



**COUNTRY PROFILE:
FGM IN ERITREA**

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Preface

*'If you don't like something, change it.
If you can't change it, change your attitude.
Don't complain.'* ~ Maya Angelou

Maya Angelou's words ring true to this day. When it comes to Female Genital Mutilation/Cutting (FGM/C), a shift in attitude is needed if real change is ever to happen.

Although FGM/C has been banned in my country of origin, Eritrea, the World Health Organization says it remains a painful reality for many women and girls there. In the diaspora, the number has declined as attitudes towards this harmful custom, practised by Eritrean Christians and Muslims alike, have shifted.

Our grandmothers and mothers were spirited women who made great sacrifices. These strong Eritrean women were at the forefront of the fight to liberate our country during the 30-year war of independence from Ethiopia. And, yet, FGM still happened to them – and to many of their daughters.

It is crucial that we not make assumptions about what type of mother does this to her child, or what type of woman that child will become.

It is a topic many Eritreans prefer not to talk about. But we need to. We must break the silence surrounding how and why this continues to happen to girls. We cannot pretend that it is something that only happens to 'others' and no longer to 'us'.

I challenge every Eritrean to ask at least five women in their family above the age of 28 who are still in Eritrea, or spent the first two decades of their lives there, whether it was done to them, or if they know of anyone else in their family who endured it.

What they tell you will surprise you.



We need to talk about it openly, to challenge attitudes and to engage in a dialogue, but this can only happen with unhindered access to the country and a change of tone and approach when talking about FGM/C.

What we in the diaspora can do is change what we don't like by continuing to talk about it openly, without prejudice, to educate and to raise awareness until it becomes a thing of the past.

By continuing to highlight, discuss and report on FGM/C, 28 Too Many is ensuring that it is in the spotlight as a basic human-rights violation that needs to be highlighted and discussed until the number is reduced from 28 to zero.

Fatma Naib
Award-Winning Eritrean-Swedish
Journalist and Digital Producer

Foreword

As we led up to launching our latest Country Profile on FGM in Eritrea, I have reflected on the journey 28 Too Many has taken so far with our research programme. We have now produced comprehensive reports on four countries in East Africa and seven countries in West Africa. Our last country profile widened our knowledge base further as we reached into the Arab nations for the first time and researched Egypt. From feedback we know that bringing together the latest information was welcomed by organisations and individuals working to end FGM both in the country and worldwide.



We have carried this experience into our 13th Country Profile on Eritrea, which, with an FGM prevalence of 83% among women and girls aged 15-49, remains one of several countries where most of the female population has either been directly subjected to FGM or has family or friends whose lives have been affected by the practice.

The political environment that exists in Eritrea means that researching FGM is a challenging task; detailed, up-to-date information is extremely limited and the restriction on international NGOs operating in-country undermines our ability to understand what progress is being made towards ending the practice. We have in this report, however, tried to set out the reasons for the practice as well as the history and spread of FGM and what we know about the Government's attempts to educate and change attitudes in communities.

We are encouraged that the data suggests a decline in both FGM prevalence and support for its continuation, and, moving forward, we encourage the Government of the State of Eritrea to continue its support and funding for the National Union of Eritrean Women and associated programmes to end the practice.

28 Too Many welcomes feedback from any individual or organisation with a connection to Eritrea who wishes to see an end to FGM. We also urge the Government to consider the opportunities they could create by sharing experience, knowledge and examples of good practice with others in the international community working to end the practice. Together, we can develop effective solutions and support all those who wish to abandon FGM.

Dr Ann-Marie Wilson
28 Too Many Executive Director

Information on Country Profiles

Background

28 Too Many is an anti-FGM charity, created to end FGM in the 28 African countries where it is practised and in other countries across the world where members of those communities have migrated. Founded in 2010 and registered as a charity in 2012, 28 Too Many aims to provide a strategic framework where knowledge and tools enable in-country anti-FGM campaigners and organisations to be successful and make a sustainable change to end FGM. We are building an information base, which includes detailed country profiles for each country practising FGM in Africa and the diaspora. Our objective is to develop networks of anti-FGM organisations to share knowledge, skills and resources. We also campaign and advocate locally and internationally to bring change and support community programmes to end FGM.

Purpose

The prime purpose of this Country Profile is to improve understanding of the issues relating to FGM in the wider framework of gender equality and social change. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. As organisations continue to send us their findings, reports, tools and models of change, we can update these reports and show where progress is being made. While there are numerous challenges to overcome before FGM is eradicated in Eritrea, many programmes are making positive, active change.

Use of This Country Profile

Extracts from this publication may be freely reproduced, provided that due acknowledgement is given to the source and 28 Too Many. We invite comments on the content and suggestions on how the report could be improved as an information tool, and seek updates on the data and contact details.

When referencing this report, please use: **28 Too Many (2017) Country Profile: FGM in Eritrea. Available at <http://www.28toomany.org/countries/Eritrea/>.**

Acknowledgements

28 Too Many is extremely grateful to everyone who has assisted us in accessing information to produce this Country Profile, as it would not have been possible without their collaboration.

28 Too Many carries out all its work as a result of donations, and is an independent, objective voice unaffiliated with any government or large organisation. That said, we are grateful to the many organisations that have supported us so far on our journey and the donations that enabled this Country Profile to be produced.

For more information, please contact us on info@28toomany.org.

The Team

Tichafara Chisaka is a research volunteer. She has an MA in International Relations with International Law. She is a project manager experienced in both the business and charity sectors.

Hanna Derewnicka is studying a BSc in Urban Studies and works for a disabled people's organisation.

Walla Hassan is a freelance translator and consultant for NGOs focused on capacity building, research and data analysis in the context of global youth and women's empowerment. She has an MA in International Development and Conflict and Security Studies, and professional experience working in the field across Africa and the Middle East.

Amy Hurn is **research manager**. She has an MSc in Transport Planning and Management. She has worked in consultancy and in the education sector.

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Dr Jenna Lane is research analyst. She has a PhD in Particle Physics and has a background in science communication, including working for BBC Science.

Emma Lightowlers is **communications manager**. She is studying for a Masters in Global Health and has a background in research and communication.

Lauren Marc is a research volunteer. She is studying a BSc majoring in Ecology and Physiology and works within the retail industry.

Caroline Pinder is **research coordinator**. She has worked as an international development consultant for 25 years, specialising in gender equality and women's empowerment issues.

Dr Ann-Marie Wilson founded **28 Too Many** and is the **executive director**. She has also written various papers on FGM and has worked extensively in Africa.

We are grateful to the rest of the 28 Too Many team, who have helped in so many ways, including **Sean Callaghan**. Thanks also go to **Jane Issell** for volunteering her time as proof reader.

Cover: Kurt Bauschardt (2010) *Eritrea Dancing*. Available at <https://commons.wikimedia.org/wiki/File%3ATraditionalgarb-erb.jpg>.

Please note the use of a photograph of any girl or woman in this Country Profile does not imply that she has, nor has not, undergone FGM.

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBO	community based organisation
CEDAW	Convention on the Elimination of Discrimination Against Women Committee on the Elimination of Discrimination Against Women
DHS	Demographic and Health Surveys Program
ELF	Eritrean Liberation Front
ENS	Eritrean National Service
EPLF	Eritrean Popular Liberation Forces
FGC	female genital cutting
FGM	female genital mutilation
GBV	gender-based violence
GDP	gross domestic product
GoSE	Government of the State of Eritrea
HIV	Human Immunodeficiency Virus
HSSDP II	2017-2021 Health Second Sector Strategic and Development Plan
INGO	international non-governmental organisation
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MoE	Ministry of Education
MoH	Ministry of Health
NGO	non-governmental organisation
NUEW	National Union of Eritrean Women
NUEYS	National Union of Eritrean Youth and Students
OECD	Organisation for Economic Co-operation and Development
PFDJ	People's Front for Democracy and Justice
PPP	purchasing power parity
SDGs	Sustainable Development Goals 2015-2030
UN	United Nations
UNCOI	UN Commission of Inquiry on Human Rights
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States of America
WHO	World Health Organization

Please note that, throughout the citations and references in this report, the following abbreviations apply.

'DHS 1995' refers to:

National Statistics Office [Eritrea] and Macro International Inc. (1995) *Eritrea Demographic and Health Survey, 1995*. Calverton, Maryland: National Statistics Office and Macro International Inc. Available at <http://dhsprogram.com/pubs/pdf/FR80/FR80.pdf>.

'DHS 2002' refers to:

National Statistics and Evaluation Office (NSEO) [Eritrea] and ORC Macro (2003) *Eritrea Demographic and Health Survey 2002*. Calverton, Maryland, USA: National Statistics and Evaluation Office and ORC Macro. Available at <http://dhsprogram.com/pubs/pdf/FR137/FR137.pdf>.

'EPHS 2010' refers to:

National Statistics Office (NSO) [Eritrea] and Fafo AIS (2013) *Eritrea Population and Health Survey 2010*. Asmara, Eritrea: National Statistics Office and Fafo Institute for Applied International Studies. Available at https://www.unicef.org/eritrea/resources_17043.html.

All cited texts in this Country Profile were accessed between June 2017 and October 2017, unless otherwise noted.

A Note on Data

Statistics on the prevalence of FGM are compiled through large-scale household surveys in developing countries known as the **Demographic and Health Survey (DHS)** and the **Multiple Indicator Cluster Survey (MICS)**. For Eritrea, DHS reports were published in 1995 and 2002. The MICS, to date, has not published any reports on Eritrea.

The most recent set of data on FGM available for the country is the **Eritrean Population and Health Survey 2010 (EPHS 2010)**, which was carried out in line with the DHS surveys by the Eritrean National Statistics Office and funded by the Norwegian Ministry of Foreign Affairs, the United Nations Children's Fund (*UNICEF*), the United Nations Population Fund (the *UNFPA*), the World Health Organization (the *WHO*) and the Eritrean Ministry of Health (*MoH*).

UNICEF emphasises that **self-reported data on FGM** 'needs to be treated with caution' since women 'may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice.'¹ They may also be unaware that they have been cut, or the extent to which they have been cut, especially if FGM was carried out at a young age.

Measuring **the FGM status of girls**, who have most recently undergone FGM or are at most imminent risk of undergoing it, may give an indication of the impact of current efforts to end FGM. Alternatively, responses to this question may indicate **the effect of laws criminalising the practice**, which make it harder for mothers to report that FGM was carried out, as they may fear incriminating themselves. Additionally, unless they are adjusted, these figures do not take into account the fact that girls may still be vulnerable to FGM after the age of 14.²

It is important to note that survey results may be based on relatively **small numbers of women**, particularly when they are further broken down by location, religion, ethnicity, etc. Therefore, in some cases, statistically significant conclusions cannot be drawn. This does not mean that the data is not useful; it simply means that one should be careful about drawing 'hard and fast' conclusions from it, and 28 Too Many has accordingly taken that approach when researching and writing this Country Profile. In particular, the number of survey respondents in both the DHS 2002 and the EPHS 2010 who reside in **Debubawi Keih Bahri** was small compared to the number of respondents who reside in the other five zobas.

In proposing a Strategic Cross-Sectoral Communication for Development (C4D) Framework, the Asia-Pacific Development & Communication Centre, which was commissioned by UNICEF in 2015 to develop the joint strategy to be implemented by sector ministries, UN agencies, the National Union of Eritrean Women and the National Union of Eritrean Youth and Students, identified '**bottlenecks**' that included '[p]oor data availability and low complexity of data' and noted that the 'Government has been reluctant to agree to surveys and evaluations.' This strategy refers to the National Union of Eritrean Women and the National Union of Eritrean Youth and Students as 'the two government-owned CBOs'.³

From the material available, it would appear that education and healthcare, in particular, have improved tremendously in Eritrea since the country's independence. Strategies have been put in place, the number of facilities has increased and training has been stepped up. However, the data available in relation to Eritrea is provided almost exclusively by the

Government of the State of Eritrea (GoSE) and documents report positive outcomes that **cannot be verified independently**.

For example, it is difficult to find any reports that critically evaluate the state of the healthcare system. Foreign embassies and the Lonely Planet guide⁴ state that, although the healthcare system has improved greatly, it does not compare with global standards and is very limited outside Asmara. GoSE documents suggest improvements in human resourcing in healthcare; however, a table of medical students from 2016 indicates that only 53 students were registered on Masters courses and 25 on degree-level courses in health-related subjects.⁵

It is, of course, possible that historical, negative reports on the healthcare system have spurred the GoSE to step up its approach and vast improvements have therefore been made. However, as Eritrea is ranked by the Committee to Protect Journalists⁶ as the most censored country in the world, and because of the immense burden placed on the country's financial resources by its perpetual 'no war no peace' state and its large, conscripted army, it is possible that some of this information has been presented in such a way as to reflect favourably on the GoSE and, therefore, 28 Too Many is unable to verify the accuracy of some of the data used in this Country Profile.

1 UNICEF (2013) *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, p.24. Available at http://data.unicef.org/corecode/uploads/document6/uploaded_pdfs/corecode/FGMC_Lo_res_Final_26.pdf.

2 *Ibid.*

3 Asia-Pacific Development & Communication Centre (2015) *Strategic Cross-Sectoral C4D Framework: UNICEF Eritrea Country Programme*, pp. 11 and 15. Available at https://www.unicef.org/eritrea/ECO_resources_xsectoralc4dframework.pdf.

4 Lonely Planet (2017) *Eritrea*. Available at <https://www.lonelyplanet.com/eritrea/health> and <https://www.lonelyplanet.com/eritrea/safety>.

5 Ministry of Health (2016) *High Level Achievements in the Annual Health Sector: Report of 2016, December 2016*, p.13. Available at <http://www.ecss-online.com/2013/wp-content/uploads/2017/05/High-Level-.pdf>.

6 Committee to Protect Journalists (2015) *10 Most Censored Countries*. Available at <https://cpj.org/2015/04/10-most-censored-countries.php>.

Executive Summary

Eritrea is a country of approximately 5.5 million¹, situated in the Horn of Africa. It has a war-torn modern history, and tensions remain high between the state and its southern neighbour, Ethiopia. Since independence in 1993, President Isaias Afwerki of the People's Front for Democracy and Justice has been **head of state and head of government**. A new **constitution**, passed in 1997, which allowed for multi-party politics and set elections for 2001, has not been fully implemented, and no elections have been held. It should be noted that the data publicly available in relation to Eritrea is provided almost exclusively by the Government of the State of Eritrea (*GoSE*) and therefore some of the information referred to in this Country Profile **cannot be verified independently**.

The country is divided into **six administrative zobas**. Less than a quarter of Eritreans live in towns, and agriculture is the **main economic activity**. However, a large percentage of the population serves in the military, as **conscription** is mandatory for both men and women, and many do not receive their discharge and are forced to stay in the military for an indefinite time. It is estimated that half of the population lives below **the poverty line**.²

The extent of **military service** has resulted in 46.7% of Eritrean households being headed by women, but an underlying patriarchal culture persists.³ Women are less likely to participate in household decision-making if they are of a young age, are unemployed, have no living children, have only or less than a primary level of education, live in a rural area, or are in the lower wealth quintiles.⁴ Women who are married or have young children are generally exempt from military service⁵, which may encourage women to marry and have children at a young age. Over one-third of the armed forces during the 30-year war for independence were female.⁶

The OECD Development Centre classifies Eritrea as having a 'very high' Restricted Physical Integrity Value, the highest classification of the value, because 71% of women justify wife beating; there is no legislation in place regarding domestic violence; legislation against rape exists, but not marital rape; legislation regarding sexual harassment is inadequate; and 28% of women have a need for family planning that is not being met.⁷ A 2017 study and the 2015 UN Commission of Inquiry on Eritrea both found that sexual violence is rife within the Eritrean National Service.⁸ This is an issue at the forefront of women's rights in Eritrea.

Eritrea has historically had one of the highest rates of FGM practice in the world. While the Demographic and Health Survey (*DHS*) of 2002 calculated the **prevalence of FGM in women aged 15-49** at 88.7%⁹, the Eritrean Population and Health Survey 2010 (*EPHS 2010*) calculated it at 83%, and 44.1% of women reported that at least one of their daughters had undergone the practice.¹⁰ This data, together with the **prevalence of FGM in daughters**¹¹, which decreases in accordance with the mother's age, strongly suggests a decline in the practice.

Prevalence in the capital city, Asmara, is 73.6%, in other towns is 85.4% and in rural areas is 85%.¹² Unlike in most countries, where FGM is more likely to occur in rural areas than in urban areas, in Eritrea, there appears to be more of a division between Asmara and the rest of the country. In Asmara, prevalence fell by nearly 18% from 1995 to 2010; whereas in other

areas prevalence fell by about 10% over the same period.¹³ Analysis suggests this may be due to a difference in levels of wealth.¹⁴

Girls in Eritrea are most likely to undergo FGM in their first five years, although girls in Asmara are generally cut earlier than girls in other areas.¹⁵ A 2012 report notes that there is a general belief in Eritrea that the younger a girl undergoes FGM, the more readily she will heal. Many mothers therefore ‘take it as an [obligation] to conduct FGM/C on their daughters at a young age.’¹⁶

All of the WHO-classified **types of FGM** are practised in Eritrea.¹⁷ According to the DHS 2002, 38.6% of women aged 15-49 reported that they were ‘sewn closed’ (Type III – infibulation), 4.1% had had ‘flesh removed’ and 46% had been ‘nicked, no flesh removed’ (11.3% did not know).¹⁸

FGM is most commonly reported to have been performed on women aged 15-49 by a traditional ‘circumciser’ (80.33%)¹⁹, but it is also performed as a ‘treatment’ by about 20% of traditional medical practitioners.²⁰

Knowledge of FGM among women aged 15-49 is almost universal (99.2%). The prevalence of FGM is slightly higher in rural areas than in urban areas, but knowledge of FGM is slightly lower among women who live in rural areas (98.8%) than among women who live in urban areas (99.5%). 58.9% of women reported that they knew of activities against FGM operating in their area, but in Anseba that figure was much higher, at 85.2%, while in Asmara only 37.2% knew of activities.²¹

In 2010, 77.2% of women and 83.8% of men aged 15-49 who have heard of FGM said they believe that it has no **benefits for a girl** (up from 29.1% in 2002). Women and men who are younger, wealthier and more highly educated are more likely to see no benefits to a girl undergoing FGM.²² The most commonly perceived benefit of FGM by women was ‘social acceptance’; by men, it was ‘preserves virginity/prevents pre-marital sex’, which is also the second-most-common response from women in general.²³ This data indicates that there is some need for factual teaching on sex and FGM in higher education.

Public support for FGM has declined significantly over the past two decades. The EPHS 2010 reports as follows²⁴:

	Women (aged 15-49)	Men (aged 15-49)
FGM should continue	12.2%	10.0%
FGM should <i>not</i> continue	82.2%	84.9%

Although the majority of respondents see no benefits in FGM for a girl, very few women report having heard objections to their daughters undergoing it.²⁵ This may indicate a need for education in communities on how to speak up about one’s objections to FGM.

Religious belief is another reason often cited for the continuation of FGM, although only 1.1% of women and 0.6% of men aged 15-49 who have heard of FGM cite ‘religious approval’ as a benefit of FGM for a girl.²⁶ None of the recent country-wide surveys for Eritrea break down the **prevalence of FGM according to respondents’ ethnicity or religion**, and there is no evidence from other sources to inform these criteria. Eritrea has nine major ethnic groups (Afar, Bilen, Hidarb, Kunama, Nara, Rashida, Saho, Tigre and Tigrinya), and the main religions practised are Christianity (primarily Coptic) and Islam.

While the 1997 Constitution forbids discrimination on religious grounds, the GoSE only recognises Sunni Islam, European Orthodox Christianity, Roman Catholicism and the Evangelical Lutheran Church of Eritrea, and there are reports of persecution, detention and even torture of people from other denominations and faiths.²⁷ Despite this, religious leaders are highly influential in the everyday lives of Eritreans and should be involved in anti-FGM campaigns.²⁸

Overall, 60.1% of female respondents (aged 15-49) who have heard of FGM believe that it is required by religion, and this belief is more common among older women and those living in rural areas. 70.1% of women with 'no education' believe it is a religious requirement, compared to 40.6% of those educated to secondary level or above. There is a similar variation according to wealth quintile.²⁹ Levels of wealth and education therefore appear to be the best determinants of whether or not a woman believes FGM is a requirement of her religion.

Eritrea has signed many of **the international and regional conventions and treaties** related to the practice of FGM. Articles 7, 14-16, 22 and 32 of the **1997 Eritrean Constitution**³⁰ are relevant to FGM and the position of women and girls.

In March 2007 **The Female Circumcision Abolition Proclamation No. 158/2007**³¹ came into effect, **outlawing FGM**, although the National Union of Eritrean Women (*NUEW*) had been campaigning against it since the 1990s. Contravention of Proclamation No. 158/2007 is punishable by imprisonment of two to three years or up to ten years if it results in death, or a fine for failing to report a planned FGM event. Although the GoSE's report in 2014 to CEDAW claimed that 144 people had been taken to court under the 2007 legislation against FGM³², there is no evidence available as to the outcome of those cases or any other indication of the extent to which the legislation has been enforced. The *NUEW* carried out a series of public meetings and distributed copies of the Proclamation to raise awareness of the law and the effects of FGM. The *EPHS 2010* reported that 90.9% of women and 83.1% of men have **heard of the law against FGM**. Those who are wealthier and more highly educated are more likely to have heard of it. People who live in Gash Barka are far less likely to know of it, as are people living in rural areas, suggesting that more work needs to be done in those areas.³³ Two-thirds of mothers with at least one daughter who has not undergone FGM state that the reason for this is because FGM is against the law.³⁴

In 2005 Eritrea passed a law requiring local, national and international **NGOs** to be registered.³⁵ In 2011 the last of the international NGOs working in Eritrea were forced to leave, and the only two registered NGOs active in relation to eliminating FGM are the *NUEW* and the National Union of Eritrean Youth and Students (*NUEYS*).

The Constitution's preamble commits the GoSE to creating 'a society in which women and men shall interact on the bases of mutual respect, solidarity and **equality**.'³⁶ The GoSE's 2013 and 2014 reports to the CEDAW state that progress in women's health and education is being made and the *NUEW* is continuing to promote equality.³⁷ However, the UK's Foreign & Commonwealth Office's Human Rights and Democracy Report 2013 states that, while **women's rights** are well protected within the law, they are not practised to the same standard.³⁸

Reporters Without Borders ranks Eritrea 179th out of 180 countries in its 2017 **World Press Freedom Index**. It was ranked last from 2007 to 2016.³⁹ There is complete government control, through the Ministry of Information, over all **media** outlets and news distribution in

the country (there are no privately owned news-media outlets), as well as the imprisonment without charge or trial of numerous journalists and editors since 1996.

Television and radio are the most popular traditional mediums, although radio is overwhelmingly the most-frequently accessed medium in rural areas.⁴⁰ Eritrea is the least internet-connected country in the world. Less than 1.5% of the population has access to it (some estimates are even lower), and access there is extremely slow.⁴¹

Both the NUEW and the NUEYS use **multimedia approaches** in their work to end FGM, as does The Sara Communication Initiative in its Sara Clubs. For example, the NUEW showed a film, *Behind the Curtains of Agony*, which contained hard-hitting footage of girls undergoing Type III FGM. This reportedly had a 'dramatic effect in villages propagating attitude and behavior change' and was instrumental in putting through the anti-FGM legislation.⁴² Videos of senior religious leaders have also been effective in sparking discussions in communities and changing attitudes towards and understanding of FGM.⁴³

Education is free (in government schools) and compulsory between the ages of six and 13. It is divided into pre-school, elementary, middle and secondary school. The GoSE is the largest education provider. All grade 12 students, some of whom are younger than 18, are required to enrol for **military service** at the SAWA Centre for Education and Training; otherwise, they cannot graduate or work in state-sanctioned employment.⁴⁴

According to the EPHS 2010, approximately 57% of the population is **literate**⁴⁵, although the Central Intelligence Agency's World Factbook puts that figure at 73.8%⁴⁶. Learning achievement remains generally low.

Enrolment in elementary school has reportedly fallen, and the **gender gap in literacy** is significant, as only 51.9% of women are literate compared to 63.7% of men. The disparity is much narrower in children and adolescents, and there is almost no disparity in the six-to-nine age group.⁴⁷

FGM has been included in the national school curriculum by the GoSE, and the NUEW, the NUEYS and the Sara Communication Initiative all use club-type environments and young people's interests as a platform for discussing health and social issues, including FGM. Education is vital to reducing FGM: 90.5% of women aged 15-49 with 'no' education have undergone FGM compared to 72.8% of women with a secondary or above level of education.⁴⁸

The GoSE states that, since Eritrea's independence, it has made **healthcare** one of its priorities.⁴⁹ The final report on the MDGs for Eritrea notes that, despite progress in the health sector, the GoSE still has a lot of work to do in order to sustain progress and improve current services.⁵⁰

The use of **traditional medicine** is prevalent throughout Eritrea but particularly frequent in rural communities, despite the GoSE's cautions. FGM is considered a traditional treatment, practised by 20.4% of practitioners⁵¹, and there is a cultural element to the use of traditional medicine: practitioners are seen as better understanding the mentality and culture of their patients (particularly women) and as being easier to communicate with, especially because many state health workers do not speak local ethnic languages.⁵²

A **national scheme to eliminate FGM**, Vision Eritrea, was run by the GoSE from 2008 to 2010, involving local authorities and teachers and consisting of events to provide information and form attitudes. Anti-FGM committees were set up in six zobas to promote

the anti-FGM message and draft locally-focused strategies. There has also been an **obstetric fistula** programme in place, supported by UNFPA, since 2003.⁵³

Eritrea is one of the 15 African governments working in partnership with the **UNFPA-UNICEF on the Joint Programme on FGM/C: Accelerating Change**. The NUEW is the main partner working with the UN. Some of the 'Lessons Learnt' from this project were the need to spark communications about FGM within communities, the effectiveness of using a range of media, wide dissemination of the Proclamations about FGM and child marriage and consistent follow-up and reporting on FGM cases.

The GoSE and the NUEW identify the holistic **Habarawi** ('collective') approach, in which anti-FGM messages and programmes are put into operation across all ministries and sectors of society, nation-wide, as the reason for the decrease in FGM prevalence. Challenges to the campaigns have included the difficulties associated with reaching more remote areas and the inconsistent prioritisation by government agents.

Specific challenges to the abolishment of FGM in Eritrea that need to be addressed are as follows.

- **Traditions, beliefs and social norms that support the continuation of FGM and override the law.** Social acceptance is the most commonly given reason for practising FGM, and pressures from family and community, particularly grandmothers, make it difficult for people who object to speak up.
- **Policies and practices of the GoSE that hinder anti-FGM work.** These include the GoSE's expulsion of NGOs and INGOs and its restrictions on foreign funding, which curtail the amount of FGM research that can be done and prevent the independent verification of existing data; the Ministry of Information's control over news and broadcasting, which limits debates and strengthens taboos; and the fact that girls often drop out of school or marry early to avoid compulsory military service.
- **Misunderstandings in relation to sex and FGM, home births and the use of traditional medical practitioners.** Misunderstandings about sex and FGM, the high rate of home births and reliance on traditional medical practitioners, who may use harmful traditional practices, increase the risks for women.
- **Limited funding and resources.** The healthcare system, in particular, is in need of additional funding to give easier access to healthcare and clear the backlog of fistula patients.
- **Disorder in the legal and justice systems.** The constitution and the 2015 Codes have not been fully implemented, and without firm laws upon which to base the legal and criminal justice systems, the GoSE cannot consistently carry out and report prosecutions for FGM.
- **Illiteracy.** The rate of illiteracy is especially high for women, making the distribution of printed material about FGM and related issues ineffective for a large percentage of the population.
- **Transport and infrastructure in remote locations.** Remote rural areas present particular difficulties in terms of a lack of infrastructure, making scaling up programmes and prosecuting perpetrators difficult.

