Community-based Approaches to Reforming Female Genital Operations in Africa:
A Case Study From the Oromia Regional State of Ethiopia

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ABSTRACT: In the past, numerous attempts by colonial governments and international agencies to abolish the practice of female genital cutting in Africa failed to make any significant impact on behaviour. In this article, we describe how, since 1996, an indigenous NGO has been attempting to reform the practice in the rural communities of Oromia (Ethiopia). We show that it has brought about enduring change by creating awareness about the health consequences of the practice, facilitating collective debate on the topic using participatory methods, and involving local elders in the decision to abandon it. We compare this approach to other successful African initiatives undertaken during the same period based on similar strategies. We argue that these programmes have been able to amend the practice by empowering the communities to direct their own process of change, based on their own traditions. We caution, however, that such interventions should not be made without a full understanding of the cultural meaning(s) of the practice, which should be seen in a holistic manner.

KEYWORDS: Oromo (Ethiopia); circumcision; female genital cutting; community-based approaches

The global campaign launched in the 1980s to reform the practice of female genital cutting (FGC) led to experimentation with a number of educational programmes in Africa to address this culturally sensitive issue at the local level. These innovative attempts include, amongst others, the work of the Reproductive, Education and Community Health programme of the United Nations Population Fund in Uganda in early 1996, the Alternative Coming of Age programme initiated jointly by the Maendeleo Ya Wanawake Organization and the Program for Appropriate Technology in Health in Kenya in mid-1996, and the Tostan Basic Education Programme in Senegal from 1997 (WHO 1999). These local initiatives succeeded where global ones had failed, mainly because they were able to adopt an insider approach to resolving the problem.

In this article, we discuss a similarly innovative experiment that was undertaken from the beginning of 1996 by Hundee, an indigenous nongovernmental organization (NGO), in the regional state of Oromia in Ethiopia. We describe Hundee’s attempts to bring about positive behavioural change in respect to FGC and compare and contrast its approach to those adopted by the aforementioned organizations. Our analysis of these approaches is based on the ‘convention shift’ theory of change proposed by Mackie (2000).

This article forms the third in a series of articles about the work that is being carried out by Hundee in the Oromo communities of Eth-
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The first article provides historical background to its formation in relation to the Oromo nationalist movement for self-determination, which began in the 1970s (Kassam 2003). The second, published earlier, analyses its ‘ethno-development’ approach (Kassam 2002). The present article examines an important aspect of its work dedicated to eliminating the problem of FGC, as a precursor to bringing about women’s development. Like the previous articles, it shows that when the intransigent problems of development are mediated from the inside, by those who speak the language and understand the culture, it is possible to bring about meaningful change. This approach involves using indigenous knowledge, customary practices and traditional organizations as the basis for modern development initiatives, in this case, through the intermediary of the council of elders. In this respect, Hundee’s approach to tackling FGC can be compared to those of a number of other local NGOs in Africa, which have also involved community elders in the decision-making process to reform it.

In broader terms, our article contributes to the study of local institutions in development (Korten 1980; Esman and Uphoff 1984; Uphoff 1986; 1992), and in particular, to the important role that can be played by indigenous organizations (IOs) (Blunt and Warren 1996). Blunt and Warren (1996: xiv) define IOs as ‘local-level institutions with an organizational base that are endogenous as opposed to exogenous within the community’. Such IOs are ‘inclined to have and to use local knowledge, to respond quickly to changes, to handle conflict and to create climates of opinion influencing behaviour (Blunt and Warren 1996: xiv). In the institutional framework, national NGOs, which operate supralocally, often act as intermediaries between IOs and international NGOs and/or government agencies to foster local capacity or to bring about change (see Uphoff 1986: 191–192).

We begin by defining FGC, discuss its prevalence in Ethiopia and its health consequences, examine the national policy framework within which the problem is being tackled and describe how both male and female forms of circumcision were conceptualized in the traditional Oromo culture as part of the gada social, political and religious institution. As Kratz (1994: 346) notes, ‘[w]hat is called female circumcision is part of numerous and diverse cultural practices and ceremonies, each differently embedded in specific institutional and social structures’. It is important, therefore, to see male and female circumcision in relation to one another, as forming part of a cultural whole, rather than to treat the latter in isolation, as has been the trend in feminist literature.1 We then discuss Hundee’s Civic Education Programme and outline the participatory model that it employs in reforming FGC. We compare this approach to those of other NGOs in Africa and analyse how and why these organizations have been successful in changing behaviour.

Definition and Types of FGC in Africa

There is no consensus among researchers and feminist activists on the politically correct term to designate the practice of cutting the female genital organ. In the literature, it is commonly referred to by the expression ‘female genital mutilation’ (FGM), but a number of scholars have objected to this designation as being ethnocentric and as carrying a negative value judgement. In this article, we follow Shell-Duncan and Herlund (2000) in designating the practice as ‘female genital cutting’, but we also use ‘female genital operation’ (Young 1965; Walley 1997) and ‘female genital surgery’ (Shweder 2002). Where we use the expression ‘female genital mutilation’, we put it in single inverted commas to indicate that it is a controversial one.

