ERITREAN HABARAWI APPROACH FOR PROMOTING SOCIAL CHANGE

Collective Systemic Action on FGM/C Abandonment
ERITREAN HABARAWI APPROACH FOR PROMOTING SOCIAL CHANGE

Communities Taking Action to Eliminate Female Genital Mutilation/Cutting

Prepared for
The Ministry of Health
Government of Eritrea

Supported by
United Nations Children’s Fund, the National Union of Eritrean Women & the National Union of Eritrean Youth and Students

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<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>EDHS</td>
<td>Eritrea Demographic and Health Survey</td>
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<td>ELF</td>
<td>Eritrean Liberation Front</td>
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<td>EPLF</td>
<td>Eritrean People’s Liberation Front</td>
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<td>FGM/C</td>
<td>Female Genital Mutilation/Cutting</td>
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<td>MoE</td>
<td>Ministry of Education</td>
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<td>MoH</td>
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<td>MOJ</td>
<td>Ministry of Justice</td>
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<td>MOI</td>
<td>Ministry of Information</td>
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<td>MoLHW</td>
<td>Ministry of Labour and Human Welfare</td>
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<tr>
<td>NCA</td>
<td>Norwegian Church Aid</td>
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<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<td>NUEW (HaMaDeA)</td>
<td>National Union of Eritrean Women (also known as Hagerawi Mahber Deki’ anistyo Eritrea in Tigrinya)</td>
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<tr>
<td>NUEYS</td>
<td>National Union of Eritrean Youth and Students</td>
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<td>TBAs</td>
<td>Traditional Birth Attendants</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VEW</td>
<td>Voice of Eritrean Women</td>
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EXECUTIVE SUMMARY

The Government of Eritrea is focused on including the rights and needs of women and children in its national development efforts. The importance of educational and health rights for women and children was recognised even during the war for liberation. While progress has been made since independence, the full range of policies ensuring these rights have yet to be fully formulated and implemented. Consistent with this progress, in March of 2007 policymakers passed a proclamation banning the practice of Female Genital Mutilation/Cutting (FGM/C - Proclamation #158/2007 to Abolish Female Circumcision, March 2007, also referred to as female circumcision) on the grounds that it violates the human rights of girls and women, burdens the health sector, and is detrimental to the families that engage in it. This report details the actions taken to enforce the ban as of May 2012 and suggests how best to proceed based on the progress made to date.

The World Health Organization (WHO) defines FGM/C as “procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons”, and has identified four types of FGM: clitoridectomy, excision, infibulation, and other. No form of FGM/C provides any health benefits, and all four types can result in complications such as shock, haemorrhage, sepsis, and infertility, in addition to the severe pain and resultant psychological trauma that the operation itself entails. It was in light of these facts that policymakers chose to ban FGM/C, despite it being a common practice in Eritrea.

The Eritrean Demographic Health Survey (EDHS) of 2002 found an FGM/C prevalence rate of 89%. Most circumcisions were performed by career circumcisers who lacked professional medical training – usually employing basic, unsanitised tools and without anesthetics – and not by healthcare providers in clinics or hospitals. The EDHS also showed that 86% of girls underwent FGM/C while still under the age of five, as opposed to when they were older as a wedding requirement or ceremony marking their transition from childhood to adulthood. The EDHS also found that mothers with at least a secondary level education were found to be 27.5% less likely to perform FGM/C on their daughters than mothers with no education, which underscores how educating girls and women facilitates the abandonment of harmful traditional practices.

A National Co-ordinating Committee was formed from members of the government ministries of Health (MOH), Information (MOI), Justice (MOJ), and Education (MOE), the civil society organizations comprising the National Union of Eritrean Women (NUEW) and the National Union of Eritrean Youth and Students, and development partners such as the WHO, the UNFPA and UNICEF.

These organisations work together to integrate Anti-FGM/C messages into programmes in the diverse fields of health care, law, education and civil society. Many have drafted action plans and conducted various public discussions, workshops and seminars throughout all six zobas, or regions, of the country in order to educate and persuade community members
and leaders to abandon this harmful practice. Many of these organisations carry out joint workshops or community consultations whereby two or more of them partner to send a more comprehensive and powerful message to community members. For example, the NUEW and UNFPA have coordinated conferences tailored for women (but also open to the general public) to explain the consequences of FGM/C to current and future mothers. They have also partnered to conduct swearing ceremonies where community members promise to stop practicing FGM/C. The MOH works with NUEYS, NUEW, UNICEF, the UNFPA, the WHO and NCA to infuse skills training projects offered to community members with FGM/C abandonment content. The Regional Anti-FGM/C Committee also conducts focus group discussions (FGDs) and consultations with secular and religious community leaders, women representatives, youth coordinators, and technical specialists in order to improve FGM/C abandonment strategies through feedback.

Members of the Regional Anti-FGM/C Committee meet regularly to discuss challenges, share ideas, and allocate resources. In addition, NUEW have been conducting community mapping projects to be able to chart and document the overall process of community declaration of abandonment of Anti-FGM/C in selected villages. The idea of using national standardised indicators for monitoring and evaluation is also being discussed among implementing partners. Furthermore, a national FGM/C abandonment toolkit is being developed. Overall, many admirable on-going Anti-FGM/C projects and efforts are being conducted in Eritrea.

Finally, increasing the awareness among the youth, parents, families, traditional circumcisers, teachers, religious leaders, health professionals, community leaders, local and regional administrators, political figures and policymakers needs to be followed by their involvement and contribution towards stopping FGM/C. Individual behavioural change and community-wide acceptance of abandonment of the practice through the reversal of stigma will be required to see realistic and lasting results.

To achieve the stated objectives, some of the implementation strategies to be used include the following: alternative income generation; create attractive events; integrate with livelihood activities; use traditional information communication channels; bridge vertical and horizontal information gaps; transfer project ownership; address the demand and supply side; consider multidimensional perspective; involve and mobilise community; stigma reduction and consider cultural sensitivity. Implementation activities for the FGM/C intervention will focus on education, advocacy at all livelihood activities as well as occasions, development of promotional materials, livelihood schemes and introduction/implementation of ongoing monitoring, evaluation and documentation systems.

Representatives from the Reproductive Health sector of the Ministry of Health and the Child Protection Unit of UNICEF supervised the compilation of this report. The NUEW, the NUEYS, and regional administrators provided data and primary documents, which were supplemented by material from the national Research and Documentation Centre.
1 INTRODUCTION
1.1 FEMALE GENITAL MUTILATION/CUTTING

The World Health Organization (WHO) defines FGM/C (also called female circumcision) as including “procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons”, and has identified four types of FGM/C: clitoridectomy, excision, infibulation, and other. No form of FGM/C provides any health benefits, and all four types can result in complications such as shock, haemorrhage, sepsis, and infertility, in addition to the severe pain and resultant psychological trauma that the operation itself entails. It was in light of these facts that policy makers chose to ban FGM/C, despite it being a common practice in Eritrea.’

1.2 BACKGROUND

Eritrea is among the sixteen Sub-Saharan African countries where the practice of FGM/C is widespread. FGM/C is tied to traditional Eritrean values, beliefs and community standards having to do with girls and women, particularly in rural areas. From the latest EDHS findings, over two-thirds of girls are circumcised within a year of birth, while others undergo circumcision before their wedding night. The operation is commonly performed, as per tradition, by untrained circumcisers and birth attendants, who lack the medical training and knowledge of medical staff.

Since the adoption of the Habarawi Systemic Approach in Eritrea following independence, the prevalence of the practice is on a downward trend. FGM/C prevalence fell from 95% in 1995 to 89% in 2002, and to 83% in 2010 among women 15-49 years, particularly within the educated communities. Preliminary findings from the 2010 Eritrean Public Health survey (EPHS) reveal that FGM/C prevalence is now at 33.3% among girls under 15 years and at 22% for girls under 5 years. The trend in public support for the practice also declined significantly from 56.8% in 1995, to 48.8% in 2002 and 12.2% in 2010.

1.3 COUNTRY PROFILE

Eritrea is located in the horn of Africa, covering a geographical area of about 124,320 square kilometres, and is a home to about 3.5 million inhabitants. In the east it’s bordered by the Red Sea, the north and west by the Sudan and the south by Ethiopia and Djibouti. There are about 300 islands in which only 11 are inhabited, and the coastline measures about 1200 kilometres. In May 1991, Eritrea ended a 30 years old struggle for independence and in April 1993 it formally became an independent nation with 99.8% of its people voting for its recognition as a sovereign state. The population consists of nine ethnic groups with nine languages residing in six regions. The majority of the population consider themselves either Christian or Muslim.

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1 2002 Eritrea Demographic and Health Survey (EDHS)
2 Unpublished 2010 Eritrean Public Health Survey (EPHS)
3 National report on the implementation of the African and global platform for action for the advancement of Eritrean women. Nov, 1999: Asmara pp. 19-21,
Historically Eritrea has had one of the highest rates of FGM/C, and still remains one of the sixteen countries in the sub Saharan Africa where FGM/C and other forms of harmful social norms are widely practiced. The practice covers all three types of FGM/C procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural, religious or other reasons.

1.3.1 Gender Discrimination in Eritrea

Eritrean culture historically valued subservience in girls and women, which has resulted in a residual of gender discrimination in modern Eritrea. Mothers still rear their children from an early age with lullabies that vary based on gender. Lullabies sung to a baby boy are about his strength, bravery and ambitions for being leaders and decision-makers, whereas lullabies sung to a baby girl are often about her beauty, obedience, household chores and her hopes for capturing the hearts of ‘strong and brave men’.

A mother who bears a girl makes sure to nurture and raise her child according to the social norms even if some practices harm the child. For instance, “archaic traditions require a girl to be circumcised and/or infibulated between the ages of seven days to seven years.”

Regardless of the child’s choice, the family has to ensure their daughter is circumcised and endure the pain, suffering and sometimes death of their child caused by the mutilation. This is due to a traditional belief that a circumcised girl will find social acceptance (45.3%), will ensure better marriage prospects (25.8%), will have religious approval (19.2%), will prevent her virginity (4.5%) and (14.3%) of those who reported specific benefits of FGM/C thought it will keep her clean and hygienic.

