Female Genital Mutilation: Prevalence, Perceptions & Effect on Girls' Health: The Case of Shebedino & Goriche Districts, Ethiopia

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November, 2013

Addis Ababa, Ethiopia

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MSW Dissertation Research Project Report

(MSWP-001)

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November, 2013

Addis Ababa, Ethiopia

Acknowledgement

I would like to express my heartfelt appreciation and gratitude to my advisor Ato Assaye Legesse for his invaluable comments, guidance and support up to the end of this study.

I am also grateful to data collectors who helped me to administer the survey questionnaire for the collection of the quantitative data from households.

Last but not least, my special thanks go to my informants (households, community leaders and government officials) for their valuable information during data collection.

Thank You
November, 2013

Abstract

Female genital mutilation (FGM) is a harmful traditional practice which involves the partial or total removal of the external female genitalia for cultural and traditional reasons. It is a criminal offence as it causes pain, violates the human rights and the health of women; and puts girls at risk. This study focuses on the prevalence of FGM, cultural beliefs and magnitude of the practice, consequences involved after the mutilation, and challenges and critical institutional gaps in fighting FGM in Shebedino and Gorichie districts in Ethiopia. A total of 140 informants (120 reproductive women, 10 community leaders & 10 government officials of the two districts) took part in the study. Survey questionnaire and semi structured interview are employed to collect the data. Both quantitative and qualitative data analysis were used to analyze the data. The results indicated that the practice and experience of FGM is highly prevalent in Shebedino and Gorichie districts. All people including the district officials, religious leaders, community elders, teachers and civil servants (educated or not educated) are practicing it upon their children due to cultural beliefs and long standing societal attitude/culture characterized by imbalanced gender relations, economic factors, lack of awareness on the adverse effects of the practices and legal and policy frameworks. The results further indicated that females suffer from a number of physical, psychological and social problems as a result of being a victim of genital mutilation. Therefore empowering people in the community with knowledge on the issue of FGM and providing the necessary resources will help eliminating the practice.

Key words: *Female genital mutilation, causes of female genital mutilation, female genital mutilation consequences, combating female genital mutilation, Ethiopia.*

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Acronyms

ACRWC- African Charter on the Right and welfare of the Child

BoWCYA- Bureau of Women, Children and Youth Affairs

BPR- Business Process Reengineering

CC- Community Conversation

DHS- Demographic and Health Surveys

EGLDAM- Ye Ethiopian Goji Limadawi Diregitoch Aswogaj Mahiber

FC- Female Circumcision

FGC- Female Genital Cutting

FGM- Female Genital Mutilation

FUS- Follow Up Survey

GTP- Growth and Transformation Plan

HTPs- Harmful Traditional Practices

HIV- Human Immune Virus

MDG- Millennium Development Goal

NCTPE- National Committee for Traditional Practices in Ethiopia

SNNPRS- Southern Nations Nationalities and People's Regional State

UNCRC- United Nations Convention on the Right of the Child

UNCEF- United Nations Children's Fund

UN- United Nations

WCAO- Women and Children Affairs Office

Declaration

I hereby declare that the dissertation entitled: **Female Genital Mutilation: Prevalence, Perceptions & Effect on Girls' Health: The Case of Shebedino & Goriche Districts, Ethiopia** submitted by me for the partial fulfillment of the MSW to Indira Gandhi National Open University (IGNOU), New Delhi is my own original work and has not been submitted earlier, either to IGNOU or to any other institution for the fulfillment of the requirements for any other program or study. I also declare that no chapter of this manuscript in whole or in part is lifted & incorporated in this report from any earlier work done or others.

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CHAPTER ONE

1. INTRODUCTION

1.1. Overview of the Study Areas

Shebedino district is one of the 21 districts making up Sidama Zone Administration in SNNPRS, covering the size of 245.15Kilo meter square. The capital, Leku town, which is located 302 km far from Addis Ababa and/or 27km from Hawassa, is the administrative center of the district. Shebedino district comprises of 35 Kebeles, of which 32 are rural Kebeles while 3 Kebeles belong to Leku town administration. The total population of the woreda is estimated to be 269, 660, out of which, 133,587 are females and 136,073 are males. About 95% of the population that is 248,695 reside in the rural areas of the district, whereas, only 5% live in the town. The number of children takes almost half of the total population of the district. The area is known to be very densely populated in which 1099 persons live per kilo meter square.

In the rural setting most of the inhabitants speak mainly 'Sidamigna" language whereas in the town residents speak both "Sidamigna" and Amharic languages. Nowadays the town comprises of 22 government institutions which provide social, infrastructural and administrative services to the district.

With regards to the distribution of educational institutions, the district comprises of 1 senior secondary school (Grade 9-12), 2 secondary schools (Grade 9-10) and 38 primary schools. In 2013 academic year, a total of 63, 594 children have been enrolled in all the educational institution of which 32,052 (50.4%) were males and 31,542 (49.6%) females. As to the distribution of health institutions, there is one district hospital, 8 health centers and 35 health posts.

On the other hand Goriche district is the youngest district in Sidama Zone which gained decentralized administrative structures very recently (six years ago). The overall observations indicate that the district is a burgeoning administration with very limited infrastructures and

services. It is one of the 21 districts of the Sidama Zone, which is composed of 22 Kebeles out of which 20 of them are rural Kebeles and 2 urban Kebeles, covering a total land area of 180.98 Kilometer square. The capital, Goriche town, which is located 318 km far from Addis Ababa and/or 43km from Hawassa, is the administrative center of the district.

The total population of the district is estimated to be 121,662; out of which, 61,526 are males and 60,085 are females. From the total population 43.8% are children under the age of eighteen. The area is known to be densely populated in which 676 persons live per kilo meter square. About 96% of the population lives in the rural area.

In 2013, Goriche district had a total of 25 schools (1 secondary school grade 9-10, 24 primary schools). In the past academic years, a total of 20, 964 children had been enrolled in the schools out of which 8,585 (41%) were girls. As to the distribution of health institutions, there are 6 health centers and 21 health posts.

1.2. Background of the Study

With a population of 80 million, Ethiopia is the second most populous country in Sub-Saharan Africa. Children below the age of 18 account for 52% of the national population while those below age 15 represent 44% of the total (Census, 2007). Far too many Ethiopian children also experience various forms of harmful traditional practices across the different parts of the country. The number of children living under difficult circumstances is highly increasing due to social, economic, political as well as cultural factors (MOLSA, 2005). It is also one of the least urbanized countries with 84% of the population living in rural areas. Among the different forms of harmful traditional practices in Ethiopia, Female Genital Mutilation (here on FGM) affects a great number of populations. Of all, women and children which are the vast majority of the population carry the burden of HTPs (EGLDAM, 2007).

According to World Health Organization (2008), there are an estimated 130 million to 140 million girls and women in the world who have undergone female genital mutilation. Every year, approximately 3 million girls and women are at risk of being subjected to such mutilation. The practice is prevalent in 28 countries in Africa and in some countries in Asia and the Middle East.

In addition, a growing number of women and girls among immigrant communities have been subjected to or are at risk of female genital mutilation in Australia and New Zealand, as well as in countries in Europe and North America (WHO, 2011).

In Ethiopia a great number of people are affected by FGM. 74 % of girls and women nationwide have been subjected to female genital mutilation. The results from a follow-up survey in 2007 showed that the prevalence of FGM decreased from 60% in 1997 to 45% in 2007. Although the national trend is encouraging for FGM in some regions, in Somali and Afar it is still affecting the lives of many girls in these regions (EGLDAM, 2007).

FGM is a brutal and criminal harmful traditional practice. Victims of FGM suffer physically, psychologically and the health consequences are severe. The Ethiopian Demographic and Health Survey of 2005 revealed that the national prevalence of FGM for the age group 15-49 was 74.3%. About 73% of the women included in the survey were cut before the age of five while 19.4% were subjected to this practice between the ages of 5-9. Subsequently, 27% of these girls reported that they have faced health problems such as extreme pain during sexual intercourse, loss of sexual interest, vaginal infections, and problems during delivery (EGLDAM, 2007).

Rationales for practicing FGM are mainly related with societal beliefs and norms. It is believed that it is important to regulate a woman's sexual desire. Many people feel that it is the only way they can ensure fidelity in marriage. Families and the girl children will be marginalized if they refuse to conform to the social norm. Many People believed that FGM has hygienic benefits and uncut girls are prone to break household goods (Boddy, 1998). FGM practitioners are often times elderly women, they perform without pain relief and under unhygienic circumstances. Seldom, health professional carry out the procedure (Yirga et al, 2012).

In Ethiopia, the age at which girls under go FGM varies from region to region. In Amhara region, it is done during infancy. In SNNPR, Somalia, and Oromia, girls are subjected to FGM between the ages of 8 to 12, or between the ages of 15 to 17 as an initiation rite to marriage.
Numerous efforts at the national, regional and international levels involving a wide range of actors have contributed to the decline (EGLDAM, 2007). Initiatives such as enactment of laws

prohibiting female genital mutilation, complemented by comprehensive policies and prevention measures, including community-based programming, have created changes in social beliefs and behavior that have led to the abandonment of female genital mutilation. For example, 15 African states where female genital mutilation is prevalent and a number of states in other parts of the world have enacted laws criminalizing the practice.

The political good will, commitment and interest of the Ethiopian government towards HTPs has been demonstrated through the several legal and policy measures it undertook since assuming political power in May 1991. The then Transitional Government of Ethiopia ratified the UNCRC through proclamation No. 10/1991. After the country became a Federal Democratic Republic, notable measures have been taken by the government in the child sector which include, the ratification of the African Charter on the Rights and Welfare of the Child; and the legislative reforms made in the Family Law and the Penal Code of the Federal government which, among other things resulted in incorporating new provisions pertaining to child rights and enhancing the existing ones to meet international and regional standards.

Ethiopia's National Plan of Action for Children for the period 2003-2010 and beyond, issued in June 2004, is another important document that demonstrates the government's level of commitment and its approach to children's welfare. It aims at protecting children from all forms of violence; providing some assistance to children in especially difficult circumstances and protecting them from various harmful traditional practices. It also enumerates the strategies and activities intended to achieve these aims (UNICEF, 2010). The Department of Economic and Social Affairs indicated that female genital mutilations continue to be widespread but appear to be declining slightly. However, although the national trend is encouraging for FGM in some regions, in Somali and Afar it is still affecting the lives of many girls in these regions (EGLDAM, 2007).

Therefore, this study will allow the local people to know the existing status of FGM and its impacts on girls' health. The study will also help stakeholders to know their gaps and to strengthen different structures at district and Kebele levels to combat the practice of FGM in the study areas.

1.3. Statement of the Problem

Female Genital Mutilation (FGM) is non therapeutic surgical modification of the female genitalia. It is an ancient tradition in large parts of Africa, including Ethiopia, especially in the eastern and south part of the country. From South part of the country, in Sidama Zone, its prevalence is high. As a result the study will explore the prevalence of FGM and capacity of agencies working to protect children from all forms of violence including FGM. Notwithstanding several institutions (government, non-government, and faith-based organizations) operating in the target districts providing a range of child protection, only piecemeal information about this practice and its work is available. The state of the phenomena of harmful traditional practices at national level remains unexamined in recent years and little is understood at specific district levels. Further, it could contribute to policy and program decisions to promote wellbeing of children in the specific study areas and address issues that undermine the best interests of children.

Most existing researches on child protection/rights dwell on sexual abuse, child trafficking, labor, and other forms of violence. The issue of FGM and institutions committing to intervene against such practices are emerging but FGM is among the least researched topics in the field though the practice is high currently. Currently, comprehensive research that encompasses wide range of FGM in all districts of the county is non-existent. The recent National study on HTPs is conducted in 2007 which came up with regional level presentation only.

