

Addis Ababa University
School of Graduate Studies

The Social Dimension of Female Genital Cutting (FGC): The Case of Harari

By
Mandy Lindner

July 2008
Addis Ababa

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College of Social Sciences
Department of Sociology and Social Anthropology**

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A thesis submitted to the Graduate School of Addis Ababa University
in partial fulfilment of the requirements for the degree of Master of
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Approved by the Examining Board

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Dedicated to my Fiancé
As well as my Family in Germany

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AU	African Union
B.A.	Bachelor of Arts
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
DHS	Demographic and Health Survey
EGLDAM	Ye Ethiopia Goji Limadawi Dirgitosch Aswogaj Mahiber
EWLA	Ethiopian Women's Lawyers Association
FDRE	Federal Democratic Republic of Ethiopia
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GTZ	German Agency for Technical Cooperation
HTP	Harmful Traditional Practices
HIV	Human Immunodeficiency Virus
IAC	Inter-African Committee on Traditional Practices Affecting the Health of Women and Children
ICPD	International Conference on Population and Development
IEC	Information, Education, Communication
M.A.	Master of Arts
MDG	Millennium Development Goal
NCTPE	National Committee on Traditional Practices of Ethiopia
NGO	Non-Governmental Organization
SNNPR	Southern Nations, Nationalities and Peoples Region
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Fund
UNIFEM	United Nations Development Fund for Women
WAO	Women's Affairs Office
WHO	World Health Organization

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GLOSSARY

Am= Amharic
Ar= Arabic
Ha= Harari

- Afotcha** (Ha) social association concerned with weddings and funerals; for married persons only
- Arab absume** (Ha) “circumcision of the Arabs”- referring to *sunna* (clitoridectomy)
- Aw Abadir Gey** (Ha) “the city of Father Abadir”
- Bertcha** (Ha) social gathering in one person’s house while chewing *khat*; normally in the afternoon
- Deira** (Ha) room belonging to the *gidir gar*, which serves as storage for household goods and food items
- Ekub** (Am) social association among friends, colleagues or merchants; monthly contribution of small amount of money that is used to fulfil the demands of its members
- Fanish** (Ha) food prepared from sorghum
- Gailatch** (Ha) group of 5-10 children of one neighbourhood; for girls only
- Gar beri** (Ha) “door of the house”; entrance door of every Harari house
- Gey** (Ha) “city”, referring to Harar
- Gey absume** (Ha) “circumcision of the city”- referring to infibulation
- Gey ada** (Ha) “culture of the city”, the Harari culture
- Gey gar** (Ha) “house of the city”; traditional Harari house
- Gey genafi** (Ha) “trousers of the city”- very tight female Harari trouser
- Gey iraz** (Ha) “garments of the city”- traditional female clothes
- Gey sinan** (Ha) “language of the city”, Harari language
- Gey usu** (Ha) “people of the city”
- Gidir gar** (Ha) “big house”- referring to the big room/living room of every Harari house
- Hamat Mot** (Ha) special basket which is expected to be prepared by the wife for her mother-in-law as symbol of respect and thankfulness
- Hashama** (Ha) female Harari scarf that is worn in a particular way
- Hashi un** (Ha) sand stone which was used to construct the Harari houses and the wall that is surrounding the old town
- Idir** (Am) social association that is offering financial and moral support in case of death of one of the members
- Injera** (Am) pancake-like stable food of Ethiopians, especially Amharas; made of *tef*, indigenous grain
- Jema’a** (Ha) group of 5-10 children of one neighbourhood; for boys only
- Kabat** (Ha) compartment that is inside the wall of Harari living rooms
- Karabi** (Ha) incense, like ash; was used to fasten the healing process of the wound after female circumcision took place

Khat (Ha)	narcotic; leaves of the <i>khat</i> bush are mainly chew by male Muslim population of Yemen, Somalia and also Ethiopia; normally reserved for weekends, weddings or funerals, nowadays used almost every day
Khol	derived probably from the word “coal” and was used in the past to fasten the healing process of the wound after female circumcision took place; today used in the cosmetics industry
Kirtat (Ha)	room belonging to the <i>gidir gar</i> which serves as additional bed room today
Kollo (Am)	roasted grain, eaten as a snack
Madinat-al Aouliya (Ar)	“City of Saints”- referring to Harar
Nadabas (Ha)	five stages in every Harari living room that are differing in size and level and attributed to particular people who can be distinguished according to their rank, knowledge and social status
Quti qala (Ha)	upstairs room in Harari houses
Shalda	special knife which was used to circumcise girls
Sunna (Ar)	“tradition”; “preferable but not mandatory” - referring to clitoridectomy
Tai iraz (Ha)	female Harari dress
Tan (Ha)	incense, like ash; was used to fasten the healing process of the wound after female circumcision took place
Taqets (Ha)	niches which are carved into the walls of Harari living rooms
Tuftuf (Ha)	Harari word for “wheat” which is used to prepare <i>ukhat</i>
Ukhat (Ha)	Harari word to describe the pancake which is also known in Ethiopia as <i>injera</i> (Am)

ABSTRACT

This study is concerned with female genital cutting (FGC) which describes all procedures that are related to cutting the female genitalia because of non-therapeutic reasons. Four types of FGC can be distinguished, of which “sunna”, the removal of the clitoris, is the “lightest” one, whereas in the case of infibulation most of the female genitals are removed and the left-over sewn closed afterwards.

FGC is mainly practiced in 28 African countries, but also appearing in Europe, North-America and Australia due to migration. An estimated 140 million girls and women are expected to have undergone one of the 4 types of FGC worldwide. About 3 million girls are at risk to experience female circumcision every year. The practice of FGC is a threat to humans’ and hence women’s rights and furthermore one expression of continued gender inequality and the superiority of men. It is practiced for decades and even many centuries, is a cross-cultural as well as cross-religious issue.

Harar is of main interest within this study paper, because of its high prevalence of the most severe type of FGC, infibulation. In Ethiopian context, it is the fourth highest prevalence rate and occurrence of FGC in general is widely spread. What did it make being practiced so frequently, which sources are cited to justify its continuance?

For generating answers on these questions, a survey has been conducted among 177 women and men. Since the survey only works as supplement, the data collection concentrated on qualitative sources like in-depth interviews, focus group discussions (FGD) and observation. Women who underwent female circumcision, but also men have been interviewed to get to know the underlying reasons to practice and maintain FGC, the most common complications which resulted from the practice and the attitudes regarding its continuance.

The outcome of the study shows that the majority of the Hararis are nowadays aware about the complications of FGC which is owed to a common effort of community and religious leaders and government offices to enlighten the people, to create awareness.

The major reasons for the practice have been the reduction of females’ sexual feelings and enjoyments and the fear of offspring out of wedlock. Although infibulation and its side effects on women’s health are known and hence a shift to “sunna” was advocated, especially elderly women are still supporting at least this kind of FGC. In contrary, the young generation is no longer willing to accept a practice which brought so much harm on the affected girls and women solely because they have natural feelings. Hence, since FGC is also not obligatory by Islam as many young people know, they have been sure not to practice female circumcision on their daughters in the future.

CHAPTER I

1. Introduction

Female genital mutilation (in short FGM), also described as female circumcision or female genital cutting (FGC), “comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female organs whether for cultural or other non-therapeutic reasons” (WHO, 1997:3). The term female *circumcision*, which was especially used in the past decades, is misleading in the sense that it draws attention to the male circumcision where the removal of the penis foreskin creates none of the negative long-term effects and consequences which can be assigned to female circumcision. Due to its cruelty and irreversible damage to the females’ health condition and to distinguish clearly between male and female circumcision the term female genital *mutilation* emerged but is nowadays replaced more and more by female genital *cutting* to avoid prejudice and pre-judgement against the initiators (most of the times family members as mothers, grandmothers or aunts) and practitioners whose original intention is in no way to “mutilate” their daughters, granddaughters, neighbours and so forth. However, in recent documents the term female genital mutilation/cutting (FGM/C) is frequently used to “capture the significance of the term “mutilation” at the policy level and, at the same time, in recognition of the importance of employing non-judgemental terminology” (UNICEF, 2005c: 2). Since this research tends to be an anthropological study first place and non-judgemental terms are of huge importance, I decided to use *female genital cutting (FGC)* in my paper.

The World Health Organization (WHO) in its latest joint statement together with other UN bodies classifies FGC into four categories:

Box 1: FGC Classification

Type I:	Partial or total removal of the clitoris and/or the prepuce (called “clitoridectomy” or “sunna”, the Arabic word for “tradition”).
Type II:	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
Type III:	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris - often referred to as “infibulation” or “pharaonic circumcision”.
Type IV:	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. In Ethiopia this type is known as “Mariam Girz”.

Source: WHO, 2008: 4

It is estimated that between 100 and 140 million girls and women worldwide have undergone any form of FGC and that about three million girls are at risk to experience the procedure every year (WHO, 2001: 2; WHO, 2008: 4). About 91.5 million girls and women above nine years old in Africa are currently living with the consequences of FGC (Yoder and Khan, 2007 cited in WHO, 2008: 4).

Most prevalent is FGC in 28 African countries, furthermore practiced in Asia, the Middle East and nowadays also known among migrant communities in European countries like France, the United Kingdom, The Netherlands and Germany, but also the United States of America, Canada or Australia. In Africa, almost half of all girls and women undergoing FGC every year are living either in Egypt or in Ethiopia (UNICEF, 2005c: 3-4). According to the *Ethiopian Demographic and Health Survey 2005* the Ethiopian prevalence rate is estimated to be about 74 per cent and therefore one of the highest worldwide. All types of FGC can be found in Ethiopia. In the regions of Affar, Somali, Dire Dawa and Harari the most severe form of FGC, type III, is practiced, and the prevalence rate in general is the highest (Ethiopian DHS, 2005: 253).

Harar, a town in eastern Ethiopia, will be the study area of this research, firstly because of its high FGC prevalence secondly because of the presence of the most severe form of genital cutting, which has in Harar the fourth highest prevalence rate of the country (after Somali, Affar and Dire Dawa) (ibid.).

This paper has four main chapters, starting from a general introduction into the topic, the objectives and methodology of the study. Chapter two will deal with the reviewed literature regarding FGC. The next part is concerned predominantly with Harar, the study site of interest, its people, their culture and other relevant topics falling into this category. The most important chapter number four will present all I found out by conducting a survey, by holding interviews and focus group discussions, and by observation. These results will lead to the final conclusion and round off by recommending further steps with regard to the practice of FGC in the future.

1.1 Statement of the Problem

FGC is a threat to human and women's rights and a violent symbol of oppression (see Mangold-Wegner, 1999: 63) and should, therefore, be prohibited and abolished. FGC takes women's opportunity for a carefree and self-determinate sexuality as well as a life without pain. FGC abuses the right for physical inviolability but is still deeply rooted in different cultures, is accepted and widely spread all over the African continent and beyond. Men

participate in its spread, but the practitioners and driving forces are almost without exception women. Reasons to continue this traditional practice are the fear of not being accepted, not being married by men and therefore also not integrated into the community. Studies from West African countries like Senegal or The Gambia show how powerful communities and extended families can be. It was found out, that uncircumcised women who lived together with their co-wives or in-laws were called *solema* which is a powerful insult, not only meaning “uncircumcised” but also “rude, ignorant, immature, uncivilised and unclean” (Shell-Duncan, 2006: 63). In addition, these uncircumcised women were forced to eat their food alone and prohibited to join their own daughters’ initiation. As a result of such social pressure not seldom women, who would normally not be cut, are “voluntarily” joining this traditional practice.

All forms of FGC are causing irreversible damage to the girl’s or woman’s health. The consequences are ranging from immediate to late complications. The most severe form of FGC, infibulation or pharaonic circumcision, as it was practiced in Harar some years ago almost universally, may cause complications like shock, trauma, infections (also risk for HIV/AIDS-infection due to use of unclean and used razors, knives etc.), excesses, excessive urine and menstrual build-up, painful intercourse, obstetric problems and so many more (see Baron, 2006: 343).

Despite the knowledge that FGC acts as a gender-based human rights violation which aims to control women’s sexuality and autonomy (see UNFPA, 2007: 12) and national campaigns to eradicate FGC, it is still prevalent and an end is not yet in sight. The main problem seems to be the repression through legislation which is counterproductive and leads to practicing FGC in secrecy (Magoha, 2000: 271) which vice versa creates perils for the affected girls and women. In countries with governmental prohibition women are afraid to consult medical staff in times of health complication related to FGC for they fear to be arrested or otherwise punished. Therefore it is important to create change which comes from inside, which is “internalized and owned by the community” (Toubia, 2003: 252).

1.2 Objectives of the Study

1.2.1 General Objective

The overall objective of this study is to search for underlying reasons to practice female circumcision, to look for the impacts FGC has on the lives of the affected girls and women in Harar as well as to document their attitude towards this practice.

1.2.2 Specific Objectives

The specific objectives of this study are the following.

- To find out what the reasons, for example religious or ethnic, are to practice and continue FGC despite growing information campaigns.
- To get to know the physiological, psychological and other consequences which are resulting from practicing FGC.
- To investigate in how far the Harari community/society is willing to abolish FGC.

1.3 Methods of Data Collection and Field Experiences

1.3.1 Primary Data Sources

Qualitative and quantitative research methods were used to collect relevant data for this study. Qualitative primary data sources were interviews, case studies, focus group discussion (FGD) and observation, whereas the quantitative source consisted of a survey which predominantly functioned as supplement with regard to qualitative findings. While the application of every means of data collection method made me experiencing challenges, obstacles and the like, my own experiences during field work are also mentioned in this section.

1.3.1.1 Interviews

My first stay in Harar lasted about two weeks from the end of January until the beginning of February 2008. Before heading there, I tried to get information about possible contacts in Harar since I had never been there before and was a bit afraid of failing to contact the “right” people. Fortunately I met Ato Abebe Kebede from *Ye Ethiopia Goji Limadawi Dirgitosch Aswogaj Mahiber* (EGLDAM) (former known as *National Committee on Traditional Practices of Ethiopia* (NCTPE) already in November 2007 and in January 2008 again, about one week before I left. Ato Abebe, very friendly and helpful, gave me some mobile numbers of people which he thought would guide me or contribute useful information regarding FGC in Harar. Furthermore, he did tell me some general things about the city and sights worth visiting.

But before I went by minibus from Dire Dawa to Harar, I met a lady, W/o Etenesh Kassa, working for the Ethiopian Women Lawyers Association (EWLA) branch in Dire Dawa. I contacted her already when I was still in Addis Ababa and informed her about my plan to visit her and ask some questions regarding their [EWLA’s] efforts in combating FGC. Actually the main problem was the language barrier since her English was lacking and my Amharic was in turn not good enough to ask more detailed questions. However, the main outcome of this

interview was the fact that there is a wide gap between well sounding theory and a much different reality:

The Penal Code of the Federal Democratic Republic of Ethiopia (FDRE) prohibits any form of FGC. If any case of FGC is reported to EWLA or W/o Etenesh finds out otherwise, she contacts the police aiming to imprison the circumciser. This accusation of the circumciser does, according to her, only work in the city of Dire Dawa, but not in the countryside. Though awareness raising campaigns were initiated the practice is still deeply rooted. Too deep for blaming the own culture or preferring to be outcaste instead of continuing something which generations before also practiced. However, being aware of the prohibition by law, the circumcisions are nowadays practiced rather in secrecy and it is difficult to access where and when it is done. That not even the accusation of circumcisers in town is working as it should is shown by the data from the reported cases in the past year, 2007. Only *one* case was reported to the police, which means only one circumciser will be (maybe) sentenced to prison. So far, there was not yet any single court judgment in this regard and everything is still under process. So, this shows that a law by its own does not make much difference at all. People always find ways in circumventing the official legislation.

However, after I arrived in Harar I instantly got in touch with people and conducting interviews was not any problem. During my first stay I mainly joined the staff of the Women's Affairs Office (WAO). They were very eager in assisting me since they were also interested in the outcome of my research. The WAO was in the past and still is nowadays very active in the fight against FGC. I interviewed the former head of WAO, W/o Shukria, as well as the present head, W/o Hafiza Bedri. Furthermore, W/o Amira Ali, an expert in the field of FGC and also working for WAO, was willing to answer some questions. Besides information which was directly related to FGC in Harar, I also interviewed one kebele official, who gave me more information about the kebele administration of Jegol, the study site of my interest.

During my second stay from mid to end of March 2008, I decided to interview six female secondary school students separately. I asked them especially about their own opinion about FGC and which experiences they made with it. One girl out of the six interviewed, had been circumcised and even undergone infibulation. However, since the selection was randomly, all girls have been either Oromo or Amhara, one has been Tigray.

My impression in the case of all interviews was that the girls and women did not bother to talk about this issue which can be attributed to the high prevalence this topic has in media and in public nowadays.

I used my third and last stay, which took about two months starting from end of April until the end of June 2008, to interview more Harari women and men as well as elders. Two elderly women aged 70 as well as one lady at the age of 35 years I interviewed at one day. All have been very patient with regard to my questions. Nevertheless, I could not ask anything detailed about circumcision related to sexuality or problems which might occur during sexual intercourse and delivery. I was told by my key informant, that such topics could not be discussed with women of this age group. This would be considered as taboo and so the answers remained very general. The eldest of the interviewed men, aged 56 years, was consulted by me in his home. He was not only willing to answer my questions, but also spoke openly about problems occurring during sexual intercourse which could be attributed to the infibulation of his wife. My interpreter and I conducted five more in-depth interviews on another day. The age of these interviewees was ranging from 21 up to 38 years. All these informants knew me in advance, were informed about my intention to ask them questions about FGC and therefore also had no inhibition to talk about this intimate topic.

Semi-structured interviews, as one of the most important qualitative research methods, were mainly held with different representatives and programme coordinators of local NGOs, bureaus and government authorities in order to get information about the history, the current situation of FGC in Harar and latest strategies to approach the affected girls and women as well as communities which are practicing it. Many casual interviews/unstructured interviews or rather conversations I hold with friends and people I met in cafés or on the street.

Furthermore, it was essential to conduct in-depth interviews with above mentioned girls and women who have undergone FGC but also who have not, to listen to their experiences and finally to write selected examples down as case studies which should humanize this study since personal experiences are illustrating at best in how far FGC is affecting the life of a woman and how far-reaching the consequences are. All in-depth interviews have been tape-recorded and transcribed afterwards.

1.3.1.2 Focus Group Discussion (FGD)

In the case of focus group discussions I concentrated on Harari women of different age. The first FGD taking place was arranged by W/o Hafiza Bedri, the head of WAO, during my second stay in Harar. Every Harari is a member of a social organization or association depending on age and sex that is called in Harari language either *afotcha* (for married persons only), *jema'a* (for boys) or *gailatch* (for girls). Such small groups (similar to *idir* or *ekub* somewhere else in Ethiopia) are meeting regularly, discussing different issues, are supporting

each member in the case of weddings or funerals and so forth. When a meeting of one of the *afotcha* took place I used my opportunity and joined this appointment. Six ladies at the age of 60 to 70 met in one of the traditional Harari houses. Passing one cloth-washing man, we sat down in the living room. I introduced myself to them and we started talking about circumcision. One WAO employee interpreted my questions into Harari language and the responses back into English.

The second FGD with girls aged 15 took place during my third stay. My key informant and I went to one of the Primary Schools in Jegol. We asked the administration head to allow us conducting a FGD with five Harari girls of the previously mentioned age. He was willing to cooperate with us and called for five girls. We went to one of the preparatory class rooms, sat down and explained the purpose of our coming. Behaving shy at the beginning, the girls participated very lively in the discussions and contributed some good ideas.

1.3.1.3 Observation

During my first visit I stayed in the hotel. This was because I had to get in contact with people first. And as a matter of fact who would accommodate a stranger after a short time of knowing? On the other hand, I wanted to observe everything with a bird's eye view. After a while I realized that it turned out to be a good decision, since I met and talked to many people who offered me a room for my second stay. Thus, arrangements were made to accommodate me during my following visits in the centre of Jegol, the walled city of Harar.

Unfortunately, that was not easy as it seemed first. It was even difficult to be accommodated during my second stay. After the visit of four traditional houses with the outcome that a daily price of up to 300 ETB cannot be afforded by me, I finally decided to choose the hotel again. This time unlike my first visit, I chose a hotel which was very close to Jegol. Furthermore, I was invited several times to the home of one of the employees of WAO which gave me an opportunity to take part in some cultural activities.

My third and last stay in Harar turned out to be more fortunate. The previous two times I had enormous problems to find appropriate accommodation within Jegol. Probably this was due to the short time of stay of just two weeks each. However, after my arrival I immediately called a Harari who spent about 17 years of his lifetime out of Ethiopia, and finally returned to Harar. I was recommended by someone else to contact this particular person, who could help me to find something suitable, which -unexpectedly though- I did indeed. He offered me to live together with his mother, an 80 year old Harari woman, who had a huge compound with lots of space but lived alone, since all her 7 children were living abroad except the son I

contacted. First of all, this house was located in the middle of Jegol, close to Feres Megala, the former horse market and central meeting point today surrounded by cafés and small shops. The Arthur Rimbaud House which hosts a cultural center today is also just a few minutes' walk away. Secondly, the price was moderate and the room suitable, not too huge, with a 'normal' bed, desk and two chairs. So, it was ideal for working, studying and finishing my thesis. The room was located upstairs, together with a toilet and a former shower room which did not work anymore. However, water was supplied in containers and washing myself every morning with ice-cold water almost under open sky became a very new experience to me. The floor where I lived on was separated from the "traditional" living rooms of the Hararis. One had to go upstairs and this floor was attached balcony-like in U-shape to the ground floor of the house.

To live in a compound with this Harari woman, within the site of my interest (Jegol), allowed me to take part in or rather observe Harari day-to-day activities, to have the opportunity to live in the 'living museum', as Harar is also called due to the unique architecture of the Harari houses and the history of the town in general.

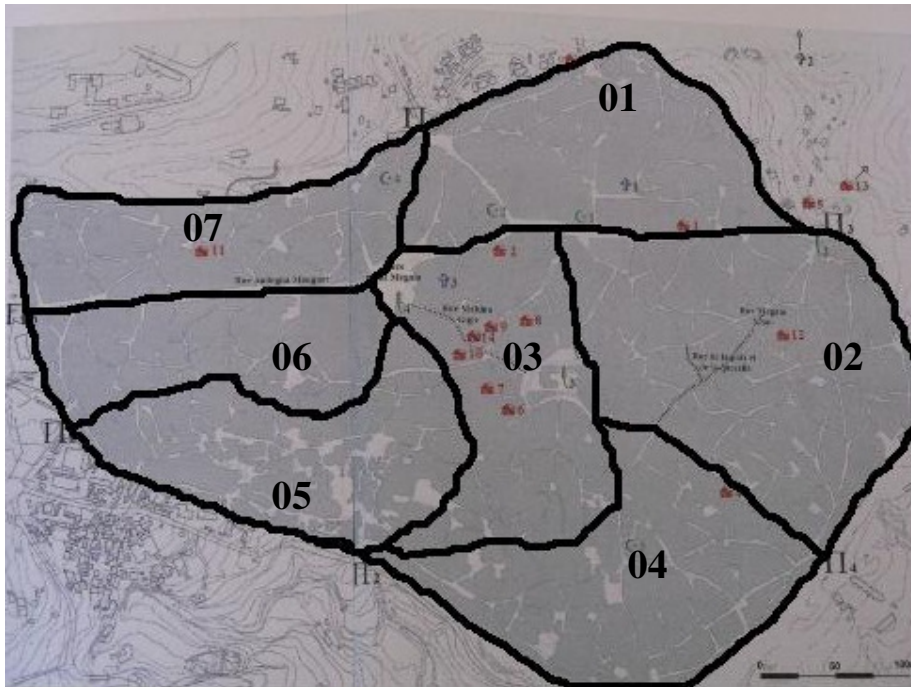
1.3.1.4 Survey Method

As a quantitative method, survey studies are contributing to the generalizing of the study findings. This method was used as supplement with regard to qualitative data.

Before I started my survey at the end of March 2008 I decided to conduct a pilot survey first for investigating what possible misunderstandings and difficulties might be and for turning open-ended into closed questions. For the pilot I was supported by two enumerators, one working for WAO, the other was a friend of him. Both spent one day to go to each kebele (altogether 7) and to interview the family members of one randomly selected household. Since the selection procedure was randomly, not only Hararis were addressed, but also Amharas, Oromos and Gurages, since all these different ethnics are living within Jegol nowadays. Afterwards we discussed the problems the data collectors faced and they suggested modifications of several questions.

After the successful conduct of the pilot I started the actual survey which took about one week. The sample population of Jegol was selected as follows. I randomly selected 10 households from each of the seven sub-kebeles (Map 1).

Map 1: Allocation of sub-kebeles within Jegol



Source: Original map from Cities of Ethiopia, 2007: 98-99; modified by the author with the help of Jamal Ahmed Yusuf and Abdurezak Ahmed.

The total amount of households in each kebele I got to know by contacting the two responsible kebele administration offices (Table 1).

Table 1: Kebeles, population and number of households within Jegol

Kebele	Sub-Kebeles	Population	Households
Amir Nur	01	9135	1500
Amir Nur	02	8530	1299
Amir Nur	07	5360	695
Abadir	03	4178	441
Abadir	04	5599	1012
Abadir	05	7792	1252
Abadir	06	3503	419

Source: Kebele administration offices.

However, of these altogether 70 households, at least the father and the mother were addressed to answer the questions which are written in the questionnaire, furthermore present daughters and/or sisters were interviewed.

Altogether four enumerators helped me in conducting the survey and collected the data. All were male, lived in Jegol, spoke next to English also Harari, Amharic and Afan Oromo,

finished at least their Bachelor of Arts (B.A.) and two of them collected already previously data for a survey conducted by the Women's Affairs Office. This ensured that by quite a few means they were familiar with the topic. Before they went to the field, we spent almost one day together, discussed ethical issues (for instance how to address the respondents, furthermore to be friendly, honest and patient and so forth) and the content of the questions. The questionnaire, originally designed in English, was translated into Amharic by one of the WAO staff and used simultaneously with the English one when asking the questions. The enumerators asked the questions face-to-face and assured in this case a high response. The English version was filled out.

From altogether 210 questionnaires, 177 were returned. Reasons for non-response were refusal or absence of family members at the time of visit.

For data analysis I used the Statistical Package for Social Sciences (SPSS). The data entry into the same programme took me almost about 4 whole days. For allowing a data entry I had to code the questions with abbreviations of about 8 letters. The answers to every respective question were expressed as values and represented by numbers I had to assign.

For analysis I used simple statistical tools such as frequency and percentage.

1.3.2 Secondary Data Sources

Relevant secondary data sources like books, articles from journals, reports and papers from known organizations (for instance ELGDAM, but also UNICEF and WHO) dealing with women's rights and health issues and particularly FGC have been selected, reviewed and included into this study paper. Since recent literature on the situation of FGC is very often only found in the internet, this source has been used, too to access publications from above mentioned organizations.

1.4 Limitation of the Study

The main limitation, especially at the beginning, was to be accommodated. At last, during my third and last stay, I got the chance to live with the Hararis within Jegol in one of the traditional houses.

Another obstacle were the frequent close ups of offices and cultural institutions due to high *khat* consumption in the afternoon. Since the whole research was time limited, it required a huge amount of tolerance, sensitivity but nonetheless tight pressure to get the necessary information.

There were no other significant limitations which could be mentioned, apart from the problems arising due to lack of sufficient language knowledge in Amharic as well as Harari. But these problems could be more or less solved with the help of trustworthy, very friendly and cooperative assistants who guided me around, introduced me to the Harari community and interpreted for me when it was necessary. However, although I tried to learn some Harari words and phrases which allowed a basic conversation, it would have been impossible to acquire a sufficient Harari knowledge for conducting the interviews on my own. Therefore, I am most grateful for the help and support I received. In this regard it should be mentioned, that the interviews that have been held in Harari were interpreted by my assistant, whereas interviewees that had sufficient English knowledge, were interviewed by myself.

A FGD with male informants could not be held due to time constraints, because of which the decision was made to only conduct two FGDs with elderly Harari women as well as young Harari school girls.

1.5 Significance of the Study

This study's importance is due to the need of shedding some more light on a topic, which is by no means entirely researched.

FGC is still a taboo especially among grassroots communities and not yet enough people are discussing this fundamental issue regarding women's health and rights in public, despite there is a significant number of famous, influential and known women and also men raising their voice nowadays at conferences, assemblies and summits.

In this context offered literature about FGC is nowadays relatively vast, covering most of the times African countries, and also Demographic and Health Surveys (DHS) included questions about genital cutting. Nevertheless, the material regarding Ethiopia in general and Harar in particular is not at all sufficient. Here, this study shall contribute to the lack of literature.

It is still a huge question mark why FGC continues despite so much effort during the last decades to eliminate this traditional practice. Much was tried but neither total prohibition nor any alternatives were really successful.