Historically FGM/C was felt more broadly by the community as something that would help the girl avoid promiscuity, and to behalf in a culturally-acceptable fashion. Traditionally “[an Eritrean girl] is told not to eat anywhere outside the confines of the innermost parts of the house. That she should learn to eat only in small portions of food, not to raise her voice, to cover her head with a shawl or a veil.” Also, her movements should be restricted to not talk or play with boys, not go out alone and follow her mother’s footsteps.

In the past, the traditional Eritrean mother trained her daughter, starting the age seven, to take a role of a housewife by learning to cook, bake, clean, do laundry, fetch water and make fire while her brothers were out running errands or playing. Boys’ chores were more focused outside the household, especially in rural areas where they played an important role in farming, tending livestock, and gathering firewood. According to the organisation Voice of Eritrean Women (VEW), the girl’s behaviour is shaped not to speak in front of men, sit with her feet tucked in, lower her head and respond softly and shyly. Therefore, the girl realises that her beauty is reflected through acting inadequate and being obedient.

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6 Voice of Eritrean Women. Quarterly Publication of the National Union of Eritrean Women: Fall Issue 90.
7 Voice of Eritrean Women. Quarterly Publication of the National Union of Eritrean Women: Fall Issue 90.
inferior, fearful, shy, submissive and voiceless. These behaviours were the opposite of what’s expected from boys. Eritrean boys grow up with confidence, voicing their opinions about family decisions and creating networks through socialising with other boys, men and families in various communities.

Any girl who violates these traditional and social norms is deemed unfit for marriage. Even if a young woman follows all the social norms, she can still be subjected to the inspection of her virginity by the family of her potential husband. If she is found to have lost her virginity, the wedding is cancelled and her family’s name. She’s turned into an outcast through ridicule by her peers and her movement in the community becomes confined. Since no man in the community or the surrounding communities will ever ask for her marriage, she turns into her family’s maid or become forced to marry to an old, widowed and/or handicapped man. Sometimes, she’s forced to run away to a far away villages or cities leading to a life of prostitution or, in extreme cases, she commits suicide.

Therefore, it is vital for a girl in Eritrean society, especially in rural communities, of all religions and cultures to stay virgin until her wedding day. Due to the strong and deeply rooted traditional beliefs, a majority of Eritrean families have been circumcising their daughters to avoid pre-marital sex, rape and ensure virginity. Furthermore, early marriage and FGM/C were seen as symbols for protecting girls from losing their virginity or having unwanted pregnancies and children out of wedlock, as these discouraged men and disqualify the girls from being ‘marriageable’. Religious organizations have long considered the practice of FGM/C as a symbol of their values and often approve the circumcision of both boys and girls. The male circumcision represents servitude to God, and the FGM/C is interpreted as “a symbol of a girl’s ‘purity’, a seal of procreative capacity, and the family reputation due to the considerable value placed on premarital chastity and marital fidelity.

1.3.2 Changing Values and FGM/C

Since independence, girls have had more freedom to interact with the public and play with boys in the neighbourhood to improve their communications skills and develop a sense of independence. Various national and international agencies have worked with families regarding the benefits education for girls and women. The Ministry of Education have allocated funds for building more schools, including in remote areas, allowing more chances for girls to attend school. In many respects education and awareness has meant that women are more likely to exercise their rights in attending schools, eating in restaurants and cafes, get skills training to find employment and defend their rights. In schools, the life skills curriculum have incorporated FGM/C abandonment lessons in grades 4 -12. Also, girls are now as competitive as boys to enter the higher educational institutions.

Since the 1970’s, the EPLF has worked hard in mobilising and educating women in every part of society about some traditional practices that can harm young people, including

female circumcision. As time has passed, religious leaders and community elders have also joined the efforts with the EPLF social mobilizers, local authorities, NUEW and NUEYS in communicating the harmful consequences of FGM/C, that it is not required by either Christianity or Islam, and that it is no longer consistent with Eritrean values.

NUEYS also supported the movement to eliminate FGM/C by mobilizing young people and community members employing a mobile video unit as a key element raising discussions among the community about gender equity, community empowerment, the rights of women and children, and in particular the right of girls to education. Advocacy training by national and international organizations is ongoing, reaching both women and men in the communities to stand for the eradication of harmful practices.

The Ministry of Information has also contributed to Anti-FGM/C Programme activities by using mass media to support messaging through drama, music, television, news, poetry and movies. The Ministry is also ensuring that women help to influence content, hiring women in the positions of television anchors, journalists, camera-women, radio programme leads, broadcasters, newspaper writers, editors and technical support. This has helped the public to accept the changing roles of women in society. This is consistent with other changes, including a more prominent role for women in Government. There are four women serving in the Cabinet, and women play leadership roles as elected and appointed officials in many sub-regional administrations. Thirty percent of the leadership positions in government are reserved for women, but Government nevertheless strives for higher rates. All government agencies also reserve certain positions for women in capacity building areas, and are careful to consider women for promotion.

As both valued members of the public and decision-makers, women are gradually becoming more influential at national and sub-national levels. This has helped ensure that change associated with reproductive health, supervised childbirth, nutritional practices, FGM/C abandonment and immunization for children and participation in the collection and reporting of data on community health issues.
2 REPORT OBJECTIVES AND METHODOLOGY
2.1 RESEARCH OBJECTIVES

The objective of this report is to describe the national systemic approach to the eradication of FGM/C in Eritrea. The main focus is to identify strategies, constraints, challenges and achievements beginning with the initial stages of community mobilization, to building consensus in abandoning the practice, through to the passage of a law to criminalise FGM/C and bring about behaviour change in communities throughout the country.

2.2 RATIONALE

Internationally there are a number actions aimed at eradication of FGM/C practices. In Eritrea, the key players in driving the movement to stop FGM/C over four decades have been many stakeholders working in a collaborative spirit to mobilise and educate communities. This study will help to identify and understand the effective and efficient efforts exerted by social mobilisers who are committed to bringing social change through the implementation of actions designed to strengthen women’s and children’s rights.

A comprehensive approach towards the elimination of FGM/C is being implemented throughout Eritrea. The approach includes men, women, boys and girls, focused on social transformation that changes attitudes and practices, and improves an understanding of the harm that can be caused by FGM/C. It is hoped that these strategies will inspire other organisations and ministries within Eritrea and other nations practicing FGM/C globally to learn from the experiences of the Habarawi Systemic Approach.

The Habarawi Systemic Approach is the culmination of years of supporting practices aimed at improving the lives and health status of women in Eritrea. Originating in the years of struggle, Habarawi is at its core based on community-level action working with a variety of actors. Since independence, the approach has been strengthened through the commitment of Government, where Habarawi has been translated into policies, programmes and strategies to continue gains made over the past two decades.

2.3 METHODOLOGY

In preparing this report, various documents were carefully reviewed in order to better understand the systemic approach taken nationally to eliminate harmful practices. A study was conducted on the actions taken during the mass movement during the struggle for liberation and following independence, FGM/C prevalence, the types of FGM/C, the level of awareness and interventions, and the network among the government organisations, civil societies and partnering agencies within Eritrea. Numerous documents were reviewed to consider successful social mobilization and organisational approaches. Sources providing qualitative and quantitative data included published reports, leaflets, magazines, reports, policies and books published by UN agencies (WHO, UNICEF and UNFPA), government ministries, as well as non-governmental stakeholders. Documents reviewed included the Eritrean Demographic and Health Survey, project documents of Norwegian Church Aid, and the National Strategic Plan on the Abandonment of FGM/C.
2.3.1 Interviews

Individual interviews and group discussions were held with a variety of stakeholders at national and sub-national levels. This included key informants from civil society, Government ministries, local administration, facilitators and activists, including women and young people. The main issues addressed during the focus group discussions and interviews include how any response to FGM/C could proceed in terms of integrating different components, co-ordinating the response, how to engage with communities, and what might undermine implementation.

2.4 TARGET AUDIENCE

The Habarawi Systemic Approach document details the efforts made to eradicate FGM/C by Eritrean community mobilisers and their partners from before independence to present day Eritrea. The contents have been prepared through the contribution of various representatives from NUEW, MOH and development partners. It is hoped that health care professionals, peer educators, life skills educators, women’s advocates and others will consider how these experiences might enlighten similar activities in Eritrea and elsewhere. Anti-FGM/C promoters, educators, religious leaders, non-specialist clinicians including nurses, midwives, healthcare providers, public health officials, medical school students and healthcare promoters can also use the document as a referral tool to further their knowledge as partners who bring lasting behavioral change in the population.

It is a valuable resource for anyone working towards the abolishment of FGM/C practices, including FGM/C promoters at the primary, secondary and tertiary levels. This document can be used by school counselors, youth peer educators, women’s group community organisers, religious leaders and law enforcement officials when campaigning for desired behavioural change. Also, the Ministry of Justice can use this document as a reference tool while implementing Anti-FGM/C activities and training their field teams. The experience written in this document can help during sensitizing and defining specific task forces on how to implement the law and can help them to plan and implement productively avoiding ineffective methodologies. Various FGM/C committees can also use this document as they follow the annual work plan of their teams.
3 OVERVIEW OF FGM/C
3.1 HISTORICAL CONTEXT OF FGM/C

There is evidence to suggest that circumcision of both boys and girls originated in Egypt. Egyptian mummies showed both Type 1 and Type 3 forms of FGM/C, and there is evidence from papyrus records from as far back as 163 B.C. reporting circumcision. The Coptic Pope Shenouda, a leader of the Egyptian Christian community, noted that ‘neither the Koran nor the Bible demand or mention female circumcision’ (see Aldeeb, 1994). Despite this long history of acceptance of FGM/C, the Al-Azhar Supreme council of Islamic Research, the highest religious authority in Egypt recently released a statement saying that ‘FGM/C has no basis in core Islamic law or any of its partial provisions and that it’s harmful and should not be practiced’ (Aldeeb, 1994).

In Eritrea, there has been a long-held traditional belief that FGM/C must be practiced to keep girls ‘pure and clean’, with FGM/C levels at almost 100% prior to independence. Favourable views towards FGM/C were held by both males and females. Indeed, in many communities, it is women who enforce the tradition of circumcision. There is a general belief that the younger the girl, the easier the would heal. As a result, many mothers take it as an obligaiton to conduct FGM/C on their daughters at a young age. The practice of FGM/C varies somewhat across ethnic groups, ranging from private FGM/C activities to public celebrations and group FGM/C. Historically, FGM/C attitudes in Eritrea were reinforced by religious leaders.

