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Understanding FGM/C in Ethiopia through looking at FGM/C interventions done by INGOs/NGOs and Ethiopian government policy

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Rogjella Anne Roluna Nydal

Abstract

In order to build on the momentum achieved to date and in line with Sustainable Development Goal 5.3 on the elimination of child marriage, the government of Ethiopia launched a comprehensive National Roadmap to End Child Marriage and FGM/C in 2019. The World Health Organization (WHO) and UN agencies estimate that there are approximately 200 million women alive today that have experienced female genital mutilation/cutting (FGM/C) and another 68 million girls are at risk of being cut by 2030 if current trends continue. In a number of countries there has been a decline of the practice. Studies done on FGM/C indicate that the practice has changed in numerous ways. FGM/C is referred to as any procedure involving the alteration or excision of external female genitalia without medical indication. The WHO divides FGM/C into four different main types. There are various strong cultural justifications for the practice. FGM/C affects the social, psychosomatic, spiritual and physical well-being of women and girls. The 2016 EDHS is the most recent cross-sectional large-scale survey that measure FGM/C prevalence rates in Ethiopia. The 2016 EDHS data is substantial but can hide sub regional variations in prevalence. The EDHS show that there has been a decline in the prevalence, but changes in practice and decline are challenging to assess due to the complex nature of the practice. The practice of FGM/C differs from region to region in Ethiopia. The seven most common approaches used in FGM/C prevention are health risk education approaches, conversion of circumcisers, training of health-care professionals as agents of change, the creation of alternative rituals, community-led approaches, public statements, and legal method. Advocacy and coordinated work with government are also central approaches utilised. This thesis stresses that in understanding the context specific justifications for the practice within the hotspot FGM/C prevalent areas interventions done by the Ethiopian government or NGOs can be more effective. In the case of Ethiopia, the government has provided a policy framework to promote total abandonment of FGM/C, however the 2009 CSO limited and restricted various NGOs ability to work with FGM/C as a human rights violation and not simply an issue of health. This thesis emphases the importance of understanding FGM/C as a human rights related issue. This thesis concludes with progress can be achieved through contextualized interventions in cooperation with Ethiopian government actors and key local actors within the intervention areas.

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Acronyms and definitions of operational terms

- Abandonment of FGM/C – The situation whereby communities reach a collective, coordinated decision to stop practising female genital mutilation/cutting (FGM/C).
- ADAA – African Development Aid Association
- ARP – Alternative Rite of Passage
- Baseline – An initial survey or canvas of a project site
- CBO – Community Based organizations
- CC – Community Conversation
- CSO – Civil Society Organization
- EDHS – Ethiopian Demographic Health Survey
- Endline – End report/evaluation of a project
- FBO – Faith based Organization
- FGM/C – Female Genital Mutilation/Cutting
- GAGE – Gender and Adolescence: Global Evidence, British NGO
- INGO – International Non-governmental organization
- MTE – Mid Term Evaluation
- MWCYA – Ministry of Women, Children and Youth Affairs
- NGO – Non-governmental organization
- Pathfinder: British NGO
- Kebele – Community or smallest administrative unit in Ethiopia
- MICS – Multiple Indicator Cluster Survey
- NCA – Norwegian Church Aid
- NKVTS - Norwegian Kunnskapssenter om Vold og Traumatisk Stress (Norwegian Centre for violence and traumatic stress studies)
- NORAD – Norwegian Agency for Development Cooperation
- SCI – Save the Children International
- SC – Save the Children
- SNNPR – Southern Nations, Nationalities and People's Region
- SHR – Sexual and Reproductive Health
- UK – United Kingdom
- UN – United Nations
- UNFPA – United Nations Population Fund
- UNICEF – United Nations Children's Fund
- WHO – World Health Organization
- Woreda – District or third level administrative division in Ethiopia (after zones and regions)
- Zero tolerance – A stance that promotes the total abandonment of FGM/C

1. Introduction

The 14th of August 2019, the Ethiopian government launched The National Costed Roadmap to End Child Marriage (ECM) and Female Genital Mutilation/Cutting (FGM/C) 2020-2024 in Addis Ababa. The Roadmap was produced by the Ethiopian Ministry of Women, Children and Youth (MWCY) with the technical and financial support of UNFPA, UNICEF and UN Women and a national alliance comprised of Non-government organizations (NGOs) and International Non-government organizations (INGOs).

The World Health Organization (WHO) and UN agencies estimates that there are approximately 200 million women alive today that have experienced female genital mutilation/cutting (FGM/C) and another 68 million girls are at risk of being cut by 2030 if current trends continue. In a number of countries where ethnic minority groups carry out the practice, there has been a decline in the practice. This decline can be seen when statistics for different age groups are compared to one another. For example, in Kenya and Tanzania, women in the age group 45–49 years in the ethnic groups that carry out the practice are three times more likely to have undergone female genital mutilation/cutting (FGM/C) than girls in the age group 15–19 years(WHO, 2019). Programmes and interventions that promote the abandonment of FGM/C have proved to have varying degrees of success in communities around the world. These interventions combined with growing urbanization, increase in education levels and other social dynamics, FGM/C prevalence rates might further decline(UNFPA, 2019b).

In Sudan and Somalia, the majority of women have experienced FGM/C and there been little or no decline in the custom. The utmost invasive type of FGM/C is located in Eastern Africa(Andro, Lesclingand, Grieve, & Reeve, 2016). In nations where more than 70 percent of women aged 15–49 years live with FGM/C (Eritrea, Ethiopia, Mali and Somalia), fewer daughters than mothers have been subjected to FGM/C, and far from all women with FGM/C support the continuation of the practice. For example, according to a study done in 2013(Rigmor C. Berg & Denison, 2013), only 31 percent of women in Ethiopia believe that FGM/C should continue to be practiced. In some countries such as Eritrea and Ethiopia, however, the number of girls subjected to FGM/C is greater than the number of women who

upkeep the practice, perhaps signifying that FGM/C occurs within a broader political framework and societal context(Rigmor C. Berg & Denison, 2013).

Studies done on FGM/C indicate that the practice has changed in numerous ways. Most encouragingly, some studies and reports have shown that the practice is declining(Kandala & Komba, 2018). This can be detected by looking at data from countries in which at least two large scale surveys are accessible, showing advanced prevalence rates in several countries. However, the decline has been deemed to be slow and in some countries, there has been little to no decline whatsoever(WHO, 2011b). In certain countries, the prevalence of FGM/C was reported to have dropped by more than 50 percent. The foremost difficulty with such studies is that these studies excessively rely on cross-sectional data evaluating the prevalence of FGM/C at a particular time point within a specific age range of women and girls, primarily women between the ages of 15-49. This can in turn hide the variations at the regional and sub-national level in particular areas (Kandala & Komba, 2018).

The World Health Organization (WHO) has also registered some increase in the actual number of girls subjected to FGM/C, due to population growth. There are different societal and cultural justifications for performing FGM/C on women and girls. FGM/C is often closely associated with ensuring marriageability, child marriage, and pregnancy among young girls, because FGM/C is the ritual seen as preparing girls for sexual activity and marriage. The practice is most prevalent in Africa, in a band that stretches across the continent from Ethiopia in the East to Senegal in the West. FGM/C follows ethnicity and cultural affiliation and is done by Muslims and Christians and across all social classes. In North Sudan and Somalia, it is estimated that more than 90 percent of women have been exposed to FGM/C. The practice is also found in diaspora communities in a number of European countries and in the US. Monitoring developments in the practice have been complicated(Shell-Duncan, Naik, & Feldman-Jacobs, 2016).

When the Ethiopian Demographic Health Survey (EDHS) that was conducted in 2016, it concluded that the national prevalence rate of FGM/C in Ethiopia has decreased over the past 16 years, dropping from 80 percent in the 2000 EDHS, to 74 percent in the 2005 EDHS, and to 65 percent in the 2016 EDHS(EDHS, 2016).

Eradicating FGM/C has been the focus of many governments and NGOs and a global development agenda the last decades(Shell-Duncan et al., 2016). The Ethiopian government has prioritized sustainable development goal 5.3 (SDG) as one of the national development targets and it outlined strategic measures to reduce FGM/C(UNICEF, 2020). These plans can contribute to the elimination of FGM/C in Ethiopia on a permanent basis. As part of the SDGs, the global community has set a target to eliminate FGM/C by the year 2030(Wilson, 2013). Despite the progress made, FGM/C remains a serious public health and a human rights issue in Ethiopia and the practice has affected 23.8 million women and girls(G. Tesema et al., 2019). Despite a decline in the prevalence of FGM/C nationally over the past decades, the UNICEF report from the 2011 Welfare and Monitoring Survey one in every four girls are subjected to the custom and the risk diverges across regions with the highest prevalence in Somali and Afar regions(G. Tesema et al., 2019).

FGM/C is an intricate practice and delicate custom that affect women and girls. Investigating a social phenomenon as complicated and complex as FGM/C encompasses digging deeper than considering national FGM/C prevalence rates and making correlations from large-scale survey results. To reach abandonment of FGM/C, researchers have claimed it is vital to have a well-defined understanding of the scale and scope of the tradition, and where it transpires, as well as the dynamics of change and the broader context surrounding it(Shell-Duncan et al., 2016). Nationally representative data on the prevalence of FGM/C among girls and women ages 15-49 are available for 29 countries(Shell-Duncan et al., 2016). Twenty-seven countries in Africa plus Yemen and Iraq. Fifteen of these countries show no clear indication of improvement, while in 14 countries, the practice seems to be decreasing. Two out of three affected women live in Egypt, Ethiopia, Nigeria, and Sudan(Shell-Duncan et al., 2016). In Indonesia, nationally representative data on FGM/C prevalence is accessible although only for girls under the age of 12 years. FGM/C also occurs in some countries that have not had any nationally representative surveys, such as India and Malaysia(Shell-Duncan et al., 2016).

1.1 Structure and purpose of the thesis

This thesis aims to understand the prevalence and praxis of FGM/C in Ethiopia as it stands today. The thesis will explain the different types of FGM/C and explain the driving factors and justifications for the practice in Ethiopia. The research questions this thesis will aim to answer is twofold and is as follows:

> "What is the current situation of FGM/C in Ethiopia and what roles doing the Ethiopian government and the NGOs/INGOs play in FGM/C prevention?"

This thesis is structured as followed: The thesis will first outline and explain what FGM/C is, present and explain the theoretical framework and then the explain the fieldwork conducted. The thesis will also go into the current political and civil society landscape in Ethiopia, showcase how FGM/C is practiced in Ethiopia mentioning the regional differences in prevalence and practice. There has been research done on the effectiveness on FGM/C interventions done in countries where the practice occurs. The studies done on understanding FGM/C prevalence might also provide a clear picture regarding the current status of FGM/C in Ethiopia. The thesis aims to understand the FGM/C prevalence in Ethiopia as well as the cultural justifications that underpins this practice. This thesis is also aimed at comprehending this complex subject by additionally looking into specific FGM/C interventions.

This thesis is partially based on fieldwork conducted in Ethiopia, during this time period I was exposed to some approaches in FGM/C interventions and it made me interested in looking into the various ways NGOs and INGOs work with FGM/C prevention. Therefore, this thesis will explain common approaches in FGM/C prevention utilised in general and in Ethiopia. In order to do so, the thesis will additionally showcase the part the Ethiopian government has participated through explaining and examining the Ethiopian government's political and legal framework regarding FGM/C prevention and their previous Civil Society Organization (CSO) laws.

The thesis will additionally use *Norwegian Church Aid and Save the Children Joint Programme on Eliminating FGM/*C aiming to contribute the national effort in abandoning FGM/C as a lens to comprehend how International Non-Government Organizations (INGOs) and NGOs work with FGM/C prevention in Ethiopia and explain why certain interventions are utilised in Ethiopia(J. Svanemyr, 2019).

The fieldwork was made possible by working with Norwegian Church Aid and Save the Children International and their partner staff in Ethiopia. During the stay in Ethiopia, I also conducted interviews with other INGOs, NGOs and Ethiopian government staff. However, NCA and SCI was the primary basis for sourcing informants.

In order to answer the main research questions, this thesis will also be guided by the following research questions:

1) What role has the Ethiopian government played in FGM/C prevention so far and what are the potential issues that can arise from the current government FGM/C policy framework?
2) What does Norwegian Church Aid (NCA) and Save the Children's (SCI) Joint Programme on FGM/C (and other NGO programmes) do to reduce the prevalence of FGM/C in Ethiopia?
3) What do we know about the FGM/C prevalence in Ethiopia, and how the numbers are changing?
4) What do we know about the FGM/C interventions in Ethiopia and which ones can be considered effective?
5) What could change in relation FGM/C abandonment potentially look like in Ethiopia?

1.2 Background and research context

This section will present the study context Ethiopia, the origin of FGM/C and the variation of the differing cuts. To understand FGM/C interventions in Ethiopia and this thesis will present the political landscape in Ethiopia in terms of legislative/policy developments and the development of Ethiopian civil society in addition to the prevalence of FGM/C in relation to ethnic and regional variation. This section also includes a brief overview of the role of media and education in Ethiopia. This section will also present NCA and SC Joint Programme on Elimination of FGM/C in Ethiopia. This section will also examine the reliability of the data collection regarding FGM/C prevalence.

1.3 Ethiopia

Ethiopia is an ancient African nation that suffered less direct Western colonial intervention than most countries in the region. In 2018, the country's total population was estimated to be reach 105 million with an average population growth rate of 2.4 percent and nearly 80 percent of the population live in rural areas. The country is located in one of the world's most conflict-ridden sub-regions, the Horn of Africa, although it has maintained a continued economic annual average growth rate of 10 percent over the past decade. Ethiopia has had a war with Eritrea in the 1990s, ending in a peace treaty in 2000. Under Abiy Ahmed's leadership, Ethiopia further cemented peace agreements with Eritrea in 2019. Warfare also occurred between Ethiopia and Somalia from 1977 to 1978 over the Ogaden region. Due to the series of conflicts, the horn of Africa is now known internationally for its refugee crises. Furthermore, Ethiopia has the world's largest internally displaced population(Semela, Bekele, & Abraham, 2019).

Ethiopia is a very patriarchal society in which gender responsibilities are distinct and great significance is assigned women's premarital chastity and matrimonial faithfulness. The country's traditions have profound historical roots that have persevered for generations. Some of these behaviours are considered to infringe on human rights, especially the rights of girls and women(Insight, 2010). The populace of Ethiopia is vastly diverse. It is made up of numerous ethnic groups, each respectively with its own language, customs, cultural expressions and traditions. Most Ethiopians are either Christian (Orthodox, Catholic and Protestant denominations) or Muslim, and live in communities where clan and ethnic attachments are central. A number of organizations and institutions or mutual-assistance groups, agricultural aid groups, women's associations or investments and credit groups, and religious groups deliver an extensive series of services and care to community members(Insight, 2010).

Since 1994, Ethiopia has been founded on ethnic federalism, dividing the country into nine regional states and two multi-ethnic chartered administrations, centred on cultural and tribal lines(Sørensen, 2018). Ethnic groups were permitted rights to self-government, and the states were given some sovereignty in legislative, executive and juridical functions(Sørensen, 2018).

In practice, however, the autonomy of the regional states has been limited by the centralised nature of the Ethiopian People's Revolutionary Democratic Front(Sørensen, 2018). Rural regions are distributed into district councils named "woredas" and city states are divided into village regions known as "kebeles". Ethiopia is predominantly an agricultural country, based on smallholder farming(Sørensen, 2018). Exports roughly solely rely on agricultural products, with coffee the largest recipient of foreign exchange(Sørensen, 2018). Other agricultural commodities include oil seeds, hides and skins, as well as live animals and, more newly, flowers(Sørensen, 2018). The importance of agriculture for the national economic development has been acknowledged since the Ethiopian People's Revolutionary Democratic Front launched the Agricultural Development-Led Industrialisation Strategy in 1991(Sørensen, 2018). Faith is central to Ethiopian culture and society. It is one of the oldest Christian countries in the world, with the Ethiopian Orthodox Church dating back to the 4th century. Ethiopia has historical ties to the three Abrahamic religions(Wilson, 2013).

In Ethiopia, interethnic conflict is mainly attributed to food uncertainty and 'a shared fear of the future'. Resource scarcity frequently results in the involuntary relocation of people and these increases contact and competition between differently identifying groups. These frictions are heightened when conflicts arise between groups who have a history of conflict over grazing land rights(Wilson, 2013). The government's decentralisation efforts have re-ignited antagonistic relations amid ethnic groups because of superimposed administrative borders over preestablished resource borders, meddling with traditional group interactions. Questioners and sceptics of the government's federalisation policy deem that the state's involvement is intended to pre-empt community support for armed groups by creating inter-community discord and thus discouraging these groups from building joint political alliances against the state(Wilson, 2013).

In Western Ethiopia, there has been on-going ethnic clashes in the Gambela region. In Southern Ethiopia, a longstanding disagreement between the Ethiopian Somali groups and the Borana people has been on-going. Since the revolution of 1974, the Borana have united with the Ethiopian State against the Somali people in Ethiopia, predominantly because of continuing inter-regional disagreements between Ethiopia and Somalia. Currently, the regional borders of the Oromia and the Somali region are not marked on the ground, but trail along the scattering of respective linguistic groups(Wilson, 2013).

The Oromo are an ethnic group that has remained independent until the 19th century and have since been subject to suppression, have had their resources taken from them, and a division of their people by region and religion. Until 1991 the Oromo did not have equal rights to the Amhara and nor did several other ethnic groups. Historically, the Oromo were not allowed to display any expressions of their art, music, and literature or language, and were not allowed to enter politics or attend schools. Oromo people continue to report discrimination against them by the government, and, as noted above, resume to fight for independence(Wilson, 2013).

The Afar are usually pastoralists, raising goats, sheep, and cattle, and somewhat isolated from mainstream Ethiopian society. The Afar are predominantly Muslim, with a patrilineal clan structure and several semi-autonomous lineages. Lineages are inter-related in a number of ways, such as intermarriage and kin ties. These interrelationships make Afar society extremely culturally coherent. However, literacy rates in Afar are among the lowest in Ethiopia(Wilson, 2013). Until the late 1950s, Ethiopia was self-sufficient in basic foods and was an exporter of grains(Sørensen, 2018). Although, from the early 1960s onwards, the national food production has failed to meet the food necessities of the people(Sørensen, 2018). Ethiopia has a long history of disastrous famines, particularly those in 1973 and 1984-85(Sørensen, 2018).

Due to famine-prevention and early-warning measures launched in 2005, food crises do not have the same disastrous effects as previously(Sørensen, 2018). Nonetheless, the country experienced a severe and long-lasting drought in 2015 until 2017, requiring emergency food support for an estimated 8.5 million people on top of the nearly 8 million people targeted by the government(Sørensen, 2018). Together with the severe food insecurity problems, Ethiopia has experienced extraordinarily high economic growth (GDP), peaking in 2014 with 10.4 percent, and then slowing down to 8 per cent in 2015-2016(Sørensen, 2018).

The government has had a vision that Ethiopia should reach middle income status before 2025, based on a carbon-neutral and climate-resilient economy(Sørensen, 2018). In line with the climate resilience strategy, Ethiopia has become the region’s leading producer of renewable energy, focusing primarily on hydropower(Sørensen, 2018). Ethiopia has also started diversification of generation from other renewable sources and is constructing some of

the largest wind turbine parks in Africa(Sørensen, 2018). In 2014, only 27.20 percent of the total population had access to electricity(Sørensen, 2018).

Despite the high economic growth and human development achievements, Ethiopia still remains a “least developed country”, ranking 174th out of the 188 countries on the Human Development Index in 2016(Sørensen, 2018). At the political level, regardless of having a multi-party democracy on paper, the reality is that the room for manoeuvre of other parties than the Ethiopian Peoples' Revolutionary Democratic Front is controlled and narrow. In the aftermath of the 2005 contested election results, the riots and demonstrations that broke out in Addis Ababa resulted in many deaths, according to human rights organisations(Sørensen, 2018).

1.4 Ethiopian political landscape

The historical political context in Ethiopia can be described as authoritarian(M. T. Østebø, Cogburn, & Mandani, 2018). Democratic rights were severely reduced both during Haile Selassie’s feudal monarchy (1930–74) and during the communist Derg regime (1974–91)(M. T. Østebø & Østebø, 2014). Despite the authoritarian regime, the Ethiopian government launched a nationwide Health Extension Program in the early 2000s to provide health care workers and services, including free family planning, to populations in rural and remote areas, including adolescents. This was followed by the launch of the 2007 National Adolescent and Youth Reproductive Health Strategy, which recognized the need for quality and tailored reproductive health services for young people. Most recently, these efforts have expanded reproductive, maternal, new-born, and child health interventions to include adolescents, while the government has also committed to expanding youth-friendly services throughout the country as evidenced by Ethiopia’s Family Planning 2020 (FP2020) commitment(Assefa, Gelaw, Hill, Taye, & Van Damme, 2019).

The key challenge, in Ethiopia has been implementation of polices. Challenges specifically concern the need to overcome significant structural and social barriers that prevent Ethiopian adolescents from having equal access to family planning and other Sexual and Reproductive Health (SRH) information, care, and services(Coast et al., 2019). In 2009, the government passed the Charities and Societies Proclamation, weakening human rights and governance-related activities of Civil Society Organisations (CSOs)(Sørensen, 2018).

Organisations working on human rights, good governance, conflict resolution, and advocacy on the rights of women, children and people with disabilities, are were not allowed to receive funding from foreign sources for more than 10 per cent of their total budget(Sørensen, 2018). More recently, human rights organisations raised apprehension in relation to regional protests in the Oromia region in 2015. The protests later extended to other regions and areas, with protesters demanding an end to haphazard arrests and release of political prisoners. The demonstrations had a violent outcome, with human rights organisations reporting a high death toll and mass arrests. Public reproach by the international community, including donors, was minimal (Sørensen, 2018). In October 2016, the Ethiopian parliament adopted a State of Emergency, restricting the right to freedom of expression, association, and assembly. Corruption in Ethiopia is relatively high, although lower than in comparable regional countries(Sørensen, 2018).

For example, corruption is found in relation to land, tax and customs administration, public services, and public procurement, according to the GAN Business Anti-corruption Portal 2017(Sørensen, 2018). Ethiopia ranks 108 out of 176 on the Corruption Perception Index(Sørensen, 2018). A wave of protests in 2017, followed by the surprise resignation of the then Prime Minister, Hailemariam Desalegn, in February 2018, opened the way for a new political era in Ethiopia. As part of a more democratic, transparent and accountable government, the new Prime Minister Abiy Ahmed, winner of The Nobel Peace Prize 2019, committed to repealing and revising a series of repressive laws, including the Charities and Societies Proclamation of 2009(Yeshanew, 2012).

1.5 Ethiopian Civil Society

Ethiopia has a long tradition of internal informal community-based organisations (CBOs) like the ‘idir’ and ‘iqub’ – self-help associations that operate at the local level and offer conjoint socio-economic provision for their participants. Formal civil society organizations are a recent advance. Historically, Ethiopian civil society has been smaller and less diverse than elsewhere in Africa, and has been distinctive due to oppositional state-society interactions(Yeshanew, 2012). There were no formal NGOs in Ethiopia until the famines of the 1970s and the 1980s, which required the government to receive outside assistance in the form of foreign aid.

Norwegian Church Aid were asked to help in 1974 as a response to a severe famine(Yeshanew, 2012).

Currently the Ethiopian civil society sector is separated between government-aligned community organizations, which includes mass-based organizations as well as religious and interest groups, and independent organizations, NGOs and advocacy organizations(Yeshanew, 2012). Most of the independent Ethiopian NGOs are not rooted in local communities, and are instead viewed as foreign, rather than native, individuals(Yeshanew, 2012).

Ethiopian government and NGO affairs warmed in the 1990s, following the Ethiopian People's Revolutionary Democratic Front (EPRDF) rise to power and the consequent period of political liberalization. The EPRDF were initially wary of independent groups, as they were perceived as being approaching challengers to the new government's authority, and the party encouraged the formation of government-aligned, mass-based NGOs formed by reigning elites(Yeshanew, 2012). However government–civil society relations improved as the government gradually permitted civil society to develop towards the end of the 1990s, when the Ethiopian government needed aid with aid in the aftermath of the Eritrean war for independence(Yeshanew, 2012). Consequently, along with growing foreign aid movements, the number of operational, Ethiopia-based NGOs grew exponentially, from 70 in 1994 to 368 in 2000, and to 2275 in 2009(Yeshanew, 2012). Throughout this time, official advocacy groups made their first appearance in the country(Yeshanew, 2012).

