Efforts towards a FGC-free world

Why are particular anti-FGC interventions more successful than others?

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This thesis is submitted for obtaining the Joint Master’s Degree in International Humanitarian Action. By submitting the thesis, the author certifies that the text is from her own hand, does not include the work of someone else unless clearly indicated, and that the thesis has been produced in accordance with proper academic practices.
Abstract

Over 125 girls and women have been subjected to female genital cutting (FGC) worldwide. Different countries and institutions pledged to end the practice in the future. Interventions have been developed and implemented, yet they do not have the intended impact. This research looks into the effectiveness of interventions to eradicate female genital cutting in Ethiopia and Somalia, and how cultural and intersectional analysis can contribute to understanding why particular interventions are successful. The main methods used are the intersectional approach and the attitude continuum, that give in insight in ‘why’ and ‘how’ FGC retains strength. The findings show that different factors like age, gender, hierarchy and religion are interconnected and that they relate differently per community. Therefore, interventions should be adapted to the target community. Hence, before developing a programme an in-depth analysis should be conducted to map the role of certain believes and practices in perpetuating FGC. Understanding the structures that maintain FGC offers a chance in the development of culturally sensitive interventions and to future abolishment of the practice.
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<th>Full Form</th>
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<tr>
<td>CDC</td>
<td>Center for Development Consulting</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention on the Elimination of All Forms of Discrimination of Violence Against Women</td>
</tr>
<tr>
<td>CEP</td>
<td>Community Empowerment Programme</td>
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<td>Children’s Convention</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CIA</td>
<td>Central Intelligence Agency</td>
</tr>
<tr>
<td>CMC</td>
<td>Community Management Committees</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>CSA</td>
<td>Central Statistical Authority, Addis Ababa [Ethiopia]</td>
</tr>
<tr>
<td>Derg</td>
<td>Coordinating Committee of the Armed Forces, Police, and Territorial Army [Ethiopia]</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Surveys</td>
</tr>
<tr>
<td>ECOSOC</td>
<td>United Nations Economic and Social Council</td>
</tr>
<tr>
<td>EECEMY-DASSC</td>
<td>Ethiopian Evangelical Church Meane Yesus Development and Social Service Commission</td>
</tr>
<tr>
<td>EPRDF</td>
<td>Ethiopian Peoples’ Revolutionary Democratic Front</td>
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<tr>
<td>Ethiopia</td>
<td>Federal Democratic Republic of Ethiopia</td>
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<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>FGC</td>
<td>Female genital cutting</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
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<tr>
<td>FGM</td>
<td>Female genital mutilation</td>
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<tr>
<td>FGM/C</td>
<td>Female genital mutilation/cutting</td>
</tr>
<tr>
<td>FGS</td>
<td>The Federal Government of Somalia</td>
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<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
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<tr>
<td>HDI</td>
<td>Human Development Index</td>
</tr>
<tr>
<td>HRW</td>
<td>Human Rights Watch</td>
</tr>
<tr>
<td>HTP</td>
<td>Harmful Traditional Practice</td>
</tr>
<tr>
<td>IAC</td>
<td>The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>ICU</td>
<td>Islamic Courts Union [Somalia]</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally displaced person</td>
</tr>
<tr>
<td>IEDP</td>
<td>The Integrated Education and Development Program</td>
</tr>
<tr>
<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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MOWCYA Ministry of Women, Children and Youth Affairs [Ethiopia]
NCA Norwegian Church Aid
NGO Non-governmental Organisation
PMC Population Media Center
REST Relief Society of Tigray [Ethiopia]
SCI Save the Children International
SDG United Nations Sustainable Development Goal
SNNPRS Southern Nations, Nationalities and Peoples’ Regional State
SOFHA Somaliland Family Health Association
Somalia Federal Republic of Somalia
Somaliland Republic of Somaliland
TBA Traditional Birth Attendants
TFP Transitional Federal Government [Somalia]
TNG Transitional National Government [Somalia]
TOT Training of Trainers
TPLF Tigray People’s Liberation Front
UN United Nations
UNDP United Nations Development Programme
UN Fact Sheet No.23 Fact Sheet No. 23, Harmful Traditional Practices Affecting the Health of Women and Children
UNHCR United Nations High Commissioner for Refugees
UNICEF United Nations International Children’s Emergency Fund
UNFPA United Nations Population Fund
UN OCHA United Nations Office for the Coordination of Humanitarian Affairs
USC United Somali Congress
WHO World Health Organization
Women’s Convention Convention on the Elimination of All Forms of Discrimination of Violence Against Women
Introduction

In 2016 over 125 million women, girls and babies were circumcised in 29 countries across Africa, Asia, and the Middle East (UNICEF Data 2016). Additionally, 30 million girls are at risk of being circumcised (UNICEF and Gupta 2013). Even though the prevalence of female genital cutting (FGC) is decreasing in percentage, the absolute number of ‘cut’ women is increasing due to population growth (Yoder and Kahn 2008). Female circumcision is often linked to religion, in particular to the Islam. Yet, in only four out of 14 African countries that were analysed by the United Nations International Children’s Emergency Fund (UNICEF), over half of the population believed that FGC is a religious requirement (UNICEF and Gupta 2013).

In 1997 the World Health Organization (WHO), UNICEF and the United Nations Population Fund (UNFPA) launched a joint statement to bring about a substantial decline in female genital cutting in ten years, and to end the practice in three generations. Moreover, United Nations member states adopted a set of goals “to end poverty, protect the planet and ensure prosperity for all” (United Nations, Sustainable Development Goals). Those goals were part of a new sustainable development agenda consisting of 17 goals to be reached by 2030. One of those goals is gender equality, with different targets including: “Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation” (United Nations, Sustainable Development Goals). Hence, all of the United Nations member states are committed to ending female circumcision.

The American Anthropologist Ellen Gruenbaum demonstrated that efforts to promote change in female circumcision started in the late nineteenth century, with the European colonizers deeming the tradition as harmful (2005). The ‘enlightenment’ of the traditional, backward African women was aspired by the ‘modern’ Europeans. Today, this exoticism of Third World women is still a dominant approach, with ‘cut’ women being pictured “as victims of brutal traditions from which they need freeing” (Bradley 2011, p.16; see also: Gruenbaum 2005; Longman and Bradley 2015). Academics argue that this binary does not contribute to the desired change of a FGC-free world (Gruenbaum 2005; Longman and Bradley 2015; Mpinga et al. 2016). They assert that interventions to eradicate female genital cutting should be more community-based to increase effectiveness, without adopting western views and terms (Longman and Bradley 2015; Mpinga et al. 2016; Le Roux and Bartelink 2017). The anti-FGC message should not be imposed from a top-down
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approach, rather it should include local stakeholders and communities (Shell-Duncan 2001). Moreover, the Oxford researcher Brian Earp emphasises that the context in which FGC is practiced varies per community (2016). Subsequently, Gruenbaum believes that eradication of FGC “requires that the socio-cultural dynamics of the practice be well understood if behavioural change is to be accomplished.” (2005, p.429; see also: Shell-Duncan 2001; Longman and Bradley 2015). Yet, eradication campaigns are often not adapted to the specific communities they are targeted at (Bedri and Bradley 2017). Hence, interventions today are not compatible with the recommendations of scholars to develop cultural-sensitive intervention programmes.

A few academic scholars have reviewed interventions to assess the effectiveness of bringing FGC to a halt (Berg and Denison 2012; Salam et al. 2016). These researchers did not analyse the importance of socio-cultural contexts in assessing the effectiveness. They recommend future “methodologically rigorous intervention evaluations” (Salam et al. 2016, p.11) and “additional and stronger research” (Berg and Denison 2012, p.143) to assess effectiveness of interventions. Additionally, main actors in FGC eradication campaigns are asking for the development of a culturally appropriate, effective programmatic intervention (UNICEF 2005). Before such an intervention can be designed, it should become clear why certain interventions are more effective than others. Yet, an overview is lacking. This research paper aims at filling this gap by making use of the intersectional approach. This approach will give an insight in ‘why’ and ‘how’ FGC retains strength. Moreover, recommendations for future interventions will be given. These findings and recommendations can contribute to accomplishing the goal of United Nations member states: eliminating FGC.

In this thesis the socio-cultural contexts of Ethiopia and Somalia will be analysed, in particular in relation to FGC, as well as different anti-FGC interventions in those countries. Ethiopia and Somalia are selected for this study, because both countries have a high prevalence rate. The aim is to understand why some interventions are more successful than others in bringing about a long-term mindset change. The importance of focussing on local contexts is supported by Brian Earp’s claim that FGC varies per context (2016). To reach the UN goal of eliminating FGC, a change should occur in behaviour in both countries, thus the local context should be studied. Yet, Mpinga et al. found that one third of the studies on FGC looked at Africa as a region (2016). The single country most investigated is Nigeria, where the prevalence rate is 25 per cent, which is classified
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as low prevalence by the UN (Mpinga et al. 2016; UNICEF Data 2016). There is a necessity to focus on high prevalence countries, such as Ethiopia and Somalia, in order to develop interventions suitable for those countries. Ethiopia and Somalia share a border, yet they have a distinctive culture. In Somalia the vast majority of the inhabitants is Muslim, whereas the majority of Ethiopians is Christian. Both countries ask for a unique intervention strategy, but what factors determine the success of those intervention programmes? The central research question in this paper is: Which interventions to eradicate the practice of female genital cutting in Ethiopia and Somalia are successful, and how can cultural and intersectional analysis contribute to understanding why these interventions are successful? Different sub questions will be answered with the aim to answer the main research question:

1. What beliefs and practices specific act to perpetuate female genital cutting in the particular socio-cultural contexts of Ethiopia and Somalia?
2. Which interventions have proven to be effective in eradicating the practice of FGC in Ethiopia and Somalia by developing a long-term mindset change in communities?
3. How can we understand the successes and failures of particular intervention programmes in the context of Ethiopia and Somalia from an intersectional theory perspective?
4. Which recommendations for future intervention programmes and policies can be determined from this study?

In chapter 1 the practice of female genital cutting will be illustrated. Prevalence, terminology, the role of religion, health consequences, the legal framework, and anthropological perspective will be discussed. Secondly, the methodology applied in this study will be introduced in chapter 2. In order to understand ‘why’ and ‘how’ FGC retains strength, the intersectional approach will be used. This approach is developed in the late 1980s by law professor Kimberlé Crenshaw. The attitude continuum, developed by the anthropologist Tamsin Bradley in 2013, will be utilized to capture the mindset change of individuals and communities. Moreover, the search strategy for collecting the interventions is presented in this chapter. Subsequently, both Ethiopia and Somalia will be analysed in chapter 3 in order to understand what believes and practices specific act to perpetuate the practice in these countries. This chapter will include a short history of each country and type of administration. Moreover, an overview of FGC prevalence and eradication efforts will be
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presented, and social-cultural contexts of administrative divisions in Ethiopia. For Somalia the social-cultural contexts of three different areas will be illustrated.

The collected interventions will be analysed in chapter 4. First, each intervention will be analysed individually, followed by an interpretation of why some interventions are more successful than others. The second and third sub question will be answered in this chapter. Furthermore, recommendations will be provided for future interventions and policies to increase effectiveness. Finally, the conclusion will provide a summary of what is discussed in this research paper. This summary is followed by the answer to the research question.
Chapter 1. Female genital cutting

In this chapter, the practice of female genital cutting will be described, as well as the influence of religion on the practice, followed by the health consequences related to FGC. Next, the terminology surrounding the practice will be explained, including the reason for using the term female genital cutting in this research paper. Finally, both the legal approach towards eliminating FGC and the anthropological approach will be outlined in this chapter. This chapter draws the relevant background for answering the research question.

1.1 Defining Female Genital Cutting: What, Who, Where, and Why?

According to the WHO, UNICEF and UNFPA female genital mutilation comprises all procedures that remove - for non-medical reasons - partly or in total the female genitalia (1997, p.3). Prior to the moment the WHO defined FGM, the practice was referred to as “female circumcision”. Today the WHO uses either the term “female genital mutilation and cutting” (FGM/C) or “female genital cutting” (FGM) (WHO 2001). The WHO classified the different types of FGM/C in four categories, that are widely acknowledged and commonly used by scholars and aid organisations. In 2007 the WHO further elaborated the four types by introducing subtypes, although irrelevant for this research, since the main focus will be the effectiveness of interventions (see: WHO 2008, p.24).

<table>
<thead>
<tr>
<th>Type</th>
<th>Name</th>
<th>Description</th>
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<tbody>
<tr>
<td>Type I</td>
<td>Clitoridectomy</td>
<td>Partial or total removal of the clitoris and/or the prepuce.</td>
</tr>
<tr>
<td>Type II</td>
<td>Excision</td>
<td>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.</td>
</tr>
<tr>
<td>Type III</td>
<td>Infibulation</td>
<td>Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris.</td>
</tr>
<tr>
<td>Type IV</td>
<td>Unclassified</td>
<td>All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, incising, scraping and cauterization.</td>
</tr>
</tbody>
</table>

Table 1. WHO Classification of FGM/C (WHO 2008, p.30).
The image of unaltered female genitalia in figure 1 points out the names of the different parts of the genitalia. Table 1 describes which parts are removed within specific cutting types according to WHO standards. In this thesis the types will be described by using their names. Infibulation is most easy to recognise, because the cut edges are often stitched together, leaving a small opening for urinating and menstruation (Shell-Duncan 2001). It is more difficult to distinguish between clitoridectomy and excision, because one grades into the other (Shell-Duncan 2001). The prevalence of the various types of cutting differs per region. Infibulation for example, is only carried out in 15-20 per cent of all cuttings, although in Sudan and Somalia the prevalence of infibulation is estimated to be 80-90 per cent (WHO 1997). UNICEF makes use a different classification that makes self-reporting in surveys easier, because the WHO classification does not correspond to local concepts (UNICEF 2005, p.15; Abdulcadir et al. 2016). Again, four categories are distinguished: 1) cut without removing flesh; 2) cut with the removal of some flesh; 3) sewn, closed; 4) type not determined, or not sure (UNICEF and Gupta 2013).

Over 125 million women have been circumcised worldwide. Female Genital Cutting is carried out on infants, girls, women before marriage, at the first pregnancy or when in labour, depending on the geographical location and the local customs (WHO 2001). The prevalence among girls and women aged 15-49 years old is especially high in Western and Eastern-Africa, with Somalia (98 per cent), Guinea (97 per cent) and Djibouti (93 per cent) dominating the top three (UNICEF Data, Female Genital Mutilation and Cutting 2016). Furthermore, in some countries e.g. Gambia and Mauritania, over 50 per cent of the girls under 14 years old has been cut (UNICEF Data, Female Genital Mutilation and Cutting 2016).
The cutting is often carried out by a woman of the village, a traditional performer, using special knives, scissors, razors or glass that may be re-used without being cleaned (WHO 2001). Additionally, the World Health Organization reports the use of sharp stones, finger nails and fire to circumcise females (2001, p.17). Young girls are often not aware of what is going to happen to them and consent is in the majority of cases not obtained (Varol et al. 2014; Longman and Bradley 2015). A local woman will stop by her house or the girl is taken to the ‘cutting’ place commonly under false pretences. Subsequently, the girl is held down by multiple women and cut, rarely anesthetised. After the cutting the wound is usually smeared with alcohol, lemon juice, ashes, herb mixtures or animal dung. Afterwards the legs of a cut girl may be bound together until the wound is completely healed (WHO 2001). This might take several days to multiple weeks, depending on the severity of the cutting. Thus, first FGC happens to a girl. However, when a girl grows up, gets pregnant and delivers a baby girl, she turns into a decisionmaker. Opinions and roles with regard to FGC are thus not static, but dynamic, and they may change over time.

In some countries medicalisation of the practice is an increasing trend, meaning that the practice is carried out by health professionals (Shell-Duncan 2001). Especially Egypt (61 per cent), Kenya (34 per cent) and Sudan (36 per cent) have a high rate of medicalised circumcision (Yirga et al. 2012). Medicalisation will be more elaborated upon in paragraph 1.4.

1.2 Terminology Surrounding Female Genital Cutting

Different terminology is used to describe the practice of cutting the female genitalia, including mutilation, cutting and circumcision. The WHO used to describe the practice as “female genital mutilation”, but as for today United Nations bodies prefer to make use of either FGM/C or FGM. Those terms illustrate the irreversible harm that is done to women and is used because the practice is perceived as being a human rights violation, which I will elaborate further on in chapter 1.5. The use of the word mutilation however, implies an insensitivity towards women who have undergone the procedure, critics argue. Moreover, some scholars argue that by referring to the practice as mutilation, a binary develops between the modern, western woman and the traditional, oppressed third world woman (in: Bedri and Bradley 2017, p.32). Yet, the term FGM is still used by (feminist) activists, because they prefer to emphasize the severity of the practice in their raising awareness and eradication attempts. However, this will only grow the division in ‘western women’ and
‘mutilated victims’ argue Longman and Bradley, who also recognized the trend of “othering” (2015, p.20).

Anthropologists prefer to make use of the word cutting, because it is less politicised (Bradley 2011). Moreover, it offers a direct description of what happens, without attaching judgement. Critics of the use of the term FGC argue that it equalises the practice to male circumcision, what is non-comparable because of the differences in the amount of tissue removed, the health consequences and the severity of the operation.

Another term that is often used is female genital circumcision, because circumcision directly translates into African languages (Bradley 2011). Especially aid workers prefer to use this term, because they are often working with locals in eradication campaigns. However, the critique on this term is the same as for ‘cutting’.

After considering the debate surrounding the terminology of the practice, I decided to use female genital cutting in my thesis to refer to all types of cutting for non-medical reasons. The neutrality of the term in combination with the research goals of this thesis resulted in this decision. When specification of cutting types is essential, I will make use of the WHO classification as presented in table 1 on page 12: Clitoridectomy, excision and infibulation.

1.3 The role of religion

There is a tendency to link FGC directly to religion, most often to the Islam. However, the practice dates back to a period long before the advent of Islam (Rizvi et al. 1999). Moreover, various Muslim religious authorities have condemned FGC and declared that FGC is sinful (Rouzi 2013). Furthermore, the practice is not only non-existing in some Islamic countries like Saudi Arabia, Algeria and Turkey, the practice can also be found among Coptic Christians in Egypt, several Christian groups across Africa and the Falasha Jews of Ethiopia (Obermeyer 1999). FGC is practiced among various faith affiliations, therefore the practice cannot be linked to one specific religion. FGC is neither subscribed in the Bible, nor in the Quran or the Torah (WHO 2001; El-Damanhoury 2013). Yet, interpretations, especially with regard to Islamic obligations, differ. Prof. Abdulrahim Rouzi, a obstetrics/gynaecology doctor, claims that the lack of religious knowledge
among FGC practicing communities is the main incentive for the practice (2013). Often, Muslims practice FGC because it is allegedly approved by the Prophet Mohammed. Practitioners call it *Sunnah*, which means: “in accordance with the specific words, habits, practices, and silent approvals of Prophet Mohammed.” (Rouzi 2013, p.11). This is preserved in the Hadiths, religious reports that are, unlike the Quran, not one single same collection. The Hadiths provide authorisation of *Sunnah* actions. Within the Islam, it is important to live in accordance with the principles of Prophet Mohammed in order to be loved by God. FGC practitioners approve FGC by referring to a Hadith in which it is written that if one cuts, you should not overdo it. These words are for some Muslim communities the reason to perform clitoridectomy in WHO terms. Various communities call this type *Sunnah* and do not regard this cutting as circumcision. This conviction could be a difficulty in eradication campaigns. When communities do not regard *Sunnah* as circumcision, they could agree on abolishing FGC in it’s entirely, yet continue *Sunnah*. Examples will be presented in chapter 3.

Islamic FGC opponents however, argue that the Islamic ‘do not harm’ principle should be followed. They claim that FGC is forbidden in Islam. The Islamic Research Council for instance, a major religious authority, declared in 2007 to support abandoning FGC in it’s entirely, including *Sunnah* (Rouzi 2013). Moreover, Ali Gomaa, the Grand Mufti of Egypt, states that “all measures must be taken to put a halt to this unacceptable tradition.” (2013, p.125). The leading perception in a community/country is visible in on one hand Muslim countries like Somalia and Egypt, where FGC is highly prevalent, and on the other hand countries where FGC is not commonly practiced.

In the Torah and the Bible religious texts on what basis FGC is approved do not exist. The Torah requires male circumcision, yet FGC was never mentioned (Genesis 12-17; El-Damanhoury 2013). The only Jewish group who is practicing FGC are the Falashas in Ethiopia, who have been living in an isolated enclave for thousands of years. Falasha women stated that the practice is normative, yet not related to religion (Grisaru, Lezer and Belmaker 1997). In 1984 and 1991 almost 15,000 Falashas immigrated to Israel by two air bridge operations after being officially recognized as Jewish by the Israeli government in 1975 (El-Damanhoury 2013). The Falashas that resettled abandoned the practice almost directly after arriving in Israel (Grisaru, Lezer and Belmaker 1997). With regard to the Christian view on FGC, Christian authorities unanimously agree that FGC is not
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supported by any Christian religious text (El-Damanhoury 2013). Yet, literature is very scarce on this topic.

The medical anthropologist Obermeyer denies a direct connection between any religion and the prevalence of FGC, she connects it to influence or justification (1999, see also: Guenbaum 2005; Le Roux and Bartelink 2017). Surveys undertaken by UNICEF show that in four out of fourteen countries over 50 per cent of the population regard FGC as a religious requirement (UNICEF and Gupta 2013). Since FGC is not literally prescribed in any of the three religious books mentioned, it is evident that the practice of religious motivated FGC has evolved from the interpretation of the religious texts, for instance the Hadith mentioned before. Given that the practice is not always justified by religious motives, other rationales behind FGC exist. Alternative arguments for cutting are: preserving a girl’s virginity; social obligations and normative expectations; hygiene and cleanliness; to uphold the family honour; fear of sexual violence; marriageability, fathers receive only a good bride price for ‘closed women’; improve fertility and prevent stillbirth; gender identity marker; enhances femininity by removing masculine parts (clitoris); transition from childhood to womanhood (van der Kwaak 1992; WHO 2001; Gruenbaum 2005; Varol et al. 2014; Bedri and Bradley 2017; Puppo 2017).

