Knowledge, Attitude and Practice of Female Genital Mutilation among the Community of Gursum Woreda, Somali Regional State of Eastern Ethiopia

A Thesis Submitted to the School of Social Work

Presented in Partial Fulfillment of the Requirements for the

Degree of Masters in Social Work

By

Tigist Moges Getanehe

Advisor: Abebe Assefa (Ph.D)

Addis Ababa University

Addis Ababa

June, 2017

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university, and that all sources of materials used for the thesis have been duly acknowledged.

Name of Student: Tigist Moges Getanehe

Signature: _____

Date of Submission: June 5, 2017

This thesis has been submitted for examination with my approval as a university advisor.

Name of Advisor: Abebe Asseffa (Ph.D)

Signature_____

Knowledge, Attitude and Practice of Female Genital Mutilation among the Community of Gursum Woreda, Somali Regional State of Eastern Ethiopia

Approved by Board of Examiners

Advisor	Signature	Date
Internal Examiner	Signature	Date
External Examiner	Signature	Date

Acknowledgement

I would like to extend my deepest gratitude and appreciation to my advisor Dr. Abebe Assefa (Ph.D),for his unlimited professional advice and support. He has helped me to realize the vague ideas into a tangible product. Many thanks go for his unflinching patience and for always challenging me to look at the bigger picture. He has widened and deepened my thoughts.

I am extremely grateful to my husband Dr.Afework Ayele. He is the source of my courage, strength and perseverance. My experience in writing this thesis has been the most worthwhile because hehas made sure that I am happy and strong enough to keep going until the end. Many thanks go tomy brother Ato Sintayehu Kebede, my son Eng. DawitAfework and my daughterEng. Bilen Afework who always believe the best in me.

I would also like to acknowledge S/r Zehara Addi, Somali Regional State Women and Children Affairs Bureau, W/ro Mariem, A/Head of Gursum Woreda Women and Children Affairs Office and for their tremendous support to undertake this study in their area. My sincere thanks go to Ato Mubarek Ahmed, who helped me in translation and Ato Sirak Beneberu for facilitating the field survey.Special thanks also go to Ato Belay Habtewold for his support in entering research variables in SPSS.

Table of Contents

LIST OF TABLES

LIST OF FIGURES

List of Abbreviations

AAU	Addis Ababa University
BC	Before Christ
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CRC	Convention on the Rights of the Child
CRR	Center for Reproductive Rights
CSA	Central Statistics Agency
DV	Dependent Variables
EDHS	Ethiopia Demographic & Health Survey
EGLDAM	Ethiopia Goji Limadawi Dirgitoch Aswegaj Mahimer
FGM	Female Genital Mutilation
GTP II	Growth and Transformation Plan Two
HDI	Human Development Index
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
HTPs	Harmful Traditional Practices
IV	Independent Variable
IFSW	International Federation for Social Workers
IFSSW	International Federation for School of Social Work
KAB	Knowledge, Attitude & Behavior
KAP	Knowledge, Attitude & Practice
MoWCYA	Ministry of Women, Children and Youth Affairs
MoWCA	Ministry of Women and Children Affairs
NPC	National Planning Commission

OLR	Ordinal Logistic Regression
OR	Odds Ratio
PATH	Program for Appropriate Technology in Health
PMC	Population Media Center
POM	Proportional Odd Model
PTSD	Posttraumatic Stress Disorder
SDG	Sustainable Development Goals
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
UN	United Nations
US	United States
VAW	Violence against Women

Abstract

Female Genital Mutilation (FGM) is a worldwide complex, deeply rooted practice and affecting almost all ethnic groups. FGM is widely practiced by Ethiopian women, specially, in Eastern part, Somali region. The practice affects the health and psychological well-being of millions of Ethiopian women and children.Moreover, it is a violation of child's and women's human rights, denying them of their physical and mental integrity and their right to freedom from violence, torture and discrimination. Psychosexual, social, hygienic and religious reasons are given for the practice.The objective of this study is to assess the knowledge, attitude and practice of FGM among the community of Gursum Woreda, Somali Regional State of Eastern Ethiopia. A quantitative cross sectional research method was employed and a total of 430 respondents participate in this study.The ordinal regression method was used to model the relationship between the orderedcategorical outcome variable, the support for the practice of FGM and the explanatory variables concerning demographics, knowledge and attitude towards the practice.The findings of the study reveals that age, education and religion of socio economic factors, knowledge and attitude towards the practice found to be statistically determinants for the support for the continuation of the practice of FGMin the study area.Increasing awareness and knowledge on the ill effect of FGM, community empowerment, girls and women education and empowerment, encouraging men involvement, working in collaboration with religious leaders, advocacy for implementation of existing policies and anti-FGM legislation were recommended to bring about change of attitude and social behavioral change towards FGM in the study area.

Keywords: female genital mutilation; knowledge; attitude, practice

CHAPTER I: INTRODUCTION

1.1. Background of the Study

Female Genital Mutilation (FGM) is a type of harmful traditional practices that affects the health and psychological wellbeing of women and girls and infringes their basic human rights. Ending FGM requires a global action from professionals of social work to challenge laws, lobby new policies or implementation of existing one and advocate for the human rights of women and girls.

Harmful traditional practices (HTPs) that violate the human rights of women are pervasive in Ethiopia, occurring in all ethnic groups throughout the country. There are around 140 types of harmful traditional practices inthe country (Dawit, et. al, 2005, p. iii).Harmful traditional practices cause pain, suffering, and humiliation and marginalization for women, especially those who live in rural areas with traditional lifestyle.

Female Genital Mutilation (FGM) is one of the common harmful practices in Ethiopia. According to UNICEF report, itaffects the wellbeing of more than 200 million women and girls around the world. Based on the data from the 2005 Ethiopia Demographic and Heath Survey (EDHS), three out of every four women had undergone FGM. Thirty eight percent of women with a daughter reported having at least one of their daughters circumcised, and about one third of all women support the continuation of the practice" (EDHS, 2005, p. 252)

In Ethiopia, FGM is practiced in all regionsbut the magnitude varies significantly from region to region. FGM, especially the worst type of it, is most prevalent among the ethnic groups of Somali and the prevalence rate reaches 99 percent in the region(EDHS, 2016, p. 45).

The practice of FGM has significant adverse impacts on the health, physical as well as psychological well-being of women and girls (WHO, 2009). It is believed that FGM is done for

healthy gender development and to control a woman sexual desire in order to remain unadulterated and innocent virgin for worthy of marriage. However,FGM is an extreme form of violence used to control girls' and women's sexuality with socio-cultural and religious reasons of preparing girls for adulthood and marriage. Furthermore, "it is a human rights violation deeply rooted in gender inequality and a reflection of discrimination against women and girls. It violates a series of well-establish human rights principles, norms and standards, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman o degrading treatment or punishment" (WHO, 2008, p.9).

The problem is not only the continuation of the practice but practicing communities and who support the practice including men are often led by misconceptions of thepractice that has been carried out for centuries without knowing much about its origins or health-related complications (NCTPE, 1999). As a result of the wide knowledge gap, FGMcontinues to be a serious public health challenge in the practicing communities.

In Ethiopia, female genital Mutilation (FGM) has become a major development and gender agenda over the past decades by government organizations (GO), the United Nations (UN) agencies and non-governmental organizations (NGOs). Ethiopia has been takingsome steps towards the abolishment of the practice. However, these efforts have not succeeded in curbing the practice and instead it remains widespread in some regions like Somali.

Female genital mutilation has been carried out among various communities in Ethiopia with reasons such related to virginity as honor of the family and the husband and mutilation as criteria for marriage, as religious requirements. Above all, its health, psychosocial trauma, and other consequences are less understood among many communities in Ethiopia.

According to MOWCA, "several personal, interpersonal, community/social, organizational factors and lack of enabling policy environment determine the prevalence of FGM" (MOWCA, 2013,p.12).

1.2. Statement of the Problem

Female genital Mutilation (FGM) is defined by the World Health Organization as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genitalia organs for non-medical reasons" (WHO, 2008, p. 4). "Over 200 million girls and women alive today have had FGM and three million girls are estimated to be at risk of undergoing FGM annually" (UNICEF, 2016, p. 1).

FGM is widespread across Ethiopia with national prevalence rate of 65.2%. It is carried out in majority of the regions and ethnic groups, with the highest prevalence in Somali region at a rate of 99% (EDHS, 2016).Studies show that Infibulations type of FGM is prevalent in the Eastern parts of Ethiopia and mostly in Somali region (Spadacini &Nichols, 2010). In the region almost all baby girls have to go through some form of FGM during infancy. The widely used form of cutting known as Infibulations involves "the total removal of the clitoris, labia minora together with the inner surface of the labia majora and stitching using a small locally made and unsterilized knife or blade" (Masresha, 2014, .p 4). "After doing the cutting, the raw edges of the labia majora are brought together to fuse, using thorns, poultices or stitching to hold them in place, and the two legs of the baby girl are firmly tied together for 2-6 weeks. Mixtures of local herbs, cow dung, ash or butter are used to treat the wound" (Wadesango, et.al, 2013, p. 121).This is to guarantee the prevention of the girl from having sex before marriage. A very small opening, equivalent with the tip of matchstick, is left to allow for the flow of menstrual blood and urine.

The small opening makes the proper flow of urine difficult and women may take more time to empty their bladder or they may need to go more frequently for urination (WHO, 1995)

It can often be difficult for women who have undergone mutilation type of circumcision to think about having sexual intercourse. Since the opening left after Infibulations is very small,loss of skin elasticity, or development a tumor or mass growing from a nerve; sexual intercourse is very painful for circumcised women. Sometimes if the opening is too small, re-cutting (defibulation) is required before sexual intercourse. The husband or female relatives using a sharp instrument like knife can sometimes do this. "Modern couples may seek the assistance of a trained health professional, although this is done in secrecy, possibly because it might undermine the social image of the man's virility" (WHO, 1995).

The severity of the problems associated with the procedure FGM depend upon the magnitude of the cutting, the hygiene or cleanness of the instrument used and the health condition of the mutilated girl.FGMcan cause immediate health problems including "intense pain and/or hemorrhage that can lead to shock during and after the procedure, wound infection, including tetanus, damage to adjoining organs from the use of blunt instruments by unskilled operators, and urine retention from swelling and/or blockage of the urethra. All these cause complications and death for many children(Brady 1999). "In most cases, the procedure of FGM is taken in unhygienic conditionsmainlyby traditional practitioners often by laypersons with no or only rudimentary training. These traditional practitioners are most commonly aged andhave poor visual acuity" (Dawit et al., 2005, p. 15). Traditional herbs or ashes are applied to the wound. This may increase the change of developing infections and tetanus. Usually, during circumcision, the same unsterilized tool is used on several girls at one time especially in-group circumcision (PATH, 2005). Such condition can increases the likelihood of spreading HIV or

other communicable diseases among girls undergone through mutilation. In addition, "if the procedure of FGM on a baby girl is undertaken where medical facilities are badly-equipped and emergencies arising from the practice of FGM cannot be treated and, a child can develop uncontrolled bleeding or infection and may die within few hours" (Koso-Tomas, 1987, p. 29).

The problems associated with FGM don't stop with the removal of the most sensitive genital parts and stitching during childhood. "The stitched genital organ has to be reopened during child delivery after marriage and it has to be stitched back again after delivery until the next pregnancy and child delivery. During this procedure sever pain; shocks, excessive bleeding and infection are common problems. This can also cause anemia that affects the health of pregnant women and causes premature delivery and lesser weight for newborns" (Andarge 2014, p. 4). If the de-fibulation process during delivery is taken place outside of the hospital setting, fetal and/or maternal complications may occur because of obstructed labor or perineal tears (WHO, 1995). Furthermore, traditionally, re-Infibulations is carried out after a woman gives birth.This is done by stitching the edges of the remaining part of the labia minora again by creating a small opening, often the same size as the previous Infibulations (same as that which existed before marriage). This is done to create the illusion of virginity, since a tight vaginal opening is culturally perceived as more pleasurable to the man. The extent of both the repeated cutting and suturing during recurring child delivery can make the negative physical, sexual and psychological consequences of Infibulations are severe and longer-lasting than other types of female genital mutilation or cutting (WHO, 1995).

In addition, painful or blocked menses abnormal menstruation, recurrent urinary tract infections, abscesses, dermoid cysts, keloid cards (hardening of the scars) and infertility are some of the long term health complication faced by circumcised women (WHO, 2009).Although this is

an area that has not been widely studied, it is indicated that“physical complications from FGM often impede sexual enjoyment of women. FGM destroys much or all of the vulval nerve endings, delaying arousal or impairing orgasm” (Rushwan, 1996, p. 10).

FGM can also cause psychological and social complications. Some researchers describe the psychological impact of FGM as ranging from anxiety to severe depression and mental illnesses.The practice is also rooted in religious, personal and societal beliefs within a frame of psychosexual and social context (WHO, 1998 & UNFPA, 2009). This will be further elaborated in the literature review part.

FGM practicing communities inEthiopia believe that the practice guarantees a young girl’s virginity – a prerequisite for an honorable marriage. “Marriage is considered as the only means for economic survival for women” (Andarge, 2014, p. 5). With a belief of men as the sole source of family income and they manage all family properties, FGM is considered as very important to women to have children and to be economically shielded by men. This condition forced parents to put their daughter into this dangerous decision. “This trans-generational problem consequently has been continued risking the health, physical and psychological wellbeing of girls and mothers through sexual and gender based inequality” (Andarge 2014, p. 5). FGM is, therefore, one of the ways by which inequality between men and women have been manifested and embedded in structures of social, economic and political conditions of societies (WHO. 2008).

From a human rights perspective, the practice of FGM reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. “Female genital mutilation is nearly always carried out on minors and is therefore a violation of the rights of the girl child. The practice violates the rights to health, security and physical integrity of the

women and girls, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death (PATH, 2005).

Religious and clan leaders are responsible for the well-being and safety of individuals as well as the community,especially in regions like Somali regional state where these groups of the society are highly influential in the day-to-day life of the people. Muslim religious leaders can have strong power as 98.7 percent of Somali people follow the same religion (Islam). Despite religions leaders and traditional elders have prominence in their follower in the region; their role of in the fight against FGM is minimal.

"Despite the wide ranging interventions and efforts of diverse actors aimed at the protection of the rights of women and girls, harmful traditional practices including FGM, continue to challenge the wellbeing and integrity of women and girls in Ethiopia. Harmful traditional practices, such as female genital mutilation/cutting (FGM/C) constitute the most prevalent manifestations of violence against women and children in Ethiopia" (MoWCA, 2013, p. 4).

It is, therefore, the depth and severity of FGM in Somali Regional State, in particular in Gursum Woreda calls for this study to find out the relationship between the practice and various factors involved around the practice and major determine factors contributing for the continuation of FGM.

This study was conducted in Gursum Woreda of Somali Regional State of Ethiopia. Somali region is among the few regions where the prevalence rate of FGM is very high and severe type of FGM (Infibulations) has been practicing. The study aims at examining the association between the practice of FGM and socio economic factors, level of knowledge and awareness, and attitude towards FGM among the studycommunity, and identifies the major

determinant factors influencing the continuation of the practice in the study area. The findings of the study will help to develop accurate and culturally sensitive anti-FGM programs to abandon it in the region. In addition, the study result will establish a baseline that could be used to compare and assess changes over time.

1.3. Objectives of the Study

1.3.1. General Objective

Thegeneral objective of this knowledge, attitude and practice (KAP) study on FGM is to explain the relationship between knowledge, attitudes and practice of FGM among the study community.

1.3.2. Specific Objectives

The specific objectives of the study include:

- To explore and describethe knowledge, attitude and practice of FGM among the study population
- To examine the association between socio-economic and demographic characteristics, knowledge and attitude towards FGMwith the support forthe continuation of the practice in the target population
- To look into the major factors influencing the continuation of the practice of FGM.
- To suggest intervention strategies that reflects specific local circumstances.

1.4. Research Questions and Hypotheses

The study explains and examines the following research questions and the corresponding hypotheses:

1. Does the support for practice of FGM associate with the socio-economic and demographic factors of the study population?

Hypothesis 1: The support for practice of FGM is associated with socio-economic and demographic factors like age, gender, education, religion, ethnicity and occupation of the study participants?

2. Does the support for practice of FGM associate with the knowledge of the study population on its ill effects/consequences?

   Hypothesis 2*:* The support for practice of FGM is associated with the knowledge of the study population on the health consequences of the practice.

3. Doesthe support for practice of FGM associate with the attitude of the target population?

   Hypothesis 3: The support for the practice of FGM is associated with the attitude of the target population towards the practice..

1.5. Rationale & Significance of the Study

1.5.1. Rationale

This study is conducted to assess howsocio-economic background, knowledge and attitude towards the practice of FGMare related with the support of the practice of FGMamong the study community.

The government of Ethiopia has given due attention to women and children issues and has established Ministry of Women and Children Affairs (MoWCA). In recognition of the need for a comprehensive strategic framework for addressing the prevention and abandonment of HTPs, including FGM, MoWCA formulated aNational Strategy and Action Plan on Harmful Traditional Practices against Women and Children in Ethiopia in 2013. The overall objective of the strategy is "to institutionalize national, regional and grassroots level mechanisms by creating an enabling environment for the prevention and elimination of HTPs including FGM, and to

ensure multi-sectoral mechanisms are available to support women and children through prevention, protection and provision/responsive services" (MoWCA, 2013, p. 8).

Different existing policies of Ethiopia underpin the elimination of HTPs including FGM and women's rights. The National Policy on Ethiopian Women (1993) incorporates the elimination of harmful traditional practices as one of its core objectives. The policy aims:"to eliminate, step by step, prejudices as well as customary and other practices that are based on the idea of male supremacy and enabling women to hold public office and to participate in the decision making process at all level" (MoWCA,1993, p. 14). The National Health Policy ofEthiopia (1993) also states: "…special attention has been given to the family particularly mothers and children health because they are affected and are vulnerable to disease due to various socio-economic, cultural problems and practices (NHPE, 1993, p.6). One of the objectives of the National Population Policy of Ethiopia is "removing all legal customary practices militating against the full enjoyment of economic and social rights by women including the full enjoyment of property rights and access to gainful employment" (MoWCA, 1993, p. 19) is among the specific objective of the policy. The education and training policy (1994), the developmental social welfare policy (1996),the cultural policy (1997), the HIV/AIDS policy (1998), the national youth policy(2004) and the criminal justice policy (2010) have also incorporated the elimination of HTP/s including FGM as their one of core objectives.

The country's constitution in its Article 35(4) makes provision for the fundamental rights and liberties of the people and explicitly of women. The Ethiopian Revised Criminal Code of 2005, chapter three is dedicated to address the issue of HTPs (Proclamation No.414/2004).

In view of recognizing FGM violates women's and girls' human rights, the Federal Democratic Republic of Ethiopian (EPRDF) is signatory to various international conventions

that protect the fundamental rights of women and children. These include “The Convent on the Rights of the Child (CRC)”, “The Convention on the Elimination of All forms of Discrimination against Women (CEDAW)”, “The African Charter on the Rights and Welfare of the Child”, “the African Charter on Human and People’s Rights” and the “Additional Protocol on Women’s Rights (Maputo protocol)”. All these international conventions forceendorsing governments/states to prohibit and condemn the practice and take all appropriate and effective measures to endthe practice affecting the rights of women and children, their dignity, normal growth and development.

Despite all theseinterventions and the wide ranging interventions and efforts of diverse actors aimed at the protection of the rights of women and girls,FGM remains a serious problem and concern in Ethiopia. “It has affected 23.8 million women and girls, making it the second highest country in Africa next to Egypt (by affected numbers)” (28TOOMANY, 2013, p. 5).

The total abandonment of FGM, therefore needs research based interventions addressing the significant determinants of the practice. The investigator, as a social worker, has the responsibility to protect girls from being cut, to advocate for service for affected girls and women, and to engage with practicing communities in the processes to curb the practice. On this ground the investigator chose the issue of FGM as a research topic. The investigatorpreferred to undertake the research in Somali regional of Gursum Woreda, because as it is well known that Somali region is among a couple of regions in Ethiopia where the severe (Pharaonic) type of FGM has been practiced for generation. The prevalence of FGM in Somali region is as high as 99% and the risks associated withit among women and girls isvery high. Besides, my work experience in the area of harmful traditional practice and the opportunity I used to work with the

Somalipeople in Somali Regional State motivated me to undertake this research in one of the Woredas of the region called Gursum.

This study deals with the knowledge, attitude, practice and other socio-economy factors associated with the practice in the study area. The study findings will serve as an input for future interventions that could lead to end the practice ofFGM.

1.5.2. Significance of the Study

Female Genital Mutilationseverely affects women and children in Somali Regional State. The problem in this region is not only the continuation of this traditional practice but the people who are taking part in the practices do not know about thenegative consequences the acts. For this reason, practicing communities are very resistant to bring about positive behavioral towards FGM (Dawit et.al, 2005).

Currently, FGM is one of the priority agenda of the Ethiopiangovernment which requiresrealizing the goal of accelerating the abandonment of the practice. The Ethiopian government entered a commitment to look at sustainable measures to tackle FGM and end the practice by 2025. The goal is in line with Ethiopia's objective to reach middle-income country status by 2025, with the country's overall development being closely linked to greater opportunities for women and girls (Girl Summit, 2014). Moreover, without ending HTPs including FGM, Ethiopia cannot achieve key targets of sustainable development goals of good health and well-being (Goal 3) and gender equality (Goal 5) by 2030 (Girls Summit, 2014). In Ethiopia, maternal and child mortality rates are still high (NPC, 2016). Women who have had Female Genital Mutilation (FGM) are significantly more likely to experience difficulties during childbirth and that their babies are more likely to die as a result of the practice (WHO, 2006). Thus, during the period of GTP II, the government focused on the need to an increased momentum to further improve on the progress made so far (NPC, 2016). Thus, the investigator

believed that this research is timely and the outputs will contribute to the achievement of the national goal as well as international commitment to end FGM by 2025.