Protection of children from HTPs has become matter of priority for the Ethiopian Government. Hence, the Ministry of Women, Children and Youth (MoWCY) has endorsed in its five years growth and transformation plan, protecting of children from HTPs as the top agenda of intervention. The Government recognizes that the issues of HTPs must be reinforced and protection of every child must consider the survival and development and principle of best interests of the child. To this end, Child protection policy and National Plan of Action against HTPs is underway. This would be exercised through strengthening of different structures at the government, schools and community levels.

This study will allow knowing the prevalence, perceptions and reasons of the local people for practicing FGM. The study will also assess factors associated with the practice of FGM regard to women's health in their future life and forward recommendations to reduce the practice of FGM in the two selected districts.

Female genital mutilation is one of the most dangerous practices that cause torture and death among those who undergo the procedure. Without much knowledge for those practicing female genital mutilation meaning the practitioners and those, undergoing the practice of FGM. The girls and women do not know much about factors associated with the practice of FGM on girls' health. Those who do practice female genital mutilation do not see as it has a negative effect on women and girls' health but rather as a rite of passage from childhood to adulthood, and as a part of their tradition that is followed. The researcher aims to find answers to the following questions by survey questioners for reproductive women, interviewing key informants and reviewing previous literature on the topic.

- ✓ What is the prevalence and magnitude of FGM in the target districts?
- ✓ What perceptions do women have on female genital mutilation?
- ✓ What reasons are there to practice female genital mutilation?
- ✓ What is the effect of FGM on girls' health in the districts?
- ✓ What are the challenges and institutional gaps in fighting female genital mutilation?

1.4. Objectives of the Study

1.4.1. General Objective

- To see the prevalence, perceptions and reasons of practicing FGM and its impacts on girls health.

1.4.2. Specific Objectives

- To identify the prevalence of FGM and perceptions of the community about the practice of FGM.
- To identify reasons of the local people for practicing FGM and impacts of this practice on girls' health in their future life.
- To assess challenges and critical institutional gaps in fighting FGM and recommend mechanisms to reduce the practice of FGM in the districts.

1.5. Significance of the Study

Among practicing cultures, FGM is most commonly performed between the ages of ten and fourteen, but can take place at any age from infancy to adolescence. Prohibition has led to FGM going underground, at times with people who have had no medical training performing the cutting without sterilization or the use of proper medical instruments. The procedure can lead to death through shock from excessive bleeding. The failure to use sterile medical instruments may lead to infections.

Other serious long term health effects are also common. These include urinary and reproductive tract infections, caused by obstructed flow of urine and menstrual blood, various forms of scarring and infertility. Epidermal inclusion cysts may form and expand, particularly in procedures affecting the clitoris. These cysts can grow over time and can become infected, requiring medical attention such as drainage. Moreover FGM would expose women to greater risk of HIV. Clearly, stopping FGM will reduce the above health problems.

The issue of FGM and institutions committing to intervene against such practices are emerging but FGM is among the least researched topics in the field even though the practice is high currently. Currently, comprehensive research that encompasses wide range of FGM in all districts of the county is non-existent. The recent national study on HTPs is conducted in 2007 which came up with regional level presentation only.

Therefore; the study is believed to allow knowing the prevalence, perceptions and reasons of the local people for practicing FGM at district level.

- The study will also assess factors associated with the practice of FGM regard to women's health in their future life and contribute mechanisms to reduce the practice of FGM in the two districts.
- The result of the study will also be an input for institutions committing to intervene against such practices such as Women and Children Affairs Offices, Health Offices and Education Offices from GOs; religious institutions and Iddirs from CBOs and ANPPCAN-Ethiopia and

likeminded organizations from NGOs which intervene at district level using different strategies, developing programs and policy changes.

1.6. Delimitations

The focus of the study is to investigate the prevalence, perceptions, reasons & effect of FGM on girls' health. Hence I delimited my target group to reproductive women, community leaders and government officials in both districts. Among these people the sample is selected.

1.7. Limitations of the Study

Length of the qualitative tools was the biggest challenge encountered in collecting data. This was particularly observed on key informant's interviews. As the list of questions were long enough, by the time of the discussion, most of the respondents were not demonstrating similar stamina in responding questions to the later as they were responding to the first section, because of exhaustion/tiredness. To some extent, this situation might have affected the breadth of information captured from key informants regarding the institutional capacity assessment. The other challenge or limitation worth mentioning was the absence of secondary data about HTPs in general and FGM in particular in both districts.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

2.1. Concepts and Definitions of Female Genital Mutilation

Female genital mutilation (FGM), often euphemistically referred to as female circumcision, is a widespread practice. Estimates of its incidence vary widely, but they tend to agree that there are over 100 million women in the world who have been circumcised, with 2 million more at risk every year (Bosch, 2001). It is concentrated in northern Africa, but it also occurs to a lesser extent in the Middle East, Ethiopia especially in Somali society, the practice of FGM is an honored tradition, southern Asia, among indigenous groups in South America, and even in some African immigrant populations in Europe, Australia, and North America. Numerous international health and human rights organizations have condemned the procedure for the extensive biological and psychological trauma it can impose on girls and women for their entire lives. Female genital cutting (FGC) is a common practice in many societies located north of the equator in sub-Saharan Africa. Nearly universal in a small number of countries, it is practiced by various ethnic groups in at least 25 African countries. In some societies, the procedure is routinely carried out when a girl is a few weeks or a few months old, while in others, it occurs later in childhood. In the case of the latter, FGC is typically part of a ritual initiation into womanhood that includes a period of seclusion and education about the rights and duties of a wife. It is often assumed that FGC "is an 'ancient' and deeply entrenched practice, that it is associated with initiation, with Islam, and with patriarchy" (Shell-Duncan and Hernlund, 2000).

Jackson et al (2003) report on a longitudinal study of women aged 15 to 49 in rural northern Ghana. The self-reported circumcision status of women interviewed in 1995 was compared with the status they reported when they were interviewed again in 2000 after the government began enforcing a law banning the practice and public information campaigns against it were launched. In all, 13 percent of respondents who reported in 1995 that they had been circumcised denied that they were circumcised in the 2000 re-interview, although denial rates were as high as 50 percent in the youngest age group. Jackson et al show that women who denied being circumcised are significantly younger, more likely to be educated, and less likely to practice traditional religion than are women who reported that they were circumcised. Factors that may explain these correlates of denial are discussed, and implications for research are reviewed. Female genital

cutting, also known as female circumcision or female genital mutilation, has received growing attention from governmental and international organizations during the past decade. It is commonly considered a human rights violation, and international pressure has been exerted on governments, communities, and individuals to eliminate the practice (Shell-Duncan and Hernlund 2000). At the same time that a variety of strategies to discourage the practice have been implemented, researchers have called for increased rigor in documenting the specific health effects of genital cutting and the impact of intervention programs to end it (Obermeyer 1999).

2.2. Prevalence and Determinants of Female Genital Mutilation

The World Health Organization estimates that between 100 and 140 million women worldwide have been affected by some form of FGM, with the potential of 3 million procedures being performed every year. Female genital cutting is today mainly practiced in African countries. It is common in a band that stretches from Senegal in West Africa to Somalia on the East coast, as well as from Egypt in the north to Tanzania in the south. It is also practiced by some groups in the Arabian Peninsula. The country where FGM is most prevalent is Somalia, followed by Egypt, Sudan, Ethiopia, and Mali. Among ethnic Somali women, infibulations is traditional and nearly universal (WHO, 2010).

Interest in research to document the prevalence, determinants, and health effects of female genital cutting, as well as in development of appropriate intervention strategies with proved effectiveness, is growing rapidly (Sedgh and Jackson 2003). Accurate measurement of the circumcision status of individuals is crucial to the success of the research agenda. Accurate assessment of individual's status is necessary for evaluation of interventions, for studies of the determinants of the practice, and for investigations of prevalence trends given in national surveys. By 2001, the Demographic and Health Surveys had collected data in 12 countries in Africa. Investigation of the possibility of response bias assumes growing importance as the legislation and informational campaigns against the practice increase, possibly affecting survey-response validity.

Jackson et al (2003) examined the determinants of inconsistent self-reporting of circumcision status by comparing women's self-reported status from survey responses in 1995 with repeat

interview responses in 2000 for a sample population living in a rural area of northern Ghana, where the practice of female genital cutting has been the subject of legislation and informational campaigns.

Okonofu et al (2002) examined the association between female genital cutting and frequency of sexual and gynecological symptoms among a cohort of cut versus uncut women in Edo State of Nigeria. The design used is cross sectional study. The sample for the study included 1836 women. Information about type of female genital cutting was based on medical exams while a structured questionnaire was used to elicit information on the women's socio demographic characteristics, their ages of first menstruation (menarche), first intercourse, marriage and pregnancy, sexual history and experiences of symptoms of reproductive tract infections. Associations between female genital cutting and these correlates of sexual and gynecologic morbidity were analyzed using univariate and multivariate logistic regression and Cox models. No significant differences between cut and uncut women were observed in the frequency of reports of sexual intercourse in the preceding week or month, the frequency of reports of early arousal during intercourse and the proportions reporting experience of orgasm during intercourse. There was also no difference between cut and uncut women in their reported ages of menarche, first intercourse or first marriage in the multivariate models controlling for the effects of socio-economic factors. In contrast, cut women were 1.25 times more likely to get pregnant at a given age than uncut women. Uncut women were significantly more likely to report that the clitoris is the most sexually sensitive part of their body, while cut women were more likely to report that their breasts are their most sexually sensitive body parts. Cut women were significantly more likely than uncut women to report having lower abdominal pain, yellow bad-smelling vaginal discharge, white vaginal discharge and genital ulcers. Female genital cutting in this group of women did not attenuate sexual feelings. However, female genital cutting may predispose women to adverse sexuality outcomes including early pregnancy and reproductive tract infections. Therefore, female genital cutting cannot be justified by arguments that suggest that it reduces sexual activity in women and prevents adverse outcomes of sexuality according to the findings of Okonofu et al (2002).

Rahlenbeck and Mekonnen (2009) reported that in 2005, the prevalence of FGM in women of reproductive age in the Amhara region of Ethiopia was 69%, while 64% of mothers with daughters had a circumcised daughter. Nearly four out of five (77%) women with ages between 45 and 49 years were afflicted and about the same rate (79%) in this age group had daughters on whom she had let the procedure be performed. Their finding suggests that the practice was still widely approved of thirty years ago, as women in this age group began to have their first daughters. In fact, efforts to eliminate FGM in Ethiopia started no longer than 25–30 Years ago. Prevalence of FGM in daughters decreased since then with decreasing maternal age: while in 2000, three quarters of mother's age 30–39 years reported having a circumcised daughter; only 64% did so in 2005. Similar observations are made in younger birth cohorts and do reflect a declining prevalence over time.

According to Elgaali et al (2005), female circumcision (FC) has remained a common practice in the countries where it has traditionally been performed. Following increased global mobility, it has also become a common medical issue in the predominantly non-Islamic countries where an increasing number of immigrants from regions where FC is still traditional, have settled. Many African Islamic women, who have migrated to Scandinavia, seem still to be in favor of the continuation of circumcision for varying reasons. Koso-Thomas (1987) interviewed 400 women in Sierra Leone, 369 of who had been circumcised, and asked why they thought women submit to circumcision. Of these, 257 answered tradition, 105 claimed societal acceptance, 51 said religion, and with 12 or fewer respondents each: increasing chances to marry, preservation of virginity, female hygiene, prevention of promiscuity, enhancement of fertility, to please husband, and to maintain health. It has already been mentioned that female circumcision clearly doesn't improve female hygiene, enhance fertility, or maintain health, but it turns out that most of the rest of the rationales listed here are the result of misconceptions as well.

