The Difficulties of Ending Female Genital Mutilation (FGM):

Case of Afar Pastoralist Communities in Ethiopia

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Disclaimer:

This document represents part of the author's study programme while at the Institute of Social Studies. The views stated therein are those of the author and not necessarily those of the Institute.

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Dedication

This paper is dedicated to

Aregash Kebede Adefris

(My Mother)

And

Nel Greep-van Ringelestein

(Former Board secretary of SK Foundation)

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List of Acronyms

AISDA	Action for Integrated Sustainable Development Association
AMREF	African Medical Research Foundation
CARE	Cooperative for Assistance and Relief Everywhere
FAO	Food and Agriculture Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
HEW	Health Extension workers
HIV	Human Immunodeficiency Virus
HO	Health Officer
HTP	Harmful Traditional Practices
ISS	Institute of Social Studies
NGO	Non-Governmental Organization
MA	Master of Arts
MDGs	Millennium Development Goals
MoFED	Ministry of Finance and Economic Development
RP	Research Paper
TBA	Traditional Birth attendant
TTBA	Trained Traditional Birth attendant
UN	United Nations
UDHR	Universal Declaration of Human Rights
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organization

Abstract

Female Genital Mutilation (FGM) is a widespread health risk and violation of the rights of women and girls in many African countries including Ethiopia. The RP focuses on the Afar region where the worst form of FGM is being practiced in Ethiopia. The RP examines how FGM is perpetuated in Afar by looking at the role played by the community- parents, Traditional Birth Attendants (TBAs), that perform child delivery services and in the process practice FGM, religious and clan leaders. The RP points to the limited scope of the Ethiopian government to put in to practice policies and legislations to prevent FGM due to lack of budget allocation and human resources specific to fighting FGM. The RP points to how NGOs have taken up the struggle to fight FGM but in an incomplete way, largely due to financial constraints to cover the entire region. The RP analysis the current attempt to eradicate FGM showing how the focus is on health issues, rather than on a right based approach to the violation of the rights of women and girls. The RP findings reveal that it is the community- the mothers, fathers and religious leaders as well as the TBAs who play a significant role in the continued practice of FGM. The RP suggests that in order to eradicate FGM it is important to understand how deep the cultural influence is in continuing FGM in the name of sustaining culture and preserving religion despite lack of reference to it in religious scriptures. *Dagu,* the fast information transmission culture which is unique to the people of Afar, is also suggested to be well recognized in the efforts of fighting FGM.

Keywords

Female Genital Mutilation, culture, women, girls, Traditional Birth Attendants, religious leaders, clan leaders, government, NGOs, approaches, rights

Word Count: 17,485 plus abstracts and references

Chapter One: Introduction

"FGM has affected both my physical and psychological power; but it has given me the strength and power to fight it back". (Halima[1], 28, Female, Government Official)

1.1. Background

Female Genital Mutilation (FGM) has been on the development and gender agenda for the past two decades by the UN (United Nations) agencies, Non-Governmental Organizations (NGOs), academics and local governments.

My Research Paper (RP) looks at FGM within the specific region of Afar in Ethiopia. It looks at how FGM is a threat both for the health and rights of women and girls and in what ways it is grounded in cultures and traditions. The RP analyses the main factors for perpetuation, reasons and attitudes of communities on FGM in Afar regional state, specifically of *Dawe* district. The main objective of the RP is to find out why the practice still continues despite its prohibition by law and efforts exerted to stop the practice. It also looks in to the motives and hidden push factors within the communities for the continuation of FGM. The persistence of the practice might be highly related to the socio-cultural and accepted patriarchal norms in the society in relation to traditional institutions. Of course, no one can downgrade the contribution of the male dominated traditional institutions in their actively engaged conflict management, resource allocation, administration and communication with the outside world. However, their role in fighting harmful traditional practices, mainly FGM, is not visible and seems lacking attention and coordination. This is one of the points to be addressed by the paper.

From my experience at *Dawe* working with government offices and later with NGOs, it is my hypothesis that the failure on the eradication of FGM could also be because of unfriendly top-down approaches as a direct replication to similar interventions. Behavioural change interventions need the active involvement of major groups of community stakeholders to quite their aged customs and thus bring attitudinal changes. The re-

[1] Halima Mohammed Bodaya is currently working as head of women, children and youth affairs office at Dawe district in Afar.

search also deeply investigates the double role of Traditional Birth Attendants (TBAs) (in childe delivery service and practicing FGM) and their perceived contributions in the lives of women and children. The current perception of communities on (TBAs) and the policies of the government on safe child delivery would be part of the discussion in the Paper. This paper explores if my suspicion on TBAs as obstacles to stopping FGM is right or wrong.

Dawe district is where FGM is widely and in its worst form (infibulation) being practiced. Although the district is continuously targeted by different projects to stop FGM, decline is not occurring as expected. The research tries to look at why reduction is so slow in the district and in Afar generally. Some of the opportunities in doing my research in the district include my knowledge about the culture, the language of Afar; good working experience with local and regional governmental institutions; and the presence of the local NGO I have been working with in the area that has provided me with logistical support in my field work.

I became aware of the problem of FGM while living and working in Afar region for about two decades. Working for a local NGO called AISDA (as co-founder and taking up the executive position) on the ground in planning, monitoring and executing FGM projects to date has exposed me to understand the problem more and to push harder in the eradication struggles in Afar. AISDA has been challenged by the complexities of FGM that is surrounded by its perpetuators operating on the ground. These issues stunted the performance of the organization in the fight against FGM even working hand-in-glove with government and with the full participation of community based institutions. Understanding the deep-rooted cultural and traditional settings and capturing the honest feelings of main actors in the community always demanded deliberate and specific study to know as to why FGM has persisted to date. My interest for doing this study arises from this particular point of digging out the main constraints and difficulties in fighting FGM in Afar region as a means to unpack the traditional and cultural complications usually mentioned as an obstacle in eradicating FGM. The knowledge I have grasped through the scholarly debates on social development and specifically on complex poverty issues at ISS (as a student specializing in poverty studies) have pushed me more to do this study on a social problem that I am familiar with, which is FGM. This has shifted my thinking from an advocate of NGO to an independent researcher. What makes this research more important is the

application of "outsider knowledge" from ISS to an "insider problem" in Afar.

FGM involves concepts of culture, tradition, sexuality, gender, right and health. Especially, the issue of culture plays a vital role in perpetuating the practice. Sylvia Tamale, discusses in her book how cultural context is the basis for the construction of gender; and how most of these interrelated concepts need to be seen with specific cultural settings. She also associates how the neglect to culture jeopardizes women's justice. The enjoyment of the rights by women, especially in Africa, is wrapped within cultural backgrounds (Tamale 2008:155-157). I am interested in taking up this observation that one of the reasons for the failure to end FGM has been the lack of recognition given to specific cultures during interventions.

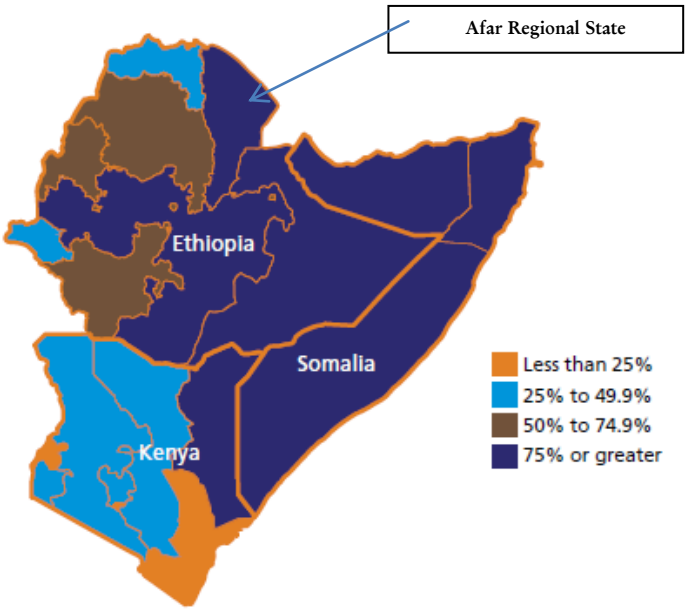
1.2 Statement of the Problem

There are 28 African countries known for the practice of FGM; Ethiopia is a high prevalence country (UNICEF 2013a). Afar region is labelled as part the group of regions having prevalence rate above 80% (UNICEF 2013a:32). Afar is one of the most underdeveloped regions in Ethiopia where peoples livelihoods is mainly dependent on raring of animals (pastoralism) with high level of mobility from arid areas to wet places to look for water and browse for themselves and their animals. The tendencies of poverty reduction in some underdeveloped regions in Ethiopia, including Afar, seem less efficient. Despite the declining inequalities among regions the level of poverty in regions like Afar is still higher. This has been proved by the Ethiopian Ministry of Finance and Economic Development (MoFED), as the government has increased its efforts to foster the adopted MDGs acceleration framework on maternal health specifically to the emerging regions including Afar as they are lagging behind(MoFED 2012:3-31) which shows the degree of maternal health gap in the region.

Afar region has an estimated population of about 1.72 million (CSA 2013). It has flat landscape with arid climatic condition having low rain fall in most of its parts. There are different harmful traditional practices in the region that include milk teeth extraction, abduction of girls, early marriage, face branding and of course FGM as the main one. What makes FGM serious in Afar region compared to highland areas of the country is the degree of severity in the practice and its deep-rooted socio-cultural reinforcements for sustenance. A number of anti- FGM projects funded by local and international NGOs have been implemented; however, the level

of reduction in the practice is still in question despite the difficulty to support it with empirical data as it is hard to get such district specific information in the region.

Prevalence of FGM in East Africa and specifically to Afar in Ethiopia



Map 1 Map Showing the Concentration of FGM in the Horn of Africa Including Ethiopia (map by Population Reference Bureau, 2014[2])

Studies show that infibulation type of FGM is prevalent in the Eastern parts of Ethiopia (Spadacini and Nichols 2010:46) and basically Afar (28toomany 2013:40). In Afar, specifically in the selected district of this research, *Dawe,* almost all baby girls have to go through some form of FGM, locally known as "*Salot*", during infancy. The widely used form of cutting involves the total removal of the clitoris, labia minora and in worst cases labia majora using a small locally made and unsterilized knife called "*Makkita*" (Andarge 2012:1). After doing the cutting, the traditional practitioners stitch the genital organ (known as infibulation) to guarantee the prevention of the girl from having sex before marriage. The two legs of the girl will be firmly tightened together for days to secure effective stitching. Cutters leave a small opening with a size meant only for urination and menstrual bleeding. The problem doesn't stop with the removal of the most sensitive genital parts and stitching, it has to be reopened during child delivery after marriage. After childe delivery, it has to be

[2] (PRB 2014) Female Genital Mutilation/Cutting: Data and Trends Update 2014, Population Reference Bureau, Washington DC.

stitched back again "*Kena"* until the next child delivery. Shocks, excessive bleeding, infection and severe pain are common during this time. In addition, 34.4% of Afar women have got Anaemia that affects pregnant mothers causing premature delivery and lesser weight for newborns (CSA 2011:189). All these cause complications and death for many women and children. Additionally, it is also reported that HIV can be transmitted through blood in the process of FGM (Brady 1999:712).