Infibulations had been the most common type of circumcision among the Somali ethnic group of Eastern Ethiopia. To my knowledge, researches undertaken on FGM measure the practice of FGM in terms of decrease or increase. However, in this study the practice of FGM was measured in terms of favoring the type of the practice.The dependent variable, the support for the continuation of FGM, was not limited to dichotomous responses of "support to stop" and "support to continue". Rather it was measured using three ordered categories of "None", "support Sunni" and "support Pharaonic". So, an ordinal regression model wasused to determine whether a number of independent variables like age, education, knowledge and attitude predict the ordinal dependent variable.Thus this study has comeacross a unique study finding of a new trend of shifting the practice of FGMfrom severe form of"Pharaonic (Infibulations)" to mild form of"Sunni" types of circumcision in the study area. Although the shifted to the milder practice and Infibulations type of the practice has decreased, the prevalence of FGM with its different form (Sunni and Infibulations)is high among the study population. This finding makes this study differentfrom the findings of others studies.This is a new insight for future research andinterventions.

Most global and local studies conducted on FGM have taken into account female respondents alone as research participants. FGM is performed by female on female; howevermen in their role as fathers, husbands and brothers can play a critical part in the continuation/discontinuation of the practice. However, in many researches on FGM, men's views, knowledge and attitude towards FGM and their potential role in the abandonment effort was not well illustrated. This research, therefore, involved men as research participants to assess

their belief and perception towards FGM. In Involving both female and male respondents from rural and urban settings make this research different from other many researchers conducted in the region of the study area.

Generally,the contributions of this KAP study are expected to benefit researchers, healthcare professionals, social workers and the community in the study area. It provides a baseline for future researches and assessments and help practitioners to implement evidence-based programs to bring about effective and sustainable social change on FGM among the population in the study area.

CHAPTER II: REVIEW OF RELATED LITERATURE

2.1. Introduction

Violence against women (VAW) remains a significant problem in all societies and Female Genital Mutilation (FGM) is one of the most severe manifestations of VAW. It is one of the crucial social mechanisms by which women are forced into a subordinate position compared with men (UN, 2014).FGM is a harmful traditional practice and a form of violence that directly affectswomen's and children's rights to physical, psychological and social health. This section reviews literature directly related to the study topic. Both published and unpublished materials pertinent to the study topics were used to define FGM, the different types of FGM, cultural and social reasons for performing it, and its health and other complications on women and girls. The section begins with a presentation of background information on historical perspective of FGM, and proceeds with the definition and classification ofFGM followed by its global and national prevalence.

2.2. Historical Perspectives of FGM

Although the origin of FGM is unclear, there have been anthropological and historical researches to help us understand how the practice came about. "It has been practiced for over 2000 years. It is found in traditional groups or community cultures that have patriarchal structures. Although FGM is practiced in some communities in the belief that it is a religious requirement, research shows that FGM pre-dates Islam and Christianity. Some anthropologists trace the practice to 5th century BC Egypt, with infibulations being referred to as 'Pharaonic' circumcision (29TooMany, 2013, p. 15).Female genital mutilation is mostly dominantly associated with the people in Africa but it is also a phenomenon of other countries in the world. According to WHO (1994),FGMhas existed in all countries at one time or another. "Historians

claim that, in the fifth century BC, the Phoenicians, the Hittites, the Ethiopians carried out the practice of FGM. It is also reported that FGM was predominantly practiced in tropical zones of Africa, in the Philippines, by certain tribes in the Upper Amazon, by women of the Arunta tribe in Australia, and by certain early Romans and Arabs" (WHO, 1993). "As recent as the 1950s, clitoridectomy was practiced in Western Europe and the United States to treat perceived ailments including hysteria, epilepsy, mental disorders, masturbation, nymphomania and melancholia" (UNFPA), 2015). Although the origin of FGM in Ethiopia is not known for sure, there are some indications that the practice is alleged to be known as early as 15th century (Yayehyirad, et.al, 2008).

2.3. Definition and Classifications of FGM

Female Genital Mutilation (FGM) or Female Genital Cutting (FGC) is defined as "a practice comprises of all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons and without any health benefits" (WHO, 1998).

Female Genital Mutilation has been classified into four major types. "Type I: Often referred to as to 'clitoridectory', it is partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris)" (WHO, 2017, p. 2). It is the most common procedure, accounting for up to 80% of all cases.

Type II also "referred to as excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva)" (WHO, 2017, p. 2).

Type III “referred to as Infibulations, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy)” (WHO, 2017, p. 2). “Fifteen percent of all women having undergone FGM are believed to have been infibulated (type III), the most invasive and damaging type of FGM. This type of FGM is predominantly practiced in Ethiopia, Eritrea, Somalia and Sudan. In Eritrea and Sudan, for example, 34% and 82%, respectively, have been infibulated” (PATH, 2005).

Type IV includes “all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area” (WHO, 2017, p. 2). Fifteen percent of all women having undergone FGM are believed to have been infibulated (type 3), the most invasive and damaging type of FGM.

In some areas particularly in North-East Africa, Type I circumcision is referred to as "Sunni", while Type III (Infibulations) is known as "Pharaonic". Type I comprises the milder forms of circumcision while Type III is the most severs type of mutilation. Type II referred as intermediate type of FGM which is a less extensive form. (WHO, 2008)

2.4. Prevalence of FGM

2.4.1. Global prevalence of FGM

According to the study conducted by UNICEF (2013), FGM is practiced in more than 28 African countries and in the Middle East and Asia. According to UNICEF’s data, while the exact number of girls and women worldwide who have undergone FGM remains unknown, it is estimated that at least 200 million girls and women have been undergoes some form of the practice of FGM. About three million women in the world experienceFGM every year (UNICEF, 2013 and 2016). “Out of the 200 million victim of FGM, more than half have just live in three

countries, Indonesia, Egypt and Ethiopia. Out of these, 44 million are girls below the age of 15 years" (UNICEF, 2016, p 3).

According the UNAIDS report, among North-East African countries, Egypt, Eritrea, Sudan and Ethiopia are countries where the prevalence rate of FGM is high. Among the West Africa countries, Guinea, Mali, Burkina Faso and Mauritania, Sierra Leone, Gambka and Liberia are countries which very high prevalence of FGM (UNAIDS, 2013). The prevalence rate in Sierra Leone (81.2%) (Bjälkander et.a. 2013), Nigeria (60%) (Onuh et al., 2006), Iran (76%)(Mozafarian, 2011), Mauritania (77%) (Ouldzeidoune et. al., 2013) and Gambia (75.6%) (Kaplan, 2013).

FGM is generally performed on girls between ages 4 and 12 and in some cultures it is practice as early as a few day after birth or as late as just prior to marriage (UNICEF, 2016) Côte d'Ivoire, Eritrea, Mali,Ethiopiaand Mauritania are African countries where 55% or more of girls underwent FGM within few days (within fifth days) after their birthday. About 90 % of girls in Egypt have undergone FGM between the ages of 5 and 14 years. In Benin and Niger, about one-third of girls underwent FGM in their first five years of life. In Kenya and Tanzania, around 60% to 70% of girls were cut between the ages of 10 and 19 (PATH, 2005).

Senegal, Burkina Faso, Ethiopia, Kenya, Tanzania are countries in which the prevalence rate of FGM prevalence is higher in their rural than in urban areas (UNAIDS, 2013).

In most cases the prevalence rate of FGM varies with religion. In most practicing countries, it has strong association with Islamic religion. According to EDHS report, the proportion of circumcised women is highest among Muslim women (EDHS, 2016). In Mail, Chad, Côte d'Ivoire, Burkina Faso, Nigeria, Eritrea, Mauritania, guinea, Benin and Egypt, there is a widespread view of relating FGM with Islamic religion (UNICEF, 2013).

For example, in Benin FGM is prevalent in 49% of Muslim women comparing 15% of Protestants, 12% of traditional religions and 7% of Roman Catholic women, in Chad it is prevalent among 61% of Muslim women comparing 31% of Catholics, 16% of Protestants, and 12% of traditional religions and in Côte d'Ivoire it is practiced on 76% of Muslim women, comparing 45% of Animist, 14% of Catholic and 13% of Protestant women (UNICEF, 2011). In 2010, UNICEF reported FGM prevalence in 99% of Muslim women, 89% of Catholics and 85% of Protestants respectively in Eritrea (UNICEF, 2010). According to Kenyas' health and demographic survey, "in Kenya FGM is more prevalent among Muslim women (51.1%) and women listing no religion (32.9%) and less prevalent in Roman Catholic (21.5%) and Protestant or other Christian women (17.9%)" (KDHA, 2014). According to EDHS, the proportion of circumcised women is highest among Muslim women (82 %) than Orthodox women (54%) (EDHS, 2016).

In most cases traditional circumcisers have carried out the procedure of FGM, but in some countries it has been performed by medical professionals. The highest rates of use of medical personnel can be found in Egypt (61%), Kenya (34%), and Sudan (36%). In Guinea and Nigeria, 9% and 13% respectively, of circumcisions are carried out by medical personnel (PATH, 2005).

2.4.2. Prevalence of FGM in Ethiopia

Based on the Ethiopia Demographic Health Survey's (EDHS) report of 2016, " 65.2% of women age 15-49 are circumcised and 3 percent of women had cutting with no flesh removed, 79 percent had cutting with flesh removed, and 7 had their genital area sown, closed after cutting" (EDHS, 2016. P. 45). The national prevalence rate for FGM was found to be 74.3 percent in 2005 (CSA, 2005). This is a decrease of 9.3% over 11 years. "FGM remain a serious concern in Ethiopia and has affected 23.8 million girls and women, making it the second highest affected country in Africa" (28TooMany, 2013, p. 14).

According to the EDHS report, FGM is practiced with varying degrees of prevalence by regions in Ethiopia. “Due to the diversity of cultures, in some regions, the rate can create a gap between 24% and 99%. It is most prevalent among the ethnic groups of Afar and Somali (98 percent and 99 percent, respectively), followed by Welaita and Hadiya women (92 percent for both)” (EDHS, 2016, p. 45). FGM is highly prevalent in rural Ethiopia than urban settings. Hence, 68% of rural women werecircumcised, as compared with 54% of women in rural areas. FGM is less prevalent among women with higher education and those in the highest wealth quintile. According to EDHS, the proportion of circumcised women is highest in Muslim women (82%) and lowest is among Orthodox women (54%) and the age at which FGM is performed varies among the different ethnic groups (EDHS, 2016).

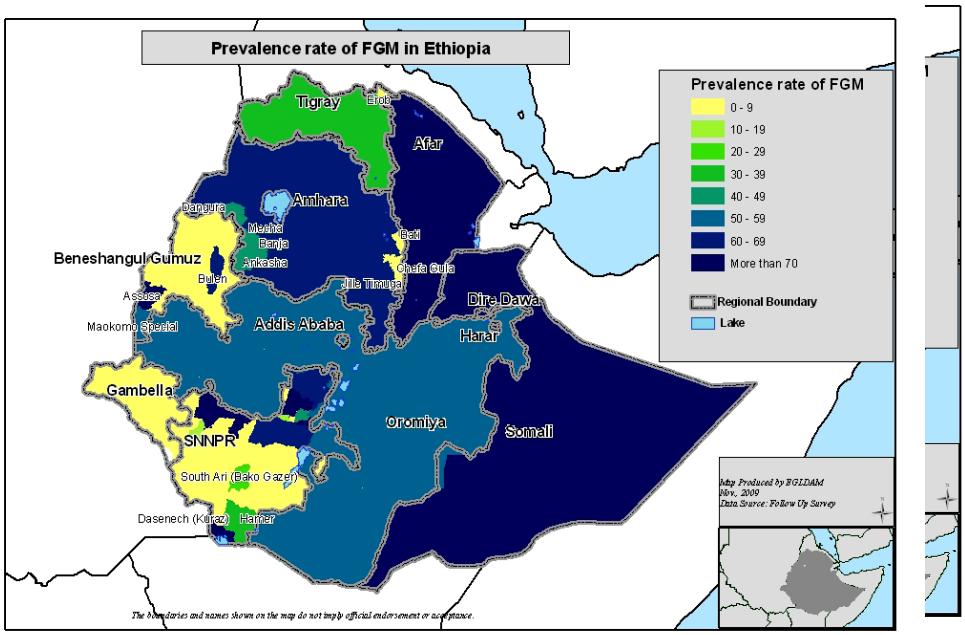

Figure 1.Distribution of FGMPractice in Ethiopia

Source: NCA, Ethiopia and partner’s engagement for the abandonment of HTPs/FGM

Overall, prevalence rates of female genital Mutilation have been declining over the past few decades globally. According to UNICEF report, “FGM prevalence rates among girls aged

15 to 19 have declined by 41 percent in Liberia, 31 percent in Burkina Faso, 30 percent in Kenya and 27 percent in Egypt over the last 30 years" (UNICEF, 20160. "Today, in the 30 countries, for which data were available, around 1 in 3 girls aged 15 to 19 have undergone the practice, versus 1 in 2 in the mid-1980s" (UN, 2016). However, according to UNICEF "… not all countries have made progress and the pace of decline has been uneven. If trend continues, the number of girls and women undergoing FGM will rise significantly over the next 15 years" (UNICEF, 2016, p. 1).

2.5. Consequences of Female Genital Mutilation

2.5.1. Health Risk of FGM

Women and girls living with FGM are exposed to the short and long term health risks. There higher the risk of adverse health outcomes with the increased severity of the practice. According to WHO (2017), the short term or immediate medical complications of FGM include: severe pain; shock which can be caused by pain and infection and; excessive bleeding as a result of cutting of the blood vessels in the clitoral artery or other blood vessels that could lead to hemorrhage, anemia, hypotension, genitalia tissue swelling due to inflammatory response orinfection (that may spread after the use of contaminated instruments, and during the healing period);human immunodeficiency virus (HIV) due to cutting of genital tissues with the same surgical instrument without sterilization; urination problems (these may include urinary retention and pain passing urine); impaired wound healing which can lead to pain, infections and abnormal scarring; and death which can be caused by infections (WHO, 2017).

The long term complications include:chronic genitalreproductive tract and urinary tract infections; painful urination due to obstruction of the urethra and recurrent urinary tract infections; menstrual problems resulting from the obstruction of the vaginal opening; keloids (excessive scar tissue formation at the site of the cutting); obstetric complications (increased risk

of caesarean section, difficult labor, obstetric tears/lacerations, prolonged labor, and extended maternal hospital stay); obstetric fistula (because of prolonged and obstructed labor); prenatal risks (obstetric complications can result in a higher incidence of infant resuscitation at delivery and stillbirth and neonatal death); and female sexual health (removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, reduced frequency or absence of orgasm) (WHO, 2017).

2.5.2. Psychological Consequences of FGM

The immediate psychological trauma may stem from pain, shock and the use of physical force by those performing the procedure of FGM (WHO, 2008). Infibulated women may suffer from long term, post-traumatic stress disorder (PTSD),such as depression, anxiety and memory loss (Banks, 2006). “Women who have undergone FGM may also be affected y chronic pain syndrome; there is an increased risk of depressed mood, with reduced social functioning, worthlessness, guild and even suicidal ideation. Reduced in social functioning can also create social isolation and role loss in society” (Whitehorn, et al, 2002, p 165).

Researches indicate that fear of the first sexual intercourse by mutilated women is common and anxiety and phobic behavior occurred as women experienced de-fibulation. Posttraumatic stress disorder (PTSD) can be present in some of these women prior to the de-fibulation. Husbands have to penetrate the stitched genitalia on the wedding night. There are circumstances that husbands de-fibulate their wives with a knife or razor with no anesthesia if unable to penetrate. In some cases women are de-fibulated by circumcisers with a sharp instrument if the husband is unable to penetrate. This event might trigger memories from the

initial FGMand result in posttraumatic stress disorder. Circumcised women's sex drive, arousal and orgasm can significantly diminish because of FGM (WHO, 2012).

2.5.3. Social Consequences

FGM has identified potential negative social consequences for families, girls and women. "The practice is performed in response to strong social conventions and supported by key social norms; thus failure to conform often results in harassment and, exclusion from important communal events and support networks, as well as discrimination by peers" (Suardi et al., 2010, p. 234). Unless there is a joint agreement within a larger group, individuals and families are likely to consider the social risks to be greater than the physical and mental health risks of FGM. Furthermore, the medical cost of treating post-FGMcomplications could be additional massive to families(Suardi et al., 2010, p. 236).

2.6. Why is FGM still practiced?

There are numerous reasons attached to the continuation of the practice of FGM. These are psychosexual; sociological and cultural, hygiene and aesthetic; religious reasons and socio economic factors (UNFPA 2015).

Psychosexual reasons:FGM practicing communities believe that uncircumcised women will not be able to control their sexuality.It is therefore carried out as a way to control women's sexuality, which is sometimes said to be insatiable if parts of the genitalia, especially the clitoris, are not removed. It is thought to ensure virginity before marriage and fidelity afterward, to increase male sexual pleasure, to regulate a woman's sexual desire, to ensure that a woman is obedient and submissive and loyal to her husband; and to fulfill rite of passage requirements into adulthood. In some communities, a girl without FGMcannot be accepted as a woman, and get married (CARE, 1999).

A study undertaken by CARE indicates that in Ethiopia, Kenya, and Sudan, FGM was believed by many communities to serve as prevention for rape or for premarital sex. FGM was, therefore, believed to be proof of a girl's virginity, thereby improving marriage prospects. In Côte d'Ivoire, an improved marriage prospect was invoked by 36% of women favorable to the continuation of the practice (CARE, 1999).FGM is also believed by some communities to ensure women's faithful and loyalty to their husband. For example, "51% of women in Egypt believed that FGM prevents adultery (CARE, 1999).

Sociological and cultural reasons**: "**FGM is seen as part of a girl's initiation into womanhood and as an intrinsic part of a community's cultural heritage. Sometimes myths about female genitalia (e.g., that an uncut clitoris will grow to the size of a penis, or that FGM will enhance fertility or promote child survival) perpetuate the practice. It is believed that women who are not circumcised are prone to break household goods. There are also taboos against uncircumcised women handling grain, serving food and drinks for elders and other respected people of the society" (Ellwood, 2005, pp.11 & 12).

There is a belief in some community that female genitalia in their natural form are ugly and removable of them through Infibulations makes them presentable and beautiful (PATH, 2005). For example, among Sudanese communities that practice cutting, FGM is said to liberate a woman from its masculine properties and when the clitoris, which is ugly and misbegotten, is excised the woman's genitalia is made more beautiful (PATH, 2005).

Hygiene and aesthetic reasons:There is a belief that female circumcision has personal hygiene benefit. In some communities, the external female genitalia are considered dirty, ugly and producefoul smell (EGELDAM, 2009). Based on this, decisions are made to remove in order to promote hygiene and provide aesthetic appeal.Cleanliness and hygiene was cited as a benefit

of FGM by 17% of women in Guinea, 21% of women in Mali, and 13% of women in Eritrea and Mauritania. Women in rural areas, older women, and less educated women were generally more likely to support this belief. In Mali and Mauritania, women were more likely than men to report cleanliness as a perceived benefit (21% vs. 17%, and 19% vs. 13%, respectively) (UNICEF, 2015).

Religious reasons:Although FGM is not endorsed by either Islam orChristianity;practicing communities associate the practice with religion and consider it as a religious obligation. For example, 60% of women in Eritrea, 30% in Guinea, 19% in Mali, 73% in Egypt and 29% in Mauritania reported FGM to be required by religion and it is a religious tradition. In all of these countries, older women, women with low levels of education, and Muslim women were more likely to citereligion reason for FGM (PATH, 2005). In Ethiopia, the EGLDAM survey of 2009indicated thatprevalence rate higher among Muslim women (65.1%), thanOrthodox Christianswomen (45%) (EGELDAM, 2009). The 2016 EDHS report also confirms that the prevalence of FGM is higher among Muslim women (82%) than Orthodox women (54%) in Ethiopia (EDHS, 2016). The EGLDAM 2009 survey suggests that the prevalence of FGM among Muslims is not only higher but is also changing more slowly, than among Orthodox and other Christians (EGLDAM, 2009).

Socio-Economic factors**:** In manyFGMpracticing communities, it is a prerequisite for marriage. In communities where women are mostly dependent on men, economic necessity could be a major driver of the procedure. FGM is considered as the guarantee of a girl's virginity and is viewed as a prerequisite for an honorable marriage. The belief that FGM enhances girl's chances of finding a husband helps perpetuate the practice. The practice is retained because parents want what is best for their children and this is the most basic value that motivates a parent’s decision

to perform FGM. Failure to comply with the social convention brings shame and social exclusion to girls and their families and they feel fear of marginalization if they refuse to comply with the social norm (UNICEF, 2016).

In Kenya, 30% of women, in Côte d'Ivoire 36% and in Nigeria similarly 36% of women and 45% of men supporting continuation of the practice agreed with the statement that FGMhelped to preserve virginity and improving marriage prospect for circumcised and unmarried girls.FGM is also believed by some communities to ensure that a woman is faithful and loyal to her husband after marriage. For example, 51% of women in Egypt believe that FGM prevents adultery (PATH, 2005).

People who reject the practice and don't comply with this social norm may face condemnation or social exclusion, and their daughters are often considered ineligible for marriage (UNFPA, 2017). As a result, even parents who do not want their daughters to undergo FGM may feel compelled to participate in the practice(UNFPA, 2017). FGM may also be a major source of income for practitioners.

2.7. FGM as Human Right Violation

"Harmful traditional practices (HTPs) described as violations of women's and girls' rights which are defended on the basis of tradition, culture or religion by some community members. HTPs are largely carried out without the consent of the woman or the girl involved and thus constitute violation of human rights as set out in the universal declaration of human rights" UNICEF, 2013, p. 70).