Recommendations to Further Reduce FGM in Eritrea

- Drafting and implementing a new constitution, as well as fully implementing the 2015 Codes;
- continuing the Habarawi approach, including involving religious leaders and teachers;
- creating public, non-judgemental arenas for discussion;
- teaching strategies on how to speak up to family and friends about difficult issues;
- creating programmes targeting older women;
- working further in rural areas, particularly Gash-Barka, to disseminate knowledge of the FGM Proclamation;
- researching why the prevalence of and public support for FGM is lower in Asmara;
- retraining traditional practitioners for alternative careers;
- continuing to work at achieving universal education;
- addressing women's limited access to family planning;
- stepping up education on reproductive health and FGM for both adolescents and adults;
- assigning healthcare professionals who speak ethnic languages to the areas where those languages are spoken, to promote trust in professionals over traditional medical practitioners;
- bearing in mind the culture of dignity in Eritrea when conveying messages that could be interpreted as critical;
- using a variety of media, which has been shown so far to be effective;
- lifting the restrictions on NGOs and INGOs and the receipt of foreign funding for social campaigning;
- providing easier access to court judgements, so that follow-up research and reporting can be done; and
- publishing the results of any mapping and evaluation exercises, as well as any challenges and successes noted by each Anti-FGM Committee in its region of influence.

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Introduction

'It is now widely acknowledged that [FGM] functions as a self-enforcing social convention or social norm. In societies where it is practiced it is a socially upheld behavioural rule. Families and individuals uphold the practice because they believe that their group or society expects them to do so. Abandonment of the practice requires a process of social change that results in new expectations on families.'

~ The General Assembly of the United Nations¹

Female genital mutilation (sometimes called female genital cutting and female genital mutilation/cutting) (FGM) is defined by the World Health Organization (WHO)² as comprising 'all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.' FGM is a form of gender-based violence (GBV) and has been recognised as a harmful practice and a violation of the human rights of girls and women. At least 200 million girls and women alive today have had FGM in the 28 African countries where FGM is practised, in Yemen and in Indonesia.³

History of FGM

FGM has been practised for over 2,000 years.⁴ Although it has obscure origins, there has been anthropological and historical research conducted on how FGM came about. It is found in traditional group or community cultures that have patriarchal structures. Although FGM is practised in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic circumcision'.⁵ Other anthropologists believe that it existed among Equatorial African herders as a protection against rape for young female herders, as a custom among stone-age people in Equatorial Africa, or as 'an outgrowth of human sacrificial practices, or some early attempt at population control'.⁶

There were also reports in the early 1600s of the practice in Somalia as a means of extracting higher prices for female slaves, and in the late 1700s in Egypt to prevent pregnancy in women and slaves. FGM is practised across a wide range of cultures and it is likely that the practice arose independently among different peoples⁷, aided by Egyptian slave raids from Sudan for concubines and the trading of maids through the Red Sea to the Persian Gulf⁸.

Global Prevalence and Practices

FGM has been reported in 28 countries in Africa and occurs mainly in countries along a belt stretching from Senegal in West Africa, to Egypt in North Africa, to Somalia in East Africa and to the Democratic Republic of Congo in Central Africa. It also occurs in some countries in Asia and the Middle East and among certain diaspora communities in North and South America, Australasia and Europe. As with many ancient practices, FGM is carried out by communities as a heritage of the past and is often associated with ethnic identity. Communities may not even question the practice or may have long forgotten the reasons for it.

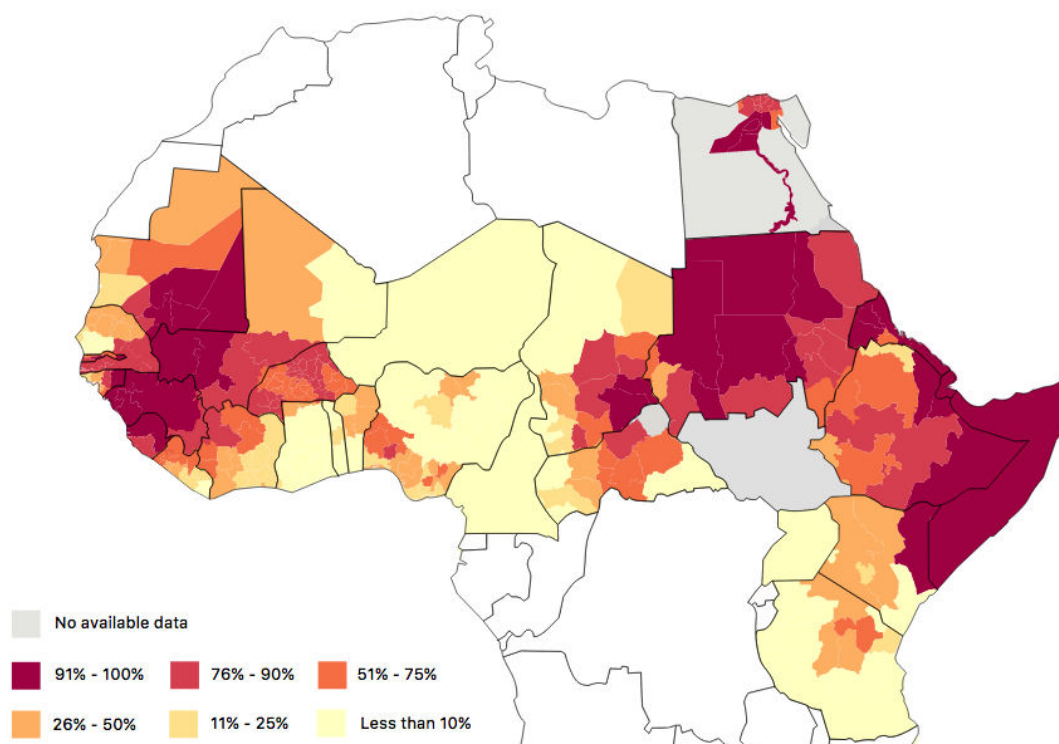


Figure 1: Prevalence of FGM in Africa (@ 28 Too Many)⁹

The WHO¹⁰ classifies FGM into four types:

Type I	Partial or total removal of the clitoris (clitoridectomy) and/or the prepuce
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). [Note also that the term 'excision' is sometimes used as a general term covering all types of FGM.]
Type III	Narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, pulling, piercing, incising, scraping and cauterization.
Re-infibulation	The procedure to narrow the vaginal opening in a woman after she has been deinfibulated (i.e. after childbirth); also known as re-suturing.

Table 1: Types of FGM as classified by the WHO

FGM is often motivated by beliefs about what is considered appropriate sexual behaviour. Some communities consider that it ensures and preserves virginity and marital faithfulness and prevents promiscuity/prostitution. There is a strong link between FGM and marriageability, with FGM often being a prerequisite to marriage. FGM is sometimes a rite of passage into womanhood and necessary for a girl to go through in order to become a responsible adult member of society. FGM is also considered to make girls 'clean' and aesthetically beautiful. Although no religious texts require the practice, practitioners often believe it has religious support. Girls and women will often be under strong social pressure, including pressure from their peers, and risk victimisation and stigma if they refuse to be cut.

FGM is always traumatic.¹¹ Immediate complications can include severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region and injury to nearby genital tissue. Long-term consequences can include recurrent bladder and urinary tract infections, incontinence, cysts, psychological problems, infertility, an increased risk of new-born deaths and childbirth complications including fistula, and the need for later surgeries. For example, a woman with Type III infibulation will likely need to be cut open later to allow for sexual intercourse and childbirth.¹²

The vision of 28 Too Many is a world where every girl and woman is safe, healthy and lives free from FGM and other human-rights violations. A key strategic objective is to provide detailed, comprehensive country profiles for each of the 28 countries in Africa where FGM is practised. The profiles provide research into the situation regarding FGM in each country, as well as more general information relating to the political, anthropological and sociological environments in the country, to offer a contextual background. This can also be of use in relation to diaspora communities that migrate and maintain their commitment to FGM.

The country profiles also offer analyses of the current situation, and will enable all those with a commitment to ending FGM to shape their own policies and practice to create conditions for positive, enduring change in communities that practise FGM. We recognise that each community is different in its drivers for FGM and bespoke, sensitive solutions are essential to offer girls, women and communities a way forward in ending this practice. This research report provides a sound information-base that can contribute to determining the models of sustainable change necessary to shift attitudes and behaviours and bring about a world free of FGM.

During our research, we connect with many anti-FGM campaigners, CBOs, policy-makers and influencers. 28 Too Many wishes to continue to build upon its in-country networking to aid information-sharing, education and awareness of key issues, enabling local NGOs to be part of a greater voice to end FGM locally and internationally.

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General National Statistics

This section highlights a number of indicators of Eritrea's context and development status.

Population

5,481,681 (6 October 2017)¹

Growth rate: 0.9% (2017 est.)

Median age: 19.4 years

Human Development Index Rank: 179 out of 188 in 2016²

Age of Suffrage, Consent and Marriage

Age of Suffrage: 18

Age of Consent: 18³

Age of Marriage: 18, according to Articles 239 and 581 of the Eritrean Civil Code; however, customary law is weighted heavily and under that the minimum age of marriage is 15 for girls and 18 for boys.⁴

Health

Life expectancy at birth (years): 64.9

Infant mortality rate (per 1,000 live births): 34 deaths⁵

Maternal mortality rate: 501 deaths/100,000 live births (2015)⁶

Fertility rate, total (births per woman): 3.99 (2017 est.)

HIV/AIDS – adult prevalence: 0.6% (2016 est.)

– people living with HIV/AIDS: 15,000 (2016 est.)

(country comparison to the world: 82)

– deaths: <1,000 (2016 est.)

GDP (in US dollars)

GDP (official exchange rate): \$5.352 billion (2016 est.)

GDP per capita (PPP): \$1,400 (2016 est.)

GDP (real growth rate): 3.7% (2016 est.)

Literacy (percentage who can read and write)

Adult (age 15 and over): 73.8%

Female: 65.5%; Male: 82.4% (2015 est.)

Youth (ages 15-24):

Female – 88.7%; Male – 93.2%⁷

Urbanisation

Urban population: 23.6% (2017)

Rate of urbanisation: 4.72% annually (2015-2020 est.)

Religions

Muslim

Coptic Christian

Roman Catholic

Protestant

Ethnic Groups

Tigrinya (55%)

Bilen (2%)

Tigre (30%)

Saho (4%)

Kunama (2%)

Rashaida (2%)

Other – Afar, Beni Amir and Nera (5%)

(2010 est.)

Languages

Tigrinya, Arabic and English (official); Dahlik, Tigre, Kunama, Afar, other Cushitic languages

Unless otherwise stated, all statistics are taken from Central Intelligence Agency (2017) *The World Factbook: Eritrea*, 6 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/er.html>.

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Political Background

Historical

Eritrea is bordered by Sudan to the north and west, Djibouti and the Red Sea to the east and south-east, and Ethiopia to the south. It occupies an important area of the Horn of Africa, with its long coastline facing Saudi Arabia and Yemen.

Until the 7th century, Eritrea formed part of the Kingdom of Aksum, which spread across northern Ethiopia and the eastern lowlands. It remained part of the Ethiopian empire until the mid-16th century, when the Ottoman Turks established a garrison at Massawa on the Red Sea coast.¹

Towards the end of the 19th century, Eritrea was colonised by Italy, then captured by the British in 1941. Throughout this period Ethiopia sought to regain control of Eritrea. In 1949 it became a UN trust territory, and it was made an independent but federated part of Ethiopia in 1952. A decade later the Eritrean administration voted to end federation and become part of Ethiopia. Many Eritreans opposed this amalgamation and established the Eritrean Liberation Front (*ELF*), which carried out a guerrilla war against Ethiopia for the next two decades.

In 1970 a rival group, the Eritrean Popular Liberation Forces (*EPLF*), was formed. It absorbed the ELF and by 1976 had almost forced Ethiopian forces out of Eritrea. However, Ethiopia, backed by the USSR, was able to defeat the Eritreans over the next couple of years, and the EPLF returned to guerrilla warfare. By the 1990s they had recaptured Asmara and other ports, and in 1993 the UN held a referendum among Eritreans on the subject of independence. The vote was overwhelmingly in favour of independence, and the leader of the EPLF, Isaias Afwerki, became the nation's first president. He renamed his party the People's Front for Democracy and Justice (*PFDJ*), and it has remained the only substantial political organisation to this day.²

Since its independence, Eritrea has been in conflict with Yemen (1995-1998) and Djibouti (2008-2010), and in 2006 it was accused by the UN of providing arms and supplies to the Islamist administration of Somalia. As a result, international sanctions against Eritrea were imposed in 2009. From external observation, Eritrea's main opponent has continued to be Ethiopia, with which it has been in dispute over borders since 1998, despite the UN's attempts to bring about peace between the two nations. The president, however, maintains in media interviews that there is no longer an issue.

Over the past couple of decades, Eritreans have fled the country in large numbers (5,000 a month, according to the UN), many of them fleeing conscription. Their main destinations are Ethiopia, Sudan and beyond to Europe via Libya.³ 21,000 Eritreans reportedly reached Europe in 2016, mostly arriving in Italy.⁴ There have been several international incidents when tourists were kidnapped and journalists imprisoned. The Government of the State of Eritrea (*GoSE*) has been accused of gross human-rights violations on a number of occasions, but dismissed these reports by the UNRHC and others as being politically motivated. During this same period, Eritrea has also experienced droughts and famine (in 2002, 2005 and 2011).⁵

Current Political Conditions

Upon taking power in 1993, the GoSE drew up a transitional constitution and held its first elections, which put President Isaias Afwerki in power. A constitution permitting multi-party politics was adopted in 1997, but it has not been fully implemented. The drafting of a new constitution began in 2014 and is still ongoing.⁶

President Afwerki is both the head of state and the head of government, giving him control of the executive and legislative sectors of government. Under the 1997 constitution, there was to be a National Assembly comprising 150 members elected by popular vote. Elections under the new constitution were scheduled for 2001, but they were not held and no elections have been held since. Afwerki remains the president and the PFDJ the sole political party.⁷ Conscription remains in force, sometimes for an indefinite length of time.⁸

The country is divided into six administrative zones (called *zobas*): Anseba, Debub ('Southern'), Debubawi Keih Bahri ('Southern Red Sea'), Gash-Barka, Maekel ('Central', which includes the capital, Asmara) and Semenawi Keih Bahri ('Northern Red Sea').⁹ Less than a quarter of Eritreans live in towns, and agriculture is the main economic activity. The official languages are Tigrinya, Arabic and English, although there are also several local languages spoken (for example, Tigre, Afar and Kunama).¹⁰

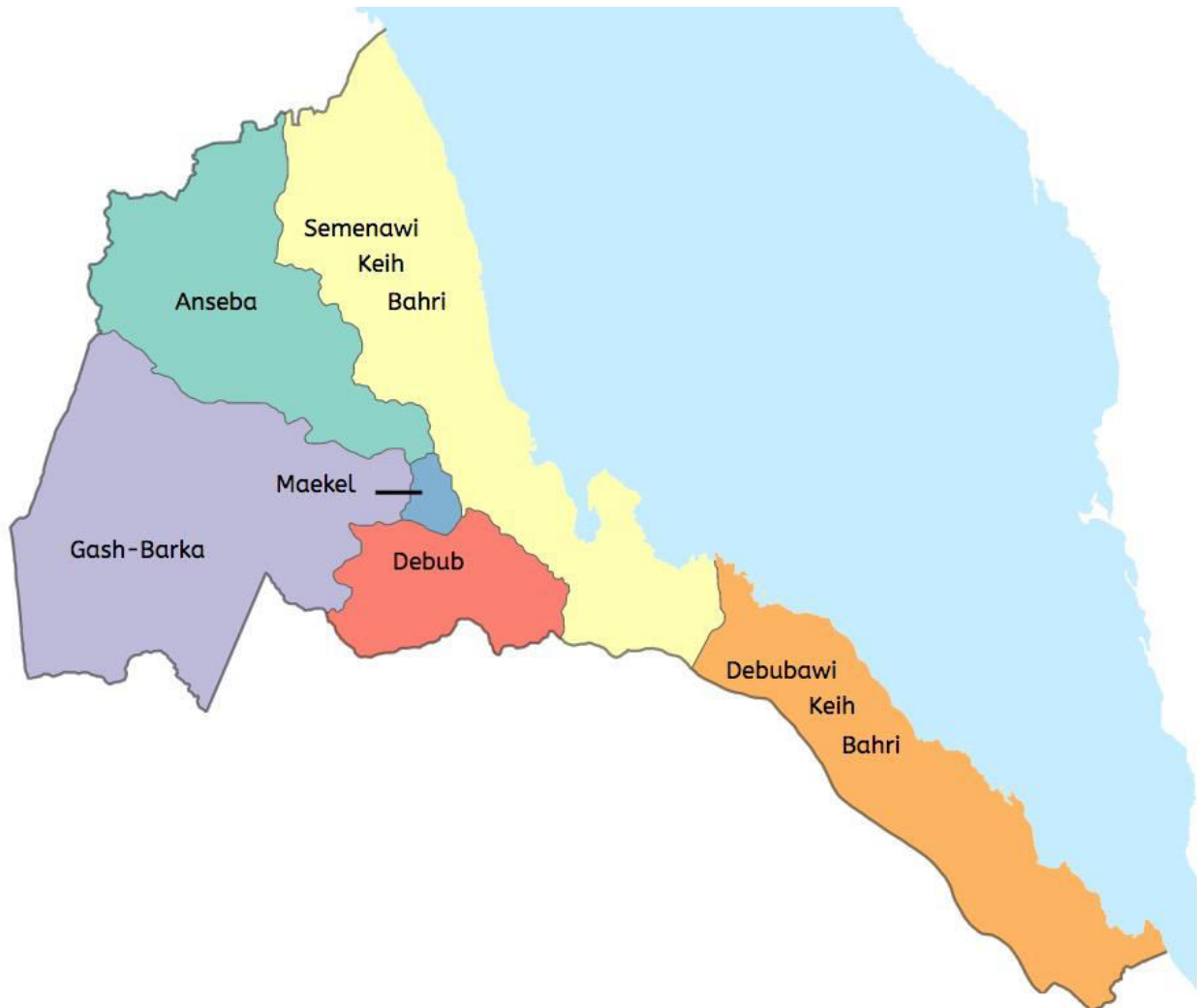


Figure 2: Eritrea's zobas (@28 Too Many)

Eritrea's justice system comprises a high court, regional/zoba courts and community courts. The latter apply local norms and customs when resolving disputes; appeals against decisions made at this level are taken up to the next level, the zoba courts, which largely deal with regional applications of statutory legislation. In addition, there are military courts and sharia courts; the latter deal only with cases related to Islamic law, notably marriage and inheritance issues.¹¹

Women in Politics

Eritrean legislation provides for 30% of seats for women in national parliament, as well as provincial and district administration.¹² However, to date only 22% of parliamentary seats¹³ and three out of 18¹⁴ cabinet positions are held by women.

Current Economic Conditions

Today, Eritrea has a population of approximately 5.5 million, of which 60% are under the age of 24. Nearly 40% of children under five (38.8% in 2010) are underweight. Three-quarters of Eritrea's land is used for agriculture, which is the main economic activity for 80% of the population; the rest are engaged in industry and services. Many Eritrean families are reportedly dependent on receiving money from relatives living in other countries. Although Eritrea has natural resources of gold and other minerals, and possibly oil and natural gas, it is estimated that half the population lives below the poverty standard.¹⁵

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 - 10 Central Intelligence Agency, *op. cit.*
 - 11 Luwam Dirar and Kibrom Tesfagabir Teweldebirhan (2015) *Introduction to Eritrean Legal System and Research*, Hauser Global Law School Program. New York University School of Law: New York, NY. Available at <http://www.nyulawglobal.org/globalex/Eritrea1.html>.
 - 12 African Development Bank and African Development Fund (2009) *Eritrea: Gender Profile (November 2008)*, p.36. Available at <https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Eritrea%20gender%20profile.pdf>.
 - 13 Ministerie van Buitenlandse Zaken (2017) *Country of Origin Information Report on Eritrea*, p.54. Available at <https://www.government.nl/binaries/government/documents/reports/2017/02/06/country-of-origin-report-on-eritrea-february-2017/COI+Eritrea+2017.pdf>.
 - 14 Human Rights Concern Eritrea (2017) *Report on Women's Rights Violations in Eritrea – HRCE Report 1/2017*. Available at <http://hrc-eritrea.org/report-on-womens-rights-violations-in-eritrea-hrce-report-12017/>.
 - 15 Central Intelligence Agency, *op. cit.*

Laws Relating to Women and Girls

For information on international and African regional laws relating to FGM, please refer to the **law factsheet** on our website.

International and Regional Treaties

Many of the international human-rights conventions and treaties related to the practice of FGM have been signed and ratified by Eritrea. The ratification of these conventions places a legal obligation on the GoSE to ensure that FGM, as an international human-rights violation, is eradicated by putting certain provisions in place. Eritrea has ratified or signed up to the following conventions and treaties¹:

International

- **Convention on the Rights of the Child** (acceded 3 August 1994)
- **Convention on the Elimination of All Forms of Discrimination against Women** (acceded 5 September 1995)
- **International Covenant on Economic, Social and Cultural Rights** (acceded 17 April 2001)
- **International Covenant on Civil and Political Rights** (acceded 22 January 2002)
- **Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment** (acceded 25 September 2014)

Regional

- **African Charter on Human and Peoples' Rights (Banjul Charter)** (signed and ratified 14 January 1999)
- **African Charter on the Rights and Welfare of the Child** (signed and ratified on 22 December 1999)
- **Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol)** (signed 25 April 2004 but not ratified)
- **Solemn Declaration on Gender Equality in Africa**, declared by the African Union (which includes Eritrea), 6-8 July 2004

In May 2014 the National Union of Eritrean Women (*NUEW*), on behalf of the GoSE, submitted the country's **fifth monitoring report to CEDAW**. Paragraphs 79-84 of the latest report describe the country's progress on dealing with FGM and are set out below.² The next monitoring report for CEDAW is not due until 1 March 2019.

**Consideration of reports submitted by States parties under
article 18 of the Convention
Fifth periodic report of States parties due in 2012: Eritrea**

Female Circumcision

79. The findings of the EPHS 2010 show that 91% of the Eritrean women have heard of the proclamation prohibiting female circumcision. 77% of Eritrean women and 82% of men believe that there is no benefit from female circumcision.
80. The practice of FGM is believed to have drastically declined in recent years. In 2002, 9 out of 10 women (89%) have been circumcised which slightly declined compared to 95% in 1995. In 2010 the prevalence of female circumcision among the young women age[d] 15-19 was around 68.8% while 93.1% of those women aged 45-49 were circumcised which shows that overtime there is a decline in FGM prevalence rate among the young girl population.
81. The percentage of women that have heard about FGM proclamation is slightly lower among the young aged 15-19 which is 86.3% while it is above 90% for all women aged 20-49 years. The percent of women that reported activities against circumcision in the area is higher for women 45-49 years of age (64.6%) while it was lower for the young girls aged 15-19 years (51.3%).
82. The Anti FGM Campaigns by NUEW and other partners which culminated in 2007 in the enactment of law banning FGM and in the introduction of innovative mechanism to enforce the government's proclamation. A community based enforcement committee has in the last four years took [sic] 144 perpetrators to court.
83. By far the largest health service providing organization in the country is the Ministry of Health (MoH) accounting for 87.8 of all the health professionals. Private organizations rank second with 5%, followed by the ECS and IND, respectively scoring 3.2% and 2.3%.
84. There are a total of 143 qualified medical and surgical doctors. Taking an estimated population figure of 3.2 million, on the average there is one doctor for every 22,377 people. Despite rapid improvements this is still a big burden. The Government has earnestly been working in building the capacity in local institutions whereby medical doctors are educated to meet the country's needs. At the end of 2012 alone some 56 medical doctors graduated from the Orotta School of Medicine in Asmara. The College of Health Science is engaged in the production of the various health professionals.³

National Laws

The Constitution

A new constitution has been in the drafting process since 2014. The **1997 Eritrean Constitution**⁴ was passed, although never fully implemented, and contains the following articles that are relevant to FGM and the position of women and girls:

Article 7: Democratic Principles

2. Any act that violates the human rights of women or limits or otherwise thwarts their role and participation is prohibited.

Article 14: Equality under the Law

1. All persons are equal under the law.
2. No person may be discriminated against on account of race, ethnic origin, language, colour, gender, religion, disability, age, political view, social or economic status or any other improper factors.
3. The National Assembly shall enact laws that can assist in eliminating inequalities existing in Eritrean society.

Article 15: Right to Life and Liberty

1. No person shall be deprived of life without due process of law.
2. No person shall be deprived of liberty without due process of law.

Article 16: Right to Human Dignity

1. The dignity of all persons shall be inviolable.
2. No person shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 22: Family

3. Parents have the right and duty to bring up their children with due care and affection . . .

Article 32: Powers and Duties of the National Assembly

4. The National Assembly shall ratify international agreements by law.

However, in a 2015 interview with *Haddas Ertra*, President Afwerki said, 'Everyone knows that the constitution does not exist.'⁵ It would appear that the justice system does not refer to the 1997 Constitution, but as court orders are not available for viewing without application, it is difficult to know what laws and legislation are used in practice.

Age of Suffrage, Consent and Marriage

Under Articles 22 and 30 of the Constitution, men and women over the age of 18 have the right to vote in elections and to marry without needing the consent of their parents.⁶

Laws Against FGM

In March 2007 **The Female Circumcision Abolition Proclamation No. 158/2007** came into effect.⁷ Although the NUEW had been conducting sensitisation exercises in villages about the health dangers of FGM since the 1990s, it was not until 2007 that there was a law specifically prohibiting the practice. This was said to be because the GoSE took the view that there was a danger a law would drive the practice underground rather than curbing it, and that education and persuasion were the preferred means of eliminating it.⁸

Proclamation No. 158/2007 is a simple, five-clause law covering all types of FGM, the contravention of which is **punishable by** imprisonment of two to three years or up to ten years if it results in death. The law also requires mandatory reporting of an intended event to perform FGM, punishable by a fine if someone fails to report it. The Proclamation is set out on the following page.

NEW CODES

Eritrea published new Penal, Civil, Civil Procedure and Penal Procedures Codes (formally *Transitional Codes*) in 2015. Although the Minister of Justice announced that the new codes were being put immediately into effect⁹, other sources, (such as the Gazette of Eritrean Laws Vol. 23) state that they have not yet come into effect and the courts continue to use the Transitional Codes.

Below is one example of an applicable article from the new Penal Code.

Penal Code of the State of Eritrea, 2015¹⁰

Article 327 – Child Neglect:

A person exercising parental authority who for gain or in dereliction of duty:

- (a) grossly neglects the children under his charge and abandons them without due care and attention, or to moral or physical dangers; or
- (b) entrusts a child for a long time to a person, an organization or an institution with whom or where he knows, or could have foreseen, that the child will be reduced to physical or moral destitution,

is guilty of child neglect, a Class 2 petty offence, punishable with a definite term of imprisonment of not less than 1 month and not more than 6 months, or a fine of 5,001 – 20,000 Nakfas, to be set in intervals of 1,000 Nakfas.

The court may in addition deprive the offender of his family or custodial rights for a period of not less than one nor more than 10 years, upon a determination that the nature and circumstances of the offence justify the deprivation.

PROCLAMATION 158/2007¹¹

A Proclamation to Abolish Female Circumcision

Whereas, female circumcision is a procedure that seriously endangers the health of women, causes them considerable pain and suffering and threatens their lives;

Whereas, this procedure violates women's basic human rights by depriving them of their physical and mental integrity, their right to freedom from violence and discrimination, and in the most extreme case, their life;

Whereas, the immediate or long-term harmful consequences of this procedure vary according to the type and customs of the procedure performed;

Whereas, its immediate consequences include severe pain, haemorrhage which can cause fainting or death, ulceration of the genital region and injury to adjacent tissues, urine retention and dangerous infection;

Whereas, its long-term consequences include recurrent infection of the urinary system, permanent infection of the fertility system, complications in childbirth (barrenness) and scar formation such as increasing abscess in the labia minora and, prevention of menstruation;

Whereas, it has been traditionally practised and is prevalent in Eritrea; and

Whereas, the Eritrean Government has decided to abolish this harmful procedure which violates women's rights;

Now, therefore, it is proclaimed as follows:

Article 1. Short Citation

This Proclamation may be cited as 'The Female Circumcision Abolition Proclamation No. 158/2007.'

