Baseline/End line Survey:
Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia

Final Report

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Glossary

***Lombotam**:* It is a derogatory term given to uncircumcised girls around West Arsi zone of Oromia Region referring cleanness of girls/women

Feistal Doctors: pseudo doctor who travels from door to door to practice circumcision with price set by himself which ranges from 300 birr to 1000 depending on number of girls gathered to be circumcised from one village

Dhimi: A girls circumcision ceremony that organized by traditional leaders before the first menstrual cycle and marriage of a girl among Dasenech community in Southern Ethiopia

Acronym

CSO: Civil Society Organizations

EDHS: Ethiopia Demographic Health Survey

EGLDAM: *ye Ethiopia Goji Limadawi Dergitoch Aswegaj Mahber*

FBOs: Faith Based Organizations

FGD: Focus Group Discussion

FGM: Female Genital Mutilation

HHS: Households

HMIS: Health Management Information System

HTPs: Harmful Traditional Practices

IDI: In-depth Interview

KAP: Knowledge, Attitudes and Practices

KMG: Kembatta Women Self Help Center

MoWCYA: Ministry of Women's Children and Youth Affairs

MOH: Ministry of Health

NCA: Norwegian Church Aid

NCTPE: National Committee on Traditional Practices for Ethiopia

NGOs: Non-Governmental Organizations

OVC: Orphan and Vulnerable Children

SCI: Save the Children International

SNNPR: Southern Nations Nationalities and People's Regional State

SPSS: Statistical Package for Social Sciences

UN: United Nations

WMS: Welfare Monitoring Survey

WHO: World Health Organization

Executive Summery

Norwegian Church Aid and Save the Children International in Ethiopia commission the current baseline/end line survey on female genital mutilation with the objectives of assessing prevalence, knowledge, attitude and practices of female genital mutilation among the target communities. It also addressed program effectiveness in terms of effectiveness of customary and statutory laws, anti-female genital mutilation message integration in works of faith based organizations, and health services integration in female genital mutilation prevention tasks. The baseline/end line survey was conducted in twenty three woredas of the six regions of Ethiopia: Afar, Amhara, Harari, Somali, Oromia and SNNPR. The research participants were sampled households with girl under age of 18 years, target community members and stakeholders working on female genital mutilation prevention at regional and woreda levels.

In this baseline/end line survey, the objectives of the inquiry were addressed by employing both quantitative and qualitative study design. Household survey questionnaire, Focus Group Discussion (FGD) and in-depth interview checklists were the main data collection tools used throughout the study. Subsequently, the data collected from 3129 sampled households, 24 FGDs, 66 in-depth interview and secondary sources were analyzed using SPSS- version 20 and thematically.

Findings

Knowledge Pertinent to Female Genital Mutilation

This baseline/end line study depicted that large segment of the study population have awareness of female genital mutilation including awareness about its forms/types. More than 90 percent of the target communities in Afar, Oromia and SNNPR know FGM in all its forms and practices. Relatively speaking, study populations in Somali and Amhara have less awareness of FGM. In most of the regions, large proportion of the study population, more than 80 %, knows that female circumcision is illegal. Health extension workers are main source of information about FGM for target communities in Amhara, Oromia and SNNPR. Religious leaders are also important source of information about FGM for residents of Harari, Afar, and Somali region next to radio/TV. The study shows high number of

circumcisers on average in Somali (4.37) and Afar (3.34) regions. The median age of circumcision in Harari and Somali is 7 years, in Amhara 7 days after birth, in Oromia 15 years, in SNNPR 10 years and in Afar two weeks. The study further reveals that traditional circumcisers are the most know circumcisers in all the regions, but new circumcisers are emerging in some of the regions. These emerging circumcisers are para-health professionals and health professionals who practice female circumcision in secret and hidden ways.

Attitudes and Opinion against Female Genital Mutilation

The baseline/end line survey finding shows that the number of study population willing to marry uncircumcised girls is high in Oromia (80 %), and SNNPR (60.4 %). The proportion is also higher in intervention areas as compared to expansion areas. The major reasons for unwillingness to marry uncircumcised girls emerge from communities' belief of sexual incompatibility and religious values. The survey shows that large segments of the study population in Amahra, Oromia, and SNNPR do not want FGM to continue, and they do not have a plan to circumcise their daughters in the future. However, only few number of study population in Afar expressed their disagreement with the continuity of FGM practice and decided not to circumcise their daughters in the future.

Similarly, the majority of study population, in program intervention areas have unfavorable attitude towards female genital mutilation. The largest unfavorable attitudes observed in Harari (75.7 %) and in Oromia (73.3 %). The current study reveals that mothers are the most influential decision makers of girl circumcision may be due to social proximity they have with their girls as compared to fathers.

Prevalence and Practices of Female Genital Mutilation

The baseline/end line survey revealed that the practice of female genital mutilation has decreased in all of the targeted regions despite variations among the regions. High proportion of reduction was observed in Dasenech woreda (45.7 %) of SNNPR while smaller proportion of reduction was observed in Harari region (18%). Similarly, the magnitude of FGM was found to be higher in expansion woredas as compared to intervention woredas.

A multivariate binary logistic regression analysis output shows that age of the study population, awareness about anti-FGM declaration, and attitude towards FGM are determinants of female genital mutilation. Accordingly, the probability of circumcision for girls from parents who are older, unaware of anti-FGM declaration and who have favorable attitude towards FGM is higher than for girls from parents who are young, aware of anti FGM declaration and who have undecided attitude towards FGM.

Effectiveness of Customary and Statutory Laws in Female Genital Mutilation Prevention

The study depicted that the role of customary laws in prevention of FGM is good in Amhara, Oromia and SNNPR (except Dasenech). This indicates the role of anti FGM deceleration played in the prevention of FGM. However, these laws do not seem to be vibrant enough in addressing FGM issues. In terms of reception and verdict of FGM cases, customary laws are more effective as compared to the statutory laws.

Integration of Anti-Female Genital Mutilation Messages in the Works of Faith-based Institutions

The baseline/end line study found out that anti-FGM messages are not adequately integrated in the teachings of religious leaders. However, some efforts have been made in regions like SNNPR, Afar, Harari and Somali since they were able to make religious leaders an alternative source of information for study population. The integration is found to be inadequate due to resource limitation, lack of interest and commitment from religious leaders and cultural influences.

Health Service Integration for Women and Girls affected by Female Genital Mutilation

The current survey revealed that the number of FGM cases taken to health facilities for FGM related treatment is very low as compared to its prevalence. Health service efforts to integrate the services are inadequate due to barriers related to service provision approach, limited knowledge of service providers to deal with FGM complications, absence of focal person and specific department for the purpose, and challenges of data management

system. For instance, FGM cases are not included in health management information system as one indicator.

Program Effectiveness in Female Genital Mutilation Interventions

In terms of its key program progress indicators, the program has achieved most of its targets. Prevalence of female genital mutilation has decreased in all target woredas with baseline value. The maximum decrement observed in Dasenech woreda and the lowest in Harari. The largest proportion, 40 to 75 %, of the study population has unfavorable attitudes towards female genital mutilation.

The baseline/end line survey showed that statutory laws are less adequate and efficient in prevention of female genital mutilation mainly due to problems related to witnesses in FGM case investigation at court level. But customary laws, through anti-FGM declaration, were effective in addressing FGM in some of the regions.

Government Sector Offices and Stakeholder Collaboration

This study shows that the level of collaboration among stakeholders is strong in Oromia and medium in Amhara as they have common work plan, established collaboration structure, and periodic meeting schedule. However, the collaboration is weak in Afar, Somali, Harari and SNNPR as they lack work plan, structure and periodic meeting schedule.

Recommendations

The main recommendations given based on the findings of this study include employing social and behavioral change strategies such as engaging multiple channels of communications, conducting targeted campaigns, targeting young mothers for anti-FGM messages, and having watch dogs for reporting malpractices. Strengthening customary/traditional laws, conducting advocacy to improve evidence presentation procedures for statutory law, and building capacity of sector offices and local partners have been forwarded as general recommendations.

1. Introduction

1.1. Background and Context of Female Genital Mutilation in Ethiopia

Ethiopia is a country of nations and nationalities with wide-range of cultural practices that has significantly contributed for social solidarity and reciprocal relationship among its people. Traditional conflict resolution and arbitration mechanisms, breast feeding, socially accepted feasts and events, and public gatherings are some of the important characteristics of Ethiopian society. However, there are also several harmful traditional practices that affect the social, psychological, physical and economic wellbeing of the society. One of these harmful practices, female genital mutilation, is the focus of this study. Women and girls among various communities of the country are victims of FGM. The practice affects not only the wellbeing, but also reproductive rights of women. Many communities have been practicing FGM for more than 2000 years as social norm in Ethiopia and elsewhere in the world (28 Too MANY, 2013).

Several efforts have been made to study the trend in the prevalence/ occurrences, and causes of FGM and other Harmful Traditional Practices (HTPs) in Ethiopia including the EDHS 2000, 2005, and NCTPE and others. Recent research findings have shown that Female Genital Mutilation/Cutting (FGM/C) has been declining across Ethiopia in the past decades. The 2005 Ethiopia Demographic and Health Survey (EDHS), for instance, indicated that 81% of women in the age range of 45-49 years and 62% of girls from 15-19 year were circumcised. The figure tells us that the practice is declining as the percent of circumcised girls is smaller than that of women. Similarly, the 2011 Welfare Monitoring Survey (WMS) shows that less than 25% of 0-14 years old girls were circumcised. It means less number of females in younger generations had undergone FGM/C. Nevertheless, the practice is still prevalent in several regions and 23.8 million women are estimated to be victims of FGM/C countrywide (UNICEF, 2013).

Due to the efforts of public sectors and partners, FGM has been declining and there are several woredas which declared free of FGM so far. These woredas are found within three regional states (Afar, Benishangul Gumuz, and Southern Nations, Nationalities and People's Region) and Addis Ababa.

Finding of NCTPE (2008) survey also shows FGM is widely practiced in Amhara, Oromia, SNNPR, and Afar, Harari, and Somali regions of Ethiopia as compared to other regions of the country (EDHS,2005).

There are international and national policy environments that support to intervene with practice of FGM. UN general assembly resolution 34/180 declared the elimination of all forms of discrimination against women and set plan of action for elimination of traditional practices that affect women and children's health. This declaration is accepted and ratified by Ethiopia. African Charter on the Right and Welfare of the Child (1999) entitles actions against protection of harmful social and cultural practices. Similarly, there are several policy directions and laws that support the prevention and elimination of FGM practices including penal code, and national strategy for harmful traditional practices and reproductive health. Ethiopia envisages eliminating FGM by 2025 and puts strategic and multi-sectorial approaches through national plan of action against elimination of Harmful traditional practices and national networks.

Despite all these effort, the practice of FGM has continued due to different reasons. Several personal, interpersonal, community/social, organizational factors and lack of enabling policy environment can determine the prevalence of FGM/C. Female genital mutilation has been carried out among various communities in Ethiopia with similar reasons such as issues related to virginity as honor of the family and the husband and mutilation as criteria for marriage. However, its health, psychosocial trauma, and other consequences are less understood among many communities in Ethiopia.

Thus, the current baseline/end line study has been conducted to enable practitioners to set benchmarks and indicators for any intervention measures to be taken against FGM. It aimed at showing progress and changes gained of program life. The finding also revealed the challenges and problems encountered in the intervention made to reduce/eliminate FGM.

1.2. Program Description

With the effort of the government and non-governmental organizations, the prevalence of FGM has shown a promising decrease by 17 % (from 73% of the baseline survey 1997

to 56 % of follow –up survey in 2008). The 2011 welfare monitoring survey report shows that 23 percent of all Ethiopian female children aged 0 to 14 years were circumcised. However, there were large regional variations. Afar region counts the highest prevalence of FGM with 87.4 % followed by Dire Dawa, Somali, Harari, Amhara, and Oromia regions with 78 %, 70.7 %, 67 %, 62.9 % and 58.5 % respectively. FGM in Ethiopia is mostly carried out on girls between the ages of few weeks and 18 years. Findings from the 2008 WHO multicounty study confirm that women who have undergone female genital mutilation, have significant increased risks for adverse events during childbirth and their babies are more likely to die as a result; they experience higher incidences of caesarean section, postpartum hemorrhage and prolonged hospitalization following delivery.

In response to the practice, the Ethiopian government has developed a national strategy on harmful traditional practice in 2013 that gives particular emphasis on Female Genital Mutilation. This has created conducive environment change the attitude and behavior of the public towards FGM.

Save the Children International and Norwegian Church Aid supported by the Royal Norwegian Embassy to Ethiopia are implementing a joint program entitled “Accelerating change towards zero tolerance to female genital mutilation in Ethiopia”. Its overall goal is to: “Reduce female genital mutilation by 31 % from the intervention areas by the year 2015”. With this joint program, Save the Children (SC) and Norwegian Church Aid (NCA) aimed to reach 700,000 children (girls: 450,000; boys: 250,000) and 1,400,000 adults (women: 700,000; men: 630,000) by the end of the project intervention period in 2015. The project is being implemented in seven regions and at federal level: Somali, Amhara, Tigray, Afar, Harari, Southern Nations, Nationalities and Peoples Regional State (SNNPRS) and Oromia.

Norwegian Church Aid and Save the Children are implementing the project in partnership with 24 locally registered Non-governmental Organizations (NGOs), Faith Based Organizations (FBOs) and government offices.

The overall goal of the project is to contribute towards elimination of female genital mutilation in Ethiopia in line with national strategy on harmful traditional practices (2013).

1.3. Justification and Purpose of the Study

The context and purpose of the baseline/end line survey are set out in the TOR at Annex 4. The current baseline/end line survey is vital to set bench marks for measuring progress and also to track changes observed as result of program intervention.

Available studies and evidences on prevalence, knowledge, attitudes and practices of FGM as well as data pertinent to statutory condition and effectiveness of services for women and girls affected by FGM in Ethiopia have limitations in terms of their scope, timeliness and in terms of employing assessment methodological mix. For instance, Ethiopia's national FGM and other HTPs s surveys have been conducted before 7 years. Other studies conducted by civil society and universities are either area specific or they did not sufficiently employ adequate method mix at least to the knowledge of the researchers. Little has been known about the broad economic, social and cultural contexts in which FGM occurs in Ethiopia especially in regions like Somali and Afar where FGM prevalence rates are relatively higher.

Taking these limitations and importance of the study into account, the current study has been conducted with reasonable and logical methodological mix and contextual considerations. It has availed timely information on knowledge, attitudes and practices related to FGM in the areas of interest and others, which can be generalized to regional and national scenarios.

The main purpose of this baseline/end line survey was to generate baseline data and indicators of progress and changes of FGM in Amhara, SNNPR, Afar, Somali, Harari and Oromia regions so that it informs programmers and policy planners.

1.4. Operational Definitions of Key Terminologies

Household: A person or group of persons who live together in the same house and who have girl less than 18 years.

Female Genital Mutilation/Cutting: All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008).

Knowledge: Information and understanding of respondents about any types of FGM.

Attitudes: Feelings toward FGM, as well as any preconceived ideas they may have towards it.

Prevalence: Proportion of household who circumcised their daughter (age below 18) in the last one year.

Forms/Types of Circumcision according to WHO definition (2008) refers to:

Type I: cutting partial or total clitoris, this is also called sunna in Muslim areas

Type II: Excision or clitoridectory

Type III: Infibulation or pharaonic

Sunna*:* In this baseline/end line survey the term *sunna* refers to partial or total removal of clitoris for non-medical purposes

Anti-Female Genital Mutilation Declaration: A statement forwarded by community based organizations such as 'Iders", religious institutions and other forms of networks to prevent FGM either in the form of social sanction or another forms of punishment with community participation and agreement.

1.5. Objective of the Research

The baseline/end line study has been conducted with broad objective of producing valuable information and recommendations pertinent to FGM that would help practitioners to set benchmarks for project progress in the course of project implementation and to track changes made due to the past efforts.

Specifically, this baseline/end line study targeted to:

1. Identify the prevalence of female genital mutilation in the targeted communities;
2. Measure community members' knowledge, attitudes, and practices against female genital mutilation in the target areas;
3. Assess engagements and effectiveness of statutory and customary law on FGM/HTPs;
4. Assess the extent to which the program created the desired results in FGM prevention in line with baseline value of major indicators;

5. Assess effectiveness of anti FGM massages integration in religious teachings and health service provisions for women/girls affected by FGM/HTPs in public health service provision center and
6. Come up with feasible recommendation for future programming and action.

1.6. Organization of the Report

This baseline/end line survey report comprises of four (4) sections. Section one gives an overview of FGM situation in Ethiopia and NCA/SCI FGM program intervention on FGM with local partner organizations and definition of key terminologies. It also describes objectives of the survey. Section two presents methodology used to carry out the baseline/end line survey. Section three describes the findings of the baseline/end line survey. Conclusions and recommendations emanating from this baseline line/end line assessment are given in section four.

1.7. Limitation of the Study

The current study has employed qualitative and quantitative approach, which enabled the research participants to interact and show group behavior (FGD) and experienced FGM practitioners (ex-circumcisers), religious/ community leaders, and young girls in the age of circumcision to share their views.

Although structured interview, FGD, and in-depth interview techniques enabled researchers to generate rich data about the desired research questions, social desirability bias, fear of violating customary laws and declarations against FGM, and others may have limited the respondents to give all the necessary information about FGM. Deception may have also minor impact on the output of this study although attempts were made to minimize it through selecting appropriate research participants, quality data collection tools and probing mechanisms.

2. Methodology and Process of the Survey

2.1 Study Design

This baseline/end line study is a mix of quantitative and qualitative cross-sectional study design whereby pertinent information – in relation to specific objectives of the study has been gathered using exploratory qualitative research tools and survey questionnaire. The assessment specifically aimed to find out knowledge, attitude and practices of female genital mutilation/cutting in the target community. Besides, it assessed the effectiveness of customary and statutory laws, and program intervention including anti- FGM messages and declarations. In line with the objective of the inquiry, four major data collection techniques such as focus group discussion, in-depth interview, document review and survey questionnaire were employed to collect the required data.

3.2. Data Collection Process

With regard to field level data collection, it took a total of 15 days where relevant information has been gathered through coordination of 23 supervisors and 70 data collectors for household survey and three teams of assessors for qualitative study who were simultaneously deployed to the selected 56 study kebeles in six targeted regions of Ethiopia. Research participants were organized for interviews by NCA/SCI local/regional partners, regional and woreda level Women, Children and Youth Affairs Bureau/offices, and ABS Development Service staff members.

2.2.1. Data Source

The main sources of data for this baseline/end line study were households with female child below age of 18 years, Women, Children and Youth Affairs bureau staffs, Police and Justice Office staffs, boys and girls in the age range of 10-24, and local NGO/FBOs staff working on FGM in the sampled region, zone, woredas and kebele.

2.2.2. Data Collection Methods

The baseline/end line study employed the following data collection methods:

1. Document Review: Relevant documents were reviewed. Most notable ones included, but not limited to Ethiopia Demographic and Health Survey, Ethiopia country profile on FGM, conceptual frameworks on FGM prevention, policy briefs of organizations, national surveys pertinent to FGM and other harmful traditional practices, national legal frameworks including constitution of Ethiopia, penal and civil code of Ethiopia. Data related to

prevalence, KAP and effectiveness of customary and statutory laws has been assessed in triangulation with in-depth interview, structured interview and FGD findings.

Conceptual Framework

The study has employed simplified version of ***Social Ecological Model*** which comprises of five level variables that helps to understand FGM prevention. Each stage is presented as follows:

1. **Individual Factors**: It identifies factors related to individuals such as knowledge, attitude, perception, fear and hope, personal history, self- efficacy, and other factors related to individual and which can have impact on practice of FGM
2. **Interpersonal Factors**: Individuals' formal and informal social networks and social support systems that can influence individual behaviors, including family, friendships, peers, religious networks, customs or traditions.
3. **Community/societal Factors:** Relationships among organizations, institutions, and informational networks within defined boundaries, including youth association, women's associations, community leaders, businesses/private and health facilities. It also focuses on social factors that include family, gender relation, peer influence, male engagement/partners role, economic factors, religious values and cultural practices and other factors such as myths and misconceptions
4. **Organizational Factors:** Organizations or social institutions with rules and regulations for operations that affect how or how well, for example, referral service availability, stakeholder's collaboration and effectiveness for girls and women affected and /or at risk individual or group.
5. **Policy/ Enabling Environmental Factors**: Local and customary laws and declarations, national laws and policies, including penal and civil code.

Source: Adapted from the Centers for Disease Control and Prevention (CDC), The Social Ecological Model: A Framework for Promotion/prevention of risks/disease http://www.cdc.gov/violenceprevention/overview/social-ecologicalmodel.html

2. Structured Interview: The quantitative data was generated from the sampled household with a female child under age of 18 in 56 sampled kebeles and 23 sampled woredas in six regions of Ethiopia using structured questionnaire. The data collection tool was translated into Amharic and then back to English to validate meaning equivalence. The Amharic version of the tool was pretested in kebeles where the study has not been conducted.

Sample size: Data was collected from household to generate information on prevalence, and KAP of FGM. Assuming the P= 56 percent (P=proportion of National FGM practices, NCTPA/EGLDAM, 2008), 5% allowance (degree of error) and 95% confidence, the maximum estimated sample size for each region is indicated below. The maximum estimated sample size for each region will be 520 households. Accordingly, the sample size for the six regions is **3120**.

The required sample is determined employing formula taken from Gordon and Gordo's (1994)

$N=\frac{Z^2 P.Q}{e^2}$ +10 (non-response rate) %

Where,

N=the sample size

Z=the standard normal value at the required confidence level (2)

P=an estimate of the population proportion assumed to practice FGM

Q=1-P

e=the maximum acceptable error margin or the confidence interval which is expressed in decimal (0.05)

1 n= $\frac{2^2 (0.56)(0.44)}{(0.05)^2}$ +10 %(non-response rate) = **433**

But since this sampling technique involved multistage cluster sampling, there is always design effect. Thus, we have included additional sample to overcome this design effects.

The design effect, *D*, gives the increase in the variance arising from the cluster design and hence the amount by which we have to increase the sample size.

In most prevalence cases, a design effect of 1.2 to 2 seems reasonable

n''=n' x d

Description:
n'' = required sample size correcting for design effect
n' = previously calculated sample size
d = design effect
n'' = 433x 1.2=520

Thus, the total sample size per region =**520**

Sampling Procedure

The sampling was done using multi stage cluster sampling techniques, simple random sampling and stratified sample as appropriate at different stages of selections. The primary sampling unit was list of target woredas in each of the targeted regions. The targeted woredas in each region was listed and selected into sample using simple random sampling techniques. Accordingly, 23 woredas have been sampled. The secondary sampling unit was list of kebeles in the samples woredas. The kebeles were

listed and selected into sample using stratified sampling method based on their geographic location such as either urban or rural. Thus, two to four kebeles (one urban and the other rural) from each woredas were selected into sample from the strata using random sampling technique. Thus, a total of 56 kebeles were sampled where 14 were urban and 42 were rural kebeles.

Finally, the study population was selected into sample employing the following procedure:

- Step 1: With the assistance of the Kebele guiders, the data collection team traveled to the center (geographic center) of the Kebeles.
- Step 2: From the first 5 consecutive HHs that are located in the right side of the Kebele center, the team selected one HH using lottery method. That HH was the starting HH. Next, every household was interviewed until the required sample generated for the cluster/kebele
- Step 3: The supervisors assigned interviewer to each HHs.

The interviewers have put a mark using choke on the interviewed household. This has helped to conduct spot checks for the supervisors after data submission by data collectors every day.