FGM as one of harmful traditional practices is internationally recognized as a violation of the human rights of girls and women, reflecting deep-rooted inequality between the sexes. FGM is a direct violation of two fundamental universal human rights under the UNDHR: "the right to

health (Article 25 s.1), the right to life liberty and the security of personhood" (UNDHR, Article 3)."FGM is almost always carried out on minors; it is also a violation of the rights of children" (Suradi et. al., 2010, p 232). On article 565 and 566 of the Criminal Code of Ethiopia, it is also stated that "whoever circumcises a women of any age is punishable for simple imprisonment of not less than three months, or fine not less than five hundred Birr. Whoever infibulates the genitalia of a women, is punishable with rigorous imprisonment from three years to five years." (Proc. No. 414/2004, p. 192). The practice of FGM, therefore, violates girls' and women's basic human rights, denying them of theirphysical and mental integrity and their right to freedom from violence and discrimination. In every society in which it is practiced, FGM is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures.

2.8. Theories Related to FGM

The practice of female genital mutilation is explained from different perspectives. The theoretical framework of this research takes into account the following theories and one model which is much related with the research topic.

A. The Social Exchange Theory

Social exchange theory emphasizes on the social, economic, political, and historical contexts of social exchanges (Hutchison, 1999). The theory of social exchange views human interactions and exchanges as a kind of results-driven social behavior. The fundamental concept of the theory of social exchange is cost and rewards. The cost and reward comparisons drive human decisions and behavior. Costs are the negative consequences of a decision while rewards are the positive results of social exchanges. Therefore, the generally accepted idea is that people will subtract the costs from the rewards in order to calculate the value.

The theory of social exchange proposes that individuals will make decisions based on certain outcomes. For example, they will expect the most profit, rewards, positive outcomes and

long-term benefits. They will also prefer the exchange that results in the most security, social approval. In contrast, they will also choose alternatives that result in the fewest costs, consequences and least social disapproval. Therefore, every social exchange decision can be a complex decision that requires the person to evaluate different costs and rewards.

This should be understood here as those cultural activities, such as harmful practices like FGM, might have meaningful contribution to maintaining a specific social structure and may be even enhancing social integration, all which might outweigh the harm in it. Exchange theory as understand in relation to the practice of FGM can be seen as performed on the basis of socio-economic reasons, especially as a kind of social safety net (daughter future), especially in more patriarchal societies (Spencer, 2012).

B. Feminist Theory

Some feminists have criticized exchange theory on the grounds that its emphasis on rational calculation of personal advantage is a male attitude and does not represent the female perspective. Other argued that social exchange is driven by collective, cultural, symbolic forces and not based simply on self-interest (Hutchison, 1999).

"Radical feminism provides a powerful framework for understanding sexual violence against women and it is an important conceptual tool for understanding harmful practices including FGM. Mainly focus on the oppression in the private sphere, which manifests itself foremost in the form of domestic violence, male control over women in the family and male control over women's sexuality" (Spencer, 2012, p. 22). According to feminist perspective "The politics of FGM is designed to affirm the powers of males over female sexuality and reproduction. One of the reasons for the practice of FGM is to make daughters virgin. The explanation given to this is that "during the Pharaohnic period, in Egypt, Pharaohsrequired virgins and mothers started to infibulate their daughters as a way to protect them. Feminists

argue that it is an inhumane form of gender-based discrimination that capitalizes on the subjugation of women, yet nations that endorse the practice define it as an integral feature of the culture" (Spencer, 2012, p. 22). .

Moller argues that cultural traditions such as clitoridectomy aim at controlling women and render them, especially sexually and reproductively, servile to men's desires and interests. Moller suggests thatsometimes, moreover, "culture" or "traditions" are so closely linked with the control of women that they are virtually equated (Moller, 1999).Many universal feminist theorists argue that FGM as a practice should be outright abolished without offering any reasonable grounds for arriving at the conclusion.

C. Social Convention Theory

Social convention theory by Mackie (1996) offers an explanation for why daughters and their families want the continuation and not the discontinuation of the practice of FGM. In the context of extreme resource inequality, FGM emerged as a means of securing a better marriage and became a prerequisite for marriage for all women. An initial assumption with respect to the decision-making process would be parents' love towards their daughters. This means as parents love their daughters, they want to do what is best for them (Mackie, 1996).

The theory also illustrates that if all families agreed to choose not to cut their daughter, then FGM would not be a prerequisite for marriage. This would allow them to retain marriage and avoid harming the health of girls and violating their rights. The theory further states that this is in an equilibrium state as no incentive will be gained by circumcising their daughters; they prefer not to cut than cutting. The challenge for families is to accept the new culture than the existing one, from circumcising to not circumcising all girls. Therefore, abandonment is possible only by coordinating a collective abandonment effort within the intermarrying community (UNICEF, 2010).

D. Knowledge, Attitude and Behavior (KAB) model

Knowledge, attitude, and behavior (KAB), also found in literature as knowledge-attitude-practice (KAP), is an important theoretical model of health education, which assert that behavior change is affected by knowledge and attitude (Schneider, 2003).

The knowledge-attitude-behavior (KAB) model proposes that as knowledge accumulates, attitudes change; and that these changes in attitude promote behavior change and good practice. We can apply the KAB model to combat the practice of FGM; it would require a person to gain knowledge of health risk of the practice, to develop positive attitudes to avoid those beliefs contributing the perpetuation of the practice and to acquire the necessary skills to overcome any barriers that may hinder ending the practice of FGM.

Marian (2014) in her thesis identified that knowledgegap as the heart of the problem and having appropriate knowledge about the harm of FGM would minimize the practice. However, this research doesn't explain how knowledge gap contributed to the continuation of the practice. Knowledge can be a pre-condition for attitudinal change. However, people having knowledge about the ill effect of the practice may not change their attitude because of the pushy determinant factors like religion, culture, strong personal and social belief, norm and social pressure.

A study conducted in Eastern Ethiopian indicates that, "due to the existing culture, the majority of Somali women have positive attitude to the continuation of FGM because they don't want their daughters left unmarried" (Abathuna et. al, 2016). This can be due to lack of knowledge, a pre-condition for attitudinal change.

A study done in Sweden about the prevalence of FGM among Sudan immigrants indicates "that the older generation believed that FGM is the normal thing to do and consider it as a good tradition" (Berggren, 2005). A behavioral assessment study conducted by Mohammed

(2015) in Kebribeyah Woreda of Somali regional state assessed the knowledge and attitude of women only and didn't disclose whether there was a shift in practice type.

2.9. Summary

Over the past decades national and international organizations have been working on eradicating the practice of FGM. Organizations such as the United Nations have campaigned against the practice; calling for its abolition as a matter of global health and human rights. But despite a decades-old movement against it, FGM rates in Ethiopia haven't changed as expected. FGM has been outlawed in Ethiopia since 2004, but because governments rarely enforce these laws they are essentially ineffective.

Researches contribute to the global as well as national evidence based on FGM and influences policies and programs to end the practice. There have been few studies undertaken on FGM in Eastern Ethiopia in the last few decades, most of which mainly focuses on the causes and consequences of female genital mutilation. A few researches were conducted on the knowledge and attitude in places other than the study area, and focused only on female population residing in towns.Men's views of FGM and their potential role in its abandonment is not well described. However, men in their roles as fathers, brothers, husbands, community and religious leaders can play a key part in the abandonment of FGM in their community.

Having reviewed the existing literature, it could be deduced that no study has been done in Gursum Wereda to determine the knowledge, attitude and practice of FGM involving both women and men in urban and rural settings. So this research includes men as research participants.

In the effort to decrease health problems due to FGM in developing countries, public awareness and positive attitude are fundamental. Measuring the level of knowledge concerning and the attitude towards harmful practices such as FGM is a critical public health issue. Hence, the investigator has decided to conduct this study to assess the knowledge, attitude and practice of FGM among female and male, rural and urban population of the Woreda. Findings of this study will give insights on the subject and guide the sign of appropriate interventions that will support the elimination effort.

CHAPTER III: CONCEPTUAL FRAMEWORK

3.1. Conceptual Framework

This KAP survey was conducted to collect information on the knowledge (what is known), attitudes (what is thought), and practice (what is done) about FGM among the study community.

This study focuses on three determinants thought to be relevant to FGM practice: socio-economic status (age, education, marital status, religion, ethnicity, education and occupation),Knowledge and awareness of the health effects of FGMand attitude towards the practice. The socio-economic status, knowledge and attitude are considered as independent variables (IV) influencing the support for the continuation of the practice of FGM. The support for the practice of FGM is the dependent variable (DV) (See figure 2 below showing these variables)

Independent Variables (IV)Dependent variable (DV)

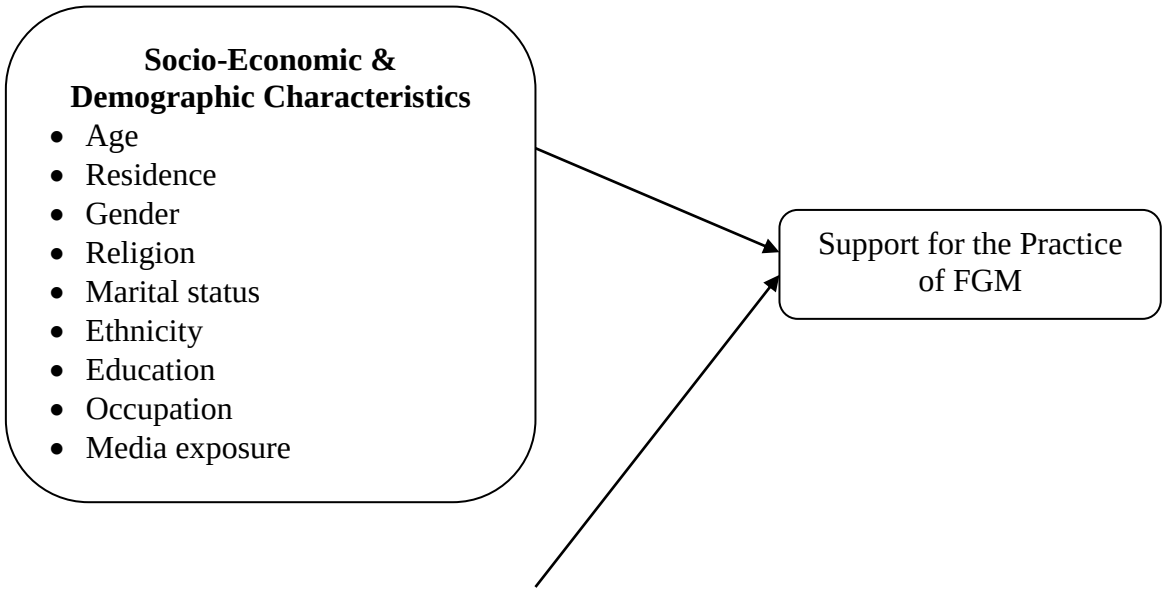

Figure 2. Predictors of the practice of Female Genital Mutilation (FGM)

3.2. Operational Definition of StudyVariables

Based on the research conceptual framework, the following are the operational definitions of the major variables

1. Socio-economic and demographic factors are independent variables (IV) include variables like residence, age, sex, religion, ethnicity, education occupation and income of the study participants. The assumption here is that socio-economic factors like age, gender, religion marital status, education, place of residence (rural-urban) and ethnicity are associated with the practice of FGM.
    a. Age : The self reported chronological age of the respondents during the data collection time .It is a continuous variable.
    b. Gender: the biological difference between female and male, which is a categorical variable measured at nominal level and coded 1=Female, 2=Male
    d. Education: The highest grade the respondent achievedwith categoriesmeasured at ordinal scale and coded as: 1= cannot read and write, 2=can read and write, 3=Grade 1=4 (lower primary), 5= Grade 5-8 (upper primary), 6= Grade 9-10 (Secondary), 7= Grade 11-12 (Preparatory) and 8= (diploma and above)

    Ethnicity: Respondents ethnicity to which group he/she belongs and coded as 1=Somali, 2=Oromo, 3=other ethnic groups. For the analysis purpose, ethnic groups other than Somali and Oromo were combined together.

e. Geographical area: It is a place where respondents were living during the data collection time. It is categorical variable measured at nominal level coded as: 1=rural and 2=Urban.

f. Religion: The religious affiliation of the respondents which is which is a categorical variable measured at a nominal level and coded as: 1=Muslim, 2=Orthodox Christian and Protestantfor the analysis purpose, the data for Orthodox Christian and Protestant were merged together

g. Ethnicity: Respondents ethnicity to which group he/she belongs. It is a categorical variable measure at a nominal level and coded as 1 for Somali," 2" for Oromo, "3" for other ethnic groups. For the analysis purpose, ethnic groups other than Somali and Oromo were combined together and coded as "3".

h. Marital Status:, which is a categorical variable measured at a nominal level and, coded as: 1=Married, 2=divorced and widowed

i. Occupation: The type of job/work that a person engaged to earn his/her income, which is a categorical variable measured at a nominal level and coded as 1=Farmer, 2=House wife, 3=Civil servant, 4=Laborer, 5=Merchant and 6=student.

j. Media Exposure: Information gained about FGM on radio or television or printed materials, which is a categorical variable measured at a nominal level and coded as.1=Yes and 2= No

2. Knowledge(independent variable) is a set of understandings; it is also one's capacity for imagining, one's way ofperceiving (Librhim, 1995). It is the ability to do, tell, describe, explain, show, and/or say. Knowledge towards FGM can be measured whether men and

women know the health consequences of FGM like bleeding, infection, menstrual problems, difficulty in labor, reduced sexual desire and dysfunction, infertility, HIV/AIDS, etc. It is assumed that when people know about the ill effects of FGM, they may quit the practice, Knowledge is a continuous variable measured at a ratio level 10 item scale. FGM knowledge related items with "Yes" & "No" responses were asked to examine knowledge of the women and men about FGM. Correct answer was given score "1" while incorrect answer was given score "0". The sum was computed and from the knowledge questions those who respond correctly the mean and above the mean value were considered as knowledgeable (good knowledge) and those who scoreless than the mean value were labeled as not knowledgeable (poor knowledge)

3. Attitude (independent variable) refers toan individual's characteristics way of responding to an object or situation. It is based on experience or knowledge and leads to certain behavior or the expression of certain behavior (Graham and Bennett, 1998). It is individuals' predisposition to respond in a favorable or unfavorable manner towards the prevention FGM. Attitude towards the practice of FGMis assessed by asking men and women whether they believe that FGM increases chance of marriage, prevent premarital sex, uncircumcised women are out of social norms, makes genitalia more attractive, protects virginity, makes child birth easier and it is religious requirement and good practice.The attitude people having towards FGM/ determines whether they are supporter or against to it which is a continuous variable measured at a ratio level.

   Attitude was assessed by 10 items Likert type scale. It was measured on an ordered, categorical five-point Likert scales that ranged from strongly agree to strongly disagree. The scoring system that was used with respect to respondents' responses were as follows:

- Non-inverted questions coded as: 1=strongly agree scored, 2= agree , 3=neutral , 4=disagree, and 5=strongly disagree
- Inverted questions coded as:5=strongly agree, 4=agree, 3=neutral, 2= disagree and 1= strongly disagree

To summarize the level of attitude, responses for each attitudinal items were totally scored and calculated and those respondents score the mean and above (>=34) were considered as having negative/unfavorable attitude towards the practice while those who score below the mean (<34)value was considered as having 'positive/favorable attitude towards FMG/C.

4. Practice/behavior (dependent variable) is the observable actions of an individual in response to a stimulus. This is something that deals with the concrete, with actions (Librhim, 1995). It is an overt behavior or habit towards FGM. Women's response of being circumcised is evidence of its prevalence. The stand of women and men during the interview time whether they are supporting or not indicate the support for the practice of FGM. in the study area. It is a categorical variable measured at a ordinal level and coded as 1= None(support neither of the practices),2=Sunni (the mildest type), 3= Pharaonic(the most severe type). "Pharaonic type of circumcision refers to the removal of the entire clitoris; the labia minora and medial part of the labia majora are cut with both sides of the organ stitched together to leave only a small opening. Sunni circumcision is removal of the prepuce of the clitoris" (WHO, 2017).
5. Respondents' future intention of the practice was also assessed if the respondents have a plan to continue with the practice by subjecting their own daughter to FGM in the future. Those who have no plan to continue with FGM on their daughter in the future were

considered as “intention to stop FGM” while those planned to circumcise was labeled as “intention to continue FGM

CHAPTER IV: RESEARCH METHOD

4.1. Research Design

The researcher employed quantitative research method to assess knowledge, attitude and practice (KAP) of FGMamong the study community. This KAP study is therefore a representative study of the target population regarding information on what they known, believe and done in relation to the practice of FGM (WHO, 2008). It is a descriptive and explanatory study that tries to establish associations between research variables.

This study was conducted from January 16 – 20, 2017. Primary data on socio-demographic characteristics, knowledge, attitude and practice on FGM were collected through structured questionnaire extracted from standardized questions applied previously indifferent KAP studies on FGM(Mohamed, 2015, pp 50-54).

4.2. Study Area andResearch Participants

Somali Regional State is by size one of the largest regions of Ethiopia, where severe type of female genital mutilation (Infibulations) is being practiced for generations. So, this FGM KAP study was conducted in one of the districts in the region called Gursum. Gursum district is found in Jigjiga Zone of Somale region. Bombas is the Woreda’s capital, located 48 km far from the regional capital, Jigjiga, towards the west direction. Gursum is bordered on the south by the Babille Woreda, on the West by the Oromia Region, on the North-East by Jigjiga Woreda and in the North by Ajersago (BoFED, 2007).

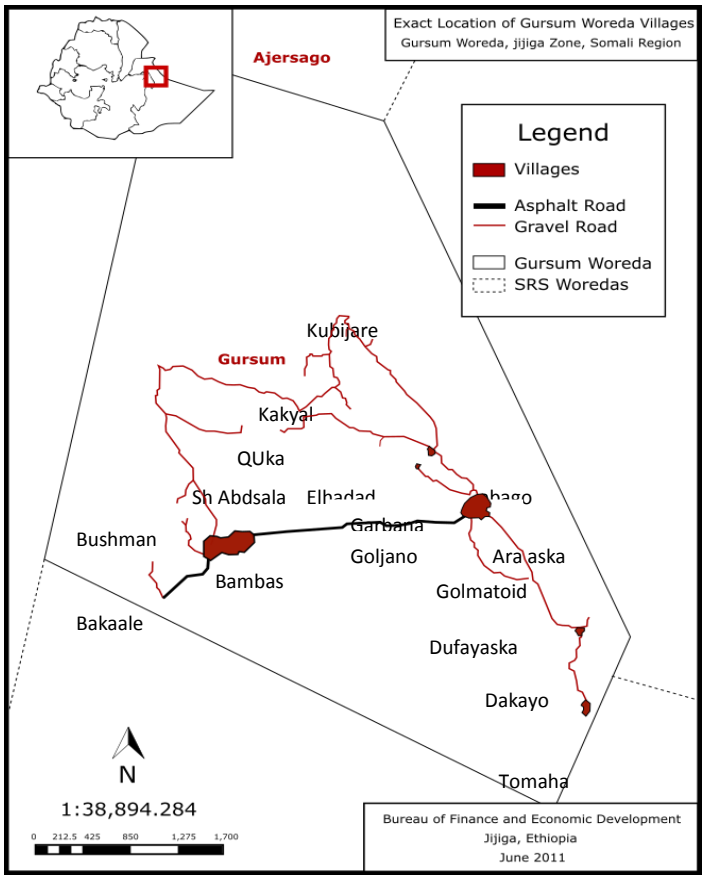

Figure 3.Map of Gursum Worda of Somali Regional State, Eastern Ethiopia

Source: Bureau of Finance & Economic Development, Somali Regional State of Eastern Ethiopia

Based on population projection figures published by the Central Statistical Agency in 2014, the Woreda has an estimated total population of 32,846, of which 17,275 are males and 15,571 are females. The urban and rural population is estimated to be 3,637 and 29,209 respectively (CSA, 2016). There are 15 kebles in the Woreda (13 rural and 2 urban). The study participants were women and men living in the selected kebeles of the Woreda who have met the selection criteria. They were drawn from both the rural and urban kebeles.

4.3. Sampling Plan

4.3.1. Unit of Analysis

The unity of analysis for the study was individual women and men residing in the selected households of the chosen kebeles from the woresa.

4.3.2. Sample Size Determination

The sample size was calculated by using the following formula. Sample size was determined taking the following assumptions; confidence interval of 95% and margin of error 5%. The following formula was used for determining sample size (Yamane, 1967).

$$n = \frac{N}{1+N(e)^2}$$

(Source Yamane Taro, 1967)

N= Known population size in the Woreda = 32,846

e= error level or % 1-percent confidence interval for 0.95 confidence interval = 0.05

n= sample size = 395

By adding 8 % for contingency the total sample size reached to 432.

4.3.3. Sampling Technique

A combination of some of the sampling method was used to select the kebeles, households and female and male respondents (see Figure 3 Schematic presentation of sampling procedure below).

A. Cluster selection

Each kebele in the Woreda was considered as a cluster. There are 15 kebeles in the Woreda out of which 13 kebeles are rural and two kebeles are urban. Four rural kebeles were selected from the 13 kebeles using simple random sampling (by lottery method) technique. The two rural kebeles are found adjacent to the main road and from these urban kebeles one kebele

was selected using simple random sampling. The sampling frame, number of households, was obtained from the selected kebeles' records.

B. Household selection

Primarily the total sample size was divided into two four rural and one urban kebeles based on their proportion of population size residing in the rural and urban kebeles. From each selected kebele, households were selected using systematic random samplinguntil the desired sample size was achieved.

k = N/n where, k = the interval size, N = number of household, n = sample size allocated for one kebele. Then every k^{th}unit was taken.

C. Selection of Men and Women

Female and male were interviewed in the selected households. Where there were more than one reproductive age women in one household only one person was selected.