The reasons given for FGM in the society are difficult to be justified scientifically but people believe it is a needed practice. In Afar, community testimonies reveal that reason include honour and respect, to sustain beliefs and marriageability. Parents want to have a 'respected girl' that is believed to make her family proud for being well protected until marriage, the World Health Organization (WHO) clarifies, the safeguarding of cultural belongingness and membership in their local community (WHO. 2008:6); and to avoid genital impurity which they believe unless those genital parts are removed the organ will remain unclean and much more larger. Additionally, FGM is thought to sustain and transfer traditions, to reduce girl's sexual desire and possible provocation which they believe unless a girl is circumcised she would ask men to have sex; and the fear for societal exclusion on parents and the possibility of a girl to be seen as shameful and less attractive for marriage.

FGM is rooted in traditional socio-cultural influences that forces women to undergo the practice. Still today virginity is seen as a sign of respect for girls and parents; and also as a precondition for marriage (Telly and Short 2012) and the same is true in Afar. Marriage is the only means for economic survival for women. It is seen as very important for women to have children and to be economically shielded by men who obviously are the sole sources of income for the household as they manage all properties of the family. For that matter parents would be forced to put their daughter in to this hazardous decision. In other places where FGM is widely practiced, despite its variation, usually girls are needed as a means to get children and free labour (Althaus 1997:131). This trans-generational problem consequently has been risking the physical and psychological wellbeing of girls and mothers through sexual and gender based inequality. It is one of the ways by which inequality between men and women has been manifested and embedded in structures of social, economic and political conditions of societies (WHO. 2008:6). This is validated through the various actors in the communities that give their own influences on the sustainable continuation of FGM.

In Ethiopia in general, 90% of child delivery attendance is performed at home and Afar has the highest 92.8% (CSA 2011:128). TBAs in Afar (singular *Ullatina*, plural *Ullatinani)* are the directly involved actors in this case. In Afar, TBAs have been known for two main services. First, they give the services of child delivery because of the limited or no health services in rural areas. Despite the slow-by-slow introduction of health services in rural Afar, mothers prefer TBAs to formal health professionals for child delivery services. Mothers want the service to be given in their own homes since they have developed trust and dependency on TBAs. They do not feel secured with public health services which are widely dominated by men and this is confirmed from my field study. As a result, the service of TBAs got more recognition in the maternal and child health programs in Afar. For example, a study conducted by the African Medical Research Foundation (AMREF) in three zones of Afar, almost 92% of mothers gave birth in their own home and valued the services of TBAs and out of which 90% were assisted by Trained TBAs (TTBAs). The study also disclosed the ability of TTBAs in identifying mothers under risk during pregnancy. Their ability both in delivery and child care after birth has been appreciated by the majority of respondents (Yousuf et al. 2010:7-18). TBAs were supported through intensive theoretical and practical training and supply with basic and sterilized medical equipment by NGOs.

Second, TBAs are also practitioners to FGM which is directly related to child delivery. Most of them circumcise girls side-by-side to the child delivery service they give to mothers. FGM as practice and TBAs as cutters, are entrenched in the day to day survival system of the society. On any training organized for TBAs, FGM is always an important topic and a major component of training and discussion. In *Dawe*, where some NGOs have been implementing projects against FGM, TBAs are taken as main focus-group of intervention. As trained and equipped TBAs start to decline in circumcision, the emergence of untrained TBAs or newly emerging practitioners has become challenging as they try to fill the gap in cutting.

Traditional opinion leaders (clan and religious) are known to have been the most influential and powerful people on all affairs of communities. The people of Afar have clan-based traditional administrative system whereby each local area has its own leaders that represent and act on be-

half of the people. Clan leaders are involved in all aspects of social, cultural, economic and political issues of their own local communities.

Religious leaders have also strong power as Afar people follow the same religion (Islam) across all the countries they belong to, Ethiopia, Djibouti and Eritrea. The role of opinion leaders in the fight against FGM is minimal despite their enormous value in the day-to-day life of the people of Afar that sustained peace and order. For example, Religious leaders have the power to testify FGM is not as Islamic commandment in the Qur'an. Clan leaders can produce district specific rules. From experience, the problem has been how to install trustworthy and sustainable behavioural change on the leaders themselves before they start convincing others. This in turn questions the strategies and approaches that are now in place by the government and NGOs operating in the area to abolish FGM. This brings FGM more in to structural form of violence on women and girls linked with other forms of social and cultural deprivations.

1.3 Research Focus and Objective

The main objective of this research is to explore (understand) the reasons why FGM is continued to be practiced among the Afar pastoralist communities even though so much money and effort is spent especially by the government and NGOs to stop it. The objective also includes finding out the level and reasons for the importance of TBAs in the society. It will look the way the community perpetuates the practice.

1.4 Research Question

Why is FGM continuing to be practiced in the Afar society?

To achieve this following sub questions are need to be answered:

1.4.1 What are the social, economic and cultural settings, push factors and justifications linked to FGM as a practice in Dawe?

1.4.2 Who are actors perpetuating the practice of FGM in the Afar society and their positive and negative stake, what are the roles they play; and their views benefits and costs of FGM?

1.4.3 What are the interventions, approaches and assumptions by the state services and NGOs to end FGM?

1.4.4 What are the roles and challenges of TBAs towards child delivery services in rural communities where there are no or inadequate health services in relation to FGM?

1.5 Methodology

This RP followed qualitative research method and employed interview and observation techniques. I mainly focused on in-depth interview as a means to get the honest feeling of the variety of groups of respondents that I communicated as direct contributors to the sustained practice of FGM. As O'Leary says interviews let a researcher to better develop trust and relationship, provide the researcher with detailed and comprehensive qualitative data, flexibility for exploration of data and even to produce consistent quantifiable data (O'Leary 2014:217). Structured interview has been conducted with two regional government representatives. I myself undertook the face to face in-depth interview with all community and NGO representatives (26 persons) in Dawe district that provided me with ample and very useful information to answer my research questions.

Dawe district has 10 administratively divided sub-districts (kebeles) with almost similar living conditions, economic status and rural life but with some variations between some kebeles. Some are close to the centre of the district where the seats for the local district administrative institutions are based. Others are far-off with very limited reach in education, health, transport and other social services because of the remoteness and distance from the centre. For this research, I have reached six kebeles from the total ten for fair geographical representation. The kebeles included for the research are named Adalil ke Woderage (where the central town of the district, Woderage, is located), Eyeledih ke Gendeuri, Killenti ke Dersadda, Wahilo ke Geddele, Yummdu ke Kebeakoma and Halbi ke Sonkokor.

Table 1 List of group of Actors interviewed and Their Gender Aggregated Representation

No	Group Identification	Position in the Community/ Regional State	Sex		Number of Inter-viewees
1	**TBAs**	• Childe delivery service and FGM	F		3
2	**Boys**	• Students	M		5
3	**Girls**	• Students	F		2
4	**Religious Leaders**	• Preaching and leadership	M		3
5	**Clan Leaders**	• Traditional leadership	M		3
6	**Mothers**	• Pastoralist (house wife)	F		3
7	**Fathers**	• Pastoralist (HH heads)	M		3
8	**Local Govern-ment**	• District administrator • District WCY head • Justice office head	M F M		1 1 1
9	**Local Health Institution**	• Health center professional and act-ing head	M		1
9	**Regional Government**[3]	• Regional health bureau (deputy head) • WCY bureau officer	M M		1 1
10	**Samara Universi-ty**	• Research director	M		1
11	**NGOs**	• Project coordinator (AISDA) • Field office coordinator (CARE Ethiopia)	M M		1 1
		Total	**M 22**	**F 9**	**31**

In my in-depth interview I have involved different groups of community members that are usually considered having a decisive stake in the practice of FGM. Using snowball and purposive sampling methods, a total number of 31 interviews have been made with community members, local and regional representatives; and a university in the region to get their current position on the topic. Observation was employed in every discussion I made with every community member I have interviewed.

Religious leaders have been seen as main perpetuating groups of the practice because of their unclear positions on FGM. I have interviewed three main religious leaders both from that have paid positions by the government as Sharia office leader and also with someone without position but

[3] The interview with the representatives of the regional state bureaus was done by the Research Director of Samara University.

having decisive religious leadership role within the local communities. Similarly, I have made an in-depth interview with three clan leaders one of whom is the chief of all clans in and around *Dawe* and having an influence on clans in other neighbouring districts. The other two are representatives of one smaller and another bigger clan that has also a presence in other adjacent districts.

The interview with TBAs included three actively functioning ones in rural areas of which one has never got any skill development training and provision of childe delivery equipment from any NGO programs. The two TTBAs have been supported by NGOs and still are actively serving their communities in child delivery services. Three mothers with special preferences given to those having daughters were selected and were interviewed on their current position on FGM and their honest reason for its continuation to date. The interview with mothers was planned to dig-out their motive and hidden reasons for wanting the practice on their own daughters while they have been suffering themselves from prolonged pain and complications because of infibulation type of FGM.

One of the main objectives of this research is to also reveal the role and interest of men (fathers and boys) on FGM. Fathers, as parents, have a decisive power in the community and my interest was to unpack the views and their seen and unseen roles on FGM. Likewise, despite the lesser degree of power, I tried to apprehend the feeling of boys on what is happening on their sisters and their future wives. Girls were also my emphasis group as they are victims of the traditional practice and suffering now and to suffer in the future. I emphasised on them because boys and girls in general are the future decision makers both as leaders and parents in the society. The age range of youth interviewees (totally seven) is between 16 and 25. Education wise the least education level is secondary education and the highest is second year university education.

Formal institutions (governmental and non-governmental) were also communicated as they have direct relations with FGM. From local government, the chief district administrator was an important respondent. I was interested on him because he has both the authority titled by the government and also as the first son of the chief clan leader to take over the chief clan leadership position after his father. My interview with the lady who is serving as head of the district women, children and youth affairs office has been very interesting also. As a woman that has passed though "Pharaonic" circumcision and as a woman that has the power and currently struggling in the fight against FGM has brought my mind to give keen

concern to get more information from her; and thus my discussion with her has given me ample information on FGM. From justice institutions, the district justice office head was one of my respondents. My interest with justice office was to see how far they are enforcing the implementation of laws against FGM produced by the regional government and also to get information if there are cases handled by the police. My interview with one of the professionals of rural health centres was to see their reaction and justification on women's resistance to come to health facilities during child delivery and also to see their challenges in relation to childe delivery and FGM.

Regionally, Samara University and two regional bureaus (health and women affairs) were communicated especially on the issue of, research, data, strategy, and to get justification why TBAs are being excluded from the system of child delivery before fully installing proper medical facilities and professionals in rural areas. NGO wise, representatives of two actively operating NGOs, AISDA and CARE, local and international respectively, were also reached by interview to see the values of their interventions and approaches. I interviewed the project managers of each of these organizations.

1.6 Specific Methods Used and Dealing with Challenges

As male researcher, I had a plan to actively involve the head of the district women and children affairs office (female) for my interview with mothers and women in general; however, this has been cancelled because of her suggestion that her involvement might endanger the trust worthiness of the information coming from women as she is known by most of the women in aggressively fighting FGM. Because of that I had to conduct the interview with all the selected respondents, male as well as female, by my own with a special support and advice from local officials. To my surprise, I did not encounter any special difficulty in interviewing women. Most of the interviews were conducted by the Afar language except with few people using the national working language (Amharic) as an alternative means of communication. I was based at the centre of the district with frequent travels to the field to get the unreached representatives from the rural communities.