The different arguments behind cutting in combination with the prevalence among different religions and inclusion or exclusion of specific types, demonstrates the complexity of FGC. Le Roux and Bartelink argue that the entanglement of faith with intersections such as ethnicity, gender, marriageability and virginity, generation, class and economic status, and other dimensions of culture makes it difficult to assess what the particular relation between FGC and faith is (2017). They claim that separating faith from other contextual factors is both empirically and methodologically problematic. Thus, FGC has to be understood in the broader context of the communities it is practiced in.

Those influencing factors raise the question of how religion affects the practice, but also on how the local culture, customs and social norms influence the practice and also each other. All of these aspects represent the image of a web, with interlocking factors. In chapter 2 an in-depth theorisation of this imaginary web will follow. The different religions, believes, customs and justifications behind cutting underscore the need for a cultural-sensitive intervention programme, because different reasons for FGC ask for different approaches when trying to eradicate the practice.
1.4 Health Consequences

Female genital cutting has no known health benefits. Yet, many disadvantages and health consequences are recognized. Anthropologist and Public Health expert Bettina Shell-Duncan divided the health complications in three categories: short-term, long-term and obstetrical (related to childbirth) consequences (2001). Among the short-term consequences she lists haemorrhage (heavy bleeding that is hard to stop), severe pain, infections and shock from blood loss that could potentially result in death (2001, p.1016). Long term health consequences are more often found among women with infibulation, for example the forming of cysts (closed sac with distinct membrane different from the nearby tissue), recurrent urinary tract infection, and pain during sexual intercourse. Infibulation also has consequences for childbirth, including severe bleeding, obstructed labour, the formation of fistulas (a hole between the vagina and rectum or bladder) and could result in infant mortality (Shell-Duncan 2001, p.1016). Varol et al. claim that “Sub-Saharan African nations continue to have some of the highest maternal and infant mortality rates in the world. It is estimated that an additional 10 to 20 babies die per 1000 deliveries as a result of FGM/C” (2014, p.401).

Adam and colleagues examined the obstetric costs for women who have undergone FGC for Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan and additionally the life expectancy of women living with FGC in those countries (2010). They concluded that circumcised women have a shortened life expectancy, on average half a year less than women that are not circumcised (Adam et al. 2010, p.281). Furthermore, they calculated the costs per circumcised women for a state. On average, it costs a state 1.71 I$ (International Dollars, adjust for the cost of living in each country) per FGC case, with a higher weighted average of 5.82 I$ for infibulation and only 0.11 I$ for clitoridectomy (Adam et al. 2010, p.284). Evidently, the more flesh is cut, the higher the costs. However, data is hard to find because FGC is in many countries forbidden by law, hospitals are inaccessible to women living in rural areas, or only severe cases are reported (Obermayer 1999). So, FGC has several short-term and long-term health consequences, but additionally contributes to high infant mortality rates and high health expenditures for governments.

In paragraph 1.1 the term medicalisation was introduced, a controversial topic when discussing FGC. Medicalisation of the practice entails that a medical specialist circumcises a girl or woman. Shell-Duncan argues that medicalisation could be seen as a harm-reduction strategy, that reduces
the risk of medical complications, and the amount of cutting (2001). She argues that “the application of harm-reduction principles to the medicalization of FGC appears to be a promising avenue for improving women's health” (Shell-Duncan 2001, p.1026). Especially in countries where FGC is practiced a lot harm-reduction strategies could be an intermediate step in eradicating the practice. The anthropologist Fuambai Ahmadu believes that the short-term risks as described above, “can be virtually eliminated through improved medical technology.”, and that medicalisation is thus not an intermediate step in eradication of the practice, but a final solution (2000, p.185). The government expenditures and the high infant mortality rate discussed in the paragraph above, might be reversed when FGC is carried out by a health professional.

Given that FGC is often not the choice of an individual, Shell-Duncan states that harm reduction is key in the time-consuming process of eradicating FGC. Moreover, when adopting a health framework, medicalisation has the potential to solve the consequences as described above, since a professional carries out the cutting in a safer and cleaner environment (Nnamuchi 2012). Thus, why not solving the health consequences and continue FGC, Nnamuchi argues (2012). Shell-Duncan states that from both a health perspective and an anthropological perspective, medicalisation is effective (2001). Finally, Shell-Duncan refutes the claim used by opponents of medicalisation that it would counteract efforts to eradicate FGC, by stating that it might slow down efforts, yet does not counteract endeavours completely (2001). When eradication of FGC is far from being reached, medicalisation could be an interim solution.

Critics of medicalisation claim that tolerating or even permitting medicalisation, has the opposite effect. They argue that the additional income for performing FGC will encourage health professionals to carry out medicalisation. Furthermore, when FGC is performed by a doctor, it does not necessarily mean that it is medically safe (Berg and Denison 2012). Moreover, it is contradictory to on the one hand oppose FGC yet allow medicalisation, because indirectly a criminalised practice becomes legitimised. Thus, from a human rights perspective medicalisation is unacceptable. Therefore, activists deriving from a human rights perspective often have a zero-tolerance policy, for instance the United Nations. Hence, the attitude towards medicalisation and the extent to which one supports medicalisation, depends on the perspective you depart from. Different perspectives will be introduced in the next paragraphs.
1.5 Legal Perspective

In 1958 and 1961 the United Nations Economic and Social Council (ECOSOC) invited the WHO to study “customs subjecting girls to ritual operations”, resulting in FGC gaining a lot of attention in both research and (domestic) legislation (Cottingham and Kismodi, in: Longman and Bradley 2015, p.18). The first country to legislate against FGC was Sudan in 1946, under British Colonial Administration (Rouzi 2013). Many countries followed in outlawing FGC, including Ethiopia in 2004, and Somalia in 2012. I will analyse the domestic legislation in both countries in more detail in the country profiles in chapter 3. Also, various treaties and conventions were concluded on the topic of FGC, some directly, some indirectly outlawing the practice. Many scholars argue that a lot of different rights are violated by performing the practice: “the right to life, the right to be free of torture or cruel, inhuman or degrading treatment, the right to equality and non-discrimination on the basis of gender” (Varol et al. 2014, p.402; see also: United Nations Fact Sheet No. 23 1995; WHO 2001; Wadesango, Rembe and Chabaya 2011). Below different international legislative frameworks for banning FGC are discussed. However, it is argued by Elizabeth Boyle and Amelia Corl, researchers from the University of Minnesota, that those laws were predominantly passed to please the international community rather than because of national willingness to change (2010).

1.5.1 Convention on the Elimination of All Forms of Discrimination of Violence Against Women

On September 3rd, 1981, the Convention on the Elimination of All Forms of Discrimination of Violence Against Women (Women’s Convention) entered into force. The convention has been ratified by 189 state parties to the United Nations today. Ethiopia has ratified the convention in 1981 already, but it took 23 more years before it outlawed the practice domestically. Somalia has not signed nor ratified the convention at all.

States are obliged to pursue a policy of eliminating discrimination against women when ratifying the Women’s Convention (1981, Article 2). Moreover, Article 5(a) includes the requirement of modifying social and cultural patterns in order to eliminate practices that are based on the inferiority of women (CEDAW 1981). One could argue that FGC is a customary practice that is based on the inferiority of women, and should therefore be outlawed. Furthermore, FGC could be seen as a form of discrimination. Even tough FGC is not mentioned directly in the Women’s Convention, the recommendation of CEDAW addressing the issue of harmful traditional practices (HTP) in 1990
supported that the practice is indeed discrimination. They adopted General Recommendation No.14 that acknowledged and supported those identifying and combatting HTPs. It also contains the recommendation for governments to support organisations that are working on the eradication of FGC, to take all measures to eradicate FGC themselves, and to encourage influential people to cooperate in their elimination campaigns (CEDAW 1990, general recommendation No.14). Longman and Bradley consider the Women’s Convention “a hallmark achievement of the second-wave feminist movement of the West” (2015, p.18) and “an important breakthrough in the implementation of a gender perspective in human rights” (2015, p.18).

1.5.2 Convention on the Rights of the Child
The Convention on the Rights of the Child (CRC) entered into force on September 2nd, 1990. Ethiopia ratified the convention in 1991, while it took Somalia until 2015, after the country signed in 2002. Even though Somalia made several reservations to the treaty, the country ratified the articles concerning children’s health. Article 19 of the CRC obliges states to take all measures to protect children from - among other things - physical harm, and Article 24 (3) reads: “State Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children” (CRC 1990). By ratifying the CRC a state pledges indirectly to fight FGC, since it is evident that FGC has health consequences. In the United Nations Fact Sheet No. 23 is stated that FGC violates the highest attainable standard of health for children, and therefore states are obliged to do everything to eradicate the practice (1995, p.3). Additionally, in 1994 UNICEF’s Executive Board requested to give high priority to promotion and ratification of both the Women’s Convention and CRC, to - among other goals - abandon FGC (in: United Nations Fact Sheet No. 23 1995, p.14). So even though FGC is not mentioned directly, it is argued that the practice is indirectly condemned in the CRC.

1.5.3 Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa
The Protocol to the African Charter on Human and People’s Rights on the Rights of Women in Africa, also known as the Maputo Protocol, guarantees an end to FGC, additional to different human rights for women. The Maputo Protocol was adopted by the African Union in 2003. The protocol is ratified by 36 countries out of 54 African countries, signed by 15 countries including
Ethiopia and Somalia. Tunisia, Egypt and Botswana did not sign nor ratify. Article 5 of the protocol deals with the elimination of harmful practices. By ratifying the protocol states accept to take all necessary measures to eliminate HTPs, including: “prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and paramedicalisation of female genital mutilation and all other practices in order to eradicate them” (Maputo Protocol 2003). The Maputo Protocol is one of the regional initiatives to bring about an end to FGC.

1.5.4 Other legal measures
Apart from the three conventions mentioned, a lot of other initiatives have been taken in order to end the practice. United Nations bodies have been calling for action for years. For instance, during the 1993 UN World Conference on Human Rights the UN called for elimination of all forms of violence against women (UNICEF 2005, p.2). This resulted in the adoption of a resolution in 1994 of the UN Commission on Human Rights to eliminate all HTPs (United Nations Fact Sheet No. 23 1995, p.13). In 1997 a joint UNICEF, UNFPA and WHO statement was made in order to bring about a substantial decline in FGC in ten years and to end the practice in three generations. Moreover, the United Nations Sustainable Development Goals (SDGs) contain the goal of gender equality, with the target to “eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation” (2015, goal 5). A more recent UN resolution was adopted by the General Assembly in February 2017, in which they pledged to intensify efforts to eradicate the practice. Finally, the WHO has a pronounced opinion and is determined to eradicate FGC. The WHO has a zero-tolerance policy and is against any harm reduction strategies like medicalised circumcision, or introducing less harmful forms of cutting (WHO 2008).

On top of different UN bodies, regional organisations have been trying to eradicate FGC as well. The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) vowed to reduce morbidity and mortality rates through eradication of FGC in 1984. Furthermore, different organisations have joined forces in 2013 and created a Joint Collaboration Strategy on Elimination of Harmful Traditional Practices between IAC, the African Union Commission, UN Economic Commission for Africa, UNICEF, UNFPA, and the African Committee of Experts on the Rights and Welfare of the Child.
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The different conventions, protocols and joint statements show a pattern of frequent international condemnation of the practice, because FGC is perceived as a human rights violation. Those (mainly western) institutions seem to forget local conditions and context, not distinguishing between different reasons for FGC, different types of cutting and other details. Locally the practice is differently perceived. For instance in Senegal, where the Jola community accepted excision as part of modernity approximately 50 years ago (Dellenborg 2004, p.80). Jola women played an important role in introducing the practice to be able to achieve a ritual status that was only achievable by marriage before the introduction of FGC. Since the introduction of FGC women do not have to rely on men anymore to get this status, so FGC contributed to women’s empowerment in the Jola community (Dellenborg 2004). A similar phenomenon can be found among Somali women argues Isha Abulkadir, a Somali herself: “while it [FGC] increases women’s value in Somali eyes, it often degrades them in the eyes of the outside world” (Abulkadir 2011, p.55). In the legal approach, the understanding of ‘how things work’ is missing, resulting in a cultural-unsensitive approach with the West imposing her standards on the rest of the world. FGC is different from the Western standards, and functions to co-construct the idea of the Western modernized women versus the traditional, yet to be liberated third world women.

1.6 Anthropological Approach

In order to overcome the binary between modernized and traditional women, it is necessary to approach FGC in a ‘neutral’ way. Gruenbaum (2001) argues that criticism of ‘outsiders’ is often simplistic and fails to address the local customs. In her opinion, it is ineffective to challenge FGC from the outset, but any intervention must work within the religious and cultural environment (Gruenbaum 2001). Longman and Bradley claim that women are more and more regarded to as ‘agents’ of their lives instead of ‘victims’ (2015, p.24). However, this turn to agency is predominantly visible in anthropological work, not yet in legislation. Instead of adopting laws against FGC, it might be more effective to assess why interventions are successful, and subsequently develop more cultural sensitive interventions. This can be done by an in-depth empirical research on human behaviour in all its diversity and by the use of the intersectional approach and an attitude continuum, that I will elaborate upon in the next chapter. It corresponds to Bradley’s claim that interventions must be adapted to specific communities (2011).
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communities where girls are cut to mark their transformation to womanhood, it might work to introduce a symbolic circumcision, while in communities where girls are cut to protect them from having sex before marriage a different intervention might work better (Bradley 2011). Moreover, most anthropologists recognize the use of harm-reduction strategies, as discussed in paragraph 1.4, as intermediate step when direct eradication is impossible.

Thus, one could adopt different lenses when discussing FGC. From a health perspective, and often from an anthropological perspective as well, medicalisation of FGC is a first step in eradication, some, for instance Fuambai Ahmadu, argue that medicalisation is the final solution. The UN and the African Union on the other hand, adopted a zero-tolerance policy from a human rights perspective. A fourth lens that one could adopt is an economical lens, that assesses the link between economy/economic security and FGC. The influence of the adopted lenses is visible in the interventions in chapter 4, where the impact of different interventions is evaluated. In the end, the goal of the different approaches is equal: to eradicate FGC. However, to develop a long-term mindset change in communities we must understand the successes and failures of interventions in their local context. “Interventions would most likely become more efficacious if consideration was taken of both the Western (etic) and the local socio-cultural (emic) meanings of female circumcision and its generally contested and multivocal character.” (Dellenborg 2004, p.91). Eradication of the practice is solely achievable, when interventions are adapted to specific cultures. The level of adaption can be measured by making use of the intersectional approach. The mindset change of the community could be assessed by making use of the attitude continuum, which I will elaborate upon in the next chapter.
Chapter 2. Theoretical and methodological framework

In this chapter, I will present the intersectional approach and the attitude continuum. Subsequently, I will explain how I will make use of both theories in the analysis of the effectivity of eradication campaigns. Moreover, the interpretation process of the successes and failures of intervention programmes will be outlined by demonstrating to what questions the literature will be subjected. Finally, I will describe the search strategy and criteria used for the intervention selection.

2.1 The Intersectional Approach

The concept of intersectionality is used to describe the joining of multiple entities – like race, class and gender - because they are overlapping. The core idea is that aspects of identity are indivisible and therefore they cannot be assessed in isolation. An analogy of a crossroad is often adopted to clarify the notion of intersectionality. An indeterminate number of roads come together at the intersection, that represents the joining of the multiple entities and their interaction, like cars and traffic lights.

2.1.1 History

In the late 1980’s law professor Kimberlé Crenshaw developed the term intersectionality “to describe the various social factors that produce the social inequalities women experience” (Longman and Bradley 2015, p.35). Even though the idea of intersectionality was not new, the term was not formally recognized yet. Bonnie Thornton Dill for example, stated already in 1983 that multiple entities are concerned with the formation of social identities because they work in groups, and when they join, they form social identities. Those entities are overlapping, and therefore Dill suggested a pluralistic approach when analysing why different segments of the female population of the USA were not identifying themselves as sisters of the white middle-class of the ongoing women’s movement (1983).

Kimberlé Crenshaw explained Bim Adewunmi in an interview for NewStatesman, a British Current Affairs and Politics Magazine, that she noticed in the 1980’s that the judicial system in the United States of America was addressing race and gender as two separate things in anti-discrimination laws (2014). When a black woman would sue a company on the grounds of race
and gender discrimination, the court would rule that not all women were discriminated against and neither all black employees. In those cases, the companies were often acquitted. To overcome this, in her eyes, unfair treatment, Crenshaw developed the idea that power structures like race, gender, and class are interlinked and interact (Berger and Guidroz 2009). She named it intersectionality.

In the 1990’s researchers built on the idea of Crenshaw. Intersectionality was further developed by a group of (African-American) scholars and activists, who accused women’s movements of neglecting black women and misunderstanding oppression (see: Andersen and Collins 1992; Crenshaw 1993; Essed 1993). They claimed that race, gender, and class were not separate things to look at, but they connect and interact. The primary focus was black women, but this focus developed in a more inclusive, broader focus.

Professor in Sociology Nira Yuval-Davis argued that different social divisions have certain parameters in common (2006). Therefore, it is important to analyse how specific positions, identities and political values are constructed and how they interrelate and affect each other in particular locations and contexts (Yuval-Davis 2006). Those parameters do not appear in a vacuum, but they are continually renewed and restructured (Valentine 2007). Moreover, Yuval-Davis states that the list of categories for an intersectional analysis is potentially boundless (2006).

Berger and Guidroz demonstrated in 2009 that intersectionality later evolved in the intersectional approach: “the intersectional approach […] is a disciplinary “border-crossing” concept produced through feminist theorizing and activism about the social relations of power” (p.7). In their opinion, the difference between intersectionality and the intersectional approach is that the new approach is an interdisciplinary approach that helps scholars to challenge traditional ways of research and produce a more inclusive framework.

### 2.1.2 The importance of the intersectional approach

The importance of the intersectional approach is demonstrated in the work of Andersen and Collins, in which they ask people:

“to think about race, class, and gender as systems of power. We want to encourage readers to imagine ways to transform, rather than reproduce, existing social arrangements. […] All social groups are located in a system of power relationships wherein your social location can shape what you know—and what others know about
you. As a result, dominant forms of knowledge have been constructed largely from the experiences of the most powerful—that is, those who have the most access to systems of education and communication. To acquire a more inclusive view—one that pays attention to group experiences that may differ from your own—requires that you form a new frame of vision.” (1992, p.2).

And:

“Dominant narratives can try to justify the oppression of different groups, but the unwritten, untold, subordinated truth can be a source for knowledge in pursuit of social justice.” (1992, p.13).

These two quotes emphasise the need for an inclusive view, and additionally illustrate what the norm is when talking about FGC: a top-down (western) perspective. Even though Andersen and Collins wrote their book in the nineties, their thoughts on dominant forms of knowledge constructed by the most powerful are still accurate today (see: Gruenbaum 2005; Berger and Guidroz 2009; Longman and Bradley 2015). The legal framework as described in paragraph 1.5 is proof of this western approach, since it does not consider the root causes of FGC but instead imposes the western disapproval. Even though the term ‘intersectionality’ is increasingly used by UN bodies and NGOs in policy making and legislation, the results hoped for have not been witnessed yet (Longman and Bradley 2015, p.35). Isha Abulkadir (2011) and Aisha Omar (2015), who have undergone FGC themselves, are among those that argue that if progress towards abandonment is to be made, it is important that the focus shifts to how women experience the practice and how they see FGC. In their opinion, in order to eradicate the practice, understanding the root cause of FGC is the only way.

The inclusive view mentioned by Andersen and Collins, and asked for by Abulkadir and Omar, is attainable when making use of an intersectional approach. Longman and Bradley argue that this approach resembles a web of interlocking factors like religion, culture, gender, age, race and so on, because this web shapes a person’s positioning, identity and experiences in relation to FGC, and therefore making use of an intersectional approach is the best way to analyse why FGC retains strength (2015). Moreover, they argue that culture, tradition and religion are not in themselves the problem, but it is often the specific context that produces FGC (see also: Bradley 2011). This is
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also stated by the Oxford researcher Brian Earp, who describes that FGC varies per context, underlining the need for community specific research (2016).

Furthermore, as Valentine points out, being part of a ‘group’ does not mean that you have the identity of that group (2007). Only when behaviour is consistent with the norms, traditions and practices of a culture, one has the identity of that group (Valentine 2007). Longman and Bradley expect that the ‘web’ will differ across countries, underscoring the need for making use of the intersectional approach when analysing FGC, given that it is practiced in multiple countries. Additionally, Longman and Bradley point out the need to focus on religion, because very little is understood of how religion influences FGC, which has led to misunderstanding of the practice (2015).

2.2 Attitude Continuum

It is crucial when assessing the successes and failures of intervention programmes to monitor the attitude change of individuals (Longman and Bradley 2015). Bradley developed in 2013 an attitude continuum to capture “cross and intergenerational differences in individual perceptions” (in: Longman and Bradley 2015, p.35). As pointed out before, different generations have different attitudes towards continuation of FGC, attitudes that could change throughout people’s lives. This shifts in attitude can be positioned at points along a continuum to show a woman’s changing perception of FGC as illustrated in figure 2. The attitude continuum should be used alongside an intersectional approach, because the combination “act[s] as an effective way of drawing out patterns and nuances in how people retell their experiences of, for example, FGM identifying the influence of class, ethnicity, and other social construct in the shaping of specific narratives around the practice.” (Longman and Bradley 2015, p.35).

In the specific context of this research, the attitude continuum could help assess the long-term mindset change. The Transtheoretical Model developed by James Prochaska and Carlo DiClemente in 1977 could be helpful in explaining behaviour change. The Transtheoretical Model assesses an individual’s readiness to adapt new behaviour and act in accordance with it (Prochaska and DiClemente 2005). In the Transtheoretical Model, change is a process with different stages, from not ready, getting ready, and ready to take action in the immediate future, to maintenance of the behaviour and finally termination of the old behaviour. This model is applicable to FGC interventions and the inflicted behavioural change as well. At one end of the attitude is the collective support for FGC positioned, in the Transtheoretical Model described as not ready, and at the other end the collective support for abandonment of the practice, definable as the stage of termination. In between those extremes, different perceptions could be placed. For instance individual awareness and changed opinions, group actions against FGC by key leaders, or public declarations, depending on the size of the support and those involved. The more approval gained and collective community support, the more sustainable the mindset change.