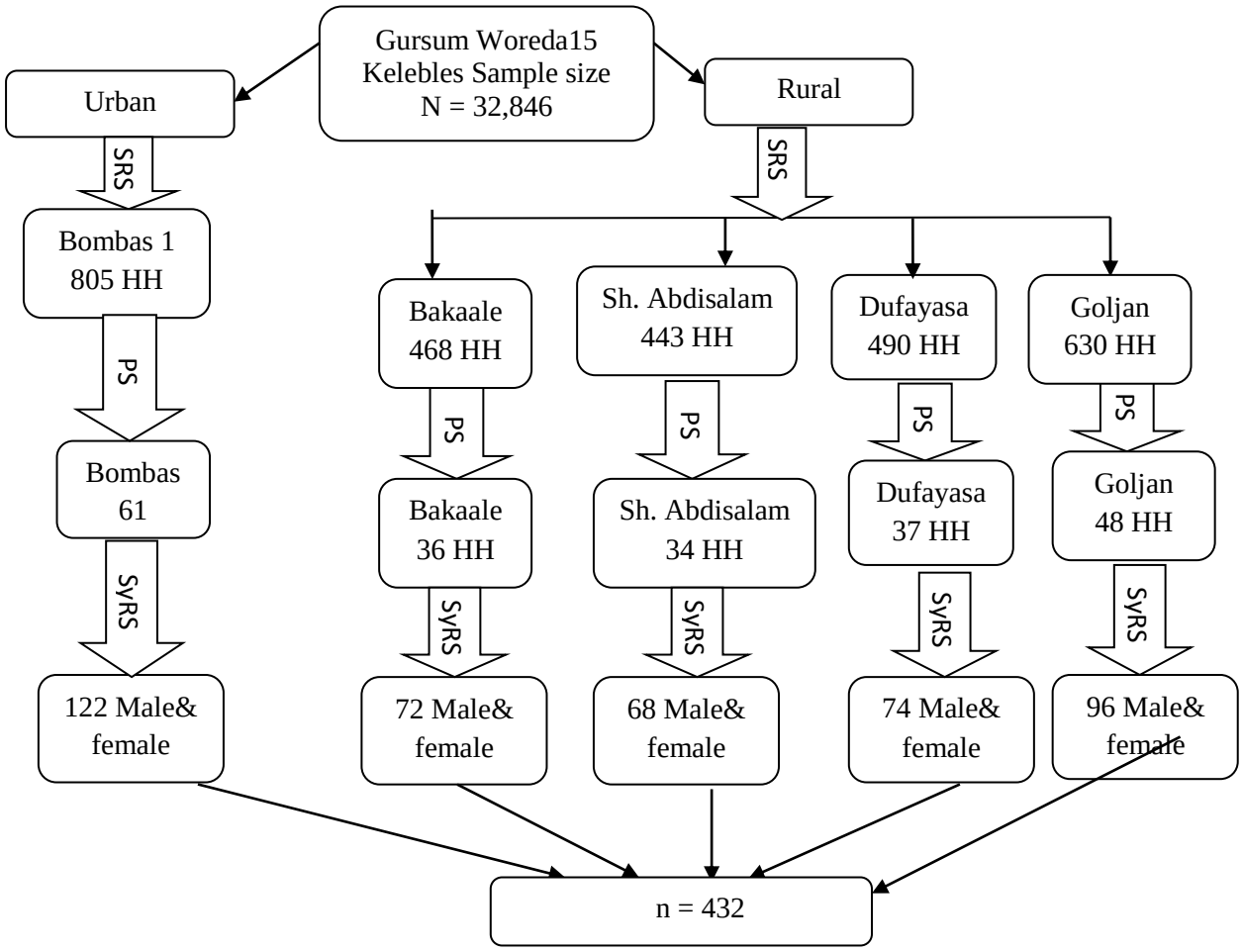

Figure 4: Schematic Presentation of the Sampling Procedure.

Key
SRS – Simple Random Sampling
PS – Proportional Sampling
SyRS- Systematic Random Sampling

4.3.4. Eligibility Criteria

4.3.4.1. Inclusion Criteria

Women of reproductive age group (15-49 years old), and women and men having at least a daughter were the participants of the study. When there were more than one reproductive age women in one household only one person (a mother) was selected. If the specified age was not found in the household or not available during the data collection time, then the nearest household was replaced. Men participants above the age of 18 were considered for the interview.

4.3.4.2. Exclusion Criteria

Women, who were not in the reproductive age boundary of 15-49, and both women and men who didn't have a daughter and not willing to participate were excluded from the study.

4.4. Data collection Instrument

Structured standardized tool used numerously by other local and international researchers was used (Mohammed, 2015, pp 50-54). In addition, the instrument was tested on three percent of the sample population. Reliability of measurement for attitude and knowledge were tested and Cronbachs' Alpha results were obtained as 0.9 and 0.62 respectively. This indicates that the ten items consistently and strongly measures the attitude and the items for knowledge measured it moderately. For these reasons, it was found to be a reliable instrument. Concerning the validity of the instrument, it measured what it is supposed to measure. The items/questions in the instrument accurately assessed what I want to know.Besides, items for measuring knowledge, the health risk of FGM were identified and proved by World Health Organization (WHO). As a result the result of the study can be generalized from the sample to the population.

Primarily, the English version of the tool was translated to local languages (Somali language) by a person who is fluent in English, Amharic and Somali languages. Again the

Somali language version tools were translated back to English. This translation was checked by another translator from similar ethnic groups. Their educational background was bachelor degree. The principal translator is qualified with the production of media programs in Somali language and Information Technology (IT) professional. He has been working on the area of FGM for long time. Both of them speak the local language (Somali) including Amharic and English languages fluently.

Then, the tool was pretested on 3% of similar population on one of the district which was not included in the final sample. There were four parts to the questionnaire. The first part included socio-economic information of participants such as age, gender, marital status, occupation, educational level, religion, ethnicity, media exposure, etc.

The second part was FGM knowledgewhich had ten items in total and included six aspects. (1) FGM exposes women to HIV, (2) FGM causes difficult during child birth and result tearing, (3) FGM causes bleeding and infection, (4) FGM had painful sexual intercourse and reduces sexual desire, (5) FGM causes infertility, and (6) FGM has difficulties during menstruation. All subjects need to respond "Yes" or "No" to each question. A correct answer was scored "1" and incorrect answer was scored "0". Scores of each item were summed up and the total score ranged from 0 to 10. Score above the mean indicated good knowledge about the ill effect of FGM (knowledgeable) while score below the mean indicated poor knowledge.

The third part was the attitude scale having ten items included five content domains as follows: (1) Socio-Economic factors (item1 &5), (2) Psychosexual reasons (item 2, 5 & 8), (3) Hygiene and aesthetic reasons (item 7-10), (4) Religious reasons (item 2), and (5) Sociological and cultural reasons (item 9). For each item, participants rated their FGM attitude on a five-point Likert scale from "Strongly agree" to "strongly disagree". For each question the answers which

"strongly agree" was scored "1" and "strongly disagree" was scored "5". If the question was invert, the opposite was true. The total score ranging from 1 to 50 was calculated by summing up the scores of each item. A score the mean and above the mean showed negative (unfavorable) attitude towards FGM while score below the mean value was considered as positive (favorable) attitude towards FGM.

The fourth part is the practice which has twelve items covering information on the practice of FGM. It included questions regarding whether the FGM is practiced in the community, at what age it is performed, who is doing it, the type of FGM practice currently prevailing, who decides to perform FGM and what instrument is used. The main question for the dependent variable was the support for the continuation of FGM. For the question on the support of FGM there were three categorical ordered responses: "None" (coded as 1), "Sunni" (coded as 2) and "Pharaonic" (coded as 3). The practice part also included questions related to respondent's future intention or plan to subject their daughter/s to FGM. It has four items indicating intention to continue/discontinue, intention to continue/discontinue the practice, reasons for the continuation.

4.5 Data Collection Procedure

Ten experienced data collectors (five female and five male) who are fluent in speaking Amharic and Somali languages were involved in the data collection process. All data collectors and supervisors were trained for one day on the objective of the study, roles and responsibilities of interviewers and supervisor, content and use of the questionnaires, respondents' selection procedure, securing informed consent and confidentiality, proper supervision and quality control procedures in the field. A couple of days before the actual data collection, a pre-test was carried out in the target population by the principal investigator. Draft questionnaires were used to

interview ten people of the target group. Based on the results of the pre-test, some changes were made on the structure of the questionnaires before data the actual collection started and the time how long it takes to complete one survey was also assessed.

Trained and experienced female and male local data collectors who completed grade 12, who have experience in data collection and who speak local language (Somali), including Amharic and English collected the data. Both the supervisors and data collectors were residence of Gursum woreda and know the geographic area of survey. Male respondents were interviewed by male, and female respondents were interviewed by female data collectors. The data was collected in a group of two (male and female). While female data collectors interviewed the women, the male interviewed men research participants. Each data collector interviewed the maximum of sixteen totwenty research participants per day. The principal investigator and the supervisors strictly followed the overall activities of data collection and check on daily bases to ensure the completeness of questionnaire, to give further clarification and support for data collectors.

Information on demographic and socio-economic characteristics, knowledge on the ill effects of FGM, attitude and intention towards FGMwere collected. The response rate was almost 98%.

4.6. Data QualityManagement

One of the most important elements of the data collection process is quality control, as led by the field supervisors. Before deploying to the field, supervisors should have a clear and agreed upon strategy for supporting the interviewers trouble-shooting problems that arises in the field and assessing and maintaining the quality of data collection. Survey team met at the end of every day to share experiences and submit completed questionnaires to the supervisors. Before

leaving community where the survey was conducted, supervisors checked completeness of all questionnaires. The supervisors and the principal investigator looked over the entire completed questionnaire to extract incomplete forms before data entry.

4.7. Data Processing and Statistical Analysis

4.7.1. Enter and data Cleaning

Then the data was entered to the computer for analysis using Statistical Package for Social Science (SPSS) version 22 and created a database to organize the information. Data cleaning such as correcting wrong codes, blank questions, unusable responses or items for which respondents have selected conflicting response (like marking both “Agree” and “Disagree” or “Yes” and “No” together). After entering the data, a final check was made to look for entry errors. Counts and frequencies were run for each response and evaluated where missing responses were present. I made extra copies of the data and keep the master files in a safe location.

As this is a descriptive and explanatory study, the statistical analysis was comprised mainly of descriptive statistics and frequencies. Univariate and multivariate analysis were conducted to detect difference in KAP among the community of the selected Woreda of various ethnic origins and both sexes.

4.7.2. Univariate Analysis

Frequency distribution and percentage were used to analyze nominal level variables like residence, gender, ethnicity and religion. For interval level variables like age and education central tendency and measure of dispersion were used. Accordingly, mean, range and standard deviation were calculated.

-

4.7.3. Multivariate Analysis

Multivariate techniques were suitable for analyzing data when there were two or more measurements on each element and the variables were analyzed simultaneously. It involved explaining the association between two or more variables at a time. In this study the dependent or outcome variable, the practice of FGM, is a three level ordinal variable coded as 1=None, 2=Sunni and 3=Pharaonic. In such type of variable having responses of more than two ordered levels, ordinal logistic regression analysis was employed to test the three hypotheses. The detail is indicated in the finding part.

4.8. Ethical considerations

Ethical clearance was obtained from School of Social Work, Faculty of Social Science, Addis Ababa University. Official letter was written by School of Social Work to the concerned bodies to allow implement the study. The objective and importance of the study was explained & informed consent was obtained from each participant. The rights of the participants regarding confidentiality and privacy were maintained. Participants who were unwilling to participate in the study & those who opted to quit from the study at any point in time were informed to do so without any restriction. No data was collected without the knowledge of each participant. Men and women respondents were interviewed separately and appropriate measures were taken to assure confidentiality of information both during and after data collection.

4.9. Dissemination of Results

The final survey report will be disseminated to relevant stakeholders from the government, non-profit making organizations and others. First, it will be submitted to the School Social Work, College of Social Sciences at Addis Ababa University. After defending the results and comments were incorporated, the final work of the study will be submitted to Somali Regional State Women and Children Affairs Bureau, Gusum Woreda Women and Children

Affairs Office and the Federal Ministry of Women and Children Affairs for their appropriate utilization of the study. The findings of this study can be used as an input to my organization to evaluate anti-FGM interventions implemented in the past and also serves as a baseline for future interventions. The results of this KAP survey will be publish to make the findings available to a wider audience. Publishing the survey results can contribute to evidence based anti-FGM interventions.

CHAPTER V: DATA ANALYSIS AND FINDINGS

This chapter presents a summary of the major findings of the study in two sections. The first section presents the main descriptive information of socio-economic characteristics of the study participants, knowledge on the ill effect of FGM and respondents' attitude towards the practice. The second part deals with the findings of the association between the dependent and independent research variables and answers to the three questions and corresponding research hypothesis.

The data used in this study were obtained from 422 women and men of Gursum Woreda of Somali Regional State of Eastern Ethiopia. The dependent variable, practice of FGM, is a variable with three ordered level of "Pharaonic type of FGM" (coded as 3), "Sunni type of FGM" (coded as 2) and "against to none of the practices" (coded as 1). The independent variables were Knowledge measured by ten items having responses of "Yes" and "No" coded as "1" and "0" respectively. Attitude towards FGM is an ordinal independent variable with responses ranging from strongly agrees to strongly disagree. Socio-economic factors like age, residence, religion, ethnicity, education were also independent variables.

Descriptive and ordinal regression analyses were used to test the association between the dependent variable and independent variables related to FGM among the study community. The descriptive section provides frequency and percentage of both the dependent and independent variables. An ordinal regression analysis was employed to assess factors most influencing the practice of female genital Mutilation in the study area.

5.1. Univariate Descriptive Analysis

The descriptive statistics presentedbelow gives the Univariate summary of the responses of dependent and independent variables and provides background information for further

analysis. It is presented in three sections. The first part deals with the independent variables of socio-economic and demographic characteristics of respondents. The second section looks into other major independent variables, knowledge and attitude. The final part addresses the description of the dependent variable, the practice of FGM.

5.1.1. Socio- Economic and Demographic Characteristics

This section addressed the socio-economic and demographic characteristics of respondents including age, gender, residence, religion, ethnicity, educational status and occupation of respondents.The purpose of this section is to provide the general descriptive picture of the study participants.

A total of 430 respondents participated in the study, with a response rate of 98%. Study participants were drawn from four rural kebels and one urbankeble of the Woreda. About 308 (73%) research participants were selected from rural kebeles and 114 (27%) participants were drawn from one urban kebele. Respondents were male and female with a sex ratio of 1:1.

The respondents' age ranged from 18-68 years for both sexes. The age for women ranged from 15 to 45years (reproductive age of women) and for men ranged from19-68. The mean age of the respondents was 32 (SD ± 9.7) for both sexes. In this study, majority of men and women respondents have been between the age group of 30-35, 25-29, 20-24 and 15-19, which account for 18.72%, 18.25 %, 15.17% and 9.24 % respectively. Another 14.93% of the study participants were between the age group of 35-39. Respondents between age 40-44, 45-49 and above 50 years old represented 8.77%, 7.82% and 7.11% respectively.

As indicated in table 1 below, significant proportion of the participants of this survey were illiterate (12.3%).The participant's grade range was from the minimum grade one to college degree.Findings of the survey indicate that those who are able to read and write account for 61 (14.5%) whereas 52 (12.3%) attended lower primary school, 37 (8.8%) respondents attended

upper primary school and 33 (7.8%) attended Grade 9 and 10.Thirty nine (9.5 %) of the respondents attended preparatory school while 25 (5.9%) reported having some college education. Among women respondents, 102 (48.34%) were illiterateand 65 (30.82%) didn't complete upper primary education (Grade 8). More men had higher education than female respondents.

Majority of the respondents, 356 (84.4 %), were from Somali ethnicity. Respondents from Oromo and other a ethnic groups accounted for 38 (9 %), and 28 (6.64%) respectively. Muslim was found to be a predominant religion which accounts 394 (93.96%) of the respondents followed by 28 (6.64%) non-Muslim respondents (Orthodox Christian and Protestant). A large proportion of respondents (398 or 94.31%) were married and 24 or 5.69% were widowed and only 2.65% of the respondents reported as divorced.

Concerning occupational status of respondents, 118 or 27.96% female respondents stayed at home as housewives during the survey time. Another relatively high percentage 27.73% or 117were farmers, 42 (9.95%) were civil servant, 55 (13.03%) were daily laborer, 64 (15.17%) were merchant and 26 (6.26%) were femalestudents.

Table 1

Socio-Economic & Demographic Characteristics of Respondents, Gursum Woreda, Somali Regional State of Ethiopia

January, 2017, N=422

Variables		Frequency	Percent
Residence	Rural	308	73.0
	Urban	114	27.0
Gender	Female	211	50.0
	Male	211	50.0
Religion	Muslim	394	93.4
	Christian	28	6.6
	Total	422	100.0
Ethnicity	Somali	356	84.4
	Oromo	38	9.0
	Others	28	6.6
Education	Can't read and write	175	41.5
	Can read and write	61	14.5
	Grade 1-4 (lower primary	52	12.3
	Grade 5-8 (upper primary)	37	8.8
	Grade 9-10 (secondary	33	7.8
	Grade 11-12 (preparatory)	39	9.2
	Diploma and above	25	5.9
Marital Status	Married	398	94.3
	Divorce and widowed	24	5.7
Occupation	Farmer	117	27.7
	House wife	118	28.0
	Civil Servant	42	10.0
	Daily laborer	55	13.0
	Merchant	64	15.2
	Student	26	6.2

Pertaining to public media exposure of respondents, they have been asked whether they have heard or seen or read anything about the practice of FGM. Out of the total respondents 267 (63.3%) respondents owned working radio and television. Of all the respondents 246 (58.3) usually listen to the radio and 229 (54.3%) have heard about FGM on the radio. Respondents who owned television set account 111 (26.3%), 104 (24.6%) watch television most often and

almost all of them have heard about FGM on television. One hundred sixteen (27.5%) have read printed materials like newspapers, magazines, posters during the last twelve months. The overall finding showed that almost majority of the respondents (302 or 71.6%) have learned something about FGM from both electronic and print media.

Table 2

Respondents' Exposure to Media, N=422

Variables	Frequency	Frequency	Percent
Is there a working radio in your house?	Yes	267	63.3
	No	155	36.7
Do you listen to the radio?	Yes	246	58.3
	No	176	41.7
Have you heard FGM on the radio?	Yes	229	54.3
	No	193	45.7
Is there television in your household?	Yes	111	26.3
	No	311	73.7
Do you watch Television most often?	Yes	104	24.6
	No	318	75.4
Have you ever watched FGM on Television?	Yes	104	24.6
	No	318	75.4
During the last twelve months have you read any printed material like newspaper, magazine, posters and etc on FGM?	Yes	128	30.3
	No	294	69.7
Have you learnt anything about FGM on television, radio and printed materials?	Yes	302	71.6
	No	120	28.4

Among the respondents who have learnt something about FGM from media (302), 129 (42.7%) have reported that they support the continuation of none of the practice of FGM, 115 (38%) support Sunni type of FGM and 58 (19%) respondents support the severe type (Infibulations or Pharaonic). On the other hand, among those respondents who have learnt

nothing regarding FGM from the media (119), 105 (88.24%) were supporter of the continuation of either Sunni or Pharaonic type of FGM and 14 (11.76%) were against any type of FGM.

Respondents were also asked about their major sources of information that increased their knowledge about FGM and its complications. As seen on the table below (table 3), majority of the respondents (103 or 25.4%) mentioned their major sources of information on FGM were health professionals, 86 (20.4%) said anti-FGM clubs, 81 (19.2%) said radio and (19%) and 53 (12.6%) reported religious leaders as their major source of information.

Table 3

Respondents' Source of Information on FGM, N=422

Sources of Information	Frequency	Percent
Family	26	6.2
Peers	18	4.3
Religious leaders	53	12.6
Health professionals	107	25.4
Radio	81	19.2
Television	8	1.9
Teachers	8	1.9
Anti-FGM clubs	86	20.4
Television & Radio	8	1.9
Religious leaders and Health professionals	2	.5
Radio & Religious leaders	2	.5
Radio, Television & Religious Leaders	6	1.4
Radio, Television & Health Professionals	4	.9
Television & Religious Leaders	6	1.4
Radio & Religious Leaders	3	.7
Television & Health Professionals	4	.9

5.1.2. Respondents' Knowledge and attitude towards Female Genital Mutilation

This section of the study addresses two major independent variables of the research conceptual framework: knowledge and attitude(see figure 2, page 33).

A. Knowledge on the ill Effects of FGM

Participants were asked about their knowledge of the health-related consequences of FGM. Knowledge was measured by ten questions with "yes" and "no" responses. It has a minimum of 1 maximum of 10 score with average score of 6.65 and SD 2.13 which indicated that those who scored below the average labeled as less knowledgeable while respondents who scored the average and above had good knowledge/knowledgeable.

The study findings showed respondents who were knowledgeable in four major complication areas such as excessive bleeding 305 (72.27%), complication during delivery 305 (72.27%), FGM causes painful sexual intercourse 301 (71.33%) and FGM result in tearing during child birth 300 (71.09%). Respondents who knew another three complications of FGM i.e. FGM exposes to HIV, decreases sexual desire and FGM causes infection account for 293 (69.43%), 281(66.59%) and 277 (65.64%) respectively. Those who knew FGM causes infertility constituted 253 (60%) of the respondents. Those who responded that FGM has difficulties in menstruation and results in scar and keloid formation represented 346 (58.29%) and 236 (55.92%) of the respondents respectively (see table 4 below).

Men are more knowledgeable than women on the seven complications of FGM. Knowledge about the relationship between FGM, and complications of difficulties in menstruation and its impact on reducing sexual desire was higher among women than men.

Table 4

Survey Questions and Responses on Knowledge on FGM, N=422

	Questions	Responses			
		No		Yes	
		n	%	n	%
1	FGM expose women to HIV	129	30.57	293	69.43
2	FGM cause difficulty during delivery	117	27.73	305	72.27
3	FGM cause bleeding	117	27.73	305	72.27
4	FGM causes infection	145	34.36	277	65.64
5	FGM has difficulties in menstruation	176	41.71	246	58.29
6	FGM results in scareand keloid formation	186	44.08	236	55.92
7	FGM result in tearing at child birth	122	28.91	300	71.09
8	FGM causes painful sexual intercourse	121	28.67	301	71.33
9	FGMcauses infertility	169	40.05	253	59.95
10	FGM decrease sexual desire	141	33.41	281	66.59

To summarize the level of respondents' knowledge, the correct response to each question was primarily summed and mean was calculated (M=6.65, SD= 2.13) (see table 4 below). Hence, 195 (46.02%) respondents who scored below seven have been taken as having poor knowledge while 227 (53.79%) respondents scored seven and above were taken as knowledgeable on the health complications of FGM.