The World Health Organization (WHO) defines female genital surgeries as ‘all those procedures, which involve partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or any other non-therapeutic reasons’ (WHO...
The WHO distinguishes four types of procedures. Type I consists of the excision of the prepuce with or without excision of a part or the whole of the clitoris. In the medical literature, this type is generally termed ‘clitoridectomy’. Type II consists of the excision of the prepuce and of the clitoris, together with partial or total excision of the labia minora. This type is also more generally known as ‘excision’. Type III involves the excision of part or all of the external genitalia and the stitching together of the vaginal opening. It is the most extreme form, which is referred to as ‘infibulation’. Type IV includes a number of procedures such as piercing, incision of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissue; scraping of the vaginal orifice or cutting of the vagina; introduction of substances into the vagina to cause bleeding or to cause the narrowing of the vagina, and other related practices. There exist a number of variations within these general categories. This classification is currently being revised (UNICEF 2004: 2).

Prevalence of FGC in Ethiopia

FGC is widely performed in Ethiopia. The most common forms of operation are Types I and II (clitoridectomy and excision). Type III (infibulation) is largely found in those regions inhabited by Somali-speaking groups (WHO 1995). The National Committee on Traditional Practices in Ethiopia (NCTPE) carried out a baseline survey in 1998 and provides prevalence rates by region, updated in 2000 (see Figure 1).

The extent of FGC varies according to ethnic and religious background.

![Figure 1: FGC prevalence rates by region](image)

*Source: Based on NCTPE 2003*
Among the Orthodox Christian Amhara of highland Ethiopia, excision (girz) is based on the traditional code of the Law of Kings (Fetha Nagast), a collection of ancient laws. It is not, however, directly imposed by the Ethiopian Church (Huber 1966: 87). Nevertheless, an uncut woman may not enter the holiest part of a church, and priests can refuse burial to such women in hallowed ground. Traditionally, infants normally underwent the operation between nine and forty days after birth.

Similarly, there is no scriptural basis for cutting in Islam, but like elsewhere in the region, it is considered to form part of a wider set of ideas relating to the chastity/fidelity code that is linked to the institution of marriage, notions of physical and spiritual purity, and definitions of gender and identity (see Gruenbaum 2001: 62–64).

Hundee’s field experience indicates that in the Christianized central, western and northern parts of the Shoa zone of Oromia, the operation is performed at an early age, usually between three and five years, and in some cases only the prepuce is cut. In the Islamized eastern parts of Shoa and in the Arssi zone, girls undergo clitoridectomy between the ages of fifteen or sixteen, shortly before marriage, with the whole or part of the clitoris being removed.

Impact of FGC on Women’s Health

The NCTPE reports that the operation gives rise to a number of health problems. The actual effects in any community depend on the type of surgery performed, the expertise of the person who performs it and the sanitary conditions under which it is conducted (Koso-Thomas 1987: 25–28). In Ethiopia, these problems include high levels of infection (tetanus has a mortality rate of 60 percent in the country), septicaemia and urinary infections at an early stage, whilst later there may be gynaecological complications, menstrual problems, urinary tract infections, painful sexual intercourse and postcoital laceration (especially in cases of the early marriage of girls). Problems associated with childbirth include painful delivery due to the narrowing of the vulva, necessitating episiotomy (surgical cutting of the vagina to facilitate birth), which may lead to rectovaginal fistula and/or fecal incontinence or vaginal fistula and/or urinary incontinence. In rural women, these medical problems may often go untreated, due to the low level of access to health care in the country, and in some cases may lead to death (FDRE/UNICEF 2002).

Ethiopian National Policy on FGC

The Ethiopian government has ratified the United Nations Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). The Constitution of the Federal Democratic Government of Ethiopia, Article 35 (4) on the Rights of Women, stipulates that the ‘State shall enforce the right of women to eliminate the influences of harmful customs. Laws, customs and practices that oppress or cause bodily or mental harm to women are prohibited’ (FRDE 1995). However, this prohibition is not legally enforced. Instead, the government works closely with the NCTPE and regional health departments to tackle the problem.

The NCTPE was established in 1979 under the auspices of the Ministry of Health, but is now an independent NGO that constitutes one of the national chapters of the Inter-African Committee on Traditional Practices affecting the Health of Women and Children, based in Geneva (WHO 1999: 86). Its board includes representatives from the government ministries, the Women’s Affairs Bureau, NGOs, major donor organizations and the relevant United Nations agencies. Through its regional subcommittees, it plays an active role in public health campaigns at the national level. With support from UNICEF, it has carried out research on FGC and other traditional practices that are considered to be harmful to the health
of women and children and provides documentary and other support to a number of local NGOs that are trying to reform the practice.

**Male and Female Genital Operations in the Oromo Culture**

Oromia is the largest region in Ethiopia, with an estimated population of 22 million, representing 34 percent of the total 63.5 million (FDRE/UNICEF 2002: 2). Agriculture and agro-pastoralism are the mainstay of the economy in the central, western and eastern parts of the region, where it provides 72 percent of the Regional Domestic Product (FDRE/UNICEF 2002: 9), whilst pastoralism is practised principally on the southern plateau. Eighty-five percent of the population of the region is ethnically Oromo (UNICEF 2004). The Oromo are divided into a number of territorially named subgroups, which include the Rayya in the north, the Tullama in the centre, the Macca in the west, the Karrayyu and Ittu in the east, the Arssi in the southeast, and the Borana and Gabra in the south (see Figure 2). They practise either Islam or Christianity, but may also continue to adhere to their own traditional, monotheistic religion (Waaqifata). In the past, male and female circumcisions formed an important part of the Oromo culture, but due to political, socio-economic and religious change, these operations have gradually lost their traditional meaning(s) in many parts of Oromia.