Table 1: Number of Sample Household in Sampled kebeles by Region

Name of region	Number of woreda	Number of Targeted Woredas		Number of Household per region	Number of Targeted kebele	Number of household per kebele
		Intervention	Expansion			
Afar	5	4	2	532	10	52
Somali	8	5	2	527	16	33
SNNPR	5	4	4	514	10	52
Amhara	1	1	0	520	5	104
Harari	2	1	0	519	9	57
Oromia	2	2	2	517	6	87
Total	**23**	**13**	**10**	**3,129**	**56**	**414**

3. In-depth Interview (IDI): A semi structure questions were employed with WCYA office experts, Police and Justice Office staffs, NGO/FBO staffs working on FGM, and health

service providers at woreda and kebele level.

Baseline/end line study participants were selected employing purposive sampling techniques from regional, zonal, and woreda levels.

In each region, at least 5 and at most 19 individuals were interviewed. Individuals with in-depth knowledge of FGM either from regional offices or zonal/woredas were interviewed. IDI was employed to assess issues pertinent to prevalence, knowledge, attitude and practices, statutory laws and customs against FGM, availability and effectiveness of referral system and Anti-FGM messages integration efforts undertaken by faith based organizations and communities. It helped to capture detailed information related to baseline/end line study and key indicators of FGM elimination efforts. A total of **66** individuals were interviewed for the current study in the six regions and 23 woredas of the study areas.

4. Focus Group Discussion (FGD): Focus group discussions were conducted with Adult men/religious/community leaders, young girls (age 10-24), women and ex-circumcisers (age more than 15), and Young boys (age 10-24) in each of the six targeted regions.

FGD discussants were selected employing purposive sampling techniques. The FGD discussion was facilitated by moderator and note taker/rapporter. With the intent of capturing dynamics of gender and sexual matters of male and female, FGD were held separately at kebele level. FGD was employed to collect data pertinent to community and target population Knowledge, attitude/perception (myths and misconceptions) and practices of FGM. It was generated from kebeles selected for structured interview. A total of 24 FGD were conducted in the six targeted regions.

Table 2: Summary of the Sample Size and Data Sources for each data Collection Tool

Study Setting	**Data Source**	**Collection Method**	**Total # of groups or individuals participants**	**Measurement highlight and themes**
Regional WCYA	Gender coordinators/ focal persons	IDI	**4**	KAP, Statutory/Customary laws and program effectiveness
Zonal WCYA Office	Gender coordinators/	IDI	**6**	

	focal persons			
Woreda WCYA, Police, Justice office	FGM/HTP focal persons, crime investigators, prosecutors	IDI	**29**	KAP, Statutory/Customary laws and program effectiveness
NGOs/FBOs at regional, zonal or woreda level	HTPs/FGM focal persons, project managers/coordinators	IDI	**14**	KAP, statutory/customary law, program effectiveness and anti FGM message integration level
Hospitals	MNH experts	IDI	**1**	KAP, effectiveness of referral system and health service provision
Health Centers	MNH experts	IDI	**13**	KAP, effectiveness of referral system and health service provision
Community	Adult men, religious/community leaders	FGD	**6**	KAP
Community	Adult women and ex-circumcisers	FGD	**6**	KAP
Community	Young boys (age 10-24)	FGD	**6**	KAP
Community	Young girls (age10-24)	FGD	**6**	KAP
Community	Household head	Household survey	**3,129**	Prevalence ,KAP of FGM

2.2.3. Recruitment of Supervisors and Data Collectors, Training and Pre-Testing

Experienced assessors/facilitators, note-takers as well as quantitative data collectors were recruited and trained on techniques of qualitative and quantitative data tools designed for this particular study prior to the data collection.

The research team has undertaken pretest of the household survey after survey questionnaire was translated into Amharic. The necessary corrections have been made to the tool based on feedback findings of pre-test results. This helped the data collectors and coordinators to conduct smooth actual field-level data collection.

2.2.4. Field Data Collection and Supervision Process

Field data collection was conducted by professionals who have been organized under team leaders. The team leaders were also facilitators/interviewers of the FGDs, and IDI. They have been involved in supervising quantitative data collectors and conducted sample spot checks. Supervisors were assigned in each kebele to facilitate the data collection process and to ensure quality of structured interview through spot checking. The research participants were voluntarily recruited by woreda level Women, Children and Youth Affair Office, NCA/SCI local partners and ABS Development Service staffs by informing the objective of the research and confirming their informal consents.

2.2.5. Research Team

This study was conducted by a team of researchers who have ample experience on baseline/end line survey. They have a proven record of undertaking similar studies. Hence, part of the research tools development, data collection, data analysis and report writing activities were done by members of the research team.

2.2.6. Ethical Considerations

Assessment permission letter was obtained from Norwegian Church Aid and other local implementing partner organizations including regional and woreda Women, Children and Youth Affair Offices. All concerned bodies were communicated through formal letter from NCA/SCI and permission was obtained from all governmental institutions and concerned individuals. The objectives of the baseline/end line study were explained to all participants of the assessment in order to get informal verbal consent. Moreover, the participants of the research were informed that their name will not appear in any part of the assessment document and they have the right to stop providing information at any time during the interview if they find the research is not important in some way.

2.3. Data Quality

The research team has employed various ways of ensuring quality of data in this inquiry. The consultants have developed standard data collection tool, and the data tool (questionnaire) was pre-tested and translated into Amharic. The Amharic version of the questionnaire was translated back to English by language expert that has been assigned by the team leader. All the data collectors were trained by the consultant team prior to

field level data collection for one day. Further, a common working guide was prepared and given to all the consultant team by the lead consultant. The quality of the final assessment findings and report was further ascertained by conducting discussion/meetings among NCA/SCI staffs and the consulting team at different stages of the baseline/end line survey.

2.4 Analysis of the Baseline/end line Survey

The method employed to analyze the collected data was content analysis approach for the qualitative data in triangulation with conceptual framework and structured interview. This has involved (1) preparation of codebook, creating categories and abstracting, (2) organizing the data and (3) interpreting and reporting (Elo S. et al, 2008).

Descriptive analysis method has been used for the quantitative data. Coding the data was followed by themes and patterns formation and ultimately the data was organized in the form of categories to give meaning to the texts for the qualitative data. This has involved summarizing the information pattern to one theme or capturing the similarities or differences in people's responses within each category. Likewise, the quantitative data was entered in to spreadsheet and transferred to SPSS-version 20 and has been organized in to tables and graphs to explain variable at univariate, bivariate and multivariate level as appropriate to explain prevalence and knowledge, attitude and practices of FGM. Appropriate statistical tools including percentage, chi-square and logistic regression were also employed to analyze the survey data.

3. Findings and Discussion

This section presents a summary of the major findings of the current study in four sub-sections. The first part deals with socio-economic and demographic characteristics of survey questionnaire respondents. The second part addressed respondents' knowledge and attitudes of female genital mutilation. Then, the prevalence of FGM is presented and discussed in line with the existing related literatures. The last part addressed effectiveness of anti FGM message integration in religious teaching, program effectiveness, effectiveness of stakeholder's collaboration and health service provision for women/girls affected by FGM/HTPs and the challenges observed in this regard.

3.1 Socio-Economic and Demographic Characteristics of the Respondents

This section deals with socio-economic and demographic characteristics of respondents. It includes age, role in the household, religion, ethnicity, and educational status of respondents, number of girls in the household, residence, and occupation. These characteristics are included to help the clients and readers to comprehend the results presented in the subsequent section in its proper context.

Ethnicity and Religion of Household Survey Respondents

Table 3.1.a presents target participants' ethnicity and religion. The Table shows that proportional sizes of ethnic groups have been sampled from each region in line with their population size. Majority of the participants, 57.2%, are Muslims as most of the sampled woredas are Muslim population majority areas.

Table 3.1 a: Frequency Distribution of household Survey Participants' Ethnic Group and Religion

Variable	**Level**	**Household Survey**	
		Frequency (N=3,129)	Percent
Ethnicity	Somali	445	14.2
	Harari	86	2.7
	Afar	516	16.5
	Amhara	739	23.6
	Tigray	30	1
	Wolayita	273	8.7

	Oromo	791	25.3
	Sidama	146	4.7
	Dasanchi	103	3.3
Sub total		3070	100
Religion	Orthodox	808	25.8
	Muslim	1789	57.1
	Protestant	366	11.6
	Catholic	51	1.6
	Traditional	76	2.4
	Others	38	1.5
Sub total		3129	100

Age and Role of household Survey Respondents

Table 3.1 b below shows participants' role in the household and their age cohorts. Majority of the participants were mothers (49.2%) followed by fathers (39.5%). The table also shows that proportional size of respondents from all age cohorts have participated in this survey.

Table 3.1 b: Frequency Distribution of Household Survey Respondents' Roles and Age in the Household

Variable	Level	Frequency (N=3129)	Percent (%)	Variable	Level	Frequency (N=3129)	Percent (%)
Role in HH	Father	1236	39.5	**Age Group**	15-25	653	20.8
	Mother	1540	49.2		26-36	915	29.2
	Elder Sister	121	3.8		37-47	887	28.3
	Elder brother	70	2.2		48-58	450	14.3
	Grand parent	117	3.7		59 and above	207	6.6
	Other	45	1.6	**total**		3112	100
Total		3129	100				

Household Survey Respondents Educational Status

Table 3.1 c reveals that majority of the participants of the current survey are illiterates (42.5 percent). This figure is nearly similar with national literacy rate that is 52 percent for female and 38 percent for male as indicated in Ethiopia Demographic and Health Survey finding of 2011. About 19.5 percent of the participants of the current study can read and write.

Table 3.1 c: Frequency Distribution of household survey Respondents Educational Status

Variable	Level	Frequency (N=3114)	Percent
Educational Status	Illiterate	1329	42.5
	Can read and write	610	19.5
	Primary (1-4)	352	11.2
	Primary (5-8)	396	12.7
	Secondary (9-10)	247	7.9
	Above Secondary	186	5.9

Household Survey Respondents' Residence and Occupation

Table 3.1 d shows residential distribution of the study population. The table depicts that majority, 64 percent, of the survey respondents lives in rural areas. Study result conducted by Andualem (2013) shows that residence is a key determinant of female genital mutilation in Ethiopia and the practice is more common among rural women than urban. That was why the current study also surveyed residence to see the difference of FGM practices and found consistent difference with the previous one. The table also shows that majority, 34.7 percent, of the current survey participants were farmers followed by housewives which accounts for 24.7 percent of the participants.

Table 3.1.d: Frequency Distribution of HHS Participants by Residence and Occupation

Variable	Level	Frequency (N=3129)	Percent
Residence	Urban	1139	36
	Rural	1984	64
	Total	2979	100
Occupation	Farmer	1087	34.7
	Animal Rearing	474	15.1
	House wife	772	24.7
	Government Employee	235	7.5
	Merchant	268	8.6
	Student	103	3.3
	Daily Laborer	108	3.5
	NGO Employee	31	1
	Other	51	0.6
		3129	100

3.2. HHS Respondents' Knowledge and Attitude towards Female Genital Mutilation/Cutting

This section presents HHS participants' knowledge, opinion, and attitude towards female genital mutilation.

3.2.1. Information and Source of Information

According to social ecological model, availability of information with appropriate medium of communication is a pathway for change in attitude and practices of female genital mutilation. Taking this into account, the current study has planned to assess sources of FGM related information in the study area and presented the results here under by region.

Figure 3.2.1 a below shows the number of study population who received information about female genital cutting in Afar Region. The number of study population who

received information about FGM is relatively higher in intervention woredas compared to non-intervention woreda. The number of study population that received information about FGM in expansion woreda (Dewe and Megale) is less than all the intervention woredas in the region.

Figure 3.2.1 a: Study Population who Received Information about FGM by Woreda, Afar Region

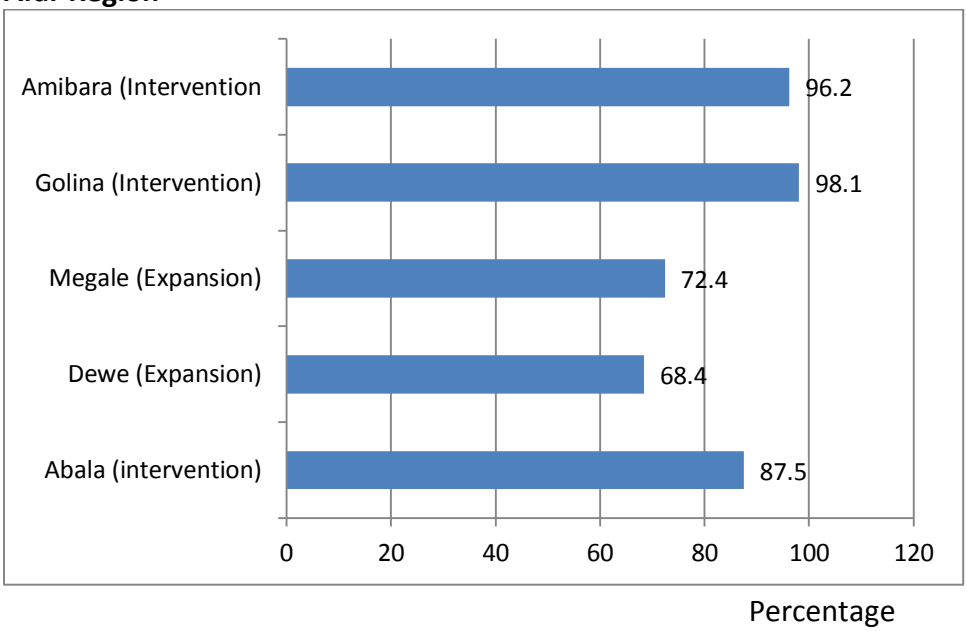


Figure 3.2.1 b shows distribution of study population who received information about FGM in Ankober woreda of Amhara region. The figure shows that 79.2 percent of the intervention community has information about FGM. Of the total HHS participants, 20.8 percent reported that they have never heard information about FGM from any sources recently.

Figure 3.2.1 b: Study Population who Received Information about FGM for Ankober, Amhara Region

Percentage

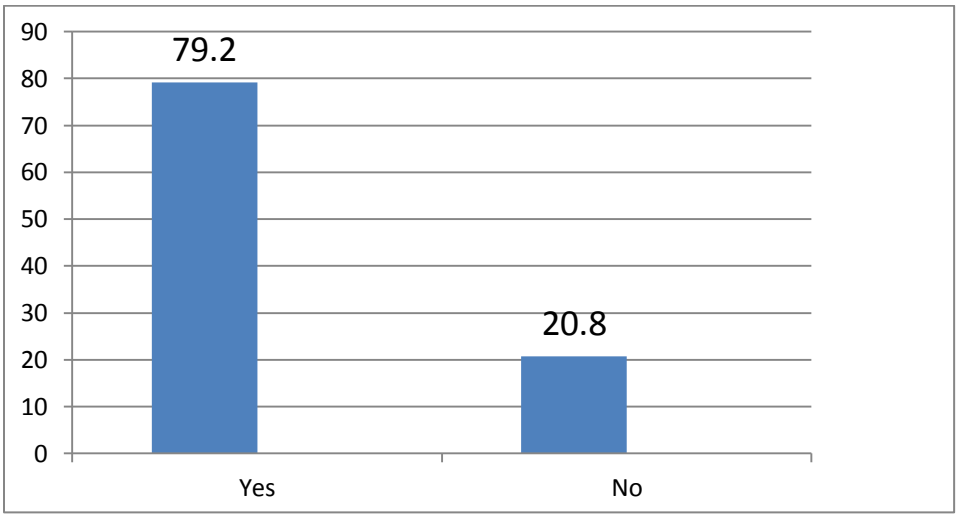


Figure 3.2.1 c portrays number of study population who received information about FGM in Harari region. The figure shows that 97 percent of population in Harari region has received information about FGM.

Figure 3.2.1 c: Study Population who Received Information about FGM by Residence for Harari Region

Percentage

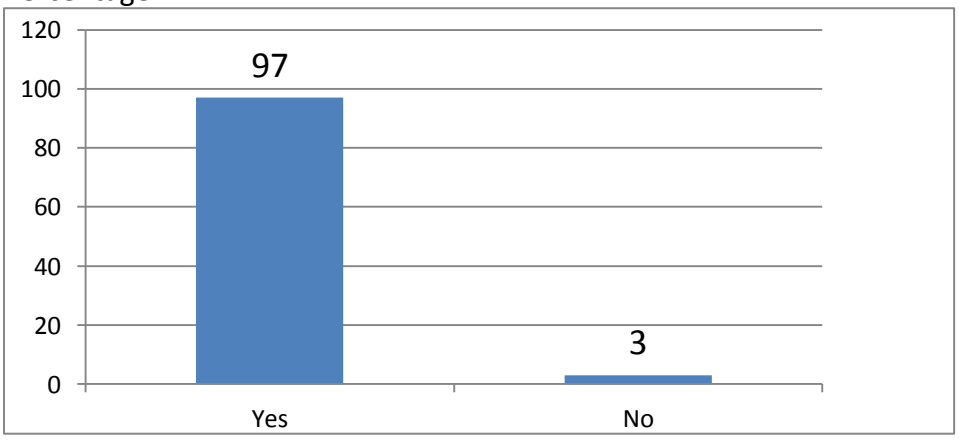


Figure 3.2.1 d shows number of study population who received information about FGM in Somali region for both intervention and expansion woredas. The figure shows most of the intervention woredas exhibit large number of population who received information about FGM. Degehabur, Afdem, Gode, Tulu Bulet, and Erer hold large number of population who received information about FGM.

Figure 3.2.1 d: Study Population who Received Information about FGM by Intervention and expansion, Somali Region

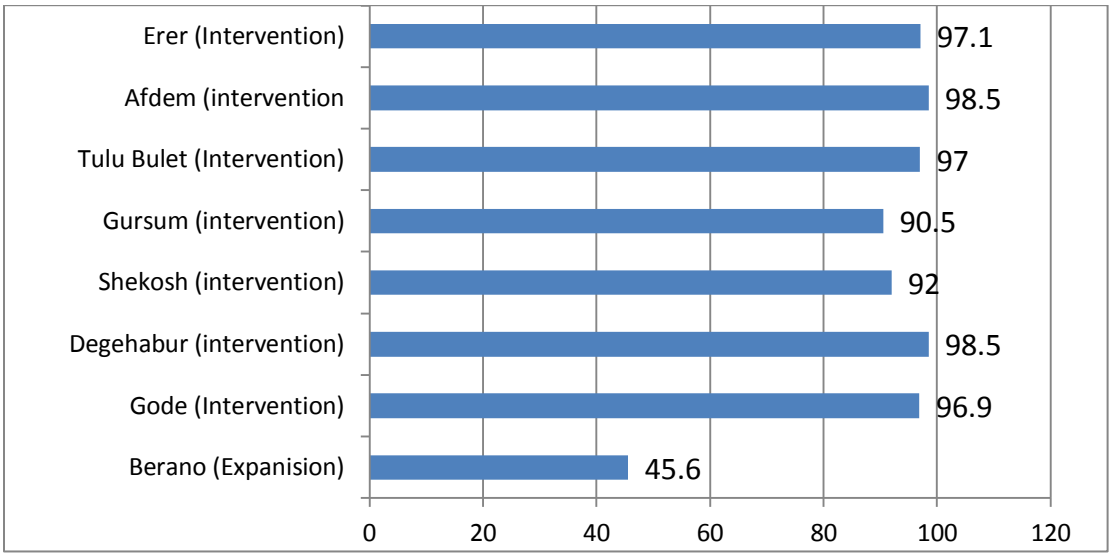


Figure 3.2.1 e below shows the number of study population who has received information about FGM by intervention and expansion woredas in Oromia Region. The figure shows that in Shashamane woreda the number of population who received information about FGM is greater, 97.7 percent, in intervention woreda compared to expansion woreda, 91.9 percent, while in Seraro nearly the same percent of the study population (79.9% and 97.1 %) received information about FGM in intervention and expansion woredas/kebeles.

Figure 3.2.1 e: Study population who received Information about FGM by Woreda, Oromia region

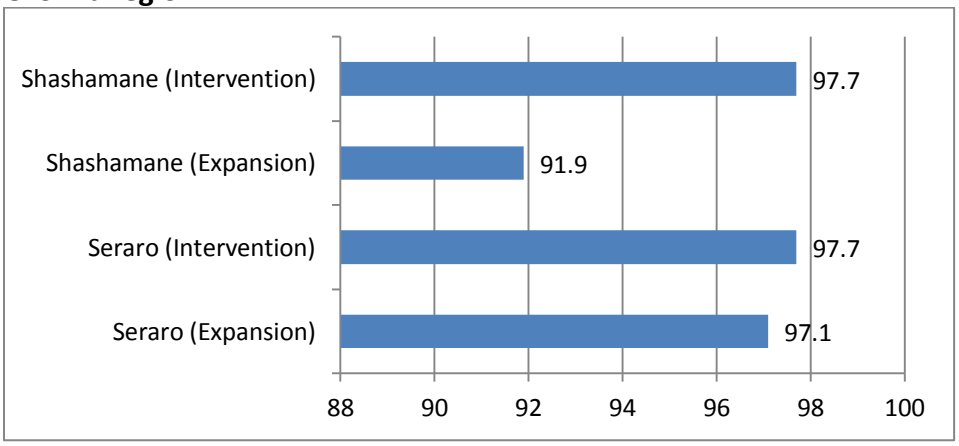
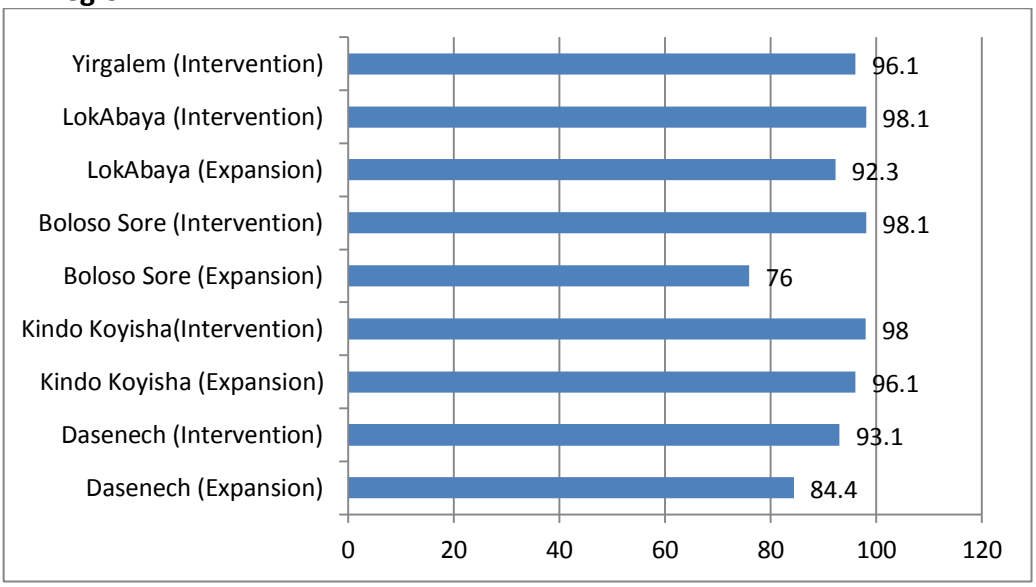


Figure 3.2.1 f below shows study population who received information about FGM in SNNPR of the study regions. The figure shows that in Lokabaya and Bolso Sore, the number of study population who received information about FGM where greater in intervention area than expansion areas/kebeles. Comparing the number of study population who received information about FGM in the current survey with the base line survey, there is an improvement in Boloso Sore and Kindo Koyisha by 1 percent and 1.9 percent respectively.