Despite the almost universal practice of FGM/C in Eritrea, attitudes towards FGM/C have changed since independence. In 1995 the FGM/C prevalence was 95%, while for 2002 it was a much lower 89%, reflecting a downward trend in prevalence rates. This change has been spearheaded by Government policy, which advocates the discontinuation of the practice. This has affected attitudes towards FGM/C, which have grown increasingly negative, as well as its acceptability among religious leaders. Video interviews of religious leaders have been recorded and effectively used in awareness campaigns for the abandonment of FGM/C in the Eritrean villages and communities. The videos, featuring the highest religious leaders, have initiated lively discussions among focus groups and community members and is felt to have been an important element in people deciding to abandon the practice. In some communities, religious leaders have been involved in mobilising communities to abolish FGM/C by explaining how their religious norms do not require it. According to Ministry of Health records, rates of FGM/C have declined rapidly over time (see the Eritrean Demographic and Health Survey, Macro International, 2003).

Despite rapid change, there is a lack of documentation on the factors that have led to these changes, and whether these gains will continue in the future.

3.2 RATIONALE FOR FGM/C IN ERITREA

Eritreans practice FGM/C because they believe that it imparts a number of benefits, all of which are related to widespread and deeply rooted cultural attitudes towards community and marriage. The following figure illustrates the most common reasons that Eritreans say lead them to engage in FGM/C.

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10 Gazette of Eritrean Laws- Proclamation #158/2007 to Abolish Female Circumcision, March
Figure 1: FGM/C Motivating Factors

Source: Macro International, 2003

The data show that a desire for social acceptance is the leading reason for FGM/C, underscoring the influence of community norms. Marriage prospects were also commonly mentioned, as was religious approval. Cleanliness was also mentioned, despite the practice having no health benefits in this regard.

Many Eritreans are under the impression that the Bible and Koran call for female circumcision, but neither of the scriptures make mention of FGM/C, let alone require it. “The practice of female circumcision is widespread among the highland Christians, while circumcision and infibulations are practiced by the Muslims living mainly in the lowlands of Eritrea” 11. As the NUEW report from the 2008 Anti-FGM/C conference in Barentu notes, many families still believe that performing FGM/C ensures “Spiritual purity and is a requirement of the Holy Bible and Koran.” 12 In the video “DiHri Degim Toba Nikishbo deki Anistyo” produced by the National Union of Eritrean Women (NUEW, also known as Hagerawi Mahber Deki’ anistyo Eritrea, or HaMaDeA), a Christian priest argues that FGM/C is consistent with Christianity by saying “Do not challenge what the Holy Book says as it’s written from the orders of the High God!” 13 The priest further compares FGM/C with non-harmful acceptable religious practices, such as baptism.

Many Eritrean women believe that circumcision assures a woman’s status in her society, particularly important for ensuring good marriage prospects. According to EDHS 2002 (Macro International, 2003), 67% of Eritrean women believe that undergoing FGM/C will help them to gain social acceptance and find better marriage partners. There is a common belief that FGM/C will help a young girl to preserve her virginity and promote good health by preventing promiscuity and unwanted pregnancy. Some ethnic groups use FGM/C

ceremonies as a rite of passage from childhood to womanhood. When a girl undergoes circumcision, her family members feel proud and their honour renewed as they invite their close friends and family members to acknowledge and celebrate the fact that they have met their traditional and religious obligations. Women who let their daughters undergo FGM/C are seen as ‘wise women’ who help to preserve their culture maintain their family heritage.

3.3 TYPES OF FGM/C

There are three types of FGM/C, as well as a ‘Type IV’ that represents variations across I-III:

- **Type I** involves the excision of prepuce, with or without excision of part or all of the clitoris, also known as clitoridectomy.
- **Type II** involves the excision of clitoris; partial or total excision of the labia minora, and is known as excision.
- **Type III** refers to the excision of part or all of the external genitalia and stitching to narrow and/or sealing of the labia majora which is the external vaginal opening (infibulations). Type III is noted as the most serious form of FGM/C. Also known as ‘pharaonic circumcision’, it means the removal of all or part of the external genitalia, followed by the joining together of the two sides of the labia majora to narrow the vaginal opening.
- **Type IV** Includes pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia and cauterization (by burning) of the clitoris and surrounding tissues, scraping of the vaginal orifice or cutting of the vagina, introduction of corrosive substances or herbs into the vagina to cause bleeding, or into the vagina or for the purposes of tightening or narrowing it.

The first three types of FGM/C, along with ‘standard female genital anatomy’, are indicated in the following figure:

**Figure 2: Anatomical Diagram of FGM/C Types**

Standard Female Genital Anatomy  
Type I Female Genital Anatomy
3.4 RESPONDING TO FGM/C IN ERITREA

As noted earlier in the report, the practice of FGM/C, while still very common in Eritrea, is in decline. Government has led a concerted effort to receive FGM/C, working with civil society actors as well as development partners. This continues earlier efforts by the liberation movement to change FGM/C attitudes and practices prior to independence.14

In 2007 a proclamation was issued outlawing FGM/C (Proclamation 158/2007).15 The action taken by Eritrea was consistent with emergent international norms. In 1997, the World Health Organisation issued a joint statement with the United Nations Children’s Fund and the United Nations Population Fund against FGM/C. Just over ten years later, in 2008, a broader statement was issued focused on expanding advocacy activities for the abandonment of FGM/C. In 2010 the United Nations published a ‘global strategy to stop health care providers from performing female genital mutilation’, building on over a decade of work in terms of advocacy, international monitoring, revised legal frameworks, health systems strengthening, and programmes on the ground.16

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The Action Plan included a flowchart reflecting how FGM/C prevention would be responded to in Eritrea:

15 Gazette of Eritrean Laws- Proclamation #158/2007 to Abolish Female Circumcision, March 2007
16 www.who.int/mediacentre/factsheets/fs241/en/
17 www.who.int/mediacentre/factsheets/fs241/en/
In implementing the Plan of Action, the Ministry of Health has focused on reaching women and their families at the time of childbirth, and where the mother’s return with their children for health services. Among civil society actors, the National Union of Eritrean Women has been especially active in combating FGM/C\textsuperscript{18}.

3.5 FGM/C IN AFRICA

The following figure shows FGM/C prevalence rates across Africa:

High FGM/C prevalence rates are found in north eastern Africa as well as the horn of Africa, and in west and central Africa. FGM/C is uncommon elsewhere in Africa. More detail, by country, is provided in the following figure. The red column indicates the percentage of women who have themselves been circumcised. The orange column indicates the percentage of women interviewed who had had at least one daughter circumcised. The latter measure is intended to establish trends:

Source: Akinboyo, 2011. The surveys were administered in different countries in different years. The 1989/90 survey in Sudan was only administered in the northern states.

Virtually all women interviewed in Guinea and Egypt had been circumcised, while extremely high rates were also found in Mali, northern Sudan (data for South Sudan are not available), and Eritrea.
3.6 FGM/C IN AFRICA

Within Eritrea, rates are highest in lowland areas, including along the coast, as shown in the following figure:

**Figure 6: FGM/C Prevalence in Eritrea by Zoba**

![Map of Eritrea showing FGM/C prevalence by region.]

Source: Eritrean Demographic and Health Survey, 2002

Although there are only moderate difference across the six regions FGM/C prevalence rate shows the highest in Northern Red Sea (Semenawi Keih Bahri) at 98% and lowest in Zoba Debub at 82% and 84% in Zoba Maekel. Zoba Anseba shows the second highest prevalence rate of 96% and Zoba Gash Barka at 95% as the third highest rate in practicing FGM/C. Zoba Anseba and Zoba Gash Barka have the highest diversity of ethnic groups (i.e. all nine main ethnic groups can be found in these two Zobas), have the most divergent FGM/C practices, and represent the greatest challenge in this regard.

According to the 2002 EDHS, over 60% of all those who had been circumcised were aged under a year, and most of these were aged under a month. Only 16.2% were circumcised after the age of four. Findings are indicated in the following figure:
Of the three types of circumcision noted earlier in this report, according to the EDHS the majority were circumcised using the so-called Type I circumcision, the least severe form (51.7%). However, almost as many were subject to Type III, the most severe form (43.8%). In looking at the type of circumcision by region, the most serious form of circumcision (Type III) was most common in Northern Red Sea (78.1%), Anseba (68.7%), and Gash Barka (63.3%) regions, and least common in Maekel (4.7%) and Debub (11.1%) regions, both in the central highlands.

In Eritrea, the vast majority of circumcisions were practiced by circumcision specialists (83.8%). Traditional birth attendants were next most commonly mentioned (8.4%), while nurses (0.5%) and doctors (0.1%) were rarely mentioned. Findings are summarised in the following figure:
Doctors were only mentioned in the region of Maekel, while Traditional Birth Attendants were most commonly mentioned in the two coastal regions as well as Anseba.

3.7 COMPLICATIONS AND CONSEQUENCES

The complications of FGM/C range from debilitating physical, sexual, psychological to psychosocial effects. FGM/C has no health benefits. Short-term health problems include bleeding and, if severe, hemmorrhaging, infections, localised pain, and trauma associated with the operation itself. Long-term physical health problems including problems urinating, pain during sexual intercourse, painful menstruation, gynecological health problems and difficulty for health workers in examining a woman’s reproductive organs, increased risk of sexually transmitted infections, including HIV, recurrent bladder and urinary tract infections, cysts, infertility, problems getting pregnant and problems during pregnancy and labour19.

In addition, women and girls also undergo severe psychological and psychosocial trauma in the mind in which they suffer feelings of anxiety and depression. The experience leaves painful physical trauma that lasts a lifetime of bad memories in which the girl or a woman enters a neurogenic shock due to the severe pain of the procedure. Furthermore, during the day of marriage, the woman experiences agony during penetration which could last two to three months of repeated attempts. Sometimes, she has to undergo de-infibulation and live with the suffering of the experiences of sexual intercourse causing psychological detachment and fear of her husband. These negative consequences also cost the public health sector a lot more to treat the mother.

4 WOMEN’S RIGHTS IN ERITREA

4.1.1 Initiating Women Participation

Eritrean women were an integral part of the liberation struggle from the beginning. Initially, the role of women in the liberation movement comprised providing food for fighters, passing vital information about the enemy, giving care to freedom fighters and their children and composing songs to strengthen the movement. After the first congress of the Eritrean Liberation Front (ELF) in 1971, the rights and equality of women were recognised and they were allowed to participate more fully in the armed struggle. Taking advantage of this new opportunity, Eritrean women increased their participation through mobilising more women to join the armed struggle in greater numbers.