The interviewing process was a bit challenging because of the fasting month of Ramadan as almost all the people in the district are followers of the religion of Islam. This has effected to the total cancellation of the plan

to undertake Focus Group Discussion (FGD) among group of community members. Very high temperature coupled with fasting could not allow me to organizing effective group discussions. Almost half of the interviews were done during the night after breaking fasting to allow energetic speaking since I found them tired and thirsty during the day time. It was quite unlikely to organize FGD in the night time as well because it is not common to organize such gatherings during nights especially for women. Of course, lack of electricity and mosquito bites were challenging to make the interviews at night but it was possible with the use of local solutions. Logistically, a four-wheel drive vehicle was assigned solely for my field works by AISDA which made my work more flexible to travel to the rural villages as required. At most clarification was given to all respondents about the purpose of the interview to avoid bias of associating responses with my organization's project on FGM. I did my best to remove my organisational identity and introduce myself as a researcher. All respondents were approached and instructed with the Afar traditional and unique greeting procedure called *Dagu* as a means to show respect, motivate for more interest in the interview and also to get valuable and honest responses through rapport and smooth communication.

Technique of Recording/Data Collection and Analysis

Most of the interviews were conducted face-to-face except few interviews made by phone with some officials who were not around during the three week field work. Note taking, photographs and sound recording were the main tools to collect qualitative data. As interviews were made both by local Afar and Amharic languages, translating the data in to English language was the first step in the analysis of the raw data. The qualitative data recorded from the interviewees were classified in to thematic areas with respect to the semi- structured questions designed for regional offcials. This method of analysis has been chosen to triangulate the response of the different group of respondents.

1.7 Organization of Paper

The first introductory chapter *(chapter one)* is made-up to introduce my background, the extent of the problem in Afar, the purpose of the study, the research objective, questions and methods. *The literature review (Chapter two)* deals with the details of some of the basic concepts as written mainly by other academics, researchers and international organizations. This chapter enriches readers with the current concepts and terminologies

of FGM and its current status supported by figures. The chapter has a model that shows the challenges and influences of actors at all levels. Chapter *three* and *Chapter four*, *Legitimized Perpetuation and the complexities of ending FGM,* respectively deal with the most basic findings of the research with respect to the research objective and questions outlined. The findings are presented in a very detailed manner so that any reader can understand the on-going situations on the ground. The Final chapter, *Conclusion (Chapter five)* addresses concluding remarks and possible recommendations.

Chapter Two: Literature Review and Constructing Conceptual and Analytical Framework

2.1 Types, Consequences and Prevalence of FGM

> *The society's understanding is baseless. People have to know girls can control their sexual desire without being circumcised. Girls are able to analyze things by their own" (Kubulli, 16, girl, student).*

The main objective of this chapter is to bring in research findings of different scholars, academics and organizations including local and international for familiarizing readers about the relevant issues on FGM. The discussion in this chapter includes its international prevalence, how FGM is perceived (as health and Human rights issue), its consequences, international and local laws and the level of enforcement, socio cultural realities and the different actors within the practice of FGM.

There is no concrete evidence where FGM was first began to be practiced, but some studies suggest it might have been first started in ancient Egypt and then spread to different parts of the world at different times (Giuliani 2006:7), "In the pre-Islamic era the custom was widespread in Egypt, Arabia and along the coast of the Red Sea" (Dirie 1992:479-482).

FGM has been identified as a major social, health and rights violation problem for millions of girls especially in Africa and also the Middle East. Half of them are done in Egypt and Ethiopia (WHO 2011:2), FGM is mentioned by different names in different literature as, 'female genital surgery' (Grisaru et al. 1997) 'female genital mutilation', 'Female genital cutting', and 'female circumcision' but the widely and alternatively used ones currently are Female Genital Mutilation and/or Cutting as used by United Nations (UN) Agencies. For this RP I would use the term FGM.

According to the WHO, FGM is classified in to four types.

> "**Type I:** Partial or total removal of the clitoris and/or the prepuce (clitoridectomy), **Type II:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision), **Type III:** Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation) and **Type IV:** All other harmful procedures to the female genitalia for non-medical

> purposes, for example: pricking, piercing, incising, scraping and cauterization." (WHO. 2008:4, WHO 2010)

FGM has both short and long term health consequences. Hard pain, bleeding, infection, and shocks are some of the major consequences of FGM and this also includes complications on maternal and child health in relation to child delivery (WHO 2011:2-3).

FGM is an accepted cultural norm to abide for millions of people around the world. The tradition continued since generations and considered as normal and beneficial. In a patriarchal society where a female without circumcision is considered as less attractive, socially isolated and discriminated, passing through the practice would be unquestionably acceptable. Without circumcision "she will not become a mature woman, even a full member of human race" and also face "social pressure from their peer and family members" (WHO 2001:23). The United Nations Children's Fund (UNICEF) puts the practice as "an extreme example of discrimination based on sex" (UNICEF 2005:1). In communities where women are strongly subject to patriarchal domination and economic dependence, marriage is perceived to be the only means to '"self-reliance" for girls. There is often an expectation that men will marry women that only have undergone the practice. One reason for the persistence of FGM is girls are expected to pass through marriage to protect their future economically and achieving the level of woman hood (WHO. 2008:6).

According to UNICFE's most recent report, among the 29 African countries that are officially known with an official national data, Egypt (27.2million), Ethiopia (23.8million) and Nigeria (19.9million) have the highest circumcision rates of girls and women so far; and with the same report the current prevalence of the practice of FGM in some countries is higher. Somalia is taking the leading percentage (98%) followed by Guinea (96%) and Djibouti (93%) (UNICEF 2013b).

Despite its bad consequences on health and human rights abuse, the progress of decline after many international and local interventions is not much satisfactory. According to the United Nations Population Fund's (UNFPA) recent report the reduction rate of FGM per year is estimated only 1%; and the projected rate of reduction per year to bring the practice down to half by 2015 is about 12.9% (UNFPA 2013).

2.2 Miscarried Policies and Sustained Subjugation of Rights

FGM is the violations of women's rights to reproductive health (Rogo et al. 2007:1, UNICEF 2005:1, WHO. 2008). One of the main reasons often mentioned for the cutting of parts of women's genital organ is to reduce sexual desire of women. This deliberate act of women's reproductive and sexuality violation has been justified, among other things, by cultural and traditional reasons.

Economic survival begins and or ends by becoming somebody's wife. FGM seems as one controlling mechanisms. For the rest of the world, and of course in reality, FGM is not only a health issue; but it is also a right issue. Its violation includes human rights in general, child rights, women rights, the right to good health and the right to development (Dorkenoo and Elworthy 1992:92-93). It involves the deliberate removal of the sexual feelings of women for socio- cultural reasons. This is against women sexual rights and shows the inequality between men and men (WHO. 2008). It is against all the international declarations on human rights and specifically to international laws directed to women and child rights ratified by most nations in the world.

FGM is prohibited by many international and national laws. A number of international declarations recognize FGM as both a threat to health and violation of the rights of women. Article 3 of the Universal Declaration of Human Rights (UDHR) which was adopted by the UN in 1948 states everyone has the right to life and personal security; and article 5 also commands that no one is subject to cruel inhuman act (UN 2008:3-4). Again the Vienna declaration and program action on human rights puts any kind of Harmful Traditional Practice (HTP) with any kind of risks on women and girls as violation of the rights of women and girls. The convention clearly puts "the human rights of women and of the girl-child are inalienable, integral and indivisible part of the universal human rights" (UN 1993). It adds on the responsibilities of nation states to act firmly on the rights of girls in relations to avoidable customs and traditions.

The Beijing conference on women also gave emphasis on the need to eradicate and stop any tradition or customary act if it is harmful and violates women's rights. It further states on the protection of reproductive rights as well as the rights to attain high standards of reproductive health ser-

vices for women (UN 1996:161-162). Later, the practice was condemned in 1979 on the conference held in the Sudan. After this conference many governments have come up with laws, ratifications and implementation plans to abolish the practice. (WHO 2010:3) In November 2012, the United Nation General Assembly produced an exclusive FGM specific resolution stating FGM as both health and rights issue through identifying major UN resolutions adopted so far; and also by recognizing the potential negative consequences it may have on women and girl's life (UN 2012).

In many parts of the world criminalization seems failing to bring changes. In Ethiopia for example, a recent study made by the university of Oxford, in southern parts of the country where criminalization of the act is under implementation, people started to undertake "underground circumcision" which might even put the problem worse because the hidden act might be done in dark places or done by someone who is not experienced. Brining behavioural change seems the cutting edge to see progress in combating FGM (Oxford University. 2014). In Kenya, anti FGM law was produced until it was backed up by another law in 2011, however, Howden interprets the Kenyan case as "changing the law was easier than changing practice" (Howden. 2014).

2.3 The Impact of Socio-Cultural Institutions

Religion has been mentioned as one reason for the continual practice of FGM even though it lacks concrete evidence from major sacred books like the Qura'an and Bible. It is practiced by followers of varieties of religions "including Muslims, Christians (Catholics, Protestants and Copts), and Animists in many parts of the world" (WHO 2001:23) and by Jews also (Grisaru et al. 1997). FGM is practiced among different societies following different religions especially in many Muslim societies, people would argue as if it is a religious commandment where in reality there is nothing mentioned in the Qur'an about it (UNFPA 2008:26). Parents insist on doing it for their daughters in fulfilling their beliefs without concrete religious evidence but targeted at controlling women's sexuality. (Cooka et al. 2002).

The contribution of TBAs as service providers has been recognized in many countries where modern health services are not well introduced. 99% of child and maternal deaths are happening in the world's developing countries; and in these countries, the contribution of TBAs in childe de-

livery services significant ranging from 50-80% because of lack of proper and modern health services (Shamsu-Deen 2013). Defined by WHO,

> "A traditional Birth Attendant (TBA) is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other traditional birth attendants. A family TBA is a TBA who has been designated by an extended family to attend births in the family. A trained TBA is a TBA or a family TBA who has received a short course of training through modern health care sector to upgrade her skills"(WHO. 1992:4).

A study conducted in Nigeria revealed that TBAs deliver broad range of reproductive health services but needed keen monitoring and supervision as the service delivered by the untrained ones is unsafe; and more than 97% of them are elderly women. (Ofili and Okojie 2005). In Afar regional state in Ethiopia, above 90% of child delivery is conducted at home by TBAs, their services include immunization, care for new born children, after delivery care (post-natal care) and family planning (Yousuf et al. 2010:7). In places like Afar, TBAs are also blamed for serving as FGM practitioners.