Article 2. Definition

In this Proclamation, 'female circumcision' means:

- (1) the excision of the prepuce with partial or total excision of the clitoris (clitoridectomy);
- (2) the partial or total excision of the labia minora;
- (3) the partial or total excision of the external genitalia (of the labia minora and the labia majora), including stitching;
- (4) the stitching with thorns, straw, thread or by other means in order to connect the excision of the labia and the cutting of the vagina and the introduction of corrosive substances or herbs into the vagina for the purpose of narrowing it;
- (5) symbolic practices that involve the nicking and pricking of the clitoris to release drops of blood; or
- (6) engaging in any other form of female genital mutilation and/or cutting.

Article 3. Prohibition of Female Circumcision

Female circumcision is hereby abolished.

Article 4. Punishment

- (1) Whosoever performs female circumcision shall be punishable with imprisonment of two to three years and a fine of five to ten thousand (5,000.00 to 10,000.00) Nakfa. If female circumcision causes death, imprisonment shall be from five to ten years.
- (2) Whosoever requests, incites or promotes female circumcision by providing tools or by any other means shall be punishable with imprisonment of six months to one year and a fine of three thousand (3,000.00) Nakfa.
- (3) Where the person who performs female circumcision is a member of the medical profession, the penalty shall be aggravated and the court may suspend such an offender from practicing his/her profession for a maximum period of two years.
- (4) Whosoever, knowing that female circumcision is to take place or has taken place, fails, without good cause, to warn or inform, as the case may be, the proper authorities promptly about it, shall be punishable with a fine of up to one thousand (1,000.00) Nakfa.

Article 5. Effective Date

This Proclamation shall enter into force as of the date of its publication in the Gazette of Eritrean Laws.

Done at Asmara, this 20th day of March, 2007
Government of Eritrea

Law Enforcement

In its national report to the Human Rights Council in 2013, the GoSE stated that, during the period 2008-2013, '207,416 FGM related disputes were brought to the courts' and, in total, '155 cases were penalised across the country.'¹²

Eritrea has also submitted reports to the Committee on the Rights of the Child (2 January 2014) and the African Committee of Experts on the Rights and Welfare of the Child (May 2015). Both reports state that 54 traditional practitioners and parents of children who had undergone FGM were convicted and fined during the reporting periods.¹³

Details of specific cases, however, are difficult to obtain, and these reports only refer to one specific case in the Southern Zone regional court involving a priest who opposed the law prohibiting FGM, was sued by the regional office of the NUEW, and was convicted and penalised.¹⁴ A 2012 report also contains a case study on the prosecution, imprisonment and education of (now former) FGM practitioner Zahra Ahmed in the Anseba district.¹⁵

Although the GoSE's report in 2014 to CEDAW claims that 144 people have been taken to court under the 2007 legislation against FGM¹⁶, there is no evidence available as to the outcome of those cases or any other indication of the extent to which the legislation has been enforced.

Following the criminalisation of FGM, the GoSE, through the NUEW, carried out a series of public meetings to raise awareness of the law and the effects of FGM, as well as distributing copies of the Proclamation to 15,000 communities.¹⁷ The EPHS 2010,

therefore, included a question about **women's knowledge of the Proclamation**. 90.9% of women aged 15-49 say that they have heard of it, but the level of knowledge is lower among the youngest age-group (15-19), at 86.9%, compared to that in the older age-groups (91-93%). Knowledge is also lower among women in rural areas, at 87.4%, compared to Asmara and other urban areas, at 96.1%. Across five of the six zobas, between 93.5% and 97% know of the proclamation, but in Gash-Barka that figure is 75.4%. Knowledge is also directly correlated with women's level of wealth and education.¹⁸

Two-thirds of mothers with at least one daughter who has not undergone FGM state that the reason for this is because FGM is against the law.¹⁹



Knowledge of the law against FGM is more common in Asmara and other urban areas than in rural areas

Non-Governmental Organisations in Eritrea

The GoSE's relations with civil society organisations and non-governmental organisations (NGOs) has been tense since the turn of the century.

In 2005 Eritrea passed a law requiring local, national and international NGOs to register with the Ministry of Labour and Human Welfare.²⁰ NGOs are also required to submit quarterly and annual reports, and the Ministry has the authority to suspend or terminate the activities of NGOs working outside their registered interests in the areas of relief and/or rehabilitation.

In 2006, when the country was going through a serious drought, three international relief agencies were expelled from the country when President Afwerki 'called on his people to practice self-reliance.'²¹

In 2011 the last of the international NGOs working in Eritrea were forced to leave, and the UN's activities have been severely curtailed and limited to those areas of work agreed with the GoSE.

The only two registered NGOs active in relation to eliminating FGM are the NUEW and the NUEYS.

UNFPA-UNICEF JOINT PROGRAMME ON FGM/C: ACCELERATING CHANGE

Eritrea has been one of 15 African governments working in partnership with UNFPA-UNICEF on the Joint Programme on FGM/C: Accelerating Change (*UNJP*). In Eritrea this partnership has been incorporated into a broader programme of co-operation between the GoSE and the UN, the Joint Programme on Gender Equity and Advancement of Women. The main partner working with the UN agencies on the implementation of this programme has been the National Union of Eritrean Women.

Output 3 of this Joint Programme was to

support policies, legislation and other legal frameworks and develop sensitization programmes to increase the general public, law enforcement officers, community leaders and women, against harmful social norms (HSN), HIV/AIDs, and develop an enforcement mechanism [*sic*].

The UN's 2016 Standard Progress Report notes that 50 cases of FGM were investigated, which resulted in 89 perpetrators being brought to justice. Over 400 awareness-raising meetings about FGM and early marriage were undertaken by the NUEW in zobas, sub-zobas and villages during the preceding year, reaching 152,729 people, including community and religious leaders, students, parents and practitioners. This led to the setting up of 548 Anti-FGM Committees, from which 265 members participated in training; six of these training sessions were broadcast on radio and television in order to reach a wider audience. Training was also undertaken with the police and other law enforcement officers, as well as staff of community courts. The aim was to ensure they had a better understanding of the 2007 law prohibiting FGM and health impacts of the practice.

Among the 'Lessons Learnt' that are listed in the 2016 report is the need to discuss FGM 'within a broader context with the objective of communities starting to discuss openly about attitudes towards FGM abandonment.' Other lessons include the importance of using a range of media, such as radio and television, which are believed to have a strong impact on attitudes, wide dissemination of the Proclamations about FGM and child marriage to parents and children, and consistent follow-up and reporting of FGM cases to see if the 2007 law prohibiting FGM is being properly implemented.²²

Looking ahead, a document has been drawn up called The Strategic Partnership Cooperation Framework (SPCF) Between The Government of the State of Eritrea and The United Nations 2017-2021. Like the earlier partnership, this contains a commitment (as a part of Outcome 7) to 'strengthen existing efforts to address the deep-rooted harmful traditional values, attitudes and practices, through continuous advocacy and sensitisation of communities.'²³ A baseline prevalence is given in the SPCF as 12% for girls under five years of age and 33% for girls under 15 years; this baseline is based on the figures reported in the EPHS 2010. Targets for FGM prevalence by the end of the period (2021) are 7% for under-fives and 21% for under 15s.²⁴

- 1 United Nations Human Rights Office of the High Commissioner (2014) *Status of Ratification Interactive Dashboard: Egypt*. Available at <http://indicators.ohchr.org/>.
- 2 State of Eritrea and CEDAW (2014) *Consideration of reports submitted by States parties under article 18 of the Convention – Fifth periodic report of States parties due in 2012: Eritrea*. Available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fERI%2f5&Lang=en.
- 3 *Ibid.*
- 4 *The Constitution of Eritrea* (1997). Available at <http://confinder.richmond.edu/admin/docs/Eritrea1997English.pdf>.
- 5 President Afwerki cited in Luwam Dirar and Kibrom Tesfagabir Teweldebirhan (2015) *Hauser Global School Program: UPDATE: Introduction to Eritrean Legal System and Research*, p.3. Available at <http://www.nyulawglobal.org/globalex/Eritrea1.html>.
- 6 *The Constitution of Eritrea, op. cit.*, pp.530 & 533
- 7 *Eritrea: Proclamation No. 158/2007 of 2007, the Female Circumcision Abolition Proclamation* [Eritrea], 20 March 2007. Available at <http://www.refworld.org/docid/48578c812.html>.
- 8 African Development Bank and African Development Fund (2009) *Eritrea: Gender Profile (November 2008)*, p.39. Available at <https://www.afdb.org/fileadmin/uploads/afdb/Documents/Project-and-Operations/Eritrea%20gender%20profile.pdf>.
- 9 Shabait (2015) 'Government of Eritrea Puts Into Effect New Civil and Penal Codes', *TesfaNews*, 11 May. Available at <https://www.tesfanews.net/government-of-eritrea-puts-into-effect-new-civil-and-penal-codes/>.
- 10 *Penal Code of the State of Eritrea* (2015) Available at <http://www.refworld.org/pdfid/55a51ccc4.pdf>.
- 11 *Eritrea: Proclamation No. 158/2007 of 2007, the Female Circumcision Abolition Proclamation, op. cit.*
- 12 Human Rights Council (2013) *National report submitted in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21: Eritrea*, p.12. Working Group on the Universal Periodic Review Eighteenth session 27 January – 7 February 2014. Available at https://www.upr-info.org/sites/default/files/document/eritrea/session_18_-_january_2014/a_hrc_wg.6_18_eri_1_e.pdf.
- 13 - State of Eritrea and Committee on the Rights of the Child (2014) *Consideration of reports submitted by States parties under article 44 of the Convention – Fourth periodic reports of States parties due in 2011: Eritrea*, p.49. Available at http://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRC/C/ERI/4&Lang=en.
- State of Eritrea (2015) *Consolidated First, Second, Third and Fourth Periodic National Reports On the Implementation of the African Charter on the Rights and Welfare of the Child*, p.161.
- 14 Human Rights Council, *op. cit.*, p.12.
- 15 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, p.34. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.
- 16 State of Eritrea and CEDAW, *op. cit.*, p.20.
- 17 - National Union of Eritrean Women and UNDP Eritrea (2014) *10 Years: Women in Eritrea – National Union of Eritrean Women*. Available at <https://www.scribd.com/document/254707719/National-Union-of-Eritrean-Women-10-Year-Report-by-UNDP>.
- State of Eritrea (2015) *Consolidated First, Second, Third and Fourth Periodic National Reports On the Implementation of the African Charter on the Rights and Welfare of the Child*, p.160.
- 18 EPHS 2010, p.347.
- 19 EPHS 2010, p.358.
- 20 *Eritrea: Proclamation No. 145/2005 of 2005, Non-governmental Organization Administration Proclamation*, 11 May 2005. Available at <http://www.refworld.org/docid/493507c92.html>.
- 21 BBC News (2006) *Drought-hit Eritrea expels NGOs*, 22 March. Available at <http://news.bbc.co.uk/1/hi/world/africa/4834936.stm>.
- 22 United Nations Population Fund (2016) *2016 Standard Progress Report: Joint Programme on Gender Equity and Women Empowerment*.
- 23 State of Eritrea and the United Nations (2017) *The Strategic Partnership Cooperation Framework (SPCF) Between The Government of the State of Eritrea and The United Nations 2017-2021*, p.36. Available at <https://www.unicef.org/about/execboard/files/ERITREA-SPCF-2017-2021.pdf>.
- 24 *Ibid.*, p.54.

Image page 35:

Matej Hudovernik (undated) *Asmara, capital of Eritrea*. Used under licence from Shutterstock.com. Stock photo ID: 124473046.

The Role of Women in Society

Rights Under The Constitutional and International Treaties

The **Constitution of Eritrea**, ratified on 23 May 1997, details in its preamble:

We the people of Eritrea, united in a common struggle for our rights and common destiny... Noting the fact that the Eritrean women's heroic participation in the struggle for independence, human rights and solidarity, based on equality and mutual respect, generated by such struggle will serve as an unshakable foundation for our commitment to create a society in which women and men shall interact on the bases of mutual respect, solidarity and equality.¹

Furthermore, in Article 7, 'Democratic Principles', it is stated that 'any act that violates the human rights of women or limits or otherwise thwarts their role and participation is prohibited.'²

However, it should be noted that, despite the Constitution being ratified in 1997, it has never been fully implemented, and there have been claims made by both Eritreans and international bodies that the GoSE is not striving to achieve full implementation of Constitutional laws. The UK's Foreign & Commonwealth Office's Human Rights and Democracy Report 2013 identifies Eritrea as a country of concern and states that, while women's rights are well protected within the law, they are not practised to the same standard.³ In 2016, a United Nations Commission of Enquiry on Human Rights in Eritrea determined that it was reasonable to conclude that gross violations of human rights are occurring in Eritrea and that Eritrean officials have been committing crimes against humanity since 1991.⁴

In 1995, Eritrea ratified the **United Nations Convention on the Elimination of All Forms of Discrimination against Women 1981**, an international treaty on women's rights. The Committee on the Elimination of Discrimination against Women (*CEDAW*) follows Eritrea's progress, as reported by the GoSE, in working towards eliminating traditional gender stereotypes. The 2013 and 2014 reports state that progress in women's health and education is being made and that the NUEW is continuing its mission to promote equality for women and improve women's participation in all areas of society.⁵

Eritrea's rankings on both the **Social Institutions and Gender Index** and the **Gender Inequality Index** have not been determined.

Resources and Entitlements

OECD Development Centre Restricted Resources and Assets Category for Eritrea (2014): LOW

Secure access to land: 0.5 ('The law guarantees the same rights to own, use and control land to women and men, but there are some customary, traditional or religious practices that discriminate against women.')

Secure access to non-land assets: 0 ('The law guarantees the same rights to own and administer property other than land to both women and men.')

Access to financial services: 0 ('The law guarantees the same rights to access formal financial services [e.g. credit, bank account and bank loans] to both women and men.')

Inheritance rights for widows: 0.5 ('Whilst the law states the same rights apply to both widows and widowers, customary, religious or traditional practices exist that discriminate against widows where they do not against widowers.')

Inheritance rights for daughters: 0.5 ('Whilst the law states the same rights apply to both daughters and sons, customary, religious or traditional practices exist that discriminate against daughters where they do not against sons.')

The Constitution of Eritrea states that any citizen has the right to both own and sell property⁷; however, **land ownership** by women is hindered by cultural prejudices of those in the Department of Land and local land-distribution committees, meaning that women often are not allocated land as readily as men.⁸ Over the period 1995-2005, the Department of Land allocated land to 27,133 women for residential, agricultural or business purposes, compared to 46,098 men (it is not reported how many applications were made).⁹

The largest **micro-credit** provider is the GoSE's Savings and Micro Credit Programme. During the period 2005-2008, 40% of its customers were women.¹⁰

UNICEF estimates that 27% of school-aged children do not have access to **schooling**.¹¹ The children who are affected most are girls and those living in rural or nomadic communities.

Access to Healthcare

Respondents in the EPHS 2010 stated that the lack of money for treatment was the main barrier to them seeking healthcare.¹³

According to the WHO, there were no psychiatrists working in the mental health sector in 2015.¹²

The chances of dying between the ages of 15 and 60 was 28.9% in 2015 for women and 22.2% for men.¹⁴ According to the WHO, the maternal mortality ratio (2015) is 501 deaths per 100,000 live births, although the GoSE's projected figure for 2015, based on previous years, was 352.¹⁵ Access to antenatal care (at least four visits) increased from 26.6% in 1995 to 57.4% in 2010.¹⁶ The percentage of births attended by skilled personnel in 2015 was recorded by the WHO as 46% and by the GoSE at 59%.¹⁷ The three most common barriers to seeking care during delivery are the lack of money for transportation, having to take transportation and the distance to a health facility.¹⁸



Women were expected to return to traditional roles after the war for independence

Civil Liberties

The OECD Development Centre Restricted Civil Liberties Category for Eritrea (2014): LOW

Political quotas: 0 ('There are legal quotas to promote women's political participation both at the national and sub-national levels.')

Access to public space: 0 ('The law guarantees the same rights to freely move to both women and men.')

Despite the above rankings, the OECD Development Centre further notes that

In its 2013 letter to the Human Rights Council, Amnesty International reported instances of arbitrary arrest and detention in Eritrea on a vast scale, with at least 10,000 political prisoners detained since its independence. This indicates that, despite technical legislative rights to free movement, women (and men) currently do not enjoy full freedom of mobility in Eritrea.²⁰

Furthermore, Eritreans are not allowed to leave the country without the permission of the GoSE.²¹

In the 2017 World Press Freedom Index, Reporters Without Borders placed Eritrea 179 out of 180 countries ranked with an index score of 84.24, relinquishing last place to North Korea for the first time in ten years.²² There is no privately owned media in Eritrea. All news and information is tightly controlled by the GoSE (see Media on page 72).

Same-sex sexual activity is illegal, punishable by between 10 days' and three years' imprisonment²³, and there are no laws to prevent discrimination based on sexuality.²⁴

Women's Autonomy and Authority in the Family

Although the extent of military service has resulted in 46.7% of Eritrean households being headed by women²⁵, the NUEW pinpoints Eritrea's underlying patriarchal culture as one of the **main barriers to gender equality** in Eritrea. The organisation also states that social conditioning causes Eritrean children to equate femininity with weakness from a young age.²⁶

The **minimum legal age of marriage** for men and women is 18 years; however, early marriages are common, particularly in rural areas, where forced marriages continue to occur. According to a survey by UNICEF, in the period 2002-2012, 19.6% of Eritreans were married before the age of 15 and 47% by the age of 18.²⁷ The UN determined in 2012 that 31% of women aged 15-19 were married.²⁸

90.6% of surveyed women are in monogamous marriages with their husbands
8.2% have one or more **co-wives**²⁹

The **OECD Development Centre Family Code Value** is calculated by considering each country's position in relation to early marriage, women and men's equality in parental authority and women's inheritance rights as daughters and wives. Eritrea is categorised as 'medium' (0.3321).³⁰

The EPHS 2010 surveyed over 6,000 married women aged 15-49 on their **participation in family decision-making**. Respondents were asked if they had equal or greater decision-making power compared to their husband with regards to six specific areas of decision-making (their own healthcare, making major household purchases, making purchases for daily household needs, visits to her family or relatives, deciding what to cook each day, and assisting her family). 59.6% of respondents participate in all six areas of decision-making. 2.1% participate in none of them.

Women are less likely to participate in household decision-making if they are of a young age (15-19 years), are unemployed, have no living children, have only a primary level of education or less, live in a rural area, or are in the lowest or second-lowest wealth quintiles.³¹

Over 2,000 married men aged 15-59 were then asked if they thought their wives should have equal or more decision-making power compared to themselves with regards to the same five areas of decision-making. 50.1% of respondents believe that wives should have equal or greater power in all five areas of decision-making, while 4.2% believe that wives should not. The percentage of men who believe women should be involved in household decision-making increases in accordance with level of education and wealth, and men living

in rural areas are more likely than men living in other areas to say that women should not have equal or greater power in decision-making.³²

For the DHS 2002, 1,500 women were asked who has responsibility for how their cash earnings are spent. Almost all women (97%) who are divorced, separated or widowed have sole responsibility, as do 76.7% of never-married women. More than half of married women (56.2%) report that they make independent decisions about their cash earnings and 39.8% make joint decisions with someone else.³³

Female Representation in Government

The legal quota for female representation in provincial and district administration and national government is 30%; however, as of 2017 this quota has not been met, as only 22% of parliamentary seats³⁴ and three out of 18 cabinet positions (16.7%)³⁵ were held by women.

These numbers suggest that quotas are not enough to promote and facilitate the entry of women into government roles.

According to the African Development Bank, women's participation in decision-making is stronger at lower levels of government, and 21 of the members of the constitutional commission were women.³⁶

National Service

Introduced in 1995 by President Isaias Afwerki, compulsory military service in Eritrea aimed to foster a sense of national pride and discipline for members of the newly independent nation. All Eritreans between the ages of 18 and 40 are required to complete national service and are unable to attend university or hold a formal job unless they have done so.³⁷ All conscripts receive six months of military training, after which they are placed in active military service, development tasks or civil-servant roles for twelve months. Many are placed in jobs in industries they do not wish to work in and on a salary that is much less than non-conscripts in the same roles.³⁸

On paper, conscription periods are 18 months; however, in 1998 conscription periods became indefinite and so are often several years long. Eritreans who have left the country have reported that individuals have spent up to 15 years in national service.³⁹ Gaim Kibreab, a professor at London South Bank University, surveyed 190 Eritreans who had engaged in national service and subsequently fled the country. The average length of time spent in national service by those surveyed was 5.8 years.⁴⁰ Former conscripts and overseas observers have likened Eritrea's compulsory military service to forced labour and slavery.⁴¹

In early 2016, the GoSE stated that it was not planning to shorten conscription periods⁴², despite the thousands of Eritreans who leave the country every month, many fleeing national service. Information Minister Yemane Ghebremeskel told Reuters Eritrea that 'demobilisation is predicted on removal of the main threat', referring to neighbouring Ethiopia.⁴³

Eritreans who refuse to partake in national service, such as Jehovah's Witnesses and Muslim women, who conscientiously abstain from military service due to religious beliefs, are effectively stripped of their citizenship rights and denied access to official identification,

public services, and the right to work and own land. They may also face imprisonment, and there are reports that many individuals have been detained without a trial.⁴⁴ The GoSE does not excuse Muslim women from participation in national service; however, Kibreab reports that the government seems to have stopped forcing Muslim women from more rural areas to perform national service, due to growing community resistance.⁴⁵

The British Embassy in Asmara states that women who are married or have young children are generally exempt from national service.⁴⁶ This may encourage young women to marry and have children at a young age in order to avoid national service.

The Impact of the War for Independence on Women

Over one-third (30,000) of those in the armed forces during the 30-year war for independence were women, who were placed in the same roles as men, including armed combat. This was unlike the majority of wars for independence elsewhere in Africa, where women were placed in assisting roles and were not combatants. Because of this, 'gender relations were equalised'⁴⁷ during the struggle for independence, and the role of women in the war for independence was an important driving force in the fight for gender equality in Eritrea. Central to the EPLF's Cultural Revolution was the idea of gender equality, the practice of which the EPLF encouraged in the areas under its control. The EPLF discouraged arranged marriages, FGM, bride prices and divorce by repudiation.⁴⁸

However, after independence had been won, women often felt pressured to fill their traditional roles once again. Many women who had served in the armed forces as combatants felt betrayed, as the skills they had learned and used in the war were not transferable to everyday life and were even seen as undesirable in a wife.⁴⁹

The DHS 2002 found that 46.7% of Eritrean households are headed by women.⁵⁰ It is estimated that almost 50% of these households are headed by widowed women, many of whom lost their husbands to the war for independence.⁵¹ Many of the men in the remaining households are in military service. Households that are female-headed are often disadvantaged in that they lose the income from the husband. The African Development Bank estimates that approximately 50% of female-headed households in Eritrea are living beneath the poverty line.⁵²



50% of female-headed households in Eritrea are living beneath the poverty line

Physical Integrity

The OECD Development Centre classified Eritrea as having a **'very high' Restricted Physical Integrity Value** (0.9712), the highest classification of the value.⁵³ The value is calculated through an analysis of the social systems that normalise violence towards women, increase their vulnerability and otherwise restrict control over their bodies, including FGM.⁵⁴

Attitudes towards violence against women: 0.71 (71% of women justify wife beating)

Laws addressing domestic violence: 1 (no legislation in place)

Laws addressing rape: 0.75 (legislation regarding rape exists but marital rape is not included)

Laws addressing sexual harassment: 0.5 (legislation is inadequate)

Reproductive autonomy: 0.29 (29% of women have a family planning need that is not being met)

Rape, Sexual Harassment and Sexual Violence Towards Women

Traditionally the rights of Eritrean women are respected under customary law, which protects them from any type of abuse, including sexual and physical.

~ Human Rights Concern⁵⁵

Under Article 307 of the Penal Code of the State of Eritrea, 2015, rape is illegal. However, spousal rape is only punishable 'where the spouses are not living together in the same household under circumstances which do not show a mutual agreement or understanding between the spouses not to live together in the same household temporarily.'⁵⁶

Between 2009 and 2012, there were 302 occasions where a woman filed a charge or made a complaint of sexual assault. These included cases of rape, adultery, sexual outrage and seduction and bigamy.⁵⁷ The full extent of sexual violence and rape in Eritrea is not known. One of the reasons for this is that being the victim of rape in Eritrean culture is regarded as shameful.⁵⁸

Domestic Violence

In the DHS 2002, 70.7% of women respondents aged 15-49 justified wife-beating in at least one of five theoretical scenarios (if she burns the food, argues with her husband, goes out without telling him, neglects the children, and refuses to have sexual intercourse with him).⁵⁹ In 2010, the percentage of women who justified wife-beating in at least one of the five scenarios decreased to 51.4%⁶⁰ – a significant reduction. 36% of women justify wife-beating if she neglects the children, 35.2% if she goes out without telling her husband, 31.7% if she argues with him, 24% if she refuses to have sexual intercourse with him, and 17.6% if she burns the food. During the period 2002 to 2010, the acceptance of wife-beating when a wife has refused to have sexual intercourse with her husband decreased from 47.9% to 24%.⁶¹ Acceptance of wife-beating is lower in urban areas (41.7%) than rural areas (58%) and is lower than the average in women with secondary education or above (35.7%) or those in the highest wealth quintile (37%).⁶²

Spousal abuse is a crime in Eritrea; however, it is apparent that much domestic abuse goes unreported. In 2003, the World Organisation Against Torture published a paper that suggested Eritrea had inadequate counselling or legal mechanisms for women who are subject to domestic violence.⁶³ The paper cited studies completed in regional Eritrea in 2001, in which 40% of married women respondents stated they had been the victim of domestic violence.⁶⁴ The US Department of State also reports that domestic violence is 'commonplace', yet incidents are rarely reported or brought to trial.⁶⁵

Sexual Violence During National Service

Professor Gaim Kibreab published a study in 2017 on the prevalence of sexual violence against women in the Eritrean National Service (ENS).⁶⁶ He found that sexual violence appears to be rife within the ENS, despite there being little empirical evidence publicly available.

The ENS has few regulations governing the conduct between commanders and conscripts, nor a regulation on sexual misconduct between commanders and conscripts. The 2015 UN Commission of Inquiry on Eritrea found that sexual violence towards young women conscripts was a common occurrence within the ENS⁶⁷, and it is suspected that the issue may be much more widespread than reported. Kibreab found that the risk of sexual violence towards women in the ENS appears to be highest for those women who remain in the SAWA military camp as cooks, cleaners, office workers and secretaries following their six months of military training.

There are many reports of commanders gaining consent from women conscripts by threatening them with punishment if they resisted their sexual advances. Reported punishments included being sent to the frontline during the border war, detention in shipping containers, beatings, forced exposure to the sun all day, and denial of home visits.⁶⁸

Because national service is compulsory for all Eritrean women between the ages of 18 and 40, risk of sexual violence and exploitation in the ENS is an issue at the forefront of women's rights in Eritrea.

NATIONAL UNION OF ERITREAN WOMEN (NUEW)

The National Union of Eritrean Women was established in 1979 as part of the EPLF's mass organisations. It describes itself as a non-governmental organisation with the aim of improving the status and wellbeing of Eritrean women and encouraging women's participation in all areas of Eritrean society, particularly in government.⁶⁹ The NUEW played a role in the drafting of the Constitution. As of 2013, the organisation had almost 300,000 members.⁷⁰

The mission of the NUEW 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].'⁷¹

Its activities have focused on:

- The development of women's confidence in themselves and respect for one another, and the raising of consciousness to ensure their rights in the political and legal systems;
- Laws that protect women's rights in the family: entitlement rights and other civil laws;
- Equal access to education and employment opportunities: equal pay for equal work and equal rights to skills development to promotion;
- Improved access to adequate health care, paid maternity leave, and child care services;
- The eradication of harmful traditional practices that endanger women's health and well-being;
- The reduction of poverty for Eritrean women and their families.⁷²

The NUEW maintains that, since 2006, over 1.2 million people, 73% of them women, have participated in meetings on FGM and child marriage. Following the introduction of the law against FGM in 2007, the NUEW held a series of public conferences around the country to make people aware of the law, and community-based committees have been set up to monitor implementation of the law.⁷³ The NUEW has also represented the GoSE at meetings of CEDAW and the Childs Rights Commission, where progress reports were presented.