However, in 2005, government–NGO relations turned hostile in the wake of Ethiopia's disputed national elections. To the dismay and surprise of many of the EPRDF, opposition parties won many votes, and electoral disputes triggered large-scale protests, some of which turned violent (Yeshanew, 2012). The government cracked down, alleging civil society of supporting both the political resistance and the violence. It then spread a series of new anti-democratic laws, including the 2009 Proclamation for the Registration and Regulation of Charities and Societies; the 2008 Mass Media and Freedom of Information Proclamation; the 2008 Political Parties Registration Proclamation; and the 2009 Anti-Terrorism Law(Yeshanew, 2012). Together, these laws provided the government with instruments to focus its control, raise the costs of disagreement, and punish the opposition(Yeshanew, 2012).

The Ethiopian government has had a history of criticizing NGOs as opportunists using foreign money for inflated salaries and unnecessary expenses(Yeshanew, 2012). Echoing the work of the scholarly NGO sceptics', the ERPDF have claimed that NGOs lacked popular support, endorse foreign neo-liberal agendas and are otherwise inauthentic, undemocratic, unaccountable, or locally illegitimate(Yeshanew, 2012). The government has stated that only the state can bring about sustainable development and advance the people's lives by sharing the benefits of economic growth, and all other opportunistic actors must be taken under the jurisdiction of the government(Yeshanew, 2012). Thus, only civil society groups established, controlled, and funded by Ethiopians, the ERPDF argued at the time, should be allowed to locally encourage Ethiopian political and human rights (Yeshanew, 2012).

1.6 The origin of FGM/C and the terminology concerning FGM/C

Female Genital Mutilation/Cutting (FGM/C) predates the rise of Christianity and Islam(UNFPA, 2019b). The exact historical and geographical origin of the practice of FGM/C is unknown. The hypothesis that the practice originated in the Middle East and the Arabian Peninsula and was then carried across the African continent by Arab traders is not shared by all experts. What does seem to be accepted is that FGM/C is an age-old practice, possibly dating as far back as Ancient Egypt, the archaeological community is split over whether marks uncovered on Egyptian mummies are indication of excision/cutting. The first reference to excision/cutting, recorded on papyrus, dates from the second century BCE in Egypt. Later sources include reports of travellers like the Ancient Greek geographer Strabo, who, after travelling to Egypt (around 25 BCE), defined the method as a usual practice(Andro et al., 2016). It is also narrated that circumcision rites were pertained to tropical zones of Africa, in the Philippines, by certain tribes in the Upper Amazon, by women of the Arunta tribe in Australia, and by certain early Romans and Arabs(UNFPA, 2019b). As recent as the 1950s, clitoridectomy was performed in Western Europe and the United States to handle supposed ailments including hysteria, epilepsy, mental disorders, masturbation, nymphomania and melancholia(UNFPA, 2019b).

Researchers have been made aware of the controversies that surround the use of the term "female genital mutilation" (FGM)(M. T. Østebø & Østebø, 2014). The terms female circumcision and female genital cutting (FGC) are perceived to be less offensive as an substitute to both cutting and mutilation, Dorothy Hodgson, an anthropologist who has published extensively on gender and women's rights in Africa, uses the term "female genital modification" (M. T. Østebø & Østebø, 2014). A spectrum of researchers settle with Hodgson in her argument that her term is a more politically impartial term; in this thesis, however, I purposely use the term female genital mutilation/cutting (FGM/C), since it is commonly used by the Ethiopian government administration and the NGO community in Ethiopia (M. T. Østebø & Østebø, 2014). The cut can differ from a symbolic nicking of the clitoris to excision of skin and partial closure of the vaginal area (infibulation). The ritual features vary from the direct cutting of an infant in the family context to complex rituals encompassing the cutting of groups of adolescent girls held in isolation for weeks or months(Serour, 2013).

In some communities, and in some situations, women are subjected to FGM/C later in life. This includes when they are about to be married, or after marriage, during pregnancy and after childbirth, or when their own daughters undergo the procedure(WHO, 2019). Most women who have experienced FGM/C live in one of the 28 countries in Africa and the Middle East, nearly half of them in just two countries: Egypt and Ethiopia. Countries in which FGM/C has been documented to occur include: Benin, Burkina Faso, Cameroon, Central African Republic, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal, Sierra Leone, Somalia, Sudan, Togo, Uganda, United Republic of Tanzania and Yemen(WHO, 2011b).

In addition, the practice of FGM/C and its potentially harmful consequences also concerns a growing number of women and girls in Europe, North America, Australia and New Zealand as a result of international migration. The exact number of women and girls living with FGM in Europe is unknown, but is estimated to be around 500 000, and 180 000 girls are estimated to be at risk of being subjected to the practice(WHO, 2011b).

In a few societies, the procedure is routinely carried out when a girl is a few weeks or a few months old (Eritrea, Yemen); in most, it occurs later in childhood or in adolescence. According to the WHO and UN agencies, the practice of FGM/C has no health benefits for girls and women (Yoder et al, 2004). The health consequences of such an potentially invasive procedure can vary(WHO, 2019). FGM/C can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications during childbirth and increased risk of new-born deaths (WHO, 2019). FGM/C also considered to violate a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death(Williams-Breault, 2018).

The practice is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths (WHO, 2019). In many situations, health care providers perform FGM/C in the flawed belief that the procedure is safer when medicalized(WHO, 2019). WHO and other UN agencies have strongly urged health care professionals not to perform such procedures(WHO, 2019). WHO is opposed to all forms of FGM/C, and is opposed to health care providers performing FGM/C (medicalization of FGM/C)(WHO, 2019).

FGM/C is recognized internationally as a violation of the human rights of girls and women. It exposes deep-rooted inequality between men and women and constitutes an extreme form of discrimination against women and girls. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death(Shell-Duncan, 2008).

1.7 Types of FGM/C

In 1997, WHO classified FGM/C into four different types(WHO, 2018). Since then, experience with operating with this classification exposed the necessity to subdivide these categories, to capture the variations of FGM/C in further detail(WHO, 2018). Severity of consequences almost constantly corresponds to the amount of tissue damaged or removed and

health risk are closely related to the type of FGM/C executed as well as the extent of tissue that is cut(WHO, 2018).

The four key types of FGM/C and their subtypes, are:

- **Type I.** Partial or complete removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals, with the function of providing sexual pleasure to the woman), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans). When it is important to distinguish between the major variations of Type I FGM/C, the following subdivisions are used:
    - **Type Ia**. Removal of the prepuce/clitoral hood only(WHO, 2018)
- **Type Ib**. Removal of the clitoral glans with the prepuce/clitoral hood.
  Type II. Partial or full removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva). When it is essential to differentiate between the main variations of Type II FGM, the following subdivisions are used:
    - **Type Iia.** Removal of the labia minora only.
    - **Type Iib.** Partial or total removal of the clitoral glans and the labia minora (prepuce/clitoral hood may be affected).
    - **Type Iic.** Partial or total removal of the clitoral glans, the labia minora and the labia majora (prepuce/clitoral hood may be affected)(WHO, 2018).
- **Type III.** Often stated as *infibulation* and it means a tightening of the vaginal opening with the creation of a covering seal. The seal is formed by cutting and relocating the labia minora, or labia majora. The cover of the vaginal opening is done with or without removal of the clitoral prepuce/clitoral hood and glands (Type I FGM/C).
- When it is important to differentiate between variations of Type III FGM/C, the following subdivisions are used:
    - **Type IIIa**. Removal and repositioning of the labia minora.
    - **Type IIIb.** Removal and repositioning of the labia majora.
- **Type IV.** All other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterization(WHO, 2018).

De-infibulation refers to the practice of cutting open the sealed vaginal opening of a woman who has been infibulated (Type III). This is regularly done to permit sexual intercourse or to aid childbirth, and is often essential for improving the woman's health and well-being(WHO, 2018).
Despite the health risks, some women experience a narrowing of their vaginal opening again after being de-infibulated, at the time of childbirth, this results in that these women may undergo a chain of repeated infibulations and de-infibulations during their life course(WHO, 2018). The WHO states that FGM/C has no health benefits and it involves removing and damaging healthy and normal female genital tissue and inhibits the natural functions of girls' and women's bodies. Generally speaking, risks of FGM/C increase with increasing severity (which here corresponds to the amount of tissue damaged), although all forms of FGM/C are associated with increased health risk(WHO, 2018). Immediate complications of de-infibulation can include: severe pain, excessive bleeding, haemorrhage, genital tissue swelling, fever, infections e.g., tetanus, urinary problems, wound healing problems, injury to surrounding genital tissue, shock and death(Serour, 2013).

In the long-term, FGM/C is associated with the potential of localized infection or abscess formation, shock, death, acute retention of urine, and contraction of hepatitis and/or HIV particularly when it is performed in non-sterile settings (Serour, 2013). Although the medicalization of FGM/C may reduce the incidence of these acute complications, it has no effect on the incidence of late gynaecological and obstetric complications(Serour, 2013).
The gynaecological complications of FGM/C include sexual dysfunction, apareunia, superficial dyspareunia, chronic pain, scar formation, dysmenorrhea, vaginal laceration during sexual intercourse, trouble passing urine, and struggle during gynaecological or urological examinations and procedures (Serour, 2013).

According to the WHO, chronic pelvic infections that can cause chronic back and pelvic pain, and repeated urinary tract infections have been documented in both girls and adults. A recent WHO-led study showed that FGM/C is associated with increased risk for complications for both mother and child during childbirth. Rates of caesarean section (29 percent increase for Type II and 31 percent increase for Type III FGM/C and postpartum haemorrhage (21 percent for Type II and 69 percent for Type III FGM/C) were both more recurrent amongst women with FGM/C paralleled with those without FGM/C. In addition, the study stated, there was an

increased probability of tearing and recourse to episiotomies. The risk of birth complication increases with the severity of FGM/C(WHO, 2011b).

FGM/C of the mother is also a hazardous for the infant. According to WHO, there are significantly higher death rates (including stillbirths) among infants born from mothers who have undergone FGM/C than women with no FGM/C. The increase was 15 percent increase for Type I FGM, 32 percent increase for Type II FGM/C and 55 percent increase for Type III FGM/C. Enquiry and research has revealed that sexual difficulties are also more usual among women who have endured FGM/C. Women with FGM /C were found to be 1.5 times more prone to experience agony or discomfort during sexual interaction, experience notably less sexual satisfaction and they were twice as likely to report that they did not experience sexual desire(WHO, 2011a).

Additional risks have been documented for the most extensive form of FGM/C (Type III). Further surgery is usually necessary later in women's' lives when infibulations must be opened to enable sexual intercourse and further again in childbirth. In some countries this is followed by re-closure (re-infibulation), and hence the need for repeated de-infibulation later. Urinary and menstrual problems are not uncommon, particularly prior to de-infibulation at first marriage. For many women sexual intercourse is painful during the first few weeks after sexual initiation, as the infibulation must be opened up either surgically or through penetrative sex. The male partner can also experience pain and complications. Type III FGM/C is also associated with infertility. Evidence suggests that the more tissue is removed, the higher the risk for infection(WHO, 2011b)

FGM/C is carried out with special knives, scissors, scalpels, pieces of glass or razor blades. Anaesthetic and antiseptics are generally not used unless the procedure is carried out by medical practitioners. In communities where infibulations is practiced, girls' legs are often bound together to immobilize them for 10-14 days, allowing the formation of scar tissue(UNFPA, 2019b).

1.7.1 Medicalization of FGM/C

The medicalization of FGM refers to situations in which the procedure (including re-infibulation) is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere, at any point in time in a woman's life. This definition was first adopted by WHO in 1997 (21) and reaffirmed in 2008 by 10 UN agencies in the interagency statement, "Eliminating female genital mutilation". The interagency statement strongly emphasizes that regardless of whether FGM is carried out by traditional or medical personnel, it represents a harmful and unethical practice, with no benefits whatsoever, which should not be performed under any circumstances. Communities may be increasingly turning to health-care providers to perform the procedure for a combination of reasons. An important contributing factor is the fact that FGM has been addressed for years as a health issue, using what is known as the "health risk approach". This approach has involved locally respected health experts expressing concern about the health risks of FGM/C, in the form of a didactic and factual delivery of messages(WHO, 2016).

In numerous high-prevalence countries, this method unfortunately did not result in individuals, families or communities abandoning the practice, but launched a shift it from traditional circumcizors to modern health-care experts in the hope that this would diminish the risk of various health difficulties. This brought to light the problem that though providing evidence about the associated health risks of FGM/C is an important part of its elimination, it is not sufficient to eradicate a practice strongly based on cultural beliefs and deeply embedded in societal traditions. As an additional side-effect of the "health risk approach" to FGM/C, some professional organizations and governments have increasingly supported fewer radical forms of cutting, like the pricking of the clitoris, performed under hygienic and medically controlled conditions. Such harm reduction strategies are an attempt to reduce the risk of severe complications arising from the procedure when carried out in precarious conditions(WHO, 2016).

According to WHO, these circumstances paired with the fact that a number of health-care providers still consider certain forms of FGM/C not to be damaging and a large proportion of them are incapable or unwilling to state a clear position when confronted with crucial issues like requests for performing FGM/C or re-infibulation have contributed to increasing the popularity of medicalized FGM across Africa and in the Middle East. In addition, the

involvement of health-care providers in performing FGM/C is likely to confer a sense of legitimacy on the practice and could give the impression that the practice is suitable for women's health, or at least that it is risk-free. Efforts to discontinue this unintended consequence were initiated by WHO in 1979 at the first international conference on FGM/C, held in Khartoum, Sudan, where WHO established that it is unacceptable to suggest that performing less invasive forms of FGM/C within medical facilities will reduce health complications. Since then, this position has been endorsed by numerous other medical professional associations, international agencies, NGOs and governments. The denunciation of medicalization of FGM/C was further highlighted and echoed in the 2008 interagency statement on the elimination of FGM/C(WHO, 2016).

WHO recognizes that stopping the medicalization of FGM/C is an essential component of the holistic, human-rights-based approach towards the elimination of the practice: when communities see that health-care providers have taken a stand in favour of the abandonment of the procedure and have refrained from performing it, this will foster local debate and questioning of the practice. WHO guidelines on the management of health complications from FGM/C(WHO, 2016).

1.7.2 Cross-Border FGM/C

The UNFPA stipulates that the practice of FGM/C cuts across national borders. In the case of East Africa, regions with high prevalence rates are often concentrated in areas that span several countries such as the border areas of Kenya, Ethiopia and Somalia, Kenya and Tanzania, Ethiopia and Sudan, as well as Ethiopia, Djibouti and Eritrea. Ethiopia, Kenya, Tanzania and Uganda have national legislations on FGM/C and specific budget lines, while Somalia constitutes an exception. The five countries have integrated FGM/C prevention, response and care into sectorial policies related to health, sexual and reproductive health, youth, gender- based violence and harmful practices. In some contexts, there is a specific FGM/C national policy or approach with an action design. There are specific FGM/C coordination bodies. In the case of Somalia, there is not yet a national law on FGM/C, however, in 2014 a zero tolerance FGM fatwa was released in Puntland and a draft of zero tolerance FGM/C Bill in Federal Government of Somalia (FGS), Somaliland and Puntland are available(UNFPA, 2019a).

1.7.3 Data collection on national and regional FGM/C prevalence rates

The global evidence that has led to the imposition of the ban on FGM/C has been subject to many studies. There are conflicting reports and views concerning the worldwide decrease in the prevalence of FGM/C(Shell-Duncan, 2016). One of the main difficulties with such studies is that they excessively rely on cross-sectional data evaluating the prevalence of FGM/C at a particular time point. These types of studies can hide disparities at the regional and sub-national level in relation to the increase or decline in prevalence of FGM/C(Kandala & Komba, 2018).

The standard approach to estimating prevalence of FGM/C was developed by the Demographic and Health Surveys (DHS) of ICF International (formerly ORC Macro)(Feldman-Jacobs, 2013). Using a special module on FGM/C, it has collected data on FGM/C from adult women ages 15 to 49 since 1989, yielding nationally representative estimates of FGM/C in surveyed countries(Feldman-Jacobs, 2013). UNICEF, through its Multiple Indicator Cluster Surveys (MICS), has used a similar module to collect information in selected countries since 2000(Feldman-Jacobs, 2013). In the case of Ethiopia, the EDHS is used a measure for stating the regional and national prevalence rate, but it only provides data on women from the ages 15-49 and one can never truthfully be certain if the self-reporting is precise. The EDHS conducted in 2016 is the most recent survey conducted and is the foundation for approximating national and regional FGM/C prevalence rate in Ethiopia(Feldman-Jacobs, 2013).

The ultimate goals of FGM/C prevention work are first to reduce the number and share of girls who are mutilated each year and second to put a definite end to the practice. Documenting changes in FGM/C as a practice is particularly challenging for a range of reasons. One issue that is important to mention and highlight is that data collection normally relies on self-reporting(Shell-Duncan et al., 2016). Unlike child marriage and foot-binding, it is not possible for others to see whether a girl has been cut, except for health personnel if she is subject to a clinical observation(J. Svanemyr, 2019). There are questions related to the reliability of self-reporting in a context where the community members may feel under pressure to hide the practice(J. Svanemyr, 2019). Under-reporting of FGM/C has been

documented in Ghana, Burkina Faso and Senegal, which has been explained as a reaction to prohibitions and sanctions against the practice(Shell-Duncan, 2016).

1.7.4 Reliability of Self-Reported FGM/C Status

Most studies on the prevalence of FGM/C are based on proportions found through self-report studies and are measured by conducting demographics and health surveys in the country. Due to factors such as tradition, culture, history and pressure from family, there are perhaps numerous who do not admit their own attitudes in relation to practice. It is challenging to verify respondents' feedback. Increased knowledge, reporting and openness about FGM/C can also lead to self-censorship and under-reporting(Shell-Duncan et al., 2016). The population-based surveys provide data for estimating two types of prevalence indications, the prevalence among women, and the prevalence among daughters. Most surveys use the question, "Are you circumcised?" or substitutes that appear to capture akin implication: "Have you been circumcised?", "Have you ever been circumcised", "Have you yourself ever had(Alradie-Mohamed, Kabir, & Arafat, 2020) your genitals cut?", and "Did you have your external genitals cut?"(Shell-Duncan, 2016).

However, self-reported data on FGM/C needs to be treated with caution as inaccuracies may arise for a number of causes. Because of the sensitivity of the matter or illegal status of FGM/C, women may be reluctant to divulge having undergone FGM/C. Additionally, predominantly when FGM/C is performed at an early age, women may be unaware of whether they have been cut or the degree of the cutting. Recollection partiality is also a possibility. A 45-year-old woman reporting about being cut at age 5 is reporting about an incident that transpired 40 years in the past and could have a misconstrued recollection of the occasion. The rendition of survey questions also opens possibilities for ambiguity. The term "female circumcision" must be deciphered into a local term, and the choice of terminology may influence which forms of cutting are understood to be FGM/C. A number of studies have endeavoured to regulate the reliability of self-reports of FGM/C status by authenticating them through clinical examinations(Shell-Duncan et al., 2016). These medical physical examinations can be a delicate and intricate affair.

1.8 International efforts in preventing FGM/C

On 20 December 2012, the United Nations General Assembly adopted a series of resolutions to eliminate practices and violations that present a grave danger to the health of women and girls. One of the five resolutions on the promotion of women's rights focuses specifically on intensifying global efforts for the elimination of FGM/C(Assembly, 2016). It urged the countries concerned to condemn all harmful practices that affect women and girls, in particular FGM/C, and to take all necessary measures, including enacting and enforcing legislation, raising awareness and allocating sufficient resources to protect women and girls against this specific form of violence. The strategy called for protection and support for women and girls who are at risk of or who have undergone female genital mutilation. The resolution is addressed to the countries where FGM/C is traditionally practised and to the countries of settlement of women who have migrated from those regions(Andro et al., 2016).

This international policy, which has now been ratified by the 194-member states of the United Nations, was elaborated slowly and in several stages. It is based on the triptych of human rights, the right to health, and women's rights, doctrines that themselves gained official recognition through the international treaties adopted in the latter half of the twentieth century(Andro et al., 2016).

For the past several decades, a diverse group of scholars, advocates, legislators and health-care practitioners have offered differing views and viewpoints about how to best answer to this UN resolution. One consistent and prevailing theme in these conversations is a call for common recognition of FGM/C as a denial of girls' and women's ability to completely exercise their human rights and to be free from discrimination, violence and inequality. WHO and UN agencies state that FGM/C violates a series of well-established human rights principles, norms and standards, involving the principles of equality and non-discrimination on the basis of sex, the right to life when the practice results in death, and the right to freedom from agony or cruel, inhuman or degrading treatment or punishment, as well as the rights of the child. As it interferes with healthy genital tissue in the absence of medical necessity and can lead to severe consequences for a woman's physical and mental health, FGM/C is also a violation of a person's right to the highest attainable standard of health(WHO, 2016).

1.8.1 The stages in the international campaign against FGM/C

The United Nations Commission on Human Rights first discussed the traditional practice of FGM in 1952. In 1958 the UN Economic and Social Council explicitly raised the issue of FGM and the harm it causes as a problem for the international community. At that time, the practice was approached primarily from a culturalist viewpoint. The WHO then refused to become involved, at the time considering FGM/C as a social and cultural practice rather than a health issue and therefore outside its competence(Andro et al., 2016).

In 1977 the NGO Working Group on Traditional Practices was set up, opening up a discussion of the consequences of FGM on the health of women and girls. The previous anthropological approach to the practice had effectively rendered the harmful effects of FGM/C undetectable. In 1979, the WHO took a stance on the issue for the first time by inventorying the medical consequences of FGM/C(Andro et al., 2016). The WHO's Regional Office for the Eastern Mediterranean in Khartoum convened a forum on "traditional practices affecting the health of women and children", joined by NGOs and doctors, at which Fran Hosken presented her report on genital and sexual mutilation of women(Andro et al., 2016).

At the World Conference for the United Nations Decade for Women, held in Copenhagen in 1980, there was a tense disagreement amid the European and African delegations. The majority of the latter were still calling for the custom to be acknowledged as a rite of passage towards adulthood on par with the circumcision of boys. Still, by the global conference on women in Nairobi in 1985, sentiments had altered, and a wider agreement commenced to develop, with perception that the tradition was detrimental to women and girls. International agencies became progressively involved from that date on. The Working Group on Traditional Practices Affecting the Health of Women and Children submitted its initial report to the UN Commission on Human Rights in 1986. In the 1990s, efforts to prohibit and sanction FGM/C became more systematized. In 1990, the Inter-African Committee on Traditional Practices, set up by feminist groups, adopted the term "mutilation", trailing UNICEF's lead(Andro et al., 2016).

The UN General Assembly adopted the Declaration on the Elimination of Violence against Women in 1993, which refers unequivocally to FGM/C. In 1994, the United Nations Sub-Commission on Prevention of Discrimination and Protection of Minorities implemented the first Plan of Action for the Elimination of Harmful Traditional Practices affecting the Health of Women and Children. The United Nations' abolitionist stance was echoed at the International Conference on Population and Development in Cairo in 1994 and Fourth World Conference on Women in Beijing in 1995(Andro et al., 2016).

Under the new policy agenda, the WHO supported the first joint statement with UNICEF and UNFPA in 1997, officialising their encouragement for programmes to avert and eliminate the practice of FGM/C and commission the support of the action of governments in that direction(Ashford, Naik, & Greenbaum, 2020).

Information and mobilization concerning the issue of FGM/C encouraged the WHO to outline the primary typology of FGM/C in 1997, together with UNICEF and UNFPA. International legal instruments could not have been developed and adopted without the campaigns in the countries concerned. The 1981 Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, known as the "Maputo Protocol", was a legal instrument, adopted by unanimity in 2003 by the heads of state of the African Union(Andro et al., 2016).

Article 5 of the protocol unequivocally outlaws and condemns FGM/C and other harmful traditional practices. It called on the signatory states to take actions to cultivate public awareness, to pass legislation backed by sanctions to prohibit FGM/C, to support victims of harmful practices and to protect women who were and still are at risk(Andro et al., 2016).The gradual emergence of a consensus around an international policy on FGM/C has been hampered by the contending discourses of various international bodies. Some researchers have pointed out that, in the United Nations itself, the recognition of the universal rights of women and the right to bodily integrity has long competed with the principles of sovereign autonomy and respect for traditions and family transmission. In the end, the former principles took precedence in the elaboration of the international doctrine on FGM/C(Andro et al., 2016).