Until their conquest and incorporation into the Ethiopian Empire by the minority Amhara at the end of the nineteenth century, the different Oromo groups were governed by a political system (“gada”) in which a set of democratically elected leaders held power for an eight-year period. This system was based on the organization of all the male members of the society into generation-sets (“luba”), made up of a number of grades in which they underwent a series of rites of passage and were socialized into the social, political, military, legal and religious roles that they would be expected to fulfil in the course of the life cycle (Legesse 1973; Baxter and Almagor 1978). The rules of recruitment varied according to group. Women generally belonged to the set of their husbands. With political change, this system declined in most of the agricultural groups (cf. Knutsson 1967; Blackhurst 1978), but it is still practised by the pastoral Borana and Gabra (cf. Legesse 1973; Baxter 1978; Torry 1978; Tablino 1999; Bassi 2005). However, even where gada was no longer active, the customary laws that were a product of the institution continued to be applied in the resolution of social conflict in rural communities. Following the restructuring of Ethiopia in 1995 into regional states based on ethnic affiliation, the gada system underwent a modest revival in some parts of Oromia.

Historical linguistic evidence indicates that the system is of great antiquity and may have existed among Eastern Cushitic-speaking peoples, to whom the Oromo belong, from at least the first millennium BC (Ehret 1998: 162). These groups are also said to have practised both circumcision and clitoridectomy as part of their rites of passage into adulthood. Mythical, historical and contemporary ethnographic data from the Oromo suggest that the circumcision of males was a precondition for participation in the system. A myth of origin of the system recorded amongst the Tullama in the late 1960s links gada with the rites of ear piercing and circumcision, in which the flow of blood causes the rain to fall after a protracted drought (see Blackhurst 1978: 262). Circumcision is thus symbolically associated with the regenerative substances of blood and rain, which are seen as having supernatural efficacy.

In the sixteenth century, ‘Abba’ Bahrey (1954: 115), an Ethiopian monk who gave the first written testimony of the system, defined “luba” as ‘those who were circumcised together’. He did not, however, indicate the timing of the operation or distinguish between leaders of a set and the community at large. Oral data from the Arssi (Feyisso Bedhaso, personal commu-
Figure 2: Oromo groups in Ethiopia and Kenya
nication to Kassam, 2006) suggests that the operation was performed collectively for the members of the set in power, regardless of age, at the end of the term of office of the leaders. This may throw light on Cecchi’s (1886: 529) statement that amongst the Tullama ‘one can see aged men in their eighties and infants of the tenderest age being circumcised’ together (cited by Legesse 1973: 122).

On the question of status, Huntingford (1955: 41) writes that in those groups where gada was still in force in the 1950s, for the leaders, the operation did not mark ‘entry into manhood’ as it did for other members of the society, but signalled the departure from the grade of leadership, as such men were circumcised during or after their period of office (see also Cerulli 1922: 170, 173; and Knutsson 1967: 165). As Lepisa (1975: 39) explains, ‘circumcision is a ceremony in which the resigning members are classified as politically powerless elders, able only to give advice’. Knutsson (1967: 170) states that at the time of his fieldwork, among the Tullama, this operation was only a ‘ceremonial circumcision’ that involved symbolically cutting the thigh, since under Orthodox Christian influence the men would already have undergone the full operation at an earlier age. He also notes that among the adjoining Macca, the man (jaala, literally ‘companion’) who held the boy during his circumcision became his ‘ritual father’ (Knutsson 1967: 42). On the basis of the literary sources of the 1920s, Huntingford (1955: 41) indicates that girls underwent the operation of clitoridectomy at puberty, also individually, sometimes in small groups, without ceremony, and remain in seclusion until the wound has healed. The operation marks the transition from the status of an immature child to that of a girl of marriageable age (Tablino 1999: 98–99).

Among the present-day Gabra of southern Ethiopia and northern Kenya, circumcision is a prerequisite for entry into the first grade of their variant of the gada system (Tablino 1999: 61). Young men undergo the operation, known as gabaamqaba or dhaagaqabaam, in their early twenties, usually individually, occasionally with their peers, without great ceremony, and enter into a short period of seclusion. Torry (1978: 191) states that uncircumcised youths ‘are barred from the battlefield [and] forbidden to marry or to participate in mortuary ceremonies’. Circumcision is thus a maturity rite that confers full adult status on a young man. Girls undergo clitoridectomy (gurra uradda) at puberty, also individually, sometimes in small groups, without ceremony, and remain in seclusion until the wound has healed. The operation marks the transition from the status of an immature child to that of a girl of marriageable age (Tablino 1999: 98–99).