The NUEW relies on income from its overseas members to fund professional training centres in rural areas, where courses, including weaving and computer skills, are offered to women.⁷⁴ Other programmes and initiatives run by the NUEW include legal counselling and education, adult literacy programmes and advocating for improvements in women's health and human rights. In their 2014 report, the NUEW described the challenges the organisation faces, citing two of the major ones to be human-resource limitations and disinterest from those in government.⁷⁵

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Image page 40:

Matej Hudovernik (2012) *DAHLAK ISLANDS, ERITREA – DEC 8: Afar women selling necklaces on Dessie island, part of the Dahlak archipelago in Eritrea, Dec 8, 2012, Zula, Eritrea*. Used under licence from Shutterstock.com. Stock photo ID: 124473091.

Image page 43:

David Stanley (2012) *A small store in the old city of Massawa, Eritrea*. Available at <https://flic.kr/p/dZzYPE>. CCL: <https://creativecommons.org/licenses/by/2.0/>.

The History of FGM in Eritrea

All of the WHO-classified types of FGM are practised in Eritrea, and the country has historically had one of the highest rates of practice in the world.¹ Traditional medical practitioners in Eritrea widely use FGM (alongside uvulectomy, milk-tooth extraction, cupping and bleeding) in their practice. One study found that 20.4% of traditional medical practitioners perform FGM.²

During the 1980's and Eritrea's conflict with Ethiopia, the **NUEW** highlighted the health dangers of FGM and embarked on social mobilisation and sensitisation programmes against its continuance across the country.

Anti-FGM committees were set up in each of the six zobas to promote an anti-FGM strategy and draft and implement action plans for sensitisation programmes in villages. The NUEW acted as secretariat to these anti-FGM committees, and the Ministry of Health (*MoH*) provided technical expertise. For example, the MoH developed the film *Behind the Curtains of Agony*, which was used in the campaign.³ In 1996 it issued guidelines on the provision of treatment and counselling, and the rehabilitation of women who had undergone FGM. The MoH also sponsored a 'safe motherhood' workshop, which included discussion on the negative health-impacts of FGM, and worked with UNICEF and UNFPA to develop campaigns against the practice at national and local levels.⁴

In 2007 FGM was **formally banned** by the GoSE and made a criminal offence.⁵

From January 2008 to June 2010, the GoSE ran a community-level elimination project called **Vision Eritrea**, which was universally applied, but with a greater emphasis in Semenawi Keih Bahri. The project included local authorities and schoolteachers, who attended special events to change their thinking about FGM. The **Reproductive Health Plus Project** was also implemented with the goal of stopping harmful traditional practices, including FGM. A major part of this was an awareness-raising campaign aimed at teachers and students. Comparative surveys reportedly 'clearly indicated a significant change in the practice of FGM, which decreased among 5-10-year-old girls from 73% in 2007 to 35% in 2010.'⁶

According to the Fifth Periodic Report submitted by the GoSE to the CEDAW, 144 perpetrators were taken to court over the four-year period 2007-2011. However, there is no reference in the report as to how many of these **prosecutions** were successful or what sentences were handed down.⁷

Presenting the Fourth and Fifth Periodic Reports to CEDAW in 2015, the president of the NUEW reported that the prevalence of FGM had declined to 12% among girls under five and 33% among girls under 15. These figures were questioned by the CEDAW Panel of Experts, as UNICEF had reported Eritrea as having, at 89%, one of the highest **prevalences of FGM** in the world, which suggested a discrepancy between the two sets of data. Responding, the NUEW's president maintained that the data presented in the EPHS 2010 was yet to be shared with UNICEF, and that UNICEF and the WHO were 'incorrect to list Eritrea as having such high rates.'⁸

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FGM: National and Regional Statistics and Trends

This section gives a broad picture of the current state of FGM in Eritrea. Other sections of this report give more detailed analyses of FGM prevalence set within anthropological and sociological frameworks, and of efforts towards its abandonment. For example, an analysis of the relationship between FGM and education may be found in the Education section.

None of the recent country-wide surveys for Eritrea break down the prevalence of FGM according to respondents' **ethnicity** or **religion**, and there is no evidence from other sources to inform these criteria.

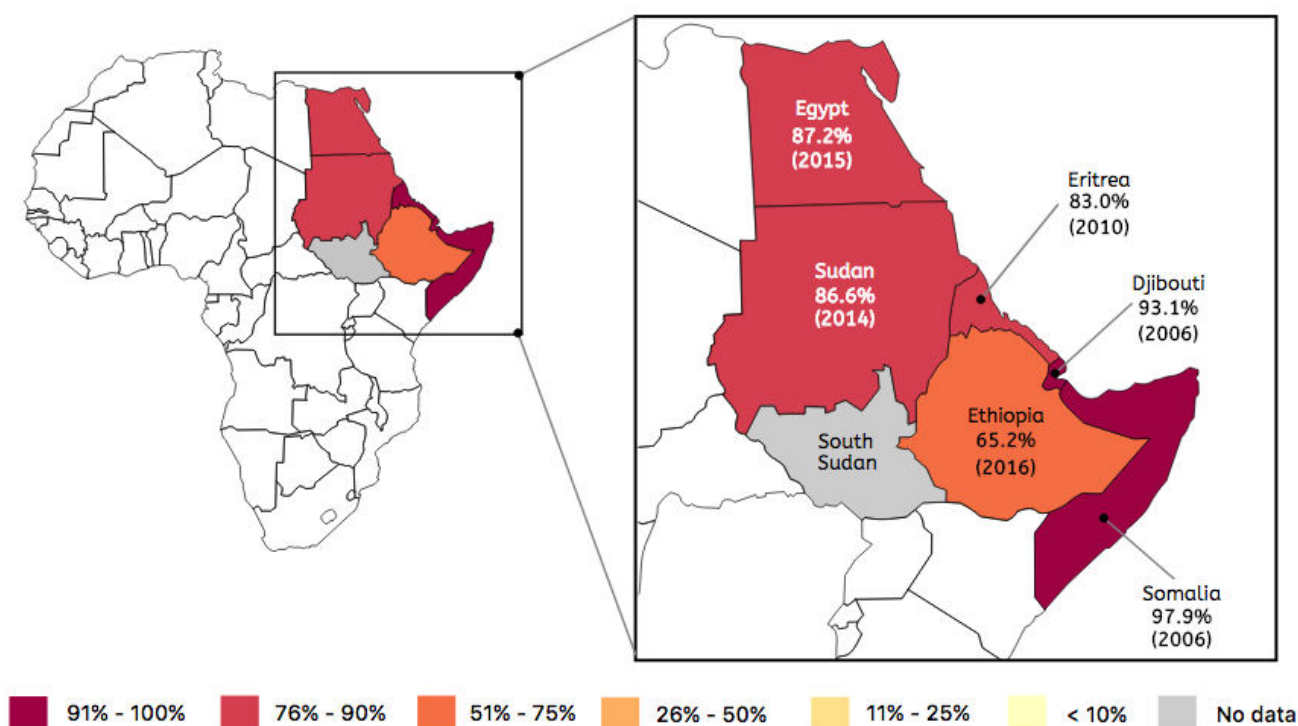


Figure 3: Prevalence of FGM in north-east Africa¹ (@28 Too Many)
Please note that the dates of these figures vary from 2006 to 2016

Based on the DHS survey in 2002, which reported the **prevalence of FGM in Eritrea** (for women aged 15-49) as 88.7% (the fifth-highest in the world), UNICEF in 2013 classified Eritrea as a **'very high prevalence country'**.² However, in its report to the CEDAW in 2014, the NUEW, representing itself and the GoSE, said this did not reflect the more recent position.³

In the later EPHS 2010, **83% of women** (aged 15-49) reported that they had undergone FGM, and 44.1% reported that at least one of their daughters had undergone the practice.⁴ NUEW maintained that this indicated a **decline of approximately 12% in overall prevalence since 1995**, when the DHS reported prevalence at 94.5%.

Among the EPHS 2010 sample of women aged 45-49, prevalence was 93.1%, compared to 68.8% among women aged 15-19, further indicating a decline in the practice (Figure 4).

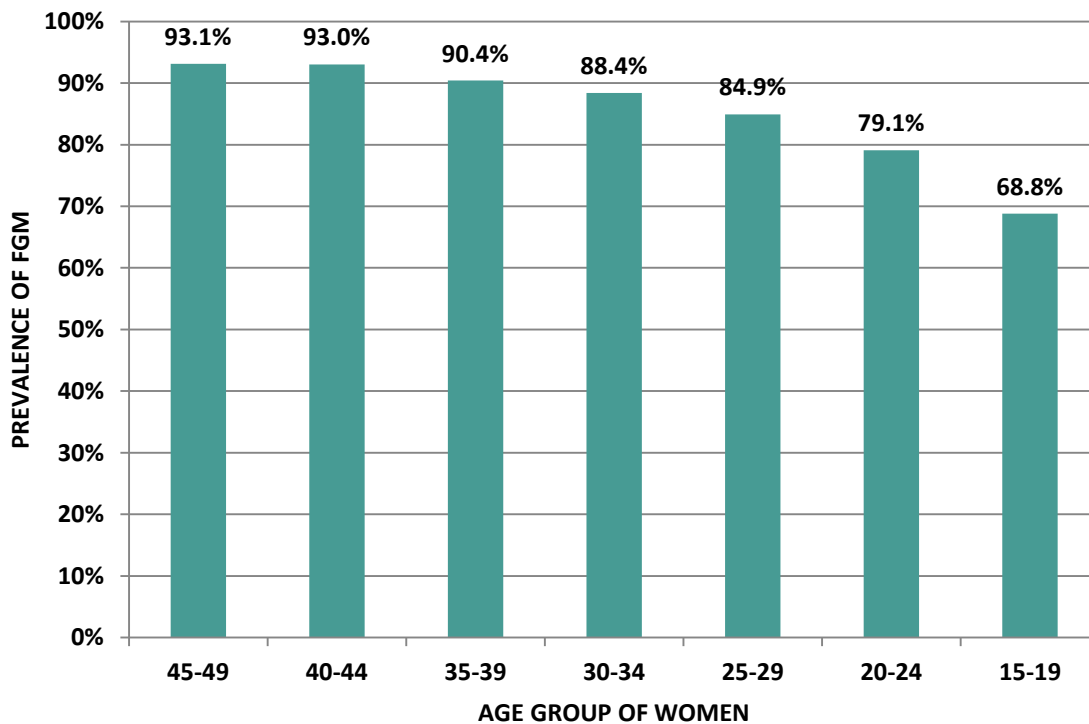


Figure 4: Prevalence of FGM in women aged 15-49, broken down by age-group⁵

44.1% of women (aged 15-49 and with a living daughter) have at least one daughter who has undergone FGM. This indicates a 19-percentage-point decline since 1995. 33.2% of daughters under the age of 15 have been cut.⁶

UNICEF, in their Annual Report 2014 on their work in Eritrea, noted that a mapping of 112 randomly selected communities across the country indicated an FGM prevalence of 7% among girls under five years of age, compared to 12% in 2010, also suggesting a drop in the incidences of FGM.⁷

Of note is the **prevalence of FGM in daughters when viewed according to their mother's age**. The available data suggests a trend towards lower prevalence in daughters of younger women.⁸ However, as sample sizes were quite small for some of the age groups, and as it is probable that younger mothers will have younger daughters and, therefore, there is a high probability that their daughters will still be cut at a later date, future data would be useful to corroborate this.

Prevalence of FGM According to Place of Residence

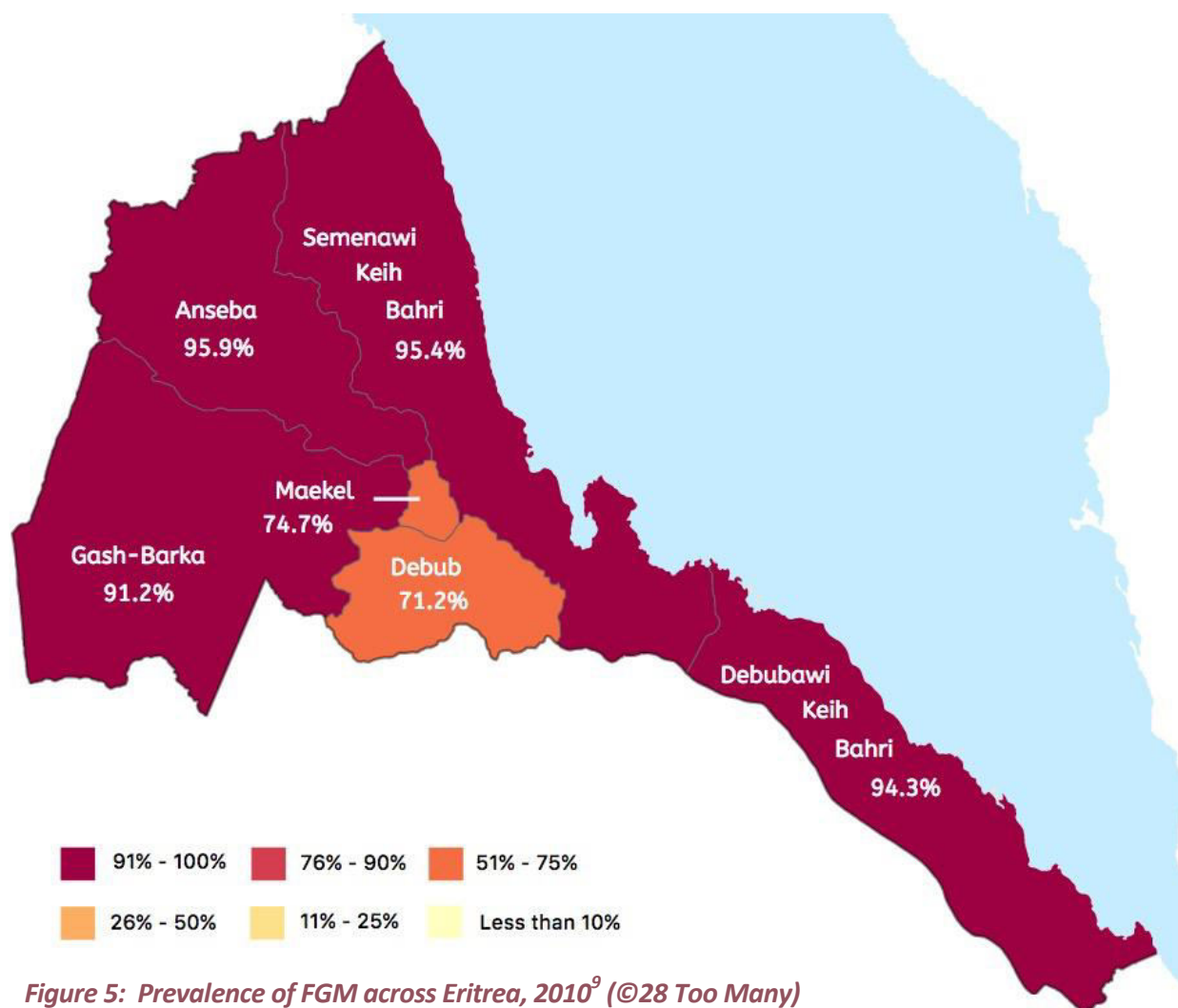


Figure 5: Prevalence of FGM across Eritrea, 2010⁹ (@28 Too Many)

There is some variation in the **prevalence of FGM in different areas of residence**: in 2010, prevalence was 73.6% among women aged 15-49 and living in the capital Asmara (located in the south of Maekel), but for women living in other towns and rural areas it was 85.4% and 85% respectively.¹⁰

It is often expected that FGM will be more prevalent in rural areas, where community ties and traditions are stronger and social norms more influential. In Eritrea, however, the main difference in prevalence appears to be between Asmara and the rest of the country (including other urban areas), rather than there being a clear divide between rural and urban areas.

Although for older women the possibility of migration between rural and urban areas must be taken into account, a comparison of the DHS 2002 and EPHS 2010 figures suggests there has been a greater decline in FGM being carried out on women living in Asmara than for those living in other urban areas and in rural areas.

In Asmara, prevalence fell by nearly 18 percentage points from 91.2% in 1995 to 73.6% in 2010. There was a smaller decrease of about 10 percentage points between 1995 and 2010 in both rural areas (from 95.3% to 85%) and in other towns (from 95.8% to 85.4%).

Area of Residence	DHS 1995 ¹¹	DHS 2002 ¹²	EPHS 2010 ¹³
Asmara (capital)	91.2%	83.4%	73.6%
Other town	95.8%	89.4%	85.4%
Total urban	92.9%	86.4%	80.0%
Rural	95.3%	90.5%	85.0%
COUNTRY-WIDE	94.5%	88.7%	83.0%

Table 2: Prevalence of FGM (women aged 15-49) 1995-2010, according to place of residence

Eritrea is divided into **six regions, or zobas** (see figure 5). In the zoba of Anseba, where FGM is most prevalent, 95.9% of women aged 15-49 have been cut. In Debub, where FGM is least prevalent, 71.2% of women aged 15-49 have been cut. In neighbouring Maekel, which borders Anseba and Debub and in which Asmara is located, FGM prevalence is 74.7%, while in all three of the other zobas, it is over 90% (although it should be noted that the number of women surveyed in Debubawi Kei Bahri was small compared to the number surveyed in the other five zobas).¹⁴

However, figures for prevalence according to women's current place of residence may not be a telling factor, as a woman may have moved since undergoing FGM, particularly if she was cut at a young age. For this reason it is more helpful to look at **prevalence among girls according to their place of residence**, which is shown in Table 3 below. Again, the prevalence of FGM in Asmara is much lower, at 17.2%, than in other towns (29.4%) and rural areas (36.8%).

Area of Residence	EPHS 2010
Asmara (capital)	17.2%
Other town	29.4%
Total urban	25.2%
Rural	36.8%
COUNTRY-WIDE	33.2%

Table 3: Prevalence of FGM in girls under the age of 15 (2010), according to place of residence¹⁵

Prevalence of FGM According to Economic Status

84.7% of households in Asmara fall into the highest wealth quintile, compared to 30.4% in other towns and 1.8% in rural areas.¹⁶ This may explain why the prevalence of FGM in Asmara is lower than elsewhere in the country, as the results of the EPHS 2010 survey show that the prevalence of FGM is inversely correlated to women's level of wealth.

Overall, three-quarters (75.2%) of women aged 15-49 who are in the highest wealth quintile undergo FGM, compared to 89.4% of those in the lowest quintile.¹⁷ 21.5% of girls under the age of 15 whose mothers are in the highest wealth quintile are reported to have undergone FGM, compared to 40.8% of those whose mothers are in the lowest wealth quintile.¹⁸

Daughters of women in the highest wealth quintile are more than twice as likely to undergo FGM during the first year of their life (89% of most-recently-cut daughters) than daughters

of women in the lowest wealth quintile (41.3%), for whom the age of cutting is distributed more evenly up to the age of eight.¹⁹

Although the overall prevalence of FGM has lowered across the last decade, the gap in experience of FGM between the daughters of rich and poor mothers has widened slightly. In 2002, 71% of women in the lowest wealth quintile and 53.6% of women in the highest wealth quintile had at least one daughter who had undergone FGM.²⁰ In 2010, 55.9% of women in the lowest wealth quintile and 32.4% of women in the highest wealth quintile had at least one daughter who had undergone FGM, widening the gap by about six percentage points.²¹

Prevalence of FGM According to Ethnicity

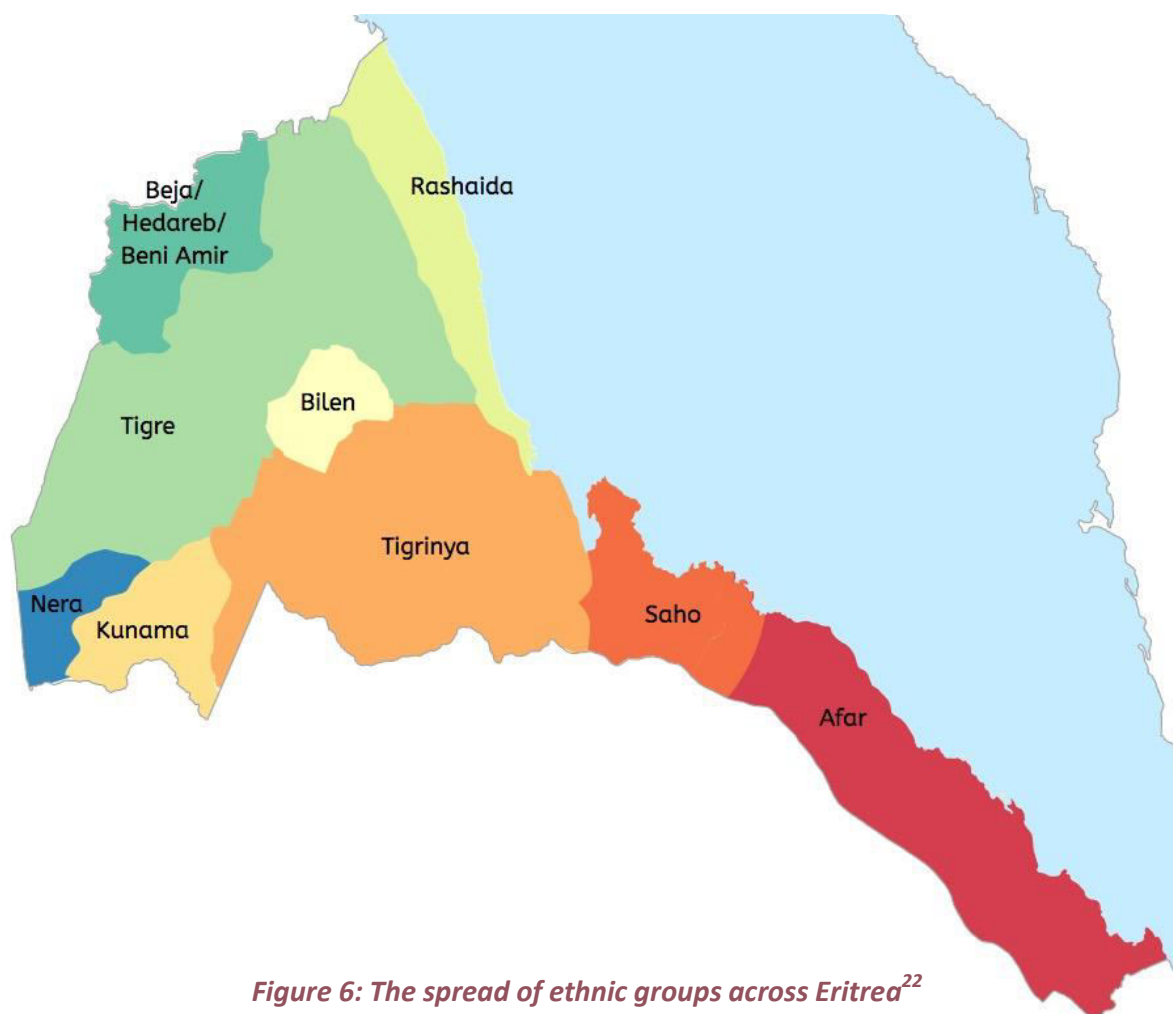


Figure 6: The spread of ethnic groups across Eritrea²²

There are no publicly available, country-wide surveys for Eritrea that show the prevalence of FGM according to respondents' ethnicity. However, Figure 6 shows the spread of the main ethnic groups across the country.

The breakdown of Eritrea's ethnic groups is as follows:

- Tigrinya – 55%,
- Tigre – 30%
- Saho – 4%
- Kunama – 2%
- Rashaida – 2%
- Bilen – 2%
- Other (Afar, Beja/Hedareb/Beni Amir, Nera) – 5%.²³

ETHNIC GROUPS

The population of Eritrea is comprised of nine ethnic groups, which are broadly profiled below, residing in six zobas.

- **Afar**
Traditional culture: pastoral; strong clan-based communities
Habitation: areas of southern Red Sea
Primary religion(s): Islam
- **Bilen**
Traditional culture: farming; societal structure based on kinship
Habitation: Keren and surrounding areas
Primary religion(s): Christianity and Islam
- **Beja/Hedareb/Beni Amir**
Traditional culture: semi-nomadic pastoralists, especially breeding camels and cattle
Habitation: the western lowlands
- **Kunama**
Traditional culture: Nilotic; renowned dancers; matrilineal
Habitation: mainly in villages between the Gash River and Barentu
Primary religion: Christianity and Islam, but some traditionalism
They 'face severe discrimination for allegedly collaborating with Ethiopia in the 1990s.'²⁴
- **Nera**
Habitation: east of the Gash River
Primary religion: Islam
- **Rashaida/Rashida**
Traditional culture: Arabian, nomadic
Habitation: northern Red Sea coast
Primary religion: Islam
- **Saho**
Traditional culture: farmers and bee-keepers
Habitation: south-eastern slopes of highlands to coastal plains south of Massawa
Primary religion: Christianity and Islam
- **Tigre**
Traditional culture: nomadic, Arabian; do not attend hospitals
Habitation: majority of north, north-east and west
Primary religion: Christianity and Islam
Societal structure: strong oral-literary history
- **Tigrinya/Tigrina/Biher-Tigrinya**
Traditional culture: farmers
Habitation: highlands
Primary religion: Coptic Christianity, Catholicism and Protestantism; Islamic minority

For certain ethnic groups, FGM forms part of a rite of passage. According to Akinboyo and Negesh²⁵, a party is attended by friends and family members 'to acknowledge and celebrate the fact that they have met their traditional and religious obligations.' Akinboyo and Negesh²⁶ also note that, in these groups, 'Women who let their daughters undergo FGM/C are seen as "wise women" who help to preserve their culture [and] maintain their family heritage.'

