ADDIS ABABA UNIVERSITY

COLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

PREVALENCE AND BELIEF IN THE CONTINUATION OF FEMALE GENITAL CUTTING AMONG HIGH SCHOOL GIRLS, IN HADIYA ZONE, SOUTHERN ETHIOPIA, 2011.

BY:

MULUGETA TAMIRE (B.Sc)

ADIVISOR:

MITIKE MOLLA (MPH, PhD)

THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNVERSITY, COLLEGE OF HEALTH SCIENCES, SCHOOL OF PUBLIC HEALTH IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF PUBLIC HEALTH.

MAY 2011

ADDIS ABABA, ETHIOPIA

ADDIS ABABA UNIVERSITY

COLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

PREVALENCE AND BELIEF IN THE CONTINUATION OF FEMALE GENITAL CUTTING AMONG HIGH SCHOOL GIRLS, IN HADIYA ZONE, SOUTHERN ETHIOPIA, 2011.

BY:

MULUGETA TAMIRE (B.Sc)

ADIVISOR:

MITIKE MOLLA (MPH, PhD)

THESIS SUBMITTED TO THE SCHOOL OF GRADUATE STUDIES OF ADDIS ABABA UNVERSITY, COLLEGE OF HEALTH SCIENCE, SCHOOL OF PUBLIC HEALTH IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE DEGREE OF MASTER OF PUBLIC HEALTH.

APPROVED BY EXAMINER BOARD

Dr. Hirut Terefe	_____
External examiner	Signature
Dr. Mitike Molla	_____
Advisor	Signature
Professor Mesganaw Fantahun	_____
Internal examiner	Signature

ACKNOWLEGMENT

First and for most, my deepest and heartfelt appreciation goes to my advisor Dr. Mitike Molla for her unlimited help and valuable support throughout this study. I would also like to thank AAU, School of Public Health for giving me the opportunity to conduct this research and for all the support during my stay in the school. I take this opportunity to extend my thanks to all of my teachers especially to Dr. Wagari Deressa and Dr. Alemayehu Worku for providing some references and giving tutorial on how to use software to analyze the data, respectively.

My sincere appreciation goes to EGLDAM for the full financial support for the research and positive treatment I received from the staff.

I would like to thank the heads of Hadiya Zonal Woman and Child Affairs, Health, and Education sectors, each of the four school principals, facilitators of data collection and study participants for their contribution to this study in many ways.

I am very grateful to acknowledge my friends Tamrat Ersido and Solen Tezera for their contribution during data collection and analysis, respectively.

Last but not least, I would like to thank Gizaw Jelebo, Mado Assefa, Selamu Nigatu, and my family for their lion‟s share for the success of this thesis and my life at all.

Table of Contents

LIST OF TABLES

LIST OF FIGURES

ACRONYMS

AAU	Addis Ababa University
AOR	Adjusted Odds Ratio
COR	Crude Odds Ratio
EDHS	Ethiopian Demographic Health Survey
EGLDAM	Ye Ethiopia Goji Limadawi Dirgitoch Aswogaji Mahber
FDRE	Federal Democratic Republic of Ethiopia
FGC	Female Genital Cutting
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
GBV	Gender Based Violence
HTP	Harmful Traditional Practices
MMR	Maternal Mortality Rate
MOE	Ministry Of Education
SNNPR	Southern Nations Nationalities and People
SPH	School of Public Health
UN	United Nations
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children‟s Fund
USAID	United States of America Agency for International Development
WHO	World Health Organization

ABSTRACT

Background: Female Genital Cutting (FGC) is a cultural practice affecting 100-140 million girls and women across the world and putting 3 million females at risk every year in Africa. Although the trend is slowly decreasing in Ethiopia the magnitude is still very high as the procedure has no any known benefit but has many consequences.

Objective: To assess the prevalence and beliefs in the continuation of FGC among high school girls in Hadiya zone of southern Ethiopia.

Methods: A cross-sectional quantitative survey with complementary qualitative method was carried out among high school girls in Hadiya zone from January 2011 to February 2011. There were a total of 10587 female students within 12 governmental high schools in the zone, 797 were systematically selected from four high schools to participate in completing a self-administered questionnaire for this study. There was a response rate of 97.8%. Three focus group discussions with community and in-depth interviews with circumcisers were conducted using a semi-structured guide.

Results: Six hundred forty one (82.2%) of the girls were circumcised at a mean age of 9 years. Half of the total participants responded that FGC was being practiced in their village. A majority 675(86.7%) had stated that FGC is harmful, while 606(77.7%) thought that a girl has the right not to be circumcised. More than half, 384(59.9%) of the cutting was performed by traditional circumcisers while 186(30%) of the cutting was performed by health professionals. Group circumcision is common in the area, 429(67%) were circumcised in groups and majority 528(82.5) of the cutting was in their own homes. Few of the circumcised girls, 60(9.4%) supported their status as a circumcised girl and only 5 % believe in the continuation of FGC.

Conclusion: While there is an urgent need to stop the practice of FGC in Hadiya zone, cultural, beliefs related to maintain the hygiene of the genitalia and social factors are sustaining the practice. Therefore, there should be collaborative efforts from Governmental and non-Governmental organizations to support and bring change within the entire community.

1. INTRODUCTION

1.1. Background

Female Genital Mutilation (FGM) also known as Female Genital Cutting (FGC), consists of all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non- medical reasons [1-3]. Globally, 100-140 million of girls and women underwent FGM and every year a further 3 million are at risk in Africa [4]. Although the practice is highly prevalent in western, eastern, and north eastern Africa, it also occurs in some countries of Asia and Middle East and certain immigrant communities in North America, Europe, and Australia [5, 6] . According to UNICEF statistical exploration in 2005, there is a significant regional and geographical variation of prevalence of the practice ranging from nearly 90% or higher in Egypt, Eritrea, Mali and Sudan to less than 50% in the Central African Republic and Cote d'Iviore, to 5 % in the Democratic republic of Congo and Uganda [6-8].

While there is no religious base for this practice, most people think it is performed for religious reasons. But FGM dates back over 2000 years and exists nowadays across most religious, racial and social boundaries being supported by centuries of tradition, culture and false beliefs [9]. FGM is a cultural practice. Efforts to end it require understanding and changing the beliefs and perceptions that have sustained the practice over the centuries [4].

1.2. Rationale of the study

Sadly, the decline of FGM has been limited, despite some 25 years of efforts to ban it in many countries around the world, it is still a long way from being eradicated [10, 11]. In Ethiopia, the prevalence of FGM was 80% in 2000 with a slow decrease in 2005, 75% of women had been circumcised. During the same time, the occurrence in SNNPR and Hadiya zone was 71% and 74.8%, respectively [12, 13]. According to a follow up survey in 2006, the rate of decrease among Hadiya was only 5.2% where the prevalence was 70.9 [14], indicating the need for further studies and interventions to address the problem. In order to have a successful campaign for the eradication of female genital mutilation, there should be an understanding, and a will to change perceptions and beliefs that cause its

continuation [12]. Thus, the aim of this study, unlike other studies, which focused on mothers, was to assess the current prevalence and the beliefs of the female students on the continuation of the practice. The findings of this study will help to design appropriate interventions to halt the practice among the new generation of females in the area.

2. LITRATURE REVIEW

2.1. Types of Female Genital Mutilation/Cutting

There are four types of female genital mutilation according to WHO/UNICEF/UNFPA joint statement. Type I (clitoridectomy) is the partial or total removal of the clitoris and /or the prepuce; type II (excision) is the partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora; type III (infibulation) is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and appositioning the labia minora and / or labia majora with or without excision of the clitoris, and type IV which is unclassified, includes all other harmful procedures to the female genitalia for non- medical purpose, for example: pricking, piercing, incising, scraping and cauterization [1, 15, 16].

2.2 Origin of Female Genital Mutilation/Cutting

Little or no evidence exists to document when and how the practice began. Some say it originated in southern Egypt or northern Sudan 2000 years ago. Others suggest that it started in several places simultaneously along the middle belt of Africa. Most agree that it was practiced from early times in many African communities and evolved before the rise of Christianity and Islam. Whereas, some areas of West Africa established the practice as late as the 19th or 20th century and there are even a few communities who are instituting it today [17].

Traditionally, FGM/FGC is performed by local practitioners, most of whom are women. In some countries, efforts have been made to „medicalize" the procedure by having medical staff performing it in or outside hospitals [18]. The age at which FGC is performed on women and girls varies. It may be performed during infancy, childhood, marriage or at first pregnancy [19]. In Ethiopia, the age at which mutilation is carried out depends on the ethnic group, the type of operation, and the region. In SNNPR, the practice of FGM is carried out at a later age, which could range from 4 years to over 20 years [12]. Among Hadiya it is done between the ages of 10 and 17 [20].

2.3 Reasons and Beliefs about Female Genital Mutilation/ Cutting

The reasons for FGM are many and complex, but the most significant seems to be the belief that a girl who has not undergone the procedure will not be considered suitable for marriage. The practice is based on prevailing beliefs that female sexuality must be controlled, aiming to preserve their virginity until marriage. Men in some cultures may have less willingness to marry uncircumcised girls because they view them as unclean or sexually permissive. Although many female genital mutilation practicing societies acknowledge the dampening effect of genital mutilation on women‟s sexual pleasure, preservation of chastity if not always is the goal. In Egypt, Somalia, and the Sudan, for example, extra-marital sex is completely unacceptable and female genital mutilation is used to ensure that it does not occur. On the other hand, in Kenya, Uganda, and West African countries such as Sierra Leone , a girl may have a child out of wedlock, and it will be considered as a proof of her fertility, then undergo FGM and marriage afterwards [12, 20].

Some erroneous cultural beliefs and reasons for FGM include, maintenance of cleanliness, preservation of virginity, improvement of male sexual performance and pleasure, religious obligation, enhancement of fertility and avoidance of difficult labor/childbirth [9, 12]. In some ethnic groups of SNNPR, including Hadiya, FGM was considered as a rite of passage, making the transition from childhood to womanhood by getting rid of the „unclean‟ body parts which signify immaturity [20].

A qualitative study done in eastern Ethiopia in three different ethnic groups has shown the main reason FGM was done in all the ethnic groups was to reduce and control female sexuality. This is because that their virginity is judged as a pre-requisite for marriage where men still seem to prefer marriage to circumcised women. Some regarded FGM as an act of profound religious importance [21].

Results from different multiple regression models for men and women in Guinea showed that, with each additional year of schooling, the odds of favouring the discontinuation of FGM increased substantially [22]. A study on factors determining Ethiopian women supporting the continuation of FGM revealed that being young, a rural resident, Muslim, married, having no education, lack of exposure to mass-media, and a history of

circumcision were significant predictors of women believing that the practice of FGM should continue in Ethiopia [23, 24].

According to EDHS 2005 one third of women who have heard of FGC believe the practice should continue where 22.9% and 27.2% were 15-19 year and 20-24 year old women respectively. To this end uneducated women are more than twice as likely as women with secondary education or higher to have a daughter circumcised [13].

2.4. Health Effects of FGM

Beyond the extreme pain during the procedure, FGM has its own immediate and long term health consequences. The immediate health complications include severe bleeding (hemorrhage), shock, urinary retention, infections and tetanus. It can also lead to long term effects on health like slow flow of urine and menstrual fluids, genital malformation, pain and bleeding during intercourse, recurrent urinary infections and development of cysts and obstetric problems which depend on the type of circumcision [25-27]. According to a study conducted in south west Nigerian hospitals, circumcised women had a higher risk of tear and stillbirth [28].

WHO‟s collaborative perspective study in six African countries has shown that FGM is likely to lead to substantial additional cases of adverse obstetric outcomes in many countries with estimates suggesting that FGM could cause one or two extra pre-natal deaths per 100 deliveries to African women who have had FGM [25].

In addition, psychological complications are also common among victims of FGM. These psychological complications are comparable with an incident in several ways, that both happen within family context, with the knowledge consent and help of beloved ones and relatives who are supposed to protect the child instead of providing support to the torturing circumciser [29].

Moreover, psycho-sexual complications can also affect the victims in different ways as indicated in a study among 2000 Egyptian women, where 30% had more need for sex (less libdo, more passive repulsive), 60% had low score of sex frequency, 50% experienced pain during intercourse, and 56% had never experienced an orgasm [30].

Men may also experience complications during intercourse if their partner has undergone FGM, especially in the case of infibulations. Marital conflicts may arise from a relationship that is sexually dysfunctional or one partner‟s pleasure is attained at the cost of the other. Sexual pleasure may be reduced on the part of the woman due to the FGM (although not always) and husbands are troubled because their wives suffer during intercourse [31].