This study tries to show how it succeeded in Harar to shift from infibulation and excision to *sunna* or total abolition. What are the solutions to the question of what could be done to maximize the willingness for abolition and to change the attitude of doubters? Examples from Harar will give an answer.

CHAPTER II

2. Literature Review

Beneath I reviewed literature available to me which was dealing with female genital cutting, the reasons for practice, consequences as well as legal issues. I will start with theoretical thoughts referring to body identity and understanding of sexuality in different cultures but especially among Muslim societies.

2.1 Sexuality, Body and Identity- Theoretical Thoughts

Sexuality, the body and resulting from this one's identity are very closely related terms and of paramount importance when dealing with a topic like FGC. Sexuality, i.e. "the feelings and activities connected with a person's sexual desires" (Oxford Advanced Learner's Dictionary, 2005), stands in direct correlation with a human's body since it is one's body through which one can experience sexual arousal. In this regard it is worth mentioning that particularly women in comparison to men have problems to identify themselves with their body and therefore also with sexuality. As the following short intersections show female sexuality has already been oppressed for a long time (see also chapter 2.2) and is a cross-cultural phenomenon, and even today finds its' expression in the continuous practice of FGC and far beyond.

2.1.1 The Female Body- Opposed Images

One must suffer to be beautiful. French Proverb; also known in Germany
(Wolf, 2002: 218)

Women are ever since judged by their body, by their beauty, by their sexuality. Women, that far one can go, are definitely defined via their physical appearance whereas men are by far less. People in general assume, that a beautiful woman succeeds in life, finds better jobs, finds a husband more easily and gets healthy children. Which accounts for the Western world, is also valid in African countries. Although this might not sound as a disadvantage, it nevertheless can be understood as a never-ending struggle of women for the right to decide by them how to look and to be recognized as thinking and feeling individuals and not just being appreciated for their sexual and reproductive attributes.

The body of humans, and especially women, is a medium of culture:

The body, as anthropologist Mary Douglas has argued, is a powerful symbolic form, a surface on which the central rules, hierarchies, and even metaphysical commitments of a culture are

inscribed and thus reinforced through the concrete language of the body (Douglas, 1982 and 1966 cited in Bordo, 1997: 90).

This can not only be understood by what we are eating and how we are dressing, but also which rituals we are addressing to the body every day or, in the case of circumcision, once in a lifetime. Although also men have bodies, women are mostly associated with their nature given cover, whereas males with the mind or reason (Currie, 1992: 2). Women are often referred to as The Second Sex, which makes exploring the social rather than the biological factors in a male dominated world and finds its expression in another notion that “the female is to nature as the male is to culture” (ibid.: 9). Sherry Ortner (1974 in ibid.) finds an explanation for this female-nature understanding in the biological attributes of childbearing and childrearing. From this it can be understood that universally women are oppressed by men according to their reproductive potential. In the Middle Ages, Augustine (15th century) and Thomas Aquinas (13th century) stated that the only function of women would be to procreate, but only as a helper in the work of generation. Women, according to them, were inferior and the source of evil and everything that is wrong in the world. Traditionally Eve in the Bible was held responsible for the fall of humankind from an original state of grace (Currie, 1992: 2-3). Shulamith Firestone (1979: 192 cited in Currie, 1992: 10) puts it as follows:

Nature produced the fundamental inequality ... which was later consolidated, institutionalized, in the interest of men. ... Women were the slave class that maintained the species in order to free the other half for the business of the world.

Males’ dominance in society finds its direct expression in the oppression of women’s bodies. Especially in patriarchal societies, women are confronted with daily fights against the male dominance which not only weakens women’s sense of self-worth and hence also their power, but also made them internalizing many demeaning images (Ferguson, 1991: 97). The anthropologist Pierre Bourdieu and the philosopher Michel Foucault have argued, that the body is a *practical*, direct locus of social control (Bourdieu, 1977: 94 cited in Bordo, 1997: 90-91) and “female bodies become docile bodies- bodies whose forces and energies are habituated to external regulation, subjection, transformation, “improvement”” (ibid.: 91) and are surfaces for manipulation (Radnoth, 1999: 74).

As stated earlier, also men have bodies and therefore are physical bodies common to all humans, while the social body is historically and culturally constructed and relative. Anthony Synnott (1990: 1 cited in Currie, 1992: 17) stated:

We [must] discuss first the social construction of the body, i.e. the attribution of meanings to the body and therefore to the self: the way in which society models our construction of ourselves as tomb (Plato), temple (Paul), machine (Descartes) or self (Nietzsche, Sartre).

These conceptual paradigms are no doubt of paramount significance for how people live their lives and regard themselves; but society has a very direct, immediate and physical impact upon people also. Our ideas do construct us, but so do our jobs, hobbies, lifestyles, and social roles. We are physically constructed by society, whether we like it or not; and in the end we are sometimes destructed by that same society.

Before we are constructing our body, it is firstly constructed by the value system of the society we are living in. Although we also have influence on what to do with our body, we are nevertheless guided by what others think, by what is expected from us to do, by what is society expecting from us how to look like. And therefore, the body is only “properly human (...) when it is culturally acceptable (see Synnott, 1990: 11 cited in Currie, 1992: 18). However, such changes of human bodies, also violently, existed at any time and in any society in history. Also tattoos and piercings in Western countries are demonstrating the belonging to and the identification with a particular culture, with a certain group (Radnoth, 1999: 73).

Women are expected -more than men- to tolerate pain and to suffer to fulfil the ideal of a particular society. The entrance quote indicates that being beautiful and hence part of society goes almost proportional to experiencing pain. Andrea Dworkin mentions in her book “Woman Hating” (1974):

Pain is an essential part of grooming process, and that is not accidental. Plucking the eyebrows, shaving under the arms, wearing a girdle, learning to walk in high-heeled shoes, having one’s nose fixed, straightening or curling one’s hair- these things hurt. The pain, of course, teaches an important lesson: no price is too great, no process too repulsive, no operation too painful for the woman who would be beautiful. The tolerance of pain and the romanticization of that tolerance begins here, in preadolescence, in socialization, and serves to prepare women for lives of childbearing, self-abnegation, and husband-pleasing (1974: 133, emphasis original cited in Currie, 1992: 19).

In many Western societies, women are undergoing nowadays plastic genital surgeries – voluntarily and without any necessity, for feeling younger, experiencing stronger sexual feelings and so forth. Although the removal of the clitoris does not take place, the minimization of the labia or liposuction of the vulva creates parallels to female circumcision (especially excision; nowadays mentioned by WHO as FGC type IV) which was always and still is highly criticized and condemned by Western countries.

2.1.2 Understanding of Female Sexuality in Different Cultural Contexts

Oppression of Female Sexuality in General

Since we got to know that many men in patriarchal societies in general use their power to oppress women through their bodies and their sexuality and hence make them feeling inferior, it is not surprising that especially in capitalist societies men need “to control and regulate women’s sexuality and reproductive capacity” (Tamale, 2005: 2). Marxist feminist theory states that male domination developed through men’s control of resources and their relatively greater economic power. This is due to men’s position as household heads who use this status to exercise control over the lives of women and children who effectively become the man’s property (Engels, 1972; Barrett and MacIntosh, 1985 cited in Tamale, 2005: 2).

Female sexuality is not only negatively defined by male domination, but it is rather negatively constructed which finds its expression in abusing and harassing women by committing crimes related to sexuality. “The Worldwatch Institute asserted in 1989 that violence against women was the most common crime worldwide” (Wolf, 2002: 154-155, 160).

Impurity of Women According to Religions

Great contributions to the negatively defined and constructed understanding of female sexuality have religions. Orthodox religions, especially patriarchal forms of Christianity and Islam, stress the impurity and inherent sin of women’s bodies (Goodson, 1991 cited in Tamale, 2005: 3). This impurity of women is manifested in the Qur’an which considers six acts to be of major ritual impurity for which Islamic legislation prescribes ablution. These are:

- 1) Effusion of semen,
- 2) the blood produced after birth,
- 3) sexual intercourse,
- 4) menstruation,
- 5) childbirth,
- 6) death.

Only No. 1 is applied to men, No. 3 and 6 are shared between the sexes, whereas the remaining three acts (No. 2, 4, 5) are solely attributed to women. During menstruation and 40 days after birth women are, due to the consideration of being unclean and impure, not allowed to enter any holy place, let alone having intercourse, and praying or fasting during Ramadan are also prohibited (Raqiya, 1982: 34). While religion seems to have major influence on the lives of women, it obviously does not in the case of men. Alfred Kinsey (founder of the Institute for Sex Research at Indiana University/USA) found in this regard that

religious beliefs had little or no effect on a man's sexual pleasure; but could slice as powerfully as the circumcision knife into a woman's enjoyment, undermining with guilt and shame any pleasure she might otherwise experience

(Kinsey, 1953: 62 cited in Wolf, 2002: 131).

This act of negating female sexuality and considering it as something shameful, dirty and impure was also part of older patriarchal religions which have sought to control “*all* women via a technique which betrays a conscious determination to deal with the “problem” of women’s sexuality by destroying it wholesale” (Miles, 1988: 115 cited in Wolf, 2002: 131).

Different Understandings of Female Sexuality

Not only in Muslim societies, but also in Western countries, the denial of female sexuality is not new, rather was present throughout the decades and also known in Christianity. Normal female sexuality was considered to be a disease still in the 19th century and sexual surgery a common treatment. Clitoridectomy, the most common operation, “is the surgical enforcement of an ideology that restricts female sexuality to reproduction” writes Showalter (cited in Wolf, 2002: 245).

The clitoris, female equivalent to the male penis, is ever since a mystical part of women’s bodies, especially when it comes to the question of how an orgasm develops- vaginal and/or clitoral. Sigmund Freud, founder of psychoanalysis, tried to shed more light on this controversial issue by maintaining “that the transfer to vaginal sexuality formed an essential part of mature femininity” (Barrett, 1988: 66) despite the historical recognition of the clitoris as the site of female sexual pleasure. However, the publication of “Human Sexual Response” by Masters and Johnson in 1966 claimed to resolve the issue by producing detailed “evidence to show that the stages of arousal and orgasm were similar in both men and women and that the female orgasm takes place through clitoral stimulation, even if this occurs in the course of vaginal penetration” (ibid.). Nevertheless, such statement cannot be understood as universally applicable to all women since every one might have different experiences of intercourse.

Since female sexuality is seen in Islamic context as “active” and women understood in this regard to be destructive elements to the social order, men had to isolate them and create cultural myths in order to sexually exploit and strictly control them. The target was to make them loyal, obedient, shy, delicate and gentle. Hence, women had to be excluded from the public, social and economic spheres and their virginity and chastity was required (Raqiya, 1982: 38-41).

This entails in many societies clitoridectomy and infibulation, all in order to control the bodies of women as the means of reproduction, and to serve as an impediment to their sexual

power. (...) both are obtained by violence and socio-economic rewards and punishment, and further reinforced by the existing exploitative social order (ibid.: 41).

While women and their sexuality are secluded and oppressed as well as their monogamy is required, are men allowed to continue their polygynous sexuality (Tamale, 2005: 2). Raqiya (1982: 49) calls it the double standard of morality:

1) Virility is the incentive especially for urban men to seek sexual experience at an early age; for some men sexual activity is a source of pride; whereas the sexual experience of women is a source of shame and a symbol of degradation.

2) The emphasis on virginity imposes circumcision and infibulation on girls; and strict prohibitions from any kind of sexual activity before marriage, otherwise man can break off engagement, divorce and /or demands the return of his bride-price.

3) The rules applying to matrimonial fidelity also require a woman to avoid any act that a jealous husband might regard as a threat to his sexual monopoly of her.

That is why in social relations there is tendency for the sexes to separate (women in one, men in another corner); such gathering can be funerals, weddings and other ceremonies.

The sexuality of women is suppressed in many societies and synonym of removal of at least the clitoris. Not so among the Baganda in Uganda, among whom young girls are instructed in sexual matters and furthermore “visiting the bush”, where nothing is cut or removed as one might expect, but rather are the inner labia of the girls stretched and elongated (Tamale, 2005: 8). This is said to serve three main purposes (ibid.: 18):

1. Enhancement of erotic experience of both the male and the female; when stimulated in the correct manner, they may be the source of immense pleasure to the couple.

2. Self-identifier for Baganda women- the stamp of legitimacy for a “true” Muganda woman; without elongated labia woman is a “half-baked” one.

3. Aesthetic reason: several Baganda men enjoy looking at and fondling the stretched labia of a woman.

Sylvia Tamale criticises in her article the classification of this practice as type IV female genital cutting (see Introduction of this paper) by the World Health Organization (WHO), although, as she is claiming, this practice would enhance the sexual pleasure for women and procedures like Western genital surgeries (as mentioned above) would not be included.¹ Most of the women she interviewed would have spoken positively about the practice (Tamale, 2005: 18). But so would probably also the women in Western societies who are undergoing genital surgeries “voluntarily”, and so would probably also women in many African countries who are eager to be circumcised, to fully belong to a community, to be considered as “real”

¹ In the latest joint statement of WHO and many other UN bodies regarding female circumcision, genital cosmetic surgeries are included under FGC type IV (WHO, 2008: 28).

woman (see following chapters). The question to answer is *why* they want this to happen to their bodies, *why* they want to modify them, to remove something, to add or to elongate? Is not the cause of this the social construct of society as discussed earlier? The values and norms every member, and especially a woman, has to fulfil? Here, the definition of women via their bodies and their sexuality remains of central importance.

2.2 History of FGC

When, where, why and how FGC originally appeared is not known. Actually, there are not many sources available which are informing about the emergence of this practice. However, some facts surrounding FGC seem to be investigated and therefore widely accepted.

Two theories are dealing with the origin of FGC. The first one is expecting FGC to have been firstly practised in the Middle East from where it was diffused to Africa. The second theory states that FGC “developed independently in different societies at various periods in history” (Raqiya, 1982: 63). Whichever theory might be the right one is not for sure, although many scientific and speculative explanations tried to find a solution.

For sure is, that FGC emerged later than male circumcision whose operations were already represented in a relief on the tomb of Ankh-Ma-Hor of the 6th Dynasty (2340-2180 BC) in Egypt (Baashir, 1977:1, cited in Raqiya, 1982: 64; Elchalal, 1999: 103). Similar records for female circumcision do not exist. Available literature is stating that according to Herodotus (Greek historian; ca. 484-425 BC), who travelled extensively through Greece, Egypt and Babylon, FGC exists since the 5th century BC and was practiced among the Phoenicians, Hittites and Ethiopians (Elchalal, 1999: 103).

The second oldest known record that mentions the practice of female circumcision is that of Strabo, the Greek geographer and historian, ca. 25 BC, who visited Upper Egypt and wrote:

One of the customs most zealously observed among the Egyptians is this, that they rear every child that is born and circumcise the boys and excise the girls, as is also customary among the Jews, who are also Egyptians in origin (Meinardus, 1967:390 cited in Raqiya, 1982:65).

Also other sources are referring to FGC to be practiced in Egypt. These sources are the London papyrus published by Peyron, the report of Bishop St. Ambrosius of Milan in 374 AD, and that of Aetios of Amido (Book 16) and Paulos Alginetes (Book 6).

The Greek papyrus dated 163 BC refers to circumcised girls in Egypt. It mentions an Egyptian woman living in Serapeum and states:

The mother of Tothemis ... came to him and represented that her daughter has reached the age for marriage and has to be circumcised according to the customs of the Egyptians. For this

occasion the girl was considered as entering the period of womanhood and has to be provided with better clothing as well as dowry (Meinardus, 1967:390 cited in Raqiya, 1982:66).

This short excerpt shows that female circumcision was obviously an important pre-marital rite for Egyptian women of that time. Also physicians of the Roman world, like St. Ambrosius, knew about FGC:

The Egyptians circumcise their males at their fourteenth year, and the women are said to be circumcised in the same year, because from that very time the passion of sex begins to burn and the monthly period of the women begin (Remondino, 1891:271; Meinardus, 1967:390 cited in Raqiya, 1982:66).

Two more physicians from Greece (Aetius Amide (or of Amido), 6th century AD; and Soramus, 138 AD) described in detail how female excision among the Egyptians was carried out, also mentioning the instruments which were used: sharp scalpel and myzon (ring-slide forceps with spoon-shaped, toothed jaws). Aetius tells why circumcision in Egypt is done:

And in addition, with certain of the women their clitoris increases in growth and becomes unseemly and shameful, but also being continually rubbed by their clothes it excites them and rouses the desire for copulation; wherefore, on account of its increased size, the Egyptians determined to take it off, especially at the time when girls were ready to be married (Raqiya, 1982: 67) .

Another Greek physician, Paul Aegina (925-960 AD), stated that the clitoris is a shameful thing which could 'erect like a penis and make lesbian coitus' (Karim and Ammar, 1965:4 cited in Raqiya, 1982: 68).

Thus, not only is circumcision a requirement for marriage, but furthermore necessary to reduce sexual arousal among adolescent girls who are discovering the pleasure of joy. Aetius describes how a female genital surgery of that time was carried out:

They cause the girl to be seated on a stool, and a strong young man standing behind her, places his forearms beneath her thighs and buttocks so as to have control of her legs and her whole body. The operator standing in front of the girl seized her clitoris with large forceps, pulling it out with his left hand, whilst with the right hand he cuts it off with the teeth of the forceps. It is necessary to wake well the amount we intend to remove, so as not to take the clitoris away by its roots, but only remove the superfluous part (Raqiya, 1982: 67).

Although the concentration of Egyptian circumcision was directed on the clitoris and the control of female sexuality by men, it was nonetheless important for them, who also carried out the circumcision, not to remove the entire clitoris, but only the "superfluous part" since the total removal might have been resulted in total frigidity which men also did not want (see Raqiya, 1982:68).

Despite it is claimed that Pharaonic circumcision, which means the most severe form, has its origin in Egypt during the time of the pharaohs, no evidence of infibulation could be found in Egyptian mummies (Elchalal, 1999: 103). Instead of infibulation, the practices of clitoridectomy or excision were prevalent, but since only members of high castes and royalty were mummified, no generalized conclusion can be drawn to all Egyptian girls (Raqiya, 1982: 68). “However, infibulation was quite general in the case of female slaves to prevent them from becoming pregnant” (Widstrand, 1965:95-124 cited in Raqiya, 1982: 68) and according to Hosken (1978:12 cited in Raqiya, 1982: 68), Widstrand also reported that infibulated slave girls were brought to Egypt mostly from the south, from Nubia and the Sudan. This gives an indication that well maybe clitoridectomy, but not infibulation, originated in Egypt, which can be also suspected by the fact that Egyptians call infibulation “Sudanese circumcision”, pointing to its origin in Sudan (NCTPE, 2006: 70). According to accounts of the Venetian historian Petro Bembo, published in the middle of the 16th century based on accounts of travellers to the Red Sea, virginity was held in high esteem in this area and “the private parts of girls are sewn together immediately after birth...” (Widstrand, 1964: 102 cited in Raqiya, 1982: 70). Strabo called the population living along the east coast of the Red Sea “mutilated people” and claimed they would “excise” their women like the Egyptians, while he describes others as ‘circumcised’ (Hosken, 1979: 10 cited in Raqiya, 1982: 70). However, infibulation can be expected to have been diffused “from Pharaonic Egypt to Somalia and the other coastal areas due to strong cultural ties which existed for centuries between Red Sea coastal tribes and Ancient Egypt” (Raqiya, 1982: 71).

FGC is always brought into connection with the Islam, since it is mostly practiced in African Muslim societies. Nevertheless, neither is it practiced in Saudi Arabia and other countries of the Middle East (only with few exceptions), nor is there any explicit reference to FGC in the Qur’an. It is even widely “accepted that the practice was current in Sudanese or Nubian populations before Islam” (UNICEF, 2005c: 12).

Evidence from outside Africa is informing that to prevent procreation among female slaves in ancient Rome “metal rings were passed through the labia minora” (WHO, 2006b: 3). The same seemed to have happened to wives whose husbands wanted to prevent them having illicit sexual intercourse. During the mediaeval time, “knights locked the chastity belts of their wives and took the key to prevent them committing adultery in their absence” (Raqiya, 1982: 80). However, the term *infibulation* seems to be derived from the Latin word “fibula”, which referred to the clasps which were used to fasten the loose ends of the male Roman clothes known as toga (NCTPE, 2006: 77; Kwaak, 1999: 31).

Clitoridectomy was carried out in many European countries like Germany, England or France during the 19th century (Magotha, 2000: 268). During this time, infibulation was “mainly practiced to safeguard virginity and to ensure pre-marital chastity” (Raqiya, 1982: 80). Since “orgasm was disease and cure was its destruction” pelvic surgery was only a “social reflex” (Wolf, 2002: 244). However, a German surgeon called Dr. Graefe performed the first reported case of clitoridectomy in 1822. His intention was to treat excessive masturbation and nymphomania. Furthermore was it believed cutting the clitoris would “cure disorders thought to be caused by masturbation, such as hysteria, epilepsy, catalepsy, melancholia and insanity” (Elchalal, 1999: 103). In England, “Dr. Symington-Brown began clitoridectomy in 1859: by the 1860s he was removing labia as well. He became more confident, operating on girls as young as ten, on idiots, epileptics, paralytics, and women with eye problems” (Stage, 1981:77 cited in Wolf, 2002: 244). However, this practice died out quickly in Europe, although it continued in the USA. The last case was reported to have taken place in 1927 (Elchalal, 1999: 103).

Despite FGC is in most countries deeply rooted and emerged many centuries ago, in Yemen, for example, it appeared just recently during the 20th century as a result of contacts with practicing communities in the Horn of Africa (UNICEF, 2005c: 7).

2.3 Prevalence of FGC

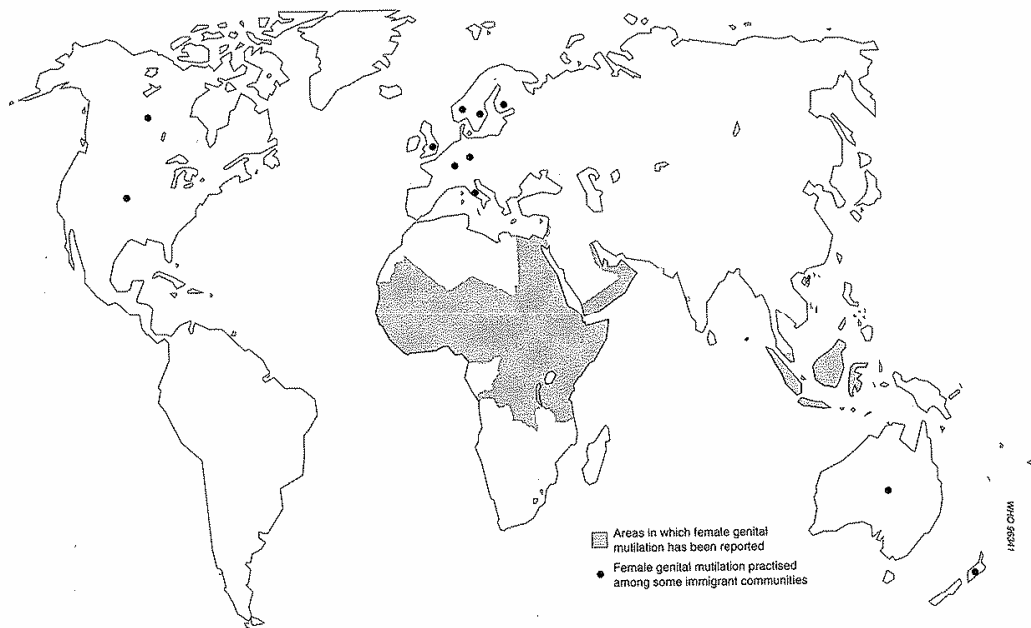
As already shortly mentioned in the introduction part of this paper, it is expected that the core prevalence area for practicing FGC is sub-Saharan Africa. It is common in a broad band of African countries from Mauretania and Guinea in the west to Somalia and Ethiopia in the east, whereas Egypt juts the north and Kenya and United Republic of Tanzania extend to the south. In Arabic-speaking countries of North Africa, like Algeria, Morocco, Libya and Tunisia, FGC is either extremely rare or not present at all (Yoder, 2004: 4; WHO, 2006b: 2-3). Outside Africa FGC is practiced by some communities on the Red Sea coast of Yemen, also Jordan, Oman, the Palestinian Territories (Gaza), in certain Kurdish communities in Iraq as well as the Muslim populations of Indonesia, Malaysia, Bohra, India, Pakistan, Malaya, Java, Sumatra and Baluchistan. In Europe it is especially practiced in France, due to migrants from West African countries, in the United Kingdom, and 1970s refugees from Ethiopia, Eritrea and Somalia brought FGC to countries like Norway, Sweden and Switzerland (WHO, 2006b: 2-3) (see Map 2).

With regard to Africa, the prevalence ranges from 80 to almost 100 per cent in North-East African countries, while in Kenya and Tanzania the prevalence lies between 14 and 32 per

cent. However, it can be stated that Egypt, Guinea, Mali, Sierra Leone and North Sudan as well as countries at the Horn of Africa² are belonging to the high prevalence countries with FGC occurring among above 90 per cent of the girls and women. But also Burkina Faso, Ethiopia and Mauretania with between 70 and 80 per cent prevalence need special attention. It should be mentioned, that these “figures represent national averages and do not reflect the often marked variation in prevalence in different parts of a given country” (UNICEF, 2005c: 3; WHO, 2008: 29) (see Table 2 and Map 3).

Map 2: Worldwide Occurrence of FGC

Areas of the world in which female genital mutilation has been reported to occur



The designations employed and the presentation of material on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Information on the map is based mainly on partial and incomplete data.

Source: WHO, 1997: 6

Although one might expect a higher prevalence rate in rural areas, especially in the above mentioned high prevalence countries there is no significant difference between urban and rural settings (UNICEF, 2005b: 10).

With reference to the practiced type of FGC, new estimates indicate that type I and II and cases where girls’ genitals are “nicked” but no flesh removed account for 90 per cent of all FGC cases worldwide, whereas type III comprises for 10 per cent (Yoder and Khan, 2007

² Emphasis lies on countries as Djibouti, Eritrea and Somalia.

cited in WHO, 2008: 5). Infibulation, type III, occurs mostly in Somalia, northern Sudan and Djibouti, but is also reported to be practiced in southern Egypt, Eritrea, Ethiopia, northern Kenya, Mali and Nigeria (WHO, 1997: 5).

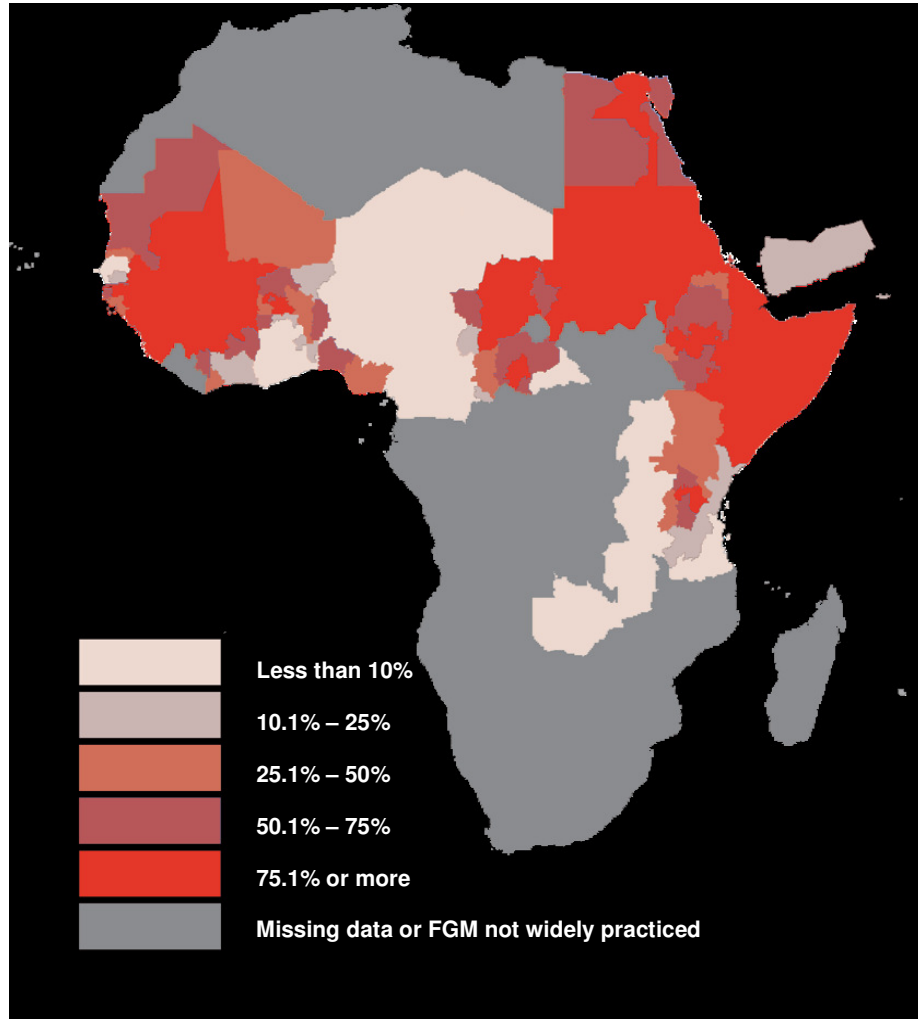
Table 2: Prevalence of FGC in African countries according to DHS data collected for the mentioned year

Country	Year	Estimated prevalence of female genital cutting in girls and women 15-49 years (%)
Benin	2001	16.8
Burkina Faso	2005	72.5
Cameroon	2004	1.4
Central African Republic	2005	25.7
Chad	2004	44.9
Côte d'Ivoire	2005	41.7
Djibouti	2006	93.1
Egypt	2005	95.8
Eritrea	2002	88.7
Ethiopia	2005	74.3
Gambia	2005	78.3
Ghana	2005	3.8
Guinea	2005	95.6
Guinea-Bissau	2005	44.5
Kenya	2003	32.2
Liberia*	--	45.0
Mali	2001	91.6
Mauretania	2001	71.3
Niger	2006	2.2
Nigeria	2003	19.0
Senegal	2005	28.2
Sierra Leone	2005	94.0
Somalia	2005	97.9
Sudan, northern (approximately 80% of total population in survey)	2000	90.0
Togo	2005	5.8
Uganda	2006	0.6
United Republic of Tanzania	2004	14.6
Yemen	1997	22.6

* The estimate is derived from a variety of local and sub-national studies (Yoder and Khan, 2007).