B. Attitude towards Female Genital Mutilation

Attitude is one of the major independent variables in this study. Hence, survey respondents were asked about their belief in relation to the practices female genital Mutilation and the responses of the respondents is presented in the table 4 below. Attitude has ten items and the measure uses a five-point Likert type scale that ranges from (1) strongly agree to (5) strongly

disagree for positive statements and the reverse for negative statements. Respondent with undecided attitude was given a score of 3.The findings indicated that it had a minimum and maximum score of 16 and 50 (M=35, SD=8.7) respectively. Respondents who scored below the average had positive or favorable attitude towards FGM and those who scored an average and above, and the average had negative or unfavorable attitude towards the practice of FGM (see table 5).

Table 5

Descriptive Data Indicating Knowledge and Attitude towards FGM, N=422

	N	Minimum	Maximum	Mean	Std. Deviation
Knowledge	422	1	10	6.65	2.130
Attitude	422	16	50	34.75	8.690

FGM was believed to be as a religious obligation and circumcised women are physically clean and hygiene than uncircumcised by 275 (65.17%) and 214 (50.67%) respondents respectively. Two hundred six(48.81%) respondents believed that circumcised woman is more loyal to her husband than uncircumcised women. FGM was believed to protect virginity and prevent premarital sex by 122 (28.91%) and 118 (27.97%) respondents respectively. One hundred nine (25.87%) respondents related it to good behavior while 90(21.33%) believed circumcised girls to be more respected than uncircumcised women in the community. Those respondents who believed that FGM increases marriageability and is a good tradition constitute 105 (24.88%) and 94 (22.27%) respectively. The percentage total exceeds 100% due to multiple responses by respondents (see table 6 below).

Table 6

Survey Questions and Responses on Attitude towards FGM, N=422

	Questions	Responses									
		Strongly agree		Agree		Neutral		Disagree		Strongly disagree	
		n	%	n	%	n	%	n	%	n	%
1	FGM increase chance of marriage	36	8.53	69.0	16.35	54.0	12.8	159.0	37.7	104	24.64
2	FGM is not religious requirement	17	4.03	83.0	19.67	47.0	11.1	135.0	32.0	140	33.18
3	Circumcised girls are more respected than uncircumcised in the community	21	4.98	69.0	16.35	95.0	22.5	149.0	35.3	88	20.85
4	FGM prevents premarital sex	41	9.72	77.0	18.25	52.0	12.3	180.0	42.7	72	17.06
5	FGM protects virginity	51	12.09	71.0	16.82	46.0	10.9	163.0	38.6	91	21.56
6	Circumcised women are not physically clean and hygiene than uncircumcised	48	11.37	73.0	17.30	87.0	20.6	150.0	35.5	64	15.17
7	FGM is a good practice/tradition	22	5.21	72.0	17.06	60.0	14.2	119.0	28.2	149	35.31
8	Circumcised girls have good behavior	26	6.16	83.0	19.67	84.0	19.9	148.0	35.1	81	19.19
9	Circumcised woman is not more loyal to her husband than uncircumcised	19	4.50	77.0	18.25	120.0	28.4	149.0	35.3	57	13.51
10	Circumcised women give more pleasure for the husband during sexual intercourse	9	2.13	75.0	17.77	139.0	32.9	123.0	29.1	76	18.01

Overall finding indicated that using the total score, 186 (44.1%) respondents who scored below the mean (<35) were seen as they are in favorof the practice of FGM and 236 (55.9%) respondents who scored the mean and above (>= 37) were seen as they are against the practiceof FGM.

5.1.3. Practice of Female Genital Mutilation (FGM)

In this study, proportions of women who have undergoneFGM were taken to assess the prevalence of the practice in the study area. Respondents who support the continuation of the practice and the discontinuation of it were used to assess the practice of FGM.

As indicated in the conceptual framework of this study, the practice of FGM is the research dependent variable (DV). Concerning the prevalence of FGM, this study revealed that almost all women respondents (209 or 99%) had themselves undergone either Pharaonic or Sunni types of FGM. Among the circumcised women, 174 (82.46%) had been exposed to Pharaonic type (Type III – Influbilation) of circumcision while 35 (16.59%) of them had gone through Sunni type of FGM. Pharonic type of circumcision is higher (91.4%) among women from Somali ethnic community than that of women of other ethnicity.

During the interview about the practice of FGM, 278 (65.88%) of respondents confirmed that they didn't perform the practice on their daughters and 144 (34.12%) didn't allow to perform any type FGM on their daughters. One hundred seventy three (41%) respondents knew that Sunni type of circumcision was practice and 106 (25%) of them knew that Pharaonic type of mutilation was carried out during the interview time.

The majority of parents (73%) reported that their daughters were circumcised by village circumcisers. Other 26.5% said that their daughters were circumcised by traditional birth attendants. Less than 1% of parents indicated that their daughters have undergone FGM by health professionals. Razor was the most used instrument for cutting/mutilating the girls.Three

hundred twenty nine (78%) of the respondents reported that the decision to circumcise the girls was taken by mothers while 91 or 21.6% said the decision was made by both parents, and less than 1% reported that the decision was by grandmothers and other close family members.Age at which FGM was performed varies in theWoreda. About 42.86% of women in the study area were circumcised while in around puberty age (10-13 years) followed by between 2 and 9 years in 57.14% of the respondents (see table 7 below).

The responses related to the support for the continuation of the practice of FGM indicated that 278 (65.88%) of the respondents supported the continuation of both Sunni and Pharaonic types of FGM while 144 (34.12%) were against to any type of the practice. Among the supporters, 174 (62.59%) preferred to perform the milder clitoral cutting (Sunni) whereas 104 (37.41%) respondents supported the continuation of the most severe type of FGM (Pharaonic).

Table 7

Descriptive Statistics Indicating the Practice of FGM, N=422

Variable	Value	Frequency	Percent
Do you practice FGM on your daughter?	Yes	278	65.9
	No	144	34.1
What kind of FGM do you perform existing in your community?	None	143	33.9
	Sunni	173	41
	Pharaonic	106	25.1
Are you circumcised?*	Yes	209	99.05
	No	2	0.95
Which type of FGM had you been exposed?*	Sunni	35	16.6
	Pharaonic	174	82.5
Who perform FGM in your area?	Traditional birth attendant	112	26.5
	Village women.	308	73
	Health professional	2	0.5
What types of instruments used to perform FGM?	Knife	10	2.4
	Razor	406	96.2
	Scissor	6	1.4
Do you support the practice of FGM	Yes	278	65.88
	No	144	34.12
What type of the practice of FGM do you support?	None	144	34.12
	Sunni	174	41.23
	Pharaonic	104	24.65
Who decide to perform FGM on daughter/s?	Father	1	0.2
	Mother	329	78
	Both mother and father	91	21.6
	Others	1	0.2
Do you have a plan to practice FGM on your daughter in the future?	Yes	262	62.09
	No	145	34.36
	Don't know	15	3.55
If yes, which type	None	143	33.9
	Sunni	171	40.5
	Pharaonic	93	22

*Information was collected from female respondents only.

Support for the continuation of both types of FGM was higher among women (55.40%) respondents than male (44.6%) counterpart. Female respondents (53.85%) were also more

supporters for the continuation of Pharaonic type of the practice than men (46.15%). More male (60.42%) respondents were against the continuation of the practice than female (30.58 %) study participants. The support for the continuation of the practice was high among Muslim respondent s (98.9%) than respondents of other religion followers (1.1%) and the support was also high among Somali ethnic group(89.57%) than respondents from other ethnicities (10.43%). Similarly, the support for the continuation of both Sinni and Pharaonic types of FGM was high among respondents residing in rural area (82.73) than respondents living in urban setting(17.27%) (see table 8 below).

Table 8

Support for the Continuation of the Practice of FGM by Sex, Religion, Ethnicity and Residence, N=422

Variables		Support for the continuation of FGM								
		None		Sunni		Pharaonic		Total	Support for the practice of Sunni and Pharaonic	
		count= 173	%	count= 144	%	count= 104	%		count= 278	%
Gender	Female	57	39.6	98	56.3	56	53.9	211	154	55.4
	Male	87	60.4	76	43.7	48	46.2	211	124	44.6
Religion	Muslim	119	82.6	171	98.3	104	100.0	394	275	98.9
	Christian	25	17.4	3	1.7	0	0.0	28	3	1.1
Ethnicity	Somali	107	74.3	152	87.4	97	93.3	356	249	89.6
	Oromo	10	6.9	21	12.1	7	6.7	38	28	10.1
	Others	27	18.8	1	0.6	0	0.0	28	1	0.4
Residence	Rural	79	54.9	142	82.1	88	84.6	309	230	82.7
	Urban	65	45.1	32	18.5	16	15.4	113	48	17.3

As shown in table 9 below, there is significant difference between the type of FGM practice in the past and the existing trend. In the past, almost 174 (82.46%) of women were undergone the most severe type of FGM (Pharaonic) while 35 (16.59%) womenwere cut the

milder type (Sunni). Out of the women have undergone Pharaonic types of FGM 159 (91.4 %) and 15 (8.6%) women were from Somali and Oromo ethnic groups respectively. From those women who have subject to Sunni types of circumcision, 16 (45.7%), 6 (17.2%) and 13(37.1%) were from Somali, Oromo and other ethnicities respectively.

However, during the time of the interview, 173 (40.8%) of them mentioned thatSunni type of FGM is being practiced in their area while 143 (25.1%) were said thatPharaonic type of FGM is being done. About 106 (33.8%) of respondents replied that they didn't want to practice any type of FGM. Comparison of the past and the existing trend of the practice indicated that the practice of FGM in the study area has shifted from the most sever type (Pharaonic) to the milder one (Sunni). The existing trend of the practice was almost similar to the support for the continuation of the practice.

Table 9

Comparison of the Past Experience and Existing Trend for the Practice of FGM among the Community of Gursum Woreda, N=422

	Types of FGM					
	Pharaonic		Sunni		None	
	Count	Percent	Count	Percent	Count	Percent
Past experience of the practice of FGM*	174	82.46	35	16.59	2	0.95
Existing practice/ Support for the practice	106	25.1	173	41	143	33.9

*Information obtained from female respondents only

Respondents were also asked about their intention of subjecting their daughters to FGM in the future. About 151 (35.78%) female and 111 (26.3%) male respondents replied that they had an intention to undergo their daughter to Sunni type of circumcision in the future. Fifty nine

(13.98%) female and 86 (20.38%) male responded didn't have any intention to circumcise their daughter/s. One female and 14 male respondents were unable to show their future intentions. Men and women had significant difference in their intention to circumcise their daughter either Sunni or Pharaonic type of FGM (refer to table 4). The intention among women to circumcise their daughter was higher (57.8%) than that reported by men (42.2%).

For respondents who support for the continuation of the support for the practice of both types of FGM, religious requirement (81.61%), hygiene and sanitation (76.14%) and better marriage prospect (64.47%) were their major reasons for the perpetuation of the practice in their area.

5.2. Test of Assumptions and Hypothesis

In this study, Ordinal Logistic Regression (OLR) analysis was employed to test the relationship between the dependent and independent variables. "Ordinal regression, also called the ordered logit model, is used with ordinal dependent (response) variables, where the independent variables may be categorical factors or continuous covariates" (Garson, 2014).

In thisFGM KAP study, the dependent variable, the practice of FGM, is an ordinalvariable having three ordered level categories of "None", "Sunni" and "Pharaonic" coded as "1", "2", and "3"respectively. Code 3 represents the most sever type of FGM (Pharaonic), code 2 is labeled as milder type (Sunni) and 1 represents normal or none.Socio-economic factors, knowledge and attitude are categorical and continuous independent variables in the study. The investigator used, therefore, ordinal regression to determine whether these independent variables predict the dependent variable, the support for the continuation of the practice of FGM, where the practice was measured using three ordered categories.

A. Test of Assumptions of Ordinal Logistic Regression (OLR)

Before embarking on an ordinal regression analysis, the investigator has checked the four basic assumptions ofOLR: 1) whether the dependent variable is measured at the ordinal level**,** 2)if one or more independent variables those are continuous and ordinal or categorical**,**3)the presence of multicollinearity, and 4) proportional oddsassumption.

The first two assumptions were met since the dependent variable of this study has three ordered categories ("None", "Sunni" and "Pharaonic"), and there are continuous variables (age and education), ordinal variables (attitude) and categorical variables(Knowledge, gender, resident, ethnicity, religion, marital status and occupation) independent variables.

The third assumption is multicollinerity. It is a phenomenon in which two or more predictor variables in a multiple regression model are highly correlated. In a multiple regression model with correlated predictors can indicate how well the entire bundle of predictors predict the outcome variable, but it may not give valid results about any individual predictor, or about which predictors are redundant with respect to others(Garson, 2014). The results of testing the third assumption of multicollinearity indicate that the maximum Variance Inflation Factor (VIF) is 4 for variable attitude and the minimum VIF is 1.095 for media exposure. The values of VIF are all below five indicating no multicollinearity. Another statistic used for multicollinearity test was tolerance and the values of Collinearity statistics of tolerance for all independent variables were above 0.20, it was not a cause for concern (See table 10below).

Table 10

Test of Multicollinearity of Independent Variables

Model		Collinearity Statistics	
		Tolerance	VIF
1	Attitude	.248	4.034
	Knowledge	.288	3.473
	Age	.659	1.518
	Residence	.837	1.194
	Gender	.843	1.186
	Religion	.368	2.716
	Ethnicity	.364	2.750
	Education	.473	2.114
	Marital Status	.967	1.034
	Occupation	.771	1.297
	Have you heard FGM on the radio	.914	1.095
	Have you ever watched FGM on TV	.737	1.357

Testing Parallel Lines or Proportional odd assumption is one of the assumptions underlying ordered logisticregression is that the relationship between each pair of outcome groups is the same. In other words, ordered logistic regression assumes that the slope coefficients in the modelare the same across response categories (lines of the same slope are parallel). Since theordered logit model estimate one equation over all levels of the response variable, the relationship between, say, the lowest versus all higher categories of the response variable are the same as the relationship between the next lowest category and all higher categories, etc (Bruin, 2006). This is called the proportional odds assumption of the parallel regression assumption. So it needs to test the proportional odds assumption commonly referred as the test of parallel line and the result of the test of parallelism is indicated in table 11 below.

Table 11

Test of Parallel Lines

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Null Hypothesis	91.680			
General	83.381	8.299	16	.939

The null hypothesis states that the location parameters (slope coefficients) are the same across response categories.

For the model used in this study, the proportional odds assumption appears to have held because the significance of Chi-Square statistics is 0.939>0.05. This test of not-significant result indicates that there is no difference in the coefficients between models and the proportional odds assumption holds.

Since all the assumptions of ordinal regression model were held in this study, the investigator, therefore, explained and examined the three research hypothesis using an ordinal regression analysis.

B. Model fitting Information

Before looking at the effects of predictors in the model, it needsto find out if the model gives adequate predictions. This is indicated in table 12below.

Table 12

Model Fitting Information

Model	-2 Log Likelihood	Chi-Square	df	Sig.
Intercept Only	908.542			
Final	91.680	816.861	16	.000

The above p-value (sig.) was compared to a specified alpha level set at 0.05. The small p-value would lead the researcher to conclude that at least one of the regression coefficients in the model is not equal to zero(Elamir E & Sadeq H, 2010).

In the ordinal regression model, the coefficient of determination,R^2, summarizes the proportion of variance for the response variable explained by the predictors (independent) variables. The value of Cox and Snell, Nagelkerke and McFadden were found to be .856, .968 and .898 respectively. Large R^2 values indicate that more of the variation is explained by the model and large values of R^2 which indicate the fitting is good.

The other important model fitting information is test of parallel lines. This is proved in the test of assumption section above (table 11, page 69).

The model fitting information, therefore, assured that ordinal logistic regression model fits to the analysis of the data in this study.

C. Test of Hypothesis

Hypothesis 1: The practice of FGM in the study Woreda is associated with socio-demographic factors of the respondents such as: age, residence, gender, education, religion, ethnicity, marital status and occupation.

An ordinal regression tested if there was a significant relationship between the independent socio-economic variables with the dependent variable of the support for the practice of FGM. The research findings revealed that of all the socio-economic factors, age, educationand religion were statistically significant predictors of the practice of FGM in the study area (see table 13 below).

The findings indicated that for every year of increase inage of respondents, the odds of the higher category (supporting Pharaonic types of FGM) versus the combined middle and low categories (Sunni and None) are 1.6 (95% CI, 1.13 to 2.25), Wald = 7.05, p<.001) times greater

than that of respondents at younger age, given that all of the other variables in the model are held constant. Likewise, the odds of the combined middle and high categories (supporting Sunni and Pharaonic types of FGM) versus the lower category (supporting none of the practice ofFGM) are 1.6 times greater given that all of the other variables in the mode held constant. This signified that there was high support of the severe types of FGM (Pharaonic) among older respondents compared with those at younger age.

There was a negative relationship between respondent's level of education and their support for the practice FGM. The findings indicated that for an increase in the level of education of respondents, the odd of supporting higher level of mutilation (Pharaonic) versus the combined middle and none categories (Sunni and None) are 0.412 (95% CI, .25 to .67, Wald = 13.12, p<.001) times less, given that all the over variables in the model are held constant.

Similarly, the odds of the combined middle and high categories (Sunni and Pharaonic types of mutilation) versus not supporting of any type of FGM is 0.412 times less among educated respondents, given that all of the other variables in the model are held constant. This indicate that the higher respondents' level of education, the lower the probability that they would support for the continuation of the practice of FGM.

It was also foundthat there is a statisticallysignificant relationship between religion of respondents and the support for the practice of FGM. We would say that for Muslim religion followers, the odds of supporting Paraonic type of circumcision versus the combined middle and low (Sunni and None) categories are 130.5(95% CI, 42.41 to 4015.66, Wald = 16.84, p<.001) times greater than respondents of Orthodox Christian and protestant religion followers together, given all other variables in the model are held constant. Likewise, the likelihoodof the combined

middle and high categories versus not supporting of FGM is 130.5 times greater among Muslim respondents, given that all of the other variables in the model are held constant.

In this study age, education and religion are statistically significant socio-economic determinant of the support for the practice of FGM in the study area. Hence, hypothesis 1 is, partially supported by the result of this study.

Table 13

Ordinal Regression Analysis for Socio-Economic Factors Predicting the Practice of FGM, N=422

	Variable	Estimate	Std. Error	Wald	df	Sig	Lower Bound	Upper Bound	Exp_B	Lower	Upper
Support for Practice	[None = 1]	-34.16	5.33	41.10	1	000	-44.60	-23.71	0.00	000	000
	[Sunni = 2]	-21.20	4.28	24.56	1	000	-29.59	-12.82	0.00	000	000
	Age	0.47	0.18	7.05	1	001	0.12	0.81	1.60	1.13	2.25
	Education	-0.89	0.25	13.12	1	000	-1.37	-0.41	0.41	0.25	0.67
Residence	[Rural=1]	-0.21	0.74	0.08	1	0.78	-1.66	1.24	0.81	0.19	3.44
	[Urban=2]	0.00			0				1.00		
Gender	[Female=1]	0.54	0.89	0.37	1	0.54	-1.20	2.27	1.71	0.30	9.71
	[Male=2]	0.00			0				1.00		
Religion	[Muslim=1]	7.17	1.75	16.84	1	000	3.75	10.60	130.503	42.41	405.56
	[Christian Orthodox and Protestant =2]	0.00			0				1.00		
Ethnicity	[Somali=1]	-1.84	1.50	1.52	1	0.22	-4.78	1.09	0.16	0.01	2.97
	[Oromo=2]	-0.94	1.59	0.35	1	0.56	-4.05	2.18	0.39	0.02	8.83
	[Others=3]	0.00			0				1.00		
Marital Status	[Married=1]	1.22	1.40	0.76	1	0.38	-1.52	3.97	3.40	0.22	53.03
	[Divorce and widowed=2]	0.00			0				1.00		
Occupation	[Farmer=1.00]	-1.83	1.67	1.20	1	0.27	-5.11	1.44	0.16	0.01	4.23
	[House Wife=2.00]	-2.47	1.70	2.10	1	0.15	-5.81	0.87	0.09	0.00	2.39
	[Civil Servant=3.00]	-1.35	1.86	0.53	1	0.47	-5.01	2.30	0.26	0.01	9.98
	[Daily laborer=4.00]	-3.01	1.72	3.05	1	0.08	-6.39	0.37	0.05	0.00	1.45
	[Merchant=5.00]	-2.17	1.71	1.61	1	0.21	-5.52	1.18	0.11	0.00	3.26
	[Student=6.00]	0.00			0				1.00		
	[Media exposure=1.00]	-1.17	0.65	3.20	1	0.07	-2.45	0.11	0.31	0.09	1.12
	[Media exposure=2.00]	0			0				1.00		

Hypothesis 2*:* The practice of FGM is associated with the knowledge of respondents about the health consequences of FGM.

The relationship between the respondent's knowledge of the ill effects of FGM and the support for the practice was examined using the support for the practice as dependent variable and knowledge as independent variable. The quantitative findings of the relationship could be seen on the table below (table 14).Data on the table showed a significant statistical relationship between knowledge on FGM and the support for the continuation of FGM practice among respondents in the study area. For knowledgeable respondents, the odds of supporting a higher practice category (Pharaonic) versus the middle and lower categories (Sunni and supporting none of the practice) are .300 (95% CI, .17 to .53,Wald = 17.8, $p < .001$) time or 31.1% less than that of respondents having poor knowledge, given that all the other variables in the model are held constant. Likewise, the odds of the combined middle and high categories (support for Sunni and Pharaonic types of FGM) versus category of supporting none of the practice type is 0.299 times less among knowledgeable respondents, given all the other variables in the model are held constant (see table 14 below). As knowledge on the ill effects of FGM increased, the likelihood of supporting the higher level of circumcision (Pharaonic type of mutilation) decreased. Therefore, hypothesis 2 is supported by the study.