A study by Gage and Van Rossem (2005) investigated socioeconomic correlates of and gender differences in attitudinal support for the discontinuation of FGM in Guinea. Data from structured interviews of men aged 15–59 and women aged 15–49 years in the 1999 Demographic and Health Survey and multiple logistic regression methods were used to examine the relationship of socioeconomic factors and gender to attitudinal support for the discontinuation of FGM. More

than 9 out of 10 women had undergone FGM. Attitudinal support for FGM discontinuation was more prevalent among men than women. The odds of supporting the discontinuation of FGM were negatively related to beliefs in social approval of and religious support for FGM and its enhancement of women's marriage ability, the number of perceived advantages of FGM, and women's low socioeconomic status. Community education, improvements in women's socioeconomic status and traditional and religious leader involvement would be critical for FGM eradication.

According to Getnet Mitike and Wakgari Deressa (2009**),** Eastern Ethiopia hosts a substantial number of refugees who originated from Somalia where Female Genital Mutilation (FGM) is a common practice in the area, despite the campaigns to eliminate it. They conducted a cross-sectional study among 492 respondents sampled from three refugee camps in Somali Regional State, Eastern Ethiopia, to determine the prevalence and associated factors of FGM. Data were collected using pre-tested structured questionnaires. They also used logistic regression for analyzing the practice of FGM and intention to circumcise after controlling for age of daughters, sex, educational status and other socio-economic factors. The study revealed that FGM was significantly associated with age of the parent and their involvement in anti-FGM interventions; FGM was more reported among younger parents <35 years, while less practice was reported among parents who participated at least in one of the anti-FGM activities; No statistically significant association was found between the practice of FGM and the duration of residence in the refugee camp, educational status of the parent or knowledge of the major complications related to the practice; intention to circumcise a daughter was significantly associated with sex of the respondents and their participation in anti-FGM interventions; being male and being involved in anti-FGM interventions were associated with low intention to practice FGM. They concluded that FGM is widely practiced among the Somali refugee community in Eastern Ethiopia, and there was a considerable support for the continuation of the practice particularly among women. The findings indicate a reported shift of FGM from its severe form to milder clitoral cutting. More men than women positively viewed anti-FGM interventions, and fewer men than women had the intention to let their daughters undergo FGM, indicating the need to involve men in anti-FGM activities.

2.3. Consequences of Female Genital Mutilation

Girls exposed to FGM are at risk of immediate physical consequences, such as severe pain, bleeding, and shock, difficulty in passing urine and faeces, and infections. Long term consequences can include chronic pain and infections (WHO, 2008). A review of the health complications of FGM (WHO, 2000) identified a range of obstetrical problems, the most common being prolonged labour and/or obstruction, episiotomies and perineal tears, post partum haemorrhage, and maternal and foetal death. A recent study investigating 28,393 women attending obstetric centers in several African countries (WHO study group, 2006) concluded that women with FGM were significantly more likely than those without to have adverse obstetric outcomes such as a caesarean, postpartum blood loss ≥500 ml, extended maternal hospital stay, birth weight <2500 g, infant resuscitation, and impatient prenatal death. The authors also concluded that the risks seemed to be greater with more extensive FGM. More recently, a systematic review on the sexual consequences of FGM determined that women with FGM were twice as likely not to experience sexual desire, 1.5 times more likely to have pain during intercourse, and they experiences les sexual satisfaction (Berg & Denison, 2011).

For many girls and women, undergoing FGM is a traumatic experience that may adversely affect their mental health. In fact, several psychological and psychosomatic disorders such as disordered eating and sleeping habits have been attributed to FGM (HRP, 2006). There are also reports of post traumatic stress disorder, anxiety, and depression associated with FGM (WHO, 2008). Data from a systematic review of the psychological consequences following FGM showed that women with FGM may be more likely to experience psychological disturbances, including anxiety, low self-esteem, and to have a psychiatric diagnosis (Berg et al., 2010a).

Lastly, given FGM is a deeply entrenched tradition among some ethnic groups it carries consequences both when it is and when it is not practiced. When girls and families conform to the practice they acquire social status, respect, and community membership (UNICEF, 2005b). In some societies, the link between FGM and value is explicit: girls who undergo FGM often receive rewards in the form of celebrations and gifts, and the bride price for a girl who has been cut is much higher than that for one who has not (Wheeler, 2003). Conversely, failure to conform can lead to difficulty in finding a husband for the girl, shame, stigmatization, as well as loss of

social status, honor and protection, resulting in the family's social exclusion in the community (UNICEF, 2005b).

2.4. Interventions to Reduce the Prevalence of FGM

Efforts to abandon the practice of FGM in Africa have used several different approaches. These approaches include those based on human rights frameworks, legal mechanisms, health risks, alternative rites, positive deviance, training health workers as change agents, training and converting circumcisers, and the use of comprehensive social development processes. Interventions based on these approaches have targeted stakeholders at individual, interpersonal, community, and national levels (Muteshi & Sass, 2005).

In 2007, the Population Reference Bureau (PRB) published their results of an extensive survey of current intervention projects taking place in African countries (Feldman-Jacobs & Ryniak, 2007). In total, the survey identified 92 projects, 27 of which were evaluated, mostly by observational designs. Only four of the 27 evaluated projects (15%) used a controlled before-and-after design. While contributing valuable understanding about the range of interventions initiated to reduce the prevalence of FGM, this was not a systematic review and it did not reach any conclusions about the effectiveness of interventions.

More recently, the authors of the present systematic review specifically examined the effectiveness of interventions to reduce the prevalence of FGM in a systematic review (Denison et al., 2009). Through our literature search of February 2009 we identified a total of seven controlled studies, six of which could be obtained in full text. All six studies were controlled before-and-after studies carried out in African countries. In contrast to the PRB[1] overview (Feldman-Jacobs & Ryniak, 2007), we included only controlled studies, i.e. studies with reference to a non-intervention comparison group, and we concluded that while the evidence base was insufficient to draw definite conclusions, there are possible advantageous developments as a result of these anti-FGM efforts. Notably, our review highlighted the uncertainties regarding relevance of the interventions (e.g. regarding objectives, intervention targets, activities). That is, since it was not a focus of the systematic review, we were unable to provide any assessment of

[1] Population Reference Bureau

the degree to which the interventions were appropriate responses to the populations' needs with respect to FGM, including the degree to which factors that contribute to the perpetuation of the practice were taken into account in the interventions. It is apparent that the degree of relevance of the intervention exerts a considerable influence on an intervention's effectiveness in reaching its designated goals, and may to a large extent help explain variation in behavioral and other outcomes among members of groups.

In sum, two recent publications have examined aspects of interventions designed to reduce the prevalence of FGM. One is a systematic review examining the effectiveness of interventions designed to reduce the prevalence of FGM (Denison et al., 2009). The present systematic review follows the same standard steps as far as systematically reviewing the evidence. However, the literature search is updated and expanded. Moreover, behavior change techniques are identified and the effectiveness of interventions within a perspective of context is assessed and a realist synthesis carried out, which allows an examination of factors that facilitate and hamper the success of interventions.

2.5. Contextual Factors Related to the Continuance or Discontinuance of FGM

FGM is a long-standing tradition that has become inseparable from ethnic and social identity among many groups (UNICEF, 2005b). Disaggregation of data from the Demographic and Health Surveys (DHS) shows that the practice of FGM varies considerably by demographic variables such as age, urban-rural residence, and region or province, and also by variables such as education, ethnicity, and religion (Yoder et al., 2004). Further analysis of DHS data by UNICEF (2005a) suggests that educational attainment, a woman's own circumcision status, and ethnicity have the greatest influence in explaining support or opposition to the practice. Thus, programs designed to reduce the prevalence of FGM should be country specific and adapted to reflect regional, ethnic, and socio-economic variances while also taking into account the diverse reasons why FGM is practiced among a given ethnic or cultural group.

According to Jo Boyden et al (2013), it is important to highlight that in many (although not all) communities the practice has strong cultural roots and a clear cultural logic, which suggests that they may not be necessarily very amenable to reform. This logic embodies two key elements.

First, the families and kin group have a strong vested interest in the productive and reproductive capacity of women, articulated through the regulation by older generations of their sexuality and sexual conduct. Second, female circumcision is seen to ensure girls' social integration and their moral and social development. Thus, it is seen not as a threat to young females but as essential to their well-being, this rationale being in stark contrast to that employed by national and international policy stakeholders. The social power of this logic is such that there is resistance to reform even in areas where government and non-government advocates have been very active with campaigns and law enforcement.

As indicated, the practice is often linked, with 'female circumcision' commonly understood as a pre-condition for marriage. At the same time, the practice is embedded within a system of values which justifies control over the young and over women. It is believed to prevent women from experiencing sexual predation and promiscuity and to curb girls' sexual appetite, ensuring that they marry appropriately and in a timely fashion and are prevented from indulging in early sexual activity or adultery.

CHAPTER THREE

3. RESEARCH METHODOLOGY

3.1. Research Design

Concomitant to the basic survey questions or objectives, a set of structured and unstructured data collection tools were developed. The extensive review of related literatures that preceded the design of the instruments served as a prelude to formulate appropriate questions for each tool. In general, two sets of instruments were developed in order to meet the desired purpose. The first set included survey questioners to capture quantitative data from households in the two rural districts. Semi-structured interview guides were also developed to gather a wide range of information through key informant interviews. The interview guides will cover issues dealing with experience of participants about the prevalence, perceptions, causes and impacts of FGM on girls' lives, and challenges & critical institutional gaps in fighting FGM in the two districts.

The tools were pre-tested, and refined in accordance with feedbacks obtained from the pre-test results.

3.2. Study Universe

The study was conducted in 10 selected rural and urban Kebeles[1] of the two districts using proportion to size of the existing householders in each Kebele. Study subjects were also recruited based on their age category from the source population in the districts. Sample size was also calculated and distributed among 10 Kebeles proportional to the size of households in each Kebele.

3.3. Sample

The source populations for quantitative assessment were reproductive women in the rural and urban Kebeles of the two target districts. The source populations for the qualitative study included community leaders and key informants of government officials in both districts. Totally, about 140 informants (120 reproductive women, 10 community leaders & 10 government officials of the two districts) took part for the study.

[1] Communities

3.4. Sampling Technique

For the purpose of this study, households were selected from each Kebele by systematic random sampling from the start point. The household interval in each Kebele was determined by dividing the total number of households into the sample size. Subsequent households were included in the study and were identified systematically through house-to-house visits, each time adding the sampling interval to the previous number. One woman of reproductive age with a husband was included in the study per household. When more than one eligible female found in the household, a woman having a husband was a part.

Data collectors were oriented before they administered the questionnaire, and a pretest or sample data collection was conducted ahead of official data collection. The questionnaire addressed women's knowledge about FGM, whether the women were circumcised themselves or not, and who were the main perpetuators of FGM in the districts. A questionnaire was developed first in English and translated into Amharic, and the translated Amharic version has been administered. The data was collected by visiting house-to-house in each household selected for the study. Member of the household who was eligible to be a study subject and was not present at the time of the visit, the next randomly selected household has been selected for the study. For interview community leaders and government officials were identified purposively who have direct work relation on HTPs in the districts.

The collected data had been checked on a daily basis for completeness and appropriateness. For the sake of confidentiality, any label identifying the respondent was avoided in the questionnaire. Thus, the data was made anonymous.

3.5. Tools (Instruments)

Related to the basic research questions or objectives, a set of structured and unstructured data collection tools were developed. The extensive review of related literatures that preceded the design of the instruments was served as an introduction to formulate appropriate questions for each tool. In general, two sets of instruments were developed in order to meet the desired purpose. The first set included survey questioners to capture quantitative data from reproductive

women in the two rural districts. The second set of semi-structured interview was also developed to gather a wide range of information through key informant interviews.

3.6. Analysis of Data and Interpretation

The collected quantitative data was analyzed using SPSS package. Basic statistical tools including frequency and percentage distribution tables, and graphs were used for data analysis and presentation. Qualitative data were analyzed using thematic data analysis method.