2.5. Human Rights and FGM

There are many international treaties and conventions that condemn harmful practices. They include the convention on the Rights of The Child (1989), the convention on the Elimination of All Forms of Discrimination Against Women(1979), the African charter on The Right of The Child (1990), a specific focus on female genital mutilation/ cutting is found in UN Generally Assembly Resolution 56/128 on Traditional or Customary Practices Affecting the Health of women and Girls (2001) and in the protocol on the Rights of Women in Africa, Maputo protocol (2003) [18, 32].

In the 1990‟s, strong African leadership on FGM led to growing international awareness, which resulted in the recognition of FGM as a fundamental violation of women‟s rights. In 1990, the Committee on the Elimination of Discrimination against Women (CEDAW), was charged with monitoring states compliance under the women‟s convention, released a general recommendation pertaining specifically to FGM. Moreover, the 1993 UN declaration on the Elimination of Violence against Women explicitly includes FGM within its definition of the phrase “violence against women”. Specific examples of practice that fall within the definition are : physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, marital rape, female genital mutilation and other traditional practices harmful to women [12, 33].

The 1997 E.C Ethiopian penal Code of Criminals states that anybody who circumcises a lady of any age will be punished with a minimum of 3 months arrest or minimum of 500 birr payment (Chapter3, Article 565, Page 364). On the other hand, anybody who sews female genitalia will be punished with three to five years arrest (Chapter 3, Article566, Number1, Page 364). If circumcised or mutilated ladies have faced any immediate complication to her health due to the circumcision, the person who put her at risk will be

punished from five to ten years arrest. (Chapter3, Article 566, Number2, Page 364). However, the awareness of the population about this law"s provision on female circumcision is limited in the country [34].

2.6. Conceptual Framework indicating the contributing factors to FGM and complications.

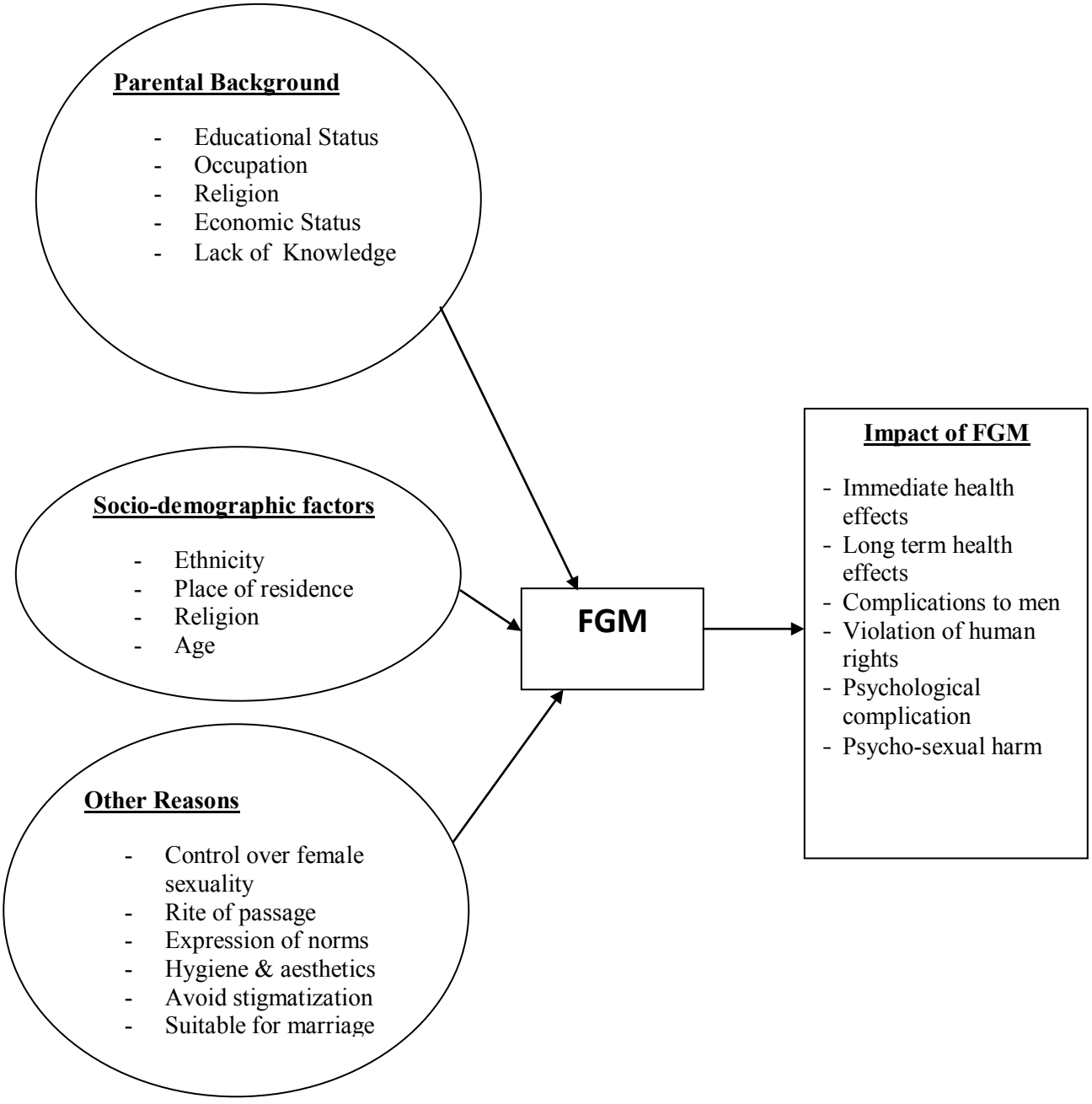

Figure 1: Conceptual Framework FGC.

3. OBJECTIVES

3.1. General Objective:-

- To assess the prevalence and beliefs in the continuation of female genital cutting among high school girls in Hadiya zone.

3.2. Specific Objectives:-

- To estimate the magnitude of FGC among high school girls.
- To assess the attitudes and beliefs of high school girls in the continuation of FGC.
- To identify factors associated with the persistence of FGC in the area.

4. METHODOLOGY

4.1. Study Area

The study was conducted in Hadiya zone, which is situated at the margin of the great Ethiopian rift valley at the western fringe in the north western part of SNNPR. The zone is located at a distance of 230 km away from Addis Ababa to the South West. According to the 2007 population and housing census, the zone has an estimated population of 1,243,776 (50% females). The zone is divided into 10 rural Woredas and one city administration as administrative political units. There were 12 high schools (grade 9 and grade 10) in the zone with a total number of 25,822 students where 41% are females.

4.2. Study Design and Period

A cross-sectional quantitative study with complementary qualitative research was conducted to determine the prevalence and beliefs in the continuation of FGM among high school girls in Hadiya zone from January 2011 to February 2011.

4.3. Source Population

All female students who were enrolled in all high schools found in Hadiya zone in the year 2010-2011 were the source population.

4.4. Study Population

For the quantitative study: - all school girls attending classes in the selected four high schools were the study population.

For the qualitative study: - FGD discussants from adult married women, unmarried males and influential people were included. Circumcisers took part in the in-depth interviews.

Inclusion criteria

- Regular students of grade 9 and 10 were included to gain recent information.
- All government high schools were recruited.

Exclusion criteria

- Night-time female students were excluded.
- Private high school female students were excluded.
- Preparatory grade female students were excluded.

4.5. Sample Size Determination

Sample size was determined using the formula for a single population proportion for cross-sectional study with the following assumptions. Taking a prevalence of 62% of FGC among women of age 15- 19 years in Ethiopia from EDHS-2005 [13] to obtain maximum sample size at 95% certainty and a maximum discrepancy of ± 5% between the sample and the population, the size of the sample is estimated to be:

$$n = \frac{(z\ \alpha/2)^2 p(1-p)\ (g)}{d^2}$$

Where, n= sample size

p= prevalence

d= margin of error

g= design effect= 2

So, $n = \frac{(1.96)^2 x\ 0.62(1-0.62)}{(0.5)^2} = 362$

362 X design effect (2) = 724

Considering a 10% allowance for non- response rate the final sample size was 797.

4.6. Sampling Procedures

A multi-stage cluster sampling technique was used for selecting the girls to be enrolled in the survey. Among the 12 governmental high schools found in the zone, 4 schools were selected purposively and the samples, 797 female students were allocated proportionately to the size of the four schools. Then, participants were selected using systematic sampling technique from each school based on their class attendance rosters.

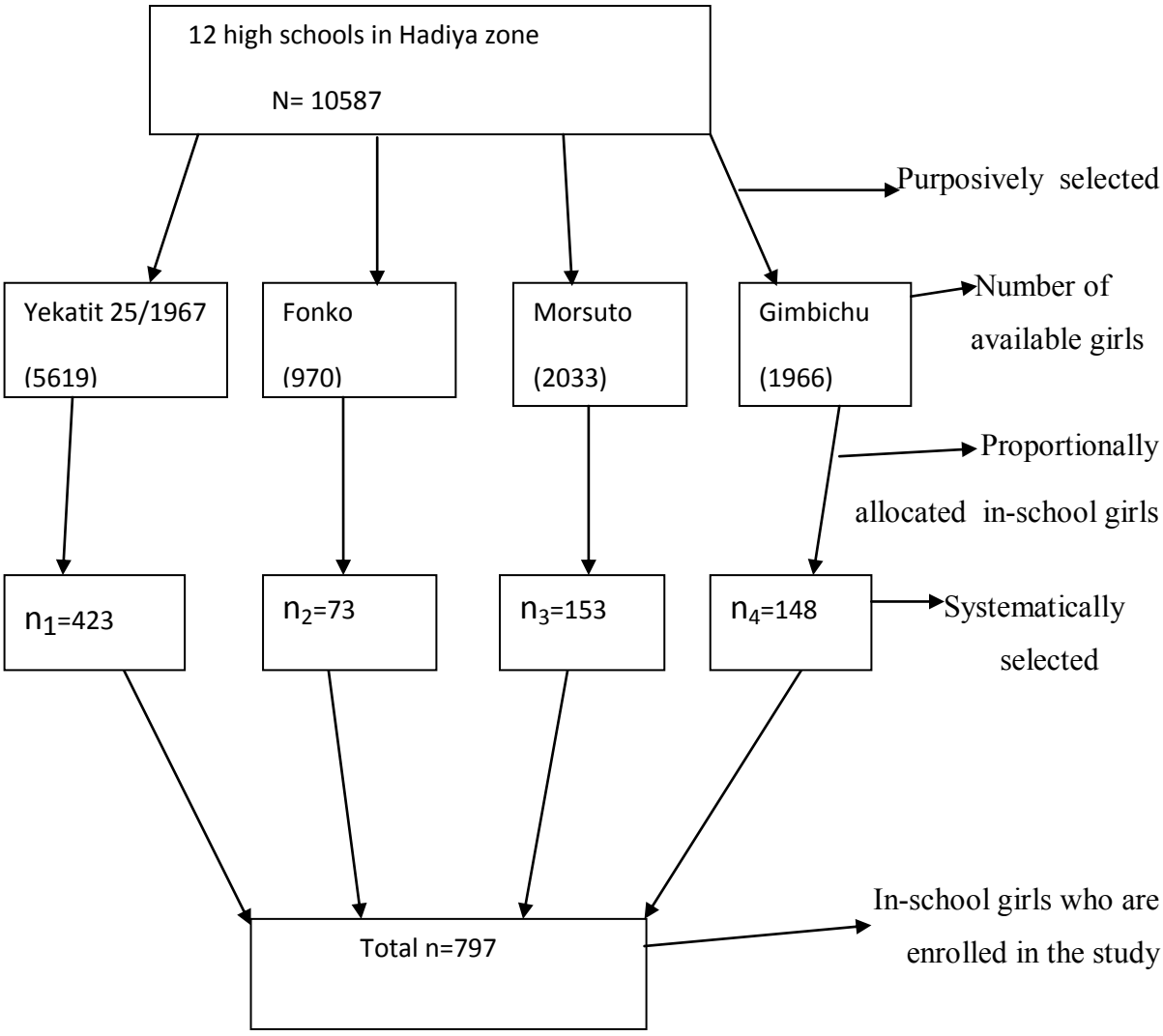

Figure 2: Schematic Presentation of the Sampling Procedure.