Age of Cutting

Girls in Eritrea are most likely to undergo FGM in their first five years. In 2010, 58.6% of women reported they had experienced FGM before they were five and 14.6% reported they were older (26.9% of women either did not know when they had been cut or did not respond to the question).²⁷

There are differences in the **age of cutting according to a woman's place of residence**: women in Asmara are more likely to have had FGM before the age of one compared to other areas, and more women are cut after the age of five in rural areas compared with Asmara and other towns:

Area of Residence	% Cut In First Year	% Cut Before Age 5	% Cut After Age 5
Asmara (capital)	62.3%	65%	2.2%
Other town	48.7%	59.6%	11.9%
Total urban	54.3%	61.8%	7.8%
Rural	42.8%	51.2%	18.8%
COUNTRY-WIDE	47.4%	58.6%	14.6%

Table 4: Age of cutting for Eritrean women aged 15-19, according to area of residence²⁸

In five zobas, between 7% and 16% of women experienced FGM before they were eight days old, but in Debubawi Keih Bahri that figure is 49.4%. However, as the number of women surveyed in Debubawi Keih Bahri was relatively low, this figure may not give an accurate indication of the real practices in that zoba. In three zobas (Semenawi Keih Bahri, Anseba and Gash-Barka), approximately a quarter of women underwent FGM after the age of five. By comparison, in Asmara, only 2.2% underwent FGM after the age of five.²⁹

A 2012 report notes that there is a general belief in Eritrea that the younger a girl undergoes FGM, the more readily she will heal. Many mothers therefore 'take it as an [obligation] to conduct FGM/C on their daughters at a young age.'³⁰

Types of FGM Practised and Practitioners

According to slightly outdated data, one-third of women who have been cut have undergone Type III (infibulation), including more than 90% of women from the Hedariib, Nara, Tigre, Bilen and Afar ethnic groups. At the other extreme, only 1% of the Tigrigna have experienced Type III. Geographically, the practice of Type III is most common in Semenawi Keih Bahri, Anseba and Gash Barka. It is least common in the central highlands (Maekel and Debub) and 'almost non-existent' in the southern and central parts of Eritrea.³¹

Respondents to the EPHS 2010 were not asked what type of FGM they had experienced. For the DHS 2002, however, women who had undergone FGM were asked about type and whether they had experienced any problems as a result of FGM. 38.6% of women aged 15-49 reported that they were 'sewn closed' (Type III), 4.1% had had 'flesh removed' and 46% had been 'nicked, no flesh removed' (11.3% did not know).³²

Of those who had been sewn closed (Type III) and had had a sexual relationship, 14.6% said they had experienced problems during sexual relations; of those who had undergone

FGM and had given birth, 21.7% had problems during childbirth. 9.4% had problems during both activities.³³

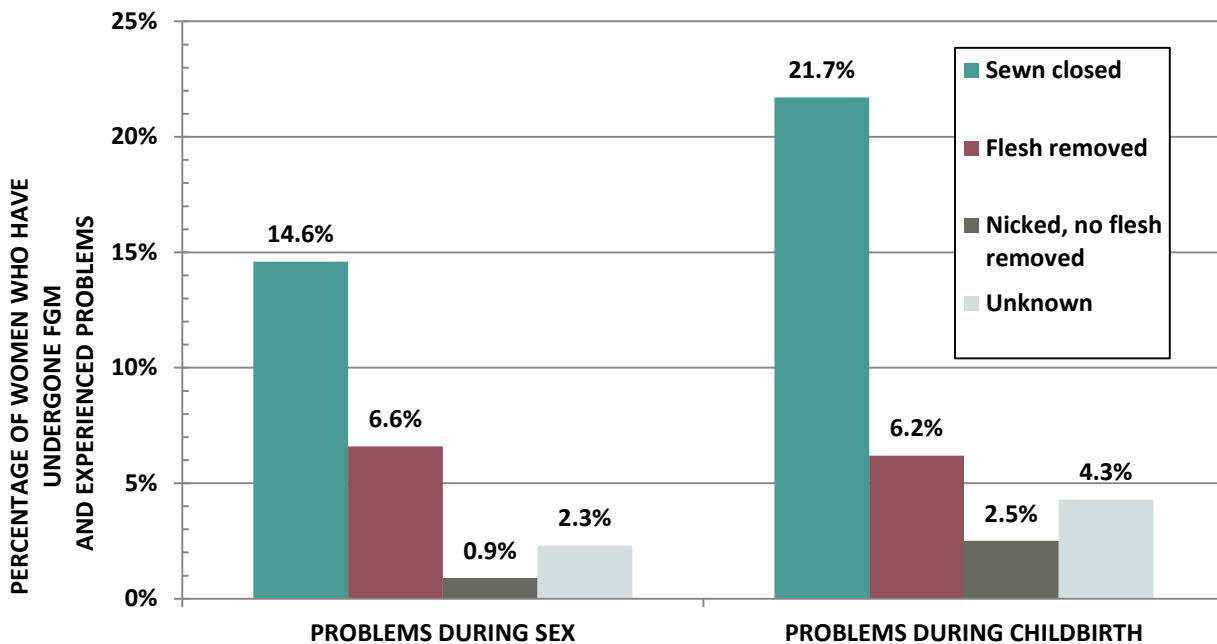


Figure 7: Percentage of women who have undergone FGM (by type) and had problems having sexual relations or giving birth³⁴

In 2010 FGM was most commonly reported to have been performed on women aged 15-49 by a traditional ‘circumciser’ (80.3%). The use of a traditional ‘circumciser’ was most frequent among women with ‘no’ education and those in the lowest three wealth quintiles, although frequency is above 75% for all quintiles and levels of education. The frequency of performance by all other types of practitioner given (doctor, trained nurse/midwife, traditional birth attendant) was low³⁵; however, 20.4% of traditional medical practitioners perform FGM.³⁶ The figures for women’s most-recently-cut daughters are very similar: traditional ‘circumciser’ – 92.3%, traditional birth attendant – 6.0%, doctor – 0.06% and trained nurse/midwife – 0.03%.

The use of medical professionals (doctors and midwives) to undertake FGM on women’s most-recently-cut daughters was recorded at only 0.1%.³⁷ **The medicalisation of FGM**, therefore, does not appear to be taking place on such a large scale in Eritrea as in other countries in the region, such as Egypt.

Again, Asmara stands out in comparison to the rest of the country, having the lowest percentage for performance of FGM by a traditional ‘circumciser’ (74.8%). It should be noted, however, that 15.4% of all women, but 21.3% of women in Asmara, either did not know who performed their FGM or would not say, and this may account for the variation.³⁸ Traditional ‘circumcisers’ performed 97.7% of cases of FGM on the most-recently-cut daughters of women who live in Asmara.³⁹

For detailed information about the medicalisation of FGM, please see 28 Too Many’s report, which is available at <http://28toomany.org/fgm-research/medicalisation-fgm/>.

- 1 **Click for source document:** Djibouti: MICS 2007; Egypt: EHIS 2015; Eritrea: EPHS 2010; Ethiopia: DHS 2016; Somalia: MICS 2006; Sudan: MICS 2014.
- 2 UNICEF (2013) *FGM: A statistical overview and exploration of the dynamics of change*, opening pages and pp26-27. Available at http://data.unicef.org/wp-content/uploads/2015/12/FGMC_Lo_res_Final_26.pdf.
- 3 United Nations Human Rights (2015) *Committee on the Elimination of Discrimination against Women considers the reports of Eritrea* [UN Response to CEDAW's Consideration of Fourth and Fifth Periodic Reports of Eritrea], p.11. Available at https://reliefweb.int/sites/reliefweb.int/files/resources/CEDAW_Eritrea_260215.pdf.
- 4 EPHS 2010, pp.347 & 353.
- 5 EPHS 2010, p.347.
- 6 EPHS 2010, p.353.
- 7 UNICEF (2014) *Annual Report 2014: Eritrea*, p.1. Available at https://www.unicef.org/about/annualreport/files/Eritrea_Annual_Report_2014.pdf.
- 8 EPHS 2010, p.353.
- 9 EPHS 2010, p.347.
- 10 EPHS 2010, p.347.
- 11 DHS 1995, p.166.
- 12 DHS 2002, p.198.
- 13 EPHS 2010, p.347.
- 14 EPHS 2010, p.347.
- 15 EPHS 2010, p.353.
- 16 EPHS 2010, p.40.
- 17 EPHS 2010, p.347.
- 18 EPHS 2010, p.353.
- 19 EPHS 2001, p.355.
- 20 DHS 2002, p.202.
- 21 EPHS 2010, p.353.
- 22 Tron9698 (2012) *Ethno-Demographic map of the State of Eritrea*. Available at https://commons.wikimedia.org/wiki/File:Ethno-Demography_of_Eritrea.png.
- 23 Central Intelligence Agency (2017) *The World Factbook: Eritrea, 15 June* (2010 estimate). Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/er.html>.
- 24 Freedom House (2016) *Freedom in the World 2016: Eritrea*. Available at <https://freedomhouse.org/report/freedom-world/2016/eritrea>.
- 25 - Eritrea – Ministry of Information (2014) 'Eritrea's 9 Ethnic Groups', *Shabait.com*. Available at <http://www.shabait.com/about-eritrea/erina/16508-eritreas-9-ethnic-groups>.
- worldatlas (2017) *Major Ethnic Groups of Eritrea*. Available at <http://www.worldatlas.com/articles/major-ethnic-groups-of-eritrea.html>.
- 26 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, pp.22-23. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.
- 27 EPHS 2010, p.350.
- 28 EPHS 2010, p.350.
- 29 EPHS 2010, p.350.
- 30 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, p.21. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.
- 31 - US Department of State (2001) *Eritrea: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10097.htm>.
- G. Akinboyo and R. Negash, *op. cit.*, pp.27 and 28.
- 32 DHS 2002, p.198.
- 33 DHS 2002, p.215.
- 34 EPHS 2010, p.352.
- 35 EPHS 2010, p.352.
- 36 GebreMichael Kibreab Habtom (2015) 'Integrating traditional medical practice with primary healthcare system in Eritrea', p.79, *Journal of Complementary and Integrative Medicine* 12(1), pp.78-87. Available at <https://www.degruyter.com/view/j/jcim.2015.12.issue-1/jcim-2014-0020/jcim-2014-0020.xml>.
- 37 EPHS 2010, pp.352 & 356.
- 38 EPHS 2010, p.352.
- 39 EPHS 2010, p.356.

Case Study: A Collective Approach

It has been suggested that one of the reasons for the reduction in FGM prevalence in Eritrea is the holistic approach taken in the anti-FGM campaign, called in the Tigrinya language *Habarawi* ('collective').

The Habarawi methodology simultaneously includes levels of society 'from the Government to religious leaders, youth and women's organizations, community leaders, former circumcisers and victims. Each sector actively played a role in building this consensus.'¹ It is aimed at improving the health and well-being of Eritrean women by changing social norms, behaviour and attitudes towards women.

Since independence, the Habarawi system has been translated into a set of policies, programmes and strategies that support a community approach to ending FGM known as *Hamadea*.² An intersectoral approach brought together various ministries to implement Hamadea, notably Health, Education, Justice and Information. They partnered with organisations such as the WHO, UNICEF and the UNFPA and brought in civil society representation through the NUEW and the NUEYS. Each of these partners brought to the table their areas of expertise and resource; for example, the Ministry of Information used state channels for delivering key messages, the NUEYS set up anti-FGM clubs, the NUEW established mapping projects to monitor declarations of abandonment of FGM, while the UN agencies provided financial support for these joint efforts.³

Regional **anti-FGM committees** in each zoba were set up, which included representatives of the various partners, to discuss challenges and ways forward in each area. Partners worked together to develop shared strategies to get the message down to village level. Examples of these include creating attractive events such as dramas and a mobile video unit to involve and mobilise communities, looking at alternative livelihoods for cutters, designing promotional materials and using both traditional and social media for communicating the anti-FGM message.⁴

The Habarawi approach includes men and boys as well as women and girls and is based on a mobilisation of whole communities, bringing in religious leaders, traditional cutters, anti-FGM activists, local teachers and health workers, parents and children. Ministries have run training courses for health workers and law-enforcement officials at all levels to ensure that all government employees understand the policies, laws and health consequences surrounding FGM.

Religious leaders have been reached through workshops and conferences, during which discussions were held about the dangers of FGM and how abandonment does not need to offend religious sensibilities. The NUEW has used the **village-level** entry point achieved by Hamadea to pass on other messages to women and girls about their rights and harmful traditional practices (forced and child marriage, workers' rights and girls' access to education). Similarly, the NUEYS has been able to take down to village level messages about the issues young people face, setting up youth clubs and encouraging them to take part in the development of policies that will benefit them.⁵



The Habarawi approach aims to involve all aspects of society and government

In 2012 a **joint study** was carried out by the MoH, the NUEW and UNICEF into the effectiveness of the Habarawi approach. The resulting report is entitled *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*. This study looked at the challenges and achievements of the approach. On the positive side, it notes that the number of village anti-FGM committees grew from 426 in 2007 to 2,745 in 2010, and the School Sara clubs (set up by the NUEYS) increased from 46 to 300 in the same period. The study concluded the Habarawi, community-based approach was the most effective mechanism for information dissemination and networking and that the steady involvement of the youth and women's associations, as well as religious leaders, facilitated a smooth diffusion of the new legal norms at the grassroots level.⁶

However, it was noted that there were **challenges in implementation**. In particular, the programme had been uneven across zobas, largely due to transport and infrastructure problems in reaching remote locations and the lack of access to electricity for getting across messages. The study reported that certain methods had been used to overcome these problems, including the use of camels and donkeys for reaching remote areas and batteries for videos and other electronic media.⁷

Another problem has been the variable prioritising of the programme by some of the participant ministries, which had limited resources and other programmes to achieve such as improved water and sanitation, immunisation and other health targets.

National **mapping, monitoring and evaluation** systems were established from 2010, focusing on highlighting the factors that had most contributed to the declining trend in public support for the practice (from 56.8% in 1995 to 48.8% in 2002 and 12.2% in 2010⁸).⁹

The study cites the following **reasons for the success** of the Habarawi strategy in contributing to the lower prevalence of FGM reported in the EPHS 2010:

- 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 [*sic*] strong political will and also provided a framework or 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 [*sic*] local media in local languages and their distribution to remote rural areas.¹⁰

The results of the Habarawi approach are being further documented for dissemination to other countries.¹¹

1 - UNICEF (2013) *Eritrea: Country Programme Document 2013-2016*, p.7. Available at https://www.unicef.org/eritrea/ECO_resources_CountryProgramme2013_2016.pdf.

- UNICEF (undated) *Eritrea: Female Genital Mutilation/Cutting*. Available at https://www.unicef.org/eritrea/protection_16761.html.

2 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, p.17. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.

3 *Ibid.*, p.14.

4 *Ibid.*, p.9.

5 *Ibid.*, p. 40.

6 *Ibid.*, p.47.

7 *Ibid.*, p.49.

8 - DHS 1995, p.171.

- DHS 2002, p.207.

- EPHS 2010, p.364.

9 Akinboyo and Negash, *op. cit.*, p.53.

10 *Ibid.*, p.58.

11 UNICEF (2013), *op. cit.*

Image page 62:

David Stanley (2012) *A minaret rises above the marketplace in Dekemhare, Eritrea*. Available at <https://flic.kr/p/dHZt5R>. CCL: <https://creativecommons.org/licenses/by/2.0/>.

The Sustainable Development Goals

The eradication of FGM was pertinent to six of the UN's eight **Millennium Development Goals (MDGs)**, which reached their deadline in 2015. In September 2015 the UN adopted the **Sustainable Development Goals (SDGs)**, which replaced the MDGs and have a deadline for achievement of 2030. The 17 SDGs focus on five 'areas of critical importance for humanity and the planet' – **people, planet, prosperity, peace and partnership**.¹



Figure 8: The Sustainable Development Goals

A document entitled *Transforming our World: the 2030 Agenda for Sustainable Development*², details the SDGs and states that they

seek to build on the Millennium Development Goals and complete what these did not achieve. **They seek to realise the human rights of all and to achieve gender equality and the empowerment of all women and girls.**

Eritrea has reportedly made significant progress in terms of the MDGs related to healthcare. It has signed up to the SDGs and is working on various programmes in collaboration with the UNDP, focusing particularly on strengthening its agricultural, pastoral and fishing capacities.³

The SDGs go further than the MDGs and **make explicit reference to the elimination of FGM**. This will strengthen the hands of governments, NGOs and multi-lateral organisations when implementing anti-FGM policies and legislation.



Sustainable Development Goal 5: Achieve gender equality and empower all women and girls

Goal 5.3 Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation.

Other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, particularly those related to education, health and gender equality, such as **Goals 3 and 4**.

In addition to the SDGs, the African Union has declared the years 2010 to 2020 to be the **African Women's Decade**.⁴ This declaration will assist in promoting gender equality and the eradication of FGM and other forms of GBV in Eritrea.

Please see our **Global Goals** document for a summary of all 17 SDGs.

1 UN Department of Economic and Social Affairs (2015) *Transforming our world: the 2030 Agenda for Sustainable Development*. Available at <https://sustainabledevelopment.un.org/post2015/transformingourworld>.

2 *Ibid.*

3 United Nations Development Programme (2014) *The United Nations Development Programme in Eritrea: People-Centre Development*. Available at https://www.scribd.com/document/255646637/The-United-Nations-Development-Programme-in-Eritrea?ad_group=157739&campaign=VigLink&content=27795&irgwc=1&keyword=ft500noi&medium=affiliate&source=impactradius.

4 African Union (2011) *The African Women's Decade*, p.2. Available at <http://pages.au.int/carmma/documents/african-womens-decade>.

Understanding and Attitudes

A widespread, correct understanding of FGM is a prerequisite to changing attitudes; thus, exposure to accurate information is essential.

Knowledge of FGM

The DHS 2002 and the EPHS 2010 collected information from Eritrean men and women aged 15 to 49 on their knowledge of FGM, attitudes towards it and level of support for the practice.

Both surveys found that **knowledge of FGM** among women aged 15-49 is almost universal at 99.2%.¹ In the EPHS 2010², despite the prevalence of FGM being slightly higher in rural areas than in urban areas, knowledge of FGM was found to be slightly lower among women who live in rural areas (98.9%) than among women who live in urban areas (99.5%). Women who are wealthier and better educated are more likely to know of the practice, although the differences in levels of knowledge are minor.

Since the law against FGM was introduced in 2007, the GoSE, through the NUEW, has undertaken a range of anti-FGM campaigns across the country. 58.9% of women reported that they **knew of activities against FGM operating in their area**. Awareness of these activities was lowest (at 41.1%) among women living in Maekel, in which the capital, Asmara, is located, and greatest among women living in Anseba (85.2%). 37.2% of women living in Asmara itself knew of activities in their area.³

90.9% of women and 83.1% of men have **heard of the law against FGM**. Those who are wealthier and more highly educated are more likely to have heard of it, although, again, the differences in level of knowledge are relatively minor. Women who live in Gash-Barka and men who live in Gash-Barka, Debubawi Keih Bahri and Debub are far less likely to have heard of the law than those living in other zobas, and people living in rural areas are less likely to have heard of it than people living in urban areas.⁴ This suggests that there is more awareness-raising work to be done in those areas.



The prevalence of FGM has decreased more slowly in rural areas than in Asmara and other urban areas

Reasons for Practising FGM and Its Perceived Benefits

In Eritrea, 77.2% of women and 83.8% of men aged 15-49 who have heard of FGM believe that it has **no benefits** for a girl.⁵ For women, this is a significant increase from the DHS 2002, in which only 29.1% stated that FGM has no benefits for a girl.⁶

Women in the youngest age-group, 15-19, are far more likely (84%) to believe that FGM has no benefits for a girl than women in the oldest age-group, 45-49 (64.3%).

91.8% of **women** with a secondary or higher education perceive no benefits of FGM for a girl, compared to 61.7% with 'no education', indicating the influence education can have on the future abandonment of the practice. 63.9% of women in the poorest wealth quintile perceive no benefits for a girl, compared to 88.5% of the wealthiest women.⁷

The same holds true for **men**: 90.2% of those with a secondary or higher education and 66.5% of those with 'no education' believe that there are no benefits for a girl; 90.8% of the wealthiest men and 74.9% of the poorest men saw no benefits in the practice. It is interesting to note that, overall, a slightly higher proportion of men (83.8%) than women (77.2%) saw no benefits in it for girls.⁸

The EPHS 2010 asked women aged 15-49 who have at least one daughter who has *not* undergone FGM **the reason she has not** been subjected to the practice. 66.9% stated that it was because FGM is against the law.⁹ The percentage distribution of all reasons given is shown in Figure 9.

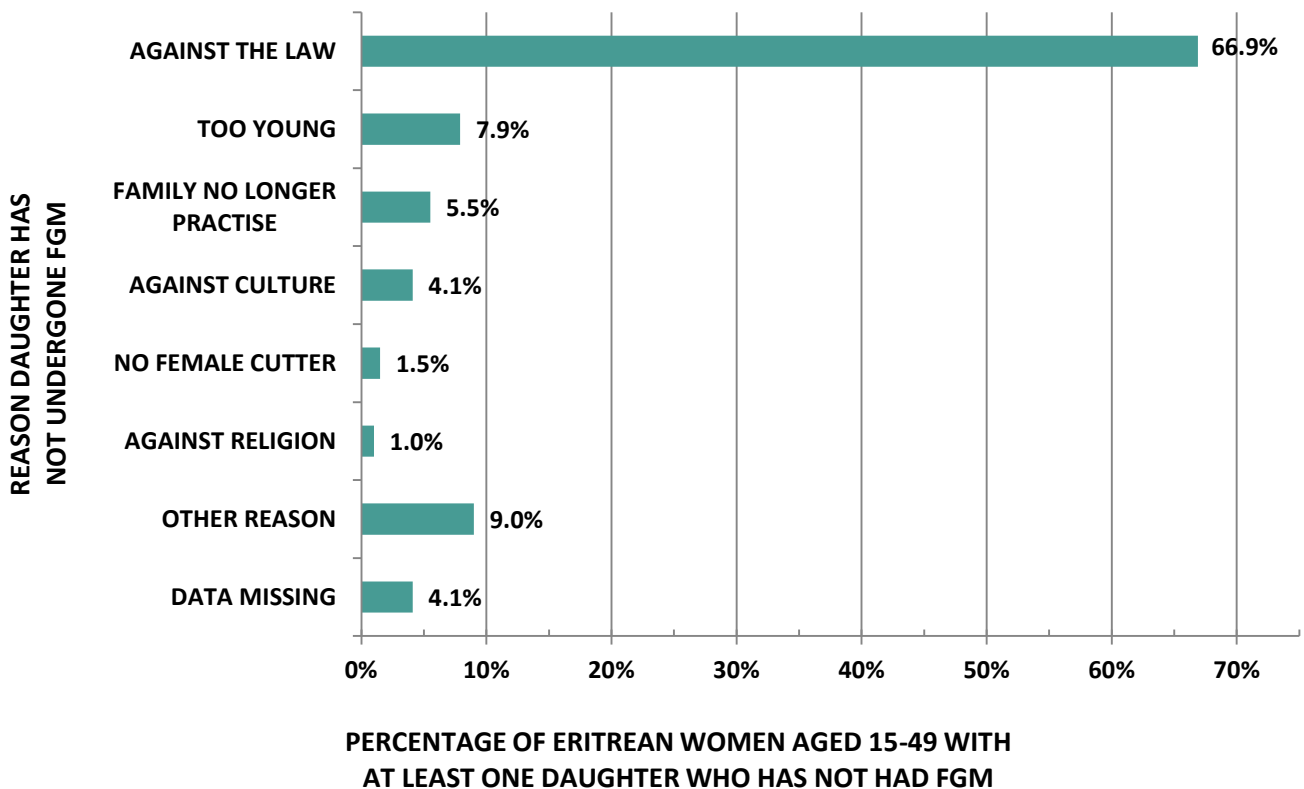


Figure 9: Percentage distribution of women aged 15-49 with at least one daughter who has not undergone FGM, by reason given for not cutting¹⁰

Traditionally, Eritreans have felt that FGM keeps a girl from promiscuity, helps her gain social acceptance and keeps her ‘pure and clean’.¹¹ A 2001 report by the US Department of State’s Office of the Senior Coordinator for International Women’s Issues notes,

*The high prevalence is also due to family and social pressures. Grandmothers are a particular source of pressure for continuing the practice. . . . In some cases in which a child’s parents have refused to submit their daughter to it, the grandmother has had it done against the parents’ wishes.*¹²

Both the DHS 2002 and the EPHS 2010 asked women aged 15-49 who had heard of FGM and believed it to be beneficial what **specific benefits** they perceived in it. The EPHS 2010 asked men the same question. Table 5 below sets out their responses.

PERCEIVED BENEFIT OF FGM FOR A GIRL	DHS 2002 WOMEN ¹³	EPHS 2010 WOMEN ¹⁴	EPHS 2010 MEN ¹⁵
No benefit	29.1%	77.2%	83.8%
Social acceptance	42.2%	10.1%	5.4%
Better marriage prospects	24.5%	2.7%	1.0%
Preserves virginity/ prevents pre-marital sex	4.3%	6.3%	7.7%
Cleanliness/hygiene	13.1%	5.7%	1.9%
Religious approval	17.6%	1.1%	0.6%
Other	3.3%	4.8%	2.2%

Table 5: For Eritrean men and women aged 15-49 who have heard of FGM, perceived benefits for a girl, 2002 and 2010

Community/Social Acceptance/Tradition

In the DHS 2002, ‘**social acceptance**’ was perceived as the most important benefit of FGM for girls, by 42.2% of women aged 15-49 who have heard of FGM. ‘**Better marriage prospects**’ was the second-most cited, by 24.5%, and is closely tied to social acceptability.¹⁶

However, the EPHS 2010 reports that, while ‘social acceptance’ remained the perceived benefit most-commonly cited by women, the percentage has dropped to 10.1% (varying from 6.1% in the 15-19 age-group to 15.6% in the 45-49 age-group). The decrease is balanced by an increase in the percentage of women who now say that FGM has no benefits, which has risen from 29.1% to 77.2%.¹⁷

Fidelity/Virginity and Marriage Prospects

While the perceived benefit of FGM for a girl most regularly cited by women aged 15-49 is ‘social acceptance’, for men in the same age-range, ‘**preserves virginity/prevents pre-marital sex**’ (7.7%) is ahead of ‘social acceptance’ (5.4%). However, ‘social acceptance’ is

the most-commonly cited benefit by men who have 'no education' or are in the lowest wealth quintile.¹⁸

For women, 'better marriage prospects' is the second-most-commonly cited benefit of FGM for a girl in the 2002 survey (24.5%), but in the 2010 survey the second-most-commonly cited is 'preserves virginity/prevents pre-marital sex' (6.3%). Again, 'preserves virginity/prevents pre-marital sex' is the most-commonly cited benefit by women who are better educated.

Overall, 10.1% of women aged 15-49 who have heard of FGM state that it **prevents premarital sex**, 77.7% stated that it does not, and 11.9% do not know.¹⁹

These figures indicate that there is some need for factual **teaching on sex and FGM** in higher education.

This need is further demonstrated in the results of a 2015 study on **traditional medical practitioners** in Eritrea. Traditional medical practitioners were found to practise FGM, uvulectomy, milk tooth extraction and bleeding techniques. One female practitioner stated that 'being uncircumcised is unthinkable' because 'one would itch' and 'run after men all the time.' In the view of the traditional medical practitioners who practise it, FGM 'reduces sexual madness for women and this would make women more faithful to their husbands.'²⁰

Religious Requirement

An analysis of FGM in Eritrea prepared for the Ministry of Information, the NUEW and UNICEF claims that 'Many Eritreans are under the impression that the Bible and Koran call for female circumcision', but points out that 'neither of the scriptures make mention of FGM/C, let alone require it.'²¹

Despite this, only 1.1% of women and 0.6% of men aged 15-49 who have heard of FGM cited '**religious approval**' as a benefit of it for a girl.²²

1% of women aged 15-49 with at least one daughter who has not undergone FGM said that this was because FGM was *against* their religion.²³

Support for FGM

The EPHS 2010 reports that opinions in relation to FGM among Eritreans are divided as follows:

	Women	Men
FGM should continue	12.2%	10.0%
FGM should <i>not</i> continue	82.2%	84.9%

Table 6: Percentages of Eritrean men and women aged 15-49 who believe FGM should be continued or discontinued²⁴

The belief that FGM should not be continued is directly correlated with men and women's levels of wealth and education.²⁵

Public support for FGM has declined significantly over the past two decades:

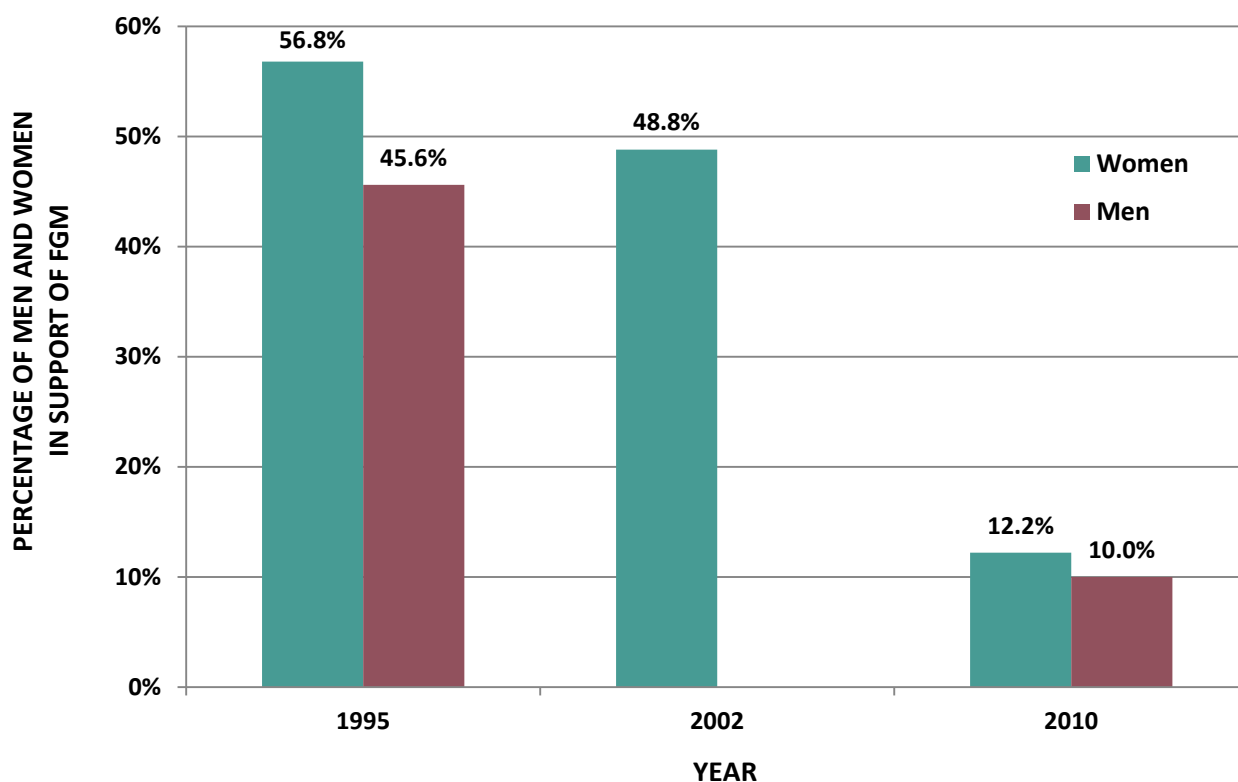


Figure 10: Percentages of Eritrean men and women who support the continuation of FGM, by year (data for men not collected in 2002)²⁶

Significantly, although the majority of respondents see no benefits in FGM for a girl, very few women report having heard **objections** to their daughters undergoing it – only 5% of women (aged 15-49) who have at least one daughter with FGM heard an objection from anyone at all, 2.8% had their husband object and 1.8% objected to it themselves.²⁷

This indicates a need for further research into why objections to FGM are not being voiced when support for the practice has declined and respondents are increasingly recognising that there are no benefits to the practice.