Source: WHO, 2008: 29

Map 3: Prevalence of FGC among women aged 15-49 in Africa and Yemen in per cent



The map shows the areas where FGM is practised, and since that can vary markedly in different parts of any country, no national boundaries are shown. Data at the sub-national level are not available for Zambia. Due to a discrepancy between the regional divisions used by DHS and the one adopted by DevInfo, it was not possible to include data at the sub-national level for Yemen.

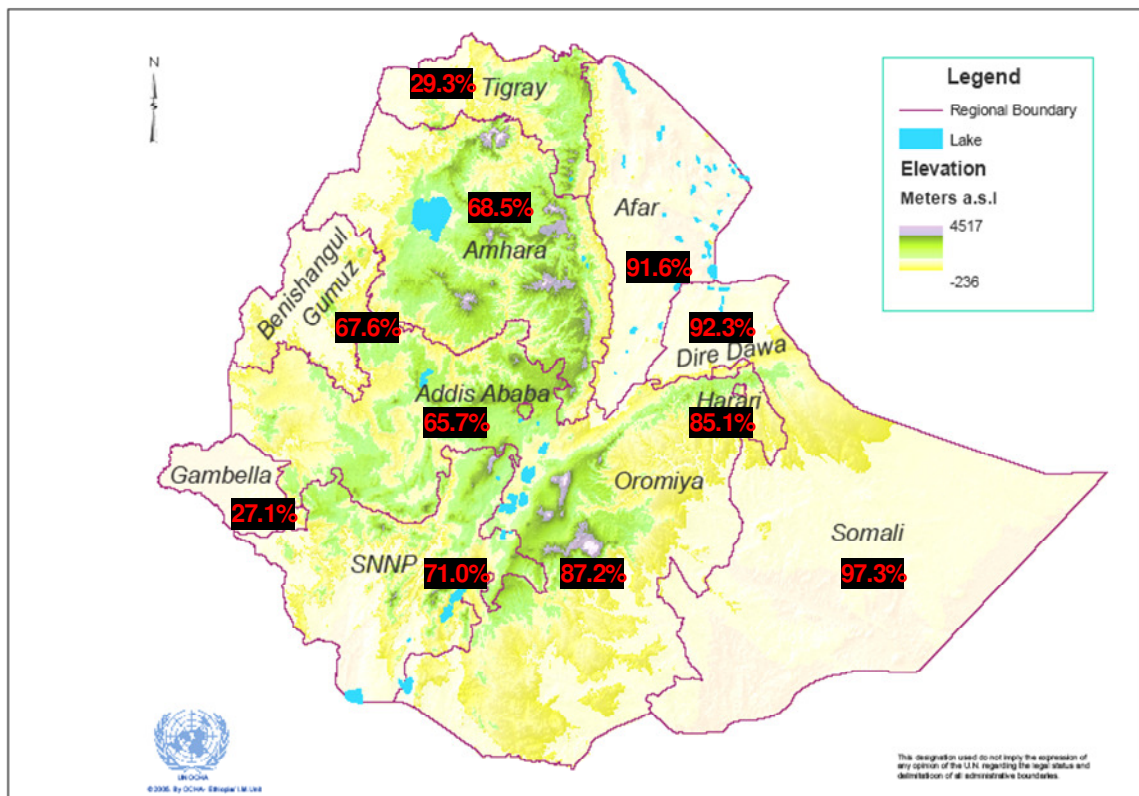
Source: WHO, 2008: 5

Although it is right that FGC is mostly practiced by Muslims, it is not restricted to them, but also performed by Christians, Ethiopian Jews (Falashas), animists and atheists and can therefore be understood as an cross-cultural and cross-religious ritual (Baron, 2006: 340; NCTPE, 2006: 73).

After this overview over the spread of FGC in Africa and the world, let us now have a closer look on this traditional practice in Ethiopian context. It can be assumed according to the *Ethiopian Demographic and Health Survey 2005* (p. 253) that 74 per cent of all Ethiopian girls and women have undergone one of the four forms of genital cutting (please see Box 1). Type I is almost universal in Ethiopia, but mainly present in Amhara and Tigray. Half of all

Ethiopian women who underwent FGC have their clitoral hood cut. Type II can be found among the Gurage as well as some communities in Tigray and Oromo. Type III is restricted to Somali, Affar, Harari and Dire Dawa. It seems to appear losing ground to less severe types of FGC. However, estimated 6 per cent of women affected by FGC in Ethiopia are infibulated. This form is especially widespread among the Somali with more than 80 per cent and the Affar with about 60 per cent of women experiencing this kind of female circumcision. FGC type IV, in Ethiopia called “Mariam Girz”, is practiced in Gojam, in the Amhara region (WHO, 1999b: 1; GTZ, 2007f: 1).

Map 4: FGC Prevalence in Ethiopia



Source: Original Map from <http://ochaonline.un.org>; prevalence data from Ethiopian DHS, 2005: 253; Modification of map and insert of data done by author.

Regions with the highest prevalence rate are Somali (97.3 per cent), Dire Dawa (92.3 per cent), Afar (91.6 per cent) and Oromiya (87.2 per cent); closely followed by Harari (85.1 per cent) and SNNP (71.0 per cent). Regions with an occurrence of about less than 70 per cent are Amhara (68.5 per cent), Benishangul-Gumuz (67.6 per cent) and the capital city Addis Ababa (65.7 per cent).

FGM is least prevalent in the regions of Tigray and Gambela, where 29.3 per cent and 27.1 per cent respectively of girls and women are affected (Ethiopian DHS, 2005: 253). Some ethnic groups in the south of the country do not practice FGM at all (GTZ, 2007f: 1) (see Map 4).

2.4 The Practitioners

When it comes to the question of the practitioner one always has to bare in mind, that it depends on the country, region or ethnic group where and by whom FGC is performed. However, it can be assumed that FGC in Africa and Asia is done by one of the following practitioners: traditional birth attendants, trained or untrained midwives, the mother or grandmother, local specialists (cutters), sometimes (as in Nigeria and parts of Egypt) the male village barber. In general these practitioners are elderly women of the community, who are known as ‘gedda’ in Somalia or ‘dava’ in Egypt and Sudan (Elchalal, 1999: 104; UNICEF, 2005c: 7). In Ethiopia, circumcision by traditional circumcisers accounts for about 90 per cent of all cases, followed by traditional birth attendants (see Skaine, 2005: 13). Irrespective of background, one thing most circumcisers have in common: the service they are offering is highly valued and a practitioner’s status in the community and income can be directly linked with performance of the operation. In West African countries circumcisers enjoy therefore huge power and a high status, whereas in Somalia they are generally not respected (Dorkenoo, 1999: 26).

However, in some countries, there is a trend towards so-called medicalization of FGC, which means, that it is increasingly performed by health-care personnel. This is the case for 60-90 per cent of performances in Egypt, but also in Sudan (36 per cent) and in Kenya (34 per cent) this observation was made (UNICEF, 2005c: 7).

Depending on the degree of ritual and celebrations, FGC is performed in hospitals, clinics, houses, huts, tents or open air (Elchalal, 1999: 104). Except for medicalized FGC, WHO identifies the following tools to remove the female genitalia: “special knives, scissors, razors, or pieces of glass. On rare occasion sharp stones are used, for example, in eastern Sudan, and cauterization (burning) is practiced in some parts of Ethiopia. Fingernails have been used to pluck out the clitoris of babies in some areas in The Gambia” (Skaine, 2005: 11). Clear is also, that most tools are not sterilized, which might cause several forms of infections.

Anaesthetics are rarely used and one might not have the power to imagine what it means for a girl or woman to have her own body parts cut with full consciousness. Normally the “child is held down by family members, who forcibly hold the girl’s legs open while the “operation” is

performed” (Elchalal, 1999: 104). This may last up to 20 minutes, depending on the struggle of the girl and the circumciser’s skill (Skaine, 2005: 13).

The age when a girl is cut also differs and no overall statement can be made. It can “be done in infancy, childhood, adolescence, at the time of marriage, or during the first pregnancy depending on country, community and type practiced” (ibid., p. 14). In Egypt 90 per cent of the girls are cut at the age between 5 and 14 years. In Ethiopia, Mali and Mauretania about 60 per cent underwent the procedure before their fifth birthday (UNICEF, 2005c: 6). In Ethiopia the median age of circumcision of the daughters is even during the first year of life, the same appears in Eritrea, Nigeria and Yemen. However, the Ethiopian Somali, Harari and practicing groups in SNNPR carry out FGC between the age of 4 and 20 (NCTPE, 2006: 83). Also regarding age there is a trend, which is leading towards performing FGC at a younger age. This might be due to legislation against the practice and therefore avoidance of government interference. Furthermore, many parents wish to reduce the trauma to their children, and to avoid resistance from their children as they get older (Skaine, 2005: 14-15).

However, both medicalization and the increasing performance of FGC at younger age should be addressed when implementing laws and developing eradication strategies. Medicalization actually is the result of early advocacy efforts which overemphasized the negative health complications FGC has. UNICEF and WHO take a firm stand regarding this trend: “medicalization obscures the human rights issues surrounding FGM/C and prevents the development of effective and long-term solutions for ending it” and “[we] strongly condemn the medicalization of female genital mutilation” (UNICEF, 2005b: 13).

2.5 Reasons for Practicing and Perpetuating FGC

*It is said to be a directly insult to apply the term
'uncircumcised' to an Abyssinian woman*

(Sequeira, 1931:1055 cited in Raqiya, 1982: 77)

Reasons to carry out and perpetuate FGC are so many-sided, like the ethnic groups who are performing it. FGC is deeply rooted in patriarchal societies and one expression for continued gender-inequality and subordination of women towards men. However, one can distinguish the most commonly cited reason “tradition” into socio-cultural reasons, sexual and health reasons, aesthetic as well as religious reasons.

2.5.1 Socio-Cultural Reasons

The main reason for continuing this traditional practice can be found in the social surrounding of the affected girl or woman. Since circumcision of girls is a women's affair, mainly female family members like mothers, grandmothers or aunts have considerable influence on whether, when and how circumcision takes place. Young Senegalese women stated that even if they would like to refuse FGC, they could never oppose decisions made by their grandmother, because of respect for their elders (see Shell-Duncan, 2006: 64-65). And especially older female family members are the ones who "tend to perpetuate particular types of FGC because they expect that younger female relatives should have the same life experiences they had" (Yoder, 2001: 19).

Apart from elder decision makers, in Africa and Asia FGC is in many societies closely linked with initiation rites (rite of passage) and coming-of-age ceremonies (Magoha, 2000: 269). Only through experiencing FGC a girl becomes a woman and therefore gets her rightful place in society. "The procedure creates status, is a proof for the girl's bravery and illustrates her future ability to endure the pain of childbirth." (Baron, 2006: 346). Normally the operation is embedded in a wide-ranging ceremony which may start several weeks before and last up to some weeks after the cutting took place. Not seldom the girl is secluded during this time. Elderly, experienced women are instructing her in personal hygiene, "womanly responsibilities", e.g. child bearing and rearing, nutrition etc. The aim is to receive training to fulfil the traditional role as female member of this particular society. After returning to her community, the girl is considered to be an adult with her genital scar as a proof that she underwent moral and practical training (Elchalal, 1999: 104).

In patriarchal societies it is a woman's main life objective to find an appropriate husband, which can be understood as a "survival strategy in a society plagued by poverty, disease and illiteracy. The socio-economic dependence on men colors their [women's] attitude toward circumcision" (Abusharaf 1998 cited in Baron, 2006: 346). Since girls are understood as property of men, they are "regarded as an economic asset bringing wealth and alliance into the family and clan by marriage etc." And especially in areas where strict seclusion of women was impossible, for instance among nomadic ethnic groups in Somalia, Sudan, Eritrea or among the Oromos, infibulation was seen "as the most effective means to keep the girls' virginity intact, and thus to ensure the highest bride-price" (Raqiya, 1982: 69-70).

FGC assures virginity and fidelity which are prerequisites for marriage, because "a bride price cannot be obtained if the bride is not 'pure'" (Dorkenoo, 1999: 24). Sudanese women, for instance, perform FGC on their daughters to secure their [the daughter's] economic and social

future, since they are saved once they are married (Magoha, 2000: 269) and can advance their social status through giving birth, especially to sons (Boddy, 1999: 46). The practice is also a beneficial income source for the circumciser as well as the father of the girl, who marries off his daughter in exchange for dowry (Baron, 2006: 353).

FGC is for most women essential due to maintenance of social cohesion and social approval, development of cultural identity, insurance of a girl's or woman's status, marriage ability, chastity, health beauty and family honour (see *ibid.*: 346; UNICEF, 2005c: 11; WHO, 1997: 4). As Raziya Haji Dualeh Abdalla (1982: 53) wrote: "preservation of purity and honour is thus essential if [a woman's] patrilineage is to maintain its social status, broaden its kinship ties and enhance its patrimony."

A study conducted in Serbo town, south-western Ethiopia, showed that an uncircumcised girl is not only considered to be sinful but also "prohibited to take part in praying, cooking food, coffee ceremony and any other form of social affair. This discriminatory act might nurture the continuation." (Abate, 2002: 67). But not only external pressure might lead to continue this practice, the women themselves support continuance. Among the age group 15-49 of African women it is estimated that 80 per cent are for perpetuating female genital cutting. For women in Guinea, FGC is obligatory for becoming an adult, the benefit is seen in social approval and the whole circumcision a "normal" event in a young girl's life. Many women are considering FGC as an act that glorifies their bodies, makes them more beautiful, and are even proud of their circumcision years later (Baron, 2006: 348-349). And since circumcision is manifested in the value system of one society, little girls will raise by hearing them and learning to accept the particular values of their community. They will get to know that an uncircumcised girl will never be married and therefore look forward their purification (Raziya, 1982: 51). Although women are aware of the negative consequences of genital cutting, they resist abandoning it because the fear of losing status and protection is too huge.

The attitudes of men are ambiguous. On the one hand many men are not taking a public stand against the practice although they might be against the continuation in private. Since men are also not directly involved in the circumcision of their daughters and not seldom even do not know when and where their daughters got circumcised, it is difficult to judge their behaviour. On the other hand, many men are insisting on FGC and are only willing to marry a circumcised woman. Statements like "We do not want our women to be prostitutes" or "We do not want any women's liberation here. This is our culture" are supporting the practice (see Dorkenoo, 1999: 27).

Therefore it should be a collective and coordinated choice to abandon FGC made by a significant number of families within a community involving women as well as men (UNICEF, 2005c: 11).

2.5.2 Sexual and Health Reasons

Sexual and health reasons to practice FGC are most closely related to women's inferior position in their societies. Summarized it can be said that securing fertility and controlling and especially reducing female sexuality are the main intentions.

By removing the female organ, female sexual urges are believed to be reduced. Uncircumcised women are considered to act wildly and crave men. "A woman is not required to be sexually active, 'like an animal', she must exhibit an unnatural passivity" (Raqiya, 1982: 57). Through practicing FGC the image of women as docile, asexual, obedient and fertile is created. Men are the direct beneficiaries of FGC since its aim is to "guarantee" premarital virginity, chastity and post marital monogamy, furthermore is male's sexual pleasure during intercourse achieved through narrowing the vaginal opening. Like a Sudanese woman said: "Sex is a man's affair and (a woman) is only a means to approach it" (Gray 1998 cited in Baron, 2006: 346-347). And Raqiya Haji Dualeh Abdalla (1982: 50) adds:

Since the main interest of the man is to father offspring whose physical, legal and ritual purity are in every way assured, the reduction of women's capacity for erotic pleasure was thus seen as necessary to enforce chastity and fidelity.

Another (wrong) perception regarding the women's organ is, that the "clitoris secretes poisonous substances that will make a man impotent, kills him during penile contact, and cause infantile death during childbirth" (Burstyn 1995, cited in Baron, 2006: 347). For the man's pleasure and the child's wellbeing, FGC and its negative consequences for the woman's health and sexual fulfilment are justified.

2.5.3 Aesthetic Reasons

In many societies the female clitoris is considered to be a hard, male part which should be removed, because it would otherwise grow down to the ground and drag. Furthermore is the clitoris perceived as ugly, dirty, unrefined and inhuman. Only through circumcision women could achieve true feminine beauty (Burstyn, 1995 cited in Baron, 2006: 347). Sudanese women believe that infibulation makes girls clean, smooth and pure. This opinion is confirmed by Somali women who are perceiving Western women as unnatural and unpleasant, and their natural genitalia as ugly (Kwaak, 1999: 31; Boddy, 1999: 46).

2.5.4 Religious Reasons

Although FGC, and especially the most severe form infibulation, is practiced among many Muslim societies in Africa and one might expect FGC to be an Islamic custom, the truth is, that it is not practiced in the cradle of Islam, Saudi Arabia, and many other Muslim countries of the Middle East. Millions of Muslims worldwide never adopted this traditional practice (Magoha, 2000: 269). There are even several passages in the Qur'an that oppose FGC by saying, that God created the clitoris for the sole purpose of pleasure for wife and husband should pleasure each other during sexual intercourse (Baron, 2006: 348). Good health is viewed as a gift of Allah and male and female bodies' integrity should be respected (GTZ, 2007e: 1). It is expected that excision and infibulation, which rooted in pre-Islamic patriarchal society, were reinforced and absorbed into Islamic culture, which was based on patriarchal rule and patrilineal inheritance patterns, in the past and spread with the advance of Islam. Those who practiced it later on, considered is as an Islamic tradition (Elchalal, 1999: 104; Raqiya, 1982: 61). Within Islamic cultures female sexuality is regarded as something which must be controlled and "great value was placed on women's modesty and chastity. That is maybe the reason why circumcision became more widespread in Islamic areas (although it is not mentioned in the Koran and was not an exclusively Islamic institution)" (Raqiya, 1982: 35).

The only type of FGC which is vaguely mentioned in the Qur'an, is type I, clitoridectomy, also called *sunna* (which is the Arabic word for "tradition"). However, the statements in the Hadith, the sayings of the Prophet, are lacking exact descriptions about how the procedure should be carried out. Nowhere in the Qur'an is directly stated "that the Prophet viewed FGM as a religious duty" (GTZ, 2007e: 1-2). Rather is reported that "Prophet Mohamed told a woman in Medina who performed female circumcision: 'Touch but do not destroy. It is more illuminating to the woman and more enjoyable to the husband.' Another version of this statement says: 'Do not go deep. This is enjoyable to the woman and is preferable to the husband.'" (Raqiya, 1982: 82). The statements "Do not go deep" and "do not destroy" are indicating that everything which goes further than sunna, i.e. removal of prepuce or tip of clitoris, cannot be meant. Otherwise, how could a woman enjoy and have pleasure when one of the most sensitive organs with regard to sexual feelings is completely removed and even beyond? Prophet Mohamed was also claimed to have had said: "Circumcision is my way for men, but is merely ennobling for women" (ibid.).

Since FGC is not practiced by Muslim societies alone, but also by Christians or (Ethiopian) Jews, it is important to note that there is no religious justification for this and no prescription

by any religion, neither Islam, nor Christianity, is existing (UNICEF, 2005c: 12). However, Sequeira (1931: 1054 cited in Raqiya, 1982: 81-82) stated that missionaries of the Roman Catholic Church who came to Abyssinia in the 16th century, wanted to forbid female circumcision among their converts. The result was that no Abyssinian would marry a Catholic girl unless she was circumcised. 'Then the Catholic community diminished and the people returned to their heathen misconceptions.' The problem was reported to Rome from where a surgeon, Paulus Aiginetes, was sent to investigate if the operation was necessary in Ethiopia; he formally declared that it was essential, on the basis that a congenital hypertrophy of the pudenda is common among Abyssinian women. The missionaries therefore permitted the practice to continue.

Nowadays most religious leaders, whether from Christianity or Islam, take firm stands against the practice, raise their voices and speak in front of their followers for convincing them to abolish and condemn female genital cutting.

2.6 Risks and Complications of FGC

Like in the case of the reasons as described above, complications which may arise out of FGC are numerous. They are always closely related to the particular type of circumcision, the tools used, the skill of the practitioner, the struggle of the girl and the treatment she may receive afterwards.

Immediate, intermediate and late complications as well as obstetrical problems can be attributed to FGC.

2.6.1 Immediate Complications

Immediate complications are problems which are appearing during or directly after the operation. While a girl is fully conscious of the procedure, she might be shocked and get a trauma due to the severe pain, fear, confusion and extreme bleeding. Extensive blood loss can be protracted and result in long-term anaemia. Because of usage of unsterilized instruments, infections, like fatal septicaemia and tetanus, are common.

Women, who are already under non-circumcised conditions 2-4 times more vulnerable of becoming infected with HIV/AIDS, experience much higher risks during or after circumcision. Not only the usage of the same unsterilized tools might contribute to this phenomenon, but also the need for blood transfusions resulting from haemorrhage (blood loss) may increase the probability of HIV transmission. Especially after the practice of FGC type II and III the risk of tissue damage to the vulva and vagina increases. Also anal

intercourse, for many infibulated women an alternative to vaginal intercourse due to impossible penetration, contributes to an increased chance of HIV transmission (GTZ, 2007a: 1).

Furthermore are urinary retentions frequent complications, especially when skin over the urethra was stitched (WHO, 2006b: 3-4; UNICEF, 2005c: 18).

Death of the girl can arise from haemorrhagic or septic shock, or tetanus (Magoha, 2000: 270).

2.6.2 Intermediate Complications

Intermediate complications include delay in wound healing, anaemia, malnutrition, pelvic inflammatory disease, keloid (thick scars) formation and vaginismus (ibid.). It can be expected that painful menstruation as well as sexual intercourse and possible incontinence due to infections may be threats to a woman's life (WHO, 1999b: 1). The higher prevalence of herpes simplex virus 2 among women who had been subjected to FGC has also been proofed (UNICEF, 2005c: 17).

2.6.3 Late Complications

Female genital cutting can cause “infections in the uterus, fallopian tubes and ovaries. Chronic kidney and urinary tract infections may lead to severe back pain and cramping” (Baron, 2006: 343), urinary incontinence, recto-vaginal fistula and infertility (Magoha, 2000: 270). Abscesses and cysts of the thick, raised scar tissue (keloids) can cause excessive urine and menstrual build-up (haematocolpos) that is unbearable painful (WHO, 2006b: 4; Baron, 2006: 343). The huge scar tissue, which is less elastic as compared to perineal and vaginal tissue, may also have influence on problems during pregnancy and childbirth. It can be generally stated, that the more extensive the genital mutilation, the higher the risk of obstetric problems. Such complications which have been attributed to FGC can be: caesarean section, postpartum haemorrhage, extended hospital stays, need for infant resuscitation, stillbirth and early neonatal death (Maurice, 2006: 4). FGC can furthermore contribute to or cause maternal death (UNICEF, 2005c: 16).

A WHO study on FGC and obstetric outcome in six African countries showed, that women with type II and III are more likely to have caesarean section and postpartum blood loss of 500 ml or greater, furthermore had 88 per cent of women with type III episiotomies (as compared to 41 per cent of women without FGC). Other frequently observed problems are tears, protracted labour and low Apgar score (WHO, 2006a: 1837, 1840). Many women need

to be de-infibulated (widening of vaginal opening) for giving birth to a child and even want to be re-infibulated (narrowing, sewing of vaginal opening) afterwards again. Both operations may cause the same short-term and long-term complications which already appeared during the original operation years before.

All types of FGC destroy the vulvar nerve endings which leads to reduction, delay or prevention of sexual enjoyment and orgasms. Women, who underwent type III, complain about painful sexual intercourse and 35 per cent of them have coital difficulties and can not perform vaginal intercourse at all because of vaginal stenosis and fibrosis (Magoha, 2000: 270).

FGC in general, but especially type III, leaves behind not only scars on a woman's body, but also on her mind. Many women are suffering from psychosomatic disorders like the following: disordered eating and sleeping habits, changes in mood and symptoms of impaired cognition that include sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks, difficulties in concentrating and learning (WHO, 2006b: 4), feelings of incompleteness, anxiety, depression, chronic irritability and frigidity, loss of trust and confidence in care-givers (WHO, 1997: 8). Out of these, marital problems may arise which will lead in the worst case to divorce which vice versa has a negative impact on women's social and economic status and that of their children. Another investigated factor is the influence FGC has on the school drop-out for girls, because of increased absenteeism, poor concentration, low academic performance and loss of interest (WHO, 2006b: 4; UNICEF, 2005c: 18).

2.7 Legal Status

2.7.1 International and National Laws Against FGC

The phenomenon of FGC is known for decades and the same time span contains several attempts to release laws and legislations in good faith to ban this traditional practice soon.

In 1979, the World Health Organization (WHO) held its first international conference on female circumcision in Khartoum, Sudan. During this meeting the recommendation to totally eradicate the practice emerged, furthermore was the unacceptability of the suggestion to reduce physical complications by performing the lesser forms of FGC within medical facilities, established (Toubia and Sharief, 2003: 251). During this time the United Nations (UN) General Assembly adopted the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) which came into force in September 1981 (Dorkenoo, 1999: 29). The UN Conference on Human Rights took place in 1993 in Vienna

and advocated the abolition of cultural practices that effect health and rights of women. One year later, in 1994, at the International Conference on Population and Development (ICPD) in Cairo, Egypt, FGC was mentioned for the first time in an international document as violation of women's reproductive health. In 1995, at the 5th World Conference on Women in Beijing, China, FGC was condemned as a violation of women's rights. Nowadays all relevant UN bodies, like UNICEF, UNFPA, UNIFEM or WHO, have policies against FGC (Toubia and Sharief, 2003: 253).

The African Union (AU) introduced an addendum to the African Charter on Human and Peoples' Rights through a draft protocol on women's rights in which FGC is explicitly mentioned and condemned. However, many Africans see the charter as "too Western and too little culturally specific" and the top-down approach is highly criticized (Kwaak, 1999: 37; Elnaiem, 1999: 103). Nevertheless are the AU's "Solemn Declaration on Gender Equality in Africa" as well as the Maputo Protocol³ seen as major contributions to promotion of gender equality and elimination of FGC (WHO, 2008: 1). In half of the 28 FGC practicing African countries legislation has been introduced. But in only four countries FGC had been brought to prosecution (WHO, 2006b: 4-5).⁴

In Ethiopia, the 1957 Penal Code ignored major forms of violence including FGC and no specific provision on FGC was contained. However, the new Ethiopia Criminal Code deals in its third chapter with "Crimes committed against life, person and health through harmful traditional practices". In Article 565 female circumcision is prohibited, whereas Article 566 refers directly to infibulation and therefore distinguishes clearly between "lighter" and more severe forms of FGC which can be also recognized with regard to the penalty (Box 2).

Box 2: Ethiopian Criminal Code

Article 565: Female circumcision

Whoever circumcises a woman of any age, is punishable with simple imprisonment for not less than three months, or fine not less than five hundred Birr.

Article 566: Infibulation of the Female Genitalia

(1) Whoever infibulates the genitalia of a woman, is punishable with rigorous imprisonment from three years to five years.

³ The Maputo Protocol is the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa. It was adopted on July 11, 2003 by Heads of State and Government of the AU in Maputo, Mozambique; from there the name Maputo Protocol is derived. It entered into force on November 25, 2005.

⁴ More international and national treaties can be found summarized in the latest interagency statement of WHO, 2008: 31-32.

(2) Where injury to body or health has resulted due to the act prescribed in sub-article (1) above, subject to the provision of the Criminal Code which provides for a more severe penalty, the punishment shall be rigorous imprisonment from five years to ten years.