4.7. Data Collection Techniques

Quantitative

A structured, self-administered questionnaire which contains socio-demographic characteristics like age, ethnicity, and religion, parental background information like parental educational status and occupation, knowledge, and belief were used to collect data. Pre- tests were conducted in Heto high school which is not included in the study, using 5% of the questionnaires prepared in English and translated to Amharic before 15 days of data collection and some corrections were made to the questionnaire. Two teachers from each selected school were recruited and trained for one day on data collection techniques to give explanations, collect data and check completeness and report to the principal investigator. The questionnaires were distributed to the selected students in the classroom and collected on the same day to avoid information contamination.

Qualitative

Three group discussions were conducted separately among purposively selected groups of adult married women, unmarried males, and influential people (community leaders, religious leaders, Kebele administrators and a school principal) separately while in-depth interviews were conducted with four circumcisers.

We choose the three different groups in order to have homogeneous groups as the issue was sensitive and to identify knowledge and attitudes of each group separately. A moderator and a note-taker with social science background, who can speak and listen to the local language, were used after giving one day‟s detailed description on the topic/ discussion guide and purpose of the study. All the discussions were recorded using a tape recorder after getting verbal consent from the participants and transcribed. On average every discussion took one and a half hours.

4.8. Operational Definitions

Female Genital Cutting: consists of all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non- medical reasons.

Promiscuity: behavior characterized by causal and indiscriminate sexual intercourse, often with many people.

Traditional circumciser: non- professional individual who performs circumcision in the local area.

Belief on the continuation: support of the procedure to continue in the future.

Grade level: the grade level the girl is currently attending.

4.9. Variables

Independent variables

Age, ethnicity, religion, grade level, place of residence, parental education and occupation, knowledge, attitude, belief, and circumciser were independent variables.

Dependent variables

Prevalence of FGC, belief in the continuation of FGC

4.10. Data Quality Management

Quantitative data

In order to assure the quality of data, a standard questionnaire was adopted from that of EDHS and is used with some adaptation to the context of the study area and culture. The instrument was translated into Amharic language by professionals to make it clearer for the respondents. Emphasis was given to minimize errors by pre-testing the questionnaire, training data collection facilitators, reviewing and checking completeness of questionnaires and discarding incomplete ones.

The data were entered into a computer by the principal investigator so as to reduce introduction of error. Data clearing was given due attention and to identify and correct errors introduced easily, each questionnaire was given identification (ID) that was considered as a variable in data entry.

Qualitative data

A moderator and a note taker were recruited from related social science background and a topic guide with probing questions was used in the FGD to reduce error from memory lapse. Data were tape recorded to capture all the information and OpenCode (software) was used to store and analyze it.

4.11. Data Processing and Analysis

Quantitative data

After data collection was completed, data entry and cleaning were done using EPI-Info version 3.5.1 and exported to SPSS 16.0 package for analysis. The first step before analysis was to visualize the general feature of the data to be analyzed. Then, descriptive, bivariate and multivariate analyses were performed step by step.

Descriptive statistics were used to calculate the mean and standard deviation for continuous variables and frequency for categorical variables. Bivariate analysis using cross tabulation and bivariate logistic regression was done to determine distribution of the study subjects by independent variable of interest and to see crude association between the independent variables and the dependent variables, respectively, whereas, multivariate analysis was used to evaluate independent effects of selected variables controlling the effects of others. Some variables like parental educational status and occupation and religion were re-categorized since there were no significances using the original categories used in the questionnaire.

Qualitative data

The qualitative data was transcribed, translated and coded with OpenCode version 3.6. Then categories and themes were developed using Content Analysis.

4.12. Ethical Considerations

The proposal was submitted to the institutional review board of, College of Health Sciences, Addis Ababa University for approval. After the endorsement by the review board Hadiya zonal and Woreda education officers and respective school principals were informed about the purpose of the study using a letter of support from School of Public Health, AAU. In addition, informed consent was obtained from each study subject. Moreover, confidentiality and anonymity of the involved individual girls was kept throughout the study.

4.13. Dissemination of Results

The finding of the study will be disseminated to the School of Public Health as partial fulfillment of a Masters‟ degree in Public Health. It will also be communicated to Hadiya Zonal Women Affairs and Health sector offices, where the study was conducted, and to EGLDAM. A dissemination workshop will be held in Hadiya zone, and the output will also be presented in appropriate forums and attempts will be made for publication in national and international scientific journals.

5. RESULTS

In this section, both quantitative study findings with high school girls and the qualitative (FGD and in-depth interviews) findings with community and circumcisers, are presented. The quantitative findings will be presented first followed by the qualitative findings. We couldn't present the findings as mixed method as there are some qualitative findings that should stand alone.

5.1. Socio-Demographic Characteristics

Responses were obtained from 780 high school girls making the response rate 97.87%. Among them, 413 (52.9%) were from Yekatit 25/1967 high school. Of all the students, 506(64.9%) were from rural areas of the zone. The age of respondents range from 13-25 with a mean age of 16.2 $\pm$ 1.35. The majority of them 444 (56.9%) were from grade 10. Almost 90% were Hadiya by ethnicity while the rest were Kembata, Gurage, Silte, Amhara and others. Regarding the religion of the girls, 626 (80.3%) were followers of protestant religion, 72 (9.2%) were from orthodox and 40 (5.1%) were Muslims.

Table 1: Socio-Demographic Characteristics of High School Girls in Hadiya Zone, Ethiopia, 2011. (n=780)

Variables	Number	Percent %
School Name		
Yekatit	413	52.9
Fonko	72	9.2
Morsuto	150	19.2
Gimbichu	145	18.2
Age		
Below 15 years	48	6.2
15-19 years	708	90.8
20-25 years	24	3.0
Residence		
Urban	274	35.1
Rural	506	64.9
Grade level		
Grade 9	336	43.1
Grade 10	444	56.9
Religion		
protestant	626	80.3
Orthodox	72	9.2
Muslim	40	5.1
Catholic	34	4.4
Others	5	0.6
No religion	3	0.4
Ethnicity		
Hadiya	694	89.0
Gurage	31	4.0
Kambata	28	3.6
Amhara	18	2.3
Silte	7	0.9
Others	2	0.3

5.2. Parental Background Information

As shown in Table 2, nearly half of the fathers, 389(49.8%) and more than half of the mothers 483(61.9%) of the girls had not attended school at all. Of the fathers-180 (24.1%) and 182(23.3%) of the mothers had attended elementary schools, while the rest 197(25.3%) and 103(13.2%) of the fathers and mothers respectively had attended high schools and above. The majority of the fathers 557(71.4%) were farmers whereas the majority of the mothers 549(70.4) were housewives.

Table 2: Background Information about the Parents of High School Girls in Hadiya zone, Ethiopia, 2011. (n=780)

Variables	Numbers	Percent
Father's educational status		
Illiterate	189	24.2
Read and write only	200	25.6
1-8 grade	188	24.1
9-12 grade	123	15.8
Diploma and above	74	9.5
Do not know	6	0.8
Mother's educational status		
Illiterate	274	35.1
Read and write only	209	26.8
1-8 grade	182	23.3
9-12 grade	78	10.0
Diploma and above	25	3.2
Do not know	12	1.5
Father's occupation		
Farmer	557	71.4
Government employee	105	13.5
Private employee	93	11.9
No job	14	1.8
Others	11	1.4
Mother's occupation		
House wife	549	70.4
Farmer	92	11.8
Private employee	86	11.0
Government employee	51	6.5
Others	2	0.3

5.3. Prevalence, Knowledge, Attitudes, and Beliefs in the continuation of Female Genital Cutting

Prevalence and Knowledge on FGM

Half of the participants of the study responded that female genital cutting is presently being practiced in their area and 68(8.7%) of them didn't know whether it is practiced or not around their village. The majority, 675(86.7%) stated that female genital cutting is harmful and 606(77.7%) thought a girl has the right not to be circumcised.

Six hundred forty one (82.2%) of high school girls were cut at their mean (SE) age of 9.0 (2.3) years. The majority of the circumcision process 384 (59.9%) being performed by traditional circumcisers while health professionals had also taken part and cut 186 (30%) of them. There were 429(66.9%) group circumcisions and a larger proportion 529 (82.5%) were cut in their own homes. The decision for circumcision was made mainly by the parents and the girls themselves as can be seen from figure 2.

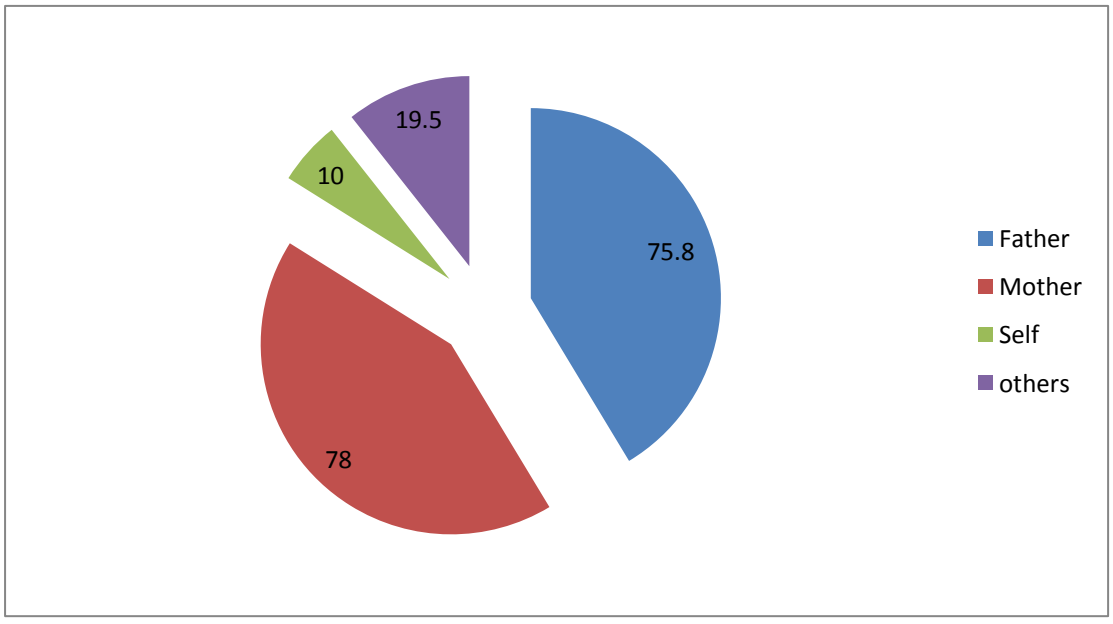

Figure 3: Decision-making on Female Genital Cutting among High School Girls in Hadiya zone, Ethiopia, 2011. (n=641)

N.B. More than one answer was possible.

Table 3: Prevalence of FGM and Knowledge on Female Genital Cutting among High School Girls in Hadiya zone, Ethiopia, 2011.

Variables	Number	Percent
Circumcision status(n=780)		
Yes	641	82.2
No	139	17.8
Operator/ practitioner (n=641)		
Traditional birth attendant (TBA)	20	3.1
Traditional circumciser	384	59.9
Traditional circumciser who is also TBA	38	5.9
Health professional	186	29.0
Grandmother	1	0.2
Don't know	12	1.9
Sex of circumciser(n=529)		
Male	538	85.5
Female	91	14.5
Condition of the circumcision (n=641)		
Group	429	67.0
Alone	190	29.6
Don't know	22	3.4
Presence of FGC in the village(n=780)		
Yes	391	50.1
No	321	41.2
Don't know	68	8.7
FGC is harmful practice(n=780)		
Yes	675	86.5
No	80	10.3
Don't know	25	1.5
A girl has the right not to be circumcised(n=780)		
Yes	606	77.7
No	162	20.8
Don't know	12	1.5

Attitude and Beliefs towards FGM

Among those who were circumcised, less than 10% supported their being cut. Their reasons for the support were mainly for hygiene (35%), to avoid shame (31.6%) and to respect culture (25%). Among those who opposed genital cutting, their reason for their opposition was mostly because they consider FGC a bad tradition. Six hundred eighty (87.2%) heard information about the harmfulness of female genital cutting from different sources, the majority of them 366(53.8%) heard it from health professionals. Only 41(5.3%) of the high school girls participated in this study believe in the continuity of the practice.

Table 4: Attitudes and Beliefs in the Continuation of FGC among High School Girls in Hadiya zone, Ethiopia, 2011.