Table 14

Ordinal Regression Analysis for Knowledge Predicting the Practice of FGM, N=422

Variable		Estimate	Std. Error	Wald	df	Sig	Lower Bound	Upper Bound	Exp _B	Lower	Upper
Support for Practice	[None = 1]	-34.16	5.33	41.10	1	000	-44.60	-23.71	000	000	000
	[Sunni = 2]	-21.20	4.28	24.56	1	000	-29.59	-12.82	000	000	000
	Knowledge	-1.21	0.29	17.80	1	000	-1.76	-0.65	0.30	0.17	0.53

Hypothesis 3: The practice of FGM is associated with the Attitude about the support for the practice.Ordinal regression tested if attitude predicts the practice of FGM using the practice as dependent variable and attitude independent variable.

The quantitative findings of the relationship could be seen on table below (see table 16).The result showed that there was a significant statistical relationship between attitude towards FGM and the support for the continuation of FGM practice among respondents in the study area. For respondents having negative attitude towards FGM, the odd of supporting the higher practice category (Pharaonic type of FGM) versus the middle and higher categories (Sunni and Pharaonic) are .517 (95% CI, .418 to .614, Wald = 46.45, p = .001) times less than those respondents having positive attitude towards the practice, given all the other variables in the model are held constant. In the same way, the odds of the combined middle and high categories (Sunni and Pharaonic) versus the"None" categories is .517 times less, given that all of the other variables in the model are held constant. As people having unfavorable attitude towards FGM, the likelihood of supporting the higher level of circumcision (Pharaonic type of mutilation) decreased. The independent variables explained 82% of the variance in the dependent variable (see table 15 below). The third hypothesis is supported by the data.

Table 15

Ordinal Regression analysis for Attitude Predicting the Practice of FGM, N-422

Variable		Estimate	Std. Error	Wald	df	Sig	Lower Bound	Upper Bound	Exp_B	Lower	Upper
Support for Practice (IV)	[None = 1]	-34.16	5.33	41.10	1	000	-44.60	-23.71	000	000	000
	[Sunni = 2]	-21.20	4.28	24.56	1	000	-29.59	-12.82	000	000	000
	Attitude	-0.68	0.10	46.45	1	0.00	-0.88	-0.49	0.51	0.42	0.62

D. Summary of the Ordinal Logistic Regression (OLR) of the KAP Survey

Based on the data, information and facts obtained, ordinal logistic regression were computed to explore the association between the dependent and independent variables. Among the Socio-economic variables age, education, and religion were significantly associated with the practice of FGM. While other socio-economic factors like residence, ethnicity, occupation and marital status were not found to be significant determinants of the practice of FGM in the study area. On the other hand, knowledge and attitude towards FGM were significantly associated with the practice of FGM. It is, therefore, socio-economic factors (partially), knowledge and attitude were determinants of the practice of FGM. Hence, the data supports the three research hypothesis.

CHAPTER VI: DISCUSSION

6.1. Major findings in the Context of Previous Literature and Theories

This KAP study provides descriptive information of the variables and it gives answers for the three research questions with the hypothesis.

6.1.1. Major Descriptive Findings

A total of 430 respondents participated in the KAP survey, with a response rate of 98%. The study participants were drawn from four rural kebels and one urban kebele of Gursum Woreda. Three hundred eighteen (73%) respondents were drawn from rural kebeles and 114 (27%) were from urban kebele based on the kebeles' population proportion. Respondents were male and female with a sex ratio of 1:1. FGM has been practiced by women on women and the practice directly affects women. Because of this reason, it is considered and remained as women's issue only. However, men can also play an important role in the continuation/discontinuation of the practice because they are the one who are going to marry women whether they are circumcised or not. They are fathers and brothers of girls. Hence, their inclusion in the study about FGM speaks for itself.

Females' genital mutilation is among the traditional practices which is not only prejudicial and harmful to the life of a child but also discriminatory against to the girl child. In this study, the reported prevalence of FGM and its association with multiple independent variables was assessed.

The descriptive findings showed that a total of 422 participated in the survey with a 1:1 ratio of female to male. Female respondents were within the reproductive age group of 15-49 and male respondents were above the age of18.

The practice of FGM, in one form or another has continued to exist in the studyWoreda of Somali Regional state of Eastern Ethiopia. This study reveals that almost all women

respondents (99.9%) were circumcised either Sunni or Pharaonic types of FGM.
This is almost similar to the EDHSreport of the prevalence rate (99%) of FGM among women between the ages of 15-49 in Somali regional state and higher than the national average prevalence rate of 65.2% (EDHS, 2016). The findings of this study are also comparable to reports of studies conducted in different countries and the prevalence in the study area is higher than the prevalence rate in Sierra Leone (81.2%) (Bjälkander et.a. 2013), Nigeria (60%) (Onuh et al., 2006), Iran(76%) (Mozafarian, 2011), Mauritania (77%) (Ouldzeidoune et.al, 2013) and Gambia (75.6%) (Kaplan, 2013).

This study also revealed that 278 or 65.88% of respondents supportthe continuation of the practice of FGMin its different forms in the study area. Among the supporters 172 or 61.87% respondent preferSunni type of FGM to continue while 106 or 38.13% support for Pharaonic type of FGM. This is lower than the regional (Somali Region) average of the support of FGM recorded in 2000 (74.3%) and almost similar with the national average of 2005 (66%)(EDHS, 2000 and 2005).

Although gender was not statistically significant determinate of the practice of FGM in this study,women respondents more likely support for the continuation of the higher practice category (Pharaonic types of FGM) than men. The result indicated that the most prominent figures in determining whether a girl was subject to FGM were female; mostly men have some say in this but not a dominant one. Besides, this study revealedthat more support for both types of FGM was reported by women (55.4%) than as reported by men (44.6%). This finding was similar with the findings of a study conducted by Getnet and Wakgari (2009) in Eastern Somali refugee camp. They conducted a cross sectional study among 429 respondents sampled from three refugee camps and concluded that FGM was widely practiced among the Somali refugee

community and there was a considerable support for the continuation of the practice particularly among women than men. This showed that despite the patriarchal nature of society, men appear less concerned about FGM than women. Women want to continue the practice because of the social pressure to conform to what others do and have been doing, as well as the need to be accepted socially. Failure to conform could lead to difficulty in finding a husband for the girls, shame, stigmatization, as well as loss of social statusresulting in the family's social exclusion in the community**.**

According to exchange theory, individuals will make decisions based on certain positive outcomes. Women in the study area were more supporter of the continuation of FGM than men because thebenefit they can get from respecting social norms and enhance social integration overweighs the cost of harm in FGM. However this is in contrary to the stand point of feminist perspective considering FGM is designed to affirm the powers of males over female sexuality and reproduction since the procedure is more preferred by women than men among the study population.

Concerning future intension, about 151 (35.78%) female and 111 (26.3%) male respondents replied that they had an intention to undergo their daughter Sunni type of circumcision. Fifty nine (13.98%) female and 86 (20.38%) male responded didn't have any intention to circumcise their daughter/s. One female and 14 male respondent were unable to show their future intentions. Concerning future intention of subjecting daughters to FGM, this study shows that significant differences were found between the proportions of men and women. Women were more likely to perform FGM on their daughters in the future than male respondents. On the other hand, there was important difference between men and women who were uncertain about their future intention. Men were less likely to show express their firm

opinion than female respondents. Similar studyconducted in Eritrea also showed that important differences were found between the proportions of men and women who were uncertain about the continuation of FGM, with men being nearly three times less likely to express a firm opinion than their female counterparts. These findings indicated to the conclusion that men may be important agents of change. This study suggests that discussions and efforts for eradication of FGM should involve not only women, but also entire communities, including men.

Likewise, residence was not found statistically significant determinant for the continuation of the practice FGM in the study area but the descriptive statistics showed that the support for the practice is high among respondents living in rural (82.73%) area than in urban (17.23%) areas.

Comparing the past trend with the existing practice in the study woreda, this study confirmed that there was a trend of shift from the most severe (Infibulations)type of FGM to milder type called Sunni or Type I. Similar finding was encountered in a study conducted in Sudan that a small but significant shift from Pharaonic to Sunni circumcision appears to have occurred in few areas in recent years (Mazharul & Mosleh, 2001). The result of this study also revealed that 65.8% of the respondents support the continuation of either Sunni(41.2%) or Pharaonic types (24.6%) of FGM and the same respondents have the intention to subject their daughters to FGM in the future.

There are serious health risks associated with all forms of FGM. Any type of FGM could also cause bleeding and infection which could lead to shock and death. Even the milder type of the practice, Sunni, could create scare which could limit the elasticity of clitoris during child birth. Although the practice is shifting to the milder type (Sunni) in the study area, there may be a possibility of doing mutilation with the name of Sunni. If there is not zero tolerance to any type

of FGM, among people practicing Sunni, there may be a chance of relapsing to the severe type of circumcision through time.

Any type of female genital mutilation was usually done using the same blade on different baby girls/women. This could easily transmit HIV and other transmitted diseases. Furthermore, Most of the study participants reported the operation is performed in their communities by traditional circumciser which is similar to other practicing countries like Iran (Pashaei et al, 2012)and Gambia(Kaplan. et.al, 2013). Thus, whether it is severe or milder form, the problems associated with any type of circumcisions remain the same.

Moreover, as someresearches indicated that removal of the clitoris (Sunni type of circumcision) disclosed loss of interest and desire for sexual needs among the women. They also experience less sexual satisfaction and pain. Due to lack of sexual desire, many of the women are experiencing stress (Mihiret, 2016).

Besides, FGM is violation of women's and girls' to be from violence, the right to life when the procedure results in death, the right to non-discrimination, and to be free from cruel, inhuman and degrading treatmentand should be stopped (WHO, 2017).

6.1.2. Test of Hypothesis

The results of an ordinal logistic regression in this study shows that age, education, religion, knowledge and attitude were the most significant variables associated with the risk of FGM in the study area.

A. Socio-economic Factors

The first hypothesis in this study is to test if socio-economic characteristics (residence, age, sex, education, ethnicity, religion and marital status) of respondents are associated with the practice of FGM in the study Woreda. Thefindings of this study indicated that among the

demographic variables age, education and religion werestatistically significant variables associated with the risk of FGM in theWoreda.

The ordinal logistic regression analysis results indicated that the probability of Paranoiac type of circumcision for girls of parents who were older was higher than for girls of parents who were younger. This compatible with the EDHS data of indicating Infibulations is most prevalent among daughters of older women (EDHS, 2000 and 2005). This could represent an important change in culture with decreased practice of FGM, whereby younger women were less willing to have their daughters undergo FGM. This unfolds possible hope that the practice may be reducing over time.

The other socio-demographic variable related with the practice of FGM is religion.Findings ofthis study point out that FGM was strongly associated with Muslim religion in the study area. Muslin women respondents were more likely to report themselves as having Pharaonic type of FGM and supporting the continuation of similar practice. Muslim respondents are also more supporter of the severe type of the practice thanrespondents of other religions in the study area and more Muslim women have undergone the Pharaonic types of FGM than other religion followers. This is support by EDHS data that the proportion of circumcised women is highest among Muslim women (EDHS, 2016).There is also a widespread view in several countries, particularly in Mail, Burkina Faso, Nigeria, Eritrea, Mauritania, guinea and Egypt, that FGM is a religious requirement (UNICEF, 2013).A study conducted by UNICEF indicate that in Benin, Chad Eritrea Côte d'Ivoire and Kenya 49%, 61%, 99%, 76% and 51% of circumcised women were Muslim respectively (UNICEF, 2011& KDHA, 2014)

Studies conducted in other countries, such as Mauritania and Niger, men were more likely than women to mention religion in supporting the continuation of the practice. In

Mauritania,FGM was reported to be a religious obligation by 29% of women compared to 41% of men (Ouldzeidoune et al., 2013). In Niger, religion was mentioned as a reason by 6% women and 15% of men who favored continuing the practice (Bjälkander et.a. 2013).

However it is even widely accepted that the practice of FGM has been existing in Sudanese or Nubian populations before the birth of Islam religion (UNICEF, 2005c: 12). Therefore, this indicates that FGM has no relation with religion. Although in the study areas the practice of FGM was highly related with Islamic religion, many Muslim scholars and academics in the West make an effort to insist that the practice is not rooted in religion(Thomas et al, 2007). The practice of FGM is not a common practiceand much condemned in countries like Saudi Arabia, the centerof the Islamic religion (Hassena, 204). Nevertheless, neither is it practiced in Saudi Arabia and other countries of the Middle East (only with few exceptions), nor there is any explicit reference to FGM in the Qur'an.Moreover, history of FGMC indicates that the practice preceded the emergency of both Islamc and Christian religions. Despite the fact that FGM predates the birth of Islam and Christianity and is not mandated by religious scriptures, the belief that it is a religious requirement contributes to the continuation of the practice in the study area. Changing current cultural concept favoring FGM practice through community and religious leaders can play an important role in modifying people's attitude towards FGM.

Among the demographic variables, the practice of FGM was also associated with respondents' level of education. The higher the respondents' level of education, the less likelihood to practice the most severe type of FGM (Infibulations) on their daughters.This is also supported by the EDHS data that Infibulations is most prevalent among daughters of less educated respondents(EDHS, 2016).Similar study conducted in Iraq also indicated that there was

significant relation between Female Genital Mutilation and education. “A higher level of education appeared to have a protective effect to perform FGM” (Mozafarian, 2011).

B. Knowledge on the ill effects of FGM

A multivariate analysis using ordinal regression showed that knowledge on the health complications of FGM among the study population were also determinants of female genital mutilation among the target communities. Accordingly, the probability circumcision for girls from parents who were unaware of ill effect of FGM was higher than for girls from parents who were aware of the consequences of FGM. Respondents who were aware of the negative consequence of FGM were found to be against the practice. There is a positive relationship between knowledge and positive behavior towards the discontinuation of the practice of FGM. This supported by the KAP model that new knowledge is a root or a base to bring about appropriate attitude change which will be followed by a desired behavior change. Thus, programs against FGM devote a good deal of resources and effort to the introduction of relevant knowledge information on.

C. Attitude towards FGM

In this study, the probability of circumcision for girls from parents with positive cultural conceptions of FGM were more likely to support for the continuation of the practice than for girls from parents w who had unfavorable attitude towards the practice/continuation of FGM. As this study indicated, attitudinal support for the continuation of FGM was more prevalent among women than men. The odds of supporting the continuation of FGM by women were related to beliefs like enhancement of women's marriage, protecting premarital sex and virginity. On the other hand, men were more likely than women to cite religion, female hygiene and loyalty of women to their husband when supporting/favoring the practice.

Overall, this study confirms that despite relatively widespread awareness about ill effects of FGM and negative attitude towards the practice, majority of the respondents reported to have circumcised their daughters. Besides, still there were parents who come out proactively to support the practice of FGM with the reasons of avoiding shame and stigmatization by their social group, to respect religion and culture that have been persisted for generation. This is in line with the social convention theory arguing that the possible reasons for parents to perform FGM on their daughter would be social pressure, not to deviate from social expectation of cutting, respecting social norm, way of life to avoid stigmatization and lose of social acceptance in their community.

Thus, increasing awareness/knowledge on the negative consequences of FGM and the changes in attitudes may be a first step towards the eradication of FGM, the abandonment of FGM may still be a long far away. Hence, change of social norm will be required, and there should be a critical mass of women who are educated, uncut, with improved socioeconomic status and employed in independent income-generating activities.

6.2. Strength and Limitation of the Study

To my knowledge no study has been done to assess the KAP of FGM in the study area. Studies conducted on FGM in Somali regional state focus on only women. Their views of FGM and their potential role in its abandonment were not well described. This study include not only women but also men as study participants becausemen consider FGM to reduce the likelihood of premarital sex increase marital infidelity and preserve the dignity (Gele & Sundby, 2013).In this studythe measurement of the dependent variables, the current support for the practice of FGM, is not limited to “yes” and “no” but the responses extended to identifying the type of FGM supported. As a result, the new trend of shift of the practice from the severe form of mutilation

(Infibulations) to the milder type of circumcision (Sunni)can provide direction for future programs and research.

The limitation of this study was that information connected with sexuality and personal relations are hidden in a private sphere. For instance, no onewants to share the information whether divorce was caused by sexual dissatisfactionoccurred because of FGM. For this reason, this study unable to see the association of family conflict and divorce with FGM. This may be because of fear of being judged. Some respondents also didn't want to disclose their personal/family income and unable to draw anyrelationship between wealth of respondents and the support for practice of FGM. Having no knowledge of Somali language by the investigator was a barrier to support the quantitative findings with qualitative data.

CHAPTER VII: CONCLUSION AND IMPLICATIONS

7.1. Conclusion

"KAP" study measures the Knowledge, Attitude and Practices of a community. It serves as an educational diagnosis of the community (Kaliyaperumal, 2004). This study can tell us what people know about FGM, how they feel and also how they behave. The knowledge possessed by the community refers to their understanding of the ill effect of FGM. Attitude refers to their feelings towards FGM as well as any preconceived ideas they may have towards it. Practice refers to the ways in which they demonstrate their knowledge and attitude through their actions. Understanding the level of knowledge, attitude and practice will enable a more efficient process of awareness creation as it will allow any program to be tailored more appropriately to end the practice of FGM.

Thefindings of this study points out that age, education, religion, and knowledge and attitude of respondents towards FGMare the major significant determinants for the continuation of the practice in the study area.The findings of this study are consistent with other studies conducted so far in Ethiopia and elsewhere in terms of peoples' knowledge and belief related to FGM and socio-economic to determine the practice. The findings are believed to add a new insight to the existing knowledge in the area of female genital Mutilation.

FGM is internationally recognized as violation of human rights and an illegal practice. Ethiopia is among those African states which have outlawed FGM. However, in some part of the country like Somali Regional State, the practice of FGM is widespread.

As revealed by the study, most of the community members in the study area knew about the negative reproductive health effects of FGM, and almost all women respondent had also experienced FGM themselves. Majority of the study population had unfavorable attitude towards

the practice of female genital mutilation.However,there was a considerable support for the continuation of the practice of eitherSunni or Infibulations (Pharaonic), 47.2% and 17.5% respectively. This adds up the rate of the current support the practice of FGM as high as 64.7% in the study area. Although there is a considerable support for the practice, the findings of this study reveal that there is a new trend of sifting from the severe type of mutilation to the milder (Sunni) type of circumcision. These can be because of awareness on the ill effect of the practice.

Although the practice is shifting to the milder type of circumcision, any type of circumcision has its own health complications as we as it is a fundamental violation of human rights. According to World Health Organization (WHO), any form of female genital Mutilation,whether it is Sunni or Infibulations, is a violation of rights of women and girls. It is the practice of cutting the normal functioning part of genitalia for no beneficial reasons. Every woman has the right to psychophysical and sexual health, and every circumcised woman should also have the right to be examined and treated by a physician or a gynecologist (WHO, 2009). In the absence of any perceived medical necessity, FGM exposes girls and women to health risks and has life-threatening consequences. Among those rights violated are the rights to the highest attainable standard of health and to bodily integrity. Furthermore, it could be argued that girls (under 18) cannot be said to give informed consent to such a potentially damaging practice as FGM.

The shift from Infibulations to Sunni can be a result of hard work of different government and non-governmental organization in the area; however, total abandonment of FGM is not going to be an easy task. Since it has been a long standing cultural tradition, it may take long time for total abandonment. A continuous hard effort is needed to reach to the level of zero tolerance to any type of FGM in the study area.

7.2. Implications

The findings of this study reveals that a new trend of shift of FGM practice from the severe type (Mutilation) to the less severe one (Sunni)A shift to less severe forms of circumcision may reduce the severity of the practice but it is not a path to eliminate FGM. The elimination of FGM by moving towards a progressive reduction in the degree of cutting does not hold much promise. It will, therefore, need efforts that encourage its fulland irreversibleabandonment of FGM rather than advocate a shift to the milder forms of the practice. The findings of this study are intended to serve as a guidefor policy-makers, program implementers, researchers and practitioners.

7.2.1. Implications for Policy and Programming

In Ethiopia, FGM has declined steadily among certain ethnic groups where it was once almost universal and has persisted among others like Somali ethnicity. The practice has almost decreased among some ethnicity in Ethiopia like Tigrai (24.2%), Addis Ababa (54%); however, the prevalence rate of FGM in Somali region is as high as 99% (EDHS, 2016). The findings of this study also reveal that about 65 per cent of study participants supported the continuation of the practice in its one or another form.

Based on this study finding, it could be suggested that national plan to eliminate FGM should not apply uniform strategies in all parts of the country. Rather, it needs to consider the specificity of various groups that share ethnicityor other characteristics like religion. Religion may not be a major reason for FGMin other regions of b Ethiopia. However, as majority of supporter of FGM(94%) among the study population indicated, religion is the primary reason for the continuation of the practice in the study area. Interventions strategies need to consider the trends in support of FGM and prevalence among different population groups like Somali ethnic groups. Strategies may also need to be adjusted over time to reflect changes in the practice

within specific groups. Focused attention may be needed for the Somali community where little or no change in the practice is evident. It is, therefore, recommended that:

1. Policy Implication

FGM affects the health and social wellbeing of women in practicing communities and violates basic rights of them. In Ethiopia women constitute almost half of the population and any development activities without women active participation is just clapping with one hand.Successful abandonment of FGM depends on the commitment of government to protect the current and future generation of girls from FGM and to provide services for affected women. Ethiopia has anti-FGM health, women,population, youth,education and criminal justice policies, ant-HTP strategy and legislations. Despite the existence of these policies and strategy, the practice has continued to challenge the wellbeing of women and girls especially in areas like Somali region where the prevalence rate is very high. It is, therefore, needed strong commitment to implement policies, strategy and laws.

FGM is a pressing issue and this study may influence policy makers to implement existing policies and strategies and anti-FGM legislations toeffectively address the issue and bring about the desired changes.All actors (both government and non-government organizations) involved in the national effort to end FGM should work in a coordinated and accountable manner and governments need to strengthen their capacity to coordinate and monitor work across sectors, and allocate budget to address FGM.

