ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCE

SCHOOL OF PUBLIC HEALTH

Assessment of prevalence and associated factors with female genital cutting among young adult female students in Jigjiga District, Somali Region, Ethiopia

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A thesis to be submitted to the School of Public Health, College of Health Science, Addis Ababa University as partial fulfillment of the requirements for the Degree of Master of Public Health in Epidemiology

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List of acronym/abbreviation

EDHS	Ethiopian Demographic and Health Survey
EGLDAM	Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber
FGD	Focus Group Discussion
FGM/C	Female Genital Mutilation/cutting
HEW	Health Extension Workers
ICPD	International Conference on Population and Development
MDG	Millennium Development Goal
NGO	Non Governmental Organization
PSU	Primary Sampling Unit
RTI	Reproductive Tract Infection
SNRS	Somali National Regional State
SPH	School of Public Health
SSU	Secondary Sampling Unit
TSU	Tertiary Sampling Unit
UNICEF	United Nations Children's Fund
WHO	World health organization

Abstract

Introduction: Female Genital Cutting (FGC) is a harmful traditional practice detrimental to the sexual and reproductive health of girls/women which is a common practice in most developing countries of the world. It is a very common practice in Ethiopia, particularly in Somali region; it is commonly being practiced since generations and it seems to be almost universal in the region. Following this ,the study was aimed to assess the prevalence and factors associated with female genital cutting.

Objective: To assess prevalence and associated factors with FGC in Jigjiga district.

Methods: School based cross-sectional mixed method combining both quantitative and qualitative research method was conducted among 679 randomly selected young adult female students from high school and college in Jigjiga district from Feb-mar2012. For the quantitative study, a multistage sampling technique was employed to select study subjects and a pretested structured questionnaire was used to collect data. The qualitative data were collected using FGDs and four FGD discussions were conducted using non directive open ended questions. Epi Info version3.5.3 was used for data entry and SPSS versions17 for data analysis. Open Code was used to analyze the qualitative data.

Results: This study revealed that the prevalence of FGC among the respondents and their youngest sister were 82.6% and 81.1% respectively. The dominant form of cutting was Type I, 265(49.3%) in the study area. Majority of girls, 575 (88.3%) and 407(62.7%) had good knowledge towards the bad effect of FGC and had positive attitude towards FGC discontinuation respectively. Religion(AOR=3.7;95%CI:1.1-12), residence (AOR=4;95%CI=2.4-6.8), respondents' educational level (AOR=0.5; 95%CI:0.3-0.8), maternal education (AOR=2.4;95%CI:1.3-4.3), attitude (AOR=0.5;95%CI:0.3-0.9)and religious requirement (AOR=1.7;95%CI=1.07-2.8) were the most significant predictors of FGC. The possible reasons for FGC practice were to keep virginity, to improve social acceptance, to have better marriage prospects, religious approval, and to have hygiene.

Conclusion and recommendation: Despite girl's knowledge and attitude towards the bad effect of FGC, the prevalence of FGC was still high. The direct and indirect effect of FGC on violation human rights of girls/women may seriously affect the effort made towards realization of empowering women and gender equity. There should be a concerted effort among women, men, religious leader and other concerned bodies in understanding and clarification of the wrong attachment between the practice and religion through behavioural change communication and advocacy at all levels.

1. Introduction

1.1. Background

Female genital mutilation/cutting (FGM/C) is any traditional surgical modification of the female genitalia, comprising all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non therapeutic reasons. It is estimated that from about 130 to 140 million women in the world have been circumcised. An average of about four girls a minute continue to be mutilated (1-5).

Laws and policies on anti-FGM/C are in place in almost every country in the world. The fight against FGM/C contributes to the achievement of MDG in 2015. Then we can effectively address abatement of the consequences that female circumcision poses to the health of these women and possibly eliminate it from future generations (6-8).

FGM/C is associated with a series of health risks and many consequences mainly during the procedure, girls are subject to violent pain, severe bleeding and, in many cases, shock and risk of HIV/AIDS infection. During puberty, many mutilated girls suffer from menstrual blood retention and predisposing girls to infection and further complications. Longer-term complications include fistula, repeated UTI, scars which may open during childbirth and which can lead to severe hemorrhage, obstructed menstrual flow, RTI and reduced fertility (15, 16).

According to EDHS 2005, FGM is common among Ethiopian women and more than 50% of female young adult women are circumcised. The report shows that 74.3% nationally, 27.1% in Gambella region to 97.3% in Somali region, and more than 50% in Addis Ababa (9-11).FGM is widespread both among in Muslim and Christian populations in Somali region. Following the magnitude of the problem, the Government of Ethiopia has launched educational programs 20 Years ago in consultation with traditional community associations and local healers. Similarly, different NGO and Embassies and regional government has been implementing different intervention programs in Somali Region (11, 12).

1.2. Rational of the study

According to some studies, the prevalence of FGM in Ethiopia, and in Somali region is very high. Considering the magnitude of the problem, government and non-government organization have started the anti-FGM campaign in Somali Region. Due to lack of published research on the status of FGM in the region, this study was conducted to assess the current status of FGM/C prevalence and to identify possible reasons and factors associated with practice. The result of the study will help to assess the impact of intervention ever made and also the study will be used as area specific baseline information to evaluate and monitor future interventions. At the same time it is important for health planners and decision makers of the region to visualize the current status of the problem and modify any possible intervention activities in order to improve the quality of life and sexual reproductive life of girls and women.

2. Literature Review

2.1 Prevalence of Female Genital Mutilation/Cutting

Worldwide about 3 million girls are at risk of undergoing female genital mutilation/cutting (FGM/C) and 130 to 140 million girls and women are currently living with its consequences. An average of about four girls a minute continue to be mutilated. In Africa it is estimated that 92 million girls 10 years old and above have had undergone FGM/C. FGM/C is practiced in about 28 African countries, the Middle East and South East Asia. Most women who have experienced FGM live in one of the 28 countries in Africa, nearly half of them in just two countries: Egypt and Ethiopia. Women and girls who have undergone FGM/C are also found in Europe, Canada, USA and Australia because of the increasing movement of communities and individuals between countries. Estimated prevalence of FGM/C in 28 countries across Africa ranged from 98% in Somalia to less than 1% in Uganda (13, 14).

FGM is mostly carried out on girls between the ages of few days old and 15 years. However, occasionally, adult and married women are also subjected to the procedure. The age at which FGM is performed varies with local traditions and circumstances, but is decreasing in some countries (7).

Recent figures for African countries show a prevalence of FGM/C of more than 70% in Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, Guinea, Mali, Mauritania, Northern Sudan, Sierra Leone, and Somalia. However, there is considerable variation in prevalence between and within countries, reflecting ethnicity and tradition (16).

W.H.O. has classified FGM operation into four types. Type I (Sunna) involves the partial or total removal of the clitoris. Type II (intermediate FGM") refers to partial or total removal of the clitoris together with partial or total excision of the labia minora. Type III (infibulation) is partial or total removal of the external genitalia and stitching or narrowing of the vaginal opening. Type IV is relatively rare and refers to any genital surgeries such as pricking or stretching the clitoris and/or surrounding tissues (17, 18).

School based cross-sectional study was done in Egypt in 2008; and the study shows that the overall prevalence rate of FGC was 50.3% among girls in the age group 10–18 years. In rural schools, the prevalence rate was 61.7% compared to 46.2% in urban schools. Of note, in private urban schools the prevalence rate was very low (9.2%)(19, 20).

A cross-sectional study was conducted among 492 respondents sampled from three refugee camps in Somali Regional State, to determine the prevalence and associated factors of FGC and it showed that the intention of the parents to circumcise their daughters was high (84%), 42.4% of 288 ≤12 girls were reported being undergone FGC and the prevalence increased with age, and about 52% and 95% were circumcised at the age of 7–8 and 11–12 years, respectively. Participation of the parents in anti-FGC interventions was statistically associated with lower practice and intention of the procedures (4).

FGM is practiced throughout Ethiopia and affects all but few ethnic groups**.** 74-85% Ethiopian women 15-49 years have undergone some form of FGM; in Somali region, 97.3% 27.1% in the Gambella region, and to more than 50% in Addis Ababa of women 15-49 years experience FGC according to the report from EDHS 2005(12). Almost 100% prevalence rate was reported for the Somali Regional State in EDHS 2000 (21, 22).
According to the 2005 EDHS report three in four Ethiopian women (74 percent) have been circumcised. The practice was low in the younger age group, 62 % of women age 15-19 compared with more than 80 % of women age 35 and above. Rural and less-educated women were more likely to have their daughters circumcised. Mothers' educational level appeared to influence the likelihood of a daughter being circumcised, 41 % of the daughters of mothers without formal education are circumcised, compared to 19% of daughters of women with at least some secondary education (11, 21, 23, 24).

The overall prevalence of FGM in Somali and Afar regions decrease negatively(there is almost no decrease) and the prevalence and age at mutilation in Somali region varies by zone mainly the highest and lowest prevalence rate is documented in Goode (83.5%) and shinele (60.3) zones respectively. Currently over 75% of the women in Somali, above the age of 15 years are circumcised .the lower prevalence rate observed for those under 15 years is mainly due to age at circumcision in different zones since ,in some areas , girls are circumcised between four years and 15 years of age (24).

2.2. Attitude and knowledge related with practice of FGC/M

A report from Kenya released by the Office of the Senior Coordinator for International Women's Issues indicate that among the groups that practice FGM/C, it is universally thought that the procedure benefits girls. There is widespread belief among those who practice it, that ancestors will curse girls who have not undergone the procedure. Mothers and grandmothers are the most influential persons to determine if girls undergo one of these procedures. Supporters argue that tradition is necessary both to the social fabric and to the maturation of girls. Many believe that it reduces female promiscuity, ensuring virginity and fidelity (26).

According to the Sudan DHS 2005, 79 % of the women in the age group 15-49 were in favour of upholding the custom. No major differences were recorded in the answers from urban or rural populations; 70% of the urban respondents were in favour, as were approximately 80 percent of the rural respondents. However, indicators such as level of education gave a far greater variation in attitudes toward FGM. 80 percent of the women who had primary or no schooling were in favour of upholding the practice. Meanwhile, only 40 percent of the women who held upper secondary or higher education shared this opinion (38).

In Ethiopia, between 2000 and 2005 attitudes towards FGM/C have dramatically changed and the prevalence of women who Support FGM/C has declined in Ethiopia, from 60 % in 2000 to 31 % in 2005. Similar study in Oromia region among 2221 women showed that 63.7% of women favored the discontinuation of FGC, while 29.7% favored its continuation. Educational level, FGC experience & religious affiliation were factors significantly associated with favoring discontinuation of the practice ,and according the EDHS2005, rural residents, Muslim, married ,uneducated and to have had no exposure to mass media (11, 23).

This decline has not followed the same pattern across the country: the level of support for FGM/C dropped from 70 % 30 %in the Oromia region and from 60%to 36 %in the SNNPR region, only minor changes occurred in the Somali and Tigray regions (25).

A study in kebribeiah indicated that Knowledge of mothers on the possible health consequences that female genital cutting posses to a women or a girl were assessed and 488(61.6%) were knowledgeable about health complications and 308(38.4%) were knowledgeable. About 651(82.2 %) knew that female genital cutting can transmit HIV, 671(84.7%) can cause severe pain, 540(68.2%) can cause infection, 527(66.5%) can cause sexual dissatisfaction for the women, 632(79.8%) can cause difficult delivery, 738(93.2%) can cause excessive bleeding and 576(72.7%) knew that it can cause menstrual disturbance (23)

2.3. Reasons why FGM is carried out.

There are many reasons for the practice of FGM, and it is often described as a means to safeguard against premarital sexual activity, prevent female promiscuity and preserve virginity, religious or health reasons, hygienic grounds, for the sake of tradition or ethnic interests, and for socio-economic or gender-related reasons (27, 28).

According to the Ye Ethiopia Goji Limadawi Dirgitoch Aswogaj Mahiber (EGLDAM.) 2009 report for Somali indicate that the most pervasive reasons are avoidance of trouble to husband, respect for tradition, to control women's reaction/emotion, to avoid difficulty at delivery, to get a husband, religious requirement and hygienic reasons with the worst type of FGM, infibulations, is performed in Somali region. There is a minor change in attitude and knowledge for the last five years; however the change in attitude and knowledge is not matched by changes in prevalence (24).