Figure 3.2.1 f: Study Population who Received Information about FGM by Woreda, SNNPR region



Percentage

Table 3.2.2 a below shows sources of information about FGM by region. The current study reveals that in Afar region, radio/TV (29.2%) peer/friends (28.2%), and religious leaders (15.8%) are the main source of information. In Amhara region, Health Extension workers (36.5%) are the main sources of information. In Harari region, radio/TV (27.9%) and health extension workers (20.4 %) are the main sources of information. In Somali region, peer/friends (18.8 %) and radio/TV (17.5) are the main sources of information about FGM. In Oromia region, health extension workers (33.1%), and radio/TV (32.9%) are the main sources of information about FGM. The most commonly stated sources of information for all regions, except Afar and Somali, are health extension workers. This may be because of Community-maternal and newborn health or integrated refresher

(IRT) course trainings on FGM administered by Ministry of Health, especially in regions where rural extension works are vibrant in their collaboration with Ministry of Women, Children, and Youth Affairs. Recently, all rural health extension workers have been trained on harmful traditional practices. Besides, partners of NCA/SCI such as regional Women, Children, and Youth Bureaus are closely working and training the health extension workers in disseminating anti-FGM messages in the intervention woredas.

Table 3.2.1: Frequency Distribution of Source of FGM related Information by Region

Variable	Level	Peer/Friends	Radio/TV	Religious Leader	Health extension Workers	Social network	School	Other
Region	Afar	28.2	29.2	15.8	6.4	7.9	7.1	3.9
	Amhara	18.3	17.1	5.6	36.5	1.5	4.8	0.4
	Harari	9.6	27.9	13.9	20.4	19.3	7.1	0.4
	Somali	18.8	17.5	10.2	3.9	12.9	3.6	3.4
	Oromia	12.2	32.9	6	33.1	9.1	1.2	3.3
	SNNPR	4.9	16.1	15.5	37.9	17.5	2.7	2.3

Similarly, FGD discussants were also asked where they have got information about FGM and they reported that they have got FGM related information from multiple sources such as radio, health development army, and health extension workers. They reported:

"We got information from multiple sources, but I usually get it from radio", Adult women FGD participant, Afar

"We got information about FGM from health development army members and health extension workers", Ex-circumciser FGD discussant, Harar

"We stopped cutting female genital organ since we get information about its effect on health of women from friends and neighbors", Adult women FGD participants, Somali

3.2.2. Knowledge of Female Genital Mutilation

In this section, study population's awareness about forms/types of FGM, perceived benefit of FGM, average number of circumcisers per study kebeles, awareness on illegality of FGM and anti FGM declaration are presented.

Forms/Types of Female Genital Mutilation

In this study, circumcision or cutting of partial removal of clitoris is considered as type I FGM, excision or clitoridectory type II FGM and infibulations or pharaonic circumcision as type III FGM.

Table 3.2.2 a below shows that type I circumcision is the major form of circumcision in Afar, Amhara, Harari and Oromia regions. The table shows that type II circumcision (81.3 percent) is common in SNNPR region while type III circumcision is practiced in Afar and Somali regions.

Table 3.2.2 a. Study Population's Knowledge of Forms of FGM by Region

Variable	Level	Type I	Type II	Type III
Region	Afar	52.3	15.4	30.1
	Amhara	52.9	23.7	1.2
	Harari	67.1	17.7	2.5
	Somali	42.9	25	31.7
	Oromia	59.6	40.4	
	SNNPR	16	81.3	

FGD discussant and in-depth interview participants have disclosed similar points:

"Before a few years, Excision or Clitoridectory was widely practiced, but now a day health professionals just cut the clitori or sunna", ex-circumcisers FGD participant, Oromia

"In this area, traditional circumcisers cut the clitoris most of the time, but in few kebeles adjacent to Afar, they practice excision", female FGD participant Amhara

"They used to remove the whole internal and external parts of female genital organ and they sew it, but now a days it is changing to cutting of clitori", Adult Men FGD participant from Harai

In-depth interview participants also reported this:

"FGM is done in a secret ways and places. Cutting and stitching /infibulations was the most common one, but now many people are cutting clitoris which is also known as Sunna", in-depth interview participant from Justice Office, Somali

"In Afar area the total cutting of clitoris and cutting of the two surrounding genital skins called labia minor and labia majora and suturing the skin with only leaving an opening for urination is widely practiced. After mutilation, the kids two legs and thigh brought together and kept stretched and kept unseparated till the wound heals", in-depth interview participants, Afar.

In connection with this, FGD participants were asked if there is some specified time or event of circumcision and they reported that there are specific times and events in most of the regions as a norm. In Afar, circumcision took place within two week after birth, in Harari during vacation and school break time, in Amhara within seven days after birth, in Somali around the mouth of October when the weather condition is cool, in Oromai (Arsi) during wedding ceremonies, in SNNPR around '*Meskel* or '*dhimi*'

Knowledge of FGM

Respondents who received information about FGM and have awareness of forms/types of FGM are considered to have knowledge about FGM. Hence, the two variables has indexed and measured target community level of knowledge. Based on this operational definition, the knowledge level of study population by region is presented in table 3.2.2 b below. The table below shows the study population has proportionally good knowledge of FGM in all intervention regions. The level of knowledge is more than 80 percent in all the study regions. People's Level of knowledge about FGM is higher in Afar, Oromia and SNNPR with 91.7 percent, 96.7 percent and 90.1 percent respectively. Respondent's knowledge of FGM is higher in intervention woreda compared to expansion woredas.

Table 3.2.2 b Respondents FGM knowledge by Region and Woreda

Variable	Level	Yes (indexed) % Intervention	Yes (Indexed) % Expansion
Region / woreda	**Afar**	**91.7**	
	Aabala (Afar)	85.5	
	Amibara (Afar)	95.2	
	Golina (Afar)	91.7	
	Megale (Afar)		89
	Dewe (Afar)		82.1
	Amhara (Ankober)	**87.9**	
	Harari	**81.1**	
	Somali	**96.85**	
	Shekosh (Somali)	93.3	
	Degehabur (Somali)	98.4	
	Afdem (Somali)	98.5	
	Erer (Somali)	97	
	Tulu Bulet (Somali)	97	
	Gode(Somali)	96.9	
	Berano (Somali)		84.6
	Gursum (Somali)		98.4
	Oromia	**96.7**	
	Seraro (Oromia)	97.7	97.7
	Shashamane Zuria (Oromia)	97.7	91.9
	SNNP	**90.1**	
	LokAbaya (SNNPR)	96.2	92.3
	Yirgalem (SNNPR)	82.5	
	Kindo Koyisha (SNNPR)	98	96.1
	Bolso Sore (SNNPR)	98.1	76
	Dasenech (SNNPR)	84.4	56

In line with this, FGD participants were also asked whether they have received information related to FGM, and whether they know types of FGM practiced in their area or not. Accordingly, the majority of FGD participants of adult men, women, boys and girls in all regions reported that they have got information about FGM mainly from local implementing partner organizations, lessons of religious leaders, radio/TV news and programs, health extension workers, woreda level WCYA, and police officers.

Circumcisers

Figure 3.2.2 a below depicts average number of circumcisers per kebele in the six study regions. The figure shows that there is relatively similar number of circumcisers in SNNPR, Oromia, Harari and Amhara regions. But the average number of circumcisers in Somali (4.37) and Afar (3.34) regions is relatively greater than other regions in the current study.

Figure 3.2.2 a: Average Number of Circumcisers per kebele by Region

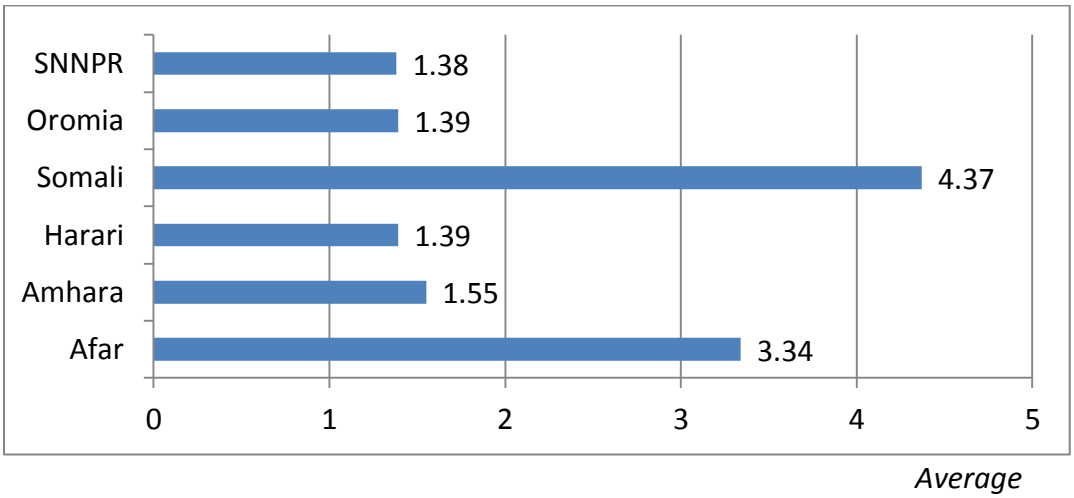


Table 3.2.2 c below shows that in all targeted regions, the main circumcisers are traditional circumcisers. Nevertheless, the number of health professionals engaged in FGM in SNNPR, Harari and Amhara regions are also significant. The result shows that the number of traditional circumcisers is very large in Oromia (94 %), Afar (79.1%), and Somali (75.5%).

Table 3.2.2.c: Distribution of Circumcisers by Region

Variable	Level	Traditional Circumcisers	Birth Attendants	Health Professionals	Other
Region	Afar	79.1	16.4	0.8	1.1
	Amhara	58.3	14	11.5	2.7
	Harari	68	20.4	13	0.2
	Somali	75.5	16.3	7	0.4
	Oromia	94	4.1	1	0.2
	SNNPR	70.8	7.6	14.2	

In line with this, majority of FGD discussants in Bolso Sore of Woliyta zone and Seraro Oromia region reported that the number of health professionals engaged in FGM is increasing over time. For instance, FGD discussant from SNNPR reported:

"These days, the circumcisers are "pestal" doctors wondering from door to door for FGM with about 20 birr payment for their service, most of them are ex-soldiers with some medical training, but does not have license from woreda health office", Religious leader FGD discussant, SNNPR.

Likewise, FGD discussants from Oromia region reported:

"Unlike older time, things are changing, now male nurses are circumcising, many family call nurses into their home or they took the girl to the nurse either in Alba or Shashamane towns", Adult women FGD participant, Oromia

According to FGD findings, the number of traditional circumcisers and traditional birth attendants are decreasing and illegal health professionals are taking the role of FGM mainly for financial benefit. In wolayita area, these health professionals are referred to as "festal doctors" which literally mean pseudo doctors since they do not have professional license and most of them are ex-soldiers who had been health service providers. In Oromia, the health professionals that practice FGM visit rural villages during the night time for circumcision and the villagers await them gathering up to 10 girls at a place and they earn up to 1000 birr for single circumcision. Majority of the FGD discussant agreed that the maximum cost for single girl circumcision was 5 birr for traditional circumcisers, but as the traditional circumcisers stopped or tilting to stop due to anti FGM declaration or law, health professionals started to practice FGM with service payment ranging from 700 to 1000 birr.

In line with this, FGD discussants from Seraro Oromia reported:

"*Most of the time, the practice is done at night as the circumcisers are punished severely*

if they are caught red-handed or arrested. They [circumcisers] charge up to 1000 birr per circumcision. Because the traditional circumcisers are afraid of the law/punishment, male health professionals or nurses are doing circumcision these days", Girl FGD participants, Oromia

Similarly, FGD discussants from Harari reported that FGM is practiced in hidden and secret ways in urban centers while some others travel to rural area during vacation for circumcision.

"My friend was recently circumcised, sunna. She was taken to rural area by her mother and they paid 100 birr for the traditional circumciser. The cost was 10 or 20 birr, but as the circumcisers fear the punishment, the cost escalated. The others still think cutting the tip of the clitoris will not harm. I have also another friend who told me that her mother warned to circumcise her if she sees her standing with boys", Girl FGD discussant, Harari.

Thus, although traditional circumcisers are the main circumcisers in most parts of the target regions, in some areas, there is a shift of task in circumcision where some health professionals are engaging in FGM mainly for financial purposes.

Beliefs and Perceptions related to FGM

Survey respondents were asked why the community practice female genital cutting and the response of the respondent is presented in the table below. Table 3.2.2.d below shows perceived benefit of FGM. The table shows that in Afar and Somali regions, FGM is mainly practiced for social acceptance. In Amhara, FGM is practiced for social acceptance and cleanness. The table also reveals that FGM is mainly practiced for cleanness in Harari, Oromia and SNNP regions as indicated below.

Table 3.2.2.d: Respondent's Belief about Circumcision by Region

Variable	Level	Cleanness	Social acceptance	Better marriage Prospect	Avoid pre-marital sex/virginity	Keep calm or Sexually inactive	More sexual pleasure for men	Religious approval	Other
Region	Afar	3.2	40.4	10.3	10.3	10.9	2.1	6.8	16
	Amhara	8.1	15.2	4.6	2.3	12.1	5.8	5.6	46.3
	Harari	19.3	12.5	6.2	5.8	10	0.2	8.1	37.9
	Somali	24.5	38.3	7	6.8	9.3	1.1	5.3	7.7
	Oromia	62.3	16.4	3.5	2.1	1.7	0.2		13.8
	SNNPR	27.8	24.7	8.2	0.8	13.4	1.2	0.2	23.7

Others consider circumcision as a means of decreasing assertiveness and disobedience of girls to her husband and family, to avoid insult of friends and discrimination of the community. Some also argue circumcised vagina looks more beautiful than uncircumcised one. Some others also believe that circumcision increases politeness of girls and make them humble and descent.

Similarly, FGD participants were made to discuss perceived benefit and beliefs of circumcision in their respective community. Table **3.2.2 e** below shows the summary of perceived benefits reported by FGD participants by region.

Table 3.2.2 e: Afar and Somali FGD Participants' FGM – Related Beliefs

FGD type	Regions	
	Afar	**Somali**
Adult women/ ex-circumcisers	-For men's sexual Satisfaction - uncircumcised girl sexual desire is very high -Uncircumcised girl damage items	-Reduce sexual desire of women -Circumcised girls are calm and humble -uncircumcised girls mostly discriminated by boys and men
Adult men/RLs	-Reduce sexual desire of women -Uncircumcised girl not obedient for husband	-Reduce sexual desire of women -uncircumcised girls become promiscuous
Boy (10-24)	-Reduce sexual desire of women -Uncircumcised girl damage of items For better marriage prospect	-Circumcised girls are calm and humble -Getting circumcised means inheriting mothers tradition -Uncircumcised girls are violent
Girl (10-24)	-To make her polite and not rude	-uncircumcised girls sexual desire is very high -Circumcision/infibulations helps to keep virginity

	-Fear that she will be over assertive -uncircumcised girl feels equals with men	and helps to avoid pre-marital sex

Table 3.2.2 f: SNNPR and Harari FGD Participants' FGM related Beliefs

FGD	Regions	
	SNNPR	**Harari**
Adult women/ ex-circumcisers	-uncircumcised girl is considered unclean or dirty -uncircumcised girls are violent and aggressive -Uncircumcised girls are sexually active than male	-Circumcision is a sign of virginity -uncircumcised girls are not obedient and act violently against her husband and family -Circumcision reduces sexual feeling of girls -Circumcised girl have better marriage prospect
Adult men/RLs	-Uncircumcised girls are rude, they insult their husbands -Uncircumcised girls face discrimination from society - uncircumcised girls will not get husband -Circumcised girl is socially acceptable-she can be eye holder for girls that get circumcised in the community	-Circumcision make girls calm and humble -Uncircumcised girls develops promiscuous sexual behavior -Circumcised girl is socially acceptable
Boy (10-24)	-Uncircumcised girls are over assertive -Uncircumcised girls damages items -Uncircumcised girls sexually exceeds her husband and won't be Calm and stable in marriage life -Uncircumcised girls are promiscuous	-Uncircumcised girl develops promiscuous sexual behavior when she grows up -Uncircumcised girls are disobedient, aggressive and disrespect husband and family -Uncircumcised girl start sex at early age
Girl (10-24)	-Circumcision help girls to be clean -Circumcision reduces the sexual desire of women/girls -Uncircumcised girls act violent with husband	-Circumcised vagina is clean and beautiful -uncircumcised girl grows talkative and promiscuous -Uncircumcised girl damage items

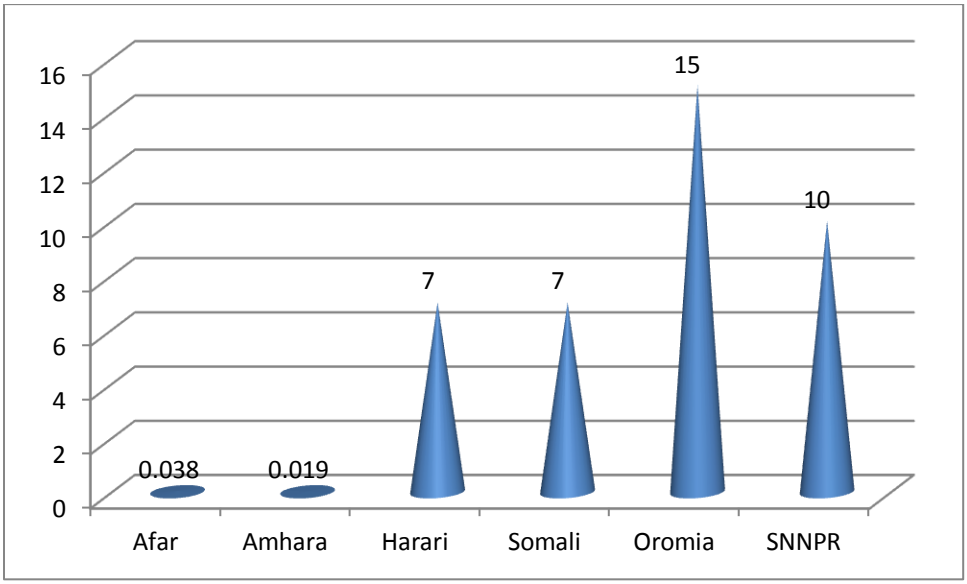
Table 3.2.2.g Amhara and Oromia Regions FGD Participants' FGM related Beliefs and Perceptions

FGD	Regions	
	Amhara	**Oromia**
Adult women/ex-circumcisers	-Uncircumcised girls damages household items -Circumcised girls will have proper menstrual cycle	-Uncircumcised girls are discriminated and insulted -Belief that uncircumcised girl grow up talkative, aggressive, -uncircumcised girl develop promiscuous sexual behavior -Uncircumcised girl is not clean
Adult men/RLs	-Uncircumcised girls/women are not obedient for their family and husbands -Vagina of uncircumcised girl is not suitable for sexual intercourse	-Uncircumcised girls is disobedient for husband -uncircumcised girl are insulted as '*lombotam*' or uncut
Boy (10-24)	-Uncircumcised girl damage household items -Vagina of uncircumcised girl is difficult for sex	-Uncircumcised girls are insulted by friends and mother's in-law as 'lombotam' or uncut -uncircumcised girls are discriminated as dirty/unclean -some believe that if not circumcised the clitoris grow and cannot cut if it elongated larger
Girl (10-24)	-Uncircumcised girl will face difficulty during child birth -Uncircumcised girls are difficult during sexual intercourse -Circumcised girls have better marriage prospect	-Circumcised girls are socially acceptable -uncircumcised girl develop promiscuous sexual behavior -Circumcision keep girls calm

Median Age of Circumcision

Figure 3.2.2 b below show median age of circumcision by region. The figure indicates that the median age of circumcision for Afar is 14 days, for Amhara 7 days while the median age of circumcision for Oromia-Arsi area is 15 years. The median age of circumcision for the remaining regions is nearly similar, it is either 7 years or 10 years as the figure below illustrates.

Figure 3.2.2 b: Median Age of Circumcision by Region



In line with this, FGD discussants and key informants were also asked about age of circumcision and discussants from Oromia (Seraro) and SNNPR (Dasenech) reported:

"In this area, they circumcise on the day of marriage. A girl is circumcised and marries immediately. The circumcision is done either at her husband's house or at her father's house in the presence of her future husband", Adult women FGD discussant, Oromia.

Similarly, in-depth interview participant from Dasenech woreda reported:

"Among Dasenech ethnic group, girls are expected to get circumcised before marriage. The practice is done before the first date of menstruation", Key informant from Justice Office, SNNPR.

Awareness on Illegality of FGM

Study participants were asked whether they have awareness about illegality of female genital mutilation in the country and their responses are summarized in the table below. Table 3.2.2 h below shows the number of study population who knows that FGM is legally forbidden. The table shows that the number of population who has awareness about illegality of FGM is high in all regions of the study. However, some segments of

the study population are not aware of the fact that FGM practice is illegal. The figure is higher in Afar and SNNPR, which is 15%. It is 8.2% and 7.5% for Somali and in Amhara regions respectively. For SNNPR, the largest proportion of the unawareness could be because of Dasenech woreda non-intervention area population's limited knowledge of FGM related laws. In Dasenech non-intervention kebeles, the number of study population who are unaware the illegality of FGM goes up to 50 percent.

Table 3.2.2 h. Study population's FGM legal knowledge by Region

Variable	Level	Yes (%)	NO (%)
Region	Afar	82.5	15
	Amhara	92.1	7.5
	Harari	92.5	6
	Somali	89.4	8.2
	Oromia	90.3	1.2
	SNNPR	81.9	15

In line with this, FGD discussants were also asked if they are aware that FGM is illegal. Majority of the FGD discussants in all the regions frequently stated that they know that FGM is illegal. For instance, one of the FGD participants reported:

"We heard that FGM is illegal and punishable from various sources including church, ider, public meeting and from KMG facilitators. I think everybody knows how much they will be punished if they practice mutilation", Adult men FGD participants, SNNPR.

"Majority of our people does not know about illegality of FGM before few years but now they are getting some information from religious leaders", Boy FGD discussant, Afar

Anti FGM Declarations

Table 3.2.2 i shows the number of study population who heard about anti FGM declaration in their kebele (intervention woredas or kebeles). The table illustrates that in Afar and Somali regions, proportionally larger number of the study population have not heard about anti FGM declaration in their kebeles. Contrary to this, proportionally

large number of study population, 90.7 percent, has heard about anti FGM declarations in Oromia.

Table 3.2.2 i: Number of Study Population who Heard Anti FGM Declaration by Region (intervention areas)

Variable	Level	Yes (%)	NO (%)
Region	Afar	62.6	33.5
	Amhara	77.7	16.5
	Harari	69	25
	Somali	69.4	30.6
	Oromia	90.7	9.3
	SNNPR	76.6	16.8

In line with this, FGD discussants and in-depth interview participants were also asked to discuss whether they heard about anti FGM declarations. Nearly all in-depth interview participants stated that they have not heard any anti FGM declaration that was declared by the community in Somali region, except in Gode woreda where all the participants reported that anti FGM declaration has been done in the woreda at community level.
FGD participants in Oromia frequently stated that they know the declaration and some of them stated that they took part in the process. They reported that:

"The declaration states that if someone practices FGM, be it a circumciser or family, we put some social sanction such as excluding from local associations like 'idir'. Next, we punish him/her birr 1200 for kebele administration, and then 2000 birr, and if he/she persists, we transfer the case to woreda level justice office", Religious leader FGD participants, Oromia.