To explain the successes and failures of intervention programmes in the context of Ethiopia and Somalia, identifying and understanding the socio-cultural dynamics of FGC is essential. Whereas the intersectional approach could help answering ‘why’ and ‘how’ FGC retains strength, the attitude continuum is most effective in assessing the success of interventions. The acquired knowledge could advance future intervention programmes and policies. As Bedri and Bradley state: “Ending it [FGC] is crucial for many reasons but the way forward has to be based on in-depth understanding into the complexity of how the practice manifests itself.” (2017, p.31).

2.3 Intervention Analysis

First, I will develop an overview of Somalia and Ethiopia in terms of norms, traditions and practices. For Ethiopia, the main source of information was The Demographic and Health Survey (DHS) 2016, conducted by the Ethiopian government in collaboration with the DHS Program that provided technical assistance. Moreover, I used Encyclopaedia Aethiopica, a five-volume encyclopaedia for Ethiopia and Eritrea, edited by Professor Dr. Uhlig, former holder of the chair of Ethiopian Studies at the Asia-Africa Institute of Hamburg University. Further information was found in different articles on specific regions or ethnic groups, as referenced to in-text. For Somalia,
the main source of information were the *Multiple Indicator Cluster Survey’s* and base-line and evaluation reports on the prevalence of FGC written by the consultant Dr. Katy Newell-Jones who has reviewed many projects throughout the world, and Crawford and Ali, who are part of the Health and Education Advice and Resource Team, a consortium of leading organisations on different development topics.

The Oxford University Professor Bent Flyvbjerg states that “Predictive theories and universals cannot be found in the study of human affairs. Concrete, context-dependent knowledge is therefore more valuable than the vain search for predictive theories and universals.” (2006, p.226). Moreover, the use of interventions is important because case-study research contribute to “the development of a nuanced view of reality.” (Flyvbjerg 2006, p.225). Therefore, adding Flyvbjerg’s justification for case-study research to the claim of Bedri and Bradley that “the inclusion of local voices will be the key to programme’s success” resulted in the decision to analyse case studies in my research (2017, p.36). I will make use of both the intersectional and the attitude continuum when trying to understand successes and failures of specific intervention programmes, that have to be interpreted while keeping the local context in mind. The intersections that are important to analyse in the interventions are age (stage in life cycle), gender, religion, hierarchy, ethnicity, education and culture. The interventions will be analysed by subjecting the programmes to an in-depth analysis of the cultural sensitivity on the basis of those intersections.

First, it is important to examine the considerations of the interveners when choosing for a specific intervention. Did the interveners start with an in-depth analysis of the community beforehand? Examples of focus points during this assessment are reasons behind FGC, attitudes towards continuation, composition of the community in terms of age, education, male/female ratio, and so on. Attention payed to these focus points beforehand are a first indication of the cultural-sensitivity of intervention programmes, and thus whether interveners understand the need for an intersectional approach in their eradication campaigns. Moreover, the impact of the adopted framework, for instance human rights, will be analysed.

Secondly, some relevant questions could be asked about the behaviour of interveners during intervening: Did the interveners pay attention to local hierarchy? Did they give community or religious leaders a role in the eradication campaign? Additionally, an intersectional gender approach can be applied by asking whether the interveners paid attention to gender roles in the
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community, and if so, did they have different strategies per gender for bringing about a long-term mindset change?

The best way to create an overview of the cultural-sensitivity of interventions is by coding the approach and behaviour of interveners based on the questions above. Codes were developed for both intersections in itself as for a combination of multiple intersections, like hierarchy and religion in for instance the involvement of religious community leaders. The codes used can be found in the codebook in annex 4.

When applying this method to multiple interventions, an overview will arise to what extent interventions were adapted to the socio-cultural context and the influence of this adaptation on long-term mindset. It will become clear from the findings what interventions are effective in what contexts, and especially: why.

Finally, it is essential to be aware of the contributors to the evaluation report. Reports tend to be more subjective when written by the organisation who carried out the intervention, in contrast with external evaluators. The UN for instance, claimed to have adopted a holistic approach, which means that the approach used is “relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts.” (Merriam Webster 2018). So a holistic approach is inclusive and is concerned with the community as a single system with different intersections having influence, instead of a focus on FGC only. This definition of holistic is also the definition used in this thesis. It becomes clear from chapter 4 that almost every intervention is holistic, yet the UN is the only one specifically mentioning it.

2.4 Search Strategy

To put the different theories into practice, interventions had to be gathered. This paragraph summarizes the search strategy used to find interventions that are eligible for this analysis. The term intervention is used in this research to describe any interference aimed at bringing about a mindset change. First of all, only English interventions were used in this study. Moreover, the data published in the report had to be relevant for this research. Finally, no (academic) studies on the effectiveness of specific interventions were reused. Only primary evaluation reports were analysed. Given that many intervention reports are not available, this resulted in the exclusion of multiple eradication campaigns.
The NGO 28toomany published a report in 2013 with Ethiopian and international organisations working on eradication campaigns in the country. After copying the list, I searched for the contact information of the NGOs and contacted them all in the beginning of September 2017. For Somalia, I found an overview of NGOs on Reliefweb. Via the snowball effect I soon came up with a list of over 100 NGOs that I send a request for interventions (annex 1). However, unfortunately most NGOs did not respond to the enquiry. Some response included reports that were not relevant, for instance future policies instead of past reports. A problem that I encountered in gathering Somali interventions was the lack of good administration or the destruction of archive. The NGO SAACID responded that their administration centre was overrun by Al Shabaab in 2009, and subsequently struck by a truck bomb in 2016. Another problem I encountered was the lack of reports in Ethiopia, due to a controversial NGO law I will elaborate on in paragraph 3.1.5.3. Yet the Norwegian Agency for Development Cooperation (NORAD) replied to take a look at their website on the evaluation section where they have published a lot of reports, many useful for this research. A limitation of contacting NGOs is however, that the reports are written for a specific public, either the donor or prospective donors, that could result in a biased report.

This selection resulted in 6 intervention programmes for Ethiopia and 6 intervention programmes for Somalia, that are attached in annex 3.
Chapter 3. Country profiles

In the following chapter, I will provide the country profiles of Ethiopia and Somalia. Both countries are located in the horn of Africa, illustrated in figure 3. Somalia is the far most right green country and Ethiopia is the large green country on the left. The countries share a border of 1640 km (CIA 2017). Nevertheless, these two countries are completely different with distinctive cultures, which will be illustrated below.

3.1 The Federal Democratic Republic of Ethiopia

The Federal Democratic Republic of Ethiopia is the oldest independent country in Africa. The country is completely landlocked since the secession of Eritrea in 1993. The capital of Ethiopia is Addis Ababa, inhabited by 3.3 million people. Ethiopia has never been colonised by European powers, however it has been shortly occupied by fascist Italy in 1935-36.

In 1974 a civil war followed the communist coup by the Derg that lasted for over sixteen years and resulted in an estimated 500,000 – 1,000,000 deaths both from the tyrannical military regime and famines (de Waal and Human Rights Watch 1991; Valentino 2004; Abbink 2011). The Derg regime abolished the monarchy and embraced communism, supported by Cuba and North Korea. The civil war was accompanied by multiple famines, because of the mismanagement, corruption, instability and the dry climate (De Waal and Human Rights Watch 1991). During the Derg regime, the Relief Society of Tigray (REST) was founded, an NGO that provided the northern region of Tigray with relief and development aid, funded by the USA, Canada, Australia and Europe (Young 1997). This support is understandable in the light of the Cold War. The presence of the REST strengthened the region, and in particular the Tigray People’s Liberation Front (TPLF) that fought the government.

The TPLF, later Ethiopian Peoples’ Revolutionary Democratic Front (EPRDF), defeated and subsequently succeeded the communist government in 1991 with over 100,000 members and decided that “ethnic identity was to be the basis of politics” (Abbink 2011, p.596). The result can be found in the organisational structure of the country, with major ethnic groups having control.
over their own region and enjoying the right to withdraw from Ethiopia to form their own state (Levinson 1998).

In 2011 the BBC reported that Ethiopia has one of the world’s fastest growing economies (Ashton 2011). However, since 2015 drought and famine resulted in an estimated 8.5 million Ethiopians in need of emergency food assistance in the second half of 2017 (Government of Ethiopia, UN OCHA 2017). Meanwhile, Human Rights Watch (HRW) keeps reporting negatively on the human rights situation in the country. In 2016 for instance, they reported that security forces killed over 400 Ethiopians and wounded thousands during peaceful protests against a federal government’s plan to clear a forest and football field for an investment project. HRW has also reported on the restriction of the rights to freedom of expression and monitoring of online and mobile behaviour by the EPRDF.

3.1.1 Demographics
Eighty per cent of the hundred million Ethiopians is living in the rural areas, mostly living off the land (CIA 2017). Ethiopia is ranked 174 out of 188 in the Human Development Index (HDI) of the United Nations Development Programme (UNDP), meaning that Ethiopia has low human development and is among the least developed countries in the world. Almost 30 per cent of the population lives below the national poverty line of around half a dollar a day (HDI 2016). The country has 258,000 internally displaced persons (IDPs), and additionally hosts almost a million refugees from neighbouring countries, including Somalia (250,000 refugees) (CIA 2017).

There are over 75 ethnic groups living in the country, with the largest groups demonstrated in figure 4. Oromo, Amharic, Somali, Tigrigna and Afar are official state languages, yet over 100 languages are spoken in the country with the main languages summarized in figure 4. Remarkable is that the languages and ethnic groups are similar in percentage, what is understandable in the light of the TPLF state reform.
Ethiopians are predominantly Ethiopian Orthodox (44 per cent) (DHS 2016). Other religions practiced are the Islam, predominantly Sunni, (31 per cent) and Protestantism (22 per cent). Most religions are concentrated in specific states or communities, with Christians mainly living in the highlands, while Muslims predominantly reside in the lowlands (Pankhurst and Piguet 2009).

Half of the population is able to read and write, with almost seventy per cent of men being literate, compared to 42 per cent of women (DHS 2016). Again, rates differ per region. On average 4.6 children are born per female, making it one of the highest fertility rates in the world (DHS 2016). The maternal and infant mortality rates are excessive and among the worst in the world (respectively 32st and 33st place).

3.1.2 Geography
Ethiopia has large altitudinal contrasts, with peaks as high as 4,000 meters in the central and northern part, and lowlands in the borderlands and the Rift, a valley that bisects Ethiopia diagonally from the northeast to southwest (Pankhurst and Piguet 2009). Pankhurst and Piguet argue that the population is mainly living in the highlands because the climate is very suitable for agricultural, in contrast to the dry lowlands (2009).
3.1.3 Administrative divisions
Ethiopia has two self-governing administrations, the cities of Addis Ababa and Dire Dawa. Moreover, the country is comprised of nine ethnically based states, illustrated in figure 5. Every state is divided into different zobas, or administrative zones, that are the second-level subdivision of the government (Young 1997). They are in turn divided into woredas, or districts, that are third-level subdivisions. Altogether, over 750 woredas exist, that are divided into kebeles that are the smallest administrative divisions in Ethiopia. The anthropologist-historian Jan Abbink, who specialised in Ethiopia, summarizes the federal structure of Ethiopia as follows: “Part of the federal structure is the aim of decentralization and devolution of power and decision-making to the ethno-regions: regarding budget, revenue collection, self-administration, the judiciary, and local development planning.” (2011, p.601). However, the results have been limited so far, due to - among other reasons - corruption and nepotism Abbink claims. Additionally, policies are created by the federal government, and not by communities themselves. Hence, the result aimed at is often not achieved, because communities might disagree with federal policies (Abbink 2011).
3.1.4 FGC in numbers and areas
The Demographics and Health Survey of 2016 shows a national FGC prevalence of 65.2 per cent among 15-49 year old women in Ethiopia, but the prevalence varies per region (table 2). The WHO terminology introduced in paragraph 1.1 will be used to describe the different types. Seven per cent of the circumcised women has undergone infibulation (DHS 2016). Women in urban areas are less likely to be circumcised than women living in rural areas. The DHS 2016 also found a link between both education and prevalence, and wealth and prevalence of FGC. The higher the education of or the wealthier the parents, the lower chance daughters will be circumcised. Prof. Dr. Uhlig claims that the motivation governing FGC is multifaced and origins are based in the social sphere (2003, p.747). Nationwide, 1.9 per cent of the girls aged zero to fourteen has been circumcised by a medical professional, the rest of them by a traditional agent, circumciser or birth attendant (DHS 2016).

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of Women circumcised</th>
<th>Fertility rate</th>
<th>Ethnic Group</th>
<th>Percentage of women circumcised</th>
<th>Religion</th>
<th>Percentage of women circumcised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afar</td>
<td>91.2</td>
<td>5.5</td>
<td>Afar</td>
<td>98.4</td>
<td>Catholic</td>
<td>58.2</td>
</tr>
<tr>
<td>Amhara</td>
<td>61.7</td>
<td>3.7</td>
<td>Amhara</td>
<td>60.5</td>
<td>Muslim</td>
<td>82.2</td>
</tr>
<tr>
<td>Addis Ababa</td>
<td>54.0</td>
<td>1.8</td>
<td>Guragie</td>
<td>78.5</td>
<td>Orthodox</td>
<td>54.2</td>
</tr>
<tr>
<td>Benishangul-Gumuz</td>
<td>62.9</td>
<td>4.4</td>
<td>Hadiya</td>
<td>92.3</td>
<td>Protestant</td>
<td>65.8</td>
</tr>
<tr>
<td>Dire Dawa</td>
<td>75.3</td>
<td>3.1</td>
<td>Oromo</td>
<td>77.1</td>
<td>Traditional</td>
<td>55.0</td>
</tr>
<tr>
<td>Gambela</td>
<td>33.0</td>
<td>3.5</td>
<td>Sidama</td>
<td>87.6</td>
<td>Other</td>
<td>9.9</td>
</tr>
<tr>
<td>Harari</td>
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<td>4.1</td>
<td>Somali</td>
<td>98.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oromia</td>
<td>75.6</td>
<td>5.4</td>
<td>Tigray</td>
<td>23.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNNPRS</td>
<td>62.0</td>
<td>4.4</td>
<td>Welaita</td>
<td>92.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somali</td>
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<td>7.2</td>
<td>Other</td>
<td>38.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tigray</td>
<td>24.2</td>
<td>4.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Prevalence of FGC in Ethiopia (DHS 2016, p.320).
3.1.5 Eradication efforts
3.1.5.1 Legislation against FGC

Ethiopia has a history of inequality and discrimination of women. Melissa Krall, working for the Community Health Alliance, claims that from the moment females are born, they are regarded as second-best (2011). The new constitution addresses discrimination of women in Article 35, in which women “are entitled to affirmative measures. The purpose of such measures shall be to provide special attention to women so as to enable them to compete and participate on the basis of equality with men in political, social and economic life as well as in public and private institutions.” (Ethiopia 2004, Article 35). However, as mentioned before it is hard to implement federal government policies on regional level, because the communities do not necessarily agree on national legislation.

The renewed Criminal Code of the Federal Republic of Ethiopia, that came into force in 2005, outlaw FGC directly. Two articles on FGC were added to the 1994 Criminal Code; Article 565 “Female Circumcision” and Article 566 “Infibulation of the Female Genitalia” (Ethiopia 2004). The Penal Code differentiates between circumcision and infibulation, with the latter being punishable with imprisonment from three to five years (Ethiopia 2004, Article 566). When the cutter causes additional injury to body and health (s)he could be imprisoned for five to ten years. Circumcision, presumably non-infibulation, could result in imprisonment for three months or a fine not less than 500 Birr (approximately 27 USD) (Ethiopia 2004, Article 565). However, UNFPA claimed in its 2015 annual report on FGC eradication that only one conviction followed out of 279 arrests. Krall argues that the issue is “the insignificance of these laws in rural communities.” (2011, p.186).

As described in paragraph 1.5, Ethiopia has ratified different international conventions. Additionally, Ethiopia ratified the International Covenant on Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights Covenant (ICESCR), both in 1993. The ICCPR protects the right to physical integrity in its preamble and in Article 9(1), a right that is violated by performing FGC many argue (United Nations Fact Sheet No. 23 1995; WHO 2001; Varol et al. 2014; Wadesango et al. 2011). Moreover, they claim that the right to health that the ICESCR recognizes is violated by unnecessary cutting. Given that Ethiopia has signed those covenants, the government has to take all measures to ensure the rights protected within the ICCPR and the ICESCR.
3.1.5.2 Federal Government efforts

Apart from the measures mentioned, the federal government of Ethiopia took additional measures within Ethiopia to fight FGC. “These [measures] include putting in place a national Harmful Traditional Practices (HTPs) strategy founded on the three-pillar approach: prevention, provision, and protection. This targeted approach guides the national effort and helps to galvanize the support of stakeholders to end the practice as well as mitigate the impact of FGM/C.” (DHS 2016, pp.315).

Moreover, the government provided traditional practitioners in the Harari and Somali region with loan to create new jobs (Abathun, Sundby and Gele 2016). Furthermore, the Ethiopian government pledged to end FGC by 2025 at the London Global Girls’ Summit in 2014.

The efforts of both the government as well as different NGOs have led to a decrease in FGC prevalence of eight per cent among 15-49 year olds over the past eleven years (DHS 2016).

3.1.5.3 NGO activity

In 2008 a controversial NGO law was passed, restricting foreign agencies to work “on human rights, democracy, election, and ethnic relations”: Proclamation No. 621/2009 (Dupuy, Ron and Prakash 2015, p.420). Additionally, local NGOs working in those fields are not allowed to receive more than ten per cent of their funding from abroad, or else they will be banned from working in those areas. Most of the NGOs active in Ethiopia during that time were international rather than local NGOs. The aim of the rule is to prevent funds to be channelled through the voluntary sector, resulting in the government being able to regulate NGO activity. Furthermore, international organisations cannot work in human rights and gender equality areas (Nega and Milofsky 2011). Dupuy et al. found that the NGO population of 3,800 organisations in 2009 declined to 2,059 organisations registered at the federal level in 2011, with the surviving NGOs having restructured dramatically (2015). Most organisations that closed down, were local, human rights NGOs. The issue of having to re-shape the activities was also mentioned by the NGO Kelem Ethiopia: “Unfortunately, we have no such report (both in hard and soft copies) at this following government’s proclamation that strictly prohibits NGOs working on such matter.” (September 25th 2017, via e-mail). Thus, one of the consequences of the restricting NGO law is that some anti-FGC NGOs had to terminate their activities. Therefore, intervention gathering was a challenge. The interventions collected are predominantly health focused, because NGOs are only able to work
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within a health framework with regard to FGC. Thus the adopted approach in interventions is not driven by effectiveness but by government restrictions (from 2008 onwards). The methodological consequence is a possible biased outcome because of the health focus of five out of six interventions that were analysed (see chapter 4). Whether a human rights framework could be effective in Ethiopia is for instance not assessed. The different (local) NGOs that are working on FGC eradication are added in annex 2.

3.1.6 Social-cultural contexts
Given that Ethiopia is inhabited by over seventy ethnic groups that are living across the country and most interventions focus on regions instead of ethnic groups, the different regions of Ethiopia will be elaborated upon in the next section, instead of various ethnic groups. Moreover, different communities from the same ethnic group might have different traditions and habits with regard to FGC. All of the statistics in the next section are retrieved from the *Ethiopia Demographic Health Survey* unless indicated otherwise.

3.1.6.1 Addis Ababa
The Addis Ababa region consists of the capital of Ethiopia and its suburbs. Almost half of the inhabitants are Amhara, but other groups include the Guragie, Oromo and Tigrie (CSA 2007). Almost 75 per cent of the inhabitants are Orthodox. Islam (16.2 per cent) comprises the second largest religion adhered to (CSA 2007). The inhabitants of Addis Ababa are compared to the rest of the country the wealthiest and most educated. The literacy rate of women is high (87.8 per cent) in comparison with the second highest female literacy rate of 54.6 per cent in Harari. Women are most empowered in the Addis Ababa city administration, visible in the highest rates in women’s involvement in decision-making processes, employment ratio, negotiation of sexual intercourse and the lowest acceptance rate of wife beating nationwide.

Four out of five women in Addis Ababa choose their husband themselves, on a median age of 23.9 years old. The median age for first sexual intercourse is 20.4, indicating that women engage in sex before marriage. Polygamy is not prevalent in the city. The child mortality rate is the lowest in the country, possibly because 97 per cent of the women bear their children in public or private health facilities.
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Even though over 95 per cent of the men and women in Addis Ababa believes that FGC should not continue, over 50 per cent of the women are circumcised in the region according to the DHS 2016. Shay, Haidar and Kogi-Makau studied schoolgirls in Addis Ababa to get more insight in the driving factors behind FGC. Girls are predominantly circumcised before the age of five, but only clitoridectomy and excision are common (Shay et al. 2010; DHS 2016). The majority of circumcised girls is cut by traditional circumcisers (62.3), or by health workers (22.6 per cent) which indicates medicalisation of the practice (Shay et al. 2010). Most frequently (38.7 per cent) the mother decides whether a girl should be cut, but fathers also decide (24.5 per cent) or parents decide jointly (22.6 per cent) (Shay, Haidar, and Kogi-Makau 2010). Almost 90 per cent of the city residents reported that circumcision is not required by religion, but FGC is rather performed because of cultural and traditional reasons (Shay et al. 2010).

3.1.6.2 Afar

The Afar region is predominantly inhabited by the nomadic Afar people. The Afar society is patriarchal, with leadership roles for men only. The vast majority of the inhabitants of the Afar region are Muslim (95.3 per cent) (CSA 2007). The Afar people value their ethnic identity highly, and they live secluded from other ethnic groups (Olsen 1996). In the Afar region, the households are the poorest in Ethiopia and the primary school attendance rate is the lowest in the country. Almost 70 per cent of the women have had no education. Women earn less than their husbands. Husbands decide on how to spend their wife’s earnings, and almost 20 per cent of the women is not involved in any decision-making process. Furthermore, 69 per cent of the Afar women justify wife beating. Krall contributes this number to the inequality of the sexes (2011).

Over 85 per cent of the Afar people live in rural communities with collective land possession in traditional pastoralist tents (CSA 2007). Clans are important in the region and clan members share a collective responsibility (Uhlig 2003). If a clan member commits a crime, the affected clan will either start a war of reprisal or asks for compensation. In rural areas the stage in lifecycle is important, with older Afar people playing a role in terms of solidarity and social control in ceremonies or festivals (Uhlig 2003).
Almost one in five Afar women marry in a polygynous union with multiple (co-)wives. Parents are deciding in 82 per cent of the cases about marriage, with the first marriage being a cross-cousin marriage, because kinship is classificatory (Uhlig 2003). Afar people marry within their own clan.