There may be a need for education in communities on how to speak up to one's friends and family members about one's objections to FGM.

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- 1 - DHS 2002, p.198.
- EPHS 2010, p.347.
 - 2 EPHS 2010, p.347.
 - 3 EPHS 2010, p.347.
 - 4 EPHS 2010, pp.347 & 351.
 - 5 EPHS 2010, pp.360-361.
 - 6 DHS 2002, p.210.
 - 7 EPHS 2010, p.360.
 - 8 EPHS 2010, pp.360-361.
 - 9 EPHS 2010, p.358.
 - 10 EPHS 2010, p.358.
 - 11 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, pp.12 & 21. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.
 - 12 US Department of State (2001) *Eritrea: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10097.htm>.
 - 13 DHS 2002, p.210.
 - 14 EPHS 2010, p.360.
 - 15 EPHS 2010, p.361.
 - 16 - DHS 2002, p.210.
- EPHS 2010, p.360.
 - 17 - DHS 2002, p. 210.
- EPHS 2010, p.360.
 - 18 EPHS 2010, pp.360-361.
 - 19 - DHS 2002, p.210.
- EPHS 2010, p.360.
 - 20 GebreMichael Kibreab Habtom (2015) 'Integrating traditional medical practice with primary healthcare system in Eritrea', p.79, *Journal of Complementary and Integrative Medicine* 12(1), pp.78-87. Available at <https://www.degruyter.com/view/j/jcim.2015.12.issue-1/jcim-2014-0020/jcim-2014-0020.xml>.
 - 21 Akinboyo and Negash, *op. cit.*, p.22.
 - 22 EPHS 2010, pp.360-361.
 - 23 EPHS 2010, p.358.
 - 24 EPHS 2010, pp.364 and 364.
 - 25 EPHS 2010, pp.364 and 365.
 - 26 - DHS 1995, p.172.
- DHS 2002, p.207.
- EPHS 2010, pp.364 and 365.
 - 27 EPHS 2010 p.357.

Image page 66:

Matej Hudovernik (undated) *Traditional hut in the village of Halib Mentel in Eritrea*. Used under licence from Shutterstock.com. Stock photo ID: 124473055.

Media

By giving voice and visibility to all people – including and especially the poor, the marginalized and members of minorities – the media can help remedy the inequalities, the corruption, the ethnic tensions and the human rights abuses that form the root causes of so many conflicts.

~ Former UN Secretary General, Kofi Annan¹

Press Freedom

Reporters Without Borders ranks Eritrea **179th out of 180 countries** in its **2017 World Press Freedom Index**.² It was ranked last from 2007 to 2016. The organisation has labelled the situation in Eritrea 'scandalous'.³

The first signs of **restriction of press freedom** came in 1996, when The 1996 Press Proclamation Law was passed, requiring all **journalists and publications** to be licensed and all publications to be approved by the GoSE prior to release.⁴ Then, in 2001, the GoSE shut down all the remaining independent media outlets and arrested the country's most prominent independent journalists, including a party known as the G-15 group, which consisted of journalists and government officials who had published open letters challenging the GoSE to implement the Constitution and hold elections. Later, the editors of the independent newspapers that had been shut down were also arrested.⁵ Since then, state journalists have also been arrested on unknown charges and held indefinitely; for example, in 2009, educational station Radio Bana was raided and 40 reporters and workers arrested, some of whom were held until 2015.⁶

NGO ARTICLE 19 made the following statement at the 35th Session of the UN Human Rights Council:

ARTICLE 19 estimates that a total of 69 journalists have been arbitrarily arrested and detained for exercising their right to freedom of expression since 2001, without charge or fair trial. While at least eight journalists are thought to have died in detention, a wall of silence means it is impossible to know how many others remain in prison, where they are, and what their condition is.⁷

The international media has dubbed Eritrea 'the North Korea of Africa'⁸, but Eritreans are less likely to have a **telephone** than North Koreans⁹ and the country is ranked by the Committee to Protect Journalists as the most **censored** country in the world¹⁰.

In response to labels such as 'the North Korea of Africa' and the 'hermit kingdom', sociologist Dr Fikrejesus Amahazion wrote an article in which he disputed 'hasty comparisons' and 'clichéd, cursory, and incorrect' statements about the country, citing visitors such as Norway's Minister of Justice, who said, '[T]hose who compare Eritrea with North Korea have not been to North Korea and certainly do not know Eritrea.'

Dr Amahazion rightly points out that a large percentage of Eritrean homes have satellite dishes, and improvements to the speed of the internet are hindered by the cost of the necessary infrastructure.¹¹

However, it should be noted that, although the Ministry of Information's Media & Communication page claims that 'Eritrea's main objectives in this field are to: develop free, responsible and credible mass media; to promote the democratization process and strengthen national unity . . . [and] to enhance public debate and discussion'¹², President Afwerki notably said in 2014, 'Those who think there will be democracy in this country can think so in another world.'¹³

Major Media Outlets in Eritrea

Eritrea is the only country in Africa without any privately owned news-media outlets. The state-owned **Eritrean News Agency distributes information** to television, radio and newspapers for publication.

The country has two **television stations**, EriTV, which broadcasts programmes in six languages 24 hours a day, and The Channel II, which broadcasts for seven hours a day, mostly education programmes, but also some sports and music.

There are three main **radio** networks, two of which are run by Voice of the Broad Masses of Eritrea (*Dimtsi Hafash*), and the other being Radio Zara.

Although it has been frequently jammed¹⁴, the **only independent source of news** is a radio station called **Radio Erena**. The station is based in Paris and run by a former Eritrean television presenter who is now a political refugee. It broadcasts via satellite, internet and mobile-phone app in Tigrinya and Arabic, for two hours a day.¹⁵

The three main **newspapers** published by the Ministry of Information are *Tigrinya Hadas Eritrea*, the Arabic *Eritrea Alhadisa* and the *Eritrea Profile*, which is in English. Since 2013, attempts at circulating an underground newspaper called *MeqaleH Forto* ('Echoes of Forto') have also been made.

Online, Eritrea has two **news websites**: the Ministry of Information's Shabait.com and Erina, which is also state-run.¹⁶

Unusually, considering the political climate, a satirical website, **The Awaze Tribune**, was launched in 2016 – the first of its kind in Eritrea, although it is largely run by Eritreans living outside the country. A spokesman from the website said:

*We get a lot of death threats. We're doing something that runs counter to the Eritrean culture of dignity . . . The Eritrean tale is a tale of struggle and pain. We just inject some comedy into it.*¹⁷

Access to Media

Traditional Media: Television, Newspapers and Radio

The EPHS 2010¹⁸ reports that television and radio are the **most popular** traditional mediums. 30.1% of women and 47.6% of men (aged 15-49) watch television at least once a week; 30.5% of women and 47.3% of men listen to the radio at least once a week (see Figure 11).

Exposure to these forms of media generally increases according to levels of wealth and education, and older women are far less likely to access any form of media than younger women.

There is a considerable division between the percentage of Eritreans who live in urban areas and have access to media and those who live in rural areas. For example, the percentage of women who access all three traditional media at least once a week is 17.2% for those who live in urban areas and only 1.9% for those who live in rural areas. As radio is overwhelmingly the most widely used medium in rural areas, it could be used effectively to spread information on FGM, particularly to very remote communities.

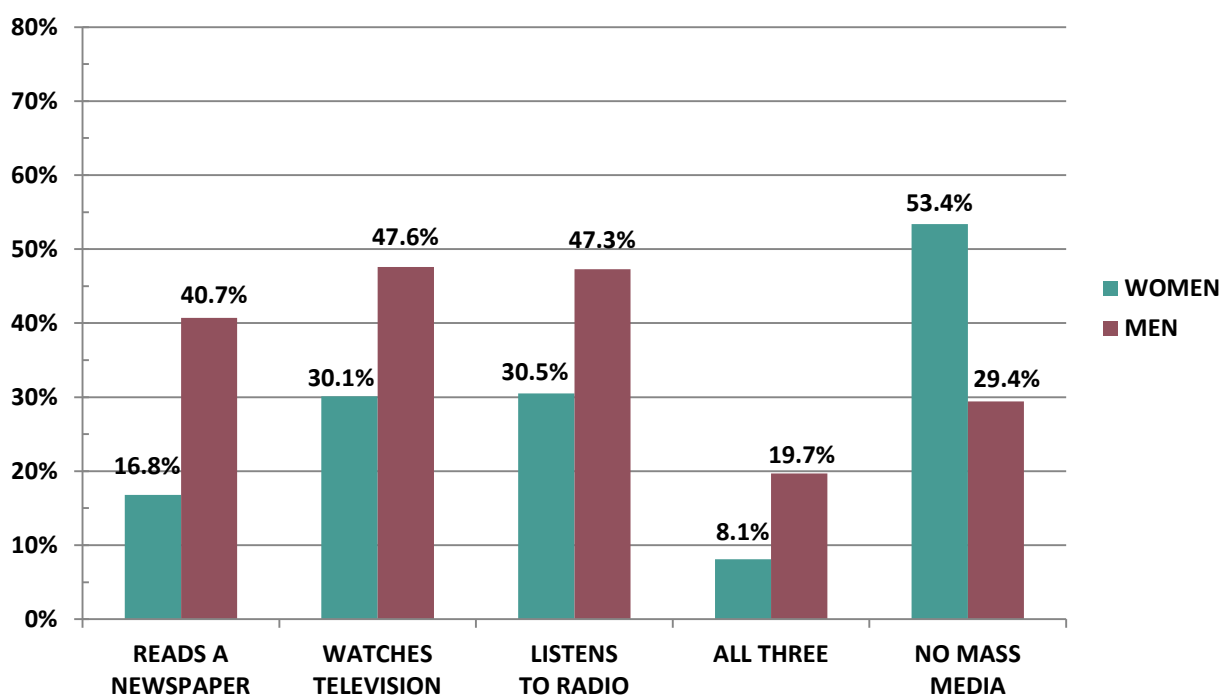


Figure 11: Percentages of Eritrean men and women aged 15-49 who access certain media at least once a week¹⁹

Except for television, women's exposure to traditional media has decreased considerably since 2002 (see Figure 12). This suggests that television programming is and will likely remain **the most effective means of spreading information about FGM** through traditional media, particularly to women who live in urban areas.

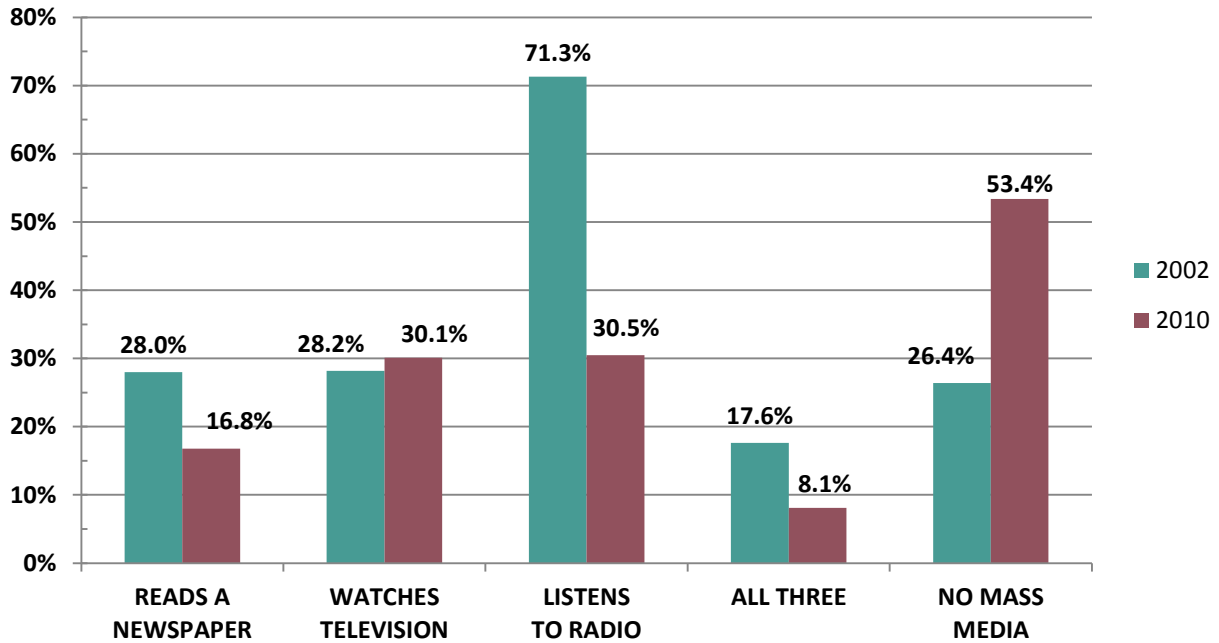


Figure 12: Percentages of Eritrean women aged 15-49 who access certain media at least once a week – comparison between 2002 and 2010²⁰

The Internet and Social Media

Again, there are divisions in the numbers of urban and rural households that possess a **computer** or **mobile phone** (see Figure 13).²¹

Eritrea is the least **internet**-connected country in the world and was the last African country to provide access to its citizens.

Less than 1.5% of the population have access (the UN International Telecommunication Union put that figure at fewer than 1% in 2016²²).²³ In 2011 the Government rescinded plans to introduce mobile internet, and a slow, dial-up connection is the only option available.²⁴ Internet cafés are now required to register customers before they may go online.²⁵ 63,000 Eritreans (about 1.1% of the population) were subscribed to **Facebook** as of March 2017.²⁶

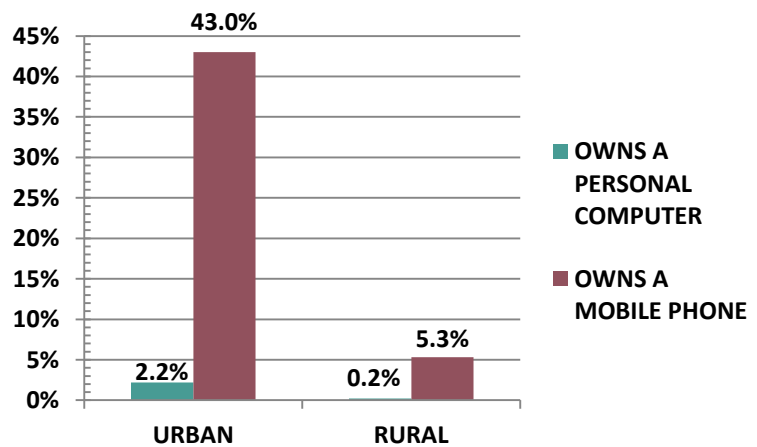


Figure 13: Urban/rural divide between percentages of Eritrean households that possess a personal computer/mobile phone²⁷

The Media and FGM

As part of its campaign to eradicate FGM, the NUEW showed a **film**, *Behind the Curtains of Agony*, which contained hard-hitting footage of girls undergoing Type III FGM. This reportedly had a 'dramatic effect in villages propagating attitude and behavior change' and was instrumental in putting through the anti-FGM legislation.²⁸ Videos of religious leaders have also been effective in sparking discussions in villages and communities. The videos show senior religious leaders and are thought to have been instrumental in changing Eritrean's attitudes towards and understanding of FGM.²⁹ The GoSE reports that about 60 movies are produced annually in Eritrea, most of which 'reflect contemporary social life, true stories of struggle for independence and other affairs that concern the society.'³⁰ This young film industry would seemingly create a major opportunity to open up discussion about FGM.

Other **visual media** that have been produced include the UNFPA's short video, *Communities Against Female Genital Mutilation: Eritrea* (<https://youtu.be/5TyPryWZ4F0>) and a documentary made for Al Jazeera by Swedish-Eritrean journalist Fatma Naib (directed by Lynn Ferguson) called *The Cut: Exploring FGM* (https://youtu.be/TWlzaD4-_y4).

The Sara Communication Initiative has been described as a 'multimedia tool for social change', due to its use of theatre, music, traditional skits, poetry and visual arts to reach and educate students about FGM and HIV/AIDs. Mrs Abubeker, a mature student and an active member of the Sara Club in her school, writes poetry and recently won an award for one of her poems.

When I go out and read my poems and participate in girls' education and FGM drama as a member of these clubs, I feel empowered in spite of all my difficulties. I know that I am doing the right thing. . . Thanks to the Sara Club, I am able to share my story with many who are suffering and do not know how to change their fate.

~ Mrs Meriem Abubeker³¹

NATIONAL UNION OF ERITREAN YOUTH AND STUDENTS (NUEYS)

From the 1950s to the early 1990s young Eritreans demonstrated in favour of independence. In 1994 the NUEYS was officially formed as a non-governmental youth and students' organisation. The aim was to contribute to a post-independence society that supported the 'well-balanced development' of young people by sharing information, educating and providing services in relation to issues that affect their lives. Its values include a commitment to the total well-being of young people, respect for human dignity and the pursuit of equitable and non-discriminatory development of young women and men.³²

The NUEYS has been particularly active in providing information and services related to HIV/AIDS and sexual-health issues, working in partnership with government-sector ministries, the UN and the NUEW. It has established centres across the country, in all zobas, providing counselling, condoms, reproductive-health services and peer education through outreach programmes to schools and communities and among youth soldiers at the SAWA military training camp. Music and drama are among the methods used to pass on information about sexual-health issues, including FGM.³³

The NUEYS has also been active in promoting the education of girls and illiterate adults, setting up programmes in the late 1990s that were subsequently taken over by the Ministry of Education. During the early 2000s, the organisation ran a programme specifically targeted at eradicating FGM by running community-awareness campaigns, training youth/peer educators and establishing anti-FGM clubs in high schools. According to the UN web page about the NUEYS during the decade 1995-2004, nearly 10,000 girls took part in these and other education activities, and over sixteen thousand young people were trained as peer educators.³⁴

During that decade the NUEYS ran a gender programme aimed at 'empower[ing] young women by increasing awareness of gender-based violence and rights of women in families and society at large.' Activities included an anti-FGM sensitisation programme using a rights-based approach. In addition to the anti-FGM clubs that were set up, over 1,000 girls were trained as peer educators in FGM.³⁵

The NUEYS' work has continued along these lines to date. According to their website (<http://www.nueys.org/>), they have organised concerts with famous stars singing against FGM (for example, Tiken Jah Fakoly in 2012).³⁶

Other activities of the NUEYS have focused on environmental issues and vocational skills training. The NUEYS has also been responsible, along with NUEW, for presenting reports on behalf of the GoSE to CEDAW and the Convention for the Rights of the Child. The NUEYS works closely with the GoSE and its sector ministries to deliver services and information. In the absence of any other NGOs in Eritrea (all others having been required to leave in 2011) it also works with the UN agencies (i.e. UNICEF, the UNFPA and the WHO) that have been able to remain in Eritrea, subject to their working only in the areas permitted by the GoSE. The NUEYS is identified as a key player in the MoH's Communication Strategy for Eliminating FGM/C in Eritrea (December 2012).

- 1 Kofi Annan cited in Adelakun Lateef Adekunle (2014) 'Finding Justification for the Practice of Peace Journalism: A Public Assessment of Media Roles towards Peace Promotion in Nigeria', *Journal of Mass Communication & Journalism*, 4(5), p.195. Available at <http://www.omicsgroup.org/journals/finding-justifications-for-the-practice-of-peace-journalism-a-public-assessment-of-media-roles-towards-peace-promotion-in-nigeria-2165-7912.1000193.pdf>.
- 2 Reporters Without Borders (2017) 'Eritrea', *World Press Freedom Index*. Available at <https://rsf.org/en/eritrea>.
- 3 BBC News (2014) *Eritrea profile – Media*, 3 December. Available at <http://www.bbc.com/news/world-africa-13349077>.
- 4 Conor Gafrey (2017) 'Africa's North Korea: Reporting from Eritrea, the Land of No Journalists', *Newsweek*, 12 June. Available at <http://www.newsweek.com/eritrea-north-korea-press-freedom-isaias-afwerki-623641>.
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- 6 Anna Sutterer (2017) 'Project Exile: Eritrean State Media Reporter Turns Critic', *Global Journalist*, 2 February. Available at <http://globaljournalist.org/2017/02/project-exile-exiled-eritrean-state-media-reporter-turns-critic/>.
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- 8 - Claire Groden (2015) 'These countries have the world's worst internet access', *Fortune International*, 6 October. Available at <http://fortune.com/2015/10/06/worst-internet-access>.
- Conor Gafrey, *op. cit.*
- 9 Claire Groden, *op. cit.*
- 10 Committee to Protect Journalists (2015) *10 Most Censored Countries*. Available at <https://cpj.org/2015/04/10-most-censored-countries.php>.
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- 12 Ministry of Information (undated) 'Media & Communication', *Embassy of the State of Eritrea*. Available at <http://eritrean-embassy.se/press-release/media>.
- 13 Isaias Afwerki cited in Reporters Without Borders (2017) *Eritrea*. Available at <https://rsf.org/en/eritrea>.
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- 15 Reporters Without Borders (2017) *Radio – last bulwark of media freedom and independence*, 13 February, updated 14 February. Available at <https://rsf.org/en/news/radio-last-bulwark-media-freedom-and-independence>.
- 16 - BBC News (2014) *Eritrea profile – Media*. Available at <http://www.bbc.com/news/world-africa-13349077>.
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- 17 Isaac G. (2017) 'The website daring to mock the Eritrean regime', *The Observers*, 1 March. Available at <http://observers.france24.com/en/20170103-awaze-tribune-parody-site-mock-eritrea-regime>.
- 18 EPHS 2010, pp.51-52.
- 19 EPHS 2010, pp.51-52.
- 20 - EPHS 2010, p.51.
- DHS 2002, p.41.
- 21 EPHS 2010, p.39.
- 22 UN International Telecommunication Union cited in Shabait.com (2016) 'Eritrea: Unexpected Eritrean Journalistic Voice Rises in Ethiopia', *All Africa*, 6 October. Available at <http://allafrica.com/stories/201612120729.html>.
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- Claire Groden, *op. cit.*
- 24 Shabait.com, *op. cit.*
- 25 ARTICLE 19, *op. cit.*
- 26 Miniwatts Marketing Group (2017) 'Internet Penetration in Africa', *Internet World Stats*. Available at <http://internetworldstats.com/stats1.htm>.
- 27 EPHS 2010, p.39.
- 28 Shabait.com (2016) *Combating FGM/C in Eritrea*, 16 March. Available at <http://www.shabait.com/categoryblog/21381-combating-fgmc-in-eritrea>.

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- 29 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, p.21. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.
- 30 Ministry of Information (2009) *Eritrea At A Glance IV*, *Shabait.com*. Available at <http://www.shabait.com/about-eritrea/eritrea-at-a-glance/1212-culture>.
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- 33 *Ibid.*, p.7.
- 34 *Ibid.*, pp.10 and 11.
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- 36 NUEYS Admin (2012) 'Press Release: Tiken Jah Fakoly in Eritrea', *NUEYS.ORG*, 11 January. Available at http://www.nueys.org/index.php?option=com_content&view=article&id=131:press-release-tiken-jah-fakoly-in-eritrea&catid=50:nueys-events&Itemid=2.

Religion

The **main religions practised in Eritrea** are Christianity (primarily Coptic) and Islam.

According to the US Department of State, statistics on the religious affiliations of Eritreans are unreliable.¹ However, the following table contains figures supplied by the Pew Research Center in 2009 and the US Department of State in 2011:

RELIGION	PERCENTAGE OF POPULATION (PEW RESEARCH CENTER, 2009) ²	PERCENTAGE OF POPULATION (US DEPARTMENT OF STATE, 2011) ³
Christianity	63%	50%
Islam	36%	48%
Other	1%	2%

Table 7: Reported percentage of Eritrean population that are Christian, Muslim or of another faith

The 1997 Constitution forbids **discrimination on religious grounds** at Article 14, Clause 2, and Article 19: 'Every person shall have the right to freedom of thoughts, conscience and belief' and 'the freedom to practice any religion and to manifest such practice'.⁴ In fact, **the GoSE only recognises** Sunni Islam, European Orthodox Christianity, Roman Catholicism and the Evangelical Lutheranism Church of Eritrea.

There are reports of persecution, detention and even torture of **people from other denominations** (such as Evangelicals and Pentecostals) **and faiths**. Jehovah's Witnesses, in particular, as a result of their conscientious objection to military service, are refused government jobs, business permits and ID cards, and their children are often unable to attend or graduate from school. Men and women are not permitted to practise a religion during their military service, even if he or she is a religious leader.⁵

Responding to a **UN Commission of Inquiry on Human Rights (UNCOI)** in Eritrea in 2015, the GoSE maintained that the country is a secular state. The UNCOI, however, found that even members of the officially recognised faiths believe they are under surveillance, as they are required to submit reports to the GoSE every six months and are not permitted to accept funds from foreign co-religionists. The GoSE has sought to appoint leaders, such as the Patriarch of the Eritrean Orthodox Church and the Mufti of the Eritrean Muslim community; many leading members of these two religious communities, and the laymen who supported them, are in prison.⁶

Although it is difficult to verify these reports, it is clear that **the clergy and ulama** are highly influential in the everyday lives of Eritreans, making it essential that they be involved in anti-FGM campaigns.⁷

Religion and FGM

The NUEW⁸ notes that many Eritreans believe that religious scripts require FGM, and that performing it 'ensures "Spiritual purity . . ."' However, FGM is not mentioned in any religious script, including the Bible or Quran, and in fact appears to predate both Islam and Christianity.

Nevertheless, these misunderstandings continue, as demonstrated in a film produced by the NUEW wherein a priest argues that FGM is consistent with Christianity and equates it with other non-harmful religious practices such as baptism.⁹

The NUEW also reports, '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.'¹⁰



The view that religious approval is a benefit of FGM for a girl appears to be dying out

The Eritrean DHS and EPHS surveys do not set out **the prevalence of FGM according to religion**. Religion is given, however, as one reason why FGM is practised.