The general consensus of WHO and UN agencies is underpinned by two legal principles: the right to health and human rights. Some researchers have described the “tense union” between human rights and the right to health in deliberations on FGM/C. It was through emphasis on the health effects of FGM/C that the practice came to be seen not in terms of a ritual of socialization but as a grave abuse of the bodily integrity of the women exposed to it, thus stipulating grounds for examination from a human-rights standpoint(Andro et al., 2016).

However, the health tactic has also proved counter-productive, because opponents mentioned a lack of medical proof of harm due to the medicalization of FGM/C procedures. Furthermore, the motives behind the efforts of international feminist movements to ban the practice have long come under suspicion. The international effort has repeatedly portrayed African women as suffering under custom without resisting it, even though it endangers the lives of their daughters(Kimani & Shell-Duncan, 2018; Shell-Duncan et al., 2016). Perceptions of the tradition have nonetheless altered considerably since the turn of the twenty-first century. FGM/C, alleged to be an exclusively African problem in the twentieth century, has now become a global concern(Andro et al., 2016).

1.8.2 Legislative developments in relation to FGM/C

In the countries of origin and of destination, legislation on FGM/C has gradually moved in line with the intensified international and regional efforts to ban the practice since the 1990s In Dakar, in 2005, the African Parliamentary Conference adopted a resolution calling on states to enact decrees to ban FGM/C. 26 of the 30 countries with the highest prevalence of FGM/C, 25 have passed decrees or laws on the practice in recent years. In the vast majority of countries, laws have been passed since the late 1990s. Except for two countries, Guinea and the Central Africa in 15 countries, they were introduced in the 2000s and 2010s. The scope of this legislation varies considerably across countries(Andro et al., 2016). The introduction of a legislative framework in the countries of origin has been simultaneous with similar changes in the countries of immigration.

The first destination countries to criminalize FGM/C, in the late 1970s and early 1980s, were France (1979), Sweden (1982) and the United Kingdom (1985). The United States, Canada, Australia and Norway passed legislation in the 1990s, and the other European countries in the 2000s. Some European countries have specific laws on FGM/C, while others, such as France,

have encompassed FGM/C in their legislation on child abuse and mutilation. These legislative provisions have led to prosecutions in six European countries, although for many years France was the only country to have taken cases of FGM/C. By 2012, 42 cases had been tried in court systems in six EU countries(Andro et al., 2016).

1.9 FGM/C in Ethiopia

This section explains the legal framework in Ethiopia and provides an overview of the status of FGM/C prevalence. National policies and legal framework concerning FGM/C and other harmful practices are recognized as violations of human rights under Ethiopian law. The country's Constitution reflects many of the principles found in key international human rights instruments. Two articles in particular, 16 and 35, specifically protect women from bodily harm and from harmful customs, laws and practices(Sørensen, 2018). Ethiopia's constitution prohibits harmful practices that affect the psychological and physical well-being of women. The Criminal Code of Ethiopia (2005) has supplies that protect women and children from violence, including harmful traditional practices(Wilson, 2013).

The National Committee on Traditional Practices in Ethiopia listed 88 practices, in 1988, as 'harmful', including FGM/C, child marriage and marriage by abduction, which are still present in varying degrees across the country. The term harmful traditional practices (HTPs) refers to practices and cultures which affect the health and well-being of women and girls. HTPs are believed to be caused by the inferior position given to girls and women in society and therefore is an added manifestation of bias against women. These HTPs adversely affect the physical as well as mental health of the victims(Alem et al., 2013). When Ethiopia's Criminal Code came into effect, it further acknowledged the grave injuries and suffering caused to women and children by HTPs. In the Code, abduction is categorized as a crime under the Code, marriage of minors is considered an illegal act, and comprehensive provisions have been included on FGM/C, domestic violence and harmful traditional practices performed on pregnant women or new-born children. The Code includes penalties and punishments for those who are accomplices, as well as those who are directly responsible

for the offence (Insight, 2010). Following the endorsement of the *National Harmful Traditional Practices (HTPs) Strategy and Action Plan*, which focuses on addressing FGM/C, and child marriage and abduction, the government has included a dedicated budget line on ending HTPs, including FGM/C, since 2013(Insight, 2010).

As part of its goal to end FGM/C and child marriage by 2025, Ethiopia has committed to increase the budget allocation by 10 percent. The *National Alliance to End Child Marriage and FGM/C* (established in 2012) and the *National HTPs Platform (*established in 2016) are the main national coordination mechanisms for the work on FGM/C(Insight, 2010).

1.9.1 Ethnic and regional variations

According to the 2016 EDHS, the incidence of FGM/C among adolescent girls in the richest quintile was 43 percent and 73 percent for girls in the poorest quintile. Changes in attitudes towards FGM/C have seen advances over the years. Only 17 percent of adolescent girls in 2016 shared the opinion that FGM/C should be continued or were undecided about it compared to 65 percent in 2000. An even lower proportion of adolescent boys (13 percent) supported the practice of FGM/C or were uncertain about according to the 2016 EDHS. Across regions, Amhara, SNNPR, and Benishangul-Gumuz achieved the greatest progress in changing attitudes towards FGM/C, whereas in Somali and Afar more than half of adolescents in 2016 thought that the practice should be sustained. Attitudes have also changed drastically among youths in rural areas of Ethiopia. Evidence of mindsets towards FGM/C across wealth quintiles shows that poorer individuals were generally more in favour of the practice(Elezaj, Cebotari, Ramful, & Neubourg, 2020).

The age of when FGM/C is undergone varied in Ethiopia, with two basic patterns involving a dichotomy between the north and the south(Wilson, 2013). In northern Ethiopia, FGM/C has tended to be carried out shortly after labour, whereas in southern Ethiopia it was usually linked to marriage. In the north, clitoridectomy and/or labiadectomy was conventional norm, customarily executed on the seventh day in Tigray and on the fifth, seventh, or fifteenth day in different parts of Amhara. FGM/C was thus carried out in infancy, before the child was given an identity, on a prescribed number of days after birth and was therefore by definition not a group matter, but rather a private, household affair. In contrast, in southern Ethiopia,

among the Oromo the procedure took place prior to puberty or shortly before matrimony(Wilson, 2013).

Only in parts of Oromia influenced by Amhara or Muslim traditions were the girls subjected to FGM/C at infancy(Boyden, Pankhurst, & Tafere, 2013). There were variations in terms of whether circumcision of men and women was performed at the same time and whether it was a collective rite of passage, as in parts of the South, or a household event, which was more common in the North. Moreover, the identity of the circumcisers, and whether they were specialists varied; in some cases in Southern Ethiopia they were 'caste-like' marginalised groups(Pankhurst, 2017)

All types of FGM//C are practiced in Ethiopia, however there is a tendency to veer more to clitorectomy, excision and infibulation (See section on Types of FGM/C). The type, prevalence and age of the girls when they are cut vary, including ethnic and geographical affiliation, religious affiliation, and parents' level of education. There have largely been traditional circumcisions without health education that perform FGM/C. Use of medical personnel is increasing in Ethiopia(Kandala & Komba, 2018).

Among Ethiopia's 66 largest ethnic groups, 46 practice FGM/C. There is considerable in uncertainty some of the data presented by the EDHS(EDHS, 2016), and it is difficult to compare data from different surveys done at different times. Regional conditions, inequality between urban and rural areas, ethnic and social affiliation, economics, and knowledge and education affect the likelihood of FGM/C occurring. At the same time, belonging to an ethnic group, geographical affiliation, social class or one's financial situation can neither exclude nor guarantee that an Ethiopian girl or woman is or will be subjected to FGM/C. There are wide variations within the various social and ethnic groups. Even in the regions where the FGM/C prevalence rate is high, there are clusters where FGM/C does not transpire amid community members.

The age of FGM/C, as noted, varies, with two basic patterns and a dichotomy between the north and the south. In northern Ethiopia it tended to be carried out shortly after birth, whereas in southern Ethiopia it was usually linked to marriage. In the north, clitoridectomy and labiadectomy has been a cultural norm, traditionally performed on the seventh day in

Tigray (despite the low prevalence rate) and on the fifth, seventh, or fifteenth day in Amhara. FGM/C is thus carried out in infancy, almost before the child is given an identity, on a prescribed number of days after birth and is therefore by definition not a group matter, but a private, household, affair, although food (especially porridge) is customarily served to those present(Boyden et al., 2013).

The practice in southern Ethiopia among Oromo and some southern Ethiopian peoples is incredibly different. Only in parts of Oromia influenced by Amhara or Muslim traditions is the girl circumcised/cut at infancy; in parts of western Oromia the procedure takes place before the age of 10, in the east between 9 and 12, and among the Arsi in central southern Oromia as a prelude to marriage. There are variations in terms of whether circumcision of men and women is performed at the same time and is a rite of passage and a collective or a household event, and regarding the identity of the person who performs the circumcision. Among southern Ethiopians groups collective rites are more common, and the role of circumciser is often assigned to specialist craft workers(Boyden et al., 2013). Among the Wolayta, clitoridectomy is performed on girls by potters prior to marriage. In Kambata and Hadiya, the collective public aspect of the FGM/C as rite of passage for girls is important, and a circumcised/cut girl is displayed in celebration in the market place(Boyden et al., 2013).

Among the Sidama it is carried out around the age of eight or just before or directly after the wedding, when the bride will be inspected for virginity. After the inspection, the girl usually goes into a two-month seclusion period during which she should be fed buttermilk and meat at the expense of the groom's family. Among the Gurage, boys and girls are circumcised between the age of eight and ten in rites-of-passage ceremonies involving several children and performed by the special caste of former hunters, followed by an initiation period. Girls circumcised at the same time undergo a symbolic ritual 'abduction' by the chief of a special caste and remain isolated for about a month in the 'bush', where they are taught a ritual language, kept secret from men and used at religious festivals, they remain members of this group until they marry. Among a number of societies in southern Ethiopia, the role of performing both male and female circumcision is given to the caste groups of potters, smiths, or tanners, such as the Chinasha among the Wolayta(Boyden et al., 2013).

19.2 FGM/C and the role of Media and Education in Ethiopia

According to UNICEF, lack of education is often associated with FGM/C, with the assumption that the educated women will be less likely to have their daughters cut. It is possible that while at school, girls have greater exposure to intervention programmes, media messages and international discourse surrounding FGM/C. They may also develop social ties with peers and mentors who oppose the practice, providing a reference group where no normative sanctions exist for not undergoing FGM/C. They may also have the opportunity to discuss new ideas in a conducive environment. In Ethiopia, the prevalence of FGM/C decreases with the level of a woman's education. In Ethiopia, the Federal Ministry of Education is responsible for setting and upholding national educational policies and benchmarks. Regional educational bureaus formulate regional educational policy and strategies, as well as managing and running places of education within their region. These local and national government institutions prepare the syllabus and resources for primary schools(Wilson, 2013). Media is governed under the 1995 Constitution of Ethiopia, as well as the Press Freedom Bill of 1992. In practise, however, the political climate is adverse to media independence and self- censorship is very usual(Wilson, 2013). Due to high levels of poverty and low literacy levels, newspapers are primarily dispersed in the capital and urban areas, and serve only a small section of society(Wilson, 2013).

1.10 Norwegian Church Aid (NCA) and Save the Children (SC) joint programme in Ethiopia

This chapter is an overview of Norwegian Church Aid (NCA) and Save the Children (SC) Joint Programme on Elimination of FGM/C and other harmful traditional practices (HTPs). In 2014, the Norwegian government launched the *Strategy for intensifying international efforts for the elimination of female genital mutilation for the period 2014–2017.* On the basis of that strategy and commitment, a review on NCA and SC joint partnership and other organizations that has received funding from the Norwegian government was commissioned. Several of the organisations working in Ethiopia supported by the Norwegian government are combining FGM/C intervention work with prevention of child marriage, gender-based violence, general empowerment of women, changing gender norms, and general child protection(J. Svanemyr, 2019). Norwegian Church Aid is described as a diaconal organization working in 33 countries worldwide and mandated by churches and Christian organizations in

Norway to eradicate poverty and injustice. In Ethiopia, Norwegian Church Aid has been operating since 1974, engaged in short term emergency response and long term development programs(NCA, 2015).

According to NCA's programme strategy, the NCA's Reproductive Health program goal is: "Women, girls and youth's reproductive health status is improved, and they are protected from any form of violence and Harmful Practices". The program is relevant to Sustainable Development Goal (SDG) 3; "Ensure healthy lives and wellbeing for all at all ages", and SDG 5: "Achieve gender equality and empowerment of all women and girls"(Bekele & Habtamu, 2015; NCA, 2015). To achieve their development goals and bring positive social change, NCA work mainly with faith based organisations , which have demonstrated strong grassroots reach and influence in the society(le Roux & Bartelink, 2017; UNDP, 2018).

NCA and SC also coordinate their efforts with their resource partners that have long years of experience in the area of water, sanitation, and hygiene, reproductive health and climate change(NCA, 2015). Since 2001, they have been coordinating efforts with different faith based and non-faith based structures to end the practice of FGM/C. Save the Children Norway-Ethiopia (SCN-E) and Norwegian Church Aid/Ethiopia (NCA/E) implemented a joint anti-FGM/Harmful Traditional Practices (HTP) programme in Ethiopia since 2006, with support from the Norwegian Embassy in Addis Ababa(Bekele & Habtamu, 2015).The joint programme was implemented in 2006 with 27 partners at different levels in 68 districts (*kebeles*).The goal was to reduce FGM/C by 31 percent in the intervention areas(SC, 2017).

The programme was initiated as part of the effort to support Ethiopia as a pilot country for Norway's FGM/C efforts. Phase I lasted from 2006-2010 and Phase II from 2011-2015. The programme was implemented at the national and regional levels and in six out of nine regional states and two city administrations (Somali, Afar, Southern Nations Nationalities People Region, Harari, Amhara, Tigray, Oromia regional states)(J. Svanemyr, 2019). According to a joint report on the second phase of the programme "*partners are diverse in nature ranging from faith based, grassroots level organizations, government bureaus, professional associations, alliances/network based and experts on media work*."(SC, 2017)

Phase one of the Joint Programme (2006-2010) focused on 'breaking the ground' through initial work to break taboos related to FGM/C. The second phase (2011-2015) highlighted the 'mobilization' where community and religious actors were involved. The third phase (2016-2020) focused on 'Cementing Change and Scaling Up' where the project seeks to consolidate and cement the already registered changes and develop interventions to new adjacent areas of the current intervention areas where FGM/C is vastly widespread. The Joint Programme adopted the three national pillars of intervention strategies:

- **Prevention:** community mobilization through awareness raising, radio program, religious leaders' dialogue, child-led initiatives and involvement of men and boys.
- **Protection:** build capacity of law enforcing officers, establishment of reporting mechanisms for cases to get verdict and
- **Provision:** those who are at risk and have already undergone FGM/C women and girls to access different (education, health and economic) services ((NCA, 2015).

The overall target of the Joint Programme was intended to reduce FGM/C incidences among girls (0-18) in all programme intervention areas. The second target is that the services (education, health, legal, livelihoods) are responsive to protect girls at risk and to care for those affected by FGM/C(NCA, 2015).

The efforts of the first phase of the Joint Programme, from 2006-2010, were focused in the Afar and Somali region, due to the high prevalence in the area and the severity of the cutting that was carried out, with infibulation prevalent those regions. The second phase focused on the Afar region, Amhara, Harari, Oromia, Somali and the SNNPR. The MTR of NCA/SC Joint Programme suggested that their strategies from the first phase have been successful with one of their strengths being the simultaneous national, regional and community-based work(Wilson, 2013).

Activities within the third phase of the Joint Programme included holding series of a community conversation (CC) meetings aiming to achieve public declarations against FGM/C at community level. These public statements can potentially encourage the creation of community level bylaws to prevent FGM/C. The Joint Programme have also supported child-led anti-FGM/C clubs in schools in the intervention areas(J. Svanemyr, 2019). Other activities included providing awareness/training to service providers, as well as specific provision of

income and education to encourage women to abandon support of the practice. NCA and SC conducted annual education forums to share lessons learned within the project areas(J. Y. T. Svanemyr, 2015).

The third phase has been implemented by 10-11 partner organisations called "implementing partners," varying from well-established and solid NGOs and faith-based organisations operating mainly at national level to smaller local partners as well as local Bureau of Women, Children and Youth Affairs(J. Svanemyr, 2019). The third phase of the joint programme that was initiated in 2016 is described in the following terms:

> *"To bring about the expected attitudinal change in the community and at individual level, different community dialogues, mass awareness raising events and radio programmes will be conducted. The programme will initiate and strengthen community-based structures such as child-led groups and anti-FGM/C committees for the protection of women and girls from FGM/C." (J. Svanemyr, 2019)*

In addition, capacity building trainings and technical support was provided to community-based structures to enable them to take organized action against FGM/C. In order to ensure improved health services for women and girls affected by FGM/C and promote the engagement of health institution in zero tolerance to FGM/C, the programme intended to organize discussions among health professionals, train health extension workers and midwives on FGM/C case management and support research activities on Reproductive Health (RH) and other effects of all forms of FGM/C practiced in different regions(J. Svanemyr, 2019).

A key component, particularly for NCA has been the participation with faith-based organisations, institutions and religious leaders. Save the Children (SC) is also working with influential people such as religious leaders and clan leaders. NCA and SC both regards community dialogues (community led approaches) leading to public declarations of abandonment of harmful practices as a central element in their intervention areas. Reports indicate that NCA and SC have good working relations with relevant government Ministries and bureaus at national, regional and local levels(J. Svanemyr, 2019).

Both NCA and SCI are members of the steering committee of the national alliance to end FGM/C. This steering committee shaped the National Costed Roadmap to End FGM/C and Child Marriage 2020-2024 that was launched in 2019. NCA and SC also report to have a close relationship with UN agencies, particularly with UNFPA and UNICEF(J. Svanemyr, 2019).

NCA and SC commissioned an Endline/baseline survey in 2015, which they claim was carefully designed and rigorously conducted by a team of experienced researchers(J. Svanemyr, 2019). It provided quantitative and qualitative data indicating that the programme had had a considerable impact in terms of changes in attitudes and reduced cutting rates. The survey found that there had been a significant decrease in FGM/C prevalence in all Programme areas from 18 to 46 percent points reduction but also confirmed that the prevalence rates continue to be excessive in numerous regions and specifically in Afar, Amhara, and the Somali region(J. Svanemyr, 2019). The End-Term Review (ETR) of the Strategic Partnership between Norwegian Church Aid (NCA) and Save the Children International (SCI) for the Abandonment of Female Genital Mutilation (FGM) (2011 – 2015), done by Joar Svanemyr and Yimegnushal Takele, concluded with:

> *"The joint program has achieved impressive changes in terms of reducing the incidence of FGM/M in the intervention areas, changing peoples' attitudes towards opposing the practice, mobilizing religious and community leaders, and in putting the issue of FGM and other harmful practices on the national agenda(J. Svanemyr, 2019)".*

The ETR found that these promising achievements resulted from a comprehensive multi-level and multi-component approach addressing a wide range of factors and involving a similar wide range of stakeholders from the level of the government to local communities(J. Svanemyr, 2019). The ETR also found that in several districts close to half of the parents intend to circumcise their daughters(J. Y. T. Svanemyr, 2015).

A key aspect of the Joint NCA/SC programme is the learning and exchange of methods, tools, documentation, reviews and reporting among partners participating in the programme(J.

Svanemyr, 2019). Mutual learning and sharing expertise and resources helps to avoid duplication and enhance efficiency. The joint activities have also increased the program visibility at the national level. The progress reports for the Joint Programme have shown that the Programme continues on the same good trajectory with involvement of numerous duty carriers and important holders including youth and other community members, health professionals, and religious leaders(J. Svanemyr, 2019).

The joint FGM/C programme has currently expanded to more districts. The uneven degrees of change and considerable resistance against changing the practice within some ethnic groups may be an indication that the programme needs to refocus towards using more resources where the resistance against change is stronger(J. Svanemyr, 2019; J. Y. T. Svanemyr, 2015).

2. Theoretic perspectives on how to reduce and change the practice of FGM/C

This section will outline the social and cultural justifications for FGM/C, present an overview of FGM/C interventions employed in order to comprehend what works and present an outline of how to gage change and the impact of FGM/C interventions. FGM/C raises issues of discrimination against women, of human rights and the right to health, of public health in terms of risk avoidance for girls, and of sexual, reproductive and maternal health for women who have endured the procedure(Williams-Breault, 2018).
But FGM/C also fosters inquiries about the exchanges concerning Northern and Southern nations in the definition of an international doctrine, about the place of minorities in multicultural societies, and about the pertinence of hegemonic explanations for customs and traditions. Considering all these factors, it is safe to say that FGM/C has and perhaps always will remain a debated, controversial and complex topic.

For all of these reasons, there is now an abundant scientific literature on FGM/C spanning most disciplines of the social sciences – anthropology, sociology, demography, history, law, political science, psychology, gender studies, social work, public health. Including as

numerous articles in medical journals(Andro et al., 2016). Most of the prior and current efforts to eradicate FGM/C has been tied to raising awareness within the communities who practice FGM/C(Shell-Duncan et al., 2016). The dissemination of information about the laws in place prohibiting FGM/C and the health risks was thought to be motivating for each household to end the practice. This has been done to perhaps to evoke fear concerning the enforcement of the law or understanding the harm done to their daughters (Johansen, N. Diop, G. Laverack, & E. Leye, 2013)

Presently it has been complicated to measure to what degree the dissemination of information has caused a change and a lasting impact within the intervention area. This section will present and discuss five central perspectives utilised to understand a change in mindset, worldview and practice concerning FGM/C(Johansen et al., 2013).Before going into these perspectives, it is vital to understand the justifications for the practice of FGM/C.

2.1 Cultural and social factors and justifications for performing FGM/C

The social dynamics that perpetuate FGM/C can also help drive its abandonment(Insight, 2010). This segment examines those dynamics and provides an analysis of the reasons for certain practices that because harm have withstood for generations, and how families and communities can be swayed to abandon them. The reasons and justifications for why FGM/C is performed differ from one region to another as well as over time, and include a mix of sociocultural factors within families and communities(WHO, 2019).

According UNFPA and WHO, the reasons given for practicing FGM/C fall generally into five categories: psychosexual reasons, sociological and cultural reasons, Hygiene and aesthetic reasons, religious reasons and socio-economic factors(UNFPA, 2019b). Where FGM/C is a social convention (social norm), the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially and the fear of being rejected by the community, are strong motivations to perpetuate the practice(Mackie, 2000).
In some communities, FGM/C is almost universally performed and unquestioned(UNFPA, 2019b). FGM/C is regularly considered a necessary part of raising a girl, and a way to prepare her for adulthood and marriage. Where it is believed that being cut increases marriageability, FGM/C is more likely to be carried out(WHO, 2019).

Families, communities and cultures in where FGM/C is performed have different intentions for doing so. A major motivation is that the practice is believed to ensure the girl conforms to key social norms, such as those related to sexual restraint, femininity, respectability and maturity. FGM/C diverges from most forms of violence against girls and women in that women are not only the targets but also involved in perpetration. A girl's female kin are normally responsible for arranging FGM/C, which, in turn, is usually performed by traditional female circumcizors. According to WHO, FGM/C is also increasingly being done by male and female health-care workers. This feature of FGM/C illustrates how both women and men can be complicit in strengthening harmful gender norms and practices that support violence against women(WHO, 2019).

FGM/C also differs from most other forms of violence against women in that, in practising communities, it is done routinely on almost all girls, usually children who cannot fully consent, and is promoted as a highly valued cultural practice and social norm(WHO, 2012). FGM/C is frequently also driven by viewpoints about what is considered acceptable sexual behaviour. It aims to ensure premarital virginity and marital fidelity within a family and marriage union. FGM/C is in many communities believed to reduce a woman's libido and therefore believed to help her oppose extramarital sexual acts(WHO, 2019). When a vaginal opening is covered or narrowed (Type 3), the dread of the pain of opening it, and the distress that this will be found out, is expected to further discourage extramarital sexual intercourse among women with this type of FGM/C(WHO, 2019).

FGM/C is associated with cultural ideals of femininity and modesty, which involve the notion that girls are clean and beautiful after subtraction of the body parts that are considered unclean, unfeminine or male(WHO, 2019). Though no religious writings stipulate the custom, practitioners often suppose the practice has religious backing(WHO, 2019). Religious leaders take different positions with regard to FGM/C, some endorse it, some deem it immaterial to religion, and others contribute to its elimination(WHO, 2019).

