

# The World Health Organization work and experiences in combating female genital mutilation in Addis Ababa, Ethiopia



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Master of Philosophy in Indigenous Studies  
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## Table of contents

<b>Contents</b>	<b>Page</b>
<b>Abstract.....</b>	<b>i</b>
<b>Acknowledgements.....</b>	<b>ii</b>
<b>List of Abbreviations.....</b>	<b>iii</b>
<b>Chapter One</b>	
<b>1. Introduction.....</b>	<b>1</b>
1.1 Problem of the statement.....	1
1.2 Research objectives.....	2
1.3 Research questions.....	2
1.4 Research methodology.....	2
1.4.1 Narrowing to the topic through written sources-documentary analyses.....	3
1.4.2 Methods applied during the field work period in Addis Ababa.....	3
1.5 Explanation, controversy and use of the terms female genital mutilation and female circumcision.....	5
1.5.1 Female circumcision.....	5
1.5.2 Female genital mutilation.....	7
1.6 Structure of the thesis.....	9
<b>Chapter Two</b>	
<b>2. Process towards thesis.....</b>	<b>11</b>
2.1. The choice of the topic.....	11
2.1.2 The choice of the WHO.....	12
2.1.2.1 The World Health Organization.....	13
2.1.3 Why I chose Ethiopia.....	14

2.1.3.1 Ethiopia as a country.....	15
2.2 Experiences in the process of narrowing to the topic through written sources .....	17
2.3 Field work period experiences in Addis Ababa, Ethiopia and Geneva, Switzerland.....	19

### **Chapter Three**

<b>3. The practice of female genital mutilation/female circumcision.....</b>	<b>23</b>
3.1 The origin and the history of the female circumcision.....	23
3.2 Understanding the issue of female circumcision.....	24
3.3 Health problems arising from female circumcision.....	26

### **Chapter Four**

<b>4. The practice of female circumcision in Addis Ababa, Ethiopia, and the legal issues associated with this practice.....</b>	<b>28</b>
4.1 Female circumcision in Ethiopia.....	28
4.2 Legal issue of female circumcision in Ethiopia.....	32
4.3 Female circumcision in Addis Ababa.....	35
4.4 Practitioners.....	38

### **Chapter Five**

<b>5. Culture and Human Rights.....</b>	<b>39</b>
5.1 Culture and harmful practices.....	39
5.2 Law prohibiting harmful traditional practices in Ethiopia.....	40
5.3 Female circumcision as a human rights issue.....	40

### **Chapter Six**

<b>6. WHO and the practice of female genital mutilation.....</b>	<b>44</b>
6.1 History of the work of the WHO in the issue of FGM.....	44
6.2 The country office of the WHO in Ethiopia, Addis Ababa.....	48
6.2.1 Activities undertaken by Country office of WHO in Ethiopia.....	49

6.2.1.1 Advocacy and policy development.....	49
6.2.1.2 Research and development.....	50
6.2.1.3 Development of training materials and training for health care providers.....	52

**Chapter Seven**

<b>7. WHO in process of combating FGM in Addis Ababa.....</b>	<b>54</b>
7.1 Experiences of WHO in the issue of combating FGM in Addis Ababa .....	54
7.2 Future plans of the National Regional Office of the WHO in Ethiopia.....	55
7.3 The cooperation of WHO with NGOs and GOs in the issue of FGM in Addis Ababa .....	56
7.3.1 The role of the NGO in the process of elimination of FGM in Addis Ababa.....	58

**Chapter Eight**

<b>8. Discussion and summary.....</b>	<b>62</b>
Discussion.....	63
Summary.....	75
<b>References.....</b>	<b>78</b>
Web pages.....	80

## **Abstract**

This thesis is dedicated to a better understanding of World Health Organization contribution to process of combating female genital mutilation in Addis Ababa, Ethiopia. The World Health Organization is well known all over the world for their work in public health. This organization is dealing with many issues concerning health and well being of people, the one of these issues is combating female genital mutilation.

The practice of female circumcision/female genital mutilation is practiced in many countries in African as in Ethiopia. The variety of reasons, age of the girl circumcised and many other aspects make the process of combating of this practice challengeable. The one of the many strategies for combating female circumcision is legal prohibition of this practice. World Health Organization have contributed to this process by adopting resolutions urging Member states to establish national policies to end traditional practices that are harmful to the health of women and children.

However, that the practice of female circumcision is recognized as violation of internationally adopted human rights, for some groups of people is this practice seen as part of their culture, tradition and norm of the behaviour.

The focus of this thesis to find out what the World Health Organization does in combating female genital mutilation in Addis Ababa, Ethiopia, and what kind of experiences World Health Organization has in combating this practice. In addition, I am focusing on the World Health Organization's cooperation with non-governmental organizations in the process of eliminating this practice.

**Key Words:** World Health Organization, female circumcision, female genital mutilation, non-governmental organizations, Ethiopia, Addis Ababa, combating female circumcision/female genital mutilation, legal prohibition of the practice of female circumcision



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### **List of Abbreviations**

AAWA	Addis Ababa Women Association
AFRO	African Health Research and Development
ECOCOS	United Nations Economic and Social Council
EWLA	Ethiopians Women’s Lawyer Association
FGM	Female Genital Mutilation
HTP	Harmful Traditional Practices
ICA	Inter African Committee on Traditional Practices Affecting Health of Women and children
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children Education Fund
WHO	World Health Organization
WHO/EMRO	Eastern Mediterranean Regional Office of World Health Organization

## **Chapter One**

### **Introduction**

The aim of this thesis is to look at the work and experiences that the World Health Organization (WHO) have in the process of combating female genital mutilation (FGM) in Addis Ababa, Ethiopia. For those who practice female circumcision, this practice is seen as a cultural tradition, heritage, and norm of behaviour. For the WHO, FGM is the partial or total removal of or injury to the external female genitalia. The practice is performed for non-therapeutic reasons and WHO states that no form of FGM should be practiced by any health professional, including all health establishments. In addition to causing pain and suffering the practice of female genital mutilation has severe health consequences for girls and women, and is a violation of internationally recognized human rights. WHO condemns all forms of FGM and calls for the elimination of the practice. (WHO/FRH/WHO/96.10, p.1, 1996, Hosken 1993: 25) The WHO is not alone in the process of combating of female genital mutilation. There are many non-governmental organizations (NGO) that try to combat this practice in Ethiopia. Some of them cooperate in combating of female genital mutilation with the WHO.

#### **1.1 Problem of the statement**

The nature of human beings is the same all over the world - parents want the best for their children; only the conviction of what is best for their children is different. The individual perspective of each person in a particular culture cannot be generalized. With the issue of FGM my assumption is that, law cannot change the attitude of individuals and their personal beliefs in relation to female circumcision, but it can have a positive impact in combating female circumcision generally. WHO has contributed to the eliminating process of female circumcision in Ethiopia by passing resolutions and recommendations. The WHO's resolution WHA47.10 urges Member States to establish national policies and programmes and with legal instruments abolish female genital mutilation. (WHO 1998: 62) Nevertheless that the Criminal Code of the Federal Democratic Republic of Ethiopia in its Article 565 and Article 566 prohibit practice of female circumcision, this practice is still prevalent in Ethiopia. However, there is some change in attitude towards elimination of this practice among Ethiopian society; it is debatable what has made this change. Is this change a result of the contribution of WHO into the eliminating process of FGM and legal prohibition of this practice in

Ethiopia? Is the legal prohibition of female circumcision result of the needs of the society or legal prohibition of this practice simply declared the position of the state?

## **1.2 Research objectives**

There are three research objectives to this study: I want explore what the challenges and difficulties are that WHO faces in the process of combating FGM and how WHO is dealing with those challenges and difficulties. The second objective is to investigate the contribution and efforts undertaken by WHO in relation to the process of eliminating FGM in Addis Ababa, Ethiopia. I wanted to find how WHO has contributed to the process of combating FGM in Ethiopia. The third objective is to observe the reaction of those who are affected or influenced by the work of WHO in relation to combating FGM. It is why I chose to make interviews in some of the non-governmental organizations situated in the Addis Ababa. Many non-governmental organizations implement plans to eradicate female circumcision into their policies. I want to investigate how non-governmental organizations what I visit during the fieldwork period in Addis Ababa are cooperating with WHO.

## **1.3 Research questions**

The focus of the thesis is to find out what the WHO does in combating FGM in Addis Ababa. What kind of experiences WHO has in combating of FGM and how is WHO contributing into process of elimination of this practice in Ethiopia? I was looking for information what influence work of WHO and NGOs in the process of combating female circumcision/female genital mutilation. What kind of relation is between the WHO and the NGOs? In addition, I was interested how the advocacy and technical support undertaken by the WHO affect processes of elimination of FGM in Addis Ababa. My interest was also based on the plans of WHO for the future on the issue of FGM in Addis Ababa. Which kind of strategies does WHO have in combating FGM in Addis Ababa and what is the main aim of the future plans for combating FGM?

## **1.4 Research methodology**

This thesis is based on the literature review and on a field research conducted in Addis Ababa, Ethiopia, and field research conducted in Geneva, Switzerland. The methods applied for the research were documentary analyses, observation and interview.

#### **1.4.1 Narrowing to the topic through written sources – documentary analyses**

The process of narrowing to the topic through written sources was divided into two main categories, in which each main category had several sub categories. The one category represents the written sources related to the legal aspect of the female circumcision; the other category represents written sources mostly related to social anthropology and history. In the beginning of the process of narrowing to the topic through written sources, I was looking for background information that established the existence of the problem and the previous research on the related topics.

The research methods related to the legal aspect of female circumcision was based on reading and analyzing written sources from the WHO and other UN bodies and also analyzing sources about legal aspects of female circumcision both generally, and particularly, are related to the present situation in Ethiopia. In this process were also included the analyses of the Penal Code of the Federal Democratic Republic of Ethiopia is also included and the analysis of the Constitution of the Federal Democratic Republic of Ethiopia. This information was used to prepare questions for interviews, and represents the basic knowledge about legal aspect of female circumcision in Ethiopia.

Narrowing to the topic through review of written sources focusing on anthropological and in some of the cases historical materials represents basic knowledge about practice of female circumcision in general. As well as the review of written sources with an emphasis on legal aspect of female circumcision, also review of written sources with an emphasis on social and cultural aspect of this practice lead to establishing research objectives and research questions and for preparing questions for interviews. This part was done with an emphasis on review of written sources from authors who come from countries where female circumcision is practiced and from authors who come from Ethiopia. In this part was also included review of the written sources regarding Ethiopian history and geography as well as sources related to Ethiopian culture. The important part of this review was searching for information concerning Ethiopian society, demographic and ethnic distribution, health system in Ethiopia as well as the religious and political situation in the country.

#### **1.4.2 Methods applied during the fieldwork period in Addis Ababa**

One of the research methods applied during the fieldwork period in Addis Ababa was interviewing. I chose interview as the research method for the reason that I wanted to elicit from the

interviewee all manner of information: the interviewees' behavior, attitudes, norms, beliefs and values. The research interview is the prominent data - collection strategy both in quantitative and qualitative research. (Bryman 2004:109, 113)

In most of the cases, I used unstructured interview with open-ended questions. Unstructured interviews had only a list of topics or issues often called an interview guide. The style of questioning was usually informal and the phrasing and sequencing of questions varied from interview to interview. (Bryman 2004: 113) Open-ended questions were employed extensively. The reason for using open-ended question was to get as much information concerning combating female circumcision as possible. I was looking for information regarding personal opinions and experiences in combating female circumcision as well as plans and outcomes of the programmes implemented.

I prepared questions that I believed would lead me to find information about the experiences of WHO in combating female genital mutilation in Addis Ababa, Ethiopia. Some of the answers made me developed new questions that I would use for future interviews. The questions were raised with the emphasis on the status of the person interviewed, which means that some of the questions asked during the interviews with people working for NGOs were not asked when interviewees were not working for NGO. During the most of the interviews, I used a recorder, however, in some of the cases the most useful and most interesting information was mentioned when I switched the recorder off.

Observation was very important tool during my fieldwork. Through observation I was looking for information how people what I met in the minibus, during the different social occasions and even on the streets react on the fact, that me foreigner coming from Norway come to Ethiopia to do research about practice of female circumcision. Through review of written sources, I have an impression that people are usually not open to speak about the practice of female circumcision. In fact, during the fieldwork period in Addis Ababa, I never come to situation that people did not want to answer questions related to this practice.

Observation was also applied when I made appointments with my informants. I was looking for information concerning the term<sup>1</sup> used by my informants during the introduction and interview it self. The willingness of my informants to answer questions or even make appointment and other aspects, which might have influence on the interview situation such as time limitations,

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<sup>1</sup> Female circumcision or female genital mutilation

the fact that I come from a foreign country, being disturbed by phone calls and visitors, permission to use recorder, etc. Phone calls or other aspects such as visitors or unexpected time limitation interrupted almost all of the interviews. I was not allowed to take camera and make still pictures in most of the organizations visited in Addis Ababa.

I tried to make appointments with my potential interviewees in person, but it was not possible in all of the cases. In some of the cases calling on the phone ended with no response and emails were ignored. Even if interview was scheduled on the exact time in advance, I had to rescheduled it because person what I wanted to make interview with had no time to answer my questions. In few cases, I did not succeed to make any appointment for interview. The Fistula Hospital situated in Addis Ababa and one of the member staff of the WHO regretted to be interviewed. The reason was that I did not have permission from the Ethiopian Health and Technology Council. The fact that my research was not part of the any project held in Ethiopia by national or international organization, and I was not student of any of the educational institution in Ethiopia made conditions for getting this permission unfulfilled.

### **1.5 Explanation, controversy and use of the terms female genital mutilation and female circumcision**

The use of the right terminology was one of the challenges during my fieldwork. There is controversy about the terminology of the practice of “female genital mutilation”. There are many terms used to describe the same practice. The tree main terms used are – female genital mutilation, female circumcision and female genital cutting, which are usually in use in different contexts. All of these three terms address the same practice. However, the meaning of these three terms might be different according to the situation, position or belongingness of those using it.

#### **1.5.1 Circumcision**

The word “circumcision” was the appropriate term to use during my fieldwork in Addis Ababa because most of my informants used it during interviews and I found it appropriate to use this term during the conversations with local people. I found it impossible to write about “female circumcision” in relation to WHO. The perspective of WHO as Simon Rye states, is that the definition of female genital mutilation encompasses physical, psychological and human rights aspects of the practice. (Rye 2002: 24) This perspective seems to be quite different from the

perspective of those who practice female circumcision, for them female circumcision is tradition, heritage, and norm of behavior. From the perspective of WHO circumcising girls is mutilation. The WHO is not dealing with “female circumcision” but with “female genital mutilation”.

I want to look at the word “circumcision” from two perspectives- epistemological and ontological perspective. The epistemological is perspective what the translation of the word circumcision is from one language to another and the ontological perspective is what represents the reality of circumcision within society.

From the epistemological perspective, the word circumcision, “*girzet*“ in Amharic language commonly used in Addis Ababa, means the word circumcise in the English language. The word is used for both female and male circumcision. From an ontological perspective, people do not mutilate their daughters, but they circumcise them. I tried to look at the epistemological and the ontological perspective from the point of view of those who practice female circumcision.

Historically, the term female circumcision was used in international literature until the early 1980s when the term female genital mutilation or the short equivalent of this term-FGM was introduced and became more widely used. In the late 1990s some writers began using other terms such as genital cutting (FGC), female genital surgery, and it has even been said that, the intent is circumcision and the effect is mutilation. (NCTPE 2006: 75)

In Ethiopia, most organizations and agencies such as the National Committee on Traditional Practices in Ethiopia (NCTPE)<sup>1</sup>, and Inter African Committee on Harmful Practices Affecting the Health of Women and Children, use FGM or the equivalent in foreign language communication. In Amharic, the word ‘*girzet*’, which is translated as circumcision, is used. In the other Ethiopian languages such as Tigrina, Afar and Oromifa similar words with traditionally accepted connotations are used. In Tigrina, the term ‘*mknshab*’ is used. This term is used both for female and male circumcision and refers more to the process than to the result. In Afar, the term ‘*selot*’ is used. This term indicates to female circumcision and ‘*andoyta*’ indicate to male circumcision. In Oromifa, particularly in Arsi, the term “*kitanna*”, refers to female circumcision. There is not clear if the distinctions based on the type of circumcision are evident in all local languages. (NCTPE 2006: 76) The Amharic word “*megrez*” is also in use and it means to

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<sup>1</sup> As of November 2004 the former name, National Committee on Traditional Practices of Ethiopia (NCTPE) is officially changed to Ye Ethiopia Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM). I chose to use the former name of this organization in my thesis. The reason for this is that the publication cited is using name NCTPE instead of EGLDAM. The other reason is that EGLDAM is transcription from Amharic language, which is not using Latin alphabet. (NCTPE 2006)



circumcise, and is both for male and female circumcision. In addition, the Penal Code of Federal Democratic Republic of Ethiopia and some materials of the Ethiopian Women Lawyers Association used term “circumcision” while materials from the NCTPE use term female genital mutilation.

The term circumcision seems to be problematic from many perspectives. Firstly, it implies an analogy with male circumcision. This seems to be wrong both from anatomical and religious aspects. (Almroth 2005: 5) The degree of cutting in female circumcision is anatomically much more extensive than in male circumcision. The male equivalent of clitoridectomy, referred to as a type 1-excision of the prepuce, with or without excision of part or all of the clitoris in the classification by WHO, in which all or part of the clitoris is removed, would be the cutting off of most of the penis. The male equivalent of infibulation – which involves not only clitoridectomy, but also the removal and closing off of the sensitive tissue around the vagina – would be the removal of the entire penis, its roots of soft tissue, and part of the scrotal skin. (Cook, Dickens, Fathalla 2003: 265, WHO 1997)

According to WHO, there is no documentation of a practice that only involves removal of the clitoral prepuce in a way that is analogous to male circumcision, without cutting any of the clitoris or other parts of the female genitalia. However, there are some indications that practice, which involves removal of the clitoral hood without cutting of the clitoris or of the surrounding tissue, is practiced in some of the Ethiopian regions. (Rye 2002: 38) Whereas there is religious authorization in Judaism and Islam for male circumcision, there is no such as clear religious authorization for female circumcision, however, the practice of female circumcision is many times seen by them who practice it, as a religious obligation. (Almroth 2005: 5)

Nahid Toubia wrote:

*“We advocate the use of the term of female circumcision when dealing with affected individuals, parents or other community members. Consider what an African woman may feel when a stranger asks her if she is “mutilated” or whether she plans to “mutilate” her daughter. It is important that we respect the feelings and beliefs of individuals even as we inform them of facts contrary to these beliefs.”* (Skaine 2005:2).