Imbalanced power relations perpetuate patriarchal overpowering of men over women. Sexuality is an equal right given without distinction between men or women. One major reason for FGM is a deliberate act of 'castrating' women for reducing their sexual desire. Short[4] named the practice as "genital genocide"(Short. 2012).The inequality between sexes is a manifestation of deep-rooted and risky discrimination on women's right and this is "upheld by local structures of power and authority such as traditional leaders, religious leaders, circumcisers, elders, and even some medical personnel" (WHO. 2008:1) as culture is regarded in actuality as fundamentally intimidating especially to women in Africa (Tamale 2008:150). According to the WHO, in most cases it is performed by traditional practitioners that are mainly elderly women (WHO 2001:24).

[4] Tim Tyson Short is a professional video maker and blogger who in 2012 came to video-record the works of AISDA in Afar as part of the Health Impact Award; and wrote his experience in detail on his personal blog.

Sphere of Influence and Challenges of Actors on Ending FGM

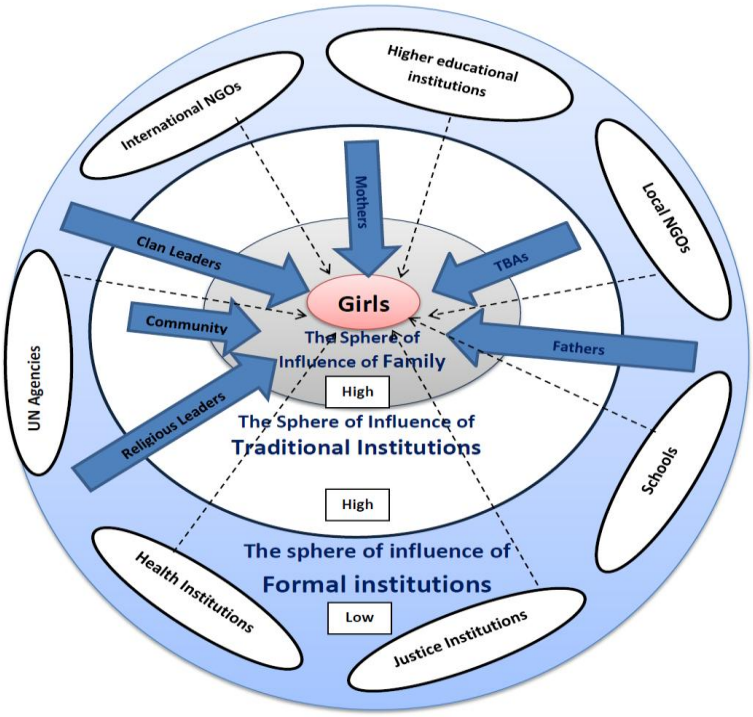


Figure 1: Stakeholder's Sphere of Influence (by author)

This analytical model shows the degree of influence of actors at different levels divided in spheres of influence. It has helped me first, in disclosing the degree of influence men have in all spheres (being as clan, religious leader or fathers). Second, how family plays a vital role in perpetuating FGM on girls; and finally, how formal institutions have low degree of reach and influence on fighting FGM practiced on girls. This model has a direct linkage with each of the following chapters (3, 4 and 5) that basically discuss on the findings from the field study.

Chapter Three: Legitimized Perpetuation of FGM

Mothers cannot forget to what has been happening in their life time because of FGM. But still, they continue to put their own daughters in to pain and sufferings of FGM giving more emphasis onto retaining their culture" (Allasa, 38, Male, Father)

3.1 The Ambiguity in Opinion Leadership

Despite variations in degree of influence in perpetuating FGM, the study shows community based institutions have each their own role to play. Religious institutions structured both formally and informally have an influential role in the community. The opinion of religious leaders at all levels varies from those who want to totally stop all kinds of FGM and those who want the *Sunna* (type I) to continue. From the study, it was possible to observe that the *Sharia* institutions set up by the government are supposed, by the law, to work in line with the legislations of the country in fighting FGM. This has been seen as good starting point despite its failures in strongly imposing the rules; and to convince their own respective communities as FGM is not a strong religious commandment. This failure has been reinforced by some leaders in the government structure that do not act on the rules they have drafted at regional level to stop FGM. The unclear act by religious leaders themselves erodes the confidence of the larger population that is dependent on their influence.

The government funded S*haria* officials accuse the non-funded *Sheiks* that have strong connection and presence in the community in their day-to-day life. These *Sheiks* are believed to have the power to influence their own communities which might make FGM to be wanted as a rule of religion.

According to one of the leaders of the *Sharia* office I have interviewed, some *Sheiks* negatively influence the community in preaching as FGM is important to continue. Some of the justifications used by the rural *Sheiks* are labeling the anti-FGM programs by government and NGOs as an imposition for "religious malpractice". They also convince their followers as other religions would like to enforce their interest on the people not to practice Islamic religion freely. This shows, the influence of religious institutions having both positive and negative impacts on the practice of

FGM. This has been confirmed by some of the respondents I have discussed with.

"You cannot find anything about FGM on the Qura'an. The Hadith that is usually quoted by most religious persons as a reason for resistance (for Sunna) is not also that strong. There are some religious figures that propagate for their own benefit than for the community. FGM is a result of culture and tradition not of religious commandment. I believe, it has to be stopped regardless of prioritizing any form of FGM. The problem is only because of lack of both secular education and religious knowledge with in the community. Awareness education would reduce the problem better. Women should be the main targets for education" (Sheik Mohammed, 68, Male, Qadhi[5])

Respondents were asked to mention the main pushing factors for continuing doing FGM in the community. The most commonly mentioned reason is to keep and preserve the culture of the community that has been done for many years and transferred from their ancestors. The Pharaohnic type which is classified as "type III" and "infibulation" (WHO 2010) and (Kwaak 1992) has been given the same name in the society. Most religious leaders, fathers and local government leaders used the same name "Pharaohnic circumcision" for infibulation and its local name is termed as also *"Addat-Salot" or "Hengeglo"* which means 'deep circumcision'. Despite its slow-by-slow declining condition with the pressure from different NGOs, governmental institutions and religious leaders; infibulation is still practiced among the rural population in many conservative and traditional clans. The question is why their ancestors wanted that kind of circumcision and why this society does still needed to further the problem while it is so much painful and life threatening.

The views of interviewees, especially religious leaders, varied in their opinion whether to totally stop the practice or continue practicing some form of FGM.

"I have two daughters; 2 and 8. Both are circumcised with Sunna type of FGM. My daughters were circumcised with the interest of my wife and I also supported my wife's decision. I am happy that my daughters are circumcised because I feel it is healthy for my kids. The experience of our ancestors shows that uncircumcised girls were in problem of itching so much to the extent that their organ bleeds. Those uncircumcised girls were less shy and were very pushed to have sex with any man. If some part (tip) of the clitoris is not cut, it will be a problem to control women. However, I

[5] Islamic scholar and currently working as paid religious leader assigned by the government.

do not agree to allow my kids to have the pharahonic type of FGM since it is bad for health" (Salih, 37, Male, Religious Figure).

This person explained his honest feeling about the necessity of FGM for his daughters. From this conversation it is possible to draw how people are anxious about preserving their tradition passed from their ancestors.

In Afar, traditional clan laws have been taken as the single most accepted rules securing justice for many years. Such problems as conflict resolution among clans and individuals, resource allocation, marriage disputes and any other major issues were brought to the clan elderly for final solutions. The main chief of all individual clans in the district mentions his past efforts to stop FGM through imposing fines (twelve cows) on any parent practicing infibulation on baby girls. But he mentions the declining power and prestige of clan-based rules and its step-by-step substitution by government structures that are challenging their voices. Clan based institutions are not so much empowered by the government for fighting FGM the same way as they are involved in resolving conflicts and serving as political agents. The chief believes FGM could be better eradicated if clan-based leadership is well incorporated and actively involved in the system of enforcement rather than government playing the role solely with the support of NGOs. Of course he admits the active role of NGOs like AISDA in involving clan leaders in their massive community mobilization but he suggests more could be done if systematically designed with utmost recognition of the government.

3.2 Hidden Patriarchal Rules, the Notion of Virginity and Colonized Mentality of Women

From the interviews conducted at the community level (excluding regional bureau and University interviewees) almost all, surprisingly, confirmed that mothers are the number one pushing group in sustaining FGM. This has been also honestly confirmed by interviewed mothers themselves. Mothers insisted most on authorizing their baby girls to be circumcised. They want their daughters to pass through the pain and suffering they have passed through. This was an interesting finding for me when every interviewee agreed on mothers as the most FGM wanting group of the community than any group I was thinking about.

"There are two main reasons why women strongly want FGM. The first one is culturally, it has been accepted by the general society that women's genital organ is very wide unless it is narrowed down. This means any man cannot be satisfied by having

sex with an uncircumcised girl. Second, if a woman is not circumcised, it is believed that women's sexual desire would become out of her control. Both reasons seem positioned to guard the interest of men. Mothers cannot forget to what has been happening in their life time because of FGM. But still, they give emphasis more on retaining their culture than to the pain and suffering of of their daughters" (Allasa, 38, Male).

Study results conducted in Guinea and Eritrea also has shown that, women support the practice of FGM than men (PRB 2001:24). The community mentions some of the general reasons for continuing the practice are to prevent girls from doing sex before marriage, to reduce girl's sexual desire, to make girls more shy not to be outgoing, fear of societal discrimination on uncircumcised girls, protecting the power and prestige of clans, respect religious regulations, secure cleanness of women's genital organ and so on. But the main factor that is not usually mentioned as a reason for infibulation is the motive to increase men's sexual pleasure during sexual intercourse through creating narrower genial organ ignoring to the feelings of women.

In *Dawe*, different forms of FGM are practiced; and one of which, infibulation, is the most commonly practiced type despite its reduction in recent days. After all the cutting is completed, it then involves attaching the already cut parts together leaving a small opening for discharging urine and blood. Some unlucky girls suffer from very narrow organ to the level that peeing becomes the most difficult experience in childhood. It is very common to see such young girls in rural areas where they can't do peeing without crying. In one of the rural villages where I interviewed a father, my attention was uncontrollably shifted to his 14 year old girl that every time cries when she feels the call of nature. Most severe, she usually urinates with the assistance of her mother using the tip of feather for stimulating the closed vaginal opening for slow-by-slow dropping of urine. At the age of puberty when girls start to experience menstrual bleeding, the number of girls with hard times increases.

"My daughter was infibulated during infancy. She is now 14. Due to the severity of the cutting, until the age of six she cried every night as a result of the over stress and pain of not being able to pee normally. I took her to a highland city called Dessie for hospital treatment (in Amhara region). I paid around birr 1600 (Euro 62) for minor surgery and she became well for some time. But her problem still persists and as she grows the problem has now aggravated. I am so much in trouble because of her health condition. Other than her, I have two daughters but they don't have that problem even though they are also infibulated" (Nuru, 48, Male).

This person has now become an active anti-FGM community mobilizer. When I asked him if he would allow circumcision to his next daughters (if any in the future), he replied "let alone my kids, I will never allow infibulation to the kids in my local area, never!". People seem to learn from their own experiences and from the experiences of others. The eradication of FGM could have better been successful with the involvement of such persons having an evidence to fight it back which can be combined with modeling of leaders at all levels (PRB 2001:18). Most people do not seem to share their experiences in public because of shame and to protect the psychological wellbeing of their kids. It is possible to guess how many kids there might be in the communities with this type of problem.