2.4. Where, by whom, and when FGM is performed.

The large majority of girls and women are cut by a traditional practitioner, a category which includes local specialists (cutters or excise user), and traditional birth attendants in Ethiopia and From study conducted in Somali refugee, almost all of the practices of FGM had been performed by traditional circumcisers and birth attendants(4). According to the EDHS2005 report showed that 98.5%and 95% of FGM/C procedure was conducted by local healers/circumcisers in Ethiopia and Eritrea (11). Generally, older women except in Egypt 61 % of cases, FGM/C had been carried out by medical personnel and it is discouraging trend when medical professionals perform the procedure due to growing recognition of the health risks associated with FGC/M in HIV transmission. The rite of FGM took place in the month of December at home (Compound) (77%), friends 'home (16%) &relative's house or bush (2%) in Kenya **(25, 29, 30)**. but in Ethiopia there is no any study that indicates when it performs

2.5. Factors associated with FGM practice

According to W.H.O, the practice of FGM is closely associated with poverty, low social status and illiteracy of women. In southern Egypt, one survey showed that 98.6% of women with daughters reported that their daughters have undergone or would undergo the procedure. Of these mothers, 92% were illiterate. This supports the opinion of Ismail follower who considered the lack of education of mothers as the cornerstone for the prevalence of this custom (31).

It is believed that FGM is one of the deeply rooted traditional practices, which has a mixed influence from culture as well as religion. All these aspects are highly linked together in Eastern Ethiopia and are very difficult to consider them separately. Many people do not easily understand the distinctions between the religion, culture and the practice of FGM. In a study conducted in Eastern Ethiopia; Somali region, religion has been found to be one of the main motives for performing FGM among Muslims. This necessitates the strengthening of national laws against FGM that seeks the support of religious and community leaders in the campaign to fight the practice and this would be helpful in convincing those who support it (4). A study conducted in Amhara region shows Age, religion and maternal education were strong predictors of having a circumcised daughter (23, 32, 33).

2.6. Impacts of Female genital cutting on women health

FGM/C is associated with a series of health risks and many consequences mainly during the procedure, girls are subject to violent pain, severe bleeding and, in many cases, shock and risk of HIV/AIDS infection. During puberty, many mutilated girls suffer from menstrual blood retention and predisposing girls to infection and further complications. Longer-term complications include fistula, repeated UTI, scars which may open during childbirth and which can lead to severe hemorrhage, obstructed menstrual flow, RTI and reduced fertility (15, 16).

Conceptual framework

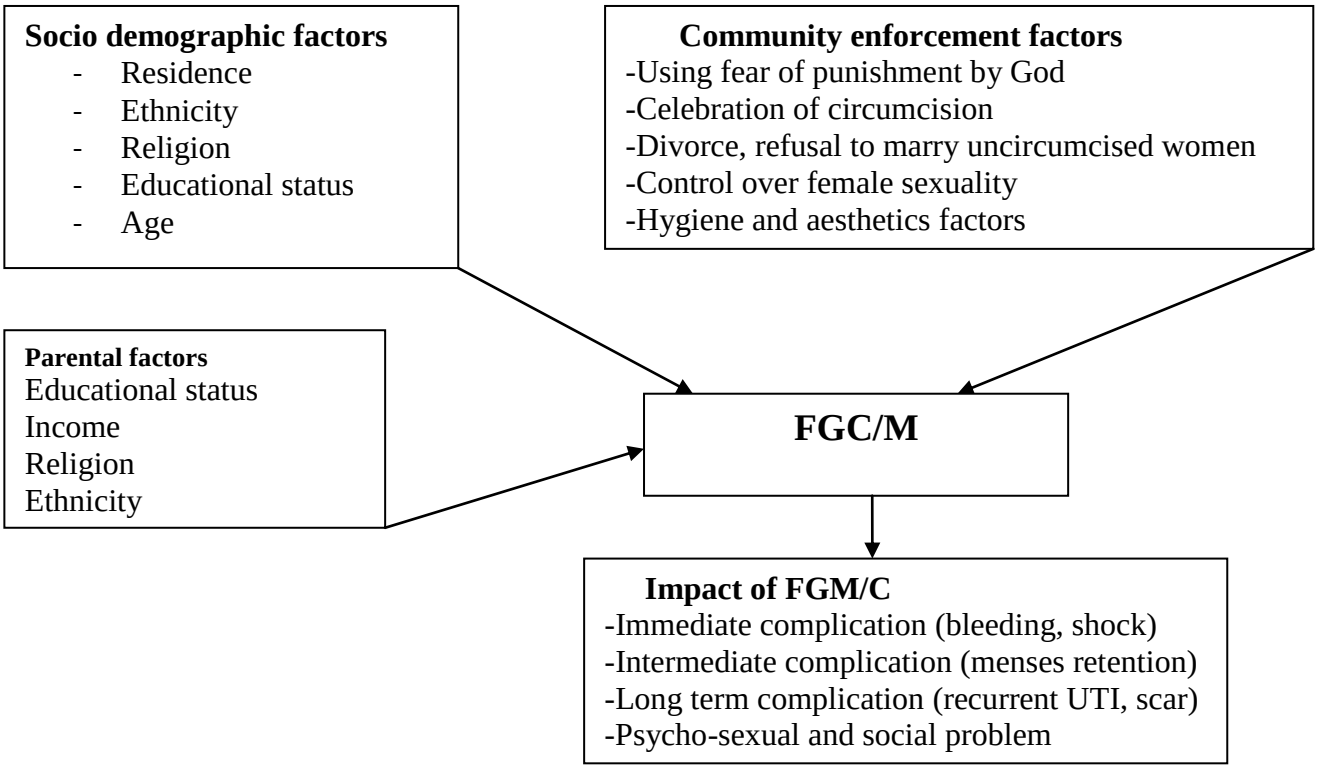


Figure 1: Conceptual frame work for the practice of Female genital mutilation and associated factors with its complications.

Female genital cutting can be determined in multifaceted ways. This is the view that factors such as knowledge towards the ill effect of it, having positive attitude of the community towards the continuation of the practice, residence, ethnicity, religion, age, educational status of mothers, and income status of the family are determining factors for the persistence continuation of female genital cutting in some part of Ethiopia and in Somali national regional state as a whole. The community enforcing factors like Using fear of punishment by God ,celebration of circumcision , refusal to marry uncircumcised women, control over female sexuality and hygiene / aesthetics are factors that play a great contribution for the continuation of the practice .This medieval practice has an effect on sexuality and reproductive health status of women like immediate (bleeding, shock), intermediate(infections) and long- term complication(recurrent UTI, scar, and infertility) both physical and psychological for the girls and women who experienced it.

3. **Objective**

3.1 General objective

To assess prevalence and factors associated with Female Genital Mutilation/Cutting in Jigjiga district, Somali Regional state.

3.2. **Specific objective**

1. To assess the prevalence of female genital cutting in Jigjiga district.

2. To assess knowledge /attitude towards the effect of female genital cutting in Jigjiga district

3. To identify factors associated with female genital cutting practice.

4. To identify reasons for female genital cutting in Jigjiga district.

4. Methodology

4.1 Study Design and period

School based cross-sectional study combining both quantitative and qualitative research method was employed to assess prevalence and associated factors with FGM among female young adult who attend high school and college in Jigjiga district from August 2012 to June 2013 where the qualitative part used to supplement the quantitative findings.

4.2 Study Area

Somali region is one of the nine regional states that make the Federal Republic of Ethiopia. It is bordered by Oromia National Regional State in the west and southwest and Afar National Regional State in the Northeast. It is found in eastern part of Ethiopia. Internationally it is bordered with Kenya in the south, Somalia in the east, and Djibouti in the north. Somali region is divided into nine zones and. the zones are further divided in to 52 woredas.

The total urban population of the region is estimated to be only 16%. The large majority of the populations are pastoralist and agro-pastoralist. Among the Six woredas in the Jigjiga Zone, Jigjiga district which is the capital city of Somali regional state located in the eastern part of the country at a distance of 635 km from Addis Ababa.

The total population of Jigjiga district was estimated to be 345,407 in 28 Kebeles. Among this, 47% and 53% are females and males respectively. About 79,789(23%) of the population, are women in 15-49 years of age (39). There are almost 13,350 female students already registered in Jigjiga district in 2005 academic year. There are 4 primary school (one private), four public high schools and four colleges (two private) in Jigjiga district. In Jigjiga district there is one referral hospital (Karamara Hospital), one health center, 7 health stations, one MCH clinic, & two health posts that are giving services for the population.

4.3 Source Population

- All female young adult students who were enrolled in high school and colleges during 2005 E.C. academic calendar in Jigjiga district.

4.4 Study Population

For the quantitative study-All female young adult students found in the randomly selected high schools and colleges in Jigjiga district.

For the qualitative study: - FGD discussants include religious leader, clan leader, mother/ father, community leader and circumciser.

4.5 Inclusion and Exclusion Criteria

Inclusion criteria

- All female young adult students who had no any hearing and eye problem.
- All Government high school and colleges were recruited

Exclusion Criteria

- Female students, who were seriously ill and those with abnormal mental status.
- Female students who were less than 10 years of age and greater than 24 years of age.
- Night female students

4.6 Sample Size and Sampling Procedure

4.6.1 Sample Size Determination

Quantitative study: The sample size was determined using the formula for a single population proportion; based on the following assumptions:

- $Z_{\alpha/2=}$ the Z- score corresponding to the 95% confidence level which is 1.96
- d=± 5% maximum discrepancy between sample and population (d= 0.05)
- P = the proportion of females circumcised, 74% (11).

$$\mathbf{n}= \frac{(z_{\alpha/2})^2 \text{ x } p\,(1-p)}{d^2} = \frac{(1.96)^2 \text{ x } 0.74(1-0.74)}{(0.05)^2} = 2\,95$$

The assumption for calculating sample size was a 95% confidence level, 5% degree of precision and 74% the proportion of female (15-49years) circumcised (11). The 74% prevalence was taken for the sake of having larger sample size. Taking this assumption 'n' became 295 and with the design effect of 2 and 15% non- response rate, the final sample size became 679.

Qualitative study: - Four FGDs comprising 8-12 participants from mothers/father, community leaders, religious leaders and circumcisers in each were conducted depended up on saturation and redundancy of information.

4.6.2 Sampling procedure

4.6.2.1 Quantitative

Multistage sampling technique was employed to select study subjects. A list of all high schools and colleges with in Jigjiga district was compiled. Among three high schools and four colleges found in the district, two colleges and two high schools were selected using lottery method. All sections from each selected high school and colleges were taken as strata and 679 students were selected using stratified random sampling with proportionate allocation to size from each section. Total students taken from each section and grade were depicted in Annex I. Students from each section were randomly selected by lottery method.