Variables	Number	Percent
Support being circumcised(n=641)		
Support	60	9.4
Oppose	581	90.6
Reasons for supporting(n=60)*		
To avoid shame and stigma	22	36.6
For hygiene	21	35.0
To respect culture	15	25.0
For religion	10	16.6
Preserve virginity	6	10.0
To avoid promiscuity	4	6.6
For better delivery	3	5.0
Pressure from family	3	5.0
Better marriage prospect	2	3.0
Reasons for opposing (n=581)*		
Bad tradition	388	66.8
Medical complications	307	52.8
Illegal	148	25.4
Painful process	108	18.7
Against women right	78	13.4
Heard message against FGC(n=780)		
Yes	680	87.2
No	100	12.8
Believe in continuation (n=780)		
Yes	41	5.3
No	739	94.7

* More than one answer was possible.

Proposed interventions to eradicate FGC

As indicated in Figure 3, the respondents tried to mention some proposed interventions to eradicate FGC in Hadiya zone. The majority (55%) suggested education against female genital cutting in schools; other interventions indicated by the students were taking legal measures, education through mass-media and education in health facilities.

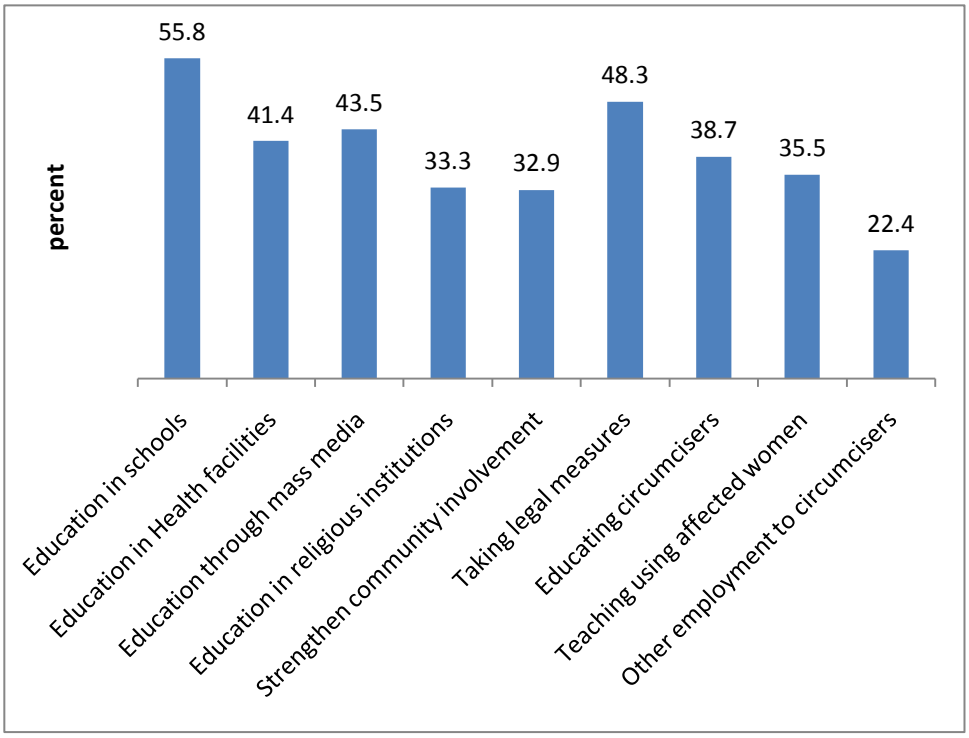

Figure 4: Proposed Interventions to Eradicate FGC as Indicated by High School Girls in Hadiya zone, Ethiopia, 2011. (n=780)

N.B. More than one answer was possible.

5.4. Factors associated with the prevalence of FGM.

Cross tabulation and logistic regression analysis were carried out to see the association of the socio-demographic and parental factors with the prevalence of the practice among the study participants.

In the bivariate analysis, residing in a rural area was positively and significantly associated with the prevalence of female genital cutting (COR=2.6: 95% CI =1.79, 3.78). Female students at grade 10 were more likely to be circumcised compared to grade 9 students (COR= 1.59; 95% CI=1.10, 2.29). Compared to all Christian religions, the Muslim had higher odds of being circumcised (COR= 4.21; 95% CI=1.01, 17.00).

With regard to parental background information, having fathers with an educational status of below high school showed higher odds of being subjected to female genital cutting compared to those who had attended high school and above(COR=3.02; 95%CI=2.05, 4.45). At the same time, the odds were also higher among those who had mothers with educational status under high school (COR=3.20; 95%CI=2.03, 5.05). The odds of female genital cutting were almost double among girls whose fathers were farmers compared to those whose fathers were currently employed in any organization (COR=2.09; 95%CI=1.42, 3.07). Having a house wife mother showed no association with the occurrence of female genital cutting (COR=1.45; 95%CI=0.92, 2.27) but there were a higher odds of being subjected to FGC among those whose mothers were farmers (COR=2.87; 95%CI=1.30, 6.33) compared to those currently employed.

All variables associated (at significance level of 0.05) with the dependent variable under consideration in the bivariate analysis were also entered to multiple logistic regressions. Among those variables entered, four of them (residence, grade level, father‟s education, and mother‟s education) were found to have significant independent associations with the prevalence of female genital cutting. The remaining three (religion, father‟s occupation, and mother‟s occupation) had no independent effects on the prevalence.

The odds of being cut was double among girls whose fathers had educational status under high school level when compared to those whose fathers had attended high schools and above (AOR=2.04; 95%CI: 1.25, 3.09). The odds of being subjected to the operation was

1.84 (95% CI: 1.01, 3.38) times higher among girls whose mothers had educational status of under high school level compared to those whose mothers had attended high schools and above.

Table 5: Association of Socio-Demographic and Parental Factors with the Prevalence of Female Genital Cutting among High School Girls in Hadiya zone, Ethiopia, 2011.

Variables	Circumcision status		COR(95% CI)	AOR(95% CI)
	Yes N (%)	No N (%)		
Residence (n=780)				
Urban	199(72.6)	75(27.4)	1	1
Rural	442(87.4)	64(12.6)	2.6(1.79, 3.78)*	1.97(1.25, 3.09)*
Grade level(n=780)				
Grade 9	263(78.3)	73(21.7)	1	1
Grade 10	378(85.1)	66(14.9)	1.59(1.10, 2.29)*	1.79(1.20, 2.66)*
Religion (n=772)				
All Christian religions	599(81.8)	133(18.2)	1	1
Muslims	38(95.5)	2(5.0)	4.21(1.01,17.00)*	3.35(0.77, 14.5)
Father's educational status (n=774)				
Under high school	501(86.8)	76(13.2)	3.02(2.05, 4.45)*	2.04(1.25, 3.09)*
High school and above	135(68.5)	62(31.5)	1	1
Mother's educational status (n=768)				
Under high school	566(85.1)	99(14.9)	3.20(2.03, 5.05)*	1.84(1.10, 3.38)*
High school and above	66(64.1)	37(35.9)	1	1
Father's occupation (n=766)				
Farmer	474(85.1)	83(14.9)	2.09(1.42, 3.07)*	1.2(0.47, 1.44)
Currently employed	153(73.2)	56(26.8)	1	1
Mother's occupation (n=780)				
House wife	452(82.3)	97(17.7)	1.45(0.92,2.27)	1.06(0.51, 1.46)
Farmer	83(90.2)	9(9.8)	2.87(1.30, 6.33)*	1.49(0.63, 3.53)
Currently employed	106(73.3)	33(23.3)	1	1

* Significant at significance level of 0.05.

5.5. Factors Associated with Beliefs in the Continuation of Female Genital Cutting among the High School Girls.

Female students who were from rural areas of the zone were more likely (COR=2.31; 95%CI: 1.05, 5.09) to believe that female genital cutting should continue compared to those who were from the urban areas. Girls who responded that female genital cutting was being practiced in their village had higher odds of believing in its continuity (COR=2.39; 95%CI: 1.14, 5.01) than those who responded that female genital cutting was not being practiced when this study was conducted. Odds of believing in the continuity of FGC were also higher among those who thought that female genital cutting is not harmful (COR=5.75; 95%CI: 2.84, 11.65) and a girl doesn't have the right to say no for circumcision (COR=5.13; 95%CI: 2.68, 9.82) compared to those who thought that female genital cutting is harmful and a girl has the right to say no, respectively.

Multivariate analysis of independent variables in relation to beliefs in the continuation of female genital cutting showed presence of the practice in the area, thinking that FGC is harmful, thinking that a girl has a right not to be cut and the status of circumcision had an impact on belief in the continuation of the practice.

The odds of believing in the continuation of FGC was 2.33(95%CI: 1.01, 5.33) times higher among those who responded that FGC was practiced in their areas. Girls who thought that FGC is not harmful were 4.03(95%CI: 1.89, 8.59) times more likely to believe in the continuation of female genital cutting compared to those who thought that female genital cutting is harmful. Belief in the continuation of female genital cutting was high among high school girls who thought that a girl has no right to say no (AOR= 3.73; 95% CI: 1.81, 7.69). The odd of believing in the continuation of FGC was also 8.22 (95% CI: 1.10, 61.28) higher among circumcised girls compared to uncircumcised ones, but the confidence interval was very wide since the frequency of those who were not cut but believe in the continuation was only one as indicated in table 6.

Table 6: Factors Associated with Beliefs in the continuation of Female Genital Cutting among High School Girls in Hadiya zone, Ethiopia, 2011.

Variables	Belief in continuation		COR(95% CI)	AOR(95% CI)
	Yes	No		
	N (%)	N (%)		
Residence (n=780)				
Urban	8(2.9)	266(97.1)	1	1
Rural	33(6.5)	473(93.5)	2.32(1.05, 5.09)*	1.78(0.37, 1.65)
Grade level (n=780)				
Grade 9	17(5.1)	319(94.9)	1	1
Grade 10	24(5.4)	420(94.6)	1.07(0.56, 2.03)	1.01(0.47, 2.03)
Father's educational status(n=774)				
Under high school	35(6.1)	542(93.9)	2.05(0.85, 4.96)	1.25(0.47, 2.03)
High school and above	6(3.0)	191(97.0)	1	1
Mother's educational status (n=768)				
Under high school	36(5.4)	629(94.6)	1.42(0.43, 2.92)	1.12(0.14, 2.13)
High school and above	5(4.9)	98(95.1)	1	1
FGC is practiced in the area(n=712)				
Yes	28(7.2)	363(92.8)	2.39(1.14, 5.01)*	2.33(1.01, 5.33)*
No	10(3.1)	311(96.9)	1	1
FGC is harmful (n=755)				
Yes	24(3.6)	615(96.4)	1	1
No	14(17.5)	66(82.5)	5.75(2.84, 11.65)*	4.03(1.89, 8.599)*
A girl has right not to be cut(n=768)				
Yes	18(3.0)	588(97.0)	1	1
No	22(13.6)	140(86.4)	5.13(2.68, 9.82)*	3.73(1.81, 7.69)*
FGC status (n=780)				
Yes	40(6.2)	601(93.8)	9.18(1.25, 67.38)**	8.22(1.10, 61.28)**
No	1(0.7)	138(99.3)	1	1

* Significant at significance level of 0.05

** Significant at significance level of 0.05 but with less power.

5.6. Results of Qualitative Data

Focus group discussions with six women, seven influential people and six unmarried men and in-depth interviews with four circumcisers were conducted in the zone.

Practice of FGC

All of the participants and respondents stated that female genital mutilation is commonly practiced in their area to date. They also stated that the practice is performed covertly while there were actions and information from the government bodies to stop it.

An influential community leader from the area stated the practice as:

"Female genital cutting is practiced in our area „lembuda". We have heard information that says circumcision should be stopped but we are still practicing it."

Reasons and Factors

The reasons and factors associated with the persistence of the practice in the area were mostly cultural and hygienic issues. Some of the participants had also mentioned that circumcision is performed to avoid shame and stigma since non-circumcision is against the norm of the community. Decreasing sexual power of the girl was also raised by some.

The Theme, Categories and Codes of the results of qualitative analysis using open code is indicated in Table 7 and the results are then presented based on each category.

Table 7: The Theme, Categories and Codes of Reasons for the Persistence of FGC among High School Girls in Hadiya zone, Ethiopia, 2011.