### **1.5.2 Female Genital Mutilation**

The term female genital mutilation has been in use from the beginning of 1990. In the spring of 1991, a seminar on Traditional Practices Affecting the Health of Women and Children was organized by the UN Human Rights Office in Geneva. This seminar was hosted by Burkina Faso. The seminar recommended that the term “female genital mutilation” should replace the term

“female circumcision”. A similar recommendation was made half a year earlier in the November 1990 at the IAC<sup>1</sup> regional conference in Addis Ababa. (Hosken 1993: 24) However, the term female genital mutilation was criticized. Some authors, staff members of the agencies and organizations and researchers did not find appropriate to use it because it is thought to imply excessive judgment by outsiders and insensitivity toward individuals who have undergone the procedure. (Shell – Duncan, Herlund 2000: 6)

In order to rectify the absence of standardized classification, WHO convened a Technical Working Group on Female Genital Mutilation in 1995. A joint statement prepared by WHO, the United Nations Children’s Fund (UNICEF) and the United Nations Fund for Population Activities (UNFPA) was presented in 1997. (Rye 2002: 23) This statement defines female genital mutilation (FGM), often referred to as ‘female circumcision’, that:

*“Female genital mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other non-therapeutic reasons. The three agencies classified the different types of female genital mutilation as follows:*

*Type I - Excision of the prepuce, with or without excision of part or all of the clitoris.*

*Type II - Excision of the clitoris with partial or total excision of the labia minora.*

*Type III - excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)*

*Type IV – Unclassified: includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into vagina to cause bleeding or for the purpose of tightening or narrowing it; and any other procedures that falls under the definition of female genital mutilation given above ”*

(WHO 1998: 6)

The term female genital mutilation seems be medically correct and accurate. The term mutilation means removal of normal healthy organs without any medical indication. However, the term female genital mutilation might be offensive to some groups, including women who had undergone the procedure. (Almroth 2005: 5) In addition, the term female genital mutilation might be understood as condemning the practice, which would not have been suitable or possible in some interview situations. (Almroth 2005: 6)

Most of my informants from Ethiopia did not use the term female genital mutilation. When I used the term female genital mutilation in my questions, they used the term female circumcision in

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<sup>1</sup> Inter African Committee on Harmful Practices Affecting the Health of Women and Children

their answer. The short equivalent of female genital mutilation (FGM) was also in use. After a couple of interviews where one side was asking about female genital mutilation and the other side was answering about female circumcision I started to think about which kind of view the women have who undergo the female circumcision about the variation in the terms used. Do circumcised women even know that for some groups of the people circumcised women might be viewed as having been mutilated? Women who have undergone female circumcision most probably do not consider themselves to be mutilated. The terms used have to be with emphasis on respect and sensitivity to women who never considered procedure mutilation. (Skaine 2005: 8)

I chose to use the term as it related to the position of those whom I was describing, or whose opinions I am referring. I did not find it appropriate to use the term female genital mutilation in the parts of my thesis that relate to information from my informants from the NGO's, because they themselves were usually not using this term. Most of my informants used the term female circumcision. The term female circumcision seems to be more effective in how to describe the position of those who "circumcise". The term female genital mutilation explains the position of WHO. (Skaine 2005)

## **1.6 Structure of the thesis**

This thesis is divided into eight chapters:

The first chapter of the thesis gives the background for the research problem, research objectives and questions and for the research methodology. In this chapter there is also included the explanations and limitations of the terms female genital mutilation and female circumcision.

The second chapter explains the process towards formulating the thesis from the early beginning through finding the way to general objectives and research questions. The chapter continues with a presentation of Ethiopia as a country where part of the fieldwork period was conducted, and as a part of the subject of the study. The WHO is also presented in this chapter. The last part of the second chapter is related to the experiences from the fieldwork period in Addis Ababa and in Geneva.

The third chapter deals with the issue of female circumcision/female genital mutilation in general, which raises the issues of the history of the practice and the cultural and health perspectives of the practice.

In the fourth chapter, the focus is on the practice of female circumcision in Ethiopia, particularly in Addis Ababa and the legal aspect of this practice in Ethiopia.

The fifth chapter deals with the cultural and human rights issues related to female genital mutilation/female circumcision. It also deals with the harmful traditional practices practiced in Ethiopia and with the legal issues related to these practices.

In the sixth chapter, the focus is on WHO. The main issues are the history of the work of WHO on the issue of female genital mutilation and especially the activities of the WHO Country office in Ethiopia

The seventh chapter elaborates on issues related to the work of the WHO Country office in Ethiopia, its plans and experiences. The chapter also gives information about WHO's cooperation with the NGOs and role of the NGOs in the elimination process of female circumcision in Ethiopia.

The eighth chapter concludes with a discussion on broader issues of female genital mutilation/ female circumcision and gives an analysis before concluding.

## **Chapter Two**

### **Process towards the thesis**

#### **2.1. The choice of the topic**

Since early age, I was always curious about how people lived and what kind of values they have, not only in the society where I come from, but also in other societies. I was curious about how these values are connected to each other, and what I could learn from others cultures. I think this curiosity springs from my childhood when my parents gave me the unique opportunity to see how people lived in other corners of the world. Together we visited many places in Asia and Europe. During our trips I had the chance to see how people are living in different societies than in the society where I come from. These experiences influenced my future studies. In 1998, I chose to study social science at Presov University in Slovakia. During the studies, my interests in social change grew and I began to focus on Islamic society. My choice for my master's thesis was to write about the revival and manifestation of Islamic fundamentalism. The issue of how culture, religion and traditions influence social determined norms of behavior inspired me in choosing my future studies.

In September 2005, I started studying in the Masters Program in Indigenous Studies. This multidisciplinary Masters Program composed of law, social anthropology, history and literature gave me an opportunity to see the process of social change from the many different perspectives. As part of the program, I had to choose a topic for my master's thesis. I wanted to write something about "change" as it related to traditions, customs and beliefs.

A practice, which is often, discussed in the media which caught my attention was the practice of female circumcision. I was born and raised in a society where female circumcision is not practiced. The limited sources of information about female circumcision, which I received before I started to research this topic, came from the media, where the practice was more or less represented as brutal and inhumane and the little space was given for those who practice female circumcision. Is it hard to say if I - a European and uncircumcised woman-can fully understand the position of circumcised women. I will never get the inside view of this practice, and I can not say that some like me who has studied issues related to this practice will know more about female circumcision than those who come from societies where female circumcision is practiced. I had to find an appropriate approach for narrowing to this problem.

After I wrote and presented my project proposal on the topic of my master's thesis, it got the attention of my classmates. I chose to focus on the legal issue of female circumcision, but from the beginning of this process, there was a lot of confusion about what I could or would particularly focus on in particular. The discussions about the issue of female circumcision from the many perspectives and views made me think about my own perspective. Some of my classmates continuously asked me the same question; what is my position. To find my position was the greatest challenge in the process towards thesis. I tried to find my position through a review of written sources. I found many articles written by scholars who went to societies where people look at this practice as a norm of behavior, a cultural tradition and a religious obligation. Numerous articles described female circumcision from many perspectives, including the opinion of those who support circumcision, but most of the authors writing about this practice do not come from the societies where female circumcision is practiced, or do not have personal experiences of female circumcision.

There is one saying in the Slovak language – “about us but without us”. The issue of female circumcision seems to me to be like this saying. Why is the effort for abolition of the practice of female circumcision coming from societies where the practice is not a tradition of behavior? Do the societies where the practice of female circumcision is a norm need such an effort? Do societies where people do not practice female circumcision think they “know” better what should be considered “good” and what should be considered “bad” and is that why they want to “help” to abolish female circumcision? Are those who “want to help” eliminate this practice invited by those who practice female circumcision, or do they think that they do not need such an invitation because their mission is to “save souls of the barbarians”? Who are they who try to combat female circumcision? How could they explain to those who practice female circumcision that this tradition might be seen as harmful? What is changing the attitudes of those who practice female circumcision? Do they believe that, the practice of female circumcision is harmful, or are they afraid to be punished by the law that prohibits this practice? How are culture and health issues related from the perspective of law?

### **2.1.2 The choice of the WHO**

The process towards the thesis has continued in narrowing of the topic of my master's thesis. Firstly, I had chosen to focus on the human rights instruments as tools for combating female

genital mutilation. This study would have included the work of the international organizations and agencies towards to the legal prohibition of the practice of female genital mutilation. After I had received comments on my project proposal from my supervisor, I tried to make the topic of my master thesis narrower. Instead of writing about the issue of female circumcision from an international perspective, which would have included many of the international organizations I chose to focus on only one - the World Health Organization. WHO seemed to be the decision-making organization in the process of eliminating FGM. I was interested in what kinds of experiences staff members of this organization have in combating female circumcision and in what kinds of cultural obstacles that WHO is confronted with when its tries to eradicate FGM.

### **2.1.2.1 The World Health Organization**

The World Health Organization (WHO) is the directing and coordinating authority on international health within the United Nations' system. WHO experts produce health guidelines and standards and help countries to address public health issues. WHO also supports and promotes health research. Through WHO, governments can jointly tackle global health problems and improve people's well-being. WHO's objective is the attainment by all peoples of the highest possible level of health. The Constitution of WHO defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

<http://www.who.int/about/governance/en/index.html> last accessed at 22.5.2007

[http://www.who.int/about/brochure\\_en.pdf](http://www.who.int/about/brochure_en.pdf) last accessed at 22.5.2007

The issue of setting up a global health organization was discussed for first time in 1945. Three years later WHO's constitution came into force and the first World Health Assembly took place in June 1948. In 1948 WHO had 55 Member States, by today this number has grown to 193 Member States. More than 8000 people from more than 150 countries work for the Organization in 147 country offices, six regional offices and at the headquarters in Geneva, Switzerland. In addition to medical doctors, public health specialists, scientists and epidemiologists, WHO staff includes people trained to manage administrative, financial, and information systems, as well as experts in the fields of health statistics, economics and emergency relief.

[http://www.who.int/about/brochure\\_en.pdf](http://www.who.int/about/brochure_en.pdf) last accessed at 22.5.2007

The World Health Assembly is the supreme decision-making body for the WHO. Its main function is to determine the policies of the WHO and to consider reports of the Executive Board,

which it instructs regarding matters upon which further action, study, investigation or reports may be required. The Executive Board is composed of thirty-four members technically qualified in the field of health. The main functions of the Board are to give effect to the decisions and policies of the Health Assembly, to advise it and generally to facilitate its work. The Secretariat of WHO is staffed by some 3500 health and other experts and support staff on fixed-term appointments, working at the headquarters, of the six regional offices, and in countries. The Organization is headed by the Director-General, who is appointed by the Health Assembly on the nomination of the Executive Board. (<http://www.who.int/governance/en/> last accessed at 22.5.2007)

The WHO and its Member States work with many partners, including UN agencies, donors, nongovernmental organizations, the WHO's collaborating centers and the private sector. The Civil Society Initiative (CSI) fosters relations between WHO and nongovernmental and civil society organizations and is responsible for the administration of formal relations. The WHO country offices may also work with NGOs at the national level. The objectives of the WHO's relations with NGOs are to promote the policies, strategies and activities of WHO and, where appropriate, to collaborate with NGOs in jointly agreed activities to implement them.

([http://www.who.int/collaboratingcentres/cc\\_historical/en/index1.html](http://www.who.int/collaboratingcentres/cc_historical/en/index1.html) last accessed at 18.5.2007)

(<http://www.who.int/about/structure/en/index.html> last accessed at 16.05.2007)

(<http://www.who.int/civilsociety/en/index.html> last accessed at 23.05.2007)

### **2.1.3 Why I chose Ethiopia**

According to the WHO, there are 28 countries only in Africa, where female circumcision is practiced. I decided to choose one of them for my fieldwork. I considered many factors before I decided where I would like to do my research. Some of the factors that I considered were my language skills, the religious and political situation in the country where I might go for my fieldwork, and last but not least the possibility of finding relevant information. (WHO/FRH/WHD/96.10 1996)

To choice of Ethiopia gave me the impression of being the best alternative. The Country office of WHO in Ethiopia is situated in Addis Ababa – capital of Ethiopia. The prevalence of female circumcision in Ethiopia is quiet high, there is law prohibiting this practice and in addition, my personal interests played an important role in the process of choosing Ethiopia as a country for my fieldwork.



Some of my classmates came from Ethiopia and they had been from the beginning of my studies important sources of information about their country and the practice of female circumcision as well. I was confronted with their questions related to the practice of female circumcision many times during the lectures and presentations of our projects. Some of the Ethiopians did not support the idea that I wanted to write about the practice of female circumcision in Ethiopia. The reactions of some of them led into a discussion about how I, an uncircumcised woman could understand this practice. Some people might probably feel confused when they realized what the topic of my master thesis was; especially for people from communities where female circumcision is practiced they might find it difficult to understand why I am interested in such as topic. Perhaps they believe that it is better to leave this “problem” for those who are personally connected to it. For those who come from societies where female circumcision is practiced but live in the Western world, it might be confusing how this practice is presented in media. In addition, the situation related to efforts towards abolishing the practice of female circumcision might also be confusing for them. Why are Westerners “still” coming to Africa to tell what Africans what they should do and what they should do not? Why are there almost no Africans who want to help solve the problems of the Western world?

### **2.1.3.1 Ethiopia as a country**

The Federal Democratic Republic of Ethiopia is a country situated in the northeast of Africa also called the Horn of Africa. Ethiopia today covers over one million square kilometers and has a great number of ethnic groups whose cultures are as rich and varied as their composition. (NCTPE 2006) Ethiopia currently (2005) has a population of approximately 70 million people. The major ethnic-linguistic groups are Oromo (40%), Amhara (22%) Tigray (10%) Sidamo (9%) and Somali (6%) (Briggs 2005). In 1994, Ethiopia became a federal republic and the regional map was redrawn along widely accepted ethno-linguistic lines. The result was eight national states and three city-states. Each region is divided into a few zones and a large number of districts-called woreda. (Briggs 2005: 3) Only 14% of the population of Ethiopia lives in urban areas. According to the National Committee on Traditional Practices in Ethiopia (NCTPE), population grows at 2,9 % per year and is estimated to reach 90 million by 2015. Women and children, the vast majority (75%) of the population, carry the brunt of harmful traditional practices (HTP) in the country. The maternal

mortality rate estimated between 700 and 1400 per 100 000 live births. The health status of Ethiopian population is low. (NCTPE 2006)

Ethiopia supports a blend of linguistic groups. Some seventy languages are spoken most of them are belonging to Semitic or Cushitic branches of the Afro-Asiatic family. (Briggs 2005) Amharic is the most widely used and understood language in the country and is transcribed in a script that is unique to the country. This consists of over 200 characters. Amharic is the official language of the media and government, and widely used in cross-cultural communications. (Kebede, Snow 2002)

The main religions in Ethiopia are Christianity and Islam. The majority of Ethiopian Christians belong to the Ethiopian Orthodox church. It is very difficult to know which religion has a majority in Ethiopian society, but numbers are close to 40% Muslims and 60% Orthodox Christians. (Briggs 2005)

I chose Addis Ababa, the capital of Ethiopia for my fieldwork. Thanks to the great help of my classmate, Gemechu Jamal Geda and his sister Zemzem Jamal Geda, who became my guide and informant, the first days in Addis Ababa were not so difficult. When I come to Addis Ababa I found that practical information such as where the places were that I wanted to visit are and how I could reach them, information related to the transportation and places where I was to stay were provided by my Ethiopian classmates was very useful. However, one can read, see, and hear about a country for many times, but it is only personal experience, that may give a life to this information.

I experienced Addis Ababa as a city of contrasts where the poverty was represented by slum areas, people without a place to stay and little kids and handicapped people begging on the streets, which were beside the rich areas where the skyscrapers were built and people were enjoying their time in luxurious restaurants. Especially the kids on the streets asking for food and sometimes running after me and shouting “lady, lady give me the money” touched my heart deeply. For me this situation was strange, but I thought that for people living in Addis Ababa it was the everyday reality. Then I was thinking, why am I so touched by the situation of the “street kids”? I found that I did not have any previous experience with it. I do not come from the society where one might find “street kids” which is why I considered the situation so strange. For those who were born into this situation and see the “street kids” every day, this situation is considered “normal”. They probably did not have the experience of how it is to walk in the streets of Addis Ababa and do not see the “street kids”. I transformed this idea into the situation related to the female circumcision. For those

who come from the society where female circumcision is part of the life is considered to be “normal”. For those, who experienced it from outside, it might be considered “strange”.

I met people in Addis Ababa who did not hesitate to help me when I found my self in a difficult situation, they were people who were interested in why did I came to their country and also a few people who insulted me or did not care at all about who I was and what I was doing there. Many times when I met people in the streets of Addis Ababa, I experienced the “small cultural exchange”. People asked me how I liked Ethiopia, and where I have been so far. I asked them which part of Ethiopia they came from and what were they doing in Addis Ababa. After this short introduction, who I am and where I came from the conversation continued with questions about why I came to Ethiopia and about what I would like to do there. From the beginning, I used to say that I was there for my fieldwork related to the issue of female genital mutilation, but most of them did not understand what female genital mutilation meant. I realized how important it is to use the “right” terminology when I was speaking with local people who were not members of NGO’s or any other organization dealing with women’s health issues. Later on, the term of female circumcision was the term that I usually used during my conversations with locals. Most of the people that I met on the streets, minibuses or in restaurants would openly answered my questions related to the issue of female circumcision, which surprised me a lot. I did not expect that people would be so open to talk about this issue. I found in many of the literal sources that I analyzed that female circumcision is taboo and people do not speak about this practice. Probably the situation in the city is different from the situation on the countryside. It seemed that people that I met talked about this practice with me because I was a foreigner, but they probably would not speak about the practice of female circumcision with other Ethiopians.

## **2.2 Experiences in the process of narrowing to the topic through written sources**

The process of narrowing to the topic through written sources began when I chose the topic of my master’s thesis. The continuously narrowing of the topic led to selecting adequate sources for future analyses. In the beginning of the process of narrowing to the topic through written sources, I was surprised about how many books and articles have been written about the issue of female genital mutilation/female circumcision.

Most of the articles that I read in the beginning of this process were in the spirit of the controversy between cultural and human rights issues. It was difficult to find articles written by

African scholars, and even harder to find articles written by Ethiopian scholars. I found that many of the articles were written in a negative viewpoint about this practice, and most of them were written by authors that do not come from a society where female circumcision is practiced.<sup>1</sup> Only few of them were written by African authors, and very few of them considered positive impacts on the wellbeing of girls in the society where she belongs.<sup>2</sup> According to the Nahid Toubia only a few studies, if any, look at the social role of FGM within gendered power relations, or document the emerging resistance to the practice within families and communities as part of a process of social change. (Toubia 2004: 39)

I tried to create perspective that did not favor any of the groups. I found that if I would have had the perspective that was only from the point of view of the WHO I might have come to the point where I would have written thesis in a way, which may seem like I am writing against those who practice female circumcision. On the other side, if my stated point would have been on the side of those who practice female circumcision I might come into troubles with my own personal belief and come up against a debate which has nothing to do with my research questions and general objectives.