CHAPTER FOUR

4. FINDINGS AND DISCUSSION

This section deals with the descriptive analysis of quantitative and qualitative data in Shebedino and Goriche districts. Survey findings were analyzed based on a total of 120 reproductive women which were randomly selected in the two districts. Moreover, in view of optimizing validity and reliability of results, numeric data were triangulated and substantiated with a wide range of qualitative information captured from multiple approaches.

4.1. Background Information of the Respondents

The data on the sex composition of sample respondents revealed that 11% were males and 89% females. The age of respondents ranges from 15-49 and more than 75% of the respondents were between the ages of 26-35. Regarding marital status, overwhelming majority (95%) of the respondents, were married, 4% were widowed while very few (2%) were divorced. With regard to religion, the majority (76%) of the respondents are followers of protestant religion. Catholic, Orthodox Christianity and others share the remaining 24%.

Table 1-Distribution of Respondents by Educational Status and Occupation

Background variables	**Response**	**Frequency**	**%**
Sex	Male	16	11
	Female	124	89
	Total	**140**	**100**
Educational Level	Illiterate	25	18
	Informal (Church & Quran schools)	14	10
	Primary	54	39
	Secondary	15	11
	High School	14	10
	Total	**140**	**100**

Occupation	Farming	76	54
	Both farming and cattle breeding	3	2
	Others (wife ,employed workers)	45	32
	Trader	16	12
	Cattle breeding	1	1
	Total	**140**	**100**

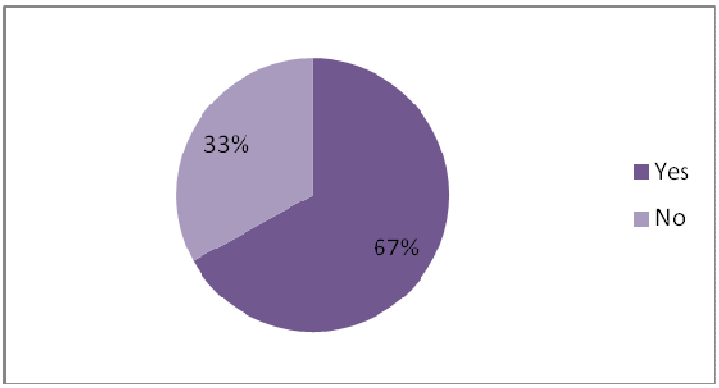
Pertaining to educational level of the respondents, 39% are at the primary level (Grades1-6). Informal (church and Quran) and Secondary (Grades 7-8) levels covered 10% and 11% of the responses respectively; while, 10% of the respondents were at High school level (Grades 9-12). Only 13% of the respondents attained higher education. On the other hand, 18% of the respondents were illiterates. The data showed that the larger mass did not access formal education and those who had access were at the very elementary level.

As far as occupation is concerned, the majorities (54%) of the respondents are cereal and cash crop farmers, 12% are traders while 32 % are housewives and employed workers. Insignificant proportions (2%) of the respondents engaged mixed farming.

4.2. Prevalence of FGM

In order to explore occurrence of FGM in the community, respondents were asked whether the community practice FGM or not. Chart 1 illustrates that majority of the respondents (67%) affirmed FGM as currently being practiced in the community.

Chart 1- Occurrence of FGM



On contrary, 33% reported that the community does not practice FGM. Most of the key informants were to the opinion that FGM is the most prevalent of all HTPs in their vicinity. In connection to this, one of the key informants from district Church said, "…FGM is continued to be practiced, it is not yet stopped and cutting the clitoris is the widely practiced form of FGM in the district. Shebedino district health office representative added, "…FGM is highly prevalent. Among the different types of FGM, 'Suna' (cutting the clitoris) is the common type in this community context. We are working on it and yet it is still a challenge, we failed to avoid it totally."

In the same manner, an Iddir leader said, "FGM prevails in the community; it is a long standing practice against the awareness raising programs launched through media and other means." Moreover, a community leader confirmed, "…FGM is among the various forms of HTPs highly affecting children in our community".

Likewise, key informant from Shebedino district education office stated, "…it is very clear FGM is widely practiced in our district. Though the society has adequate understanding about the negative consequences of FGM, there are cases where people are doing it covertly during the night times."

Besides, the Survey on HTPs in Ethiopia, SNNPR report depicted Sidama zone is among the strongholds of FGM practice with the prevalence rate of 73.3% in 1997 and 54.7% in 2007 which shows that it is decreasing since the result of the current finding in Shebedino and Goriche districts is 44%.

Table 2- Distribution of Households Practicing FGM

Responses	**Frequency**	**Valid Percent**
Yes	53	44
Gave up (abandoned)	30	25
No	37	31
Total	**120**	**100**

Respondents were asked if they are currently practicing FGM or not. As shown in Table 2, 31% are against FGM, while 25% have abandoned the practice and yet about 44% are still doing it.

Many of the key informants also confirmed that the community is still circumcising the girl child. As part of the background information, it is mentioned that prevalence of FGM showed decrease from 60% in 1997 to 45% in 2007. Hence, the prevalence in Shebedino and Goriche districts is almost equivalent to the national level FGM prevalence rate.

FGM is extraordinarily deep rooted in the minds of the two districts community. It is a manifestation of the dignity of girls and their families and a precondition to get a husband and establishing a family. It is perceived as a symbol of mat fullness of a girl and others; which is indeed more than enough to overwhelm the immature minds of the girl children. Hence, girls in these districts wish and strive to undergo circumcision regardless of the different initiatives to ban FGM including the legal repercussions.

4.3. Perception of FGM

Regarding identifying the perception of respondents 74% of them believed that FGM is a harmful traditional practice and the rest 26% said no. Those respondents who said no believe that FGM helps a woman to get husband; helps her to be respected by the community; and she will be blessed and avoid insult from her colleagues. In connection to this one of the key informants said; “when you ask people about FGM they will tell you that FGM is a bad tradition and do not practice it. But in reality they do it.”

When the respondents were asked whether they protest to FGM, 40% of them reported that the role of fathers is paramount in defending their children from FGM. It is paradoxical, in a society where it is hard to access a husband if not circumcised; father’s being prominent opponents of the practice flags up the question ‘where the problem and the solution resides in’. In fact, 25% of the respondents replied mothers also stand against FGM. Mother’s contribution is encouraging even if they are identified as the prominent actors, facilitators as well as practitioners by many. This study shows that similar result with the findings in Getnet Mitike and Wakgari Deressa (2009) which indicate more men than women positively viewed anti-FGM interventions, and fewer men than women had the intention to let their daughters undergo FGM indicating the need to involve men in anti-FGM activities.

Children are found incapable to defend themselves from FGM. In a nut shell, less participation of children on matters affecting their life is evident in this community. It is unfortunate to realize that about 20% of the respondents asserted no one stands against FGM. As lawyers quote 'silence is acceptance'; if these people are not standing against the practice they may have accepted it as a good practice. Thus, reaching out to the hesitant population regarding FGM will benefit to save a number of children at risk of FGM.

4.4. Causes of FGM

Various causes were mentioned by participants behind FGM. More than half (60%) of the respondents replied that societies determination to maintain the culture is the major cause for FGM. One of the key informants said, "FGM is prevailing as inherited from our ancestors." In addition, lack of knowledge on the adverse effects of FGM and to avoid breaking of household items followed as contributing factor by 5% of the respondents. Other factors include: the need to get husband, peer pressure, religious and societal taboos shared the rest 35% of responses. Other key informants further elaborated the deep rooted and complex nature of FGM in their community. An Orthodox religious leader said, "…the community believes that if a girl is not circumcised she will break household utensils, and her sexual feeling will be uncontrollable. She will be difficult to handle and cannot be faithful to her wedlock. The community does not consider uncircumcised girls as equal to the rest of the community members; they are rather disrespected and considered as disabled or have lacked something."

Key informant from the Evangelical church added, "FGM is done because mothers usually influence their daughters claiming that unless they are circumcised, it will cause bigger damages to their family reputation. In our cultural thinking, unless circumcised a girl cannot get someone who will be willing to marry her. Non-circumcised girls are considered as dirty who carry a shameful thing."

The above result on the causes of FGM is almost equivalent with a study made by UNICEF (2005b) which states, failure to conform can lead to difficulty in finding a husband for the girl, shame, stigmatization, as well as loss of social status, honor and protection, resulting in the family's social exclusion in the community.

Girls own initiative to undergo circumcision is raised by key informants. Education office representative said, "… Nowadays girls are circumcised by their own interests. In rural areas specially when the families are educated and opposing the practice what the children usually do is, they go to their relatives in other far districts and get there circumcised by their own interests." Key informant from Goriche district health office added, "…culture is the main cause behind FGM. If the girl is uncircumcised she will be devalued by herself and among colleagues." Similarly, religious leader said, "girls fear that unless they are circumcised, the others/colleagues will insult them."

One of the key informants said, "…circumcised girls are considered blessed and respected by all around her while uncircumcised girls suffer from derogatory names given by the community. The fact that girls themselves prefer to be circumcised so as to be respected in their community and ultimately get husband is the result of negative community attitude towards uncircumcised girls. Peer pressure as a fundamental cause behind FGM". A community leader said, "…we have this concern, you are requiring us to stop FGM, what if men refuse to marry uncircumcised girls?"

Such cultural and societal based factors are mainly related with gender based power imbalance prevailing in the community. This situation calls for the need to address gender relations and male involvement in fighting against FGM.

The findings are also similar with a study conducted by Koso-Thomas (1987) except some of the causes like enhancement of fertility and to maintain health are included in his study. However, in this study causes like to be considered as blessed, to avoid suffer from derogatory names and insult by colleagues and community, to be considered as equal to the rest of the community members are findings which deviate from other studies.

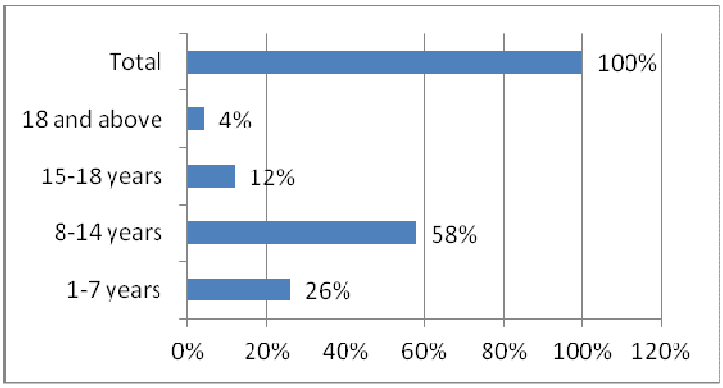
4.5. Magnitude of FGM

Regarding the magnitude of FGM sadly enough, 44% of the respondents said that FGM is frequently practiced and 30% replied that it is sometimes practiced. In fact, it is encouraging that the rest (26%) have abandoned the practice. However, 44% of respondents up laud how

widespread the practice is. The pervasiveness of the practice was supported by key informants. Religious leader said, "…everyone is engaged in this cultural practice (FGM). There are many in our churches who circumcised their children. Everyone, educated or non-educated, religious or non-religious, including people who hold public offices are indeed circumcising their children."

To further explore the current practice of FGM, respondents were asked when did the last time they let their girl circumcised. Accordingly, 10 % of the respondents affirmed that their girl daughter is circumcised before a year. Before 3 years 29% of them had exposed their child for FGM and 37% had circumcised their girl child before five years. Overall the quantitative data conveyed how severe the magnitude of FGM in the community is. Correspondingly, a religious leader from Goriche said, "One day while I was teaching the issue in my church, there were 60 people. When I asked 'how many of you have not circumcised your female children?', I got only one person- who claimed that he has not done it on his girls who are currently attending their university education outside Goriche. I do not actually know how his children shall withstand the 'insult' if his daughter decides to come and work here after graduation.