Theme: FGC is practiced because of culture, shame and stigma, control sexuality and hygienic reasons .					
Categories	Culture	Hygienic	Avoid shame	Avoid stigma	Control sexuality
Codes	Inherited culture Tradition Against norm Devotion Parental pressure Unable to say no	Foul smelling Growing of worms To keep clean Impure	Fear of shame Taboo Be laughed at shameful	Isolation Seen as inferior Fear of stigma Rumor Disgraced	Respect marriage Faithful Restful life Less active Infrequent sex Not waste energy Single partner

1. Respect for the Culture (Table 7)

The majority of the participants mentioned that the practice of female genital cutting is mainly for the respect of the culture. They do it because they see others performing it and their ancestors had been practiced it. Most of them agreed that there is no known benefit for females but they have been practicing it until now.

An old man who is a community leader had indicated the situation as:

"The reason is that it is our culture which has a long history with our people. And people at this time are simply following the tradition."

2. For Hygienic Reasons (Table 7)

Some participants of the focus group discussions and three of the four circumcisers had raised the issue of hygiene that uncircumcised girls would have odor. The circumcisers further mentioned that the tip of clitoris will form a worm unless it is cut.

One of the circumcisers had mentioned:

"Since worms are growing on the genital and causing bad odor parents and their daughters usually ask us to cut the tip of it…."

3. To Avoid Shame (Table 7)

Almost all girls, as stated by the participants do not want to be called "*Lumbutamo" (literally meaning uncut*) in the local language Hadiyissa. Those who are cut may use the word whenever they want to embarrass those who are not cut on the way to school and the village.

A kebele administrator of the area "Hage" participated in the focus group discussion had pointed out the issue as follows:

"I have two daughters (8 and 9 years old) and they will be circumcised unless the culture is stopped and others who are cut stop embarrassing. But, I know that circumcising a girl is an illegal act."

4. To Avoid Stigmatization (Table 7)

An uncircumcised girl can be seen as inferior and friends and neighbors may make rumors against her. This may force the girls to insist to their parents they are circumcised for fear of the stigma.

A woman who was ready to let her daughters‟ undergo circumcision explained the situation as follows:

"I have 8, 10, and 13 years old three daughters and I will let them cut (hopeless face) because of fear of the stigma from their friends and the neighbors. They always raise the issue and asking me to bring the circumcisers."

5. To Control Sexuality (Table 7)

Some of the participants of the focus group discussions reflected that female circumcision is essential to control the sexual activity of girls. Even though most of them didn‟t raise this point during the discussion there was some intentions of agreement after the issue emerged.

A young, unmarried man stated it as follows:

"The use of circumcision is that a circumcised girl becomes honest for her marriage as she doesn't need any additional sexual partner and her husband doesn't waste so much energy as she doesn't want frequent sexual intercourse."

Age and Time of Circumcision

As all indicated, the practice of FGC happens mostly during September and January relating with the Meskel holiday and semester breaks (vacations) of the girls. The appropriate age for circumcision of the females in the area is above 8 years to 15 assuming that a girl knows about it and her body will be strong to tolerate the pain during this age. If there are two or more girls of this age group in the same household, they will be cut at the same time, all may undergo group circumcision.

One of the circumcisers in the in-depth interview responded:

"Females are cut when they are 8 to 15 years. They are not cut in their childhood because their body is not strong enough to resist the pain at that age. It is mostly performed during September and January…"

Decision Makers

Decision for female genital cutting in the area is mainly made by the parents and the girls themselves. Most of the respondents said that the girl has right to say no for circumcision. However, participants of the FGDs with exception of the Kebele administrator and one circumciser considered that circumcising a girl is not illegal.

A young FGD discussant, who is a leader in a local church, indicated the situation as follows:

"Circumcisers perform it based on the decision of the parents and the girls themselves. I do not consider female circumcision is illegal, because the girls themselves are choosing to be cut."

Type of Circumcision and Perception of FGC problems

As all the circumcisers and some of the influential people indicated, the type of circumcision in the area might be a "type I" (Clitoridectomy) category where only the tip of the clitoris is cut off.

Most of the participants of the study had positive attitudes towards stopping FGC in the area and almost all of them had an awareness of some of the problems related to the practice.

An old woman participating in the focus group discussion stated:

"Yes, circumcised females face problems during labor and delivery. We lost mothers and their fetus because of long labor and delivery difficulties. Many mothers also faced cesarean section as their organs could not relax normally."

In addition, a 28 year old unmarried man expressed his view towards the problems of female genital cutting in relation to sexuality the satisfaction as follows:

"...I think that circumcision can decrease love because of less sexual satisfaction. Some women may expect that her husband is not capable of satisfying her and some males also go in search of other females for more enjoyable sex. This will even be dangerous for HIV/AIDS in our area."

Against this point, one of the unmarried men had indicated his point of view as follows:

"I support female genital cutting and I need to marry to circumcised female. This is because circumcision is our culture in one way and circumcised woman will not need sex with different men that means she respect her marriage. So, our culture should continue."

All of those who opposed the continuation of the practice had proposed different methods of intervention to eradicate female genital cutting from Hadiya zone. Most of them indicated that as it is a cultural practice, the awareness should be created on the related problems and attitude of the community should be changed first. As they said this can be achieved by implementing education and training in religious institutions, community gatherings and schools focusing on not only those who are not cut but also the ones who

are cut to stop the stigma. They also stated that parents and community leaders should take responsibility to stop the tradition. Finally, taking legal measures against those who practice the cutting undercover should be started.

A community leader in the focus group discussion pointed out his idea as follows:

"To stop circumcision, first education should be given on the problems of circumcision and benefits of not being cut to all parents, females and circumcisers, then take legal measures."

Taking legal measures against circumcisers was also indicated by some of the participants. But, circumcisers indicated that while they need to stop it, the community is forcing them to perform the cutting and some even may take the issue strongly and become their enemies.

One of the circumcisers expressed his feeling as follows:

"…they always force us, we cannot stop it. We need to live peacefully without suffering our social relation. This is not the only source of income for us, but they come to our house and force us"

6. DISCUSSION

This study attempted to assess the current magnitude and beliefs in the continuation of female genital cutting including the associated factors for the persistence of it among high school girls in Hadiya zone, southern Ethiopia.

The study showed that the prevalence of female genital cutting among high school girls in Hadiya zone was 82.2%. This indicates that despite the efforts made so far, girls in the area are still facing the problem. This figure is very high compared to both national and some other Sub Saurian African countries. For example, the 2005 DSH report indicated that the total prevalence in Ethiopia and SNNPR was 74.3% and 71.0%, respectively [13]. Whereas, the prevalence among the age group of 15-19 years in the whole country was 62.1% [13]. Report of a study from Tanzania also showed that the prevalence among high school leavers was 10% while that of Kenya was 15% among age group of 15-19 years [4, 35]. On the other hand, the prevalence within the same age group in some other African countries was even higher for example 97% in Somalia, 81% in Egypt [4].

A follow-up national survey conducted in 2006 and a base-line study conducted 10 years before that had shown the prevalence of female genital cutting in Hadiya ethnic group as 70.9% and 74.8%, respectively [14]. These were lower than the result found in this study. The difference in the magnitudes may be due to the age group of the samples included and/or the population sampled. The fact that most girls among Hadiya, are circumcised when their age becomes 8 years and above, will affect the estimate as including those below the age of 8 years may result in underestimation of the magnitude.

Results of the focus group discussions and in-depth interviews supported the result from the quantitative data as all the participants and respondents stated that the practice is still ongoing but hidden due to different factors indicated in their area.

From the quantitative data circumcision of girls occurs mostly at the age of nine years. This was also supported by the results from qualitative data where the age for circumcision was mentioned to be 8 to 15 years, considering the girl could know about it and tolerate the pain. But it was a little bit different from other findings which indicated the mean age of

circumcision in Hadiya to be 10-17 years [20], but, there may be variations with different geographic locations [15] and the girls might not remember exact age of their circumcision. In SNNPR, the practice of FGM is carried out at a later age which could cover ranges from 4 years to over 20 years [12]. A study done in eastern Ethiopia showed that there was a variation in age of circumcision with different ethnic groups; where the Adere and the Oromo conduct FGM among women aged from 4 years to puberty and the Amhara on the 8th day after birth [21]. Other studies in Guinea and Khartoum also stated the age variation from 4 to over 14 years and median age of 7 years [36, 37].

The decision to perform FGM was mostly made by parents and the girls themselves as indicated in figure 2. But, nowadays as indicated by the circumcisers and focus group participants, the girls are playing a significant role in insisting to be circumcised due to the stigma associated with being uncircumcised. This is an indication of the cultural pressure from the community, where girls choose to suffer from this brutal practice rather than being rejected by the society. In contrast, other studies indicated most often decision was made by the parents [21, 36, 38].

The main reason for the continuation of the practice, as indicated by the focus group discussions and results of quantitative data, was the cultural factor similar to other studies [24, 27, 39]. This indicates the importance of culture in the continuation of the practice and it supports other studies indicating that tradition and social importance were the main reasons that subject a girl to circumcision [36, 44]. There were also hygiene/cleanliness, avoidance of shame and stigmatization considerations reflected, consistent with other studies [11,19]. The involvement of health professionals in circumcising the girls may also contribute for the continuation as the community might think that it is done for the sake of health, too.

But, the issue of sexuality in this study was presented two opposing ideas. Some related circumcision with decreasing female sexual interest which will at the end help to have a faithful wife, while others were raising points related to sexual dissatisfaction with circumcised women, where a man will look for other women for sexual satisfaction. The former idea is supported by other studies too [40] while a research which was conducted among female students at Delta University, Abraka, Nigeria indicated that the frequency of

sexual intercourse was the same (three times or more a week) for 32% of the circumcised and uncircumcised students [41]. However, the fact that men could not drive sexual satisfaction from circumcised women as reported in this study may be a green light for halting the practice in the coming generation, but on the other hand; men also will be at risk of sexually transmitted infections while in search of satisfaction.

Qualitatively, the opinions of unmarried men towards marrying a circumcised or uncircumcised girl indicated that mostly they intended to marry uncircumcised girls. This may be a good indication of an attitude towards the discontinuation of the practice. It was also indicated by those who intended to marry uncircumcised girls that getting uncircumcised girl from that area in the current generation may be totally very difficult and they indicated that they will end up marring a circumcised girl.

The findings of the study have indicated that being from a rural area was associated with the prevalence of FGC. This was consistent with Ethiopian DSH 2005 [13] where there was a variation in the place of residence. Other studies from different countries have shown that the prevalence is lower in urban community [7, 25]. Grade level had an association with the prevalence of female genital cutting, indicated by the odds of being circumcised being greater among grade 10 female students. This may support a slight decrease in the prevalence through time. However, there is similar age aggregate in batch grade 9 and 10; thus, this study could not differentiate the variation in a significant way. According to a study done in Guinea, the effects of age on female genital cutting was insignificant [36]

Religion had association with the occurrence of female genital cutting in the bivariate analysis though the association was not significant at multivariate level. Other studies also indicated that female genital cutting is not a result of religion and neither the Bible nor the Koran mention FGM as a religious requirement and most faiths including Islam, forbid physical violation of the human body [12, 24]. However, in other studies conducted in Sudan and in Ethiopia, Muslim religion followers were more likely to be circumcised than other religions while shifting from infibulations to *sunni* [12, 44, 45].

Increased education of both parents might contribute to the decrease of the occurrence of female genital cutting. Daughters from parents with educational status below high school level were almost two times more likely to be circumcised compared with those with parental educational status of high school and above where it was consistent with other studies [12, 13, 37, 41].

With regard to our outcome, belief in the continuation, only 5.3% of the respondents of the quantitative study and a few of participants in the focus group discussions and in-depth interview believe in the continuation of the practice. This implies that if any intervention is taken to the community against the continuation of the practice, changes can possibly be achieved.

Residence had significant association with the belief in the continuation of female genital cutting in the bivariate analysis, but it disappeared in the multivariate analysis. This was similar with the results of a study conducted in Guinea, where residence had no association with the belief in the continuation of FGC [22]. But, it was not consistent with a study which was done in eastern Ethiopia which showed that women who resided in rural areas were more likely to be in favor of continuing female genital cutting [23]. There were only 40 Muslim female students participating in the study and none of them supported the continuation of female genital cutting. But there was a difference in the odds of believing in the continuation of FGC as indicated in other research done in Ethiopia. Religion had a significant influence and Muslim women were twice as likely to believe in it continuation [23]. According to the present study, educational status of the parents had no influence on the beliefs of the girls in the continuation of female genital cutting.

The present study also found that being from the villages where female genital cutting is practiced influenced the belief in the continuation of the practice among high school girls. Those who responded that FGC was practiced in their area were 2.33 times more likely to support the continuation compared to those who responded that the practice had stopped. This is supported by the idea of the participants of the focus group discussion that in some areas FGC has stopped but in their area there was no change in the magnitude. So, those from village where FGC is practiced in their village had self-commitment and cultural pressure to believe in its continuation.