Later on, I found relevant books and articles, which were not written simply against the practice of FGM, but included also “positive” aspects of this practice. The point of view of both sides of the issue is very important in my writing. We have no right to say that others cultures are wrong because they seem to be different from our culture. For people who practice female circumcision is this practice not a health issue, but it is more or less related to heritage, religion and culture.

WHO published several articles, books, and fact sheets related to the issue of the FGM. I tried to look at closer at those, which were dealing with FGM particularly in Africa, and specifically in Ethiopia. The purpose of data analyses from the sources of WHO was to understand how WHO

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<sup>1</sup> “Most studies on female genital cutting in Africa have been conducted by “outsiders”, individuals who are not from the societies they analyze and who have no personal experience of any form of the operation. The limited number of African women who have written about female genital cutting either come from the ethnic groups where the female genital operations are not practiced or have never undergone the procedures themselves.” (Ahmadu 2000: 283 in Shell-Duncan, Hernlund 2000)

<sup>2</sup> “The discussion about practice of female circumcision tends to focus almost exclusively on the physical pain and harm suffered by the child at the expense of the positive feelings that she may experience as a circumcise woman. It has been argued that the strong cultural and traditional ties might mitigate the feeling of pain, degradation, and betrayal felt by the girls as they begin to feel socially and morally acceptable through their circumcision which also allows them to become economically valid members of their community”. (Breen 2002: 132)

is dealing with the issue of FGM. What is the perspective of WHO in combating FGM and what kinds of activities does WHO have for the elimination of FGM. In addition, the collecting of information about Ethiopia was an important part of my research. I had never visited Ethiopia before; therefore, the preparation for the fieldwork was intensive.

### **2.3 Fieldwork experiences in Addis Ababa, Ethiopia and in Geneva, Switzerland**

After difficulties getting a visa for Ethiopia and some troubles with canceled flight tickets the process of my fieldwork continued in Ethiopia, particularly in Addis Ababa. Soon after my arrival to Ethiopia, I contacted the Country office of the WHO in Addis Ababa and found where some of the non-governmental organizations (NGO) that I planned to visit were located. I felt a time pressure, every single day was important for my research. I was worried about finding some useful information for my master's thesis in Addis Ababa. Would I spend one month in Ethiopia and return with nothing?

My highest goal was to make an interview with a representative of the Country office of the WHO in Addis Ababa Dr. Abonesh Haile Mariam, who is the head of the Women's health department. I tried to contact Dr. Abonesh Haile Mariam before I arrived to Ethiopia, but I was not successful. I made a several phone calls to the Country office of WHO in Ethiopia after my arrival there. After a couple of days in Addis Ababa, I made an appointment with Dr. Abonesh Haile Mariam.

My first meeting with Dr. Abonesh Haile Mariam was informal. I was invited to have lunch with her in the WHO building. The meeting took almost two hours. Dr. Abonesh Haile Mariam talked about the issues she is working on, her position in the process of eliminating FGM in Ethiopia and her personal opinion about this practice. Her personal belief is that FGM is related to gender inequality in Ethiopia. In her opinion the men power over the women and their low status of education are some reasons why in opinion of Dr. Abonesh Haile Mariam FGM continued until the present day. In this first meeting, I came closer to the problem of female genital mutilation related to the perspective of the Country office of WHO in Ethiopia. According to the Dr. Abonesh Haile Mariam, only a continuous effort for abolishing the practice of FGM might bring a successful result.

In my second appointment with Dr. Abonesh Haile Mariam, she agreed to be interviewed. I was also trying to have interviews with the staff of the WHO Country office in Ethiopia who work on issue of FGM. I was expecting a team of workers, who were participating on the projects related

to the issue of FGM, and that they would be working in the field. I prepared myself well for the interview. I was not expecting to find only one person working in the office for Women Health – only Dr. Abonesh Haile Mariam. My dreams to join a team of WHO workers in the field were gone. Dr. Abonesh Haile Mariam made it clear to me that she had only thirty minutes for the interview and the time limitation had a negative impact on the interview. It seemed as if Dr. Abonesh wanted to answer to my questions as short as possible so I had no time to get deeper into the problem of FGM in Ethiopia during this interview.

The information by Dr. Abonesh Haile Mariam provided surprised me. My expectations were different from the reality. After the interview with Dr. Abonesh Haile Mariam I had to rethink about what WHO actually does to combat female genital mutilation in Ethiopia. I also realized that it was impossible to write my masters thesis about the Oromyia region<sup>1</sup> as I had planned. I asked myself how I could write about female genital mutilation in Oromyia when Oromyia is so large and I have no time and possibility to reach more than one Zone for several days. In addition, the question arose as to what I could find there, without support and help from any of the NGOs or directly from WHO. I asked Dr. Abonesh Haile Mariam and my informant's from the NGO's, if it would be possible for me to find answers on my questions in the local community.

I wanted to ask people in the local community what their perspective is on the projects of WHO, and what could bring a change in their attitudes related to the abolition of female circumcision in their community. Why do they practiced female circumcision and why do they not practice it anymore? Most of my informants told me that I could try, but it would be very difficult, almost impossible to be successful to get any answers. According to them, the reasons why I might not be not successful were lack of time in the field period, and the time I could spend in the community, and the willingness of the people to talk with an outsider. Also the fact that WHO does not have any project related directly to combating female genital mutilation in the society played an important role in my decision to stay for my fieldwork period in Addis Ababa rather than in Oromyia. I could not find answers related to projects held by WHO when this kind of projects does not exist. I decided to stay for my fieldwork in Addis Ababa. This choice was even more strengthened by the short field period and also the fact that the organizations I planned to visit were in Addis Ababa.

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<sup>1</sup> Oromyia covers an area of 367 000km<sup>2</sup>- more than 30% of Ethiopia's total surface area-and its population has risen from 18 to 21 million over the last decade. (Briggs 2005)

Many of the people, which I talked to about my fieldwork in Addis Ababa, mentioned that female circumcision is no longer a part of life in the capital city. Their explanation was that people living in Addis Ababa are “modern enough” that they do not circumcise their daughters anymore. Addis Ababa, like other capital cities in the world, is populated by people from all of the country. According to the information from NCTPE from 1978, the number of people who had migrated to the capital was 819,389 people. Migration from rural areas was estimated to be 363,075 people. When the prevalence of female circumcision is estimate to be 60% (NCTPE Survey from 1997) and the number of people who migrated in the population to capital city so high, the opinion that in Addis Ababa people does not practice female circumcision anymore seemed to be inadequate. The accuracy of the data used from the 1978 might be arguable. I use this data only as an example of the diversity of the population in Addis Ababa, but not as a primary source for describing the situation related to female circumcision in Addis Ababa.

During my stay in Addis Ababa, I visited some of the local NGO’s. The visits to NGOs were of great help to understand the difficulties related to the issue of combating FGM. It was from the NGOs I have gotten a glimpse of the situation of female circumcision in Addis Ababa and the reaction of community to the activities undertaken by NGOs. In my fieldwork, I usually used formal and informal interviews. Most of the time I did not make notes during the interviews but I used a tape recorder. In some cases, using the recorder was a disadvantage, because the most interesting information and some of the most relevant answers came when I switched the recorder off.

Fieldwork in Addis Ababa included also the “small talks” about female circumcision. At first I did not see the importance of this kind of information, but later on I realized, that these “small talks” are a unique source of information on the view of the issue of female circumcision in Addis Ababa. The views of those who do not work for any organization dealing with issue of female circumcision were “colorful”. Many of the people told me that female circumcision represents power of men over women, and almost everybody advocated that their daughter is not to be circumcised and that they do not come from the society where female circumcision is practiced. Some of them mentioned that only people in the rural areas who are illiterate and poor who practice female circumcision. I did not find the answer to questions as to why all of the people in Addis Ababa who talked with me about female circumcision in an informal way thought that the practice of female circumcision is wrong. One of the reasons could be that they were just telling me what I

wanted to hear. I did not have any possibility to find out whether their daughters or wife's are circumcised or not. Because even if people say that they are against this practice, the reality might be different. My fieldwork period in Addis Ababa continued, and after I finished my research there, I left for fieldwork at the WHO offices in Geneva.

My research at the WHO in Geneva was based on the review of written sources in the library of WHO. My conversation with people who work for WHO on the issue of female genital mutilation was limited on email communication. Even if I got the telephone numbers, I could not reach the people I wanted to speak with. They did not pick up the phone and when they picked up the phone, they said that, they were busy. In the WHO in Geneva, one person seemed to care about my questions, and the rest did not seem to care at all that I had questions to ask. I did not have any interviews with the members of the staff at WHO in Geneva, the part of my fieldwork there was important. I did not find answers why I did not reach any people working with the issue of FGM in the WHO in Geneva. It seemed to me that my fieldwork research that I was doing was probably not important to the members of the staff of WHO in Geneva.

I return from Geneva with no interview only written materials and with the feeling that maybe it would have been better to stay at home. When I compared my fieldwork experiences in Geneva and in Addis Ababa, it seemed that everyone I met in Addis Ababa was open to help me to find answers to my questions. I heard many times people telling me that the study I was doing was important and that it would help to stop the practice of female circumcision when the “world” will be aware of the situation in Ethiopia.

The reasons why they saw my research in Addis Ababa as important might vary according to their personal beliefs related to the female circumcision. I did not find answers to the question of how I, a student from Norway who had done research in Addis Ababa might help in the process of combating FGM by simply writing my masters thesis. I did not find an answer to the question of how those, who had such limited information about my research might see any benefit of my research and later on what a masters thesis would mean for them.

The following chapter deals with the issue of female circumcision/female genital mutilation in general, which raises the issues of the history of the practice and the cultural and health perspectives of the practice.



## Chapter Three

### The practice of female genital mutilation/female circumcision

#### 3.1 The origin and the history of the female circumcision

The problem of female circumcision does not fall easily into the category of health problems or violation of human rights. This practice has a strong cultural and religious base without which it would not exist today. (Koso-Thomas 1987: 1) The practice of female circumcision has existed in one form or another in almost all known civilizations throughout history, it means, that it is impossible to confine this practice to a particular culture or religion. (Momoh 2005)

It is very difficult to date the first operation or to determine the country in which it took place first. Several sources claim that female circumcision originated in the Middle East, most likely in Egypt. However, its origins remain obscure, two facts seem evident: male circumcision preceded the female operation and both operations existed long before the Islamisation of Africa (ad. 632-732) and the area, which is now called the Middle East. (NCTPE-CAMPAIGN 1995: 5, Hosken 1993, Koso-Thomas 1987)

It is, however, certain that in all societies where female excision is practiced, male circumcision is also performed. Nevertheless, the male operation exists in many more societies, both in the past as well as in the present, than the operations on females. Male circumcision operations are represented in a relief of the Egyptian tomb of Ankhama Hor of the Sixth Dynasty (2340-2180 B.C.) Other Egyptian representations of pharaonic times show the circumcised penis. Male circumcision evidently has been practiced in Egypt for many thousands of years. No similar records exist for female genital mutilation, though many speculate that it started in the same areas as a parallel to the male operation at puberty. Since the Egyptian records are unique, it is impossible to make any conclusive statements about the earlier origins of the male or female operations or about how the practice spread. (Hosken 1993: 71) It is said that both the Jews and the Arabs learned circumcision in Egypt. The practice was unknown to Romans until they conquered Egypt and the Middle East. There is also very little concrete evidence to determine whether the custom moved from a core area to other regions or whether it sprang up independently in various places. (NCTPE-CAMPAIGN 1995: 3) What we know is that the Romans performed a technique involving the slipping of rings through the labia majora of female slaves to prevent them from becoming pregnant and the Scythian sect in Russia performed female circumcision to ensure virginity. Christian

missionaries and colonial administrations in Africa attempted to prevent the practice as early as the seventeenth century. These efforts met with resistance because they were seen as a colonialist attempt to destroy the local culture. (Skaine 2005: 120, Momoh 2005)

In the 1960s and 1970s, African activism against FGM further developed. In many countries, women's groups led intermittent campaigns to educate the population about the harmful effects of the practice. In addition, doctors—mostly in Sudan, Somalia and Nigeria—who observed patients suffering from complications of FGM, began to document the procedure and write about its clinical complications in medical journals. (Rahman, Toubia 2001: 10)

It is also known that female circumcision or “genital surgery” took place in the 19<sup>th</sup> to the mid 20<sup>th</sup> century in some Western countries. Clitoridectomy was performed to cure nymphomania, masturbation, hysteria, depression and epilepsy. (Koso-Thomas 1987) There is no evidence to support that female circumcision is practiced in the Arabic countries in the Middle East, but nothing guarantees the exclusion of female circumcision in these countries. A recent United Arab Emirates survey indicates that female circumcision takes place in this country. (Abu-Sahlieh 2001) While the traditional forms of female genital mutilation have all disappeared in the West—except, covertly, within immigrant communities—it continues in the developing world. (Momoh 2005: 6)

### **3.2 Understanding the issue of female circumcision**

To understand FGM, one must look at variations in type, consequences, and cultural, religious and social beliefs. Female circumcision is carried out for a variety of reasons, which are not fully documented and vary from country to country and from culture to culture. (Hirut 2000) There are many reasons for practicing female circumcision. According to materials of WHO the reasons given by families for having FGM performed include psychosexual reasons, sociological reasons, hygienic and aesthetic reasons, and myths and religious reasons.

(<http://www.who.int/mediacentre/factsheets/fs241/en/> last accessed at 20.1.2007)

The psychosexual reasons are mostly related to the perceiving virginity and maintaining chastity and as a prevention of promiscuity. There is also argued that female circumcision is done to increase male sexual pleasure. Sociological reasons for female circumcision are mostly related to the belonging to the community. Female circumcision might be seen as an initiation of girls into womanhood, but it is impossible to generalize this fact for all communities where female circumcision is practiced. Female circumcision might be also seen as a ritual, which confers full

social acceptability. In some of the societies where female circumcision is practiced females genitalia are considered as ugly and dirty. The practice of female circumcision predates Islam and Christianity; however, for some of the groups of people is this practice seen as a religious obligation. The myths surrounding the practice of female circumcision are mostly related to the child's survival during delivery. In addition, female genitals are in some groups considered as a male element it is why they have to be cut of. The superstition that genital organs of female would grow is also believed. The reasons for female circumcision vary from one society to another. The well knowing of reasons for female circumcision might probably contribute to eliminating process of this practice.

(<http://www.who.int/mediacentre/factsheets/fs241/en/> last accessed at 20.1.2007, Koso-Thomas 1987, NCTPE 2006)

There are many perspectives on the practice of female circumcision. From the perspective of those who do not practice female circumcision, it may seem that such human behaviors and cultural values related to the female circumcision, and especially the reasons for female circumcision look destructive, harmful and senseless. For them who practice female circumcision has this practice meaning full and functional aspect. (Rye 2002, NCTPE 2006, Koso-Thomas 1987)

Female circumcision is related to many cultural elements. Marriage and relations between the community members are the two cultural elements, which has a strongest impact on continuing the practice. It is very important to understand how the practice of female circumcision is related to the other parts of the culture, and how these parts of the culture influence and are interrelated to each other. Otherwise, it would be like taking out one part of an engine. The lack of that part may damage the whole vehicle and finally the vehicle may case to function properly. (NCTPE 2006: 31)

What will happen with other cultural practices, which are influenced by female circumcision when the community stops circumcising? Is it possible that this situation will lead to disturbance in the rest of the cultural practices? Is it possible that the symbolic circumcision will possibly replace the cutting of the clitoris, sawing and narrowing of the vagina? Will this replacement satisfy members of the societies where the infibulated girl is considered a virgin?

In the areas such as Affar and Somali where many communities live from pastoralism, girls usually stay with the animals outside for many days. It is believed that infibulation will protect them against rape. It is known that in many African societies virginity of a girl is one of the conditions for marriage. Many believe that to rape an infibulated girl is not easy and that infibulation will protect

girls from unwanted pregnancies and illegal children. Pregnancy and delivery of children before marriage are taboo in many of the traditional societies where female circumcision is practiced, but it is also the taboo in many societies where female circumcision is unknown. (NCTPE 2006) The question if the female circumcision might be used as a protection against rape is discussable. In the society where the majority of the girls are circumcised might be difficult to think in the relations that for men, is a circumcised girl something unaware.

### **3.3 Health problems arising from female circumcision**

The severity of the operation or damage done to the girl seems to depend on the type performed, the skills of the circumciser, the sanitary conditions under which the operation was conducted, the local customs, the tools used (knives, glass, splinters or razor blades) the co-operation and the health of the child at the time of the operation. (Koso-Thomas. 1987, Hirut 2000) Health problems arising from female circumcision are usually divided into two categories. The immediate complications represent one category and the long-term health complications represent the second category.

[http://www.who.int/reproductive-health/docs/systematic\\_review\\_health\\_complications\\_fgm.pdf](http://www.who.int/reproductive-health/docs/systematic_review_health_complications_fgm.pdf)

The post circumcision problems may lead to complications at the delivery of the child and at consummation of marriage. Pain, shock, fever, urinary infections are only few of many complications arising from female circumcision. (Koso-Thomas 1987: 26)

Most of the attention given to health problems associated with FGM concentrates on the physical aspects, with little attention paid to the psychological problems. No studies have been conducted to measure the effect of the trauma on children. The psychological complications of FGM may be submerged deeply into the child's unconscious. However, many children do exhibit behavioral changes, and some problems may not become evident until the child reaches adulthood. (Toubia 1995: 19) Psychological complications of FGM and sexual complications of FGM are mostly related to difficulty in penetration, lack of orgasm, frigidity and many others.

(Koso-Thomas 1987, WHO 2001 last accessed at 25.5.2007 [http://www.who.int/reproductive-health/publications/rhr\\_01\\_18\\_fgm\\_policy\\_guidelines/fgm\\_policy\\_guidelines.pdf](http://www.who.int/reproductive-health/publications/rhr_01_18_fgm_policy_guidelines/fgm_policy_guidelines.pdf)) Consummation of marriage often necessitates the opening up of the scar by the husband using his fingers, a razor or a knife. Very little research has been done on the sexual experience of circumcised women, a subject surrounded by taboos and personal inhibition in most societies. (WHO Chronicle 31 1986,

p.410 in Steiner, Alston 2000) The women themselves know little of the physical and psychological consequences of genital mutilation. They do not associate possible physical problems with genital mutilation but they take them as being normal, just part of a woman's life. (Smith 1995: 16)

*“The viewpoint on the practice of female circumcision is almost exclusively focuses on the physical harm done to a child when she is circumcised, and does not address the positive feelings she may have as a circumcised woman. In Africa communities with strong cultural and traditional ties, the perceived need to be circumcised mitigates the hellish remembrances of the event. Little girls who are initially hurt, betrayed, and degraded by the operation later come feel socially and morally acceptable because they have been circumcised. As the girls grow into women, they may forget the pain and argue that the practice needs not to be banned. Furthermore, it is difficult to attack a practice as harmful to children when it later gives them both social and economic benefits.” (Boulware-Miller 1985: 414)*

The difficulties related to willingness to undergo female circumcision might be seen as a social pressure on the girl child. When all of her friends are circumcised, and she is the only one who is not, the willingness to be part of the group, to be same as the other are is clear. In addition, the lack of the information about function and anatomy of the genital organs, which child could not have, may play significant role in cases where girl child want be circumcised.