In the Afar region 91.2 per cent of the females is circumcised, with higher numbers among the Afar ethnic group (table 2). Generally girls are cut before they reach the age of five, and almost 70 per cent is infibulated. The majority of the Afar people regard FGC as a religious requirement (74.6 per cent), explained as follows by Save the Children Norway-Ethiopia and Partners:

“In Afar, circumcision is defined as a religious act performed on girls to maintain cleanliness, preserve virginity and good health and to increase matrimonial opportunities. The cutting is organized as a tri-annual event in connection with Islamic holidays (Id) and is perceived as closely associated with Islam.” (2009, p.8)

This quote illustrates the intersectionality of religion, culture, believes, but also economy, given that a girl only enjoys economic security when married. FGC is usually carried out by an aged woman, a traditional circumciser, from the same or a neighbouring village. Almost 70 per cent of the Afar people supports continuation of FGC.

3.1.6.3 Amhara

The vast majority of the Amhara region inhabitants are Orthodox (CSA 2007; Andualem 2016). Through migration, trading networks, intermarriage and their size the Amhara have a great political influence on the federal government level (Uhlig 2003). The Amhara live in compounds, and their households function as units of political economies, rather than kinship units (Uhlig 2003). Over 85 per cent of the population lives in rural areas (CSA 2007). One single senior male assigns tasks to members of the community to work on the communal owned land, based on gender and status markers (Uhlig 2003). In general, household decisions are taken jointly, with a relative dominance of men (Haile, Bock and Folmer 2012).

Similar to the Afar region, parents decide on who to marry in 83 per cent of the marriages. The Amhara people are not allowed to marry closer than seven houses, so they marry outside their community in a monogamous marriage (Uhlig 2003).
The regional prevalence is with 62 per cent just below the national average. Traditionally, the Amhara people circumcise boys 8 days after birth, and incision girls 7 days after birth (Aspen 2001). In Amharic both actions are described with the same word, gerzät (Aspen 2001). A priest is often present to bless the infant, both sexes, in order to clean children from their impurity so they can enter a church. In the Amhara community, circumcision for boys and girls is thus comparable, since the age and rituals are similar. The most commonly practiced type of FGC is clitoridectomy (Uhlig 2003; Andualem 2016). Usually, girls are circumcised because of community acceptance (24 per cent), culture (18 per cent), marriageability (19.5 per cent), preservation of virginity (11.5 per cent) and religion (8 per cent) (Andualem 2016). Contrary to the Afar ethnic group, almost 75 per cent of the Amhara people believe that FGC is not required by religion and over 80 per cent is against continuation of the practice. Remarkable is that more than half of the population studied by Andualem declared that decisions on infants’ circumcision were made by husbands (2016).

3.1.6.4 Harari

The region of Harari has a low population density, with only 0.2 per cent of the Ethiopians living in this region. The population consists of approximately 180,000 inhabitants, mostly Oromo (103,468), Amhara (41,768) and Harari (15,863) (CSA 2007). The Oromo and Amhara people mainly live in the rural areas as farmers, whereas the Harari are predominantly relative wealthy merchants and reside in the city of Harar (Olsen 1996; Uhlig 2003). The Harari marry within their own ethnic group and discourage social contacts with other ethnicities (Olsen 1996). The inhabitants of the Harari region are for 70 per cent Sunni Muslim, predominantly the Oromo and Harari people, and 27 per cent is Orthodox (CSA 2007). Almost 60 per cent of the women and 75 per cent of the men have enjoyed some education, with the second highest secondary education complement and literacy rate in the country (DHS 2015). Usually, women are involved in decision-making processes, for instance in what to do with her earnings. Three out of five men in the Harari region engage in household chorus, which is relatively high in comparison with the national average. Also, 60 per cent of the women do not accept wife beating and 75 per cent is allowed to choose their own husband, mostly in a monogamous marriage. Altogether these numbers indicate a certain level of empowerment of women in the region.
Around 82 per cent of the females has been circumcised in the region, mostly between the age of five and nine (51.4 per cent) or ten to fourteen years old (28 per cent). FGC, generally clitoridectomy, is regarded as a religious requirement by one third of the population (Abathun et al. 2016). This type of cutting is locally referred to as *Sunnah*, because of the alleged Islamic obligation as explained in paragraph 1.3.

Rahlenbeck and Mekonnen examined in 2009 that FGC in the Amhara region was exclusively performed by untrained individuals (traditional circumcisers or TBAs). The reasons behind FGC can be found in restricting sexual behaviour of girls, because inhabitants of the region believe that removing the clitoris makes girls calm and sexually inactive (Abathun et al. 2016). Social acceptance was also mentioned as a reason for performing FGC, in which encouragement by elderly women plays a role in the decision-making process whether or not to perform FGC on daughters (Oljira, Assefa and Dessie 2016).

### 3.1.6.5 Oromia

In the Oromia region 85 per cent of the inhabitants identify themselves as belonging to the Oromo ethnic group (Rahlenbeck, Mekonnen and Melkamu 2010). The region has approximately 27 million inhabitants (CSA 2007). The region is heavily populated and hosts 36 per cent of the Ethiopian population. Over 85 per cent of the inhabitants live in the rural areas of the region, which could be explained by main occupation of the Oromo people, farmer or pastoralist (Olsen 1996; Uhlig 2003). Almost half of the inhabitants of the region are Sunni Muslim, over 8 million are Orthodox and 5 million Oromia inhabitants are Protestant (CSA 2007).

About half of the female population did not enjoy education. The literacy rate of women is below the national average, for males it is just above. Almost 70 per cent of the women engage in decision-making processes, which indicates that women are relatively empowered. However, the region is also known for the highest level of marital control (22 per cent), a high level of spousal violence (38 per cent) and a high justification rate of wife-beating by women (67 per cent).

Women in the Oromia region marry mostly via patrilineal descent, often decided upon by their parents (61.2 per cent). Fourteen per cent of the women marry in a polygamous union.
The prevalence rate of FGC is above national average. Reasons for FGC vary from reducing female hyperactivity in sexual practice (60.3 per cent) to preventing girls to engage in sexual behaviour before marriage (25.1 per cent) (Yirga, Kassa, Gebremichael and Aro 2012). During the Sinana Project evaluation a community member reported that an uncircumcised married women would destroy house utensils (2012). Around two per cent is infibulated in the region, but this number differs per community, because Yirga et al. found an infibulation prevalence of 10 per cent in the Kirsa district, Oromia (2012). Girls are not cut on a specific age, however, only ten per cent is cut after her fifteenth birthday. In the region, 70 per cent of the women and almost 80 per cent of the men believe that FGC is not required by religion, additionally over 80 per cent is against continuation of the practice.

3.1.6.6 Somali

The inhabitants of the Somali region in eastern Ethiopia are Sunni Muslim Somalis similar to the Somalis living in Somalia, with the exception of a small number of other ethnic groups living in the region (Levinson 1998). The region has never been a main priority of the Christian government, resulting in few facilities and an alleged famine campaign initiated by the federal government in 2000 to attract international aid to the country (Khalif and Doornbos 2002). Somalis are pastoralist nomads, mainly having camels as livestock (Khalif and Doornbos 2002; Uhlig 2003). The Somali society is organised in six large clan-families, that are divided in thousands of clans and sub-clans (Uhlig 2003). Patrilineal descent is the first fundamental principal of the Somali society, with social contracts within and between lineages as a second principal (Uhlig 2003).

The region has the highest proportions of both females and males without education, and the lowest literacy rate in the country, but the DHS 2016 does not state whether or not this numbers includes Islamic education. It is the second poorest state within Ethiopia. Husbands are least likely to participate in household chores in the region, compared to the rest of Ethiopia. The Somali women are least likely to negotiate sexual relations with their husband, rather the husband decides when they will have sexual intercourse. This is contradicitive to Somali women reporting to experience the least spousal violence and marital control in the DHS 2016. This could be the result of a low level of empowerment of Somali women, thus they do no experience violence and marital control as such, rather as part of their culture.
Almost 30 per cent of the women live in a polygamous union, mostly decided upon by themselves (67.9 per cent). The fertility rate is 7.2, which only eight per cent of the Somali women wants to limit. Somali women do not use modern contraceptives at all.

The Somali region FGC prevalence numbers are similar to Somalia. Almost 75 per cent of the Somali women are infibulated, which is high in comparison to the rest of Ethiopia yet similar to Somalia. Most of the Somali girls are circumcised between the age of five and nine (61.8 per cent) or between ten and fourteen (24.5 per cent). In the Somali society mothers are responsible for daughters, and fathers for sons. Hence mothers play a major role in the decision of circumcision (Abathun et al. 2016). Stigmatization of uncircumcised women plays a role in the continuation of the practice (Abathun et al. 2016). Also, over 56 per cent of the women living in the region believes that FGC is required by the Islam and that FGC helps to prevent rape (2too many 2013; DHS 2016). About the same percentage favours continuation of the practice.

3.1.6.7 Southern Nations, Nationalities and Peoples’ Regional State
The SNNPRS is inhabited by different ethnic groups, like the Gamo, Guragie, Hadiya, Sidama and Welaita, all making up for at least one fourteenth of the total inhabitants. There is no ethnic majority like in the other regions. The anthropologist Data De’a claims that “there is a high-level of shared cultural knowledge and practices across this region.” (2000, p.165). The majority is Protestant (57 per cent), but other religions adhered to are Ethiopian Orthodox (18.5 per cent) and Islam (13.6 per cent) (CSA 2007). SNNPRS is Ethiopia’s most rural region. Because of the great variety of ethnic groups in the SNNPRS, it is difficult to write a regional profile without generalizing. Clanship is really important in the region, with everyone belonging to a qomo for the rest of his or her life, that constitutes one of the basic forms of personal identity (De’a 2000). Because of the importance of the qomo and its extension to the whole of Ethiopia, people will always ask each other which clan they are part of (De’a 2000). The ethnic groups in SNNPRS are interdependent, and interact on different levels like trade, ritual exchanges and marriage in which clan exogamy and polygamous unions (16 per cent) are common (De’a 2000). Over 50 per cent of the women can decide for herself who she wants to marry.

About half of the women enjoyed some form of education, however, the percentage of both sexes who completed secondary education is the lowest in the country. Approximately one thirds of
women and two thirds of men are able to read and write. Women in SNNPRS are the least involved in decision-making processes compared to the national level (61.1 per cent v. 70.6 per cent) and almost two third of the women justify wife-beating. Many women in the region experience marital control by their husbands.

The prevalence of FGC is below national average (figure 5). It is mostly performed on girls younger than fourteen years old, with an almost equal dispersion between the age groups below five, between five and nine and ten to fourteen year olds. The region has the highest rate of after fifteen circumcision. In the Kembatta/Tembaro zone girls are cut when they are between 12 and 18 years old as part of the celebration for becoming a woman (Dagne 2009). Around eighty per cent of the females and ninety per cent of the males do believe that FGC is not a religious requirement, and even more inhabitants of SNNPRS believe that the practice should not continue.

### 3.1.6.8 Tigray

The Tigray province is inhabited by the Orthodox Tigrigna, who are predominantly nomadic pastoralists (Olsen 1996). It appears from the DHS 2016 that the literacy rate is above average for both sexes. Three per cent of the inhabitants of Tigray live in polygamous unions. Parents decide in eighty per cent of the cases about marriage. Women are relatively empowered, visible in the high percentage of women who reported that they can negotiate (safe) sexual relations and the joined decision-making process of money expenditures. Man are more engaged in households chorus than their national counterparts and women report that the marital control of their husbands is relatively low.

The prevalence of FGC is lowest in the Tigray region, but when carried out predominantly before the age of five (93 per cent). The practice of infibulation is almost absent. One in five women believes that FGC is required by religion. The continuation of the practice is least supported by women in the Tigray region. Remarkable is that women oppose the practice more than men, while in every other region except Amhara, men are more often against continuation than women.
3.2 The Federal Republic of Somalia

The Federal Republic of Somalia is the most eastern country of the African mainland. The country borders Kenya, Ethiopia and Djibouti as illustrated in figure 6, and has a coast line of 2,385 km (CIA 2017). The capital of Somalia is Mogadishu. The country gained independence from Italy and Britain in 1960 and formed the new nation of Somalia by the joining of British Somaliland (Somaliland in figure 6) and Italian Somaliland (Puntland, and Central and South Somalia in figure 6). Nine years after independence Mohamed Siad Barre seized the power in a coup. He established a socialist rule that was characterized by its brutality, though he installed social programmes like literacy campaigns and anti-FGC campaigns, and he advocated for more individual rights for women (Nelson and the American University 1982; Greenfield 1991; Besteman 1999; Osman 2017).

The authoritarian regime collapsed in 1991, mainly because of the efforts of the rebel group United Somali Congress (USC), and was followed by a civil war that “destroyed what national governance structures remained, dividing Somalia into a patchwork of clan fiefdoms” (Bruton 2010, p.6). The professor African history Lidwien Kapteijns explains the growing importance of clans during Barre’s administration by the regime’s capacity to exploit clan feeling with for instance collective clan punishments resulting in reinforcement of the clan construction (2013). During the last years of Barre as head of state, the USC had been starting to advocate against the Marehan, a sub-clan of the Daarood clan that Barre belonged to, by developing clan hate-narratives. Clan-based militias emerged in which “collective clan-based brutalization of civilians associated with the other side became the strategy of habit” (Kapteijns 2013, p.157). This led to “a campaign of clan cleansing that turned ordinary civilians, outside any mediating state institutions, into both perpetrators and victims of communal violence” after 1991 (Kapteijns 2013, p.192). Thus, the difference between the USC and Barre’s ‘clan’ campaign was that the violence was no longer delivered by way of state institutions, but by civilians.
The lack of a central government following the fall of Barre resulted in the development of a few democratic administrative structures, mostly in the northern part of Somalia. The former British Somaliland declared the independent Republic of Somaliland, with its own capital Hargeisa (figure 6). The de facto state has had a relatively stable existence since May 1991 with a democratically elected government, government institutions, a police force and an own currency (Harper, M., International African Institute, Royal African Society and Social Science Research Council 2012; Renders 2012). However, despite efforts Somaliland has not been recognized internationally. Hence Somaliland will be treated as a part of Somalia in this thesis.

After the collapse of Mohamed Siad Barre’s government it took eight years until a Transitional National Government (TNG) was formed in 2000 and subsequently the Transitional Federal Government (TFG) in 2004 (Osman 2017). Meanwhile a group of Sharia Courts united themselves in the Islamic Courts Union (ICU) to form a rival administration to the TFG. The ICU assumed control of the southern part of Somalia and directly imposed Sharia law in controlled territories. After the ICU was defeated by the TFG and its Ethiopian allies in January 2007, the ICU splintered into multiple fractions including the militant organisation Al-Shabaab. Al-Shabaab has been carrying out terroristic attacks in mainly Central South Somalia as well as neighbouring countries, for example on the SAACID office as described in chapter 2 and the recent car bomb on Saturday 14th of October 2017 in Mogadishu that left over 275 people dead and destroyed a central part of the city (BBC 2017; Osman 2017).

On August 20, 2012, the Federal Government of Somalia (FGS) was established, right after a new constitution was adopted. Despite these efforts, Somalia has been regarded as a failed state since the early nineties. The American think tank Fund for Peace has been publishing the Fragile States Index since 2005, in which Somalia has been dominating the top two for the past ten years (2017). The scholars Bruton et al. summarized it as follows: “Even among failed states-those countries unable to exercise authority over their territory and provide the most basic services to their people-Somalia stands apart.” (2010, p.vii). The instability of the country is also visible in the number of IDPs in Somalia and Somali refugees in neighbouring countries. UNHCR estimated the number of IDPs around 1.5 million, and the number of refugees in neighbouring countries at 875,664 (2017).
3.2.1 Demographics
Due to the absence of a government for years and the instability in the country, a data gap on multiple topics exists. The country is for instance not ranked in the HDI, even though it is clear from the existing data that Somalia is among the least developed countries in the world. Somalia has a population of 10,817,354 inhabitants. Almost 40 per cent of the inhabitants live in the cities, with 2.138 million Somalis living in Mogadishu (CIA 2017). Over 80 per cent of the population faces multidimensional poverty (HDI 2016).

Somalia is ethnically almost homogenous. The population consists for 85 per cent of Somalis, with Bantu, Arabs and non-Somali making up the rest of the population (Nelson et al. 1982; CIA 2017). The Somali identity is based on a shared language, culture, adherence to Islam and membership of one of the six regional clans: Daarood, Isaaq, Hawiye, Dir, Rahanwayn, and Digil (Nelson et al. 1982; Levinson 1998). The Rahanwayn and Digil clan are living in the south and they farm while living a sedentary lifestyle. Together, they make up for around 20 per cent of the Somalis (Nelson et al. 1982). The first four clan-families however, are living a more nomadic lifestyle in the central and northern regions while raising livestock (Levinson 1998; Osman 2017). Membership of those clans is traced through males from a common male ancestor, but the clan system is flexible with movements possible for the purpose of protection, marriage, labour or political reasons (Nelson et al. 1982; Besteman 1999; Osman 2017). Like the Afar people in Ethiopia, Somali clans share a collective responsibility. Non-Somalis are seen as inferior because they are not part of one of the clan families, and therefore they are often discriminated against (Uhlig 2003; Harper et al. 2012).

The official state languages are Somali and Arabic, adopted in the 2012 Constitution (Article 5). The Somali language was introduced in 1973 by Barre, to unite the former colonies in one national language. Yet, Italian and English are still spoken as a result of former colonisation. The official religion of the country is Sunna Islam: “No religion other than Islam can be propagated in the country” and “No law can be enacted that is not compliant with the general principles and objectives of Sharia’ah” (Somalia 2012, Article 2).

The maternal and infant mortality rates are in the top three worst in the world. Moreover, the country has the fourth highest fertility rate with an average of 6.6 children born per woman (HDI 2016). The life expectancy is 54.1 years for males and 57.4 years for women (HDI 2016).
The Somali society is patriarchal, with clan elders making the majority of decisions (Dini 2009; Osman 2017). The anthropologist Grassivaro Gallo claims Somali women are not allowed to participate in communal meetings and their opinions are only valuable when supported by men (1985). The degree of patriarchy is visible in over 75 per cent of the females justifying wife beating (World Bank 2006) and the female enrolment rate in school that is half the rate of boys (UNESCO 2007). The 2006 Multiple Indicator Cluster Survey (MICS) showed that 75 per cent of the adults was illiterate, with greater literacy number for females in Puntland (36.1 per cent) and in Somaliland (44.1 per cent) (UNICEF Somalia Support Centre 2014a; 2014b).

### 3.2.2 Geography

The country of Somalia has a total area of 637.657 square kilometres, that is – like Ethiopia – predominantly used for agriculture (70.3 per cent; CIA 2017). Agriculture is accounting for almost 40 per cent of the GDP and 50 per cent of the export earnings (CIA 2017). Somalia borders the Gulf of Aden to the north and the Indian Ocean to the East. The population is mainly living in the areas in and around the big cities. Puntland, the central regions and the regions bordering Kenya are less populated. A 2002 UNICEF report summarized the environment as follows: “Nature too, has been unkind to Somalia. The country is constituted largely of vast stretches of desert and arid lands where people have traditionally led a nomadic pastoral life. With rapid soil erosion and land degradation, recurring drought has become common.” (p.16).

### 3.2.3 Administrative divisions

Somalia is divided into 18 gobolka (regions) as illustrated in figure 7. The state structure is described as a parliamentary representative democracy republic. The Somali government does not recognise the secession of Somaliland, that claimed its independence in 1991. The
organisation of Somaliland directly after secession was mainly clan based, with clan elders having the power and deciding upon issues. However, Somaliland evolved into a state “with a strong executive controlling state power and resources” (Renders 2012, p.226) and a pluralistic political system with a three-party system to avoid formation of clan parties (Harper et al. 2012). The organisation Freedom House analyses freedom and democracy around the world, and developed a state index of global freedom. They ranked Somaliland 145 of 211 (Freedom House 2017). It is the only (self-declared) state in the Horn of Africa that is regarded as partly free, also surpassing countries like Russia and China. Somalia is ranked 203rd in this index, illustrating the difference in governance.

In 1998 the north-eastern part of the former Italian Somaliland declared the autonomous region of Puntland in order to deliver services to its population, because of the absence of a Somali government. The region of Puntland is self-governing but does not aim at independence like Somaliland.

3.2.4 FGC in numbers and areas

The prevalence of circumcised women in Somalia is the highest in the world (UNICEF 2016). The Somali population predominantly refers to FGC with the word *Sunnah*, that denotes every form of alleged religious required circumcision, as described in paragraph 1.3. The Nugal region has the lowest prevalence, yet 97.4 per cent of the women are circumcised in this region (UNICEF Somalia Support Centre 2014a). The anthropologist Gallo examined the support for FGC among women, from which he concluded that the practice is supported by women from all over the country, regardless the ethnic group they belong to (1985).

When women are not circumcised, they are often stigmatized: “A failure to circumcise daughters may result in a long-lasting stigma and shame on the girl and her mother. The word “*buuryo qab*” (uncircumcised), which is the worst kind of insult a Somalian can hurl at another Somali, is frequently said to the daughter by her age-mates.” (Gele et al. 2013b, p.2; see also: Crawford and Ali 2015). On top of that, man have to prove their strength, virility and worth of a man by penetrating an infibulated woman, Crawford and Ali found (2015). He will be judged by his capacity to do so, and if the woman is either de-infibulated before the wedding night or opened by him with a knife, he will be regarded weak. For practitioners, infibulation is more profitable, given
that infibulation costs around 50 USD, whereas Sunnah is cheaper (Crawford and Ali 2015). In table 3 a summary of the FGC and infibulation prevalence is presented per region.