One might ask why the size of the opening of the women's genital organ is as such needed to be so narrow to the extent of creating hard times during urination. Besides the prevention of the girl from practicing sex before marriage, the main secret behind is to make men more happy by creating narrower organ. Until recently, most people in the society believed natural virginity doesn't exist unless it is made manually by practitioners. The cutting of those sensitive parts of the organ and stitching, generally called infibulation, is wished for the pleasure of men by producing "man-made virginity". This brings the notion of virginity more important and valuable for women's future life.

Infibulation is also claimed by the society to reduce the enlargement of labia minora and clitoris that makes the organ less attractive and unclean leading to aggressive itching throughout life. Cutting those parts of the organ makes the girl "free from itching" and "respectable" to be valued by the society and basically by men. Otherwise she would be given the name of "a girl with bigger organ". Form my interview and observation; there are no uncircumcised grownup women that can disprove the society's beliefs in this regard. According to a father whom I interviewed, it is commonly disgusting to see baby girls with their genitalia uncovered contributing for encouraging infibulation. Being circumcised even, if a girl experiences some kind of free discussion with man, or she talks loudly, the most common local verbal abuses include *"Kantar leh" or "Kantare"* which equivalently means *"a girl with erected clitoris"*.

Patriarchal thinking of men is the basis for gender inequality in most under developed countries (Okojie 1994:1237). With all these complications, the obligatory acceptance of FGM by women seems emerged from the needs of men. The power of men in the Afar society is unlimited and it still works. The suffering of women from FGM is not done as something

imposed by anyone but as something necessary and mandatory part of life that every woman hood should pass through. The pain and suffering from FGM is taken as given by most mothers. They believe passing through such lifelong pain since childhood is something a woman should pass through as a naturally fated part of life. This has made most of them to admit the suffering and pain of FGM as nothing bad but focusing only on meeting cultural duties. Mothers try their best to make their daughters the most comfortable girls for their future husbands. Mothers want their daughters to face the same pain as they did in their life. Otherwise, a girl would not compute with the local strong proverb that was cited for me by most interviewees (both men and women). The proverb states *"Women always wanted to have both their genital organ and the entrance to their hut to be narrower, but they could never achieve it".*

This proverb clearly positions how women should fulfill the interest of men even better in the expense of their life. The complicated and aged social pressures forces mothers to admit their pain as given and normal, they apply the same thing on their daughters without questioning; and even giving deaf ear to what educators say about the consequences of FGM. The reluctance of fathers in response to their wives' decision on their daughter's circumcision shows their hidden agreement over the action.

3.3 Power and Prestige at the Cost of Quality of Life

The out crying of a newly married girl during her first intercourse with her husband is not totally enjoyable but it is a moment of praise for the practitioner that did the girl's circumcision during infant-hood. In *Dawe* district, the traditional wedding ceremony is done with the slaughtering of cattle and some additional goats or a camel depending on the wealth of the family and/or the clan. For the groom it is a day of joy where he prepares himself to show his full man-hood and strength over the bride. The whole community would eagerly wait to see what would happen to his aggressive approach to the girl. It is not a day to enjoy for the girl as she would face the aggressive approach of the groom. These all depends on the degree of narrowness of her genital organ which was made by a practitioner that has a big place during the day of the wedding where she awaits to be "praised" or to be told for "improvements".

A "good" FGM practitioner in the society feels proud to be praised for her "best work" in creating uneasy-to-penetrate and narrow genital organ.

This is only measured during the night of the wedding when the bride shows her obedience and the groom showing his strength. It is usually common for brides to deny approaching the man until some women accompany and push her to the small shanty where the husband awaits to show his power. It is justified as cultural phenomenon but the bride puts the groom to struggle to sleep together. Around 04:00 AM in the morning before its dawn, the bride has to come back to a place where a group of women, mainly her mother and the practitioner (the woman that made the bride's circumcision in childhood) waiting for her to clean her body and mainly to check if she has been "reached" by the man very well. If the girl had sexual intercourse and the groom was able to penetrate the hardship made by the circumciser, it shows as the man is very strong and prestigious in penetrating the "well done" narrow genital organ. But, if he couldn't make that, the prestige and praise comes to the practitioner. The practitioner is praised as *"her good work always makes men's knee twisted*'. This is the time when a circumciser gets good status giving her the courage for "better" and "ever improved" circumcision. Such praiseful instances even make the pain and suffering of women worse. Everybody ignores to crying voice of the bride during that night but ensure the fulfillment of the culture for continuity.

"If a girl is found extroverted people start to ask which FGM practitioner did her cutting and she will be blamed as weak circumciser". (Halima, 28, Female, Government Official)

A very depressed father because of his bad memories of FGM on newly married girls told me that there are many girls who could not tolerate painful sex during the first few days of marriage and disappear from their husbands for some times (days or weeks). They do the same disappearance from their parents as the girls know their parents would not help them to refuge. They are brought back again and again to their husbands to let them try and adapt with the situation. Allasa, the father I interviewed, told me the experience in the society to get pregnant girls without their "manmade virginity" being penetrated but only because of the ejaculation of men outside the genital organ through the struggle to break the artificially narrowed vaginal opening.

A women who is governmental official explained to me that societal punishment for not being virgin is manifested in differ ways. Where the girl seem suspected of not having virginity (it could be because of the "weakness" of the practitioner of not doing the stitching "harder"), the community will be informed by hanging the lung of the slaughtered cow or ox

(of the wedding day) on top of the external wall of the mother's house. This is to show for the community that the girl has been found guilty and has become a reason for "downgrading" the prestige of her family as well as the clan that she belongs to. This dictates the rest of the society on how to protect the good name of parents and the respect of a clan by securing the "best type of infibulation" through the "most famous practitioners". The praise for FGM practitioners starts from the date of circumcision and it continues throughout the time when the baby girl cries out loud during childhood and when later the girl need the assistance from her mother to help her urinate drip-by-drip with the help of a feather. Even before marriage, a girl also could be judged by the community based on her fast approaches, stress-free communication and less shyness by saying *"who did her circumcision?"* blaming the practitioner. Men believed and still many believe, it is impossible to control and withstand women unless they are well circumcised.

3.4 Where is Right and Equality?

As a person who has been working in the area for many years, I feel desperate because of my new findings. The faces of gender inequality on Afar women seem multiple and complicated. Inequality is under covered in the name of preserving culture and tradition. Since childhood, boys and girls are identified unequal in the cultural circumcision ceremonies. During the circumcision of boys (age 15) there would be group of men dancing, firing machine guns, and slaughtering animals and also shaving the boy's head at his fourth and sixth birthdate and wash it with butter. The boy will be given a traditional medicine to drink for him to be the best warrior. The traditional medicine is given to him through his nose, eyes and later on his fifteenth age by his mouth. Contrastingly speaking, there is no any circumcision ceremony for girls. During girl's first date of birth and circumcision, the FGM practitioner is the only figure that has a better place. She is praised, mostly by women, by saying *"her work has never been simple for men to penetrate"* so that she does her best for infibulation. This is the time for the practitioners to be proud of their practices and make preparations for deep cutting, removal of the most sensitive part of the sex organ and more genital narrowing. Though declining this type of mutilation is still underway. In this case, my point is not to suggest on the value of ceremony that seems the girl is "deprived of", but my concern is on the manifestation of sexual inequality in the society starting from childhood that grows with the growing children. It is possible to understand how inequality is demonstrated in shaping attitude towards gender

inequality. This justifies how FGM is gendered; and regardless of the forms and types, how it damages the wellbeing of girls and women (Bell 2005:131).

As a new finding, the age of girl's circumcision varies in Afar. For example, as most of my respondents expressed, in the southern part of Afar (Gabbi Rasu or Zone 3), FGM is usually done between the age of 12 and 15. In the past few years, many local and international NGOs have been operating in the area fighting FGM that has brought some positive changes on increased awareness. In *Dawe*, south western Afar (Harri Rasu or Zone 5), FGM is performed immediately within few hours difference after child's birth. Once a mother has delivered to a baby girl, a TBA will be ready for the next task of "praiseful" cutting. If the TBA is not a practitioner (all TBAs are not practitioners) one of the famous practitioners will be called soon to do the cutting. Doing FGM would be late only if the practitioner is late to arrive. From my study, it seems logical to observe that fighting FGM in the other part of Afar (zone 3) is relatively easier than in *Dawe*. This is because as girl's education advances, they would have the probability to resist from being mutilated. Doing FGM at maturity or puberty age might give better chance for girls to repel the decision of their parents. Increasing school enrollment and organizing girls clubs by itself would have its own positive contribution in reducing the rate of circumcision since girls would get the chance to think about it and as a result resist through time.

Whereas, in *Dawe* district, FGM is done during infancy and the chance of saving baby girls from circumcision is much more difficult as it is only under the control of parents. Girls find themselves circumcised when they reach puberty age and as a result they cannot make any difference on their already made circumcision. Their education and school clubs might contribute in convincing the society to save the coming generation. That would also potentially help to protect their future children as the girls are the future parents. But it does not make any difference on their personal experience of FGM. Therefore it is possible to judge that early circumcision could be one contributing factor for not having faster reduction rate on FGM.

From my interview, boys and girls in *Dawe* district see FGM as horror. Boys agonizingly express how FGM is negatively affecting the psychological and physical well-being of their sisters in the community. Girls feel very distressful because of their painful experiences since childhood. One

of the girls whom I interviewed explains her distress with irritation as she has undergone infibulation.

"I was married last year at the age of 15 but now I am divorced. Infibulation has created so many problems on me including severe pain during menstrual bleeding. People believe circumcision prevents a girl from being active in sex, allows for self-control and other things. The society's understanding is baseless. People have to know girls can control themselves without being circumcised. Girls are able to analyze things by their own" (Kuhulli, 16, Female, student).

All the young people I met and formally interviewed or discussed with feel so much of anger on all those community members perpetuating FGM. All of them mentioned their own parents, especially their mothers, as primary responsible body. Most of the boys told me their plan to marry uncircumcised girls than the circumcised ones to avoid complications in their future sex life; and on the health of their wives and children. Those who resisted this idea of marrying uncircumcised girls have positive reasoning of not neglecting the circumcised girls and also it might be difficult to get uncircumcised girls for marriage in the near future. But they strongly blame the societal traditional and cultural taboos that are affecting the health and rights of women and girls. One of the influential local political leaders (a woman) that I interviewed bitterly explains how infibulation has so much reduced her own psychological power to date. Adversely, she proudly explains how the bad circumcision has provided her with true power and strength to fight against FGM within Dawe district and beyond.

From my interviews, I was able to understand and observe that people are more concerned on the health part of FGM than on rights. They are more worried by the sufferings of mothers and babies, not of the violations of rights of the mothers and girls, which is not mentioned. When I was asking about rights, one of the interviewees from the local government said, *"Yes, FGM is both health and right issue. I cannot compare the existing health problem with right issues. Mothers in Afar are dying because of health complications not of rights".* It possible to understand from these findings how FGM is legitimized by community members which creates complexities in fighting it as will be shown in the following chapter.