Despite these gains, in the absence of broader change in gender norms in society, many challenges remained. With the emergent dominance of the Eritrean People’s Liberation Front (EPLF), the role of women in the liberation struggle was strengthened, with the EPLF adopting the slogan “A revolution cannot succeed without the full and conscious participation of women”. More attention was devoted to changing attitudes towards women within the struggle as well as in the public in general. In EPLF ideology, transforming society meant eliminating religious and ethnic biases that undermined the position of women, and raising consciousness regarding women’s rights throughout the movement with the aim of eliminating detrimental and discriminatory practices and laws through enforcing justice and equality. As the significant part of the society, women in the EPLF were made conscious to fight for their rights and have gained strength to survive beyond the ordeals of war and contribute to the development and nation building activities. Concurrently, women also fought to eradicate the oppression of local cultures and traditions in the EPLF occupied territories. Due to this major role played by women during the struggle, the Eritrean Peoples’ Liberation Front promoted the equality of women in many instances, including property ownership and marriage laws, education for children and adults, participation in village affairs, equal pay for work, healthcare in rural and remote areas and equal rights in the family.

Discussions involving the changing roles of women included discussions of harmful practices that were felt to violate women’s rights. This took place as part of broader challenges to the traditional roles played by women in Eritrea society, and reflected the bridgehead role played by the fighters and the movement in this regard.

4.1.2 Building Consciousness on Women’s Equality

The struggle for independence has yielded a strong Eritrean identity. Within this national identity, there are nine main language groups and varied cultural practices. Broadly, the main differences fall across the highland areas and lowland areas along the coast and in the south, where nomadic pastoralism is common. Throughout the long years of the struggle until self-rule in 1991 and independence in 1993, the liberation movement made a concerted effort to enable social transformation in terms of gender norms. Based on cultural differences, the movement employed varied approaches.
In the highlands, people get together in large numbers during weddings, funerals and other festive occasions. During these events, the freedom fighters used to disseminate the EPLF’s political objectives. Later, these gatherings became key places to advocate for social transformation, including with regard to FGM/C. In contrast, in the lowlands, where the majority of the inhabitants are Muslim, it was difficult to campaign as men and women did not gather together in the same places except on rare occasions. The EPLF studied the social interactions in various parts of the nation and took a number of steps to tackle these serious problems. First, the traditions and cultures of each area were studied and efforts were made to include culturally-sensitive messages and respect the local traditions. At these initial stages, a programme was structured to approach men and women in separate settings.

4.1.3 Religious Leaders for Equality of Women

In the lowlands, a committee composed of defendants of the Islamic Sharia law, including senior religious personnel, were formed to find a quotation in the Sharia law which said that a woman is not allowed to get educated. As the committee could not find such a statement in the Koran, the EPLF indicated that this proved that Islam is not against educating women and girls. This formed an important basis for a nuanced response to women’s liberation in the lowlands, building agreement that women could participate and voice their opinion about their villages’ concerns. Some men still continued not to allow their daughters and wives to attend local meetings or attend school, but this changed over time. Despite all the obstacles they faced, many women started coming out of their homes to participate in public meetings, attend literacy classes as well as other educational programmes. Women began to ask questions and express their opinions in public in a manner and at a level that was not previously the case. The selection and training of female cadres from various villages strengthened this process, and broadened support for the expanded influence of women in local politics and society. These trained women’s cadres began to teach political education, village administration, healthcare issues and agricultural extension training.

4.1.4 The National Union of Eritrean Women

With the role of women in the liberation struggle strengthening, support for the activities of the National Union of Eritrean Women (NUEW) also strengthened. Established in 1979 as one of the mass organisations of the Eritrean People’s Liberation Front, the NUEW has
been at the forefront of changing gender norms in Eritrea at community level and within the liberation movement. This includes public celebrations such as those celebrating International Women’s Day on the 8 March, Children’s Day on 8 December, and Zero Tolerance for FGM/C on 6 February (first celebrated in 2003). NUEW activities include seminars and workshops on gender awareness, communication and leadership skills, counselling, legal rights, and land rights, training programmes in literacy, reproductive health, vocational training, and others, and direct income-generation support (see www.nuew.org). One example of activism is illustrated in the following photograph:

**Photograph 1: Women’s Rights Demonstration Organised by the Liberation Movement**

According to Luu I Ghebreab of NUEW, ‘FGM/C is a socially constructed attitude and practice that contravenes basic human rights principles by perpetuating acts of violence against girls, such as the cruel and inhumane cutting and infibulating part of the external genitalia. It is also a gender inequality issue that hampers the bodily integrity of a girl child and many women also have to endure the practice throughout their lifetime. Based on these considerations, the NUEW strategy to eradicate FGM aligns with critical theory in deconstructing the dominant ideology, including its historical roots and deeply-rooted cultural norms and value systems’.

She went on to note that ‘deeply rooted cultural norms can only be challenged through grassroots level discussions to break the silence and building consciousness to persuade opinion leaders in the communities. Then, the opinion leaders (governors, religious leaders, administrators and elders) can in turn influence the community to accept breaking the tradition and stop the practice by teaching the short term and long term harmful consequences of FGM/C. Upon communities’ accepting the new idea, behavioural change among the society drives the evolving of new traditional practices to stop harmful practices’.
Overall, the liberation movement’s progressive social policies enabled Eritrean women to bring about many changes to their lives and within their communities. This included health, which improved in the liberated areas, particularly in the areas of hygiene, child-care and nutrition, and harmful traditional practices such as FGM/C were felt to be increasingly unacceptable.

4.2 POST-INDEPENDENCE: 1991-2011

The government of Eritrea has a strong commitment towards the advancement and promotion of women. The historical development of the NUEW under the EPLF focused on the adoption of principles, policies and practices to drive the social transformation of Eritrean society. Accordingly, all efforts continued to be undertaken to increase awareness and ensure discussion about the role of women in the socio-economic and cultural transformation of the country.

Following independence, the NUEW has emerged as the key autonomous non-governmental organisation dedicated to improving the status of Eritrean women. Their mission is to ensure that all Eritrean women confidently stand for their rights and equally participate in the political, economic, social, and cultural spheres of the country and share the benefits. In considering the perceived slow progress of the Anti-FGM/C campaign efforts, NUEW decided to integrate and work collaboratively with other stakeholders to advocate for a broader and more aggressive commitment to the eradication of harmful traditional practices, including FGM/C. The fourth national women’s conference was held in 1992, just after liberation in 1991, to recognise the contribution made by women fighters, and to

**Case Study 2: Zahra’s Regret**

Zahra Ahmed lives in Zoba Anseba in sub zone Halhal and was interviewed while she resided in prison. Zahra had been working as a circumciser from 1998-2007. When she was asked to what benefit does FGM/C brought to her life, her response was “Nothing! Nothing at all! Few families gave me some gifts but, it wasn’t an obligation to them.” In her community, Zahra was known as respectable and sensible woman who helped families to enforce their traditional values by circumcising their newborn children. She inherited the practice from her mother and grandmother who practiced circumcision all their lives and passed the skill to Zahra. Zahra practiced FGM/C with pride and only accepted gifts if the family offered to be generous; if not, she did not oblige any payments as she accepted the practice as a calling to her family’s lineage. Following her arrest, Zahra was given detailed education about the harmful effects of FGM/C within the prison. At the time of the interview, She had understood and accepted her punishment and she stated that “We (the circumcisers) will stop the habit of this harmful practice; only if we are imprisoned and given ample education about the laws and consequences of FGM/C.” In addition, she condemned any kind of FGM/C practice and vowed to get involved in giving lessons to all community members who don’t know the facts about the harms of FGM/C. Finally, Zahra admitted that she had practiced FGM/C due to lack of knowledge and planned to bring those who continue to practice to the law. In Zahra’s case, a complete behavioural change can be observed and she concluded by saying “From now on, I have regretted about practicing FGM/C and I will see any family who approaches me about conducting FGM/C to their daughters as my personal enemies. Also, I will share my prison experience and my knowledge about the truth about FGM/C to let the hard core traditionalists in my community. Due to my past experience, I know I have the power to persuade.
shift towards the expansion and protection of women’s rights in an independent Eritrea. Members were reminded to continue the struggle by shifting their focus to the economical and civil challenges of day-to-day life. In addition to the NUEW, the National Union of Eritrean Youth and Students (NUEYS) has been actively involved in responding to FGM/C. The overall aim is to ensure that, as attitudes change at individual and family levels, the social environment around FGM/C is receptive to these changes.

4.3 AWARENESS RAISING CAMPAIGNS AND EXPANDED DIALOGUE

In recognition of the multifaceted nature of the challenge, Eritrea has moved on a variety of fronts to improve gender norms and ensure equal rights. This has meant attention to economic transformation for households through micro-credit programmes to start businesses, the expanded provision of safe water and the provision of donkeys and camels to reduce labour burdens, improved availability of animals especially for poorer households for meat, milk products and eggs, skills enhancement and improved market access for handicrafts and vegetables, etc. This has gone along with social transformation involving advocacy work about human rights, the law, health issues, and harmful traditional practices. Among many other preventive health issues on the agency include malaria, tuberculosis, HIV&AIDS and other sexually transmitted diseases, underage marriage, and FGM/C. Religious leaders, village elders, and other community opinion leaders are important actors involved in advocacy, and they often use social events such as Mahber and Ukub (monthly community social gatherings), child baptisms, weddings, funerals and Nigdet (annual community celebrations). The media also plays an important role in expanding public awareness, with the radio and television services especially important in this regard.

Especially in the rural areas, community gatherings or Bayto take place periodically and individuals are given chances to view their opinions on many issues and the forum is open for discussion. These events have given many villages a chance to learn about FGM/C and hear witnesses in their communities speak about the negative experiences they have had.

Case Study 3: A former Traditional Circumciser

The analysis presented in this section is based on the real life story of Lete, a changed traditional circumciser who conducts FGM/C. Lete believed that every mother approved of and supported cutting their daughters, and that FGM/C was a societal norm dictated and demanded in her community. She became an ardent advocate, cutting several girls and her daughters. She also knew that everyone expected her to perform circumcisions and she did not disappoint them. However during her granddaughter’s cutting, the baby bled profusely until she turned pale and blue. With immediate therapeutic support, the child fortunately survived. After the ordeal, Lete was in a dilemma to cut or not cut again, but could not face the social sanctions that would follow if she unilaterally vowed to stop. Nevertheless, she secretly agreed with her family never to perform FGM/C on any child again. The risks were, however, consideration. She lost her status as a respected community circumciser, her daughters risked stigmatisation which could have hurt their marriage prospects, and the family suffered from social stigma.

