she told us that the community laugh when she teaches about avoiding FGM.*

Alongside efforts to eliminate FGM/C, our research highlights the need for improved services for girls who have undergone Type 3 FGM/C. Girls who have undergone infibulation spoke at length about the *'severe pain'* they experienced during sex. A clan elder from Community B admitted that *'excessive bleeding'* is common, given husbands' *'energetic efforts to dis-virgin [have sexual intercourse with] their wives'* and a married girl from Community B reported that many girls *'cry during sexual intercourse'.* Girls who have undergone Type 3 FGM/C added that not only is giving birth dangerous, because *'the organ that was connected during circumcision doesn't allow her to give birth freely',* but that they are sometimes humiliated by medical professionals who associate such

traditional practices with 'backwardness'. For example, a 19-year-old married girl from Community A reported that:

> *Doctors are insulting girls during childbirth … They say that because we are circumcised, we are unable to labour … When we tell them there was nothing we could do about it, they reply, saying that we know nothing about giving birth because we are circumcised.*

Urban areas

GAGE findings underscore the importance of including cities in efforts to eliminate FGM/C, despite having lower incidence. Of the older girls in our sample, 19% of those in Debre Tabor, 29% of those in Batu and 46% of those in Dire Dawa reported having been cut. Our findings also underscore the importance of including cities and urban areas in such efforts in ways that recognise their diversity.

Differences between urban areas reflect where they are located, because cities generally mirror (to some extent) the areas that immediately surround them; and reflect which rural migrants they attract, because migrant girls and women often arrive in urban areas having already undergone FGM/C. Debre Tabor is a mid-sized city in South Gondar. Most of its residents are from the Amhara region, which has a relatively lower rate of FGM/C. Batu, which is an emerging town in Oromia's East Shewa zone, has a higher rate than Debre Tabor not only because FGM/C is more common in Oromia than in Amhara, but also because it attracts a large number of migrants from the Sidama region, where prevalence rates are also high. Dire Dawa (a large city in Oromia located near Ethiopia's border with Djibouti) has a much higher rate than even Batu because it attracts many migrants from Afar and Somali – regions where nearly all girls and women have undergone FGM/C. An older girl living in Dire Dawa recalled, *'I was circumcised age 13 … According to our tradition, FGM is a must because it is considered haram [bad] if a girl is not circumcised.'* Another older girl from the same city added that even the adults meant to be leading progress in tackling FGM/C feel pressure to conform:

> *I know a teacher who forced her daughter to get cut. She used to teach us about harmful traditional practices and HIV and AIDS. She even goes to rural villages to raise awareness on this. I remember how shocked I was to learn this. I did not expect this from her.*

Girls from Dire Dawa who are taking part in GAGE's participatory research reported that FGM/C most often takes place during school holidays and in rural areas.

5 Policy and programming implications

GAGE research highlights that FGM/C in Ethiopia cannot be seen as a singular practice. Although there are commonalities across regions in that it is driven by social norms that seek to control female sexuality, the diverse ways in which it is practised – and the complex narratives that surround it – highlight the need to address FGM/C as a constellation of related practices, and to tailor approaches accordingly. Indeed, where messaging is mechanistic and fails to account for the myriad ways in which FGM/C is embedded in broader culture, efforts to eliminate it are instead rendering future progress more difficult, by forcing it underground, leading it to become something that many girls actively choose, or solidifying community opposition to change. With this in mind, we suggest the following policy and programming actions to accelerate progress towards the elimination of FGM/C.

Address underlying gender norms through context-tailored approaches

- Eliminating FGM/C will require working with parents and broader communities (to protect the youngest girls) and adolescent girls and boys (to protect older girls as well as to expedite generational change).
- Messaging about FGM/C should be balanced and address both its perceived costs and perceived benefits. It is not enough to teach that FGM/C entails

risks such as infection and difficulty during childbirth; it is also important to address misunderstandings about the perceived benefits – such as improving girls' behaviour or facilitating sexual intercourse with their husband. Messages should be contextualised with attention to broader gender norms, including on female sexuality.

- In communities where FGM/C is believed to be required by religion, it is vital to work with religious leaders to disseminate messages that clearly state the reverse – teaching community members that FGM/C is not required by religion.
- Messaging for parents should be provided through parent education courses, women's associations and health extension workers, carefully timed to address community practices (e.g. provided during maternity care where FGM/C is practised in infancy or at the time of child vaccinations where it is practised in late childhood or early adolescence).
- Messaging for communities should include community conversations, led by religious leaders where possible, as well as using mass media, especially radio.
- Adolescents, including those in urban areas, should be targeted for FGM/C education through the school curriculum and also through school clubs. Girls' clubs should provide girls with opportunities to discuss specific harmful traditional practices, including FGM/C, as well as broader gender norms that disadvantage girls. They should also address peer pressure (in communities where FGM/C is practised on older girls) and provide a venue for girls to report planned FGM/C (on themselves, their peers or their siblings). Clubs should be participatory and support both the development of girls' voice and agency as well as the expansion of real opportunities open to them. Boys must be exposed to these same messages. They need to understand how gender norms work to restrict the lives of girls and boys (but especially girls), and how boys and men can become champions of change to protect their sisters, wives and daughters.

Raise awareness of the criminalisation of FGM

- The value of fines should be considered on a community-by-community basis, to ensure that they are not forcing practices underground. Amounts and enforcement mechanisms should be transparently agreed by the community for the community.
- In communities where girls 'choose' to undergo FGM/C, it is important to pair awareness-raising efforts with exposure to role models or champions for eliminating the practice, to counter the weight of peer pressure.
- Expanded efforts should be made to trial whether and under what circumstances efforts to expand the livelihoods of traditional circumcisers might reduce the pressure that older, respected women in the community are able to levy on mothers – and ultimately reduce FGM/C.

Engage with healthcare providers

- Healthcare providers – including health extension workers – should receive iterative training that emphasises how FGM/C violates the medical code (to keep it from becoming medicalised), also ensuring that girls and women who have undergone FGM/C are not stigmatised or blamed for having been cut – even when it causes medical complications.

Adopt a long-term lens to programming, recognising that social norm change processes are non-linear

- It is vital to recognise that because FGM/C has been widely practised across Ethiopia for millennia, eliminating it will take continuous pressure over time. To prevent resurgence, it is important to acknowledge that even when most people believe the practice has been eradicated, there will be pockets of resistance that could lead to its re-emergence if education and enforcement efforts weaken.
- Given the diverse ways in which FGM/C is practised even with a single zone, it is important to assess progress through regular community-based monitoring exercises aimed at tracking both its incidence and type(s), and how practices might be shifting to make them less visible.

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About GAGE

Gender and Adolescence: Global Evidence (GAGE) is a nine-year longitudinal research programme generating evidence on what works to transform the lives of adolescent girls in the Global South. Visit www.gage.odi.org.uk for more information.

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This document is an output of the Gender and Adolescence: Global Evidence (GAGE) programme which is funded by UK aid from the UK government. However, views expressed and information contained within do not necessarily reflect the UK government's official policies and are not endorsed by the UK government, which accepts no responsibility for such views or information or for any reliance placed on them.

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ISBN: 978-1-913610-73-9

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