Furthermore, the Constitution of the Federal Democratic Republic of Ethiopia (FDRE) from 1994 protects in Article 35(4) women from any harmful traditional practices (Yegomawork, 2003: 8, 11). Ethiopia also ratified the Convention on the Rights of the Child (CRC) and the Convention on Elimination of All Forms of Discrimination Against Women (CEDAW). Despite ratification, the implementation remains a major challenge (UNICEF, 2005a: 2).

In 1984 a group of African women established The Inter-African Committee on Traditional Practices Affecting the Health of Women and Children (IAC) in Dakar, Senegal. Within the following 15 years, IAC founded affiliates in over 26 African countries.

Since 1987 *Ye Ethiopia Goji Limadawi Dirgitosch Aswogaj Mahiber (EGLDAM)*⁵ is representing IAC in Ethiopia and primarily carrying out FGC elimination activities. This NGO established eight years later, in 1995, 10 regional sub-committees, which are responsible for planning and implementing strategies in their particular region.

Several government ministries of Ethiopia also founded their own Women's Affairs Departments. So-called Women's Affairs Offices (WAO), firstly operating under the Prime Minister's Office, were established in 1994. Nowadays, they are working independently on governmental/national level and have offices in every of the 11 regional states. These WAO are closely cooperating with EGLDAM, but also UNICEF or UNFPA, regarding elimination activities of FGC. A Ministry of Women's Affairs was just recently established, in 2006, and is solely concerned with women's and gender issues (WHO, 1999a: 86; NCTPE, 2006: 115).

2.7.2 Approaches to Eliminate FGC

Since it is known that legislation on its own is more or less counterproductive and hardly bears any success at all (for the practice will be continued in secrecy), there was a call for a combination of laws with community programmes working on the grassroots-level. Interventions should especially concentrate on women who are responsible for the intergenerational transmission of the practice (Baron, 2006: 352). There is repeated call for change from inside, from insiders, who are coming from the communities under concern and who are directly involved in perpetuating the practice, like circumcisers or religious leaders (Elaniem, 1999: 105-106). Cardenas (1999) explained, "criminal sanctions might not work if

⁵ Since 2004 the former National Committee on Traditional Practices of Ethiopia (NCTPE) is officially called *EGLDAM*.

the majority of the society is convinced that female circumcision serves the common good, because criminal sanctions are only effective once a substantial body of public opinion has been raised against the practice” (cited in Baron, 2006: 351).

The original emphasis on harmful physical effects FGC causes, shifted towards understanding this act as a social phenomenon resulting from a gender definition of women’s sexual and reproductive roles. “It is a problem resulting from the use of culture to protect social dominance over women’s bodies by the patriarchal hierarchy” (Toubia and Sharief, 2003: 254). This should be kept in mind before designing new eradication programmes and strategies.

Many approaches to address the practitioners, the decision makers and the whole community emerged, but not all have been really successful. The organization *Rainbow* reviewed six approaches⁶ between 2001 and 2002 regarding their effectiveness. While the Health Risk Approach was leading to medicalization of FGC, the targeted circumcisers in the second approach were replaced in the communities through others from the neighbour village or even continued their work in order not to lose their customers and market. Even if the supply had been reduced, the demand was still present. Alternative Rites of Passage only make sense in communities where FGC is related to coming-of-age rituals (Toubia and Sharief, 2003: 255). They “preserve the ritual or symbolic component of FGM marking the admission of young girls into the community or into adulthood but without unduly harming their bodies” (WHO, 2006b: 5). In Kenya such interventions (“circumcision through words”) have been successful in the past. The *Maendeleo Ya Wanawake Organization* carried out extensive educational and awareness tours throughout the districts with the highest prevalence of FGC. In the Meru district it organized “circumcision” ceremonies for young girls without actually carrying out the physical FGC, all other rituals were performed and the participants declared adults without FGC (Magoha, 2000: 271).

But only when FGC is addressed within broader and combined health, literacy or economic development projects the approach seems to be fruitful (Toubia and Sharief, 2003: 256). In this case abandonment of FGC is part of a “development package” that includes reduction of poverty and of inequities and inequalities between the sexes, and an increase in access to education and health services, since these are the contributory factors for perpetuating FGC. Another approach is group discussion as well as media campaigns, to raise awareness among parliamentarians, religious and civic community leaders, traditional and modern health-care

⁶ 1. Health Risk Approach, 2. Targeting Circumcisers, 3. Alternative Rites of Passage, 4. Integrated Social Development, 5. Social Marketing Approach, 6. The Positive Deviance

providers and other decision makers (WHO, 2006b: 5). Much emphasis should lie on the involvement of religious leaders since they “have a strong network at community level” and furthermore can their opinion be understood as a “form of guidance for community members” (GTZ, 2007b: 2).

In general it can be stated that education (of especially women) rather than legislation is seen as a way forward. Education increases self-esteem and strengthens empowerment (GTZ, 2007d: 1). In families with higher socioeconomic status, girls and women might be more exposed to Western ideas through mass media and better educated, which vice versa might lead to less exposure towards traditional practices. Better educated women may have a greater understanding of the potential health hazards of circumcision and are less likely to select it for their daughters (Yoder, 2001: 17). This means that the mother’s characteristics may be better indicators of the type of FGC chosen than the girl’s characteristics since the girls have most of the times no influence on whether they are going to be circumcised or not and the relationship between mother’s level of education and how and whether their daughters will be cut, is obvious (ibid.:17, 30). An example from Egypt shows that infibulation and clitoridectomy have decreased not because of legislation but because of equal opportunities in and access to education and work for women (Kwaak, 1999: 37). Also in Ethiopian context, education is crucial. Over half of all women who undergo FGC have no education at all, whereas only 25 per cent of women who have received secondary education or above continue the practice (UNICEF, 2005a: 2).

The ICA uses traditional forms of communication like theatre, dance, music and story telling. It is believed, that when women, who have been affected by FGC, are actively involved in such programmes, it might effectively challenge the practice (Ladjali, 1993: 460). In general, community members should participate in implementing programs “as they might appear to be less imperialistic” (Baron, 2006: 352).

In Ethiopia, EGLDAM is mainly focusing on training of trainers (e.g. committee members, community leaders, journalists, teachers etc.), Information, Education and Communication (IEC) which includes material production, usage of mass media and information campaigns. Furthermore, EGLDAM generates alternative income for practitioners and mainstreams FGC into other agencies’ work (WHO, 1999a: 87-89). It is also working together with UNICEF and the Ethiopian Women Lawyers’ Association (EWLA). Advocacy programmes were implemented throughout the country to help victims and most importantly to prevent the continuation of FGC (UNICEF, 2005a: 2).

As we have seen already from the previous as well as the recent chapter, the fight against FGC and Good Governance go hand in hand. The practice of female circumcision is a societal problem, deeply rooted in culture and communities, which makes it necessary for the state to create an enabling environment for achieving positive change. Good governance does not only include respecting, protecting and guaranteeing human rights for a country's citizens, but also taking all efforts to reduce poverty, minimize gender inequalities, promote democracy and advocate transparency, all of which are more or less related to the practice of FGC. For avoiding top-down regulations and hence counterproductive results, good governance must also relate to informal local social orders and regulatory structures that have grown organically (GTZ, 2008: 1-2).

Reaching the overall goal of totally elimination all forms of FGC is still a very long road to go. Changes, especially from practicing type III to abolition, can not be expected to take place over night. Therefore, small steps like the practice of less drastic forms should be accepted, but attempts, to fully eradicate even them, continued.

Actually there is already a slight change visible. DHS data indicate that in many countries women aged 15-19 are less likely to have been circumcised than women in older age groups.

Nine out of 16 countries in which DHS has collected data demonstrate a marked decrease in prevalence in the younger age groups (15 to 25 years of age): Benin, Burkina Faso, Central African Republic, Eritrea, Ethiopia, Kenya, Nigeria, Tanzania and Yemen. In the remaining seven countries (Côte d'Ivoire, Egypt, Guinea, Mali, Mauritania, Niger and Sudan) prevalence is at roughly the same level for all age groups, suggesting that rates of FGM/C in these cases have remained relatively stable over recent decades. Of the four countries that demonstrate the highest rates of prevalence (Egypt, Guinea, Mali and Sudan) – none have shown any evidence of change in prevalence over time (UNICEF, 2005c: 7).

Furthermore, the opposition towards this practice seems to increase. The Ethiopian Demographic and Health Survey from 2005 showed that among the asked women only 31.4 per cent still support the FGC practice as compared to 60 per cent five years ago (Ethiopian DHS, 2005: 253). Nevertheless, the shift of attitude does not automatically lead to change of behaviour, i.e. abandonment of circumcision.

Hence, it is important that strategies for eradication must be holistic in the sense that community-based education and awareness-raising come together, the programmes are country specific and adapted to regional, ethnic and socio-economic conditions (UNICEF, 2005b: 28-29).

CHAPTER III

3. Profile of the Study Site

Plenty of books have been written about Harar, its inhabitants and their culture. There are so many facets, aspects and facts surrounding Harar that this thesis could be filled by writing only about them. For this is by no means the intention of this thesis, I will rather concentrate on some selected parts of this interesting culture which are in my opinion not only of importance to understand -at least a little bit- the Hararis, but also interesting for the reader who might never have heard about Harar and Hararis before. I would like to apologize in advance for the shortened version regarding history or cultural aspects due to the limited space attributed to the description of the study site.

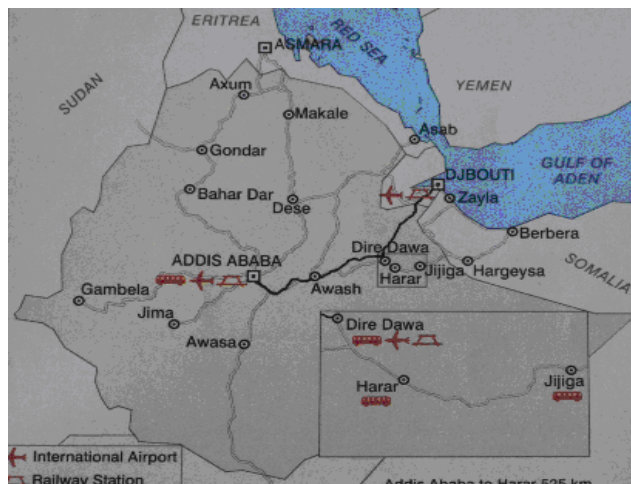
In this chapter emphasis was led on a general introduction to the history and present situation of the old city of Harar, called Jegol. Furthermore, the Hararis themselves, their houses and their culture are described. Finally, it will be referred to the main interest of this paper: FGC in Harari context, which serves as a kind of introduction and background information with regard to the study findings of the following chapter. It should be mentioned that all culture related terms are written in *italic* letters and described in the glossary that can be found in the introductory part of this thesis.

3.1 Harar

3.1.1 Introduction

The Harari region is located in the eastern part of Ethiopia, close to the city of Dire Dawa, and is about 525 kms away from Addis Ababa, the Ethiopian capital (Map 5). Harari region has altogether 17 rural and 19 urban kebeles, of which the urban ones are located in Harar.

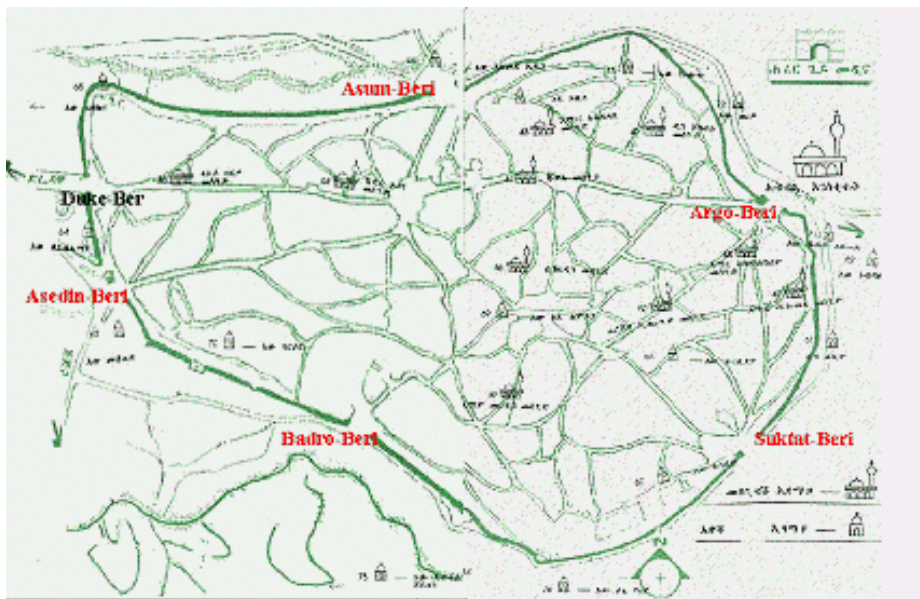
Map 5: Allocation of Harar within Ethiopia



Source: International Map of Harar, Ethiopia. CIRPS and Harari People National Regional State. 1st Edition, 2002.

Harar, the capital of the Harari region, is a historic Islamic town with an altitude of 1856 m as well as warm climate throughout the year. From its altogether 127,000 inhabitants (CSA, 2006: 54) half is constituted by the Hararis, the other half are Oromos. The indigenous Hararis are predominantly living in the old city of Harar, which is surrounded by a huge wall from the 16th century that was originally constructed for reasons of protection against enemies. The wall also preserved their own language, the Harari. Harar, due to its unique architecture and its huge importance for the Muslim culture, is one of the UNESCO cultural heritage sites and was awarded the UNESCO “City of Peace” Prize for its “contribution to the promotion of the values of peace, tolerance and solidarity in everyday life”. Harar is furthermore considered to be the fourth holiest city of Islam (after Mecca, Medina and Jerusalem) due to circa 84 mosques and numerous shrines which can be found in the walled city and this is also the reason why it is often called *Madinat-al Aouliya* (“the City of Saints”) (Map 6).

Map 6: Walled City of Harar- Jegol



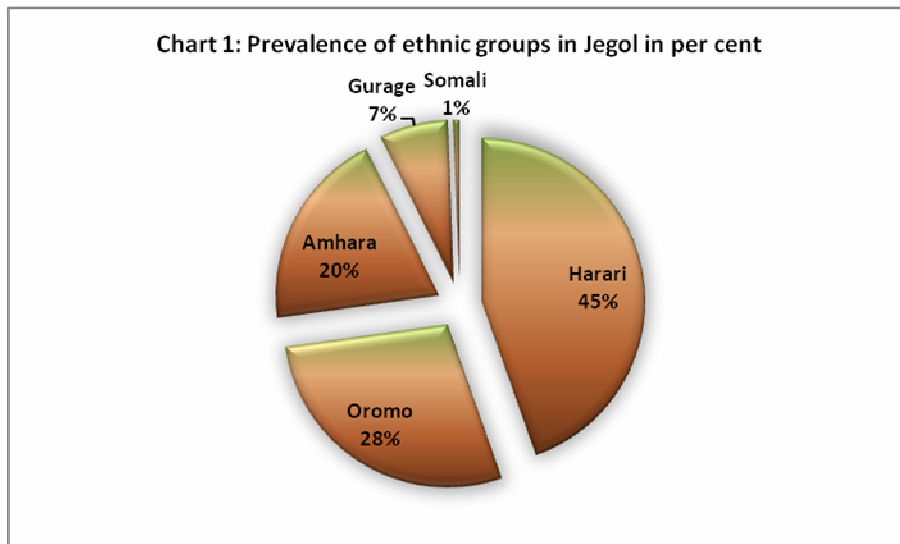
Source: Harari Architecture "Tradition" Magazine, Abdusemed Ahmed (Civil Engineer), May 1991, <http://hararconnection.com/Map2.html> (accessed on 10.10.2007)

The walled city of Harar –Jegol⁷- consists of two main kebeles (Amir Nur and Abadir) as well as 7 sub-kebeles which can be related to the two former ones (Table 1; for allocation of kebeles see Map 1). Jegol has a total population of 44,097, of which half is constituted by women, the other half by men. Although Jegol is still mainly inhabited by the indigenous

⁷ Originally, the term Jegol described the stone wall itself. Nowadays Jegol refers not only to the wall but to the old city in general. In this text, by using Jegol, the old city is meant.

Hararis, there are nowadays also Oromos, Amharas, Gurages and Somalis living inside of the wall.

As the survey conducted by me showed, from 177 asked men and women, about 45 per cent, i.e. one can say almost half, have been Hararis. Besides them many Oromos are living in Jegol, 28 per cent, whereas 20 per cent of the neighbours are constituted by Amharas and 7 per cent are Guarages. The amount of Somalis is very low, not even 1 per cent (0.6 per cent) (Chart 1).



Source: Survey conducted by the researcher in March 2008.

3.1.2 History

Harar's history starts many centuries ago. It is expected that a man called Haboba was the true founder of the city and its first Emir. The foundation is supposed to have taken place in the 7th century AD by Semitic speaking people. However, other names are more bound with the city's history and still today highly revered. The first one is that of Sheik Abadir Umar Al-Rida who came, as the legend tells, to Harar with an entourage of 43 other holy personalities. They are assumed to have originated from Hedjaz, a place in Arabia. The exact time of their arrival is not confirmed. Some sources make him a contemporary of Prophet Mohamed; others are dating either in the 10th or 12th-13th century. The last estimate seems to match with the Fath Madinat Harar (a Harari narrative in Arabic of the 18th century) which makes Sheik Abadir to have arrived in 1216. Abadir, who accomplished many miracles, finds his immense importance for Harar reflected in expressions like *Aw Abadir Gey*, which refers to Harar as "The City of Father Ababdir". Furthermore is he the only of the 44 famous Arabic men whose tomb can be find within Jegol (Cities of Ethiopia, 2007: 1-2).

Another important name in Harar's history is that of Emir Nûr. In 1520, Harar became capital of Muslim Ethiopia after Sultan Abû Bakr decided to settle over there. One of his Emirs, Ahmed ibn Ibrahim (later called "the Left-handed"- *Gragh*), adopted the title of Imam, assassinated the sultan and started to fight and overthrown the remaining Christian forces, reigning in the rest of Ethiopia. In 1530-31 the whole empire of Ethiopia was conquered. Ahmed became ruler of Ethiopia whose churches he burned and whose inhabitants he converted to Islam. After his death in 1543, Emperor Galawdewos tried to restore the kingdom of his father. But in the 1550s Nûr became more and more influential in Harar and defeated the imperial armies at the end of the 16th century. Galawdewos was killed during this battle and Nûr returned triumphal to Harar. After Imam Ahmed, Nûr was given the title Sahib Al fath ath-thâni, which means "second conqueror". However, Nûr was already awaited by another threat to his city: the arriving Oromos, who started to settle in Ethiopia at this time. To protect Harar from their migration as well as the Christian forces, Nûr is said to have been responsible for the erection of the huge stone wall⁸, known as Jegol, through which the unique Harari culture, their language and their identity were preserved and maintained until today (Cities of Ethiopia, 2007: 3-5). The Hararis see their city as the city *par excellence*, and are referring to this condition by adding the word *gey* ("city" in Harari) to all issues/terms related to Harar like *gey sinan* ("language of the city"), *gey ada* ("culture of the city") or *gey usu* ("people of the city").

There are five gates⁹ in the wall which allowed Harar to be connected to the surrounding areas. The five portals are Asmaddin Beri in the west, Badro Beri in south-west, Suqutat Beri in south-east, Argo Beri in the east and finally Assum Beri in the north (see also Map 5). During the time of the Emirs, the gates were kept watchfully during the day by a particular appointed officer, who was mostly of Amhara origin and known under the name "Berhanu". The officer closed and locked the gates at dusk and handed over the keys to the respective Emir who kept them over the night (ibid.: 6-9). Several holes which can be found in the wall were planned to allow hyenas enter at night and eat the leftovers and therefore clean the streets and alleys.

Since the construction of the wall, no foreigner was allowed to enter the city. But since the 18th century Harar flourished in terms of commercial trade because of its ideal location

⁸ The wall covers an area of 48 hectares, has a total circumference of 6.666 cubits, a height about four metres and a thickness about 50-75 centimetres.

⁹ Hararis relate the circumference of the wall (6.666 cubits) and the number of gates (5) to the number of verses in the Holy Qur'an (6.666) and the five pillars of Islam as well as to the five daily prayers.

between the Gulf of Aden and the Ethiopian Highlands¹⁰, also explorers like Richard Burton found their ways to the Horn of Africa. In January 1855, the disguised Burton entered the “forbidden city”, stayed 10 days and wrote down his experiences in a chronicle titled “First Footsteps in East-Africa”. In 1875 Harar was conquered by the Egyptians who left it again in 1884. They left behind buildings like the “Egyptian Bank” constructed during their occupation. Emir Abdullahi, who tried to expel the foreigners from his city, was defeated in January 1887 at the Battle of Tchellenqo which he was fighting with Menelik, King of Shoa. Harar lost its last Emir and was annexed to the Ethiopian Empire whose administration was forwarded to Ras Mekonnen. After the reign of Haile Selassie I. (1930- 1974) and the militaristic regime of Mengistu Haile Mariam (1974-1991), Harar has become an autonomous administration with the creation of the “Harari People’s National Regional State” (Ahmed Zekaria, 2007: xii). There is an idiom referring to the special status of Harar through time: *Harar through the centuries walked tall as a city, when others were just limping as a village.*

3.2 Study Population: Hararis

The Hararis have a very strong identity bound with their culture and city. During my time in Harar, I met many people who left Ethiopia during the time of DERG¹¹ and returned after many decades to Harar. “*More than twenty years are enough*” said one of my informants after I asked him why he returned after such a long time of living abroad. Whether the reasons are bound to the birthplace or rather of personal nature, many Hararis tried nevertheless to hold the ties with their origin throughout the years, and this is nowadays much easier through internet platforms and other modern communication opportunities. However, for making it more attractive for the diaspora to return to their town and invest their accumulated money in Ethiopia, it is not only assured for every Harari to be employed in one of the government offices, but they also will be offered cheap land for purposes of construction.

Not only Hararis living outside of Ethiopia try to uphold their identity, also Hararis living in Harar are proud by their origin. I asked one friend of mine what it meant to him being a Harari. He answered:

¹⁰ Harar was especially known for its coffee and produced and exported it already during the 16th century. Nowadays coffee as an export source is remaining, but more and more replaced by the more lucrative *khat* which is sold to Somalia, Yemen and Europe.

¹¹ During the transition time between the reign of Haile Selassie (until 1974) and the DERG, i.e. the socialist regime in Ethiopia (1974-1991), Hararis founded an Opposition Party “Ehapa” that was the students’ movement against the government, which they highly criticized and wanted to be replaced by another one. During this time estimated 15,000 Hararis died and 10,000 left the country. After the socialist regime started to govern, especially young men, also under age, were recruited to join the National Army. Within another refugee wave, 5-7,000 Hararis left again the country, most of them via Somalia to the USA or Canada.

I think we mainly distinguish ourselves from other Ethiopians by our culture. We are all living in a very dense area, in Jegol, which is unique in Ethiopia. Our clothes, the colourful dresses of the women, the spectacular traditional weddings, the unique basketry, where else do you find this? However, our culture is anyway rather bound to the Arab than the Ethiopian world. Last but not least, of course we are a minority and proud by achievements we made and the great historical past we can rely on.

3.2.1 Gey sinan- The Language of the City

The Hararis were isolated throughout many centuries, protected by the huge stone wall that tried to keep their identity and their language, too. This can be observed nowadays by talking to elderly people. I was told and also experienced this on my own in the house where I have been accommodated, that elderly women not seldom do not speak any other language except Harari. For them, there was never the need to learn Amharic since they remained staying and living in their town dealing with other Hararis, who speak the same language. In recent days, however, some elders speak also Afan Oromo, not only because it is one of the two official government languages, but also since many cleaning personnel, employees and market sellers are Oromos and a conversation for instructions and advices requires a common language.

Harari, the *gey sinan*, derived from a common origin like Amharic or Tigrigna¹² and belongs to the Semitic language family. It uses the same alphabet as Amharic and has adopted many words from Arabic due the close ties which existed during time of trade.

Whereas within Jegol most people still speak Harari; the predominant language of the new city, outside Jegol, is Amharic. In rural areas of Harari region most people speak Afan Oromo. The two languages which are used in government offices in the Harari region are Harari as well as Afan Oromo.

3.2.2 The gey gar- The Traditional Harari House

The Harari house makes Harar and its culture so special. Every visitor, entering a traditional house for the first time, will be amazed about the beauty of the inside part, the decoration of the walls with baskets and the height of the rooms. One is not expecting these cube-shaped houses to be that huge inside, as to offer enough space for a living room and usually two extra rooms which are either attached at the same level or on a second floor upstairs. Nowadays they are used for sleeping purpose. Every item, every colour and the way how everything is arranged and organized tell a story or at least have a particular meaning.

¹² Amharic is the official language, but also a lingua franca in Ethiopia and spoken by almost everyone, whereas Tigrigna is restricted to the northern region of Ethiopia, Tigray, as well as the neighbour country Eritrea.

The Hararis started to construct their houses about 1000 years ago. The *gey gar* are made of sand stone (*hashi un*) and mud and the height of the rooms (4 metres) and the thickness of the walls always guarantee a pleasant cool climate inside of the house throughout the year.

When entering a *gey gar* through a highly decorated wooden door, called *gar beri*¹³ (Photo 1), the first thing which catches one's attention are the *nadabas*, stages of different size and level that are decorated with carpets and pillows. The different levels of *nadabas*¹⁴ are attributed to people who can be distinguished according to their rank, knowledge; age and social status (see Photo 2).

Photo 1: Gar beri



A traditional *gey gar* can be divided into one big room, the *gidir gar*, and two additional rooms at the same level, *kirtat* and *deira*, of which the latter serves as storage for household goods, the other one as bed room. The upstairs room, nowadays an additional bed room, is called *quti qala* (see Photo 4). Furniture are not necessary since the shelves are already carved into the walls as niches (*taqets*), which serve different purposes today: exhibit handicraft like baskets and pottery, or keep books or household items as pots, pans and classes.

Photo 2: Nadabas in the gidir gar



Another compartment which is inside the wall called *kabat* can be locked and represents a kind of cupboard which intends to accommodate clothes (see Photo 3). In every Harari house, the *nadabas* will be painted red, symbolizing the bloodshed and the deaths of many young Harari men during the war against Menelik. Although the similarity

¹³ The *gar beri* used to indicate how rich the owner of the house was. The richer the door was decorated with grooves and ornaments, the wealthier the inhabitant seemed to be, the higher his social status.

¹⁴ The names of the *nadabas* are pointing to place and size of the particular stage and indirectly to the person who was supposed to sit there: *amir nadaba* („king“), *gidir nadaba* (“big”), *sutra nadaba* (“hidden”), *tit nadaba* (“small”) and *gabtieher nadaba* (“back door”).

between the houses represents the solidarity and the unification among the Hararis, they can be nevertheless distinguished by different coloured walls and items which are displayed.

Photo 3: Decorated wall and *kabat*



Photo 4: To the *quti qala*; below *kirtat* and *deira*



3.2.3 Social Activities

One of the countless social activities that can be carried out in the *gidir gar* while sitting and lying on the *nadabas*, is definitely *bertcha*. It is the social gathering originally in the afternoon. Friends or family members join together for having a *khat* ceremony. *Khat* (lat. *Catha edulis*) are the leaves of a bush that is growing in Arabia and Africa, which are either chew or drank as tea and used as narcotic/stimulant. Since chewing the leaves of the *khat* bush takes several hours, the same time it takes to achieve different levels of mind bending, it is ideal to spend the meantime with your friends, to chat, talk, exchange news and information and just have a nice afternoon. The *khat* leaves are said to make you first being talkative, later on you turn in a condition of alertness, despite you are going to be much calmer, concentrated on yourself. However, many people suggested to me to chew *khat* especially when one has to concentrate on work, research or to study for exams. The late stage makes one awake for many hours, why many people cannot go to bed early, rather staying awake until late evening or even early morning, and therefore are not able to get up again after sunrise.

Khat also has a high value in the case of weddings. It is expected that the family of the future husband will bring a bundle of *khat* to the family of the bride meant as engagement gift or rather to confirm the engagement. The girl's family will do the same in turn. This exchange of *khat* symbolizes the mutual engagement of both families.

Originally intended to be used on rare occasions, like weddings or funerals, but also on Saturday afternoons, and for religious purpose, the *khat* consumption was rising enormously during the last decades. Although part of the Harari culture, the excessive usage of *khat* constitutes not only advantages in terms of maintaining friendship. Nowadays, some people's only goal is to buy new *khat* in the morning, to start chewing around noon, staying awake until midnight, just for repeating this procedure throughout the week. I also met people who told me, extensive *khat* chewing would result in suppression of hunger which makes people losing too much weight. Another reported side effect is that the simultaneous consumption of cigarettes or even alcohol was not the original intention of the *khat* ceremonies since Muslims are normally prohibited from drinking alcohol.