Nevertheless, her decision coincided with expanded Anti-FGM/C efforts, and as a result over time the situation changed, and it became more acceptable to challenge the traditional practices around FGM/C. In 2010, she openly joined the local elders and about 138 circumcisers in her community to enthusiastically welcome the FGM/C Law. Currently, Lete is one of the leading community change agents advocating against FGM/C.

encountered in their immediate families. Also, former circumcisers have spoken against the practice which had brought some families to change their minds about circumcising their daughters.

Photograph 2: Ministry of Health/NUEW Anti-FGM/C Advocate Training

Source: Anseba, Ministry of Health photograph, 2011

Inter-sectoral collaboration across various government ministries has been another measure which has helped ensure that awareness is raised on gender issues in the workplace. Life skills’ teachers have attended various Anti-FGM/C seminars and have been encouraged to advocate against it. Also, MOH, NUEYS and NUEW provide educators with resources such as reading materials, brochures, posters and other promotional materials for teachers to use in their classrooms in order to educate boys and girls about gender issues. Members of the partner organisations travel to colleges and teach classes to raise awareness about gender equality, including discussing the issue of harmful practices. The following photograph shows an Anti-FGM/C advocate conducting a home visit to discuss FGM/C:
Photograph 3: Anti-FGM/C Advocate Conducts a Home Visit

Source: Anseba, Ministry of Health photograph, 2011
5 HABARAWI SYSTEMIC APPROACH
ADVOCACY AGAINST FGM/C
5.1 THE APPROACH

The NUEW was instrumental in ensuring that Government passed policies that advocated women’s rights. The Anti-FGM/C proclamation (Proclamation #158/2007 to Abolish Female Circumcision; GSE, 2007) is one of the laws that NUEW advocated to become the law of the land. “The principles of social justice and gender equality have been the motto for all the social changes and social equality envisaged”. Furthermore, many colonial family laws were repealed to ensure gender equality after independence such as: giving the wife equal rights as the husband, opposing dowry, kidnapping and abduction for marriage and parental consent for marriage.

In addition, the organisation mobilises communities to improve their lifestyles and support low socio-economic families with financial and material assistance such as: micro-credit programs to fund various projects. As the number of educated Eritrean girls increased, HaMaDeA provides job training and skills transfer opportunities to novice employees and volunteers (local and from the Diaspora) in order become capable, qualified and productive partners of the job market in Eritrea and in the Diaspora. The diagram below indicates the holistic programs that exist to improve the livelihoods of the Eritrean women through NUEW. Women can enter at any level of the cycle and become participants of all the programs at any time.

Figure 9: The Holistic Approach Cycle Used for Sensitisation

Source: Negash, 2011.
HaMeDeA is a women’s organisation committed to the goal of abolishing FGM/C. The main approach is community mobilisation and, through this, the establishment of partnerships with local stakeholders in terms of leadership, religious authorities, activists and others, building coalitions around a response to FGM/C. They use consultative approaches to share experiences and build relationships among and between communities and activists at local, national and international levels. NUEW, as an active member, also uses these approaches and these linkages to eradicate other harmful practices that constrain the exercise of the rights of women and children, including underage marriage, uvulectomy, and other harmful practices. They also support the education of girls, improved employment practices that support employment of women, child immunisation, birth registration, the rights of women to own and inherit land, and strengthening the legal and cultural environment supporting women’s entrepreneurship.

5.2 RELIGIOUS LEADERS

The Habarawi approach has focused specific attention on the creation of partnerships between change agents and religious authorities, as among the reasons noted for the practice of FGM/C was religious requirements. Religious authorities are reached through consultations and workshops, and those who are interested are engaged as change agents in the process. The extent to which religion underpins FGM/C cannot be underestimated, therefore the Anti-FGM/C Programme in Eritrea has been careful to discuss with religious leaders how changes in the practice of FGM/C can be effected in a manner that does not offend religious sensibilities.”

As there is no specific mandate that supports the practice of FGM/C in the Bible scriptures and the Koran, Anti-FGM/C conscious religious leaders in Eritrea have been teaching their followers to cease the practice. In addition, many scholars and theologians of Islam state that any form of FGM/C is not prescribed by their religious doctrine, emphasizing the practice is almost never performed in major Islamic nations such as Iran, Saudi Arabia and Pakistan.
Photograph 4: A Religious Leader Reads Aloud the Harmful Consequences of FGM/C

Source: NUEYS, Zoba Anseba, 2009

5.3 VILLAGE HEADS AND PARENTS

In traditional Eritrean society, key cultural influences include guidance from elders in the community and religious teachings. The aim is to ensure that important social norms are transmitted from older to younger members of society. These norms are also transmitted within families, with grandparents especially important in ensuring that social norms are respected by younger family members. Considering the strength of social norms and the importance of effecting change within families and within communities, the Habarawi approach emphasised changing social norms on FGM/C at each of these points.

Photograph 5: Anti-FGM/C Neighbourhood Seminar

Source: NUEW, Zoba Maekel, 2008
5.4 MOBILIZING YOUTH VIA THE NUEYS

With its focus on young people and students, NUEYS has been an important actors in the campaign to end FGM/C. Consistent with the Habarawi approach, NUEYS has been one of the partners engaged in community-level actions to effect social change. This has included working with student leaders to effect change within schools. Partners, such as the Ministry of Health and NUEW, provide training manuals, outreach materials, and other materials targeted young learners. Drama, powtrry and music are also used as tools to reach young people and students.

The photo shows a workshop held with young people where FGM/C was discussed with in the context of considering a variety of health issues. These approaches are complemented by door-to-door advocacy, the use of mobile video units, and small group discussions. In addition, national holidays are especially important in reaching younger people attending these events.

5.5 HEALTH PROFESSIONALS

Over time many of Eritrea’s health workers have been trained in how to treat women who have undergone FGM/C, and how to advocate how those who have been directly affected can prevent this from happening to young women and girls in their families. Pregnant women who seek treatment at health facilities are specifically advised about not practising FGM/C on newborn daughters, discussing the health consequences and advising on the legal restrictions against FGM/C.

Source: NUEW, Zoba Maekel, 2008
5.6 LAW ENFORCEMENT OFFICIALS

Given that FGM/C is illegal in Eritrea, law enforcement agencies have an important role to play in preventing the practice. Law enforcement officers are carefully trained to understand FGM/C as a human rights challenge for girls and women, and a risk to their health. The declaration is considered in some detail, and means of enforcement discussed. Law enforcement agents themselves become part of the local response, working with other stakeholders.

5.7 MEDIA

The media in Eritrea has been actively involved in the FGM/C response. Partner agencies have worked with the media at national and sub-national levels to strengthen knowledge and change attitudes, and media organisations have regularly been invited to observe various activities. This has regularly been the case during celebrations, with joint planning between agencies involved in the response and media organisations especially common around days such as World Children’s Day, annual Women’s Day activities, and International Zero Tolerance of FGM/C. Live talk shows engage those in the FGM/C response, including call in shows.

Radio stations, such as Radio Numa, regularly broadcast messages about FGM/C and other harmful traditional practices, and hosts the agencies involved in the FGM/C in discussion and call in shows.

5.8 PARTNER ORGANIZATIONS

The high prevalence rate of FGM/C and its negative consequences have brought governmental ministries and non-governmental organizations to participate in eradicating the practice. Stakeholders such as ministries (MOH, MOE, MOJ, MOI and MLHW), civil societies (NUEW and NUEYS) and other partnering international organizations (WHO, UNFPA and UNICEF) have been working together to accelerate the abolishment of harmful practices, including FGM/C.

Agencies involved in the response use their particular areas of expertise to support the Anti-FMG/C Programme. NUEYS, mentioned above, is specifically able to reach young people and students, in the latter response working with the Ministry of Education. NUEW targets women of all ages, and has an effective strategy in place to strengthen the response to FGM/C and other harmful traditional practices as a challenge to women’s rights. The Ministry of Justice is engaged in strengthening the legal and law enforcement response.

The Habarawi approach also includes working closely with partner agencies, including UNICEF, WHO and UNFPA, that have expertise to bring and who can offer financial support.

The Habarawi approach also recognises that there are key change agencies in society.
that can be very influential in effecting important social change. On example of a popular musician being involved is indicated in the following photo:

Tiken Jah Fakoly, 2012
6 THE HABARAWI ANALYSIS AND CHANGE STRATEGY
6.1 COMMUNITY MOBILIZATION AND CONSENSUS-BUILDING

As part of the process of introducing social change, the Habarawi approach encouraged engagement from various change agents. Anti-FGM/C Committees are at the centre of the response, building local level responses to FGM/C eradication.

6.2 SYSTEMATIC APPROACHES TO EFFECTIVE TARGETING

During the year, there are various days where different causes are celebrated. Those involved in the FGM/C response take advantage of high attendance as these events to raise awareness about FGM/C. Innovative approaches are employed, materials are distributed, discussions are held, and relationships are built. As noted above, organisations with particular strategic advantages such as NUEYS and its focus on young people and students are involved in targeting their audiences.

Partnering organizations have decided to collaborate efforts to support the regional committees and facilitators who already have messages for specific targets within communities. For example, NUEW advocates mainly reach mothers, grandmothers and circumcisers through the help of local administrators and religious leaders. NUEYS reaches out to students through school clubs and the working youth through the national worker’s organization and conducts the awareness and consensus building workshops. The Ministry of Health (MOH) provides technical support and promotional materials to both organizations. Overtime, the Anti-FGM/C Committees expanded into other villages and became the most effective mechanism for information dissemination and networking. Far more than the expected projections, the village committees grew from 426 in 2007 to 2,745 in 2010, and the School Sara clubs also increased from 46 clubs to 300 within the same period. The steady involvement of the Youth and Women Associations as well as religious leaders facilitated the smooth diffusion of the new legal norms at the grassroots level.

The diagram below clearly presents the interdependence of norms, incentives and network relationships. The collective consensus of various actors actually became the entry point for introducing legal norms and a tipping point for accelerating change. The colour variation is to highlight the interactions and natural networks that emerged over time.

