BERHAN Programme: Lessons learned from engaging Female Genital Cutting practitioners in community-led interventions to end the practice

LEARNING BRIEF

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INTRODUCTION

The BERHAN program, a 48-months initiative in Ethiopia's Amhara region, aimed at improving Sexual and Reproductive Health and Rights (SRHR) of 32,116 individuals in rural communities within Este and Fogera woredas. The program was implemented by CARE from March 2020 to February 2024 with financial support from the Austrian Development Agency (ADA), the operational unit of Austrian Development Cooperation (ADC). BERHAN sought to improve the SRHR of girls and women, and to address issues of Female Genital Cutting (FGC) and Early Marriage (EM) in particular, and adopted a comprehensive approach, using evidence-based, community-led interventions to empower girls and women and transform community dynamics and structures.

This study focuses on assessing the contribution of community-based interventions towards halting the practice of Female Genital Cutting within the community- and more particularly the role of FGC practitioners. In the project, FGC practitioners were integrated into Social Analysis and Action/Village Savings and Loan Associations (SAA/VSLA) groups and received training on the consequences of FGC and Income Generating Activities (IGA). By the end of the project, 213 FGC practitioners had rejected the practice. This study delves into societal and other contributing factors behind the successes but also explores what remains to be done and the problems of the persistence of the practice.

METHODOLOGY

The study was conducted in October 2023 within two intervention Kebeles of the BERHAN project in Fogera Woreda, situated 60 km from Bahir Dar town. Qualitative and quantitative methods were applied, and primary and secondary data utilized.

Two Focus Group Discussions (FGD) were conducted with 21 individuals (14 women and 7 men- all SAA group members). Key informant interviews were held with 13 participants (5 women and 8 men) and 12 individuals (8 women and 4 men) were engaged in in-depth interviews (IDI), including woreda and kebele Government office representatives (Health, Cooperative, WSCA, Administrative and Justice departments; kebele managers and chairmen) and Health Extension Workers (HEWs) and one testimony was obtained. Purposive sampling technique was employed to select participants based on their experience and involvement in the BERHAN project's SAA/VSLA groups, ensuring a targeted and informative participant selection process.

Why does FGC happen?

a. Community Beliefs and Social Pressure:

Traditional beliefs reinforcing the practice include the belief that an uncircumcised girl may develop a strong desire for sex, lose her virginity, display restlessness in behaviour, and face societal unacceptance. This is contrasted with the belief that circumcised girls exhibit calmness, maintain genital cleanliness, attract husbands, and experience shortened delivery periods. With these beliefs – linked ultimately to issues of control over women's fertility - come the social pressure to maintain the practice.

"*If a girl is not circumcised, the community stigmatizes her by labelling her as 'Woshela'. This results in societal shame, making it difficult for her to find a marriage partner, and she often remains unmarried without securing a husband in the community*." IDI respondent

b. Government Engagement:

The government actions to tackle the problem were limited, mainly because government authorities do not collect data on FGC practices and therefore think it does not exist. However, the project baseline report contradicted this assumption, revealing the existence of hidden FGC practices within the community. This revelation prompted a shift in sectoral focus, as stakeholders became more attentive to FGC cases.

At the beginning, CARE found that governmental efforts in raising community awareness about the dangers of Female Genital Cutting (FGC), including consequences on maternal and infant health, are limited. Likewise in terms of making people aware of the criminal nature of the practice. There was inadequate implementation of legal enforcement and remedial action against FGC practitioners. The process of reporting and identifying cases of FGC within the community were also ineffective.

c. Incentives of the practitioners

FGC practitioners receive incentives, including monetary or in-kind rewards, an enhanced role and prestige in the community. This itself contributed to the persistence of the practice.

How does it happen?

FGC is practiced within 7–10 days after a mother gives birth. If a woman has not undergone circumcision, it is performed within a week before her marriage ceremony. During the circumcision process, practitioners utilize unsterilized and not well cleaned materials. Parents or relatives organize a simple ceremony for the practitioners and participants, often providing incentive payments and accommodation for those coming from distant areas.