In the next chapter, focus is on the practice of female circumcision in Ethiopia, particularly in Addis Ababa. The chapter is dealing with the legal issues associated with the practice of female circumcision.

## Chapter Four

### The practice of female circumcision in Addis Ababa, Ethiopia, and the legal issues associated with this practice

#### 4.1 Female circumcision in Ethiopia

The origins of FGM in Ethiopia are not clear. Female circumcision could be inferred to have preceded the conversion to Christianity in the 4<sup>th</sup> century. The Judaic influence might be one of the reasons how female circumcision have been originated in Ethiopia. Infibulation in Affar goes back to the Turkish invasion of the Red Sea coast in the early 15<sup>th</sup> century. The purpose of the practice was to protect women from rape and impregnation by the invaders. This kind of protection seems to be like a solution for mothers who want protect their daughters. However, if the practice of female circumcision continued until present days, it has to be some social need of the community which is this practice satisfying. (NCTPE 2006: 30, 70)

*“In Ethiopia, mostly old women, traditional birth attendants, or other traditional practitioners perform the mutilation under unhygienic conditions using a razor blade, a knife, or other sharp instrument. For the services, the woman will be paid a small token in cash or kind. In many instances, the mutilation is done at the girl’s home, but sometimes – if it entails a ritual whereby many girls are involved.”* (NCTPE 2006: 80)

It is very debatable when it comes to issue of unhygienic conditions. What are unhygienic conditions in the African perspective? Should we expect the same hygienic conditions in rural Africa as in industrialized countries? Does it mean that if the conditions are not sterile they are unhygienic? From the other side, the knife or razor blade that has already been used several times may not be hygienic and the risk of infection or transmission of HIV might be very high. Especially when the circumciser used the knife or razor blade for many times the quality of this instrument as an instrument for cutting human flesh might be inappropriate. It is possible that medicalization of female circumcision should be seen as a solution for unhygienic conditions? The discussion related to medicalization of FGM was the topic of the Khartoum seminar (see history of work of the WHO in issue of FGM). Since that time WHO states that the practice of female circumcision should be practiced not by any health care providers. (WHO/FRH/WHD/96.10 1996)

One of the perspectives on the importance of female circumcision might be seen as a test of survival. If an individual is strong enough to survive pain, suffering and infections, which are related to female circumcision, than this individual will be strong enough to live in the conditions of the

particular community. Girls who undergo circumcision will be strong enough to give birth to many children, to survive health diseases and take care of family.

The procedure of FGM varies depending on the type of FGM, the age of the girl, and the experience of the practitioner, who in many cases is an old woman. Practitioner usually also serves as a traditional birth attendant. In some parts of the country, circumcision is done on an infant. This is the case in most Amhara and Tigray regions and parts of Oromyia. Some ethnic groups have their daughters undergo mutilation as a prerequisite and preparation for marriage just a few days before the wedding. This occurs among Arsi Oromo, Fadashi and Goffa. In Ethiopia there has been not reported circumcision done on the pregnant women. (NCTPE 2006: 80, 83)

National boundaries are not all important, however, as the distribution of genital cutting often straddle national boundaries. Those close together geographically do not necessarily share the practice. In the case of Ethiopia where the boundaries of the federal states are based on ethnic boundaries practice of female circumcision varies from one ethnic group to another. In the national state of Gambella, there is no evidence of female circumcision, while in the neighboring national state of Oromyia the prevalence of female circumcision, according to national survey from 1997, is estimate to be at 80%. (Hernlund, Shell-Duncan 2000: 7, NCTPE 2006) In 1997/1998, the National Committee on Traditional Practices in Ethiopia (NCTPE) carried out a national baseline survey to determine the prevalence of female circumcision. In all ten regions of the country, both rural and urban some 44,000 people were interviewed in a study reaching sixty-five of Ethiopia's eighty ethnic groups. (NCTPE 2006: 86, 87)

The survey taken by the NCTPE is the not only one of its kind. The several other studies that were done in Ethiopia had results that varied from 80% to 90%. A survey in 1990, sponsored by IAC, included twenty of the thirty-one administrative zones covering 73% of the population of the country and showed that 85% of the women surveyed had undergone female circumcision. UNICEF in 2005 published findings of a Demographic and Health Survey (DHS) from 2000, which estimated prevalence of female circumcision at 80%. Some other sources such as Nahid Toubia estimated the prevalence of female circumcision at 90%. The WHO in 1994, 1996 and 1998 published that the prevalence of FGM went down from 90% in 1994 to 85% in 1998. (UNICEF 2005, NCTPE 2006, WHO 1998, Rahman, Toubia, 2001, Abu Sahlieh 2001) The difference between data published shows how difficult is to estimate the “real” prevalence of female circumcision in Ethiopia. There are factors, which might influence the research on the prevalence of

female circumcision. As I wrote before, there are differences in the prevalence of female circumcision among ethnic groups; this might be the significant factor, which has influenced the findings published. When research is done mostly in the regions where the prevalence of female circumcision is high, the final finding might bring different results when research covered also the regions where the practice of female circumcision is unknown. The other factor influencing the findings might be related to the age of the respondents, their settlement –urban or rural – and the type of practice.

The most radical form of the female circumcision is infibulation. According to National survey in Ethiopia in 1997 infibulation takes 58% of all of the circumcisions in Afar region and 90% from all of the circumcisions in the Somali region. In National survey held in Ethiopia in 1997 states, that there is 0% of infibulations in Addis Ababa. (NCTPE 2006: 90) The fact that it is 0% of infibulations in Addis Ababa seems be quite inaccurate.

As I mentioned above, the migration population to the capital city is high. There is quite high probability that some people from the Somali region migrated to Addis Ababa. When people move from one place to another they usually carry their habits and traditions with them. It seems to be difficult to understand that people from the Somali region, who are known to be traditional, left the practice of infibulation when they migrated to the capital city. Virginity in the Somali community is considered to be highly important. Virginity is not understood to be a natural condition but has to be enforced in sewing vaginal opening of girls while they are still young. The hymen of women evokes strong sanctions if it is broken before marriage; however, men in Somali region are often unaware about existence of this membrane. To them sewn girl means virgin. (Hirut 2000: 38) The preservation of virginity is not only the norm among nomadic Somali, but also among societies which are not necessary nomadic, African or Muslim.

There are great contextual differences and the personal experiences of girls and women with female circumcision and the women's views may differ from those of men as well. (Sæverås 2005: 14) Aud Talle maintains that reliable portrayal of the problem of female circumcision should consider cultural meaning as well as individual experience. (Talle 2003: 9, my translation from Norwegian original) In addition, youth's views may differ from those of elders, women's views from those of men. The norms within society do not generalized personal experiences and values of the members of the society.



*“Norms constitute basic rules and standards for interaction between community members. Adherence to norms helps create a sense of identity, normalcy and belonging to a fellowship of “same doers”. Norms reward compliant behavior with honor and punishes deviant behavior with social exclusion. FGM sets the standard for “normal” and “good” “clean” (a women whose genitals were cut) and “unclean” (a girl whose genitals are uncut) and “mature” versus “immature”” (Sæverås 2005: 14 in Hejll 2002)*

The classifications of different types of FGM by WHO do not necessary corresponded with operations commonly performed in Ethiopia. Clitoridectomy and excision is common among Orthodox Christians in highland Ethiopia. This type of circumcision is also common in Addis Ababa. In some of the cases circumcisers excise parts of the labia without cutting any of the clitoris or the clitoral prepuce, for fear of 'strong bleeding' (excision without clitoridectomy) does not; however, seem to correspond with any of the categories listed by WHO. The difficulties with classification are related to the style and experiences of the circumciser. (Rye 2002: 56, 57)

In many African countries, women who live in the urban areas are less likely than those who live in rural areas to practice FGM. The findings at the national level in Ethiopia, present a higher prevalence in the urban areas than in the rural ones. (NCTPE 2006: 87) The urban women are usually more educated, or have better access to education than the rural women have. In addition, the role of the information related to the women's health might be more easily distributed in the urban areas than in rural areas. The question of tradition also plays an important role. As Mrs. Yatarick mentioned, women in rural areas hold their traditions much more strongly, than the women in urban areas, and especially the women from the Somali region do not leave their traditions even if they are living in the city and are educated.

However, the fact that urban women are less likely to undergo any of the type of female circumcision might be related to the uncertainty of the methodology and reliability of such studies. Women in urban areas have more possibilities to be examined by medical personnel than, the women in the rural area. As Simon Rye states in his article:

*“One source of uncertainty relates to the fact that one cannot know for sure whether or not a girl or woman has been circumcised without clinical examination. The possibility to undertake such clinical examination is restricted to health centers and hospitals and contingent upon the compliance of clients or, in the case of children, their parents. But such examination is not, for example, commonplace in Ethiopia and only take place upon indication that something is wrong, if at all. The increased politicisation of female circumcision, and the perceived risk of legal prosecution associated with the practices in some countries, are other sources of uncertainty. People may have good reason not to expose their views and, above all, the practice of their community.” (Rye 2002: 26)*

According to the information from my informants, the legal aspect of FGM might be seen as a double-edged sword. On the one side, the legal prohibition of FGM might help to eradicate the practice, and show the clear national policy related to issue of FGM, on the other side, the procedure of FGM might go to an underground level which brings with it more health complications.

#### **4.2 Legal issue of female circumcision in Ethiopia**

Passing anti-FGM legislation is one of the most controversial aspects of the FGM elimination movement. In the last past decades has Ethiopia ratified major international human rights instruments adopted by the United Nations. Principles contained in international human rights instruments are reflected in the current Constitution of the Federal Democratic Republic of Ethiopia. The following is the list of these instruments:

- The 1948 UN Universal Declaration of Human Rights proclaims the right of all human beings to live in conditions that enable them to enjoy good health and health care and the entitlement in motherhood and childhood to special care and attention.
- The 1966 UN International Covenant on Economic, Social and Cultural Rights condemned discrimination on the grounds of sex and recognized the universal right to the highest attainable standard of physical and mental health
- The 1966 UN International Covenant on Civil and Political Rights Prohibits torture and cruel, inhuman or degrading treatment forbids discrimination and guarantees equal enjoyment of civil and political rights by men and women.
- The 1979 UN Convention on All forms of Discrimination against Women can be interpreted to require State Parties to take action against female genital mutilation.
- The 1989 UN Convention on the Rights of the Child protects the right to equality irrespective of sex (Article 2), to freedom from all forms of mental and physical violence and maltreatment (Article 19.1), to the highest attainable standard of health (Article 24.1), and to freedom from torture or cruel, inhuman or degrading treatment (Article 37a). Article 14.3 of the Convention explicitly requires States to take all effective and appropriate measures to abolish traditional practices prejudicial to the health of children.
- The 1990 OUA Charter on Human and Peoples Rights
- The 1990 African Charter on the Rights and Welfare of the Child

Those instruments categorically condemn all forms of HTP's that result in bodily injury or mental harm of the human person. (Teshome 2005: 6, WHO 1997)

The Penal Code of Federal Democratic Republic of Ethiopia from the 1957 does not have any specific provision on harmful traditional practices or specifically on female circumcision. The Code from 1957 has included only provisions on grave and common willful injury. These provisions may be construed as incorporating offences relating to female circumcision, because practice of female circumcision causes bodily injury on the victims. Those who practice FGM do not carry it out with a view to causing harm on the victim. The act is rather taken for something that is done in the interest of the victim. (Teshome 2005: 8, 9)

The Criminal Code of the Federal Democratic Republic of Ethiopia from 2004 looks at the problem from two perspectives, namely female circumcision and infibulation of the female genitalia.

Its states thus:

*“Article 565. Female circumcision - Whoever circumcises a woman of any age is punishable with simple imprisonment for not less than three months, or fine of not less than five hundred Birr. Article 566. Infibulation of the Female Genitalia - (1).Whoever infibulates the genitalia of a woman is punishable with rigorous imprisonment from three years to five years. (2). Where injury to body or health has resulted due to the act prescribed in sub-article (1) above, subject to the prevision of the Criminal Code which provides for a more severe penalty, the punishment shall be rigorous imprisonment from five years to ten years.”*(The Criminal Code of the Federal Democratic Republic of Ethiopia Proclamation NO.414/2004: 332)

The above provisions cover persons who are directly responsible for the crime. In addition, Article 569 provides that persons who are accomplices to the crime as parents, guardians are punishable with simple imprisonment not exceeding three months or fine not exceeding Birr 500. . (Teshome 2005: 9)

In addition, Article 561 address indirectly to FGM, especially to re-infibulation.

Article 561 1) c)

*“through the exercise of other traditional practices known by the medical professions to be harmful, is punishable with fine or simple imprisonment from three months to one year”.* (The Criminal Code of the Federal Democratic Republic of Ethiopia, proclamation No.414/2004: 330)

As the fight against HTP's, should start from the community itself, the law will provide an additional impetus to the community and the law enforcement organs. (Teshome 2005: 15) Legal measures, if they are to be effective, have to be combined with widespread backing of the policies among practicing communities, which requires raising public awareness as well as governmental

strategies that support the empowerment of women. Governments must also be prepared to support the institutions through which the laws are implemented. (Teshome 2005) According to my informants from several NGOs and from the WHO Country Office in Ethiopia, it is not enough to make laws prohibiting female circumcision. Efforts to change a law must come from the side of the people who practice female circumcision; otherwise, it is impossible to implement laws prohibiting female circumcision into the public. My informants claimed that people who practice female circumcision would not understand that a practice that was part of their life and part of the life of their ancestors is suddenly prohibited. They need better explanation as to why this law has come to be and who has imposed this law on them. Many people who practice female circumcision are not aware about the existence of such a law, and it is very debatable if knowledge about legal prohibition will help to eliminate female circumcision. According to the perspective of my informants from the Addis Ababa Women's Affairs Office, one could never know what happened behind closed doors of the family homes. People may say that they do not support the practice of female circumcision, that they will not circumcise their daughters, but what they really do, no body knows.

On the other side in the article 39, sub-article 2 of the Ethiopian Constitution it states that :

*“Every nation, nationality and people shall have the right to speak, write and develop its language and to promote its culture, help it grow and flourish, and preserve its historical heritage. In this context, it seems that if female circumcision is a part of the culture and historical heritage is protected by law.”*

<http://www.ethiobar.net/English/cnstion/conchp32.htm> last accessed at 1.3.2007

There is a clear controversy in this perspective. How is it possible that there exists one law that prohibits one cultural practice and on the other side, there is a law that is protecting culture and historical heritage? Are harmful traditional practices a part of the culture? If yes, than it has seems that the law protects them, not only the Ethiopian law, but also the international law is protecting culture. The Ethiopian government in 1993 ratified International Covenant on Civil and Political Rights (ICCPR) where in article it 27 states:

*“In those States in which ethnic, religious or linguistic minorities exist, persons belonging to such minorities shall not be denied the right, in community with the other members of their group, to enjoy their own culture, to profess and practice their own religion, or to use their own language.”*

<http://www.ohchr.org/english/law/ccpr.htm#art27> last accessed at 1.3.2007

The nature of legal and human rights instruments legitimizes efforts to advocate the eradication of female circumcision. The challenge of using this approach is related to the problem that activists themselves are not familiar with these instruments. (Cook, Dickens, Fathalla 2003: 274)

### **4.3 Female circumcision in Addis Ababa**

Female Genital Mutilation in Addis Ababa according to the information from my informants from several NGOs and from the WHO has not been an issue of the past decades. One might think that in a city like Addis Ababa, the capital of Ethiopia, cultural and administrative center people do not practice female circumcision. My informants mentioned that people are not more “modern” in the way that they would leave behind their traditions and be different in Addis Ababa from those who live in the rural area.

I tended to experience Addis Ababa as a modern city, it might be related to the type of research I was doing in Addis Ababa. The majority of the organizations that I visited during my field period in Addis Ababa are housed in the modern buildings close to the city center. If my research had only focused only on the people living in the slum areas my impression from the city might be different. However, the impression that Addis Ababa is a modern city disappeared when I went to the slum areas which one may find in all corners of Addis Ababa. My trips to the slum areas were not directly linked to my research but it was mostly a matter of curiosity.

I found that in Addis Ababa the city has many faces. Like in the other parts of the world in the capital cities, in Addis Ababa people from whole country are living there. Also the differences between those who are rich and those who are poor are extremely visible. I would say that Addis Ababa was a city of contrasts, rich and poor, dirty and clean, healthy and ill, everything is in strong contrast.

I was looking for information about female circumcision in Addis Ababa in many places. There is couple of published documents, which show a prevalence of female circumcision in Addis Ababa. The most recent and reliable source of information about the prevalence of female circumcision in Ethiopia is the National Committee on Traditional Practices in Ethiopia (NCTPE). The NCTPE made national baseline survey in 1997. (Rye 2002: 51) This survey indicates a prevalence of FGM in Addis Ababa of 70%. (NCTPE 2006: 87) According to this survey, they are only three regions in Ethiopia (Affar, Harar and Amhara) where the prevalence is higher than in

Addis Ababa. The survey also indicated that there is only a 30% attitudinal change within society. (NCTPE-FGM, 1999) Rye stressed that female circumcision is less common among the educated middle class in Addis Ababa than it is among the poor and illiterate. (Rye 2002: 52) WHO is working on the new survey related to the prevalence of FGM in Ethiopia. So far, data are not available, but according to information given by Dr. Abonesh Haile Mariam, the prevalence in all of the regions of the country has gone down. Especially the prevalence of those who support the practice has drastically gone down. This factor is a positive indicator in the long-run process of the elimination of FGM. When the generation of circumcised mothers does not circumcise their daughters, than the next generation will probably not continue this practice at all. I do not have information about the methods used or information about which kind of indicators made the change in the attitude among those who no longer support circumcision. It will be very interesting to know what has changed the attitude of those who are no longer supporting the practice of female circumcision anymore. Are they really against the practice or is the information that the practice is illegal in Ethiopia make them afraid to say what they truly believe?

Female circumcision is handed from one generation to the next or from one group of people to another, without realizing that this practice may create damage to the society. It then becomes a pattern of behavior shared by the members of the society. A survey carried out in Ethiopia in 1985 shows that the prevalence of the practice was over 75% for the country and was as high as 95% in some areas. Surprisingly the findings indicate that 84% of the respondents had plans to have their daughters mutilated. Many of the respondents were literate, and were residing in the capital, Addis Abba. (Hirut 2000: 12)

My informants from several NGOs operating in Addis Ababa mentioned that the main problem related to female circumcision is that women are not aware enough about the negative effects of this practice. Some of the NGOs are working with the project of income-generated activities, which not only help to make the economic status of women better, but also help to share information about HTP, which includes female circumcision. Women among them share information about meetings that are organized by NGOs or organized café ceremonies where they talk about HTP. In addition, having men participating in activities that are related to female circumcision seems to be important. Most of my informants stated that in order to abolish FGM, it is necessary to give information about the practice of female circumcision to men as well.