Obviously, the effect of thinking that either FGC is harmful or not was highly significant in this study; those who thought that female genital cutting is not harmful were more likely to favor to the continuation of the practice when compared with those who thought that FGC is harmful to the girl who undergoes the process. This was also found in the result of the qualitative study, as one of the circumcisers and some of the participants of the focus group discussions said that FGC is important to the girl stated that it should continue. Similarly, another study also indicated that as the number of perceived advantages of female genital cutting increased the tendency to support the discontinuation of FGC declined [22]. Thinking that a girl has the right to say no for circumcision was also independently associated with the belief in the continuation. Those who thought that a girl has no right to say no to circumcision were at higher odds of believing in the continuation of FGC indicating that it‟s important to create awareness among students on the issues of human rights, including international conventions that condemn harmful practices and the Ethiopian penal code of criminals against female genital cutting [12, 18, 32, 33].

Circumcision status was also found to be associated with the belief in the continuation of the practice both in the bivariate and multivariate analysis with large 95% confidence intervals (AOR=9.18; 95% CI: 1.25, 67.8 and AOR=8.22; 95% CI: 1.10, 61.8, respectively) indicating that the power was weaker. This might be due to the frequency of the girls who are not cut and favor the continuation as it has been shown in table 6 is low. Similar results were obtained in other studies [21, 22, 35].

7. STRENGTHS AND LIMITATIONS OF THE STUDY

7.1.Strengths

- To obtain reliable data and ensure confidentiality, experienced and positively recognized teachers were recruited and trained to instruct the data collection using self administered questionnaire.
- Focus group discussions were facilitated by individuals of the same sex as the participants and who have a social science background and MA students to get better results.
- Using a mixed method study helps to assess the problem from both the youth and the community perspectives in-depth.

7.2.Limitations

- Since it was institution based study, this study could not link the prevalence with specific geographic area of the zone.
- Self-reported information may be subjected to reporting errors, missed values and bias.

8. CONCLUSION AND RECOMMENDATION

8.1. Conclusion

From this study we can conclude that the prevalence of FGM/FGC is still high in Hadiya zone. Culture, stigma and hygiene were the reasons for the continuation of the practice. The information from this study indicated that the girls themselves demand to be circumcised should be handled carefully as they are trying to escape from the shame and stigma because of their uncircumcised position. On the other hand, high parental education (high school and above) and living in the urban areas are factors that will help to decrease the practice of FGC. The presence of the practice in the community, thinking that FGC is an important practice and being circumcised are also contributing factors in supporting the belief in the continuation of the practice.

While most of the community parts including the circumcisers and unmarried men have an urgent need to stop the practice of FGC in the zone, there are social mechanisms and cultural factors sustaining it which deserves serious attention.

8.2. Recommendations

The following recommendations are forwarded based on the main finding of the study:

- Local organizations in collaboration with religious institution and community leaders, should work to support a process of change within the entire community by arranging sensitization programs especially in the rural areas of the zone.

- Efforts should be made to change the attitude and practice of traditional circumcisers as the majority of the process is performed by them and they are well known by the community to be easily identified and used as change agents.

- Persuasion, sensitization and education should be given in elementary schools on Human Rights and the health aspects of FGM to change the attitudes and beliefs of the girls towards the tradition, shame and stigma.

9. REFERENCES

1. WHO: Global Strategy to Stop Health- Care Providers Performing Female Genital mutilation, WHO Document Production Services. Geneva, Switzerland, 2010.
2. WHO: Female Genital Mutilation: A joint WHO/UNICEF/UNFA statement. WHO, Geneva 1997.
3. American Academy of Pediatrics CoB: Female Genital Mutilation. Pediatrics1998; 102:153-6.
4. Population Reference Bureau: Female Genital Mutilation/ Cutting: Data and Trends Update 2010.
5. WHO: Eliminating Female Genital Mutilation: An Interagency Statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO. Geneva, Switzerland 2008.
6. NUICEF: Female Genital Mutilation/Cutting: A Statistical Exploration 2005. New York 2005.
7. Cook R: Female Genital Cutting/Mutilation/Circumcision: Ethical and Legal Dimensions. International Journal of Gynecology and Obstetrics 2002; 79: 281-7.
8. Chelala C: An Alternative Way to Stop Female Genital Mutilation. The Lancet 1998; 352:126.
9. Rymer J: Female Genital Mutilation. Current Obstetrics and Gynecology 2003; 13: 185-90.
10. Morris K: Feature Issues on Female Genital Mutilation/Cutting- Progress and Parallels. Lancet 2006; 368:564-6.
11. Salem A, Shawerby E: Female Genital Cutting. Obstetrics, Gynecology and Reproductive Medicine 2008; 18:9:253-5.
12. Kitaw Y, Hailemeskel F, Dejene A: Old Beyond Imaginings: ETHIOPIA Harmful Traditional Practices. Second ed. Addis Ababa 2008.
13. Central Statistical Agency, ORC Macro: Ethiopia Demographic and Health Survey, 2005. Addis Ababa, Ethiopia, Calvertor, USA 2006.
14. Hailemeskel F, Kitaw Y, Dejene A: Follow-up National Survey on the Harmful Traditional Practices in Ethiopia. Addis Ababa: EGLDAM 2008.

15. WHO: Female genital mutilation: fact sheet, 2001. Report No: 241.
16. WHO: Female Genital Mutilation Info Pack. Geneva 2007.
17. Koso O, Thomas: The Circumcision of Women, a Strategy for Eradication. London and New Jersey: Zed books LTD; 1992.
18. UNICEF: Female Genital Mutilation/ Cutting: Child Protection Information Sheet. New York 2006.
19. Odi A, Brody S, Elkins T: Female Genital Mutilation in Rural Ghana, West Africa. International Journal of Gynecology and Obstetrics 1997; 56:179-80.
20. Willcox S. Cut Flowers: Female Genital Mutilation and a Biblical Response. First ed. Addis Ababa: SIM publishing; 2005.
21. Missalids K, Gebre- Medhin: Female Genital Mutilation in Eastern Ethiopia, The Lancet 2000; 356.
22. Gage J, Rosseni R: Attitudes Towards the Discontinuation of Female Genital Cutting among Men and Women in Guinea. International Journal of Gynecology and Obstetrics 2006; 92:92-6.
23. Saba W, Masho, Matthews L: Factors Determining whether Ethiopian Women Support Continuation of Female Genital Mutilation. International Journal of Gynecology and Obstetrics 2009; 107: 232-5.
24. Figo Committee Report: Female Genital Cutting. International Journal of Gynecology and Obstetrics 2006; 94: 176-7.
25. WHO: Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries. lancet2006; 367:1835-41.
26. WHO: A Systematic Review of the Health Complications of Female Genital Mutilation including Sequel in Childbirth. Geneva 2000.
27. Brisson P, Patel H, Feins N, etal: Female circumcision. J Pediatr Surg 2001;36: 1068-9.
28. Larsen U, Okonofua F: Female Circumcision and Obstetric Complications. International Journal of Gynecology and Obstetrics2002; 77:255-65.
29. Reyners M: Health Consequences of Female Genital Mutilation. Reviews on Gynecological Practice2004; 4:242-51.
30. Mahran M: Medical Risks of Excision. Med Bull IPPF1981; 15:2.

31. Almorth L: Male Complication of Female Genital Mutilation. 2002.
32. WHO: Violence against Women: A Priority Health Issue. Geneva 1997.
33. UNDP: Empowering Women: the Key to Achieving the Millennium Development Goals. 2003.
34. Ministry of Justice: Ethiopian Penal Code of Criminals. Addis Ababa, 1997 E.C.
35. Sia E, Msuya, Elizabeth M, Akhtar H: Female Genital Cutting in Kilimanjaro, Tanzania: Changing Attitude? Tropical medicine and Internal health 2002; 7:156-165.
36. Daman K, David B: Community Based Survey on Female Genital Excision in Farehen District Guinea. Reproductive health matters 2001;9:18.
37. Alia S, Susan E, Hibba B: Prevalence and Determinants of the Practice of Genital Mutilation of Girls in Khartoum, Sudan. Annals of Pediatrics 2006; 26: 303-310.
38. Thewdros Zewude: Prevalence and Determinants of Female Genital Cutting among Primary schools in Addis Ababa. Addis Ababa University 2009.
39. Julie L: Female Circumcision/Female Genital Mutilation. Paediatr adolesc gynecol 2001; 14: 109-112.
40. Susan D, John E, Ebere A: Female Genital Mutilation in Developing Countries: An Agenda for Public Health Response. European Journal of Obstetrics and Gynecology and Reproductive Biology 2004; 116: 144-151
41. Samuel D, Andrew I: Female Mutilation: Implication for Female Sexuality. Women Studies International Forum 2003; 26: 575-580.
42. M.U. Mandara: Female Genital Mutilation in Nigeria. International Journal of Gynecology and Obstetrics 2004; 84: 291-98.
43. Ramzi M, Irene Van: Disentangling Bargaining Power from Individual and Household Level to Institutions: Evidence on Women's Position in Ethiopia. World Development 2010; 38: 783-96.
44. Almroth L, Almroth-Berggren V, Hassanein OM, Hadi NE1, Al-Said SSE, Hasan SSA, Lithell U-B, Bergström S: A Community Based Study on the Change of Practice Female Genital Mutilation in Sudanese Village. International Journal of Gynecology and Obstetrics 2001; 74: 179-185

45. Getnet M, Wagari D: Prevalence and Associated Factors of Female Genital Mutilation among Somali Refugees in Eastern Ethiopia: a Cross-Sectional Study. MBC Public Health 2009; 9:264.

10. ANNEXES

Annex I: Data Collection Format

Data collection format for Addis Ababa University, MPH research project on prevalence and belief in the continuation of Female Genital Mutilation, 2011

Name of the school---------- Code number----------Questionnaire ID-----

Addis Ababa University

Faculty of Medicine, School of Public Health

This is a Questionnaire prepared for the assessment of the practice of female circumcision among high school girls who are found in Hadiya Zone. Before proceeding to fill the Questionnaire, Read the following information and Informed Consent Form.

I. Information sheet

Dear participant!

This study is conducted by Ato Mulugeta Tamire who is the member of AAU school of Public Health Research Team. The main objective of the study is to determine those societal, cultural and religious factors which may have direct or indirect influence on the knowledge and practice of Female Genital Cutting; otherwise it will not have any other mission. In the study we don"t use the name of each participant rather we use our own identification code numbers. During the publication of the study result, we include the general result; otherwise we don"t publish individual information. All information collected will be confidential and will not be handed over to anyone in raw form. You are not obliged to fill this questionnaire without your interest and you do have the right not to participate and the right not to continue completing the questions at any time. However, your participation in the study has a great role for decision-makers who use the results for the future planning of interventions. I will greatly appreciate your co-operation and help in response to this study.

II. Consent form

I, the undersigned have been informed about the purpose of this particular research project and have been informed that the information I give will be used only for the purpose of the study. In addition, I am also informed that my identity as well as the information I will be providing will be kept confidential. Based on this, I agree to participate in the research voluntarily.

Started at---------- Ended at----------

Name of the instructor …….. sign……

If you need any additional information, here is the address of the principal investigator.

Mulugeta Tamire: Mobile-0911805081 e-mail: awonmuller@yahoo.com

Thank you!