FGC is now practiced clandestinely in the community, which itself is a cause of distress (KII). The prevalence and implementation of FGC varies from one woreda to another, influenced by cultural beliefs, norms, and religious concerns. The skill and tradition of FGC are esteemed within families, passed down to new practitioners from ancestors, relatives, and elders. Observing the practice involves practitioners who can be female or male cutting children (both boys and girls) in their village and honing their skills on their own children.

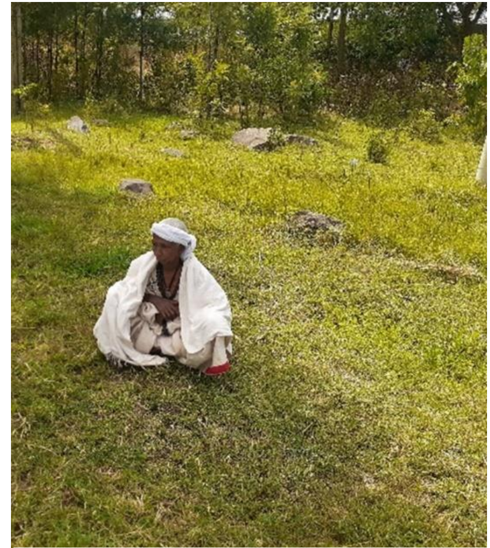
Why does someone choose to become an FGC practitioner?

FGC practitioners gain social respect, dignity, improved social bonds, and privileges from their role. It links them to their parents, relatives, and ancestors, i.e. those whom their learned their practices from. There is also satisfaction and enjoyment of being involved in the ceremonies, and benefitting in the form of food, beer, alcohol, coffee, and other offerings, organized at the girls' family's home.

"*Some practitioners engage in FGC for perceived religious benefits, believing that being a practitioner and performing the circumcision ritual brings religious advantages*" IDI respondent

On top of other gifts (cereals, labour support), FGC practitioners can receive monetary incentives, up to ETB 200 (3.64$) per event. However, many practitioners face financial constraints as they do not gain sufficient funds for this practice to be the source of their main income.

Additionally, engaging in the practice often results in a loss of social acceptance and dignity by some within the community. Those who oppose the act of cutting may also express their grievances as might those whose babies or young girls suffered complications from the circumcision. Lastly, there is a potential health risk for practitioners as they may face blood contamination during the cutting process, leading to health issues or the acquisition of diseases.



An FGC practicioner from Fogera Shina Kebele. Credit: CARE Ethiopia

Why do some choose to continue as FGC practitioners and others stop?

Those who continue to practice do so for the same reasons that they practised it in the past, i.e. due to the entrenched social and religious values that gives them status, income source and the lax enforcement of criminal laws. Also, the low awareness of its negative impact in the community.

"*The practitioner is aware that Female Genital Cutting (FGC) is legally prohibited, yet continues to engage in the practice covertly, evading regulatory scrutiny."* KII-Respondent.

Practitioners decide to stop due to awareness that cultural norms need to be questioned if they have negative effects and a recognition of the health impacts and complications of Female Genital Cutting (FGC). Additionally, the fear of law enforcement rules plays a significant role in motivating the practitioner to discontinue the practice.

> **"Since joining the BERHAN project, I have learned extensively about Female Genital Cutting (FGC). As a result, I have completely ceased practicing it. I now understand and firmly believe that FGC is a harmful practice with negative impacts on girls' lives. I am committed to never passing on this skill to anyone anymore."** FGC Practitioner

"*All practitioners [in our kebele] have ceased the practice of cutting female genital organs. They share a common belief and agreement that the practice of Female Genital Cutting (FGC) should be banned not only within their own kebeles but also in other communities."* FGD participant.

Factors that Encourage FGC Practitioners to Cease the Practice

- The project played a significant role, by targeting practitioners and kebele-level decision-makers as key group members in their activities- they were not shunned but invited in.
- FGC practitioners received training from the project in Social Analysis and Action[1] (SAA), acquiring skills in norm analysis, and in Village Saving and Loan Association (VSLA) methodology, and Income Generating Activities (IGAs) to engage in alternative income

[1] Social Analysis and Action (SAA) is one of CARE's models for gender transformation. It is a community-led social change process through which individuals and communities explore and challenge social norms, beliefs and practices around gender and sexuality that shape their lives.

generation activities.