Chart2. Distribution of Age at FGM



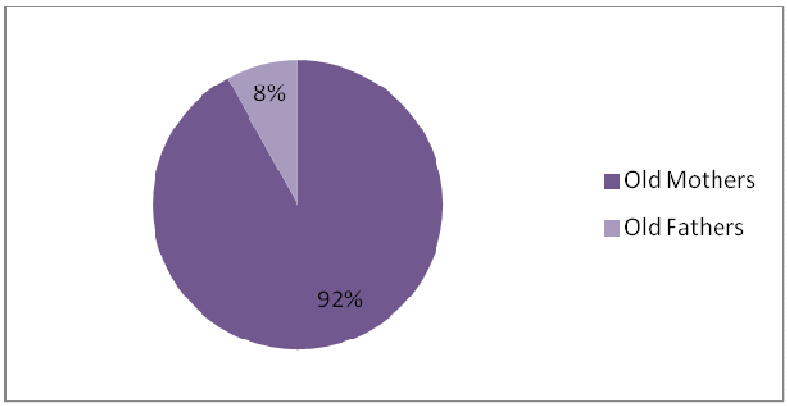
Data presented in chart 2 depicted the age at which circumcision is conducted. 58% of the respondents reported that circumcision is between the ages of 8-14. FUS report of the SNNP report confirmed that in Sidama (Shebedino and Goriche are in Sidama); age at circumcision is during puberty. Most likely, children at this age are enrolled in schools. Hence, targeting schools will help rescue girls vulnerable to FGM. Secondly, FGM is practiced up on children in between 1-7 years as 26% of the replies confirmed. In addition, 4% of the respondents have affirmed that

FGM is practiced on girls between ages 15 and above. With this regard, key informant from Shebedino district education office said, "…in our district female children are circumcised above the age of 8 years. In old times it was done when the girl reaches the adolescent age. Even there were times where girls were circumcised after marriage in their husband's houses. Now they are circumcised at their family's homes before marriage." Religious leader said, "Nowadays female children are circumcised at an average age of below 10 years."

One of the key informants also confirmed that FGM used to be done when the girl is adult enough, but now FGM is happening at early ages. Further, FGM practice is coming to be seasonal. Previously, community prefers the conventionally better days ('birra ken')[1]; nonetheless in recent years summer (July and August) which actually related to end of the academic calendar. Iddir[2] leader also confirmed that the school break period (July-August) is high time for FGM for girls will be available home for a relatively longer period.

Surprisingly, 92% of the respondents confirmed that FGM practitioners in the two districts are elderly women and the rest 8% are elderly men.

Chart3. Practitioners of FGM



Women in the two districts are keen enough to perpetuate FGM which might already have affected their own live. In fact, they may not be aware of the negative consequences that FGM cost them. Raising their awareness on the adverse effects of FGM and criminality of the practice

[1] A day when the rain stops
[2] Local association formed to give social services at community level

shall then be areas where all may need to focus. A key informant from Shebedino district Health office said, "Mothers facilitate the process even hiding from the father." In addition, religious leader added, "…practitioners are usually women who come from the remote rural villages. In many cases they inherit the practice from their fore mothers. They believe that it is an obligation to keep the practice. The practitioners are paid for rendering the service".

From the term itself, FGM is typically female focused harmful practice; paradoxically almost all the practitioners are female and mothers' contribution is immense in perpetuating the practice. With this respect, women focused interventions are highly recommended acknowledging crippled gender relations are the root cause behind FGM.

As confirmed by most participants of this study, the prevalence and magnitude of FGM is high in the two districts. The unanimity of information up on the occurrence, prevalence and magnitude inform the need for urgent action against FGM. The level of pervasiveness give no time to think twice, action against FGM is in a very higher level of demand to save a great number of children who are on the verge of undergoing FGM.

4.6. Effects of FGM

Respondents were asked about the adverse effects of FGM. Accordingly, the majority of respondents (74%) said that FGM causes harm to the girl child, whereas the remaining 26% acknowledges no harm related to FGM.

Unlike the education and awareness raising programs communicated through various media, still a substantial amount of respondents assume no harm is actually associated to FGM. Hence, an innovative intervention on awareness raising and education targeting these segments of the community is vital. Key informant interviewee from Iddirs[1] said, "…the community is not that much aware of the negative consequences, they rather are concerned on what will the girl face if not circumcised."

[1] Local association formed to give social services at community level

Pertaining to the negative consequences associated to FGM, 57% of the respondents said FGM resulted complicated delivery, while 26% of them gave no response with regard to the potential risk associated with FGM. Others (17%) highlighted reproductive health/organ related defects.

Similarly, qualitative data revealed negative impacts of FGM. Key informant from Iddirs[1] said, "FGM resulted birth complications and maternal and child mortality. Likewise, a community leader added, "…if the girl is circumcised, she will suffer for her body cannot smoothly let the child born." Also, a religious leader added, "…we have observed very visible negative impacts of the practice both during sexual intercourse and child delivery. For instance, one day I have heard that six women were taken to the Yergalem Hospital for fistula treatment from our district".

With this regard, the religious leader added, "…since open discussion on sexuality is a taboo in rural communities, due to FGM wives usually stay longer to go to bed during the evenings in order to skip/reduce the sexual intercourses moments with their husbands. For they lack the sexual desire. This resulted disagreements between couples which often leads towards divorces and multiple marriages. An informant from Shebedino district education office said, "…due to the negative consequences of FGM on their sexual lives, wives start to separate their beds from their husbands at the ages of 30 to 40."

Generally as a result of this study shows that the public does not have a clearer understanding that it is really harmful practice which does not have any meaningful advantages or not. The fact that they are practicing it despite knowing it is illegal; affirm that the communities are not fully convinced that FGM should be abandoned. As a result aggressive campaign on this issue should be launched by involving all stakeholders in the areas. Awareness on boys and young men should be increased so as to not to marry circumcised girl/woman and to be aware of the negative consequences of FM.

[1] Local association formed to give social services at community level

4.7. Reporting and Responding to FGM

a) Sources of Information and Reporting to FGM

Regarding to sources of information about FGM, as 23% of the respondents confirmed, health professionals are serving the community in accessing information about the adverse effects of FGM. Secondly, 20% reported that personal communication played an important role for disseminating information on the same issue. Trainings/workshops and schools served 11% of the respondents each. Another 11% said radio/TV[1] is serving as information. Combinations of all the replies covered the remaining 24%. The data showed that the role of religious institutions to disseminate information on the negative consequences of FGM is found very week. Further, it is noted that 70% of respondents in this study conveyed FGM often happen on school aged children (8-18).

Nevertheless, schools are not efficiently delivering information on FGM related issues. This indicates the necessity to engage with schools for the high prevalent aged children resides in there.

With regard to reporting, majority of the respondents (77%), report to government structures (mainly Kebele, women and children affairs or to the HEW/posts). As a means of reporting for FGM, community leaders are also recognized by 18% of the respondents. It is unfortunate that only 2% are assuming to report to the police which are supposed to be the primary organ to receive reports against any forms of violence. With this connection, key informant from Goriche district Health Office said, "…sometimes, even the Police refrain to take action even if they exhibit FGM. It may be due to lack of awareness at their level."

In the study, awareness of the informants on FGM as a criminal act was explored. As shown in Table 3 below, 92 % of the respondents realized that the Ethiopian law criminalizes FGM. In the same manner an Iddir[2] leader said, "…parents send their children to rural areas for circumcision. This happened for the community is aware of the legal consequences. Even in the rural areas, they are doing it hiding from the mass. These days there are no ceremonies to practice FGM for

[1] Television
[2] Local association formed to give social services at community level

they are aware of the legal repercussions." Moreover; a religious leader added, "Nowadays FGM is usually done secretly and covertly during mid-nights. This is because the families and the practitioners have come to understand that it is an illegal practice to carry out FGM."

Table 3- Awareness of Respondents about FGM as a Criminal Act

Is FGM a Criminal Act in Ethiopian Law	Frequency	%
yes	111	92
No	5	4
I don't Know	4	4
Total	**120**	**100**

On the other hand, 4% said FGM is not a criminal act in the Ethiopian law and the remaining 4% have no information whether the Ethiopian law criminalizes FGM or not.

Regarding penalties associated with FGM, 41% of the respondents believed that it results imprisonment accompanied with financial fees. In addition, 30% of the respondents think that a person convicted of practicing FGM will be imprisoned, while 8% believes it is only about financial penalties. On the other hand, 12% replied that they do not realize what repercussions to follow for practicing FGM. Combinations of all responses covered the remaining 9%.

b) Responding to FGM

Concerning response to FGM, respondents' perception is found inconsistent. About half of the respondents (49%) reflected that perpetrators will be advised at first and legal repercussions will follow if found guilty again. The other 34% believe that practitioners will be penalized as stated in the criminal law while others (13%) do not have any idea regarding the responses attached to FGM practice.

With regard to loosen response mechanisms, key informant from Shebedino district education office said, "…there are gaps in implementing the law. Our main problem is not the gap in the

law and our social institutions such as 'Iddirs'[1], but our inability to implement them so as to create minimum impacts. If we try to stop the practice applying the existing laws we will get good results. For that matter, we argue that the law enforcers themselves do not have the required commitments for stopping the practice. The law enforcing body should be exemplary so that others will follow their models."

A religious leader supplements the idea that responding to FGM is not being done in a coordinated and aggressive manner, "…We do not see many efforts from religious organizations and others with regards to stopping FGM. But the district Women, Children and Youth office has done better. However they are fruitless. No one is supporting their efforts. Except making fun of it while they are teaching, nobody has dared to strengthen what they have been trying".

A community leader from Shebedino reflected, "…to avoid FGM, Elders, church, GO & NGOs have to work collaboratively and increase societal awareness on FGM in general. We are willing to discuss on FGM related issues on a regular basis as far as support is provided from potential actors working on the issue. We can mobilize our society advice the community. We can also devise community bylaws to condemn perpetrators. Yet, it is encouraging since community respect the words of elders seldom. Nowadays, government officials are more recognized than the community leaders.

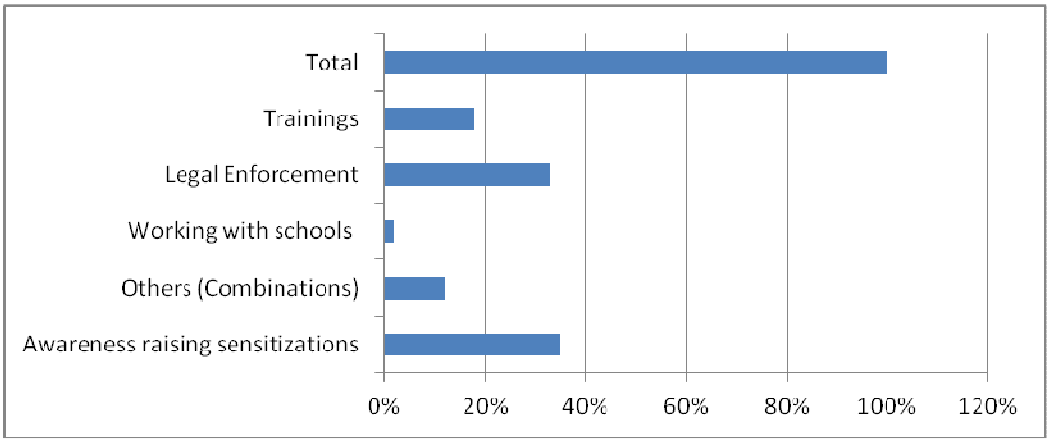
4.8. Ways to Reduce FGM

Initiatives

Regardless of the variance in the degree of prevalence and magnitude, the study outcomes revealed that there are various forms of HTPs affecting the life of children in the districts. From these various HTPs practices FGM is the main one. To this end, the key informants were asked if there are any initiatives introduced to combat FGM. Consequently, about 80% of the informants witnessed that there are initiatives against the prevailing FGM in their district while the vice versa is true for rest (20%) of informants; they argue no initiatives are going on to address FGM. Specific to the actors behind these initiatives, government took the lead with 94% of the replies.