Local structures of power and authority, such as community leaders, clan leaders, religious leaders, circumcisers, and even some medical personnel can contribute to upholding the practice. Likewise, when informed, they can be effective advocates for abandonment of

FGM/C(WHO, 2019). In most societies, where FGM/C is practised, it is considered a cultural tradition, which is often used as an argument for its continuation(WHO, 2019). In some societies, recent implementation of the practice is related to copying the behaviours of neighbouring ethnic groups(WHO, 2019). Sometimes it has started as part of a wider religious or traditional revival movement(WHO, 2019). The UN/WHO justifications are intended to be general to apply to a different context. The interviews/ primary data from Ethiopia shows different justifications and contextual realities as to why the practice continues.

2.2 The Context Around FGM/C

A large body of literature has documented considerable variation in when and how FGM/C is performed. Studies have also shown recent changes in the nature of the practice(Shell-Duncan et al., 2016). The changes in the practice of FGM/C is an important factor to consider in the outworking of FGM/C prevention. In nearly half of the countries with information on age of the cutting, the majority of girls were cut before the age of five(Shell-Duncan et al., 2016). Even in dwellings where the custom commonly transpires at older ages, there has been a downward shift in the average age at cutting. As the timing of FGM/C shifts from adolescence to early infanthood or even right after labour, other changes sometimes follow. For instance, cutting may be performed individually rather than in groups(Shell-Duncan et al., 2016). In addition, it might lose its significance as a coming-of-age ritual and the restorative period after FGM/C may no longer function as a time of preparation or groundwork for adulthood(Moreau & Shell-Duncan, 2020).

2.3 FGM/C in relation to gender roles and gender norms

In the vast literature on female genital cutting, there exist two dominant but conflicting views on the role of men in the maintenance of the practice. One paints men as perpetrators, with FGM/C viewed as a display of the patriarchal repression of women. By making women sexually submissive, FGM/C ensures women are chaste prior to marriage, and loyal to their spouses in matrimony. By serving to signal fidelity, it is claimed that FGM/C increases paternity certainty, and thus improves marriage prospects. In settings where women's future comfort and well-being are linked to their role as a wife and mother, having undergone FGM/C becomes a criterion for marriage. An alternative angle portrays men as relatively uninvolved in a practice described as "women's business"(Moreau & Shell-Duncan, 2020).

Seeing that the custom of FGM/C is often organised and executed by women on women, anthropologists in various African settings have stressed women's agency, and the significance of community initiation in the formation of a ritual that creates bonds amongst women. These two opposing perspectives on the role of men in the perpetuation of FGM/C can potentially lead to conflicting predictions and affect how FGM/C intervention is carried out. Understanding the underpinnings of the practice and how it is carried out might also affect how NGOs chooses their intended target group within an intervention area. If FGM/C is an underpinning of male-controlled structures, men should be expected to be ardent supporters of the practice, as its elimination may pose a threat to their superior status in the social hierarchy. Otherwise, if FGM/C is indeed "women's business," men should have limited interest in whether or not the practice is maintained and have little influence in the decision-making process(Moreau & Shell-Duncan, 2020).

2.4 FGM/C as a social norm/convention

For several years, UNICEF Ethiopia and its partners have been supporting the government in Ethiopia to encourage local level declaration of abandonment of FGM/C through social convention theory strategy(Alem et al., 2013). Political scientist Gerry Mackie's theory concerning FGM/C as a social convention has been the most popular theory to understand change the past decades (M. T. Østebø & Østebø, 2014). This theoretic perspective has been used as a basis for UNICEF's and UNDP's joint efforts towards ending the practice(Mackie, Moneti, Shakya, & Denny, 2015). In his article "The beginning of the End" (2000) Gerry Mackie states that FGM/C is a matter of proper marriage and process of securing a good future for a daughter through marriage.

Mackie then goes on to claim that FGM/C is a certain kind of "Schelling convention": what one family chooses depends on what other families choose. He bases this theory on an article prior to this one in which Mackie expands his theory further(Mackie, 2000). In 1996, Mackie published a more or less complete, although condensed, "convention" theory on FGM/C which attempted to account for the roots, spreading, preservation, and possible abandonment of what he then claimed to be a perplexing practice. In the ,article published in 1996, Mackie did what social scientists often preach but seldom practice, he made a prediction(Mackie, 2000).

Mackie predicted in 1996 that the formation of a certain kind of pledge association would help bring FGM/C to an end(Mackie, 2000). If there was some critical mass of individuals and it definitely need not be a majority, and also the more genuinely influential the individuals, the fewer that might be needed, within a group of people whose children marry one another, who have come to the point that they would like to abandon FGM(C, a public pledge among such individuals would forever end FGM/C for them and also quickly motivate the remainder of the intermarrying population to join in the pledge and abandon FGC as well (Mackie, 2000).

The production of public declarations against FGM/C is also an aim for many NGOs (Save the Children, NCA, Plan, UNICEF, Care) working at the community level in Ethiopia. The focus on public declarations reflects an international trend informed by the experiences of a Senegal-based NGO called Tostan and by Mackie's (2000) social convention theory. One of the major assumptions in Mackie's theory is that if a critical mass in a community publicly declares that it will abandon the practice of FGM/C, this will lead to a shift in social conventions and "help bring female genital mutilation to an end. Mackie makes particular reference to Tostan in his work, claiming that the organization's successful use of public declarations in its efforts to eradicate FGM in Senegal supports his theory(M. T. Østebø & Østebø, 2014). Tostan's approach has gained status as a best practice by the WHO and its apparent success has been explained with reference to the use of participatory, empowering approaches (M. T. Østebø & Østebø, 2014). NGOs working in Ethiopia represent their activities in the same manner(M. T. Østebø & Østebø, 2014) .

The theory of social convention might perhaps clear solutions to date to several key challenges concerning FGM/C. First is not all preventative projects that build on this model are equally successful in all settlements(Johansen, 2017). One example is the Gambia, where over 100 girls sought help due to immediate complications after genital mutilation at the same site and time several public declarations against genital mutilation were arranged(Johansen, 2017). Tostan projects have not always led to the intentional the change in social norms. In the context of Ethiopia, public declaration was done against to most invasive form of FGM/C. This could be ascribed to translation issues and language barriers given the fact that in some languages FGM/C only refers to infibulation. Third, is that Mackie's model is adapted to small communities with close ties between group who traditionally marry each

other (intermarrying groups)(Johansen, 2017). Research has shown that we do not yet know how well suited this theory is to formulate measures in more urban areas and the African diaspora(Johansen, 2017).

2.5 Transformative human rights deliberation

Since the early 1990s, the global anti-FGM/C. campaign has actively attempted to distance itself from the health approach, largely adopting instead an alternative human rights framework for justifying opposition toward the practice. Possibly as a result of these health risk messages, some parents turned to medical practitioners to cut their daughters or chose less severe forms of cutting. Medicalization of the of FGM/C was often perceived to address both health and marriageability concerns. It reduced the immediate health complications yet did not compromise the possibility of the girl getting married(Insight, 2010). Major rights-based claims include the following: the rights of the child, the rights of women, the right to freedom from torture, and the right to health and bodily integrity(Shell-Duncan, 2008).

Medicalization, however, did not offer individuals with the opportunity to revise self-enforcing beliefs, did not change the expectation of rewards and sanctions associated with conforming or not conforming to the socially accepted norm, and tended to legitimize the practice while obscuring the fact that it is a violation of the rights of women and girls. An in-depth analysis of experiences that have led to wide-scale abandonment of harmful practices shows that addressing FGM/C within a stronger framework of human rights allows communities to review the social norms and conventions that have endured in local tradition and culture(Insight, 2010).

Introducing human rights alters the conversation about FGM/C by providing the space for individual and communal consideration, which is considered to benefit to alter social agreements and norms. To comprehend the function of human rights deliberation, it is beneficial to introduce the concept of moral norms and explain the role these work in supporting and abandoning the practice of FGM/C. A moral norm is a behavioural tenet driven by personal values of right and wrong. For an individual, it offers a rise of feelings of righteousness for compliance with the rule and guilt for non-cooperation. It is intrinsically driven rather than extrinsically encouraged by social rewards and sanctions. Moral norms are

found throughout different groups and tend to withstand time. These moral norms are often demonstrated in distinctive ways according to the particular circumstances. Being a good parent, for example, is imperative to individuals across all cultures and settings, yet what it takes to be a good parent diverges by context, culture and other social circumstances. The moral norm to 'do what is best for your child' motivates kin in several social settings to cut their daughters(Insight, 2010).

Nevertheless, once another alternative become socially acknowledged within a community and people realize that the society might be better off if they were to jointly abandon the practice(Insight, 2010). Some findings have indicated that when provided with credible new information and the opportunity for joint contemplation, families regularly prefer to change their practices in order to realize their fundamental values without injuring their girls(Insight, 2010). Participatory deliberation drawing on human rights principles seems to play a crucial role in carrying out this shared transformation(Insight, 2010).

As described by Diane Gillespie and Molly Melching, it inspires individuals to describe and communicate their own principles, come to a consensus on their communal goals, and contemplate about what obstacles are in the way of achieving their common objectives(Insight, 2010). This can lead to a process of reflection and acts that can with any luck result in large-scale social transformation(Insight, 2010).

Participants of the community present and discuss concrete issues that appear as fixed and absolute. When these participants link these actual situations to the more abstract sphere of human rights, discussing such subjects as the right of everyone to be free from all forms of violence, communities are encouraged to become proactive and find solutions. This may be in the form of setting up a mechanism that can protect at-risk girls and women and intervening to prevent violence. As communities reflect on their local experiences and values, they begin to connect human rights ideals and principles to their practical needs and common aspirations. They can discover that the human rights ideals are not dissimilar from their own values. Manufacturing those values overt and sharing them with others can motivate the community to analyse and debate which social practices help them to achieve the new communally

determined vision and which ones need to be abandoned. Ideally, they start to make changes and experience that by acting out these values, they can bring about change(Insight, 2010).

Human rights deliberation can expand a community's capability to pursue its own fundamental values and aspirations(Insight, 2010). The process need not undermine traditional values but rather adds new dimensions to the discussion around abandoning FGM/C(Insight, 2010). When such discussions bring to light the differential treatment of girls and boys and of women and men, they generate dialogue about discriminatory practices that violate the rights of girls and women, such as FGM/C, forced marriage and child marriage.

As anthropologist Sally Engle Merry wrote:
"…human rights ideas are more easily adopted if they are packaged in familiar terms and do not disturb established hierarchies, but they are more transformative if they challenge existing assumptions about power relationships"(Insight, 2010).

Human rights deliberation also cues an significant process that further values these rights: Once people realize they have rights – once rights are placed on their mental map – they attach high value to securing and protecting them(Insight, 2010). It is believed that successful abandonment of FGM/C requires a process of community discussion, decision and public commitment. As implied or suggested by social convention theory, and as shown by Gerry Mackie, FGM/C can perhaps be abandoned at scale when abandonment is a coordinated act undertaken by a large enough proportion of the intermarrying group to ensure that the shift is both effective and stable(Insight, 2010). Families might act only when they believe that social expectations have changed, and that most or all others in their community will make the same choice around the same time. FGM/C abandonment can begin with an initial core group of individuals who set in motion a dynamic of change. After this point, the abandonment would become stable because it would permanently change social expectations.
Community members would be expected to not cut their daughters, and would be socially compensated or sanctioned accordingly(Insight, 2010). But for abandonment to occur, it is essential that people are aware of and trust the intention of others to also abandon. Social expectations will change if people have a guarantee of the commitment of others to abandon.

A moment of public affirmation of commitment to abandon the practice is therefore required so that each individual is assured that other community members are willing to end the practice. For the alternative possibility of not cutting to become a reality, new attitudes and a willingness to change need to be made explicit and public. This opens the way for behaviour change and for an actual and stable abandonment. Families can still be able to maintain their social status and avoid harm to their daughters, while at the same time girls remain eligible for marriage(Insight, 2010).

2.6 Diffusion of Innovation

The sociologist and communication theorist Rogers' step-by-step theory of change (diffusion of innovation) has also been explored as a tool to understand and change female genital mutilation as a practice(Johansen, 2017). The theory is based on over 100 years of experience change measures, primarily within development work(Johansen, 2017). Rogers pulls two key factors for change. First, that people find it easy to listen to, and acquire, knowledge from people they perceive to be close and similar to themselves(Johansen, 2017). Second, that different groups have different degrees of willingness to change(Johansen, 2017). Some want to try different things, while others sit on the fence(Johansen, 2017).

Roger developed a model that included several steps toward change, where the change starts with the most willing; the pioneers(Johansen, 2017). The "pioneers", he claims, is a small group in the community, perhaps only 1-2% of population(Johansen, 2017). These people are willing to practice new ideas despite the massive social resistance, even face rejection or social sanctions(Johansen, 2017). The pioneers may next convince a group Roger refers to as the "settlers". They form a larger group, and they take on new ideas although they are not initially consciously looking for them. They are willing to face resistance if they get some social support. They are also willing to be controversial and become unpopular due to their commitment. The newcomers can then manage to convince "most people"(Johansen, 2017).

The hardest to change is the last group in Rogers' theory are the "conservative forces". They can only be convinced by "most people ", that is, when the great masses have acquired new knowledge and then change their behaviour(Johansen, 2017). The "conservative forces" hold onto their traditions because they believe they stand to lose the most when change occurs(Johansen, 2017). In this group one can include some religious leaders, community

elders and circumcisers. Rogers emphasizes that a successful change requires involvement in the right order from all of these different groups. Rogers claims that this process can be difficult, but not impossible(Johansen, 2017).

However, FGM/C differs in some essential respects from the types of development projects Rogers' theories have been applied to(Johansen, 2017). FGM/C is a painful and dangerous intervention that is performed because the parents think it is in the best interests of the child. Otherwise, loving and good parents arrange such a violent, painful and frightening intervention(Serour, 2013). This is something other than gaining increased knowledge about more effective cultivation methods or the use of medicines, which are some of the examples that underlie Roger's theory.

Changing the practice of FGM/C requires a deeper understanding. The realization that one has been subjected to harmful and negative interventions by their beloved parents/caregivers – and/or that one has even exposed their daughters to this. Therefore, it is not sufficient to understand change at a structural societal level like Mackie and Rogers' theories focus on. Perhaps, there might be a need for a better understanding of intellectual and emotional change process at the individual level and how this interacts with a larger societal discourse(Johansen, 2017).

2.7 Mental maps and stages of change

The theory of mental maps and stages of change was developed in the early 1980s(Johansen, 2017). The theory is based on a comparative analysis of therapy systems used in health challenges such as smoking, alcohol abuse, use of birth control and mental health problems(Johansen, 2017). A few years later, the physician Toubia, in collaboration with public health researcher Izett, developed this theory into a model for phasing out FGM/C. This customized model presents five stages a person must go through to ensure lasting behavioural change(Johansen, 2017).

Pre-contemplation (no reflection or critical thinking around practice), contemplation (reflection on practice), preparation (reflection and preparation for change in pattern of action), action (changed action) and maintenance (continuity of changed action). The stages describe a movement from a situation without reflection(Johansen, 2017). The progression of change can be initiated by various factors, such as personal negative experiences, exposure to

new information or social changes(Johansen, 2017). In the same way as Mackie's theory, it is assumed here that a person who changes his point of view will announce his change of attitude publicly. If the individual receives social support, the change in attitude will lead to a change in practice. However, criticism or the absence of social support will put an end to change(Johansen, 2017).

This theory provides better insight into change processes at the individual level and can provide better insight into how a change process starts and spreads. It also concretises the interaction between individual and social factors in the change process. Nevertheless, there are also some uncertain factors here. Both in this and the first two theories, it is assumed that people who change attitudes will express this publicly, that they need support for changed practices, and that they will actively seek to convince others(Johansen, 2017).

However, empirical research does not indisputably corroborate these expectations. Among other things, it has been seen that some change attitude in hiding the practice and driving it underground. Others oppose FGM/C but accept it as an essential albeit immoral course of action. While still others secretly change behaviour. In one study, a woman had not undergone FGM/C told some researchers how her parents had concealed this from the outside world. They arranged hospital visits and parties while she had to stay still in bed, so everyone would think she had been infibulated the same day (Johansen, 2017).
One strength of the theory of mental maps is that it considers various triggers for change. It is not only new information that can stimulate change, but also personal experience(Johansen, 2017).

Some research suggests that changing attitudes and practices in relation to genital mutilation can also be a profound psychological process. Those affected do not automatically receive information about health damage related to genital mutilation. They do not necessarily perceive the information as true, and it need not change attitude or action. To be willing to act on the basis of new knowledge, one must be able to absorb the information and be deeply convinced of the importance of changing a practice, especially if this involves a breach of

social norms and expectations(Johansen, 2017). Therefore, the last theoretical perspective we will look at goes even deeper into the individual change process. This perspective is important to understand why information about health injuries does not always lead to change in attitude and action. At the individual level, change requires as much emotional as intellectual processing of new factual knowledge(Johansen, 2017)**.**

2.8 Reproductive justice

Transformative human rights deliberation has also laid the groundwork of *reproductive justice.* A concept that maintains that humans have the right to personal and bodily autonomy. Reproductive justice is a concept often used within the context of access to reproductive health. In recent years, this framework has also been linked to FGM/C(Braun, 2012).

2.9 Internalization of knowledge

A study by anthropologist Inger-Lise Lien showed how individual change process is also a deeply emotional process which can be both painful and challenging. She uses anthropologist Melford Spiro's Theories of Cultural Reproduction to investigate how and why information does not necessarily lead to change. Spiro's theory examines the individual's role in cultural change processes(Johansen, 2017). If new knowledge is to lead to changes in culturally constituted beliefs and actions, the knowledge must reach the deepest of four levels of reaction.

The first level is when you get to know a message, but disagree(Johansen, 2017). For example, information about health damage following genital mutilation can be dismissed as misleading Western propaganda. In other words, the knowledge will be rejected. At level two, knowledge is recognized on an intellectual level, however it is not internalized and linked to one's own experiences and feelings(Johansen, 2017). In such cases, the new information will not change action(Johansen, 2017).
An example is when men in Eritrea learned about FGM/C but did not want to challenge their mothers in what they perceived as their domain. So, they accepted the knowledge, but it did not lead to change at the action level. Only at the third level does the person receive the message, internalize it and act on the basis of it(Johansen, 2017).

2.10 Concluding thoughts on individual and social change in relation to FGM/C

Examination has shown that FGM/C is a complex societal and personal practice. Measuring the change that has happened and the change that is ongoing is challenging. Some research can explain some aspects of the status of FGM/C. Contextualisation of the practice is important. It affects people at a societal and an individual level. Theory informs policy. These theories can explain how change can potentially occur on an individual and societal level. At the same time, all the theories presented show the close interaction between the individua within a given community and society as whole(Johansen, 2017).

The theory of social convention focuses on how changing social and cultural norms are a prerequisite for broad social change. The theory of incremental change and diffusion of innovation shows how change starts with individuals who break and take chances and spread to increasingly conservative groups. The theory whether mental maps are based on the individual and their dependence on social support to move forward in the change process. The theory of internalization describes the process of how an individual internalizes knowledge and how they can proceed to act in accordance with the new knowledge. The theory of transformative human rights deliberation frames FGM/C as a violation of human rights and not just a public health concern. The human rights angle can potentially lay the groundwork for further advocacy for lasting change and reproductive justice.

2.11 Overview of common approaches and interventions in FGM/C programmes

This section uses the term “interventions” and “approaches” interchangeably in order to describe the different methods used in FGM/C prevention work. The use of the term “programme” is often related to the all-encompassing work INGOs or NGOs do associate with the abandonment of FGM/C. In relation to the government agencies work, this thesis uses the term “policy” or “legal framework”. In Ethiopia, a various number of actors work in differing ways in relation to FGM/C prevention either through cooperation or they work independently. A deep understanding of the context in which FGM/C is embedded can help

decisionmakers make appropriate choices for policies and interventions. This understanding can also inform researchers to provide evidence that can also shape and influence FGM/C interventions.

Universally FGM/C abandonment interventions have varied from local, regional, national and international levels. Local and regional interventions may for example focus on increasing awareness and/or changing the belief system from which the practice arises within a community. The former could involve NGOs educating communities of the negative health effects of FGM/C while the latter alternatively may focus on facilitating and informing community discussions on the custom. Researchers have long studied influences that might present indications for abandonment of the practice, such as household wealth, urbanization, and education given the complexity of FGM/C(Engelsma, Mackie, & Merrell, 2020). Displaying how the practice is placed within a larger social context delivers an opportunity to assess factors driving the practice of FGM/C and determine whether and how broader social change may open opportunities for abandonment and influence the shaping of FGM/C interventions(Shell-Duncan et al., 2016). Some experts on FGM/C suggest that numerous factors related to modernization may be influential, including the waning of traditional family and power structures, an upsurge of women making their way into the workforce; changes in women's economic and social roles and authority in decision-making; and changes in their dependence on FGM/C as a means to guarantee a secure future through marriage(Moreau & Shell-Duncan, 2020).

In most countries where FGM/C is practiced, support for its continuance is usually higher in rural than in urban settings, probable for a number of reasons. Rural regions are more prone to have kin-based communities with limited cultural variety, making it challenging to depart from enduring social norms and conventions. These are factors to consider in relation to FGM/C interventions. Urban settings, by contrast, may be more ethnically diverse, offering the prospect to interact with a greater assortment of individuals, who might be both practicing and non-practicing. In urban settings, social ties may be broader and less linked to home communities, and negative social sanctions for non-adherence to FGM/C may be less common and effective(Shell-Duncan et al., 2016).

More recently, in other settings, data suggests that economic development projects can have contradictory impacts on FGM/C, predominantly if they do little to enhance women's autonomy and instead reinforce patriarchal relations and women's economic dependency(Shell-Duncan et al., 2016). Numerous studies have documented a strong positive association between women's level of education, measures of health, and access to healthcare. Similarly, there is a strong linkage between women's education and the perpetuation of FGM/C(Engelsma et al., 2020). The data show that in high- and low-prevalence countries alike, daughters' risk of FGM/C is commonly highest amid mothers with no education and tends to decrease extensively as mother's education goes up(Engelsma et al., 2020). Yet, the explanations for these associations are not well explained and researchers have claimed that these factors merits further research(Ashford et al., 2020). Some researchers have claimed that it could be that those with greater education have more exposure to intervention programmes and messages and are more amenable to receiving and accepting them. It may also be that the more-educated women participate less in the social networks of female relatives who might otherwise exert a strong influence on decisions regarding daughters' FGM/C(Mackie et al., 2015; Shell-Duncan et al., 2016).

Another area of study has been the influence of urbanization, education, and economic development on FGM/C preferences and decisions made by individual women(Alradie-Mohamed et al., 2020). At the national level, anti-FGM/C legislation may act as a legal deterrent to perform the practice. Examples of international interventions include enhancing advocacy and capacity skills of national NGOs, enabling them to gain funding from governments and thereby implement their desired interventions.
These are but a few examples of the many interventions created by a vast number of agencies worldwide(Organization, 2011; WHO, 2011a, 2019). Although a decline in the practice has been noted, this decline has been at a slower rate than was hoped. This might imply that whilst a vast array of interventions has been developed, many of these may be ineffective in their desired outcome. Nevertheless, as only few interventions include either a self or external evaluation component, it is difficult to assess which interventions work and which do not(Johansen et al., 2013).

Many measures by governments and organizations aimed at fostering abandonment of the practice have contributed to a decline and change in the practice of FGM/C. A systematic

review on FGM/C interventions by Johansen, Diop, Laverack, and Leye (Johansen et al., 2013) revealed the seven most common approaches were health risk education approaches, conversion of circumcisers, training of health-care professionals as agents of change, the creation of alternative rituals, community-led approaches, public statements, and legal methods. This thesis will utilise this review and present the benefits and challenges in the use of these different interventions(Johansen et al., 2013).

2.11.1 Health Risk Approaches

Since interventions against FGM/C first started more than 40 years ago, providing information about the health risks associated with FGM/C has historically been the most prevalent approach. It builds on the idea that if people are informed about the negative health effects of FGM/C, they resolve to abandon the practice. Health risk interventions have been targeted at various population groups both as a stand-alone activity and as part of other interventions. In its crudest form, it can include delivering factual and moralistic messages around the physical complications of FGM/C by local health providers, community facilitators, or NGO staff. In its broadest form, it includes local knowledge and personal sharing and reflection coupled with the provision of health care services for complications of FGM/C. It is believed that an increased knowledge of the negative health effects can stimulate reflection and critical thinking, leading to reduce the approval of, and eventually to the abandonment of FGM/C(Johansen et al., 2013).