One of the reasons why female circumcision is continuing is that men refuse to marry an uncircumcised girl. When men change their attitude on this issue, change will be possible. In most of the families, it is the father who is the decision-maker and it is the father who is dealing with the family's finances. When the mother decides that her daughter has to be circumcised, she has to ask her husband for the money to pay for it. When the father refuses to give the money to his wife for the circumcision and if he is against it, theoretically the daughter will have a chance to not get circumcised. However, some of my informants mentioned that the attitude of people vary in relation to the situation. Pressure from the older generation, and the community's attitude in relation to female circumcision might be the significant factors for families when it comes to deciding – circumcise or not circumcise.

According to Mrs. Yayanesh from the Addis Ababa Women's Affairs Association, when men come to a meeting they usually say that they are against FGM, they say that FGM is a bad practice, but no one knows how they treat their wife and children at home. Many times men say that their wives are equal to them: But are they treating her equal at home? Gender-based violence is one of the problems in the society. Little or no knowledge about human rights is closely related to poverty and economic issue. Mrs. Yayanesh states that in many families girls are treated unequal to boys. The boy is sent to school but the girl must stay at home and help her mother with daily routines. Later, when she grows up it will be hard to make an income when she has no education, she will be dependent on her husband. My informant continued by explaining the situation within a family. When a girl is in the marriageable age, the mother wants her to have a good life, a good life means a good husband. She can find a good husband for her daughter only when her daughter is circumcised, which means being accepted by the community. In a community where female circumcision is the norm, no man will marry an uncircumcised girl. An unmarried girl is a shame for family.

The cultural and social pressures on the most enlightened and educated do not venture to discard the tradition totally, even if they are in principal against it. In the perspective of Mrs. Hirut, even educated parents support circumcision, they usually are aware about physical and psychological damage of this practice. Hirut explained that a few years ago some medical doctors practicing gynecology in the Black Lion Hospital in Addis Ababa mentioned that they never came across an uncircumcised women among those who came to deliver their baby. (Hirut 2002: 13)

Changing the attitude of people is a long-term process. According to Mr. Abebe from NCTPE, people usually did not want to listen from the beginning a project for the eradication of female circumcision started. This happened especially when people who came to raise awareness about it were not from the particular community. One of the solutions of creating awareness is to ask people from the communities that practice female circumcision what they think about this practice, what might be a possible solution and how to stop this practice. The problem of female circumcision is their own, and they have to find the solution, that would be acceptable for them. Also the participation of circumcisers in activities held by NCTPE is very important in creating awareness creation. To create awareness in circumcisers about the negative effect of the practice is part of the programs for several NGOs.

#### **4.4 Practitioners**

Female genital mutilation is usually carried out by certain women in the community, or by traditional midwives. These women derive a high social status from the profession of “circumciser”, and can earn their living from it, when they leave the profession of “circumciser” they lose their income. The profession of circumciser is many times interrelated with the profession of midwife. The work of circumciser is not done only when a girl is circumcised. When an infibulated girl marries, she has to be opened again to make sexual intercourse possible. In some communities, this is carried out by the husband, but there are also cases when this is done by the circumciser. The circumciser is also called when a woman is about to give birth. Circumciser has to open the vaginal opening to allow the passage for the baby, and to stitch the vaginal opening up after the delivery. In this way, the circumcisers are kept in employment. (Smith 1995: 14, 15)

Several of from my informants mentioned that to change the attitude of a “circumciser” on the issue of female circumcision is one of the most difficult issues. Some of the activities related to income-generating activities for “circumciser” were held in Addis Ababa, but without expected success. A number of practitioners changed their attitude but most of them keep working. Female circumcision is illegal in Ethiopia; several NGOs implemented project about creating awareness or projects for income-generated activities especially for practitioners. Through these activities, practitioners get information about the illegality of this practice to circumcisers, and give them a loan for making alternative income. However, so far, their services are still demanded and they still have somebody to circumcised, and they keep their “business” running.



## Chapter Five

### Culture and Human Rights

#### 5.1 Culture and harmful practices

The term culture was for the first time used in the mid 19<sup>th</sup> century by anthropologist Edward B. Taylor. In his opinion culture is the complex whole, which includes knowledge, belief, art, law and other capabilities and habits acquired by men as a member of the society. In later years, culture became a term used to describe the distinctive human mode of adapting to the environment or to refer to distinctive groups of traits characterizing particular tribal societies. There were other meanings and approaches to examining culture by different anthropologists, however all anthropologists agree that culture consists of the learned ways of behaving and adapting, as contrasted to those that are inherited. Culture has several distinguished characteristics. It may be symbolic, shared learned and adaptive. Each new generation reshuffles and changes the system of ideas, meanings, and rulers, so that social traditions keep changing through time to reflect to specific time and society. (NCTPE 2006: 27, 28, 29)

As it is common among many traditional societies, most ethnic cultures in Ethiopia are bound up with myths, superstitions and false conceptions of humans, including their psychic and sexual lives. There are traditional practices in almost all ethnic cultures. These traditional practices adversely affect the health of people and gender equality. Traditional practices have also impact on the political and social rights, and economic development of the country. FGM is part of the practices called Harmful Traditional Practices. In Ethiopia, according to the NCTPE, 138 harmful traditional practices are recognized. Most of the HTP in Ethiopia are related to women or children. (NCTPE 2006)

I discussed the topic of HTP with Dr. Abonesh Haile Mariam. In her opinion, most of the HTP are related to gender issues. Dr Abonesh explained the situation of woman in Ethiopian society. From her perspective, the position of women in Ethiopian society is still not equal with the position of the man. It is very important to create awareness in men about HTP, because, there are usually men who are the decision makers in the community or they are the religious leaders. Decision makers and religious leaders are those who can create awareness in community members about negative aspects of HTP

## **5.2 Law prohibiting harmful traditional practices in Ethiopia**

The important roles in HTP that women play are not only as victims but also as perpetrators. It is clear that women will play an important role in any changes in HTP in the future. The rights of women are part of the Constitution of Federal Democratic Republic of Ethiopia, especially article 35; sub article 4 says:

*“The state shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited.”* (NCTPE 2006: 57, <http://www.ethiobar.net/English/cnstiotn/conchp32.htm> )

According to the Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No. 414/2004, Article 570:

*“Incitement Against the Enforcement of Provisions Prohibiting Harmful Traditional Practices. Any person who publicly or otherwise incites or provokes another to disregard the provisions of Criminal Code prohibiting harmful traditional practices, or organizes a movement to promote such end, or takes part in such a movement, or subscribes to its schemes, is punishable with simple imprisonment for not less than three months, or less than five hundred Birr, or both.”*  
<http://www.ethiobar.net/English/cnstiotn/conchp32.htm>

This article clearly says that practicing HTP, which includes female circumcision, is a violation of human rights.

Both the Constitution and Criminal Code of the Federal Democratic Republic of Ethiopia clearly explicate the state policy against harmful traditional practices. These legal instruments are based on the internationally recognized human rights principles. However, it does not seem to be that Constitution nor Criminal code might end harmful traditional practices in Ethiopia.

## **5.3 Female circumcision as a human rights issue**

The first documented action to bring attention to the practice of female circumcision dates back to the early 1900s, when missionaries and colonial administrators in several African countries attempted to stop the practice. The effort to stop the practice by enacting laws and church rulers did not succeed, it only provoked anger against foreign intervention. However, it is possible that undocumented efforts and initiatives by local populations aimed at stopping the practice were carried out prior to this time. (Rahman, Toubia 2001: 9) It is questionable if the missionaries and colonial administrators were protecting the human rights because human rights as we know them in

the present time were not recognized in the early 1900s, or they were just simply forbidding the culture, which was not their own culture, from their positions of power.

Later, in the early 1950s was female circumcision challenged at the international level as a practice harmful to health. Forty years later, in 1990 was practice of female circumcision fully recognized as a violation of human rights. (Packer 2005: 230 in Nnaemeka, Ezeilo 2005)

*“The fundamental objective of human rights is to afford protection for the individual, and thereafter to promote conditions for the rationalization of the talents, skills, and interests of the individual. In relation to FC, the human rights approach has sought first to protect individuals against harm and then to release them from the effects of this practice so they may be free to pursue their full development.” (Packer 2005: 233 in Nnaemeka, Ezeilo 2005)*

The study of the issue of traditional practices affecting the health of women and children was held in 1994 by the UN Sub-Commission on the Prevention of Discrimination and Protection of Minorities. This study found that the international community has been struggled with the conflict between human rights and the right to one’s culture. The reason for the conflict was that the practice of FGM is so tied deeply into rooted cultural and social values and standards. (Gumpi, Msofe 1999) My informant the executive director of NCTPE Ato Abebe stated that FGM is not a culture because no culture is harmful. In his opinion, FGM is a tradition. NCTPE is trying to influence the human rights issue into their activities. Mrs. Yatarick from the NCTPE mentioned that when people are aware about negative effects of the practice of female circumcision they do not view it as being part of the culture; because they do not want to accept the culture with negative health effects.

*“Some of the international documents also clarify the resolution of the conflict between human rights and culture by stating that guarantee of cultural integrity does not negate the basic human rights of all peoples. For example, in the Declaration on the Rights of Persons Belonging to National and Ethnic, Religious or Linguistic Minorities, the guarantee to practice your culture and carry out your traditions and customs is subjected to international human rights. There is no custom that violates an individual’s human rights that covered by the protection in this covenant.” (Gumpi, Msofe 1999: 4)*

The position of the child related to the practice of female circumcision seems to be that the child usually does not have a choice if she wants to or does not want to be circumcised. The child having no formed judgment does not consent but simply undergoes the operation. According to Mr. Abebe from NCTPE child does not know about their rights, children are silent victims of the practice, and only few of them know what female circumcision means. The descriptions available

of the reaction of children on circumcision are comparable to torture. Many countries that are signatory to Article 5 of the Universal Declaration of Human Rights<sup>1</sup> violate this clause. (Female Genital Mutilation: Proposals for Change Minority Rights Group International Report 92/3: 11.)

Ethiopia as other African countries where is practiced female circumcision sign and ratified the Universal Declaration of Human Rights and other International treaties related to rights of the child and women. According to information given by Women Affairs Office, society is not aware about these rights. The role of education plays very important role in awareness creation related to the human rights issues.

According to Mr. Abebe from NCTPE, the younger generation is more aware about human rights issue, and many girls them selves said no to female circumcision. It is important to support the younger generation in their fight against female circumcision. Mrs. Yatarick from NCTPE mentioned that the more women is educated, reached highest level of education, the lower they accept the practice. However, there are some parts of the country, where culture is predominant and even educated women support practice of female circumcision. The situation in Addis Ababa, according to Mrs. Yatarick, where the culture has not such as strong impact on the daily life of the people has education most strong impact on elimination of the female circumcision. Education is empowering women, knowledge, skills and self-confidence received through education may contribute to enhancing socio-economic change. (Belete 2002: 8)

The difficulties how to address issue of female circumcision to grass roots level people are common for most of the NGO which I visited during my field work in Addis Ababa. The authoritative nature of the ethical, legal and human rights languages legitimizes efforts to advocate the eradication of female circumcision. A challenge of using this approach is that local activist and people to whom are activities addressed are not familiar with these languages. The challenge is to train people in the use of human rights that are protected by national constitutions, local laws, and ethical norms. One cannot seek to have ones rights protected if one does not know that such as laws exist or how they may be protected. (Packer 2005 in Nnaemeka, Ezeilo 2005)

Many of my informants described the difficulties in eradication process of female circumcision based on the human rights approach. The Ethiopian society is men dominant society, even if the article 35 of Ethiopian Constitution declares women's rights in a positive way people are not aware about it. According to Dr. Abonesh Haile Mariam, the empowerment of women is the

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<sup>1</sup> which provides that no one shall be subjected to torture or to cruel, inhuman or degrading treatment

key stone in elimination process of FGM. Education for women is an important factor influencing the practice, and should play a decisive role in future projects to eradicate FGM. Using the right approach, especially with the male support, change is possible. (Cook, Dickens, Fathalla 2003, Almroth 2005: 53)

*“Communities do not have enough grass-roots support to adopt significant changes of tradition on the basis of the human rights argument. In many cases, individuals are still not convinced that the practice should be stopped.” (Packer 2005: 242 in Nnaemeka, Ezeilo 2005)*

In the following chapter, I focus on WHO. The main issues in the sixth chapter are history of the work of WHO on the issue of female genital mutilation and especially the activities of the WHO Country office in Ethiopia.

## Chapter Six

### WHO and the practice of female genital mutilation

#### 6.1 History of the work of WHO on the issue of FGM

In the last decades, there has been a lot of effort for combating FGM. WHO has been concerned with the issue of HTP, which includes also FGM, when the United Nations Economic and Social Council (ECOSOC) requested a study of the health implications of FGM. In 1958, the ECOSOC invites WHO to undertake a study of the persistence of customs that subject girls to ritual operations and of the measures adopted or planned for putting stop to such practices. (Abu-Sahlieh 2001: 293) In the same year, the United Nations Commission on Women had requested that WHO should investigate the health aspects of traditional practices. Later in May 28<sup>th</sup> 1959 in a resolution the World Health Assembly said

*“that it considers that the ritual operations in question are based on social and cultural background, the study of which is outside the competence of the WHO”* (Abu-Sahlieh 2001: 294)

This resolution was never mentioned in WHO documents. In 1960, in a United Nations seminar “On the Participation of Women in Public Life,” held in Addis Ababa, the participants asked WHO to study the medical aspects of “operations based on custom.” WHO at that time took the position that the operations in question were based on “social and cultural backgrounds,” and therefore were outside of the WHO’s competence. One of the outcomes of this seminar was the report of statements, which number 62 was related to the work of WHO. The view was expressed that the WHO could show that this mutilation has no medical justification and rather it is harmful to health and should be abolished forever. WHO continued to claim for years that the organization could do nothing without specific request by the governments of the countries involved.

(Hosken 1993: 59, 331, 332)

In 1976, the WHO’s first answer to ECOSOC’s demands was the report by Dr. Cook, adviser of the WHO regional office for the Eastern Mediterranean. This report distinguishes between three types of circumcision. It illustrates that the WHO’s expert did not condemn all types of female circumcision. Dr. Cook report goes further by stating that the first type of female

circumcision is actually useful, referring to what is done in the United States.<sup>1</sup> One year later, in 1977 WHO created a working group to examine female circumcision. (Abu-Sahlieh 2001: 294)

A couple of years after the UN Commission of Women first requested that WHO should address the health problems related to FGM, and under the growing pressure of women worldwide, the seminar was scheduled with Sudan offering to host this meeting. (Hosken 1993: 59) The WHO seminar Traditional Practices Affecting the Health of Women and Children was held in Khartoum, Sudan in February 10–15, 1979. The seminar was organized by the Eastern Mediterranean Regional Office of WHO (WHO/EMRO). Delegations from nine African and Middle Eastern countries participated in the seminar. Representatives from different UN agencies and observers from many countries participated as well. The topic of the seminar, Traditional Practices Affecting the Health of Women and Children, which had been prepared by the Eastern Mediterranean Regional Office of WHO, included a number of subjects: Nutritional practices and food taboos during pregnancy, traditional practices related to child birth, breast feeding, weaning and nutrition of both mother and baby were discussed, also early teen age childbirth, and the health problems related to child marriage. The main subject to which most of the time was allotted was female circumcision. This was the first time ever that the subject of female circumcision was discussed from the health point of view at an international gathering. (Hosken 1993: 57)

*“After five days of discussion and extensive presentation and discussion four recommendations were unanimously voted on by the delegates at the end of this groundbreaking meeting:*

- *Adopting clear national policies for the abolishment of the female circumcision*
- *Establishment of national commissions to coordinate and follow up the activities of the bodies involved including, where appropriate, the enactment of legislation prohibiting female circumcision*
- *Intensification of general education of the public, including health education at all levels, with special emphasis on the dangers and the undesirability of female circumcision*
- *Intensification of education programs for traditional birth attendants, midwives, healers and other practitioners of traditional medicine to demonstrate the harmful effect of female circumcision, with a view to enlisting their support along with general efforts to abolish the practice.”* (Hosken 1993: 58)

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<sup>1</sup> *“Type I. Circumcision proper. The circumferential excision of the clitoral prepuce, analogous to male circumcision. It is known in Muslim countries as the sunna circumcision. It is also sometimes practiced in the United States to counter failure to attain orgasm on the part of the women associated with redundancy or phimosis of the female prepuce. At it has not been reported to have any adverse health consequences, this review is not concerned at all with this form of circumcision.”* (Abu-Sahlieh 2001: 294)

The largest discussed topic of the Khartoum seminar in 1979 was medicalization of the female circumcision. Many of the delegates argued that the medicalization of female circumcision could bring positive effects on the well-being of women and girl children, and may possibly reduce deaths related to the genital operations on females. Many of the delegates stressed that recommendations prepared for the seminar should be taken from the perspective to teach health personnel to perform excisions and infibulations. There is the issue that practicing FGM in health institutions may keep an imbalance of ethical issues related to medical and health care assistance. For most of the people living in rural areas, medicalization of FGM may cause destruction of the meaning and purpose of female circumcision, related to expenses and the “western style” of the procedure when it is carried out in the health care institution. The income from genital surgeries to health care institutions is evident and may negatively affect the traditional role of the female genital operations. Finally in 1982, WHO released a statement condemning the medicalization of female circumcision. (Hosken 1993: 58-60)

*“WHO has consistently and unequivocally advised that female circumcision should not be practiced by any health professionals in any setting— including hospitals or other health establishments.” (Hosken 1993: 65)*

After the Khartoum seminar, the issue of FGM came up at the international level. Eradication of FGM began to be a part of the programs of the UN bodies such as WHO and UNICEF. A nongovernmental seminar in Dakar, Senegal in 1984 hosted by the Health Ministry of Senegal on “Traditional Practices Affecting the Health of Women and Children” was held as a follow-up to the Khartoum Seminar with the participation of WHO and UNICEF. During the seminar, the Inter African Committee on Traditional Practices Affecting Health of Women and Children (IAC) was organized. The IAC is the main partner for the cooperation of the WHO Country Office in Ethiopia. (Hosken 1993: 67) In final recommendations of this seminar states, that the practice of female circumcision is contrary to medical ethics. (Abu-Sahlieh 2001: 294)

Three years later in 1987, a seminar on the traditional practices was organized in Addis Ababa by the Inter African Committee in collaboration with WHO, UNICEF and the Ethiopian health ministry. It adopted a detailed plan of action to fight against female circumcision and to abolish this practice in all forms by the year 2000.<sup>1</sup> (Abu-Sahlieh 2001: 294)

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<sup>1</sup> *“Besides the educational and sensitization measures on all levels, plan proposes legislative and administrative measures as instruments to abolish female circumcision. According to the plan, through*



In 1989, the WHO Regional Committee for Africa adopted resolution AFR/RC39/R9 that called upon Member States to adopt appropriate policies and strategies to eliminate FGM. Later in 1993, the World Health Assembly, by its resolution WHA46.18, urged all Member States to establish national policies and programmes that will effectively, and with legal instruments, abolish female genital mutilation. To collaborate with national nongovernmental groups active in this field, draw upon their experience and expertise and, where such groups do not exist, encourage their establishment.