2. Enhancing community awareness and community empowerment

This study indicated that when people know more about the negative health consequences of FGM on girls and women, could change their attitude and the less likelihood of supporting any type of the practice of FGM. The KAP model also implies relevant knowledge on FGM can

bring about attitudinal and practical change. Hence, education and awareness raising campaigns emphasizing the negative consequences are necessary to inform individual as well as the community about risks of this ritual. This could help to lower the support for the practice among communities.

There is a possibility that individuals who want to stop FGM are unaware that others also want to end the practice since people can believe that their opinion might not be shared by others. Thus, facilitating communitydialogue/discussions amongmembers of a practicing community could help communities to develop their own strategy to abandon FGM. This study revealed that younger generation tended to have less interest than their older counterparts to continue the practice. Promoting intergenerational dialogues could have also major contribution in generating social change. This method allows young and adult, and women and men to reflect upon their values, customs, traditions, expectations, and to consider under what conditions changes ought to be made. The findings of this study indicate that those respondents who have better knowledge on the ill effect of FGM and those who have unfavorable attitude towards FGM were less likely to support for the continuation of the practice. Likewise, the level at which the entire community is aware/educated on the negative health consequences of the procedure, the more likely they will be to question the necessity of the practice. According to social convention theory, total abandonment of FGM is possible only by coordinating a collective abandonment effort within the practicing community (UNICEF, 2010). If communities believe that no incentive will be gained by circumcising their daughters, they prefer not to cut than cutting.

3. Promoting access to education for girls and women and women empowerment

Education can play a significant role in changing individual and societal views on FGM and changing social and gender norms. This argument is supported by the finding of this study that there was a positive relationship between education and the desire for the discontinuation of FGM. According to this research finding, those who had higher educational level were less likely to perform any type of FGM than less educated member of the communities in the study area. Thus, girls' and women's education is an important mechanism to increase awareness of the dangers of FGM and also enhances questioning and discussions, and could provide opportunities for individualsincluding women to take on social roles in the abandonment of FGM.

However, the rate of early childhood education participation in 2013/14 was found to be the least in Somali regional state (3.39% for female and 3.91% for male). So girls' participation level at early childhood education remains much lower in the region (UNESCO, 2015). So, expanding and improving girls' and women education in the region needs special attention.

In the study communities, FGM is a prerequisite for marriage. Where women are largely dependent on men, economic necessity could be a major driver of the procedure. As this study reveals that almost 90% of respondents who supported the practice of FGM considered FGM as a prerequisite for marriageability of girls. Women development and empowerment programs can help to change norms whereby women are dependent on men. This will enhance economic status of women increases stability and security. FGM is performed by women and on women and girls. Women more know and feel the pain and harm of the practice than men. When women are empowered in all aspects, they can raise the issue in family, groups and community discussions and dialogues and this can contribute to accelerate eradication of FGM.

4. **Encourage male involvement in any effort towards ending FGM**

As the result of this research revealed, men respondents had more unfavorable attitude towards the practice of both Sunni and Pharaonic types of FGM than their female counterparts. Besides, men as fathers, husbands, brothers, religious and community leaders, have responsibility for the health and social well-being of their daughter/s, wives and sisters. However, the role of men in decision making about the practice of FGM was limited. The most determinant among the family members to circumcise daughters were women in the study area. Thus, discussions on FGM need to happen within the family, between couples including girls and boys. Engaging men in the decision making process of FGMand in any community-based interventions to end FGM could accelerate the process of abandonment of this hurtful practice.

5. Involving Religious and traditional leaders to bringing about positive behavior towards the discontinuation of FGM

As revealed by the findings of this study, religionwas significant determinants for the practice of FGM in the study area. Muslim respondents were more supporter of the practice than respondents from other religion. Muslin respondents associated the practice of FGM with Islamic religion and they considered the practice as a religious obligation. The practice has been continuing for generations because of this strong belief. Islamic religion is predominant in the study area and religious leaders have enormous value in the day-to-day life of the Somali people. So, they should be among the target social groups having the strength to address the issue of FGM. Religious leaders have the power to testify FGM is not related with the religion and it is not an Islamic commandment in the Qur'an.

Policies or strategies which actively encourage engagement of religious leaders in its refutation would be beneficial. Islamic leaders and scholars should first have to declare that

theyare against all forms of the practice and integrate anti FGM messages with religious teachings. Due to their prominence within communities and the strong networks they have, religious leaders opposing the practice could educate their communities on the danger of FGM and proof that the practice is nothing to do with Islamic religion. Religions leaders can incorporate anti-FGM articles in their Sharia Law and clan/traditional leaders can produce region/district specific rules than can contribute to the abandonment of the practice in their respective areas.

6. Working towards social change by decreasing social expectations to carry out FGM

This study discoveredthat majority of the respondents knew about the ill effects of FGM and had positive attitude for the discontinuation of the practice. Although better knowledge and shift in individual attitude were crucial, the result of the study showed that this did not lead to behavior change towards total abandonment of all types of the practice in the study area. Though individual attitudinal changes were an important link in the process of eradication of FGM, it may not be sufficient that individual women and men to oppose the practice. In the study, those who have positive attitude towards the continuation of the practice of FGM believed that FGM increases their daughters chance of marriage, prevents premarital sex, and circumcised women are not out of social norms.

The social convention theory illustrates that in FGM practicing communities where FGM is considered as a criterion for marriage, no single family wants to abandon the practice because it affects the possibility of their daughters being married. The possible reason would be no benefit to the family if they deviate from the social expectation of cutting. The main reason for

this is that individuals in the study area were considering FGM as a social and religious obligation which was expected from them.

According to the perspective of social convention theory, total abandonment of FGM is possible only by coordinating a collective abandonment effort within the community. Thus ending FGM, therefore, requires going beyond a change in individual attitude rather it needs collective change in a way that could bring impact on decreasing considering FGM as social expectation. Interventions, such as community dialogue and discussions, sharing information and debate through existing familial and social networkscould bring about social change towards ending FGM.

Any intervention towards the total abandonment of FGM, therefore, must use a bottom-up community-led approach to address deeply rooted traditional value and belief. It needs partnership and collaboration with family, male, community elders and religious leaders in the affected communities. Community members have their own strength to address their issues like FGM.

7. **Increasing media intervention**

Though in this study media was not statistically significant determinant of the practice of FGM, practically it has a critical role in awareness creating on the harm or consequences of the practice women and girls. Reporting communities' efforts to abandon the practice can have trigger effects in other practicing communities

7.2.2. Implication for Research, Social Work Education and Practice

1. Implication for Research

The findings of many researches undertaken on the practice of FGM indicated whether the practice of FGMis decreased or increased. In this research the dependent variable (the support for the practice) was not limited to the dichotomous question of having response of

‘support’ and ‘don’t support’. Pharaonic type of genital mutilation is well known practice in the study area and people could respond “don’t support for the questions whether they are supporting the practice or not even if they are practicing Sunni type. This may lead to erroneous conclusion. Thus, a filter question was asked to determine what type of FGM the respondents prefer to practice. For this reason, the practice of FGM (the dependent variable) have three responses (Pharaonic, Sunni and None) instead of ‘support’ and ‘don’t support’ responses. As a result, the findings of the research, therefore, revealed a new trend of the practice - shifting from the type of Pharaonic (Infibulations -the most severe part) to Sunni (cutting the tip of the clitories – the mild type). This is a new insight for future research.

The research findings could also be used as a baseline to compare with findings of future research in the study area. It will also allow others to undertake cross-regional comparative research on FGM. Since researches on the role of social work in relation to FGMare limited, this study could serve as a research input to School of Social Work.Future research is suggestedfor an in-depth understanding of the relationship between Islamic religion and the practice of FGM and methods for involving religious leaders in the effort to end the practice.

2. Implication for Social Work Education

International Federation of Social Workers commits social workers to promote human rights, including the elimination of all forms of gender-specific discrimination, violence and challenge unjust practices (IFSW, 2012). FGM is clearly a form of discrimination against vulnerable groups of women and girls, and it is illegal and identified as a child protection risk.

From mystand point and experience as a student of social work, female genital Mutilation is often overlooked in social work curricula. Social workers have the responsibilities to protect girls from being cut, to advocate for service for affected women that address the physical and

psychological consequences of FGM; and to engage with practicing communities in the processes to stop the practice of FGM. In order to realize these responsibilities, social workers need to have a sound knowledge base on the concept ofFGM, its harm, the cultural complexities and social bases of cutting the girl child, and culturally respectful strategies in order to ensure the safety of women and children within their social environment.

Mostly, FGM is carried out on the girl child, and it is therefore, a child as well as women's rights and it is an issue for the social work profession. Social workers should have a particular concern to uphold human rights because human rights are fundamental principle to the social work profession.

This research therefore,suggests that social work education in Ethiopia to incorporateissues of FGM in the curriculum so that professionals be informed all aspects of the practice and aware the importance of their role in proactively preventing the irreversible procedure ofFGM. In addition, this study adds up the knowledge base of social, and research findings can serve as additional input is the School of Social work to inform students aboutFGM.

3. Implications for Practice

From a framework of social justice and human rights, social workers have roles in advocating respect for women affected byFGM and addressing the rights of girls not to be cut. FGM is a global issue, occurring across different cultures and ethnic groups. Putting an end to FGM requires "a global action from professionals including social workers to challenge and lobby for new polices or implementation of existing policies; advocate for the human rights of women and children; negotiate for changes in the health care system to address the need of women that have been mutilated, and create educational literature, thus increasing awareness on FGM" (Berg, 1997, p 1).

This study explains factors contribution for the practice of FGM in the study area. It also reveals a new trend ofshift inthe practice of FGM to Sunni type. This study therefore gives research based knowledge or information for professional working in the area of FGM to shape their intervention strategy towards total abandonment of any types of FGM. The research findings also suggest the importance of building community's knowledge on the ill effect of the practice of FGM that could bring about attitudinal change which in turn can lead to positive behavioral change. This argument is supported by the research findingsthat the support for the discontinuation of any type of FGM was higher among those respondents of having better level of knowledge and unfavorable attitude towards FGM. Therefore, designing mechanisms that maximize people's awareness should be required by social workers engaged in the area.

Public awareness can contribute to breaking the silence on FGM, allow for open discussions. Ending FGM requires individual awareness as well social change. "Social work is a practice based profession and an academic discipline that promotes social change and development, social cohesion andempowerment and liberation of people.…"(IFSW, 2014, p.1).Social workers, therefore,can help the practicingcommunities' self- empowerment using bottom up approach. This includesactivities of organizing communities, facilitate open dialogue, generating awareness and discussions with groups so that to bring about attitudinal change among individuals, families and communities in the practicing areas. This will help practicing community members to identify their health need and the corresponding determinants and to organize effective individual and collective action to control the practice.

As this study reveals that religion is one of the significant determinants of FGM in the study area. Cooperation with groups of religions leaders, increasing their awareness and influencing them could have a strongly likelihood to end FGM since FGM is not related with

religion. Furthermore, the inclusion of men in any Anti-FGM campaign and capacity building programs could facilitate diffusion of information through them, and encourage family and group discussions.

Another area of practice intervention is encouraging girls' education and women empowerment. In many FGM practicing communities, FGM is a prerequisite for marriage. This is because of a belief that women are largely dependent on men and their economic necessity could be satisfied through marriage. This study also reveals that for respondents who support for the continuation of the practice of FGM; marriageability is a major drive of the procedure of FGM. Thus, any campaign to end FGM cannot be successful unless it addresses the social and economic injustices that force women to submit to such practice as a means of economic satisfaction and social acceptance. Thus, social work professionals should advocate for preventive mechanism of securing access to formal and informal education and economic empowerment for women to change their attitude and beliefs towards the tradition, shame and stigma. This can also decrease the importance of marriageabilty for economic subsistence of girls and women. This argument is supported by the findings of this study thatthe higher level of education the respondents have, the less likely they are to circumcise their daughter.

Social work professionals can also organizing campaign and lobby activities that will put the issue of FGM in the attention of policy-makers, the legislators and the public at large. This will, therefore, help encourage for a dialogue between stakeholders,enhanceimplementation of policy and laws that protect girls and women fromFGM, organize pressure groups, establish anti-FGM networking at Woreda, regional and national level. Through networking, it would be possible to share experiences and learn from one another.

The other intervention area of social work profession is provision of the necessary services for girls and women affected by the procedure. A holistic approach of addressing the health and psychological problemsas well as strengthening the capacity of women and girls is required. This includes medical and legal assessment, providing or referring young women to counseling and support to deal with the trauma they have experienced.

Further, social workers need to conduct researches and periodic assessment on the situation of girls and women in FGM practicing communitiesin order to implement informed or evidence-based interventions that could bring about effective and sustainable social and behavior change. Thus, the results of the present study help practitioners to inform and guide their practice.

References

28TOOMANY (2013). …. let's end it (2013). Country Profile: FGM in Ethiopia. P 5.

28TOOMANY (2013). …. let's end it (2013). Country Profile: FGM in Tanzania. P 15.

Abathun, A.D., Sundb,. J. & Gele, A.A. (2016). Attitude toward female genital mutilation among Somali and Harari people, Eastern Ethiopia

Actionaid Ethiopia: Women's Development. Retrieved from http://www.actionaid.org/ethiopia/what-we-do/women's-development

Banks, E. (2006).*Female genital mutilation and obstetric outcomes: WHO collaborative prospective study in six African countries*. The Lancet, p. 367.

Mihiret Belay (2016). *The Social, Psychological and Sexual Impact on the Women and their Rationale Behind Continuation of Female Genital Mutilation*: A Case Study in Sidama Zone, Bona Zuria Woreda.

Berggren, V. (2005).*Female genital mutilation, Studies on primary and repeat female genital cutting*. Department of Public Health, Division of International Health (IHCAR) Karolinska Institute, Stockholm, Sweden

Berg, K. (1997). Female genital mutilation: Implications for Social Work. USA. Retrieved from http//www.ncbi.nlm.nih.gov. p 1

Bjälkander, O., Grant, D.S., Berggren, V., Bathija, H., & Almroth, L. (2013) Female genital mutilation in Sierra Leone: forms, reliability of reported status, and accuracy of related demographic and health survey questions. Hindawi Publ Corp: Obstet Gynecol Int. 2013, 1-14.

Brady, M. (1999) *'Female genital mutilation: Complications and risk of HIV transmission', AIDS Patient,* Care and STDs 13(12

Bruin , J. (2006). Newtest: command to compute new test, UCLA: Statistical Consulting Groups. Retrieved from https://stats.idre.ucla.edu/stata/ado/analysis/

Dawit Assefa, Eshetu Wassie, Masresha Getahun, Misganaw Berhaneselassie and Atsinaf Melaku, A. (2005). *Harmful traditional practices: For the Ethiopian health center Team.* In collaboration with the Ethiopia Public Health Training Initiative, The Carter Center,

the Ethiopia Ministry of Health, and the Ethiopia Ministry of Education. Awassa College p. iii & 15

Elamir, E.& Sadeq, H. (2010). *Ordinal Regression to Analyze Employees' Attitudes towards the Application of Total quality Management*. Journal of Applied Quantitative Method.5(4). 653-656.

Ellwood, A. (2005). *Female genital cutting, "circumcision" & mutilation: Physical, psychological and cultural perspectives*. University of Nevada School of Medicine, Department of Family Medicine, Las Vegas, Nevada, pp. 11-12

Federal Democratic Republic of Ethiopia, Central Statistical Agency Addis Ababa, Ethiopia. (2005). *Ethiopia demographic and health survey*. Addis Ababa. P. 254.

Federal Democratic Republic of Ethiopia, Central Statistical Agency Addis Ababa, Ethiopia (2011) *Ethiopia demographic and health survey*.. Addis Ababa

Federal Democratic Republic of Ethiopia, Central Statistical Agency Addis Ababa, Ethiopia and EGLDAM. (2013). *Prevalence of FGM in Ethiopia:* Based on the aligned data of 2005 EDHS and 2007 EGLDMA National follow up survey on HTPs- citing follow up survey on HTPs at National Level

Federal Democratic Republic of Ethiopia, National Planning Commission of Ethiopia (2016).*Growth and transformation plan II (GTP II)(2015/16 -2019/20)* Addis Ababa, Ethiopia.

Federal Democratic Republic of Ethiopia, Central Statistical Agency Addis Ababa, Ethiopia (2011) *Ethiopia demographic and health survey*.. Addis Ababa

Federal Democratic Republic of Ethiopia Central Statistical Agency (CSA) (2013).*Ethiopia mini demographic and health survey*. P. 14

Federal Democratic Republic of Ethiopia Central Statistical Agency Population Projection of Ethiopia for All Regions At Wereda Level from 2014 – 2017, August 2013, Addis Ababa

Federal Democratic Republic of Ethiopia Central Statistical Agency (CSA). (2016). *demographic and health survey. P 45.*

Federal Democratic Republic of Ethiopia National Plan Commission (2016).Growth and Transformation Plan II (GTP II) (2015/16-2019/20). Volume I: Main Text, Addis Ababa

Federal Ministry of Economic Cooperation and Development, Germany (2011). *Female genital mutilation in Côte d'Ivoire.*

Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth Affairs (MoWCYA) (2013). National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children in Ethiopia, Addis Ababa. Pp 8-20.

Garson, D.G (2014). Ordinal Regression. Statistical Associates Blue Book Sereis..School of Public and International Affairs, North Carolina State University.G. David Garson and Statistical Associates Publishing. USA. Retrieved from http://www.statisticalassociates.com/ordinalregression_p.pdf

Gele AA, Bø BP, Sundby J. *Have we made progress in Somalia after 30 years of interventions? Attitudes toward female circumcision among people in the Hargeisa district.BMC Res Notes.*2013;6(1):122.PubMedPubMed CentralView ArticleGoogle Scholar

Getnet Mitike & Wakgari Deressa. (2009).*Prevalence and associated factors of female genital mutilation among Somali refugees in Eastern Ethiopia: a cross-sectional study*. School of Public Health, Addis Ababa University.

Girl Summit (2014).*Ethiopia to end FGM and child marriage by 2025; budget to achieve this target increased. London, England.*

Grahama and Bennett Grahama, H.T. and Roger Bennett, (1998). *Human resources management* (9th Edition).London:

Hutchison, E.D. (1999). *Dimensions of human behavior, person and environment.* Pine Forge Pres. p. 45

Human Development Index (HDI) (2014).Retrieved from http://www.hdr,undp,or>files>hdr14-report-en-1

Hussen, A. M. (2014). *Services for women with female genital mutilation in Christchurch: Perspectives of women and their health providers*. A dissertation submitted in partial fulfillment of the requirements for the Degree of Master of Health Science. School of Health Science, University of Canterbury. Retrieved from https://en.m.wikipedia.org/wiki/Multicollinearity#/search

International Federation of Social Workers IFWS (2012). Retrieved from http://www.ifsw.org/policies/statement-of-ethical-principles

International Federation of Social Workers IFWS (2014). Global definition of social Work profession. Retrieved from http://www.ifsw.org/policies/definition

James, S. M. & Roberts, C.C. (2002). *Genital cutting and transnational sisterhood*, Chicago IL,

Kenya National Bureau of Statistics (KNBS).(2014) Health and demographic survey.Retrieved from https://www.dhsprogram,com>pubs>pdf

Yayehyirad Kitaw, Fisseha Hailemariam and Amare Dejene (2008). *Old beyond imagines: Ethiopia – Harmful Traditional Practices*. Egldam (2nd edition) Addis Ababa.

Kaliyaperumal, K. (2004). *Guideline for conducting a knowledge, attitude andpractice KAP) Study*. Vol. IV, No.1, Jan - Mar 2004 retrieved from. Retrieved from http://v2020eresource.org/content/files/guideline_kap_Jan_mar04.pdf

Koso-Thomas, O. (1987).*The circumcision of women*: *A Strategy for eradication.* London: Dotesios Ltd.; pp. 29.

Mackie, G. (1996). Ending *Foot binding an Infibulations: A Convention Account.* American sociological Review, Vol. 61, No. 6 (Dec., 1996), 999-1017. Pp 1014 -1015. Retrieved from https://www.reddit.com.

Masresha Yazew Andarge (2014) The Difficulties of Ending Female Genital Mutilation (FGM): Case of Afar Pastoralists Communities in Ethiopia. The Hague, The Netherlands. Pp 4-5

Mazharul, M. & Mosleh, M. (2001). Female circumcision in Sudan: Future prospects and strategies for eradication. Pp 71-76.

Mohamed Mohamud, (2015). *Assessment of barriers of behavioral change to stop FGM practice among women of Kebribeyah Woreda, Somali Regional State of Ethiopia*, pp 50-54.

Moller, O. S. (1999). *Is multiculturalism bad for women?* ed. Joshua Cohen, Matthew Howard, and Martha C. Nussbaum. Princeton, New Jersey: Princeton University Press, 1999.)

Mozafarian, R. 2011.*A survey on social-cultural factors related to Female Genital Mutilation: A case study of age 15-49 in Qeshm Island* , 2011. Master, Shiraz University. Iran

National Committee on Traditional Practices of Ethiopia, NCTPE. (1999). *National baseline survey on harmful traditional practices*.

Onuh, S. 0., Igberase, G. 0., Joaness O.U. Umeora, Okogbenin A. S.,Otoide, O. V. and Gharoro P.E. (2006). *Female Genital Mutilation: Knowledge,Attitude and Practice among Nurses*. Benin City, Edo Stote and Eku, Delta State, Nigeria.

Ouldzeidoune N, Keating J, Bertrand J, Rice J: *A description of female genital mutilation and force-feeding practices in Mauritania: implications for the protection of child rights andhealth*. PLoS One. 2013, 8 (4): e60594-10.1371/journal.pone.0060594.Retrieved from Available at http://www.ArticlePubMedPubMed CentralGoogle Scholar

Program for Appropriate Technology in Health (PATH) I. (2005).*Female genital mutilation in Africa*. An analysis of existing abandonment approaches. Nairobi: Kenya.