Chart 4- Initiatives to Address FGM

[1] Local association formed to give social services at community level



When asked about the initiatives going on in addressing FGM, in their community, data in chart 4 revealed that 35% of the respondents mentioned awareness raising sensitizations, legal enforcement (33%), and trainings (18%) as the three major priority interventions. Combinations of the other responses cover the remaining 12%.

Yet; the responses showed that these initiatives neglect engaging schools in their interventions. Engaging the community in IGA[1] is also seldom attempted to defy the prevailing FGM which are associated with economic problems.

The various initiatives, which are mainly government initiated, are acknowledged by qualitative data sources. One key informant said, "…we are striving to fight FGM, we have got support from district administration office, elders are also working on this in various social gatherings, yet the practice is not declining tangibly." Another key informant from district health office said, "…HTPs are among the 16 health packages government aspired to address. Hence, the office is mandated to respond. To this end, we are conducting CC[2] to raise community awareness on the adverse effects of HTPs. CC contributed a lot to raise community awareness against FGM." Education Office informant added, "…so much has been done in stopping the practice by many including the schools, Kebeles and other groups. Evidently, people are not doing the practice openly, they rather deed covertly during mid-nights". He also witnessed that school clubs sporadically address issues regarding HTPs.

As part of the non-governmental initiatives, a religious leader from Shebedino addressed, "…FGM have no religious ground in Orthodox Christianity. We educate our followers that

[1] Income generating activities
[2] Community conversation

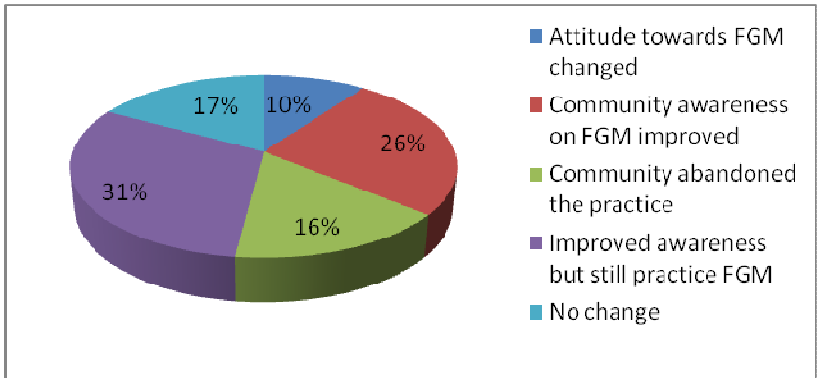
circumcision refers to boys only not for female. The government is launching various awareness raising programs against HTPs, and yet there is a challenge to actually address CM."

Indeed, most of the stakeholders are claiming that they are contributing to the campaign against FGM with all their potential. However, those initiatives are stand alone and no attempt of integrating effort and sharing resources towards ending FGM is observed. Except the Women and Children Affairs Office, no institution has clear intervention mechanisms budget to combat FGM thus far. This communicates that no real commitment is exerted to alleviate the problem children in the community are facing in relation to FGM. Many are sympathizing on the issue which is not contributing to lighten the gravity of the problem in actual facts.

Outcomes

As a result of the initiatives aforementioned, 31% of the respondents revealed that community awareness is improved and yet the community keeps doing the undesired practices thus far. 26% respondents replied that community awareness has improved. To the contrary, 17 % of the respondents reported, there is no change exhibited associated to the initiatives at all. Only, 16% witnessed that the community at large abandoned the practice of FGM. On top of this, 10% of the respondents said residents' attitude towards FGM is changed.

Chart 5- Results of FGM Focused Initiatives



With this regard, a religious leader said, "…awareness is already created among different sections of the communities- Almost everyone knows that FGM is a bad practice. There are some families which have already decided not to circumcise their female children, which can be role models for further campaign against FGM."

Moreover, a community leader said, "…there are improvements regarding FGM prevalence following educating the wider community but not completely abandoned. FGM was done overtly but now it is hidden by some parts of the community. The biggest challenge we see is not lack of understanding on the teachings, but getting someone who actually decide to live on these teachings. No models have yet created for the people to follow."

Up on the existing initiatives, respondents' were asked what shall be done to improve efficiency and effectiveness of the interventions. Subsequently, 70% of the respondents focus on expanding education and awareness raising through promoting dialogue among family members and the larger community. Significant others (20%) have no response for this question. The remaining (10%), stressed on strengthening legal enforcement as an ultimate measure to combat FGM prevailing in their community. Similarly, key informant from Iddir said, "… Legal enforcement should follow in depth awareness raising campaigns and education on HTPs, there should be a lead office/organ to follow up cases and report to the legal bodies.

Further upholding the relevant government sector's accountability and ownership is highlighted by the informants. According to the key informant from Goriche District Health Office; lack of ownership to address FGM is observed. HEWs considered this engagement as an additional job not their primary focus. They also lack to collaboratively work along with the volunteer community health workers. FGM is no one's priority. We also lack to engage influential leaders in the community to lead CC and engage the community at large. CC is also less monitored to evaluate the success of the intervention.

Unlike the above mentioned intervention, some believes that there are no meaningful initiatives which particularly targets HTPs. Those who claimed no initiatives are launched asked why they assume so. Accordingly, the majority (90%) of them have no idea why there are no initiatives against FGM. Absence of education is mentioned by 6% of the respondents. Other factors like deep rooted culture and tradition, economic reasons and lack of self initiated acts cover the rest 4% of replies. In line with this, key informant from district health office said, "…the community is not transparent enough to communicate FGM related issues. They also give less attention to participate in CC and it is quite difficult to held open discussion where men and women are in the same CC. Also, there is lack of CC facilitators' commitment and participants' negligence if

no incentives are provided. Further, Education office key informant from the two districts said, "…no adequate budget is allocated for HTP prevention at both the district and school levels."

4.9. Capacity Assessment

One of the scopes of this study was to conduct the institutional capacity gap assessment of stakeholders in Shebedino and Goriche districts i.e., government offices, networks, and community structures. This section, therefore, provides description of qualitative data on institutional capacity of major stakeholders operating in the two districts, whose mandate and functions are directly aligned to address harmful traditional practices in general and FGM in particular.

The overall purpose of the assessment was to identify existing institutional and structural set ups in child protection and to explore the extent into which such structures plaid their roles in addressing FGM. Moreover, the study also emphasized assessing major capacity gaps and challenges often encountered by the institutions which affect proper execution of their mandates. The findings from the assessment were to provide recommendations for establishing partnership and working relationship among the institutions in fighting against FGM. Specifically; this assessment is intended to respond to the following objectives:

- Understand the present organizational capacity of the institutions ;
- Identify areas of organizational strengths and weaknesses;
- Identify appropriate interventions and suggest workable recommendations based on the findings of the assessment to address weaknesses in order to achieve organizational sustainability to combat FGM.

All major stakeholders in the two districts were targets for this assessment. However, due to circumstances related to absence of information and focal sources during the assessment period, some organization were not included. Moreover children's parliament structure was put in place in both districts but not that much functional. However, the researcher realized that the idea of strengthening children's parliament was endorsed by the district councils and there is an urgent need to support this structure in the near future. In consultation with the Women and Children Affairs Offices, ten institutions were identified from each district which have direct stake on the subject of concern.

4.9.1. The Assessment Process

For this assessment, qualitative data was captured primarily from key informants interviews held with representatives of the institutions. In addition, the researcher also used observations in the field to consolidate the findings. The capacity assessment tool was designed to provide qualitative data on the range of variables which could portray the proper image of the reorganizations pertaining to their current institutional capacity. The tool allows interviewer to work with the organizations and assess and determine the appropriate level to which the organization is more likely to be placed on the scale. To generate broader perspectives, the tools mainly covered issues on the following specific areas of capacity:

- Roles (mandates) of the institution in child protection (particularly in relation to FGM)
- Strengths and weaknesses in human and financial resources/skills
- Involvement of the constituencies and target groups
- Networking and partnership

In order to be able to get individual perspectives and draw objective conclusions, every institution was allowed to let one or two staff members to participate and share their opinion in the capacity assessment interview. Accordingly, generation of strengths and weaknesses was done per capacity area. The researcher led the discussions on what the capacity area was seeking to measure and the ideal characteristic of that capacity area. This was then followed by sharing what (in the participants' views) is the current practice in their organization with regard to that capacity area. Having this information, participants were then asked to generate a list of strengths and weaknesses for the capacity area. The generated list was then displayed and reviewed together (both by the participants and the researcher) to ensure that they have portrayed the correct image of the organization in the four-leveled scale. Before assigning levels to each capacity component, the four levels were clearly defined and communicated to the participants in order to have common understanding on the scale. The distinctive meaning of the four levels has been described as follows:

Level One: (Clear need for increased capacity).Characterized by components of a particularly capacity which is at the nascent stage of development. In other words, the major salient features of this stage are that the component is at the rudimentary stages of development or non-existent at all.

Level Two: (Basic level of capacity in place)-This is an emerging stage. A component or category will be under this stage if it has some emerging capacities developed and is vivid in some areas.

Level Three: **(**Moderate level of capacity in place) - This stage is characterized by the expansion of a particular component often with some degree of achievement. At this stage there are recognizable track records of achievements. Even with such achievements, the organization will still need to improve in some areas.

Level Four: (High level of capacity in place). This is the matured and highest stage of an institutional growth. The institution in this stage is fully functioning with most of its components at a sustainable stage. It has a diversified resource base, varied partnerships and existing networks at local, national and international levels.

4.9.2. Findings and Observations in the Districts

Findings on capacity assessment presented in two categories. In the first section, using inductive analysis of the qualitatively exercises, some common observation were identified in the aspects of strengths and weaknesses which were cross cutting or uniformly characterizing most of the institutions visited. In the next section, specific findings were presented using a capacity assessment grid showing each component of the institution vis a vis the description of the capacity at the level where each component falls.

4.9.3. Common Areas of Strengths

4.9.3.1. Availability of Local Structures Mandated to Child Protection

In most of the stakeholders visited, particularly in government offices, child protection issues seem to be central, in which most of them are perusing it by integrating with their mandates and day-to-day activities, although it was not endorsed and shared with all the staff members in the organizations as internal policy of the organization. In most of the offices, particularly in women and children affairs, health, education, police and justice offices, their missions and goal statements vividly included issues of protecting children as their primary responsibilities in various ways. For instance, the following responsibilities were extracted from the list of mandates documented in various offices.

- Protecting and supporting children in extremely difficult circumstances (Women and Children Affairs Offices)
- Fight against harmful traditional practices affecting children and women by strengthening community sensitization (Women and Children Affairs Offices).
- Prevent, protect and rescue, children and women form all forms of violence (District Police Offices)
- Identify barriers for school enrolment of boys and girls and work in collaboration with the local community and schools to address the problems. (Education Offices)
- Protect the rights and needs of vulnerable children. (Child protection and care unit at District Women and Children Affairs Offices)
- Ensure legal protection of minors (Justice Offices).