In **the DHS 1995**, 'religious demand' is one of the least-commonly given reasons for favouring the continuation of FGM, but it is more likely to be given as a reason by people living in rural areas (18.3% of men and 13.4% of women aged 15-49) and those with 'no education' (19% of men and 13.3% of women aged 15-49).¹¹

The reasons most-commonly given for favouring its continuation are 'custom and tradition', 'good tradition', 'preservation of virginity/prevention of immorality' and 'cleanliness'.¹² Conversely, the reason most-commonly given for favouring the discontinuance of FGM is that it is a 'bad tradition'. Less than 10% of men and women said that it should be discontinued because it is *against* their religion.¹³

The DHS 1995 is the only survey to give any indication of a **variation in attitude to FGM according to religion**, stating:

Fulfilling a religion demand is cited by one-fifth of Muslims and 1 in 25 Christian women as a reason for supporting circumcision. In contrast, more than one quarter of Christian women compared with only 5 percent of Muslim women give preservation of virginity or prevention of immorality as a reason. Another difference by religion is in considering ‘cleanliness’ a reason for supporting continuation of circumcision. Christians are twice as likely as Muslims to cite cleanliness as a reason.¹⁴

The **DHS 2002** analyses perceptions of FGM in relation to religion more deeply, except that only women were surveyed. Overall, 60.1% of female respondents (aged 15-49) who have heard of FGM and were specifically asked whether FGM is required by their religion believed that it was. This belief is more common among older women (68.6% of those aged 45-49, compared to 53.4% of those aged 15-19), and those living in rural areas (66.8%, compared to 51.3% of women living in urban areas). The level of a woman’s education is the weightiest indicator: 70.1% of women with ‘no education’ believe it is a religious requirement, compared to 40.6% of those educated to secondary level or above. There is a similar variation according to wealth: 71.2% of women in the lowest wealth quintile believe it is a religious requirement, compared to 47% of those in the highest.

Levels of education and wealth, therefore, appear to be the best determinants in Eritrea of whether or not a woman believes FGM is a requirement of her religion.¹⁵

Where women were asked to list what **benefits of FGM they perceive for a girl**, the DHS 2002 and **EPHS 2010** surveys suggest that attitudes are changing. According to the EPHS 2010, 77.2% of women believe that there are no benefits of FGM for a girl, compared to 29.1% in 2002. Of the 22.8% who do report specific benefits, only 1.1% cite ‘religious approval’. Men’s views are also reported in the EPHS 2010, and, similarly, less than 1% cite ‘religious approval’.¹⁶

Perceived Benefit of FGM	DHS 2002 ¹⁷	EPHS 2010 ¹⁸
No benefit	29.1%	77.2%
Religious approval	17.6%	1.1%

Table 8: Comparison of 2002 and 2010 perceived benefits of FGM for a girl (as a percentage of women aged 15-49 who have heard of FGM)

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 - 18 EPHS 2010, p.360.

Image page 81:

Matej Hudovernik (undated) *The old city of Massawa in Eritrea*. Used under licence from Shutterstock.com. Stock photo ID: 124364065.

Education

The Eritrean **Constitution** (Article 21) states that 'every citizen shall have the right of equal access to publicly funded social services. The State shall endeavour, within the limit of its resources, to make available to all citizens health, education, cultural and other social services.'¹ Improving education forms a major part of Eritrea's strategy to reduce poverty and stimulate social and economic development.²

The Eritrean **education system** comprises two years of pre-school, elementary (grades one to five), middle school (grades six to eight) and secondary (grades nine to twelve).³ Elementary and secondary education, as well as vocational and technical training, is overseen by the Ministry of Education (*MoE*); tertiary and higher education by the National Commission for Higher Education.⁴

Education is compulsory between the ages of 6 and 13.⁵ Basic education is free in government schools.⁶

The GoSE is the largest education provider, operating over 90% of schools.⁷ The GoSE reports that, during the period 2008 to 2011, it consistently spent between 8% and 10% of its total national budget on education. External support from partners including the African Development Bank, UNICEF and the Islamic Development Bank provides an unquantified but probably significant contribution to the education sector.⁸

The existing types of non-government schools are:

- community schools administered by municipalities or local or foreign communities;
- Awkaf (Mahad) schools administered by Awkaf, an Islamic association; and
- mission schools administered by Coptic, Catholic or Protestant churches.⁹

Beyond or during secondary school, which is taught in English¹⁰, children can move to **Technical Vocational Education and Training (TVET)** courses. TVET programmes are intended to provide a skilled workforce capable of meeting the development needs of the agricultural, industrial, commercial, infrastructure and service sectors.¹¹

Founded in 1958, the University of Asmara was the only **higher-education** institution in Eritrea until 2004 when, in a move claimed to be decentralising higher education and improving regional access, the University was disbanded into seven separate colleges.¹²

This move has been perceived in some quarters to be a dismantling of the higher-education system. The new institutions were seen to 'primarily function as centres for military training and political indoctrination.'¹³ The new colleges are reportedly poorly equipped and many books from the research library of the University of Asmara were taken to a locked storage facility after its closure.¹⁴

Access to higher education is only permitted to those who have completed military service. All grade 12 students, some of whom are younger than 18, must enrol for **military service** at the SAWA Centre for Education and Training, where they complete the Eritrean High School Leaving Certificate.¹⁵ SAWA was established in 2003 in Gash-Barka, near the Sudanese border, and is variously reported to accommodate 20,000¹⁶ or 30,000¹⁷ residents.

Concerns have been raised over the ‘militarisation’ of the Eritrean education system and reports that students can be readily detained in facilities, both official and secret, for transgressions such as ‘suspected breaches of the school rules and regulations, for asking questions or for suspicions of wanting to leave the country.’¹⁸ In 2010, the MoE distributed a training manual entitled *Avoiding Corporal Punishment in Eritrean Schools*, to promote the abandonment of violent methods of discipline.¹⁹

Students, particularly girls, have also been recorded as intentionally dropping out of school, repeating classes or marrying early to avoid conscription.²⁰ State-sanctioned employment cannot be offered to those who do not hold a certificate of completion of national service, reducing the economic prospects of those, mostly women and girls, who do not obtain one. Children who are Jehovah’s Witnesses withdraw from school before grade nine and are often forced into hiding to avoid registering for military service, which would compromise their religious values.²¹

Literacy

According to the EPHS 2010, approximately 57% of the population is literate²², although the Central Intelligence Agency’s World Factbook puts that figure at 73.8%²³.

There is also marked geographic inequality, as 92.8% of the male and 80.8% of the female population of Asmara are literate, compared to only 53.0% of men and 39.2% of women resident in rural areas.²⁴

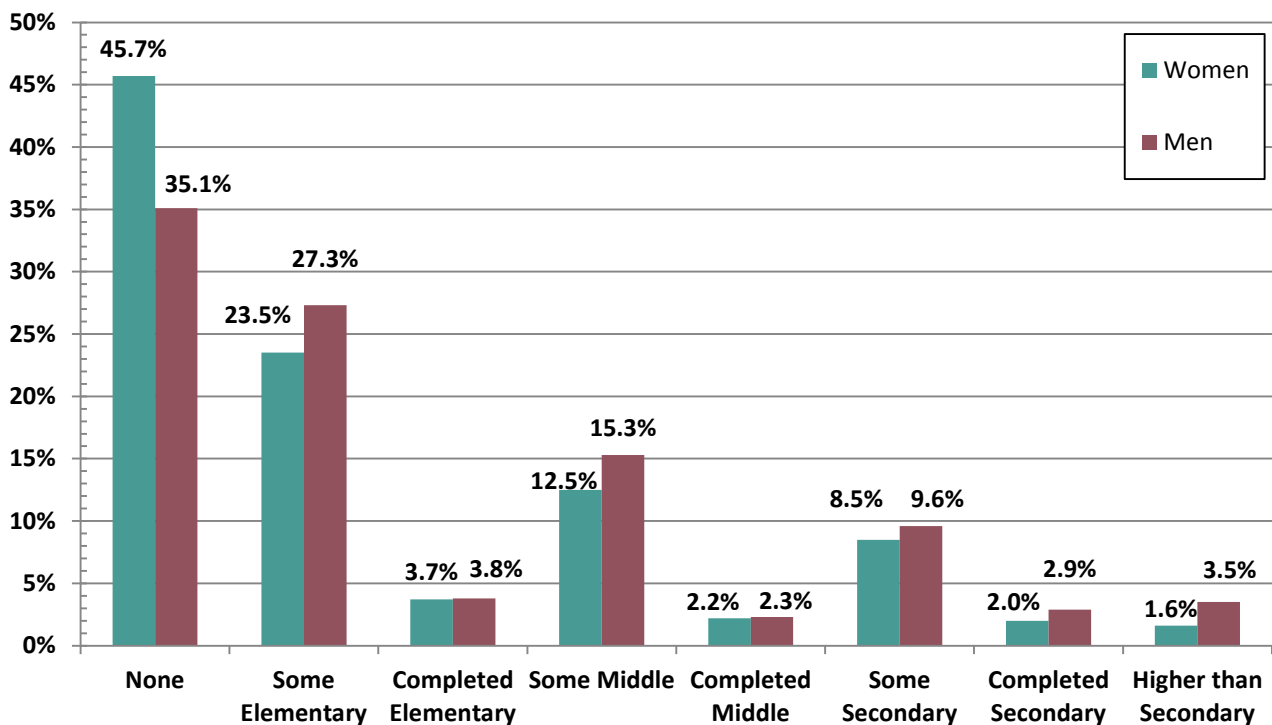


Figure 14: Highest level of education completed for Eritrean men and women²⁵

As shown in Figure 14, the level of **learning achievement** remains generally low in Eritrea. A 2008 study found that schools were consistently failing to meet the ‘Minimum Mastery Level’ (‘80% of the learners should attain at least 50%’). There is a disparity between

regions as, for example, grade three pupils in the Maekel region recorded achievements 2.6 times higher than their counterparts in Anseba.²⁶ Overall, only 58.9% of entrants passed the national grade eight examination (in 2013/14).²⁷

In 2013/2014, 55,218 people enrolled on the **adult literacy programme** (although 6.2% of learners were under the age of 15), 83.0% of whom were women. 52% of participants were learning in Tigre. 16.6% of learners dropped out without completing the programme.²⁸

Education and the Development Goals

The two **Millennium Development Goals** most pertinent to the campaign to stop FGM were 2 and 3: *Achieve Universal Primary Education* and *Promote Gender Equality and Empower Women*.

Enrolment and Access

UNESCO reports that, by 2015 in Eritrea, **enrolment in elementary school** had dropped to just 49.6% (female 45.9% and 53.2% male) from a high of 70.6% in 2005.²⁹ In 2014, 73.1% of attending children persisted to the last grade of primary school.³⁰ However, the GoSE's final report on the MDGs gives a more hopeful picture of 81% net elementary school enrolment in 2013.³¹

The GoSE identifies an intersectoral approach and close collaboration between the health and education sectors as central to its development approach, regarding schools as key to its community-outreach strategy.³²

The MoE acknowledges that the following all represent **barriers to accessing education** for many children:

Educational (supply side) factors include: shortage of schools especially in sparsely populated rural areas, combined with overcrowded classrooms; shortage of female teachers; shortage of trained teachers in mother tongue; lack of sanitation facilities; implementation of the school curriculum to adapt to local realities and inadequate supply of learning and instructional materials.

Environmental (demand side) factors comprise: poverty including inability to afford the direct costs of schooling as well as the indirect, opportunity costs (demand for children's labour); long distance to schools; limited parental and community involvement in schooling; social and cultural obstacles, such as early marriage and undervaluing the benefits of education.³³

In 2009, the African Development Bank identified a shortfall in qualified teachers across Eritrea, particularly in secondary and higher education.³⁴ It has delivered interventions in-country to address this, including financing teacher training.³⁵

The MoE reports that the number of elementary-school teachers increased 22.4% to 8,166 in the decade 2000/01 to 2011/12 and the proportion of trained teachers increased from 70.5% to 85%. The number of middle-school teachers increased 180.8% to 3,867 in the same decade, and the proportion of trained teachers increased from 35.5% to 81.5%. The number of secondary-school teachers increased 108% to 2,845 in the same decade, and the proportion of trained teachers increased from 73.1% to 80%.³⁶

As of 2014, there was only one teacher training institution in the country.³⁷ An average of 350-400 new teachers complete their training every year, but this is far short of the 2,000 additional teachers that Eritrea needs. The INGO Finn Church Aid has been working with the Eritrean Government to improve teacher training in Asmara (this programme reopened in 2015 following a four-year hiatus).³⁸ There is evidence that in some schools children are taught in shifts – one cohort in the morning and a second in the afternoon – to help manage oversubscription.³⁹

There are several other **reasons why Eritrean children may not attend school**. Some of these are outlined below.

- *Special Needs*

Provision for children with special education needs (SEN) appears to be poor. The only existing specialised institutions are two non-government primary schools for the hearing impaired and one government elementary school for children with visual impairments, although plans are in place to build two new SEN schools and train specialist teachers.⁴⁰

- *Environmental Factors*

Seasonal weather changes and extreme heat have also been identified as a cause for poor attendance.⁴¹ Enrolment in pre-school education is low and access is particularly poor in the Debubawi Keih Bahri and Semenawi Keih Bahri regions. Pastoralist, nomadic or semi-nomadic and remote or dispersed communities have insufficient access to education and other social services.⁴²

- *Displacement*

There are many thousands of children internally displaced by war who have insufficient access to education. In 2016, The INGO CARITAS secured US\$823,530 funding from the Norwegian Ministry of Foreign Affairs to undertake a project to benefit internally displaced persons in Eritrea, including US\$56,400 to rehabilitate and re-equip two schools and train its teachers.⁴³

- *Sexual Assault*

Some girls are kept out of formal education by their families for fear that they will be the victims of sexual assault travelling to or attending school.⁴⁴

- *Child Labour*

The minimum legal age for employment is 14⁴⁵, but this does not apply to self-employment.⁴⁶ The EPHS 2010 reports that 2.4% of men and 1.9% of women aged 4-29 and not attending school cited the need to earn money as the reason.⁴⁷ Eritrea has come under scrutiny for reports of the enrolment of some minors, some allegedly as young as 11, in national military service at SAWA Centre for Education and Training.⁴⁸ Also highlighted is a scheme called *maetot* (or *matot*), which requires children in grades nine to eleven to participate in community service such as environmental and agriculture activities.⁴⁹ The GoSE defends this as an educational programme with a duration of just one month.⁵⁰ There are, however, reports of children having to work to support themselves or their families in both urban and rural areas (for example, by assisting on the family farm or selling items in the street), which may be a barrier to them attending school.⁵¹

The EPHS 2010 reports the following reasons for non-attendance:

Reason for not attending school	Female (%)	Total Urban (%)	Asmara (%)	Other Town (%)	Rural (%)
No school in the area	0.6	0.4	0.3	0.5	0.6
School very far from the area	2.9	0.8	0.7	0.9	4.5
Disability/health problem	7.9	9.1	9.1	9.1	10.8
Help family at home	15.9	12.1	10.8	13.5	19.6
Help family on farm/ business	1.7	1.6	0.9	2.3	5.9
Needed to earn money	1.9	2.5	2.9	2.0	1.7
Dismissed for academic reason	1.5	3.5	4.4	2.6	1.8
Did not pass entrance exam	4.3	9.2	10.2	8.0	3.1
Graduated/had enough schooling	7.5	16.4	21.0	10.9	4.0
Disliked going to school	4.2	6.7	7.6	5.7	6.1
Not accepted by school because of age	8.6	5.8	1.6	10.7	7.8
Because of marriage	38.4	25.1	21.4	29.4	29.7

Table 9: Percentage of the de-facto household population aged 4-29 years who are not currently attending school, by reason for not attending⁵²

FGM is an indirect cause of girls' non-attendance. Not only may girls be forced out of school while they heal, but in many cultures, once a girl has been cut, she is considered ready for marriage. Once married, it is highly unlikely that a girl will finish her education.

With assistance from the Global Partnership for Education, the MoE drew up a new **Education Sector Plan 2013-2017** in 2013. Eritrea was given a grant of US\$25.3 million to implement the plan. The main objectives were to improve equitable access, quality and institutional capacity. Much of this was to be accomplished by building new schools and making improvements to teacher training.⁵³ Many existing schools are poorly supplied and have inadequate facilities or the buildings are badly maintained.⁵⁴

Gender Parity

The **gender gap in literacy** is significant, as only 51.9% of women are literate compared to 63.7% of men. The disparity is much narrower in children and adolescents, and there is almost no disparity in the six-to-nine age group.⁵⁵

At grade three level, girls were performing worse than their male counterparts in English by 12%; however, they managed a similar attainment in maths, and girls outperformed boys by 9.6 percentage points in mother-tongue study. By grade five, both genders were performing equally, but overall performance was markedly down. Girls' attainment is slightly poorer than their male counterparts at the grade eight level, where girls represent 47% of exam entrants and 46% of the pass rate.⁵⁶

49% of those enrolling for TVET are female. Some subject areas in which female enrolment outstrips male include soil and water conservation, animal science, agro-mechanics, accounting, material management, secretarial science, drafting and survey.⁵⁷



Gender parity in literacy has been achieved in children aged six to nine

The Education Sector Plan 2013-2017 notes that the GoSE drafted a National Education Gender Policy and Strategic Framework of Action (which does not appear to be publicly available) in May 2014, recognising that sustainable development could not be achieved without ‘the full and equal participation of girls at all levels of education.’ The Plan notes that this requires:

- ‘undertaking training and mobilization campaigns for the community;
- ‘formulation of gender awareness training materials to sensitize communities and teachers about gender issues and the socio-cultural practices that hamper the participation of girls and women in education;
- ‘strengthening relations between schools and communities through devolution of responsibilities for school management to the school and community level;
- ‘Reviewing curriculum and teaching materials to make them more gender sensitive –in general, adult, TVET education and teacher training;
- ‘Expanding the number of female teachers in schools by expanding their enrolment in teacher training institutions;

- 'Opening boarding schools and hostels for girls in remote areas, as well as for nomadic and semi-nomadic communities;
- 'In particular, ensuring that girls enter grade 1 at the proper time (age 7) and progress normally through the system because past experience shows that they start dropping out at age 14-16;
- 'Expanding opportunities for non-formal education, including adult education and skills training, for those who have been bypassed by the educational system;
- 'Improving the collection and production of gender disaggregated data on education, enhancing gender-based research and monitoring of progress towards EFA and MDG goals.
- 'Providing guidance and counselling services to help girls overcome problems that affect their education;
- 'Providing girls from low-income families with financial support as an incentive to compensate for the opportunity costs of their attendance; and
- 'Conducting extra tutorial classes to girls in need of support in core subjects where they lag behind.'⁵⁸



The GoSE has recognised the importance of girls' education to sustainable development

Goal 4 of the new **SDGs** is relevant to FGM in that it relates to education:

Goal 4: Ensure inclusive and equitable quality education and promote life-long learning opportunities for all.

The targets for Goal 4 make specific reference to ensuring girls and other vulnerable people receive equitable early-childhood development, inclusive and effective schooling at all levels, and vocational training and university education; they also include aspirations for adult women and men to receive equal skills training to achieve literacy and numeracy and enable them to take up decent jobs and start businesses.

Of particular importance in relation to the elimination of FGM is Target 4.7:

By 2030 ensure all learners acquire knowledge and skills needed to promote sustainable development, including among others through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship, and appreciation of cultural diversity and of culture's contribution to sustainable development.

The **Strategic Partnership Cooperation Framework** drawn up between the GoSE and the UN lays out a plan for achieving the SDGs. 9.5% of the budget outlined (equivalent to US\$31,027,238) is allocated to improving basic education, with the objective that 'by 2021, children in vulnerable communities, including refugees, have increased access to inclusive, equitable and quality early learning and basic education.'⁵⁹

The UN has committed to supporting Eritrea to achieve Goal 4 in the following ways:

1. Increasing infrastructural capacity, including the training of new and existing teachers and updating the national curriculum.
2. Promoting access to education for girls by expanding community-led initiatives in disadvantaged areas and strengthening preparedness and responsiveness for providing education in emergencies and better integrating provision for displaced and refugee children.
3. Strengthening partnerships with the private sector and external stakeholders.
4. Enhancing management, planning and monitoring through the Education Management Information System.
5. Advocating for increased investment in early years and secondary education to bring out-of-school children back into formal education and to build 'systematic linkages' between all levels of education.⁶⁰

THE DONKEY CANVAS PROJECT⁶¹

The NUEW has implemented innovative strategies to provide practical and material support to girls and their families and help keep them in school. In areas where girls and women are expected to travel long distances to wells, directly limiting their opportunities to enrol in education, The Donkey Canvas Project issued a donkey and barrels to relieve the time and energy burden of collecting water. Bicycles were provided to female students who travelled a distance of more than nine kilometres to Debre Bizen Secondary School in Semienawi Keyih Bahri, which had been experiencing high drop-out rates. Of the 60 participants in the scheme, 55 of the girls went on to complete secondary school. The NUEW have also given out radios as rewards to high-achieving girls in grades one to three.

Education and FGM

FGM is a violation of human rights, and progress towards achievement of this target is supported by the subject's inclusion in school and healthcare-training curricula. The MoE has included FGM in the school curriculum – specifically, discussion of its 'harmful nature and its adverse effects',⁶² and the Habarawi approach to FGM eradication identifies schools as central to its outreach programme.⁶³

The NUEYS operates youth clubs centred on young people's interests, such as sports, reading and the creative arts, through which they create a platform to communicate with young people about a range of health and social issues, including FGM.

The Sara Communication Initiative was launched by UNICEF in 2003 before the MoE assumed responsibility for continuing the programme in 2005. Sara Clubs were formed in schools for the dissemination of multimedia messages on health and social issues faced by the student population, including FGM.⁶⁴ By 2010, there were 300 School Sara clubs across the country.⁶⁵

Women's knowledge of FGM does not vary much according to their level of education, but there are differences in the prevalence of FGM according to level of education (see Figure 15).

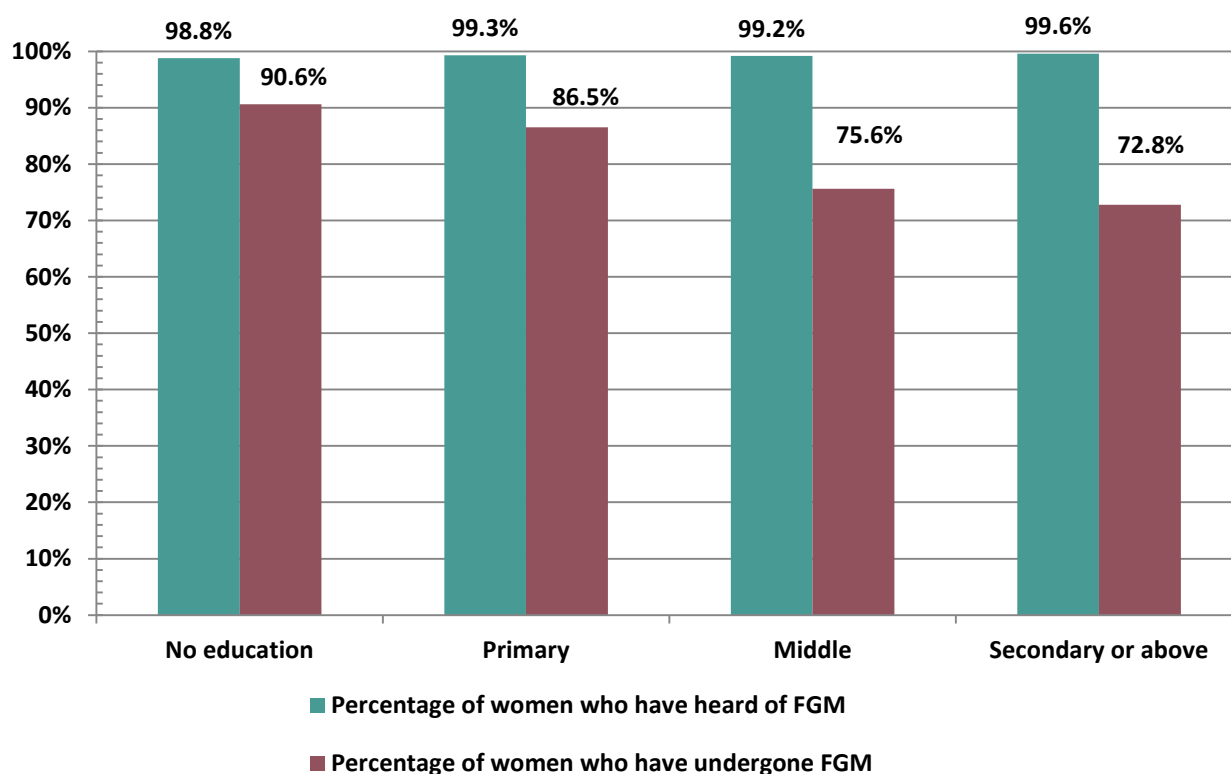


Figure 15: Knowledge and prevalence of FGM among Eritrean women aged 15-49, according to level of education⁶⁶

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Healthcare

Status of the Healthcare System

Since Eritrea's independence, the GoSE states that it has made healthcare one of its priorities, adopting Primary Health Care as its main strategy. To achieve this, it has focused on 'equity, comprehensiveness of services, community involvement, an intersectorial approach and political commitment.'¹

Eritrea is split into six health regions (Anseba, Debub, Debubawi Keih Bahri, Gash-Barka, Maekel and Semenawi Keih Bahri) and 54 health districts.²

Since 1991, the number of health facilities in Eritrea increased from 126 to 340 in 2010, supported by a number of pharmacies, drug stores and rural drug vendors. According to government figures, around 60% of the population now lives within five kilometres of a health facility. To support this growth in health facilities, a number of training establishments have been set up, including three nursing schools, a college of nursing and health technology, a college of health sciences and the Orotta School of Medicine and Dental Medicine. Additionally, a programme of continuous education and on-the-job training has been implemented.³ Figures from the MoH in 2016 state that there are 29 hospitals, 56 health centres, 195 health stations, 8 maternal- and child-health clinics and 60 general clinics, supported by a workforce of 9,805, of whom 6,228 are technical staff and 3,577 are administrative staff.⁴

The Health Sector Strategic Development Plan set its main goals as 'the improvement of health status, general wellbeing, longevity and economic productivity for all Eritreans.'⁵ In addition, the National Health Policy and the Health Sector Strategic Development Plan set an agenda of developing self-reliance and intersectoral approaches to health.⁶ These were followed by the launch on 2 June 2017 of the 2017-2021 Health Second Sector Strategic and Development Plan (*HSSDP II*) by Ms Amina Nur-Husein, Minister of Health. The plan, a follow-up to the 2012-2016 strategic plan of action, aims to move 'from policy to action', setting objectives, strategies and targets for the next five years.⁷ The five objectives of the plan are as follows:

1. Medium-term, strategic directions that facilitate Eritrea's contributions to national development and global health agendas.
2. Drafting a five-year strategic plan focused on improving health security and achieving universal health coverage.
3. Guiding the development agenda towards attaining the health SDGs.
4. Bringing together all stakeholders to implement the plan.
5. Creating an overview document to help maintain stakeholders' accountability and responsibility for their roles.⁸

In addition, a three-year national action plan for health security was adopted in April 2017 with the objective of controlling both human and livestock cross-border communicable diseases through effective information systems and partnerships with government and international organisations.⁹

According to the final report on the MDGs for Eritrea, despite progress in the health sector, the GoSE still has a lot of work to do in order to sustain progress and improve current services. The report attributes the successes so far to a number of initiatives, including intersectoral collaborations between ministries (for example, between the MoH and the Ministry of Education). Additionally, it states that a comprehensive service strategy has been developed and a three-tier healthcare delivery system has been implemented, providing basic health care at the community level, health stations for areas with a 2,000-3,000 head of population and a community hospital, which acts as a referral hospital, providing basic healthcare services for 50,000-100,000 people.¹⁰

Among the challenges still faced by Eritrea are reducing maternal and infant mortality rates, achieving universal health coverage, addressing the double burden of communicable and non-communicable diseases, and addressing the issue of health-resource shortages, both in terms of personnel and physical resources. The GoSE aims to achieve this by:

- 'Upgrading human resources capacity, both in quantity and quality;
- 'Increasing access and quality of services;
- 'Intensifying disease prevention efforts;
- 'Up-scaling advocacy and social mobilization in public health; and
- 'Enhancing outreach services.'¹¹

Healthcare Funding

According to a survey of senior staff-members of selected Eritrean ministries and agencies, in 2008, general government expenditure contributed to 44.9% of total health expenditure, and 55.1% of expenditure was private, out-of-pocket payments.¹² In 2013, general government expenditure on health as a percentage of total government expenditure was 4%.¹³