Among the territorially adjacent Borana, youths are collectively circumcised when a new age-set (hariyaa) is officially formed, usually when they are about twenty years old. The initiation is marked by a sacrifice (sooriyoo korbeessa hariyaa) (Bassi 2005: 69–72). Borana girls are expected to undergo clitoridectomy at the same age as Gabra girls. Baxter (1954: 267) indicates that a youth may not legitimately engage in sexual activity until he has undergone the operation. As in other Oromo groups, Borana leaders appear to be an exception to this rule. Unlike their peers, men who are in the ruling gada class are not circumcised until the third year of this grade, when they are in their late forties, are married and have fathered children (Legesse 1973: 90; Bassi 2005: 65). This is because only those men who were born at the ‘right time’ (exactly forty years or one generation after their fathers) can qualify as leaders. Such men are known figuratively as ‘sons of bulls’ (ilmaan kormaa) and are initiated into their leadership roles at an early age. In the Oromo culture, a bull (korma) that has not been castrated signifies wholeness, strength and prowess, implying that a man must be intact at the time of assuming office. The operation is performed for both the men and their wives at one of the Borana ritual shrines.

Among the Islamized Arssi, FGC (kitanna) is considered to form part of the laws of marriage (seera fuudhaa fi heerumatii) (Gemeda 2002: 121).
A girl who has not been excised is considered to be legally ‘male’. The operation thus renders her both female and marriageable. A girl who is betrothed undergoes clitoridectomy shortly before her marriage (Gemeda 2002: 119). The mother of the girl holds a neighbourhood feast to celebrate the event (Baxter 1979: 6).

This ethnographic data would tend to support the thesis advanced by Young (1965), according to which genital operations are a physical means of dramatically marking a status change in society for both males and females, through which their sex-roles are defined and solidarity is created within each gender group. It can be said, therefore, that in traditional Oromo society, on the one hand, male circumcision was a means of marking a status change from boyhood to manhood and to active membership in a group of men recruited on the basis of age and generation who were expected to assume collective social responsibilities that transcended kinship ties (i.e. based on solidarity), such as in warfare and military defence. On the other hand, it was also used to distinguish potential leaders from the rest of the members of the society, or those men who were born at the ‘right time’ from those who were born ‘out of time’. The former, uncut men, as the fertile ‘bulls’ of society, were responsible for carrying the sceptre (baalli) of power for an eight-year period, ensuring that law and order were maintained, performing the rituals that affected the social and moral order, and handing over power to the next set. Circumcision signalled the (imminent) departure from this grade. For women, clitoridectomy marked the social transition from girlhood to incipient womanhood through which she too would become part of the gada system and would perform its domestic and communal rituals in the capacity of wife and mother. Hence, traditionally, circumcision was the socially institutionalized means of legitimizing male sexuality, of preparing women for marriage and sanctioning childbearing, and of defining their distinct but complementary sex roles.

Unlike in other cultures, these transitions did not feature in community-wide rituals. In the case of women, in particular, they were domestic rituals, carried out individually at the level of the home and family. They constituted what Firth (1957[1936]: 380) terms ‘general rites of initiation’, through which women were inducted into social life as a whole. Nevertheless, the operation formed part of a larger complex of ideas, symbols and cultural values underlying the gada institution, which linked human and social reproduction, procreation and leadership, time and the social becoming of both men and women.

Today, however, these ideas relating to fertility and sexuality and to generation and regeneration, which formed part of the traditional Oromo culture and religion, have been overlaid by other meanings. As a result of the historical interaction of the Oromo with Islam and Orthodox Christianity, the uncut female sexual organ has come to be perceived as unclean and polluting (Gemeda 2002: 119). With the decline of the gada system in most parts of Oromia, female circumcision no longer has a ritual meaning, but has retained its social significance of regulating sexuality and marriage, although nowadays in conformity with the tenets of Islam and Christianity, rather than with traditional religious values. Moreover, as a consequence of the national anti-‘female genital mutilation’ campaign, which depicts it as a ‘harmful traditional practice’, the operation is now associated with other such practices as early marriage and abduction, as well as with domestic and sexual violence against women more generally, which have arisen as a result of social and economic change in the region.

In the central parts of Oromia, the operation has, therefore, come to be considered by the elders as a non-Oromo practice, which violates women’s traditional rights and should be eliminated from the culture. Hundee has played an instrumental role in reviving the legislation process through which the operation is prohibited under customary law.
Hundee’s Civic Education Programme

Hundee was formed in mid-1995 as part of the expansion of the voluntary sector following the change of regime in Ethiopia. The word *hundee* literally means ‘roots’ in the Oromo language. Hundee sees its mandate as one of bringing about the social and economic transformation of the rural communities of Oromia from within the culture, based on their own understanding of development, rather than imposing change from the outside. The organization regards its role as one of mediating between the ‘inside’ and the ‘outside’. Its approach is a rights-based one, which emphasizes the Oromo right to development (RTD) in general, and gender rights in particular, based on participatory processes (on the RTD approach see Sengupta et al. 2005).8 One of its primary aims is to empower the communities by educating them about their constitutional rights and by teaching them how to gain access to the court system and the legal institutions of the country. Hundee is one of the only local NGOs in Ethiopia that combines an interest in indigenous institutions with civic education and development goals (see Kassam 2002; 2003). Since its inception, Hundee has been operating mainly in the central part of the Oromia regional state, in the northern, western and eastern Shoa zones, as well as more recently in the southeastern Bale zone.