Khat, highly profitable for the owners who are selling it (one bundle costs between 50 and 100 ETB depending on the quality), replaces nowadays coffee more and more in terms of cultivation, export and fame for the region.

3.2.4 Other Harari Identifiers

Clothes

Traditional female Harari dresses are very beautiful. Shimmering in colours as pink, violet or red, they are decorated with many shiny applications in gold and silver. These clothes, the *gey iraz* ("garments of the city"), consist of a leggings-like (skinny-like), very tight trouser, the *gey genafi* ("trousers of the city") which can have different colours and designs. Furthermore is there a dress called *tai iraz* which is worn above the trouser and which due to its immense length has to be wrapped around the waist for shortage purpose and therefore gives the impression the woman would wear two skirts or dresses above each other. Finally, the cultural dress is topped by a scarf. Previously, the women were supposed to wear a *hashama* after wedding. A *hashama* is a scarf which is wrapped and bound in such a way around the head that two "bags" are created in which the hair is "collected" and that are positioned on both sides of the face next to the cheeks. Although rare today, elderly women can be still seen wearing *hashama* and *gey genafi* every day. Normally, the traditional dress with all its components is worn at weddings and funerals. For the latter occasion the *tai iraz* is worn inside-out which gives appearance to its black inside colour.

Since the applications are handmade, I was told, the dresses would be very expensive; understandable once one has seen them.

Basketry

Harar is known for its basketry. They are not only prepared for household usage, but also displayed in almost every *gidir gar*.

In the past, mothers used to teach their daughters how to make and decorate a basket in an appropriate manner. But even today, basic basket making remains a skill common to all Harari girls and women. Every mother-in-law still expects from her daughter-in-law a particular basket called *hamat mot* which is said to symbolize the following: The *hamat mot* is the gift of every daughter-in-law to the mother of her husband. Before she is handing over the basket, there is one year of making and preparing it. It is the year after the wedding took place. During this time, the new bride is not expected to prepare any kind of food, only to fulfil other household tasks like washing clothes and- making the *hamat mot*. The food is prepared during this year by the mother-in-law and other female relatives, so there is enough time remaining to deal with basket making. To hand over the accomplished piece, is not only a symbol of the thankfulness of the son's wife, but it makes every mother-in law proud. Therefore, the *hamat mot* will be exhibit in the *gidir gar* of the mother-in-law, visible for every visitor who immediately understands that the son of the lady is married.

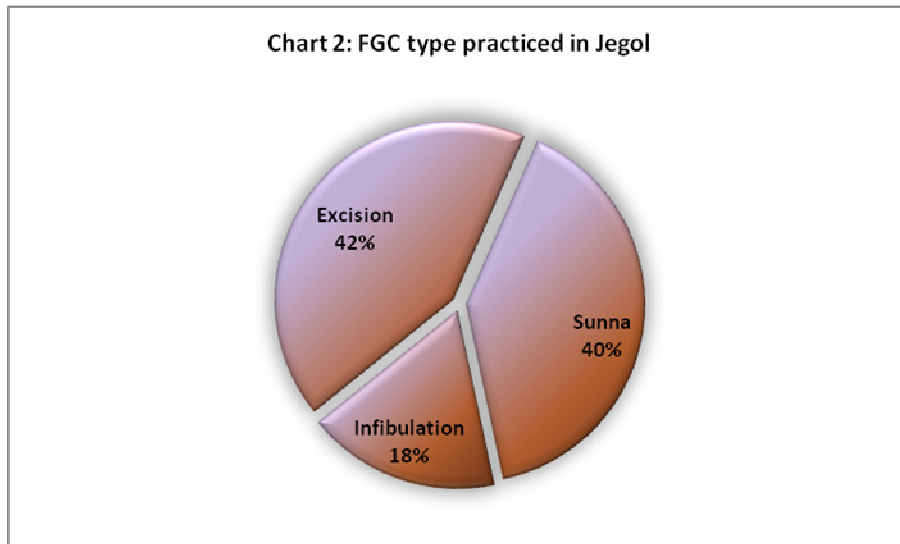
The making of baskets with complex decorative arrangements of geometric patterns and designs remains a rare craft and hence a high-valued good of Harari culture.

3.3 Harar and FGC

3.3.1 Prevalence, Type and Age

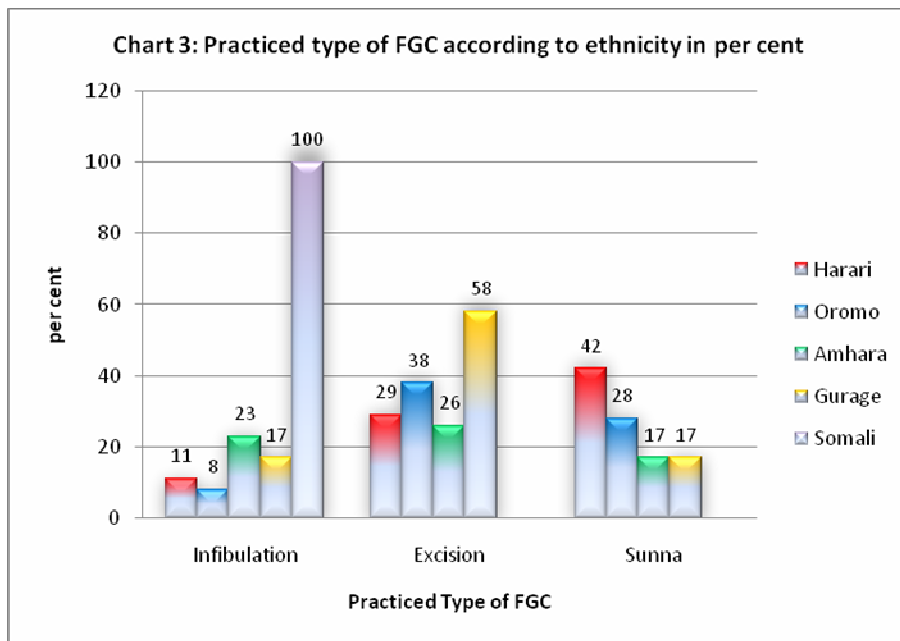
According to the Ethiopian Demographic and Health Survey (DHS) from 2005 almost 100 per cent of women living in the Harari region heard about FGC and 85.1 per cent are circumcised. About 13 per cent of the circumcised women underwent type III, infibulation (Ethiopian DHS, 2005: 253).

The results of my survey showed similar estimations. About 81 per cent of the interviewed women living in Jegol underwent circumcision. When asked about the practiced type, women referred to themselves and husbands to their wives as follows: The most frequent practiced type of FGC is excision, FGC type II, with 42 per cent followed by *sunna* (40 per cent) and infibulation (18 per cent) (Chart 2).



Source: Survey conducted by the researcher in March 2008.

Almost 92 per cent of the women, who underwent any type of circumcision, got circumcised at the age between 6 and 11. While the age at which FGC is done is not much differing among the different ethnic groups, the following Chart 3 illustrates at best which ethnic group practices which type of FGC.



Source: Survey conducted by the researcher in March 2008.

Among the interviewed Hararis, the majority (42 per cent) underwent *sunna*, followed by excision (29 per cent) and infibulation (11 per cent). Most of the Oromos practised excision (38 per cent), followed by *sunna* (28 per cent) and infibulation (8 per cent). Surprisingly many

Amharas were infibulated (23 per cent). Only excision is carried out more often in 3 per cent of the cases. *Sunna* is estimated to be done by Amharas at a percentage of 17. Although literature is stating that Amharas are mainly practicing *sunna*, type I, a possible explanation can be found in merging of ethnic groups by weddings and assimilation since Jegol itself is not a vast area and closely living together might change customs over a period of time. 58 per cent of the participating Gurages told they or their wives underwent excision, while *sunna* and infibulation are practiced both at a range of 17 per cent. The 100 per cent in the case of Somalis referring to infibulation only came into existence because a single Somali woman was interviewed. This data is therefore not representative; nevertheless it is known that infibulation is practised by Somalis at a very high percentage (compare earlier statements under chapter 2.2).

3.3.2 History of FGC in Harar and Approaches to Overcome

During my first visit, as stated earlier in this thesis, I mainly concentrated on general facts about FGC in Harar. Therefore, I interviewed former and present employees of the WAO.

The WAO in Harar started its work regarding female circumcision about 15 years ago. During this time, it was not only a shame to talk about this topic; rather no one talked about it at all. It was also the time when infibulation was very prevalent.

From the very beginning, WAO collaborated with EGLDAM, which was still called NCTPE at this time. NCTPE's contribution was considered to be an icebreaker. Influential persons, like practitioners and kebele chair persons, had been selected to attend an awareness creation workshop. Afterwards they were asked to forward their knowledge and teach about the health perspectives of Harmful Traditional Practices (HTPs). People started to condemn it because they understood the cons of these acts. Since the issue of FGC was difficult to discuss on grassroots level, the right choice of role models and change agents was of paramount importance.

NCTPE also decided to show a motion picture movie to the people for teaching purpose. The movie, originally from other Muslim countries like Morocco and Egypt, was enlightening about physical and psychological consequences of FGC. People reacted so touched, sensitive and shocked, that it obviously really had influence on how they thought about the practice of FGC afterwards. It was considered as the first step to condemn it. At the same time, offices started to educate children at the age of 7/8 years (the age in which they normally got circumcised) and the film was showed to them. They reacted similar as compared to the adults: They refused to be circumcised.

The following question was raised during this time: Is the practice of FGC a religious or rather cultural order? The consensus was found that religion is definitely not forcing anyone to be mutilated. However, it was difficult to approach religious leaders since they shut their ears towards Western opinions and prohibitions. Hence, doctors, gynecologists and religious leaders (Muslims, Ethiopian-Orthodox Christians and Catholics) came together and discussed the issue with the outcome that circumcision is not a religious demand. Afterwards, a committee related to FGC was founded and many interviews with victims conducted.

The ties with religious leaders have been and remained very close because without their contribution the target of abolition of FGC could not be reached. Since the people are rather listening to them, religious leaders became part of different media programmes. They show their cooperativeness by coming to meetings and workshops and talking about that even religion condemns the practice of FGC. And since the grassroots community was asked about the reason for the continuance of the practice and the common answer has been "*it is part of our religion*", the contribution of religious leaders remains of major importance.

Later on different NGOs emerged, one of which was Intra Health International. This NGO had much budget and resources and started to use leaflets, brochures and local media to broaden information on FGC in Afan Oromo, Harari as well as Amharic.

Still 5 to 6 years ago, no Harari girl was uncircumcised, female genital cutting was almost universal and surrounded by big party celebrations. Then, Intra Health initiated that gate keepers, religious and community leaders started to control their areas and circumcising families were charged and punished. This public discussion and enlightenment finally lead to the real circumcision being substituted by a ceremony during which the girl would just be pricked in her arm for making her believe that she was circumcised.

About four years ago Intra Health organized the following: A girl announced in public that she was not circumcised and was eventually rewarded by Intra Health. This girl told about her sister and how she suffered when she had to undergo FGC. The openness made her not only receiving plenty of encouragement, but also opposing opinions. However, after her announcement, 40 school girls formed an Anti-Circumcision Group, which started to work as watchdog in the society since it searched for the practitioners of female circumcision. This action was not only preventive; the detected cases were also reported to the kebele chair man. One and half years ago, the first Anti-FGC-Clubs were established. Nowadays, Anti-FGC-Clubs, which are led by students, are operating in five schools.

Today, the Penal Code of Ethiopia prohibits any kind of female circumcision, because of which it is no longer practiced in public or surrounded by big parties. In the past, girls asked

their parents to be circumcised because of huge amount of gifts they received. After prohibition of FGC and the abolition of gifts and celebrations in public, the practice was decreasing or turned at least to a hidden agenda. Since the awareness in the town is very high, girls are circumcised outside, in rural areas, in the countryside. The problem over there remains crucial. The people are illiterate and believing that circumcision decrease a girl's sexual feelings. Here, the focus should lie, but also on young children in general to prevent circumcision in the future. Nowadays, people are talking about the disadvantages and the practice is condemned even by many mothers and fathers. Refusal can be found among the grandmothers or the elder generation in general since they are saying: "*Abolition is against our culture.*"

However, every month one facilitator from the WAO, who works as a role model, religious leaders, women representatives, the kebele chairman, kebele secretary, one kebele justice representative as well as 17 inhabitants of one kebele come together and are taking part in discussions related to family planning, HIV/AIDS and other health related issues including FGC. These community discussions are concentrating on the rural kebeles of Harari region during these days. I observed one of these community discussions during my third stay. Staff of WAO drove to the Erer Valley, a very mountainous region, nevertheless fertile due to a river stream down in the valley. However, Oromos inhabit this region and the practice of FGC remains a crucial issue. That is why the WAO decided to show the motion picture movie which was mentioned earlier in the text. People of different age, sex and rank came together in one of the two class rooms of the local primary school and waited for watching the video. However, since it was also my first time to see the video, I was as shocked as most of the present people. The video showed in detail how a girl is circumcised, excised and afterwards closed by using needle and thread. The screams and shouting of the girls have been so unbelievable horrible demonstrating the cruelty of the act, that the majority of the people during the afterwards discussion immediately promised not to practice FGC anymore on their children and grandchildren. One little girl, maybe aged 2 years but not older, watched the video, started to cry and detached herself from the embrace of her mother since she thought she would experience the same like the girl in the video. Although the mother tried to calm her down, she refused to stay any longer side by side with her mother and was running, under the laughter of the surrounding people, to her grandmother, who opened her arms to embrace the girl. Despite 10 years ago infibulation was still present in the Harari region and is according to different sources expected to be absolutely abandoned, *sunna* is still practiced.

Its abolition remains the final target of the joined forces of government officials, religious leaders and the Harari community.

CHAPTER IV

4. Research Findings

4.1 Socio-economic Background of Informants

When I conducted my survey, I split the questionnaire into two parts. In the first part I was mainly concentrating on general background information of the respondents as this is important with regard to their answers on FGC related questions. In this connection I raised questions regarding the sex, age, ethnic background, religion, and number of children, marital status and their occupation.

The following gives an overview on some selected components.

4.1.1 Sex, Age, Marital and Educational Status

Table No. 3 shows how frequent different social variables like sex, age, and educational as well as marital status can be attributed to the respondents of the survey.

62.2 per cent of all 177 interviewees have been women, whereas the remaining 37.9 per cent were male. Also in the case of individual, in-depth and one-to-one interviews the majority of the people who were cooperative to answer some questions have been female. This was due to the solely reason, that women are directly affected by the practice of FGC, whereas men are not. Nevertheless, did also men play an important role in this study, because they are the ones who are going to marry women, whether they are circumcised or not. They are the ones, who have been afraid of female sexuality in the past. Hence, their inclusion in a study about FGC speaks for itself.

The majority of interviewed men and women have been between the age of 25-34 and 35-44 (which accounts for 28.8 per cent and 27.7 per cent respectively). Another 21.5 per cent were between 15 and 24 years old. Adolescents below the age of 15 count only 1.1 per cent. Men and women of the age group 45-54 make up 12.4 per cent of this study, while the remaining 7.4 per cent can be attributed to elder people above 55 years. In the case of the one-to-one interviews I also tried to keep the balance between the ages since different opinions regarding the practice of FGC are expressed by different age groups and hence I tried to interview at least one representative of every decade starting from an age of 15.

An approximately 39.6 per cent of the people interviewed received secondary education, i.e. visited school at least up to grade 10. This is represented by the majority of the participants of the survey. The second most frequent received educational status is primary education (17.5 per cent) followed by illiterate people with a percentage of 17 per cent. At least 13 per cent visited colleges or universities and therefore joined higher educational institutions. The

remaining 11.3 per cent are only able to read and write. When analyzing according to sex and age, it can be stated that the majority of young people of the age 15-24 and 25-34 received secondary education independently from the sex. Primary education is most prevalent among the interviewees between the ages of 35 and 44. The majority of illiterates are aged between 35 and 55+. Higher education only appears among the younger generation in its early twenties up to the age of 44. Most women participating in the survey had either secondary education (42.2 per cent) or were illiterate (22 per cent), followed by primary education (15.6 per cent) and reading and writing only (12.8 per cent). Only 8 out of 109 asked women attended a higher education training institute (7.3 per cent). Out of 65 men that participated, most received secondary education (36.9 per cent), followed by higher education (23.1 per cent) and primary education (21.5 per cent). In the case of reading and writing only and illiteracy, only 6 cases count for it respectively (9.2 per cent each).

Table 3: Frequency and percentage of variables like sex, age, education and marital status

SOCIAL VARIABLES	FREQUENCY	PERCENTAGE
Sex		
Female	110	62.2
Male	67	37.9
Age		
less than fifteen	4	1.1
	38	21.5
15-24	51	28.8
25-34	49	27.7
35-44	22	12.4
45-54	13	7.4
55+		
Education		
Higher Education	23	13
Secondary Education	70	39.6
Primary Education	31	17.5
Reading and writing only	20	11.3
Illiterate	30	17
Marital Status		
Single	37	20.9
Married	128	72.3
Divorced	6	3.4
Widow	6	3.4

Source: Survey conducted by the researcher in March 2008.

While holding the individual interviews, most elderly people were illiterate; interviewees between the age of 35 and 50 received at least primary education, whereas younger women and men visited school up to grade 12 and in most of the cases continued their education at diploma or bachelor level.

A huge majority of all participants has been married (72.3 per cent), which seems logical when bearing in mind which age groups have been predominantly interviewed: 25-44, an age in which most girls are finding a husband and also men are reaching the stage of life being ready and capable to afford a wedding. Although Harari girls are marrying at an early age today, the generation of their grandmothers (55 years and above) waited until they reached at least the 30th or 35th year. The reasons can be seen in the complex and expensive wedding ceremonies and dressing styles. Furthermore, was the wife-to-be expected to collect all the baskets and decorative items, which have been intended to be displayed in the *gidir gar* of the common house, before the wedding takes place. If she had less financial means, she was asked to prepare them by herself which took a lot of time, otherwise buying them would have saved time but was on the other hand extremely expensive. During this time it was also usual to choose the right husband, to be selective according to his economical status, his behaviour, and his family background, which again was time-consuming. Until all of those requirements have been fulfilled, the women had reached already the mentioned age. Today, only the basic items for the common house are collected and the exhaustive wedding ceremony with all its components is no longer a cultural imperative. Hence, also younger girls are expected to marry.

However, 20.9 per cent of the young people (age up to 24) participating in the survey is still single, whereas divorced people and widowed women account for 3.4 per cent each.

4.1.2 Respondents' Religious Background

From the table below it can be understood that the majority of the informants living within Jegol are either Hararis or Oromos (45 per cent and 28 per cent respectively). An overwhelming 84 per cent of them are followers of Islam, whereas 15 per cent have chosen the Ethiopian-Orthodox belief as their faith and one per cent is Catholic.

Islam has a very high importance for Hararis and, as already described in the historical and cultural chapter, is also manifested in the construction of the ancient Harar: Jegol. Its circumference of 6.666 cubits is expected to refer to the 6.666 verses in the Holy Qur'an. The five gates inside of the wall are said to symbolize the five pillars of Islam as well as the five daily prayers and even the five *nadabas* in every cultural Harari house are pointing to these

facts. During one interview with the head of the Office for Islamic Affairs, Ibrahim Sharif, he summarized what makes Islam being special in Harar:

All the history of Harar is Islamic. Once it was one of the four known Muslim cities. People were involved in studying and spreading Islamic affairs. By 48 hectares we have 84 mosques. There are so many things related to Islam. If you take the wall as whole: It says it is 6.666 cubits which refers to the 6.666 verses in the Qur'an. Another thing, are the five gates. Even if you go to the cultural houses you have got 5 "nadabas" that point to the five pillars of Islam. Therefore, Harar has been the fourth holy centre of Islam. It makes it unique. At the same time, people living here are almost all Muslims. If you go to the countryside all around here, people are followers of Islam. We have about 140 shrines. So if there will be any problem, people have contact to each other, can help each other.

Table 4: Frequency and percentage of variables like religion and ethnicity

SOCIAL VARIABLES	FREQUENCY	PERCENTAGE
Religion		
Islam	148	83.6
Ethiopian-Orthodox	27	15.3
Catholicism	2	1.1
Ethnicity		
Harari	79	44.6
Oromo	50	28.3
Amhara	35	19.8
Gurage	12	6.8
Somali	1	0.6

Source: Survey conducted by the researcher in March 2008.

4.1.3 Occupational Status

Most of the female participants in the survey stayed at home as housewives which can be indicated by 22 per cent of the answers (Table 5). This is valid for almost all elderly women as well as medium-aged ones. Previously, we were informed that these generations are illiterate or received at maximum primary education. Many of these women took responsibilities for the household, gave birth to children and were the ones rearing them.

Another relatively high percentage of about 23 per cent accounts for government officials of both sexes. Many young Harari people are employed in one of the countless government offices since vacancies are occupied first of all by Hararis. Still 17 per cent are students, either

at school or at higher education institutions. Business women and men are represented by 10 per cent each in the study. Less frequent occupations have been farmer, driver, daily labourer and health workers.

The majority of one-to-one interviewees have been either government officials or housewives.

Table 5: Frequency and percentage of occupational status

SOCIAL VARIABLE	FREQUENCY	PERCENTAGE
Occupational Status		
Housewife	39	22.3
Farmer	4	2.3
Driver	2	1.1
Daily Labourer	14	8
Business Woman	18	10.3
Business Man	18	10.3
Health Worker	2	1.1
Nurse	1	0.6
Government Official	41	23.4
Student	30	17.1
Unemployed	6	3.4

Source: Survey conducted by the researcher in March 2008.

4.2 Experiences of Women with *gey absume* and *arab absume*

From different literature it is known that circumcision is a painful, traumatic and shocking experience for girls and women alike which may last up to a high age with appearance of different late problems and complications, for instance during delivery which can be attributed to circumcision. However, also problems during sexual intercourse, especially after infibulation, were reported by plenty of women experiencing this kind of genital cutting.

Due to the cultural sensitivity, it was impossible to raise questions regarding sexual matters during my interviews with Harari elderly women since they are too private, too sensual, and too intimate. That is why the detailed description of the circumcision and feelings related to it are missing. Also with reference to problems which arose afterwards, the interviewees remained general in their answers, not willing to go into detail. This aspect had to be accepted by me. Here, the survey conducted may be a helpful contribution to understand from which consequences elder Harari women suffered most. In contrary, it was surprising how open the men have been. Especially problems during sexual intercourse they mentioned because men are not expected to take part in the delivery process of their wives. Also young men and women spoke frankly about the disadvantages, emphasizing the decrease of sexual enjoyment.

In the cases as will be described on the following pages, all names of interviewees had been changed or rather invented by me to secure their anonymity.

4.2.1 Preparation, Circumcision, Recovery

The following cases will show how women of different age experienced their own circumcision and the surrounding activities. *Gey absume*, “the circumcision of the city”, refers to infibulation. The term including “gey” demonstrates how deep rooted the practice has been in the past since it was obviously very tightly bound to Harar. In contrary, *arab absume*, “circumcision of the Arabs”, points to *sunna* having originated in Arabia.

Case 1

Nuria, a 70 years old Harari woman who never received any kind of education and therefore remained housewife, told me the following about the time of her own circumcision.

The circumcision period was divided into two parts: first, pre-circumcision period, during which there was food prepared like bananas, “kollo” and other things; after the circumcision another ceremony was organized, a small family ceremony taking place at home for which also some neighbours have been invited. They all brought some kind of rewards for me, gifts like meat, honey or even money. The time difference between these two ceremonies was not more than one day. Circumcision which was practiced at these days was “gey absume”, i.e. infibulation. I got circumcised at the age of 6. I was informed that the circumcision would take place; I even asked my mother in advance when the time would be. I wanted it, I was eager to get circumcised, I was happy at this time, because this was required for growing properly, for being a woman. My circumciser was an Oromo woman, who was well-known for carrying out the procedure, whereas most Hararis did not know how to perform it. The woman came from the surrounding area and was well-paid for the circumcision. She used a knife for cutting. After everything was cut, some thorns were used to close, attach the two parts to each other. The thorns were removed after I was recovered. Everything took place in the house of my parents. I do not exactly remember the amount of people which were present, but I think my mother as well as some women who held me down. The feeling during the procedure is somehow common, after circumcision you are bleeding. Although it was painful and I cried of course, I was not angry about my parents, because how can I refuse them? I accepted the idea; it is part of the tradition.

The recovery time in my case was about 7 days. Traditional medicine was used for recovery: “karabi” as well as “khol”. The medicine was applied every day to fasten the healing process. During these 7 days, I got special food to gain back my strength: meat and “ukhat”

made by “tuftuf”. I drank honey, whereas milk was not allowed, because it was believed to elongate the recovery process.

Case 2

A similar description of this time I heard from Meymuna, who is in the same age group as Nuria. Also Meymuna is illiterate and has one daughter only.

I got circumcised at the age of nine; they practiced “gey absome”. During pre-circumcision time food was prepared (like meat, honey, bananas, “fanish”, the same occurred after the circumcision. This took place only within the family. Everything took place at one day.

I was informed and actually looking forward. I wanted to be a woman and protecting myself from different evil things, like sexual intercourse, protecting my virginity, being clean. Being a woman means being a virgin.

They used a knife to circumcise me, named “shalda”, which is a special knife for circumcisions. Where it was coming from, I don’t know. The circumciser came from the Harari community, she worked as circumciser, as traditional midwife, traditional birth attendant. My mother decided on my circumcision. Because it is many decades ago, I don’t remember any details regarding the circumcision itself, I forgot. But I know that after 6 or 7 days of recovery I could do normal things again. “Khol” and “tan” were used as traditional medicine. “Khol” is made of raw materials, which was imported by Arab traders. It looks black and is also used for cosmetic products. After cutting “khol” into small pieces, it was spread over the wound and was applied only once, it was not repeated. I got meat and “ukhat” to eat.

The two cases above are illustrating at best how a circumcision was carried out at Harari girls aged 6-9 more than 60 years ago. The circumcision itself was embedded in wide-ranging preparation of different kind of food and sharing of this huge step in every Harari girl’s life with family members, friends and neighbours.

The outcome of the FGD with elderly women showed similar results. The women told me, that the main facilitator and initiator in every case has always been the respective mother of the girl child. The surrounding celebrations and ceremonies were also prepared by her; nevertheless did she receive help from other female family members. The age at which the *gey absome* took place was between 6 and 9 years, the maximum 11. The cause for the surrounding ceremonies lies in the idea to compensate the girl for loosing blood by receiving gifts, food and so forth. Hence, the blood and the pain should be replaced by happiness and proud. Like in the previous cases, also the elder ladies from the FGD discussed the fact that

they themselves wanted to be circumcised since they were eager to belong to the community, they did not want to be discriminated. During and after the circumcision they observed pain and bleeding as the major problems. But since society is accepting this and considering it as something normal, something common, they could not do anything except accepting their destiny. In contrary to the women before, the ladies from the FGD had the opinion that their recovery took more than one week, rather 3-4 weeks. However, also they are all proud by the operation they underwent, proud to be circumcised.

Most common traditional medicine which was applied on the wound was *khol*, which is a coal-like substance, nowadays used in the cosmetics industry for producing kajal, that women utilize to emphasis their eyes, to make themselves more attractive. *Karabi* as well as *tan* refer to incense or ash which should stop the bleeding.

Case 3

As we got to know, still up to 10 years ago infibulation was widely practiced. Hence, it is not surprising, that the following case of Azia, who is 38 years old, shows a woman undergone *gey absume* who could be the daughter of the two previous ladies.

My life experience is the following: people are mixing up the different types of circumcision. They tell you it is “arab absume”, but they are practicing “gey absume” finally. So, I also underwent “gey absume”, although they told me it would be “arab absume”.

When I have been a child I had no idea about its meaning, the advantages or the types of circumcision. I haven’t been mature at the age of 5 or 6. The only thing I knew was that “absume” is part of our culture. Most of the Harari men knew well, also the scholars, they could differentiate, but the mothers and women didn’t know these things. The initiation of the practice is always related to the mothers, the fathers don’t know. The mother is related to culture. Yes, my mother was the initiator. Also my father knew I am circumcised, but he didn’t know which type I underwent because he was not present at this time and not participating in the circumcision. So, he was hoping and imagining I would have undergone “sunna”.

I got circumcised at the age of 5-6 and it was done at home by the traditional circumciser, who was not educated, who knew nothing about the female biological organs, she cut everything. Now, I dislike what happened previously. I can’t remove from my mind what happened.

We had a ceremony at our house, at home. It was only done for the family. Special food like honey, “doro wot”, “tuftuf” was prepared. After I got recovered, I was rewarded with new clothes, with new dresses. This was also part of the ceremony.

Different things have been given only to the girls who have undergone circumcision. When other young girls have seen this, they were surprised and hoped to be circumcised in the future. They asked their families why they wouldn't practice this. These girls have been attracted by all the gifts. They had no conception about the future. Yes, the ceremony is attractive, but as soon as you get to know the inside, you will change your opinion.