Some evidence proposes that the harmful health effects of FGM/C presented by a health expert such as a medical professional can be a significant motivational element for religious leaders to take a sharp and robust position against the custom, and which may lead to the issue religious edicts against FGM/C(WHO, 2011a). Health information has additionally swayed policymakers to endorse decrees and protocols such as the care for complications(Rigmor C Berg, Denison, & Fretheim, 2010; Denison, Berg, Lewin, & Fretheim, 2009).There are however also challenges to health risk approaches. Experience indicates that health information can lead to deviations rather than abandonment and most commonly an increase in the extent to which health providers are performing FGM/C, a trend associated with a probability of institutionalisation and continuance of FGM/C rather than its desertion. It can also lead to the intention to change the type of FGM/C.

2.11.2 Challenges in using health risk approaches

Health risk approaches are not without their challenges. Numerous researchers have pointed to the difficulties posed by employing a "laundry list" of health risks that is not adapted to the local setting. For example, though only approximately 10% of all FGM/C cases are infibulations (Type III FGM/C), the "health risk approach" often focuses on complications mainly associated with Type III as common complications of all types of FGM/C, whilst other common complications (e.g., cysts and scarring) are infrequently mentioned(R. E. B. Johansen, N. J. Diop, G. Laverack, & E. Leye, 2013).

Accusing, forceful, and alarming messaging can aggravate defence reactions(M. T. Østebø & Østebø, 2014). To underline the negative health effects of FGM/C, health information messages often use strong visual images, such as the use of razor-blades and gore. However, one review uncovered that such messages were seen as commanding or were difficult for people to comprehend. Health risks can also be considered a minor danger compared to the dangers coupled with abandoning FGM/C. In communities where FGM/C is usual, it is upheld as a social norm and enforced through social sanctions of individuals or families that do not adapt(R. E. B. Johansen et al., 2013). The risk of being socially shunned, barred from community activities, denied financial and practical support, as well as marriage possibilities, can overshadow the health hazards associated with the practice(Denison et al., 2009).

2.11.3 Conversion of Circumcizors

The vast majority of FGM/C in Africa, around 80 percent is carried out by traditional practitioners(R. E. B. Johansen et al., 2013). A popular approach has been to target traditional birth attendees or practitioners to convince them to stop performing FGM/C. Such interventions commonly contain education on the physiology of female genitalia, the harmful health concerns of FGM/C, their role in perpetuating it, and encouragement to stop performing FGM/C. In some cases, training and financial support is provided for traditional circumcizors to help them find sources of income other than performing FGM/C(R. E. B. Johansen et al., 2013). The expected outcome is a reduction in the numbers of these women performing FGM/C subsequently leading to a reduction in the number of FGM/C performed.

One benefit of this form of intervention is their clear and limited range and consequently sharp and simple indicators to measure achievement, that is, number of circumcizors "dropping their knife"(R. E. B. Johansen et al., 2013) . Furthermore, reports of public ceremonies of "dropping knives" shown in the media provide visibility to the topic of FGM/C and can fuel discussion. However, numerous concerns have been observed with the conversion of circumcizors. Nevertheless, converted circumcizors may resume to practice or hand over their knife to apprentices. Furthermore, if there is no alteration in the demand for FGM/C, other persons will step in to fill the need, involving health care providers or new recruits(R. E. B. Johansen et al., 2013). Moreover, ex-circumcizors could not be considered trustworthy when turning against FGM/C. A vital motivation for converting circumcizors is to take advantage of, and maintain, the respected place they are assumed to have in their group. However, limited assessments of their social role and position are stated. Additionally, being a circumcizor is rarely a full-time engagement and is commonly combined with other responsibilities, such as labour and maternal care. Little is identified about the analysis to which community participants are listening to or are convinced by the influence of converted former circumcizors(R. E. B. Johansen et al., 2013).

Alternate income for circumcizors is meant to reimburse them for their loss in income if they give up practicing FGM/C in their community. However, current data suggests that the financial profit for circumcizors is usually quite minor. Most circumcizors responsibilities are requested unevenly and consequently the income from FGM/C seems to be an add-on rather than their principal revenue.
Circumcizors share their frequently precarious living situations with the bulk of the community. Some data suggests that singling out circumcizors for financial provision and schooling in such precarious settings can contribute to internal conflicts and can advance the role of the circumcizors in the community or contribute to the enlistment of new circumcizors(Johansen et al., 2013).

2.11.4 Training of Health Experts as Change Agents

Several interventions have targeted health professionals, with the aim of preventing them from performing FGM/C, constructing their capacities to identify and treat complications and recruiting them as change agents. Evaluations implemented at the end of trainings for health

professionals report an increased knowledge about FGM/C, health complications of FGM/C, and how to manage the complications, as well as an increased negative attitude to FGM/C(Johansen et al., 2013).

However, interventions of engaging health providers as change agents have been met with a number of challenges. Health care providers can also resist working against FGM/C. Health care providers are often part of the same communities that support FGM. Hence, these health professionals may support FGM/C or be scared of involving themselves in such a sensitive issue. Some research have documented that some health care providers support FGM/C in general and in its medicalized form in particular(R. E. B. Johansen et al., 2013). For health care providers is certain communities the content of the training might be inadequate.

The training time and content in the interventions varies widely from two 60-minute sessions to five sessions of seven days with a comprehensive reproductive and child-health training. Though no analysis comparing the content of the training is available, it is evident that shorter training gives less room for content, reflection, and discussion(R. E. B. Johansen et al., 2013). The work load and lack of inclusion of FGM/C relevant measures within standard procedures can inhibit a practical implementation of counselling and the provision of information. The ability of health professionals to translate training into action both requires structural support, that is, in the form of resources and time allocated, and techniques, encouragement and empowerment strategies(Esho, Karumbi, & Njue, 2017).

A study from Mali found that health care providers were not counselling against FGM after their training because of the extra burden on an already heavy workload. The importance of the training will therefore be contingent on the opinion of health providers against FGM/C, their motivations and commitment to stand up against FGM/C, as well as the assets and time they have at their disposal to work on the subject(Denison et al., 2009).

2.11.5 Alternative Rites Programmes

In many communities, FGM/C is part of a larger rite of passage. In some of these communities, interventions have been developed to replace the rite of passage with FGM/C,

by an alternate rite without FGM/C. These alternate rites programmes are anticipated to achieve the cultural tradition of a coming of age ritual, so that girls can be publicly acknowledged without having to go through FGM/C. These interventions are supposed to show a progressive attitude and admiration for cultural traditions and thus prevent cautious reactions against efforts to abandon FGM/C and to enable abandonment of FGM/C by upholding the ritual structure. In other circumstances, a key encouraging element to implement such interventions has been to protect girls throughout ritual periods(Johansen et al., 2013).

2.11.6 Community-Led Approaches

Community-led programmes, or so called bottom-up or grassroot level approaches, have been identified as a necessary factor to tackle the social convention of FGM/C by several NGOs working in Ethiopia(M. T. Østebø & Østebø, 2014). Assessments of FGM/C abandonment interventions suggest that community participation is crucial to create viable change. Community-led interventions to forsake FGM/C aim at supporting the liberation of women and girls and the community at large to enable them to analytically inspect their own rituals and to gain the power to abandon FGM/C for their own advantage. Empowerment refers to the procedure by which the girls, women, and their districts gain power over the factors and decisions that shape their lives(Johansen et al., 2013). Understood as an empowerment exercise, interventions usually integrate the issue into a wider learning package, including aspects such as gender and development, as well as the social, political, legal, health, and economic development of a community(Johansen et al., 2013).

The current most widespread and systematically implemented community-led programmes show favourable result. One of these consists of an education programme with four modules, covering hygiene, problem solving, women's health, and human rights and has been carried out in several countries(Johansen et al., 2013). Other community bases initiatives include school clubs, either girl clubs or male engagement clubs. Such programs may have positively affected the prevalence of FGM/C and participants' knowledge about the consequences of FGM/C(R. E. B. Johansen et al., 2013). However, success varies between communities. A specific challenge with community-led approaches is that some interventions that claim to be empowering use vertical programs that "lecture" and "educate" the communities from the

outside, rather than using a participatory approach to involve the community to empower themselves(R. E. B. Johansen et al., 2013).

Community- led approaches generally be categorized into two different categories:

- Community-level advocacy
- Community-level information and education

The advocacy aspect is linked to *transformative human rights deliberation* and the dissemination of information at the local level can also be tied to a health risk approach (see section on FGM/C interventions).

2.11.7 Public Statements

An important element in the process of mobilizing communities is a public statement, often referred to as public declarations, of a decision to abandon FGM/C by a larger group, usually a significant part of a community. Such public statements both express and facilitate change in the social conventions of the community(R. E. B. Johansen et al., 2013). Public statements can take different forms, including signing a statement, alternative rites of passage celebrations, and community gatherings(R. E. B. Johansen et al., 2013). A public declaration can in theory create a sense of collective change, which can help to empower families to abandon FGM/C and encourage others to follow(R. E. B. Johansen et al., 2013). When public statements are made, this suggests that a sufficient number of individuals have decided to abandon FGM/C, which can further promote broad-scale abandonment. It is important to note however, that when a public statement has been made, this does not necessarily indicate that the whole community supports the abandonment of FGM/C and some may continue to do so(R. E. B. Johansen et al., 2013). Depending on the stage of readiness for change and processes running prior to the public statements, they can mark a final decision already made to abandon FGM/C in some communities, whereas in others they are a milestone that signifies readiness for change, and further support is needed to sustain and accelerate the process. While public statements appear fundamental to accelerate large-scale transformation in high prevalence communities, there are certain risks(R. E. B. Johansen et al., 2013). Interventions ensuring public statements from subgroups rather than whole communities seldom result in total abandonment, even when the selected subgroups form an authoritative voice, such as circumcizors, religious leaders, or men(R. E. B. Johansen et al., 2013). For example, while

public statements from men are expected to be influential due to their powerful role in society, data proposes that their possible power is mitigated by the fact that the responsibility for FGM/C most frequently lies with the women. Furthermore, while religious decrees from high-ranking religious organizations or personalities are anticipated to generate change, the effect has never been analytically measured(Johansen et al., 2013; M. T. Østebø & Østebø, 2014).

2.11.8 Legal Measures

Studies indicate that legislation and its implementation can have a preventive effect. Most African countries with documented FGM/C have now passed laws against the practice(R. E. B. Johansen et al., 2013).This delivers an official legal platform for action and offers legal protection for women and can discourage the circumcizor's families for fear of prosecution. It can also offer health professionals a legal framework to oppose requests for performing FGM/C(Johansen et al., 2013).

Laws against FGM/C are an important policy commitment and create an authorising environment. When preceded and complemented by education campaigns and advocacy and the sensitization of leaders, as well as adequate implementation, their effect is expected to be higher. For example, it was found that the beginning of the abandonment of FGM in Burkina Faso mostly coincides with the time of the adoption and application of the law banning the practice. There are challenges with legal measures. One challenge to the effectiveness of legal measures is that the practice may go underground. FGM/C rituals appear to have diminished but instead the cutting has continued in some countries outside the law as a way to avoid legal implications(Denison et al., 2009; R. E. B. Johansen et al., 2013).
In several contexts, laws and debates about passing or enforcing legal measures led to resistance and protest. A concern has been that the existence of a law may also scare people with immediate health complications after FGM/C from seeking health care and force the practice to go underground(R. E. B. Johansen et al., 2013).

2.11.9 Coordinated work between NGOs and Government

A WHO assessment (WHO, 2011a) had found an impressive array of efforts between NGOs, governmental institutions, donors and funding organisations to coordinate activities and

facilitate exchange of information and resources. The WHO report state that fifty percent of survey respondents stated that when developing messages for their programmes they had involved staff from other agencies. However, the review had found that collaborative efforts were impeded by competition for funding, disapproval of each other's strategies and personality differences. WHO goes on to state that these obstacles should not discourage anti-FGM/C agencies from collaborating to build on each other's strengths(WHO, 2011a)

2.11.10 Advocacy

An important of advocacy within some NGOs is to ensure that FGM/C elimination programmes are funded, implemented and maintained until FGM/C becomes eliminated. NGOs may use advocacy and lobbying as a means to ensure their intervention can take place in certain areas. Advocacy can also be a useful tool at the grassroot level to empower different actors in their local community to take part in activism against FGM/C. Trained civil society entities (organizational and individual advocates) can have the potential to advocate for changes in community norms, helping to lead to the reduction of FGM/C.

2.11.11 Concluding perspectives on common FGM/C prevention approaches and interventions

This section will present some concluding thoughts on the differing tactics used in FGM/C intervention. This section uses the article "What Works and What Does Not: A Discussion of Popular Approaches for the Abandonment of Female Genital Mutilation" as a basis to provide an understanding of further suggestions to be utilised in terms of carrying out FGM/C interventions.

The article has pointed out that the varied decline in prevalence of FGM/C after nearly four decades of campaigning against FGM/C. The study in turn raises issues concerning the effectiveness of interventions and approaches used to eradicate the practice of FGM/C. What the study did conclude with is that some of the most frequently used approaches presented

have a significant lack of in-depth evaluations(Johansen et al., 2013).The existing information is adequate to debate and evaluate some important feats and challenges in FGM/C prevention, however more precise data could provide a more detailed and nuanced picture. Some studies have claimed that evidence on the effectiveness of interventions is insufficient, particularly whether they have led to an actual decline in the incidence or prevalence of FGM/C. There is also inadequate evidence on whether secondary goals, such as change of attitude and internalized knowledge, ultimately led to a decline in the practice and that the process can be tied to the theory of change presented in this is thesis.

Some studies claim that there is inadequate evidence on the fundamental factors of fruitful interventions, especially since almost identical interventions can have extremely different results in different contextual settings. This information would be key to improve and scale up successful approaches(Johansen et al., 2013). Interventions tend first to appeal to those that are already questioning or have abandoned the practice, seeing the intervention as a way to get societal acceptance for their change(Johansen et al., 2013). This is a common pattern in social change and helps those that are now converted to translate their conviction into action and gives a shove towards change to those that are undecided. More information about varying results based on similar interventions could be an essential first step that later facilitate transformation among more traditional participants of the community in intervention areas(Johansen et al., 2013).

However, this might imply that the next steps trying to bring along the more sceptical or conservative groups may require a revision of approaches and support for a longer period. The need for interventions to be driven by and involve the whole community underlines the importance of gaining in-depth knowledge of the community and the need to pay careful attention to strategies to engage with communities. Reviews have shown that targeting FGM is most effective and well received when a broader approach is used, assisting the community with other challenges(Johansen et al., 2013).

While conversion of leading persons such as community and religious leaders to speak out against FGM/C and a favourable legal framework create an enabling environment; evidence

shows the importance of pioneer groups as outlined in the *theory of diffusion of innovation*. Only when information comes from someone akin to oneself, are the of people willing to accept and adapt to the information(Johansen et al., 2013).

Resources for the abandonment of FGM/C including financial support from foreign donors can be instrumental to get interventions carried out, and incentives can be key to ensure participation and engagement. Yet, it can also obscure the process. Individuals who engage in interventions can be driven by access to resources, such as money or influence. Incentives can be used directly, such as sponsored weddings or education for uncut girls, alternative income for circumcizors, and compensation for taking part in coaching and meetings. Free training, funding of activities, and access to employment are more indirect incentives. If this leads to actual change in attitude and practice, the project can be seen as effective, though sustainability may be a challenge. But there is also a risk that the persuasion is not genuine, and societies are just pretending to give support for the cause in order to get access to the resources promised(Johansen et al., 2013).

More common is an expressed mistrust of how genuine the message of leaders against FGM/C is, and people and their messages, have been accused of being "bought" by the donors(M. T. Østebø & Østebø, 2014).Some studies have raised the issue of how rarely discussed in evaluation reports the motivation behind the change is. Researchers believe that many of the challenges deliberated in this thesis can be overcome if they are included in a more comprehensive and holistic programme, rather than as stand-alone approach to desert FGM/C(Johansen et al., 2013).

Although information about health complications might be insufficient in bringing about large-scale changes alone, it is shown to be a key component in all interventions. Communities and individuals have a right to get information about health and the health complications associated with FGM/C. Concern over the health consequences of FGM/C is one of the most significant incentive for abandonment of the practice. The current research has proven that for information to be effective, it has to be reliable and communicated in a way that it can be absorbed and combined into a wider health information package. The involvement of health providers in identifying and caring for complications as well as disseminating their local knowledge might be a potential way to improve this approach. Training of health providers on all aspects of FGM needs to consider that most health

providers tend to share the same support for the practice as the community they serve. Therefore, interventions must ensure that they also take a stand against the practice and realise that medicalizing the practice will not benefit the community. The training must become integrated as a standard curriculum for all health providers, monitoring, and follow-up of trained providers being an essential part(Johansen et al., 2013).

Whereas conversion of circumcizors as a stand-alone activity cannot be expected to have an effect on the prevalence of FGM/C, including circumcizors in a comprehensive programme can prevent a risk that they obstruct the intervention and that they are not ostracized from the community. Alternative rites programmes can be an effective approach only in communities in which FGM is a traditional part of such a ritual, and where girls, their families, and the whole community are involved in the efforts to abandon FGM. Interventions based on community engagement require long-term investment, a comprehensive education package, and a supportive context. It is key that it is well adapted to the local setting, including sociocultural and religious factors, as well as human resources (i.e., well-trained individuals)(Johansen et al., 2013).

Research has shown that sustainability is best achieved through the effect of change, in which the abandonment of FGM/C by a smaller group or community is disseminated to the larger community, for which organizational support is provided. Public statements can be an important way of making publicly known that the local social convention is changing. Such statements should be the result of a community-wide process to be effective, as statements made by subgroups have limited effect. Further research to investigate the effects of religiously founded public statements(Johansen et al., 2013).

Besides the aforementioned significance of a comprehensive and rounded programme for the abandonment of FGM including different types of activities, the authors believe that it is equally important to have a thorough design and planning and local adaptation of the intervention. The basic content of this should be a situation analysis and baseline assessment prior to any intervention. This can establish a community's readiness to change, as well as other factors related to FGM/C (decision making processes, power dynamics, implications and values attributed to FGM/C etc). A good programme design should equally include plans and procedures for monitoring the process. This might involve an in-depth documentation of each phase of the intervention. Lastly, a good strategy should include assessment of the

output and outcomes to either compare the condition before and after and/or establish a comparison site. It should be considered that interventions require substantial time before they can result in actual change. The time needed may vary considerably between communities, depending on various local and contextual factors(Johansen et al., 2013)

To document changes and better understand variations in FGM/C practices, further studies are needed, including studies using clinical observations of women attending health services and qualitative studies in the communities(J. Svanemyr, 2019).

3. Method and Research design

This chapter will present the research methods, approaches and techniques used in this thesis. This section will reflect on the reliability, validity and probable issues while managing qualitative research tied to fieldwork within social sciences. This section will also explore ethical considerations, data collection limitations and biases.

The data collection was conducted through canvassing and selecting relevant secondary literature (research) prior to and during fieldwork, semi structured interviews with informants, email correspondence and participatory observation during the fieldwork period. Literature on FGM/C in Ethiopia, UN/WHO guidelines and different reports were read to obtain an overview of the current state of FGM/C in general and in particular in Ethiopia. Furthermore, the interviews and informant selection process were done within the context of the fieldwork in Ethiopia. Qualitative methods were favoured in obtaining descriptions of perceptions and experiences of individuals and groups in particular programmes to aid with understanding the internal dynamics of programmes, however some qualitative approaches may not show cause and effect in an objective manner(Ngwabi & Wildschut, 2019). The purpose of the interviews was to get a more holistic view of the work done in FGM/C prevention and obtain understanding of the practice of FGM/C in Ethiopia through the lens of NGO workers in Ethiopia. Participatory observation mainly consisted of attending settings were FGM/C was a focus such as meetings, seminars and in-field observation.

3.1 Sampling of informants and access to study area

The sampling of informants was conducted prior to and during the fieldwork conducted in Ethiopia. I was permitted to use the head office of NCA as the main research base in Addis Ababa. Due to a needed visa renewal, I spent a week in Kenya. The fieldwork was conducted in two phases. The first phase lasted from the 12th of August 2019 until the 14th of October 2019. The second phase lasted from the 18th of January 2020 until 1st of February 2020. Prior to the first phase of the fieldwork, a relationship with NCA was established. I met with NCA staff at their head office in Oslo three times to discuss my intentions and then showed them a tentative project outline. Given the sensitivity of the topic, I only wanted to mainly interview NGO workers, and primarily NCA staff and their implementing partners in the intervention areas. The interviews were semi structured and in-depth. During the fieldwork, some aspect of finding informants changed causing me to reassess the criteria for being selected as an informant. The project outline also changed as the informant pool became different as to what was originally intended. The interview guides were formulated based on the research questions.

3.2 Informed consent in relation to the use of interviews

The informants were provided with informed consent forms and an information letter.

I informed all the informants that their consent could be withdrawn at any time during the duration of the fieldwork and the writing process and the information letter provided informed the informants of how the data would be used after the fieldwork. All of the informants asked to participate signed the consent form prior to the interview being held. All documents and audio recordings through audiotapes that can pinpoint the interviewees will be erased after the end of the project. I only used the personal data for the purpose(s) specified in the information letter given to informants. I processed the personal data confidentially and in accordance with data protection legislation (the General Data Protection Regulation and Personal Data Act).

3.3 Bias, personal bias and limitation the use of interviews

In utilising interviews as a means of obtaining data, one needs to consider the fact that interviews have an inherent ethical dimension, they concern interpersonal interaction
Many observations within the interview situations can carry the risk of bias. In terms of own personal bias, I have to include in this thesis that I personally believe in the abandonment of FGM/C and I believe it is a harmful practice. Therefore, it was very important to be mindful of my own personal opinion in relation to others who might have experienced FGM/C or knew someone who had undergone the practice. In discussing delicate matters like FGM/C within the framework of fieldwork, I tried to be context sensitive. Other issues I had to consider was regarding the use of interviews were selective data entry, interpersonal matters and counter-transference, expectancy effects, selective memory, reactivity and decisions on how to record the interviews. In interpreting the interviews, I often looked back on the notes taken during the conversation and listening to the audio recording to ensure lack of selective memory(Cohen, Manion, & Morrison, 2017).

3.4 Interview process and interview guide

All of the in-person interviews were audio recorded and done by me. All of the informants were anonymous. I included the interview done in Kenya because it speaks to the complexity of the practice and prevention of FGM/C. Also approaches that proved to have “success” in

Ethiopia were employed by the NCA staff in Kenya heading the intervention areas in Somalia.

By conducting semi-structured interviews, I got the chance to ask more open-ended questions, to formulate follow-up questions to pull out more relevant and specific data and a two-way communication where those being interviewed could ask questions in return(Brinkmann & Kvale, 2015). I followed up most of the interviews with some email correspondence, this correspondence was usually done to clarify something that was left uncovered in the in-person interviews. Some of the informants also provided contact details of other potential informants who were then contacted through email. The primary data acquired from the interview was intended to work complementary to the secondary data (literature). I also met up with NCA staff in Norway to ask some follow up questions to summarise the first phase of the fieldwork (12th of August 2019- 14th of October 2019).

The second phase of the fieldwork was primarily done to visit an intervention area where NCA worked primarily with faith-based organisations and during that phase the data collection was done through participatory observation and email correspondence. The data collection was officially ended on the 6th of February, the International Day of Zero Tolerance for Female Genital Mutilation in which I attended an event held at Norad where NCA staff from Ethiopia and Kenya attended to present their work. The overview below contains the complete list of places visited and organizations met during my time in Ethiopia.

Overview of places visited, and organizations met in Ethiopia

- Addis Ababa: NCA, SC, GAGE, Population Council, Ministry of Women, Youth and Children.

- Oromia: Sashamene, Siraro district
    - Met with NCA partner ADAA (African Development Aid Association) and attended a community gathering, witnessed a public statement being made
- Amhara: Ankober, Shewa Zone
    - Met with Ethiopian Orthodox Church Aid, visited Ethiopian Orthodox theological college, visited father confessors (Ethiopian Orthodox priest visited a school to meet with a girl club.

3.5 The data collection process in relation to the field research

The quality of results obtained from field research depends on the data gathered in the field. The data in turn, depend upon the field worker, his or her level of involvement, and ability to see and visualize things that other individuals visiting the area of study may fail to notice. I felt that the primary data collection obtained in 2019 was insufficient and I decided to return to Ethiopia in 2020 (see section on limitations). In conducting fieldwork, the researchers are faced with ethical dilemmas and executing research requires planning(Cohen et al., 2017).