Similarly, FGD discussants from SNNPR disclosed that:

"We were called at woreda level from all kebeles and made to promise to stop FGM and we were also oriented to formulate declaration. We declared that anyone who practice

FGM will be excluded from local association' ider' and will be charged birr 600 that will go to the kebele administration", Religious leader FGD participant, SNNPR.

3.2.3. Opinion and Attitude towards Female Genital Mutilation

In this section, the study population's opinion and attitudes were measured employing five points Likert scale of 10 questions having maximum sum score of 50 with favorable attitude for FGM and minimum sum score of 10 with unfavorable attitude towards FGM and the results are presented and discussed. Moreover, study populations willingness to marry uncircumcised girl/women, influential figures who engage in decision making of FGM, opinion of the continuity of FGM, plan and attitude of the participant towards FGM are presented in this section of the report.

Willingness to Marry Uncircumcised Girl/Women

Table 3.2.3 a below depicts number of study population who are willing to marry uncircumcised girl/women in intervention and expansion areas of the six study regions. In Oromia and SNNPR, as the intervention and expansion kebeles are in the same woreda, significant difference was not observed between the two in the current study. However, the table reveals that high proportion of the study population is willing to marry uncircumcised girl/women in Oromia and SNNPR, which is 81.4 percent and 60.4 percent respectively. The number of study population willing to marry uncircumcised girl in Afar, Somali and Harari is relatively low. In these regions, larger proportions of the study population are either unwilling or undecided to marry uncircumcised girl/women as the table below indicates. However, comparing intervention and expansion woredas in Afar and SNNPR, there is significant differences in terms of the proportions. In other areas, the difference is not proportionally significant may be due to proximity of the intervention and expansion areas and spillover effects of the intervention program.

Table 3.2.3 a: Number of Study Population Willing to Marry Uncircumcised Girls/Women by Region

Region	Level	Yes (%)	NO (%)	Undecided (%)
Afar	Intervention	46	22	31.6
	Expansion	31.4	52.7	15.5
Amhara	Intervention	48.7	9.2	38.7
Harari	Intervention	46	26.6	27.2

Somali	Intervention	41.1	48.9	9
	Expansion	40.2	49.1	8
Oromia	Intervention	81.4	2.3	16.3
	Expansion	80.1.1	3.1	16.2
SNNPR	Intervention	60.4	19.8	16.2
	Expansion	52.6	34.8	8.9

In connection with willingness of marriage to uncircumcised girl, Boy (10-24) FGD participants were asked to discuss whether they think to marry uncircumcised girl in the future or not. Boy FGD participants in Oromia unanimously agreed that they do not have problem in marrying uncircumcised girl. Boy FGD participants from SNNPR, Afar and Amhara also frequently stated the side effect of FGM and confirmed that they won't be shy to marry uncircumcised girl in the future. However, half of the participants in the two FGD from Harari and Somali reported that they are not willing to marry uncircumcised girls. Those boys who are not willing to marry uncircumcised girls linked their reasoning with sexual incompatibility. They further argued that if she is not circumcised, she will not be sexually satisfied with them, and she will look for another man that will put their marriage in divorce. They fear that their wife will be more sexually active than they are. On contrary, half of boy FGD discussants from Harari and Somali frequently stated FGM associated effects such as fistula, prolonged labor and infection as their reason to marry uncircumcised girl.

Influential Figures in FGM Decision Making

Table 3.2.3 b shows study population's perception on influential figures in deciding female circumcision at household and community level. The table portrayed that mothers are the influential decision maker in female genital mutilation in all the targeted six regions of Ethiopia. The role of religious leaders in influencing the outcomes of FGM is minimal, except in the case of Afar (29.9 %) and Somali (22.6 %). In Amhara and Oromia, fathers influence FGM outcomes as equal as mothers, which is 35.2 percent and 34.2 percent respectively. In SNNPR, the influence of the peer or the social

network is strong in influencing decision of FGM, but still the mothers are key figures in influencing FGM outcomes in the region. Others referred to the community, girls themselves, grandmothers, mothers of the husbands, and husbands themselves.

Table 3.2.3 b: Influential Figures in FGM Decision Making by Region

Region	Influential Decision Makers				
	Religious leaders	**Peer/social network**	**Father**	**Mother**	**Other**
Afar	29.9	4.3	15.8	42	6.6
Amhara	11.5	5.2	35.2	37.5	0.4
Harari	18.7	6.7	13.5	48.9	0.8
Somali	22.6	6.3	17.3	49.1	2.8
Oromia	10.1	16.4	34.2	32.1	5.2
SNNPR	4.1	28.8	18.7	36.4	7.2

In line with this, FGD and in-depth interview participants were asked to discuss who influences the decision of FGM at household and community level. Out of the 24 FGD groups, 18 of them stated mothers as influential person in making the decision to circumcise their daughters while 2 stated fathers and 4 mentioned others. The two FGD group who stated fathers as influential decision makers are male FGD groups from Amahra and Oromia, which is consistent with household survey finding. For instance, FGD discussant from Oromia reported that:

"Mostly fathers think his daughter will not find husband if she is not circumcised and the husband who proposed to marry also requests the family to circumcise his future wife for him", Community leader FGD participant, Oromia

Similarly, majority of in-depth interview participants frequently stated mothers as the most influential decision maker in female genital cutting. In-depth interview participant from Harari reported this, for instance:

"Practically, no one is a sole decision maker. FGM is done due to cultural influences. But, mothers are usually the trajectory of this culture. Though some fathers are opposing it, their wives are doing it secretly in their absence", In-depth interview participant, Harari

In line with the influence of mothers, adult men FGD participant from SNNPR also reported:

*"The mother usually says, 'your friends have circumcised and get clean how do you attend school with them or take shower with them. They will point a finger at you and insult you in front of others'. H*e further added *"Especially if the girl faces what the mother says, they reach on decision without knowledge of the father", Adult FGD participants, SNNPR*

Although the extent of these FGD participants is small, some linked the influence with the community itself. They argued that community uses myths and practices discrimination to influence the outcome of FGM. For instance, FGD discussant from SNNPR reported:

"The community is not willing to eat food and drinks prepared by uncircumcised girls or women. They think food and drink prepared by uncircumcised girl or women does not have good smell", Adult man FGD participant, SNNPR

"The community uses unsubstantiated myths like uncircumcised girls are rude and ill-mannered. Some goes to the extent of be insulted as "lombotam" which literally mean dirty and unclean" Adult Women and ex-circumcisers, FGD participant, Oroma.

Few FGD discussants also argued that the girls themselves insist to be circumcised due to various reasons. The main reason is peer pressure and the other is to appear virgin for husband during their marriage. FGD participants from SNNPR and Oromia stated these arguments as follows:

"Friends push each other a lot; they blame each other saying -you have bad smell as you

are not circumcised. When the girls hear this, they force their mothers to circumcise them. They go up to warning or intimidating the mothers 'if you don't circumcise me, I will hang myself. Then, the mother fear and circumcises them", Adult men and religious leaders FGD participant, SNNPR.

"I know one girl who refused to go home with her husband since he did not want to circumcise her during their marriage day. She said 'I will not marry you unless you circumcise me before marriage.' I later learned that she want to appear virgin since it is difficult to know whether someone is virgin or not during circumcision. Likewise, I heard many girls using this tactic when the husband put high value on virginity", Religious leader FGD participant, Oromia

In Dasenech area, the influence of community is stronger as they link FGM with peace and safety of the family and the community. In-depth interview participant from Dasenech woreda reported that the community organizes a feast or ceremony known as *"dhimi"* for FGM. Unless she gets circumcised, she is not considered as Dasenech and the probability of getting husband in the community is nearly zero. The in-depth interview reported:

"Among Dasenech ethnic group, culturally no girl gets married without circumcision. FGM is practiced with open ceremony by the coordination of traditional leaders and preparation of feast by the girls' family. There is strong belief in the community that if a girl gets married uncircumcised, something bad will happen to her family and Dasenech community as a whole. Thus, they prepare a circumcision ceremony called 'Dhemi'"

Generally, based on the above findings, one can conclude that mothers are the most influential figure in female circumcision in all targeted regions followed by fathers in Amahra and Oroma regions. In SNNPR, mothers and peer have big role in making decision related to FGM. In areas like Dasenech, the belief system of the community has determining role in influencing decision of FGM. In regions like Afar and Somali, in

addition to mothers, religious leaders have also significant role in influencing decision of female genital cutting.

Study Population's Opinion about Continuity of FGM Practices

Table 3.2.3c below shows opinion of study population about continuity of FGM by intervention and expansion woredas/kebeles and regions. The table depicts that there are clear difference between intervention and expansion woredas for Afar, Somali and SNNPR. High number of study participants (100%) in intervention kebeles in Oromia and in SNNPR (92.7%), believes that FGM should not continue. High proportion of the study population in Dasenech non-intervention kebeles reported that FGM should continue which is 77.6 percent as indicated in the table below.

Table 3.2.3 c: Study Population's Opinion about the Continuity of FGM by Region

Regions	**Opinion**	
	Should Continue	
	Intervention (% Yes)	**Expansion (% Yes)**
Afar	**12.9**	
Abala (Afar)	11.5	
Amibara (Afar)	17.3	
Golina(Afar)	39.6	
Megale(Afar)		41.7
Dewe(Afar)		9.4
Amhara	**4.4**	
Harari	**12.7**	
Somali	**10.8**	
Afdem (Somali)	27.3	
Erer (Somali)	7.6	
Tulu Bulet (Somali)	10.4	
Shekosh (Somali)	9.7	
Degehabur (Somali)	2.9	
Gode (Somali)	6.2	
Bureno (Somali)		13.5
Gursum(Somali)		3.2
Oromia	**-**	**-**
Seraro (Oromia)	-	12.5
Shashamane Zuria (Oromia)		5.8
SNNPR	**8.3**	**9.7**
Boloso Sore (SNNPR)	13.5	18
Kindo Koyisha (SNNPR)	2	17.6
Yirgalem(SNNPR)	1.9	
LokAbaya (SNNPR)	1.9	2.9
Dasenech (SNNPR)	31.1	77.6

FGD participants were also asked about their opinion on continuity of FGM practice in the future. All FGD participants in all the regions unanimously agreed that FGM should not continue. The key reasons they forwarded is related with FGM adverse effect on reproductive function of women and girls. They cited that there is no religious teaching that order FGM circumcision.

However, with further probing to overcome social desirability effects and fear of punishment, half of the adult women and adult men FGD participants showed their readiness to continue the practice of FGD, especially circumcision if there is no legal prohibition. For instance, adult female and ex-circumcisers FGD participants from Oromia said:

"I like the songs, the ceremony of FGM. After all, it is our culture and we lived with it as Arsi since long time. But I fear not to be imprisoned", Adult women FGD participant, Oromia

"These days, everybody knows the effects of circumcision, but the practice continued. In our locality those educated person are practicing FGM, so how can we the illiterate abandon circumcision", Adult and ex-circumcisers FGD discussant, Afar.

"I have heard religious leaders telling the people not to cut the whole portion of the vagina rather very small part for sunna. Most elders and religious leaders react not to circumcise during public meetings, in the presence of legal bodies, but they go home and practice it secretly", Girl FGD participants, Afar

Boy FGD participants from Harari also disclosed that they prefer circumcised girlfriend and wife mainly linking with sexual compatibility. The FGD participants reported:

"Traditionally it is said that there is a difference among girls who are circumcised and who are not. If they are circumcised, they will be obedient to family. She will not be hurry to start sexual intercourse at teen age. So, I support FGM because it prevents the girl from being resort to sex", boy FGD participant, Harari

"In my family FGM is just cutting of clitoris since our family believes that when the girl grows, she will become promiscuous and have high sexual feeling. They start sex at their earlier age than girls who are circumcised. It is correct. There is a difference between the circumcised and uncircumcised girls during walking, physical appearance and conversation type. So, I support FGM, but it should be limited to cutting of clitoris", boy FGD discussant, Harari

Plan for Circumcision

Table 3.2.3 d below shows study population's plan to circumcise their daughters by region and intervention verses expansion woredas/kebeles. The result shows that there is proportionally significant difference between intervention and expansion areas as well as between regions. The lowest plan to circumcise their daughters in the future is reported in Oromia where 2.3 percent of the study population have plan for circumcision. Respondents from Somali and Afar exhibits larger proportion of the study population with the plan to circumcise their daughter in the future. When we compare intervention and expansion woredas/kebeles in the target regions, proportionally high differences observed in Afar, Somali, and SNNPR. High proportion of population in Dasenech and Gursum has a plan to circumcise their daughter in the future which is 74.1 percent and 66.7 percent respectively.

Table 3.2.3 d: Study Population and their Plan to Circumcise their Daughter by Region and Woreda

Region	**Groups**	
	Intervention (Yes %)	**Expansion (Yes %)**
Afar	**28.56**	
Abala(Afar)	16.3	
Amibara(Afar)	29.8	
Golina(Afar)	39.6	
Megale(Afar)		47.6
Dewe(Afar)		22.2
Amhara (Ankober)	**21.2**	

Harari	**13.1**	
Somali	**28.2**	
Afdem (Somali)	27.3	
Erer (Somali)	43.9	
Tulu Bulet (Somali)	22.4	
Shekosh (Somali)	23.6	
Degehabur (Somali)	38.2	
Gode (Somali)	13.8	
Bureno (Somali)		44.6
Gursum (Somali)		66.7
Oromia	**2.3**	
Seraro (Oromia)	2.9	13.9
Shashamane Zuria (Oromia)	1.2	9.3
SNNPR	**12.2**	
Boloso Sore (SNNPR)	13.5	28
Kindo Koyisha(SNNPR)	2	5.9
Yirgalem(SNNPR)	2.9	
LokAbaya (SNNPR)	3.8	23.1
Dasenech(SNNPR)	53.1	74.1

Similarly, FGD and in-depth interview participants were also asked whether they have a plan to circumcise their daughter in the future or not. Majority of the FGD discussants in all regions frequently stated that they would never circumcise their daughter. Some of the discussants attributed their belief to health and psychological impacts of FGM. Others fear the persecution either by the local government or community/religious leaders. Majority of Adult women FGD participants from Oromia argued that they will practice FGM if they were not punished. Majority of boy FGD discussants from Harari opt to practice circumcision or cutting of clitoris for sunna attributing the practice with benefit of avoiding pre-marital sex, and making calm and humble. Some reported that their family practice circumcision for sunna, and they want to follow the foot step of their family.

In-depth interview participants unanimously responded that they do not have a plan to circumcise their daughter in the future. Some goes up to regretting their old practice of circumcising their daughters.

Attitude towards Female Genital Mutilation

With the intent to measure attitude of study population with appropriate scale of measurement, a likert scale having 10 items with five negative and five positive statements were developed and employed in the current survey. Options of the scale ranges from strongly disagree to strongly agree (Strongly agree = 5, disagree = 4, undecided = 3, disagree = 2, and strongly disagree = 1). Strongly disagree alternatives for positive statements were given value or score of 1 while strongly agree options for positive statement were given value/score of 5. Respondent with undecided attitude was given a score of 3. The maximum possible score for unfavorable attitude towards FGM is 50 and the minimum possible score for favorable attitude for FGM is 10. Accordingly, respondents with score of 10-25 are labeled to have favorable attitude for FGM and respondents with score of 36-50 are labeled to have unfavorable attitude for FGM. Those respondents that score in between such as from 26-35 are labeled to have undecided attitude towards FGM.

Table 3.2.3 e below shows study population's attitude towards FGM by region in the intervention and expansion woredas/kebeles. The study population in Somali, Afar and Amhara has relatively higher number of population with favorable attitude towards FGM which is 50.9 percent, 42 percent and 38.3 percent respectively. Study regions (intervention) with lower number of population with favorable attitudes towards FGM are Harari, SNNPR and Oromia, which are 16.6 percent, 24.1 percent and 22.9 percent respectively. There is relatively larger proportion of study population with undecided attitudes towards FGM in Afar (intervention) and SNNPR (intervention), which accounts for 17.8 percent and 12.9 percent in the order already mentioned.

Table 3.2.3 e: Study Population and their Attitudes towards FGM by Region in terms of Intervention and Expansion Areas

Regions	Attitudes					
	Favorable (%)		Unfavorable (%)		Undecided (%)	
	Intervention	*Expansion*	*Intervention*	*Expansion*	*Intervention*	*Expansion*
Afar	**42**	**51.2**	**40.2**	**34.8**	**17.8**	**14**
Abala	41.3		54.8		3.8	
Amibara	52.9		19.2		27.9	
Golina	45.6		38.1		16.3	
Megale		58.3		26.2		15.5
Dewe		33.3		46.2		20.5
Amhara	**38.3**		**56.3**		**5.4**	
Harari	**16.6**		**75.7**		**7.9**	
Somali	50.9	61.9	35.3	31.3	13.6	6.3
Afdem	30.3		59.1		10.6	
Erer	25.8		53		21.2	
Tulu Bulet	16.4		80.6		1.5	
Shekosh	23.2		69.1		7.7	
Degehabur	44.1		32.4		23.5	
Gode	53.8		43.1		3.1	
Bureno		70.8		29.2		
Gursum		52.4		47.6		
Oromia	**22.9**	**29.6**	**73.3**	**70**	**3.9**	**0.4**
Seraro	31.4	27.8	68.6	72.2		
Shashamane Zuria	11.6	40.7	87.2	57	1.2	2.3
SNNPR	**24.1**	**29**	**63**	**54**	**12.9**	**16.7**
Boloso Sore	15.4	12	73.1	78	11.5	10
Kindo Koyisha	11.8	13.7	88.2	84.3		2
Yirgalem	26.2		62.1		11.7	
LokAbaya	26.9	44.2	73.1	55.8		
Dasenech	40	63.8	11.8	36.2	46.7	

The findings on the attitude of respondents towards FGM is consistent with other variable such as opinion about continuity of FGM and plan to circumcise daughters as presented in section 3.2.4 above. FGD discussants also frequently stated that some peoples are practicing FGM in hidden and secret places as their attitudes are not yet changed.

3.3. Prevalence of Female Genital Mutilation/Cutting Practices

In this section, variables pertinent to prevalence of FGM practices are presented and discussed. It discusses prevalence of female genital mutilation, forms of FGM girls and spouses underwent, and practices of infibulations in the study regions.

3.3.1. Prevalence of Female Genital Mutilation

In this baseline/end line survey, prevalence of female genital mutilation has been measured employing an item which asks if respondents have circumcised their daughter in the last one year. Table 3.3.1.a below shows prevalence of female genital mutilation by region. It compares baseline survey findings with follow up/current study. It also compares prevalence of FGM in intervention and envisaged expansion woredas/Kebeles.

The table shows that proportionally there is high difference between intervention and expansion areas in Afar, Somali, Oromia and SNNPR. Similarly, when we compare baseline prevalence rate with the current survey result, proportionally high reduction reported in most regions except for Harari, which shows reduction by 18 percent. The result shows that in Somali –Erer and Gode woredas, FGM reduced by 41.2 percent and 30.6 percent respectively; in Oromia Shashamane Zuria woreda by 33.2 percent; in SNNPR -Boloso Sore woreda, by 23 percent; in SNNPR-Kindo Koyisha woreda, by 43.5 percent; in SNNPR - Yirgalem woreda, by 23.2 percent; in SNNPR-Lokabaya, by 27.9 percent, and in SNNPR Dasenech woreda, by 45.7 percent.

Table 3.3.1 a: Prevalence of Female Genital Mutilation by Region

Regions	Prevalence of FGM (%)			
	Baseline (intervention)	**Current (intervention)**	**Difference**	**Expansion**
Afar (Amibara)		51(49)		
Afar (Golina)		50(52)		
Afar (Megale)				59.2(62)
Afar (Abela)		49(51)		
Afar (Dewe)				58.7(69)
Amhara (Ankober		**38.1(198)**		
Harari	**36.7**	**18.7(97)**	**18**	
Somali (Bereno)				69.1(45)
Somali (Gusum)				47.6(30)
Somali (Afdem)		42.4(28)		
Somali (Shekosh)		47.8(32)		
Somali (Degehabur)		50(34)		
Somali (Erer)	93.4	52.2(34)	41.2	
Somali (Gode)	84	53.4(35)	30.6	
Somali (Tulu Bulet)		40.3(27)		
Oromia		**33.7(87)**		**39(101)**
Oromia (Seraro)		35.5(61)		39.2(103)
Oromia (Shashamane/Zuria)	63.4	30.2(26)	33.2	37.2(32)
SNNPR		**36(109)**		**41.7(88)**
SNNPR (Bolso Sore)	64.2	40.4(21)	23.8	48(24)
SNNPR (Kindo Koyisha)	86.6	43.1(22)	43.5	62.7(32)
SNNPR (Yirgalem)	35.8	12.6(13)	23.2	
SNNPR (LokAbaya)	79.8	51.9(27)	27.9	59(31)
SNNPR (Dasench)	94.6	48.9(22)	45.7	62.2(36)

The figure above further revealed that in most intervention regions with high proportion of FGM practice such as Afar, Somali and in two woredas of SNNPR (Lokabaya and Dasenech) , FGM practices are 50 percent, 47.4 percent, 51.9 percent and 48.9 percent respectively. Similarly, in the non-intervention woredas and kebeles of these regions, FGM practices ranges from 58 percent to 62.2 percent.

Similarly, FGD and in-depth interview findings revealed that community awareness is gaining momentum in the intervention areas through continuous awareness raising forums created by anti FGM facilitators at grassroots level, and implementation of customary laws and declarations formulated by community and religious leaders.

In line with this, FGD and in-depth interview participates were asked about prevalence of FGM in their respective localities. The majority of FGD discussants and in-depth interview participants from Oromia, SNNPR, and Harari frequently stated that FGM practices are minimal in their respective localities, which is consistent with household survey findings. For instance, the FGD and in-depth interview participants reported:

"We are not hearing FGM practices these days, but I cannot say it has stopped, some people do it somewhere. Actually, the traditional circumcisers have stopped, but health professionals are circumcising in hidden ways", religious leader FGD participant, Oromia.

"I have three daughters. I circumcised the elder one since I did not know the effects of FGM. Two of them are not circumcised. Few people circumcises their daughter in secret ways like taking girls to rural area in Harar", Adult women FGD participant, Harari

"FGM is decreasing in our woreda. The circumcisers are engaging in other income generation schemes. But we have two problems: one is the girls themselves are requesting, in some areas, to be circumcised due to peer influence. The other problem is new circumcisers such as uncertified nurses and ex-soldiers with some know how about medical care that the community call them 'festal Doctor are appearing'", in-depth interview participant, SNNPR.

FGD discussants and in-depth interview participants from Afar, Somali and Dasenech woreda in SNNPR were also asked about magnitude of FGM in their worda, and most of them frequently reported that FGM practice has been significantly reduced. It is practiced by nearly half of the society in their localities, which is consistent with household survey finding. They reported that:

"We circumcised our girls since we did not have enough knowledge about its effects. Our males were also used to say 'narrow house and narrow vagina are good.' We learnt through hard ways that the side effect of circumcision outweighs. But still half of the community is practicing since our level of understanding is different", Adult women and ex-circumcisers FGD participant, Afar

"Circumcision is decreased among our communities living nearer to urban center and FGM information sources. Nevertheless, still significant numbers of the people are practicing it in secret ways. The community is not willing to disclose information related to FGM which made legal protections difficult for them", In-depth interview participant, Somali.

"In some kebeles of Dasenech, there are better changes observed. There are many uncircumcised girls. Many get married uncircumcised although still significant number of people are practicing FGM", In-depth interview participants, Dasenech

Forms of Circumcision

This section describes forms/types of female genital mutilation done to that girls and women in the study areas with the assumption that it helps to understand shifts in type of FGM across age cohorts. In this assessment, type I refer to cutting of clitoris, type II refers to excision or clitoridectory and type III refers to infibulations or pharaonic. Similarly, the term sunna refers to partial or total removal of clitoris.