In 1995, a WHO technical working group meeting on FGM was convened in Geneva. One outcome was the WHO definition and classification of FGM that is currently being used internationally. WHO's Regional Office for Africa launched a 20-year regional plan of action for accelerating the elimination of FGM in countries of the region in March 1997. WHO also published a joint statement on FGM in collaboration with the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) in April 1997. Since then, African countries have started preparing plans of action, using a multisectoral approach to eliminate FGM. (<http://www.state.gov/g/wi/rls/rep/9293.htm> at 20.05.2007) In the 1998, WHO published an overview of female genital mutilation exposing its harmful effects and measures undertaken to eliminate it. (Abu-Sahlieh 2001: 294)

There are also other international instruments related to the practice of FGM such as “The Vienna Declaration” and the Program of Action for the World Conference on Human Rights in 1993. This declaration expanded the international human rights agenda to include gender-based violations, which include female genital mutilation. (WHO 1998: 52) The Declaration on Violence against Women expressly in the Article 2 states:

*“Violence against women shall be understood to encompass, but not be limited to, the following: (a) Physical and sexual and psychological violence occurring in the family, including ... dowry-related violence ... female genital mutilation and other traditional practices harmful to women”.* (WHO 1998: 52)

Later in 1994, The Programme of Action of the International Conference on Population and Development (ICPD), included recommendations on female genital mutilation, which commit governments and communities to:

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*these measures, governments can guide and institutionalize changes in attitude towards harmful traditional practices.”* (Abu-Sahlieh 2001: 294)

*“urgently take steps to stop the practice of female genital mutilation and to protect women and girls from all such similar unnecessary and dangerous practices”.* (WHO 1997: 11)

*“ The Platform for Action of the Fourth World Conference on Women in 1995 included a section on the girl child and urged governments, international organizations and nongovernmental groups to develop policies and programmes to eliminate all forms of discrimination against the girl child, including female genital mutilation.”* (WHO 1997: 12)

## **6.2 The country office of WHO in Ethiopia, Addis Ababa**

Part of my research in Ethiopia was interview members of the staff of the WHO Country office in Ethiopia. I found information about the WHO Country office in Ethiopia on the WHO’s web page where I also found contact information for representatives of the department of Women’s health, Dr. Abonesh Haile Mariam. The Country Office of WHO in Ethiopia is in the building of the UN in the middle of the capital city, in Addis Ababa.

My first contact with Dr. Abonesh Haile Mariam was after my arrival to Addis Ababa. Dr. Abonesh Haile Mariam has worked for the WHO Country office of Ethiopia for more than a decade. She is also the representative for three other departments, namely Child and Adolescent Health, Mental Health and Reproductive Health/Making Pregnancy safer. I wondered how it is possible that only one person, working in four departments, could reach issues which concern 74 00 000 people? Where is the issue of female circumcision among so many health problems related to so many departments? Is the issue of female circumcision included into programmes in all four departments? Is the issue of female circumcision a very small part of the women’s health department activities, maybe it is not important enough, when there are perhaps so many more important diseases which need to be treated? On the other hand, is the issue of FGM so wide and multisectoral than why is it part of only the one department of the WHO Country office in Ethiopia?

I observed in Addis Ababa that there are many diseases which needed to be treated. Extreme poverty and people with physical disabilities one can be found all over the Addis Ababa. There are many issues related to health which might be part of the programmes of WHO and the NGOs, which are more visible issues affecting the health and well- being of the society than HTP, which includes FGM. In addition, the fact that FGM needs more than just physical treatment makes the issue of eradication of FGM more difficult. Therefore it is important that the WHO Country Office in Ethiopia have special activities related to the issue of FGM.

### **6.2.1 Activities undertaken by the Country office of WHO in Ethiopia**

According to Elise Johansen from the WHO office in Geneva, the work on issue of FGM is more or less on administrative and an overall policy basis. In general, WHO does not conduct studies or implement activities on FGM, but supports and encourages local researchers to do so. According to the WHO fact sheet No. 241 published in 2000, current activities related to the issue of FGM are in the three categories: advocacy and policy development, research and development and development of training materials and training for health care providers.

<http://www.who.int/mediacentre/factsheets/fs241/en/>

Support is one of the activities undertaken by WHO according to information given by Dr. Abonesh Haile Maria. I was curious about how Dr. Abonesh Haile Mariam would specify they types of support by WHO. Support to whom and in which way, and what kind of support? Dr. Abonesh Haile Mariam explained to me that the support of WHO has various forms. Providing evidence based on materials for advocacy for health workers. She mentioned that WHO is not providing financial support, only technical support. Technical support means providing evidence based materials for advocacy. One of the activities undertaken by WHO is cooperation with NGOs and GOs and cooperation with other UN agencies operating in Ethiopia.

#### **6.2.1.1 Advocacy and policy development**

One of the activities of the WHO Country office in Ethiopia is advocacy and policy development. The example of advocacy and policy development is cooperation with the Ethiopian Women Lawyers Association. The WHO Country office of Ethiopia was promoting and cooperating with the lawyer's association when they were working on the revision of the law related to female circumcision. Since 2005, the elimination of FGM has legal support from the Ethiopian government. Proclamation No. 414/2004, The Criminal Code of Federal Democratic Republic of Ethiopia includes two articles are directly addressing 'Female Circumcision article 565', and 'article 566' and 'Infibulation of The Female Genitalia'. It is important to mention that article 565 of the Criminal Code is addressing female circumcision, not female genital mutilation. However, there is a law against practicing female circumcision in Ethiopia, according to my informants from the Ethiopian Women Lawyer Association, the law is still not in force, and cases related to female circumcision do not exist. According to my informants, most of the society does not know about the law prohibiting female circumcision.

I asked Dr. Abonesh Haile Mariam what her opinion was about the legal issue of female circumcision. She stated that female circumcision is not only the physical issue of injury to the human body, but it also has psychological and emotional aspects. Dr. Abonesh Haile Mariam mentioned that some people look at the practice only from the cultural perspective. “We should reconcile it,” said Dr. Abonesh Haile Mariam. Her personal opinion was that every type of cutting is wrong, that it should not be acceptable. Only the male circumcision is supported by hygienic reasons, and like the prevention against HIV, which refers to research done by WHO. (See WHO Volume 84, Number 7, July 2006, 505-588) There is not scientific evidence that FGM has a positive impact on the well being of women. Dr. Abonesh Haile Mariam stated that Dr. Abonesh Haile Mariam commented that “when you have a law, you have to be able enforce this law, you have to educate decision makers, and in Ethiopia, there are a lot of influential people on the grassroots level, we have to listen to what we have to prepare, and really address, through advocacy.”

From the point of view of my informants from several NGO’s, the legal issue related to female circumcision has not been implemented into projects to promote awareness creation. In particular, Mr. Abebe from the NCTPE explained the relation between the legal issue of female circumcision and the creation of awareness in the way that people do not consider female circumcision a legal issue. In his opinion, it will take a long time before the law prohibiting female circumcision will come into force.

#### **6.2.1.2 Research and development**

One of my questions during the interview with Dr. Abonesh Haile Mariam was related to research on the prevalence of FGM in Ethiopia, and the prevalence of the FGM in Addis Ababa in particular. Dr. Abonesh Haile Mariam response was that the prevalence is still very high. According to the sources from the UNICEF, the prevalence of FGM went down. Research was conducted in 2005, and shows that when compared to previous research by WHO when the prevalence was 80%, now the prevalence is at 74%. [http://www.unicef.org/ethiopia/ET\\_fgm.pdf](http://www.unicef.org/ethiopia/ET_fgm.pdf) last accessed at [23.5.2007](#) The percentage of people who supported the practice has especially gone down. Dr. Abonesh Haile Mariam mentioned that the prevalence of FGM in Ethiopia varies by region. There are regions where there is no FGM at all, and regions where the prevalence is close to 85%.

What is the importance of doing research about the prevalence of FGM? How would this kind of information affect the elimination process of FGM? How does the information affect people who practice female circumcision to understand that the practice has harmful effects? Evidence based on numbers is presented by professional researchers but for whom?

I tried to find out how research about the prevalence of FGM in Ethiopia is conducted, but unfortunately, I did not succeed. My informant from the WHO Country office in Ethiopia believed that it was against his ethical principles to explain to me how the research about the prevalence of FGM is conducted. I did not have any official permission to conduct such research from the Ethiopian government; therefore, it was against his personal beliefs to give me any information.

According to information from other authors, only the research about the prevalence of female circumcision which is based on a medical explanation is relevant research. (Rye 2002) How many females in Ethiopia, especially in the rural parts of the country, have access to a hospital? "It is estimated that only about 60% of Ethiopians live within walking distance from one health facility."

<http://www.who.int/hac/crises/eth/en/index.html> last accessed at 12.2.2007

According to the data mentioned above and the method of examination by health personnel used to estimate the prevalence of the female circumcision in Ethiopia, only 60% of all women in Ethiopia might be examined by a health personnel if they are or they are not circumcised. The relevance of the data seems to be debatable: How is it possible that the prevalence of FGM in Ethiopia is estimated to be 74% when only 60% of all females has access to a health facility? What is their purpose of visiting a hospital? They are not going there to be examined by health personnel to determine if they are or are not circumcised. Even if it is a hospital or any other health institution close to the place where those who practice female mutilation live, how often are they using such as institutions and how many of the women use them?

There are people who are using data of the prevalence of female circumcision in each country or region for developing projects related to the process of eliminating female circumcision. Certainly, it is important to know what percentage of people changed their point of view on female circumcision over the last ten years, but even more important is to know what has brought about this change. Research concerning prevalence or supporters of the female circumcision is necessary for identifying the existing needs, for designing intervention, for monitoring implementation and

progress of programs, and for evaluating the impact of health-related efforts. (WHO 1998: 48) How is one to know what people who practice female circumcision really need to hear in order change their attitude when the voices of these people who circumcise their daughters is probably not being heard? Maybe it is more important to ask those who practiced female circumcision, what brings about change, which perspective in creating awareness is most acceptable to them. What did they think about the practice of female circumcision when they were circumcising their daughters and what do they think about female circumcision now that some of them have stopped circumcising their daughters.

From this perspective, it might be clearer which kind of awareness is most effective for which group of people, and for which community. Dr. Abonesh Haile Mariam mentioned the importance of cultural listening. On one side, there is evidence based on scientific materials, but it should be both quality and quantity in the research outcomes, especially in the case of Ethiopia, where the cultural practices vary from one group to another and in a country with great ethnic diversity.

Mr. Abebe from the NCTPE mentioned that observation is the way to be successful in doing research about the needs of the people eliminating female circumcision. He stressed that people who are aware about the negative health consequences and legal issues of female circumcision may answer researchers' questions politely, only because they know that this practice is illegal and considered harmful, but it is questionable if they really believe that the practice of female circumcision is harmful. One of my informants said that the researchers, staff of the NGO's and others who come into communities reach only a certain level, but what people do behind closed doors of their houses, no one knows and no one can reach. Training people who can influence the community is therefore important. Developing materials and training of personnel who might reach the community level is an important part of the activities of WHO and also for many NGOs.

### **6.2.1.3 Development of training materials and training for health care providers**

In 2001, WHO published several materials, which might help to spread knowledge about female circumcision. They are training materials for teachers, nurses and midwives and students. The purpose of these materials is to provide strategies for the prevention of FGM and to provide knowledge on how to manage clients with FGM complications for nurses and midwives. Policy guidelines that are included in those materials might provide knowledge to those who are

responsible for developing policies and directing midwifery and nursing. As my informants mentioned, those materials are not distributed to any NGOs where I conducted interviews during my fieldwork. The one reason might be that most of the NGOs are not dealing with the education of nurses or midwives. Only some of them are dealing with traditional birth attendants, or with circumcisers.

In my opinion, the knowledge of English or any other foreign language among traditional birth attendants and circumcisers is very low, so that the usefulness of those materials might be arguable. So far, according to my information, none of the materials are translated into any language commonly used in Ethiopia.

The cooperation between NGO's, WHO and the community is important in this process. In my opinion when this cooperation exists, the materials support and advocacy activities might be distributed from WHO through NGOs to communities. When the reaction from communities on the activities undertaken by NGOs are heard and when projects related to female circumcision are evaluated, then the progress in combating FGM might be seen. When evaluations and reactions are known by WHO, only then will they know what and how to prepare because the work of WHO on the issue of FGM is about people and for people. A participatory approach is important for preparing useful recommendations and programs.

The next chapter elaborates on issues related to the work of the WHO Country office in Ethiopia, its plans and experiences. The seventh chapter also gives information about WHO's cooperation with the NGOs and role of the NGOs in the elimination process of female circumcision in Ethiopia.

## **Chapter Seven**

### **WHO in the process of combating FGM in Addis Ababa**

#### **7.1 Experiences of WHO in the issue of combating FGM in Addis Ababa**

I learned an important lesson during my fieldwork. I had huge expectations before I traveled to Ethiopia to do my fieldwork. The materials which I brought back home had a different character than what I expected. But what is important is to accept that not every answer to my question would be positive. Good research is done when both positive and negative aspects are considered. It is difficult to write about the experiences of WHO in Addis Ababa in combating FGM, because WHO is working on the national level, not focusing on particular regions, zones or cities. In my opinion, particularly in Ethiopia where there is diversity of ethnic groups, languages, and cultures, it is impossible to look at the country as a whole. In Addis Ababa in particular, one can find a diversity of cultures, where traditions and modernity are side-by-side and connected to each other. This diversity requires a different approach for each particular group.

According to the information given by Dr. Abonesh Haile Mariam, the WHO Country office in Ethiopia is a technical agency. People who start with any project related to the issue of FGM are welcomed in the WHO Country Office in Ethiopia, mentioned Dr. Abonesh Haile Mariam. According to information from my informants from several NGOs, the cooperation between WHO and NGOs is not established on high level. Most of the NGOs cooperate with NCTPE, or with IAC. Through IAC may NGOs get information from WHO. Dr. Abonesh Haile Mariam described the situation of FGM at the international level. She stressed that a few years ago it was only a small group of people in the UN who were talking about gender-based violence, about FGM. Dr. Abonesh Haile Mariam mentioned that people in the UN were not very open to these issues, but time brings many changes and now the issue of FGM is discussed and is a part of the program for several UN agencies.

According to the view of Dr. Abonesh Haile Mariam, changes come slowly, global influence is changing the policy of the states on the issue of FGM, but gender equality still does not exist, especially not in Ethiopia. Dr. Abonesh Haile Mariam mentioned that the level of gender equality is different in the “west” than in Ethiopia. She views the reason for this on poverty and the low educational level of Ethiopian women. Dr. Abonesh Haile Mariam maintained the perspective of combating FGM in Ethiopia through lateral and multilateral forums, in implementation of



resolutions at the UN and WHO into policy of the state and in global forums. Combating FGM in Ethiopia requires multi-sectoral efforts and WHO has a cartelistic role in it.

## **7.2 Future plans of the National Regional Office of WHO in Ethiopia**

One of my questions to Dr. Abonesh Haile Mariam was related to the future plans of the WHO Country Office in Ethiopia on the issue of FGM. Dr. Abonesh Haile Mariam described her work in the WHO from the early beginning and in her opinion; changes in attitude on female circumcision are visible in the society. Dr. Abonesh Haile Mariam mentioned that urban areas are changing and men are involved in activities related to the issue of FGM, which brings a positive impact on combating FGM in Ethiopia.

According to the view of Dr. Abonesh Haile Mariam, indicators of change, especially cultural changes are dynamic. Females go to school and are more and more economically independent, but it is still not enough. Changes have to be related to development of the entire country. From her perspective, the Country office of WHO in Ethiopia is successful in the issue of combating FGM in Ethiopia. I asked Dr. Abonesh Haile Mariam how she views the perspective of eliminating FGM in Ethiopia. In her opinion, elimination is possible, and she hopes that within ten years there will not be FGM in Ethiopia. According to the latest research done in Ethiopia, especially the younger generation, they are not supporting the practice. FGM, according to view of Dr. Abonesh Haile Mariam, is connected to the level of education and the economy status of women, and has a clear link with the level of poverty in the country.

The Zero Tolerance of FGM is one of the future plans of the WHO Country office in Ethiopia. The representatives of WHO Country office in Ethiopia participated on the International Conference on Zero Tolerance to FGM in Addis Ababa organized by IAC in February 2003.

<http://www.afro.who.int/regionaldirector/speeches/rd20050206.html> last accessed at 20.1.2007

How it is possible that a change of attitude related to the issue of FGM might be transformed from supporting the practice to not supporting it within so short time? Is the position of WHO on the issue of FGM in Ethiopia so strong that any change is possible? Is the Zero tolerance within 10 years only a plan, but the reality at the grassroots level is far way from this goal? What do people need to hear in order to change their attitude on the practice of female circumcision, which kind of activities and materials are the most effective, if any? Is WHO aware of the needs of the people on the grassroots level? Who or what are the sources of the information for WHO on the

issue of FGM? What is the link between WHO and NGOs which have contact with the people who practice female circumcision?

### **7.3 The cooperation of WHO with NGOs and GOs on the issue of FGM in Addis Ababa**

My choice to visit NGOs in Addis Ababa was related to the lack of time, which I had for my fieldwork in Ethiopia. The topic of my master's thesis is linked to the community reaction to activities undertaken by WHO. I knew that it is impossible to reach the community level in such a short time. Even to just come to a community and be accepted as a researcher, not even like part of the community, probably takes more than a couple of months. The frame of a master's thesis' fieldwork is three months, so that I had to find another solution on how to find information about the community reaction to activities undertaken by WHO.

I thought that activities of WHO in Ethiopia are clearly linked with NGOs and that recommendations of WHO are mostly implemented to the public through NGO's. The other reason why I chose to interview staff of the several NGO's was that I was looking for information related to cooperation between NGO's and WHO. I was curious about how this cooperation works and which kind of relationship WHO has with several NGOs, which I had visited during my fieldwork.

WHO cooperation with NGO's is one of the important parts of combating FGM in Ethiopia. The main partner for cooperation with the WHO Country Office in Ethiopia is the Inter African Committee on Traditional Practices Affecting the Health of Women and Children (IAC), IAC is an international NGO with its head quarters in Addis Ababa and office in Geneva. IAC consist of twenty-six African countries and four affiliated European countries. IAC is a non-governmental organization working to promote the health of women and children in Africa and amongst migrant communities by HTP including FGM. The main aim of IAC is the eradication HTP and the promotion of good traditional practices. According to the information given by the IAC, the IAC has an official status with the World Health Organization WHO. The IAC participates at the regional meetings of the WHO and has access to use materials published by WHO. The materials relevant to the work of IAC are also distributed to IAC National Committees, which are based in 28 African countries.