A: survey questionnaire for quantitative data

Part I: section on socio-demographic data

S.No.	Questions	Coding categories
101	How old were you at your last birthday?	_____years
102	Where is your origin of residence?	1. Urban 2. Rural
103	What grade are you currently attending?	1. Grade 9 2. Grade 10
104	What is your religion?	1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. No religion 6. Others (specify)_____
105	To which Ethnic group do you belong?	1. Hadiya 2. Kambata 3. Gurage 4. Silte 5. Amhara 6. Others (specify) _____
106	With whom are you living currently?	1. With both parents 2. With father only 3. With mother only 4. With relatives 5. Alone 6. Others(specify)_____

Part II: Back ground information about the parents

S.No.	Questions	Coding categories
201	What is your parents‟ marital status	1. In marital union 2. Divorced 3. Separated 4. Both are died 5. Mother died 6. Father died 99. Do not know
202	What is your father‟s educational status?	1. Illiterate 2. Read and write only 3. 1-8 grade 4. 9-12 grade 5. Diploma and above 99. Do not know
203	What is your mother‟s educational status?	1. Illiterate 2. Read and write only 3. 1-8 grade 4. 9-12 grade 5. Diploma and above 99. Do not know
204	What is your father‟s occupation?	1. Farmer 2. Government employee 3. Private sector 4. No job 5. Others(specify)_____

205	What is your mother‟s occupation?	1. Farmer 2. Government employee 3. Private employee 4. House wife 5. Others(specify)_____

Part III: Knowledge attitude and practice about female genital cutting

S.No.	Questions	Coding categories
301	Is female circumcision practiced in your village currently?	1. Yes 2. No 99. Do not know
302	Do you think that female circumcision is harmful?	1. Yes 2. No 3. Don‟t know
303	Does a female have a right not to be circumcised?	1. Yes 2. No 99. Do not know
304	Are you circumcised?	1. Yes 2. No (**Go to Q316)**
305	How old were you when you were circumcised?	_____
306	Who made the decision that you would be circumcised? **More than one response possible. Circle all that apply.**	1. Father 6. Community leader 2. Mother 7. Religious leader 3. Grandmother 8. Others(specify)__ 4. Aunt 99. Do not know 5. Self
307	Do you support or oppose that you were circumcised?	1. Support 2. Oppose**(Go to Q309**)

308	Why do you support? **More than one response possible. Circle all that apply.**	1. Religious requirement 2. Cleanliness/hygiene 3. Avoidance of promiscuity 4. Respect for culture 5. To avoid shame 6. To avoid stigmatization 7. Preserve virginity 8. Better marriage prospects 9. Pressure from family 10. To avoid difficulty at delivery 11. Other reasons (specify)_____
309	Why do you oppose? **(More than response is possible. circle all that apply.)**	1. Medical/health complications 2. Painful experience 3. Against women‟s rights/dignity 4. Prevents sexual satisfaction 5. Illegal 6. Bad tradition 7. Others (specify)_____
310	Who performed the circumcision?	1. Traditional birth attendant(TBA) 2. Traditional circumciser 3. Traditional circumciser who is also TBA 4. Health professional 5. Grandmother 6. Other relative(specify)_____ 7. Other non-relative(specify)_____ 99. Do not know(**Go to Q312)**
311	What was the sex of the circumciser?	1. Male 2. Female

312	Were you circumcised in group or alone?	1. In a group 2. Alone 99. Do not know
313	Where the circumcision was performed?	1. Own home 2. Another home 3. Home of circumciser 4. Health facility 5. Other (specify)
314	Have you experienced problems as a result of circumcision?	1. Yes 2. No (**Go to Q316)**
315	What problems have you experienced? **More than one response is possible. Circle all that apply.**	1. Pain during healing process 2. Pain during urination 3. Pain during menstruation 4. Pain during intercourse 5. Loss of interest in sex **6.** Others (specify) (**Go to Q316)**
316	Do you believe in the continuation of Female Genital Cutting?	1. Yes 2. No
317	In the last year, have you heard message/information against female genital cutting?	1. Yes 2. No **(Go to Q319)**
318	Who made the public pledge? **More than one response is possible circle all that apply.**	1. Community leader 2. Religious leader 3. Women‟s leader 4. Family member 5. Health profession 6. Charity association 7. Others(specify) _____

319	What intervention should be taken to eliminate female genital cutting? **More than one response is possible circle all that apply.**	1. Education through educational institution 2. Education through health institution 3. Education through mass media 4. Education through religious institution 5. Strengthen community participation 6. Take legal measure 7. Educating the circumcisers 8. Educating through circumcised females 9. Other employment for circumcisers 10. Others(specify)_____

B: Survey questionnaire for quantitative data (Amharic)

1. **<u>መጠይቅ</u>**

የ ትምህርት ቤቱ ስም----------የ ት/ቤቱ መለያ ቁጥር --------- የ መጠይቁ ሚላያ ቁጥር -- ---------

<u>በአዲስ አበባ ዩኒቨርሲቲ</u>

<u>የ ሕዝረተሰብ ጤና ትምህርት ቤት</u>

በሀዲያ ዞን በሚ ኙ የ ሀለተኛ ደረጃ ት/ቤቶች ወስጥ በሚሙ ሴት ተማሪዎች ላይ በሴት ልጅ ግርዛት ዙሪያ የ ሚደረጉ ወሳኝ ሁኔታዎችን ለ ማወቅ የ ተዘ ጋጀ መጠይቅ፡ ፡

1. **<u>ለ ጥናቱ ተሳ ታፊዎች አጠቃላይ ሚ ጃ</u>**

ይህ ጥናት በሴት ልጅ ግርዛት ላይ የ ሚ ተኩር ሲሆን ጥናቱን የ ሚ ካሂዱት በአዲስ አበባ ዩኒቨርስቲ የ ደህረ ምረቃ ጥናት ቡድን አ ባል የ ሆኑት አቶ መኡጌታ ታምሬ ና ቸው፡ ፡ ጥናቱ በሴቶች ግርዛት ዙሪያ የ ሚ ከናወኑ ማህበራዊ፣ ባህላዊና ሃ ይማኖታዊ እምነቶችና ክ ንውኖች ላይ ያሉ ተጨ ማሪ ሁኔታዎችን ከ ማወቅ ባለፈ ሌላ ምን ም አይነት አላማ ተልዕኮ የ ሌለው መሆኑን አረጋግጥ ለታለሁ፡ ፡ በተጨ ማሪም በዚህ ጥናት እያንዳንዱ ተሳ ታፊ ለ መለየት መለያ ቁጥር እን ጂ ስም የ ማን ጠቀም ሲሆን የ ጥናቱ ወጤትም ሲታተም የ ጥናቱ ተሳ ታፊዎች ጥቅል መረጃ እን ጂ የ ተናጥል መረጃ አይታተምም፡ ፡ እርስዎም የ ሚሰጡ ማን ኛውም መረጃ ሚ ስጥራዊነቱ በከፍተኛ ሁኔታ የ ተጠበቀ ነ ው፡ ፡ መጠይቁን መመላት በፈ ቃደኝነት ላይ የ ተመሰረተ ሲሆን እርስዎ በጥናቱ ወስጥ የ መሳተፍም ሆነ ያለመሳተፍ እንዲሁም የ መቃወም መቦትዎ በማን ኛውም ሰዓት የ ተጠበቀ ነ ው፡ ፡ ሆኖም ግን የ እርስዎ ተሳትፎ ጥናቱን ለ ማሟላትና ለ መቀጠል ከጥናቱ በሚ ኘው ወጤት የ ሴት ልጅ ግርዛት ዙሪያ የ ሚሰሩ የ ጠፍ ፕሮግራሞች ላይ የ ተሻለ የ ጠፍ እቅድን ለ መቀየስ አ ስፈላጊ ነ ው፡ ፡ በእውነቱ ስለ ትብብርዎና ለጥናቱ ስለ ሚ ደርጉት አ ስተዋጽኦ በጣ ም ላመሰ ግንዎት እ ወዳለሁ፡ ፡

ተጨ ማሪ መረጃ ቢያ ስፈልግዎት በ ሚቀጥለው አ ድራሻ መጠቀም ይችላሉ፡ ፡ 0911 80 50 81 ወይም በኢ-ሜይል awonmuller@yahoo.com

2. <u>የ ጥናቱ ተሳታፊዎች የ ስምምነ ት መግለጫ ወፅ</u>

ከዚህ በታች በፊርማ ተጠቃሹ ግለሰብ ስለጥናቱ አላማ በሚ ባ ተረድቻለሁ፡ ፡ በምሰጠው መረጃም ተግባር ብቻ እንደሚውልና በምሰጠውመረጃም ሆነ ማንነ ቴ በሚስጥር እንደሚጠበቅ ተረድቻለሁ፡ ፡ በዚህ ማስረት በፍቃደኝነ ት በጥናቱ ለመሳተፍ ተስማምቻለሁ፡ ፡

የ ተጀመረበት ጊዜ ---------- ያለቀበት ጊዜ ----------

የ ሱፐርቫይዘር ስም---------- ፊርማ----------

አመሰግናለሁ!!

ንዑስ ክፍል 1 ማህበራዊና ስነ -ህዝባዊ ገጽታዎች

ተ.ቁ	ጥያቄዎች	ቁጥሩ ላይ በማክበር ያመልክቱ
101	እድሜዎ ስንት ነው?	---------- ዓመት
102	ቋሚ መኖሪያዎ የት ነው?	1. ከተማ 2. ገጠር
103	በዚህ ዓመት የስንተኛ ክፍል ተማሪ ነዎት?	1. 9ኛ ክፍል 2. 10 ክፍል
104	ሃይማኖትዎ ምንድነው?	1. አርቶዶክስ 2. ሙስሊም 3. ፕሮቴስታንት 4. ካቶሊክ 5. ሃይማኖት የለኝም 6. ሌላ (ይጠቀስ) --------
105	የእርስዎ ብሔር ወይም ብሔረሰብ ከሚከተሉት ውስጥ የትኛውነው?	1. ሀዲያ 2. ከንባታ 3. ጉራጌ 4. ስልጤ 5. አማራ 6. ሌላ /ይጠቀስ/ --------
106	በአሁን ጊዜ ከማን ጋር ነውየሚኖሩት?	1. ከአባት ጋር 2. ከእናት ጋር 3. ከአባትና ከእናት ጋር 4. ከዘመድ ጋር 5. ለብቻ 6. ከሌላ ጋር (ይጠቀስ) ------

ግብርና ንዑስ ክፍል 2 የ ወላጆችን ሁኔታ የ ሚመለከቱ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	ቁጥሩ ላይ በ ማክበር ያመልክቱ
201	በ አሁን ጊዜ የ ወላጆችዎ የ ጋብቻ ሁኔታ ምን ይመስላል?	1. በ ጋብቻ አንድ ላይ ይኖራሉ 2. ተፋተዋል 3. አባቴ በ ህይወት የ ለም 4. እናቴ በ ህይወት የ ለችም 5. ሁለቱም በ ሕይወት የ ሉም 6. አላ ውቅ ም
202	ወላጅ አባትዎ የ ትምህርት ደረጃ?	1. ምን ም አልተማሩ ም 2. መጻ ፍና ማን በ ብ ብቻ ይችላ ሉ 3. ከ 1ኛ -8ኛ 4. ከ 9ኛ -12ኛ 5. ኮሌጅና ዩ ኒ ቨ ር ሲቲ 6. አላ ውቅ ም
203	ወላጅ እናትዎ የ ትምህርት ደረጃ?	1. ምን ም አልተማሩ ም 2. መጻ ፍና ማን በ ብ ብቻ ይችላ ሉ 3. ከ 1ኛ -8ኛ 4. ከ 9ኛ -12ኛ 5. ኮሌጅና ዩ ኒ ቨ ር ስ ቲ 6. አላ ውቅ ም
204	የ ወላጅ አባትዎ ቋሚ ሙ ተዳ ደሪ ያ ሥራ ቸው ምን ድነ ው?	1. ግብር ና 2. የ መን ግስ ት ሥራ 3. የ ግል ስ ራ 4. ስ ራ የ ላ ቸ ውም 5. ሌላ ካለ /ይ ጠ ቀ ስ / ---------

205	የ ወላ ጅ እ ና ትዎ ቋሚሙተዳደሪ ያ ስ ራቸው ምን ድን ነ ው?	1. ግ ብር ና 2. የ መን ግ ስ ት ስ ራ 3. የ ግ ል ስ ራ 4. የ ቤት እ መቤ ት 5. ሌላ ካ ለ /ይ ጠቀ ስ / ---------

ን ዑስ ክ ፍል 3 በ ሴት ል ጅ ግ ር ዛ ት ዙ ሪ ያ ጠቅ ለ ል ያ ለ ጥ ያ ቄ

ተ.ቁ	ጥ ያ ቄ ዎ ች	ቁ ጥ ሩ ላ ይ በ ማ ክ በ ር ያ መ ል ክ ቱ
301	በ እ ር ስ ዎ አ ካ ባ ቢ በ አ ሁ ን ጊ ዜ ሴ ት ል ጆ ች ይ ገ ረ ዛ ሉ?	1. አ ዎ 2. አ ይ ደ ለ ም 3. አ ላ ወ ቅ ም
302	የ ሴ ት ል ጅ ግ ር ዛ ት ጎ ጂ ተ ግ ባ ር ነ ው ብ ለ ው ያ ስ ባ ሉ?	1. አ ዎ 2. አ ይ ደ ለ ም 3. አ ላ ወ ቅ ም
303	ሴ ት ል ጅ ያ ለ መ ገ ረ ዝ መ ብ ት አ ላ ት ብ ለ ው ያ ስ ባ ሉ?	1. አ ዎ 2. አ ይ ደ ለ ም 3. አ ላ ወ ቅ ም
304	እ ር ስ ዎ ስ ተ ገ ረ ዘ ዋ ል?	1. አ ዎ 2. አ ይ ደ ለ ም **(ወ ደ ጥ. 316 ይ ለ ፉ)**
305	**ለ ተ ገ ረ ዙ ሴ ቶ ች ብ ቻ** በ ስ ን ት አ መ ት ዎ ተ ገ ረ ዙ?	---------- ዓ መ ት