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage of women circumcised</th>
<th>Percentage of women infibulated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awdal (SL)</td>
<td>99.4</td>
<td>79.8 (2014b)</td>
</tr>
<tr>
<td>Bari (PL)</td>
<td>97.7</td>
<td>83.4 (2014a)</td>
</tr>
<tr>
<td>Maroodijeex/Saaxil (SL)</td>
<td>98.7</td>
<td>82.9 (2014b)</td>
</tr>
<tr>
<td>Mudug (PL)</td>
<td>98.8</td>
<td>90.7 (2014a)</td>
</tr>
<tr>
<td>Nugal (PL)</td>
<td>97.4</td>
<td>87.6 (2014a)</td>
</tr>
<tr>
<td>Sanaag (*)</td>
<td>99.7</td>
<td>87.5 (2014b)</td>
</tr>
<tr>
<td>Sool (*)</td>
<td>99.3</td>
<td>88.3 (2014b)</td>
</tr>
<tr>
<td>Togdheer (SL)</td>
<td>99.4</td>
<td>91.6 (2014b)</td>
</tr>
<tr>
<td>Central South (2006)</td>
<td>99.2 (2006)</td>
<td>-</td>
</tr>
<tr>
<td>Mogadishu</td>
<td>-</td>
<td>77.5 (1985)</td>
</tr>
<tr>
<td>Lower Shabellei</td>
<td>-</td>
<td>47.8 (1985)</td>
</tr>
<tr>
<td>Gedo</td>
<td>-</td>
<td>74.4 (1985)</td>
</tr>
<tr>
<td>Ogaden</td>
<td>-</td>
<td>94.1 (1985)</td>
</tr>
<tr>
<td>Middle Juba</td>
<td>-</td>
<td>66.7 (1985)</td>
</tr>
<tr>
<td>Lower Juba</td>
<td>-</td>
<td>71.9 (1985)</td>
</tr>
</tbody>
</table>


### 3.2.5 Eradication efforts

#### 3.2.5.1 Legislation against FGC

The 2012 Constitution of Somalia banned all forms of female circumcision in Article 15: “Female circumcision is a cruel and degrading customary practice, and is tantamount to torture. The circumcision of girls is prohibited.” (Article 15(4)). As elaborated upon in chapter 1.5, Somalia did sign and ratify international treaties that are either directly mentioning FGC or are indirectly attributable to FGC. In addition to ratifying the CRC and signing the Maputo Protocol, Somalia ratified, like Ethiopia, the ICCPR and the ICESCR in 1990.
The Constitution of the Republic of Somaliland is less clear when it comes to banning FGC: “the Government shall encourage, and shall legislate for, the right of women to be free of practices which are contrary to Sharia and which are injurious to their person and dignity” (2001, Article 36(2)). Given that it is still debated in Somaliland whether Sunnah is against the Islam, this article does not provide protection against all forms of FGC (Newell-Jones 2016).

3.2.5.2 Government efforts

In 1988 the Barre administration endorsed a campaign to eradicate FGC in Somalia in its totality, however, due to the overthrown of the regime the campaign collapsed (Rahman and Toubia 2000; Gele et al. 2013a). During the years that followed, no administration was governing Somalia, so no governmental efforts were possible. However, NGOs and local organisations started advocacy campaigns against FGC, but as Gele et al. presented in their research, no real progress was made past thirty years (2013a). Today, the federal government’s position is zero tolerance to FGC, and three key ministries are concerned with the abolishment of FGC: The Ministry of Labour and Social Affairs in Somaliland, the Ministry of Women’s Development and Family Affairs in Puntland and the Ministry of Women and Human Rights Development in the southern and central part of the country (Crawford and Ali 2015). Additionally, Crawford and Ali report that government-owned FGC Task Forces are established with UNFPA and UNICEF support, but government authorities encounter difficulties in funding, access to communities and lack of consensus among religious leaders (2015).

The Puntland Ministry of Religious Affairs and Endowment has issued a fatwa, an legal opinion within the Islam, against FGC in all its forms. Almost twenty religious leaders in Puntland signed the fatwa, stating that FGC has no roots in Islam (UNICEF Somalia 2013). Because FGC is predominantly justified by religion in Somalia, it is seen as a step forward in the abolishment of female circumcision. Furthermore, the Puntland administration drafted an anti-medicalisation strategy, but a lack of funding halted this effort (Crawford and Ali 2015).

The Minister of Religious Affairs in Somaliland is also supportive of work towards a fatwa. However, there is a lack of understanding among sheikhs in rural areas who stick to supporting Sunnah and insufficient funds (Crawford and Ali 2015).
3.2.5.3 NGO activity

Many NGOs are active in Somalia, partly because of the high prevalence of FGC in the country, but also because of the absence of a government for years. An overview of NGOs working in the field of FGC eradication can be found in annex 3. However, Chege et al. claim that the result of the NGO presence and interventions are limited: “The study shows that the prevalence and support towards the practice among the people of Hargeisa is similar to the prevalence recorded in Somalia three decades ago. This demands an alternative approach other than continuing the status quo.” (2013a, p.8). These findings are confirmed by the high prevalence rate of FGC today, which indicates that little change occurred.

3.2.6 Social-cultural contexts

Data is wider available for the northern regions Puntland and Somaliland than for Central South Somalia. Given that they are considered more stable, more NGOs are active in the northern part of Somalia. Because of the data gap, I will discuss Puntland, Somaliland and Central South Somalia as three distinct areas instead of zooming in on administrative regions. This will result in a generalisation, given that the different regions within those areas are not completely homogenous in culture. However, the advantage of this classification is that it will give a more complete overview. Moreover, many different reports use this classification as well, so it is convenient to use the same categorisation.

3.2.6.1 Puntland

The most recent data on the situation of children and women in Puntland is published in the *Northeast Zone, Somalia – Multiple Indicator Cluster Survey 2011: Final report 2014*. The data in this paragraph is copied from this report, unless indicated otherwise. The survey was undertaken in three regions: Bari, Nugal and Mudug. The boundaries of three more regions are disputed with Somaliland and are covered in the MICS for Somaliland.

The literacy rate in Puntland is 36.1 per cent, thus above the national average. Higher rates can be found in the urban regions and among the richer households. The primary school attendance rate
Efforts towards a FGC-free world – F. van de Ven

is 43 per cent, with nine girls attending school for every ten boys. Nationwide, three out of four women accept wife beating, but in Puntland only 35 per cent of the women would accept it, mostly for refusing sex. In the MICS, the assumption is made that the answers to the question reflect reality and culture (2014a).

Around one in five women are married in a polygynous union, with an increase in number with increasing age. Twelve per cent of the Somali women marry before the age of 15 in the Puntland region. The poorer the family the more chance to marry before 15. This could be explained by the economic security that a married woman enjoys. For poor families it is thus beneficial if girls marry young, so families do not carry the burden of feeding a daughter anymore. Over 35 per cent of the 15-19 years old is married to a man who is older by at least ten years. Again, intersectionality of culture, religion and economy can be identified.

The majority of the inhabitants is pastoral or agro-pastoral, with over half of the population having nomadic livelihood (Crawford and Ali 2015). During the rainy season those nomadic groups remain in one area. Therefore, FGC is only performed during this season in Puntland, in general on girls aged 10-14 years old, so that they have the time to heal when the family is not moving (UNICEF Somalia Support Centre 2014a; Crawford and Ali 2015). Girls usually undergo FGC in groups, with urban families sending their children to rural communities to be cut. Girls are predominantly cut by TBAs, but also – to a lesser extent – by health professionals who visit the girls at home. The mothers host a celebration after the procedure, because FGC is considered a milestone in the whole of the country (Crawford and Ali 2015).

The main form practiced is infibulation, with a subtype existing only in some rural, nomadic communities in Puntland and Central South Somalia, Fadumo Hagoog (Crawford and Ali 2015). This type of infibulation does not involve any stitches, presumably because the communities do not have the proper tools to stich girls up, but the amount of flesh removed is similar to other types of infibulation. Therefore, the amount of time to recover from Fadumo Hagoog is longer, because the wound is unprotected and open during healing (Crawford and Ali 2015).

Around 58 per cent of the women support continuation of FGC. Approval of continuation of the practice increases with a decrease in level of education and wealth. Furthermore, women in the Mudug region are more likely to believe that the practice should be continued (61.1 per cent v. 53.3 per cent in Nugal). The older women get, the more they believe that the practice should continue.
A small decrease is visible in the prevalence of infibulation. Among the 15-19 years old in 2011, approximately 80 per cent was infibulated, while the prevalence among 20-24 years old was 85.4 per cent, a number that is even higher among elders. This change in type of cutting among younger girls predicts a further decline for infibulation in the future.

3.2.6.2 Somaliland

All the statistics in the next section are retrieved from the *Somaliland – Multiple Indicator Cluster Survey 2011: Final report 2014* unless referenced differently. The survey focused on five different regions, namely: Maroodijeex/Saaxil, Awdal, Togdheer, Sool and Sanaag.

In terms of literacy rate and education, Somaliland is leading in Somalia. Among the age group 15-24, 44 per cent of the women is literate, with higher rates for urban and/or females from rich families. The attendance rate in primary school is around 50 per cent, with nine school going girls per ten school going boys. As elaborated upon before, the Somali society is patriarchal (Dini 2009). Over 50 per cent of the women justifies wife-beating in Somaliland, which is significantly higher than in Puntland. In general, women do not have a voice in decision-making processes. An exception is Edna Adan Ismael, who was appointed Minister of Family Development and Social Affairs and subsequently Foreign Minister, but she is one of few examples (Renders 2012).

The MICS shows that on average 8.7 per cent of the women married before the age of 15 years old, yet a decline is visible. Only 2.3 per cent of the 15-19 years old entered into marital union before their 15th birthday in 2011. Around 17 per cent of married women are in a polygynous marriage, this proportion increases with age indicating that men often marry a new woman when the current wife is aging. Over 30 per cent of the 15-19 year olds is married to a man that is ten or more years older.

In Somaliland, the most prevalent cut is infibulation, which is linked to the economy Gallo and Abdisamed claim, because nomadic tribes practice infibulation more often than farmers (1985). They argue that women are infibulated again when men are traveling around to make sure women do not involve in any sexual relations when their men are absent (1985).

Research carried out by Gele et al. in the Hargeisa district in 2011 showed that 85 per cent of the Somalis intended to have their daughters circumcised (2013a). However, only 13 per cent of the
participants intended to subject their daughters to infibulation, motivated by maintaining the honour of the girls and preventing alleged adultery. It is also believed that FGC leads to a trustable marriage participants claimed (97 per cent). Because the society is patriarchal, marriage is critical for a woman’s economic security, whereas circumcision is necessary for marriage. The parents who intended to perform the *Sunnah* form, did so because FGC is regarded as a religious requirement (91 per cent) and they do not regard *Sunnah* as harmful. A topic that was discussed in paragraph 1.3. Hence FGC is performed for both cultural and religious reasons. The participants who were planning on not subjecting their daughters to FGC (14 per cent) were predominantly women, however, the vast majority of men reported that they would prefer to marry circumcised women (96 per cent) (Chege et al. 2013a). Those findings are different from Newell-Jones’ findings for the Orchid Project and Somaliland Family Health Association (SOFHA), who carried out a baseline survey on FGC prevalence in Somaliland in its entirely in 2017. One of her findings was that men appear to be more open to change than females, which she attributes to social pressure from female relatives for women. She observed an overall FGC prevalence of 98.9 per cent in Somaliland, with a decline in prevalence of infibulation among girls (2017; see also: Newell-Jones 2016). Evident suggests that the type of FGC is changing, yet the prevalence rate has not significantly changed. The prevalence rate could be maintained because almost 70 per cent of the community leaders do not discuss the topic of FGC in their communities and discussion about FGC between sexes is rare (Gele et al. 2013b; Newell-Jones 2016).

Newell-Jones 2016 observed that decision-making about FGC is the responsibility of women: “Men and boys are only involved in the decision-making process in 8% of households, however, they are influential in creating the social climate within which decision-making about cutting takes place.” (p.4). For women it is a difficult to decide whether or not to subject their daughters to FGC, because on one hand they do not want their daughters to experience the health consequences and pain they went through themselves, yet they want to ensure purity and virginity at marriage. It is remarkable that a “higher proportion of younger women aged 15-19, thought FGM/C should continue compared to older woman.” (UNICEF Somalia Support Centre 2014b, p.101).

The average age at which girls are cut is around 10 years old Newell-Jones found (2016). The majority of girls are cut by traditional cutters (Newell-Jones 2017). Yet there is evidence of a
growing trend towards the medicalisation of circumcision in urban communities, with 16 per cent of the women reporting that their daughters were cut by medical personnel (2017).

3.2.6.3 Central South Somalia

Central South Somalia refers to the region south of Puntland, illustrated in figure 7. This part of Somalia is more unstable than the northern parts due to recurring droughts, famines, presence of IDPs and of terrorist groups, hence less data is available (Crawford and Ali 2015). In 2014 the Federal Government of Somalia had control of only five of the eleven districts, the rest of the districts were controlled by Al-Shabaab (Crawford and Ali 2015). The data presented in this paragraph is duplicated from the Somalia – Multiple Indicator Cluster Survey 2006, unless indicated differently. The survey provides data on three regions: Somaliland, Puntland and the Central South in its entirely.

It becomes clear from the MICS 2006 that women from Central South Somalia report to have access to less facilities than the northern regions and that they are in general less developed. School attendance was for instance 13 per cent, while the national attendance rate was 23 per cent for children of primary school age in 2006. Moreover, the literacy rate was substantially lower in the Central South. A possible explanation could be that due to the absence of a central government or authority the region could not develop while the northern regions have developed their own institutions after declaring independence/autonomy.

One in ten girls married before the age of 15, while the northern regions reported 3 per cent (Somaliland) and 3.6 per cent (Puntland). The older the woman, the more likely she is married in a polygynous union. This high number is attributable to parents’ wishes for economic security for their daughters. The women in Central South Somalia report the topmost acceptance rate of wife beating. The fertility rate is the highest in this region, which could be linked to the theory that when incomes rise, fertility tends to fall (National Research Council 1986). It becomes clear from the survey that fertility rates decrease when education or wealth increases.

Girls in Central South Somalia are circumcised in groups at home around six and seven years old, which is slightly younger than in the other regions. As illustrated in table 3, the prevalence of infibulation is significantly lower in this region compared to Somaliland and Puntland. This could
be partly explained by the inhabitants of the Somali-Ethiopia border, where the Somali Bantu riverine community lives who does not practice any form of infibulation, like some rural communities of the *Rahanweyn, Reer Xamar* and *Reer Baraawe* clans (Crawford and Ali 2015). Also, the inhabitants of this region are predominantly settled farmers, so infibulation does not have to be practiced because of the nomadic lifestyle of the community. In some parts of the region the *Fadumo Hagoog* type of cutting is carried out by rural communities.

Whereas many women in Puntland and Somaliland indicate that they would not support continuation of the practice (respectively 65.9 and 44.5 per cent), women in Central South Somalia predominantly support continuation (79.5 per cent). Crawford and Ali found that in Mogadishu, the medicalisation of FGC was a trend (2015). Subjects of their study reported that practitioners of FGC are openly advertising on the streets. However, respondents also reported that those health workers do not practice infibulation, only *Sunnah*. When referring to the medicalisation discussion (paragraph 1.4), this phenomenon could be classified as either harm-reduction or as unacceptable. When looking at the prevalence rate of Somalia, the anti-FGC efforts past decades and the limited results of those efforts, firmly condemning medicalisation might be too short-sighted.

### 3.2.7 Concluding remarks

It becomes clear from chapter 3 that the motivation for, customs and believes surrounding FGC vary not only per country, but on community level as well. In both countries various factors are involved in maintaining FGC. In Ethiopia, the prevalence of FGC, type of cutting, reasons behind FGC and the average age of performance differ per region and community. Whereas Muslims predominantly report that FGC is a religious habit, the Ethiopian Orthodox believers practice and approve FGC from a cultural and traditional background. Differences in socio-cultural contexts can be identified in Somalia as well. Examples are age of performance, type of cutting and attitude towards continuation. The acceptance of *Sunnah*, as elaborated upon in paragraph 1.3, differs per region in Somalia. Moreover, in some regions the importance of economic security could be identified, that is strongly linked to maintaining FGC. Different factors intersect with regard to this security, that are not limited to economy, gender, religion, age and culture. Thus, both in Ethiopia and Somalia, different beliefs and practices specific act to perpetuate the practice of female genital cutting.
These findings call into question the accuracy of the WHO classification as introduced in paragraph 1.1 on page 12. One could argue that this classification is a simplification of the reality. The WHO only focuses on the physical execution of FGC, leaving behind other factors. Chapter 3 illustrates the complexity by taking into account the intersections of class, age, hierarchy, gender, economy and local customs regarding the practice. The adopted human rights framework fails to address the practice in its entirety. Following this conclusion, the WHO classification will still be used throughout this thesis. Yet with some reluctance, since this classification fails to address the complexity of the practice.

In this chapter we have seen ‘why’ and ‘how’ FGC retains strength in different communities by looking at different intersections and how they influence each other. The next chapter will set out which interventions have proven to be effective, and how we can understand these effectiveness in the context of Ethiopia and Somalia.
Chapter 4. Intervention analysis

The next chapter consists of an in-depth analysis of different interventions. The goal is to assess the effectiveness of those interventions by making use of the attitude continuum and the Transtheoretical Model as explained in paragraph 2.2. The effectiveness is evaluated by looking at the development of a long-term mindset change. The gathering of the interventions is described in paragraph 2.4 and an overview of the analysed interventions is attached in annex 3. The analysis is followed by an interpretation of the successes and failures in the particular socio-cultural contexts of Somalia or Ethiopia. The interventions are listed per country in a random order.

Given that most of the projects were reviewed by either internal consultants or a combination of internal and external consultants, the reported results might be biased. Østebø and Østebø claim that NGOs tend to present only the successful accounts of interventions (2014). Moreover, not every project started with a baseline survey beforehand, so results are often not compared to attitudes towards FGC before the intervention took place. Finally, some evaluations were carried out in the final phase of the project, while other projects were reviewed one year after termination. Therefore, differences in effectiveness could have been influenced by the time between the assessment and the project execution.

4.1 Interventions in Ethiopia

4.1.1 Integrated Community-Based Approach for Encouraging Abandonment of Female Genital Cutting

The CARE project in the Afar region ran from January 2001 till October 2002. From January 2002 till June 2002 little was done on project activities due to a severe drought, so the project facilitated humanitarian aid instead. The FGC abandonment activities were integrated in an existing health project. This resulted in continuation of the efforts after the project ended and, according to the consultants, to better results because discussion of FGC was part of a larger set off issues. The project was the first FGC intervention in the region.

The impact was measured by both a survey and Focus Group Discussions (FGDs). A 50 per cent rise in percentage of respondents that reported to be exposed to anti-FGC messages was detected, with no significant differences per age group. Awareness was significantly raised on negative
effects of FGC, yet the same increase was reported in the control areas. In terms of human rights violations “the change in beliefs among intervention men and women had increased to the extent that the intervention site respondents had significantly higher proportions (425% and 600%) than the control (90% and 70% respectively) site.” (CARE International 2004, p.25). Remarkable is that never married and young respondents were more likely to agree that FGC is a human rights violation. Support for abandonment of FGC increased with 145 per cent. However, awareness raising does not necessarily lead to action, as 78 per cent of the women and 42 per cent of the men reported to not undertake action. According to Prochaska and DiClemente, raising awareness is followed by getting ready to take action and taking action (paragraph 2.2; 2005). Therefore, a future continuation of the project might bring about collective abandonment of FGC.

The intervention programme targeted the inhabitants of the Awash region in Afar. Beforehand, CARE conducted formative research to develop context-specific activities. In the baseline survey was captured what the age of cutting was, who usually carries out the circumcision and where, circumstances like instruments and in groups or alone, and the person who decides upon circumcision. The circumstances in the intervention areas match in general the circumstances as described in paragraph 3.1.6.2. CARE did extensive research to develop a cultural-appropriate intervention, whilst keeping in mind, gender, age, the role of religion and social norms. The project departed from a health perspective, but human rights education was also included in the activities. Given that the intervention started in 2001, no limitations on human rights projects were introduced yet (paragraph 3.1.5.3). The project encompassed educational activities on community level and advocacy activities through key religious and community leaders. Early in the project, key religious leaders were targeted because of the central role religion plays among the Afar, which is described in paragraph 3.1.6.2. CARE believed that when bringing about a mindset change in religious leaders first, the rest of the community will – slowly – follow, because of the patriarchal Afar society. Endorsement of respected males is valuable, thus focusing on the most influential villagers is key CARE beliefs. The consultants confirmed this assumption, based on the survey and FGDs answers. The CARE strategy of playing a facilitative rather than an educative role, worked very well in this community, because the interveners were not regarded as western aid workers who were imposing their norms. Rather as neutral actors that provided information, fostered dialogue and advocacy, and supported change. The community members were the main actors. The theory behind this approach is that these activities will lead to individual change, that might result in
collective action by (small) groups, which ultimately results in social change. Therefore, this project is a positive example of a community-based project.

The sustainability was promising according to the evaluators. The awareness raising resulted in individuals and families taking positions publicly, and collective action by village elders. Approximately fifteen months after the campaign ended, seventy village elders both from the intervention and control sites publicly declared an end to FGC. Given that elders are highly respected in the Afar community and that they are role models, these results are hopeful. The fifteen months could be described as the Transtheoretical Model stage: maintenance of the new behaviour (Prochaska and DiClemente 2005). However, the declaration is not an assurance for termination of the old behaviour of practicing FGC, because women and men reported to have not undertaken action, which is necessary for complete behavioural change according to the Transtheoretical Model. Given that religious leaders are not deciding on whether a girl gets circumcised, but are rather role models and influencers, efforts should continue in the patriarchal Afar community.

When taking the duration of the project into account, the project can be evaluated as successful. The effectiveness was also confirmed by Susan Igras, a senior programme advisor for CARE USA, c.s. (2004). Yet, Igras works for CARE International hence the academic case-study could be biased.

**4.1.2 Awash FGC Elimination Project**
The Awash FGC Elimination Project is the follow up project of the prior described intervention (4.1.1) and took place in the Afar region from January 2003 until December 2005. Because the community is homogenous and FGC is deeply rooted, CARE targeted the entire woredas of Awash Fentale and Amibara. According to the report, different achievements were documented. An increase in the proportion of respondents who knew health effects and psychological effects FGC increased significantly. Additionally, a rise of 60 per cent was reported in support for abandonment of the practice. The consultants, who were not part of the CARE team, reviewed the project as successful. Yet sustainability was questioned, because of the short time the project ran and the community structure as explained below.