- The Project SAA groups conducted monthly discussions on the topic of FGC and developed action plans, particularly focusing on following and educating mothers who gave birth at home.

- Practitioners actively participated in cross-learning events focused on discussing the consequences of FGC, particularly around childbirth, drawing lessons from others and engaging in public education within the community.

- Review meetings with SAA facilitators and core groups at the kebele level helped evaluate progress around SRH related issues and provided a forum to address challenges, including the role of FGC practitioners. The case referral strategy with government was one key factor that led to positive change.

- Girls' group discussions were instrumental in providing information to SAA group members about what the younger generation were thinking and experiencing, providing a way through which to discourage FGC. The inclusion of religious leaders in the SAA and core group of the project facilitated a clear understanding of the relationship between FGC and religious ideology.

- Both in schools and in the community, and in market squares, drama and conversations were used to raise awareness of the dangers of FGC, address taboos and social norms around the practice and ensure actions are taken.

"CARE platforms, specifically the SAA dialogue, played a pivotal role in enhancing practitioners' knowledge and understanding of the health consequences of female genital cutting. In project interventions, group dialogue sessions on FGC were conducted, resulting in a transformation of beliefs and attitudes among group members and religious leaders. This transformation empowered practitioners to confidently cease the practice and report cases to the government. The inclusion of religious leaders in the SAA group further supported practitioners in promoting the refusal of the practice. Additionally, Health Extension Workers (HEWs) played a crucial role by regularly tracking postnatal mothers with female infants, providing valuable information to SAA and Core group members. These successful strategies serve as valuable lessons that the government can incorporate and use within its existing structure." KII respondents from Health, WSCA, Justice offices.

What else, outside the project supported the work?

Some respondents mentioned that Health offices and Women, Children and Social Affairs (WCSA) Offices conducted FGC awareness campaigns. In addition, WABI Children Aid operated in Fogera woreda, covering three non-BERHAN intervention kebeles and Action Aid Ethiopia operated in Guna Begemider and Farta Woreda, spanning 10 intervention kebeles also working on the issue. In these Kebeles, government representatives, such as kebele chairmen, managers, Health Extension Workers (HEWs), and religious leaders were actively involved in FGC prevention efforts.

According to a key informant, FGC was much less likely in areas where there were additional development partners involved, with government offices also more likely to engage more effectively when there were others engaged- however the impact did not spread beyond the project areas.

As for the policies against Female Genital Cutting (FGC): The criminal codes encompassed in articles 565-569 address various aspects related to Female Genital Cutting (FGC). These include: Criminal code 565 - Female circumcision; Criminal code 566 - Infibulation of female genitalia; Criminal code 567 - Body injuries caused through other Harmful Traditional Practices (HTPs); Criminal code 568 - Transmission of diseases through HTPs; Criminal code 569 - Participation in Harmful Traditional Practices

These criminal laws are fully acknowledged by the Justice Office and partially known in WCSA offices. Government staff in the Police, the Health and Education sectors have heard of the law but lack detailed knowledge of the criminal codes and how to take legal action when needed.

What does not work?

The full implementation of laws related to Female Genital Cutting (FGC) faces challenges due to a lack of documents and witnesses at all levels of the government structure. However, when sufficient documentation and witness accounts are available, implementation becomes feasible. Respondents consistently noted that the specified penalties, such as a fine ranging from 150 to 1,000 Birr (2.6 – 18$) and a prison sentence of 3-6 months, are not widely applied despite being stated in the laws.

"*All respondents believed that the criminal law should undergo revision, be clearly articulated, that it should be given heightened attention, and be implemented across all levels of the government structure*." KII respondents.

RECOMMENDATIONS:

1. The government should adopt the working modalities of the project, which successfully improved awareness and attitudes to effectively curb Female Genital Cutting (FGC) practices in other areas- including a reduction of people who want to continue the practice.