Table 3.3.1 b below shows forms/types of female genital cutting by region. The table shows that type I FGM is widely practiced in Amhara, Oromia and Harari. In Amhara, 42.9 percent of girls and 58 percent of spouses were cut for type I. In Oromia, 21.3 percent of girls and 52.8 percent spouses were cut for type I. In Harari, 27.2 percent of girls and 44.7 percent of spouses circumcised for type I. The table depicts that type II is widely practiced on girls and spouses in SNNPR in SNNPR, 35.8 percent of girls and 66.7 spouses underwent type II.

Table 3.3.1 b reveals that type III is widely practiced in Afar and Somali regions. In Afar, 38.8 percent girls and 63 percent of spouses, in Somali region 32.3 percent of girls and 59.6 percent of spouses underwent type III FGM.

3.3.1 b: Forms/types of Circumcision

Regions	**Forms of Circumcision**					
	Type I		**Type II**		**Type III**	
	Daughter	Spouses	Daughter	Spouses	Daughter	Spouses
Afar	15.4	16.5	9.6	13.9	35.8	63
Amhara	42.9	58.1	16.9	23.5	1.7	1.7
Harari	27.2	44.7	5.4	22.5	0.8	3.5
Somali	24.3	12.5	6.8	24.5	32.3	59.6
Oromia	21.3	52.8	14.5	31.5	0.4	-
SNNPR	2.5	17	35.8	66.7	-	-

FGD participants have also frequently reflected on the importance of perpetuating circumcising girls for *type I* in line with their religious and gender perspectives. For instance, boy FGD discussant from Harari stressed that:

"I heard that religious leaders teaching encourage to practice circumcision for sunna [cutting of clitoris] and also telling the congregants/followers not to practice infibulation and excision", girl FGD participant, Harari

"I respect my religion (Islam) It says a girl should get cut in small amount and it is sin not to get practice sunna circumcision", girl FGD participant, Somali

3.3.2. Determinants of Female Genital Mutilation

Socio-economic variables that are found to have statistically significant association at bi-variant data analysis level with help of chi-square test were examined using binary logistic regression for further statistical analysis and three variables such as, age of the study population, attitude towards FGM, and hearing about anti FGM declaration were found to be determinant factors. Multivariate analysis result shows that female genital mutilation has statistically significant associations with age of respondents, attitude

towards FGM, and awareness of anti FGM declaration at 95 and 99 % degree of confidence.

The study shows that girls from older parents, parent that did not hear about declarations against FGM, and parents with favorable attitude towards FGM are at risk (odd ratio approaches 1). This means, a girl from older parent, or parent that did not hear about anti FGM declarations and parent/household with favorable attitude towards FGM has higher probability of getting cut or mutilated. A unit change in age cohort from age group 59 and above to lower age groups decreases the likelihood of circumcision by 11 percent. Probability of circumcision increases by 1.9 times for girl from a parent who has not heard about anti FGM declaration compared to girl from parents who have heard anti FGM declaration. Similarly, the likelihood of circumcision for a girl from parent or household with favorable attitude towards FGM is 18 percent compared to a girl from parent with undecided attitude towards FGM.

Table 3.3.2: Determinants of Female Genital Mutilation

Variables	**FGM Practice**		
	Yes	**NO**	**EXP (ß)**
Heard declaration about anti- FGM			
Yes	822	1459	****1.979**
NO	432	372	1
Age of Respondent			
15-25	245	393	
26-36	354	632	
37-47	352	483	
48-58	217	210	****-0.897**
59 and above	87	113	1
Attitude towards FGM			
Favorable	399	667	**-**0.828**
Unfavorable	704	1039	
Undecided	152	125	1

***Statistically significant at both at 95% and 99 %*

3.4. Effectiveness of Program Intervention on Female Genital Mutilation/Cutting

Under this topic, effectiveness of statutory and customary laws, anti FGM messages integration, health service integration and performances of key program indicators are presented and discussed. Besides, barriers and challenges associated with program intervention efforts are also discussed.

3.4. 1 Engagement and Effectiveness of Customary and Statutory Laws in Alleviating Female Genital Mutilation/Cutting

In this section, engagement and effectiveness of both customary and statutory laws are discussed.

Engagement of Customary Law

One of the main objectives of this study was to examine how much customary/statutory laws are established and utilized in the prevention of female genital mutilation in the target regions. In line with the conceptual framework, social ecological framework, availability and utilization of customary laws which can impact other factors like knowledge, attitude and practice of FGM at individual level, and other factors like peer pressure, availability of media outlets, religious teachings and family influences at social or community level are equally important variables in predicting the outcomes of female genital mutilation.

As stated under section 3.2.3 above, the number of study population who have heard about anti FGM declarations and set it as customary laws at kebele level varies from region to region. The current finding reveals that the number of people who heard about anti FGM declaration and set it as customary law in their kebeles is 62.6 percent in Afar, 77.7 percent in Amhara, 69 percent in Harari, 69.4 percent in Somali, 90.7 percent in Oromia, and 76.6 percent in SNNPR. The number of study population who has heard about anti FGM and put it as part of customary law is relatively high in Oromia, Amhara and SNNPR.

In line with this, Adult men, religious and community leaders FGD discussants who were part of the anti FGM declaration and customary laws formulation, and in-depth interview participants from Justice and Police offices of intervention woredas stated the following concerning the role of customary laws in the efforts of FGM prevention:

"We have established customary law at our kebele that put some social sanction on families of the girls and circumcisers. It includes forms of social sanction like excluding from community based organization-ider, and denying social support during risks and challenges. We also put some punishment in the form of fine which goes up to 200 birr which is in our bylaw", Adult men, religious/community leaders FGD participant, Oromia

"We received training at woreda level and developed bylaw that puts a punishment of up to 600 birr against families, collaborators and circumcisers to be paid for kebele administration. After developing the bylaw, we have sent it to woreda Justice office and they ratified it for us", Adult men, religious/community leaders FGD participant, SNNPR

"We first thought the people at 'ider' and churches about harmful effects of FGM. Then the 'ider' put an article in its bylaw that penalize those families who circumcise their daughter", Adult men, religious/community leaders FGD participant, Amhara

"I know Rohi Wedu facilitating establishment of customary laws and declarations in collaboration with WCYA and Justice offices, but that effort is limited to some kebeles", In-depth interview participant, Afar.

In-depth interview participants from non-program intervention area unanimously confirmed that there are no anti FGM declarations formulated that put clear obligations on members of the community to stop FGM in their woredas and kebele, except the occasional statutory laws related training given by justice and police office staffs. Similarly, there is no customary law and anti FGM declaration in one program intervention woreda Desench woreda. The in-depth interview participants reported that:

"We do not have customary law yet since we opt to create adequate awareness about FGM before engaging in the development of customary laws and declarations", in-depth interview participant, Dasenech

"We are using statutory laws, and we don't have customary laws that support us in dealing with FGM at community level", In-depth interview participant, Dasenech

The findings imply that customary laws have been put in place in majorities of the intervention woredas to deal with FGM practices though not all kebeles in Afar and Somali regions are engaged. The engagement of customary law is better in Oromia, SNNPR, Amhara and Harari regions in that they have adequate and clear bylaws, and obligations announced for the community.

Effectiveness of Customary Law

In order to assess the effectiveness of the customary laws in preventing female genital mutilation, FGD and in-depth interview participants were asked about the number of FGM cases reported and got verdict in previous year. Table 3.4.1 below shows number of FGM cases reported and got verdict by customary laws. The table shows that proportionally better cases are reported for customary law jurisdiction in SNNPR though the largest proportion of the cases reported attributed to Yirgalm woreda. Though there was lack of data mainly due to problem of proper documentation and under reporting of the FGM problems by the community, most of the cases reported have got verdict with the help of customary laws in most of the region, except in the case of Oromia (50%) and Amhara (33%).

Table 3.4.1: Number of Cases Reported and Got Verdict by Customary law in the previous year

Region	Number cases reported	Number of cases got verdict	Percentage
Afar (two woreda)	1	1	100
Amhara (one woreda)	3	1	33
Harari (regional)	2	1	50
Somali (two woreda)	4	4	100
Oromia (two woredas)	12	6	50
SNNPR (three woreda)	40	30	75

Key challenges associated with customary laws implementation identified by in-depth interview and FGD discussants are the following.

- Most of the bylaws are initiated by external bodies such as woreda WCYA/Justice office in collaboration with local NGOs/FBOs and the community did not own them.
- Some of the punishment levels put forward on the bylaws are very strong and it exceeds the punishment threshold put by the government for similar offences. This may frustrated the community and they preferred practicing FGM in secret and hide the cases.
- Some community members are not willing to report FGM cases, and not willing to witness in court cases since the punishment follows are severe.
- Putting social sanction/customary law for malpractices that has been accepted as social norm by the community members puts its implementation at infancy stage in some regions and
- Some of the practitioners of the customary law themselves are not well convinced as they took it as cultural practice, and they are not willing to see such reports

This implies that the function of customary laws in dealing with females genital mutilation cases is low in some of the regions. Nevertheless, it is strong in some woredas like Yirgalem in NNPR, and Shashamane Zuria in Oromia.

Engagement of Statutory Laws

This section presents availability of international and national laws that can be used to deal with FGM practices. It also described the legal awareness of study population and practitioners of FGM prevention/interventions of various levels about FGM.

The main International and national statutory laws/protocols and conventions put in place and ratified by Ethiopia on female genital cutting are indicated in the table below.

Statutory laws and Declarations	Level of engagement	Area of Emphasis
Convention on the right of children (CRC) article 24/3	International	States the importance of abolishing traditional practices prejudicial to the health of children
African Charter on the	Regional	Entitles against protection of harmful social and

Right and Welfare of the Child (1999)		cultural practices
The protocol to the African charter of human and peoples' rights on the right of women (Maputo, 2003)	Regional	Prohibits all forms of female genital mutilation, scarification, medication and para-medicalization of female genital mutilation
Constitution of Ethiopia (article 35 6)	National	-Elimination of the influences of harmful customs and practices that can cause bodily or mental harm
Penal code of Ethiopia(article 565 and 566 of 2003)	National	-Article 565 states circumcising women at any age entails simple imprisonment of up to 3 months and fine of up to 500 birr -Article 566 states any person who cut and sewed reproductive organ of a women be punished imprisonment ranging from 3 years to 5 years. It further states if the sewing resulted in any harm on bodily or health entails a imprisonment ranging from 5 to 10 years
National reproductive health strategy (2006-2015)	National	The strategy seeks to institutionalize educational, legislative enforcements in eradication of harmful traditional practices
Growth and Transformation Plan (GTP)-phase two	National	It emphasizes the importance of minimizing harmful traditional practices on children and women
National Strategy and Plan of Action against Women and Children in Ethiopia (2013)		-Institutionalization, regional and grass root level mechanisms by creating an enabling environment for prevention and elimination of all forms of HTPs and ensure the availability of multi- sectorial prevention, protection and provision of services

In line with these international and national laws, study population was asked if they are aware that circumcising girl/women is illegal. Accordingly, majority of them knows that FGM is illegal as described under section 3.2.3 above. The proportion of the awareness is more than 80 percent in all the regions, but half of the study population in Dasenech woreda is unaware of the illegality of FGM.

Similarly, in-depth interview participants from WCYA, Justice, and Police Office were asked if they are aware of national laws granted to protect girls/women from female

genital circumcision. Majority of in-depth interview participants from WCYA and Police office are unaware of national laws and penal code articles, and the magnitude of punishment stated although they know that female circumcision is punishable act. However, in-depth interview participants from region, zone and woreda Justice Offices know the legal procedures, laws/articles and magnitude of punishment for various forms of circumcision. Majority of In-depth interview participants from WCYA, Justice and Police Office reported that they have been engaged in investigating and following cases of FGM in all targeted regions. Most of in-depth interview participants from Justice Office have stated penal code article 565 and 566 that they have utilized to deals with female genital mutilation.

Effectiveness of the Statutory Laws

With intent of measuring effectiveness of the statutory laws, the number of cases reported to the legislative bodies, and the number of cases that got verdict have assessed in the current study. Besides, in-depth interview participants from WCYA, Justice and Police Offices at all level were asked how they perceive effectiveness of the statutory laws in their respective regions and woredas and their responses have been summarized in the table below.

Table 3.4.2 a below depicts number of cases reported to the legislatives bodies, and number of cases got verdict of reported FGM cases. The number of FGM cases reported is very low as compared to its prevalence stated in the above sections. The table also shows that in spite of low number of cases reported, the number of cases that got verdict is below 50 percent in all regions. In regions like Harari and Amhara none of the reported cases have got verdict.

Table 3.4.2 a: Number of Cases Reported and Get Verdict by Region

Region	Number of Cases reported	Number of Cases that get Verdict	Percentage
Afar (two woreda)	12	6	50
Amhara (one woreda)	5	-	0
Harari	15	-	0
Somali (two woreda)	14	5	35.7
Oromia (two woredas)	19	9	47
SNNPR (three woreda)	9	4	44

Similarly, in-depth interview participants from WCYA, Justice and Police offices were asked about the effectiveness of statutory laws in prevention of harmful traditional practices in general and FGM in particular. Most of the in-depth interview participants frequently stated that the statutory laws are not adequately implemented to prevent female genital cutting for the following main reasons that were frequently stated.

- Lack of adequate information related to FGM practices in the community. Some of the community is not reporting the practices and also not willing to be a witness in case the practice is reported to the court.
- In line with absence of adequate information about the practices, there is long jurisdiction process that discourages the efforts of the reporting and prevention practice through the laws
- There is weak collaborations among the key stakeholders such as WCYA, Justice and Police offices to present cases to the court
- The court requests complete and the whole evidence at a time about the alleged cases of FGM and legal interpretations, which give a loop for witness to disappear and bribed by the circumcisers and
- In Dasenech, most of the executive body collaborate with community leaders who organize circumcision ceremony known as 'dhimi' and less willing and cooperative to follow and execute FGM cases

This implies that effectiveness of the statutory law is weak due to several factors stated above mainly due to absence of adequate evidences and procedures of evidence presentation and willingness of the executive bodies to follow and practice statutory laws at helm.

3.4.2. Effectiveness of Anti- Female Genital Mutilation Messages Integration in Religious Teachings and Challenges

This baseline/end line survey has undertaken to assess the extents of anti FGM message integration in the religious teachings of the target community. But it has not assessed the effectiveness of religious leaders in FGM prevention. Under this section effectiveness of messages disseminated in addressing FGM and associated barriers and

challenges are described. Household survey questions pertinent to source of information and message dissemination were also employed to assess effectiveness of the anti-FGM messages integration in religious institutions. In addition, adult men, religious and community leaders FGD and in-depth interviews with NGOs/FBOs and WCYA staffs were employed to assess effectiveness of the integration and their views are discussed below.

Effectiveness of Anti-Female Genital Mutilation Messages Integration

Table 3.4.2 b below shows percentage of study population who heard about anti FGM information from religious leaders by region. The table illustrates that although religious leaders are not the main source of anti FGM messages, religious leaders are alternative channel of communication in regions like Afar, Harari, Somali and SNNPR. However, in regions like Amahra and Oromia, religious leaders are remote channels of communication of anti FGM messages dissemination. Health extension workers and radio/TV are the main channel of communication for FGM in these two regions.

Table 3.4.2 b: Distribution of Religious Leaders as Source of Anti FGM Information by Region (Intervention)

Regions	Percentage of Population who Heard anti FGM Information from Religious Leaders
Afar	15.8
Amhara	5.6
Harari	13.9
Somali	7
Oromia	3.9
SNNPR	7.3

In line with this, FGD discussants and in-depth interview participants were also asked to discuss the source of information and effectiveness of anti-FGM message integration in their religious teachings.

Summary of FGD participants' responses regarding sources of information about FGM shows that few FGD participants stated religious leaders and institution as source of information of FGM. In Oromia, no FGD attendants stated religious leaders and religious institutions as source of information of FGM. In SNNPR, Somali and Amhara one FGD group out of 4 groups stated religious leaders and religious institutions as source of FGM

information. In Harari and Afar, two FGD groups out of 4 groups in each region stated religious leaders and religious institutions as source of information of FGM. Hence, 7 FGD group stated religious leaders as source of anti FGM messages out of the total 24 FGDs conducted which is less than one third.

Regions	# of FGD group stated Religious leaders as source of anti-FGM information	Total FGM per regions
Afar	2	4
Amhara	1	4
Harari	2	4
Somali	1	4
Oromia	0	4
SNNPR	1	4
Total	**7**	**24**

Similarly, in-depth interview participants were also asked about anti-FGM integration in religious teachings. Majority of FB/NGOs working with religious institutions on anti-FGM message integration frequently reported that they have not adequately integrated anti FGM messages in religious teachings due to the following reasons.

- Although, some religious leaders start integrating anti-FGM message in religious teachings during certain campaign or training of FGM and halt then after. Majority of them lacks interest and commitment to integrate anti FGM messages beyond religious teachings.
- Some still misinterpret FGM as one component of religious obligations
- Cultural practices like 'dhimi' are key obstacles to integrate anti FGM in religious teachings as this lead the religious institution with direct confrontation with local cultural practices and
- Resource limitation to meet religious leaders request for budget to design and produce IEC materials having both contents of religious teachings and anti-FGM messages are the factors.

These indicate that anti FGM messages are not adequately integrated in religious teachings although there are good starts by local NGOs and religious institutions like in

SNNPR Yirgalem area, which developed manuals on how to facilitate the integration tasks.

3.4.3. Effectiveness of FGM Integration in Public Health Service and Challenges

With the intent of measuring magnitude of FGM related health problems, household survey respondents were asked if they have ever visited nearby health service outlets for health problem related to FGM. Table 3.4.3 below shows numbers of study population who visited health facilities for FGM related health problems by region (intervention). As indicated in the table, proportionally larger number of study population visited health facilities for cases related with FGM in Somali (34.6 %), Afar (30.1%), and in Amahra (19.6 %). However, the figure is lower in Oromia, (1.2%) and SNNPR (3.3%).

Table 3.4.3: Number of Study Population that Visited Health Facilities for FGM related health problems

Regions	FGM Related Medication	
	Yes (%)	No (%)
Afar	30.1	67.8
Amahra	19.6	78.5
Harari	5.6	92.1
Somali	34.6	60.7
Oromia	1.2	96.9
SNNPR	3.3	93.1

In connection with this, in-depth interview participants working in public hospitals and health centers were asked whether they have clear system to provide services for women and girls visiting them in relation with FGM related health problems. Some system related questions asked to know the integration of the service includes availability of admission rosters for FGM cases either with other services or stand alone, reporting system for FGM related services, referral and feedback system, and number of cases visited the facilities for FGM related cases and number of cases diagnosed and treated for FGM related cases.

Availability of Registries and Reporting System

In-depth interview participants from all the target regions unanimously said that there is no clear registry for FGM related cases in their facilities. FGM cases are not included in health management information system (HMIS) as well. FGM cases are reports registered among others medical cases.

Majority of the in-depth interview participants reported that because FGM is not included in HMIS, services related to FGM is not being reported or under reported. They are registered under column of soft tissue injuries, but the causes of the injuries are not specified.

For instance in-depth interview from Harari reported:

"We have integrated FGM in our health system services, but we have neither specific department nor focal person for it", in-depth interview participant, Harari

"Our health center treats FGM cases as emergency patient and no separate reporting form is available for FGM", in-depth interview participant, SNNPR.

Referral and Feedback System

In-depth interview participant in Amhara, Oromia, SNNPR and Harari reported that as harmful traditional practices, including FGM, are included in the training manual such as integrated refresher training (community-maternal and newborn health/module-II) for health extension manual, and women's health development army guide, we are receiving cases of FGM in the form of referral. Nevertheless, majority of them reported that they do not have referral either forms or feedback mechanisms for FGM related cases.

Number of Cases Visited and Treated

In all health facilities visited for the current survey, we hardly found number of cases visited and treated for FGM cases in written form. However, few in-depth interview participants have reported cases referred and treated in health centers.

Regions	FGM related Medical Cases	
	Number of cases Referred	Number of cases treated
Afar (two woreda)	10	9
Amhara	-	-
Harari	1	1
Somali (three woreda)	58	46
Oromia (two woreda)	4	4
SNNPR (three woreda)	3	3

Challenges

In-depth interview participants from public health facilities were also asked about challenges related to treating FGM related medical cases, and they frequently reported the following.

- The health service providers have limited knowledge of identifying cases related to FGM since most of them are not well trained on complications related to FGM
- Sometimes FGM cases are treated in Out-Patient Department (OPD) while other time treated first in youth friendly service centers, and then referred to delivery facilities in the health centers. This creates a gap in reporting services of FGM cases.
- There is no clear indicator of reporting for FGM related cases in the public health service system and
- In Afar and Somali regions, clients' health seeking behavior is very low and they do not usually visit health facilities but traditional healers. Some in-depth interview participant link this with fear of the clients for punishment associated with FGM in Afar region.

This implies that although the number of FGM cases visited health service centers for FGM related health problems is large in absolute number in Afar, Amhara and Somali regions, the number of cases referred and treated is small in general. Service integration mechanisms and systems are at their lower stage in most of the targeted regions due to service related challenges stated above and lack of clear data capturing systems in place.

3.4.4. Program Indicators and Key Achievements in FGM Prevention

In order to assess extents of overall program contribution for FGM prevention, an attempt was made to measure program target indicators in the current survey. The key indicators and variables employed to assess are prevalence of FGM, change in attitude of target communities, enforcement of traditional/customary law on prevention of FGM and integration of anti FGM messages in religious teachings against the baseline data.

Prevalence of FGM

As discussed in section 3.3.1 above, compared to baseline FGM prevalence rate, the current finding shown that the prevalence decreased in most of the target regions though the magnitude of reduction vary among the target regions. Current prevalence in comparison with baseline data is presented in Table 3.4.4 a below. In most of the intervention areas, FGM prevalence has decreased ranging from 45.7 percent decrement in Dasenech to 18 percent decrement in Harari region.

Table 3.4.4 a: FGM Prevalence Comparison between Baseline and Follow-up

Regions	Prevalence of FGM (%)			
	Baseline (intervention)	Current (intervention)	Difference	Expansion
Afar (Amibara)		51(49)		
Afar (Golina)		50(52)		
Afar (Megale)				59.2(62)
Afar (Abela)		49(51)		
Afar (Dewe)				58.7(69)
Amhara (Ankober		38.1(97)		
Harari	36.7	18.7(97)	18	
Somali (Bereno)				69.1(45)
Somali (Gusum)				47.6(30)
Somali (Afdem)		42.4(28)		
Somali (Shekosh)		47.8(32)		
Somali (Degehabur)		50(34)		
Somali (Erer)	93.4	52.2(34)	41.2	
Somali (Gode)	84	53.4(35)	30.6	
Somali (Tulu Bulet)		40.3(27)		
Oromia		33.7(87)		39
Oromia (Seraro)		35.5(61)		39.2(24)

Oromia (Shashamane/Zuria)	63.4	30.2(26)	33.2	37.2(32)
SNNPR		36(109)		41.7(88)
SNNPR (Bolso Sore)	64.2	40.4(21)	23.8	48(24)
SNNPR (Kindo Koyisha)	86.6	43.1(22)	43.5	62.7(32)
SNNPR (Yirgalem)	35.8	12.6(13)	23.2	
SNNPR (LokAbaya)	79.8	51.9(27)	27.9	59(31)
SNNPR (Dasench)	94.6	48.9(22)	45.7	62.2(36)

Attitude of Target Communities towards FGM

Change in attitudes of target communities towards FGM measured shows reduction in number of study population who support FGM and number of ex-circumcisers in the target communities.