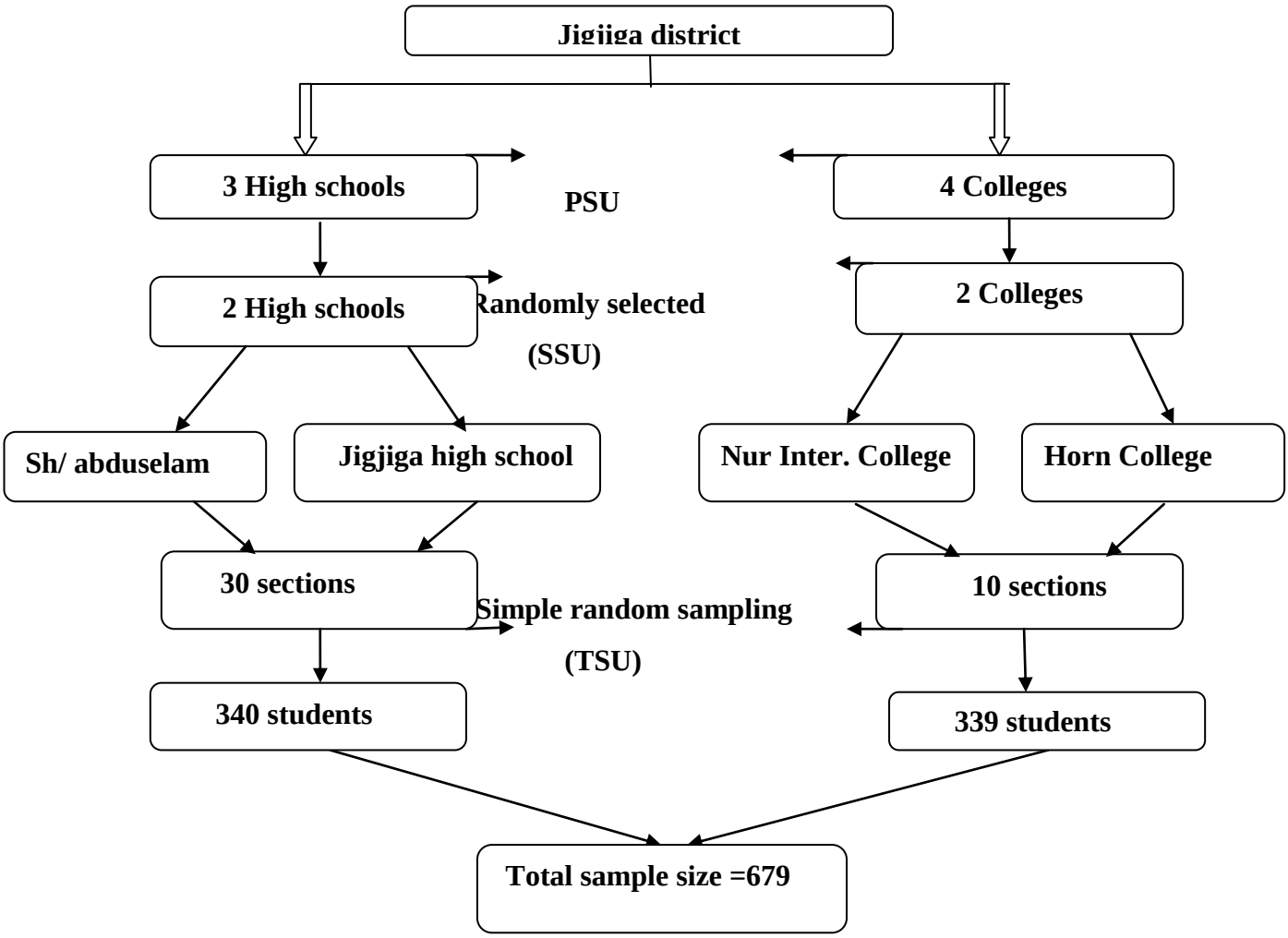


Figure 2: Schematic presentation of sampling procedure for quantitative study

4.6.2.2 Qualitative

Four FGD's were undertaken among women/husbands, and local leaders (religious, clan and community) and circumcisers separately. Each FGD was comprised of 8-12 participants. Study participants were selected purposively after discussion with community health workers and briefing them on the study objectives. The data were collected with diploma holder nurses. In selecting each member of the FGD participant's age, educational status, occupation, and residential backgrounds was considered.

4.7 Variables of the study

4.7.1. Dependent variable

Female genital cutting prevalence among young adult female students

4.7.2. Independent/ explanatory variables

1. Socio-demographic and economic variables
2. Knowledge and attitude towards the bad effect of FGC.
3. Parental factors

4.8 Operational definitions

Current practice: Any Female who circumcised within the last ten years.

Fair knowledgeable: those who give correct response about 3 or 4 knowledge questions.

Good Knowledgeable about FGC: those female students who give correct response more than median and above of all questions about Knowledge score

Intention to circumcise: the plan to perform FGC to their sister/daughter in the future

Negative attitude towards FGC: those female students who give correct response for less than the median of attitude score

Poor knowledge: those who answered less than two knowledge questions

Positive attitude towards FGC: those female students who give correct response for greater than the median of attitude score.

Type I FGM/C (clitoridectomy): Genital area just nicked without removing any flesh (11).

Type II FGM/C (excision): when any flesh removed from the genital area (11).

Type III FGM/C (infibulation):-when any flesh cut away from the genital area & sewn shut (11).

Young Adolescent: female students who are presented with in 10-24 years of age (21).

4.9 Data collection tools and procedures

Data were collected using structured self- administered questionnaire. The questionnaire was first prepared in English then translated to local language (Somaligna) & back translated to English to maintain the consistency of the questionnaire by local language translator. Two supervisors and eight female data collectors were participated in the data collection process. Two days of intensive training was given to the data collectors and supervisors on how to conduct the data collection. Brief introduction to data collectors, supervisors and students was given before and during the collection process. The principal investigator and supervisor monitored closely the process and the questionnaires were checked for completeness immediately after collection. The data collection was carried out from Jan. 2013- Feb.2013.

Data quality was managed by training and appropriate supervision of data collectors. Overall supervision was made by the principal investigator. Pre-test was done on 5% of the study participants in the administrative area which was not included in the study before 20 days. An appropriate modification was made to the questionnaire after analyzing the pre-test result before the actual data collection like time modification and skipping pattern arrangement.

FGD's topic was first introduced to each homogeneous group. Each group consisted of 8-12 focus group discussants conducted for the following sections of the society for they were direct or indirect contributors in the practice of FGC/M.

Focused group discussion members were mothers/fathers, community leaders, religious leaders/clan leaders and traditional birth attendants (circumcisers). A discussion guide was prepared first in English and translated into Somaligna and then back to English. The issues the topic guides tried to address the following; how people defined female genital cutting; the meanings they attached to female genital cutting; reasons for female genital cutting and possible ways to stop the problem. The moderator (health officer) was responsible for making sure the discussants knew the focus group questions and for taking notes in English during all focus group discussions. In addition to this, the moderator had recorded the talks of the discussants. Training was given for the focus group facilitators (diploma holder in nursing) about the nature of qualitative study and how to take note during the discussion.

4.10 Data processing and analysis

Quantitative Study: Each completed questionnaire was checked for completeness, cleaned using frequency and cross tab to check outlier and missing values after entered in to Epi Info3.5.3 statistical software and then exported to SPSS version 17.0 packages for analysis. Frequencies, Proportions and cross tabulations were used to summarize descriptive statistics of the data. Tables, summary statistics and graphs were used for data presentation. All variables which were significant at bivariate analysis was entered in to multiple Logistic regression and finally the variables which had significant association was identified on the basis of AOR with 95%CI and p-value less than 0.05 to fit the final regression model.

Qualitative study: The qualitative data were audio taped, transcribed and coded with open-code version 3.6 and inductive content analysis was applied (34, 35). Patterns and themes were documented and reviewed with participants for accuracy before written into the report. Finally the narrative qualitative information was organized and integrated according to emerging themes and concepts that used to answer the research questions. Units of relevant meaning were coded segment by segment. As part of the analysis four categories were developed that illustrated the manifest meaning of the findings, while the single theme represents the overall joint interpretation of the qualitative and quantitative information and reflects the latent meaning of the data.

4.11 Ethical considerations

Ethical clearance was initially obtained from the Institutional Ethical Review Board of school of Public Health, College of Health Science, University of Addis Ababa. Official permission was secured after Communication with the district and respective school administrators through formal letter obtained from the school of Public Health, University of Addis Ababa. Respondents were informed about the purpose of the study, and verbal consent was obtained from the study participants. For those students who are under the age of consent, assent was taken from their school members and/or themselves when they were independent minor.

Confidentiality was maintained by anonymity their names on the questionnaire. Participants were also informed that participation was on voluntary basis and they could withdraw from the study participation at any stage if they are not comfortable about the questionnaire. In order to keep confidentiality of any information provided by study subjects, ID was used.

Risk/ Discomfort

By participating in this research project, participants may feel that it has some discomfort especially on wasting time about 30 minutes. There is no risk in participating in this research project.

Benefits

By participate in this research project, there may not be direct benefit, it is likely to help us for understanding the current situation of FGC Ultimately, this was helping us to work on awareness creation and other interventions on factors contributing to the practice as per the findings of the study.

4. 12 Dissemination of results

The findings of the study will be forwarded to University of Addis Ababa, School of public health, Jigjiga district health office, Somali regional health bearuea, Somali women's affair & Gender office and to any organization involved in anti-FGC activities. More over efforts will be made to present the findings in different conferences, workshops and will be sent to publication on scientific journals and conferences

Table 1: Theme, category, and code of the factors associated with the practice of FGC among female young adult students in Jigjiga district, May 2013

Theme: - 'FGM is still practiced due to wrong attachment to religion, bad perception and community enforcement'				
Category	1-Community enforcement	2-Controlling sexuality	3-Misperception	4- Wrong religious attachment
Codes	Ceremony Refuse to marry uncircumcised girl Income source Family honor Maintain chastity/virginity Social acceptability Norm/value/culture	Faithful Reduce multi- sexual partner Reduce hyper- sexuality	Belief Looks ugly and bad odor Attitude Intention Clitory threats penis	Ordered by Sharia Fear of punishment from God Islamic identity Spiritual cleanliness

5. RESULTS

The results of this study is presented mixing both quantitative and qualitative research where the qualitative research results are presented using the four categories presented in table one of the methodology section.

5.1. Socio-demographic and Economic characteristics of the respondents

Six hundred sixty two respondents participated in the quantitative study making response rate of 97.5% of the study. Of those, majority 374(56.5%) were in the age range of 15-19 whose mean age of the respondents was 20 (±2.4) years.

The majority of the respondents were Muslim 511 (77.2%) by religion, Somali 430 (65%) by ethnicity, reside in rural area accounting for 355(53.6%). All most all, 626 (94.6%) of the respondents were never-married. Two hundred forty three (36.7%) and 214 (32.3%) of the respondent's mother and father did not attend any formal education (illiterate) respectively. Out of the total, 347 (52.4%) respondents' mothers were housewife. Three hundred forty four (52%) of the respondent's family had average family income between in the range of 500-999 followed by 230(34.7%) in greater than1000 B.r.(Table 2).

Table2: Socio-demographic and economic characteristics of female young adult students in Jigjiga district, Somali regional state, Ethiopia, May 2013(n=662)

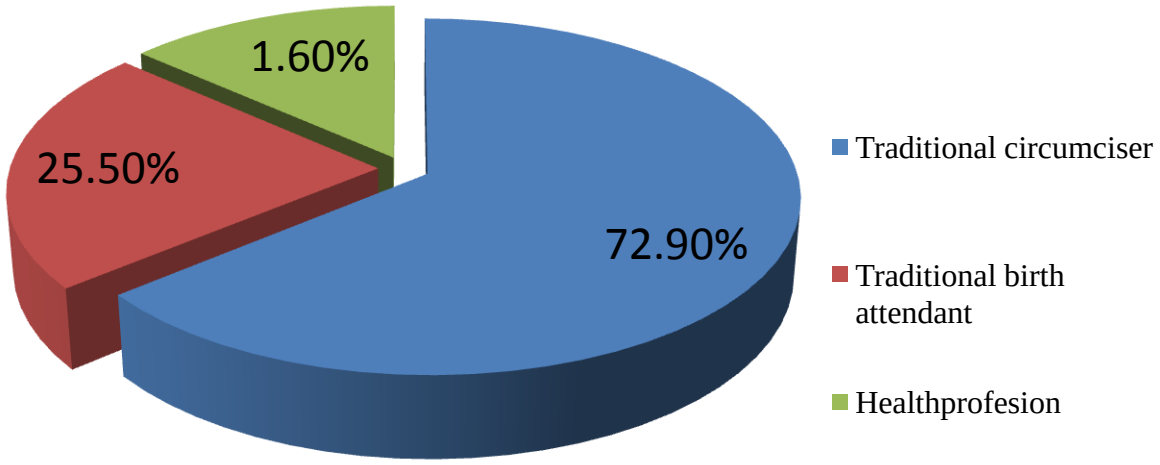
Variable		Frequency	Percent
Age	15-19	374	56.5
	20-24	288	43.5
Religion	Muslim	511	77.2
	Orthodox	132	19.9
	Protestant	19	2.9
Ethnicity	Somali	430	65
	Amhara	124	18.7
	Oromo	19	2.9
	Other	89	13.4
Residence	Rural	355	53.6
	Urban	307	46.4
Educational stage of student			
	Secondary	330	49.8
	College /TVET	332	50. 2
Marital status (students)			
	Never-married	626	94.6
	Married***	36	5.6
Occupation (mother)			
	Housewife	347	52.4
	Jobless	105	15.9
	Others++	210	31.8
Educational status (mother)			
	Illiterate	243	36.7
	primary	206	31.1
	secondary and above	213	32.2
Educational status (father)			
	Illiterate	214	32.3
	primary	206	31.1
	secondary and above	242	36.6
Monthly income			
	<500	88	13.3
	500-1000	344	52
	>1000	230	34.7

Other ++-like circumciser, merchant, employee etc.
Married***-married/Cohabited/separated/divorced

5.2. Prevalence of FGC/M among young adult female students

Five hundred thirty eight (82.6%) of the respondents were undergone one or more of the different forms of FGM/C. Of these, 268(49.9%) were circumcised during the age of7-10years (with mean age e of 8.3years. Majority 414(63.6%) of the respondents FGM/c was performed at their own home. Majority 473(72.7%) of it was performed by traditional circumciser followed by traditional birth attendant, 166(25.5%) (Figure 3).