This section outlines the what the data collection for this thesis was comprised of. The primary data collection for this thesis was encompassed of semi structured interviews done with informants, email correspondence with key informants and participatory observation. The secondary data collection was comprised by selecting prior research on the theme. In order to understand NCA and SC joint programme it was key to differentiate between NCA and SC reports and reviews on their projects (most of the literature selected were reviews on NCA and SC joint work commissioned by Norad). I used NCA and SC campaign material as a basis to assess the nature of the Joint Programme.

Some of NCA's and SC campaign material were then compared against the reviews of the Joint Programme commissioned by Norad to gage the validity of the results used in the campaign material. Some of the publications produced by NCA or SC were reports commissioned by NCA/SC Head Quarters to Norad. Other NCA and SC publications were educational material produced to build capacity among partner staff.
Some of the publication canvassed were theological reflections written with the intention of educating religious leaders on total abandonment of FGM/C. These theological reflections were also written and published in Amharic and Oromo.

3.5.1 Email correspondence

The use of this form of communication with informants became a vital source of information and worked as means of clarifying some statements made in prior communication with informants. Email was also used due to time constriction or as means of communicating with informants that were not able to meet in person. After a visit to an intervention area, I did not have time to interview a key implementing partner and therefore had to use email as means of communication. I also used email correspondence to help point me toward other supplementary data material. Another factor in using email was to see if there was any commonality in any of the approaches used across NGOs working with FGM/C prevention in Ethiopia. I contacted UN Women, UNICEF Ethiopia, Child Fund, CARE, Pathfinder, GAGE, Population Council, Amref and WHO staff based in Ethiopia. Those who responded were: Pathfinder, Population Council, WHO- Ethiopia and GAGE.

In the email correspondence that followed, some similarities in approaches these NGOs used were revealed. These similarities could potentially be result of potential leading questions. This correspondence pointed toward more secondary research done on FGM/C in Ethiopia and provided a more holistic overview of the status of FGM/C prevention in Ethiopia. The email correspondence was thematically analysed alongside the data collection provided by the interviews and secondary data.

3.5.2 Strengths and weaknesses in relation to using email correspondence

In communicating with informants, it can be challenging to gage if the respondents are being truthful through email. The questions posed in the email correspondence can also be leading causing the respondent to answer in a specific manner creating a sort of confirmation bias. In the email correspondence I made sure to be clear as who I was and what the purpose for the communication was. In communicating with informants working for NGOs it could also be challenging to assess whether the answers provided were their own personal opinion or if they were more concerned with representing the NGO they were working for and not wanting to fully critique their own place of work.

3.6 Participatory observation

The participatory observation was conducted by following the NCA staff member and their partner staff on their day to day duties, familiarizing with the project (Reproductive Health Programme/ NCA and SC Joint Programme on Eliminating FGM/C) and the project field offices. Using the NCA offices gave me access to their publications, campaign material and staff members for both informal and formal conversations. During my stay in Ethiopia, I attended events alongside NCA staff. These events provided information and contacts Using participatory observation as data collection made me aware of the fact that power dynamics is a dimension to consider in a research project both in its design and implementation, in this project's case I tried to be aware of my role as a foreign researcher working with a Norwegian NGO in Ethiopia(Desai & Potter, 2006). I used a notebook to record on the go and used my iPhone to take pictures and take notes during meetings. When I took notes, I tried to make sure that the people in these settings were made aware of my documentation.

Ensuring validity and reliability is the intended goal of the research and in order to I tried to remain context sensitive and honest about my intentions concerning my research both in informal and formal settings while trying to maintain an awareness that bias might occur(Desai & Potter, 2006).

3.6.1 Strengths and weaknesses in using participatory observation

Observational data was very useful in terms of recording non-verbal communication done in interview settings and informal conversation. Participatory observation also helped cultivate a relationship with key informants outside of the interview setting enabling me to get a sense of the situation(Cohen et al., 2017). These observations can however be heavily influenced by bias, selective fieldnote descriptions, interpersonal matters and selective memory. In the case of this thesis, when workshops or events were conducted in Amharic or Oromo, it was challenging to estimate what was being communicated and how it was received by the differing parties involved. I was also affected by attention deficit during events taking place in the heat.

3.6.2 Working with an NGO

It was important for me to consider what it meant to work with an NGO during my fieldwork given that foreign NGOs can have a political role in development(Desai & Potter, 2006). Given the nature of the fieldwork and the short amount of time spend in Ethiopia, the working relationship with NCA and SC was needed to gain access to certain areas in Ethiopia using NCA's and SC's connections and position in Ethiopia. In terms of this project the working relationship was not only vital in providing data, but the partnership provided a sense of daily routine and community in using NCA office spaces. This thesis is not aimed at providing an evaluation of NCA's and SC joint work. This thesis did however use NCA and SC's work as lens to understand the nature of FGM/C interventions in Ethiopia. It was therefore important to get access to informants other than NCA and SC staff.

3.7 Safety measures in relation to fieldwork in Ethiopia

Working with NCA staff provided a sense of security. Upon arriving Ethiopia, some parts of the internet were blocked by the government due to prior unrest. There had been considerable civil turmoil in Addis Ababa July 2019. During my stay in Ethiopia both during the first and second phase of the field research luckily things had settled.

3.8 Other ethical considerations

Ethical clearance for this project was obtained from the Norwegian Social Science Data Services (NSD) preceding the fieldwork. The guidelines for NSD align with the principle of "Do no harm", ensuring that the information gained is stored safely and properly disseminated after the completion of the project. FGM/C is a personal and complex issue. Sensitive information is material that is delicate and could also be personal in nature(Desai & Potter, 2006). Sensitive information can place the researcher in a delicate situation. Discussing FGM/C can be very delicate, even when discussing FGM/C in relation to work. Using the head offices of NCA in Addis Ababa while discussing my thesis with other staff members made me privy to personal information that helped inform the direction the thesis was headed and the personal details given during informal conversation helped me understand the complex and personal nature of FGM/C(Desai & Potter, 2006). In conducting research for this thesis most of my participatory observation was overt to ensure an ethical data collection.

3.9 Overall limitations

The possibility of bias in selection of secondary literature, informants and the presentation of the data. During the visits to intervention areas outside of Addis Ababa language became a barrier. In the project sites areas some of the communication was exclusively done in Amharic or Oromo. Some communication was translated on the go, but I had to assess what was being communicated by reading the tone or body language in different settings. Being based in Addis Ababa for most of the fieldwork required me to mainly focus on informants based in the same area (NCA, SCI staff at head offices) and coming alongside NCA staff given NCA had means of transportation. Time constriction was also a limitation, but this was partly solved through email correspondence.

An important limitation was the cultural difference between the informants and I. Nearly all of the NCA based in Addis Ababa staff are Ethiopian and most of my informants were Ethiopian. In the beginning it was challenging to understand how to approach informants. I did not want to feel like I was distracting people from their work. At the time of my stay in Addis Ababa, NCA and SC were finalizing some projects and applying for funding from Norad and other grants. During this critical time, I found it challenging to assert myself, partly because I am not an assertive person by nature. The informants were very helpful, looking back, I should have been more unapologetic in wanting to establish contact with key people. The lack of assertion and uncertainty in terms of who to approach made for a limited sample of informants. Due to lack of in person interviews, I utilised email correspondence.

Another limitation was related to canvassing secondary data. It was challenging to find reliable source material describing the nature of NCA and SC Joint Programme. This is thesis utilises some of the reports (Baseline/Endline and Mid Term Reviews) commissioned by Norad evaluating the Joint Programme, these reports offer some estimations that describe whether the Joint Programme achieve it's intended outcome. However, estimating the exact number of "implementing partners" within the intervention area was complex. From the outset and the data collection, some of the interventions were integrated with other social issues in addition to FGM/C. It was also challenging to estimate the difference in how SC and NCA approached their interventions and how the cooperation was set up. I primarily utilised NCA and SC own descriptions of their Joint Programme.

4. Findings and discussion

This section will answer the five research questions presented in the introduction by using primary findings and presenting secondary data. The data utilised are primarily studies done on FGM/C interventions in Ethiopia and studies on FGM/C prevalence in Ethiopia. This section will also tie in the relevant theory to the findings presented in this section.

4.1 What role has the Ethiopian government played in FGM/C prevention so far and what are the potential issues that can arise from the current government FGM/C policy framework?

This section explores the Ethiopian legislative and political framework that has shaped the relationship between the Ethiopian government and INGOs and NGOs working on FGM/C prevention in Ethiopia. The political landscape has affected the work the NGOs have been able to do on the within the intervention areas. NCA and SC has maintained a relationship with the Ethiopian government and cooperated with emergency relief since the 1970s. And the joint programme with SC is predicated on a working cooperative relationship with the Ethiopian government. The Ethiopian government has introduced a wide range of FGM/C preventative measures, largely comprising awareness campaigns around the adverse health and social consequences in schools, in the media and among local associations (Boyden et al., 2013). This thesis will focus on policies related to legislation, health care and briefly mention Sexual and Reproductive Health (SRH) education.

4.1.1 FGM/C legislation and policies in Ethiopia

Ethiopia has a civil law system, with some religious and traditional customary law. The civil procedure is influenced by UK common-law principles(Many, 2018). The implementation of Ethiopia's national strategy on FGM/C is overseen by the Ministry of Women,

Children and Youth Affairs(Wilson, 2013). Articles 561–570 of Chapter III of the Criminal Code deal with 'Crimes Committed Against Life, Person and Health through Harmful Traditional Practices'. These decrees criminalise the performance and procurement of FGM/C in Ethiopia, but do not provide a clear definition of the practice(Many, 2018).
Specifically, the Criminal Code sets out and covers various offences. Articles 561 and 562 pf of the Criminal Code refer to endangering life or causing bodily injury or mental impairment of a pregnant woman or new-born child as a result of the function of harmful traditional practices known by the medical profession to be harmful.

Articles 565 and 566 respectively set out punishments for the performance of FGM/C on 'a woman of any age' and infibulation of 'the genitalia of a woman'. Article 568 states that the transmission of communicable disease through harmful traditional practices is subject to penalties. Articles 569 and 570 cover the procurement of, and aiding and abetting, FGM/C by making it a criminal offence for 'a parent or any other person' to commission the practice or encourage someone to disregard the legislation prohibiting harmful traditional practices. The revised code also criminalises organising or taking part in any movement that promotes FGM/C(Many, 2018). The Criminal Code does not specifically criminalise the failure to report FGM/C, whether it is organised or has taken place. Nonetheless, more generally, Article 443 sets out the punishments for failing to report certain crimes. The Criminal Code also fails to protect uncut women and their families from verbal abuse or marginalization from society, which is included in the laws of some other countries in East Africa(Many, 2018).

From banning the medicalization of FGM/C including FGM/C in the revised Ethiopian Criminal code (2005), the establishment of the National Alliance spearheading the National Costed Roadmap to End Child Marriage and FGM/C in 2024, one can claim that the Ethiopian government has played a pivotal role in creating an environment to build on and further promote FGM/C prevention. The National Costed Roadmap was created with the intention of being an evidence-based costed plan which outlines the key strategies, packages of interventions, and expected results, targets and milestones towards the elimination of child marriage and FGM/C in Ethiopia. The Ethiopian government strategy ties FGM/C to Child Marriage (CM) and other harmful traditions (HTPs). There is some research that link these to

practices together. According to a report titled “Child Marriage and Female Circumcision (FGM/C): Evidence from Ethiopia” (2014) claim that:

> *“Child marriage and female circumcision are linked practices that are prevalent in Sub-Saharan Africa and common traditions in Ethiopia.(A Pankhurst, 2014).”*

Although there is little documented evidence that show medicalization of FGM/C can end up in reduction in prevalence, in countries were medicalization of FGM/C is allowed it may limit at least the complication imposed by traditional circumcision(Atlaw, Seyoum, & Gezahegn, 2020).

However, securing a marriage for a daughter is not the only motivation for carrying out FGM/C on women and girls. Some research have concluded that the enactment of FGM/C legislation and the implementation of health policies designed to prevent FGM/C and accelerate its abandonment in the 28 countries where the practice is concentrated has had a limited impact in the majority of these countries to a large degree because of sporadic enforcement of the laws, lack of comprehensive legislation, lack of robust institutions to enforce the law and programmes aimed at addressing the underlying social norms that perpetuate the practice(Muthumbi, Svanemyr, Scolaro, Temmerman, & Say, 2015). Some research claim that for anti-FGM/C laws to be successful, enforcement of the law must be complemented by capacity-building efforts among enforcement authorities, with robust monitoring at the local level. This monitoring can be compilated to carry out in areas where local policymakers have no legitimacy(M. T. Østebø & Østebø, 2014).

Research has shown that legal measures to combat FGM/C in Ethiopia has been a somewhat complicated strategy partly because criminalizing FGM/C does not in actuality tackle the root of the practice. Consequently, government policy aimed at changing societal perceptions towards FGM/C need to address underlying social norms that are at the root of the practice(Muthumbi et al., 2015).

Research has shown that legislation needs to be widespread, with provisions and firm penalties for medicalization as well as for individuals that abet and aid FGM/C in order to address legal loopholes that may inadvertently encourage individuals to practice FGM/C(Shell-Duncan et al., 2016). Legislation should also coincide with the Convention on

the Rights of the Child (CRC), which has provisions that prohibit FGM on children(Muthumbi et al., 2015). In Ethiopia there have been challenges in enforcing the law, an example of this. The enforcement of the law might also drive the practice underground in some communities for fear of consequences.

Another factor influencing FGM/C abandonment in Ethiopia, has been the 2009 CSO law. In the interviews and the email correspondence, informants mentioned that steps had to be taken to work around the restrictive legal measure that on NGOs working in Ethiopia. NCA and SC had to redress the issue of FGM/C as a health issue alone, rather than a human rights violation because FGM/C interventions could be thought be akin to advocacy.

A study conducted found that human rights organizations in Ethiopia said they had reduced staff, scaled down activities, restructured their organizations, merged with other groups or split their NGO into different components(Dupuy, Ron, & Prakash, 2015). Seventeen NGOs had rebranded by changing their mission statement from human rights based to development focused, while 35 percent of human rights NGOs said they had done both rebranding and restructuring(Dupuy et al., 2015). A report commissioned by CMI in 2018 also showcased a number of NGOs funded by the Norwegian government had begun to phase out their FGM/C interventions due to the Ethiopian governments policy.

> *"We currently have no projects working with FGM/C. 6-7 years ago we tried on a project specifically aimed at this but had to put it down because the authorities viewed it as rights-based work (which was not allowed at that time - this has changed now)."* (Written response received 30th of September 2019 from Norwegian Lutheran Mission (NLM) translated from Norwegian)

Another factor in issues arising from legal measures enforcement by the government used in Ethiopia is the case of underreporting during surveys or driving the practice underground.

> *"Since FGM/C is criminalized, people undertake it in hidden ways in many places. In some communities like Afar and East Hararghe zone areas of Oromia as well as Somali regions, it has still been carried out openly. I think the EDHS data is true. GAGE research also confirms the prevalence of the practices particularly in FGM/C*

> *hot spot districts. Our data show that the change is only in relation to the type of circumcisions in which in many places people change harsh one (total elimination of the clitoris and sewing) types into a kind of mild suna (sic) type. That seems to be the change but little indicator of the decline in the practices particularly in rural areas though the practices has truly show decline in major urban areas where awareness has been expanding.* (Written response form Ethiopian GAGE staff, the 2nd of October 2019)

A 2019 GAGE report from their study sites revealed that FGM/C is a deeply rooted cultural practice carried out on girls at very different ages in their research sites, ranging from early infancy to early adolescence. Their findings suggest that in Afar and Oromia, where historically the practice has been more invasive and severe, there appears to be a trend towards the less invasive forms, locally known as the sunna cut, rather than elimination of the practice(Jones, Presler-Marshall, et al., 2019). GAGE's work and research is primarily focusing on adolescence. Findings from the GAGE mixed-methods 2018 baseline research highlights that while the patterning of violence experienced by adolescent girls and boys is shifting across generations at the micro-level, gender- and age-related social norms remain deeply entrenched in both migrating and settled pastoralist communities in Afar(Jones, Gebeyehu, & Hamory-Hicks, 2019).

At the meso-level, institutional barriers to addressing adolescents' experiences of violence include a lack of basic infrastructure, a dearth of confidential reporting spaces, inadequate adolescent- and gender-friendly personnel within the police and justice sectors, and poor organization. Findings from GAGE's research show that at the macro-level, the research underscores the significant disconnect between Ethiopia's progressive national policies and adolescents' experiences of violence, reflected in the availability and quality of prevention and response services. The baseline concludes that to adequately tailor services to local realities and tackle adolescents' specific vulnerabilities, a fine-grained analysis of the gendered and generational experiences of violence and human rights abuses in its diverse forms is critical(Jones, Gebeyehu, et al., 2019).

The Chr. Michelsen Institute (CMI) (2019) and a WHO report has additionally raised the issue of funding in relation to FGM/C prevention in Ethiopia. Resources for the abandonment

of FGM/C including financial support from foreign donors can be instrumental to get interventions carried out, and incentives can be key to ensure community participation and engagement. However, being dependant on foreign/donor resources might restrict and affect the quality of the FGM/C prevention.

4.1.2 Health care policies in relation to FGM/C

In 2004, the Ethiopian government launched the Health Extension Programme (HEP) in order to increase access to and quality of primary health care(M. T. Østebø et al., 2018). New health centres and health posts were constructed at woreda (district) and at kebele (village) levels, respectively. The seeming success of the programme was attributed to the political will and commitment of the current regime, but also to major contributions and investments by key global health actors. Researchers are critical of Ethiopia's health care policies due to the authoritarian regime. Nonetheless, a number of donor countries have invested in the HEP, partially due to Ethiopia's tactical position for regional safekeeping and stability. The present work to strengthen Ethiopia's primary health care system can be clarified to some extent a continuation of the health initiatives and strategies developed during the previous political regimes. However, the political stability that the Ethiopian government has been capable of maintaining is delicate, exemplified by political developments over the past years(M. T. Østebø et al., 2018).

In 2017, as part of its endeavours to safeguard the health and wellbeing of its citizens, including women and children, Ethiopia's Ministry of Health banned medicalization of FGM/C in all public and private medical services in the country and medical personnel who participate in any form of FGM/C in medical facilities will be exposed to legal action(Kimani & Shell-Duncan, 2018).

4.1.3 Sexual and Reproductive Health Education (SRH) in relation to FGM/C

Education is considered an important means of addressing gender inequalities in Ethiopia. According to UNESCO statistics, Ethiopian primary and secondary schools have nearly achieved gender parity. The SRH education in the education system in Ethiopia is targeting gender based violence, HIV awareness and issues concerning reproductive health in addition

to FGM/C(Le Mat, Altinyelken, Bos, & Volman, 2019). Between 2000 and 2016, attendance rates for pre-primary, primary, and secondary education increased radically(Elezaj et al., 2020). The gender gap in primary school turnout has been reduced. The school attendance rate of adolescent girls (aged 10-14 years) surpassed that of their male peers, 80 percent compared to 78 percent, respectively(Elezaj et al., 2020). The gender gap in secondary school attendance has narrowed to a five-percentage point difference in favour of boys. Across regions, Amhara, Tigray, SNNPR, and Benishangul-Gumuz made the most significant progress in narrowing the gender gap in secondary school attendance rates over the 16-year period(Elezaj et al., 2020).

Ethiopia has demonstrated significant progress in SRH outcomes over the last two decades. Notable achievements have been made in a wide range of health indicators including increased rate of contraceptive prevalence rate from 3 percent to 36 percent and reduction in the total fertility rate from 7.7 to 4.6 children between the 1990s and 2016(Dessalegn et al., 2020). However, the progress is not uniform across regions and population groups. While the national contraceptive prevalence rate is a little over 50 percent amongst women in urban regions, a vast number of women in the lowest wealth quintile and adolescents and women from majority pastoralist regions still do not receive any form of family planning. Nomadic individuals, like the pastoralists residing in Afar, face intricate hurdles to healthcare access that can be broadly categorized as external such as geographic isolation, socio-cultural dynamics, logistical and political factors. Internal factors such as lifestyle, norms and practices, perceptions factors are also important to consider(Ali, Cordero, Khan, & Folz, 2019). There is however limited research on how efficient SRH education alone is as a strategy for preventing FGM/C and how SRH can be linked to the concept of *reproductive justice.*

4.1.4 Concluding thoughts on the Ethiopian political context in relation to FGM/C

The Ethiopian government has made strides in relation SRH education and expanded primary health care services. However, the rollout and implementation has lacked proper execution. The 2009 CSO law affected the work NGOs has been able to within intervention areas. In Ethiopia, lack of adequate government budgets and logistical problems in reaching rural and faraway areas has also affected FGM/C interventions. The research presented in the findings

section underscores a significant disconnect between Ethiopia's progressive national policies that aim to secure education, health care, access to SRH and freedom from bodily harm than the actual results. Although FGM/C is a prohibited act in Ethiopia, there is no adequate legal protection of victims by the law and there is weak punishment meted out to perpetrators. This weakens the preventive effect of the law, and does not encourage deterrence amongst practitioners(Alem et al., 2013).

4.2 What does Norwegian Church Aid (NCA) and Save the Children's (SCI) Joint Programme (and other NGO and International organizations) do to reduce the prevalence of FGM/C in Ethiopia?

This section will explore the interventions used in Ethiopia and attempt to uncover why these methods are utilised. This section will present the present some of the work done by international organizations like WHO and UN agencies because these international organizations set the agenda and shaped the frameworks in terms of how NGOs and INGOs approach FGM/C intervention in addition to other NGOs.

This segment will also present a general overview of interventions in Ethiopia. It is important to preface this section by mentioning that research on FGM/C interventions in Ethiopia is lacking. What currently is available are some cross-sectional studies done on specific regions or studies done on specific interventions. These studies are also done at fixed point in time. A report authorized in 2013 by 28 Too Many, an INGO, revealed that here were more than 82 local NGOs, CBOs, FBOs, international organisations (INGOs) and multilateral organisations working in Ethiopia on women's health issues(Wilson, 2013).
There have been strong social and political movements for the abolition of FGM/C, especially in urban areas, and the Ethiopian government has ensured a favourable legal and policy environment for change. The revised Criminal Code was passed in 2005 which specifically outlaws FGM and although there have been prosecutions, there is scope for greater and more effective law enforcement(Wilson, 2013).

A range of initiatives and strategies have been used to end FGM/C. Among these are: health risk/harmful traditional practice approach; addressing the health complications of FGM;

educating traditional circumcizors and offering alternative income, alternative rites of passage, religious-oriented approach, legal approach, human rights approach ('Community Conversations'), promotion of girls' education to oppose FGM/C, supporting girls escaping from FGM/child marriage and media influence(Wilson, 2013). During the fieldwork. I was able to witness a community conversation, meet a school club comprised of young girls and meet with some Ethiopian Orthodox priest in Amhara who promote FGM/C abandonment. These visits informed presentation of the findings and the focus of this section is somewhat built around some of the impression gathered when visiting intervention areas.

In canvasing the literature available on interventions on eliminating FGM/C in Ethiopia, there were commonalities across where and how NGOs are operating overall (Esho et al., 2017; R. E. B. Johansen et al., 2013; WHO, 2011b). NGOs and international organizations are combining community mobilisation, schooling and participation of community and religious leaders, with advocacy work at district, national, and regional levels. Most programmes and particularly those working at a large scale also aim at changing policies and seek to influence the governments' position and support to end FGM/C. All the organisations in Ethiopia mostly support and work in collaboration with local NGOs and community-based organisations and emphasise capacity building and local ownership of the interventions(J. Svanemyr, 2019).

In 2007, UNFPA and UNICEF launched a Joint Programme on "Female Genital Mutilation/Cutting: Accelerating Change" with the objective of helping reduce the practice among girls aged zero-15 years by 40 percent, and at least one country declaring total abandonment of FGM/C by the end of the programme. The programme was implemented in Ethiopia in 2008. The programme is currently in its third five year phase. (Malmström, 2011). In terms of resources for the health sector, in May 2016, WHO launched the "WHO guidelines on the management of health complications from female genital mutilation", the first evidence based clinical guidelines on the management of complications of FGM/C. This has been achieved in collaboration with the UNFPA-UNICEF Joint Programme.