Table 3.4.4 b below shows that in all intervention regions, the number of study population that supports FGM has decreased.

Table 3.4.4.b: Number of study Population who Supports FGM Practices

Regions	Baseline Intervention	Current intervention	Differences
Afar		12.9	
Amhara		4.4	
Harari	46.7	12.7	34
Somali			
Somali (Erer)	18.2	7.5	10.7
Oromia (intervention)		-	
Oromia (Shashamane/Zuria)	2.7	-	2.7
SNNPR		8.3	
SNNPR (Bolso Sore)	31.9	13.5	18.4
SNNPR (Kindo Koyisha)	46.6	1.9	44.7
SNNPR (Yirgalem)	6.7	1.9	4.8
SNNPR (LokAbaya)	3.7	1.9	1.8
SNNPR (Dasench)	86	31.1	54.9

Average Number of Ex-Circumcisers

With intent to know the number of ex-circumcisers and average number of current circumcisers, information has been collected from all the sampled intervention areas. Section 3.3.2 above shows that the average number of circumcisers is around 1.3.

However, the average number of circumcisers is larger in Somali is 4.37 and in Afar 3.34 as can be seen in the subsequent table.

Region	Current survey (Intervention)
Afar	3.34
Amhara	1.55
Harari	1.39
Somali	4.37
Oromia	1.39
SNNPR	1.38

FGD and key informant participants were also asked whether the numbers of circumcisers are increasing or decreasing in their respective regions. Majority of both FGD and in-depth interview participants frequently stated that the number of traditional circumcisers and birth attendants has largely decreased. Most of them reported that there is no traditional and/or birth attendant that practice FGM in their area. But the participants unanimously disclosed a shift from traditional circumcisers/birth attendants to para- professionals like what they call '*Festal doctors*' and health professionals. The traditional circumcisers have either changed due to trainings or fear of punishment by customary/statutory laws. As result of the shift, the amount of service charge has largely increased. In Oromia the service charge goes up to 700 birr per person. In Afar, Somali, Amhara, SNNPR and Harari, service charge ranges between 20 birr to 100 birr per person. FGD participants argued service charge cost could lower when circumcisers are invited for more than 5 girls at a village level.

Statutory and Customary/traditional laws Against FGM

Section 3.4.1 above states status of customary and statutory laws enforcement and their effectiveness in FGM prevention at all levels and in the program intervention woredas. Customary/traditional laws have been put in place with support of NCA/SCI local partners. In most kebeles and woredas of the intervention area, anti-FGM declarations have been formulated as stated in detail in the above section. However, their implementations are shallow due to barriers and challenges stated in the above section. Compared to customary/traditional law enforcement, effectiveness of statutory

laws is inadequate in serving as means of FGM prevention. Table 3.4.4 c below shows comparison of the number of cases reported to customary laws and statutory laws in the intervention areas. Although there is larger number of FGM cases reporting to statutory laws jurisdiction, customary laws performance or effectiveness is better in terms of getting verdicts. Hence, in most of the regions, 50 percent of cases reported to customary laws have got verdict compared to statuary laws as indicated in the table below.

Table 3.4.4 c: Percentage of FGM Cases Reported and get Verdict by Region

	FGM Cases Verdicts					
	Customary Laws			**Statutory Laws**		
Region	**# cases reported**	**# of cases that get verdict**	**%**	**# cases reported**	**# of cases that get verdict**	**%**
Afar (two woreda)	1	1	100	12	6	50
Amhara (one woreda)	3	1	33	5	-	0
Harari (regional)	2	1	50	15	-	0
Somali (two woreda)	4	4	100	14	5	35.7
Oromia (two woredas)	12	6	50	19	9	47
SNNPR (three woreda)	40	30	75	9	4	44

Integration of Anti FGM Messages in the Works of Religious Teachings

Study population in the target area reported that religious leaders are not the main source of FGM related information; however, they are alternative source of information especially in Afar, Harari and SNNPR regions. Few participants of FGD and key informants have discussed problems and challenges of religious leaders and institutions as:

- Lack of interest and commitment by majority of the religious leaders to integrate anti FGM messages beyond religious teachings are prevalent. In fact, some religious leaders start integrating the messages in religious teachings during certain campaign or training of FGM and halt then after.
- Some still misinterpret FGM as one component of religious obligations

- Cultural practices like 'dhimi' are key obstacles to integrate anti FGM in religious teachings as this lead the religious institution with direct confrontation with local cultural practices and
- There is resource limitation to meet religious leaders request for budget to design and produce IEC materials having both religious contents and anti-FGM messages.

Although, the number of faith communities, which incorporated anti FGM messages in their works is low in most of the intervention areas, there are promising beginnings in regions like SNNPR (Yirgalem and Boloso Sore) and Oromia Shashamane Zuria woreda.

3.4.5. Effectiveness of Government Sector Offices and Stakeholders Collaboration

With intent of measuring effectiveness of government sector offices and stakeholders/partners collaboration, in-depth interviews had been conducted with sixty-six individuals at all levels. The participants were asked about (1) the availability of structure or platform for collaboration, (2) area of collaboration, and (3) periodic meeting to classify regions level of collaboration. Those regions with clear platform, area of collaboration, area of collaboration and period meetings has labeled as strong, those regions that fulfilled at least two of the stated criteria stated labeled as medium and those regions that fulfilled below two criteria's has labeled as weak.

Collaboration Structure/Platform

Majority of the in-depth interview participants frequently stated their attendance of meetings organized by office of WCYAO on the issues of FGM. However, few have indicated that there are child right committee and OVC task forces that were organized to work on child rights and prevention of harmful traditional practices including FGM. It is reported that these platform exists in all government structures up to kebele level though its functionality decreases as it goes down to woreda and kebele level in terms of having clear plan, periodic meetings and execution of planed activities.

Areas of Collaboration

Areas of sector offices and stakeholders collaboration depends on local contexts and local challenges related to FGM. Hence, in-depth interview participants were on which

area they have collaborated so far and the following are the most frequently stated area of collaboration by them.

- Awareness creation and behavior change activities
- Legal enforcement
- Joint planning, monitoring and evaluation
- Information sharing about FGM practices

Level of Collaboration

In-depth interview participants were asked whether the collaboration among stakeholders is strong, medium or weak in line with criteria's stated above, and their responses presented in the table below.

Region	Level of Collaboration	Comments
Afar	Weak	No committee, area of collaboration and periodic meeting
Amhara	Medium	There is committee but not meeting and working on FGM
Harari	Weak	No committee, area of collaboration and periodic meeting
Somali	Weak	There is committee but not meeting frequently and working on FGM
Oromia	Strong	There is committee with clear plan, clear agenda and meeting schedule
SNNPR	Weak	There is committee but not meeting frequently. But in Yirgalm the committee is strong with clear plan, area of collaboration and meeting schedule

Hence, in most of the intervention areas the level of collaboration is weak due to various barriers and challenges.

Barriers and Challenges Pertinent to Collaboration

In-depth interview participants were also asked to describe key challenges to strengthen the collaboration among sector offices and stakeholders. The following are the main frequently stated challenges:

- Government staff turnover
- Shortage of resource to coordinate the collaboration
- Absence of political willingness and commitment
- Perceiving FGM/HTP activities as auxiliary and additional job

4. Conclusions and Recommendations

This section presents conclusions emanated from the study findings and some recommendations forwarded based on the conclusions.

4.1. Conclusions

The findings of this baseline/end line survey are consistent with other studies conducted so far in Ethiopia and elsewhere in terms of peoples' belief system related to FGM and other socio-economic determents of FGM practice. The findings of this study are believed to add a new insight into the existing knowledge in the area female genital cutting in general and it's driving forces in particular.

It is assumed that the findings of the current study will improve the understanding of policy makers, service providers and program implementers about the prevalence, knowledge of female genital mutilation, and communities' perception/ attitude towards the practice. It also suggests areas of emphasis and improvement for customary and statutory laws to deal with FGM practices. The findings further highlighted challenges and opportunities for health service institutions to integrate the issue of women and girls affected by female genital cutting in public sectors. It also indicated barriers to stakeholders' collaboration to address the issues of FGM practices effectively.

Knowledge Pertinent to Female Genital Mutilation

Knowledge has operationally been defined as study population's information possession and understanding of forms/type of female genital mutilation. The variable, knowledge, has been indexed from having information and awareness about forms/types of female genital mutilation and other variables identified in social ecology model that has been employed to measure knowledge level of the study population.

It is found that large segment of the study population has awareness of female genital mutilation including its types and effects on women and girls. Household survey finding reveals that high proportion of population in intervention woredas of the targeted region received information about female genital mutilation compared to the expansion regions. More than 90 percent in Afar, Oromia and SNNPR has knowledge about FGM while this figure is relatively low in Somali and Amahra. The main source of information in Amhara (36.5 percent), Oromia (33.1 percent) and SNNPR (37.9 percent) is health extension

workers. Religious leaders are also important source of information about female genital mutilation in Harari, Afar and Somali regions although radio/TV is a more frequent source of information.

Household survey findings depicts that on average high number of circumcisers are found in Somali and Afar regions, which is 4.37 and 3.34 respectively. Similarly, female genital mutilation is practiced with similar reasoning in the target regions based on FGD finding of the current survey. These include:

Psychology and Gender related Factors of FGM: Circumcision, especially cutting clitoris, is done to reduce sexual feeling of girls and women. It is also exercised to avoid pre-marital sex, to increase faithfulness of girls and women for their husband. In regions like Amahra, it is associated with easy penetration of penis during sexual intercourse while study participants in regions like Afar believes that sewing after circumcision narrow the vagina and increases sexual pleasure for men. It is also related with obedience to husband and family. It is also practiced to reduce assertiveness of girls and women.

Social Reasons of FGM: It is practiced to transfer girls to womanhood, decrease discrimination and increase integration with the society. Besides, in regions like SNNPR and Oromia, circumcision took place to ensure that the girls can easily get husbands. Most practice circumcision to overcome bashing/insult and discrimination from peer especially in Somali, SNNPR, and Oromia.

Cleanness and aesthetic value: In most of the study area, circumcision is done to clean oneself from unnecessary sexual organ wastes. Some think clitoris can grow to the extent of penis if not circumcised. Others in regions like Harari perceive that circumcised vagina is more attractive than uncircumcised one.

Myths based reasoning: Some believe, like in Ankober area, uncircumcised girl may not give birth properly. Others link with having proper menstruation cycle

Religious Reasoning: In Harari, Somali and Afar, most of the participants are convinced that sunna/ circumcision or cutting tip of the clitoris is order of a religion/ is practice of Islamic faith.

The current study found out that there is clear timing or events for female genital mutilation in the study area. FGM is conducted in October (when the weather is cool) in Somali, within two weeks after birth in Afar, during vacation in Harari, either during 'Meskel' or 'dhimi' festival in SNNPR and on wedding days in Oromia. The study reveals that the medium age for circumcision is 7 year in Harari, 7 days in Amhara, 15 years in Somali, and 10 years in SNNPR and two weeks in Afar.

Household survey finding shows traditional circumcisers are the most known circumciser in all the targeted regions, but FGD finding reveals there is a trend of shift from traditional circumcisers to *para-medical* health professionals. Besides, the survey finding shows that a large proportion, more than 80 percent, of the study population in all the intervention areas of the program knows that female genital mutilation is illegal. And, similarly, large segment of study population ranging from 62.7 percent in Afar to 90.7 percent in Oromia, have heard about anti FGM declaration and most of them have developed bylaw to deals with FGM

Attitude and Opinion against Female Genital Mutilation

Variables envisaged measuring opinion and attitude of the study population extracted from social ecology model including willingness to marry uncircumcised girl, plan for circumcision, influential figure in FGM decision and attitudes towards female genital mutilation were employed. Attitude of the study population towards female genital mutilation has been measured with help of a likert scale having 10 questions where attitude of the respondent categorized as favorable, unfavorable and undecided.

The finding of the survey showed that the proportion of the study population who are willing to marry uncircumcised girl or women is higher in Oromia (80.1 percent) and SNNPR (60.4 percent). The proportion of study population who reported to marry uncircumcised girl or women is higher in intervention area as compared to expansion area in all the regions although the difference is not significant in terms of absolute number. FGD finding also showed that majority of boy FGD participants from Afar, Oromia, Amhara and SNNPR have frequently stated that they are willing to marry uncircumcised girl in the future, but half of boy FGD participants from Somali and Harari

reported that they are not willing to marry uncircumcised girl citing sexual incompatibility and failure to meet religious obligations as major reasons.

The baseline/end line survey found out that mothers are the key influential person in making decision about female genital mutilation due to social proximity to girls.

It was found out that majority of the study participants have an opinion to stop female genital mutilation in the future. In Afar 36.7 percent reported that FGM should be stopped and 51.1 percent does not have a plan to circumcise his/her daughter in the future. In Amhara region, 81.3 percent reported FGM should be discontinued and 67.3 percent does not have a plan to circumcise his/her daughter, which is similar to Oromia and SNNPR. In Somali region, 66.4 percent reported FGM should be discontinued and 40.4 do not have a plan to circumcise his/her daughter in the future.

Based on likert scale finding, majority of the study population in program intervention areas have unfavorable attitude towards female genital mutilation. The larger proportion of unfavorable attitude score is in Harari which is 75.7 percent followed by Oromia with 73.3 percent. The lowest unfavorable attitude towards FGM is scored in Afar, which is 40.2 percent. The proportion of respondents with undecided response is also higher in SNNPR (16.7 percent) and Afar (14 percent).

Prevalence and Practices of Female Genital Cutting

In the current baseline/end line survey proportions of study population who recently circumcised their daughters, forms of female genital mutilation they used to circumcise their daughters and determinants of female genital mutilation have been employed as major variables in line with the social enological model to assess magnitude/prevalence and practices of female genital mutilation among the targeted communities.

It was found out that the proportion of study population who circumcised their daughters recently has decreased in most of the target intervention woredas and regions although there are variations across woredas. In the current survey, high proportion of reduction observed in Dasenech, 45.7 percent, while lower proportion of reduction is observed in Harari which is 18 percent reduction as compared to baseline.

Similarly, the magnitude of female genital mutilation is lower in intervention woredas/kebeles compared to the expansion woredas/kebeles in most of the regions.

It was found out that in Afar and Somali regions girls who underwent type III-Infibulations/ pharaonic form of circumcision accounts for 35.8 percent and 32.3 percent respectively. Type II circumcision is mainly common in SNNPR, which accounts 35.8 percent of the three forms of circumcision. Type I circumcision is most common in Amhara, which accounts of 42.9 percent of the three forms of circumcision.

A multivariate analysis using binary logistic regression shows that age of the study population, awareness about anti-FGM declaration and attitude of the study population are determinants of female genital mutilation among the target communities. It was found out that a unit change in age cohort from age group 59 and above to the other age cohort decreases the likelihood of circumcision by 11 percent. The likelihood of circumcision for girl from household who are aware of anti FGM declaration decreased by 1.9 times compared to girl from parent who are unaware of anti FGM declaration. The likelihood of circumcision for girl from parent/guardian with favorable attitude towards FGM increased by 18 percent compared to girl from parent/guardian with undecided attitude towards FGM. The finding is consistent with social ecology model and other studies which predicts that when awareness on circumcision increases and attitude towards FGM changes, female circumcision decreases.

Effectiveness of Customary/Traditional and Statutory Laws in the Prevention of Female Genital Mutilation

It was found out that customary/traditional laws made to prevent female genital mutilation are strong in Amhara, Oromia and SNNPR (except for Dasenech) where majority of the household survey respondents and FGD participants repeatedly stated anti FGM declarations and bylaws developed to punish those who do not abide by the declarations/bylaws. However, in other regions, though local implementing partners made efforts to facilitate/strengthen customary laws in association with anti FGM declarations, most of in-depth interview and FGD participants frequently stated that they do not have vibrant customary laws that prevent female circumcision. Some of the

key informant in Dasenech stated that the customary law promotes female genital mutilation. Although either few cases are reported or the cases are under reported at woreda level, more than 50 percent of cases reported to customary laws jurisdiction have got verdict. This implies the effectiveness of traditional/customary law compared to statutory laws although several challenges are yet to be resolved.

The current survey found out that compared to prevalence of FGM, the number of cases reported to Police and Justice Offices is low. The main reason for low case report is associated with availability of evidences according to in-depth interview participants. Although there are low reports on female genital mutilation, the number of cases that get verdict is also below 50 percent in most of the regions and no case got verdict in Harari and Amhara (Ankober woreda). The effectiveness of statutory laws in dealing with female genital mutilation is weak mainly due to absence of adequate evidence on the practice and absence of willingness of executive bodies to engage in FGM prevention.

Integration of anti-Female Genital Mutilation Messages in Faith-based Institutions and Religious Teachings

The findings of household survey, FGD and in-depth interview, revealed that anti-female genital mutilation messages are not adequately integrated in religious institutions and religious activities in most of the regions. However, in regions like Afar, Harari and Somali, religious leaders are alternative sources of information on anti-female genital mutilation. This implies that religious institutions in these regions have made some efforts to integrate anti female genital mutilation in their religious teachings despite several challenges stated by the in-depth interview participants. The challenges include resource limitation, lack of interest and commitment by religious leaders and cultural influences.

Public Health Service Integration for Women/Girls Affected by Female Genital Mutilation

The baseline/end line survey finding showed that compared to the number FGM cases – brought to health facilities in Afar, Amahara and Somali regions, the number of cases

that received treatment is low. This indicates that service integration mechanism and systems is at its lower stage in most of the targeted regions due to service provision related challenges and lack of clear data capturing and service integration systems. Service related challenges include low level of service providers knowledge in identifying FGM related complication, and absence of focal person or specific department to provide service for FGM cases.

Program Effectiveness on Female Genital Mutilation Prevention

In this study, key program indicators were traced to assess their effectiveness in alleviating female genital mutilation. These were prevalence of female genital mutilation, change in attitude towards female genital mutilation, effectiveness of statutory and customary laws in female genital mutilation prevention, and integration of anti-FGM messages in the works of religious institutions.

The goal of the program is to reduce female genital mutilation by 31 percent by the year 2015. The study revealed that female genital mutilation has shown reduction in all program intervention woredas. The reduction ranges from 18 percent to 45.7 percent.

The current survey found out that the program has reduced female genital mutilation more than its target (31%) in four woredas: Erer (41.2 %) in Somali region, Shashamane Zuria (33.2 %) in Oromia region, Kindo Koyisha (43.5 %) and Dasenech (45.7 %) in SNNPR region. Equally, the program intervention has reduced female genital mutilation below its target (31%) in five woredas such as Harari (18 %), Gode (30.6 %), Boloso Sore (23.8 %), Yirgalem (23.2 %), and Lokabaya (27.9 %).

Change in attitude towards female genital mutilation has been measured by proportion of the study population that supports female genital mutilation and average number of circumcisers per kebele. The baseline/end line survey found out that significant changes observed in both reducing number of study population who supports FGM and average number of circumcisers although new circumcisers (para health professionals such as

'*pestal*' doctors and health professional-nurses) are emerging replacing traditional ones in some of the regions such as Oromia, SNNPR and Harari.

The study revealed that statutory laws are not adequately and efficiently implemented in female genital mutilation prevention in most of the intervention areas. But the effort made through customary law (anti-FGM declaration) was effective since the number of cases presented and got verdict were more than 50 percent in most of the regions despite several barriers and challenges limited optimal effectiveness.

Government Sector Offices and Partners Collaboration

Government sector offices and partners collaboration has been measured through assessing availability of collaboration platform, area of collaboration/common interest, and joint efforts/activities undertaken by the stakeholders. The baseline/end line study found out that the level of collaboration is strong in Oromia and medium Amhara. Stakeholders working in these two regions have developed work plan, established structure of collaboration and have periodic meetings schedule. But the level of collaboration is weak in Afar, Somali, Harari and SNNPR (except Yirgalem) as they do not have common plan of action, periodic meeting schedule, and common area of engagement collaboration.

4.2. Recommendations

Based on the major findings of the study and concluding remarks given above, the research team would like to forward the following recommendations. The recommendation points are forwarded as general and specific suggestions. However, the recommendations needs to be understood with contexts where some of them fit for certain regions/woredas while the others may apply to all the target areas. Hence, it is vital to apply the appropriate recommendations in the appropriate region/ woredas in line with the finding and conclusions given in the above sections.

Specific Recommendations:

The consultant team recommends application of Social and Behavioral Change Communication Strategies (SBCC) in line with the social ecology model employed in this

study to reduce female genital mutilation taking the contexts of target regions into account. Some of these strategies are:

Engage Multiple Channels of Communications: The current survey found out that community dialogue and dissemination of anti-FGM messages are the key channel of communication to reach the community with messages of anti-female genital mutilation. The current study showed that the driving forces for FGM are related with psychological and gender related reasoning, social reasoning, one's faith, peer pressure, myths, and personal factors such as cleanness and aesthetic values. In line with social ecological model, factors affecting female genital mutilation acts at individual, social and community, environmental, and legal/policy framework level. Thus, engaging multiple channels of communication such as peer education, media out lets (community radio), and tailored and targeted information, and formal education could contribute a lot in reaching community at grassroots level, and tackling the myths and misconceptions and eventually changing the behavior and practices of female genital mutilation.

Conduct Targeted Campaigns: The baseline/end line survey found out that there are specific events and timing of female genital mutilations. For instance, FGM is conducted during 'Meskel' or 'dhimi' festivals in SNNPR, during wedding ceremony (mostly in winter around March to April) in Oromia, and around October - when the weather is cold in Somali. Thus, organizing targeted awareness creation and attitudinal change campaign during these occasions would help avert parents/guardian decision to circumcise their daughters.

Conduct Targeted Intervention with Young Mothers: The current study found out that mothers are highly influential in making decision of girls in all the target regions. Besides, age of the parents/guardian is found to be determinant of female genital mutilation outcome. A unit change in age cohort from age group 59 and above to the other age groups decreases the likelihood of circumcision of girl by 11 percent. Thus, focusing anti-FGM education on young mothers would make the prevention efforts fruitful.

Establish Watch Dogs: It is found out that new circumcisers are emerging in SNNPR, Harari and Oromia. These are medical professionals and para-medical professional such as ex-soldiers known as 'pestal' doctors, who practice female genital mutilation mainly to earn money. They practice female genital mutilation in secret manner and mostly during nighttime. These circumcisers can be brought to justice if the program has watchdogs that can report such malpractices.

General Recommendation

Strengthen Customary/Traditional laws: The study reveals that the probability of circumcision for a girl from parents who heard about anti FGM declaration is 1.9 times lower than a girl from parents who have not heard about anti FGM declaration. In regions where customary/traditional laws are strong, the prevalence of FGM is low. However, there are barriers and challenges that reduced the effectiveness of customary laws from supporting anti-FGM endeavors. The program need to overcome such problems and challenges and create adequate awareness before establishment of anti FGM declaration, bylaws and declarations. Obligations should emanates from the community, and the punishment need to focus on social sanction than putting large amount of financial punishment that exceeds that of statutory laws. Hence, strengthening customary/traditional law in all target regions could help in addressing the aforementioned challenges and meaningfully reduce the prevalence of female genital mutilation.

Conduct Advocacy Works to Improve Evidence Presentation/generation Mechanisms: One of the barrier and challenge found out in this study with regard to effective use of statutory law in FGM prevention is the quest for medical evidence and eye witness in courts. Law enforcing bodies such as police, prosecutors, are mostly discouraged to present FGM cases to court for verdict since most of the time it is difficult to present eye witnesses to court with medical evidence. Medical evidences are given after the healing of the circumcised reproductive organ. The eye witness that gave word to police mostly disappears when they are requested to appear in court because they are often bribed by either the family of the victim or circumcisers.