Chapter Four: The Complexities of Eradicating FGM

"I am not a trained TBA. But I have been serving as TBA for many years. I have never circumcised a girl. There are other TBAs for that. When those practitioners say no to FGM, I remember mothers doing it by their own". (M.Damis, 40, Woman, Untrained TBA)

One of the contributing factors for the slow reduction of FGM practice is lack of proper linkage between the main actors within the society and factors that directly affect the process of eradication. Main actors include the local government as powerful decision maker, NGOs, the informal institutions within the communities, family, individuals, and socio-economic institutions. The failure in the coordination and collaboration among these actors could be seen as failure in action. This coupled with the miss allocation of resources and the improper designing of relevant approaches that could not involve the communities at large have their own significant contribution in the failure. The following model shows the ideal linkage among actors and most important factors in the fight against FGM.

The Linkage between ACTORS and FACTORS in the Fight against FGM

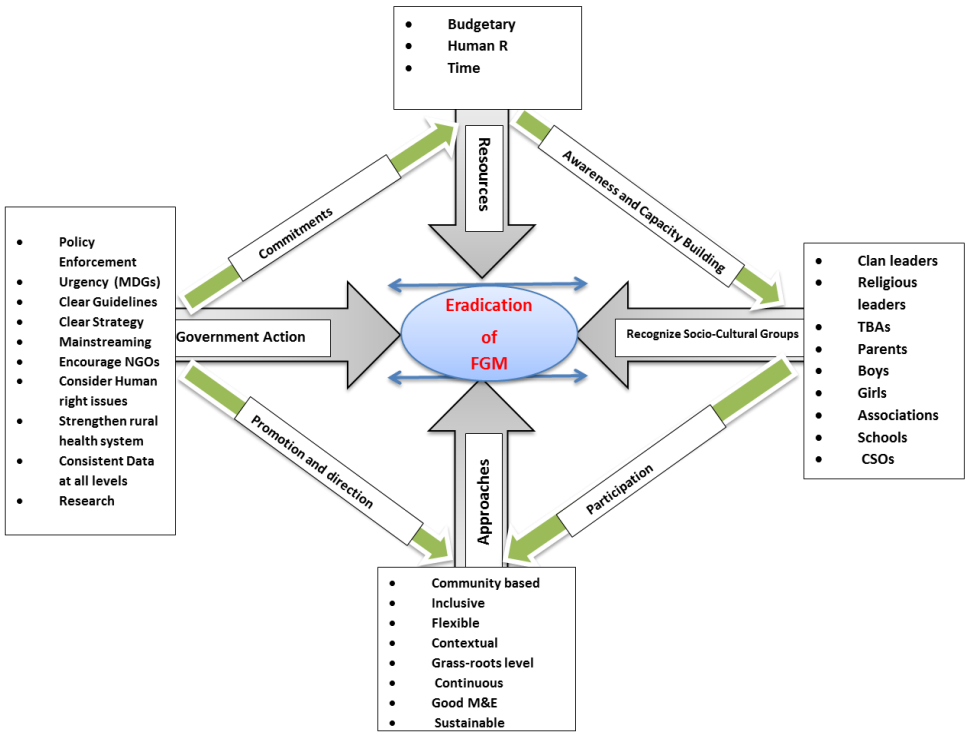


Figure 2: An analytical ideal model showing how actors and factors can be linked for better success. (By author)

4.1 The Controversy over TBAs

TBAs have been serving mothers in child delivery services. The contribution of TBAs where there has not been proper medical support by professionals and well equipped institutions has been greatly valued in saving the lives. Their traditional services in pre natal, ante and post natal periods has been the only means for mothers to get such assistance. Still today in Afar, TBAs take the lion share of child delivery assistance services in the rural areas and even in towns (Yousuf et al. 2010, 28toomany 2013). For that matter many NGOs supported TBAs through theoretical and practical training in combination with the provision of basic and sterilized child delivery equipment. This has been valued by the communities, health professionals and the government because of its enormous contribution in maternal and child health care.

For the local people TBAs are considered to be important to date despite government's plan to exclude them from the system. The main argument for the people I have interviewed (100% of the interviewees in the district agreed positively on using TTBAs) is that mothers prefer TBAs more than professionals working in formal health institutions. All the interviewed mothers prefer the assistance of TBAs for many reasons. One of the main reasons is their strong shyness not to be seen naked by medical workers as most of them are men. A father told me *"mothers prefer delivering at home because the infibulation related complication that has usually so much stress and pain even leading women to uncontrollably defecate during delivery"*. In addition, he adds, *"their infibulated sex organ can be opened and reattached better by TBAs that have the experience in dealing with it than clinical professionals"*. Therefore, this brings the status of TBAs up to a very high level in the communities.

My interview with a health professional who has been working and living in the area for about eight years relates the home based assistance of TBAs with the interest of women not to be seen by men. He adds,

"Culturally, most Afar women do not want any information leakage on their labor and process of childe delivery because they do not want anyone to know about the process. They want that information to be disclosed (if necessary) after everything has been completed". (Tedla, 38, Male, Health officer)

Pregnant women do not want anyone to be around them during the process except the TBA and additionally their mothers. Still as a culture, whatever degree of pain a woman feels during the whole delivery process,

an Afar woman never loudly shouts for help. All these things combined, women choose to deliver at home.

"...I can tell you a recent experience of a pregnant woman who was in complications and referred to the nearest health center by a TBA (not me). She was forced to go to the health center by her family. Later the health staff decided to refer her to a better hospital in Dessie (about 150 Kms faraway) since they found her condition very risky. Up on arrival to the hospital and visited by male doctors, she refused to be treated and forced her family to bring her back to her village without getting any medical assistance. They couldn't convince her at all. She resisted. This happened in this village yesterday and we are waiting what would happen to her next. That is how much our women are attached to giving birth at home with TBAs." (Medina, 45, woman, TTBA)

Institutional assistance for Afar women with scar tissues because of infibulation is also a very stressful task for health professionals. The experience of professionals shows that it is not seen as simple when an infibulated woman with stitches comes to their facility for child delivery. The same health officer confessed *"it becomes a very stressful moment for us helping a pregnant woman with infibulation in delivery"*. That is because it is always difficult to reclose the vulva to its original place since most of the labia minora and some parts of the majora is cutoff. Mothers with infibulation seem to have more childe delivery complications when compared with type I and II FGM (Berg and Underland 2013).This makes the medical staff more nervous to follow professional. But this problem seems relatively easier and adapted for the experienced TBAs. Despite all those challenges, the number of pregnant women coming to the health center has now started growing from about ten in the past five years to about 55 in 2013 per year (Mekonnen 2014)[6]. This is because of the current massive expansion of awareness creation programs basically undertaken by NGOs and government's institutional improvements.

In addition to women's less interest to visit health facilities pastoralist life by itself has also its own huge contribution. According to the national policy, Mekonnen Adds, a health center is capable of serving 15, 000 people in a community. Statistically, the three health centers in Dawe seem very satisfactory and are ideally able to serve more than 90% of the people. He also affirms there is no problem of quantity of access to facilities and health practitioners in the district. The problem is accessibility of the

[6] Tedla Mekonnen is one of the health officers working as medical staff as well as the current acting medical manager of Woderage health center based at the center of Dawe district.

facilities by the people. The main problem he mentions for that is the large geographical size, the scattered living style of the people and the mobile nature of the society as most of the people are pastoralists. According to the policy, about 600 mothers are expected to get child delivery and care services in a health center but in *Dawe* practical experience shows it is far from success. He adds, the two other health centers are located in the very rural areas with less staff and thus accessed by less people. The deputy head of the regional bureau of health also agrees as the problems are associated with culture and less accessibility rather than insufficient staff and facilities in the rural areas.

4.2 TBAs: Life Savers or Threats?

Almost all my respondents (at community level) agreed on the patience and skill of TTBAs and to continue serving communities and also to be supported in training and equipment as has been done so far by NGOs. They need this not to be jeopardized until the society become aware of using formal health institutions, until the health institutions are fully equipped with staff (female health practitioners) and facilities; and until the rural infrastructure, especially road access, is improved.

Community members could not hide the negative sides of TBAs as they are responsible in practicing FGM. Most people I have interviewed believe, as long as TBAs are linked in childe delivery services it might be difficult to expect fast and lasting success in abolishing FGM. It seems difficult to separate TBAs from circumcision. Another failure of TBAs according to some respondents is their incapacity to assist mothers while there are complications beyond their skills. This brings down the dependency of the community on TBAs. Strong referral system needs to be in place to avert such problems. Yet, the demand and interest towards TBAs is still unquestionable within communities.

"A person with full stomach perceives everybody as if all having the same full stomach". This was a proverb I was told when I was discussing on the possible plan of the government in avoiding TBAs from child delivery system. The attachment of mothers with TBAs is at high level that people ignore such policies by the government. The regional state is now trying to exclude TBAs from the maternal and child health system. This is mainly to address the national policy on improved and accelerated maternal

and child health programs and especially to expand safe child delivery services in rural areas. Research director of Samara University[7] whom I interviewed states that the regional state is training female-only health extension workers that can replace TBAs in rural areas. According to his information, in the first round about 200 girls have now been enrolling for six months training to avert the shortage of personnel in rural areas. This is being implemented in partnership between Samara University and the regional bureau of health.

The fate of Afar mothers and children needs reliable and sustainable solution in the long term. While such rapid actions of the government are appreciated, until the government fulfills trained personnel in most of the rural health institutions and until people's awareness gets matured and people's attitude changes step-by-step, it could be difficult to totally exclude TBAs from the system immediately. Ignoring the TBAs might expand unsafe and underground child delivery service that endangers more mothers and children. This needs massive community mobilization and education to bring behavioral changes while the institutional service transforms through time. Immediate exclusion could also encourage practicing FGM secretly as means to income generation. This is one of the main fears of the people until such government plans are put in place which might possibly take years.

*"The service delivered by TBAs is very crucial in Afar region. There are villages that cannot be accessed by car at all. There are many people that cannot access health institutions because of distance. Our people are mobile. There are also deep rooted cultural issues in the society. As most mothers are infibulated they cannot give birth to a child without the assistance of someone besides them to first open their organ. Practically, in rural areas where health practitioners are assigned, the staff doesn't want to live permanently in those remote areas and that is becoming another problem. In this case, a pregnant woman has to get the nearest service from a TBA or die. Most of the death of mothers in rural Afar is related to child birth and specifically related with FGM. This keeps the position of TBAs higher for the moment at least until we can bring behavioral changes" (*Ali[8], 35, Male, district administrator)

4.3 TBAs as FGM Practitioners

The linkage between TBAs with FGM has a strong bondage. It is undeniable that all TBAs might not be FGM practitioners but most of them give

[7] Ebrahim Mohammed (MPh) is research director of Samara University.
[8] Ali sultan is the current chief administrator of Dawe district.

both child delivery and the circumcision services at the same time. It is in rare cases and it is a recent phenomenon where some TTBAs stopped practicing FGM. TBAs become a TBA through knowledge transfer from a mother or a grandmother or it could be from a neighbor practitioner. One of the TBAs I found in the very rural areas was not trained by any person or organization. She has been serving the community as TBA for many years. She became a TBA because of an incidence where her pregnant sister could not get a TBA the night she was in active labor. Then she had to decide to help her sister in the delivery process which by chance was successful. Then after, she became famous because of that situation and now she feels as one of the most preferable TBAs in her community called *Balla'adulo* village. Any woman with courage and self-confidence can become a TBA. It is seen as a lifesaving act.