The person who made the decision to have FGM/C were their mothers 555(83.5%), followed by their grandmothers 247(37.9%) and religious leader 157(24.1%).Majority 265(49.3%) had type I, followed by 244 (45.4%) type III which is the sever form (Table 3).



N.B. more than one response was possible.
Figure 3: Reported Circumciser among young adult female students in Jigjiga district, Somali region, Ethiopia, 2013, (n=651).

Table3**:** Prevalence of FGC/M among young adult female students, Jigjiga district, Somali regional state, Ethiopia, May, 2013

VARIABLE	FREQUENCY	PERCENT
Circumcised (n=651)		
Yes	538	82.6
No	113	17.4
Age of circumcision (n=538)		
<=6	110	20.4
7-10	268	49.8
11-14	160	29.8
Decision made by (n=651)		
Mother	555	85.5
Grandmother	247	37.9
Religious leader	157	24.1
Types of circumcision (n=538)		
Type I	265	49.3
Type III	244	45.4
Both (type I and III)	29	5.3

5**.3. Prevalence of FGC/M among youngest sister of the study participant**

As shown in table 4, more than three quarter, 385 (81.1%) responded that their youngest sister were circumcised. Of those, 306(79.5%) were circumcised during the age of 7-10 years making the mean age of 7.6 years. With regards to the forms of circumcision, 190(49.3%) had undergone type I followed by type III, 180(46.8%).

Table4: Prevalence, age of circumcision and type of FGM/C among youngest sister of the study participants, Jigjiga district, Somali regional state, Ethiopia, May 2013

Variable	Frequency	Percent (%)
Circumcision status (n=475)		
Yes	385	81.1
No	90	18.9
Age during circumcision (n=385)		
<=6	63	16.4
7-10	306	79.5
11-14	16	4.1
Type of circumcision (n=385)		
Type I	190	49.3
Type II	15	3.9
Type III	180	46.8

5.4. **Knowledge among young adult females towards FGC/M and its ill effect.**

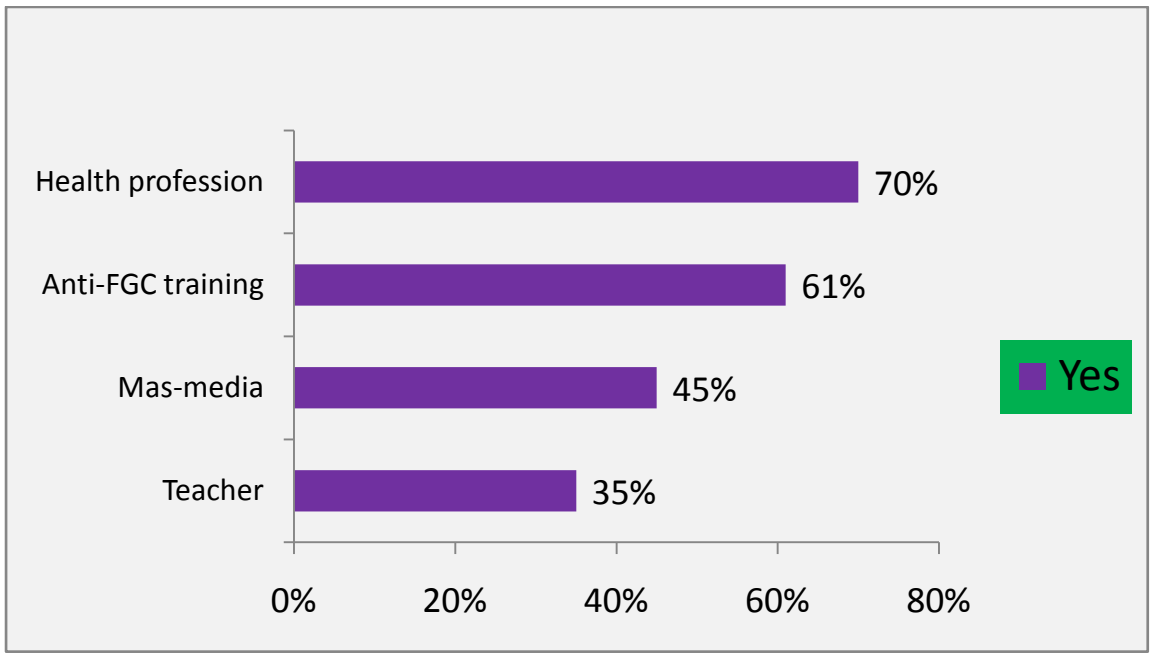
As shown in table 5, majority 573 (88.3%) of study respondents had a good knowledge about the practice and its complication. Knowledge about the specific complications of FGM/C was asked, and it was consistently above 50% in major complication areas.Among 651 female students who reported to know the grave effect of FGM/C on the health of women/girls; 557(85.6%) responded that it transmits HIV, followed by it causes severe pain during the procedure 537(82%). Those who said it can cause excessive bleeding accounts for 528(81.1), and 521(80%) said it can lead to sexual dissatisfaction and 367(56.4%) said it can create difficulty during delivery.

Table5. Report on knowledge of female student regarding to the FGM/C and its ill effects on health of women/girls in Jigjiga district, Somali state, Ethiopia, May 2013

VARIABLE	FREQUENCY (Yes)	PERCENT
Transmit HIV (n=651)	557	85.6
Sever pain (n=651)	537	82
Excessive Bleeding (n=651)	528	81.1
Sexual dissatisfaction (n=651)	521	80
Difficult delivery (n=651)	367	56.4
Wound infection (n=651)	363	55.8
Transmit Hepatitis (n=651)	332	51
Menstrual disturbance (n=651)	326	50.1
Knowledge score (n=651)		
Good (5-9 point)	575	88.3
Fair (2-4point)	46	7.1
Poor (0-1point)	30	4.6

NB. *More than one response was possible* and *the percent might be greater than 100%.*

The source of information with regard to the FGM/C and its bad effects, were health professions, 456(70%) followed by anti-FGM training 397 (61%) (Figure 4). Most of the study participants were aware of the types of circumcision particularly, 479(89.5%) type I (clitoridectomy), and 333(62.2%), type III (infibulation



N.B. more than one response was possible and the percent might be greater than 100%.

Figure 4: Source of information for FGM/C among female students in Jigjiga district, Somali regional state, Ethiopia, 2013 (n=662)

4.5. **Reasons for performing female genital mutilation**

Above three quarter, 518 (79.6%) of female respondents believed that there is at least one benefit or reason to be carried out. Of these, 395(60.7%) said it can prevents from having premarital sex, or it prevents her virginity and attenuation of female sexuality by reducing "female hyperactivity" in sexual practice, 359 (55.1%) reported that it help to have social acceptance from the community, 192(29.5%)said it help to have better marriage prospects, Few 116(17.8%), and 113(17.4%) responded that it is beneficial in providing hygiene/cleanliness and r it is important for the religious approvals respectively (Table 6).

1- ***Community enforcement factors as a reason for FGC***

The group discussants and respondents were also discussed about female circumcision following community enforcing factors. The participants stated that an uncircumcised woman is considered a marginal woman, hypersexual, infidel, non-Muslim and non-pure. According to some participants also, they consider FGC as a license for marriage. The majority of

focused group informants said that most of families are forced to practice FGC due to fear of discrimination for deviating from community norms in their area. All women in FGDs were agreed that women are generally more supportive of FGC compared to men because they assume that it uses to maintain the girl's chastity/virginity, important for family honor and as income source for local traditional circumcisers. Forty five years of age circumciser shared this idea and explain:

> *"From my point of view, an uncircumcised woman is hypersexual, infidel, non-Muslim, and non-pure. Even if she gets married, she may face immediate divorce or forced excision. So, FGC is pre condition for girls to get marriage. Girls who do undergo FGC receive rewards, including public recognition and celebrations, gifts(gebartin in Somali language), potential for marriage, respect and the opportunity to engage in adult social events."*

Some of the respondent 52 years old circumciser agree with the above mentioned and say:

> *"Most families in our area are victimizing their daughter to FGC to get honorability and respect from the society unless otherwise the society does not give any value to the family. The practice also serves as a source of income for elder mothers (circumciser)".*

The respondents also expressed their idea on the physco-sexual and social reasons of female circumcision. As some of the group participants reflected their views that uncircumcised female is unclean and she has bad odor than circumcised female. Because enlarged clitoris is unnecessary part that creates worm if it is not cut at the right time. The practice is still performed in the study area for fear of discrimination and stigmas for the families and girls themselves from the community according to the majority of the respondent's idea.

Among the circumciser women aged 43 year strongly agreed with the idea and pointed out her view as follows.

"Uncircumcised women is unclean, has bad odor, and she feels looks like ugly following this Men are unwilling to marry uncircumcised women, insistence that women from other clan get circumcised. Clitory is not important to get in touch with penis during sexual intercourse, and creates worm if it is not cut at the right time".

Almost all of the participants and respondents also raised the issue of tradition and female circumcision in their area. According to the FGDs participants, female circumcision is a long-standing tradition which is inherited from their ancestors that consider it as a cultural norm and value in Jigjiga district; Somali as a whole and because of this, the society is still practicing female circumcision in the study area.

One of the clan leaders says:

> *"The practice is carry out based on its reason. Tradition is one of the reasons to perform FGC on our daughters that come from generation to generation. But now days, the society more understands its benefit and risk".*

2- **Controlling sexuality as a reason for FGC**

The participants stressed on the issue of sexual control. Female circumcision is important to control female hyper sexuality over her husband, prevent female from early initiation of sexual intercourse before marriage, be reliable for her marriage, and fix a girl for a single partner before and after marriage as to the respondents and FGDs participants' view. Some of the respondents also reflected that an uncircumcised woman may not get marriage; even if she gets marriage, she may face immediate divorce.

From the respondents a religious leader aged 55 supported the stated idea and provides his argument as follows:

> "*Female circumcision is important to reduce the power of sexuality and more need of sex, unless the female is requested more energy by her husband and additional sexual partner to get frequent sexual intercourse. For example, if there is one prepared food, it is enough for one person rather for fifty people. This will facilitate the separation of women from her husband.*"

An elder woman who is a circumciser also shared the idea and explained her standing as follows.

> "*Uncircumcised girls may not get marriage and respect from the society. Because of this the families as well as the girls themselves are asking the circumciser to perform the procedure by preparing ceremony in their home as to ensure and enhance marriage probability of the girls and their possibilities of fulfilling lives as mothers and responsible wives if not, she remains with her family till the end of life without any husband".*

3-**Wrong religious attachment as a reason**

All of the informants also discussed about factors that facilitate female circumcision in their area. All the respondents stated that religion is one of the most long–standing and strongly attached factors with female circumcision. According to the participants in FGDs, Sunna type of Female circumcision is strongly supported by Islam; sharia, but pharaonic type (infibulation) which is a dominant practice in the area, is not emanated from Islam that is why the current generation strives to fight against it. Some respondents also discussed that the Somali community as a whole has fear of God punishment if it is not performed in their female daughter and struggles to transfer to the next generation.