Hundee has five development programmes, which are interlinked and overlap to a certain degree: (1) Civic Education; (2) Women’s Economic Support; (3) Food Security; (4) Environmental Rehabilitation and Protection; and (5) Elderly Support. It does not have a specific gender programme, but this issue is addressed throughout its work, in particular in the Civic Education and Women’s Economic Support programmes, which focus on women and establish their strategic and practical rights to development, in both human and legal terms. More recently, Hundee established an independent micro-finance institution (known as *Buusaa Gonofaa*, based on the southern Oromo traditional institution of welfare assistance), which provides loans to small groups of women on a revolving basis.

The Civic Education Programme comprises two interrelated components: (a) combating harmful traditional practices affecting women; and (b) improving women’s access to and control over economic resources.9 These two dimensions of gender and development in Oromia were identified by the women who participated in the focus group discussions organized by Hundee in rural communities at an early stage in its activities. At these meetings, the women spoke without inhibition to Hundee staff in the Oromo language about the physical abuses that they had suffered, such as rape and domestic violence, as well as the health complications arising from FGC. They described how they had been forced to enter into a number of nontraditional marriages, such as marriage by abduction and contractual marriages. They reported that adolescent girls were not attending school due to the fear of being abducted. The women indicated that they had few or no rights of access or control over the property of their ‘spouses’, particularly in cases of divorce, despite the long hours that they worked in the home and in the fields. This emotional outpouring revealed the extent to which women had been exploited in the patriarchal system of production and the nature of the physical and psychological damages they had suffered for generations.

Through these initial and subsequent workshops, Hundee made two important findings of an ethnographic nature, which influenced its approach. First, it found that like the ‘ritual father’ of boys, female initiates acquired a ritual or ‘eye mother’ (*haada ijaa*) during circumcision. It learnt that the girl established a lifelong bond with the woman who supported her by covering her eyes during the operation, which was reinforced by the exchange of gifts at other important ceremonial occasions. This female bond of solidarity widened the girl’s network of fic-
tive kin relations in the community. Hundee sought ways of retaining this positive dimension of the practice. Second, through its discussions with the women, who constantly referred its staff to the elders, it also discovered that the Oromo customary law still prevailed in these rural communities. It became evident to Hundee that any interventions made to address women’s issues would need to include the participation of men and would have to involve the elders.

Hundee’s Participatory Model

Hundee’s participatory approach to sensitize the communities to the health risks of FGC and to mobilize them in abandoning it evolved empirically. It changed and was refined as a result of the interactions of the organization with the communities and of the problems encountered in applying the approach in practice. Hundee’s model currently consists of a six-pronged approach, which is outlined below.

Stage One: Planning Workshop

At the first stage, Hundee holds a planning workshop, to which are invited various government officials and representatives of the Women’s Bureau in the district where the programme work is to be carried out. Hundee outlines the objectives of the programme. Participants then discuss the practical details of whom to invite to the workshops, where to hold them and how to conduct them. An ad hoc committee is then formed to liaise with Hundee staff and to oversee the implementation of the programme. In this way, all the relevant authorities of the district are fully informed about and involved in planning and approving the proposed activities. In principle, any administrative obstacles to the subsequent workshops should be removed, but in practice, bureaucratic obstruction at different regional levels constantly hampers Hundee’s work.

Stage Two: Women’s Sensitization Workshop

The second stage consists in holding a women’s sensitization workshop, to which are invited representatives of women’s associations, female schoolteachers, selected female students, female household heads, traditional birth attendants and local circumcisers. Hundee’s facilitators do not challenge the traditional ‘wisdom’ of FGC. Rather, they allow the women to analyse the practice for themselves, making the case against it by highlighting its harmful effects based on the medical evidence, and finally induce a new, informed, collective awareness of it that will lead to a willingness to change it. The women are asked to form small discussion groups, to which a Hundee facilitator is assigned to act as rapporteur, to examine the different dimensions of the practice, the justification for it and problems encountered with it in their particular localities. The reasons given by participants for the operation include: conformity to tradition; ensuring the chastity of girls and their fidelity after marriage by reducing libido; facilitating penetration during sexual intercourse; rendering a woman clean and ‘complete’; and making a woman a ‘cultured’ person. In effect, in the Oromo culture, it is believed that a female or male who has not been circumcised has not been properly socialized and lacks self-control. The women then reconvene to report back on their discussions.

At this point, Hundee facilitators outline the potential health risks of the operation by drawing on the women’s own experiences of contracting infections as a result of unsanitary conditions. They discuss the chronic urination problems, through which women become socially outcast, as well the complications experienced during child delivery that sometimes result in death. They also show that if the same razor is used for cutting several girls it could cause the transmission of HIV/AIDS. Occasionally, they screen an NCTPE video on FGC to reinforce these health messages. After shar-
ing this information, the facilitators ask women to consider whether they wish to expose their daughters to the same health risks. They also inform them of their constitutional right to refuse to undergo the operation. At such workshops, traditional circumcisers sometimes dramatically announce that they are ready to renounce the roles that they have played hitherto in maintaining the practice. Schoolgirls often declare that they do not want to undergo the operation and are supported by their teachers. Such emotionally charged responses encourage other women to affirm that they, too, wish to abandon the practice. After such sessions, few openly dissenting voices remain.