I don't remember everything, but I think it took about 15-30 days to recover. My family checked from time to time how my recovery was going. As soon as I could walk in the compound it was almost over. There have been many traditional medicines, but I don't know most of them, only "khol" and "karabi" which have been applied. They also used a kind of disinfection that is used nowadays in hospitals, something like alcohol.

Azia expresses in a clear manner what she experienced at the time of her circumcision. Also during her time the cutting was surrounded by a ceremony, similar food was prepared as compared to Nuria's and Meymuna's case. Nevertheless, she puts emphasize on the ignorance of the females with regard to *gey absume* and all its side effects. The mother is said to be the initiator, the decision maker, the perpetuator of culture, of which circumcision is one part. The father is understood as the opposite, who believes or rather expects a particular kind of circumcision, but actually does not know since he is not participating in the procedure and obviously also not discussing such issues with his wife.

During the interview, expressed by gestures and mimic, Azia made a clear stand against the practice. But she herself had no any influence whether it happened or not. "*I can't remove from my mind what happened*" points to the cruelty of the procedure she underwent so many decades ago and the problems she might still have. She described furthermore in detail how important the gifts have been to attract little girls, to make them undergoing circumcision voluntarily without any resistance, not yet aware of the complications which arose afterwards.

Case 4

Kemia is three years younger than Azia, and experienced what one would call "excision". Kemia is married and has four children, of which two are daughters.

Me, I got circumcised at the age of 10, I was excised, clitoris and a little bit more was removed. It took place at the home of my parents, the circumciser was coming from the Harari community. She used a blade for cutting. Since it is more than 20 years ago, I don't exactly remember the time of circumcision, but I had my own ceremony, my friends and other family members celebrated together with me afterwards. Different food items like meat, honey

and butter were prepared. The recovery didn't take longer than 3-4 days, through which I got "khol" and "karabi" applied on my wound. I ate special food like meat, "ukhat", butter, honey and chicken.

The only difference to the previous three descriptions is the type of circumcision; all the other facts are more or less the same. Also in her case, the cutting was imbedded in ceremonies and exchange of food items.

Case 5

The youngest among the one-to-one interviewees was Iman, a 27 years old energetic woman, mother of three children. She underwent the less severe form of female genital cutting: *sunna*.

It was done inside of our home. At the time of the ceremony, special food was prepared like honey, "tuftuf" and "doro wot" for rebuilding my body. Only family members and friends have been invited for the ceremony. People, who are economically strong, also invited the neighbours. However, they brought candy, Vimto, other food items but also money. Gifts I received in cash and kind. This is modified and changed today, in the past everything was imbedded in ceremonies.

During my circumcision I was about 7 years old. It was not as such complicated, after two days I could do my normal things again. Traditional medicine, like "karabi" and "khol" were used, but I also remember water and salt to be applied.

Iman still experienced the ceremonies, the exchange of gifts for her genitalia, the traditional medicine which was applied on the wound afterwards.

In all cases the circumcision, be it *gey absume* or *arab absume*, took place at home, in the house of the girl's parents. The circumciser came from the respective community, thus was Harari, or as in the first case came from the surrounding villages. Whereas the elderly women were circumcised by using a particular knife, the other women told me, a blade was used.

By choosing the selected histories, I intended to show that the way in how the circumcision was carried out did not much differ from each other, although more than 40 years are lying between the cases. The one and only difference occurs with regard to the practiced type. The younger the women are, the less drastic the experienced type of circumcision.

The survey found out the following with regard to the surrounding activities and the questions by whom, where and how the circumcision of the girls has been carried out. The majority of the asked women and men stated that a ceremony took place and the girls received gifts of

different kind. However, as can be seen from Table 6 most of the practitioners have been traditional circumcisers (61 per cent), whereas 28.6 per cent of the operations have been performed by the respective mother of the girl child. Cuttings by nurses account for the third most frequent mentioned practitioner (4.7 per cent).

Table 6: Frequency and percentage of practitioner according to ethnicity

<i>Ethnicity</i>	<i>Mother</i>	<i>Traditional Birth Attendant (TBA)</i>	<i>Traditional Circumciser</i>	<i>Nurse</i>	<i>I don't know</i>	<i>Other</i>	<i>Total</i>
Harari	12 (11.4)	1 (0.9)	34 (32.4)	3 (2.7)		1 (0.9)	51 (48.6)
Oromo	8 (7.6)		19 (18.1)				27 (25.7)
Amhara	8 (7.6)		7 (6.7)	2 (1.9)	1 (0.9)	1 (0.9)	19 (18.1)
Somali			1 (0.9)				1 (0.9)
Gurage	2 (1.9)		3 (2.9)		2 (1.9)		7 (6.7)
Total	30 (28.6)	1 (0.9)	64 (61)	5 (4.7)	3 (2.9)	2 (1.9)	105 (100)

Source: Survey conducted by the researcher in March 2008.

From the following Table 7 it is obvious that almost all circumcisions of the respondents took place in the house of the parents of the girl who was going to be circumcised. This is assured by the high response of 94.3 per cent independently from the ethnic background. Female genital cutting in the hospital occurred only in two cases.

Table 7: Frequency and percentage of place of circumcison according to ethnicity

<i>Ethnicity</i>	<i>In Girl's Home</i>	<i>In the hospital</i>	<i>I don't know</i>	<i>Total</i>
Harari	50 (47.2)	2 (1.9)		52 (49.1)
Oromo	26 (24.5)		1 (0.9)	27 (25.5)
Amhara	19 (17.9)			19 (17.9)
Somali	1 (0.9)			1 (0.9)
Gurage	4 (3.8)		3 (2.8)	7 (6.6)
Total	100 (94.3)	2 (1.9)	4 (3.8)	106 (100)

Source: Survey conducted by the researcher in March 2008.

Everyone who answered the question regarding the used tool during circumcison mentioned it would have been a razor (Table 8). This was also confirmed by the one-to-one interviewees, especially the younger ones.

Table 8: Frequency and percentage of tool that was used to circumcise according to ethnicity

<i>Ethnicity</i>	<i>Razor</i>	<i>I don't know</i>	<i>Total</i>
Harari	52 (49.1)		52 (49.1)
Oromo	27 (25.5)		27 (25.5)
Amhara	19 (17.9)		19 (17.9)
Somali	1 (0.9)		1 (0.9)
Gurage	6 (5.7)	1 (0.9)	7 (6.6)
Total	105 (99.1)	1 (0.9)	106 (100)

Source: Survey conducted by the researcher in March 2008.

4.2.2 Most Common Cited Complications Afterwards

While conducting the survey I distinguished among the complications between immediate, intermediate and late, as it is referred to in most available literature. However, as I stated already earlier, the complications cited during the one-to-one interviews with elderly women remained general in their statements and most of the times pointed to immediate problems during or directly after the circumcision.

Nuria, for instance claimed:

I didn't have any problems at all. During delivery it was a normal condition to have some problems. Immediate problems like bleeding were treated by using traditional medicine.

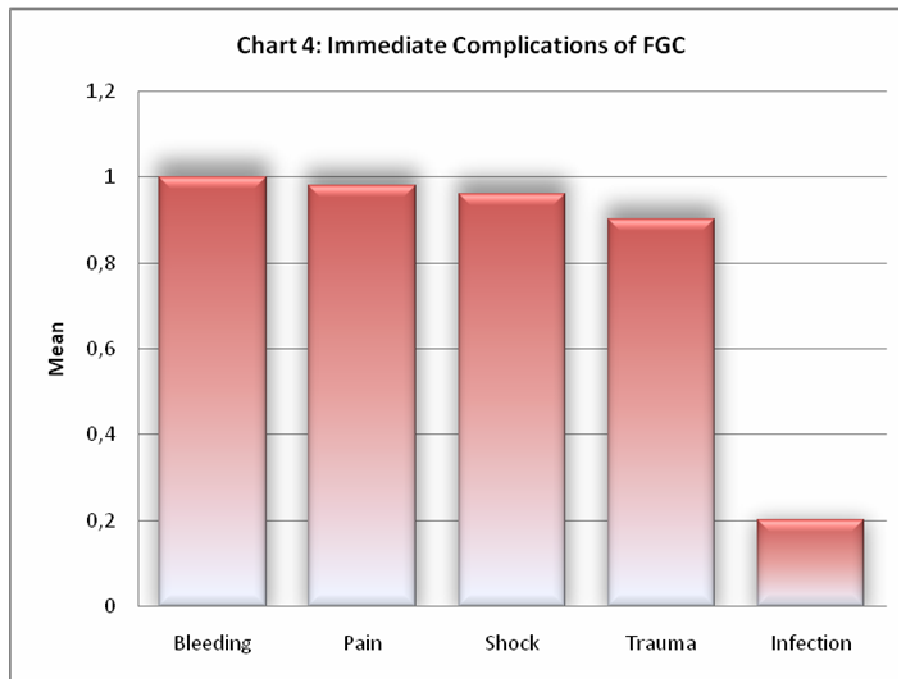
And her friend Meymuna did add:

The only problems which occurred were immediate like bleeding. At the time of delivery, the labour was prolonged, the wound was bleeding. Although the delivery was not easy, I was not defibulated, no extra cutting took place. The traditional birth attendant was maybe pushing to fasten the delivery process.

Nuria and Meymuna accepted the pain, considered it as something normal, usual, common that should be tolerated. Their generation speaks about *gey absume* and the related experiences with a sort of indifference which is no longer prevalent when talking to younger people. This fact tells a lot about the position of women of this time and their fate. Later on in another context one of them said, that the present generation would be so weak as compared to them, one reason why you could not practice infibulation on them anymore. Hence, they perceived themselves as strong; at least strong enough to withstand the procedure of *gey absume* and the following arising difficulties.

As the following chart No. 4 shows, there have been five major immediate complications which were attributed to the practice of female genital cutting by the participants of the survey. The mean is describing, whether the interviewees stated one complication to have been appeared and how often in total this occurred. Hence, one can see that bleeding, pain and shock are the most cited complications, closely followed by the psychological condition of trauma, whereas infections did not seem to have happened very often. A trauma is “a mental condition caused by severe shock, especially when the harmful effects last for a long time” (Wehmeier, 2005: 1634). Azia described how she still suffers and remembers the time of her own circumcision. In her case one can speak of a trauma related to an incident in her life which makes her still sad, angry and undergoing the cutting again.

The low amount of infections could be explained by the careful treatment of the wound afterwards as all of the interviewees described.



Source: Survey conducted by the researcher in March 2008.

Also younger women as Kemia are confirming immediate problems like bleeding and pain, but are also referring to delivery problems, which can be considered as late complications.

Azia, who underwent *gey absume*, described the following:

The menstrual cycle is not normal; it is not comparable to the cycle of uncircumcised women. The circumcised women experience pain during menstruation. At the marriage time, sexual intercourse is a must. During the wedding night, since intercourse was not possible, the scar was cut by the

traditional circumciser. Also afterwards, sexual intercourse remains painful. Lastly, at the time of delivery of a child, the female organ cannot relax, it contracts, and so at this time also problems are occurring.

In the case of *gey absume*, but also excision, the development of a scar tissue, which is compared as to the normal tissue of uncircumcised women's genitalia less elastic, mostly contributes to the problems that were described above. The hard, inelastic tissue complicates the drain of liquids as urine or menstrual blood which leads in turn to the mentioned pain. Sexual intercourse is made more difficult due to the minimized vaginal opening and the pain which occurs simultaneously to the attempt of penetration.

One of the male interviewees, Imaj who is 56 years old, married to a woman who underwent *gey absume* and father of a son, told about his experience in this regard:

During the wedding night, we had many, many problems, difficulties. For me, it was so difficult to penetrate her. She was bloody and she was not willing, because of the pain. My wife's circumcision was cut; she was defibulated by the traditional circumciser, whom you had to pay for. Harari women married at a very late age in the past, not before the age of 40. Hence, they had already life experience, had several times sexual intercourse before they gave birth to a child. That is the reason, why there were not so many problems which occurred at the time of delivery in the case of my wife. And we also have just one child, one son.

Iman, who underwent *arab absume* knows which complications occur in the case of *gey absume* since her sister told her:

I didn't observe any complications in my case, not during delivery or in other regards. But I know from which problems my sister suffered. She underwent "gey absume" and had difficulties during sexual intercourse with her husband, furthermore, terrible pain during delivery of her children and enormous blood loss.

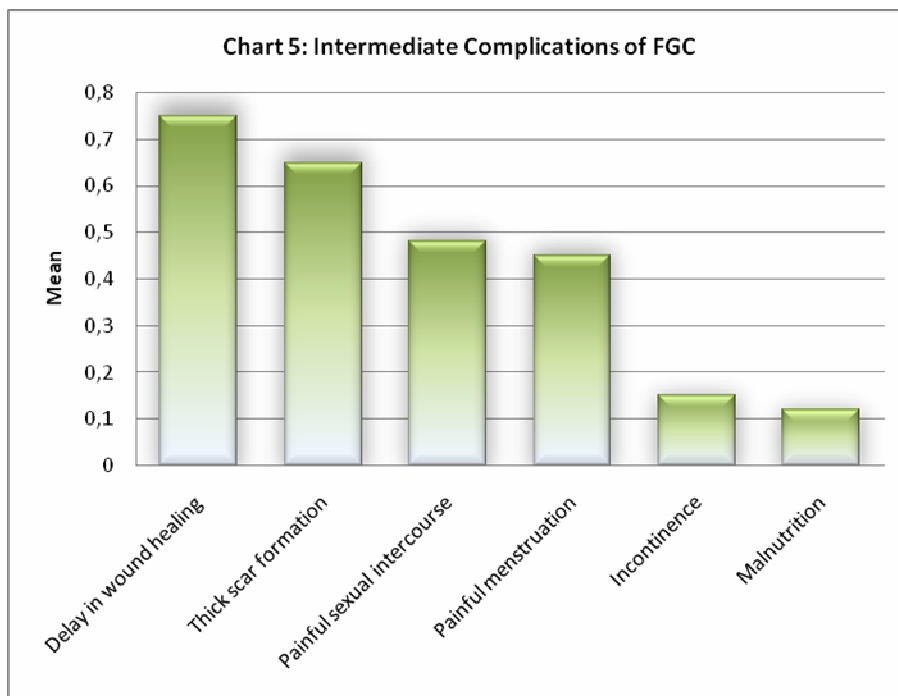
The pain during sexual intercourse as well as delivery is the most cited complication which can be attributed to *gey absume*. Common to this type of circumcision, but also *sunna* are reduced sexual feelings in general. The focus group discussion with 15 years old Harari girls shed some light on the problems from a different perspective:

There are problems during delivery. Furthermore, although we are students and don't know yet about these effects, we are nevertheless informed about sexual dissatisfaction. It decreases the sexual satisfaction of a woman. When women are circumcised at the same time and one tool, one blade or knife will be used; there is

the danger of transmitting diseases like HIV/AIDS. There is also a very high blood loss during circumcision.

Especially reduced or no sexual satisfaction and the transmission of diseases like HIV/AIDS are a common concern among the younger generation. Young people are enlightened about the normal functions of the female genitalia, might it be through school or media. If not within the family, at least among friends such topics are discussed, even if they are still students and do not know yet about the effects, as was stated by one of the participating girls of the FGD, referring to the obligation to wait with sexual intercourse until marriage. Nevertheless, the young generation is aware of the dangers pandemic diseases as HIV/AIDS have on the development of a country like Ethiopia, to whose spread practices like FGC can contribute.

Most frequent cited intermediate complications among the participants of the survey have been delay in wound healing, thick scar formation as well as painful sexual intercourse and painful menstruation (Chart 5).

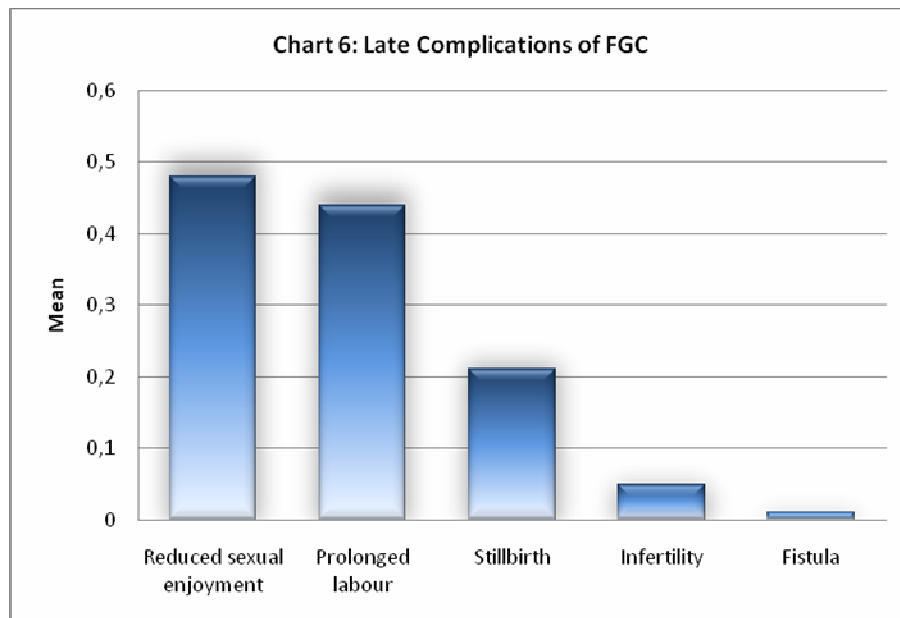


Source: Survey conducted by the researcher in March 2008.

Since the percentage of the more severe types of circumcision (excision and infibulation) account for 60 per cent among the survey participants, the mentioned problems are quite self-understanding to occur. Painful sexual intercourse and problems during menstruation were also reported by individuals, which I attributed to the development of the scar tissue as

described above. Delay in wound healing was not explicitly mentioned, rather it was claimed the recovery time would have been only one week even after infibulation. However, it can be expected, that the more severe the type of circumcision is, the longer it takes until the wound is completely closed and healed. To be able to walk again and fulfil simple tasks does not tell anything about the condition of the healing process and under which circumstances life is tried to be managed.

Incontinence and malnutrition have been mentioned as intermediate complications in the survey, but in less frequent way. At least among Hararis malnutrition is not imaginable after the description of the surrounding ceremonies and the food the girl received to gain back her former strength. Most late complications observed by the men and women participating in the survey have been reduced sexual enjoyment and prolonged labour (Chart 6).



Source: Survey conducted by the researcher in March 2008.

Reduced sexual feelings are caused by all types of circumcision, regardless whether a scar is formed or not. Since even the less severe type of FGC, *sunna*, is including the removal of the clitoris which is centre of plenty of nerve endings which are leading to sexual excitement during and after stimulation, a reduction or even abandonment of sexual enjoyment especially after the practice of *gey absome* is not surprising. Prolonged labour or problems during delivery have been reported by all interviewees as known problems to be occurred after *gey absome* has been practiced. Stillbirth might be a result from prolonged labour, especially in cases where the women did not get defibulated and had to suffer from a delivery process

lasting up to many days. Since I came along many infibulated women of different age who either have only one child or no children at all, the traumatic experience of a prolonged labour on the one hand or/and a stillbirth on the other hand might be contributory factors for a decision against many children, which are normally common among younger Harari women who underwent less severe forms of genital cutting.

Infertility and fistula are reported by a minority of survey participants and by none of my informants.

4.3 Why FGC is (still) practised

Reasons to support and practice female circumcision are manifold and complex. Sometimes it seems so simple to abolish, since only the “narrow minded” thinking of the people with regard to their understanding of women’s body and sexuality has to be removed. But one cannot forget that these ideas are deeply rooted in the society and FGC was practiced for many decades and even centuries. What seems for outsiders as barbaric and cruel has for the practicing community a meaning that was bound to its culture for a very long time. People have been uneducated and not aware of the complications that are attributed to FGC. They practiced, because it was perceived as a must, as a cultural imperative. The generation of the grandparents thought like that, their parents and so forth. But also the whole social construct, its understanding of gender and maybe religious obligations contributed to its maintenance. However, in this section we will see what the main reasons for the Harari community have been, and sometimes even still are, to support the practice of female circumcision.

Nuria, one of the two elderly Harari women, answered on my question for the importance of *gey absume*:

It was important for being a woman, I could protect myself from premarital sexual intercourse; I was and I am still proud by my circumcision. I am proud by the practice, women appreciated this cultural practice. I am supporting it.

For my husband it was a requirement to be circumcised. Men were assured and happy that women who underwent circumcision were virgins. Without that, marriage would have been impossible. My husband understood it as a must. Men didn’t accept women who didn’t undergo circumcision. The most common reasons for the community to insist on female circumcision were the protection of their virginity and remaining clean.

Meymuna had a similar opinion:

The community has the following reasons: to make girls remaining virgins, to be clean, to protect their health from evil influence. Furthermore, circumcision was a requirement for weddings, it was a must for marriage; otherwise I wouldn't have found a husband. Me personally, I am accepting it of course. The already mentioned reasons make me supporting it.

The ladies who took part in the FGD told me that they had the following expectations before they underwent *gey absume* to which they were looking forward. They assumed it would make them clean, they would keep their promise for their husband, hence remain virgin, they could search and finally find a husband, they could protect and promise their virginity until marriage and they would demonstrate which good girls they are.

The emphasis in the case of *gey absume*, as stated by the women above 60 years, lies on keeping virginity until marriage, hence avoid any sexual experience before one gets married, and demonstrating one's compliance towards the culture of the society and the norms which are expected to be fulfilled by every Harari girl. The inferiority as compared to men is in the above cases not questioned at all, women are simply accepting their status. To remain virgin meant simultaneously being clean which indicates that sexual intercourse, at least out of wedlock, was understood as something dirty, something which has to be controlled. Women also told me, that after they underwent *gey absume*, they were considered as real women. Meymuna said: *Being a woman means being a virgin*. This sentence indicates how much a woman was defined via her virginity. Not to remain virgin until marriage was equivalent to animal-like behaviour, shame and being an outcaste. Virginity was a pre-marital requirement. One might raise the question how *gey absume* originally came into existence in Harari context. During my interviews I heard about a legend which is referring to the origin of infibulation in Harar. According to my informants, infibulation was understood as a means of protection during the invasion of Menelik's soldiers and other Christian highlanders at the end of the 19th century. It is said that they raped many Harari girls, who, to protect them from any further harassment, got sewn. Furthermore, the *gey genafi*, the female Harari trouser, was said to have been invented during this time. Its intention was to complicate an attempt to rape a girl since these tight trousers were not easy to take off and the girl could meanwhile shout for help.

After this means of security was invented, its original intention, hence to protect girls from rape through others, was obviously shifting to prevention of sexual experiences which might have been wanted by the women themselves. Imaj, a 56 years old Harari man, said about the circumcision of his wife:

Yes, she got circumcised and she underwent “gey absume”. In the previous times, circumcision was common. An uncircumcised woman could not marry at this time. It was a criterion: If I would have had married her without circumcision, it would have been impossible. The women were believed not to be honest, not to be responsible for the home. These were reasons, why boys were allowed to reject the girl. Due to her infibulation she was considered as clean, being protected from evil things, never had pre-marital intercourse. The community said that the sexual desire of women had to be reduced, her sexual behaviour changed and she should remain virgin until marriage. But all these ideas changed today. The previous thinking is replaced by education.

Imaj raises another issue, the issue of reducing a woman’s sexual desire, to change her sexual behaviour. Earlier he said an uncircumcised woman was considered as not to be honest, not to be responsible for the home. Hence, increased sexual behaviour and irresponsibility are related. Women were thought to be solely concentrated on their sexual desire which in turn would lead to the neglect of the home (breaking of glasses and other household items), of their children and finally of their husband. The 25 years old Adib, a young Harari man, is adding in this regard:

We think that the advantage is... it makes, you know, the sexual feeling of women may decrease. Because she won’t give her family a child born out of wedlock, this is what they fear. We are Africans, full of culture, dominated by culture. We don’t like children out of marriage. We blame for education. Sex without marriage is also prohibited in our culture. So women are considered to have more sexual feelings than men, because it is natural. According to science, it is a true thing. They say women have more sexual feelings than men. We must, to decrease such kind of interaction, we must circumcise her. But this thinking is 20-30 years old. There was shift in thinking. Today, media tells you what’s bad about circumcision and different kinds of NGOs work to achieve this goal to change people’s attitude. Even religious scholars tell the people it’s not good to undergo circumcision. Whether a girl has high sexual feelings or not, it doesn’t matter anymore. In the past they gave you the reason why they practiced circumcision, but nowadays it is a silly reason. You can’t hurt her, because she has sexual feelings.

Adib knows that women have increased sexual feelings as compared to men, why it was necessary to circumcise them in the past. Sex before marriage is prohibited in general and a child born out of an extramarital relationship was the worst thing to happen. To condemn this

and to rule out this to happen from the beginning, infibulation was understood as the best means.

Azia, the 38 years old Harari woman who experienced *gey absume* herself, mentioned about its reasons to be practised in the past:

As a means of protection, for protecting a woman wherever she goes from pre-marital intercourse. She can protect herself before she is going to marry, she can keep her virginity until marriage, she is honest, and it makes her family proud. The second reason is cultural. People know it is a cultural practice and that's why they are practicing it, although they don't know about the problems and outcomes.

Here, Azia cited that the people simply practiced without thinking about possible short and long term consequences which might occur after cutting a female's genitalia. Everyone did it, so everyone was expected to do it. There was no questioning, no refusal. As Imaj said previously: *"If I would have had married her without circumcision, it would have been impossible"*. Men, not aware of the procedure women had to undergo (Azia said earlier that even her father did not know about her status of infibulation), also accepted the circumcision of women as something ordinary like the circumcision of men. Which problems occurred, they realized at the latest during the wedding night, when sexual intercourse made the newly married couple facing probably the greatest challenge of their life (as stated earlier).

In the case of infibulation the reasons for practice seem obvious and understandable, whereas *sunna* neither protects against rape nor prevents a women from having pre-marital intercourse. The elder women participating in the focus group discussion had the explanation that since the girls are not sewn closed in the case of *sunna*, the promise of their virginity is rather of theoretical kind. The family promises but cannot assure. Therefore, the will of the girl, to wait until marriage, is shaped by religion. But to ease this decision and to "help" girls remaining abstinent from any kind of sexual involvement, the removal of the clitoris, *sunna*, is considered as necessary, because the clitoris is the centre of plenty of nerve endings which are related to sexual stimulation and comparable in its function to the male penis.

Many interviewees also understand *sunna* as a transitional practice from infibulation to total abolition. Iman said:

In the case of "sunna" these ideas [with regard to infibulation] are not valid. The people are aware about the problems and decided to practice a less drastic form of circumcision: "sunna". Also nurses can perform "sunna". Within culture circumcision has its own position. To remove it, takes time. That's why the less severe

types like “sunna” have been practiced in recent years. Also with regard to this type, the people’s intention was to minimize female sexual feelings.

And Meymuna knows about the circumcision that was practiced on her granddaughters:

There was a community consensus about the severe problems “gey absume” has: during delivery etc. The people understood this and shifted to” arab absume” (“sunna”). Infibulation was no longer accepted because of its negative health impacts. Nowadays, girls are no longer strong as compared to our time. If you would practice infibulation on them, imagine what would happen. That’s why “sunna” is practiced. Although “sunna” is not obligatory, it is nevertheless somehow advised by our Prophet. From the religious point of view, the removal of the clitoris is accepted. Although not sewn closed, psychological protection is given, which means that sexual intercourse among Hararis before marriage is very rare.

The elderly women from the FGD also referred to *sunna* as a practice that is supported and required by religion. Religious scholars would support it, according to them. Despite it was mentioned by the elderly women, the religious aspect of female circumcision is not considered as being very important among the rest of the people I interviewed. In contrary, almost all said it would not be obligatory from the religious viewpoint and hence there would be no any need to practice female circumcision.

To clarify these viewpoints and to get a better understanding of female circumcision in religious regard, I met Ibrahim Sharif, the head of the Islamic Affairs Office. For clearly understanding what is stated in the Qur’an, one has to know the exact meaning of *sunna* first. Although plenty of literature is referring to *sunna* as the Arabic word for “tradition”, Ibrahim Sharif tried to explain the real sense.

In English it means: It is preferable, not compulsory. “Sunna” are the things what our Prophet has done, we are following this one. For example, to pray five times a day is compulsory. If you leave that, it is not good. “Sunna” means it is not a must.

Ibrahim Sharif stressed many times, that *sunna* is not a must, rather can be understood as advice, that if any kind of female circumcision has to be practiced because of which reasons ever, than “only” the tip of the clitoris should be removed, hence *arab absume* or *sunna* practiced. But if you do not carry it out, you will not be punished according to Islam. No one is forced to practice *arab absume*.