A 50 years old religious leader in rural Kebele shared and strengthens the above mentioned idea as follows:

> *"Sunna type of female circumcision is ordered and supported by Allah; sharia. An enlarged clitoris is not good in our spiritual cleanliness and unnecessary part to touch with penis during sexual intercourse. The order of sharia on our culture is our Islamic identity and it performs for fear of punishment from Allah, but pharaonic type of FGC is not supported and ordered to perform on Islam female."*

However, few FGD participants rejected the mentioned idea, and one of them a 35 years old community leader elaborated as it has not religion ground as follows:

> *"The practice has no religious origin rather it is because of our inherited long-standing tradition and culture. That is why we…ahh… have been trying to stop the practice since the last ten years through the help of different governmental and non- governmental organizations".*

Table6. The perception and reasons towards female genital mutilation among young adult female students in Jigjiga district, Somali regional state, Ethiopia, may, 2013(n=662)

Reasons	Number (Yes)	Percent (%)
There is at least one reason to perform	518	79.6
Preserve virginity/premarital sex	395	60.7
Social acceptance	359	55.1
Better marriage prospects	192	29.5
Cleanliness/hygiene	116	17.8
Religious approval	113	17.4
More sexual pleasure for men	24	3.7

NB. *More than one response was possible* and *the percent might be greater than 100%.*

4.6. Attitude and belief towards FGM/C continuation/intention among young adult female students

The study participants were also asked about attitude toward the practice of continuation, discontinuation, effect on chance of marriage, reason to be continued or discontinued, and the best way to stop it.

Two Hundred forty four (37.5%) respondents favor for the continuation of the practice because 190(79.5%) respondents responded that due to religious demand, 219(91.6%) it preserves virginity by reducing sexual hyperactivity. One hundred seventy five (73.2%) of the study subjects react that it increased better marriage prospects, 141(59%) good tradition, 104(43.5%) for clean /hygienic, and 60(25.4%),as good custom.

More than half of the respondents, 407(62.5%) were in favor of discontinuation of the practice in the study area because 223(54.1%) respondents responded that, it is against human right or dignity, 249(60.4%), causes sexual dissatisfaction in women/girl later life, 161(39.1%) medical complication, 108 (26.2%) painful personal experience, and 47 (11.4%) can cause infertility (table7).

Two hundred eighty three (43.5%) study participants reported that female circumcision was increased the chance of marriage than uncircumcised female where as 168(25.8%) of them believed that the chance of marriage was reduced by the procedure and 200 (30.7%) believed the practice has no effect on chance of marriage (Table 7).

4-Mis perception towards the ill effects of female circumcision

As the respondents indicated, the practice is currently performed in Jigjiga district community, even though it changes its degree from severe form of FGC (Type-III); pharaonic to the simplest form of FGC (type-I); Sunna according to the participants' view.

Some of the respondents also reflected that the community is currently tried to stop the practice by involving in different anti –FGC campaigns. As to all circumcisers and FGDs participants view, the pharaonic type of FGC (type III) is totally discontinued in the study area but type I.

Currently most of the society in the study area understands the severe effects of the practice on women health and the practice is considered it as against their right according to some participants. The bad effect of the practice on mother's /girl health is very high because it is performed by untrained women with unsterilized material in unsterilized environment like with untreated razor blade, local prepared gauze (mashesha in Amharic) without any local anesthesia. For this reason, the society understands blood loose, shock; menstrual disturbance and other are the end results of the practice. Educational campaigns against the practice, changing women's attitude towards the practice, men involvement in decision making regarding to the practice and religious education were the suggested ways to struggle against female circumcision pointed out by respondents.

A man of 35 years old among the respondents explained his experience by focusing on the types and the type he applied for his daughters as follows:

> ***"****I have four daughters; 21, 19,17and16 years old. The first 21and 19 years old daughters were victimize for the sever form of FGC (type III) while the remaining are subjected for Sunna form of circumcision because pharaonic type of FGC is legally forbidden in our area today. Sunna is an important practice because the clitoris is not an important part for hygiene that causes bad odor".*

Thirty five years old of diploma holder mother in FGDs says*:*

> *"As far as I am concerned, if mother understands about the ill effect of the practice, good income, participation of religious leaders to fight against FGC, legal enforcement to stop it after creating better awareness about the ill effect of FGC on women health in the community can facilitate for ending of the practice in our area. For example all my daughters in the future will not be subjected and victimize for female circumcision".*

Table7. Attitude and belief of young adult female students towards FGM/C continuity in Jigjiga district, Somali regional state, Ethiopia, May, 2013

VARIABLE	FREQUENCY	PERCENT
Reasons to be continued (n=244)		
Preserves virginity	219	89.8
Religious demand	190	77.9
Better marriage prospects	175	71.7
Good tradition	141	57.8
Cleanliness/hygiene	104	42.6
Good custom	60	24.6
Reasons to be Discontinued (n=407)		
Cause sexual dissatisfaction	249	61.2
Against human right/dignity	223	54.8
Medical complication	161	39.6
Personal painful experience	108	26.5
Infertility	47	11.5
Effect of FGM/C on chance of marriage (n=651)		
Increase	283	43.5
No effect	200	30.7
Reduce	168	25.8
Total	651	100
Attitude/Belief (n=651)		
*Negative (0-1)	244	37.5
*Positive (2-5)	407	62.5

NB. *More than one response was possible* and *the percent might be greater than 100%.*

4.7. **Factors associated with the prevalence of FGM/C among young adult female students.**

Cross tabulation and logistic regression analysis were done among dependent and independent variable of the study mainly to see the association between socio-demographic, personal and parental factors associated with the female genital cutting/mutilation.

In the bivariate analysis, Muslim were subjected positively and significantly to female genital mutilation practice compared to Christian respondents (COR=3.7; 95% CI=1.3, 10.9). The prevalence of female genital cutting were 2.9 more likely among rural residence compared to their counterpart in urban (COR=2.9; 95% CI= 1.5, 3.5). Female circumcision were 2.2 times more likely among Somali when compared to other ethnicity (COR=2.2; 95%CI=1.5, 3.4). The practice of FGM/C was less by 50% among respondents within 15-19 years of age compared to 20-24 years of age (COR=0.5; 95% CI=0.3, 0.76). Female students at high school level were less likely to be circumcised compared to female students at college level (COR=0.29; 95% CI =0.18, 0.45). The prevalence of FGC is less by 50% in those who

had positive attitude towards discontinuation of the practice than who had negative attitude (AOR=0.5; 95CI=0.3-0.8)

The odds of circumcised female students whose illiterate mother were 3.6 times more likely to be circumcised compared to those whose mother had completed high school and above (COR = 3.6; 95% CI=1.9, 6.7). The odds of the practice was 2.3 times higher and statistically significant among who believe FGM/C is required by their religion compared to those who were not believe (AOR=2.3; 95% CI =1.5- 3.5).

When all significantly associated independent variable with the dependent variable(at significance level of 0.05) under consideration in the bi-variate analysis were entered in to the multiple logistic regressions, out of those variables, religion , residence, educational status of mother, attitude, educational level of the respondents and FGM/C is required by religion were significant predictors of the prevalence of female genital mutilation/cutting by holding others constant, while mother's occupation, ethnicity, income, father's educational status and age of the respondents were not significant predictors of the independent variable of the study as presented in table 8.

Table8: Associations of Socio-demographic and parental factors with FGM/C among young adult female students in Jigjiga district, Somali regional state, Ethiopia, May, 2013

Variable	**Circumcision status**			
	Yes (%)	No (%)	COR(95%CI)	AOR(95%CI)
Religion (n=651)	**			
Muslim	445 (87.7)	61 (12.1)	**3.7(1.3,10.1)**	**3.7(1.1, 12)**
All Christian	93 (64.1)	52 (35.9))	1	**1**
Residence (n=651)	**			
Rural	305 (88.2)	41 (11.8)	**2.9 (1.5,3.5)**	**4 (2.4,6.8**)
Urban	233 (76.4)	72 (23.6)	**1**	**1**
Ethnicity (n=651)				
Somali	369 (86.8)	56 (13.2)	**2.2(1.5,3.4**)	1.3 (0.8,2.1)
Others††	169 (74.8)	57 (25.2)	1	1
Age of female students (n=651)				
15-19	282 (77.3)	83 (22.7)	**0.5(0.3,0.76)**	1 (0.52,1.9)
20-24	256 (89.	530 (10.5)	**1**	1
Educational level (n=651)**				
High school	238 (74.1)	83(25.9)	**0.29 (0.18,0.45)**	**0.5 (0.3, 0.8)**
College	300 (90.9)	30(9.1)	1	1
Mother's education (n=651)**				
Illiterate	210 (88.6)	27(11.4)	**3.6 (1.89,6.71)**	**2.4 (1.3, 4.3)**
primary	169 (82.8)	35(17.2)	**2.1 (1.05, 4.37)**	0.96 (0.5,1.7)
secondary & above	159 (75.7	51(24.3))	1	1
FGM/C required by religion(n=651)*				
Yes	149 (64.8)	81(35.2)	**2.3 (1.5, 3.5)**	**1.7 (1.07, 2.8)**
No	389 (92.4)	32 (7.6)	1	1
Attitude				
Positive	216 (88.5)	28 (11.5)	**0.5 (0.3-0.8)**	**0.5 (0.3-0.9)**
Negative	322 (79.1)	85 (20.9)	**1**	**1**

Employee***-currently employed, circumciser, religious leader, teacher, pretty trader

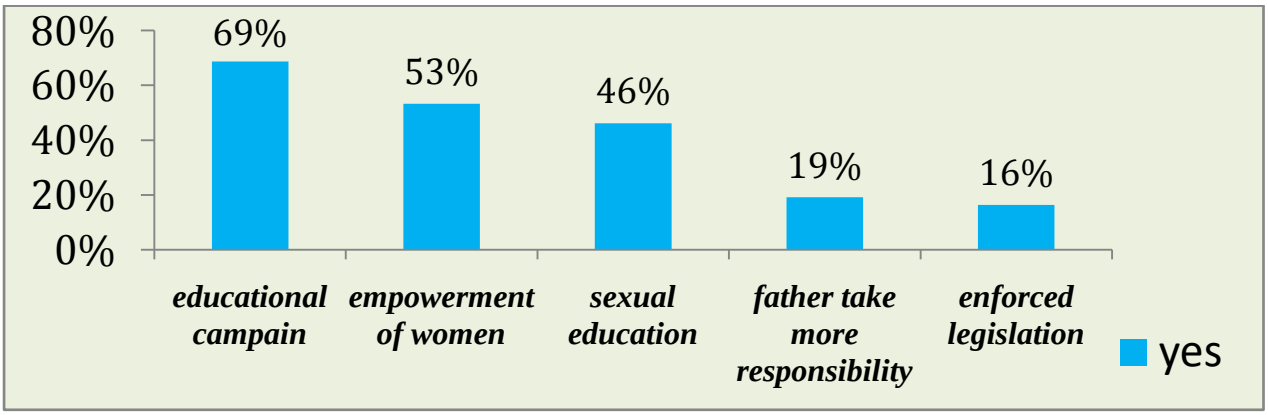
Others††-Amhara, Oromo,

*Significant at *p-value < 0.05 and **p-value < 0.001*

Fitted Model, p=0.809

4.8: **What should be done to discourage the practice??**

The study participants had mentioned the best way to struggle against the practice, 283(69%) through educational campaigning, and 219(53.2%) women empowerment in socioeconomic and other related factors. One hundred ninety (46.1%) of them through sexual education for the whole community as a promoter and enforcer, 79(19.2%) believed that father should take more responsibility, and 67 (16.3%), implementing enforced laws / legislation were the main methods to fight against the practice and other harmful traditional practices **(**Figure 5).



N.B. *More than one response was possible* and *the percent might be greater than 100%.*
Figure 5: Proposed intervention to fight against female genital mutilation reported by young adult female students in Jigjiga district, Somali regional state ,Ethiopia,2013(n=662).

6. Discussion

Female Genital Cutting is a long standing harmful traditional practice that violates human rights of girls and women having no scientific justification and univocal answer in the world including Ethiopia. The complication of Female Genital Cutting is one of the most important public health problems and abolishing of the practice contributes to the achievements of $MDG_{2, 3,4,5,6}$ in the 2015 years.

This study showed that the prevalence of FGC among respondents was as high as 82.6%. The attitude of the respondents towards discontinuation of FGC was significantly increased (62.3%) and had good knowledge (88%) towards the risky effect of FGC on women health. Residence, religion, respondent's level of education, mothers' education, and belief in religious requirement were individually and collectively the most significant predictors of the practice of FGC among the respondents in the study area. The main reasons for the persistent practice of FGC were to prevent virginity, to improve social acceptance, to get better marriage prospects, for religious approval, and hygiene.