Stage Three: Men’s Sensitization Workshop

At the third stage, a parallel men’s sensitization workshop is held shortly after that for women, to which are invited community elders, gada leaders, local government officials, schoolteachers and other residents of the community. The men’s discussions follow the same format as that of the women’s workshop. Men are generally more conservative about changing traditional practices such as FGC than are women and are less easily persuaded by the detrimental health information. However, when they begin to examine the legal dimensions of the practice, led by the traditional leaders, they surmise that it is not based on Oromo natural law (uuuma), but has been adopted from other cultures and is, therefore, socially constructed. They argue that the practice has no historical basis in Oromo cultural tradition, contrary to the ethnographic evidence presented above. They conclude that it should be abandoned, but agree that the role of the ‘eye mother’ can be retained as part of the custom of gift-exchange (galata).

Stage Four: Joint Consensus-building Workshop

At the fourth stage, a consensus-building workshop is held to which both the male and female participants who attended the single-sex workshops are invited. The meeting enables participants to review FGC, to reconsider its negative health consequences and to agree on the collective measures to ban it. At such sessions, men solemnly and publicly promise their wives to support them fully in their decision to change the practice.

Stage Five: Law-making Assembly

The fifth stage marks the culmination of the previous consultation process. It consists in a law-making (seera tummaa) assembly, held at a mutually convenient date, to ban FGC from the community. Seera tummaa literally means to ‘forge’ or to ‘beat out’ the law. It is a community-wide event that is attended by all workshop participants, their neighbours and friends, local government officials and members of the law-enforcement agencies. It is convened and presided over by the elected leader (abba gadaa), assisted by other officers. Its performance varies from community to community, and is often highly choreographed. Generally, the men arrive at the ritual meeting ground (chaffee) astride colourfully bedecked horses. The women and their daughters come in groups, the former wearing their best finery and carrying their traditional marriage sticks (siqqee). The gada leader bears his spear (waarana) and whip (alanga) that are ritual emblems of his authority. A bull of a specific colour is led to the scene in readiness for the final sacrifice.

The leader announces the law (or laws) to be enacted and invites male members of households present who object to it (them) to make their opinion known. This process of dissent is known as gunguma (expressing one’s doubts). If objections are raised, they are collectively debated until consensus is reached. When there is full agreement, the leader pronounces each ‘article’ of the law with a crack of his whip, and the members of the community affirm in unison that it will be upheld; this assent is both legally and morally binding. He then invites
the traditional circumcisers to make a solemn pledge before the assembly that they will no longer carry out the operation. Finally, an assistant sacrifices the bull, which seals the new law. This dramatic act brings the proceedings to an end.

**Stage Six: Performance Assessment and Monitoring Report System**

At the sixth stage, a meeting is held at the inter-locality level a few weeks after the event to assess the effectiveness of the law-making assemblies on attitude change in the communities and to establish a system for monitoring and reinforcing the new law instituted. Male and female community representatives are invited to provide feedback on Hundee’s intervention in their localities. Their reports normally indicate a high rate of compliance with the new law, with few or no cases of violation. Women’s Defence Committees are then formed to monitor the situation and to deal with any problems arising. The locality and subdistrict committees are made up of community representatives and local administrators; the district-level committee is composed of government officials and representatives of the women’s bureau and of the police authority. This three-tiered structure creates a mechanism for reporting any cases of violation to the appropriate authorities and an institutionalized means of taking action against the offending parties when social pressure alone fails. Hundee also monitors compliance through its other programmes, participation in which depends on having abandoned the practice of FGC.

In this way, Hundee’s participatory approach gradually draws all the key actors in the community and local government into an inclusive process and encourages them to take concerted action in reforming FGC through a culturally instituted means recognized by both customary and national law. It involves the different stakeholders in the various stages of planning, implementation and evaluation of the programme. This model is doubly effective because it is implicitly based on the nested decision-making and consultative processes that are characteristic of the traditional Oromo democratic system of government, presided over by elders.\(^\text{10}\) This method of reaching consensus on social issues through debate under the guidance of the elders is common to a number of other African societies (see Richards and Kuper 1971).

**Comparing Approaches to Reforming FGC in Africa**

There is little published data on the approaches used by other African organizations to reform FGC. For our comparison, we draw mainly on a WHO (1999) report that reviews the work of these organizations, supplemented by other sources.