Figure 10: A Diagram Showing a Consensus of all Partnering Organizations to Drive FGM/C Policy Change

Source: Akinboyo, 2011
The educational materials developed with information on FGM/C impact and provisions of the law were widely disseminated through the core groups and also integrated into line ministries existing programs. Before the legal norms were introduced, awareness was created through life skills education for in and out of school adolescents, school Health and Sara Clubs, teachers’ orientation, reproductive health programs, radio broadcast, TV slots and newspaper articles. Communication channels between the core groups were strengthened through the youth peer to peer education introduced at the household level. Policy makers and women living with disabilities were also trained. The passage of the FGM/C law was therefore a response to the nationwide wake up of the statutory tool to reinforce the social change process already created.

Implementation of the Anti-FGM/C Programme has been uneven across zobas. As a consequence, those practising FGM/C have sometimes moved from one area to another to continue the practice. Recognising this challenge, the Anti-FGM/C Programme has focused attention on strengthening cross-border collaboration among government authorities and other actors involved in the response. ‘South-south’ approaches have been employed whereby active Anti-FGM/C Committees are used to strengthen weaker committees.

**Figure 11: FGM/C Abandonment Acceleration Strategies**

The above diagram illustrates strategies that will lead to the acceleration of the abolishment of FGM/C practices.

### 6.3 RESOURCE CHALLENGES

The Anti-FGM/C Programme team and its partners have considered key resource challenges, identifying the main ones as follows:
• difficulty in prioritising needs for financing;
• difficulty in reaching remote and inaccessible locations;
• inadequate funds to continue local level programme implementation, key to enabling community-level responses;
• lack of effectively targeted IEC materials, and inadequate quantities;
• the need to share IEC materials across organisations;
• factors such as lack of access to electricity or power failures.

Within the various agencies involved in the anti-FGM response, the many demands on their resources requires prioritisation, and needs such as water, sanitation, health provision, immunisation, etc. may be prioritised over support to eliminate harmful traditional practices. Where they can, partner agencies such as WHO, UNFPA and UNICEF collaborate with government to help fill financing gaps and provide other support as identified. Further, recognising the particular problems facing those working in remote and inaccessible locations, innovative approaches have been employed, including relying on camels and donkeys, travelling with batteries to support audio-visual equipment, and expanding outreach via media.

Since FGM/C is deeply in-rooted in all parts of the country, the remote areas in Eritrea are hard to reach due to lack of proper infrastructure. The roads leading to the remote areas are in poor condition breaking cars and trucks used by the Anti-FGM/C promoters. Sometimes, the mobilizers use various methods, such as hiking, biking, mule, donkey and camels, to reach the target communities. Also some villages do not have access to electricity, therefore, microphones and campaign videos cannot be used during the mass meetings. Other promoters who work in remote areas have also expressed the difficulty to access computers and copier machines when reproducing IEC materials to use during community meetings. When new publications are produced by the organization, the promoters often travel for days to retrieve the materials.

Media connections faces challenges and are in need of improvement to be used in promotional activities and report successes of various programs. Especially, radio programs (Radio Numa and Radio Bana) need specially trained reporters who write on regular bases to promote the Anti-FGM/C and other activities as majority of the population in Eritrea tune in to radio on daily basis. Even the villages without electricity own battery operated radios to tune in to news and other radio programs. There are also challenges to maintain most websites using current activities as the general internet and web access in Eritrea is slow and time consuming. However, these days many Eritrean youth look for access to information over the internet and the desktops of computers in many internet cafés and so these can be used to provide the means of promoting projects in many towns and cities.
6.4 DECLARATION OF NATIONAL ANTI-FGM/C LAW

NUEW and partners worked in parallel to advocate the cessation of FGM/C among the cabinet members of the government to drive the policy change. As a result of these efforts, Anti-FGM/C proclamation was ratified and publicly declared. At the implementation stage, HaMaDeA along with its partners MOH, NUEYS and Regional administrators invited the public for discussions to increase the awareness of the negative consequences of FGM/C, video viewing of the FGM/C procedures followed by discussions and public swearing ceremony to abandon the practice. Finally, the Anti-FGM/C proclamation was read aloud to the public to ensure that all literate and illiterate at least hear the law collaborate in implementing the abolishment of the practice. The implementation stage includes the following three aspects: public health officials to monitor health of women and girls, the public to report any circumcision of re-infibulations and the law enforcement officials to arrest and prosecute any violators according to the law.

Figure 12 Steps Taken by the Government of Eritrea to End FGM/C

Source: Negash, 2011
7 MAPPING OF FGM/C ABANDONMENT BY COMMUNITIES
HaMaDeA has conducted a mapping project to be able to map and document the overall process or the different activities carried out in eight selected villages of Gash Barka and Anseba. This section of the document presents the summary of the mapping project to elaborate the systematic approach Eritrea has taken towards the elimination of FGM/C. In the Gash Barka region, the villages of Engerne, Derat, Shilab, Aderde were chosen while in Anseba provinces, the villages were Filfle, Karubel, Gelet, and Aretai. These villages were selected due to the fact that a report shows a considerable transformation of their communities towards the abandonment of the FGM/C and other harmful traditional practices such as early marriage. Mapping the overall process of these villages is expected to contribute towards the transformation of communities in other villages to abandon FGM/C.

This is a simple mapping system of communities promoting the collective abandonment of FGM/C. The paper informs readers on the process and challenges faced in strengthening community structures, capacities, services and resources towards promoting normative behaviour change. The coordination of stakeholder engagement and interactions between the mapping team and local stakeholders yielded solid insights into who was involved in FGM/C and how the Anti-FGM/C Programme could effectively respond. It must be noted that this phase was successful coordinated by the National Union of Eritrean Women (NUEW) with financial support received from the Netherlands government.

The need to conduct a national mapping and assessment of the larger child protection system in the country was initiated in 2010. Following a series of consultations, a window of opportunity emerged in 2011 when the key partners agreed to initiate the approach starting at the community level with the hope of adapting the lessons learned when scaling up into the larger formal system. The mapping focussed on assessing the existing structures, standards and services, including the enablers that contributed to the desired change in behaviour on abandonment of Female Genital Mutilation/Cutting practice in Eritrea. The mapping attempts to reflect the linkages, gaps and emerging networks influencing decision making, relationships and behaviour change, the flowchart produced highlighted the community interactive process that accelerated their collective action.

7.1 OBJECTIVES

To sustain the gains made, the mapping exercise was a collective effort by the national partners to further understand the dynamics of community system, its structures, coordination, connections, capacities and obstacles in the environment contributing to this desired change. The mapping exercise also provided a learning curve for future research work on community mapping in Eritrea. Three major objectives were set for the mapping:

- To critically examine the progress, challenges and strategies adopted by communities in the process of promoting collective action on abandonment of FGM/C and other harmful social norms.
- To generate a simple flowchart diagram as evidence in providing a clearer picture and understanding of the activities conducted and connections with stakeholders functions.
- To provide recommendations for strengthening the linkages between community systems and the formal systems.
7.2 METHODOLOGY

The study was conducted in eight villages with the Gash-Barka and Anseba zobas. Both qualitative and quantitative data were collected. However, the mapping was completed in only four communities. Four major factors were considered in the selection of the villages, namely:

- Communities that have made collectively and specific effort towards the abandonment of harmful social norms.
- Communities where individuals including children are encouraged to report to law enforcement agencies on anybody practicing FGM/C.
- Communities with local courts prosecuting and penalizing offenders reported.

A semi structured questionnaire was developed for data gathering through community focused group discussions (FGDs) and in-depth interviews of key informants. Structured questionnaire was also developed for gathering data from a random sampling from about 160 households in selected villages. Households were selected using a linear systemic random sampling (SRS) based on the list of village household in the administrative offices. All questionnaires were translated into local dominant language. Field work was conducted with a space of one month following the training of the enumerators. This contributed to the 99.4% of respondents provided feedback. Detailed desk review was also conducted based on available information from the key informants.

The key informants interviewed included the following:

- National level: The Women Associations and UNICEF.
- Community/Village Level: Village administrators, Women and Youths, Traditional birth attendants, former circumcisers, religious leaders and local media.

7.2.1 Steps Adopted for Data Quality Assurance

- Development of Concept Note and Terms of Reference for common understanding
- Selection of institutional consultants for the community mapping
- Development of the data collection tools and guidelines for focused group discussion
- Selection of the communities based on agreed criteria
- Identification, selection and training of field key staff with local language knowledge
- Identification of key informants and definition of key concepts
- Community sensitization and social mobilization about the benefits of mapping
- Engagement of local administration officials and village heads
- Piloting and finalization of the household and key informants questionnaire
- Focus group discussions, intensive key informant interviews and field supervision
7.2.2 Stakeholders Involved

The key actors during the community mapping exercise were the village elders, religious leaders, FGM Abandonment Committees, local authorities, TBAs and ex-circumcisers, youth community based promoters and change agents, CBOs, judges, police and legal personnel, teachers, health personnel, NUEW, PFDJ (People’s Front for Justice and Democracy), NUEYS, Councillors, elders, household heads and religious leaders, administrators, TBAs, MLHW, MOH).

61.6% of the respondents were the household heads, farmers and nomads with a strong cultural belief in FGM/C. 37.1% were spouses that had lived in the area for several years. Overall, 52.8% of respondents were females. Forty-eight percent of the participants were between 35-54 years, 33.3% were in the age bracket of 15-34 years, while 18.9% were 55 years and above. Age of the respondents’ ranges from 15 -74 years with a mean average age of 41 years. Overwhelming, 45.9% had attended elementary school and only 27.7% had basic education while 10.7% had secondary education. 16% were also able read and write without any formal education.

93.1% were Muslims from which 89.9% belong to the Tigre ethnic group. Only 6.3% were orthodox.

7.2.3 Key Components of the Community Mapping

The components included in the framework for the mapping exercise are as follows:

Community Structures: Local courts, school health clubs, health facilities and police stations, churches, mosques, National Union of Youth and Women offices, local administrative offices, political parties, households, village halls and open spaces with canopies for community meetings.

Community Functions: Legal enforcement, knowledge dissemination and mobilization, focused group meetings, counselling, treatment, clinical assessment, monitoring, reporting, decision making, resource allocation, documentation and networking.