The study revealed that the prevalence of female circumcision was as high as 82.6% among the respondents in the study area. This was also supported by qualitative data where uncircumcised woman consider as hypersexual, infidel, non-Muslim, refused to marry and non-pure. It is higher than that reported from the recent national figure (74%) and closely related with the Somali region (97.3%) (11).The prevalence of FGC among 15-19 and 20-24years of age in this study were 77.3% and 89.5% respectively. This finding is also higher than the national prevalence for 15-19(62.1%) and 20-24(73%) years of age and other sub-Saharan countries according to EDHS 2005 (7, 11, 16, 17, 21). This might be because of the deep-seated negative values given by the society to uncircumcised girl considered as unfaithful and hyperactive sexually, supported by the local religion and direct legal measure was not taken. Moreover, the overall prevalence in the study area on the younger age group was somewhat decreased that might be attributed due to a time change and the increasing understanding of parents about the harmful effects of FGC which could be the result of different awareness raising anti-FGC interventions implemented in the area and the advancement of education provision as compared to the previous time. This also might be due to sample size variation and skewed to one ethnicity as compared to the national study.

The common age for FGC was as early as few days old for Christian people; nevertheless for the majority of respondents, 49.8% were circumcised during 7 - 10 years of age .This study is

closely related to a study conducted in Northern Amhara, Tigray, and Somali region refugee camps; for example, FGC is performed at infancy usually on the eighth day after birth and 7 to 10 years of age (4, 11, 24). This study is also closely related to a study conducted in Egypt, 80% of girls were circumcised between the ages of 5–9 years old and in Sudan 20% of girls between 4–9 and 50% of girls above ten years of age (1). This shows that in Ethiopia, the age at which FGC is performed varies among the different ethnic groups. This finding is in contrary to the study conducted in Sudan and report from EGLDMA 2009; where the probability of subjecting a girl to FGC increases beyond the age of ten (24, 37). This inconsistency might be due to early initiation of menarche i.e. once the girls saw menses FGC is prohibited and increasing awareness of girls towards the risky effect of the practice.

Mothers, grandmothers and religious leaders were involved in decision making process to perform FGC. The qualitative data had also revealed that girls themselves had intention to be circumcised. The study finding is in line with study done in Oromia region, Somali region refugee camps (4, 23, 24). and elsewhere (19, 20, 37). This might be due to the fear of isolation from the society, likelihood of their daughters' marriage and their religious obligation. Women may have been engaged in home management and child care than men that contributes for the persistent continuation of female genital cutting.

Regarding to the forms of female circumcision, type I (clitoral cutting) was becoming a dominant practice in the study area accounted around 49.3% followed by infibulation 45.3%. There is an increasing shift from infibulation to the less severe form of FGC among the respondents. The result is in contrary with EDHS 2005; more than 80% of women in the Somali region have been victims of the most severe form of FGM, along with 60% in the Afar region (11). This is in line with a study done in Sudan, students who favour the practice believe that it is a religious dictate especially type I FGC (18, 37). This might be due to the fact that fears of any legal challenges, expansion of ant-FGC intervention. In addition, they believe that infibulation is not supported by religion. The higher rate and persistency might also explained by religious demand and other social reasoning like uncircumcised female is socially discriminated.

The finding of the study indicated that, almost three quarter of FGC procedure was carried out by local traditional circumciser (73%), and health professional (1.6%). This is in line with a study conducted in Somali refugee and other studies (2, 4, 11). The society may think that traditional practitioners have experience, social acceptance and being respected. Health professional involvement in the procedure and lack of coordination in fight against the practice may be contributes for the continuation of FGC that needs attention for the anti-FGC intervention. Furthermore, health professional involvement might be want to reduce the spread of infectious disease following the unsterilized material and unnecessary procedure having no knowledge on anatomy of female pelvis and may be due to the community enforcement/having bad attitude towards FGC.

In this study, most of the respondents around 88% had good information and knowledge about the grave effect of FGC on women health. Their main sources of information were from mass media, anti-FGC intervention, school, and health professions. This is related with a study conducted in eastern Ethiopia, Oromia region and other Sub-Saharan countries (1, 2, 4, 11, 14, 24, 32). Though there is a good knowledge towards the practice, there is a gap between the prevalence and knowledge .This may be because of the prevailing social pressure, religious demand, and having positive attitude towards continuation of the practice.

The finding showed that the main reasons for the continuation of FGC were to keep virginity, to improve social acceptance, to have better chance of marriage, and religious approval. This finding is in agreement with study conducted in Oromia region, Somali refugee and in Sub-Saharan African (4, 11, 16, 24, 30). This is also underpinned by qualitative result that the practice is still to date commonly practiced in Somali region as a result of religious demand, social pressure, cultural identity and psycho- sexual reasoning. This might be due to lack of knowledge and the prevailing negative attitude. The wrong attachment between the religion and practice may be attributed to the FGC which have no scientific justification.

The prevalence of female circumcision was significant predictor among rural respondents when compared to their counterpart in urban. It was 4 times higher among rural respondents than those who lived in urban area (AOR=4; 95%CI: 2-6.8).This is in line with the report of EDHS 2005 (11). This may be because of the tight tradition and religious association and loose legal concern for the practice in the rural and may becoming a convenient place for the practice, additionally rural women mostly influenced by traditional practices .This may be

most anti-FGC interventions, health promotion through media and legal punishable action might not addressed in rural areas as urban areas.

Women's education appears to be positively and independently predict for the occurrence of FGC in this study. Mothers, who did not attend formal education is more likely to perform the procedure in their daughter as compared with mothers' who had completed secondary and above. This finding is in agreement with a study conducted in Amhara and Oromia region showed that maternal education was strong predictors of having a circumcised daughter (4, 31-33, 36). This may be because educated women are able to make wise decisions about their own health and seek proper modern health care than their counterparts.This shows that improving education status of women is the most important factors that need attention while aimed to reduce and abolishing FGC. Education is likely to enhance female autonomy so that women develop great confidence and capability to make decision regarding their own health. Moreover, educated women are more likely to be aware of the risky effect of FGC and as a result, they are more likely to fight against the practice.

Educational levels of the respondent were also an important predictor of FGC among the respondents. The practice of FGC in this study was less likely occurred in those who were high school female students as compared with those who did attend college level. This indicates that the current prevalence of FGC in the study area is decreased positively in high school students by 69% compared to college students (AOR=0.29; 95%CI=0.2-0.45).This is consistent with study done in other studies (2, 4, 31, 37). This may be due to increase their awareness, knowledge and attitude towards the bad effect of FGC on women health from time to time and the high school respondents were relatively younger age.

Religious requirement was a significant predictor of FGC in the study area. The odds of female circumcision were 2.3 times more likely performed in those who believe FGC is required by their religion than those who did not believe (AOR=4.5;95% CI=2.64-7.55). This is in agreement with study done in other part of Somali region (4) and elsewhere (37).This may be due to deep rooted values given for FGC by religion and socio-cultural factors. Some religious leaders believe and recommend especially the Sunna form of circumcision. This practice may be wrongly attached with religion having no logical reason and univocal answer why they are associated. FGC is not referred to in any reliable hadith while sharia law is clear on other points; Islam teaches respect, equality and sexual pleasure for women. The verse (Quran: 4: 125) is only applicable to male circumcision but nothing is

written about the Sunna form of FGC. Islam condemns harmful cultural practices including female infanticide (Quran: 81: 8-9).

The attitude of the respondents significantly increases the intention towards the discontinuation of FGC on younger age group (62.3%). But there is a gap between the prevalence and attitude. This is higher than that reported from the recent figure in Somali region (25.7%) according to the EDHS 2005 (11). This may be clearly visible due to partake in Ant-FGC campaign, time variation, educational advancement and a wide spread discourage to the practice. This might be because of FGC is a deeply-rooted norm which is accepted by the society as a whole, and by the women themselves. For example, men generally prefer to marry women who have undergone FGC as they might not want a woman who is sexually hyperactive and unfaithful.

7. Strength and Limitation of the study

7.1. Strength of the study

- The study used a mixed method research which helps to explore sensitive issues.
- Study subjects were young adult which showed the current status of the practice.
- Data collectors speak local languages and the same sex with study subjects could have helped to minimize information biases.
- High response rate
- The use of Standardized questionnaire from EDHS.

7.2. Limitation of the study

- Difficult to establish temporal relationship between the factors associated with the practice of FGC.
- Report for the types of FGC was based on self report, for this reason there could be a misclassification of the types of FGC that leads to the misinterpretation on the current status of FGC.
- There could be a recall bias since the respondents were asked for events prior to the study.

8. CONCLUSIONS AND RECOMMENDATIONS

8.1. Conclusions

- The prevalence of FGC on young adult female was still high in Jigjiga District irrespective of ant-FGM campaign during the last two decades.
- Respondent's level of education, religion, maternal education, residence, attitude and belief in religious requirement were the most determinant factors associated with FGC practice.
- Primary reasons for continuing of the practice were for hygienic/cleanliness, to preserves virginity/chastity, social acceptance, to get better marriage prospects/increase chance of marriage, and a religious requirement which have no scientific justification.
- The decision for FGC was mainly made by mother, grandmother, and religious leader; it was performed by local traditional female circumciser.
- The Knowledge and attitude of the respondents' mainly young girls towards the bad effect of the FGC has increased though there is a gap between the prevalence and knowledge/attitude of the female respondents.
- Therefore, the direct and indirect effect of the practice violates human rights of girls and women and may seriously affect the effort made towards realization of empowering women and gender equity.

8.2. Recommendations

Based on these findings, it is recommended that:

- The government and development partners should work together towards developing and disseminating sensitive programmes targeted at both parents and the adolescents on FGC and ways to stop it.
- The Health bureau of the region should take more responsibility on the eradication of the practice in collaboration with different stake holders to achieve MDG4 and MDG5 by establishing strategy and policy appropriate for agro-pastoral society.
- Health bureau of the region should trained female health extension workers as they have a greater contribution in the fight against FGC.
- Health bureau of the region should establish and give emphasis on setup of developmental army (one to five) for coordinating and tracing for these who victimized their daughter to the medieval practice.
- Community organizations (religion, legal and teaching institutions) should involve in giving authenticity to the banning of FGC.
- Community conversation should be promote and made among women, men, religious and clan leaders as they are the key in making decision on most of reproductive health issues for women and on clarification of the misconception attached between the practice and religion.
- Change the attitude of the men towards the uncircumcised women through behavioural change communication and advocacy at all level.
- Increasing educational level of women and men should be made a priority since educational achievement of women is an important means to reduce FGC.
- The religious organizations should involve reproductive health in their religious program.
- Effort should be made to ban the practice of FGC by women through media exposure, health education programme to women, husbands and the community as a whole.
- Research should carry out on the impact of the anti–FGC intervention and physco-social effect.

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Annex I: Sample frame from Secondary school and college students in Jigjiga district for quanitativestudy,may 2013

High school(both high schools)		**Total F.**	sampled
Grade 9	**Sections**		
Jigjiga highschool	A	40	10
	B	64	16
	C	56	14
	D	52	13
	E	48	12
	F	20	10
	G	36	9
Abduselam high school	A	52	13
	B	44	11
	C	28	7
	D	60	15
	E	32	8
	F	36	9
	G	60	15
Grade 10			
Jigjiga High school	A	52	13
	B	48	12
	C	44	11
	D	40	10
	E	36	9
Abduselam high school	A	40	10
	B	56	14
	C	52	13
	D	36	9
	E	44	11
Grade 11			
Abduselam high school	A	48	12
	B	40	10
	C	36	9
Grade 12			
Abduselam high school	A	52	13
	B	40	10
	C	48	12
Total		1340	340

College	**Total F.**	Sampled	
Year I			
A	72	36	Horn coll
B	66	33	
A	70	35	Nur coll
B	68	34	
Year II			
A	64	32	Horn coll
B	66	33	Nur coll
C	68	34	
Year III			
A	66	33	Nur coll
B	68	34	
A	70	35	Horn coll
Total	698	339	

Annex-II; Questionnaire

ADDIS ABABA UNIVERSITY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF PUBLIC HEALTH

Information Sheet and Consent Form

A. Information Sheet

Questionnaire for school based survey prepared to assess the prevalence and associated factors of female genital cutting among young adult in Jigjiga District, Somali Region.
Greetings!