The project had multiple focus points, including HIV/AIDS, malaria, diarrhoea and family planning. Hence, this project departed from a health perspective. The health education packages
that CARE developed, broke the silence in the community to discuss the different health related issues, including FGC. Health problems used to be topics that were not discussed in the community, hence people had little knowledge about health. The population was targeted via education campaigns for health workers, women, religious leaders and children, thus targeted at specific age groups, level of education and gender.

CARE collaborated with the local government and religious leaders, which was evaluated as a success given that village development committees were compiled by the villagers themselves. Additionally, initiative from villagers was observed in punishment for parents who subjected their daughters to FGC. These activities assume sustainability, because the population was involved and initiated action. Questionable is whether it is desirable that villagers punish other villagers, instead of using either a local or a national legal framework. Society structures might change when neighbours start punishing each other, which is not an objective of FGC intervention. However, when considering this punishment in terms of the Transtheoretical Model, one could argue that punishment of others is corresponding with the last phase of the Transtheoretical Model, termination of old behaviour (2005). Thus, some community members adapted new behaviour, and acted in accordance with it.

Inter-village marriage is common in the Afar region and men from neighbouring villages who were not targeted by the campaign are still reluctant to marry uncircumcised women. Furthermore, it became clear from the FGDs that all the children were supporting abandonment, but not all of the parents. Hierarchy is important in the Afar society and girls are generally cut before the age of five, hence children as agents of change is not effective.

The perception of the Afar communities on CARE and the project itself were “extremely satisfactory” (CARE International 2005, p.5). The project collaborated with local stakeholders and sponsored trainings/workshops hosted by other organisations, and the community by providing essential health care items. Moreover, the impact of the media campaign was reviewed as very high.

### 4.1.3 Sinana Female Genital Mutilation Elimination Project

The evaluation report assesses the impact of the second phase (2010-2012) of the Sinana project in four rural kebeles in Oromia. This second phase incorporated the community specific
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recommendations from the first phase. The intervention was developed and implemented by EECMY-DASSC, a local Christian organisation. The evaluation was carried out by a team of experts consisting of external consultants and the interveners themselves. The whole evaluation was based on qualitative information. The intended activities were fulfilled, except for one audit charge and two repetition trainings of twelve planned. The evaluation team concluded that the objectives were reached: awareness was raised resulting in 85 per cent of the targeted community rejecting the practice, yet this assumption was made based on FGDs, it was not measured; government lines were strengthened with the goal to integrate the activities in the government’s regular duties after termination; and community and religious leaders were influenced to spread the message on a regular basis. Impact included open discussion, which was unthinkable before; the targeted Christian leaders started to believe that the Bible does not support FGC; and the majority of Muslim leaders as well. Noteworthy is that the interveners also conducted refreshment training for phase one representatives to ensure sustainability.

The whole community was addressed, with specific strategies for youth, women, FGC practitioners, religious leaders and government staff. On top of school campaigns, the project educated youth on how to prevent being cut during holidays. Given that girls are not cut on a specific age in Oromia, targeting girls directly to oppose getting circumcised is a suitable strategy for the Oromia region. The government played a notable role in the project, and representatives received many different trainings that consisted of ten rounds to improve capacity and to ensure sustainability. The project supported the development of grassroots level policies, in addition to federal government policies. This strategy is important when acknowledging that national policies are not always accepted on community level (Abbink 2011). Given that Muslims, Protestants and Ethiopian Orthodox people are living in Oromia, the project was well targeted at different religions by providing training for religious leaders from various backgrounds.

Good practices of the project include the integration of recommendations from former projects, refreshment training and targeting girls. Additionally, respected religious leaders, who were trained during the project, were asked to elaborate in subsequent training sessions on whether or not FGC was supported by holy books. This was reviewed as effective. Thus, the community hierarchy was utilized to obtain a greater impact. It is difficult to identify stages of behavioural change among the community members, but ingredients for a collective change were present by targeting the whole
community. The majority of the FGD participants rejected the practice, which is similar to the stage of getting ready of the Transtheoretical Model. However, as mentioned before, these numbers are disputable due to the lack of measuring impact.

4.1.4 No Girl or Woman Shall Undergo FGM: Accelerating Change towards Zero Tolerance to FGM in Ethiopia

This project was carried out by Norwegian Church Aid (NCA) in collaboration with Save the Children International (SCI), and implemented by 27 partners. Accelerating Change was the second phase of the project, and ran from 2011 until 2015 in Somali, Oromia, Afar, Amhara, Harari, Tigray and SNNPRS. The project was externally reviewed during the last months of the project, with the goal to provide recommendations for the third phase. The target of the second phase was to reduce FGC prevalence by 31 per cent in the intervention kebeles, that was presumably reached: “there are a good number of reasons to believe that FGM has nearly been abandoned in all sites visited.” (Svanemyr and Takele 2015, p.4). The programme was targeted at 70 kebeles in different woredas and it is estimated that the project reached 700,000 children and 1.4 million adults. Different indicators for the success are the registration of 112,878 uncut girls till 2014, the declaration of 8,206 men and boys who declared that they would marry uncut girls, six public declarations by religious institutions who denounced the practice and eleven national, regional and local level networks were strengthened. However, Jones, Gupta and Tefera argue that the report lacks evidence to back up the results reported by NCA and SCI (2015). Moreover, Jones et al. dispute the effect of boys that are willing to marry uncut girls, since parents often have to approve marriage in hierarchical societies (2015). Therefore, it is necessary that parents support abandonment of FGC, or agree upon marrying an uncut girl.

The consultants evaluated the project genuinely satisfactory. The project was holistic in both a multiple element and multiple level approach. Moreover, they valued the project for its community specificity, yet no examples were given. The interveners utilized community and religious leaders to spread the anti-FGC message. Training was given to youth, law enforcing officers, community leaders, religious leaders and students, and community conversations were organised for men and women. Additionally the Koranic school curriculum was changed to dismantle the alleged Islamic obligation for female circumcision. This change makes the prospects of abandonment realistic,
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since it is a form of taking action. So, when looking at the results published by NCA and SCI, action was undertaken, yet termination of old behaviour was not measured.

The sustainability is promising according to the evaluators, because the whole community is targeted, religious leaders support the project and government stakeholders are included. Given that federal government policies are hard to implement on regional level, collaboration with the local government is a good practice. Different government institutions declared to be well willing to continue efforts to end FGC in the community, what could be explained by the fact that the programme is closely aligned to government priorities and strategies (Jones et al. 2015). The consultants “consider there is very little risk that FGM will return and become common again but it cannot be excluded.” (Svanemyr and Takele 2015, p.30). In terms of a changed mindset, different TBAs stopped cutting girls, community and religious institutions made declarations on ending FGC and a critical mass emerged that said no to the practice. The attitude in this community shifted from collective support for the practice to both individual and collective actions against FGC continuation, hence progress towards a long-term mindset change was made because behaviour changed in terms of the Transtheoretical Model. However, Jones et al. claim that in the woredas of KAT zonal administration the “commitment to abandoning the practice is relatively shallow and that progress was short-lived and is being reversed in some areas.” (2015, p.37). Additionally, Jones et al. mention that the programme in SNNPR resulted in a worrying trend of parents having their children circumcised at an earlier age to prevent detection of FGC. Regarding some of the data, the findings of the evaluators are contradictory to the findings of the academic reviewers. However, Jones et al. noted a systematic change in government efforts to fight FGC and position papers of religious institutions, that they attribute to the long-term support and holistic approach of NCA and SCI (2015).

4.1.5 UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change
The Joint Programme ran from 2008 till 2012 and was designed for seventeen countries in Africa, including Ethiopia and Somalia (paragraph 4.2.2). The project aimed at strengthening national actors and local initiatives with the objective to contribute to a forty per cent reduction of FGC prevalence. A country specific evaluation for Ethiopia is lacking. The evaluation report is a general report for all countries the project runs in and was reviewed by a team of external consultants.
The UN programme is a human rights-based model, that supports multiple stakeholders on different levels of society. However, as will become clear in this chapter, a more health focused approach was utilized as well. The evaluation report states that the Accelerated Change Programme is a cultural sensitive approach “that places emphasis on a collective approach and seeks to motivate social dynamics that can lead to social change.” (UNFPA and UNICEF 2013b, p.52). Although five of the six intervention regions in Ethiopia declared publicly to abandon FGC, the evaluators concluded that the programme was not country specific and that the ‘one model fits all’ approach was not accurate for the set goal. UNFPA/UNICEF claims to have recorded a FGC prevalence of between zero and ten per cent in the six intervention districts. The evaluators found that the number of married girls that are uncircumcised increased past years and that over 400 communities collectively abandoned FGC. So on top of abandonment statements, action was undertaken. Therefore, according to UNFPA/UNICEF, a long-term mindset change was accomplished.

The interveners promoted open discussions, established a partnership with five faith-based organisations representing Islamic, Catholic and Orthodox leaders, and they established the first regional network of thirty representatives from the government, NGOs and civil society organisations working on the eradication of FGC. The collaboration of different stakeholders from different levels of society could be an effective way to interchange knowledge and best-practices. Moreover, parliamentary hearings were facilitated to discuss FGC, health professionals were trained to integrate FGC in health interventions in Afar, and religious leaders’ networks were created or expanded. Additionally, a registration-card system was introduced in Afar to track mothers and new-born girls to protect them and follow-up on FGC. The first four years a TBA is responsible for the follow-up, later on a girl’s teacher. These four years are important, given that girls are cut before the age of five in Afar and often on the seventh day (paragraph 3.1.6.2). However, over sixty per cent of the girls in Afar do not have access to education. Therefore, this card-system would be more effective when the follow-up would continue till at least a girl’s sixth birthday. Additionally, as mentioned in paragraph 3.1.5.1, law enforcement is still problematic.

The Center for Development Consulting (CDC) carried out a study to validate the findings in ten woredas who claimed to have abolished the practice. The CDC found that the prevalence rate under teenagers was much lower than under adult women in all sample areas. Yet, after facilitating FGDs, they suspected due to given answers that the practice has gone underground. Hence, the conclusion
was that “[t]he declaration itself was a useful mechanism to promote abandonment of FGM/C” yet collective action was not reached everywhere (Center for Development Consulting 2013, p.35). In terms of the Transtheoretical Model, the intervention communities are moving towards collective support for abandonment, yet efforts should continue in the future to bring about a long-term mindset change. Efforts that monitor cutting and try to prevent it from happening are the first step in total abolishment, but in order to eradicate FGC completely, new behaviour should be adapted and old behaviour terminated (Prochaska and DiClemente 2005)

4.1.6 Whole Society Strategy effort to address Female Genital Mutilation
The Population Media Center (PMC) started a nationwide health campaign to address FGC in 2007. The campaign consisted of Sibrat, radio talk shows, a radio magazine, capacity building workshops, books, numerous tv and radio spots and leaflets that were distributed in three national languages. All of the actors, writers, production staff and other co-workers were locals, to ensure cultural appropriateness.

Sibrat (“Trauma”) is a 226-episode radio serial drama, that aired twice a week in Amharic from September 2007 to the beginning of 2010. Sibrat was developed to address female circumcision via encouraging self-reflection and discussion. Other, mainly health related, topics were discussed as well, yet FGC was the main focus of the project. Sibrat was extremely popular PMC claims, based on the thousands of letters they received from listeners. Each episode is 25 minutes long and consists for seventy per cent of entertainment. The episodes are still available online

PMC has developed a specific methodology for entertainment education, in order to reach the desired goal. First of all, extensive research is done in the intervention area, to identify issues, local laws and policies in order to develop a culturally-specific story. Throughout the broadcast period, monitoring and evaluation is done. When a programme has ended, both qualitative and quantitative analysis is carried out to assess the impact. The format is specifically designed to encourage interaction among listeners.

The two radio magazine programmes, Igaddaa (“We do not want it anymore”) and Naedetai (“Let’s stop”) were specifically targeted at the Somali and Afar region, because the FGC prevalence is high and infibulation is commonly practiced. Both shows were broadcasted in the region’s dominant languages and focused on the customs behind perpetuation of FGC. Additionally,
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Awareness creation workshops were organised for the Afar and Somali religious and community leaders, given that they enjoy respect and authority. National religious leaders and clan leaders were also targeted in different workshops. Moreover, a youth radio programme was utilized to discuss the topics raised in Sibrat. Listeners could call-in and discuss Sibrat or ask questions on how to address the issues in their own lives. Lastly, 40,000 leaflets were print specifically for the Somali and Afar region, both in the dominant languages (dr. Negussie Teffera via e-mail on September 13, 2017).

The PMC assessed the success of the project via FGDs, no qualitative data is available. A past intervention on the topic of HIV/AIDS was evaluated as successful by Farr, Witte, Jarato and Menard, because stigma reduced and people started to take precautions in sexual intercourse (2005). The results of this study can be used as an indication of the success rate of Sibrat, since the same methodology was used for the development of the HIV/AIDS drama, and HIV/AIDS was, prior to the intervention, not regularly discussed in the community, which is a similar to FGC. The study found that many people listened to the drama, the drama was well appreciated and listeners were able to recall the story line with low error rates. The authors concluded that the exposure and influence of the HIV/AIDS drama was “high and strong” (Farr et al. 2005, p.234). It is likely that this also applies to Sibrat. This assumption is supported by Dr. Beth Osnes, a theatre specialist, who describes PMC’s efforts as “an outstanding and profoundly effective example of applied theatre.” (2013, p.117). It is unknown if the efforts let to individual or collective action, thus the Transtheoretical Model is not applicable to this intervention. Yet it is likely that opinions regarding FGC have changed, based on both FGDs and the similarities with the HIV/AIDS drama.

4.2 Interventions in Somalia
4.2.1 Accelerating Change towards Zero Tolerance to FGM/C in Somalia
In 2011 the NCA and SCI campaign started in Ethiopia to fight FGC (paragraph 1.4.4). The Somali programme ran from 2014 to 2016, and drew lessons from the Ethiopian programme. The interveners facilitated a platform for faith actors from both countries to discuss the relation between FGC and religion. This platform was particularly helpful for the Somali leaders, who were often for the first time exposed to anti-FGC messages. They could learn from religious Ethiopian counterparts. The project was implemented in four districts in Gedo (Central South Somalia) and in Puntland. The campaign was country specific, but not community specific.
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The entry point was to bring about change through religious and key leaders, given that Somalia is a religious country and hierarchy is important. The qualitative outcomes reported by the evaluators are that FGC survivors have access to safety and justice; faith and community-based organisations were influenced to transform beliefs, attitudes and practices that uphold FGC; and that these organisations are mobilised to prevent and reduce FGC.

The main strategy was to target the whole community, authorities, government ministries, students, community groups and (ex-)circumcisers via media, community dialogues, capacity building, mobilization, awareness raising and theological reflections. Thus, the interveners aimed at a holistic approach. Before the project started, religious leaders were chosen as main agents of change, which indicates cultural sensitivity. Eighty religious leaders were engaged during the project. They reached an general agreement that FGC was harmful, however, agreement on Sunnah being damaging was not reached. Difficulties the interveners encountered were the presence of militia groups in the Central South, medicalisation of FGC and the different opinions on continuation of Sunnah cutting. Both medicalisation and Sunnah cutting are disputed, which is explained in paragraph 1.3 and 1.4.

Sustainability is not assessed, yet a prediction can be made on the basis of the Transtheoretical Model. Changes were observed among young men, of whom some indicated that they were willing to marry uncut girls. Action was undertaken by religious leaders, who pushed TBAs to offer public apologies for past circumcisions. One could question this outcome, because a powerplay is facilitated by the NGO’s efforts. On the one hand, religious leaders gain more power by condemning TBAs, but on the other hand the TBAs are the one who have the actual power, given that they carry out circumcision. Thus, the question arises whether NGOs should embrace this outcome, or reject it. Moreover, religious leaders were showing off their uncut daughters to endorse other community members to abolish FGC. Again, a powerplay is facilitated. On the other hand, NCA and SCI only educated the community. These outcomes are initiated by the community itself. Thus, they might fit within the community structures and habits. Finally, forty families were documented to have publicly declared commitment towards abolishing FGC. In terms of the Transtheoretical Model, these forty families are ready to take action. This number is small in comparison to the reached beneficiaries (1.2 million), and therefore it is no guarantee of
sustainability. However, given that the efforts continue within the next phase, prospects of adapting new behaviour exist.

### 4.2.2 Joint Programme on Accelerated Campaign for total abandonment of Harmful Practices- Child/Early marriages and Female Genital Mutilation/Cutting (FGM)

The evaluation of the 2009-2013 intervention period in Somalia (Phase I) was done by both an independent consultant and an UN worker in 2014. The evaluation report is based on a survey, interviews and FGDs. The goal was to develop recommendations for Phase II. The detected changes detected after four years of intervening are as follows: 3,050 communities declared to abandon FGC, the programme reached 3.5 million community members (one third of the population), 41.5 per cent of the population is in favour of continuation of the practice and 73.5 per cent is aware of health impacts. Yet 94.9 per cent of the respondents believed that FGC does not violate human rights, which was probably questioned because of the legal UN approach (paragraph 1.5). Moreover, 82.2 per cent of the respondents answered that religious leaders do not favour eradication of FGC, while in 2013 over 2,000 leaders made public declarations about the absence of a link between the Islam and FGC. This is contradictory, and reasons are not given. Possibly, the behaviour of religious leaders when out of sight of the UN is different from the declarations made in collaboration with the UN.

The UNFPA/UNICEF is targeted at different levels of the community in terms of hierarchy, gender, age and education, but also at both community and governmental level. The programme involves different strategies to bring about a change. Youth for instance, is targeted via school and university clubs and via social media like Facebook and Twitter. An example is the Ifrah Foundation Facebook page that had over 3,300 followers at the end of 2017. A completely different strategy was adopted to change the mindset of midwives and nurses, who got a training in FGC-related complications. It also involved an anti-medicalisation strategy, again understandable from a UN perspective. Moreover, given that health personnel is highly respected in Somalia, the UNFPA/UNICEF programme educated nurses in delivering the anti-FGC message to patients. So the impact is twofold, on the one hand midwives and nurses were educated within the programme, on the other hand they passed along the message to their patients. The programme supported the formation of religious leaders networks in both Puntland and Somaliland, and contributed to the Puntland Fatwa. The interveners educated the leaders to make sure they spread the message in
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Friday prayers or through meetings. Moreover, religious leaders went abroad to discuss FGC with leaders from neighbouring countries and to share knowledge. The UN believed that the anti-FGC message is more accepted when delivered by notorious foreign religious leaders. The deployment of community-members as agents of change appears to be effective. Finally, UNFPA/UNICEF supported the government in anti-FGC legislation and programmes, a major focus of the legal UN approach.

However, even though different stakeholders are included and the population is targeted via different approaches, the results seem limited. According to the evaluators, the community awareness increased, but the statistics raise questions, especially those on whether participants believe that FGC is a human rights violation and on the attitude of religious leaders. Moreover, the programme is designed for multiple countries, with similar approaches everywhere. The programme is adapted to Somalia in general but it became clear in chapter 3 that even though the population of Somalia is regarded as homogenous, differences exist.

The UNFPA/UNICEF programme departed from the perception that FGC is a cultural norm in Somalia, but the findings from chapter 3 show that in Somaliland FGC is predominantly regarded as a religious requirement and/or carried out for economic security. The evaluation shows that a year after the programme terminated, the impact was not widespread throughout the community. A long-term mindset change was not achieved, thus the last two stages of the Transtheoretical Model were not reached. Moreover, it is questionable if the reported results match the stages of getting ready or being ready to undertake action. Results were reported by the UN, yet consultants raise questions on the effectiveness. The same outcome was reported for the Ethiopian intervention. However, in both countries the efforts continue, so the desired outcome might be achieved in the future.

4.2.3 The Integrated Education and Development Program (IEDP)

The IEDP was carried out by PYM AID Somaliland in the Saaxil region, the northern part of Woqooyi Galbeed in Somaliland (figure 7). The project was reviewed by a regional consultancy firm: TAABCO. The reviewed timeframe 2012-2014, entails the third phase of the programme and is in its nature an educational project. One of the four main objectives of the third phase was creating awareness on FGC effects and lobbying for policy formulation against the practice.
The outcome of the project with regard to education is very promising, given that the Sheikh District National Teacher’s performance ranking improved from 280 in 2007 to a top ten position in 2011, 2012 and 2013. This improvement is attributed to the efforts of PYM AID in their ambition to develop the educational system in the region and to increase the enrolment rate.

The consultants reported that the FGC campaigns had succeeded in raising awareness in 41 villages and that the programme reached 3,200 persons. The IEDP predominantly targeted 48 FGC practitioners to reform and subsequently sensitize the communities they used to work in, which was evaluated as an effective way for raising awareness, because this approach minimized the forces opposed to change. The benefit of this approach is that once a TBA is convinced that FGC should be abolished, she could continue the efforts without the interveners being present. Moreover, songs and drama were developed to be spread by women in the villages. Local religious authorities were also engaged and contributed to the project achieving its goal of awareness raising. Subsequently, the campaign contributed to the development of an anti-FGC policy that is awaiting discussion in the Somaliland cabinet.

The consultants were positive about the sustainability. However, the programme targeted predominantly women, specifically TBAs, and a few religious leaders to bring about a change in the villages, but no other audience. As described in chapter three, the Somaliland society is patriarchal. Endorsement of males is valuable and often necessary. The religious leaders could disclaim that infibulation is obliged by religion, yet females are also cut in the region because of economic security. Circumcision is critical for marriage, whereas marriage is critical for economic security. Therefore, only targeting the TBAs and religious leaders, without paying attention to other members of the society, will probably not result in the desired behavioural change given that religion and economic security are linked. Since the project focused mainly on education, they could have added an anti-FGC curriculum to the educational kits they supplied to schools to enlarge the impact.

As we have seen in other projects discussed above, bringing about a long-term mindset change might take years. This project has led to some individual changes, but presumably not to collective action. When applying the Transtheoretical Model to this achievements, some individuals might have been ready to take action, but termination of old behaviour or collective abandonment was not observed. Moreover, the anti-FGC policy that IEDP supported has not been passed by the
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Somaliland government yet, since no consensus has been reached on the topic of Sunnah being equal to circumcision (paragraph 1.4). Therefore, sustainability is discussable. Given that the practice is deeply rooted in the Somali society, the intervention may have had a too narrow target audience and the duration was too short to bring about the desired change.