Community Standards and Tools: FGM/C law, terms of reference for Anti FGM/C committees, monitoring checklist, court orders, declarations by religious leaders, school policies, health policies and community public declarations.
Community Enablers: Local judges, police, teachers, social workers and health professionals, volunteers in the Anti FGM/C committees, farmers, traditional media, religious leaders, village elders, political leaders, village chiefs, traditional birth attendants, circumcisers, youths and women leaders, family heads and children.

7.3 IMPACTS OF THE 2007 DECLARATION ON FGM/C

The sustained and on-going awareness on the consequences of harmful social norms and the FGM/C law issued in 2007 created a strong incentive for people to change. Many of the community members only needed the backing of the law to in enabling open and public refusal from the societal pressure to cut or not to cut. Gradually, the fear of stigmatization and feelings of guilt and remorse was removed due to the approval by important and central leaders in the community. For many years, efforts had also been made in setting up the village and zonal Anti-FGM/C committees, youth peer promoters, whose members were trained to clearly understand the social and health impact of the practice.

7.4 RELEVANT AND USEFUL SPACES/Locations THAT BENEFITED THE PROCESS

In most rural settings of Eritrea, community meetings take place at open locations where village elders discuss local and national issues. Some of these places are churches, mosques, under the trees, locally constructed sheds, and where it exists, community halls can also be used. To influence behaviour change at household level, schools and health facilities are part of the community locations where issues on FGM/C and early marriage are extensively discussed with parents and children. Sensitization meetings and activities were conducted in many of these places. Campaigns in schools and government offices were promoted to respectively raise the awareness of students and policy makers on the rights of women and girls. Usage of these facilities greatly contributed to the social mobilization activities on FGM/C.
7.5 GROUP DYNAMICS THAT FACILITATED THE ABANDONMENT PROCESS

The Women and Youth Associations were to a high degree the enablers of the changes at the grassroots level and this created the needed space for mobilizing a collective response in the government system. The Anti FGM/C Committees were mainly expected to enforce the law, monitor compliance and act as change agents; membership to this group was voluntary but it had a status symbol as members included the religious leaders, TBAs, village elders, former circumcisers, police and local administrators. Overtime, the Anti FGM/C Committees facilitated the diffusion of key messages into remote villages and became the group became an effective mechanism for information dissemination and networking. The established networks were the entry point for information dissemination and interactions; it also played a crucial role in managing the various contention areas.

7.6 CULTURAL IDENTITY

Changing social norms and behaviours usually requires a lead time. For many decades, the religious and cultural settings provided a normative expectation for the continuation of the practice among Christians and Moslems, often affirming that it was a religious duty that follows the example of the prophets and descendants of old. In addressing the increasing tensions and misconceptions at the grassroots level, the need for involvement of religious leaders was very obvious and subsequently became part of the intervention strategies towards the abandonment of FGM/C practice in Eritrea. This promoted the cultural acceptance among community members.

7.7 EXISTING COMMUNITY SERVICES USED AS ENTRY POINTS

Under the auspices of the local administration system, efforts were extended to ensure the expansion of Anti-FGM/C committees reaches the village level. The sustained support of the community based volunteers, development committees and national union strengthened the coordination of various interventions. Community dialogue was identified from the outset as a tool for mobilizing community support. The training of community volunteers and refreshers training for partners were an integral part of the work done by implementing partners. The Anti-FGM/C committees also had clear terms of reference, roles and responsibilities.

7.8 SOURCES OF INFORMATION

The main sources of documented information for the mapping were received from the zoba local Ministry of Health, National Union of Eritrean Youth and Students and the National Union of Eritrean Women (MoH, NUEYS, and NUEW). High levels of community involvement were evident in the celebration of the International day of Zero Tolerance for FGM/C. Collectively, over 350,000 policy makers, village elders, women’s groups, circumcisers, religious leaders and community health attendants were empowered with knowledge on FGM/C through this special event. The process for conducting the Clinical Assessment for girls under the age of five was clearly documented in community health facilities.
7.9 EMPLOYMENT AND INDUSTRY

The most dominant form of employment in the selected communities relates to agriculture (farming and livestock).

1. Limitations, challenges and success factors

More analysis still needs to be done to further reflect the process and inter linkages of activities conducted by the communities. In addition, the lack of systemic documentation and data gaps on activities conducted or actions initiated at the community level was a major obstacle and time consuming.

7.10 CHALLENGES

- The deeply rooted cultural, traditional beliefs and attitudes of the community on FGM/C still remain very challenging to change in communities in the hard to reach areas.
- The shortage of fuel and transportation was more pronounced on access to remote and scattered settlements. Regular monitoring and social mobilization activities were also affected.
- No agreed indicators or guidelines on the process for community collective abandonment of FGM/C and other harmful social norms.
- Lack of infrastructure of roads prevented mobilizers from reaching some remote area and nomadic communities.
- During the data collection, the lack of electric power regular supply in the rural areas hindered the video shows during the focused group discussion.

7.11 SUCCESS FACTORS

- The sustained financial support of the Swedish government, the Swiss NATCOM, the European Union and the Netherlands government.
- The legal instrument (FGM/C proclamation 158/07) reaffirms the government strong political will and also provided a framework for the Anti-FGM/C committees.
- The existing strong partnership between the religious leaders (Islam and Christianity) in the fight against FGM/C in most of the communities.
- Anti-FGM Committees accountability to the local Zoba administrative offices for planning, funding, capacity development, monitoring and feedback.
- The engagement of TBAs, male political leaders, political and religious leaders as change agents, influenced the perception and approach towards abandoning the practice.
- The sector wide approach and the new alliances with civil society, opinion leaders, women’s group, media and children were also contributory factors to the progress made.
- Enhanced production of relevant IEC materials including and use of local media in local languages and their distribution to remote rural areas.


7.12 OTHER FINDINGS

The mapping and assessment exercise identified the strength and weaknesses from various actions, customs, roles, procedures and external factors that informed the collective community response, including success, challenges and obstacles.

Community monitoring: A monitoring mechanism was found to be in place for effective reporting and sustaining the collective pledges and commitments of the community not to cut.

Community incentives: Information from focus group discussions and key informants in the villages of sub-zoba Haboro (Filfile, Karubel, Gelet, and Arietai) revealed that a major motivation and entry point for the collective response was the 2007 FGM/C legal tool and public dialogue around the issue.

Community mobilization: Series of the community and government led coordinated Anti-FGM/C campaigns were conducted through various stakeholders (traditional media, involvement of the community elders, religious leaders, traditional birth attendants, government officials and civil society organizations such as NUEW, NUEYS and PFDJ.

Community preferences: The preferences being made among individual families and traditional circumcisers to further comply with the FGM/C practice requires a minimum of about five years to be able to have impact on the larger community networks.

Community engagement: The collective engagement of religious leaders, youths, women, schools, health facilities and the media strengthened the coordination, diffusion and networking. Community judges and the police were also very active in the local anti FGM committees.

Community gaps: In general, the major gaps observed from the community mapping were also confirmed in the 202 FGM/C Evaluation report. This included the lack of incentives for community volunteers, limited support for effective monitoring and reporting, inadequate information materials in local languages, slow prosecution of cases reported and fear of family neglect of other children when mothers are in prison. There is a critical need to mobilize more resources to further strengthen the implementation of the community action plans and promote cross border initiatives.

Similarly as the reports of the FGD participants and key informants, 83.0% and 74.8% of the respondents of the household surveys reported that the source of their knowledge on the harmful consequences of FGM/C is NUEW and Anti-FGM/C committees, respectively. The next frequency cited sources of knowledge are: Ministry of health (65.4%), mass Medias (37.1%), and community health agents (32.1%). In addition, majority of the respondents (96.9%) revealed that FGM/C has no benefits at all to girls. Therefore, there has been major behavioural changes towards the acceptance of abolishing FGM/C has been seen within the target mapped communities.
7.13 KNOWLEDGE AND MANAGEMENT

Planning steps for monitoring and evaluation--- clarify project aims, objectives and values, clarify the target group, identify outputs and outcomes, set performance indicators, set targets.

7.13.1 Monitoring Tools

Monitoring tools are used in monthly, quarterly, semi-annually and annually depending on the activity and the organization. The Anti-FGM/C committee mostly monitor their progress according to the planned out agenda of awareness campaign. The advocates collaborate with schools and local administrators to take into account any social activities such as: national testing schedule and farming seasons. Then, they plan accordingly to reach out to all targeted families within the community. In addition, training session are prepared by all stakeholders to improve the skills and knowledge of all facilitators in specific areas. During some monitoring sessions, the media sector also is invited to record and publicize progress of various activities in order to encourage other communities to show progress. Furthermore, there are monitoring tools used by various stakeholders to be able to follow through programs in a meaningful and productive manner.

7.13.2 Evaluation

Ongoing evaluation systems are put in the form of collecting data and sharing information across the country. Various organizations have a set evaluative systems to measure the efficiency of their programs advocating against FGM/C. However, more needs to be done to evaluate and articulate collaborative efforts in resource sharing and building the capacity of human resources. Furthermore, many of the partnering organizations and ministries are starting to use technology in order to assist the development processes that help the evaluative processes.

7.13.3 Documentation

Documentation remains one of the major national challenges as the work on the ground far outweighs the reports documented due to the culture that was inherited during the liberation struggle “talk less, work hard.” The literacy programs provided in various regions need to be supplemented by capacity building programs that will empower women and promoters to document the activities on the ground. In addition, data collection tools need to be updated and used properly to maximize the accuracy and efficiency of projects.

7.14 LESSONS LEARNED

One of the many challenges that any organization faces is the fact that many rules and regulations impede their logistical activities. Various administrative zones have unnecessary bureaucratic procedures that slow down the efforts to effectively carry out programs in time. Other zones lack the right infrastructure such as roads, electricity and other facilities.
to be able to reach the remote area communities. Since it’s vital to reach the right person within the community, advocates and mobilizers need to be able to identify the influential person and gather families to pass the message. Hence, proper communication channels are vital to find out what will be the right channel to reach the most influential person in the specific community before conducting the seminar that will produce satisfactory results. Also, if the mothers and grandmothers are not individually persuaded to stop the practice, they tend to migrate to other communities to perform the practice on their daughters.