The first health-financing policy in Eritrea (from 1996) was revised in 1998 and covered cost-sharing through user fees, but did not look at other forms of revenue collection. The MoH requested external support to develop a National Health Financing Policy, in order to look at revenue collection, revenue pooling, risk management, resource allocation and strategic purchasing, but no further information is available on the progress of this.¹⁴

Women's Health

Reproductive Healthcare

From 1995-2000, Eritrea received support from two German NGOs, the Hammer Forum and Archemed, to improve maternal health care. The programme focused on prenatal care, contraception, counselling, post-abortion care and the centralisation of obstetric and neonatal services in Asmara and Keren. Access to comprehensive emergency obstetric care increased from 43% in 2006 to 84% in 2010. In 1991, 19% of women had at least one prenatal-care visit; in 2010 this rose to 89%. Eritrea's strategies to improve maternal health included providing quality prenatal care, skilled assistance during delivery, postpartum home visits and post-abortion care, and the expansion of emergency obstetric facilities. However, a study of the 11 emergency obstetric facilities in 2011 found they were heavily understaffed, although highly compliant with clinical standards. The fatality rate was low, at

0.65%, but 45.6% of obstetric admissions and 19.5% of maternal deaths were as a result of abortion complications.¹⁵

A UNICEF report from 2013 states that, although great improvements have been made in maternal healthcare, there is a need for prenatal, perinatal and postnatal care services to be improved and for greater coverage of emergency obstetric care, particularly as the main cause of death (27%) in under-fives is neonatal complications. 20% of under-five deaths occur in the first week of life.¹⁶



There is an unmet need for family planning assistance in Eritrea

According to a 2015 report, there is a lack of **knowledge of reproductive health** among girls in Eritrea, despite the adoption of a Youth Development Policy in 2012. Data relating to reproductive health is available on married women only and is not disaggregated by age, making it extremely difficult to obtain a true picture of the state of adolescent reproductive health. The Eritrean National Sexual and Reproductive Health (SRH) strategic plan document does include adolescent reproductive health as part of the national Primary Health Care system, however, the strategy focuses mainly on maternal health, rather than adolescent reproductive health.¹⁷ According to another report, despite a low knowledge of reproductive health, many young people engage in sexual relationships, which leads to unsafe sexual practice and unplanned pregnancy. This is a particular problem in the highland societies of Eritrea, where out-of-marriage pregnancy is seen as a disgrace to the family and often results in the young mother being driven away from home, committing suicide or having an unsafe and illegal abortion.¹⁸

Although the DHS 2010 reports that **early childbearing** is not common in Eritrea (the median age at first birth is 21.6 years among women aged 25-49), 10.4% of women aged

15-19 have already given birth or are pregnant. This is a reduction from the DHS 1995 figure of 23% and the DHS 2002 figure of 14%. Childbearing begins at an earlier age for women in rural areas than for women in urban areas, and those with 'no' education are more likely to be pregnant or have given birth in the age range 15-19 (18%) than those with at least some secondary education (4%).¹⁹

A minimum of 24 months between births is considered safest for mother and child. 20.6% of non-first births take place within 24 months of the mother previously giving birth and 39.2% between 24 and 35 months. The median **birth interval** is 32.7 months.²⁰

Contraception and Family Planning

Data collected for the EPHS 2010 shows that 95.9% of currently-married men aged 15-49 are **aware of at least one modern method of contraception**, compared to 85.5% of currently-married women in the same age-range. Knowledge of modern methods of contraception increases with women's level of education, and is more common in women from urban areas than women from rural areas. Only 74.4% of women with 'no' education had knowledge of at least one modern method, compared to 99.8% of women with a secondary-level education or higher.²³

Fertility rate (2016): 3.99²¹
(remaining roughly constant since 2002)

Adolescent birth rate (2015): 54.3 births per 1,000 women aged 15-19²²

Knowledge of the timing of a woman's fertile period is very low: only 12.6% of women and 17.5% of men aged 15-49 correctly state that it is halfway between menstrual periods; 22.9% of women and 25.5% of men have no knowledge of it at all.²⁴

59.1% of married women aged 15-49 who know of a contraceptive method **approve of family planning methods** and 41.5% believe their husbands approve. Two-thirds of currently-married women aged 15-49 who have heard of modern contraceptive methods have never **discussed family planning methods with their husbands**.²⁵

During the period 1995-2010, the prevalence of use of **contraception** in married women remained steady at about 8%.²⁶ The most popular forms of contraception among all women aged 15-49 are the pill (1.4%), injectables (1.1%), breastfeeding (1%) and male condoms and traditional methods (both at 0.8%).²⁷

91.2% of women not using contraception have not discussed family planning with a healthcare worker or a fieldworker.²⁸

For the period 2008-2012, 29% of married women did not want a child within two years but were not using any form of contraception at the time.²⁹ This indicates an unmet need for **sexual education and family planning assistance**.

Although **exposure to family planning messages** increased throughout the period 1995 to 2002, since 2002, there has been a declining trend in exposure. As of 2010, 64.7% of women and 68.4% of men aged 15-49 had not heard about family planning methods in the mass media during the previous few months.³⁰

RAHWA

Rahwa ('freedom from hardship') is an organisation that works to address the following 'key barriers to quality maternal and child healthcare':

- Healthcare worker shortages
- Financial barriers to childbirth and postpartum care (hospital fees, transportation costs, etc.)
- Lack of trust-based communication between families, home birth attendants, and clinical staff.³¹

The organisation trains and employs women as 'Maternal Health Agents'. Throughout pregnancy, childbirth and the postnatal period, these Agents assist women who live in rural areas of southern Eritrea and who do not have easy access to other healthcare.³²

Health and The Development Goals

Figures provided by the GoSE show that Eritrea successfully met the child-mortality and maternal-health goals of the MDGs (**Goal 4: Reduce Child Mortality** and **Goal 5: Improve Maternal Health**). The WHO, however, reports the maternal mortality ratio in 2015 as 501 per 100,000 live births.³³

	1990	2013	Projected Value 2015	MDG TARGET
Infant mortality (deaths per 1,000 live births)	92	58	34	30.7
Under-five mortality (deaths per 1,000 live births)	151	89	47	50 (TARGET MET)
Maternal mortality ratio	1,700	670	352	425 (TARGET MET)
% of births attended by skilled health personnel	21%	55%	59%	70%

Table 10: Achievements in MDGs related to maternal and child health³⁴

According to Dr Samson Abbay, a paediatrics specialist from Mendefera Referral Hospital, high rates of new-born deaths (babies less than one month old) are hindering efforts to further bring down child mortality rates, accounting for 20 of the 42 deaths per 1,000 live births in 2016. Dr Samson cited the main causes of this as being mothers giving birth at home without health professional assistance, and the use of traditional medicine.³⁵

Although births attended by skilled health personnel did not meet the target of 70%, there has been a significant increase since 1995 (21%) to 55% in 2013, with a projected value for 2015 of 59%. Once again, the WHO reports a different rate for 2015 of 46%.³⁶

The DHS 1995 and EPHS 2010 report that antenatal coverage (at least four visits during pregnancy) increased from 26.6% in 1995 to 57.4% in 2010.³⁷

2015-2030 – Challenges and Opportunities

The MDGs have now been replaced by the **SDGs**, which have a deadline for achievement of 2030.

In addition to **Goal 5.3 (Eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation)**, which makes specific reference to the elimination of FGM by 2030, several other SDGs have relevance for women and girls who have experienced or are likely to experience FGM, in particular those related to education, health and gender equality; for example:

Goal 3 (Ensure healthy lives and promote wellbeing for all at all ages) aims to

- (3.2) End preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births

and achieve

- (3.7) Universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes.

Eritrea has committed to the SDGs and plans to achieve them are included in the HSSDP II, which was launched on 2 June 2017.³⁸

Healthcare and FGM

A national scheme to eliminate FGM, Vision Eritrea, was run by the GoSE from January 2008 to June 2010, with a particular focus on Semenawi Keih Bahri. The scheme involved local authorities and teachers and consisted of events to provide information and form attitudes.³⁹

Unfortunately, there is little information available on what clinics are in place or how well healthcare professionals are trained to aid girls and women who have undergone FGM.

Traditional Medical Practices

Traditional medical practices are used extensively in Eritrea, and many people see them as complementing the state healthcare system. Particularly in rural communities, where there are no clinics or hospitals nearby, the use of traditional medicine is very commonplace.

Traditional medical practitioners use medicines made from plant, animal and mineral substances. They also use spiritual healing, hydrotherapy, massage, cupping (extracting blood using a cow's horn through which blood is sucked), surgery, FGM, bone-setting and midwifery, using methods passed from generation to generation.⁴⁰ However, the GoSE has warned that such treatments are unregulated and may be inappropriate, thus contributing to the level of maternal health problems in Eritrea.⁴¹

Many people use traditional medicine because they identify with it culturally as well as because of frustrations with standard medicine. Traditional medical practitioners are seen as better understanding the mentality and culture of their patients (particularly women) and as being easier to communicate with, especially because many state health workers do not speak local ethnic languages.⁴²

Obstetric Fistula

Obstetric fistula is a condition caused by prolonged obstructed labour, which results in a hole between the vagina and the rectum or bladder.⁴³ Although FGM does not directly cause obstetric fistula, it can lead to complications in labour that in turn lead to obstetric fistula.

Obstetric fistula is common in Africa, accounting for the majority of the estimated 200 million women who are affected globally, and it is usually the result of poor maternal care or giving birth at a young age.

There has been an obstetric fistula programme in Eritrea supported by the UNFPA since 2003. The programme involves complicated cases of obstetric fistula being treated by visiting US specialist surgeons, while less-complicated cases are dealt with by the national surgeon, Dr Habte. Treatment is carried out for free by the MoH at the National Fistula Center at Mendefera Referral Hospital. Expenses such as food and travel are also often covered. The programme also includes the training of health workers on the diagnosis, management, rehabilitation and reintegration of obstetric fistula patients and additional training of community advocates, who assist in the prevention and treatment of fistula.⁴⁴

In 2013, the Fistula Rehabilitation Centre was opened, with support from UNFPA, to provide accommodation for women prior to and after surgery.⁴⁵ During a recent visit to the Mendefera Referral Hospital by members of the NUEW, Dr Habte stated that 99% of those treated at the hospital for obstetric fistula had been cured and were able to resume their normal lives.⁴⁶ However, the initial success rate is around 80%; around 20% of patients having to undergo surgery again because of complications. Most of the fistula cases treated are as a result of women who have undergone FGM Types II and III, underage marriage and/or rape. Poor health care or incompetence by health workers were also given as causes.⁴⁷

Although the UNFPA-supported programme has so far treated over 1,000 patients, there remains a backlog of patients to be treated, due to a shortage of qualified obstetricians/gynaecologists. The lack of support and integration of services for rehabilitation and reintegration into communities is a particular weakness of the programme, as the majority of patients treated said that they had been 'divorced and stigmatized by the community because of their condition.' A lack of a direct hospital budget for rehabilitation, as well as a lack of consumables such as sutures, are additional challenges to treating obstetric fistula in Eritrea.⁴⁸

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- EPHS 2010, p.167.
- 38 Shabait.com (2017b), *op. cit.*
- 39 Holzgreve, Greiner and Schwidtal, *op. cit.*
- 40 GebreMichael Kibreab Habtom (2015) 'Integrating traditional medical practice with primary healthcare system in Eritrea'. p.74, *Journal of Complementary and Integrative Medicine*, 12(1), pp.71-87. Available at <https://www.degruyter.com/view/j/jcim.2015.12.issue-1/jcim-2014-0020/jcim-2014-0020.xml>.
- 41 Shabait.com (2017d), *op. cit.*
- 42 GebreMichael Kibreab Habtom, *op. cit.*
- 43 Fistula Foundation (2017) *Fast Facts & FAQ*. Available at <https://www.fistulafoundation.org/what-is-fistula/fast-facts-faq/>.
- 44 Charles Oyaya, PhD, Emily W. Kaburu and Yerdanos Tewelde (2016) *Assessment Report of the Government of the State of Eritrea (GoSE) and UNFPA: 4th Country Programme (2013-2016)*, p.31. International Development Institute Africa. Available at <https://executiveboard.unfpa.org/downloadDoc.unfpa?fileName=Eritrea%20-%20CPE-Evaluative%20evidence.pdf~25-57-2016-15-57-10-742>.
- 45 *Ibid.*, p.32.
- 46 Shabait.com (2017e) *Eritrea: Mendefera referral Hospital: Effective Fistula treatment*, 6 January. Available at <http://www.geeskaafrika.com/26277/eritrea-mendefera-referral-hospital-effective-fistula-treatment/>.
- 47 Oyaya, Kaburu and Tewelde , *op. cit.*, pp.31-32.
- 48 Oyaya, Kaburu and Tewelde , *op. cit.*, pp.31-32 & 34.

Image page 98: Andrea Moroni (2014) *Adi Keyh*. Available at <https://flic.kr/p/qk6zyl>.
CCL: <https://creativecommons.org/licenses/by-nc-nd/2.0/>.

Ending FGM: Challenges

Challenges to the abolishment of FGM in Eritrea fall into two categories.

Firstly, there are cultural challenges related to the structure of Eritrean society that must be negotiated or surmounted, such as traditions, beliefs and social norms that support the practice of FGM.

Secondly, there are practical challenges, such as accessing remote areas and maintaining a consistent, clear message about FGM when civil society is impacted by political policies and practices.

Cultural Challenges

Traditions, beliefs and social norms that support the continuation of FGM and override the law

It is clear that FGM is an ingrained part of Eritrean society. Among Eritrean women, 'social acceptance' is the most-commonly perceived benefit of FGM for a girl, as opposed to 'religious approval' or 'cleanliness/hygiene'.¹ In communities where FGM is seen as a rite of passage, women who have their girls undergo FGM are seen as 'wise'.² Therefore, there are many pressures from family and community, and particularly from grandmothers, who have in some cases had their granddaughters cut when the parents have refused.³ In close-knit families and communities, the strength of social pressures can result in a reluctance to speak up about objections to the accepted culture. Various commentators have noted that Eritreans are in general reluctant to speak out or 'go against the grain', due to the regularity of government surveillance and the control of information dissemination. Although FGM is illegal, this may add to the repression of free speech in communities.

These pressures are compounded by the underlying patriarchal culture identified by the NUEW⁴ and the custom of silence about violence towards women (for example, in the military).

Policies and practices of the GoSE that hinder anti-FGM work

The GoSE's expulsion of NGOs and INGOs from the country means that FGM research is limited and existing data cannot be independently verified. Community leaders and politicians have very limited resources, and, therefore, anti-FGM campaigning is likely to be placed low on their lists of priorities. Electing more women at all levels of government may help to bring greater attention to the issue.

The Ministry of Information's control of news and broadcasting has meant that Eritreans 'hardly ever watch the national television'.⁵ Television is still one of the most frequently accessed media, however, as evidenced by the prevalence of satellite dishes installed on Eritrean houses. One challenge for INGOs is, perhaps, to broadcast anti-FGM messages on satellite stations that would reach Eritreans.

Girls often drop out of school or marry early to avoid compulsory military service. As FGM is more common among women with less education⁶, this is of some concern and may result in the practice of FGM continuing from generation to generation.

Misunderstandings in relation to sex and FGM, home births and the use of traditional medical practitioners

Among Eritrean men (aged 15 to 59), 'preserves virginity/prevents premarital sex' is the most-commonly perceived benefit of FGM for a girl, and it is the second-most-commonly perceived benefit among women (aged 15 to 49).⁷ This indicates a need for accurate and up-to-date education on sex and FGM for both men and women.

The high rate of home births increases maternal and infant mortality rates as a result of complications during childbirth, many of which are likely related to FGM.

Eritrean's trust in and reliance on traditional medical practitioners, about 20% of whom practise FGM as a 'treatment', also increases the risks for women.

Practical Challenges

The NGO situation

The NUEW has noted that it relies upon funding from overseas to provide some of its services in rural areas⁸, and a study into the Habarawi approach credits the financial support of international governing bodies with the decrease in the prevalence of FGM in Eritrea⁹. Therefore, it is clear that the lack of NGO and INGO presence and the restrictions on foreign funding curtail the amount of work against FGM that can be done.

Limited funding and resources

The funding available for healthcare and other services for women and girls who have undergone FGM is very limited, in part because of Eritrea's perpetual 'no war no peace' state and the size of its armed forces. Ministers and local leaders have long lists of priorities, as they do in any developing nation, and FGM may be placed lower on those lists than other services. The NUEW has identified disinterest from those in government as one of the challenges in eradicating FGM.¹⁰

The healthcare system, in particular, is in need of additional funding, personnel and resources. There is a backlog of fistula patients, and women cite the distance to healthcare centres as one reason for not obtaining appropriate healthcare during and after pregnancy.

Additionally, women often turn to (untrained) traditional medical practitioners, as they feel their culture is better understood by them and in many cases because state health workers do not speak local languages.¹¹

Disorder in the legal and justice systems

Eritrea does not have a fully implemented Constitution; neither are its Civil and Penal Codes, and Civil and Penal Procedures Codes, fully implemented. Without firm laws upon which to base the legal and criminal justice systems, the GoSE cannot consistently carry out and report prosecutions for FGM to deter the practice and present an unwavering stance against it.

Government censorship and information control

The limited access to the internet and outside sources of news and information, and the GoSE's control and censorship of information limits debate and conversation and strengthens taboos.

The inability of international organisations to independently verify existing data and conduct further research also limits progress towards the abandonment of FGM.

Illiteracy

The rate of illiteracy in Eritrea is especially high for women, at 51.9% as reported in the EPHS 2010, or 65.5% as reported in the World Factbook.¹² This makes distributing printed material about FGM and related issues ineffective for a large percentage of the population, particularly in rural areas, where the rate of illiteracy is higher than in urban areas.

Transport and infrastructure in remote locations

Remote rural areas also present difficulties in terms of infrastructure. The opportunity for anti-FGM programmes to be scaled up and reach the communities where prevalence is highest is severely challenged when basic infrastructure (such as a lack of electricity, which requires additional supplies such as batteries and generators) is lacking. This situation also restricts the ability of law enforcement personnel to reach target areas to combat an illegal practice and bring perpetrators to justice.

1 EPHS 2010, p.360.

2 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, pp.22-23. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.

3 US Department of State (2001) *Eritrea: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10097.htm>.

4 National Union of Eritrean Women and UNDP Eritrea (2014) *10 Years: Women in Eritrea – National Union of Eritrean Women*, p.7. Available at <https://www.scribd.com/document/254707719/National-Union-of-Eritrea-Women-10-Year-Report-by-UNDP>.

5 Abraham T. Zere (2017) 'Remembering the day the Eritrean press died', *Aljazeera*, 18 September. Available at <http://www.aljazeera.com/indepth/opinion/remembering-day-eritrean-press-died-170918074330130.html>.

6 EPHS 2010, p.347.

7 EPHS 2010, p.361.

8 National Union of Eritrean Women and UNDP Eritrea (2014) *10 Years: Women in Eritrea – National Union of Eritrean Women*, p.11. Available at <https://www.scribd.com/document/254707719/National-Union-of-Eritrea-Women-10-Year-Report-by-UNDP>.

9 G. Akinboyo and R. Negash (2012) *The Habarawi Approach: Communities Taking Action to Eliminate Female Genital Mutilation/Cutting*, p.58. Prepared for the Ministry of Health, the National Union of Eritrean Women, and UNICEF/Eritrea, Asmara. Available at https://www.unicef.org/eritrea/ECO_resources_socialchange.pdf.

10 National Union of Eritrean Women and UNDP Eritrea, *op cit.*, p.9.

11 Charles Oyaya, PhD, Emily W. Kaburu & Yerdanos Tewelde (2016) *Assessment Report of the Government of the State of Eritrea (GoSE) and UNFPA: 4th Country Programme (2013-2016)*, p.31. International Development Institute Africa. Available at <https://executiveboard.unfpa.org/downloadDoc.unfpa?fileName=Eritrea%20-%20CPE-Evaluative%20evidence.pdf~25-57-2016-15-57-10-742>.

12 - EPHS 2010, pp.19 and 20.

- Central Intelligence Agency (2017) *The World Factbook: Eritrea*, 6 September. Available at <https://www.cia.gov/library/publications/the-world-factbook/geos/er.html>.

Conclusions and Strategies for Moving Forward

Eritrea's independence has created an opportunity for the GoSE to bring about developments in all aspects of society. One of the GoSE's policies to date has been women's equality, of which the abolishment of FGM is an important facet.

However, **drafting and implementing a new constitution** should be made a priority for the GoSE, along with fully implementing the 2015 Civil, Penal, Civil Procedures and Penal Procedures Codes. That will allow all levels of government to present a consistent message in relation to FGM, particularly when it comes to prosecuting and sentencing FGM cases.

This type of united, intersectoral and inter-ministerial approach – a **Habarawi approach** – has already been identified as being effective in the fight against FGM to date. It is credited with the recent decline in practice of and support for FGM reported in the EPHS 2010.

The DHS 1995 reported the **prevalence of FGM** in women aged 15-49 as 95.4%, but the EPHS 2010 reported the prevalence as 83%. This indicates a 12.4-percentage-point decrease in prevalence during that time. In the 2010 survey, prevalence among older women (aged 45-49) is reported as 93.1% and among the youngest age-group (15-19) as 68.8%, further indicating a decline in recent years, as girls are most likely to be cut before the age of five.¹

Support for the continuation of FGM has greatly declined, from 56.8% among women and 45.6% among men in the DHS 1995, to 12.2% among women and 10.8% among men in the EPHS 2010.²

In addition, the percentage of women who believe that FGM has **no benefits for a girl** has increased significantly from 29.1% in 2002 to 77.2% in 2010.³ Despite this, only a small percentage of women with at least one daughter who has been cut have heard any objections to it.⁴ This may be due to the taboos surrounding FGM, which make it difficult for people to speak up about their objections. That would suggest a need in communities for public, non-judgemental arenas for discussion and some teaching on how to speak up about difficult topics to family and friends. Grandmothers, in particular, have been known to take matters into their own hands and have their granddaughters cut against the parents' wishes⁵; therefore, supplying parents with strategies to avoid this, as well as targeting programmes at older women, would be helpful.

For women, the reluctance to speak up may also be due to the underlying **patriarchal culture** identified by the NUEW.⁶ Although women's equality and rights are protected under law and the GoSE's stated policies, traditions and culture often override the law.

The NUEW has done good work in achieving the **criminalisation of FGM** and in spreading knowledge of the FGM Proclamation. 66.9% of women (aged 15-49) with at least one daughter who has not undergone FGM say that they have not because it is against the law, so the Proclamation, at least, appears to be having a positive effect. However, knowledge of the Proclamation is lower in rural areas than in urban areas, and is significantly lower in Gash-Barka, suggesting that more work is needed there.⁷

Generally, the prevalence of FGM and public support for its continuation is lower in **Asmara** than in other parts of the country. This may be to do with greater wealth in the capital city, as higher levels of wealth correlate with a lower prevalence and a better understanding of FGM. A study to confirm this or to discover if there are other reasons for the difference in Asmara would be useful.

Improving the financial prospects of traditional practitioners who abandon FGM, by retraining them for **alternative careers**, would also be of benefit.

Another aspect of the Habarawi approach that has reportedly been effective in Eritrea is the **involvement of religious leaders**, who are highly influential in Eritrean's everyday lives. The idea that religious approval is a major benefit of FGM for a girl appears to be dying out – in the EPHS 2010, it was the least commonly cited benefit – however, when women were directly asked in the DHS 2002 whether FGM is required by their religion, 60.1% said that they believe it is.⁸ A persistent stance against FGM from both head and local religious leaders would help to further dispel these beliefs.



There are hopeful signs that the incidence of FGM is falling, as the prevalence among girls and young women is much lower than the prevalence among older women

The GoSE's Vision Eritrea and the Reproductive Health Plus Project both targeted teachers and the Reproductive Health Plus Project reported 'a significant change' in practice as a result of that strategy.⁹ Continuing to make improvements in various aspects of **education** would be highly beneficial, as better-educated women are less likely to have their daughters cut and perpetuate the practice. Better-educated women are also less likely to support the continuation of FGM and tend to have more involvement in family decision-making.¹⁰ Girls' understanding of reproductive health is lacking, despite the adoption of the Youth Development Policy and the SRH strategic plan. Data from the EPHS 2010 shows that this lack of knowledge extends to older women's understanding of fertility, family planning, sex and FGM. Addressing women's limited access to family planning and stepping up education on reproductive health and FGM for both adolescents and adults may help to bring down maternal and infant mortality rates as well as the prevalence of FGM.

The GoSE is aware that there is a need for easier access to **healthcare** as well as greater resources and has taken steps to improve the situation, but more work needs to be done to provide clinics, supplies and trained personnel, particularly in remote areas. There is also a backlog of fistula patients who need urgent care. It may be helpful to assign healthcare

professionals who speak ethnic languages to the areas where those languages are spoken. This would promote trust and understanding between women and trained professionals and, in time, cut down their reliance on traditional medical practitioners, who are untrained and may ‘treat’ their patients using harmful traditional practices. **Medicalised FGM** does not appear to be a major problem in Eritrea.

Anti-FGM campaigners and other activists must consider in their approaches the inherent **dignity** of Eritreans. Any message that could be interpreted as a criticism of their beliefs or way of life might be rejected without consideration.

In this regard, the use of different forms of **media** may be of assistance. Media can be useful not only for subverting strongly-held ideas and traditions, but also for sparking discussion and breaking down taboos. Television remains extremely popular, as does radio, and radio is capable of reaching people in remote rural areas, where other traditional mediums may not be as effective due to illiteracy or a lack of infrastructure. Dramas and videos appear to have been effective in village-level awareness campaigns and in youth clubs. The burgeoning Eritrean film industry is perhaps another opportunity for the Ministry of Information, the NUEW, the NUEYS and other campaigners to spread messages and promote debate about FGM in the public arena. One Sara Club member also noted that creating media (poetry, in her case) has proved to be a form of psychological therapy.¹¹

Further **research** into the issues surrounding FGM in Eritrean society is necessary as part of the work to abolish the practice. However, this will be hampered unless the GoSE lifts its restrictions on NGOs and INGOs working in Eritrea and receiving foreign funding. The campaign would also benefit from easier access to court judgements, so that follow-up research and reporting on FGM cases can be done. Furthermore, the publication of any mapping and evaluation exercises would create a cache of information that could encourage collaboration and be put to use intersectorally, as would the publication of any challenges and successes specific to each Anti-FGM Committee’s region of influence.

1 - DHS 1995, p.166.

- EPHS 2010, p.347.

2 - DHS 1995, p.172.

- EPHS 2010, pp.364 and 365.

3 - DHS 2002, p.210.

- EPHS 2010, p.361.

4 EPHS 2010, p.357.

5 US Department of State (2001) *Eritrea: Report on Female Genital Mutilation (FGM) or Female Genital Cutting (FGC)*. Available at <https://2001-2009.state.gov/g/wi/rls/rep/crfgm/10097.htm>.

6 National Union of Eritrean Women and UNDP Eritrea (2014) *10 Years: Women in Eritrea – National Union of Eritrean Women*, p.7. Available at <https://www.scribd.com/document/254707719/National-Union-of-Eritrea-Women-10-Year-Report-by-UNDP>.

7 EPHS 2010, p.347 and 358.

8 - EPHS 2010, p.360.

- DHS 2002, p.214.

9 W. Wolfgang Holzgreve, D. Greiner and P. Schwidtal (2012) ‘Maternal mortality in Eritrea: Improvements associated with centralization of obstetric services’, p.551, *International Journal of Gynecology and Obstetrics* 119(2012) pp.S50–S54. Available at <http://www.sciencedirect.com/science/article/pii/S0020729212001580>.

10 EPHS 2010, pp.329, 353 and 364.

11 Meriem Abubeker cited in UNICEF (2008) ‘Sara Communication Initiative helps a young widow return to school in Eritrea’, *Eritrea*, 2 September. Available at https://www.unicef.org/education/eritrea_45449.html.

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Andrea Moroni (2014) *We admit all, we just stole the snacks.....* Available at <https://flic.kr/p/pqMGTj>. CCL: <https://creativecommons.org/licenses/by-nc-nd/2.0/>.