The other important partner of WHO in the eradication process of FGM is the National Committee on Harmful Traditional Practices in Ethiopia (NCTPE). NCTPE was established in

1987 and its main objectives are awareness creation, training information campaigns, community mobilization training and school programs.

NCTPE is one of the NGOs with a great effort on the elimination of female circumcision in Ethiopia. According to the Executive Director of the NCTPE—Mr. Abebe, there is no direct communication or cooperation between WHO Country Office in Ethiopia and NCTPE. Information from the WHO Country Office in Ethiopia is distributed to NCTPE through IAC. One of the organizations operating directly in Addis Ababa is Addis Ababa Women's Association (AAWA). AAWA is one of the NGOs dealing with the issue of HTP, which includes female circumcision and is also dealing with domestic violence. My informants from AAWA stated that this organization have not received technical support from WHO. AAWA was founded by the international organization Pathfinder International, and receives technical material from this organization.

The Ethiopian Women's Lawyer Association (EWLA), is a non-profit voluntary organization founded by group of Ethiopian women lawyers and donors from other countries. Legal aid offices of the EWLA provide free counseling in legal and criminal cases. The other activities undertaken by EWLA are sending letters to NGOs and GOs to seek solutions for problems, which are the suffering experienced by clients of EWLA. EWLA is also providing support and shelter for victims of sexual violence. EWLA was one of the organizations, which has wedged a persistent struggle and made significant contributions for the reform of the Penal Law. The Criminal Code of the Federal Democratic Republic of Ethiopia was reformed in July 2004, and came into force in May 2005. According to information given by EWLA, there is only minimal cooperation between WHO Country Office in Ethiopia and EWLA.

Mr. Afork, one of my informants, who heads the office of gender issues in the Ethiopian Red Cross, mentioned that the Ethiopian Red Cross have no projects related to female circumcision anymore. The last project ended a couple of years ago, and female circumcision is not among the main objectives of the organization currently. There are no plans to implement any project related to female circumcision in the future. However, the Ethiopian Red Cross and especially Mr. Afork were extraordinary sources of information related to gender issues in Ethiopia. Technical support from the Ethiopian Red Cross in Addis Ababa of great help during my fieldwork.

The Women's Affairs offices are part of the federal authorities in Ethiopia. The Ministry of Women Affairs is supposed to coordinate governmental efforts to eliminate FGM in the country.

The Women's Affairs Offices were established at regional and at woreda levels, which brings it into a closer relationship with the society. The main programmes of the Women's Affairs Offices are related to the HTP, domestic violence, and based on the gender violence and abduction. The programs evaluation and cooperation with other GOs and NGOs is an important part of the program of the Women's Affairs Office. The cooperation between WHO and the Women's Affairs Offices seem to not be developed enough.

The cooperation between WHO and the NGOs that I visited during my field work in Addis Ababa is probably not very close. The majority of the NGOs that I visited in Addis Ababa do not cooperate directly with WHO.

### **7.3.1 The role of the NGO in the process of elimination of FGM in Addis Ababa**

NGOs play one of the most important roles in the process of combating FGM in Addis Ababa. The programs and methods of NGOs vary from one organization to another, but the aim is the same: the elimination of FGM.

The process of eradication of FGM is long term, and the activities most of the NGOs vary from community to community. According to Ato Abebe from NCTPE, knowledge about the community where the activities might be implemented is one of the main issues in the eradication process of female circumcision. Practices of female circumcision might vary from village to village. The differences are based on the ethnic origin of the significant group and on the predominant religion in a particular community. In addition, the reasons for practicing female circumcision might vary, which is why it is important to have adequate knowledge about the community where activities of an NGO could be implemented.

All of the NGOs, which I visited during my fieldwork in Addis Ababa, have implemented activities related to the grassroots level. Knowledge about the community and having people who work for NGOs to have come from the particular communities where the issue of negative impacts of female circumcision is going to be addressed, seems to be the right strategy in eradication process of female circumcision. Being in contact with communities which practice female circumcision, is important in the implementation of activities, related to the elimination process.

Mrs. Yayanesh from the Addis Ababa Women's Affairs Office claimed that the best way to address the issue of female circumcision in communities is to show them that the problem is their own, that it is not far away from them, and is affecting their own child. She as well as some other

informants stated that no one has the right to command the people or to tell them that they cannot practice female circumcision. This approach will not be successful because it is not coming from the community. Every change has to come from the community itself. The role of NGOs is to coordinate and to promote awareness, educate and influence the leaders of the community. Mrs. Yayanesh from the Addis Ababa Women's Affairs Office contends that the projects, which are provided by other organizations, such as UNICEF, year after year are not successful. In her opinion ideas about what has to be done have to come from the community, not from international organizations. She mentioned that it is important to ask people what might be the solution for the eradication of the practice, because when the solution comes from the community themselves, they will accept it.

It seems to be that the projects related to eradication of female circumcision are made without the participation of those whom these projects are addressed. The role of the NGOs is limited to the implementation of given projects. The variety of ethnic groups, reasons for circumcision, and beliefs make any kind of generalizing in addressing the issue impossible.

Mr. Abebe and Mrs. Kedir explained that only a person from the particular community might be successful in the work with community. Even if a Christian comes to a Muslim community, the success would be debatable. Changing the attitude of the leaders is one of the most important parts of the projects related to eradication of female circumcision. Mrs. Kedir from the Oromyia Women's Affairs Office mentioned that many people are resistant to hear about female circumcision because they think that these "new ideas" are not their culture. People from NGOs address something, which is perceived to be going against beliefs and values of the community. It is not difficult to be respected, but it is very difficult to be accepted. Mr. Abebe mentioned that people will be polite and respond with socially determined answers, but they will not take it seriously when the person is coming from outside.

The role of the NGOs in this process is to work on the local level, come closer to the community, and to find the best solution as to how to address the issue related to female circumcision. When the work of the NGOs has to be done on the local, what is the importance of any national or even international organizations working with issue of female circumcision? Are the projects made by international organizations useful? Is it better to leave the problem of female circumcision to local NGOs because they are "closer" to the needs of those for whose are their projects are created? Who are the people who work for NGOs? One of my informants mentioned

that even the response that I had gotten from the staff working for local NGOs is questionable because they want to present their work in a “good light.” Almost none of the NGOs, which I visited, are founded by an Ethiopian foundation. The lucrative job and prestige might be more attractive than the issue of female circumcision or HTP itself.

Similarities in the projects of the several NGOs related to elimination process of female circumcision were not surprising for me. The variety of methods used in these projects shows how huge the issue of female circumcision is. Most of the NGOs are focusing on the negative health consequences of the practice and actively encourage male participation in the projects. According to Mrs. Yatarick from the NCTPE, male participation in the projects is very important because they usually do not have enough knowledge about the practice of female circumcision. In her opinion, the lack of knowledge makes them unconcerned. When men receive adequate information, they usually pay attention to the problem and resist the practice. The patriarchal society, such as Ethiopian, is where most, if not all, of the leaders in the communities are male, which makes them the target of such activities. The various ways as to how to address the issue of female circumcision create many possibilities for narrowing the problem for particular communities.

Evaluation of the programs is one of the activities of the NGOs. The evaluations of the projects are usually based on the information on how much the project has achieved the goal, how much the creation of awareness has changed society’s attitude. As I understood, the evaluation of the projects in the community is through questionnaire or observation. Do the people from the community say what they really think about the female circumcision or do they say what the people from NGOs want to hear, or should hear? When the prevalence of female circumcision went down, did it mean that the project was successful? Mr. Abebe from the NCTPE states that, when people from the communities where female circumcision is practiced know that this practice is illegal and are aware about the potential punishment, it is preposterous to think that they will answer the question of if they are or they are not practicing female circumcision honestly. In his opinion, many people send their daughters to relatives living in different parts of the country, where there is no danger that somebody will inform police about circumcision, or they do it secretly in their homes, because what happens behind closed doors of the family home stays there.

The work of the NGOs in Addis Ababa seems to be uncoordinated and without cooperation between particular NGOs. Projects given by international organizations usually only run for several years, and to find an answer about what happen after projects ends is very difficult.

The opinion of Mrs. Yatarick from the NCTPE is that the solution to the problem of “what after” is to create awareness the issue of female circumcision to leaders of the communities, to people who have influential positions within communities. So far, none of the community took over the projects given by NGOs in this way.

In the view of my informants from the NGOs that I visited during my fieldwork in Addis Ababa, there will be no female circumcision in Ethiopia within ten years. They see their work with communities as being quite successful. Many of them linked the development of the country with encouraging of women positioned within society and with eliminating HTP. If this is only utopia or reality is hard to say now, change has to come from inside and international and national organizations may only promote awareness, knowledge, but they do not have right to forbid the practice.

The following chapter concludes with a discussion on broader issues of female genital mutilation/female circumcision and gives analyses before summary.

## Chapter Eight

### Discussion and summary

#### Discussion

In the last few decades the efforts for the eradication of the practice of female circumcision/female genital mutilation has grown. Many international and national organizations and agencies, both governmental and nongovernmental, have approved plans for abolishing this practice and have implemented the issue of eradication of the female circumcision /female genital mutilation into their policies. Many of these organizations and agencies set up programmes to halt or reduce the prevalence of FGM. Thanks largely to their efforts, clauses prohibiting the practice have been incorporated into a large number of international legal instruments and into the legislation of a growing number of countries. Half of the 28 African countries where it is practiced have introduced legislation forbidding it. There is no doubt that the practice has a negative effect on the health and well being of women and children and has serious health consequences, however there are millions of people who practice female circumcision.

(<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed at 20.05.2007)

WHO estimates that there are two million females who undergo female genital mutilation every year. The shocking number of victims may evoke dismay among those who do not practice female circumcision. On the other side, there are many examples where the women from the communities where female circumcision is the norm are unaware about the fact that female circumcision is not practiced in other societies and is even considered to be a crime. (Sæverås 2005)

WHO is one of the international organizations that have implemented the issue of the eradication of female genital mutilation into their programs and policies. The position of WHO in the process of eradication of female genital mutilation from the international perspective might be seen as the leading and decision-making position. The recommendations, resolutions, and publications related to the issue of female genital mutilation are internationally recognized and it may make sense that WHO is one of the leading actors in the process of eradication of female genital mutilation. On the other hand, there is a lack of information as to how these recommendations and publications are used, because the evidence about the evaluation of these materials does not exist.



<http://www.thelancet.com/journals/lancet/article/PIIS0140673607606758/fulltext?isEOP=true> last accessed at 20.5.2007)

The role of WHO in the process of eradication of FGM is unquestionable. However, there are many aspect such as a global perspective on the issue of FGM, no particular projects related to the eradication process of FGM implicated in Ethiopian society and the lack of the staff working on the issue of FGM in the WHO Country office in Ethiopia which, may make it questionable if WHO is the “leading” or has a “decision making” position in the eradication process of FGM, particularly in Ethiopia.

As I mentioned above, the WHO Country office in Ethiopia is situated in Addis Abba. There is one person in the WHO Country office in Ethiopia working directly on the issue of FGM in Ethiopia, the head of the four departments – Dr. Abonesh Haile Mariam. One can imagine how many issues related to the four departments at the WHO Country office in Ethiopia has Dr. Abonesh Haile Mariam goes through in the course of her work. The issue of FGM is probably only one of the many issues at the women’s health department. However, it seems to me that female genital mutilation is not an isolated problem but it has a link with other health problems related to women’s health. As an example of this relationship to other health problems, I want to explain the relationship between female genital mutilation and maternal mortality in Ethiopia.

The maternal mortality in Ethiopia is one of the highest in the world. Maternal mortality rate in Ethiopia is estimate on 700 and 1400 per 100 000 live births. The risk of dying from maternal causes is several hundred times higher than women experience in the industrialized world. (NCTPE 2006) I did not find any studies related to the link between maternal mortality and FGM in Ethiopia, but as I mentioned above, the infibulation may cause the complications during delivery. The results of the study conducted by WHO in six African countries demonstrates that deliveries to women who have undergone FGM are significantly more likely to be complicated than deliveries to women who had not undergone FGM. Generally speaking, the more extensive the genital mutilation, the higher the risk of health complications.

<http://www.who.int/reproductive-health/fgm/lancetfgm.pdf> last accessed at 20.05.2007)

From this perspective, the link between maternal mortality and FGM is clear. However, treating the health complications without abolishing the reason for the health problems might be seen as a “fight against wind mills.” One of the reasons for the health problems, which women in Ethiopia are suffering, might be female circumcision. It is better to prevent health problems than to

treat them. WHO and also other organizations and agencies implemented policies for the eradication of female circumcision. The one of the methods used is explanation how negatively female circumcision is affecting health.

The medical explanation why one should not circumcise might not be enough to abolish the practice. A recent study from WHO shows that possibly as a result of an emphasis on the negative health implications of FGM, the number of operations held by trained health care personnel dramatically increased. This trend may obscure the human rights aspect and could hinder the development of long-term solutions for ending the practice. (<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed on 20.05.2007). As it is mentioned in publication “Female Genital Mutilation Programmes to Date: What Works and What Doesn’t”

*“Agencies and groups working on FGM prevention are reaching only a small percentage of the people for whom FGM is a traditional practice. There is need to re-orient the communication strategies from awareness raising to behavior – change intervention approaches. Current strategies on FGM are based on the message that FGM is a harmful traditional practice that has negative health consequences for women and girls. This message does not address the core values, the myths, or the enforcement mechanism that support the practice.”* (WHO 1999: 2)

This article was published in 1999, since that time there seems be little change in the choice of a communication strategy for eradication of female circumcision. It is debatable about what the strategy is useful for the WHO Country office in Ethiopia, when the WHO Country office in Ethiopia has no particular project where it could implement any of the strategies mentioned above. Certainly, it is important to have information about which strategy is most appropriate to use when it comes to the eradication process of FGM, but when it could not be implemented it is only the information, but without any particular impact on the eradication process. The difficult process of finding the appropriate strategy is losing its importance when the strategy is not used for abolishing the practice.

The way to find the appropriate strategy is based on the experiences of using different types of strategies at the community level. So far, WHO is a technical agency, which means that it does not have any particular contact with communities where strategies are implemented. The processes of developing the WHO’s recommendations rely on experts in a particular content area and not on representatives of those who will have live with the recommendations.

(<http://www.thelancet.com/journals/lancet/article/PIIS0140673607606758/fulltext?isEOP=true> last accessed at 20.5.207)

This means that the recommendations made for combating female genital mutilation in Ethiopia are probably made by outsiders rather than using the experiences of those who might possibly have personal experience from working in some organizations which are focusing on the abolition of this practice or who come from the community where female circumcision is practiced and where the activities for eradication of this practice are implemented.

Only the one perspective—the medical—on the issue of FGM, might lead to the misunderstanding of the need to abolish the practice. The research about the health complications more or less describes the situation after the procedure of cutting. Certainly, it is important to know what kind of health complications this practice might bring for the future treatment of patients with complications caused from circumcision. However, the reason for the circumcision is not medical, circumcision is not the result of treating illness, or accident, but the result of a personal belief that to circumcise is the best for well being of girl child. I do not think that circumcised women look at themselves as victims, mutilated, or as patients. FGM is not only a health issue but also a tradition or some may say a part of the culture. It is impossible to “treat” culture through medical instruments.

As Nahid Toubia points out:

*“The female genital mutilation is not a disease, it is something people do, which involves hearts, minds, beliefs, societies, religion, relationship between men and women and between young and old. Thirty years of experience tell us that if you take a disease approach you will fail.”* (Momoh 2005: 151)

There are many diseases and illnesses that might be treated immediately by vaccination or surgery and the result is visible soon after treatment. The FGM is “health-cultural” issue, which is why any immediate “treatment” is impossible. The Western help, or rather the International help, that comes from the industrialized countries is usually based on financial or material support. The importance of this kind of help for treating tuberculosis, malaria, cholera and other diseases, which are not common in the industrialized countries, is unquestionable. The financial support seems to be used for medical instruments, drugs, food and vaccines. The results of using this kind of support is “visible.” They who were sick are healthy, or they are treated and they can live without complications. The situation surrounding female circumcision is different. Circumcised women are

not sick, circumcision is not a diagnosis and any immediate effort for “treating” it is almost impossible.

Ethiopia remains a variety of ethnic groups and the prevalence of FGM varies from one to another. The reasons for the practice, age of the girl circumcised, beliefs, myths and values surrounding the practice vary as well. Is it possible that one plan, one recommendation can be implemented for the whole spectrum?

The WHO Country office in Ethiopia faces many challenges related to the elimination process of FGM in Ethiopia. As I found, one of the major challenges is that the eradication of the practice of female genital mutilation is based on the approach and the strategy used in this process. The willingness for eradication must come from the community itself. To come to this point it is necessary that the issue is approached in an acceptable way for those who practice it. It is debatable what the WHO Country office in Ethiopia is aware about the ways of this approach. If the WHO Country office in Ethiopia is aware about the ways of approach, how is it possible that there is only one person working on issue of FGM in this office?

The strategies for eradication of FGM are based on different types of approaches. According to WHO there are many strategies aiming to stop female genital mutilation. WHO made or participated in several research initiatives related to the prevalence of FGM in Ethiopia. It also seems that WHO analyzed the usefulness of strategies for the eradication of FGM.

In 2006, the Department of Reproductive Health and Research, World Health Organization published the “Progress newsletter in Sexual and Reproductive Health Research” with publications subtitle- “Female genital mutilation—new knowledge spurs optimism.” However, there is one paragraph in this publication, which might not bring a lot of optimism.

*“The World Health Organization does not warrant that the information contained in this publication is complete and correct and shall not be liable for any damages incurred as a result of its use.” (<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed at 20.05.2007)*

It is questionable why WHO is publishing information that is probably not complete or correct and why it tries to affranchise from any damages incurred as a result of its use. Probably WHO has to carry out some kind of activity as planned in annual their plans or millennium plans which is why it is publishing “materials”.

In the Progress newsletter published in 2006, the argument “stop FGM” remained based on the danger of this practice to health and on its violation of human rights. According to WHO, some of the “more successful” strategies include promotion of alternative “rites of passage.” I did not find any information that this kind of strategy was used for abolishing the practice of female circumcision in Ethiopia. None of my informants mentioned that this strategy was implemented into the programmes for eradication of female circumcision as well. The group discussion and media campaigns are one of the strategies that WHO recognized as “more successful.” This strategy aimed to raise awareness among parliamentarians, religious and civic community leaders, traditional and modern health care providers and other decision makers, as well as among public. (<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed at 20.5.2007) As I mentioned above, WHO does not warrant that the information in its publication “Progress” that were used as a source of information in my thesis, are correct and complete. This makes the reliability of information from this source questionable.

The controversy between the publication “What Works and What Doesn’t” published in 1999 and the “Progress” published in 2006 is based on the creation of awareness as a strategy for the eradication of FGM. It seems to be that in 1999 creation of awareness was “not good enough” but in 2006, it was recognized as a “more successful” strategy. This brings the question: has WHO found that the awareness raising based on the health consequences of FGM is, however, one of the most successful strategies?