In addition to these mandates and government structures, the formation of local associations and community level group structures in most of the offices were pronounced as one of the strengths in structural set ups which are considered to be significant channels to promote accountability and participation of the community. Explaining this point, some key informants mentioned the following:

> *"…local associations and group structures play overarching role in addressing our mandates at the grassroots level. They are serving as a bridge between the government and the community. It is unthinkable to move an inch to the direction of our development goal without involving the local community. Therefore, these structures are best mechanisms to involve the community in our endeavors and through which we are able to demonstrate accountability to our constituencies…"*

4.9.3.2. Human Resource

In almost all offices, the organizational structure was put in place offering clear lines of command and responsibilities for respective groups of actors. Staff members have clear job descriptions signed, indicating their duties and responsibilities and chain of working relationships. In terms of number of staff, except religious institutions and women associations, most of the institutions have reported having adequate number of qualified/professional staff members assigned to the business process positions. Following the structural reform (Business

Process Reengineering /BPR) which was undergone in every government office, critical measures were taken on staff assignments to suit to the newly revised structures. As remarked by many of the key informants, BPR has emerged as the implementation and administrative tool in expediting the implementation capacity than ever before. In the new structure, HTP has focal persons assigned to run specific activities. Commenting on this point a key informant from Women and Children Affairs Office said;

> "*When it is fully materialized, BPR is more likely to bring fundamental change in speeding up the pace of program implementation and enforcements procedures at all levels. It was only after the BPR that a stand-alone position on HTP came into being. Previously, HTP activities were overlooked and used to be performed as one components of the social welfare section. Now, a focal person has been assigned to lead and coordinate specific activities pertaining to harmful traditional practices in the region."*

Witnessing adequacy of staff in the office, another key informant form education office also mentioned the following:

> "*We have enough number of staff assigned to each position. There is no vacant position in the structure. Despite recruiting appropriate staff is commendable, familiarizing the staffs with the HTPs issues in general and FGM in particular has a long way to go. Knowledge and awareness of the staff on the legal repercussions of HTPs and intervention strategies seem to be not matured and therefore, it needs to be bolstered…"*

In spite of the fact that the management and structural reform is in place, some key informants were skeptical about the outcomes. In the discussions, some staffs argued that BPR is not yet to bear fruit. To the opinion of these individuals, the change in the structure alone couldn't bring any significant transformation in the capacity of the institutions, unless it is supported with strategic directions to revamp the human and financial capacity of the organization. As one key informant simply put*;*

> *"People mistakenly equate the principle of BPR with the strategic planning exercise, which are so distinct."*

4.9.3.3. Emerging Signs of Collaborations and Networking

Female genital cutting is a multifaceted problem which requires multi-dimensional interventions. In this regard, it goes without saying that multi-stakeholders collaborations are paramount to effectively address the problems. In recognition to this, it was observed that small scale local networking initiatives are emerging in the districts, although they are premature. A good example is the joint effort of collaboration in preventing violence against children. Intervention was scaled up when the following major offices established a network at district level which is coordinated by WCAO. Members of network are Education office, women and children affairs, police and justice, Health Office, ANPPCAN-Ethiopia[1] and local CBOs.

However, there are challenges and limitations. Financial and logistic resource limitations, inadequate skilled human power at Kebele structures, misconceptions and negative outlooks, corruptions, etc. are the serious impediments reported by the respondent which are affecting the progress of the collaborative efforts.

The other significant networking initiative, currently in progress, is the Regional HTP Network formed by relevant sector stakeholders drawn from religious institutions, community organizations, NGOs and relevant governmental sector offices. It was reported by the HTP focal person at the Women and Children Affairs Office that effort is underway to replicate the same at zonal and district level soon. In order to give more weight to the initiative, the zonal and district networks will be coordinated and led by the heads of the Zonal and District Administration Councils.

However, these initiatives are largely at the nascent stage and need to be bolstered if sustainable networking should develop. The ensuing major limitations were observed in the networking and collaborative efforts in the districts;

- Networking and collaborations are often ad hoc activities which do not sustain longer. As one of the key informants mentioned, *"… we usually seek the collaboration only in case of emergencies and campaigns…"*

[1] Local NGO working on child protection issues

- Coordinators of the networking initiative are engaged with other painstaking duties and therefore, they seldom spare much of their time on it.
- A referral system within the networking is not well developed; it is based on the interest of the leaders of the offices.

4.9.3.4. Regular Monitoring and Evaluation Practice

There are some encouraging practices observed in the sphere of monitoring and evaluation practices of the organizations. In many of the offices visited, activity and financial progress reports (annual & quarterly) were compiled and shared with respective users (mainly to the higher level structures). Monitoring and evaluation was done using different formats as demanded by respective authorities. It was also observed that with variations in regularity among the organizations, the monitoring forums to share program progress were in place including for example staff meetings, management meetings, etc. In general , the promising foundations for monitoring and evaluation practice of the district sector offices was applauded by a high ranking key informant as follows;

> *"The new business processing procedures demands every office to include Monitoring and Evaluation section as one core process (section) which is responsible to conduct regular monitoring and periodic evaluations of the office and suggest actions for future planning. Moreover, there is a quarterly evaluations procedure conducted by the district council during which every core process heads evaluated up on their performance and achievements according to the set objectives and operational plans."*

Interestingly, most of the informants recognized that monitoring and evaluation tool has been used as means to ensure upward and downward accountability of their organizations to their respective constituencies in the district. Apart from regular reporting to the higher level structures, some offices (WCAO, Women Associations, and Justice and Police Offices) have a regular practice of providing and receiving feedbacks about the progress of their activities from the target community using the existing lower structures. As reported by the informant form WCAO,

"At the beginning of every fiscal year, the office communicates its annual plan to the community structures and conducts quarterly evaluative meetings with the focal persons and group leaders of the structures".

Similar practices were reported from police office in executing community policing programs. It is also worth mentioning that some organizations used evaluative assessments to explore the extent to which they have achieved their plan and the performance status of each core process in the office. Justice and health offices could be exemplars in this regard. This process enabled them to clearly see the image of their office, learn from failures and improve service delivery. Results of the evaluation informed the offices to identify the most efficient and effective core processes with objective evidences. In this regard, a key informant said:

"…at the end of the last fiscal year, we prepared and distributed assessment questionnaire to be filled out by different stakeholders including the community to get feedback about our strengths and failures. The results were compiled and produced as a comprehensive report. Our limitations and strengthens were clearly identified. We believe that we are honest and transparent in this regard. Even I was also evaluated as a leader of the institution by the assessment and the result about my status was included in the report. I can say that this is one means of receiving feedbacks from our constituencies"

4.9.4. Major Capacity Limitations

The study identified several capacity limitations among stakeholders in the districts, which cause critical bottlenecks that seriously hamper the functions of the institutions. Some of the constraints are said to be institution-specific while others are cross cutting. In this section, the most common gaps which were widely and frequently replied by most of the stakeholders are presented.

4.9.4.1. Financial and Physical Resource Constraints

Findings vividly depicted that almost all institutions were financially under resourced. There was unanimous response among the stakeholders explaining that most of the offices secure budget only from a single source (particularly from the government) or have limited resource base.

Many key informants in the government sector were to the opinion that limited annual budget earmarked by the government to the social sector offices is an indication of the fact that little importance has been given to the sector compared to other development areas. The key informant in WCAO said,

> *"Our office is one of the offices in the social sector often allotted with the least amount of annual budget. Under such condition, it is less likely to design comprehensive intervention plan".*

4.9.4.2. Limitations in Documentation/Record Keeping Practices

It is evident that information is a cornerstone for any intervention. The capacity of the institutions with regards to securing, storing and disseminating information (relevant to their mandates) was explored and the overall findings indicate serious shortfalls prevailing in the documentation practice of stakeholders. Intermittent recording, inconsistency of figures, manual and unsafe filing systems and lack of documentation skills were critical limitation facing the implementation process. It was observed that in many of the offices, secondary data about FGM were hard to come by and if they do prevail; they are not as properly recorded as they should. Existing archival records in some organizations such as Police, WCAO, and Justice Offices reveal very little about the actual magnitude of the problems since they are mostly underreported or less properly documented.

In brief, the practice of the documentation and data management system of the offices visited had been entangled with the following major limitations:

- Except few, many of the stakeholders had no computer facilities and no access to internet service.
- There is no effort in the districts for recording vital statistics, for example, formal birth registration which is critically impeding the decision making capacity of the managements in child protection issues.
- Most of the structures at district level do not include qualified information technology personnel to handle management information systems.

4.9.4.3. Lack of Strategic Plan

A few points were identified in this assessment which needs to be noted regarding the capacity of stakeholders in relation to planning. It was found out that none of the stakeholders had the strategic plan to objectively guide attainment of organizational goals and objectives. Overall activities of the organizations are steered with operational plans trickled down to the district from higher structures. Here, the critical gap was observed in the knowledge of the concept of strategic plan. Despite some offices claimed having the strategic plan, it is found that the documents only containing the operational plans. Some stakeholders also likened the strategic plan with the five year's growth and transformation plan (GTP) of the government.

Although individual staff's competence on the strategic planning process was not assessed, management reports and anecdotal evidences showed the effort in this regard is lagging far behind. The researcher identified that in most cases planning happens on ad hoc bases only and not supported by systematically collected data. When asked about how the planning process was carried out, the key informants form Education, Police and WCA Offices reported that their need to conduct a comprehensive strategic plan planning process has been challenged with acute budget constraints. As one of the key informants said,

> *"Conducting strategic planning requires trained staff in the strategic planning skill. Therefore, we have to make our staff to be familiar with the process, which requires financial resource. In our case, there is a need for a comprehensive strategic plan, which would identify priorities and estimate the resources required for each office's functions, provide an aid to advocacy for additional funding and to serve as a blueprint for future capacity development.*

CHAPTER FIVE

5. SUMMARY, CONCLUSION AND RECOMMENDATION

5.1. Summary

This paper explores the prevalence, perceptions and reasons of practicing FGM and its impacts on girls health in Shebedino and Goriche Districts of Sidama Zone, SNNPRS. FGM has been designated as Harmful Traditional Practices (HTPs) by the Ethiopian government and is proscribed by law, with designated punishments. This is in line with Article 24 of the United Nations Convention on the Rights of the Child, which calls for the prohibition of traditional practices that are prejudicial to the health and well-being of children. Apart from the fact the practice is labeled as 'harmful' and relates only to girls which tend to be seen as a necessary precursor.

The study points to identify the prevalence of FGM and perceptions of the community about the practice of FGM; reasons of the local people for practicing FGM and impacts of the practice on girls' health in their future life; and to assess challenges and critical institutional gaps in fighting FGM and recommend mechanisms to reduce the practice of FGM in the two districts.

The study allows knowing the prevalence, perceptions and reasons of the local people for practicing FGM at district level. It will also assess factors associated with the practice of FGM regard to women's health in their future life and contribute mechanisms to reduce the practice of FGM in the districts. The result of the study will also be an input for institutions committing to intervene against such practices at district and regional level by developing different programs and policy changes.

The practice is widespread still, despite international and national efforts to eradicate it, and reflects deep-rooted beyond imaginations. The underlining causes are long standing societal attitude/culture which is manifested in imbalanced gender relations, inherited from their ancestors, economic factors, lack of awareness on the adverse effects of the practices on some of the community and legal and policy frameworks. Still a substantial amount of respondents assume no harm is actually associated to FGM. However, the majority of the respondents have

awareness that FGM resulted complicated delivery and reproductive health/organ related defects. The study shows that though the community has awareness on the adverse effects of FGM, their attitude towards stopping the practice of FGM is not changed.

It finds that the efforts of government and elite leaders to eradicate it are contributing to the reduction or transformation of FGM, although with different understandings and considerable contestation and resistance in the communities. The public does not have a clearer understanding that it is really harmful practice which does not have any meaningful advantages. The fact that they are practicing it despite knowing it is illegal; affirm that the communities are not fully convinced that FGM should be abandoned.

Except District Women and Children Affairs Offices, no institution has a drafted strategy or action plan and/or budget to combat FGM thus far. This communicates that no real commitment is exerted on other government institutions to alleviate the problem children in the community are facing in relation to FGM though other stakeholders like FBOs, CBOs, and NGOs have shown their commitment to prevent FGM and ultimately eradicate from the districts. In doing so, it emphasizes the challenges confronted by child-protection measures designed to bring about change to long-established customs.

The source populations for quantitative assessment were reproductive women in the rural and urban Kebeles[1] of the two target districts; and also for the qualitative study included community leaders and key informants of government officials in both districts. Totally, about 140 informants (120 reproductive women, 10 community leaders & 10 government officials of the two districts) took part for the study.

The paper used basic statistical tools including frequency and percentage distribution tables, and graphs were used for data analysis and presentation. Qualitative data were analyzed using thematic data analysis method to assess the prevalence, perceptions and reasons of practicing FGM and its impacts on girls health and ways to reduce the custom. It gives an overview of the

[1] Communities

prevalence, perceptions, causes and effects of FGM and ways to reduce the custom in the target districts of Sidama Zone, SNNPRS.