My Name is _____. I came from Addis Ababa University. I am a member of the research team organized by Ato Kidanu G/mariam, who is MPH student in University of Addis Ababa, school of public health. First of all I would like to thank you for allowing us to share your time for a brief discussion about a study to be conducted in Jigjiga district. Before you start, please read about the purpose and general condition of the study.
The purpose of this study is to assess the prevalence and associated factors of female genital cutting among young adult females in this district. You are selected to be one of the participants in the study. The study will be conducted through self -administered interviews. We are asking you for a little of your time, about thirty minutes, to help us in this study. At the end, it is hoped that the information you give us could help to design appropriate intervention strategies aimed at improving community health status.

We would like to assure you that the privacy would strictly be maintained throughout. A code number will identify every participant and no name will be used. Your responses to any of the questions will not be given to anyone else and no reports of the study will ever identify you. The interview is voluntary. You have a full right to participate throughout, or to discontinue at any time, or never participate in the study. However, we hope that you will participate in this survey since your views are important to eliminate harmful traditional practice mainly Female Genital mutilation in this region particularly in Jigjiga district.

With regards!

For students whose age is below 15 years old

I, the undersigned, am the parent or legal guardian (teacher) of the student being invited to participate in the study. I have read the informed consent or have had the informed consent read to me, was given an opportunity to clarify any questions I have regarding the study, and I give permission for my child or legal ward or student to participate in the study**.**

Signature_____Date_____

School: _____ Respondent's code _____

Questionnaire to assess the prevalence and factors associated with FGC

Section I: socio-demographic and economic characteristics of the respondents.

No	Questions	Response category	Skip to
101	Your Age in completed years	_____years	
102	Religion	1.Muslim 2.Orthodox 3.protestant 4.Others_____	
103	Residence	1.Rural 2.Urban	
104	Ethnicity	1.Somali 2.Amhara 3.Oromo 4.others(specify)_____	
105	Your Educational stage	1. Primary 2. Preparatory/Secondary 3. College	
106	Educational stage of your father	1. Illiterate 2. Primary 3. Preparatory/Secondary 4. TVET/College 5. University	
107	Educational stage of your mother	1. Illiterate 2. Primary 3. secondary 4. TVET/College 5. University	
108	What is your marital status?	1. Single 2. Married 3. Divorced 4. Widowed 5. Separated 6. Cohabited	
109	What is your mother's occupation?	1. Housewife 2. Jobless 3. Student 4. Teacher 5. Religious leader 6. Circumciser 7. Merchant 8. Employee 9. Other_____	
201	What is your family monthly income	_____in birr	

SECTION II: QUESTIONS ABOUT FEMALE GENITAL CUTTING PRACTICE

S N	Questions	Response categories	Skip to
202	Have you ever heard of female circumcision?	Yes.....1 No.....2	
203	Have you ever heard about female genital practice?	1. Yes 2. No ——————→	end
204	Have you yourself ever been circumcised?	Yes.....1 No.....2	
205	Was any flesh removed from the genital area?	Yes.....1 No.....2 Don't know.....88	
206	Was the genital area just nicked without removing any flesh?	Yes.....1 No.....2 Don't know.....88	
207	Was your genital area sown closed?	Yes.....1 No.....2 Don't know.....88	
208	How old were you when you were circumcised? If the respondent does not know the exact age, probe to get an estimate.	Age in completed years_____ During infancy.....95 Don't know.....88	
209	Have any of your sisters/daughter been circumcised? If yes: how many?	Number circumcised..... No daughter/sister circumcised.....95	
301	Does your youngest sister circumcised? Yes…… 1 No ……..2----------→		306
302	What was done to your youngest girl when circumcised? Was any flesh removed from her genital area? Yes.....1 ---------- ----------→ No.....2 Don't know.....8		305
303	Was her genital area just nicked without removing any flesh?	Yes.....1 No.....2 Don't know.....88	
304	Was her genital area sown closed?	Yes.....1 No.....2 Don't know.....88	
305	How old was your youngest sister when this was done? If the respondent does not know the age, guess to get an estimate.	Age in years____ During infancy…….95 Don't know.....88	

306	Who performed the circumcision?	Traditional circumciser.....1 Traditional birth attendant.....1 Doctor.....3 Trained nurse/midwife.....4 Don't know.....88 Other(specify)……..99	
307	Who decides to be circumcised for your sister /daughter?	Mother ----------1 Father ----------2 Grandmother----------3 Religious leader ----------4 Don't know.....88 Other(specify)……..99	
308	Do you need to have your sister/daughter circumcised In the future?		Yes.....1 No.....2 Don't know.....88
309	At what age do you need to circumcise your youngest sister/daughter or yourself?		Write the age_____

SECTION THREE: REASONS FOR FEMALE GENITAL CUTTING

401	What is the benefit of circumcision? Probe: any other benefits? And record all mentioned.	Cleanliness/hygiene.....1 Social acceptance.....2 Better marriage prospects.....3 Preserve virginity /Premarital sex.....4 More sexual pleasure for the man.....5 Religious approval.....6 Other(specify) ……99 No benefits.....8

SECTION FOUR: knowledge questions about the different types of FGC and health consequences of FGC.

S.NO	QUESTIONS	RESPONSES	SKIP
402	Do you know the different forms of FGC?	Yes……1 No ……..2	
403	Would you mention those you know?	Type I Clitoridectomy…1 Type II (excision)……2 Type III, infibulation…...3 Others _____	
404	Does FGC transmit HIV?	Yes ……..1	

		No ……2	
405	Does FGC transmit Hepatitis?	Yes ……..1 No ……2	
406	Does FGC can cause Pain?	Yes ……..1 No ……2	
407	Does FGC cause Wound Infection?	Yes ……..1 No ……2	
408	Does FGC cause Sexual Dissatisfaction?	Yes ……1 No ……..2	
409	Does FGC can cause Difficult Delivery?	Yes ……1 No ……..2	
501	Does FGC can cause Excessive Bleeding?	Yes ……1 No ……..2	
502	Does FGC can result in menstrual disturbance?	Yes ……1 No ……..2	
503	What are the sources of information about complications of FGC?	Radio /television……1 Health professionals.....2 Anti- FGM committee…3 Training on anti-FGM Activities.....4 Teachers.....5	

SECTION FIVE: QUESTIONS ON ATTITUDE TOWARDS FEMALE GENITAL CUTTING

504	Do you believe that this practice is required by your religion?	Yes.....1 No.....2 Don't know.....88
505	Do you think that this practice should be continued, or should it be stopped?	Continued.....1 Discontinued.....2 Depends.....3 Don't know.....88
506	What is the effect of female circumcision on your chances of marriage?	1. Increase 3. No effect 2.reduce 4.don't know ----88
507	Which type of female circumcision Would you prefer to continue?	Infibulation ……..1 Excision/Clitoridectomy (Sunna)…. 2

		Others (Specify) _____ 3 No Response…… 99
508	Why do you think it should continue? **Multiple answers are possible!**	Good tradition…… 1 Good Custom…… 2 Religious demand…… 3 Cleanliness…… 4 Better marriage prospects ……..5 Greater pleasure of husband…...6 Preservation of virginity ……7 Prevention of immorality ……..8 Increased fertility…….. 9 Never thought about reason ….10 Others (Specify) _____ 11 No Response ……99
509	Why do you think it should not continue? **Multiple answers are possible!**	Religious prohibition…….. 1 Sexual dissatisfaction…… 2 Medical complication…….. 3 Painful personal experience……. 4 Against human rights/woman's dignity…… 5 Causes infertility…….. 6 Others (Specify) _____ 7 No Response…….. 99
601	What do you think is the best way to stop female circumcision? **Multiple answers are possible!**	Enforced legislation…… 1 Educational campaign to women…. 2 Improvement of status of women…. 3 Fathers should take more responsibility..... 4 Sexual education ……5 Others (Specify)_____ 6 No Response…….. 99
602	Do you think that this practice is against your right?	Yes.....1 No.....2 I don't know.....88

Annex- III **Focus Group Discussion**

Semi-Structured questionnaire for Focus Group Discussion

GREETINGS!

We would like to eliminate the FGM and other harmful traditional practice being practiced in Jigjiga as a whole in Somali region. We hope that discussion with you would be very helpful to strengthen and to promote the general wellbeing of both the mother and female daughters. Hence, I would like to raise a question for discussion about the general concept of FGM. Before the beginning of the discussion, I wish to express my appreciation to all of you for your voluntary participation.

For Mothers/fathers group

1. Introduction first let's introduce each other
2. What is female genital mutilation?
3. What is the advantage when girls and women are circumcised?
4. What if not circumcised?
5. Who is decision maker to be circumcised?
6. What is the common age, most girls or women circumcised?
7. Should these practices continue/discontinue?

8 Then what can we do to stop the practice?

Circumcisers

1. Introduction?
2. Why female genital cutting is practiced in Jigjiga?
3. How you become a practitioner/circumciser?
4. Why did you become a practitioner/circumciser?
5. How long have you been in this practice?
6. What is the benefit of the practice to you, your family and the community at all?
7. If someone says STOP this traditional practice because he/she sees it harmful and if he/she gives you alternatives (work) would you STOP?

Many thanks

Community leaders

1. Do you identify the harmful traditional practices in this community? How many?
2. What are these practices?
3. What are the good contributions these practices have made to the community?
4. What are the problems associated with these practices?
5. Which ones do you think we could stop starting from now on wards?
6. Why do you think we should stop or continue?
7. Did you try to stop the practice?
8. What can be done to stop the practice from this area?
9. are there any organization working on traditional practices? What they do

Religious Leaders

1. What are the religious teachings about the practice of Female Genital cutting?
2. is it a traditional belief or authorized by the Koran/bible?
3. Give reasons why the practice should continue or be stopped.

Jaamacada Addiss Ababaa

Kooleejka cilmiga dhakhatarnimada iyo sayniska caafimaadka

Waaxda caafimaadka dadwanaha

Su'aalahan waxaa loogu tala galay in lagu qaato heerka gudniinka fircooniga ah iyo waxyaabaha la xidhiidha ee lagu sameeyo gabdhaha da'doodu ka hoosayso shan iyo toban jir ee magaalada qabri bayax dawlada deegaanka soomaalida

Hordhac

Magacayguwaa_____ waxaan katirsanahay kooxda daraasadka kufulinaysa ato Kidanu G/mariam,ookasocda jaamacada addis abbaa,waaxda caafimaadka dadwaynaha, ujeedada ugu muhiimsan ee laga leeyahay daraasaadkan waxay tahay in la ogaado lurka gudniinka fircooniga ah iyo waxyaabaha la xidhiidha natiijada daraasaadkani wuxuu warbixin muhiim ah kabixin doonaa gudniinka fircooniga ah si wax looga qabto loogana hortago waxyeelooyinka uu u gaysto dumarka.

Adiga oo ah hooyo dhashay gabadh ama gabdho waxaan jeclaanlahaa inaad nagala qaybqaadato magacaaga looma baahana waxkasta oo aad tidhaana inaga uunbay inagu koobnaanaysaa la iskuma qasbayo inaad ka jawaabto su'aal kasta xorna waxaad utahay inaad iska dayso su'aalahani waxay kugu qaadanayaan daqiiqo inaad ka jawaabto diyaar maan utahay inaad ka jawaabto?