7.15 OPPORTUNITIES

One strength of Eritrean culture is its ability to organise to support the attainment of shared objectives. This was evident during resistance to colonial rule, and has been applied to development since independence. Networking was important during the struggle, and it has proven to be important in responding to FGM/C, especially in effectively reaching remote areas. The Anti-FGM/C Programme’s communication strategy has been built on these structures. Nevertheless, the effectiveness of the strategy has been undermined by some problems in implementation. For example, it is vital to inform the local administrator before starting any kind of mobilizing project. In addition, the local government has strong ties with religious leaders and village elders. All communities have their leads to inform and guide them with the events that take place. Announcements are mostly done verbally by word of mouth or sending messengers to various parts of the communities. With the exception of the big cities, majority of Eritrean villages live a communal, agricultural lifestyle where they help each other and share their activities. Therefore, it’s easy to pass vital information and inform families to participate in Bayto (public gathering). In addition, there is a long lived societal habit of listening to the radio programs both in the rural and urban societies. Since electricity has entered majority parts of the nation, many families gather and watch the news in four different languages every evening. Eri-TV also reaches the international Diaspora families which is another opportunity to educate all families within or outside the nation about all the traditional harmful practices. Also medicalization of FGM/C by health professionals is a national crime. Doctors, nurses or midwives face losing their license and prosecution if they perform FGM/C in health facilities or anywhere else in the country.

7.16 INNOVATIONS

Inclusion of village leaders and religious leaders has been successful in bringing about changes in behaviours and acceptance of new ideas due to the important role that religious leaders play. Continuous education of families has been vital to bring behavioural change in the abolishment of FGM/C. Strong community based mechanisms and structures to prevent and monitor FGM/C are already in place, and there is great commitment to attain reduction of FGM/C prevalence by enforcing the law and raising awareness. Also, the Ministry of Health has adopted reporting of the clinical assessment of girls under the age of five. Field support staff from partnering organizations adopted routine usage of monitoring
and evaluation checklist. In some regions, NUEW branch representatives have focused attention on building systematic relationships with law enforcement officials to prosecute violators of FGM/C and other harmful practices.

7.17 RECOMMENDATIONS

To sustain the national effort to eradicate FGM/C, the systematic approach employed by the Anti-FGM/C Programme to date should continue. The multi-sectoral response has proven effective, but there are problems association with collaboration. There is a particular need to strengthen the partnership strategy at national level and consider how this can strengthen co-ordination at sub-national level. Anti-FGM/C Committees at community level are sometimes weak, and they need support to continue and a clarify of vision and demand for their actions. Partners involved in the FGM/C response need to do what it takes to strengthen these community-level institutions. There is also a need to deepen the legal response so that behavioural change can be effected, and prosecutions increased.
ANNEX A: RESEARCH QUESTIONS

1. What are the social mobilization initiatives at the community level?

2. What key messages against harmful practices are passed to community members?

3. What processes and methods are used to build consensus among community members?

4. How do communities declare with collective statements of intention to stop the practices of harmful practice, especially FGM/C?

5. Which holistic systemic approaches have been effective or non-effective in the coordination of FGM/C interventions?

6. Who are the key partners and stakeholders involved in promoting the eradication of FGM/C?

7. What has been the role of MOH? NUEYS? Law enforcement?

8. What are possible influences from neighbouring communities/zones?

9. Who are included in the (change agents) FGM/C committee at the village? Subzone? Zone?

10. What alternative livelihood schemes are provided for circumcisers?

11. What teaching aids are used to deliver messages in communities and schools? What are the sources of information used for the campaign?

12. How will you rate the community sensitization coverage? Monitoring at risk girls? Above 80%, 50%, below 50%?

13. Is there a monitoring mechanism at the community/village level?

14. Which court handles the complaints of FGM/C cases? How many cases have been brought to court and handled?

15. What lessons are learned to help accelerate the eradication FGM/C completely without any relapses?
ANNEX B: FOCUS GROUP DISCUSSION QUESTIONS

FGDs were conducted in all the selected villages with 8-12 participants including representatives from local administration office, NUEW, NUEUS, MoE, MoH, Members of Parliament, representatives from PFDJs, Police, community elders (male, female), religious leaders, students (male, female), and women and men from the community.

1. What is the historical background of Female Circumcision and other harmful traditional practices in your community? (When do you think it started?)
2. What is the magnitude of female circumcision or harmful traditional practices in your community?
3. What type of female circumcision is practiced by your community?
4. What are the main reasons for female circumcision in your community?
5. What benefits do girls themselves get if they undergo circumcision?
6. How do you see the acceptance of female circumcision by religious leaders in your community?
7. How do men in your community see female circumcision?
8. Who mainly perform female circumcision in your community?
9. Do you think that female circumcision has problem? If “YES” could you please list them?
10. What do you think is the level of awareness and understanding of the community in general and women in particular on the rights of children including health and education?
11. How do you evaluate the level of campaigns against female circumcision in your community?
12. Who are the main actors in the campaigns?
13. How do you evaluate the involvement of NUEW in conducting awareness raising campaigns against female circumcision?
14. What types of activities were conducted by NUEW?
15. How do you evaluate the involvement of mass medias (radio, TV, newsletter) in the campaigns against female circumcision?
16. What types of activities were conducted by mass media?
17. How do you evaluate the level of knowledge of the community in general and women in particular about the existence and content of the law against FGM in the country?
18. What do you think is the level of enforcement of the proclamation in your community?
19. Are there people person penalized by the law for his/her involvement or support of FGM in the community?
20. How do you evaluate the current level of practice of FGM compared to the previous times?

21. What do you think is the level of discussion among members of the community on the harm or costs of FGM?

22. Is there any effort, activities, or collective decision made by the community to abandon the practice of FGM in their community? If YES, when was decisions made, the outcome of the activities or decisions?

23. Were there any incidences of groups or individual against the collective decisions? If YES, what corrective measures were taken?

24. What do you think should be done by (Mass medias, NUEW, Ministry of Health, local government, others) to increase reduction or eliminate FGM practices in your community?
ANNEX C: KEY INFORMANT INTERVIEW INSTRUMENT

National Union of Eritrean Women (NUEW) and Traditional Birth Attendants

1. What is the level of awareness and understanding of the communities on children and women’s, particularly rights of health and education and the right not to be circumcised?

2. How do you evaluate the involvement of the local administration or other concerned bodies in the protection and realization of rights in the community?

3. Are there any campaigns or activities conducted in your community against FGM/C? If yes, list the type of activities and responsible coordinating agency. (local campaigns, mass media campaigns, seminars, establishment of FGM abandonment committee, video show campaigns, production of IEC materials, etc.)

4. Are there any efforts, activities, or collected decision made by the community members to abandon the practice? If YES, please list.

5. How do you evaluate the level of collective commitment of the community to reduce or abandon FGM?

6. How do you measure the extent of the commitment?

7. What do you think is the level of commitment on the government side at all levels (zoba, sub-zoba, administration areas, village) to transform to the abandonment of FGM?

8. How do you evaluate the level of knowledge of the community in general and women in particular about the existence and content of the law against FGM in the country?

9. What do you think is the level of enforcement of the proclamation in your community?

10. Is there any individual penalized by the law for his/her involvement or support of FGM in the community?

11. How do you evaluate the current level of practice of FGM compared to the previous times?

12. What do you think is the attitude of your community on the continuation or discontinuation of the practice in your area?

13. How do you rate the level of coordination of the NUEW with MoH, or other concerned ministries or agencies in the areas of work related to female circumcision, including raising awareness?

14. What do you think should be better done by (Mass media, NUEW, Ministry of Health, local government, others) to reduce or eliminate FGM practices in your community?
ANNEX D: MINISTRY REPRESENTATIVES

These KII guideline will be administered to government representatives from Ministry of Health (MoH) Ministry of Labour & Human Welfare (MoLHW) Ministry of Education (MoE), Ministry of Justice (MoJ), all at the zoba and sub zoba levels.

1. Are there any campaigns or activities the Ministry of Health conducted in the communities or villages against FGM? IF YES, List the activities. (Local campaigns, seminars, video show campaigns, production of IEC materials, etc.)

2. Are there reports of girls, adolescents and women with health problems caused by circumcision in your community?

3. How do you evaluate the level of collective commitment of the community to reduce or abandon FGM and how can you measure the extent of the commitment?

4. What do you think is the role and level of commitment on the government side at all levels (zoba, sub-zoba, administration areas, village) to promote the abandonment of FGM?

5. How do you evaluate the level of knowledge of the community in general and women in particular about the existence and content of the law against FGM in the country?

6. What do you think is the level of enforcement of the proclamation in your community?

7. Is there any individual penalized by the law for his/her involvement or support of FGM in the community?

8. How do you evaluate the current level of practice of FGM compared to the previous times in the communities or villages? Why?

9. What do you think is the attitude of your community on the continuation or discontinuation of the practice in your area?

10. How do you rate the level of coordination of the MoH with NUEW or other concerned ministries or agencies in the areas of work related to female circumcision in your community?

11. What do you think should be the role and commitment of the Mass media, NUEW, Ministry of Health and local government, others to reduce or eliminate FGM practices in your community?
ANNEX E: TRADITIONAL FGM PRACTITIONERS QUESTIONNAIRES

This questionnaire was administered in each village to assess the practitioner’s attitude, and experience on female circumcision.

1. What is the historical background of female circumcision in your community?
2. What type of female circumcision is practiced in your community?
3. Who mainly do perform the practice?
4. At what average age is the practice performed?
5. What groups of the population do mainly perform female circumcision?
6. What are the main reasons of circumcision in your community?
7. What benefits do girls have if they undergo circumcision or if they don’t undergo circumcision?
8. Do you know the negative consequences of female circumcision? IF YES, please mention them?
9. How do see the attitude of your community in general and men and women in particular towards female circumcision?
10. Have you ever been involved or participated in any activities or campaigns against female circumcision in your community?
11. How do you rate the role of NUEW, NUEYS, MoH, MoE, and local government (zoba, sub-zoba, village) as well as mass media (radio, TV, newsletter) in raising the level of awareness of the community on female circumcision and reducing the practice?
12. How do you rate the level of knowledge of the community in general and women in particular on female circumcision?
13. How do you rate the level of commitment of the government (local, sub-zoba, and zoba) in eliminating the practice?
14. Do you know that the government has issued proclamation that bans the practice of female circumcision in the country? If YES, how do you see its level of enforcement?
15. When do you think the practice of female circumcision be abandoned or stopped in your community?
16. Do you like the practice to continue or discontinue?
17. What factors drive or motivate you to engage in performing the practice?
18. How many years did you do the practice?
19. Are you currently practicing female circumcision? Why?
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