The Reproductive, Education and Community Health (REACH) Programme was created by the United Nations Population Fund in 1996. It grew out of a workshop held in 1995 to discuss the problem of FGC that was attended by community leaders, local elders, youth and political representatives of the Sabiny (also known as Sebei) group, who live in the Kapchorwa district of eastern Uganda. The Sabiny are farmers and pastoralists who traditionally practised both male and female circumcision, as part of the initiation rites into adulthood. Goldschmidt (1976) provides a description of the traditional rites. He describes the female operation as a ‘labiodyctomy’, which involves the ‘severing of the whole labia minora’ (Goldschmidt 1976: 267). All attempts to reform the practice by Christian missionaries in the 1930s and 1940s failed. Following a campaign to impose a ban on the operations by the Ugandan government and the Inter-African Committee on Traditional Practices (IAC) in 1989, there was a resurgence of the practice. As the WHO (1999: 117) report comments: ‘The Sabiny community felt offended that “outsiders” were passing judgement and finding fault with their culture and tradition, implying that they were backward and bar-
baric’. The REACH Programme took a similar approach to Hundee’s by involving different sections of the community in its health education seminars and workshops, which included, most importantly, the Sabiny elders. It also involved other actors at the national and international levels. In this way, it enabled the Sabiny to determine their own process of change based on their own cultural values. The solution proposed by the community was to continue to celebrate the ceremonial aspects of the initiation rites for girls, but to relinquish the practice of cutting. As a result, the number of operations decreased from between 36 percent and 90 percent in some areas in 1996 (WHO 1999: 119). In 1998, the Sabiny Elders Association received an award from the United Nations Family Planning Association in recognition of their efforts to reform the practice.

The Alternative Coming of Age Programme in Kenya was developed jointly by the Maendeleo Ya Wanawake Organization (MYWO) and a US NGO, the Program for Appropriate Technology in Health (PATH), in 1996, among the Meru in the Tharaka Nithi District. The MYWO is a national NGO formed in 1952 that has played an active role in promoting women’s development. It operates through committees at various administrative levels. The Meru programme forms part of a wider strategy to identify culturally accepted alternatives to FGC in seven districts in Kenya with the participation of the communities concerned (WHO 1999: 107–111). The Meru traditionally practised clitoridectomy, and like the Kikuyu, they defied colonial campaigns to ban it (Thomas 2000). The programme has been successful in reforming the practice, by substituting surgical cutting with a programme of ‘excision by word’ (Ntanira Na Mugambo). These alternative rites include a week of seclusion during which the ‘initiates’ are given instruction into both traditional wisdom and modern ‘family life skills’ by a group of mothers trained by the MYWO, and a coming-of-age ceremony that publicly celebrates their new status.

As in the REACH and Hundee approaches, the MYWO involves the major stakeholders (mothers, daughters, fathers and community leaders) at all stages of implementing the programme and begins by educating them about the harmful effects of the practice. As a result, mothers have become the most vocal advocates of reform and have played an instrumental role in convincing their husbands and community leaders to abandon the practice. The men make a public vow that they will prevent the operation being performed on their daughters. The success of the programme, widely reported in the media, has led another ethnic group, the Kisii, to adopt a cultural variant of the model in their own district. The programme has initiated a movement for change in Kenyan communities.

The Tostan Basic Education Programme, founded in 1991 in the USA to provide literacy and skills training to women in the Thiès region of Senegal, uses a nonformal, participatory approach to changing FGC. Tostan means ‘breakthrough’ in the Wolof language. Its mandate is to empower communities by educating them. The programme is composed of a number of modules, one of which provides instruction in health and hygiene (WHO 1999: 112–115; UNICEF 2005: 23). The Senegalese populations practise a variant of infibulation, in which the clitoris is excised and the vagina ‘sealed’ through the coagulation of blood, rather than being stitched together (Shell-Duncan and Hersh 2000: 5). In July 1997, a group of women from the Bambara village of Malicounda who had undergone the health-training module took the decision to persuade other women, their husbands and religious leaders to abandon the practice. The consultative process that ensued, led by the elders, persuaded the villagers to make a collective pledge, known as the Malicounda Commitment, to end FGC. This declaration created a movement for reform that gained wider momentum, leading other groups of villages in the region to make similar pledges. As of 2000, over one thousand villages had made such declarations. As a result of this grassroots
movement, the government of Senegal legislated against the practice in 1999. The programme has won a number of international awards for its work, which include the WHO best practice award in 2003. Since 2000, its model has been applied in a number of other African countries, such as Mali, Burkina Faso, Guinea and Sudan.

**Analysing Change: The ‘Convention Shift’ Model**

Mackie (2000: 254–255) describes the movement for change that was initiated by villagers in Senegal as marking what he calls a ‘convention shift’. He hypothesizes that certain practices, such as foot binding in China or female surgeries in Africa, revolve around a set of conventions relating to marriage, which are collectively followed by members of a community. Parents who do not adhere to the established tradition will not find marriage partners for their offspring. Hence, the custom is highly resistant to change. However, when a critical mass of people agrees to modify an aspect of this tradition, it can effect a convention shift. As Mackie (2000: 279) explains, such a convention shift can be brought about through a ‘tripartite strategy: basic education, public discussion and public declaration’. This analytical framework can be applied equally to all the programmes discussed here.