4.2.4 The Tostan Project: Ending FGM/C in Somalia
The Ending FGM/C in Somalia project was initiated in 2006 as a pilot programme and ran until 2009. The project was led by Tostan, who ran a similar project in Senegal before. Lessons were drawn from this prior intervention. The Tostan project has been rewarded with the Hilton Prize, the world’s largest humanitarian prize (Tattersall 2007).

Different from what the project title suggests, the Tostan Project also focuses on empowerment, education and child marriage. The whole country was targeted initially, but due to insecurity in southern Somalia the project closed down and continued in Puntland and Somaliland. Tostan’s project “aimed to empower communities to create healthier, more gender sensitive, environmentally sound and financially secure lives” and “was grounded in traditional African learning models that made training familiar and accessible to Somali participants.” (Tostan Project 2012, p.viii). Examples are classes led by locals fluent in local customs and traditions and classes taught in the Somali language. Moreover, a decentralised strategy was adopted of direct beneficiaries passing gained knowledge on to friends and family, and inter-village meetings. This project design is called the Community Empowerment Programme (CEP).

In terms of raising awareness and changed community attitudes, the intervention villages reported to have gained knowledge and changed behaviour as a result of the intervention. Moreover, they now held open discussion on FGC, which did not happen before the intervention. The surrounding villages, that were expected to be reached through diffusion, reported the same outcomes, yet less extensive. Moreover, women and men in the intervention and surrounding villages indicated that the practice is declining. In Somaliland, 90.3 per cent of the directly reached women, 78.9 per cent of the women from surrounding villages and 43.2 per cent of the women from the comparison villages responded that FGC is in recession. Hence, the Tostan project had impact on community behaviour. Yet, the prevalence of FGC was not observed to be changing, indicating that a difference
exists between willingness to change and taking action, which is also visible in the Transtheoretical Model of Prochaska and DiClemente, in which these stages are separately described.

The CEP existed of two stages: Kobi (to ploy the soil in preparation for planting) and Aawde (to plant the seed). The programme promoted development and use of critical thinking skills. During the Kobi stage information on different health related topics, including FGC, was spread among the participants. Moreover, different skills were trained and open discussions were encouraged. In the Aawde stage, literacy and numeracy skills were taught, and included lessons in management skills and in how to start own businesses. The total educational component lasted for almost two years. Moreover, radio shows were broadcasted to reinforce the message.

Tostan aimed at reaching 42 communities, with the expectation that direct participants would share their gained knowledge with ten other people. Communities selected a minimum of 40 participants, from both sexes, different ages and roles in the society, resulting in 1,600 direct beneficiaries of the classes. Participants were asked to adopt one acquaintance, and the entire communities were asked to adopt a neighbouring community to promote dialogue and spread the message. It is estimated that indirectly over 100,000 people were reached. Additionally, Community Management Committees (CMC) were established by villagers themselves. CMCs conducted community outreach activities like awareness campaigns, public discussion forums, sending girls to school and engagement of religious leaders in the anti-FGC campaign. The CMCs were reported to increase the visibility of women in the community.

Different outcomes were observed for Puntland and Somaliland, hence a more community specific approach is recommended for a future intervention. When analysing the data in the evaluation report, it becomes clear that respondents from Somaliland reported significantly more impact. When assessing the long-term mindset change, termination of the practice is not yet observed. Beneficiaries seem to get ready for change, but action is not undertaken. To assure sustainability, a follow-up project should be implemented.

4.2.5 The Somali Gender Based Violence Sub Cluster Strategy
The Somali Gender Based Violence (GBV) Sub Cluster Strategy is a collaboration between key UN entities, civil society organisations and the federal government of Somalia. The project lasted from 2014 until 2016. The programme was targeted at the whole country, however, most activities
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focused in Lower Juba and the region were Mogadishu is located, the regions where women are least empowered in the country. The campaign comprised of a zero-tolerance on FGC message. The evaluation was carried out by the same cluster, with the purpose to inform the preparation of the next phase.

Different goals were accomplished with regard to GBV. The main FGC related achievements are the establishment of a religious leaders’ network against FGC in Somalia and the joining of the broader regional network in the Horn of Africa, the establishment of eight anti-FGC clubs in Somaliland schools and universities, different policies were drafted in the three areas, a midwifery curriculum was developed with FGC prevention integrated within the curriculum and a five-day capacity training was held for FGC stakeholders in Uganda. Anti-FGC campaigning was integrated in almost every activity that addressed GBV. In total, almost one million persons were targeted, of whom the majority women. Given that the society is patriarchal and women are not very empowered in this region, the appropriateness of this focus is discussable. On the one hand, women are decision-makers with regard to FGC thus should be a main target, but on the other hand men have authority in the society.

Different challenges included limited funds, weak legislative framework, stigma about GBV, limited access to intervention areas and the absence of recognition for GBV in social norms. Together with the broad focus that was country specific, but not community specific, the results with regard to behavioural change seem limited. During December 2016, the last weeks of the second phase, open discussion was reported among the participants, which is a first step in the eradication process. Additionally, prominent religious leaders undertook action against FGC and spread the message in mosques during Friday prayers or during meetings, equal to the Transtheoretical Model stage of taking action. However, only a limited number of community members engaged in the anti-FGC campaign, predominantly key leaders. On community level, no change was observed. Therefore, in order to have a sustainable impact, more efforts are needed for collective support for abandonment of the practice. An example is the involvement of community members or the focus on women empowerment in general.
4.2.6 FGM Program in Gedo
Norwegian Church Aid carried out an intervention in the Gedo region in Southern Somalia from August 2001 until the evaluation in July 2004. The intervention was specifically developed for the inhabitants of the Gedo region, hence it was community specific. Moreover, the whole region was targeted to accomplish the desired change. The evaluators found that due to the intervention open discussion was promoted in the region, and different villages had created their own forums to discuss FGC. Before the intervention, the community did not discuss FGC, so an environment of discussion was established and subsequently strengthened. Secondly, awareness was raised, with over ninety per cent of the inhabitants of the Bardhere and Garbahareey towns reporting that they had heard anti-FGC messages. However, in for instance the El wak region, only 56 per cent reported to have heard those messages, which is presumably caused by the limited access due to (inter)clan wars and instability in this region. Around 98 per cent of the respondents indicated that they had been influenced by anti-FGC messages. Hence, a change of perception on the individual level was reported.

The project consisted of different activities to abolish FGC in the Gedo region. The Training of Trainers (TOT) was one of the main activities. For the TOT, 25 carefully selected community members, different ages and both sexes, were selected to spread the message among their fellow residents. Additionally, a team was organised to perform drama, poems and songs about circumcision and its consequences. Moreover, the message was spread through posters, radio campaigns and house-to-house awareness raising by the TOTs. Finally, health providers spread health messages with the possible effects of FGC; imams and sheiks spread religious messages during Friday prayers who were targeted at all men; and women and children received educational messages. Thus, the project adopted a cascading approach in their campaign to eradicate FGC in Gedo that is similar to the Tostan project.

One of the notable outcomes is the development of six months action plans by different community members. Specific action plans were developed by and for religious leaders, practitioners, youth and women groups. “To eradicate FGM, all the intervention groups encompassing the youth, the religious and women groups have drawn a six month community action plan targeting all the people in the region, from the urban to the rurals, including even the nomadic shifting groups.” (NCA 2004, p.7). Therefore, the mindset change is expected to last, given that almost all of the respondents of the survey stated that they were influenced by the anti-FGC messages and the action
plans. Even though in terms of the Transtheoretical Model neither maintenance of the behavioural change nor termination of the old behaviour are reported, the prospects are promising. The community is slowly changing towards collective abandonment of the practice, visible in both the survey answers and the collective action undertaken by different groups in the society. NCA indicated in the evaluation report to start another phase of the project, which is beneficial to the sustainability and necessary when taking the support for continuation of FGC in Central South Somalia into account.

4.3 Cross-referencing results
When assessing to what extent an intervention was effective, it is important to keep in mind that a difference exists between raising awareness on the one hand and communities taking action on the other hand. This is illustrated by the reported results of the CARE project (paragraph 4.1.1). The consultants found that awareness was significantly raised and knowledge increased in the community, yet almost 80 per cent of the women reported that they would not undertake action. Collective abandonment is especially aimed at in the international community, when in fact interventions have less far-reaching objectives, for instance awareness raising. None of the interventions reached total abandonment (yet). Moreover, what total abandonment of FGC entails is disputed, because the definition varies per community and per NGO or researcher. Reported abandonment of FGC could actually mean the abolishment of infibulation, given that the Sunnah cut is not regarded as circumcision by everyone. Hence, the declaration that practicing FGC has stopped does not necessarily apply to all kinds of FGC according to Vestbøstad and Blystad, who carried out extensive research in Somaliland (2014). Furthermore, every intervention reported impact of their eradication campaigns, but differences exist in the extent of effectiveness. When examining the Transtheoretical Model, different intermediate steps exist before old behaviour is terminated. When combining the Transtheoretical Model and the attitude continuum, it becomes clear that the road to collective abandonment of FGC is a long one. The reality supports this claim, given that various projects that ran for a second or third phase did not result in total abandonment of FGC.

Medicalisation of the practice is a growing trend in Mogadishu, but also in other parts of Somalia and Ethiopia. The majority of the medicalised circumcisions entails Sunnah. As explained in
paragraph 1.4, two sides exist with regard to this topic. A zero-tolerance policy is adopted from a human rights perspective, because all forms of FGC violate a child’s right to bodily integrity (Gruenbaum 2005). When departing from this perspective, nuance on changing social norms is lost because no continuum is used, just the two complete opposites: total eradication of FGC or practicing FGC. Proponents of medicalisation regard medicalisation as a sufficient change when compared to infibulation at home, which is not performed by a health professional in a clean environment. When regarding medicalisation as harm-reduction, it is applicable to the attitude continuum, because a detailed understanding of how and which visible changes could be analysed. In between the two extremes, the social norm and the achieved or desired change in FGC could be placed, resulting in a detailed understanding of how and in which way changes occur. When looking at the interventions, not one reached complete termination of FGC. Thus, when using the two extremes of either practicing FGC or not practicing FGC, information is lost. With regard to medicalisation, it is remarkable that not one evaluation report discussed the acceptance or condemnation of FGC. Among academics and within multilateral institutions medicalisation is discussed, but on executive level, no position is taken and no reference is made.

An intervention is evaluated successful when a mindset change is observed that leads to taking action. Taking action is manifested in the establishment of village councils, communities punishing each other for circumcising daughters and voluntary sharing of knowledge. Projects that have proven to be effective in eradicating female genital cutting are the Awash FGC Elimination Project, the Sinana Female Genital Mutilation Elimination Project, No Girl or Woman Shall Undergo FGM: Accelerating Change towards Zero Tolerance to FGM in Ethiopia, the Whole Society Strategy effort to address Female Genital Mutilation, the Tostan Project and the FGM Program in Gedo. These interventions have in common that they are community-based, acknowledge and utilize the impact religious or community leaders could have and the collaboration or integration of the project in/with local initiatives.

Some interventions were evaluated as effective, but external evaluators contradicted those claims. For instance the results of the Joint Programme initiated by UNFPA/UNICEF, which were called into question by The Center for Development Consulting due to self-reporting of FGC prevalence. Self-reporting is often regarded as inconsistent, because respondents tend to over- or underreport (Newcomer, Udry and Hill 1988; Lauritsen and Swicegood 1997; Austin, Deary, Gibson, et al.)
1998; Østebø and Østebø 2014). In Ethiopia, practicing FGC has been criminalised in 2004 and therefore FGC was forbidden by law during most interventions. Different interveners emphasised the prohibition of FGC including the possible consequences of violating the law. Law enforcement with regard to FGC is in general weak, yet the respondents might have suspected survey answers to be reported to the authorities. Therefore, it is possible that the findings of the CDC are applicable to more interventions, and that the results are in reality less promising. Moreover, instability in some regions has influenced the projects and contributed to not achieving the objectives. The NCA intervention in Gedo for instance showed impressive results for the areas intervened in. Yet surrounding villages were occupied with inter-clan wars and militias, and therefore reported less results.

Not all projects resulted in a long-term mindset change or abandonment of the practice, although some do have the potential to change the behaviour. An example is the CARE International project (4.1.1), which lasted for less than two years. Fifteen months after this relatively short intervention, community leaders declared an end to FGC. So the long-term mindset change was not manifest in the whole community, but respected leaders were ready for change. The UNICEF researcher Haile Dagne, who carried out a review of interventions to end harmful practices for UNICEF, states that when community or religious leaders act as leaders of their village or organisation, they could be influential in freeing community members from the perceived FGC obligation (2010). In her opinion, they are the first to change and are able to influence the rest of the community. Østebø and Østebø acknowledge the recent change in development activities from not including religion to utilizing religious leaders as a potential resource (2014). Yet, they emphasis on recognition for the power structures:

“We contend that it is of particular importance to recognize the dynamic, decentered, and relational aspects of power in a context characterized by a strong presence of monological discourses and authoritative structures, which in this case refers to the global anti-FGM movement and the socio-political culture of Ethiopia. This influences anti-FGM interventions, local responses to interventions, power relations between actors, and religious leaders’ legitimacy.” (Østebø and Østebø 2014, p.85)
This process is recognisable in different interventions. For instance in ‘Accelerating Change towards Zero Tolerance to FGM/C in Somalia’ executed by NCA and SCI. During this intervention religious leaders pushed TBAs to offer public apologies, a powerplay that is elaborated upon already in paragraph 4.2.1. Thus, utilizing religious leaders could be a good practice, provided that the community structures and relations are taken into account. The different ways of utilizing them will be discussed hereafter.

For the interpretation and understanding of the successes and failures of particular intervention programmes in the context of Ethiopia and Somalia, it is important to consider the different factors that play a role in maintaining the practice of female genital cutting. The misconception that culture and tradition are the only driving factors behind FGC is refuted in chapter 3. The complexity and interrelation of different factors is described for both Ethiopia and Somalia. The differences between the two countries, and the differences in the beliefs and practices that perpetuate FGC assume even more diversity among other countries where FGC is practiced. This expectation corresponds with the assumption of Longman and Bradley as introduced in chapter 2: the web of interlocking factors like religion, culture, gender, age, race and so on, differs across countries. Understanding the overlapping of different entities and the relation between them, is important in order to challenge dominant narratives that try to justify the oppression of different groups as Andersen and Collins called it (paragraph 2.1.2; 1992). When linking the chapter 3 findings to the interventions, interesting conclusions can be drawn.

First, whereas some interveners utilized the hierarchical community structures to make an impact, others misunderstood the hierarchy. Often, religious leaders were engaged. Two possible ways of utilizing religious leaders are either as key community actors, when leaders are encouraged to change perceptions, or, educating them on the consequences of FGC and the alleged Islamic obligation. The difference is either an instrumental use, or utilizing them as key. Especially in the instrumental approach, the powerplay mentioned by Østebø and Østebø should be kept in mind. In the analysed interventions, religious leaders were often mobilised because of their respected positions in the Somali or Ethiopian society, with the goal to dismantle the alleged Islamic obligation for FGC, an instrumental use. However, when utilizing religious leaders only to communicate a message they do not necessarily believe in, does not lead to a change in the
community intervention 4.2.2 illustrated. Thus, an instrumental utilization only is not enough for a mindset change.

An example of a key role only is the CARE intervention described in paragraph 4.1.1. Because of extensive research beforehand, CARE expected religious leaders to pass along gained knowledge from FGC education to the community. Thus, CARE educated and subsequently facilitated opportunities to pass along the knowledge, but key leaders were not mobilised to instruct others. Hence, intersectionality of gender, hierarchy and religion was successful observed and deployed.

Convincing religious leaders first and subsequently supporting them to spread the anti-FGC message has also resulted in a mindset change in different communities. An example is the FGM Program in Gedo (4.2.6) that was very effective. Again, a focus on religion was not sufficient, but multiple intersecting factors like age, gender, religion, hierarchy and culture were taking into account. However, the IEDP illustrated that approaches that do not involve religion at all could also be effective.

Jones and Petersen argue that the literature regarding religion and development is in general positive about the involvement of religious leaders (2011). They argue that this ‘discourse’ of utilizing religious leaders and/or institutions successfully is partly contributable to the donor- or NGO-funded research initiatives on this topic, that “produce the sorts of formulations that emphasise the positive or the practical.” (2011, p.1297). Moreover, research on this topic is often too narrow they claim. Finally, Jones and Petersen argue that normative assumptions concerning religion are dominant, without taking into account local influencing factors (2011). When other motivations behind FGC are not addressed, the efforts to eradicate the practice do not have the desired change. This is illustrated in the IEDP that targeted women, TBAs and religious leaders but overlooked families marrying off their daughters for economic security. Intersectionality of gender, age and hierarchy was detected by the IEDP, yet the influence of economy was underestimated.

When developing an intervention, all of the contributing factors for conserving FGC should be considered. The CARE International report underlines the need for an intersectional approach: “education, age, and exposure to anti-FGC messages were significantly associated with support for FGC abandonment” (2004, p.32). Different intervention programmes established school and university clubs, Facebook pages and supported the change of school curriculums to include the
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topic of FGC. Youth can serve as agents of change, but only when the whole community is targeted. In the Accelerating Change project in Ethiopia, boys were targeted to distance themselves from FGC and in particular from marrying circumcised girls. In spite of many boys declaring to be willing to marry uncut girls, this is not expected to result in a decline in FGC. As long as parents support continuation of FGC and decide on marriage, boys will be obliged to marry circumcised women. Thus only targeting boys does not have the effect wished for, parents need to be targeted as well. An intersectional approach is lacking. Otherwise, the hierarchical society structures will contribute to the unheard voices from the youngest society members.

The importance of adapting an intervention to socio-cultural contexts is also illustrated in the difference between the interventions described in paragraph 4.1.2 (CARE International) and 4.1.3 (EECMY-DASSC). Both campaigns specifically addressed youth, resulting in youth abolishing the practice in both intervention sides. However, in the Afar region girls are generally cut before the age of five, thus uncut girls are not targeted in the campaign. When the mindset change is sustainable and lasts for a generation, this strategy could have future results. Although, when the message is not reinforced and action is not undertaken immediately, it is likely that the message will be forgotten or weakly/not enforced. In Oromia however, girls are cut on various ages, hence educating the youth on how to prevent circumcision is an adequate strategy. When a girl feels at risk of being cut, she now knows who to inform to prevent circumcision. These findings correspond with the findings of Haile Gabriel Dagne. She found that mobilising girls to rescue fellow schoolmates from early marriage was very effective in Ethiopia. A contributing factor to this example is the fact that the whole society was targeted, similar to the EECMY-DASSC intervention. Girls just had to report the suspicion of circumcision resulting in that the community would help her prevent the actual cutting.

Some interventions adopted the strategy of using community members as agents of change. The nurses in the UNFPA/UNICEF Intervention (4.2.2) for example, were educated in FGC consequences and asked to spread the message among their patients. The nurses’ authority encouraged patients to think about the topic. Moreover, participants in the Tostan Project had to adopt someone to share the gained knowledge with, and villages had to adopt a surrounding village. This cascading approach resulted in a visible change in the attitude towards continuation of FGC in both intervention and surrounding villages. Both strategies were evaluated as successful. Thus,
mobilising community members, preferably those who are respected, to influence others has proven to be effective. On individual level, but also in the context of inter-community knowledge sharing. The CARE interventions also utilized community structures. Although a setback of using community members as agents of change is that the message might be less diffused than reported, because the agents of change do not completely support the message, or are not believed. However, in general, a cascading approach was effective especially in the Tostan project, but also in the FGM Program in Gedo (paragraph 4.1.6).

Multiple interventions were integrated in existing programmes. For instance the CARE International programme, that used an existing health programme to start the debate on FGC. The effectiveness of interventions is expected to increase when making use of existing structures. Dagne argues that because FGC is not perceived to be a priority by communities, the topic should be incorporated into more urgent issues for the communities, for instance HIV/AIDS (2010). The importance of health is a recurrent theme in the interventions. FGC is often a sensitive, non-discussed topic in communities. When integrated in a broader health framework, the topic is more palatable for communities. To catch the attention of the community, integrating the message in existing efforts to improve public health in general is a good practice. This finding corresponds with the existing literature. Le Roux and Bartelink concluded in their research on HTPs that a public health approach stood out as effective in working with faith leaders (2017). They argue that the cause of effectiveness is that “many faith leaders lack the basic sexual and reproductive health knowledge relevant to certain HTPs. Raising awareness of the health consequences of HTPs creates a shared concern with the health and well-being of women and girls and opens up space for conversation and reflection.” (Le Roux and Bartelink 2017, p.6). However, given that the discussed societies are patriarchal, this strategy is more suitable to start a conversation on the topic than to stop FGC in its entirety.

Another possible reason for the effectiveness of integrated interventions, is that existing programmes are known by the community. Interveners could assess the popularity of an existing programme when considering whether to integrate the anti-FGC campaign. However, the integration of the anti-FGC campaign into the IEDP showed that when the focus of the main project is completely different, the results could be limited. The NCA and SCI programme in Ethiopia
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looked into the government positions and priorities beforehand, and aligned their project to their first concerns. After the project terminated, the campaign was continued by the government.

Finally, the role of women in patriarchal societies should be taken into account when addressing communities. Although the IEDP targeted predominantly women who are the main decisionmakers with regard to FGC, the intervention was not very effective. The reason could be found in the main focus of the programme, education, but also in the patriarchal structure of the Somaliland society. Longman and Bradley explain that women in patriarchal communities have no chance to break away from the practice, because the wider state structures often do not provide support (2015, p.33). Therefore, an intervention should focus on the state apparatus and customs as well. The same limitation is visible in the Somali Gender Based Violence Sub Cluster Strategy, where women were targeted to stand up against GBV, including FGC. Yet women did report in the MICS that they did not experience wife-beating as unjustified, neither spousal violence. Thus, women empowerment is a factor that should be addressed as well. Women are both subject and agent with regard to FGC, but they need to have the opportunity to speak out against the practice. Again, the importance of the intersectional approach is underlined. Focusing on male religious leaders that subsequently pushed TBAs to offer public apologies, an example which has been used before, illustrates that not including women in interventions does not have the desired effect. Women could be utilized as agents of change, especially when they have are fulfilling a respected role in the community, for instance the nurses in the UNFPA/UNICEF intervention (paragraph 4.2.2). Considering that women are performing FGC, they should be included in interventions. Moreover, women could reach other women more easily than men would reach other women, because of the patriarchal structures. However, endorsement of males is often necessary, so religious leaders could be utilized to influence men, and respected women for influencing women. The complexity of community structures and the necessity of the intersectional approach is again confirmed.