Su'aalaha laga qiimaynayo heerka gudniinka fircooniga ah iyo wayaabaha la xidhiidha

Qaybta koowaad: nolol bulsheedka ka qaybqaataha

101. Da'daada _____ sanno
102. Diintaada
    1. Muslim
    2. Orthodox 3.Kuwa kale
103. Heerka waxbarasho
    1. waax ba baran
    2. Wax qora waxna akhriya
    3. Ilaa dugsiga hoose
    4. Ilaa dugsi sare
    5. Heer kooleej
    6. Heer jaamacadeed
104. Guurka
    1. Xaas leh
    2. La furay
    3.Laga dhintay
    4.Kala maqan
105. Waa maxay shaqadaadu?
    1. Guri jog
    2. Bilaa shaqo
    3. Arday
    4.Macalin
    5.Hogaamiye diimeed
    6.Wax gudid
    7.Kuwo kale _____
106. Waa imisa lagactaad hesho bishii qiyaas _____birr

Qaybta labaad su'aalaha ku saabsan gudniinka fircooniga ah

107. Waligaa maad maqashay gudniinka gabdhaha
    1. Haa ----------→**Skip to 203**
    2. Maya ----------→**202**

108. Waligaa maad maqashay gudniinka xubnaha taranka ee gabdhaha laga jaro

1.Haa

2.Maya----------→**end**

109. Adiga qudhaada miyaa lagu guday?

1.Haa ----------→**204**

2.Maya ----------→**209**

201.Maxaal lagugu sameeyay? Qaybka mid ah xubinka taranka miyaa lagu jaray?

1.Haa

2.Maya

3. Magaranayo

202.Xubinka taranka miyaa lasaray oo kaliya iyada oo aan waxba laga jarin?

1.Haa

2.Maya

3. Magaranayo

203.Miyaa lagu tolay?

1.Haa

2.Maya

3.Magaranayo

204.Imisa jirbaad ahayd? Markii lagu guday qiyaas?

_____ Sano

88. Magaranayo

205.Ayaa ku guday?

1. Dumarka waxguda
2. Umuliso nick
3. Xirfadle
4. Caafo,aad
5. Cidkale (cayin)

88.Magaranayo

206.Gabdhahaaga maa la guday? Hadii jawaabtu haa tahay?

1. Tirada laguday
2. Kuwa aan la gudin

207.Gabdhahaaga tee mudo dhaw laguday?

1.Haa

2.Maya

208.Maxaa lagu sameeyay? Qaybka mid ah xubinteeda taranka maalajaray?

1.Haa

2.Maya

3. Magaranayo

209.Miyaa la saray oo kaliya iyadoon waxba laga jarin xubinka taranka?

1. Haa

2.Maya

3. Magaranayo

301. Xubinta tarankeeda miyaa la isku tolay?

1. Haa
2. Maya
3. Magaranayo

302.Gabdhahaaga tii ugu yarayd markii laguday imasa jirbay ahayd?qiyaas hadaadan garanayn?

_____Sano

22. Magaranayo

303. Ayaa guday?

1.Dumarka waxguda

2.Umuliso

3.Dhakhtar

4.Neeris

5.Magaranayo

6.Kuwo kale

304.Miyaad rabtaa inaad gabadhaada ama gabdhahaaga gudo mustaqbalka?

1. Haa

2.Maya

3. Magaranayo

<u>Qaybta saddexaad</u>

<u>Sabaha loo sameeyo gudniinka gabdhaha</u>

305.Maxay gabadhu ka faa'iidaysaa hadii lagudo ?

1. Inay nafiid noqoto

2. Maadaama ay bulshadeedu raali ka tahay

3.Inay guur fiican rajayso

4.Inay gabadhu bikir ahaato oo ayna sina ku dhicin

5.Si ay ninkeeda gogosha ugu qanciso

6.Diintaa tidhi

7.Kuwo kale hadii ay jiraan _____

8.Faa'iido malaha

Qaybta afraad :

Su'aalaha la xidhiidha aqoonta gudniinka gabdhaha iyo saamaynta uu ku leeyahay caafimaadka

306.Wax miyaad ka taqaanaa noocyada gudniinka gabdhaha?

1. Haa

2.Maya

307. Miyaad noo sheegi kartaa kuwaad taqaano?

1. Nooca I (Kintirka oo la jaro)

2.Nooca II (In dabnaha lajaro)

3.Nooca III (In la isku tolo)

4.iyo kuwa kale_____

308.Gudniinka fircooniga ah miyaa lagu kala qaadaa cudurka aydhiska?

1. Haa

2.Maya

309.Gudniinka fircooniga miyaa lagu kala qaada cudurka ku dhaca beerka (jooniska)

1. Haa

2.Maya

401. Gudniinka fircoonigu miyuu sababi karaa inuu naburku infekshin qaado?

1. Haa

2.Maya

402.Gudniinka fircoonigu miyuu sababi karaa xanuun marka gabadha lagudayo?

1. Haa

2.Maya

403.Gudniinka fircoonigu miyuu sababi karaa in ay gabadhu dhibkala kulanto galmada?

1. Haa

2.Maya

404.Gudniinka fircoonigu miyuu sabab unoqonkaraa in hooyada fooshu ku adkaato?

1. Haa

2.Maya

405.Gudniinka fircoonigu miyuu sababi karaa dhiig bax?

1. Haa

2.Maya

406.Gudniinka fircoonigu miyuu caadada gabdhaha saamaynkaraa?

1. Haa

2.Maya

407.Inuu gudniinka fircoonigu dhibaatooyinkan leeyahay xageed ka maqashay?

1. Raadyawga/ tiifiiga
2. Khibradle caafimaad
3. Ururada u ololeeya cidhibtirka gudniinka fircooniga
4. Tababar ku saabsan gudniinka fircooniga ah

Qaybta shanaad

Su'aalaha ku saabsan waxyaalaha aad ka aamin santahay gudniinka fircooniga ah

408. Miyaad aaminsantahay inay diintu fartay gudniinka fircooniga ah?

1.Haa

2.Maya

22.Magaranayo

409. Ma in dhaqankan lajoojiyaa mise waa in lasii wado?

1. Lasiiwado -----→503
2. Lajoojiyo ----→505
3. Waxbay ku xidhantahay
4. Magaranayo

501. Gudniin noocee ah ayaad doorbidaysaa in gabdhaha lagu gudo?

1. In latolo
2. In la suneeyo (kintirka oo kaliya la jaro))
3. Kuwo kale (cayin)
99. Jawaab malaha

502. Maxaad udoor bidaysaa gudniinkan fircooniga ah?

1. Waa dhaqan fiicaan
2. Waa caado fiican

3.Diintaa tidhi
4.Sharafta gabdhaha ayuu ilaaliyaa
5.Inay guur fiican rajayso
6.Si ay ninkeeda gogosha ugu qanciso
7.Si ay bikir u ahaato
8. Si aan loo caayin
9.Si ay caruur badan u dhasho
10.Sababta magaranayo
11. Kuwo kale (cayin)
88.Jawaab malaha

503.Waa maxay sababta aad u doorbidayso in la joojiyo?

1. Diintaa mamnuucday
2. Galmaday gabadhu dhib kala kulmaysaa
3. Caafimaad darro
4. Dhibbaan kala kulmay
5. Waxay meel ka dhac ku tahay xuquuqda iyo sharafta haweenka
6. Gabadhu madhalays bay noqonaysaa

88.Kuwo kale hadii ay jiraan noosheeg

504. Maxaad u malaynaysaa in ay tahay sida ugu fiican ee lagu joojinkaro gudniinka fircooniga ah

1.In sharciga la adkeeyo
2.In dumarka lawacyi galiyo
3.koradhka awooda dumarka
4.In aabayaashu xil iska saaraan
5.Wacyi galin ku saabsan galmada
6.kuwo kale (cayin)
88.Jawaab malaha

Focus group guide (somaligna version)

Angia oo ah KIDANU G/MARIAM, oo ka diyaarinaya masterayt ku saabsan caafimaadka bulshada (master of public health) Jaamacada addiss abbaa, waxaan wakiil ka ahay daraasaad ay jaamacadu doonayso inay ka samayso magaalada qabri bayax taa soo ku saabsan gudniinka fircooniga ah.

Daraasaadkani waxaan ku eegaynaa sababaha gudniinka fircooniga ah loogaga dhaqmo qabri bayax, waxaanan kuu dooranay inaad ka qaybqaatado daraasaadka fikradihiinu waxay naga caawinayaan in xal loo helo si loo yareeyo caadadan taa soo yaraynaysa dhibaatooyinka ay dumarku kala kulmaan gudniinka fircooniga ah.

Sidaas darteed waxaan ubaahanahay in aad su'aalahan si daacad ah uga jawaabto, maadaama oo ay waxku kordhinayso korna u qaadayso qorshayaasha caafimaadka.
Waxaan fadlan kaa codsanayaa inaad ka qayb qaadato kaalintaadu waxay doormuhiim ah ka ciyaaraysaa daraasaadkan markaa sideed u aragtaa?

Markaan isbarano kadib, waxaan ka wada hadli doonaa arimo ku saabsan gudniinka fircooniga ah, waanan isla falanqayn doonaa sababaha caadadan loogaga dhaqmo magaaladan qabri bayax. Wakhtibaan ku siinayaa aad kaga jawaabto mawduuc kasta, saaxiibkay _____ wuu qori doonaa, waxaa kale oon kaaga duubaynaa cajalad si aanan uga tagin waxaad tidhi, waxkasata oo aan ka wada hadalno wuxuu ku koobnaan doonaa aniga iyo saaxiibkay, ugu dambayntiina waxaan kusoo gabagabaynayaa anagoo ku waydiinayna waxyaabaha aad ka leedahay siloo yareeyo ama joojiyo gudniinka fircooniga ah ee kajira bulshada aad la nooshahay mustaqbalka, markaa miyaad rabtaa in aad ka qaybqaadato?

Miyaad arin leedahay inta aynaan bilaabin?
Waxaan fahmay faa'iidada daraasaadkan iyo doorka aan ka ciyaari karo daraasaadkan, waxaan ogolahay inaan ka qaybqaato daraasaadkan

a. haa
b. maya

Magaca waraysi qaadaha _____ saxeexa _____

(saxeexa warysi qaaduhu wuxuu ka turjumayaa in uu ogolaansho ka helay la waraystaha)

Maalinta _____wakhtiga _____

Su'aalaha ku wajahan Waalidka

1. marka hore is barasho wanaagsan
2. maxaad ka aaminsantahay gudniinka fircooniga ah?
3. gabdhaha iyo dumarkuba maxay ka helayaan hadii lagudo?
4. balkawaran hadii aan la gudin?
5. ayaa go'aanka iska leh in gabdhaha lagudo?
6. magaalada qabribayax, gabdhaha badankooda imisa jirbaa lagu gudaa?
7. gudniinka fircooniga ah ma inlasii wadaa mise waa in lajoojiyo?
8. maxaan samaynkarnaa si loo joojiyo caadadan?

Su'aalaha ku wajahan Dumarka Waxguda

1. marka hore is barasho wanaagsan
2. waa maxay sababta gudniinka fircooniga ah loogaga dhaqmo magaaladan qabribayax?
3. maxaa kugu kalifay inaad gabdhaha gudo? Sidayse kuugu suurto gashay inaad barato xirfadan?
4. muddo intee le'eg ayaad ka shaqaynaysay gudniinka?
5. muxuu faa'iido uu kuu leeyahay gudniinka fircoonigu? Muxuuse faa'iido uleeyahay qoyskaaga iyo bulshadaba?
6. hadii shaqo tan dhaanta lagu siiyo miyaad joojinaysaa?

7. waad mahadsantahay

Su’aalaha Ku Wajahan Hooyeyaasha Bulshada

1. caado dhaqameedyo miyay ka jiraan bulshadan dhaxdeeda?
2. hadii ay jiraan, wax miyaad nooga sheegi kartaa?
    a. kuwee ayaad umalaynaysaa in ay faa’iido leeyihiin, ku weese bilaa faa’iido ah?
3. waa maxay faa’iidooyinka ay uleeyihiin bulshada?
4. waa maxay dhibaatooyinka la xidhiidha caadadan?
5. tee ayaad umalaynaysaa in la sii wado, teese ay tahay in la joojiyo?
6. wali midaad isku dayday si aad u joojiso?
7. miyay jiraan dad u ololeeya caado dhaqameedyada? Hadii ay jiraan maxay qabtaan?
8. maxaa lagu joojin karaa caadooyinka xun xun ee ka jira deegaankeena?
9. waad mahadsantahay

Su’aalaha Ku Saabsan Khibradlayaasha Caafimaadka (Dhakhaatiirta, Neerasta, Umulisooyinka, Macalimiinta)

1. waa maxay dhibaatooyinka ay gabdhu kala kulanto gudniinka fircooniga ah?
2. miyaad dhiiri galisaan in gabdhaha lagudo? Sabab?
3. waa maxay faa’iidooyinka laga helayo hadii gabadha lagudo?