In 2018, WHO launched a new clinical handbook to help health care workers provide health care to meet the specific needs of girls and women who have been subjected to FGM/C(J. Svanemyr, 2019). For several years, UNICEF Ethiopia and its partners have been supporting

the government of Ethiopia to encourage local level declaration of abandonment of FGM/C through the social convention theory strategy advocated by UNICEF and UNFPA(Alem et al., 2013). The evaluation of the Joint Programme UNICEF and UNDP was conducted by UNICEF in collaboration with the government of Ethiopia in 2012 in ten different woredas that during the project period made public statements against FGM/C. These woredas were located within the three regional states of Afar, Benishangul Gumuz, and SNNPR and the capital city, Addis Ababa. Each woreda consisted of a different number of *kebeles* and the geographical characteristics of the *kebeles* varied(Alem et al., 2013).

Through email correspondence with an Ethiopian WHO staff, I asked "What is WHO Ethiopia doing to work towards FGM/C prevention/abandonment? What are the focus areas/ target groups?" The WHO staff wrote that WHO is targeting the regions with high prevalence rates and focusing on understanding the cultural underpinnings that sustain the practice. The correspondence also revealed that WHO worked closely with government officials and UN agencies in Ethiopia to create policy and strengthening the capacity of health workers. In terms of WHO's strategy regarding FGM/C on a community level asked I asked: "what methods are being utilized to mobilize the communities by WHO in Ethiopia?

The response to this question was:

> *"Health literacy and community mobilization utilizes a multimodal approach such as using the existing Health extension workers for providing health education to the risk families which needs to revise and validate which type of health education works in different context while audio-visual media also can be utilized to mobilize towards the prevention and abandonment of FGM. However, the mobilization of community for preventing and abandonment of FGM in Ethiopia has been utilizing high ranking official such as state president's wife to advocate beside utilizing pregnant mother forum which has been conducted on quarterly bases in the community"* (Written response from Ethiopian WHO staff the 5th of February 2020)

The research on interventions done in Ethiopia are currently narrow. There have been studies conducted on specific interventions. The research available on interventions can indicate some trends that can in turn point policymakers and NGOs in a more effective direction.

Some research featured interventions done in *kebeles* or very specific small communities. An example of small studies done was a school-based cross-sectional study that was conducted in the Somali and the Harari Regional States of eastern Ethiopia from October to December 2015. Though purposive sampling was implemented to select the study zones from the two Regional States, stratified random sampling method was used to select 480 study subjects from those areas(Asresash D. Abathun, Sundby, & Gele, 2018).

The study result showed that multiple information channels that include school-based awareness campaigns were found to be the best way to support the abandonment of FGM/C. That means information from different sources is the powerful tool to disseminate the harmful effect of FGM/C among the study population. This was reflected in the study by the high proportion of support toward the abandonment of FGM/C, and the high number of female study contributors who didn't experience FGM/C(Asresash D. Abathun et al., 2018).

INGOs and NGOs in Ethiopia have attempted to work in accordance with the exiting legal framework. The Criminal Code of 2005 deals with a range of harmful traditional practices, prescribing diverse penalties, including imprisonment. There have been powerful government- and NGO-supported campaigns against FGM/C throughout the country, with a strong focus on the regions where the problem is most prominent, notably in the agropastoral areas of the east and in southern Ethiopia. A National FGM/C Network was established in 2002 under the auspices of Norwegian Church Aid, and the coordinating role was given to the former National Committee on Traditional Practices (NCTPE), renamed Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM), the Association for the Elimination of Harmful Traditional Practices. The Network became active and was officially launched in November of 2010(Boyden et al., 2013).

There have also been important initiatives by religious groups and local and international NGOs, done through cooperation with NCA and their joint work with SC. The Evangelical Churches Fellowship of Ethiopia agreed on a five- point declaration on 26th of January 2010 in which they condemned FGM/C as unbiblical, barbaric and going against the divine value of caring for the body, as well as being unfair and degrading toward women and robbing them of their fundamental human rights, affecting them physically, psychologically and emotionally. FGM/C was then announced contrary to the divine principle of parental love and

security that children should be afforded and was also condemned for diminishing women's sexual pleasure, causing marital difficulties, unbearable pain and suffering during childbirth and serious health complications after birth(Boyden et al., 2013).

The position statement by the protestant Ethiopian Christian denomination concludes with a declaration of zero tolerance. The Ethiopian Orthodox Church produced a similar six-point statement on 13th of October 2011 regarding FGM/C and other forms of gender-based violence. The statement condemns the practice of FGM/C as inappropriate, going against God's complete creation of the female body, and women's human and constitutional rights. The statement adds that the prevention of FGM requires the strong involvement of church leaders and men, and collaboration of the Ethiopian Orthodox Church with other partners. The statement was followed by a book on the subject in Amharic, entitled *Theological Reflection on Female Genital Mutilation*, with a foreword by the Ethiopian Orthodox Patriarch. There have also been initiatives, by the FGM/C network in Ethiopia, to celebrate 6th February as the international awareness day of zero tolerance toward FGM/C(Boyden et al., 2013).

Another study done on an NCA key partner, Kembatti Mentti Gezzimma (KMG), specified that from the outset, KMG's intervention to eliminate FGM/C has engaged men as supporters and critical vehicles of transformation in efforts to forsake FGM/C. Men were engaged as members of FGM/C prevention community committees known as Women's and Girls Advocacy and Support Groups, which were supported to disseminate prevention material and advocate for the eradication of FGM/C through public consciousness activities and encouraged to develop and device sanctions for those who continue the practice(Alula Pankhurst, 2014; Pankhurst, 2017). Community Conversations, one of KMG Ethiopia's most notable initiatives, was intended to draw on the tradition of resolving problems through community gatherings. Where those discussions were usually dominated by some leaders, KMG invited everyone to take part and share their concerns and ideas(Green, 2020).

This included men making general and public declarations of sanctions at the sub-district and at district levels. The reasoning for engaging men in abandoning FGM/C is linked to the underlying gender norms and inequalities stimulating the practice of further dialogue(Stern & Anderson, 2015). Throughout the fieldwork being introduced to NCA/SC joint programme

with the FGM/C intervention it was challenging to quantify partners and which partners that where key in NCA and SC intervention areas. The intervention in certain areas seemed to be tied to the implementing partner(J. Y. T. Svanemyr, 2015).

The ETR on NCA and SC joint programme done in 2015 briefly stated the role of the partners in NCA/SC joint programme:

> *"Although difficult to quantify, program partners have had a key role at national level in mobilizing the government, religious leaders and in institutionalizing FGM/C. The program has also demonstrated its relevance by contributing to improved coordination and collaboration among organisations working on FGM/C and other HTPs (Harmful traditional practices*" (J. Y. T. Svanemyr, 2015)

The community led approach I was able to witness was a community gathering in Sashamene in the Siraro district in the Oromia region was very vital in understanding community-led approaches. In observing, interviewing and then corresponding with NCA staff about community gatherings and the justifications for utilising this method the response was:

> *"Community conversation is a very good tool for social norm change projects. However how it is used differ by organizations due to capacity, resource, and contextual differences. In areas it has been done well it has brought a lot of changes."* (Written response from NCA staff the 10th of October 2019)

Another informant, from NCA's implementing partner, ADAA, working in Sashamene wrote in response to their choice of approach with:

> *"...ADAA have started Community conversations (CC) before 2008 in previous projects like Alternative Basic Education (ABE) and other projects before NCA funded project in 2 districts and one Zone.*
> *CC (Community conversations) organized two times per month with a member of 60-30 female and 30 male) as one cc (sic) group and all community segments and*

community financial persons and kebele level government responsible bodies are participated in the group.
- yes, ADAA integrates in its operating current projects the issue of FGM/C through incapacitating the girls/ women economically and mobilizing them to fight FGM issues in their localities" (Written response from ADAA staff the 20th of September 2019)

This reply gave an impression of the frequency of the community gatherings in the intervention area. In the case of Ethiopia, there are regional differences and different justifications for the practice of FGM/C. These underpinnings seem to have influenced the approaches used in FGM/C prevention. Engaging with the kebeles /districts was done through Community Conversations and school clubs. ADAA has worked with NCA in combating FGM/C in the West Arsi Zone of Oromia. The prevalent type of FGM the area where ADAA is operating is Type I. In the Siraro district (woreda) FGM/C often performed before marriage, a couple of days before the matrimonial ceremony. The NCA-ADAA intervention in the Siraro woreda has targeted households and community, religious and traditional institutions, CBOs and local government offices (woreda offices). The strategy has included information and awareness raising, alternative rites of passage (ARPs), including promoting positive parts of the culture, involvement of religious and traditional leaders(Wilson, 2013).

With regards to NCA, these community engagements also intersected with other programmes (climate resilience, water and sanitation). In conversation with GAGE (Gender and Adolescence: Global Evidence) staff, it seemed that many approaches were similar in the intervention areas across most of the NGOs working in Ethiopia.

4.2.1 Community conversation has a human rights-based approach

With regards to Community Conversations (CC), a key SC staff member wrote in an e-mail:

> *"…. May need adaptation for some areas such as for pastoralist communities, people with disabilities. May need resources including time to implement the serial sessions to complete the whole cycle. Effectiveness may also depend on the capacity and experience of the Facilitator/s."* (Written response from SC staff 3rd of September 2019)

The same SC staff also mentioned in a prior interview that Ethiopian pastoralist live in hard to reach or remote areas. Therefore, in communities where people are migrating due to various reasons, a steady and regular community gathering may be hard to follow through. A Norad evaluation of Norwegian aid stated that a range of initiatives and strategies have been used. These include raising awareness around the health risks of harmful traditional practices, community dialogue/conversation, educating those who carry out the practice and offering alternative sources of income, promoting alternative (non-harmful) rites of passage, tackling religious-oriented beliefs about circumcision, adopting a legal/ human rights approach, promoting girls' education as a way of combating FGM/C and enabling girls to avoid early child marriage(Jones et al., 2015) These approaches seem to be aligned with the common approached utilised. In conversation with SC staff and NCA staff it was hard to differentiate between what engagement was utilised in the within the intervention areas and how the work was conducted in Addis Ababa. From my understanding, the approaches done at an institutional level done with NCA/SC directly in cooperation with UN agencies or the Ethiopian government. In attending network gatherings in Addis Ababa, much of the work seemed to be in engaging with the Ethiopian government and UN agencies. Norad evaluation reports show that some of the difference between NCA and SC were the choice of different implementing partners in the intervention areas.

Still, in conversation many of the approaches at community level appeared to be similar in nature (girls school clubs, boys school clubs). In an interview with SC, one staff member said that SC also work with religious leaders. In email correspondence with Pathfinder, a British NGO, a key staff member described their tactic/approach. And Pathfinder's approach seemed to be similar to SC and NCA's school clubs. The school clubs, are according to SC conversation, were primarily child led. Using these gatherings to discuss personal and complex issues while touching upon social norms seems to be a general trend.

> *"…. The project has aim of helping adolescent girls' healthy transition into adulthood. Adolescent girls will have peer mentor-led discussion weekly and one of the sessions is Harmful traditional Practice including FGM/C. We also implement Social Analysis Action (SAA) approach to address the unhealthy gender norms including FGM/C. The SAA (action and reflection) is facilitated by volunteer facilitators and there is a discussion manual to guide SAA group meetings. One of the modules is on FGM/C."* (Pathfinder staff in written correspondence on the 10th of October 2019)

Many of these community led approaches seemed to be run on voluntary basis. Training seems to be offered to those who lead these community-led approaches. In visiting a school club in Ankober (Amhara region), I was able to get an overview of the log and written record of the meetings. The composed log was in Amharic, but the dates seemed to indicate steady and regular meetings. Some of the girls attending and engaging with these clubs might have undergone FGM/C prior to entering school, there is no way of knowing. However, attending these gatherings can potentially ensure that girls who have undergone FGM/C might not let their daughter undergo the practice in the future.

In an interview with GAGE, the person mentioned that some girls could not remember the day they had undergone FGM/C due to the fact that it occurred during early childhood. There have been intermittent reports regarding law enforcement and FGM/C in Ethiopia over recent years, but detailed evidence on cases is not extensively available. In 2012, for instance, a circumcizor and the parents of six girls were arrested and charged. The circumcizor received a six-month sentence and the parents were penalized with 500 Birr (equivalent to US$27 at the time)(Wilson, 2013). Isolated cases were also reported in 2011 and 2010(Many, 2018).
It appears that, although the number of arrests may have increased, law enforcement is weak and very few cases proceed to court in Ethiopia(Wilson, 2013). The UNFPA-UNICEF Joint Programme to Eliminate Female Genital Mutilation (UNDP) report for 2015 noted that, although 279 arrests had been recorded in Ethiopia that year, there was only one conviction. In 2016, again, only one conviction was recorded(Many, 2018).

In email correspondence with SC staff, the response to "If there has been a decline, what has caused it?" was:

> *"… Using focused and mixed Social and Behavioural Change Communication strategies: Community Conversation, Serial and continues Radio Program (establishing Radio Listening Groups), strengthened collaborative work with schools, child led groups, FBO (faith-based organisations) and CBOs (civil based organisations) and teach at religious places.*
> *Working with different entry points and change agents such as children/child led groups, religious and clan leaders, youth and women association,*
> *Close collaboration with other stakeholders including Women, Children Youth offices as well as integrating with other sectors such as health/Health Extension Program, Education, Law enforcement bodies"* (Written response from SC staff the 10th of October)

4.2.2 Partnering with faith-based organisations

Several studies (Alem et al., 2013) acknowledged that religious leaders or other instrumental persons are quite effective allies for aiding the acceleration of the abandonment of FGM/C because they have power to convince the community. Apart from community conversations, some intervention strategies in Ethiopia focuses also on dialogue with religious leaders, health workers, and law enforcement officers to teach and raise awareness.
These studies have found that targeting local religious leaders with a view to turning them into allies especially helps to correct the people's misconception that FGM/C practice is supported by religion(le Roux & Bartelink, 2017; UNDP, 2018).

A religious oriented approach refers to tactics which demonstrate that FGM/C is not compatible with the religion of a community, thus leading to an adjustment of attitude and conduct. This approach has been used with both Christian and Muslim communities in Ethiopia. Both the Ethiopian Orthodox Church and the Evangelical Churches Fellowship of Ethiopia and Muslim religious institutions have published declarations declaring in support of abandoning FGM/C. In a visit to an intervention area in Ankober, we met with Ethiopian Orthodox parishioners who seemingly frequently visit the households they are given spiritual responsibility over. In conversation with an Ethiopian Orthodox priest, priest was assigned a certain number of households. The choice to partner with "Faith based leaders" is not only due to their influential role in their communities, but their ability to frequently "check in on" the people they are the spiritual leaders for.
The Ethiopian Orthodox Church Development and Inter Church Aid Commission (EOC-DICAC) is the development wing of the Ethiopian Orthodox Church and the oldest faith-based development organisation in Ethiopia and is viewed as a role model by other local organisations(Wilson, 2013). They are active in many regions of the country. EOC-DICAC has worked with NCA in combating FGM/C in Dahana district, Amhara region(Wilson, 2013).

Some argue that religious leaders are not that influential to begin with and question the legitimacy of their influence(M. T. Østebø & Østebø, 2014), however according to an informant, the Ethiopian Orthodox Christians usually perform FGM/C in early infancy. Therefore, in theory, having a priest ensuring the family unit not undergo the procedure by visiting the family to bless the child and use their role to advocate for abandonment of

FGM/C can help lead to lasting change. Leaders of religions and faith-based organizations are to some degree at grassroots level and can therefore have influence where the State cannot. These religious leaders are able to reach the remote areas because they themselves reside with the community.

Their influence lies in daily contacts within the communities, and is, in some regions, much more intense and more influential than that from the State or other sources, especially on the aspect of daily lives within the community. In summation, research has shown that local community led initiatives seemed to work if the intervention is suited for the given context. Religious leaders are not necessarily motivated by what the "foreign" NGO can provide given the fact that they already have a responsibility outside of the. In sum, interventions are similar across the board in Ethiopia. Frequency, consistency and local legitimacy are a key component of a good intervention. The theory chapter stresses the dissemination of information and raising awareness a means of influencing communities to eliminate FGM/C. In canvassing NCA/SC publications, radio programmes and media campaign were mentioned as a means of spreading information to at risk women. In retrospect, I would have liked to uncover the nature of these radio programmes in order to get a sense whether these measures where effective(SC, 2017; Wilson, 2013).

4.3 What do we know about the FGM/C prevalence in Ethiopia, and how are the numbers are changing?

There have been some studies done on the prevalence on FGM/C and the regional differences in prevalence in Ethiopia While national FGM/C prevalence provides a useful overall picture of the situation in any given country, it can mask important and sometimes dramatic variations across sub-regions or ethnic groups. The data available can indicate what might work in terms what can lead to effective FGM/C interventions. It is challenging to assess the validity of the overall decline in FGM/C. If the decline only occurs in the intervention areas or Ethiopia as whole. The studies done on FGM/C in Ethiopia have been limited to certain

geographical areas and compared smaller sample findings/smaller sample data collection to large surveys conducted like the EDHS or MICS (UN Cluster Surveys).
This section will compare some studies done on FGM/C prevalence and showcase some of the primary data to provide a holistic picture of FGM/C prevalence in Ethiopia as it stands currently. The 2016 EDHS is the most recent large-scale survey done on FGM/C prevalence in Ethiopia. In the regions where prevalence is under 30 percent there hasn't been any clear estimations to explain why some areas have lower prevalence. Informal conversation with NCA staff revealed the low prevalence rate in Gambela can be tied to the ethnic grouping residing in that region, ethnic groupings that historically have never practiced FGM/C.

"There is no homogeneity" was something that was mentioned in passing at an event by NCA staff (1st of October 2019, Anti-FGM Network gathering) and the same person stressed the need for FGM/C prevention to be contextualised. Some studies describe the decline of FGM/C to slow(G. Tesema et al., 2019) with regards to the extensive campaigning done for decades and other studies have described Ethiopia as a success story(A Pankhurst, 2014). Other studies have said that the decline is slow and even increasing in the intervention areas though there are no clear reasons as to why.

According to the report "Prevalence of Female Genital Mutilation among reproductive age women in Ethiopia: Systematic Review and Meta-analysis" (Atlaw et al., 2020) FGM/C has declined in some and some areas show little to no drop in prevalence. The regional prevalence rate is a good indication as to where in Ethiopia the issue of FGM/C is severe, however this study highlights the need to understand the variation within the regions(Atlaw et al., 2020). Another study called "Geographic Variation and Factors Associated with Female Genital Mutilation among Reproductive Age Women in Ethiopia: A National Population Based Survey"(Setegn, Lakew, & Deribe, 2016) showcases the need for explaining the regional differences.

One study titled "Hotspots of female genital mutilation/cutting and associated factors among girls in Ethiopia: a spatial and multilevel analysis"(Geremew, Azage, & Worku, 2020) utilised the EDHS done in 2016 and made an attempt to uncover FGM/C hotspots. The study discovered that FGM/C is spatially clustered in Ethiopia. Hotspot clusters of FGM/C were detected in Eastern Amhara, West and North-East Oromia, and East and North-East SNNPR

region, Harari, Dire Dawa while cold spot clusters were found in most parts of Tigray, and Gambela, including Central and South-West Afar regions. This finding is supported by other studies conducted in Ethiopia where FGM/C was spatially clustered with high spot clusters found in Central and East Amhara, North part of SNNPR and East Oromia(Muluneh, Kassa, & Merid, 2020).

A hotspot can be defined as a specific area where prevalence of FGM/C high. These hotspots may in turn provide a more nuanced picture as where and how FGM/C is practiced in Ethiopia. Another issue that these studies raises is the age of cut. These hotspots may be due to the fact that the neighbourhood areas of the regions may share common characteristics in relation to traditional practices. In addition, FGM/C hotspots were detected Somali region, Benishangul Gumuz region, and SNNPR region including Dire Dawa Town(Geremew et al., 2020). This local clustering of FGM/C can also indicate that daughters who lived in the FGM/C hotspot areas had a high probability of undergoing FGM/C compared with those who lived outside of these hotspots' areas. This may be due to differences in community setting characteristics such as ethnicity, religion, community perception to FGM/C, and this identification of clusters with high FGM/C practice can lead to targeted interventions(Geremew et al., 2020).

Another study called "Trends and Spatio-temporal variation of female genital mutilation among reproductive-age women in Ethiopia: a Spatio-temporal and multivariate decomposition analysis of Ethiopian demographic and health surveys (G. A. Tesema et al., 2020)" also corroborated some the findings done in other studies. The majority (89 percent) were study participants were rural residents. Nearly two-fifth (40 percent) and one fourth (25 percent) of the study participants listed their ethnicity as Oromo and Amhara. Nearly one-third (67 percent) of women's literacy rate was low, and almost half (50%) of the communities had low regular media exposure. The proportion of community in the poor wealth quantile was 75 percent (Geremew et al., 2020).

These studies had several strengths. First, the studies were primarily based on nationally representative large datasets (EDHS), and thus they have adequate statistical power. The EDHS done in 2016 is very comprehensive and can be a useful basis used in studies conducted on FGM/C interventions done in Ethiopia. However, the EDHS can conceal

regional variation. Underreporting can also be an issue regarding the EDHS. Ethiopia is a vast and diverse country with a large population prone to drought, food insecurity, civil unrest, political upheaval and ethnic conflicts. FGM/C can be affected by various societal factors that can lead to change in many behaviours. These nuanced measures are then challenging to assess even in the use of large-scale surveys with adequate statistical power. Ethiopia is additionally a nation that has the largest internally displaced population and a large pastoralist population. These movements perhaps influence prevalence rates and move one hotspot area to another area.

4.4 What do we know about the FGM/C interventions in Ethiopia and which ones can be considered effective?

There are several challenges with approaches undertaken by Ethiopian government agencies, INGOS, NGOs and CSOs related to FGM/C interventions. This section will present an overview some of the results reviews of interventions done in Ethiopia. A factor to consider in analysing the effectiveness on FGM/C interventions is that the research on this theme is currently lacking. Some research has also discovered the issue of data validity due to the case of families underreporting FGM/C in surveys and that the EDHS (2016) only cover women aging from 15-49. It is therefore challenging to assess whether or not some intervention strategies work better than others.

One of objective of this thesis was to explore the influence of FGM/C interventions on community deliberations related to FGM/C prevalence, social norms and practises in intervention areas. If these interventions can lead to the *internalization of knowledge* and thus create change. If so, does the change match the process outlined in the theory chapter. This section outlines the main findings related to FGM/C interventions focusing on actors and some of the achievements of implemented interventions(Mehari, Molla, Mamo, & Matanda, 2020). Another objective was to identify the key pioneers outlined in Roger's theory of Diffusion of Innovation.

A study entitled “Exploring changes in female genital mutilation/cutting: Shifting norms and practices among communities in Fafan and West Arsi zones, Ethiopia” (Mehari et al., 2020) (2020) revealed that the major actors in the specific study areas were government institutions and offices (e.g., Women Affairs Offices, health bureaus, healthcare institutions, and schools), women’s associations, local NGOs, and international organisations(Mehari et al., 2020). Religious organisers, community leaders, health extension workers, and educators were also among change agents. This study was conducted in two administrative zones located in Oromia and Somali regional states(Mehari et al., 2020). The two study sites exhibited varied socio-cultural and religious contexts. The conclusions made in this study were founded on the discoveries from the two study sites. The first objective of this study was to explore the influence of FGM/C interventions on community deliberations related to FGM/C norms and practises in the two study settings(Mehari et al., 2020).

This section outlines the main findings related to FGM/C interventions focusing on actors and some of the achievements of implemented interventions. Despite various actors in FGM/C prevention in Ethiopia, the government was the leading actor in implementing FGM/C programmes in the two study areas. This was because the 2009 CSO law barred local NGOs from implementing rights based programmes, leaving government agencies as the primary actors with the freedom to implement anti-FGM/C programmes(Mehari et al., 2020). The study concluded with programmes implementing FGM/C interventions experienced several challenges including: opposition to change, absence of sustainability of interventions, implementation delays in the form of trainings, coverage and shortage of funding, and constraints related to legal constraints.

The study done on the Fafan and West Arsi zone further uncovered that FGM/C prevention programme implementers used various approaches to inform community members and encourage them to abandon FGM/C. The main FGM/C intervention approaches were community conversation, legal intervention, religious-orientation and health-risks approaches. Study findings revealed that interventions implemented in the two study sites have had varied levels of influence on community values and deliberations related to FGM/C(Mehari et al., 2020).