For the rural community, the difference between trained and untrained TBAs does not have much difference and priority. In some rural areas the preference to untrained TBAs is growing since the trained ones foremost tell to mothers that they will not cooperate in doing FGM if their new born is going to be a girl. For many people that are conservative in continuing FGM, the value of TTBAs is lower. This is because the trained TBAs have brought some behavioral changes and try to resist the community by less cooperating on FGM issues. Of course, in some rural communities trained TBAs have been observed cooperating for FGM secretly.

The income benefit of being a TBA and /or an FGM practitioner is usually clear until recently. In Dawe, TBAs do not serve their community for generating an income in their livelihoods. It has been seen as skill based and voluntary service compensated with some kinds of gifts after the whole processes of assisting a pregnant mother. If a TBA also does FGM, she has to complete both the services (childe delivery and circumcision) altogether within short time difference. In Dawe, immediately after a mother gives birth to a child, whether the newborn baby is a boy or a girl, a goat or two will be slaughtered as a scarification before the TBA leaves the house of the assisted mother. As the goat is slaughtered, soon she has to touch the fresh blood with the tip of her finger and transfer it to her own and the foreheads and palms of the mother and the new born baby. This is done to protect the mother and child from evil. Up on leaving the *Afar-Ari* (Afar traditional house) She will be given, as a very common practice, the best part of the meat of the slaughtered goat as in Afar language called "*Hakale*" brisket (chest floor of a goat) and skin of the same goat. Skin of a goat is detached from the meat in a way it does

not have holes to be used as water container. This is to show respect for the TBA for her services in childe delivery but may not specifically meant for the service of circumcision. There are similar experiences in some parts of the world where FGM is widely practiced. In Sudan and Egypt, FGM practitioners are not paid directly but are compensated with some parts of meat from scarified animal, soap or fragrances since their work is seen as a free public service for their own communities(Gruenbaum 2005:437).

But, now days, things seem changing from time to time. Since TTBAs have started to resist on doing FGM, there is an emergence in labor division. A pregnant mother has to choose between a TTBA that only offers clean and better delivery or a TBA that gives both services with less quality and experience; or she has to decide getting the service separately from two different TBAs; which means getting the child delivery service from a TTBA and the circumcision from another TBA. Here follows the shift from a commonly known gift in the community to a payment or kind of bribe in money terms. Where a mother insists on getting both the services from a TTBA; she tries by all means to convince the TTBA to get circumcision service as well and pay her between Birr 30-100 (Euro 1- 4) depending on her or her family's financial capacity. The service given by those untrained TBAs is not also for free. It is done with hide-and-seek and indirectly-paid manner since using untrained TBAs is widely discouraged through awareness creation interventions. Therefore, the step-by-step withdrawal of untrained TBAs from the system seems working but also challenging at the same time. In some places where both types of TBAs say no to FGM, there has been the experiences of mothers either bringing an FGM practitioner from adjacent districts (outside Dawe) if it is close to the boarder, or there are mothers doing the cutting themselves if they find no cooperation for doing FGM.

The status of TBAs is so much jeopardized by the linkage they have with the practice of FGM. Even though the decision of circumcising a baby girl remains with the parents, it is inevitable to ignore the contribution of TBAs for the continuation of FGM. The reputation that has been given to TBAs is now being downgraded especially by the government through shifting expanding modern health services for safer child delivery. However, the expulsion of TBAs may have to be done with care to compromise the interest of the people, especially mothers that have strong emotional and cultural attachment. Avoidance without a clear awareness both for the people and TBAs might strengthen the rate of unsafe child delivery as well as FGM as a new means to generate income. There has to be

also a proper and well established strategy that gives TBAs a place in any community health development task linked to the formal system. Otherwise, the chance to fight the worst form of FGM (Infibulation), if not all types, including Sunna, might take longer time yet affecting the lives of many more coming girls and mothers. Ali says, *"It should be a step by step process. TBAs must be supported until our people are educated. Regional context has to be seen. Otherwise, this would sustain the practice of FGM".*

The final question would be what would happen to the TBAs when they are totally excluded from maternal and child health services. It seems there is no specific policy in the region as to where the TBAs would end up. Total avoidance might strengthen underground practices. Some suggest that the regional government should not only focus on putting health facilities and services in the rural areas but also should look ways in to assigning TBAs in some community development activities as in Ghana for example. In Ghana, TBAs are "involved in other health promotion programs like health education, immunization, environmental hygiene, bed net distribution and some other community development activities" (Shamsu-Deen 2013:39). Others suggest creating an alternative income source for TBAs through education and training so that they drop their practices on FGM (PRB 2001:17). This remains a good idea but the reproduction for more practitioners in need of training and funding for income generation program should be seen cautiously.

4.4 FGM in the Lens of Enforcement of Laws

Most people agree only at least the *Sunna* type of FGM may continue if not totally stopped. Awareness creation pressure has produced some positive changes but has not yet brought lasting variations and is still seems far from success. A wife of rural village administrator was by chance my interviewee. She has two daughters from the chief. Both of her daughters were not circumcised and that took my attention during the interview. Her reason for that is her husband who decided FGM would never happen to his daughters. He has been attending different trainings and conferences on the issues of FGM and he come up with the decision of avoiding the practice on his kids. But his wife is still not happy. She told me her regrets for not being able to apply any type of circumcision on her daughters. Unlike this rural local government chief, there are many district level officials who propagate against FGM on public stages but still allow FGM on their own baby girls against the state laws. The failure of local leaders at all levels in enforcing laws whether in traditional or local

government structures has been criticized and seen by the local people negatively. This is because the active full-fledged participation of such opinion leaders is very important in fighting FGM (Gage and Rossem 2006:95). Failure starts from lack of action by leaders themselves.

One of the solutions the government has put in place to fight FGM, in spite of its in practicality, is criminalization through producing legislations and enforcing recently amended (2005) criminal law. Afar regional state has produced FGM specific legislation (in 2009) that particularly concentrates on infibulation as it is a widespread problem in the region. The general principle of the proclamation is forbidding any act of genital cutting, mutilation, sewing or stitching for cultural reasons. The percolation further states "...persons who are engaged in the practice of Female Genital Mutilation are prohibited from perpetrating these traditional practices....aiding and enabling the practice of Female Genital Mutilation directly or indirectly is an illegal act". The proclamation stresses on fully applying the amended Ethiopian criminal law in 2005 with specific penalty to FGM acts. According to the law anyone who is found of committing, cooperating and/or aware of any of such acts of Female Genital Mutilation would be liable to spend up to 2 months in jail or a payment of birr 300 (equivalent to EUR 11) (ARS 2009:5). But the law lacks practical back up. One reason might be the level of the complex socio-cultural conditions in the region that slowed enforcement. Of course, there are some who advise on the effectiveness and values of education and counseling by trained health staff than promoting and forcing to implement unresponsive criminal laws (Cooka et al. 2002:286).

The chief of justice office in the district admits there are almost no criminal cases coming before the law in Dawe district. One reason he mentions is the limited awareness of the people on government laws that deteriorates the implementation. He explains, first, emphasis is being given on educating the people on the details of the laws rather than imposing the implementation of laws that he believes would allow for hide-and-seek games resulting in worsening the problem. According to Giuliani, FGM could be eradicated by brining criminalization followed by education. It is strongly difficulty to apply laws against FGM; first, it should be focused on developing the basic social development infrastructures, especially access to health services. She adds, "There is a fear that heavy handed enforcement may drive the practice underground....The key is to use the law in a positive fashion—as a vehicle for public education about and community action against FGC"(Giuliani 2006:25-51).

Of course it is undeniable that lack of enforcement of laws for any reason could be mentioned as a reason for the perpetuation of FGM. It seems very difficult to apply laws in a society where development in education is in its infancy stage. Even in the developed world where FGM is practiced by immigrants, the enforcement of laws has not yet brought the desired results. In the UK alone, there are about 65,000 baby girls within the age range of 0-13 that are under the risks of FGM but with limited legal access. Reasons include the disempowerment of girls for complaints, lack of witnesses, legal gap in considering the FGM practice on newly arriving immigrants and lack of testimony from mutilated children (Dias, et al. 2014). It could be possible to draw from this, in Afar, enforcement would be possible when all stakeholders come together in to an integrated, coordinated and sustained campaign against the practice. This has been shown on the diagram at the beginning of this chapter where the interaction of different actors and factors affecting the fight against FGM is vital for success.

Chapter Five: Conclusion

> *NGOs come and go-out depending on the availability of funding. They are not sustainable. Eradicating FGM fails when the government does not take the driver's seat. Sustainability can be secured only when we (as government) produce unitary plan and budget at all structures (region and district level), incorporate informal institutions and NGOs. Then we can stop it. (Ali, 35, Male, District Administrator).*

5.1 Actors with Reasons for Sustenance of FGM

I had been very confident when beginning this research that I knew how to approach the eradication of FGM. In undertaking more detailed research I realized that to my surprise more was needed. Even though my organization had won awards for our engagement in fighting FGM during my leadership I realized that I had not been fully aware of the role culture played in perpetuation of FGM. I have come to realize that culture plays the greatest role and the tension between health and rights is less emphasised as NGOs (by law) are not encouraged to mix development agendas, in this case health, with right issues in Ethiopia.

My study concludes that the main reasons for the continuation of FGM arises from the societal interest in preserving culture, association with religion despite lacking concrete evidence, the assumed pleasure of men to enjoy sex via this form of man-made virginity. The challenges of eradicating FGM seem entrenched mainly in tackling the many and complicated cultural beliefs that serve what is understood as the 'sexual' needs of men which are then performed and understood as desired by good women filling their duties. Perpetuation on the practice of FGM is apparently mainly pushed by women who internalize the cultural need of FGM as a religious and traditional need. Women are obediently scarifying their bodies, life and dignity to satisfy the control and apparent sexual interest of men as the women obey rules of female virginity and chastity. To change this is complex as the fight against FGM appears to be male led, where, following dominant patriarchal understanding of women as there to serve men, women are cast as victims to be rescued by men rather than as agents and right holders who need to take up their own empowerment. This is shown in the first analytical model (second chapter) where girls are encircled by men-dominated informal actors and it is difficult to be

reached by formal actors who want to help them transform this situation. In the model, the power of men is stretched in all authoritative spheres from family to formal institutions that make women voiceless. Both this and the second model (chapter four) show the hindrances and difficulties in fighting FGM. The second model tries to depict the ideal interaction between actors as an ideal solution for eradicating FGM. It clearly shows the interaction of important actors, basically government and community based institutions and the crucial factors (resources and approaches) in fighting FGM.

In *Dawe*, the need for FGM or man-made virginity is symbolic and widespread despite the cost to women's wellbeing and rights to a good quality of life free from pain. FGM is culturally understood as a virginity which is a source of pleasure for men which overcomes any pain and suffering for women and girls. It is sign of marriageability, purity, a reduction of female sexual desire and a way to ensure girls fear of men. The perpetuation of FGM is a direct result of the given value to virginity by men who control women's sexuality and fertility. This domination of women – bodily as well as psychological – as the way to give them social identity in the community explains why women and girls themselves do not join into the fight against the practice.