2. Scaling up the project's successful interventions to non-BERHAN intervention kebeles and Woreda is crucial for preventing FGC cases.

3. Broader education and awareness campaigns are necessary to ensure that the criminal law on FGC is well-understood by government sector experts and the general population. Grassroots implementation, closely monitored by Woreda and Zonal government structures, are essential.

4. Community awareness efforts, utilizing role-playing, drama and discussions, are crucial to start conversations, gather evidence and facilitate law enforcement in combating the clandestine nature of FGC implementation.

5. Efforts that engage with FGC practitioners rather than shun them are critical if we are to eradicate a practice that they have usually inherited from ancestors and relatives.

6. The inclusion of religious leaders at all levels of religious structures is vital for addressing and challenging religious-related FGC beliefs.

7. Strengthening referral linkage systems and feedback mechanisms at Zonal and Woreda levels is essential, and they need to provide better support to kebele-level structures.

CONCLUSION:

The study demonstrates that in BERHAN intervention kebeles, discussions among SAA group members played a pivotal role in changing_beliefs and attitudes and social norms, fostering an understanding of the consequences of FGC and other harmful traditional practices. The VSLA modality significantly influenced the lives of FGC practitioners, facilitating alternative income generation activities and ultimately leading to the cessation of FGC practices. Although the practice is often hidden, the study affirms that the SAA group members' action plans and follow-up have effectively minimized and, in some cases, stopped the practice in each village.

Nevertheless, the practice remains in and around the project area which does not operate in a vacuum and therefore the dangers of regression and re-introduction of the practice remain, unless more widespread change is affected within the wider region.

TESTIMONY

"I could never again perpetuate the practice."

Tirualem Getahun,38, lives in Tiwazakana kebele, Fogera woreda, South Gonder zone. “ I am married and have 8 children (5 daughters). I acquired the FGC skill from my mother, and my involvement began over 12 years ago, since cut my sister in-law’s child. My mother had stopped cutting due to her old age, and the appointed practitioner repeatedly cancelled the appointment, prompting me to take up the responsibility. I did this despite my husband's opposition, as he is a teacher and aware of the health consequences of FGC. I continued the practice discreetly, in and beyond our village, and became more confident and skilled over time.

Tirualem Getahun. Credit: CARE Ethiopia

Before the BERHAN project started, I lacked a clear understanding of the consequences of FGC on girls. In the community more generally (including me), there was low awareness of the dangers and mothers secretly asked me to circumcise their newborn girls. Accepting their requests, I willingly cut female babies genitalia. But it took time away from my busy schedule and meant I couldn’t fulfil my other duties. I was also concerned about disease transmission to me due to blood contamination. My husband also retained his objections, and we would quarrel, he would say: "I have told you multiple times, why don't you stop and focus on what you need to do at home?” However, I was convinced that circumcised girls would face fewer challenges in marriage and childbirth, and I was doing the right thing by circumcising them. All my daughters were circumcised by my mother.

In 2020, CARE Ethiopia introduced the BERHAN project in our Kebele. The project's selection criteria included FGC practitioners, and I was chosen as a project participant. By joining the SAA group named "Alemayehu," I attended regular meetings, participated in discussions, and underwent training on SAA concepts and the Village Saving and Loan Association (VSLA).

The project significantly altered my beliefs and attitude towards FGC. I learned about the severe consequences of FGC, such as prolonged labour and fistula and that uncut women do not face

problems during sexual intercourse. The training provided a new perspective, leading to a complete change in my understanding. I am grateful to CARE for enhancing my knowledge, changing my attitude, and inspiring my decision to permanently ban FGC. Now I provide guidance to pregnant women, and actively work towards preventing FGC. I have become an example by halting the practice for my daughter's child and my brother's child. I have advised and prevented 15 mothers from cutting their female babies.

I have fully ceased the practice, making a personal commitment not to return to my previous harmful activities. Collaborating with other FGC practitioners, I work to ensure the non-transfer of this harmful skill to the new generation."

Cover image: SAA / VSLA group members who are part of the BERHAN project. Credit: CARE Ethiopia