306	እርስዎ እንዲገረዙ የወሰኑ ውሳን ነበር? **(ከአንድ በላይ መልስ ይቻላል፡ ፡ የሚመለከትዎትን ሁሉ ያክብቡ)**	1. አባቴ 6. የጎሳ መሪ 2. እናቴ 7. የሃይማኖት መሪ 3. አያቴ 8. ሌላ /ይጠቀስ ------ 4. አክስቴ 9. አላውቅም 5. እራሴ
307	እርስዎ መገረዞን ይደግፋሉ ወይስ ይቃወማሉ?	1. እደግፋለው 2. እቃወማለሁ **(ወደ ጥ. 309 ይለፉ)**
308	የሚደግፉት በምን ምክንያት ነው? **(ከአንድ በላይ መልስ ይቻላል፡ ፡ የሚመለከትዎትን ሁሉ ያክብቡ)**	1.ለሃይማኖት ግዴታ 2. ለንጽህና ስለሚጠቅም 3. የወሲብ ፍላጎት እንዲቀንስ 4. ባህልን ለመጠበቅ 5. የሴቶችን ክብር ለመጠበቅ 6. ከህብረሰተብ ላለመገለል 7. ክብረ ንጽህናን ለማቆየት 8. ባል ላለማጣት 9. በቤተሰብ ግፊት 10. በወሊድ ጊዜ ችግር እንዳይፈጥር 11. ሌላ (ይጠቀስ) ----------
309	የሚቃወሙት በምን ምክንያት ነው? **(ከአንድ በላይ መልስ ይቻላል፡ ፡ የሚመለከትዎትን ሁሉ ያክብቡ)**	1. የጤና ጉዳት ስለሚያስከትል 2. ሕመም ስላለው 3. የሴት ልጅን መብት ስለሚጸረን 4. የወሲብ እርካታን ስለሚያሳጣ 5. ሕገ -ወጥ ስለሆነ 6. ጎጂ ባህል ስለሆነ 7. ሌላ ካለ /ይጠቀስ /---------

310	የ ግ ር ዛ ት ተ ግ ባ ር የ ፈ ጸ መ ው ማ ን ነ በ ር ?	1. የ ባ ህ ል አ ዋ ላ ጅ 2. የ ባ ህ ል ገ ራ ዥ 3. የ ባ ህ ል አ ዋ ል ጅ የ ሆ ኑ ገ ራ ዥ 4. የ ጤ ና ባ ለ ሙ ያ 5. ሴ ት አ ያ ቴ 6. ሌ ላ ዘ መ ድ (ይ ጠ ቀ ስ) ---- 7. ሌ ላ ዘ መ ድ ያ ል ሆ ነ (ይ ጠ ቀ ስ)---- 8. አ ላ ወ ቅ ም **(ወ ደ ጥ . 312 ይ ለ ፉ)**
311	የ ገ ረ ዘ ዎ ት ሰ ው ጸ ታ?	1. ወ ን ድ 2. ሴ ት
312	የ ተ ገ ረ ዙ ት ለ ብ ቻ ዎ ነ በ ር ወ ይ ስ በ ህ ብ ረ ት ሎ ሌ ች ም ነ በ ሩ ?	1. ህ ብ ረ ት 2. ለ ብ ቻ 3. አ ላ ወ ቅ ም
313	የ ት ነ በ ር የ ተ ገ ረ ዙ ት ?	1. በ እ ር ሶ መ ኖ ሪ ያ ቤ ት 2. በ ሌ ላ ሰ ው መ ኖ ሪ ያ ቤ ት 3. በ ገ ራ ዥ መ ኖ ሪ ያ ቤ ት 4. በ ጤ ና ተ ቋ ም 5. በ ሌ ላ (ይ ጠ ቀ ስ) -------
314	በ መ ግ ረ ዝ ዎ ም ክ ኒ ያ ት ያ ጋ ጠ ም ዎ ት ች ግ ር ነ በ ር ?	1. አ ዎ 2. አ ይ ደ ለ ም **(ወ ደ ጥ . 316 ይ ለ ፉ)**
315	ም ን አ ይ ነ ት ች ግ ር ነ በ ር ያ ጋ ጠ ም ዎ ት ? **(ከ አ ን ድ በ ላ ይ መ ል ስ ይ ቻ ላ ል ፡ ፡ የ ሚ መ ለ ከ ት ዎ ት ን ሁ ሉ ያ ክ ብ ቡ)**	1. ቁ ስ ሉ ሲ ድ ን የ ነ በ ረ ው ህ መ ም 2. በ መ ሸ ና ት ጊ ዜ የ ነ በ ረ ው ህ መ ም 3. በ ወ ር አ በ ባ ጊ ዜ የ ነ በ ረ ው ህ መ ም 4. በ ወ ሲ ብ ጊ ዜ የ ነ በ ረ ው ህ መ ም 5. የ ወ ሲ ብ ፍ ላ ጎ ት መ ቀ ነ ስ 6. ሌ ላ (ይ ጠ ቀ ስ)..... **(ወ ደ ጥ . 316 ይ ለ ፉ)**
316	ለ ወ ደ ፊ ት የ ሴ ት ል ጅ ግ ር ዛ ት መ ቀ ጠ ል አ ለ በ ት ብ ለ ው ያ ም ና ሉ ?	1. አ ዎ 2. አ ይ ደ ለ ም

317	በባለፈው አመት ውስጥ የሴት ልጅ ግርዛትን የሚቃወመው ትምህርት ወይም መልዕክት ሰምተዋል?	1. አዎ 2. አይደለም **(ወደ ጥ. 319 ይለፉ)**
318	ማን ነበር ያስተማረው/መልክእክቱን ያስተላለፈው? **(ከአንድ በላይ መልስ ይቻላል፡ ፡ የሚመለከትዎትን ሁሉ ያክብቡ)**	1. የጎሳ መሪ 2. የሃይማኖት መሪ 3. የሴቶች መሪ 4. ቤተሰብ 5. የጤና ባለሙያ 6. መገናኛ ብዙሃን 7. መንግስታዊ ያልሆኑ ድርጅቶች 8. ሌላ (ይጠቀስ) ----------
319	የሴት ልጅ ግርዛትን ለማስወገድ ወይም ለማጥፋት ምን መደረግ አለበት ብለው ያምናሉ? **(ከአንድ በላይ መልስ ይቻላል፡ ፡ የሚመለከትዎትን ሁሉ ያክብቡ)**	1. ትምህርት ቤቶች ውስጥ ትምህርት መስጠት 2. በጤና ተቋማት ውስጥ ትምህርት መስጠት 3. በመገናኛ ብዙሃን /ሬድዮና ቴሌቭዥን ትምህርት መስጠት 4. በሃይማኖት ተቋማት ትምህርት መስጠት 5. ሕብረተሰቡን መቀስቀስ 6. ሕጋዊ እርምጃ መውሰድ 7. ግርዛት የሚፈጽሙሰዎችን ማስተማር 8. ድርጊቱ በተፈጸመባቸው ሴቶች ትምህርት መስጠት 9. በግርዛት ስራ ለሚተዳደሩ ተለዋጭ ስራ መስጠት 10. ሌላ (ይጠቀስ)--------

አመሰግናለሁ!!

C: FGD GUIDES

1. FGD guide for mothers

Situation of female circumcision in the area

a. Is there female genital cutting in the area currently?
   If yes,…is the magnitude increasing or decreasing?
   Who is affected?
   At what age and season?
   Why at this age and season?
   How was it performed (group/individual)
   Who does?
   Who made the decision?
b. What are the major factors that can influence the attitude of people for performing female circumcision?
c. Do you believe the practice is important?
   Why?
   Why not?
d. Do you think that circumcised females face some problems?
   If yes, what type?
e. Do you want the practice to continue?
   Why?
   Why not?
f. Does anyone of you have a daughter who is not circumcised?
   Age?
   Would you circumcise later?
   Why/ why not?
g. Do the community hide it (do hidden)
h. Suggest the points of entry for stopping the practice if you believe in stopping the practice.
i. If you need to give or suggest any comment on the practice of FGC, you are welcomed.

Thank you for participating on the discussion!

2. FGD guide for influential people

Situation of female circumcision in the area

a. Is there female genital cutting in the area currently?
   If yes, is the magnitude increasing or decreasing?
   Who is affected?
   At what age and season?
   Why at this age and season?
   How was it performed (group/individual)
   Who does?
   Who made the decision?
b. What are the major factors that can influence the attitude of people for performing female circumcision?
c. Is there any requirement of the practice by your religion or culture?
d. Do you believe the practice is important?
   Why?
   Why not?
e. Do you want the practice to continue?
   Why?
   Why not?
f. Does anyone of you have a daughter who is not circumcised?
   If yes, Age?
   Would you circumcise later?
   Why/ why not?
   Is your last daughter circumcised?
   If no, would you like to circumcise?
g. Do the community tend to hide it (do hidden)
h. Is circumcising a girl crime or not?
i. Is a girl has right not to be circumcised?
j. Suggest the points of entry for stopping the practice if you believe in stopping the practice.
k. If you need to give or suggest any comment on the practice of FGC, you are welcomed.
   Thank you for participating on the discussion!

3. **FGD guide for unmarried males**
   a. Is female circumcision currently practiced in your area?
   b. Do you support or oppose the continuity of it?
      Why? Why not?
   c. Does female circumcision have any benefit for men?
   d. Are you willing to marry to uncircumcised female?
   e. Suggest the points of entry for stopping the practice if you believe in stopping the practice?

      Thank you for your participation!

4. **In-depth interview guide for circumcisers**

   a. Is female circumcision is practiced in your community by now?
   b. How is the magnitude increasing or decreasing?
   c. At what age and season is circumcision practiced?
   d. Have you ever circumcised a girl?
      If yes, how frequent? - per week, per month, per year?
      Where do you do the circumcision (area and place of circumcision?)
      At what age and season do you circumcise?
   e. Who made the decision?
   f. Do the community tend to hide(do hidden)
   g. What type of circumcision or process of cutting?
   h. Would you like to continue on it or not?
      Why or why not?
   i. Is circumcision is a source of income for you?
      If yes, is it the only source?
   j. Have you ever heard or been told that circumcision is crime?
   k. What should be done to stop female circumcision?
   l. Any additional points or comments?

      Thank you for the participation!

D: Profile of participants of FGD

1. Mothers

S.no.	Code	Age	Kebele	Status
1	P1	53	Hage	House wife
2	P2	40	Hage	House wife
3	P3	36	Lambuda	Farmer
4	P4	48	Lambuda	House wife
5	P5	38	Abushura	House wife
6	P6	37	Abushura	House wife

2. Influential people

S. no.	Code	Age	Kebele	Status
1	P1	52	Hage	Church leader
2	P2	66	Hage	Community leader
3	P3	70	Abushura	Community leader
4	P4	42	Abushura	Church leader
5	P5	43	Lambuda	School principal
6	P6	40	Hage	Kebele administrator
7	P7	65	Lambuda	Community leader

3. Unmarried males

S.no.	Code	Age	Kebele	Status
1	P1	28	Hage	Farmer
2	P2	25	Hage	Student
3	P3	30	Abushura	Farmer
4	P4	23	Abushura	Student
5	P5	20	Lambuda	Student
6	P6	32	Lambuda	Farmer

4. Circumcisers

s.no.	Code	Age	Kebele
1	I1	69	Lambuda
2	I2	50	Lambuda
3	I3	55	Abushura
4	I4	52	Ashwala

Declaration

I, the undersigned, declare that this thesis is my own original work and has not been submitted or presented for any award elsewhere. All the sources of materials used for the thesis have been fully acknowledged.

Name _____

Signature _____

Date _____

This thesis work has been submitted for the examination with my approval as a University advisor.

Name _____

Signature _____

Date _____