Ethiopia developed new penal code article 565 and 566 in 2003, but this penal code do not have procedure of punishment and this oblige the court to use the old procedure in evidence presentation- all evidence at a time. A new procedure is under development and it is vital to advocate for having a procedure that enables public prosecutors present evidences step by step for FGM cases without waiting for medical evidences.

Sector Office and Partners Capacity Building: The level of collaboration in most of the targeted regions except Oromia and Amhara was found to be weak due to challenges related with capacity. Most of the challenges were related to technical knowledge to coordinate sector offices, partners and resources required to establish platforms. Hence, it is pivotal to build the capacity of WCYA office to play coordination role at all level. Besides this, building capacity of WCYA offices will enable them to work with ministry of health to integrate health service provision systems for women and girls affected by female genital mutilation and to strengthen health extension and women development army related educations on female genital mutilation and other harmful traditional practices.

Annexes

Annex 1: Reference

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Annex 2: Household Questionnaire

I. Assessment on Prevalence and its related KAP of Target Community

Household Consent Form

Hello, my name is_____. I work for NCA/SCI (local partner). We are conducting a survey in your locality to learn about Female Genital Mutilation. You have been chosen by chance to participate in the study. You are not the only person to participate from this kebele. I want to assure you that all of your answers will be kept strictly secret. It will not be disclosed at any stage of the study. I will not keep a record of your name or address. You have the right to stop the interview at any time, or to skip any questions that you don't want to answer. There is no right or wrong answers. Your participation is completely voluntary. The main objective of this inquire is to capture data about prevalence of FGM and its related KAP in this community.

Do you have any questions?

(The interview takes approximately 30-40 minutes to complete).

Do you agree to be interviewed?

Yes _____ (continue)

No _____ (stop) Go to the next household

Instruction to Interviewers: The respondents of this questionnaire are households who have at least one female child under age of 18 years .Put the appropriate answer/ number in the given box or space in relation with the corresponding question. For questions with specified choose tick the appropriate answer given by the respondent and write the opinion of respondent when specification is required. For questions with more than one option tick the appropriate answers.

Section One: Certification and Identification

Questionnaire/HH ID Number: _____

Region: _____

Woreda:_____

Kebele: _____

Interviewer's name: _____

Signature: _____

Date of data collection: _____

Field Supervisor name: _____

Signature: _____

Date (DD-MM-YYYY):_____

Section Two: Socio- Economic and Demographic Data of Respondents

No	Questions	Coding	Skip
200	Age:	1. 15-25 2. 26-36 3. 37-47 4. 48-58 5. 59 and above	
201	Religion:	1. Orthodox 2. Muslim 3. Protestants 4. Catholic 5. Traditional Belief 6. other specify_____	
202	Number of girls in the HH:	_____	
203.	Role in the household:	1.Father 2.Mother 3.elder sister 4.Elder brother 5.Grand parent 6.other specify_____	
204	Ethnicity:	1. Somali 2. Harari 3. Afar 4. Amhara 5. Tigray 6. Woliyta 7. Oromo 8. Sidama 9. Dasanachi 10. other specify_____	
205	Educational Status:	1.Illitrate 2. Can read and write 3.primary (1-4) 4.Primary (5-8) 5.Secondary (9-10) 6.Above secondary	
206	Residence:	1. Urban 2. Rural	
207.	Occupation	1.Farmer 2.Animal rearing 3.House wife 4.Government employee 5. Merchant 6. Student 7.Daily Laborer 8. NGO employee	

		9. Other specify_____	

Section Three: Knowledge, Opinion and Attitude

No	Questions and Probes	Coding and Categories	Skip
300	Have you received information about FGM recently?	1.Yes 2. No	
301.	What is your source of Information?	1.Peer/Friends 2.Radio/TV 3.Religious leaders 4.Health extension workers 5.Social network 6.School 7. Other specify_____	
302.	Which form of FGM commonly occurs in this area?	1. Circumcision or Sunna circumcision 2. Excision or clitoridectory 3. Infibulations or pharaonic circumcision 99. IDK	
303.	How many traditional circumcisers do you know in this kebele?	_____	
304	What do girls get if they get circumcised? Probe any other benefit	1.Cleaneness/hygiene 2.social acceptance 3.Better marriage prospect 4.Preserve virginity/avoid pre-marital sex 5.keep calm/sexually inactive 6.More sexual pleasure for men 7.Religuous approval 8. other specify_____ 9. No benefit	
305.	Who did the circumcision?	1.Traditional circumciser 2.Birth Attendant 3.Health Professionals 4.Other specify _____	
306.	At what age women/girls circumcised in this locality? Age in complete year	_____	
307.	Have you ever heard that female genital mutilation is legally forbidden?	1.Yes 2.NO	
308	Have you heard any anti FGM declaration in this locality?	1.Yes 2.No	
309.	Are you (your boy) willing to marry uncircumcised girl/women? (For male only)	1.Yes 2.No 99.IDK	

310	Whom do you think most influential in the decision of female circumcision in your society?	1.Religious leaders 2.Peer/social network 3.Father 4.Mother 5.Other specify _____	
311.	Do you think that FGM should?	1.Continued 2.Discontinued 3.It depends 99.IDK	
312.	Do you have a plan to circumcise any of your daughter(s) in the future?	1. Yes 2. NO 99.IDK	

Rating Scale on Attitude towards FGM

313. Please mark the Scale of your Attitude towards FGM

Item	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
I believe that an individual should circumcise his daughters to get her accepted in the society					
I prefer to marry circumcised girl/woman					
I believe that circumcision does not have any effect on health and psychology of women					
I feel that my son should marry circumcised girl					
I believe that religion allows FGM practice					
I feel that husband who have uncircumcised wife is more happier than husband who married to circumcised wife					
I will not let my daughter to be circumcised in the future					
If I saw circumcisers performing FGM I will report to police or justice bodies					
I believe that FGM has nothing to do with faithfulness to partner					
I can convince a neighborhood who thinks not circumcising a daughter is "creating a problem on her marriage life" to abandon his idea					

Section Four: Prevalence and Practice of FGM

No	Questions and Probes	Coding and categories	Skip
400	Do you have daughter circumcised in the last one year?	1.Yes 2.NO 99. IDK	No go to Q 403
401	Which form of circumcision happened to her?	1.Circumcision or Sunna circumcision 2.Excision or clitoridectory 3.Infibulations or pharaonic circumcision 99. IDK	
402.	How many of the girls in the household circumcised?	_____	
403	Did this happen to your spouse/yourself?	1. Yes 2. NO	
404.	Which forms of circumcision happened to your spouse/yourself?	1.Circumcision or Sunna circumcision 2.Excision or clitoridectory 3.Infibulations or pharaonic circumcision 99. IDK	
405	In some parts of Ethiopia, there is type of circumcision where the genital area is sewn. Was that happened to your spouse/yourself?	1. Yes 2. NO	
406	In some parts of Ethiopia, there is type of circumcision where the genital area is sewn. Was that happened to your daughter?	1. Yes 2. NO	
407	Have you ever visited health facility for severe cases or some kind of complication related to circumcision?	1.Yes 2.No	
408.	Have you observed any changes in the practices of FGM?	1.Yes 2.No 99.IDK	

Annex 3: Qualitative Data Collection Guides

1. IDI guide for WYCAO Staffs, Police officers and Justice Office Staffs

<u>Section One:</u> Background Information

1. Sex:
2. Age:
3. Educational status:
4. Position:
5. Length of service in the office:
6. Name of the Office:
7. Woreda/place of Work:
8. Region:

<u>Section Two:</u> Knowledge, Attitude and Practice

Areas of Inquiry	Sr. No	Specific Questions	Suggested Probes
General observations	1	How do you understand FGM?	1. What is FGM? 2. Please describe overall situation of FGM in the region? 3. Is FGM practice increasing or decreasing?
Knowledge and experience of FGM	2	Do you think adequate information is available on FGM in this area?	1. What are the sources of information on FGM/HTPs? 2. Who mostly do the circumcision practices? 3. Which form of FGM is common in this area?
Attitude/Perception of FGM	3	Do you think FGM/HTPs practices should continue?	1. Who is most influential in deciding FGM practice? 2. Do you think you will circumcise your daughter in the future? 3. Should FGM practice continued and if Yes/NO why?
Practices	4	How do you see FGM/HTP practices in this area?	1.If someone wants to circumcise their daughter, what would they do? Why do you think FGM practiced in the area? 2. Have you heard any declaration against FGM practices in this community? 3. How do you see

Areas of Inquiry	Sr. No	Specific Questions	Suggested Probes
			collaboration among sector office in FGM prevention? Strong? Weak? 4. In which areas of FGM eliminations do you think stakeholders can collaborate? 5.What was the key barriers for collaboration in the pervious year(s) 5. Have you observed any change in the practice of FGM? If yes what are these?

<u>Section Three</u>: Engagement and Effectiveness of Statutory and Customary Laws

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General observations	1	What statutory and customary laws are available that helps to protect women and girls from FGM/HTPs?	1. What are the national and regional level laws and procedures protect women and girls from FGM/HTPs? 2. What customary laws are available to protect women and girls from FGM/HTPs?
Engagement of statutory laws	2	How much statutory laws engage in helping women protected from FGM/HTPs?	1. How many FGM/HTP cases reported to your office on average in pervious year? 2. How many of the cases get verdict in the previous year? 3. What are the key challenges to get verdicts as required?
Engagement of customary laws		How much customary laws engage in helping women protected from FGM/HTPs	1. How many cases do you refer to customary laws? 2. How much of them get timely verdict?
Effectiveness of statutory laws		Do you think statutory laws are effective in preventing FGM/HTPs?	1. What factors enabled statutory laws to be successful? 2. What factors prohibited statutory laws from becoming successful as required? 3. Do you think the existing statutory law effetely

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
			implanted? 4. Do you think new approach, rule, law and legislative is required on FGM/HTP? If yes why?
Effectiveness of customary laws		Do you think customary laws are as effective as statutory laws to prevent FGM/HTPs?	1. What factors enabled customary laws to be successful? 2. What factors prohibited customary laws from becoming successful remedy? 3. Do you think the existing customary law has effectively implemented?
Challenges and Recommendations		What challenges do you face in implementing statutory and customary law? what do you recommend to improve the challenges	1. What are the key challenges to implement statutory laws? 2. What are the key challenges to implement customary laws? 3.What do you suggest to improve the implementation of statutory laws 4. What do you suggest to improve the implementation of customary laws?

2. IDI Guide for FBOs, NGOs and UN staffs and/or FGM/HTP focal persons

<u>Section One:</u> Background Information

1. Sex:
2. Age:
3. Educational status:
4. Position
5. Length of service in the office:
6. Name of the Office:
7. Work Place:
8. Region:

<u>Section Two:</u> Knowledge, Attitude and Practice

Areas of Inquiry	Sr. No	Specific Questions	Suggested Probes
General observations	1	How do you understand FGM?	1. What is FGM? 2. Please describe overall situation of FGM in your program intervention area? 3. Is FGM practice increasing or decreasing in your portfolio?
Knowledge and experience of FGM	2	Do you think adequate information is available on FGM in your area of intervention?	1. What are the sources of information on FGM/HTPs? 2. Who mostly do the circumcision practices? 3. Which form of FGM is common in your area of operation?
Attitude/Perception of FGM	3	Do you think FGM/HTPs practices should continue?	1. Who is most influential in deciding FGM practice? 2. Should FGM practice continued and why?
Practices	4	How do you see FGM/HTP practices in your operation area?	1. Why do you think FGM practiced in these areas? 2. Have you heard any declaration against FGM practices in these communities? 3. How do you see collaboration among sector office and stakeholders in FGM prevention? Strong? Weak? 4. In which areas of FGM

Areas of Inquiry	Sr. No	Specific Questions	Suggested Probes
			eliminations do you think stakeholders can collaborate? 5.What was the key barriers for collaboration in the previous year(s)

<u>Section Three:</u> Integration of anti FGM messages in the interventions

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General observations	1	How do you see integration of FGM/HTPs prevention in program/project activities?	1. Do you think your office has adequately integrated FGM/HTPs in project interventions?
Anti FGM messages integration	2	Do you think anti FGM/HTPs messages are adequately integrated in project activities	1. What do you think facilitated the integration? 2. What was hindrance to integrated anti FGM/HTP massages in IEC/BCC, media intervention and other activities? 3. Do you think FBO (s) you are working with has integrated anti FGM/HTPs messages in its activities? 4. Have you heard any anti FGM/HTPs deceleration in this area by religious leaders or institutions?
Challenges and Recommendation	3	What are the key challenges to integrate anti FGM/HTPs messages in projects?	1.Please tell me key challenges to integrated anti FGM/HTPs messages in project activities 2. Have you faced any challenges/resistance to integrate anti FGM messages in religious teachings? 3. What do you recommend to overcome the challenges?

3. IDI guide for Health Service Providers

<u>Section One:</u> Background Information

1. Sex:
2. Age:
3. Educational status:
4. Position
5. Length of service in the office:
6. Name of Health Center:
7. Woreda/Zone:
8. Region:

<u>Section Two:</u> Knowledge, Attitude and Practice

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General observations	1	How do you understand FGM?	1. What is FGM? 2. Please describe overall situation of FGM in this area? 3. Is FGM practice increasing or decreasing in this area?
Knowledge and experience of FGM	2	Do you think adequate information is available on FGM in this area?	1. What are the sources of information on FGM/HTPs? 2. Who mostly do the circumcision practices? 3. Which form of FGM is common in this area?
Attitude/Perception of FGM	3	Do you think FGM/HTPs practices should continue?	1. Who is most influential in deciding FGM practice? 2. Should FGM practice continued and why?
Practices	4	How do you see FGM/HTP practices in your operation area?	1. Why do you think FGM practiced in these areas? 2. Have you heard any declaration against FGM practices in these communities? 3. How do you see collaboration among sector office and stakeholders in FGM prevention? Strong? Weak? 4. In which areas of FGM eliminations do you think stakeholders can collaborate? 5.What was the key barriers

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
			for collaboration in the previous year(s)

Section Three: FGM/HTPs Service Integration in the Health System

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
Service Integration	1	To what extent FGM/HTP cases are integrated in the health service system?	1. Which department provides the service? Any focal person? 2. Do you have registries for such cases? 3. How do you report such cases? Separately or with other service?
Referral System	2.	To what extent women/girls referred for FGM/HTP cases?	1. Who mostly refer such cases to this health facility? 2. How many women/girls referred for FGM/HTPs in the previous year? 3. How many women/girls treated for FGM/HTP cases in the previous year? 4. Is there referral slips and feedback mechanism?
Challenges and Recommendation	3	What are the key challenges to integrate the service and to improve the referral system?	1. What factors facilitated the integration process? 2. What factors facilitated the referral system? 3. What are the key challenges to integrated FGM/HTPs with other health service? 4. What are the key challenges in the referral and linkage process? 5. What do you recommend to improve service integration and referral system?

Focus Group Discussion Guide

FGD Guideline for Girls

Section one – Introduction (Notes for the moderator)

1. Give a culturally appropriate welcoming address.

Introduce your name and give culturally appropriate greeting. Explain that you have come from NCA/SCI or partner in the woreda/town.

2. Introduction and Consent

Explain objective of the assessment: Capture data pertinent to KAP of the community on FGM. Explain confidentiality of the study to the participants and seek for their consent to participate in the study. It would also be vital to introduce note takers to the group and the participants to the FGD participants as well.

Start time:

End time:

Section Two – Background of FGD Participants

S.NO	Name	Age	Educational status	Religion	Kebele	Woreda	FGD venue
1.							
2.							

Section Three – FGM Knowledge, Opinion, Attitude and Practices

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General	1.	What are the most common beneficial and harmful traditional practices in this area?	1. What the most beneficial traditional practices in this area? 2. What are some of the harmful traditional practices?
Knowledge	2.	Do you think that you have adequate knowledge about female circumcision?	1. If someone wants to circumcise their daughter, what would they do? 2. What is your source of information about FGM? 3. Which form of FGM is common in this area? 4. Do you know someone in the community who circumcised his daughter? 5. Who mostly did the circumcision practices?

			6.Have you heard any declaration Against FGM in this area? 7. Have you heard that FGM is legally forbidden?
Opinion and Attitude	3.	Do you support circumcision of girls for some reason(s)?	1. Who do you think most influence the decision of FGM on girls? 2. What are the common myths and misconception about FGM? 3. Do you mind to have a circumcised friend? Doe that affect your relationship? 4. Do you think FGM should continue in the future? 5. Do you think you will circumcise your daughter in the future? 6. Do you think FGM practices have now stopped in this locality?
Practices	4.	How do you see the magnitude of FGM practice in your locality?	1. Do you have a circumcised sister? 2. Which form of FGM is common in this area? 3. Did this happen to you? How that was happen? 4. What do girls benefit if they get circumcised? 5. Do you think the magnitude of FGM is extensive/ medium/ or low?
Challenges	5	What key challenges girls face if they do not get circumcised?	1. What challenges she face from friends, neighborhood, and the community? 2. What factors prohibited your friends from refusing circumcision?
Recommendations	6.	How do you think girls can overcome challenges that aroused because she is not circumcised?	How do you think girls can overcome challenges coming from friends, neighborhood, and the community for not getting circumcised in the future?

FGD Checklist/ Guide for Boys

Section one – Introduction (Notes for the moderator)

1. Give a culturally appropriate welcoming address.

Introduce your name and give culturally appropriate greeting. Explain that you have come from NCA/SCI or partner in the woreda/town.

2. Introduction and Consent

Explain objective of the assessment: Capture data pertinent to KAP of the community on FGM. Explain confidentiality of the study to the participants and seek for their consent to participate in the study. It would also be vital to introduce note takers to the group and the participants to the FGD participants as well.

Start time:

End time:

Section Two – Background of FGD Participants

S.NO	Name	Age	Educational status	Religion	Kebele	Woreda	FGD venue
1.							
2.							

Section Three – FGM Knowledge, Opinion, Attitude and Practices

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General	1.	What are the most common beneficial and harmful traditional practices in this area?	1. What the most beneficial traditional practices in this area? 2. What are some of the harmful traditional practices?
Knowledge	2.	Do you think that you have adequate knowledge about female circumcision?	1. If someone wants to circumcise their daughter, what would they do? 2. Do you know someone in the community the community that circumcised hi/her daughter in the previous year? 3. What is your source of information about FGM? 4. Which form of FGM is common in this area? 5. Who mostly did the circumcision

			practices? 5.Have you heard any declaration Against FGM in this area? 6. Have you heard that FGM is legally forbidden?
Opinion and Attitude	3.	Do you support circumcision of girls for some reason(s)?	1. Who do you think most influence the decision of FGM on women/girls? 2. What are the common myths and misconception about FGM? 3. Do you mind to have a circumcised girl-friend? Doe that affect your relationship with other friends (boys)? 4. Do you think you will marry uncircumcised woman in the future? 5. Do you think FGM should continue in the future? 6. Do you think you will circumcise your daughter in the future? 7. Do you think FGM practices have now stopped in this locality?
Practices	4.	How do you see the magnitude of FGM practice in your locality?	1. Do you have a circumcised sister? 2. Which form of FGM is common in this area? 3. What do girls benefit if they get circumcised in your? 4. Do you think the magnitude of FGM is extensive/ medium/ or low?
Challenges	5	What challenges women/girls face if they are uncircumcised?	1. What challenges she face from friends, neighborhood, and the community? 2. What factors prohibited her from refusing circumcision?
Recommendations	6.	How do you think girls can overcome challenges that aroused because she is not circumcised?	How do you think girls can overcome challenges coming from friends, neighborhood, and the community for not getting circumcised in the future?

FGD Checklist/Guide for Adult Women and Men

Section one – Introduction (Notes for the moderator)

1. Give a culturally appropriate welcoming address.

Introduce your name and give culturally appropriate greeting. Explain that you have come from NCA/SCI or partner in the woreda/town.

2. Introduction and Consent

Explain objective of the assessment: Capture data pertinent to KAP of the community on FGM. Explain confidentiality of the study to the participants and seek for their consent to participate in the study. It would also be vital to introduce note takers to the group and the participants to the FGD participants as well.

Start time:

End time:

Section Two – Background of FGD Participants

S.NO	Name	Age	Educational status	Religion	Kebele	Woreda	FGD venue
1.							
2.							

Section Three – FGM Knowledge, Opinion, Attitude and Practices

Area of Inquiry	Sr. No	Specific Questions	Suggested Probes
General	1.	What are the most common beneficial and harmful traditional practices in this area?	1. What the most beneficial traditional practices in this area? 2. What are some of the harmful traditional practices?
Knowledge	2.	Do you think that you have adequate knowledge about female circumcision?	1. If someone wants to circumcise their daughter, what would they do? 2. Do you know someone in the community that circumcised his/her daughter in the previous year? 3. What is your source of information about FGM? 4. Which form of FGM is common in this area? 5. Who mostly did the circumcision practices? 6.Have you heard any declaration Against FGM in this area?

			7. Have you heard that FGM is legally forbidden?
Opinion and Attitude	3.	Do you support circumcision of women/girls for some reason(s)?	1. Who do you think most influence the decision of FGM of women/girls? 2. What are the common myths and misconception about FGM in this area? 3. Do you think FGM should continue in the future? 4. Do you think you will circumcise your daughter in the future? 5. Do you think FGM practices have now stopped in this locality?
Practices	4.	How do you see the magnitude of FGM practice in your locality?	1. Do you have a circumcised daughter? 2. Which form of FGM is common in this area? 3. What do girls benefit if they get circumcised in your? 4. Do you think the magnitude of FGM is extensive/ medium/ or low?
Challenges	5	What challenges women/girls face if they are uncircumcised?	1. What challenges women/girls face from friends, neighborhood, and the community if they are not circumcised? 2. What factors prohibited her from refusing circumcision?
Recommendations	6.	How do you think girls can overcome challenges that aroused because she is not circumcised?	How do you think girls can overcome challenges coming from friends, neighborhood, and the community for not getting circumcised in the future?

Annex 4: Terms of Reference (TOR)

Terms of Reference (TOR)
For
End line/ Base line Survey on Female Genital Mutilation in Save the Children (SC) – Norwegian Church Aid (NCA) Joint program intervention areas.

Program background

With efforts of the government and non-governmental organizations, the prevalence of FGM has shown a promising decrease by 17% (from 73% of the baseline survey 1997 to 56% of follow-up survey in 2008). The 2011 Welfare Monitoring Survey report shows that 23 percent of all Ethiopian female children aged 0 to 14 years are circumcised. There are, however, large regional variations. Afar Region counts the highest prevalence of FGM with 87.4% followed by Dire Dawa, Somali, Harrari, Amhara, and Oromia Regions with 78%, 70.7%, 67%, 62.9% and 58.5% respectively. FGM in Ethiopia is mostly carried out on girls between the ages of few months and 15 years. Findings from the 2008 WHO multi-country study confirm that women who have undergone female genital mutilation, have significant increased risks for adverse events during childbirth and their babies are more likely to die as a result; and they experience higher incidences of caesarean section, post-partum hemorrhage and prolonged hospitalization following the birth.

In response to the practice, the Ethiopian government has developed a national strategy on harmful traditional practices (2013) that gives particular emphasis on Female Genital Mutilation. This has created conducive environment for working towards changed attitudes and behavior to FGM.