He explained where the reference to female circumcision appears:

The Qur’an is our guideline, in the case of women’s circumcision; our Prophet mentioned it in the Hadith. It is not compulsory for women, for men it is. There are

two types of mutilation: “gey absume” and “arab absume”. Certain people in Harar decided 60 years ago to abolish “gey absume” and other HTPs. They decided that women should not be mutilated completely, not more than necessary. According to the Prophet’s Hadith it is preferable, but not compulsory. A little bit of the tip of the penis is “sunna”, if you do it or if you don’t do it, it doesn’t harm you. This is what our religion allows.

Ibrahim Sharif mentioned that Islamic leaders got involved in this issue already 60 years ago. It was the time when they started to teach the people which harmful effects infibulation would have on the health of a woman. And they tried to convince their followers, to cut a maximum of only the tip of the clitoris, as stated in the Hadith. Hence, the elderly women who referred to the sayings of the Prophet as supporting *arab absume* are absolutely right. It is tolerated, supported, but not required. About the starting to abolish infibulation, Ibrahim Sharif continued: *You know, one of the basic solutions is women’s education. About 50-60 years ago, people established a school in Harar. They started to learn about modern education as well as religion. They have started improving female mutilation. Nowadays, cultural mutilation stopped, no woman can practice it anymore at home. Usually they are taking the girl to the hospital. This couldn’t be reached at once. It took so many years; it started 50-60 years ago. Also the women are asking nowadays, why do they do that? It has its own contribution. Even when you cut a small part, the sexual feelings will be decreased. Because of the law we have, the constitution, the rights of the women, people started to reject to have those types of mutilation, both types.*

But why are people always referring to their religion to justify what they are doing?

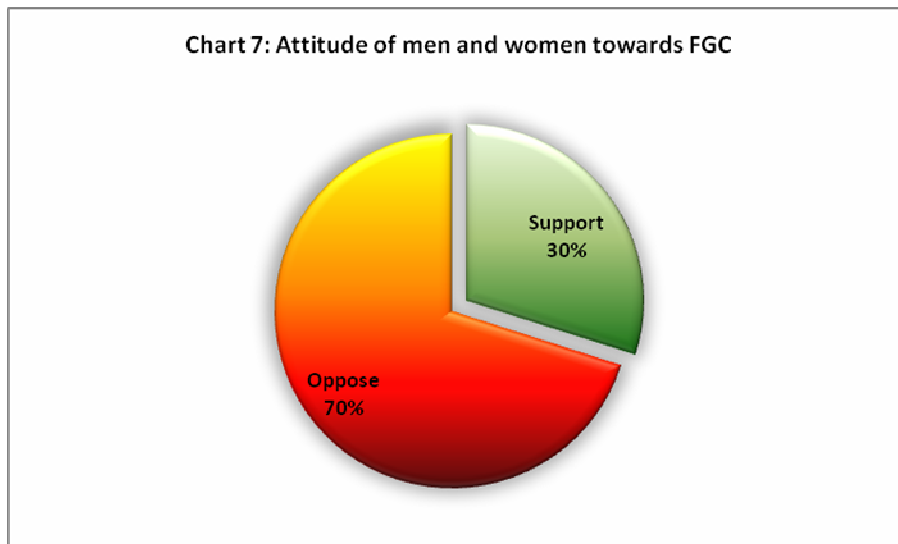
The understanding of the religion is related to the culture. Those who know detailed problems to be occurred after mutilation, won’t advocate its’ continuance. To take out my teeth without any problems, is not good. Nature has put all necessary parts in our body. Persons who require “sunna” didn’t understand their religion. You have to analyze your religion. “Sunna” and compulsory are two different things. In the case of men it is compulsory. Science proved that male circumcision prevents diseases. The level of understanding the religion is different. The one’s who know about their religion, may accept “sunna”, but may not allow the mutilation. You have to understand what “sunna” is.

If I am doing it is good for me, but if I am leaving it I won’t have any problems.

Culture has its effect. A long time ago they shifted from “gey” to “arab absume”. Now there is the shift to completely abolish even “sunna”. Today students are learning about this, have their own subject. So in maybe 5 years, also “sunna” won’t be practiced anymore.

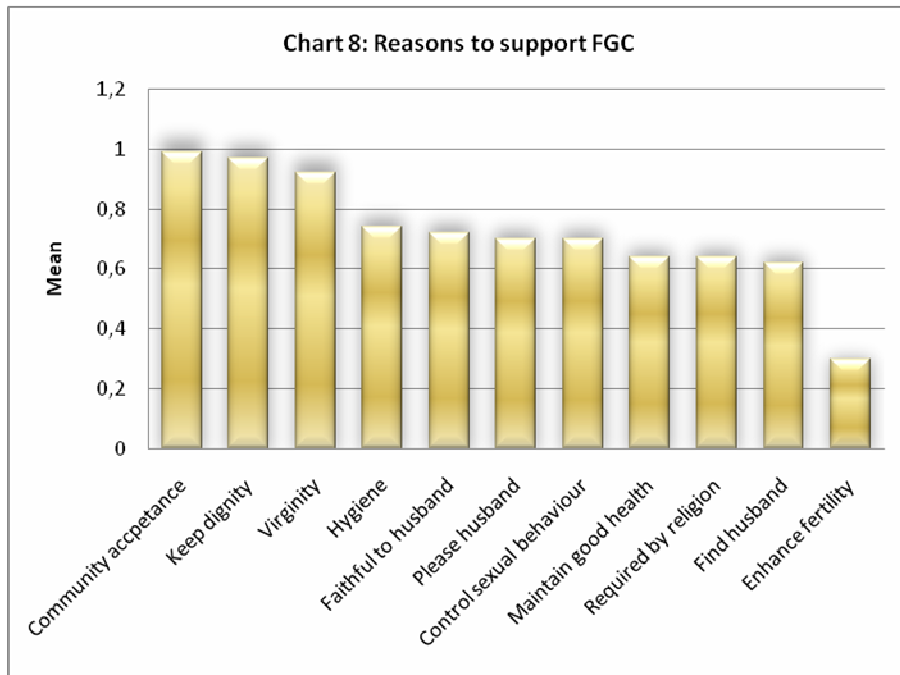
Religion and especially Islam takes a clear stand against any kind of female circumcision. In the past the Imams in Harar preached weekly about health affecting cultural practices including FGC and enlightened their followers. Especially nowadays, where any kind of FGC is prohibited, also *sunna*, the religious leaders are playing a major role in dispersing the necessary information.

The outcome of the survey showed, that from altogether 177 interviewed men and women, 30 per cent support FGC, whereas 70 per cent oppose the practice (see Chart 7).



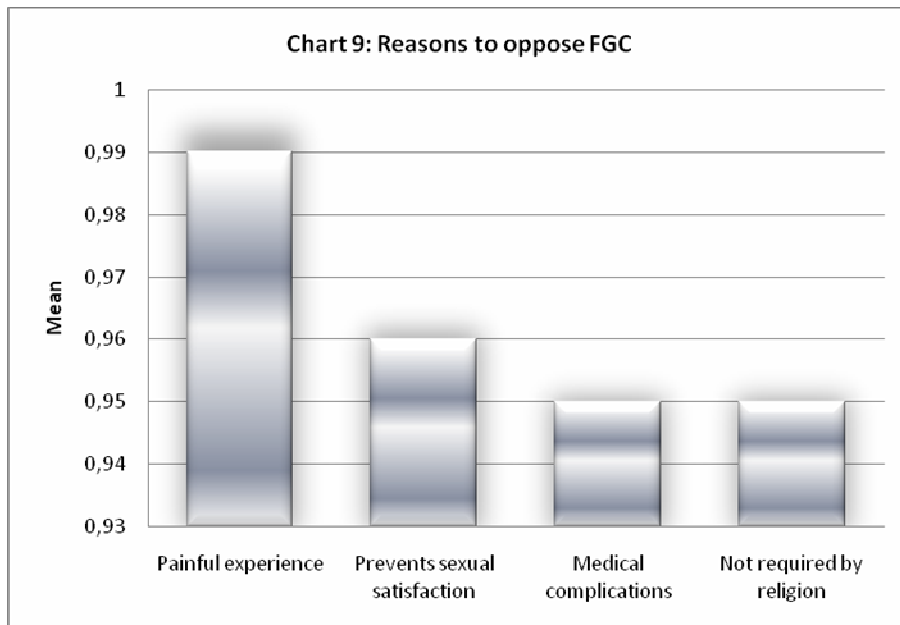
Source: Survey conducted by the researcher in March 2008.

The most cited reasons to support the practice are, as displayed in the chart No. 8 below, community acceptance; keep dignity and preservation of virginity. This reconciles with the previous mentioned reasons. Community acceptance was and still is bound to the fulfillment of societal values and norms. The value of a virgin bride was very high for it guaranteed to find a husband and therefore secured the inclusion into the community.



Source: Survey conducted by the researcher in March 2008.

Circumcision did not only prevent pre-marital sexual intercourse, but also made a woman being faithful to her husband, since at least in the case of infibulation for sure no woman underwent extramarital sexual intercourse voluntarily considering the pain which occurred. Hygiene, being faithful as well as please husband and control sexual behaviour of women were also reasons cited very often among the participants of the survey.



Source: Survey conducted by the researcher in March 2008.

From the above chart one can see that all interviewees understood the pain which is experienced by the women as the most important reason to oppose FGC. Also the reduction or prevention of sexual satisfaction is considered as major disadvantage.

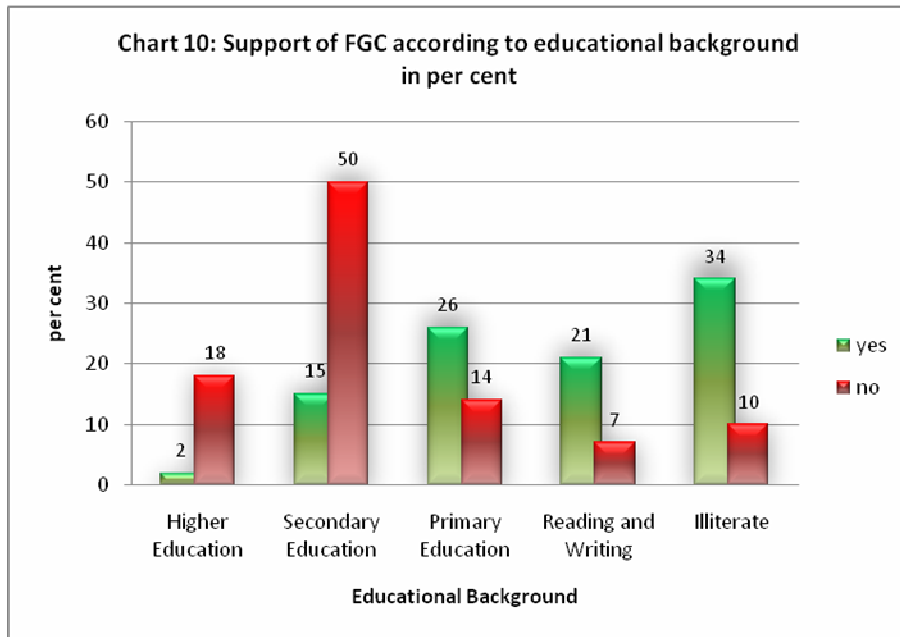
With regard to the continuance of female circumcision, during all my interviews the reference to education was prevalent. Especially young people always referred to their educated parents and their own status of knowledge which would mainly contribute to the abolition of FGC.

The focus group discussion with school girls taught me, that not only the educational background of the family is a contributory factor to practice FGC, but also newly established government regulations and the enlightenment of the people about their existence have influence on whether female circumcision is practiced or not:

FGC is related to the educational background of the family. The more the family is educated, the more the practice will decrease. Illiterate people practiced it in the past. Now we can compare with earlier periods. There are governmental regulations, there are agencies protecting the rights of women. The government is doing more, giving awareness creation, putting more emphasis on this issue nowadays.

Chart No. 10 shows that support of FGC almost proportionally raises with a decreasing educational status of the respondents. The support is highest among illiterate participants with 34 per cent. Men and women, who received primary education or are only able to read and to write, support FGC with 26 and 21 per cent respectively. The opposition against the practice is very high among interviewees who attend secondary education (50 per cent) as well as in the case of higher educated respondents (18 per cent).

Hence, the educational background is, as we can see, a decisive factor whether circumcision is practiced or not.



Source: Survey conducted by the researcher in March 2008.

4.4 “We will never stop *sunna*” – Women’s Attitude towards FGC

The headlining statement was given by a very emotional lady who works for the kebele administration of Harar town. During my first visit we came along each other while I was waiting for someone to talk to regarding kebele size and the respective population of each of the kebeles within Jegol. So, while waiting, everyone got aware of me, among others this Harari woman. She asked my companion about the reason for my stay. She was told that I am there to conduct research about female genital cutting. Suddenly she started to shout out: “*We are not accepting any prohibition from outside [Western world]. It is our culture; never we will stop practicing “sunna”. To remove the tip of the clitoris is a must, which will never be stopped.*”

Unfortunately we could not go further into detail and continue this discussion for my original reason of being at the kebele administration, one of the employees, was coming and asked me to enter his room. The lady disappeared but her words remained in my mind unforgotten.

The majority of the participating 110 women in the survey opposed the practice of female circumcision which accounts for 68 per cent. The remaining 32 per cent support its continuance. As follows the one-to-one interviewees have their own opinions about the pros and cons of different types of female genital cutting.

Nuria, the 70 years old Harari woman, practiced *gey absome* on her own daughter, but advocates *arab absome* for her granddaughter, who is approaching the age of being circumcised. She expressed the following:

I got infibulated and my daughter, too, at the age of 6-7 years. It took place at home. The circumciser used also a knife but I don't remember where she came from. Thorns were used too to hold the two parts together. My daughter is married nowadays. In the case of my granddaughter it is a bit different. She is at the age of 6. She will be circumcised at the age of 7 or eight, but unofficially, since there are these governmental restrictions. I don't know the opinion of others in the family, but if they want, the girl will be circumcised. Actually my own daughter and her husband both don't support the continuance of the practice. If I would have the power, I would let the girl be cut, but without the support of her parents it is impossible. In general, this is according to the respective family. If they want to practice circumcision, they will do it. But the community can't force anyone to do it. One family will do, the next won't. There are not many problems regarding this topic in the community.

There are governmental restrictions nowadays, because of which the official number declined. Nevertheless it is practiced in secrecy. But actually, I don't know about other families, because it is a secret and such issues are not discussed, even not among friends.

Meymuna also has granddaughters who all experienced *arab absume*. As previously described, Meymuna understood *sunna* as a necessity after the community got aware about the negative health impacts infibulation has on the lives of girls and women. Furthermore, *sunna* finds acceptance in religious terms as well as offers psychological protection for pre-marital sexual intercourse.

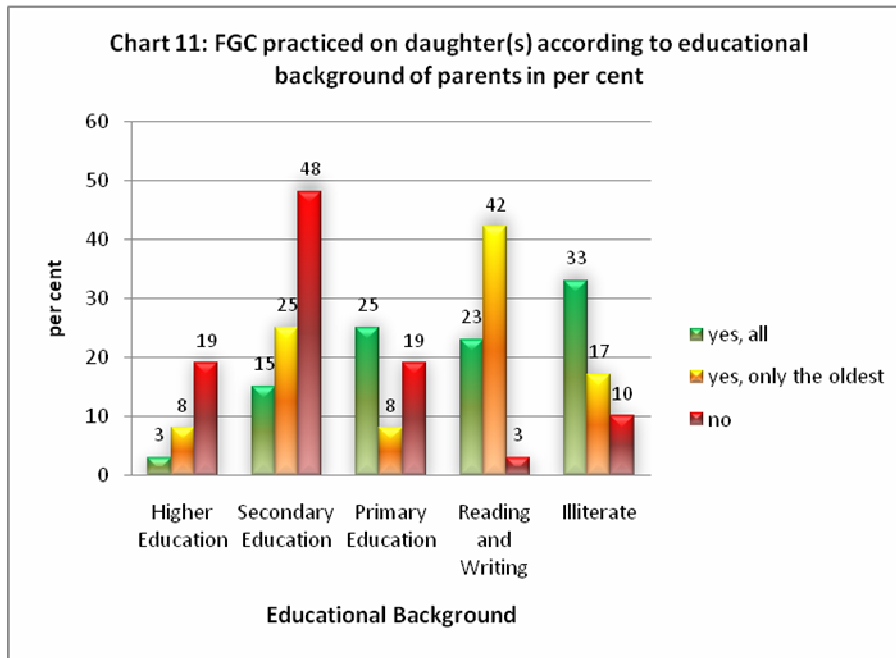
I have four female granddaughters aged between 15 and 25. All of them underwent circumcision. "Arab absume" ("sunna") was practiced on them. Only the tip of the clitoris was removed and the recovery took only 5-6 hours, after which they could walk again without any problems. The girls' mother was deciding on their circumcision. The traditional midwife carried out the procedure in our home and used a blade for cutting.

Previously we practiced circumcision, but nowadays it stopped already, because of governmental regulations, watchdogs in the community and the education of the younger generation.

From the statements Nuria and Meymuna made, one can understand that the support at least for *sunna* is still present. Nevertheless they are both enlightened about the prohibition by law and are accepting others' opinion as in the case of Nuria, whose own daughter is opposing the continuance of FGC. Despite the knowledge and the tolerance for others' attitudes, Nuria

suspects the practice to be taken place in secrecy. But since such issues are no longer discussed among friends and neighbours (whether a girl undergoes circumcision or not) her claim remains speculative. Whereas Nuria and Meymuna advocated *gey absume* for their own daughters and *sunna* was practiced on their granddaughters, a slight difference appears when referring to the elderly women who participated in the first focus group discussion. All of them stated, their own daughters would have undergone *sunna*, since the problems which occurred after infibulation were so manifold and it would have been practiced only by the ignorant ones, in contrary to *sunna* that was also practiced by scholars, the ones who knew about their religion. Their main reasons to support *sunna* for their daughters were, therefore, its support by religion and not to repeat the traumatic experience which they themselves had. They all were very sure, that infibulation is nowadays no longer practiced among the Harari community and even about *sunna*, the less severe form, would be many enlightenment campaigns. This might be one reason, why the participants' own daughters did not even practice *sunna* on their granddaughters. They explained: *“Ethiopia signed so many conventions. For that reason they [their daughters] are not supporting “sunna” anymore.”* The women told that the thinking of the society was changed due to different women associations that showed much effort to create a different attitude among the people. Hence, with regard to abolition of FGC, education plays a major role as we already found out earlier. *“The young girls can refuse the practice. They learn about it at school which makes them no longer accepting it. Even if the family should support, the girls could go to the police.”*

The outcome of the survey in this regard showed the following as one can see from chart 11. Most parents who practiced any kind of FGC on all of their daughters are either illiterate or received a maximum of primary education which accounts for 81 per cent. The opposition increases the higher the educational background is. About 67 per cent of all parents who did not practice any kind of female circumcision on their offspring received either secondary or/and higher education. The circumcision of only the oldest daughter does not necessarily refer to whether it will be stopped or not, but rather only indicates that the younger daughters did not reach yet the proper age.



Source: Survey conducted by the researcher in March 2008.

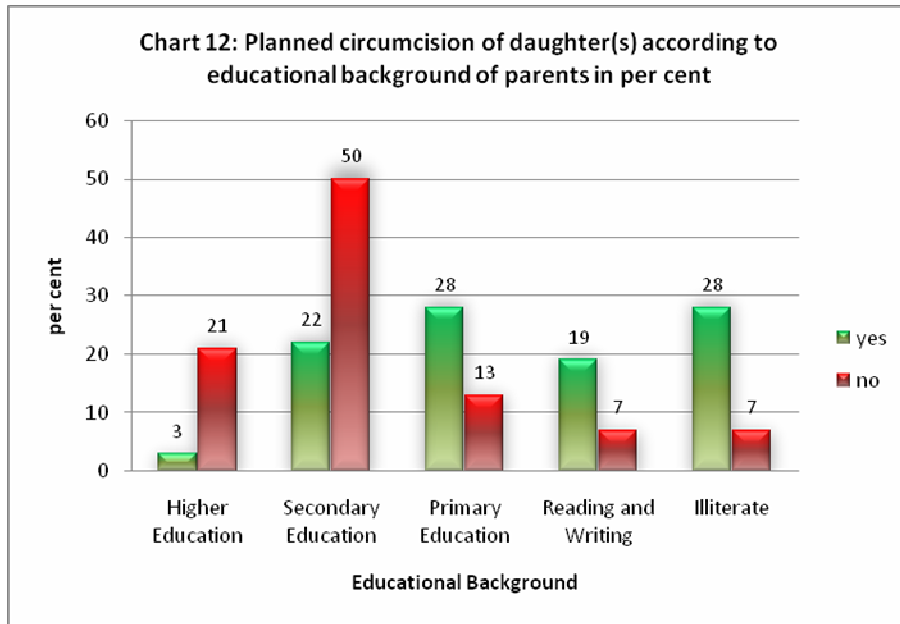
Table 9 gives a clear picture on which type of FGC was practiced on the daughters according to the type that the mother underwent. The shift from infibulation and excision to predominantly *sunna* is visible. Whereas 44 out of 52 women underwent excision or infibulation during their childhood, they decided to practice *sunna* in 34 cases, and excision in 10 cases on their daughters. Hence, 15.4 per cent of the mothers underwent *sunna*, 55.8 per cent excision, and infibulation was practiced among 28.9 per cent of the females. Most of the mothers experienced either excision or infibulation. The ones who experienced *sunna* or excision made a clear stand for *sunna* to be practiced on their daughters. The 15 mothers who underwent infibulation, made the same decision for their daughter in one case, whereas the remaining 14 women decided half for excision and half for *sunna*. Of all interviewed women, 78.9 per cent, the majority, practiced *sunna* on their daughters, 19.2 per cent have chosen excision and for infibulation there was only one choice which accounts for 1.9 per cent of all cases.

Table 9: Frequency and percentage of practiced FGC types on daughter(s) according to FGC type practiced on mother

FGC TYPE MOTHERS	Sunna	FGC TYPE Excision	DAUGHTERS Infibulation	Total
Sunna	8 (15.4)	--	--	8 (15.4)
Excision	26 (50)	3 (5.8)	--	29 (55.8)
Infibulation	7 (13.5)	7 (13.5)	1 (1.9)	15 (28.9)
Total	41 (78.9)	10 (19.2)	1 (1.9)	52 (100)

Source: Survey conducted by the researcher in March 2008.

Chart No. 12 shows whether participating parents in the survey have the intention to circumcise their daughters in the future. A means of judgment is their respective educational background. 71 per cent of all parents who said they will not practice FGC anymore received secondary and higher education. The high percentage referring to secondary education developed because the majority of survey participants attend secondary school. Surprisingly many parents with this educational background are also supporting and even planning FGC on their daughters. This accounts for 22 per cent of all backgrounds with regard to continuance.



Source: Survey conducted by the researcher in March 2008.

Parents with primary educational background, reading and writing skills or who are illiterate and want to continue the practice are represented by 28, 19 and 28 per cent respectively. In their case continuance prevails over abolishment. With the future generation, the girls who still underwent *sunna* circumcision and will get their own children in 5-10 years, I dealt with in the second focus group discussion. The five Harari girls have been 15 years old and visited grade 7. Regarding the practice in the past and today, its change and the attitudinal shift of younger people, they mentioned the following. One girl was telling me:

There have been many problems regarding FGC which we are now understanding. For instance, there are many complications at the time of delivery. We, nowadays, are learning at school level about the risks, so we are aware. We are also discussing with our families about the problems. The people who practiced it in the past didn't know anything about it, whereas the people today are aware.

Her friend was adding:

Our parents practiced it in the past. But it changed today, because different media is raising awareness and discusses the problems of FGC. There are still two kind of people: the ones who are not seeing any disadvantage and are willing to continue, to maintain; but the majority of the people are educated and aware about its disadvantages.

A third participant contributed:

Most students learn about FGC at school and can give simultaneously awareness for the society. This practice is not good for women; therefore the practice will stop in the future. We are discussing the issue at home and with friends. The Anti-FGC-Club at our school is also contributing to awareness raising.

A new issue was raised by another girl:

Another problem is of religious nature. Some people claim, it would be a religious criteria/duty to circumcise a girl or a woman, so it can't be rejected. We, the students, are not accepting this idea. But of course, the idea can't be changed overnight, just gradually. The advocates are especially elder people who are referring to religion, in contrary to us.

On my question whether an uncircumcised girl would face any problems within the community or with regard to find a husband in the future, the girls said:

Actually there are not so many problems when a girl is not circumcised. She can even get advantages, like: An educated man will prefer an uncircumcised woman. But most of the times a criterion for being together is love and not the circumcision. Nowadays, a HIV/AIDS test is more important and should be a criterion for marriage and not the circumcision of the woman.

One of the girls interviewed described:

I underwent "sunna" about 5-6 years ago. At this time the people have not been aware. Later on I asked my family why they practiced it on me, it has no any advantage, and problems occurred like bleeding and so forth. For sure is, I won't practice it on my daughters in the future.

All other girls confirmed her and stated they also would not practice it anymore. On my question what they would do if their future husband would insist on, one of the girls replied:

I would aware him and try to change his ideas. I would tell him about the complications. There are not so many men remaining who have such an idea or opinion. We can change his idea. And actually, it is almost impossible to insist on this, people are educated and are not practicing it anymore. When we give awareness to

the people and enlighten them about the health problems, they will change their behaviour, they will reduce the practice.

Iman (27) describes as follows what makes her opposing *gey absume*, but supporting *arab absume*. *When I have been young, they didn't practice infibulation on me, but "sunna". There were not so many problems, but I got to know from people who underwent "gey absume" that there are so many health complications, for instance during delivery. After marriage the woman's sexual feeling is low that's why many men are shifting their minds to other women. People are thinking that without sex, love is nothing. Problems are so many sighted. Therefore I think for 100 per cent that "gey absume" is bad. In the case of "arab absume", only the tip of the clitoris is cut, so there are not so many problems. To practice "arab absume" is good, also in religious terms, since she, the wife, is obligated to satisfy her husband within marriage. If she underwent "sunna", she is in position to do this. She makes herself beautiful and attractive for her husband, using different perfumes solely to satisfy him, for attracting him. She can satisfy him whether by sexual intercourse or by any other thing. They can satisfy each other, because most Harari people are respecting and tolerating each other during the time of marriage. In the past, Hararis have been farmers and traders and when they came home, the wife had prepared everything meanwhile and invited her husband to feel comfortable. This she can only do, when "sunna" is practiced. The infibulated woman can't do this, at least not with regard to sexual fulfilment, because she experiences pain and doesn't feel anything anymore. An uncircumcised girl [undergoing "sunna"] has a greater capacity to attract her husband. When he returns home maybe after a quarrel or other things which made him sad, his wife has all the means to make him happy again, to satisfy him, to compensate his bad mood with the love she is offering. Hence, she will be a good wife. "Sunna" can reduce social problems, since the woman can make her husband being satisfied by her in sexual regard, therefore he can't go anywhere.*

Although Iman describes the advantages of *sunna* as compared to infibulation, nevertheless she has no intention to practice any kind of circumcision on her daughter.

"Arab absume" is not obligatory from our religion, when you are rejecting it you won't face any obstacles. For 100 per cent it is not a requirement. The only must is male circumcision. My daughter is three years now and I won't practice it on her because previously there were so many complications. Especially my sister's case [she underwent "gey absume"] taught me about how people suffered from this. In the

future it will stop, because the people's educational background changed, they got aware.

With regard to elderly women's opinion about the practice, their indifference related to complications, as well as their reference to religion, Azia (38) told me the following:

I can relate to friends and modern education system. The natural organ of women is perfect. But due to cultural believes people are cutting something perfect. The elders have their own believes. They say it's normal to have pain or to be circumcised because they are not educated. They don't know about a biological circle of delivery, the different steps, and the problems which develop owed to the practice of "gey absume". If a woman is uncircumcised there are little problems during deliver to be occurred, whereas the danger among circumcised women is tripled. An organ created by GOD is perfect and people just cut and change because of different cultural reasons, that's the problem. The awareness was low, especially in the past. Furthermore, there is no any religious relation. People, who are claiming this, interpret our religion wrongly. They don't understand what Prophet Mohamed said, what he was meaning. He said, only the tip should be cut, the people should not go too deep. But they simple don't understand and are only following their own belief and their own interpretation. The ignorant people just practiced it and later on justified it by religion. I am not accepting any type of circumcision. Not any type is required by our religion, so how can I accept? Our religion is not focusing on the female, rather only on the male circumcision. There are problems of different kind: delivery, fistula. If you are a follower of Islam, you cannot amend anything from our religion, because we believe it is perfect. Hence, how can you amend just as you like? It is not obligatory and mandatory to circumcise girls. That's why I don't accept it at all.

On the question whether she would practice circumcision on her daughter, she emphasized:

No, from my own experiences I know which problems are occurring, so I don't want to repeat on my daughter. Also government offices (WAO etc.) are tackling the HTPs, awareness is created. I also work as a trainer for the community.