Pashaei, T., Rahimi, A,, Ardalan, A,, Felah, A. & Majlessi, F. (2012). *Related factors of female genital mutilation (FGM) in Ravansar (Iran).*J Women's Health Care. 2012, 1:2.Retrieved from http://dx.doi.org/10.4172/2167-0429. 1000108

Rushwan, H. (1996). *"Female genital mutilation: Overview and framework for the integration of activities into UNFPA three core program areas*". Unpublished working paper for UNFPA technical consultation on female genital mutilation.Addis Ababa, Ethiopia. p. 10.

Spadacini, B. and P. Nichols (2010) *"Campaigning against female genital mutilation in Ethiopia using popular education*" , Gender and Development 6(2): 44 -52

Spencer, P. (2012). When Culture Harms: *A case study on female genital mutilation Ethiopia and reverberations felt in a wider context from a political and ethical perspective.* Halmstad University, School of Social and Health Sciences.

Short, T. (Last updated 2012) *'Thethumb is mightier: A slice of life, Ethiopia.*Retrieved from http://thethumbismightier.blogspot.co.uk/2012/10/44-million-years-ago-small-hairy-small.html.

Suardi, E., Mishkin, A., & Henderson, S. W. (2010). Female Genital Mutilation in a Young Refugee: A Case Report and Review. Journal Of Child & Adolescent Trauma, 3(3), 234-242.

The Criminal Code of the Federal Democratic Republic of Ethiopia. (2004). Proclamation No.414/2004

The Transitional Government of Ethiopia, The prime Minister's Office National Health Policy of Ethiopia. September 1993, Addis Ababa. Pp 6 & 9

The Transitional Government of Ethiopia, The prime Minister's Office, Women's Affairs Sector. National Policy on Ethiopian Women. September 1993, Addis Ababa. P 14

Thomas V.O. & Thomas U. (2007), Is Female Genital Mutilation an Islamic Problem? Middle East Quarterly, pp. 29-36

United States Agency for International Development (USAID) (2013). Female Genital cutting: The Interpretation of Recent DHS DATA, DHS comparative Reports 33, ICF International Calverton, Maryland, USA

UNESCO. (2006). Culture, Mexico city declaration cultural policies.Retrieved fromhttp://portal.unesco.org/culture/en/ev/php

UNESCO (2015).National Education for All 2015 Review Report. Retrieved from efa2015reviews@unesco.org

UNESCO (2016). Progress towards the Sustainable Development Goals Report of the Secretary-General, "Progress towards the Sustainable Development Goals", E/2016/75.

UNFPA. (2009): *Global Consultation on Female Genital Mutilation*, Technical Report; .

UNFPA (2017), Female Genital Mutilation (FGM).Retrieved from http://www.unfpa.org/female-genital-mutilation#sthash.m2Kri25o.dpuf

UNICEF (2010). Ethiopia: Social Dynamics of Abandonment of Harmful Practices. Experiences in four Locations.

UNICEF, 2013. *Female genital Mutilation. A statistical overview and exploration of the dynamics of change*. Pp. 69-71

UNICEF (2016).*Female Genital Mutilation/Concern: A Global Concern.* Retrieved from *https://www.unicef.org/media/files/FGMC 2016 brochure final_UNICEF_SPREAD. pdf, p 1*

Wadesango N, Rembe S, Chabaya O: Violation of women's rights by harmful traditional practices. Anthropologist. 2011, 13 (2): p 121.

Whitehorn, J., Ayonrinde, O., & Maingay, S. (2002) Female Genital Mutilation: Cultural and psychological Implications, Sexual and Relationship Therapy, pp. 161-171. Retrieved from http://www.tandfoline.com/doi/pdf/10.1080/14instName+University+of+Oxford

World Health Organization. Female genital mutilation, Report of a WHO Technical Working Group, Geneva:WHO 1995

World Health Organization. Eliminating female genital mutilation: an interagency statement. Geneva 2008:1-47

World Health Organization. (1998). *Female Genital Mutilation An overview*. Geneva, Switzerland. Pp 1-5.

World Health Organization. (2008) Advocacy, communication and social mobilization for TB control: A Guide to Developing Knowledge, Attitude and Practice Surveys.

World Health Organization. (2008) Eliminating Female Genital Mutilation. An Interagency statement.Retrieved from http://apps.who.int/iris/bitstream/10665/43839/. Pp 5-9

World Health Organization. (2012). *Understanding and Addressing Violence against Women: Female Genital Mutilation*World Health Organization. (2017).Retrieved from *http://www.who.int/reproductivehealth/topics/fgm/health_consequences_fgm/en/ p. 2*

World Health Organization (2017). Female genital mutilation: fact sheet. Retrieved from www.who.int/mediacentre/factsheets/fs241/en/

Yamane, Taro (1967), *Statistics; An Introductory Analysis*. 2nd Edition. New York University, N.J. Pp 129-162

Appendix: KAP Survey Questionnaire

Questionnaire in Amharic

Survey objective: To explore FGM related knowledge, attitude and practice among the Community Gursum Woreda, Somali Regional State of Ethiopia

Date: Jan. 16, 2017

Consent Form

Read the following paragraph for the selected person.

My name is Tigist Moges. I am working as student researcher at Addis Ababa University, School of Social Work. To conduct the study, I would like to ask you some questions which may take about 15 minutes. As your participation is very important to the outcome of the study, I kindly request you to give us your sincere and truthful answer. All the information that you and other respondents are going to provide us will remain confidential and you don't need to mention your name and you are also free to withdraw at any time and if you have any question during interview you can ask.

Are you willing to participate in the interview? Yes, _____ (continue the interview if the respondent says, "Yes") No, _____ (Thank and stop here if respondent says "No")

Signature_____ Date_____

(Signature of the interviewer certifying that consent has been obtained verbally)

Instruction: - The following are interview questions in order to identify the knowledge, attitude and practice on FGM. Please give your honest and truthful answer to each question from the indicated choices.

Contact Address:-

Mobile: - 09-12-01-83-71, Email: - tigist2015@yahoo.com

Study Questionnaire in English

I. Socio-demographic Characteristics - Circle one only

No	Questions	Alternative Response	Skip
101	Age	1. _____ years	
102	Sex	1. Female 2. Male	
203	Religion	1.Muslim 2.Orthodox 3.Protestant 4.Others(specify)_____	
104	Ethnicity	1.Somali 2.Oromo 3.Amhara 4.Others(specify)_____	
105	Marital status	1. Never married 2.Married 4.Divorced 5.Widowed 6. Living with partner	
106	If the answer for question number 6 is divorced, why?	1. Because sexual intercourse was painful 2. Woman's lack of sexual desire 3. Other specify ———	
107	Educational status	1.Can not read and write 2.Can read and write 3.Grade 1-4 (lower primary) 4.Grade 5-8 (upper Primary) 5.Grade 9-10 6. Grade 11-12 (Prep) 7.Diploma and above 8.Others(specify)____	
108	Occupational status	1.Farmer 2.House wife 3.Civil servant 4.Daily laborer 5.Merchant 6.Student 7.Others(specify)	
109	Family income per months	_____ Eth. Birr	

II. Media Exposure - Circle one only

No	Questions	Alternative responses	Skip
201	Is there working radio in your household?	1.Yes 2. No	
203	Have you ever heard about FGM on radio?	1.Yes 2. No	
204	Is there television in your household?	1.Yes 2. No	
205	Do you watch television most often	1.Yes 2. No	
206	Have you ever watched about FGM on television?	1.Yes 2. No	
207	During the lat twelve months have you read any printed material like newspaper, magazine, posters and etc?	1.Yes 2. No	
208	Have you learnt anything about FGM on television, radio and printed materials?	1.Yes 2. No	
209	If 'Yes' What did you learn	1. Types of FGM	If no skip
		2. Prevention of FGM	
		3. Impacts of FGM	
210	Which sources of information helped you to increase your knowledge related to FGM?	1. Family 2. Peers 3. Religious leader 4. Health professionals 5. Radio 6. Television 7. Teachers 8. Anti-FGM clubs 9. Others (specify)_____	

III. Knowledge about the ill effects of FGM - Circle only 1 If yes and 2 If No

No	Questions	Alternative Responses	Skip
301	FGM expose women to HIV/AIDS	1. Yes 2. No.	
302	FGM cause difficulty during delivery	1. Yes 2. No.	

No	Questions	Alternative Responses	Skip
303	FGM cause bleeding	1. Yes 2. No	
304	FGM causes infection	1. Yes 2. No	
305	FGM has difficulties in menstruation	1. Yes 2. No	
306	FGM results in scare and keloid formation	1. Yes 2. No	
307	FGM result in tearing at child birth	1. Yes 2. No	
308	FGM causes painful sexual intercourse	1. Yes 2. No	
309	FGM causes infertility	1. Yes 2. No	
310	FGM decrease sexual desire	1. Yes 2. No	

IV. Attitude towards FGM - Circle only one

No	Questions	Alternative Responses	Skip
401	FGM increase chance of marriage	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
402	FGM is not a religious requirement	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
403	Circumcised girls are more respected in the community than uncircumcised	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
404	FGM prevents premarital sex	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	

No	Questions	Alternative Responses	Skip
405	FGM preserves virginity	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
406	Circumcised women are not physically clean and hygiene than uncircumcised women	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
407	FGM is a good practice/tradition	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
408	Circumcised women are not physically clean and hygiene than uncircumcised women	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
409	Uncircumcised woman is not more loyal to her husband than uncircumcised women	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	
410	Circumcised woman gives more pleasure for her husband during sexual intercourse than uncircumcised.	1.Strongly agree 2. Agree 3 .Neutral 4 .Disagree 5. Strongly disagree	

V. Practice

No.	Questions	Alternative Responses	Skip
501	Do you practice FGM on your daughters?	1.Yes 2. No.	
502	What Kind of FGM do you perform existing in your community?	1. None 2. Sunni 3. Pharaonic	

No.	Questions	Alternative Responses	Skip
503	Are you circumcised? (for women only)	1.Yes 2. No.	
504	At what age you were exposed to FGM? (for women only)	1.Yes 2. No..	
505	Which type of FGM had you been exposed?(for women only)	1. None 2. Sunni 3. Pharaonic	
506	Who perform FGM?	1.Traditional birth attendant 2.Village women 3.Healh professional 4.Others(specify)_____	
507	What types of instruments used to perform FGM?	1. Knife 2. Razor 3. Scissor 4. Others(specify)___	
508	Do you support the practice of FGM?	1.Yes 2. No	
509	Which type of the practice of FGM do you support?	1.None 2. Sunni 3. Pharaonic	If no skip
510	Are all of your daughters circumcised?	1. All are circumcised 2. Elder daughter are circumcised 3. Daughters not old enough 4. Daughters old enough but uncircumcised	
511	How many of your daughters circumcised?	_____	
512	Who decides to perform FGM	1.Father 2.Mother 3.Both mother and father 4.Others(specify)__	

VI. Intention towards FGM

No	Questions	Alternative Responses	Skip
601	Do you think Sunni should be continued or should it be discontinued?	1. Continued 2. Discontinued 3. Don't know	

No	Questions	Alternative Responses	Skip
602	Do you think Pharaonic should be continued or should it be discontinued?	1. Continued 2. Discontinued 3. Don't know	
603	Do you have a plan to practice FGM on your daughter in the future?	1. Yes 2. No. 3. Do not Know	
604	If the answer for question no 503 is yes which type?	1. None 2. Sunni 3. Pharaonic	If no skip
605	Why do you think Sunni/Pharaonic should be continued?	1. Because it is good tradition and custom 2. Because it is religious demand 3. Because circumcised women are physically clean and hygiene than uncircumcised 4. Better marriage prospect 5. Greater pleasure of husband 6. Preserve virginity 7. Other, specify____	
906	Women/men should actively participate in anti FGM activities	1.Yes 2. No.	

Questionnaire in Somali Language

Ogalanshaha ka qaybgalayasha

Magacaygu waa_____ waxaan uruurinayaa xog ku saabsan GUDNIINKA FIRCOONIGA taasoo oo uu cilmi baadhis ku samaynayo Arday kaqalinjabinayawaxbarashada mastar-ta ee jaamacada ADDDIS ABABA qaybta caafimaadka. Waxaan si naxariis leh idiinka codsanayaa inaad feejignaan i siisaan si aan idiinku sharaxo xog uruurintan laydiin soo xushay.

Cinwaanka cilmi baadhista

Caqabadaha hortaagan in labadalo dhaqamada gudniinka fircooniga ee qabri bayax ee deegaanka soomaalida itoobiya. Sirtinu way qarsoonaan doontaa, natiijadu bulshada waxay u gaadhi doonta iyadoon muujinaynin cid ama qoys, wax magac ah laguma qori doona waraaqaha xog uruurinta, wax raadraac keena oo xidhiidhiya ka qayb qaataha iyo cilmi baadhaha majirayo qoraal iyo hadalba. Ka qayb qaatuhu waa mutadawac(iskii), xaq waxaad uleedahay inaad cadaysato ka qayb qaadashada iyo diidmada, waad joojin kartaa xiligaad doonto, su,aashaadan doonaynin kama jawaabaysid.

waan akhristay ama la ii akhriyay, waan fahmay ula jeedada, qaabka, khasaaraha iyo faa,iidada, xaalada kalsoonaanshaha, xuquuqda iyo cinwaanka hadii su,aal loo baahdo.

Hadaba waxaan cadaynayaa inaan iskay u ogalaaday ka qayb qaadashada xog-waraysigan anigoo ku qeexaya saxiixayga hoose

saxiixa; xog-bixiyaha_____

saxiixa xog-uruuriyaha_____

Wixi faahfahina nagala soo xidhiidh:-

Mobile: - 09-12-01-83-71, **Email**: - tigist2015@yahoo.com

Study Questions in Somali Language

I. Qalab Xoogta kaqaybgalayasha - Mid kali ah goobaab

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
101	Dada	1. _____sano	
102	Jinsi	1. Dhadig 2. Lab	
103	Diinta	1. Muslim 2. Ortodhokis 3. Beendee 4.Wax kale (caddee)_____	
104	Isirka	1. Somali 2. Oromo 3. Amxaaro 4. Wax Kale (caddee)____	
105	Xaaladaguur	1. Waligay Ma guursanin 2. Guursadey 3. Lafuray 4. Lagadhintay	
106	Haddii jawaabta su'aasha 6aad aad ka dhigtay furriin, maxaad uga dhigtay?	1. Maadaama, galmadu ay xanuun igu beeraysay 2. Maadaama dumarku rabitaan galmood aysan lahayn 3. Sabab kale (caddee	
107	Heerkaa aqoonta	1. Ma Qori/ akhriyikaro 2. Qori/ akhriyikaraa 3. Fasalka 1- 4aad 4. Fasalka 5- 8aad 5. Fasalka 9- 10aad 6. Fasalka 11- 12aad (Preparatory) 7. Diploma iyokasareeya 8. Wax kale (caddee) ____)	
108	Shaqada	1. Beeralay 2. Guri jog 3. Shaqaaledawladeed 4. Xoogsade 5. Ganacsade 6. Arday 7. Wax kale (caddee)_____	
109	Dakhliga Qoyska bishii	_____ Itob. Birr	

II. Adeegsiga isgadhsinta la xidhiidha gudniinka fircooniga - Mid kali ah goobaab

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
201	Rikodh ma leedihiin?	1.Haa 2.Maya	
202	Caada ma u leedahay inaad raadyoowga dhagaysato?	1.Haa 2.Maya	
203	Waligaa raadiyaha ma kamaqashay gudniinka fircooniga?	1.Haa 2.Maya	
204	Telefishin ma leedihiin?	1.Haa 2.Maya	
205	Mar mar ma daawataa telefishinka?	1.Haa 2.Maya	
206	TV-ga waligaa ma kadaawatay gudniinka fircooniga?	1.Haa 2.Maya	
207	Afartii usbuuc ee ugu danbaysay ma akhriday wax yaalaha la daabacay sida joornaalka ,jaraidyada iyo tabeelayowga IWM ?	1.Haa 2.Maya	
208	Haba yaraatee wax uun ku saabsan Gudniinka Fircooniga ah ma ka baratay telefishinka iyo/ama raadyoowga?	1.Haa 2.Maya	
209	Haday Haa tahay maxaad kabaratay?	1.Qaybaha Gudniin Firconiga	
		2.Wax yeelada Gudniin Firconiga	
		3.Qaabka looga hortago Gudniin Firconiga	
210	Xagee laga hela xogaha aqooneed ee la xidhiidha gudniinka fircooniga?	1. Qoyska 2. Saaxiibka 3. Hogaamiye yaasha diinta 4.Xirfadlayasha caafimaadka 5. Raadiya 6. Telefishinka 7. Macaliminta 8. Kooxaha kahortaga Gudniin Firconiga 9. Wax kale(caddee)____	

III. Aqoonta laxidhiidh gudninka firconiga - Mid kali ah goobaab 1 If Haa and 2 If Maya

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
301	Gudniinka fircoonigu wuxu sababi kara xanuunka HIV/AIDS	1.Haa 2.Maya	
302	Gudniina fircoonigu wuxu waxyeelo ku keena xiidhiidhka galmada dumarka ee mustaqbalka	1.Haa 2.Maya	
303	Gudniinka fircooniga wuxu sababa dhiig bax	1.Haa 2.Maya	
304	Gudniinka Fircooniga waxa uu sababaa caabuq	1.Haa 2.Maya	
305	Gudniinka Fircooniga waxa uu keenaa dhibaatooyin marka dhiiga caadad	1.Haa 2.Maya	
306	Gudniinka Fircooniga waxa uu reebaa cabsi iyo argagax	1.Haa 2.Maya	
307	Gudniinka Fircooniga waxa uu sababaa in la jeexo dumarka xilliga dhalmada	1.Haa 2.Maya	
308	Gudniinka Fircooniga waxa uu sababaa xanuun badan xilliga galmada	1.Haa 2.Maya	
309	Gudniinka Fircooniga waxa uu sababaa madhalaysnimo	1.Haa 2.Maya	
310	Gudniinka Fircooniga waxa uu yareeyaa shahwada qofka	1.Haa 2.Maya	

IV. Dhaqanka iyo habdhaqanka gudniinka fircooniga - Mid kali ah goobaab

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
401	Fursada guurka ayuu kordhiya gudniinka fircoonigu	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
402	Gudniinka fircoonigu ma aha amar diineed	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
403	Gabdhaha laguday xurmo kuma laha bulshada dhexdeeda	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
404	Gudniinka fircoonigu wuxu ka hortaga galmada guurka kahore	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
405	Waxa lagu ilaaliyaa bikranimada/Gabadhnimada	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
406	Dumarka la guday jidh iyo nadaafad ahaan kama nadiifsana kuwa aan la gudin	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
407	Gudniinka Fircooniga waa dhaqan wanaagsan	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
408	Gabdhaha la guday akhlaaq wanaagsan ayay leeyihiin	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
409	Gabadha aan la gudini daaced aya u tahay ninkeeda	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	
410	Gabdhaha la guday ragoodu way u roonyihiin wayna u raaxeeyaan xilliga galmada	1. Aad ayan u amiinsaahay 2. Amiinsan 3. Dhexdhexad 4. Kaso hor jeeda 5. Aad uga so horjeda	

VI. Fal - Mid kali ah goobaab

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
501	Gabdhahaaga ma ku samaysaa Gudniinka Fircooniga ah?	1.Haa 2. Maya	

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
502	Haday Haa , gudniinka noocee ayay bulshadiinu samaysaa?	1. Midna 2. Sunni 3. Pharaonic	
503	Adiga gudniin fircooni ma lagugu sameyay (Dumarka Kaliya ayuu)	1.Haa 2. Maya	
504	Imisa jir ayad ahayd markii lagugu sameyay gudniinka fircooniga (Dumarka Kaliya ayuu)	____ sanno	
505	Gudniin nooceya ayaa lagugu sameyay (Dumarka Kaliya ayuu)	1. Midna 2. Sunni 3. Pharaonic	
506	Ayaa sameya gudniinka fircooniga	1.Umuliso dhaqamedka 2. Hawenka tulada kunool 3.Xirfad layasha cafimaadka 4.Waxkale(cadde)	
508	Ma taageersantahay falka Gudniinka Fircooniga ah?	1.Haa 2. Maya	
509	Haday Haa , gudniinka nooceebaad taageersantahay	1. Midna 2. Sunni 3. Pharaonic	
510	Gabdhahaaga oo idil miyaa la wada guday?	1. Dhamaan way gudanyihiin 2. Gabadha wayn ayaa gudan 3.Gabdhuhu wali gudniin ma gaadhin 4. Gabdhuhu gudniinkii way gaadheen balse wali lama gudin	
511	Gabdhahaaga imisaa gudan?	_____	
512	Yaa go.aamiya in gabadha lagu sameyo gudnin fircooniya	1.Abaha 2. Hooyada 3. labada waalidba 4. Waxkale(caddie)	

VII. Damaca in la joojiyo gudninka fircooniga

Tiro	Su,aalaha	Jawaabaha	Ugu-dub
601	Ma rabtaa in gudniinka Sunniga ah uu sii socdo?	1. La sii wado 2. La joojiyo 3. Ma garanayo	
602	Ma rabtaa in gudniinka fircooniga uu sii socdo?	1. La sii wado 2. La joojiyo 3. Ma garanayo	
604	Gabadhaada miyaad ku samayn Gudniinka Fircooniga ah	1. Haa 2. Maya 3. Ma garanayo	
604	Haday Haa , Kee?	1.Midna 2. Sunni 3. Pharaonic	
605	Maxaad u aaminsantahay in la sii wado Gudniinka gabdhaha?	1. Maadaama oo uu yahay dhaqan iyo caado suuban 2.Diiniyan waa lo bahanyahay gudniinka fircooniga 3.Maadaama dumarka la guday jidh iyo nadaafad ahaan ba ay ka nadiifsanyihiin kuwa aan la gudin 4.Fursadda in lagu guursado ayaa fiicnaanaysa 5.Raaxa badan ayay ragu ka helaan 6.Waxa lagu ilaaliyaa bikranimada / Gabadhnimada 7.Waxkale(cadde)____	
605	Dumarku/Ragu waa inay si firfircon uga qayb qatan barmaamijka ka hortaga gudniinka fircooniga	_____	