All of my informants’ stated that the creation of awareness related to the negative health consequences for women is one of the most often used strategies for the eradication of female circumcision in Ethiopia. My informants from the NCTPE and Addis Ababa Women’s Affairs office mentioned that women themselves do not recognize that their health problems might be a result of female circumcision. The explanation, or better said the awareness creation from the health perspective, makes them think about the negative effects of female circumcision, but it is unclear if this is the reason why they might stop supporting the practice.

Some of the organizations such as EWLA and NCTPE published facts sheets, booklets or even books related to female circumcision or directly about the negative aspects of this practice. Materials were published with the financial help of numerous international and national organizations and agencies. I did not find information if WHO took a part in this process or not. The materials that I received were in English, it is possible that most of the materials are published also

in the Amharic language, that is the official language in Ethiopia, but the usefulness of those materials is debatable. According to the information from UNICEF, the materials prepared by EWLA in partnership with UNICEF were published in 2005 in five major languages spoken in Ethiopia, which makes these materials more useful.

I did not find information on how these materials were distributed in the public and if they were distributed at all. The media campaign on the radio, television, and through posters, as many of my informants had mentioned occurred in Ethiopia some time ago. I cannot clearly say if this strategy was successful or not, because there are many issues to be discussed related to this strategy. For example, the level of literacy among Ethiopians is estimated at 43%. (<http://www.state.gov/r/pa/ei/bgn/2859.htm> last accessed at 20.5.2007) It means that for almost half of the population of the Ethiopia the written materials are not useful. In addition, the limited access to the media might be one of the difficulties in implementing this strategy. The variety of languages, reasons for female circumcision, and the religion of the practitioners might make this strategy very challengeable.

One of the WHO strategies for eradication of female genital mutilation is the so-called “development package.” This “package” includes a reduction of poverty, increasing the access to education and to health services. In many cases, female circumcision is associated with poverty, illiteracy and the low status of women—with communities in which people face hunger, ill health, overwork and a lack of clean water. However, the signs are that education and a widening range of choices for women are slowly but surely undermining the practice. (WHO Chronicle 31, 1986, in Steiner, Alston 2000: 410, 411) I did not find the reason why female circumcision might be associated with poverty and illiteracy. As in the case of Ethiopia, to make a 70%<sup>1</sup> of female inhabitants illiterate, facing hunger and poverty, it seems to be questionable whether it is possible to relate traditions and culture with poverty and illiteracy. People who are living in a traditional way are not necessarily poor. Probably they are poor in the western perspectives, but they might not consider themselves as poor. The reason why female circumcision might be associated with poverty is probably the fact that the countries with higher prevalence of female circumcision are in Africa. For example, Ethiopia is ranking at 99 out of 103 on the UNDP Human Poverty Index, and remains one of Africa's poorest states. Close to 80% of the 70 million Ethiopians live with less than 2 USD per day. ([http://www.who.int/hac/crises/eth/background/Ethiopia\\_Aug06.pdf](http://www.who.int/hac/crises/eth/background/Ethiopia_Aug06.pdf) last accessed at

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<sup>1</sup> The number represents the percentage of the circumcised females in Ethiopia.

20.05.2007). Especially the rural parts of the country are considered to be poor, there is also according to several sources a higher prevalence of female circumcision there than in the urban parts of the Ethiopia.

There are some differences in prevalence of female circumcision, awareness and attitude toward eradication of this practice among women living in the rural areas and the urban areas. The higher prevalence both in awareness and in attitude toward eradication of the practice is in the urban areas of Ethiopia. On the other side in rural setting of Ethiopia access to information is limited, the level of awareness is low, and support for the eradication of the practice is still lower. (NCTPE: 2006, 110) The reason for this situation might be vary. The access to information in the urban areas is much higher than in the rural areas. The women, who have awareness about laws prohibiting female circumcision and about negative health consequences of this practice, might easier change attitude related to female circumcision than the rural women, who have not had such access to information. Generally, it is easier to reach people in the urban areas than in the rural areas and it is the fact, that the culture might probably have a more strong impact on the societies in the rural areas than in the urban areas. On the other side, reliability of responses from a person who knows that the female circumcision is illegal in Ethiopia might be questionable.

One of the reasons why the rural women are more likely to be circumcised is the possible relation between education and female circumcision. The urban women have better access to educational institutions than the rural women. As Dr. Abonesh mentioned, that, the cultural changes are dynamic in Ethiopia, females go to school and the educated group of the population does not take their children for circumcision. As the many statistics show, there are some kinds of relations between education and female circumcision, but for example, the UNICEF statistics from 2000, published in 2005, shows that in Ethiopia the prevalence of female genital mutilation among daughters whose mothers were not educated was 55.7% to 51.8% of daughters circumcised; whose mothers have primary or secondary education. (UNICEF 2005, (<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed at 20.5.2007)

However, education might be seen as one of the strategies for the eradication of female circumcision in Addis Ababa. According to Dr. Abonesh Haile Mariam from WHO, education is one of the most important pillars in female reproductive health. The importance of education as a strategy for eradication of female circumcision is based not only on giving information about

female circumcision, but more or less about whole spectrum of issues which might be related to female circumcision.

In my opinion, education might contribute to a reduction of this practice, but as other strategies could probably not be used as a primary strategy or isolated strategy. The whole spectrum of information that people might receive through education might give them the opportunity to think about the practice of female circumcision from many different perspectives and to see this practice not only as a cultural or religious obligation but also as a health or human rights issue. Mrs. Yatarick from the NCTPE, Dr. Abonesh Haile Mariam, and also Mrs. Yayanesh from the Women Affairs association saw the role of education in the elimination process of female circumcision very clearly. In their opinion, female circumcision is not only a part of Ethiopian culture, but also a demonstration of power of men over the women. Education may empower women, give them the potential status of equality with their husband and give them an opportunity to make decisions about herself and her life. As my informants from the Women's Affairs association and NCTPE said, many of the international instruments related to human rights are ratified by Ethiopia, but people do not have any information about these instruments. In their opinion, educating youth and the younger generation might be a successful strategy in process in eradication of female circumcision in Ethiopia.

The lack of information related to female circumcision among the younger generation may lead to a lack of concern about this issue. When the younger educated generation do not receive enough information in the time when their life priorities are built, and their perspectives on their own life are made, the pressure from their parents or from the older generation may lead later to the acceptance of this practice as a part of life, as a part of culture without considering the other possible solutions. The circle of awareness creation will continue and most likely nothing will change in the prevalence of female circumcision in Ethiopia. When the younger generation gets enough information and knowledge about this practice and decide to say NO to female circumcision, than the plans of many organizations about zero percentage of female circumcision in Ethiopia within ten years might be realistic.

The UN "Millennium Development Goals" are the primary source of the future plans of WHO. One of the several aims of the Millennium Development Goals is to bring an end to female genital mutilation and other harmful traditional practices. Female genital mutilation refers to the first five goals concerning equal rights to education, women's empowerment and reduction of infant and



maternal mortality rates. (Sæverås 2005) As Dr. Abonesh Haile Mariam stated the Millennium Development Goals and the Zero tolerance for female genital mutilation are the primary future plans for the eradication of this practice. Information about achieving development goals in Ethiopia, published by WHO, shows that the situation is far behind the aim of the Millennium Development Goals. Most of my informants answered my question if it is possible to achieve the zero prevalence of female circumcision in Ethiopia, that indeed this is possible. Some of them mentioned ten years, some of them added that the vision of zero prevalence of this practice makes them keep working on this issue. Mr. Abebe from NCTPE stressed that for total eradication of female circumcision in Ethiopia is need to revitalize strategies and carry out impact assessment.

As I wrote above, the variety of ethnic groups and the reasons for the practice, age of the girl undergoing the circumcision, traditions, values and habits surrounding the practice vary from one community or ethnic group to another. As well as the reasons, age, traditions and values vary; so varies also the approaches. To generalize approaches for the eradication of FGM for the whole of Africa or for the whole of Ethiopia might not be successful. However, since WHO is an international organization and its role in the eradication process of the FGM is more or less policy-making, it does not mean that this policy has to be global. What works on the one place for one group of people might not work for another group of people. It is probably impossible to make a policy related to eradication of FGM individual for each of the groups considered, but the decentralization of the issue might be one of the solutions as to how to approach the issue of eradication of FGM more effectively.

This solution contains “cultural listening.” As Dr. Abonesh Haile Mariam mentioned “we have to listen what we have to prepare.” I do not know whether “they” were or “they” were not listening to what “they” have to prepare, but the law prohibiting female circumcision in Ethiopia with the effort of the WHO came into practice in 2005. So far, there are no legal cases of female circumcision in Ethiopia. The law is still not in force and it seems to be that the recognition of this law is explaining more about the policy of the state related to the issue of female circumcision than the willingness of the legal institutions to make the majority of the inhabitants of the Ethiopia a criminals. It is very debatable if the law itself can change the attitude of those who practice female circumcision, or it will cause the “underground” type of this practice.

It seems to be even more difficult to find whether people support the practice or not. When people are aware about the existence of such laws, and they know that they might be punished when they circumcise their daughters there is probability, that on the question of if they support the practice or do not support the practice, the answer is in the socially determined way. In my opinion, it seems to be that the knowledge about the existence of such a law might make the discussion about supporting the practice irrelevant.

The age of the girl undergoing the practice of female circumcision is according to the WHO decreasing. This may be the result of anti FGM legislation. The younger the girl, the easier it is to elude legal scrutiny. (<http://www.who.int/reproductive-health/hrp/progress/72.pdf> last accessed at 20.5.2007) Also the fact that young girls often in the very young age do not have information that the practice is illegal, or at all what this practice contains, which may lead to the results of lower percentage of girls who might inform authorities that they were or they would be circumcised . The parents or relatives would on the possible question if they support or do not support practice of female circumcision probably answer that they are against this practice. The percentage of those who support the practice is due to such behavior naturally decreasing and the real situation stays undiscovered. Nobody wants to be seen as a criminal, and nobody will risk the threat of prison by saying that, they are or they were doing something that is against the law. The findings related to the percentage of the supporters of the practice of female circumcision are probably not the real picture of the situation in the Ethiopia.

In addition, the position of those who ask the question about supporting the practice might have an impact on the result of the prevalence of FGM in Ethiopia. Many of my informants stated that to be accepted from the community is the necessary part of the eradication process of female circumcision. Who are those people who come to Ethiopia to do research about FGM there? More likely, they are like me—westerners. May “we”, westerners, expect that when “we” ask the questions or try to explain that the female circumcision is violation of the human rights, that “we” will be heard? Is there any guarantee that the programs, plans, recommendations, and projects prepared from far away from the place where they might be implemented will be accepted? Why do “we” expect their acceptance? Is this approach not an example of western imperialism and post colonialism? Do “we” have the right to choose for these people what is good, normal, and beautiful?

The WHO Country office in Ethiopia is a technical agency. Dr. Abonesh Haile Mariam mentioned that whoever starts any project related to female circumcision in Ethiopia is welcomed to visit the WHO National Regional office situated in Addis Ababa. I did not find out why the agencies or NGOs would come to the WHO Country office. Dr. Abonesh Haile Mariam mentioned that WHO is looking for partnership with other organizations, but it seems be that “the other” organizations could operate without any kind of support from WHO.

The leading and decision-making position of WHO is probably on the international level. When it comes to the national level, the leading and decision-making position is losing its importance. In the work with people who practice female circumcision it is not important how many publications, recommendations, and resolutions agencies or organizations have published. Probably people on the grassroots level do not know about the existence of WHO at all. What matters in the work with people who support this practice is that it is important to know about their needs, their reasons for practicing female circumcision, their opinion about the efforts for eradication this practice. WHO is not reaching this level. It seems to be that WHO is collecting information from the several agencies and organizations, doing research mostly on the prevalence of FGM or health consequences and publishing the outcomes of these findings with the addition that WHO does not warrant that the information contained in this publication is complete and correct. The social or socio anthropological approach is lost in the numerous health issues related to the practice of female circumcision.

The activities for eradication of female circumcision are made for the people. The main aim of these activities is to eradicate female circumcision. For people who are affected by these activities it is not important who is involved in these activities. The important thing for them is that they will not lose part of their culture when they stop practicing female circumcision. Most of the agencies and organizations working on eradication of female circumcision in Ethiopia are founded by international or foreign organizations and agencies. These organizations and agencies need to know how the funding is used, which is why it is necessary to make outcomes or results from the activities. In some of the cases, such as in Addis Ababa Women Affairs Association, the programmes or projects for eradication of female circumcision are given by agencies or organizations that are funding these projects. The outcomes showing the lower prevalence of female circumcision are taken as a success and then cooperation and funding might continue.

In most of the materials published by WHO are the results of the research done on the findings related to the prevalence of FGM in particular countries, plans for eradication or the description of the health consequences of this practice. To find in these publications the opinion of those who practice female circumcision is almost impossible. I do not know whether WHO uses the results of the research in terms of the opinions of those who were researched, because my effort to find out how the research is conducted ended with a rejection for the interview.

WHO has information about the prevalence of female genital mutilation in Ethiopia and the other information related to this practice, such as reasons for it, health consequences and knowledge about more effective strategies, but to implement its own regulations and recommendations is very challenging. The evaluation of the usefulness of those materials does not exist. The decline in the prevalence of the female genital mutilation in Ethiopia is however, useful information, but it does not exactly show what the reason for the change was. It is hard to say whether the fact that WHO participated on the eradication process of this practice had an impact on its lower prevalence. According to the A.O.Oxman, who conducted research about the use of evidence in WHO recommendations, WHO has not clearly articulated whether and how it will support member states in their efforts to adapt and implement recommendations.

(<http://www.thelancet.com/journals/lancet/article/PIIS0140673607606758/fulltext?isEOP=true> last accessed at 23.5.2007)

When is it up to member states to adapt and implement recommendations, than in Ethiopia the work was done. Since 2005, the law against female circumcision is in practice, Ethiopia has done as the WHO recommended. The opinions about such a law have a controversial character. On the one side, the legal prohibition of this practice is necessary to give legal support to organizations and agencies who are advocating against female circumcision. On the other side, the practice, due to legal prohibition, might go underground and the research for future development of strategies for its eradication will probably not be successful. It is also important to consider the fact that female circumcision is not being done intentionally to harm anyone. The risk of prosecution might bring a potential risk for women suffering from complications caused from female circumcision. As Dr. Horowitz said for the magazine Time:

*"If your only message is that this is barbaric, women who have been circumcised will be less likely to seek the medical care they need. They are not doing it to their children to hurt them.*

*They are doing it because they love them. Until they got here, they never realized it could be any other way."*

<http://www.time.com/time/magazine/article/0,9171,980337,00.html> last accessed at 23.5.2007

During my fieldwork period in Addis Ababa, I learned one important lesson. Every single number in the prevalence of female circumcision represents women affected by this practice. In Ethiopia it means at least 26, 640, 000 females.

## **Summary**

In this thesis, I have tried to show the experiences of WHO when it tries to combat FGM in Ethiopia, particularly in its capital, Addis Ababa. The challenges that WHO faces when it tries to combat FGM in Ethiopia are mostly related to cultural obstacles. Practice of female circumcision is widely spread among Ethiopian society. It is hard to say where the practice of female circumcision originated, but it is a fact that this practice crosses national, religious and cultural boundaries and is widespread among Muslims, Christians as well as among other religious practices in Ethiopia.

Different sources show that the prevalence of female circumcision in Ethiopia is around 70%. However, it is impossible to make any general statement when it comes to the issue of combating female circumcision in Ethiopia. The diversity of ethnic groups, different reasons, myths surrounding this practice, religious belonging of the practitioners and also the age of the girl circumcised make the strategies for eradication of female circumcision challenging. The generalization of approaches used for combating FGM seems to not be the right strategy.

Many organizations and agencies, governmental, nongovernmental, national and international try to combat female circumcision in Ethiopia. The Country office of WHO in Ethiopia is one of those agencies. The position of the WHO Country office in Ethiopia is that this agency is a so-called technical agency, providing material and technical support and advocacy. The cooperation with other UN agencies seems to be well established, especially UNICEF is a close partner of the WHO Country office in Ethiopia when it comes to the issue of combating FGM. The WHO Country office in Ethiopia participates in renewing the Penal Code of the Federal Democratic Republic of Ethiopia particularly on the part related to harmful traditional practices. However, the

existence of such laws does not guarantee that the practice of female circumcision could be abolished within a couple of years.

The strong cultural impact of female circumcision on Ethiopian society makes the enforcement of such laws difficult. However, such laws may contribute to the process of eradication of female circumcision. The legal support for eradication of female circumcision shows the clear policy of the state and may encourage advocacy for eradication of this practice. There are numerous organizations that are using the legal approach to female circumcision in their strategies for eradication of this practice. On the other hand, there are some organizations that do not use this approach in their strategies for the eradication of female circumcision. They advocated that the existence of such a law could lead to the “underground” type of female circumcision and efforts for eradication of the practice would be even more difficult.

The WHO Country office in Ethiopia cooperates with the IAC. The close cooperation with other nongovernmental agencies and organizations seems to not be established enough. This might be due to the lack of people working on the issue of FGM in the Country office of WHO in Ethiopia. Increasing the staff working for the WHO Country office in Ethiopia, might be one of the possible solutions to how to more effectively implement recommendations of WHO. The issue of female circumcision included many aspects that affect the life of the people who practiced it and also affected the work of the eradication of this practice. The knowledge of this aspect might be gained through dialogue between both sides included. The approaches used in strategies for eradication of female circumcision have to come from within communities. WHO has no capacity to make different strategies for each community. To strengthen cooperation with other agencies and organizations who have close relation with communities, might be the solution for preparing more effective strategies for eradication, and for appropriate recommendations.

This research related to work and experiences of the WHO in combating female genital mutilation in Addis Ababa, Ethiopia investigated some points which might contribute to knowledge and future research about eradication of this practice in Ethiopia. More space could be given to investigation of the history of the work of the WHO Country office in Ethiopia on the issue of female genital mutilation as well as to a deeper investigation of the implementation of the WHO’s recommendations. The space for the thesis and the time limitation of the fieldwork period had a

major influence on covering every aspect regarding the work and experiences of WHO in combating female genital mutilation in Addis Ababa, Ethiopia.

For the future development of this study, I would like to deeply focus on WHO's activities related to the issue of female genital mutilation and their impact on eradication of this practice in Ethiopia. In my opinion, the well knowing of the usefulness of these activities might develop effective strategies for eradication of female genital mutilation and may contribute to strengthening dialogue between agencies and organizations working towards abolishing this practice. Well knowing of the usefulness of these activities might also develop cooperation between WHO and the societies where the programs for eradication of female genital mutilation are implemented. As Dr. Abonesh Haile Mariam said, we have to ask locals what we have to prepare instead of coming with the answers without asking them. This might be taken as a strategy for a future project.

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