The study also reveals the ambiguity among religious leaders whether to stop FGM completely or whether to do it gradually - by promoting the less physically damaging and harmful, the *Sunna* type of FGM. Some religious leaders I interviewed see FGM not only as it is demanded by religion but also to preserve culture. The community lacks awareness on State laws and regulations. The clan leaders see their power as declining. This sense of neglect and loss of power might minimize the application of their own traditional laws to fight FGM. Fighting FGM can be well planned and coordinated through recognizing the power of influential community leaders and their traditional laws over their people that legitimized their authority for centuries.

5.2 Variations within the Same Region and the Shift from Free to Paid Community Service

I was able to identify significant variations of age of circumcision on baby girls within the same region; immediately after birth in Dawe and the surrounding areas as well as at the age of 13 to 15 in the southern parts of the

region. This shows how specific approaches to specific cultures are crucial when fighting FGM. It is important to take into account these cultural differences, and to ensure there are culture specific policies that are multidimensional and motivate communities for change (Jones et al. 2004). In Afar it is important to approach districts in different ways to avoid mismatched generalized approaches.

The RP identified TBAs (both as service providers and as mothers) as key to the eradication of FGM given their value in the communities for their sustainable child delivery services. While improvements in government health service delivery policy is important in the long run, it might take years for Afar women to access health facilities if there is no accompanying behavioral change. Mother's preference to use TBAs comes from FGM related complications and cultural influences coupled with fear from male dominated health institutions even if at all these institutions are fully equipped and staffed. TBAs as child delivery service agents will continue as they are seen as serving their people. Policy changes need to be sensitive to the TBA role, and work with this reality in designing policy.

On the other hand, similar to my hypothesis at the beginning of this paper, TBAs as FGM practitioners contribute to the perpetuation of FGM. Their lack of awareness of the problems of FGM coupled with the demands for their means that TBAs continue the practice. Most of the women that are trained in the problem of FGM did bring about behavioral changes despite some newly emerging practices like the need for cash payment (as bribe) for their undisclosed service of performing FGM. However, the issue of untrained TBAs is important to end FGM. TBAs need to be included in the trainings; and otherwise the problem remains is that mothers go to untrained TBAs who are at the moment much in demand.

5.3 Response of the Youth and Political Commitment

The future generation, boys and girls, are strongly against FGM. The repulsion to FGM by girls basically comes from their real life experience of FGM as they are deprived of quality of life, subjugated human and sexual rights; and gender based violence. Boys are divided over whether continuing the *Sunna* type, but they completely agree to end infibulation. Most

boys agreed to marry non-infibulated girls as they understood its severity in affecting women's and children's life as well as its consequences on sexual discomfort. This suggests that more focus needs to be giving to the young generation in-and-outside schools as they are the future families and leaders.

From my findings, government's leading role, integration and coordination seem overlooked and deficient in attention. Government's political support and legal back up combined with more research is needed (WHO 2011:7). Most NGOs work closely with the government with respect to the policies of the state. But that is not enough. There is a need for more than legislation. Fighting FGM I Afar is lacking clear and specific strategy, guidelines, budget, research initiatives and structurally assigned human resources. This has been confirmed as a gap by the relevant regional bureaus and Samara University. Active stakeholder involvement, massive (campaign) for awareness creation; and enforcement of laws as appropriate are also some of the observed gaps for the government side.

The issue of FGM is mainly recognized as a right issue by many international human rights organizations and UN agencies; the UNFPA states "FGM is a gross violation of the human rights of women and girls" (UNFPA 2013). One of the potential limitations of the approaches at the grassroots level is the inability of NGOs in intervening FGM as a violation of rights. This is because it is prohibited by law for a development organization to intervene on right issues (FDRE 2009). As a result, these organizations have to respect the policies of the government and have to stick to the health part only neglecting FGM as a violation of the rights of women and girls which should have been equally treated. This makes the effort to the fight against FGM slower and incomplete leading to continued life hazard on women and children.

5.4 Did Approaches Matter in Eradicating FGM?

Alongside the shortage of resources and lack of enforcement of laws, unfitting approaches to the socio-cultural conditions of the society play a great role for the failure in achieving goals. Until recently, most NGOs (both local and international) have been using top-down approach that has little contribution in addressing the desired objectives of interventions. But now the trends are now changing and NGOs have started basing their office at local community level for close coordination and implementation. At *Dawe*, there are two actively working NGOs (one local and another International) that have been implementing anti FGM pro-

jects. Their approach seem friendly to the living styles and cultures of the people of Afar. AISDA, a local NGO that is based its office in the community and that started implementing anti FGM project since January 2011, uses what they call it "an innovative approach" that participates all groups of the communities from different back grounds. The interventions are run with the full involvement of government staffs and officials, clan and religious leaders at all levels; women representatives, TBAs, health extension workers, schools and the youth at large in the rural areas. Periodically planned community conversations and conferences, capacity building trainings for health professionals and TBAs, provision of materials and equipment; and megaphone assisted health education promotion programs at market places and food aid distribution sites seem working well. CARE Ethiopia has also been experienced working in many districts of the region on FGM. In *Dawe* it has the same strategy of implementation like AISDA with an additional effort in sharing and applying successful experience of anti-FGM programs implemented in the southern part of the country.

As the livelihoods of Afar people involve high mobility, pastoralist friendly approaches are more advisable. Senior governmental officials agree with the kind of approaches these two organizations are following in Dawe and also admit their progress in bringing changes against the fight on FGM. Some government officials also appreciated the participatory approaches but commented on the works of NGOs as having lack of stronger follow up on the sustainability of their good outputs after implementation. I have personally observed also that organizations lack the study of culture as complex issue in relation to FGM.

What my findings add is that approaches to end FGM need to consider culture. Inclusive and participatory approaches seem very useful to address behavioral changes through creating common understanding among all actors in the community. In participation also, giving space and empowerment to ways to change cultural expectations in order for Afar women to fight FGM would have its own great contribution towards success. Interventions should strongly consider lasting behavioral changing approaches.

The people of Afar have a strong and positive culture that could be harnessed to end FGM as a practice. *Dagu*, the fast information sharing culture is unique to the people of Afar. It is an unwritten law of the people having an obligation to share information with anyone meeting at any place. Formal or informal contacts made with known or unknown per-

son, with family and clan member; a guest or stranger and anyone who seeks help should be greeted by *Dagu*. This could be a very good opportunity to be used for such problems as FGM eradication. This culture of *Dagu* has not been developed and strategically used for massive community mobilization to avert such community problems. Little but sound awareness creation education programs could reach thousands of people in few days without any cost.

5.5 The Way Forward

As a graduate majoring in Social Policy for Development and specializing on Poverty studies, I have come to understand FGM can be abolished by strengthening our actions on poverty reduction efforts especially fostering on local social development programs in the lens of gender equality and rights of women and girls; as world bank affirms, this traditional practice has a direct effect on the economic and social development of a given country since it hinders the contribution of women(Rogo et al. 2007). The impact of delivering quality health care access and services is very crucial to the positive change in the well-being of citizens and there by contribute to the productivity of a country. Usually, while focusing on economic development, the impact of health service improvements is not considered as a significant means for success (Ortiz 2007:48). The quantity and quality of education and health services greatly matters for human capacity development and its contribution to county's overall growth and wellbeing and quality of life for citizens (UNRISD 2010:161-162). FGM is can be associated with poverty because of lack of development in education, health, gender and other components of social development. From this aspect of development discipline, my paper is absolutely relevant to the current local and international poverty trends and social development agendas like the Millennium Development Goals (MDGs).

Beyond fulfilling the requirement for earning MA Degree in Development Studies, for me, the findings of this study would have additional purposes. One of the bottle-necks in eradicating FGM in the region is lack of information. It is hard to find research based-evidence on FGM and why it is continued to be practiced to date. This research would surely give a spark of light for anyone working on FGM to consider knowing the problem before fighting. My main motive here is to deliver my contribution in extracting the secrets behind FGM which surely would be used by my employing organization, AISDA, for its ongoing and upcom-

ing projects on FGM. Intervention wise, AISDA will work more on educating mothers, concentrating on in-and-out of school boys and girls, avoiding direct replications of projects and switch to planning exclusive projects for every new target district, focusing on religious leaders and TBAs with modified approaches. AISDA would also strengthen its partnership with its existing partners as well as establishes new partnerships with academic and other international organizations to conduct regional level comprehensive research. As this paper will be communicated, it would also be used as an activating piece for the government, educational institutions like Samara University and NGOs to do more research; better understand the reason for poor success in fighting FGM and to take actions accordingly; and revise interventions and approaches in their projects and programs to eradicate FGM.

The need for further research is important to widen the scope of the research at inter ad intra-regional level, to identify cultural variations within the same and adjacent regions having similar situations, to find out whom to focus on and how to address issues; and to look for appropriate approaches on fighting FGM. The key to succeed in eradicating FGM needs, knowing the deep-rooted reasons before fighting. Knowing the complicated webs of reasons in the Afar society need more regional level research and investigation. This in turn would make the road to the battle easier and faster. The eye-opener findings I have got from this RP need more research and more investigation. Welcome!

Appendix I:

S/N	Health centers & catchment Health posts under each HC	Location/ Kebele	Number of staffs										
			Diploma				Degree				Certificate		Total
			Clinical Nurse	Mid-wifery	phar-macist	labor-atorist	BSc Nurse	HO	phar-macist	labor bor-ator-ist	HEW	Front line	
1	**Woderage Health Center**	Adalil&Woderage	4	2	2	1	3	2	-	1	-	-	**15**
2	Sisibilidaba Health Post	Eyeledi& Gendewori		-	-	-	-	-	-	-	2	1	**3**
3	Beleadulo Health Post	Kilenti & Dersada	1	-	-	-	-	-	-	-	2	-	**3**
4	Eabelidear Health Post	Wahilo & Gadali	1	-	-	-	-	-	-	-	2	-	**3**
5	Yomudu Health Post	Yomudu & kebeakoma	-	-	-	-	-	-	-	-	2	-	**2**
6	Kou'sobora Health Post	>>	-	-	-	-	-	-	-	-	1	-	**1**
7	Ateadaba Health Post	Adalil&Woderage	-	-	-	-	-	-	-	-	1	-	**1**
8	**Kilelu Health Center**	Kilelu & Gamora	2	1	-	-	1	-	-	-	1	-	**5**
9	Fereskori Health Post	Gedansa & Fereskori	-	-	-	-	-	-	-	-	1	-	**1**
10	dawebora Health Post	Dawebora & Kubet	-	-	-	-	-	-	-	-	1	1	**2**
11	Gedansa Health Post	Gedansa & Fereskori	-	-	-	-	-	-	-	-	1	1	**2**
12	**Ferodaba Health Center**	Halbi & Sonkokor	2	-	-	-	1	-	1	-	-	1	**5**
13	Kahertu Health Post	Kahertu & Tutli	-	-	-	-	-	-	-	-	1	-	**1**
14	Egoli Health Post	Halbi & Sonkokor	1	-	-	-	-	-	-	-	2	-	**3**
	Total		**11**	**3**	**2**	**1**	**5**	**2**	**1**	**1**	**17**	**4**	**47**

Appendix 1: Detail of Health Institutions and Health Staffs Data in *Dawe* District (September 2014, source District health office)

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