FGM/C interventions have been implemented in both study communities by different actors. The first set of actors are government agencies including women's affairs offices, health bureaus, healthcare institutions, and schools(Mehari et al., 2020). Government actors have a greater level of freedom to implement anti-FGM/C programmes in Ethiopia due to the CSO law. International organisations were totally excluded from direct involvement in FGM/C intervention and their role was limited to providing government actors and local NGOs with technical and financial support leading up to the slow repeal of the CSO law.

In response to this restriction, local NGOs, NCA and SC crafted their programmes carefully, without explicitly mentioning FGM/C or hiding it under broader programmes like reproductive health and maternal health(Dupuy et al., 2015; Mehari et al., 2020). The legal restrictions constrained the prospective of local NGOs to expand their programmes, reach wider areas and communities, and accelerate the abandonment of the practise. The endorsement of the CSO law led to a significant reduction in the number of local NGOs implementing rights-based programmes. Nonetheless, it is important to note that the restrictions of the CSO law are becoming relaxed as the law is replaced by a new law, the Organization of Civil Societies Proclamation, endorsed in 2019.

The achievements of local NGOs were also constrained by other factors including a shortage of 32 funding, lack of sustainability/continuity of intervention activities, local resistance to change, and poor implementation capacity. The second objective of the study was to explore changes in FGM/C norms and practises. Changes in FGM/C-related norms and practises observed in the two study settings varied significantly(Mehari et al., 2020).

As compared to the Somali region study context, the situation in West Arsi was more dynamic and changing. Variations in West Arsi were not limited to an increasing awareness of health risks of FGM/C and the anti-FGM/C law. Community associates were involved in enacting bylaws and enforcing the anti-FGM/C law. Community values and norms related to marriageability, purity, and esteem, alleged advantages of FGM/C, were challenged in West Arsi. The study noted that changes in norms associated with FGM/C were followed by abandonment of the practice. Furthermore, changes in norms and practises were manifested in various ways, the number of girls abandoning FGM/C was increased, uncut girls were getting

married, social pressure on uncut girls and their parents was declining, and uncut girls were considered to be modern and educated(Mehari et al., 2020).

Despite these changes, there were some levels of resistance observed in West Arsi. Though the influence of parents in arranging FGM/C has been declining as a result of consent-based/love marriages, uncut girls were exposed to trials in their marital home mainly propagated by in-laws and people connected to their husband's clan. In some cases, mothers-in-law force uncut daughters-in-law to undergo the practice through exercise of their social authority. As Mackie and colleagues note in the social norms theory, FGM/C is seemingly an interdependent behaviour guided and sanctioned by social norms (Mehari et al., 2020).

The conditions in the Somali study setting were quite different from West Arsi. Shifts related to FGM/C were mainly limited to awareness of the health consequences of FGM/C. Significant alterations of FGM/C norms and practises were not observed. The association between FGM/C and marriageability, purity, virginity, and respect were still very present within the community. Uncut girls are considered "haram" (impure/unclean) and omitted from social duties. FGM/C is considered to be a method of cleansing girls. Community awareness of the health risks associated with FGM/C did not lead to abandonment of the tradition. Forsaking FGM/C encompassed a high social risk as sanctions against uncut girls/women including exclusion from social interactions and religious activities. Compared to previous discoveries, findings of this study displayed slight variations towards a hypothetically less severe type of FGM/C (the Sunna cut) predominantly in metropolitan areas. The study found that infibulation, locally known as "Gudinka Faronika", was generally still highly esteemed and extensively practised in the study community despite the FGM/C interventions(Mehari et al., 2020)

4.4.1 Framing the issue of FGM/C as health issue vs a human rights violation vs a health concern

The issue of rights-based community approaches and educational rights-based approaches to eradicating FGM/C present communities with a package of opportunities for learning. However, such interventions can sometimes be perceived by some communities as an unsolicited, invasive top-down approach(Williams-Breault, 2018). There is also the issue of

people within these intervention areas can be sceptical to the government's directives due the historically authoritarian rule. And if the Ethiopian government is the focal implementing actor within an intervention area, the individuals residing within that area might not oblige and follow the governments heed regarding FGM/C. It is also important to note, that healthcare-seeking behaviour rates are lower in rural areas compared to urban areas. Poorer households have been found to seek professional healthcare less often than wealthier households(Cebotari, Ramful, Elezaj, & Neubourg, 2020).

4.5 What could change in relation FGM/C abandonment potentially look like in Ethiopia?

FGM/C is a multifaceted, delicate public and private issue. The process of creating change through various methods have been in employed by several actors over several decades across the countries where the practice occurs. This section will go into key structural societal factors to consider in relation to FGM/C and also look into the decision-making process that family unit goes into in considering FGM/C. This section will also refer to studies done in Ethiopia in order to further explain what measures that could potentially lead to change. The theory section outlines the process of changing norms to the internalization of knowledge. Change of this scale is difficult to assess. However, some research can pinpoint some direction as what FGM/C might look like in the foreseeable future and for coming generations. In Ethiopia, the government has provided legislation as a means of creating lasting change. However, research has shown that criminalising FGM/C whilst restricting NGOs ability to work on human rights advocacy and lack of enforcement of the law does not in actuality lead to change. Launching the National Costed Roadmap and spearheading a national alliance comprised of key organisations can be a step in the right direction. However, issues regarding political and civil unrest can lead to complications in carrying out the policies.

According to UNICEF, changes in attitudes towards FGM/C in Ethiopia have seen improvements over the years. Only 17 percent of adolescent girls in 2016 shared the opinion that FGM/C ought to be continued or were unsure about it compared to 65 percent in 2000. An even lower percentage of adolescent boys (13 per cent) supported the practice of FGM/C

or were unsure about it in 2016. Across regions, Amhara, SNNPR, and Benishangul-Gumuz achieved the greatest progress in changing attitudes towards FGM/C, while in Somali and Afar more than half of adolescents in 2016 thought that the practice should be continued(Cebotari et al., 2020). Stances and opinions have also changed significantly amid adolescents in rural areas of Ethiopia. Evidence of attitudes towards FGM/C across wealth quintiles presents that poorer individuals were commonly more in favour of the practice of FGM/C(Cebotari et al., 2020).

Regarding FGM/C as primarily a maternal health and sexual reproductive health issue and not as violation of women's rights and children's rights can limit the effectiveness of certain FGM/C intervention. The role of women and children within the decision-making process and also considering the role of women as a whole in Ethiopian society. Consent is also an important factor to consider in relation to FGM/C(Andarge, 2014).

The article "Unprogrammed abandonment of female genital mutilation/cutting"(Engelsma et al., 2020) outlines important factors to consider in measuring change related to FGM/C(Engelsma et al., 2020). This paper draws notice to the process of *unprogrammed* FGM/C abandonment, that can be defined as a decline in FGM/C participation that occurred prior to the widespread introduction of enormous, programme efforts by NGOs, donor states, and the international community(Engelsma et al., 2020).

While the process of FGM/C abandonment is complex and often context-specific, the analysis made in the paper offers some verification that declines of FGM/C at the national level have in many cases occurred prior to continued intervention by governments, NGOs, and other external actors. This study stresses the significance of reviewing mechanisms that motivate shifts away from long-held traditions even in the absence of significant governmental or external pressure(Engelsma et al., 2020).

The study's objective was to explore several macro-level country characteristics in relation FGM/C prevalence. These macro level characteristics were female economic development,

modernization, female education levels (gender equality), autocracy, regime durability, political stability, civil conflict and whether FGM/C was outlawed(Engelsma et al., 2020). This analysis the study provided suggested that the issues concerning justifying FGM/C are multifaceted and context-specific, with few strong relationships that can be generalized across countries. However, the study's evidence highlights several patterns that merit further investigation. In the case of Ethiopia, uncovering what macro level characteristics influence FGM/C prevalence rates could potentially lead to more successful and effective interventions(Engelsma et al., 2020). The study failed to detect a significant relationship between FGM/C prevalence and civil conflict.
While civil conflict may introduce social upheaval, it does not seem to be strongly associated with FGM/C prevalence. The article goes onto say that the results do suggest a probable relationship between political steadiness and FGM/C, however. More robust political regimes, whether they are authoritarian or democratic, are linked to lower levels of cutting (Engelsma et al., 2020).

The study does not however take into consideration conflict related to internally displaced refugees. Though there is research lacking one can speculate that issue of different groupings moving from one area to another might influence geographical variation in the Ethiopian regional prevalence rate (Engelsma et al., 2020). Lastly, the study's results indicate that places where FGM/C is criminally banned are associated with lesser rates of FGM/C prevalence. Ethiopia banned and criminalised FGM/C in 2005 in addition to banning the medicalization of FGM/C.

In visiting Ankober a woman we interviewed on the street mentioned that the law was a big motivation in not performing FGM/C on two of her three daughters. While this is perhaps encouraging material for those who seek to bring about a termination to FGM/C, the paper goes on to caution and claim that cannot say with any certainty why outlawing FGM/C is associated with decline.

The results may, for example, result from an amplified trepidation in relation to legal sanctions, the range of information campaigns concerning the prohibition of FGM/C, or shifting social anticipations around the practice's future. In the case of Ethiopia, execution of

the law has been absent. Alternatively, the Ethiopian government may be most likely to pass laws banning the practice in places where FGM/C is already on track to decline. Regardless, the relationship between FGM/C legality and its prevalence merits vaster scholarly attentiveness, and the data this study stipulated can be a basis for additional research(Engelsma et al., 2020).

Change does not only occur on structural level, but it occurs on an individual scale as well**.** The study on *unprogrammed abandonment* focused on macro-factors associated with changes in FGM/C prevalence, it is vital to consider different *meso-level* factors, at the level of ethnicity, religious background, or subnational community, may be associated with changes in FGM/C prevalence. This unites several other works discussing the explanatory power of individual level measures in explaining the persistence of FGM/C. Such as community led approaches tied to either public statements or community gatherings with several key people within a local context discussing FGM/C.

FGM**/C** interventions**,** presented in the theory section, by Johansen, Diop, Laverack, and Leye found that the seven most common approaches were health risk education approaches, conversion of circumcisers, raining of health-care professionals as agents of change, the creation of alternative rituals, community-led approaches, public statements, and legal method(Cappa, Thomson, & Murray, 2020; Johansen et al., 2013). Other approaches also feature advocacy and coordinated cooperation with governments. The authors found that the interventions that had the greatest successes were those that used several methods in conjunction with one another. They contend that the local context and source of decision-making power must be considered for an intervention to be successful(Cappa et al., 2020)**.**

In looking into *meso-level* factors the article "Decision-Making Process in Female Genital Mutilation: A Systematic Review" (2020) explores the family unit how decisions are being made within a smaller context(Alradie-Mohamed et al., 2020). The article claims that individual or collective decision-making is a process that goes through different stages, occurring over time rather than an instant act. The objective of the article was to examine the FGM/C households' decision-making progression and to pinpoint the core decision-makers in the household(Alradie-Mohamed et al., 2020). Another way to capture the social dynamics of the abandonment of this practice is to examine the opinions of women (and men) who express

support for its continuation. Some studies examined the time-shift in the FGM/C *Decision Making Process* and showcased the shift in the decision-making from "when" to circumcise to "whether" to circumcise, taking the power of decision-making from the community and handing it to the family. In the case of Ethiopia, the age of the cut and how the cut was performed varies from region to region.

According to a study on the Somali and Harari society of Eastern Ethiopia, mothers are the decision-makers in relation to FGM/C and play a major role in the practice. The mothers desire to circumcise their daughters to optimize their future prospects due to their own fear of violating the tradition(Asresash Demissie Abathun, Sundby, & Gele, 2016; Asresash D. Abathun et al., 2018). A more recent study in the same area confirmed their previous findings, where the majority of the sample cited their mothers as the decision-makers for their circumcision, followed by their grandmother, while a small percentage claimed that their fathers were the decision-makers(Asresash D. Abathun et al., 2018). In Jigjiga Town, Ethiopia, researchers found that the mother was the primary decision maker in 67% of FGM cases, with the decision being made jointly between parents 24 percent of the time(Hussein, Adem, & Mohammed, 2013).

On the other hand, research in Bale Zone, Ethiopia, discovered that most of the partakers in the study recognized both parents as the decision-makers; however, they rarely identified the father as the only decision-maker(Bogale, Markos, & Kaso, 2014). Although it might be the mother who introduces the practice, it is the father that facilitates the action of the practice beforehand (Shay, Haidar, & Kogi-Makau, 2010). Another study on FGM/C in Addis Ababa, found that almost a quarter of the sample cited only fathers as decision-makers, while one-third of the sample claimed only mothers and the rest of the decisions were made by either parents or relatives(Alradie-Mohamed et al., 2020). These studies, in comparison to the studies mentioned prior, were done on specific regions in Ethiopia and could indicate to a wider pattern across the country, however these studies were done prior to the EDHS 2016. Another study done on a community in Afar uncovered that both parents in Afar generally have the decision-making power about whether their daughter undergoes FGM/C; particularly the father and male relatives. It is practised at an early age before celebrating the first anniversary of the child(Dessalegn et al., 2020).

5. Summary of findings/overall concluding thoughts on findings and discussion

In summary, FGM/C is a complex subject matter. In Ethiopia, FGM/C interventions are implemented by various actors in cooperation and conjunction with one another in Ethiopia. Interventions are usually integrated with other projects and include various activities. The interventions that prove to be most successful are the interventions that utilise local community power structures. However, research is limited. The findings revealed that it is important to consider FGM/C as both a public health concern and a violation of human rights. In conveying the health risk concerning, one can drive the practice underground or cause an upsurge in "milder" forms of FGM/C.

Communicating the message of human rights and FGM/C needs to be in union with influential people within the intended community where FGM/C prevalence is high. In Ethiopia, it is important to consider the age of when the cut is performed. The age varies from region to region. Education is an important feature in relation to FGM/C. However, some educational approaches can feel invasive. The Ethiopian government has both made strides in terms of creating a political framework where FGM/C is outlawed. However, there is a lack of thorough evaluation, implementation and enforcement of the law especially in hard to reach rural areas.

Identifying key factors like unprogrammed macro-level structures and meso-level factors like how decision-making processes within households look like can help improve FGM/C interventions in Ethiopia. It is also vital to consider the regional differences, like age of the cut, in the practice of FGM/C and the different justifications that can vary from region to region to facilitate a more effective intervention design. Considering the differences and the particular ethnic and cultural traditions and beliefs that underpin FGM/C in the region, it is important to tailor the initiatives and strategies accordingly. Strategies should be adapted to

the FGM/C dynamics per region and per community. For instance, where girls are subjected to FGM in their early age (1 to 2 years) the alternative rite of passage (ARP) wouldn't perhaps be appropriate response. Parents, especially mothers or caregivers should be better targeted for interventions. Where adolescents and young girls are mostly subjected to FGM/C beyond that ages, the ARP and girl's empowerment are strategies to be considered. Another factor to consider is where the medicalization of FGM/C is on the rise, specific interventions should target health care providers(UNFPA, 2019a).

6. Critique and limitations of the thesis

It is challenging to present a cohesive and comprehensive understanding of FGM/C in Ethiopia. The issue of FGM/C is nuanced and delicate in nature. This thesis employed a wide variety of secondary literature on interventions in Ethiopia and attempted to use recent studies done on national prevalence rates. On the basis of the fieldwork conducted, I could assess that there were some similarities in how various actors set up and implemented their FGM/C interventions. On the basis of that notion, the best overall report on interventions in Ethiopia was conducted in 2013. The 2019 CMI report also provides a brief overview of interventions in Ethiopia, but only the interventions funded by the Norwegian government.

It was also an issue in finding recent sources to describe the nature of NCA and SC Joint Programme to fully explain the nature of their interventions. In the 2016 EDHS, Ethiopian women were asked how often they read a newspaper, listened to the radio, or watched television. Those who responded at least once a week are considered to be regularly exposed to that form of media exposure. This thesis uncovered that decision making is informed by the ability to process information and internalize key knowledge. NCA and SC said in their reports that the Joint Programme employed radio programmes, print media and other media outlets. It was however challenging to apprehend what these media campaigns entailed and how communities were reached through these media campaign, especially in rural areas where pastoralist reside. In retrospect, I would have liked to ask key informants on their

media strategies and the results from these campaigns. Ethiopia is a very interesting case with regards to media given that most media outlets available are strictly regulated by the Ethiopian government.

The EDHS data available are cross-sectional and not optimal for capturing changes that occur over time. EDHS cross-sectional samples does offer insights into generic changes in the patterns of the empowerment of women and girls over time, but not into the perseverance of these dimensions amongst individuals(Elezaj, Ramful, Cebotari, & Neubourg, 2019).Time constriction during the fieldwork in Ethiopia caused a lack of overall overview of the various activities within intervention areas.

7. Conclusion

This thesis aimed to answer the research question:
"What is the current situation of FGM/C in Ethiopia and what roles doing the Ethiopian government and the NGOs/INGOs play in FGM/C prevention?" In order to answer the main research question, this thesis was guided by the following research questions:

1) What role has the Ethiopian government played in FGM/C prevention so far and what are the potential issues that can arise from the current government FGM/C policy framework?
2) What does Norwegian Church Aid (NCA) and Save the Children's (SCI) Joint Programme on FGM/C (and other NGO programmes) do to reduce the prevalence of FGM/C in Ethiopia?
3) What do we know about the FGM/C prevalence in Ethiopia, and how the numbers are changing?
4) What do we know about the FGM/C interventions in Ethiopia and which ones can be considered effective?
5) What could change in relation to FGM/C in Ethiopia potentially look like?

FGM/C refers to all procedures that comprise the partial or total removal of the external female genitalia, and other harm inflicted on the female genital organs for reasons that are not medical(WHO, 2019).WHO classifies FGM/C into four major types:

- Type I (clitoridectomy)
- Type II (excision)
- Type III (infibulation)
- Type IV includes all other harmful procedures to the female genitalia for non-medical purpose.

These types cause harm. However, the injury correlates to the amount of tissue removed.

The prevalence of FGM/C varies within Ethiopia. The EDHS done in 2016 showcased the national and regional prevalence rate, however further studies uncovered that FGM/C is spatially clustered in so-called hot spot areas. In understanding the context specific justifications for the practice within the hotspot FGM/C prevalent areas interventions done by the Ethiopian government or NGOs can be more effective. In the case of Ethiopia, the government has provided a policy framework to promote total abandonment of FGM/C, however the 2009 CSO limited and restricted various NGOs ability to work with FGM/C as a human rights violation and not simply an issue of health. This thesis stresses the importance of understanding FGM/C as a human rights related issue.
Despite the current data output done by various researchers, there is still lack data and therefore accurate knowledge of some dimensions of FGM/C and the effectiveness of FGM/C interventions, be it medical data or information about the associated dynamics of social change.

Ethiopia is a vast country with a history of foreign NGO presence, despite their "underdeveloped" civil society(Yeshanew, 2012). Each intervention area has their own set of unique characteristics given the fact that Ethiopia is very ethnically diverse. These ethnic differences rage from differing customs to different languages spoken. Ethiopia is one of the poorest and most donor-dependent countries in Sub-Saharan Africa, which has experienced decades of civil conflict, poverty and famine, compounded by a history of authoritarian rule dating back to imperial times(Camfield & Tafere, 2011).

Research featured mentioned the limitations and biases of self-reported data in relation to understanding FGM/C prevalence. Several recent reviews and studies have confirmed and deepened the understanding of the importance of working through communities, with a broad-based target, long-term investment and a focus on human rights as understood in the local context, to support collective change and public declarations that support the change of local norms. To strengthen this process, Ethiopian government political and legal support is crucial for NGOs and other key actors, as is the education of and support to health-care services so they can supply the change in their communities. Cooperation can further promote communities' refraining from performing FGM/C, as well as providing care for those who suffer negative health outcomes from FGM/C. Further research is, however, still needed to understand the changing and complex nature of FGM/C. Communities vary in the extent to which interventions succeed in change, and an even deeper understanding of motivations and processes of decision-making in more communities is needed(WHO, 2019). There are also large areas of research on health care, health effects, including psychological and social consequences of FGM/C, that need further studies to improve the quality of care and effectiveness of preventive efforts in a wide variety of contexts.

On the basis of the concluding remarks, this thesis sheds light on key areas for future investments that would ensure that FGM/C policies and programmes are informed by rigorous research-based evidence that is effective and trustworthy. These recommendations can be divided into to two categories:

- Government policy and programme/interventions
- Future directions in research

In terms of improving Ethiopian government policy, this thesis suggest that the Ethiopian government ensure the enforcement of the FGM/C laws that exist. Rectifying the strict 2009 CSO law and allowing civil society organisations and other organisations to engage in advocacy is a step in the right direction. Researchers have mentioned the challenging issue of an authoritarian regime acting in areas where the government has little to no legitimacy(M. T. Østebø & Østebø, 2014; T. Østebø, 2018). Therefore, collaboration with local leadership and power structures that exist within the communities are key for effective FGM/C interventions.

Given that the practice of FGM/C is changing in nature, this thesis suggest research into further "Cross-border FGM" and medicalization of FGM/C and the impact of emergency situations on FGM/C. The reason this thesis suggest further research on emergency situations in relation to FGM/C is due to the fact that Ethiopia is prone to draught, famine and civil unrest. The repercussions of emergency situations such as wars, natural disasters and related situations of crisis, are intrinsically gendered(Ryan, Glennie, Robertson, & Wilson, 2014). These factors can affect the rollout and implementation of FGM/C intervention. In light of COVID-19, it is also important to note that FGM/C can a becomes a secondary concern in the eyes of the international community in times of crisis.

As I conclude this thesis, I would also mention that though the primary data was collected prior to the severe outbreak of the global pandemic CIVID-19 and how it affects women and girls at risk of FGM/C, it feels important to mention that the 27th of April UNFPA released a State of World Population 2020 report titled "Impact of the COVID-19 Pandemic on Family Planning and Ending Gender-based Violence, Female Genital Mutilation and Child Marriage". The report stated that COVID-19 could have far-reaching impacts on the effort to end FGM/C. Specifically, when health systems are overcome and people abstain from calling on health facilities owing to movement restrictions or fears of exposure to illness, both direct mortality and indirect mortality from preventable and treatable conditions increase(Bellizzi, Nivoli, Lorettu, & Ronzoni, 2020).
Due to COVID-19 disruptions, UNFPA anticipate a 1/3 reduction in the improvement towards ending FGM/C by 2030. Due to pandemic-related disruptions in prevention programmes, UNFPA also estimate that 2 million FGM/C cases could ensue globally over the next decade that would otherwise have been deterred. The situation as it stands today changes day to day as the COVID-19 pandemic could most likely postpone the deployment and rollout of programmes to eliminate FGM/C. Social distancing precludes some of the most effective prevention programming such as community empowerment programmes and public abandonment proclamations, which are typically applied in group settings. It is additionally possible that economic uncertainty and school closures could cause an uptick in the incidence of FGM/C, although this requires further investigation(UNFPA, 2020).

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Appendices

Appendix 1: Informed consent form

1. Consent form

I have received and understood information about the project *Understanding FGM/C in Ethiopia through looking at FGM/C interventions done by INGOs/NGOs and Ethiopian government policy* and have been given the opportunity to ask questions.

I give consent:

¨☐ to participate in a semi structural individual and/or group interview. ¨☐ to participate in being observed by the researcher.

I give consent for my personal data to be processed until the end date of the project, approx. *5th of August 2020.*

(Signed by participant, date)

Appendix 2 – Overview of informants

Overview of informants				
Interviews done in Ethiopia:			9	
Interviews done in Kenya:			1	

Interviews done in Norway:			2	
NCA staff:				
Ethiopia		3		
Kenya		1		
Norway		1		
SCI staff		3		
Other		4		
GAGE Pathfinder Population Council WHO NKVTS				

Appendix 3: Interview guide for NCA staff

1. What kind of activities does the project include?
2. What is the role of project partners?
3. How do you measure FGM prevalence? (Data Sources)
4. What have been the changes in the project area?
5. In your opinion, what has caused these changes? (Other causes)
6. In your opinion, what future strategies should be employed to further reduce FGM?
7. Can you explain the relationship between prevalence and praxis of FGM/C?
8. The issues concerning data collection?

Appendix 4: Interview guide for NCA partner staff

1. What is your role in the project?
2. How is the situation with FGM in this area? Have there been any changes of the project period?
3. How do you measure prevalence and changes in prevalence?
4. Do you believe these changes are due to the project and/other factors?

Appendix 5: Approval from NSD

Based on an agreement with *OsloMet – Metropolitan University*, NSD – The Norwegian Centre for Research Data AS has assessed that the processing of personal data in this project is in accordance with data protection legislation.

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