Thus, the extent of success of interventions is inseparably linked to the degree of adaption to the intervention community. A specific strategy might be effective in one community, yet might not have the same impact in another community. The significance of hierarchy, religion and patriarchy in communities should be taken into account when developing an intervention.
4.4 Future recommendations

Different recommendations can be made from these findings in order to improve FGC eradication interventions. The recommendations are based upon the outcomes of prior paragraphs. Self-evidently, interventions should be designed for the communities they target.

Firstly, it is important to integrate FGC abandonment activities in existing, local projects or governmental programmes. The justification of this project design is twofold. First of all, when integrating an anti-FGC campaign in existing structures, it is likely that efforts will continue after termination of the project. This will contribute to sustainability of a long-term mindset change. Secondly, different interventions, for instance 4.1.1 and 4.1.2, have shown that when FGC is discussed as a part of a larger set of issues, the impact is more extensive. Often, FGC is not discussed in a community, because it is supported widely and regarded as something that is part of the identity. Before an intervention, communities had often never considered discussing FGC. When community members get familiar with discussing the topic in general, they are more likely to speak up during facilitated meetings, but also in private. This will result in reflection of behaviour, and might contribute to a mindset change. However, this claim is only applicable when the main focus of the project is FGC eradication. The IEDP programme aimed at improving education, and succeeded, yet the impact of the few anti-FGC activities was small.

Moreover, interventions should last for multiple years, given that the interventions analysed showed that a long-term mindset change is hard to achieve. The practice is deeply rooted in intersections of class, age, gender, hierarchy, economy, local customs and believes regarding health, religion and beauty in both countries. Therefore, multiple years of eradication campaigns are needed to bring about the desired change. A good practice during these subsequent years of intervening is the integration of outcomes and best practices of former projects. Moreover, refreshment training for participants of past projects could contribute to sustainability of the mindset change.

Thirdly, it is recommended to target whole areas and whole communities. A backlash of the impact might appear when neighbouring villages that were not targeted retain their believe that girls should be cut. Intervillage communication occurs on different levels. Between youth, women, elderly and religious leaders. They all play their own role in preservation of FGC. Therefore, the whole community should be targeted. This intervillage interaction is for instance visible in marriage. In
order to facilitate intervillage marriage, it is more likely that the targeted community will start circumcision again, than villagers who have not participated in an intervention programme suddenly abandon FGC. Given that it takes years of efforts before change occurs, it is likely that the parents and the soon-to-be wed are not open for marriage with uncut girls. Hence, the impact will be more sustainable when an entire woreda or area is targeted.

Finally, the majority of evaluation reports cited the use of media as good practice. The impact was more widespread when making use of video. Moreover, the use of radio shows to reinforce or to introduce the message is assessed as extremely successful. Hearing about the message when at home facilitates discussion among spouses, their children and in class. The more often the message is heard, the more impact it has.
Conclusion

The aim of this thesis is to understand why particular interventions to eradicate the practice of female genital cutting are successful in the context of Somalia and Ethiopia. First, female genital cutting is explained, including the terminology, consequences, the legal and the anthropological perspective. This chapter is followed by the methodology that is used to analyse the effectiveness of interventions. Subsequently, the socio-cultural contexts of Ethiopia and Somalia are discussed, with a specific focus on the beliefs and practices that specific act to perpetuate female genital cutting in both countries. These beliefs and practices are community specific and vary per region in both heterogenous Ethiopia and alleged homogenous Somalia. In the final chapter the effectiveness of interventions is assessed, followed by an elaboration on how we can understand the successes and failures of the intervention programmes. It has become clear that even though every intervention reported has made an impact, differences in effectiveness exist. Moreover, some positive evaluations were contradicted by academics who did complementary research or disturbed efforts by instability in the intervention regions.

The interventions that have proven to be effective in bringing about a change in mindset had a similar project design. The majority of the interventions was community-based, utilized the status of religious leaders to influence other community-members and integrated their campaigns in existing programmes or worked closely together with local stakeholders. The successes and failures have to be understood in the broader context of community structures. Socio-cultural contexts cannot be ignored. Similar strategies have had completely different outcomes, due to differences in believes and practices of the target communities. The intersectionality of religion, economy and FGC has been overlooked by some interveners. Moreover, reasons behind cutting have been misunderstood, resulting in approaches that did not contribute to the intended result of FGC abolishment. Therefore, future interventions should be community specific and integrated in existing projects, or designed in collaboration with local stakeholders. The interventions should last for multiple years in entire communities, and finally media should play a central role.

The central research question in this paper was: Which interventions to eradicate the practice of female genital cutting in Ethiopia and Somalia are successful, and how can cultural and intersectional analysis contribute to understanding why these interventions are successful? The
answer became clear in the analysis of the interventions, where the same strategies had different outcomes. Communities are dynamic groups that are not defined by borders but rather consist of individuals that share a culture, bond and traditions. All of the factors that make up the culture, play a different role in perpetuating certain believes and practices. When trying to understand why FGC retains strength and how the beliefs that preserve FGC can be challenged, the analysis of these factors, intersections, could give an insight. Community leaders play a different role than religious leaders, women than men and youth than elders. Therefore, understanding the structures that maintain FGC, offers a chance in the development of culturally sensitive interventions. These interventions could contribute to a future FGC free world. The Sustainable Development Goal to end FGC by 2030 might be to ambitious, however, when adapting interventions to communities, ending FGC is realistic.
Discussion

In this thesis some limitations have been mentioned already. The limited availability of data, the challenge in collecting English intervention reports that were eligible for this study and the differences between the different interventions. This study was based on 12 interventions, which is a limited number when considering the number of NGOs active in the field of FGC eradication. All the NGOs mentioned in annex 2 were contacted, but many stopped to exist or did not respond. Moreover, various intervention reports mentioned in academic literature were not available (anymore). Different NGOs that did respond mentioned the difficulty they encountered in evaluating projects due to limited funds, limited access or the destruction of archives. Also, the restricting NGO law in Ethiopia, limited the work field of different NGOs. Furthermore, differences exist in the quality of the collected interventions. Self-reporting in surveys could have influenced the results and therefore surveys might present a higher effectiveness than in reality. Finally, many interventions lacked a base-line measurement beforehand. Therefore, the actual increase of awareness and/or action is often untraceable.
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Annex 1 Mail sent to NGOs

Dear sir/madam,

Currently I am writing my master thesis in International Humanitarian Action at the Rijksuniversiteit Groningen, the Netherlands. I conduct a study of the effectiveness of interventions to eradicate the practice of female genital mutilation/cutting in Somalia and Ethiopia. My intention is to analyse interventions through an anthropological lens to be able to write recommendations to improve effectiveness of future interventions.

During my research, I came across your organisation because of your eradication campaigns in either Somalia or Ethiopia, or both. In order to analyse the effectiveness of interventions, I am in need of intervention policies and implementation, monitoring and evaluation reports for both Ethiopia and Somalia. I would kindly request your organisation to provide me with your reports regarding FGM/C eradication campaigns. Undoubtedly, I will assure you complete confidentiality and integrity. I will not publish or spread anything you will hand to me, neither will I write about the subjects of your interventions. I will write about the effectiveness, the cultural-sensitivity of multiple programmes and the eradication approaches that are most adequate, in order to come up with general suggestions to improve FGM/C interventions worldwide.

Hopefully you will be able to provide me with your reports. Thank you in advance.

Should you need any further information, please do not hesitate to contact me. I am more than willing to provide you with the final thesis or a summary if you are interested in the outcomes.

Yours sincerely,

Fieke van de Ven

Master student at the Rijksuniversiteit Groningen, the Netherlands
Annex 2 List of NGOs contacted via e-mail

1. Aba Wolde-Tensae Gizaw Mothers and Children Welfare Association
2. Actionaid International Ethiopia
3. Actionaid International Somaliland
4. Action Professionals Association for People (APAP)
5. ADEHENO integrated rural development association
6. Adeso African development
7. Adventist Development and Relief Agency Ethiopia (ADRA)
8. Afar Mother and Child Care Organisation
9. Afar Pastoral Children’s Development organisation
10. Afar Women Affair Bureau
11. African Center for Women (ACW)
12. African Development Aid Association
13. African Medical and Research Foundation (AMREF)
15. African Rescue Committee (AFREC)
16. African Rural Advancement Organization (ARAO)
17. Aktion Afrika Hilfe
18. Alliance of Civil Societies of Tigray (ASCOT)
19. Amnesty International
20. Amref
21. ANPPCAN
22. Anti-FGC Mother’s Association
23. Association for Integration and Development (AID)
24. Association for the Promotion of Indigenous Knowledge (APIK)
25. Association New Life Community Organisation (NLCO)
26. Austrian Development Agency
27. AWSAD Association for Women’s Sanctuary and Development
28. Bayer
29. Beza Youth Health and Counseling Center (BYHCC)
30. Birhan Integrated Community Development Organization (BICDO)
31. CAF-ACTION
32. Candle light
33. CARE international
34. CARE SSS
35. Center for Democracy and Human Rights (CDHR)
36. Christian Aid
37. CIIR Catholic Institute for International Relations
38. Circus in Ethiopia for Youth and Social Development
39. Coalition for Grassroots Women Organizations (COGWO)
40. Comprehensive Community Based Rehabilitation in Somaliland (CCBRS)
41. Concern Ethiopia
42. Concern for Integrated Development (CFID)
43. Concern Worldwide
44. Consortium of Christian Relief and Development Associations (CCRDA)
45. Consortium of Reproductive Health Association (CORHA)
46. Cordaid
47. COSONGO
48. Covenant for Ethiopia Support (CFES)
49. Dan Church Aid
50. Danish International Development Agency (DANIDA)
51. Defense for children
52. Deutsche Gesellschaft für Technische Zusammenarbeit (GIZ )
53. Developing Families Together (DFT)
54. Diakonia
55. Doba Integrated Development Organization (DIDO)
56. EOC-DIDAC
57. Equality Now
58. Eshet Children and Youth Development Organization (ECYDO)
59. Ethiopian Catholic Secretariat/ Ethiopian Catholic Church (ECS)
60. Ethiopian Evangelical Church Mekane Yesus (EECMY)
61. Ethiopian Midwives Association
62. Ethiopian Muslims Development Agency (EMDA)
63. Ethiopian Orthodox Church Development and Inter Church Aid Commission (EOC-DICAC
64. Ethiopian Women Lawyers Association (EWLA)
65. European Union
66. Evangelical Churches Fellowship of Ethiopia (ECFE)
67. Family Economic Rehabilitation Organization (FERO)
68. Farm Africa
69. FEMNET
70. FOKUS
71. for Relief and Development Organization (FATXA)
72. FORWARD (foundation for Women’s Health Research and Development)
73. Galkayo Education Centre for Peace and Development
74. GECPD Galkaya Education Center for Peace and Development
75. Generation in Action Development Association
76. German Foundation for World Population (DSW)
77. German Technical Cooperation for Development Agency (GTZ)
78. Global Alliance against FGM
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79. Gondar Educational Media Centre
80. Good Samaritan Association (GSA)
81. Government
82. Gudina Tumsa Foundation
83. Hamlin Fistula Ethiopia
84. Hargeisa Institute of Health Sciences HIOHS
85. HAVOYOCO
86. Healing Hands of Joy
87. Health doctor
88. Health Poverty Action
89. Health unlimited
90. Hirda
91. Horn Relief
92. Human Rights Watch
93. ICRC
94. IFRC
95. Integrated Community Education and Development Association (ICEDA)
96. Integrated Family Service Organization
97. Inter-African Committee
98. Inter-African Committee on Traditional Practices (IAC) – Ethiopia
99. Interreligious council of Ethiopia (IRCE)
100. Intra Health International – Ethiopia
101. KELEM Ethiopia
102. KMG Ethiopia
103. Light Ethiopia
104. Love for Children Organisation (LCO)
105. MAAXAAY foundation
106. Médicines sans Frontières
107. Menschen für Menschen (MfM)
108. Mudan Youth Umbrella
109. Mudug Youth Organization (MYO)
110. MUJEJEGUWA LOKA Women Development Association (MLWDA)
111. Multi-Purpose Community Development (MCDP)
112. MYWO
113. Nagaad
114. NAMATI
115. National Committee on Harmful Traditional Practices of Ethiopia
116. National FGM network Ethiopia
117. National Women’s Affairs Bureau
118. Nazareth Children Center and Integrated Development (NACID)
119. Network for Ethiopia Women Associations (NEWA)
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<table>
<thead>
<tr>
<th>Number</th>
<th>Organization Name and Full Name</th>
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<tbody>
<tr>
<td>120.</td>
<td>Network of Ethiopian Women’s Association (NEWA)</td>
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<td>121.</td>
<td>New Millennium Hope Development Organisation (NMHDO)</td>
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<td>122.</td>
<td>Norwegian Church Aid</td>
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<td>123.</td>
<td>Norwegian People’s Aid (NPA)</td>
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<td>Norwegian Refugee Council (NRC)</td>
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<td>125.</td>
<td>NOVIB</td>
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<td>126.</td>
<td>Ntaniro na Mugambo</td>
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<td>127.</td>
<td>ODWaCE</td>
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<td>128.</td>
<td>Ogaden Welfare and Development Association (OWDA)</td>
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<td>Orchid Project</td>
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<td>130.</td>
<td>Oromo Grassroots Development Initiative (HUNDEE)</td>
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<td>131.</td>
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<td>132.</td>
<td>PACT Ethiopia</td>
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<td>133.</td>
<td>PAMBAZUKA</td>
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<td>134.</td>
<td>Panos Ethiopia</td>
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<td>135.</td>
<td>Pastoralist Concern</td>
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<td>136.</td>
<td>PATH</td>
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<td>Pathfinder International - Ethiopia (PI-E)</td>
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<td>138.</td>
<td>PDRC</td>
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<td>139.</td>
<td>Plan international - Ethiopia (PIE)</td>
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<td>Population Council</td>
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<td>Population Media Center (PMC)</td>
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<td>142.</td>
<td>Professional Alliance for Development Ethiopia (PADET)</td>
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<td>143.</td>
<td>PSA</td>
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<td>144.</td>
<td>Puntland Minority women development organisation</td>
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<td>145.</td>
<td>Puntland Youth Organization (PYO)</td>
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<td>146.</td>
<td>RADES</td>
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<td>147.</td>
<td>Rainbo</td>
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<td>148.</td>
<td>Relief and Development initiative</td>
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<td>149.</td>
<td>Relief Society Tigray (REST)</td>
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<td>150.</td>
<td>Rohi Weddu Pastoral women development organization</td>
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<td>151.</td>
<td>SAACID</td>
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<td>152.</td>
<td>SACB</td>
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<td>153.</td>
<td>SAGAL Help to Self Help Organization</td>
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<td>154.</td>
<td>Sahal organization</td>
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<td>155.</td>
<td>Samo Development Organization (SDO)</td>
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<td>156.</td>
<td>Save Somalia Women and Children (SSWC)</td>
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<td>157.</td>
<td>Save the Children International</td>
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<td>158.</td>
<td>Setaweet</td>
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<td>159.</td>
<td>SFCN Somali Family Care Network</td>
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<tr>
<td>160.</td>
<td>Siqqee Women’s Development Association (SWDA)</td>
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</tbody>
</table>
161. Smart Vision Consultancy
162. Somali Agro Action Community (SAACOM)
163. Somali Development and Rehabilitation organization (SDRO)
164. Somali Diaspora Organisation (SDO)
165. Somali Family and Health SOFHA
166. Somali Media Women Association (SOMWA)
167. Somali Peace Line (SPL)
168. Somali Poverty Relief
169. Somali Relief and Development Action
170. Somali Women Development Center
171. Somali Women Development Organisation (SOWDO)
172. Somali Women Self-Help Association (SOWSHA)
173. SOMLINK
174. SOS Children’s Village
175. SOYDEN
176. Tadamun
177. Tamira Reproductive Health and Development Organization (TRHaDO)
178. The Cooperation of Medical Services and Development (COMSED)
179. The National Committee on FGM/FGC
180. Tostan International
181. UNFPA
182. UNHCR
183. UNICEF
184. UNIFEM
185. United Religions Initiative (URI)
186. USAID
187. WAWA We are Women Activists
188. WHO
189. Woman Kind Somalia
190. Women support Association (WSA)
191. Women’s Development Organization (IIDA)
192. World Vision
193. WUNRN
194. Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM)
195. Yeso
196. Youth Employment Summit (YES)
197. Y-peer network Somalia
Annex 3 Overview of interventions


Feldman-Jacobs, C. & Ryniak, S. for Population Reference Bureau. 2006. *Abandoning Female Genital Mutilation/Cutting: An In-depth Look at Promising Practices*. Available at:

FERO. 2016. *Somalia Gender Based Violence Sub-Cluster*. Received via e-mail from FERO on September 18, 2017.


Norwegian Church Aid and Save the Children. 2015. *Joint Summary Report 2011-2015: Norwegian Church Aid and Save the Children in Ethiopia and Somalia Programmes on ‘Female Genital Mutilation/Cutting’*. Received via e-mail from NCA on September 4, 2017.


Svanemyr, J. & Takele, Y. 2015. *End-term review of the Strategic Partnership between Norwegian Church Aid (NCA) and Save the Children International (SCI) for the Abandonment of Female Genital Mutilation (FGM)(2011-2015)*. 14 October 2015. Received via e-mail from NCA on September 4, 2017.


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Annex 4 Codebook

Categories:
AC Accountability
DI Different indicators
FR Future recommendations
PD Project design
PO Project outcomes
TTM Transtheoretical Model

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC-DCl</td>
<td>Data collection through interviews and/or focus group discussions.</td>
</tr>
<tr>
<td>AC-DS</td>
<td>Data collection through document study.</td>
</tr>
<tr>
<td>AC-DsI</td>
<td>Data collection through document study and interviews and/or focus group discussions.</td>
</tr>
<tr>
<td>AC-EE</td>
<td>The evaluation is carried out by an external party.</td>
</tr>
<tr>
<td>AC-FGC</td>
<td>Usage of the neutral term for female circumcision, namely FGC.</td>
</tr>
<tr>
<td>AC-FGM</td>
<td>Usage of the more controversial reference to female circumcision, namely FGM, as explained in paragraph 1.2.</td>
</tr>
<tr>
<td>AC-HRV</td>
<td>Mentioned in report that FGC is a human rights violation or emphasis on the cruelty of the practice.</td>
</tr>
<tr>
<td>AC-IE</td>
<td>The evaluation is carried out by the same body as the project.</td>
</tr>
<tr>
<td>DI-COS</td>
<td>Collaboration with other anti-FGC initiatives.</td>
</tr>
<tr>
<td>DI-DLS</td>
<td>Intervention targeted at different levels of society, for instance local and regional.</td>
</tr>
<tr>
<td>DI-GLP</td>
<td>The development of grassroot level policies in addition to federal government policies.</td>
</tr>
<tr>
<td>DI-LS</td>
<td>Collaboration with local stakeholders.</td>
</tr>
<tr>
<td>DI-LSG</td>
<td>Collaboration with local stakeholders from the government.</td>
</tr>
<tr>
<td>DI-LSR</td>
<td>Collaboration with local religious stakeholders.</td>
</tr>
<tr>
<td>DI-POD</td>
<td>Promotion of open discussion during the intervention.</td>
</tr>
<tr>
<td>DI-RLIC</td>
<td>Role for religious community leaders during the intervention.</td>
</tr>
<tr>
<td>DI-SD</td>
<td>Facilitation of discussion at schools.</td>
</tr>
<tr>
<td>DI-TTW</td>
<td>Trainings/workshops targeted at specific groups.</td>
</tr>
<tr>
<td>DI-TTW/A</td>
<td>Trainings/workshops participation based on age.</td>
</tr>
<tr>
<td>DI-TTW/ED</td>
<td>Trainings/workshops, participation based on level of education.</td>
</tr>
<tr>
<td>DI-TTW/GE</td>
<td>Trainings/workshops, participation based on gender.</td>
</tr>
</tbody>
</table>
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| DI-TTW/RL  | Trainings/workshops targeted at religious leaders in general. |
| DI-TTW/RLS | Trainings/workshops targeted at religious leaders of specific religions. |
| DI-TTW/ST  | Trainings/workshops, participation based on the community hierarchy. |
| DI-WE      | The project focuses on women empowerment. |
| FR-CS      | Community-Specific Future Recommendations |
| FR-G       | General Future Recommendations |
| PD-CDM     | Community involved in decision-making process. |
| PD-CE      | The interveners developed a conducive environment for the community they intervened in. Examples are local interviewers and facilitators from own region. |
| PD-CS      | The intervention is adapted to a specific ethnic group and its traditions and beliefs, and therefore community specific. |
| PD-CT      | Clearly set targets beforehand with well formulated indicators. |
| PD-DA      | The intervention programme comprises of different activities to reach the objectives. |
| PD-DCS     | Development of community structures or integrating in existing structures. |
| PD-ED      | The interveners adapted eradication programme to the different level of education of the community. |
| PD-FI      | Facilitation for procurement of capital items e.g. computers, cameras, megaphones. |
| PD-IE      | The FGC abandonment activities were integrated in existing (health) projects. |
| PD-IR      | Incorporating recommendations from other projects |
| PD-MC      | Media campaigns |
| PD-MF      | The project has multiple focus points, for instance public health in general. |
| PD-PR      | Project review during intervention. |
| PD-SS      | The intervention is adapted to the local context of this state, and therefore state specific. |
| PO-GR      | Goals/objectives of the project reached. |
| PO-SU/FS   | Sustainability assumed because of the development of or linking to local structures to secure the work carried out by the project after termination. |
| PO-SUN     | Sustainability of the project assessed, with a negative outcome. |
| PO-SUP     | Sustainability of the project assessed, with a positive outcome. |
| TTM-NR     | Stage of Transtheoretical Model, not ready to take action. |
| TTM-IA     | Stage of Transtheoretical Model, individual awareness raised. |
| TTM-OC     | Stage of Transtheoretical Model, individual opinions with regard to FGC have changed. |
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<table>
<thead>
<tr>
<th>TTM-GAK</th>
<th>Stage of Transtheoretical Model, group action against FGC initiated by key leaders. For example making a public declaration against FGC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>TTM-GAC</td>
<td>Stage of Transtheoretical Model, group action against FGC by whole community.</td>
</tr>
</tbody>
</table>