Save the Children International and Norwegian Church Aid supported by the Royal Norwegian Embassy to Ethiopia are implementing a joint program entitled “Accelerating change towards zero tolerance to female genital mutilation in Ethiopia”. Its overall goal is to: “Reduce female genital mutilation by 31% from the intervention areas by the year 2015”. With this joint program, Save the Children (SC) and Norwegian Church Aid (NCA) aimed to reach 700,000 children (girls: 450,000; boys: 250,000) and 1,400,000 adults (women: 770,000; men: 630,000) by the end of the project intervention period in 2015. The project is being implemented in seven regions and at federal level: Somali, Amhara, Tigray, Afar, Harrari, Southern Nations, Nationalities and Peoples Region (SNNPR) and Oromiya. Save the Children and Norwegian Church Aid are implementing the project in partnership with 24 locally registered non-governmental organizations (NGOs), Faith-Based Organizations (FBOs), and government offices.

The joint program has the following outcomes:

1. Attitude of target communities against FGM improved.
2. Statutory National, regional and customary/traditional laws against FGM and other HTPs enforced in the intervention areas.
3. Faith Communities in the intervention areas institutionalized/integrated the issue of FGM in their engagements
4. Women and girls affected by FGM and other HTPs in need of medical and other psychosocial services assisted in the intervention areas
5. The issue of FGM became a National, regional and local agenda

2. Objective of the Survey

The main purpose of the survey is two-folded: 1) To establish end lines in order to confirm to what extent the project in the geographic intervention areas have contributed to the planned 31 % reduction of FGM. 2) To establish baselines, which provide a picture of the current status quo with regard to prevalence, knowledge, attitudes and practices of FGM in new and scale-up geographic intervention areas. It should be noted that for some districts the end-line will also be a baseline for the continued efforts to abolish FGM in these locations.

The survey should in addition assess the contribution of the various program components towards the abolishment of FGM. This will include:

- Measure the extent to which the attitude of target communities against FGM has improved.
- Assess the enforcement of statutory national and regional laws against FGM in the intervention areas.
- Assess the inclusion and/or enforcement of customary/traditional laws against FGM in the intervention areas.
- Assess the availability, and effectiveness of referral services for women and girls affected or at risk.
- Assess the integration/institutionalization of FGM in the engagement of faith communities in the intervention areas.

It is expected that the consultant team based on survey findings, will present recommendations for future programming for even better performance and results in the next project phase.

2. Methodology

The end and baseline survey should primarily be based on quantitative methodology, complemented by qualitative methods as appropriate. Sampling and data collection methodology for the end line survey has to consider constraints associated with availability of baseline values.

Survey questions

The End line/ Base line survey should be structured around the five outcome areas, disaggregated by age and gender and how these have/will contribute to a reduction in prevalence.

The questions are just indicative and for illustration. The consultant is expected to develop more detailed survey questions.

1. What is the current prevalence and incidence of FGM in the intervention and scale up districts
2. To what extent has the program contributed to the reduction of FGM incidences in the intervention areas? What is the reduction?
3. What is the current knowledge, attitudes and practices of the target population towards FGM compared with the baseline in the intervention districts?
4. What is the knowledge, attitudes and practices of the target population towards FGM in the new districts?
5. To which extent did the program create the desired critical mass for the abandonment of FGM? This includes assessing changes in:
    a. What is the engagement and effectiveness of statutory and customary laws
    b. To what extent has a faith community institutionalized/incorporated anti FGM messages in their works?
    c. To what extent has health institutions (health workers) integrated FGM in their work?

d. To what extent has women and girls affected by FGM/HTPs been referred to medical treatment and/or assisted in other ways, and what has been the effect of this in terms of informing the community about FGM?
e. To what extent the coordination and integration with sectoral officers and other stakeholders is effective at local levels while the survey is conducted at District level.

2. Profile of the consultancy Firm

The Consultancy firm should have:

- Extensive experience in survey design and implementation, statistical analysis of survey data and presentation of survey results
- A team of professionals with MA/MSC degree or above in Development/Social anthropology /Sociology/Law/ Psychology and statistics
- In depth understanding of child protection, gender and HPs
- Proven experience in conducting similar baseline and end-line surveys as well as KAP surveys in Ethiopia,
- Proven experience on quantitative and qualitative research
- Proficiency in Amharic and English, oral and written

3. Timing and responsibilities

The task and the overall process of conducting the assessment, including all field visits, analysis of findings, submitting draft and final reports should not take more than 45 calendar days from the signing of the agreement.

NCA and SCI will be responsible for:

- Recruiting the consultancy firm
- Overall coordination of the assessment
- Providing documents for desk review and reference materials related to the project(eg. baseline documents, previous evaluations, project document, reports)
- Providing list of existing and new districts to establish end- and baselines.
- Facilitating and liaison the team with implementing partners
- Participating in validation and feedback workshops,
- Participating in the assessment meetings and field visits as deemed necessary
- Assisting the assessment team with the provision of information and contacts of implementing partners.

The consultancy Firm is responsible for:

- Submitting a technical and financial proposal. The technical proposal shall include an overview and CVs of the consultancy team, ideas for survey questions and methodology as well as a delivery schedule for all stages of the survey.
- Submitting an inception report with a detailed synopsis describing the survey plan.
- Developing and sharing with NCA/SC details on methodology including sampling techniques and data collection instruments.
- Submitting a progress/preliminary report on the collection and analysis of data from the intervention areas.
- Presentation of the draft report in writing and at a validation workshop. (The draft report will be presented to SCI, NCA and other relevant stakeholders)
- Submitting a final report after accommodating the comments and feedbacks.
- The survey should be completed within 45 calendar days i.e., including preparation, travel, data collection, and analysis and reporting. The final survey report will be submitted to SCI/NCA in two hard copies and a soft copy using CD/ DVD.
- Recruitment of independent interpreters if required

Deliverables:

The following services and outputs are expected from the consultant:

The End line/baseline study will be completed within 45 Calendar days. The following table outlines the major outputs at different stages along with the tentative schedule for undertaking the task.

Step	Activities	Output/ Deliverables	Date	Responsibility
1	Agreement signing	Agreement signed	Sep. 9, 2015	NCA and the Consultant
2	Introduction, briefing on the service and handing over of relevant materials		Sep. 11, 2015	NCA/SCI
3	A comprehensive Inception Report (covering literature review and analysis, detail descriptions of data source, data collection methods, tools for data collection, sampling, sample size/participants, data organization, analysis and synthesis, Presentation	A comprehensive inception report	Sep. 14, 2015	Consultant

	outline/format, detail work plan highlighting also how to pilot the tools, etc.)			
4	Provide feedback on the comprehensive inception report		Sep 16, 2015	NCA and SCI
5	Submission of first draft report		Oct.17 , 2015	Consultants
6	Organize workshop and present preliminary findings	-	Oct. 18, 2015	Consultants
7	Give feedback on the first draft		Oct. 20, 2015	NCA/SCI and partners
8	Submit final end line/baseline document	Final baseline study report (one hard copy and soft copy)	Oct. 23, 2015	Consultant

Annex 5: Consent Form

Study Topic: Baseline/End line Survey on Female Genital Mutilation in Selected regions of Ethiopia

Purpose of the Study: To collect baseline and bench mark data for project entitled "Accelerating change towards zero tolerance to female genital mutilation in Ethiopia"

Reasons for Selection: You are selected to participate in this study since we thought you have adequate knowledge about FGM and other harmful traditional practices that occurs in this area.

Confidentiality: Information you give us will help to measure progress of the envisaged project in this locality. All information you give us will be kept confidential and your name will not be registered and appear in any part of the report.

Benefit: You will not get any materials or financial benefits for participating in this study.

Participation: Your participation in this study will be on voluntary base. You can stop providing answers for some or all of the questions at any stages of the interview. This will not affect you in any form now and in the future.

Any form of Harms for participation: You will not face any harm for taking part in this study

Use of Sound Recorder: In order to remember all the points that you will tell me, I will record your voice in sound recorder. The recorded voice will be accessed only by research team. If you are not interested in getting recorded you can stop from giving information. Are you willing if I record your vice?

Voluntarism: Do you have any questions about the study and your participation? Are you willing to participate in the study and let us to use all the information you will give us? Yes/No

Interviewer's signature **Date**

_____ _____

Annex 6: Survey questionnaire Amharic Version

በተመረጡ የኢትዮጵያ ክልሎች

የሴት ልጅ ግርዛት የቅድመ /የድህረ ትግበራ ዳሰሳ ጥናት ለማድረግ የተዘጋጀ ቃለ መጠይቅ

መስከረም 2008 ዓ.ም

<u>የስምምነት ማረጋገጫ ቅፅ</u>

ጤና ይስጥልኝ እንደምን አረፈዱ/ዋሉ፡ እኔ---------- እባላለዉ፡፡ የምሰራዉ ---------- ----- ለተባለ ድርጅት ነዉ፡፡ በተለያዩ ስድስት የኢትዮጵያ ክልሎች የሴት ልጅ ግርዛትን የተመለከተ የዳሰሳ ጥናት በማድረግ ላይ እንገኛለኝ፤ እርሶም የዚህ ጥናት አባል እንድሆኑ በዕጣ ከሌሎች ጋር ተመርጦወል፡፡ በዚህ ጥናት ዉስጥ የሚሰጡን ማንኛዉም መረጃ ምስጥራዊነቱ ፍፁም የተጠበቀ ይሆናል፡፡ በማንኛዉም መልኩ የእርሶ ስም ሆነ አድራሻ ተመዝግቦ አይቀመጥም፤ በጥናቱ ላለመሳተፍ ከፈለጉ በማንኛዉም ጊዜ ማቀዋረጥ ይችላሉ፡፡ በጥያቄዎቹ ዉስጥ ትክክለኛ ወይም ትክክለኛ ያልሆነ መልስ የሚባል ነገር የለም፤ የተሰማዎትን መልስ መመለስ ይችላሉ፡፡ ስለዚህ የእርሶ ተሳትፎ በፍቃደኝነት ላይ የተመሰረተ ይሆናል ማለት ነዉ ፤ ነገር ግን ይህ ጥናት ኣላማዉ የሴት ልጅ ግርዛትን ለማስቀረት ለሚደረገዉ ስራ ጅምር ስለሚጠቅም የእርሶ ተሳትፎ ይበረታታል፡፡ የጥናቱ ዋና ዓላማ የሴት ልጅ ግርዛት ሁኔታ፣ የሰዉን/የማህበረሰቡን እዉቀት፣ አመለካከትና ድርጊት መለካት ይሆናል፡፡

ስለዚህ በጥናቱ ለመሳተፍ ፍቃደኛ ኖት?

አዎ----------(ቀጥል)

አይደለም----------(አቁም) ወደሚቀጥለዉ ቤት ሂድ

የጠያቂ መመርያ፡ ተጠያቂዎች በሙሉ እድሜዋ ከ 18 ዓመት በታች የሆናት ሴት ልጅ ያላቸዉ ቤተሰቦች ይሆናሉ፡፡በተሰጠዉ ምርጫ ላይ መልሱን አክብብ/ቢ፤ የተጠያቂዉን ሀሳብ እንድገልፅ በተሰጠዉ ቦታዎች ላይ ደግሞዉ ሙሉ መልስ ጻፍ፤ ከአንድ በላይ ምርጫ ላለቸዉ ጥያቄዎች የተሰጡ መልሶችን ሁሉ አክብብ/ቢ፡፡

ክፍል አንድ፡ መለየትና ማረጋገጥ

የጥያቄ/የአባወራ ቁጥር፡----------

ክልል፡----------
ወረዳ፡----------
ቀበሌ፡----------
የጠያቂዉ ሙሉ ስም፡----------
ፊርማ፡----------
መረጃዉ የተሰበሰበበት ቀን፡----------
የተቆጣጣሪ ሙሉ ስም፡ ----------
ፊርማ፡ ----------
ቀን(ቀን/ወር/ዓ.ም)፡ ----------

ክፍል ሁለት፡ አጠቃላይ መረጃ

ተ.ቁ	ጥያቄዎች	ኮድ	የሚታለፍ
200	እድሜ	1. 15-25 2. 26-36 3. 37-47 4. 48-58 5. 59 እና ከዛ በላይ	
201	ሀይማኖት	1. ኦርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. የባህላዊ እምነት ተከታይ	

		6. ሌላ (ይገለጽ)----------	
202	በቤት ዉስጥ እድሜቸዉ ከ 18 ዓመት በታች የሆነ ሴት ልጆች ብዛት	----------	
203	በዚህ ቤት ዉስጥ የእርሶ የስራ ድርሻ	1. አባት 2. እናት 3. ታላቅ እህት 4. ታላቅ ወንድም 5. አያት 6. ሌላ (ይገለጽ) ----------	
204	ብሄር	1. ሱማሌ 2. ሃረሪ 3. አፋር 4. አማራ 5. ትግራይ 6. ወላይታ 7. ኦሮሞ 8. ሲዳማ 9. ዳሰነች 10. ሌላ (ይገለጽ) ----------	
205	የትምህርት ሁኔታ	1. ያልተማረ 2. መጻፍና ማንበብ የሚችል 3. አንደኛ ደርጃ (1-4) 4. አንደኛ ደርጃ (5-8) 5. ሁለተኛ ደርጃ (9-10) 6. ከሁለተኛ ደርጃ በላይ	
206	የመኖርያ ቦታ	1. ከተማ 2. ገጠር	
207	ስራ	1. ገበሬ 2. አርብቶ አደር 3. የቤት እመቤት 4. የመንግስት ሰራተኛ 5. ነጋዴ 6. ተማሪ 7. የቀን ሰራተኛ 8. መንግስታዊ ያልሆነ ድርጅት ሰራተኛ 9. ሌላ (ይገለጽ) ----------	

ክፍል ሶስት፡ የተጠያቂዎችን እዉቀት ፣ሃሳብና አመለካከት የተመለከቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	ኮድ	የሚታለፍ
300	በቅርቡ ስለ ሴት ልጅ ግርዛት መረጃ አግኝቶዋል?	1. አዎ 2. አላገኝዉም	
301	ስለ ሴት ልጅ ግርዛት መረጃ ከወዴት ያገኛሉ?	1. ጓደኛ 2. ሬድዮ/ቴሌቭዥን 3. የሀይማኖት አባቶች 4. የጤና ኤክስቴንሽን ሰራተኛ	

		5. ከማህበራት/ቡድኖች 6. ትምህርት ቤት 7. ሌላ (ይገለጽ) ----------	
302	የትኛዉ የግርዛት አይነት በዚህ አከባቢ ይዘወተራል?	1. ባህላዊ ግርዛት ወይም ሱና 2. የሴት ልጅ ብልት ጫፍ መቁረጥ 3. የሴት ልጅ ብልት መተልተል ወይም መስፋት	
303	ሴት ልጆች ስለተገረዙ ምን ጥቅም ያገኛሉ?	1. ንጽህናቸዉ የተጠበቀ ይሆናል 2. በማህረሰብ ዉስጥ ተቀባይነት ያገኛሉ 3. ጥሩ የትዳር ዕድል ያገኛሉ 4. ክብረ ንጽህናቸዉን ይጠብቃሉ 5. በወሲብ ላይ የተረጋጉ ይሆናሉ 6. ለወንዶች የወሲብ እርካታ ይጨምራሉ 7. በሀይማኖት ተቀባይነት ያገኛሉ 8. ሌላ (ይገለጽ) ----------	
304	በዚህ ቀበሌ ዉስጥ ስንት ባህላዊ የሴት ልጅ ብልት ገራጮች እንዳሉ ያዉቃሉ?	ብዛቱን ፃፍ ----------	
305	የሴት ልጅ ግርዛት አገልግሎት የሚሰጠዉ ማነዉ?	1. ባህላዊ ገራዝ 2. የልምድ አወላጅ 3. የጤና ባለሞያ 4. ሌላ (ይገለጽ) ----------	
306	ሴት ልጆች ከስንት ዓመት ጀምሮ ይገረዛሉ?	----------	
307	የሴት ልጅ ግርዛት በህግ የተከለከለ መሆኑን ያዉቃሉ?	1. አዎ 2. አላዉቅም	
308	በዚህ አካበቢ ባህላዊ የፀረ-ሴት ልጅ ግርዛት አዋጅ/ክልከላ ሰምተዉ ያዉቃሉ?	1. አዎ 2. አላዉቅም	
309	እርሶ ወይም የእርሶ ልጅ ያልተገረዘች ሴት ለመግባት ፍቃደኛ ነዉ?	1. አዎ 2. አይደለም 99. አላዉቅም	
310	በሴት ልጅ ግርዛት ዉሳኔ ላይ ማን ከፍተኛ ተጽኖ ማሳደር የሚችል ይመስሎታል?	1. የሀይማኖት መሪ 2. ጓደኛ 3. አባት 4. እናት 5. ሌላ (ይገለጽ) ----------	
311	ስለ ሴት ልጅ ግርዛት ምን ያስባሉ?	1. ይቀጥል 2. መቆም አለበት 3. እንደ ሁኔታዉ 4. አላዉቅም	
312	ሴት ልጆን ወደፊት ለማስገረዝ እቅድ አሎት?	1. አዎ 2. የለኝም	

		99. አላዉቅም	

ተጠያቂዎች በሴት ልጅ ግርዛት ላይ ያላቸዉን አመለካከት የሚለኩ ጥያቄዎች

313. ከተዘረዘሩት ዉስጥ የትኛዉ የእርሶን አመለካከት ይገልጻል/እስማማላዉ ወይም አልስማማም ብለዉ ይመልሱ

አመለካከቶች	በጣም አልስማማም	አልስማማም	አልወሰንኩም	እስማማለዉ	በጣም እስማማለዉ
በማህበረሰቡ ዉስጥ ተቀባይነት ለማግኘት ማንም ሰዉ ሴት ልጁን ማስገረዝ እንዳለበት አምናለዉ					
የተገረዘች ሴት ማግባትን እመርጣለዉ					
ግርዛት በሴት ልጆች ጤና እና ስነ-ልቦና ላይ ምንም የጎንዮሽ ጉዳት እንደማያመጣ አምናለዉ					
ወንድ ልጄ የተገረዘች ሴት ማግባት እንዳለበት ይሰማኛል					
ሀይማኖት የሴት ልጅ ግርዛት እንደሚፈቅድ አምናለዉ					
ያልተገረዘች ምስት ያለዉ ባል የተገረዘች ምስት ከለዉ ባል የበለጠ ደስተኛ እንደሆነ ይሰማኛል					
ሴት ልጄ ወደፊት እንድትገረዝ አልፈቅድም					
የሴት ልጅ የግርዛትን የሚፈፅሚ ሰዉ ብመለከት ለፍትህ አካላት መረጃ እሰጣለዉ					
ሴት ልጅ ለባለቤትዋ ያላት ታማኝነት ከሴት ልጅ ግርዛት ጋር አይገናኝም					
ሴት ልጅን አለመገረዝ "በትዳር ህይዎቷ ላይ ችግር መፍጠር ነዉ" ብሎ የሚያስብ ጎሮቤትን ስለ ሴት ልጅ ግርዛት ጎጅነት ማሳመንና ማስቆም እችላለዉ					

ክፍል አራት፡ የሴት ልጅ ግርዛት ድርግቶችን የተመለከቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	ኮድ	የሚታለፍ
400	ሴት ልጅን በለፈዉ አንድ አመት ጊዜ ዉስጥ አስተገርዞዋል?	1. አዎ 2. አልተገረዘችም 99. አላወቅም	መልሱ አልተገርዘችም ከሆነ ወደ ጥያቄ 403
401	የትኛዉ የግርዛት አይነት ነበረ?	1. ባህላዊ ግርዛት ወይም ሱና 2. የሴት ልጅ ብልት ጫፍ መቁረጥ 3. የሴት ልጅ ብልት መተልተል ወይም	
402	በዚህ ቤት ዉስጥ ካሉ ሴት ልጆች ስንቶቹ ተገርዞዋል?	----------	
403	ይህ በርሶ/በባለቤቶ ላይ ተፈጽሞዋል?	1. አዎ 2. አልተፈጸመም	
404	በልጆ/በባለቤቶ ላይ የትኛዉ አይነት ግርዛት ተፈጸመ?	1. ባህላዊ ግርዛት ወይም ሱና 2. የሴት ልጅ ብልት ጫፍ መቁረጥ 3. የሴት ልጅ ብልት መተልተል ወይም	
405	በአንዳንድ የኢትዮጵያ አከባቢዎች የሴት ልጅ ብልት መተልተልና መስፋት የተለመደ ነዉ፤ ይህ በባለቤቶ ላይ ተፈጽሞ ይሆን?	1. አዎ 2. አልተፈጸመም	
406	በአንዳንድ የኢትዮጵያ አከባብዎች የሴት ልጅ ብልት መተልተልና መስፈት የተለመደ ነዉ፤ ይህ በሴት ልጆ ላይ ተፈጺሞ ይሆን?	1. አዎ 2. አልተፈጸመም	
407	ከግርዛት ጋር በተያያዘ ባገጠሞት የጤና መተወክ ምክንያት ወደ ጤና ተቋም ሄዶ ያዉቃሉ?	1. አዎ 2. አላዉቅም	
408	በዚህ አከባቢ በሴት ልጅ ግርዛት ሁኔታ ላይ የተስተዋሉ ለዉጦች አሉ?	1. አዎ 2. አልተፈጸመም 99. አላዉቅም	

Annex 7: List of Study Woredas

The following table shows data Collection Woredas in 6 regions of Ethiopia

No.	Region	Zone	intervention woredas	baseline available	expansion woredas	selected woredas
	Save the Children International					
1.	Somali	Fefan	Dedemene, Harshin, Kebribeya, tulubulet	Tulubulet	Awbare , Gursum	Gursum, Tulubulet
2.	Somali	Jerer	Degehabur, Birkot, Gashamo,Ararso	Ararso		Degahabur
3.		Korahe	Shekosh			Shekosh
4.		Siti zone	seven woredas(Aysha, Mulu,Shinile,Erer,Afdem,Dembel,Mieso)	Aysha, Mulu, Shinile, Erer		Afdem, Yerer
5.	Harari		Harari region, urban Amir nur, Abadir, Jinela, Shenkor, Hakim and Aboker woredas, and rural sofi, Erer and Dire teyara woredas.	Four rural and five urban kebeles		3 urban and 3 rural sample kebeles (as one woreda)
6.	Afar	Zone 2	Abala, Berhale, Dalul and Koneba		Megale and Erebti	Megale, Abala
7.	Afar	Zone 3	Awash fentale, Amibara,			Amibara
8.	Afar	Zone 4	Awra, Ewa, Golina, Teru, Yallo			Golina,
9.	Afar	Zone 5	Dulecha , Dewe, Telalak		Dalifage, semurobi ,adeleila	Dewe
	Total Woredas					13
	Norwegian Church Aid					
1.	Somali	Shebelle	Gode, Adale, Denan	Gode	Berano	Gode and Berano
2.	SNNPR	Sidama	Dale, Lokabaya, Wensho, Yirgalem town	Yirgalem town, Lokabaya		Yirgalem town and Lokabaya
3.	SNNPR	Wolita	Boloso sore, Boloso Bombe, Kindo Koisha, Damote Sore, Damote Fulasa	Boloso sore, Kindo koisha		Boloso Sore and Kindo Koisha
4.	SNNPR	South Omo	Dasenech, Hamer	Dasenech		Dasenech
5.	Oromia	West Arsi	Siraro, Shashemene zuria, Shalla, Shashemene town, Arsi Negele	Shashemene Zuria		Siraro , Shashemene zuria
6.	Amhara	North Showa	Angolelana tera, Basona, Ankober, Ensaro Wayu	-		Ankober
	Total woredas					10
	Grand Total					**23**