It will stop, because most young ladies are not practicing this anymore. But anyway, it will be minimized step by step. All HTPs you can't abolish at once.

4.5 Men's Attitude towards FGC

Of 67 for the survey interviewed men, 18, i.e. 27 per cent, support the practice of FGC, whereas 49 men (73 per cent) are opposing it.

All men with whom I had the one-to-one discussions, except one, opposed the practice of FGC. Imaj (56) knows why, since he experienced the problems to be occurring during wedding night and delivery of his and his wife's son. Asked about his personal opinion, he stated the following:

For men there are no any advantages. For me it is not important. Circumcision is prohibited by the people nowadays. The "afotcha" are also teaching about the governmental regulations and which dangers it contains for girl's and women's health. Women are tackling the practice, since most problems are occurring during sexual intercourse or delivery, which are related to women, whereas men do not suffer directly. Most of the girls and women nowadays are opposing the practice. I also didn't hear from anyone who is still supporting or practicing it. "Jema'a" and "afotcha" are discussing the issues. Furthermore, the women do have their own experiences and learnt from them. Now they don't want to repeat their mistakes on their own daughters. We have only one son, but even if we would have a daughter, we wouldn't circumcise her. The practice should be stopped.

Amir (33) in contrary to Imaj claims to know why at least *sunna* should be continued.

I am married to a young woman who is pregnant now and soon will give birth to our first child. My wife underwent "sunna", but she never told me about any kind of complications.

In my opinion, especially in remote areas, in rural areas, when girls are at danger to be raped, I advocate circumcision, especially "gey absume". This can prevent rape. In some areas it is necessary. In our region, in Harar, it is not happening anymore.

Therefore, I support "sunna" at this time for preventing pre-age sexual feelings. Before marriage, a girl has to study, she has to receive education. But during this time she also develops and discovers her sexuality and wants to gain sexual experiences. To minimize this behaviour and hence her sexual desire, "sunna" at least should be practiced. Otherwise a girl would crave men and would have too many boyfriends. After 15 is a dangerous age. If a girl is circumcised, she keeps her dignity, her personality. Uncircumcised girls have a higher sexual feeling than circumcised ones. This is a biological problem.

“Sunna” circumcision is what I want, support. A woman underwent “sunna” accepts my word, she keeps care for her family, she is good. After marriage, the sexual feelings are balanced, she is a good wife. But also men should wait until marriage for having sexual intercourse.

Asked for his intention to circumcise his baby if it should be a daughter, Amir answered:

Yes, Inshallah. If my wife also wants and we would get a baby girl, I would advocate the practice on her. If my wife is opposing me and her arguments are good ones we won't practice it. We will see, GOD willing.

Despite his support of FGC, I had the impression that he could be convinced by his wife. Since I know that she worked as a nurse, she will have good arguments which make also Amir willing to abandon the practice from his mind. But since their daughter, if they should get one, would not be circumcised before her 5th birthday, a minimum of 5 years is remaining to make the attitudinal shift of Amir come true.

Adib, a young man of 25 years, single and not yet married, has at least no experiences with a circumcised wife. Nevertheless, he did hear about the practice and has his own view on this:

My big sisters are circumcised. When we have been kids, they have been circumcised. I see it in my home. It's a culture and even males are circumcised. When the girls were asked to go out we knew they would be circumcised. We don't see, but we know that such things are going to happen. We are not allowed to see. Even females are not allowed to see. Only their father or their mother is present at that time.

Nowadays, you know, we gain some education, even are getting a degree which makes a big difference in your attitude. You see a lot of media. It's gender-sensitive, there are women's affairs offices. The victims are showing how it damaged their life. In my opinion, whether she will be circumcised or not, I don't care. I mean, even I don't require that much a circumcised girl. My religion, I think, allows it. I don't care whether she underwent circumcision or not. I will marry if I love her. We don't need female circumcision. I would support it, if my religion would allow me to do, or tell me to do. But the religion doesn't force us to do it.

Nevertheless, I think we can't achieve the goal of total abolishment in recent years because it is connected with teaching and creating awareness among the people. So, it takes a long time and a lot of effort. And also for the young generation it is not easy. The power is with their parents. If you know something bad about circumcision, you won't do anything. But the girl's father can take her and get her circumcised. Hence,

only if that generation will pass away, and the younger generation will grow up, they will change everything, avoid and create awareness.

Adib stressed the importance of love for marriage over the status of circumcision and makes his own view clear. But he also mentioned that the abolition of FGC will only come true when the young generation (5-15) will grow up and get its own children. In their case it would be almost for sure, that they will not continue or practice circumcision on their female offspring. But since the elder ones, the ones who are supporting, do still have influence whether a girl child of 10 years will undergo circumcision nowadays, the practice remains prevalent and will not end soon.

The youngest among the male interviewees has been Duz, a 21 years old Harari man. I asked him about his experiences with FGC and he told me:

What comes into my mind at first, is mutilating female reproductive organs. I have two brothers and three sisters, and all of them are circumcised. This is what I know. Actually, at this time I was too young. So, I only remember the ceremony, the occasion was unique. Neighbours were called, people gathered. It took place in the morning, the ceremony and the occasion. The ceremony and the circumcision were carried out simultaneously. According to the people, they wanted to reduce a female's emotional feelings, the emotional need of women. But actually, I am not sure, this is what I know. But I don't think so, I am against that. Everybody should get his natural feelings. A lot of people who support FGC have a sexual phobia. Regarding the problems, I heard in the media, that there are some during pregnancy and delivery. I don't know more complications, this is what I know.

I am telling you, if I should marry one day, it is not a requirement for my wife to be circumcised. No, she has not to be. I don't worry. Whether she is circumcised or not- it would be okay, in both cases. But I prefer uncircumcised. I don't want that problems are occurring during delivery or something like that. I think, also other men have this opinion. As long as the attitude is concerned, there are not so my people remaining to prefer someone circumcised. It doesn't matter. And also Islam is not supporting circumcision. I have not come across any single version of my religion that is saying females have to be circumcised. There is no do or don't as long as the religion is concerned. And on my future daughters I also would not practice it.

All men stressed the negation of female circumcision within Islam. Besides the right of women to have sexual feelings, the negation by their religion, is men's main reason to say "no" to the continuance of female circumcision.

Table 10: Frequency and percentage according to whether a man would marry an uncircumcised woman

<i>Would you marry an uncircumcised woman?</i>	<i>FREQUENCY</i>	<i>PERCENTAGE</i>
Yes	52	77.6
No	11	16.4
I don't know	4	6.0
Total	67	100

Source: Survey conducted by the researcher in March 2008.

The survey showed that more than three quarter of the participating men would have no problem if their future wife would be uncircumcised (Table 10). This is valid for exactly 77.6 per cent of the male answers. A minority of 16.4 per cent stated a clear “no”, they would only marry a woman who underwent circumcision. Six per cent are not yet sure, whether their wife should have undergone genital cutting or not.

With regard to the decision on the circumcision of future daughters or daughters that are approaching the age of potentially being circumcised, Table 11 indicates that the majority of the respondents, whether they have been female or male, said “no”. 79 per cent of all male participants do not support the practice to be performed on their daughters, in contrary to only 48 out of 71 women which makes up 67.6 per cent. This means that more men are against the circumcision of their daughters than women.

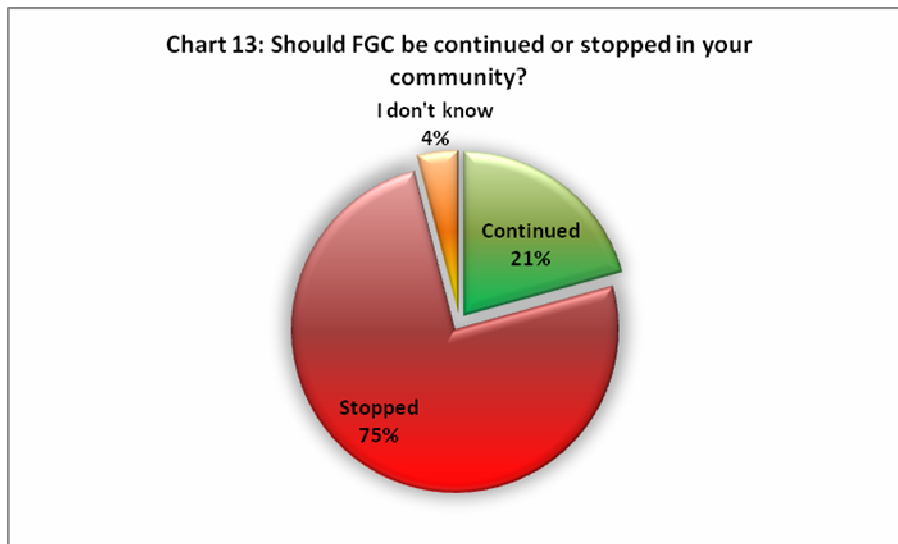
Table 11: Frequency and percentage of female and male intention on whether the (future) daughter(s) should be circumcised

<i>Do you have the intention to circumcise your (future) daughter(s)?</i>	<i>FEMALE</i>	<i>MALE</i>	<i>TOTAL</i>
Yes	23 (20.2)	9 (7.9)	32 (28.1)
No	48 (42.1)	34 (29.8)	82 (71.9)
Total	71 (62.3)	43 (37.7)	114 (100)

Source: Survey conducted by the researcher in March 2008.

The following chart No. 13 summarizes what the participating women and men thought about FGC’s abolishment or continuance. Three quarter, that means 75 per cent, want the practice of FGC to be stopped. 21 per cent wished it would continue, whereas 4 per cent of the participants have not been sure yet, whether it should stop or not. Most of the ones who want

it to be stopped have been between the age of 15 and 44. The elder participants (35 -55+) preferred it to take place also in the future. More women than men want FGC's continuance.



Source: Survey conducted by the researcher in March 2008.

Although the question for stopping of continuing FGC is similar to opposing or supporting attitudes as was displayed in chart 7, the result shows a slight difference. In chart 13 more interviewees want FGC to be stopped in the future as compared to the people who oppose it (see chart 7). The reasons for different answers to almost the same questions can be manifold. Many elderly women during the one-to-one interviews expressed their support for at least *sunna*, but also have been aware of the prohibition by law and stated it would stop soon. Hence, despite their supporting attitude, they would have answered probably negatively when asked them the question as it is stated in chart 13. Other simple reasons for this slight difference of about 5 per cent might be boredom, fatigue or being convinced after answering the questionnaire, that a continuance of female genital cutting is not desirable.

CHAPTER V

5. Conclusion and Recommendations

5.1 Conclusion

FGC in Harari context was justified by an increasing female sexual desire which had to be curbed. Infibulation above all, but also *sunna* was created to deal with this reduction, minimization and the total abolishment of female sexual feelings of any kind. Infibulation in particular, but also other types of circumcision in Harari context were mostly related to an ill understanding and perception of female's body and sexuality.

Especially elderly women never thought about to lose their sexual feelings almost completely and one part of their body for ever. As one of my informants said: "*The tasting part is removed. They are removing our tongues, we can't taste anything anymore.*" In the past the emphasis was lying on purity and cleanliness of the body as well as the preservation of virginity and the defense against all evil powers which might have prevented to find a suitable man which resulted in the following marriage.

Brought into connection with religion by the elder generation, the younger women and men no longer see any religious imperative which advocates the continuance of the practice. But even when FGC is not explicitly mentioned in and required by the Qur'an, the social order of the community of which religion is one element or at least contributes its part has enormous influence whether female circumcision is done or not. Although it is written in the Qur'an that both husband and wife should satisfy each other mutually, also sexual, I had the impression after the discussions with my informants that this interpretation especially benefits men. It was mentioned by my interviewees that the husband hardly could satisfy the alleged increasing sexual desire of his uncircumcised wife. This indicates that men were afraid to be at the mercy of the sexual craving of women. A woman who was expected to have a hypothetical 5 times sexual intercourse a day, which was impossible to be fulfilled by the man, would surely also go out with other men and therefore could not be faithful -which has been the logical conclusion.

When I asked for difficulties and complication of FGC in general, I heard almost always that an extremely horrible pain develops during sexual intercourse and delivery of a child. Blood loss was also mentioned. These are complications which are in direct relation to infibulation. Only the young Harari girls mentioned, that their sexual satisfaction was no longer possible-also not after *sunna* had been practiced. Among the other women *sunna* was considered not to be of any matter since delivery problems cannot be brought into connection with the removal of the clitoris. In contrary: *Sunna* was perceived as a means to maintain the social order. It is

said that which cannot be done any more in the case of infibulation, adds a new dimension to the practice of *sunna*. A woman, who is according to the Qur'an expected to satisfy her husband, would reach unknown spheres after *sunna* was practiced. Her animal-like behavior would be reduced, nevertheless she would be able to react to the demands of her husband and therefore to act in the sense of her religion. But here it should be stated clearly again, that the Qur'an calls for an equal treatment of husband as well as wife after marriage. Ibrahim Sharif said in this regard:

If a woman satisfies her husband, he will not go to other women. There is one saying: "A man who is blind and a woman who is deaf can live a good life" because he will not see another person/other women and his concentration with all his love will be on his wife. If the woman is deaf, she will never hear what her husband is going to say. If she is satisfying him he will never go outside. So, this is one way keeping her husband. As soon as I get home and don't get satisfied in my wife, automatically I will try to find someone else.

The satisfaction should be in both sides that increases love. If you satisfy me, I should also satisfy you. That is the way to increase our love. Most quarrels develop from what? If he doesn't satisfy her, he will have shortage of food etc. But if he does, she will wait for him in good condition, she will think of you. At the same time, if you love your wife you will look after her. You don't have another way of living at home. This is the way we wish for all. In the Qur'an is written: "Your wives are your clothes", at the same time you are also her clothes, so you have to love each other.

Sunna was never perceived that dangerous to have caused an immediate abolishment- in contrary to infibulation. Although this might be correct with regard to health complications, it is not regarding the unbalanced gender relationship. The emphasis of the health problems makes people forgetting that also women have the right for unharmed bodies that can be explored, and the development of their sexual emotions.

However, the majority of the Hararis interviewed for this study, spoke negatively about the practice of FGC and did not question its total abolition in the near future. Though, the young people doubted the complete abandonment within the next years, for being convinced that the 5-15 years olds have to grow up and might have the chance to raise their own children without practicing FGC. Also some elders said it would need time for step-by-step solutions to be advocated and accepted. Important to note is that educational background, age and negative experiences are interrelated and contribute to an opposing attitude with regard to FGC's continuance.

Anti-FGC-Clubs at schools are a recent phenomenon of the last 2 years and only known among the 15 years old Harari girls I interviewed. The problems which may appear and the whole issue of female circumcision is included in the science curricula and taught at grade 5-6. These young girls and boys will grow up and know the issue from the beginning. The 13-15 years olds still underwent circumcision themselves or have elder siblings who can tell about. All the ones who heard about or experienced themselves, refused to circumcise their future daughters. The young men also do not require anymore a circumcised girl, rather prefer to explore feelings together. However, the community discussions as were practiced throughout the last years with every member of the community- old, young, illiterate, educated and so forth- were the right decision. Social associations like *afotcha*, *jema'a* or *gailatch* still discuss the issue and disperse information to all their members, including the elders and parents. These social associations are one of the major contributors to the high awareness among the Hararis and remain important source of knowledge distribution.

5.2 Recommendations

FGC is a worldwide and cross-religious as well as cross-cultural phenomenon. Conventions have been signed already decades ago, laws designed and campaigns created to enlighten people about its side effects on the health and life of women. Different approaches in different countries were caused by different underlying principles to practice any type of FGC, may it religious, sexual, or as initiation rite. Hence, the analysis of the reasons is most essential for implementing any kind of eradication strategy. One has to understand, how the practicing community perceives a circumcised woman, for which parts of life the circumcision is crucial. As stated earlier, in Harari context, the need for female circumcision was seen in the reduction of a woman's sexual feelings and the preservation of her virginity until marriage. Religious leaders were involved to enlighten believers already 60 years ago, other organizations followed later.

The shift from infibulation to *sunna* in Harar was owed to them. The abolishment of even *sunna* within the next years seems to be out of question. The most successful strategies in Harar to educate the people have been:

1. Community discussions under the umbrella of gate keepers as religious leaders, former circumcisers, health personnel and kebele administration heads.
2. The public announcement of girls regarding their uncircumcised status. The public stand against the practice to show that a life without FGC is feasible.
3. Inclusion of FGC in the school curricula.

4. The establishment of Anti-FGC-Clubs at schools which are led and managed by students themselves to inform other students.
5. Advocating the open discussion of gender related issues at home, with parents and friends and within the whole community.
6. Usage of visual materials like posters and videos since they illustrate at best how people suffer from certain traditional practices.

These strategies have been successful in supporting the shift from infibulation to *sunna*, because they emphasized the health complications operations as infibulation can have on women. These explanations are no longer tenable in the case of *sunna*. Although also this kind of genital cutting is prohibited by law, the people perceive it as less dangerous and therefore, its continuance in secrecy is to be expected.

Here, the following approaches or starting points for interventions might be helpful. NGOs, Women Affairs' Offices and all other relevant bodies dealing with any kind of female genital circumcision and its abandonment might use them as guidelines of what has been missed so far in Harari context or what should be paid more attention to, to make also the willingness for non-continuance of *sunna* come true.

1. The inequality between the sexes has to be stressed. While men's sexual exploration is perceived as natural, women's is considered to be shameful, dirty and impure; their natural understanding as being much wilder and demanding than men is an argumentation that lacks plausibility. Also women can control themselves and are not obsessed by running after men's sexual attitude. Their natural attributes and given facts do not have any influence on their faithfulness, their behaviour towards their husbands. Any kind of overgeneralizations are to be avoided in such an intimate matter.
2. Women's rights in general should be stressed more by not only mentioning health related complications of FGC.
3. The focus should lie particularly on medium-aged people and the younger generation. The medium agers are maybe at the point of the decision whether their children should undergo FGC during these days, whereas the young girls and boys are the decision makers of tomorrow.

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APPENDICES

1.) Questionnaire for Female Respondents;

No. _____

Date: March _____, 2008

Kebele _____

A Socio-Economic Indicators

Please tick one answer only

1. Sex

female [0]

male [1]

2. Age

Less than fifteen [1]

15-24 [2]

25-34 [3]

35-44 [4]

45-54 [5]

55+ [6]

3. Educational Background

Higher education (University, College) [1]

Secondary education [2]

Primary education [3]

Reading and writing only [4]

Illiterate [5]

Other, specify: _____ [6]

4. Marital Status

Single [1]

Married [2]

Divorced [3]

Widow [4]

Other, specify: _____ [6]

5. Religion

Islam [1]

Ethiopian-Orthodox [2]

Protestantism [3]

Catholicism [4]

Indigenous Religion [5]

Other, specify: _____ [6]

6. Ethnicity

Harari [1]

- Oromo [2]
- Amhara [3]
- Somali [4]
- Afar [5]
- Other, specify: _____ [6]

7. Family Background

- Number of ever born children: 0 [1]
- 1-3 [2]
- 4-6 [3]
- 7+ [4]

8. Daughters/Sons

How many of your children are

- | | | | | | |
|--------|----|-------|------|----|-------|
| Female | 0 | [1] | Male | 0 | [1] |
| | 1 | [2] | | 1 | [2] |
| | 2 | [3] | | 2 | [3] |
| | 3 | [4] | | 3 | [4] |
| | 4+ | [5] | | 4+ | [5] |

9. What is your occupational status?

- Housewife [1]
- Daily labourer [2]
- Business woman [3]
- Health worker [4]
- Nurse [5]
- Government official [6]
- Student [7]
- Unemployed [8]
- Other, specify: _____ [11]

10. Who is the breadwinner of your family?

- Me [1]
- My husband/spouse [2]
- My parents [3]
- My siblings [4]
- Other relatives [5]
- Other, specify: _____ [7]

11. Are your children attending school?

- Yes, all (boys and girls) [1]
- Yes, but only the boys [2]
- No, none of my children [3]
- Other, specify: _____ [4]

B FGC Related Questions

12. Did you ever hear about circumcision?

- Yes [1]
- No [0] Thank you, you have finished!

I don't know [2]

13. Is circumcision practised in your community?

Yes [1]

No [0] switch to question No. 49

I don't know [2]

14. Have you been circumcised?

Yes [1]

No [0] switch to question No. 29

I don't know [2]

15. If yes, what has been done to you?

Sunna (removal of clitoris or part of it) [1]

Excision (removal clitoris, partial or total labia minora) [2]

Infibulation (removal of clitoris, labia minora and majora, sewn closed) [3]

Other, specify: _____ [4]

16. How do you call in your language the operation which you had undergone?

Absume [1]

Grizat [2]

I don't know [3]

Other, specify: _____ [4]

17. How old have you been when the operation took place?

0-5 [1]

6-11 [2]

12-17 [3]

18-24 [4]

25+ [5]

18. Do you remember this time?

Yes [1]

No [0] switch to question No. 28

I don't know [2]

19. If yes, who carried out the procedure?

My mother [1]

My grandmother [2]

Traditional birth attendant (TBA) [3]

Traditional Circumciser [4]

Nurse [5]

Doctor [6]

I don't know [7]

Other, specify: _____ [10]

20. Where was it carried out?

In our house [1]

In someone else's house [2]

In the forest/bush [3]

In the hospital [4]

Other, specify: _____ [7]

21. What was used to circumcise you?

Stone [1]

Knife [2]

Glass [3]

Razor [4]

Scissor [5]

Other, specify: _____ [7]

22. Was the circumcision accompanied by a ceremony, celebrations or festivities?

Yes [1]

No [0] switch to question No. 25

I don't know [2]

23. Did you receive gifts from relatives, friends etc.?

Yes [1]

No [0]

I don't know [2]

24. How long took the whole ceremony?

1-3 days [1]

About one week [2]

More than one week [3]

Other, specify: _____ [5]

25. How long took the circumcision itself?

Some minutes [1]

One hour [2]

More than one hour [3]

Other, specify: _____ [5]

26. How long did the wound take to heal?

One week [1]

Two weeks [2]

Three weeks [3]

Four weeks [4]

Longer than four weeks [5]

Other, specify: _____ [7]

27. Was there any medicine used locally to fasten the healing process of the wound?

Alcohol [1]

Herbs [2]

Traditional medicine "khul" [3]

Other, specify: _____ [5]

28. Did/Do you have any problems, difficulties or complications resulting from your own circumcision?

Please tick as many answers as necessary

Immediate

Shock yes [1] no [0]

Switch to question No. 34

32. If no, can you explain why you didn't want to be circumcised?

Please tick as many answers as necessary

It is not essential yes [1] no [0]

Health and psychological problems yes [1] no [0]

Problems during labour yes [1] no [0]

It is not obligatory in my religion yes [1] no [0]

It is prohibited by law yes [1] no [0]

Other, specify: _____

33. Who decided on your circumcision?

Mother [1]

Father [2]

Parents [3]

Grandmother [4]

Grandfather [5]

Grandparents [6]

Aunt [7]

Uncle [8]

Other relatives [9]

Friends [10]

Other, specify: _____ [12]

34. Is your mother circumcised?

Yes [1]

No [0]

I don't know [2]

35. Is/Are your daughter(s) circumcised?

Yes, all [1]

Yes, but only the oldest [3]

No [0] switch to question No. 42

I don't know [2]

36. If yes, at which age the operation was carried out?

0-5 [1]

6-11 [2]

12-17 [3]

18-24 [4]

25+ [5]

37. Which kind of circumcision was done?

Sunna (removal of clitoris or part of it) [1]

Excision (removal clitoris, partial or total labia minora) [2]

Infibulation (removal of clitoris, labia minora and majora, sewn closed) [3]

Other, specify: _____ [5]

38. Why do you think it is essential to circumcise a girl in your community?

Please tick as many answers as necessary

Requirement of religion	yes [1]	no [0]
To be accepted by the community	yes [1]	no [0]
Hygiene	yes [1]	no [0]
To keep dignity	yes [1]	no [0]
Preservation of virginity	yes [1]	no [0]
To find husband	yes [1]	no [0]
To be faithful to husband	yes [1]	no [0]
To please husband	yes [1]	no [0]
For controlling sexual behaviour	yes [1]	no [0]
To enhance fertility	yes [1]	no [0]
To maintain good health	yes [1]	no [0]

39. By whom was the circumcision of your daughter(s) done?

Me/mother	[1]
Grandmother	[2]
Traditional birth attendant (TBA)	[3]
Traditional Circumciser	[4]
Nurse	[5]
Doctor	[6]
I don't know	[7]
Other, specify: _____	[8]

40. Who decided on the circumcision of your daughter(s)?

Me/mother	[1]
Father	[2]
Parents	[3]
Grandmother	[4]
Grandfather	[5]
Grandparents	[6]
Aunt	[7]
Uncle	[8]
Other relatives	[9]
Friends	[10]
Other, specify: _____	[11]

41. Are you proud by your daughter(s) circumcised?

Yes	[1]
No	[0]
I don't know	[2]

Switch to question No. 48

42. If your daughter(s) is/are not yet circumcised, do you intend to do it?

Yes	[1]	
No	[0]	switch to question No. 47
I don't know	[2]	

43. By whom the operation should be carried out?

- Me/mother [1]
- Grandmother [2]
- Traditional birth attendant (TBA) [3]
- Traditional Circumciser [4]
- Nurse [5]
- Doctor [6]
- I don't know [7]
- Other, specify: _____ [8]

44. When is the right age for a girl to be circumcised?

- 0-5 [1]
- 6-11 [2]
- 12-17 [3]
- 18-24 [4]
- 25+ [5]

45. Who will make the final decision on whether your daughter(s) are going to be circumcised or not?

- Me/mother [1]
- Father [2]
- Parents [3]
- Grandmother [4]
- Grandfather [5]
- Grandparents [6]
- Aunt [7]
- Uncle [8]
- Other relatives [9]
- Friends [10]
- Other, specify: _____ [11]

46. Can you explain why it is important to be circumcised in your community?

Please tick as many answers as necessary

- Requirement of religion yes [1] no [0]
- To be accepted by the community yes [1] no [0]
- Hygiene yes [1] no [0]
- To keep dignity yes [1] no [0]
- Preservation of virginity yes [1] no [0]
- To find husband yes [1] no [0]
- To be faithful to husband yes [1] no [0]
- To please husband yes [1] no [0]
- For controlling sexual behaviour yes [1] no [0]
- To enhance fertility yes [1] no [0]
- To maintain good health yes [1] no [0]

47. What would happen if you would refuse to circumcise your daughter(s)?

- Outcast from family [1]
- Outcast from community [2]
- Divorce from husband [3]
- Daughter wouldn't get married [4]

Nothing would happen [5]
Other, specify: _____ [7]

48. Do you support circumcision?

Yes [1]
No [0] switch to question No. 50
I don't know [2]

49. What are your reasons to support circumcision?

Please tick as many answers as necessary

Requirement of religion	yes [1]	no [0]
To be accepted by the community	yes [1]	no [0]
Hygiene	yes [1]	no [0]
To keep dignity	yes [1]	no [0]
Preservation of virginity	yes [1]	no [0]
To find husband	yes [1]	no [0]
To be faithful to husband	yes [1]	no [0]
To please husband	yes [1]	no [0]
For controlling sexual behaviour	yes [1]	no [0]
To enhance fertility	yes [1]	no [0]
To maintain good health	yes [1]	no [0]
Other, specify:	_____	

Switch to question No. 51

50. What are your reasons to oppose circumcision?

Please tick as many answers as necessary

Not required by religion	yes [1]	no [0]
Medical complications	yes [1]	no [0]
Painful personal experience	yes [1]	no [0]
Prevents sexual satisfaction	yes [1]	no [0]
Other, specify:	_____	

51. Is your husband supporting circumcision?

Yes [1]
No [0]
I don't know [2]

52. Should the practice be continued or stopped in your community?

Continued [1]
Stopped [2]
I don't know [3]

THANK YOU VERY MUCH!!!

2.) Interview Schedule

Interview Schedule *FGD young Harari school girls*

Date:

Time:

Sex:

Ethnicity:

Religion:

Age:

Grade:

Topic: The Social Dimension of Female Genital Cutting (FGC): The Case of Harari

Question 1	What are your experiences with FGC?
Answer	
Question 2	Why do you think people practice(ed) it?
Answer	
Question 3	Does FGC have any advantages?
Answer	
Question 4	What are the most common complications?
Answer	
Question 5	What do you think about uncircumcised girls?
Answer	
Question 6	What are your opinions about FGC?
Answer	
Question 7	Do you want the practice to be continued or stopped?
Answer	
Question 8	Would you circumcise your future daughters?
Answer	
Question 9	Is the topic discussed within your family?
Answer	
Question 10	What would you tell to people who want to continue FGC?
Answer	

3.) Declaration

I, the undersigned, declare that this thesis is my original work and had not been presented for a degree in any other university. All sources of information used for this thesis have been duly acknowledged.

Name: Mandy Lindner

Signature: _____

Date: July 11, 2008