Finally, the discussion reflects on wider issues of initiatives introduced to combat FGM in the target districts. Earlier engagements showed unilateral and events based actions which resulted resource and effort duplication and hence no remarkable outcome against FGM recorded. This shows that the networks and the community structures are not strong and active to eliminate FGM from the districts.

5.2. Conclusion

As inspired from the study, the two districts experience FGM in a highly prevalent manner. It is continued to be practiced everywhere and by everyone in the districts. All people including the district officials, religious leaders, Iddir[1] leaders, community elders, teachers and civil servants (educated or not educated) are practicing it upon their children. The practice FGM is highly deep rooted beyond imaginations. The underlining causes are long standing societal attitude/culture which is manifested in imbalanced gender relations, economic factors, lack of awareness on the adverse effects of the practices and legal and policy frameworks. The good news is that there is a growing public awareness regarding criminality of FGM. Nevertheless, the public does not have a clearer understanding that it is really harmful practice which does not have any meaningful advantages. The fact that they are practicing it despite knowing it is illegal; affirm that the communities are not fully convinced that FGM should be abandoned.

As part of initiatives against FGM, except the Women and Children Affairs Office, no institution has a drafted strategy and/or budget to combat FGM thus far. This communicates that no real commitment is exerted to alleviate the problem children in the community are facing in relation to FGM. Many are sympathizing, simply giving a 'lip service' which is not contributing to lighten the gravity of the problem in actual facts.

Similar to many rural communities elsewhere in Ethiopia, the Sidama people highly respect elders. Their view and decisions are solid enough and are accepted by many unanimously.

[1] Local association formed to give social services at community level

Nonetheless, with regard to responding to FGM, elders in many cases are playing a destructive role which goes up to jeopardizing the legal procedures regarding victims of FGM. Their role should be redefined and hence they shall serve as agents of change against FGM, yet it is undeniable convincing elders and bringing them out of the long standing attitude and practice to be agents of change will be the hardest chore.

The government has set various structures which have a potential to reach the wider community at grassroots level. The CRC[1] committees, HEWs[2], development groups, community volunteers and so on are the strong holds that one can access the community and pave the way to influence as well as promote beneficial practices. Community's response towards these structures and government officials is also highly encouraging. Besides, other stakeholders like FBOs, CBOs, and NGOs have shown their commitment to prevent FGM and ultimately eradicate from Shebedino and Goriche districts. However; action is remained to come to the real practice. Earlier engagements showed unilateral and events based actions which resulted resource and effort duplication and hence no remarkable outcome against FGM recorded. Hence, an integrated, inclusive and participatory approach of all the stakeholders is highly recommended.

5.3. Recommendation

This part of the study had received a relatively unanimous response in all the thematic areas of the recommendation: prevention, protection, reporting, responding and addressing capacity limitations with the study in Shebedino and Goriche districts.

5.3.1. Prevention

- Create a wider understanding among all the key stakeholders on the issue of FGM. Clear understanding on harms of the practice (FGM), enable the community recognize FGM is illegal and is an offence to the law and harm to the girl child
- Reach a wider consensus among all stakeholders towards stopping the practice. Everyone has a non-substitutable role to play; and has to contribute. Yet, the district WCAO should

[1] Child right committees
[2] Health extension workers

take the lead in the organizing the campaign against FGM so that resource is fairly and efficiently utilized to reach to the aspired goal.

- Aggressive campaign should be launched by involving all stakeholders. Awareness on boys and young men should be increased so as to not to marry circumcised girl/woman. While doing so utmost care need to be taken for those people who are already the victims of the practice. Minimize damages on those who are already victimized.
- Working with Iddir[1] and community elders is crucial for one institution alone cannot combat FGM.

5.3.2. Protection

- District political and administration leaders, justice officials, police, religious leaders, community leaders, teachers, nurses, civil servants, students, fathers, mothers, brothers, sisters, etc. should work collaboratively and be on the same page towards protecting the girl child from FGM.

5.3.3. Reporting

- Community awareness on the modalities of reporting on FGM cases and the wider abuse on children should be improved through education. To this end, using religious institutions to access the wider mass is essential.
- Collaborate with children structures (children councils, school clubs and any other forms of children associations…) for identification of cases before/when happening of cases in the district.

5.3.4. Responding

- Existing laws and community institutions bylaws (since bylaws are strong in Sidama's culture) should be properly enforced. Giving rooms for unlawful mediation by elders should be stopped. Law enforcing authorities should be clear and take serious actions.
- Collaboration of the different stakeholders is vital to proactively respond to the prevailing FGM in the districts.

[1] Local association formed to give social services at community level

5.3.5. Addressing Capacity Limitations

1. The study made it clear that absence of strong networking and inconsistencies in collaboration among responsible sector institution and stakeholders seem to have caused a considerable degree of impediment to the process of implementation of child protection programs in each district. It is therefore worthwhile to establish and strengthen networking among governmental and nongovernmental organizations at all levels.
2. Among others, it is vital to raise the consciousness stakeholders in the range of child protection concepts, mechanisms and procedures.
3. Information is basic element for any program intervention. The study identified that the paucity of data on HTPs in general FGM in particular were one of the serious challenges all stakeholders currently facing. It is therefore recommended that a comprehensive regional and district level data base should be established to foster implementation of child protection programs.
4. The role of both electronics and print media in advocating for the implementation of existing policy and legislations is unquestionable. Efficient use of these channels requires the effort of enhancing the technical and human resource capacities in terms of updating the media officials and pertinent journalists on issues concerning FGM.
5. Shortage of financial resource is found to be the major underlying cause for the limitations in many other aspects of institutional development. It is therefore important to consider enhancing the skill of the organization in fund raising and mobilizing local resources and diversification of budget sources.
6. It is also worth mentioning that there is an important need to enhance participation of the community in the child protection process at all levels. Experience shows that interventions are doomed to fail without the genuine and active participation of the community and the concerned stakeholders. Therefore, efforts need to be made to improve the capacity of stakeholders in community participation strategies.

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Appendix 1

Questionnaire

The questionnaire is prepared under Indra Ghandi National Open University in Social Work Department to prepare a thesis for the fulfillment of MA Degree. The questionnaire contains questions related to the prevalence, perceptions and reasons of FGM and its consequences. Since your response is confidential you can give genuine information without any hesitation.

Do not mention your name in the questionnaire.

Thank you very much for your cooperation.

1. Questions Related to Background Information

1.1. Sex A. Male B. Female

1.2. Age A. 15-25 B. 26-35 C. 36-45 D. 46-49

1.3. Educational Status:- A. Illiterate C. Primary Education
B. Able to write and read D. Secondary Education
E. Higher Education

1.4. Occupational Status:- A. Unemployed C. Government Worker
B. Daily worker D. Private Organization worker
E. If other mention_____

1.5. Marital status:- A. Not married D. Divorced
B. Married E. Widowed
C. Separated F. If other mention_____

1.6. Religion:- A. Orthodox D. Catholic
B. Muslim E. If others mention_____
C. Protestant

1.7. How many children do you have? A. No children C. 2-4 children
B. One child D. More than 4 children

2. Questions Related to the Prevalence of FGM

2.1. Does the community practice FGM or not in your district? A. Yes B. No

2.2. Are you currently practicing FGM in your family? A. Yes B. No

2.3. Was FGM practiced on you? A. Yes B. No

3. Questions Related to Perception of FGM

3.1. Do you believe that FGM is a harmful traditional practice? A. Yes B. No

3.2. If your answer is no why the practice is "**not perceived as harmful**" in your locality?

1) …….
2) …….

3.3. Do you agree on the practice of FGM? A. I disagree B. I agree

3.4. If you disagree what is your reason?

1) …….
2) …….
3) …….

3.5. Who opposes/resists the practice of FGM in your family?

A. Father C. Girls
B. Mother D. All the family members
E. No one opposes

4. Questions Related to Causes of FGM

4.1. What is the reason that FGM is practiced in the district?

A. It is the community's cultural values
B. The community has lack knowledge about the negative consequences of FGM
C. It has religious reason
D. Other reasons (to get husband, to be fertile, to avoid promiscuity, etc.)

5. Questions Related to the Magnitude of FGM

5.1. In what magnitude the practice of FGM occurs in your locality?

A. Frequently practiced
B. Sometimes practiced
C. Rarely practiced
D. Not practiced

5.2. If FGM is practiced when is the last date that FGM occurred?

A. Before 5years C. Before a year
B. Before 3years D. It is practiced still now

5.3. What is the age at which FGM is mostly practiced?

A. 1 to 7 years C. 15-18 years

B. 8-14 years D. 18 and above

5.4. Who are the practitioners of FGM?

A. Old mothers C. Medical experts

B. Old fathers D. If others _____

6. Questions Related to the Effects of FGM

6.1. Do you have the knowledge of the negative consequences of FGM on girls/women?

A. Yes B. No

6.2. If your answer is yes, what are the possible negative consequences of FGM on girls/women?

1) ……..
2) ……..
3) ……..
4) …….

7. Questions Related to Reporting and Responding

7.1. What is your source of information about the adverse effects of FGM?

A. Health professionals E. Radio/Television

B. Personal communication F. Religious institutions

C. Trainings/Workshops G. Others _____

D. Schools

7.2. What is your preference to report when FGM occurred on girls and women in your locality?

A. Do not report
B. To police office
C. To court
D. To women's children and youth affairs offices
E. To Keble security force
F. To schools (teachers/clubs)
G. To family members
H. If others, mention……

7.3. Is FGM a criminal act in the Ethiopian law?

A. Yes B. No C. I don't know

7.4. What is your perception about penalties associated to FGM?

1) Imprisonment accompanied with financial fees
2) Imprisonment only
3) Financial penalty
4) Not realize what repercussions follow
5) Other _____

7.5. What response is given to the perpetrator from Justice?

1) Perpetrators will be advised first
2) Perpetrators will be penalized as stated in the law
3) Do not have any idea
4) Other_____

8. Questions Related to Ways to Reduce FGM

8.1. Are there any initiatives introduced to combat FGM?

A. Yes B. No

8.2. If you say no, why you assume that no initiatives are launched?

1) _____
2) _____
3) _____

8.3. If yes, what are the initiatives which are going on to combat FGM?

1) Awareness raising sensitizations 3) Trainings/workshops
2) Legal enforcement 4) Others_____

8.4. What is the result of FGM focused initiatives?

1) Community awareness on FGM improved and the practice reduced
2) Community awareness on FGM improved but still practice FGM
3) Community abandoned the practice
4) Attitude towards FGM changed
5) No change
6) Others_____

8.5. What shall be done to improve the efficiency and effectiveness of the interventions?

1) _____
2) _____
3) _____

Appendix 2

Semi-Structured Interview Questions to Gather a Wide Range of Information from Key Informants

1. How do you perceive Female Genital Mutilation?
2. What are the contextual factors related to the continuance and discontinuance of FGM?
3. What is the prevalence of the practice of FGM in the district?
4. How did FGM originate from according to your culture?
5. What is your perception about FGM?
6. What are the reasons of the local people for practicing FGM in the district?
7. In what magnitude the practice of FGM is occurred?
8. What is the average age that FGM is mainly practiced on girls?
9. When is FGM mainly practiced in your community (season/months)?
10. Who performs FGM in the district?
11. How is religion involved in the practice of FGM?
12. What is the level of knowledge of the community on the effects of FGM in your locality?
13. What are the different effects on girls/women caused by FGM in the district?
14. Are there any initiatives introduced to combat FGM in the district?
15. If there are initiatives what intervention mechanisms are being used to reduce the prevalence of FGM?
16. What is the outcome/result of the initiatives (If there are)?
17. What is the role, strengths and challenges/ gaps of the institution in fighting female genital mutilation in the district?