As we have seen, firstly all four organizations provided a nondirective programme of basic education to the communities on the harmful consequences of FGC. In all four, cultural insiders usually provided this instruction in the language of the participants. In this way, they were able to gain the trust of the community and to deal with any issues arising in a sensitive way. Secondly, the organizations initiated a community-wide discussion on the topic, which included the participation not only of women, but also of their husbands and daughters, and crucially, of the elders of the community, who provided the legitimacy and moral authority for the change. In this way, the NGOs were able to empower the communities to propose a culturally acceptable form of abandonment. In the Ugandan and Kenyan cases, the reform consisted in substituting alternative rites, or ritual without cutting. As Mackie (2000: 274) concedes, such cessation also constitutes a convention shift. Thirdly, in all the communities, a socially binding declaration was made by all sections of the community to maintain the ban. This declaration can be compared to taking a public oath. Further to Mackie (2000), it can be said that such pledges, whether they are made through a law-making assembly or as a public declaration of commitment, have efficacy and binding power as a result of their ritualization. Like the initiation rites that they displace, pledges are performative events (Kratz 1994). Once such a convention shift takes place and becomes socially acceptable, it gathers its own momentum, and has the tendency to spread from community to community.

We can draw a number of conclusions from these case studies. There are three points that relate specifically to the topic of indigenous knowledge and development.

Firstly, the four educational programmes seeking to reform FGC in Africa refute the modernist view that traditional societies are resistant to change. They query the pessimistic opinion of international campaigners that the problem is an intractable one and that it will take several decades to modify such behaviour. The studies presented support the view that if change is approached from the inside, from the point of view of the actors, in a culturally sensitive manner using participatory methods, which are inclusive and take account of people’s own indigenous institutions and value systems, it is possible to bring about meaningful development. As Mackie (2000: 6) also notes, the abolition of FGC should not be seen as an end in itself, but should constitute a foundation for furthering women’s health and human rights, as a prerequisite for their development, and should form part of a multisectoral approach.
Secondly, as La Fontaine (1985: 116) also points out, before action is taken to change FGC, it is important to understand it in its social, economic, cultural and historical contexts. None of the organizations studied here appear to have carried out such a preliminary cultural analysis, probably due to the fact that FGC is a donor-led issue, which focuses exclusively on women’s health problems.

Thirdly, our own attempt to contextualize both male and female circumcision in the traditional Oromo culture raises some important epistemological issues for the application of indigenous knowledge in development. As we have shown, the ritual significance of the practice in the traditional way of life of the Oromo has been obscured by the economic, political and religious changes that have taken place in the society over the last century, leading to a form of ‘cultural amnesia’ in respect to its meaning by the elders in the central parts of the region most influenced by Amhara occupation. This is an interesting phenomenon that would merit further analysis in terms of the interaction of dominant and nondominant knowledge and religious systems. This finding teaches us that prior to embarking on a plan of reform, it is important for development programmes to fully document the historical and contemporary meanings of any practice they seek to modify, so that their interventions can be located temporally in the anthropological knowledge base by future scholars of social change.

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Notes

1. There is no comprehensive study of circumcision in the Oromo culture. This article provides the first overview of the issue, based on an analysis of scattered references in the ethnographic literature. The topic needs further detailed investigation.
2. The Southern Nations, Nationalities and Peoples (SNNP) regional state comprises more than fifty ethnic groups, only some of which practise FGC. In the Gambella region, only the Nuer practise it.
3. See also Huber (1966). As far as we know, there are no national statistics for these health problems.
4. The Oromo make a symbolic equivalence between ear piercing and circumcision. Gurra uradda (to pierce the ear) can be used to designate circumcision in both sexes, as can dhaqaqabaan and qabaanqaba, but is more generally applied to that of girls.
5. Hassan Arero (Horniman Museum, London) informs us that amongst the urbanized Gabra and Borana in Kenya the operation is now being medicalized.

6. As in all Oromo groups, Gabra and Borana, girls are expected to be virgins at marriage. Young men can only have sexual access illicitly to married women. The woman’s husband remains the social father of any children born of this union. The lover-mistress (jaala-jaaltuu) relationship is quasi-institutionalized, but due to the spread of HIV/AIDS, under pressure from the federal government, Borana leaders are now advocating marital fidelity.

7. The operation is performed at the shrine of Ejersa Gurura, near Nura in Boranaland (Legesse 1973: 90). According to Dabassa Guyyoo, a Borana elder of the Hawaatuu clan interviewed by Aneesa Kassam in Kenya in 2003, the women only receive a token cut of the clitoris, but the men (and their assistants) are fully circumcised.

8. The Declaration on the RTD was adopted by the United Nations in 1986. Article 1, paragraph 1 states that ‘[t]he right to development is an inalienable human right by virtue of which every human person and all peoples are entitled to participate in, contribute to and enjoy economic, social, cultural and political development, in which all human rights and fundamental freedoms can be fully realized’. This rights-based framework encompasses seven interrelated approaches that link human rights principles with development. These approaches (1) connect all human rights in a holistic manner; (2) are based on international human rights principles; (3) seek to contribute to social justice; (4) strive to improve human capabilities; (5) consider development itself as a human right; (6) treat equitable development as an obligation and responsibility of the state; and (7) employ a transformative pedagogy using participatory methods (Marks 2005).

9. Hundee’s Civic Education Programme has received funding from a number of agencies, including the Inter-Church Association for Development Cooperation, Oxfam (Canada) and Oxfam Community Aid Abroad, the National Endowment for Democracy, the German Technical Aid Agency (GTZ) and, more recently, Equality Now, which has been supporting its work on FGC.

10. On the Borana decision-making process, which is still operational, see Bassi (2005).

References


