Baseline Survey: Accelerate to end FGM/C in selected zones, Oromia region, Ethiopia

Final Report

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ABBREVIATIONS

CORHA	Consortium of Reproductive Health Associations
DEFF	Design effect
EDHS	Ethiopia Demographic and Health Survey
FGDs	Focus group discussions
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender based violence
HC	Health center
HEfDA	Harmee Education for Development Association
HEW	Health extension worker
HTP	Harmful traditional practice
IDIs	In-depth interviews
IMAGES	International Men and Gender Equality Survey
KIIs	Key informant interviews
NGO	Non-governmental organization
RMNCH	Reproductive, maternal, neonatal, and child health
SDG	Sustainable Development Goal
SRH	Sexual and reproductive health
TaYA	Talent Youth Association

EXECUTIVE SUMMARY

Background

The Consortium of Reproductive Health Associations (CORHA), Harmee Education for Development Association (HEfDA), and Talent Youth Association (TaYA) designed the project entitled "Accelerate to end FGM/C (Oromia)". Using a proven community-led model and national advocacy this project aims to ensure: communities are motivated to choose to abandon FGM/C; FGM/C is understood not to be a religious requirement; positive change is welcomed at local and national levels, and better status and opportunity for women and girls. It also aimed at reducing FGC and other harmful practices in the woredas of West Arsi, Arsi, and East Shewa zones of the Oromia region in Ethiopia.

The purpose of this baseline assessment is to determine the: knowledge of and attitudes towards FGM/C, gender and power relations, women and youth participation in decision making amongst the targeted community members within the identified woredas; level of community action to end FGM/C in the targeted areas; and the level of engagement and commitment from local, regional and national civil society stakeholders towards ending FGM/C and other harmful practices.

Methodology

The study was conducted in the three project intervention Liben Cuqalla, Munessa, and Heban Arssi woredas of East Shewa, Arsi, and West Arsi zones respectively. This baseline survey employed mixed data collection approaches including desk review, quantitative household surveys, and qualitative approaches. The data collection approach involved structured questionnaires, semi-structured in-depth interviews, and focus group discussion guides. The survey covered 415 women in the household survey, 14 key informants (four females[1] and six males), and 14 FGD sessions (9 female-only and 5 male-only groups). Descriptive analysis was conducted using frequencies, percentages, and some cross-tabulations. Composite scores were computed to determine the overall attitude, women's decision status, and experiences concerning FGM/C and other gender-based violence.

Key findings

Attitude against FGM/C

- **76.9%** of the respondents believe that female circumcision is a harmful tradition for girls and women.
- **80.3% and 74.5%** of the respondents respectively believe that 'severe' and 'all' forms of female circumcision should be stopped (abandoned).
- Only **17.1%** of the same respondents believe that FGM/C is a requirement by religion
- **85.3%** of the study participants had a favorable (positive) attitude against FGM, and **40.5%** of the study participants believe that uncircumcised girls and women are more promiscuous than circumcised girls

Women's decision-making status

- **44.6%** of respondents have a positive (supportive) attitude towards women status (women equality, against violence, women's family responsibility, decision on health care)

[1] *Women and Children Affairs Office, Health Office, NGO representative, and Police Officer from the three Woredas.*

- **21.0%** of the study participants had favorable decision-making status (decide by themselves or jointly with others and at least partly engage on household matters as that of her partner)
- **40.7%** of the respondents did not participate (were not involved) in making decisions about their health care (decided by their husband/partner), while 18.8% of the women usually make decisions by themselves and 40.5% jointly with their husbands and/or others.
- **51.1%** of the women are not usually involved in decisions on how the money they earn is used.

Knowledge of the respondents on the effect of FGM on the victims

- While **91.1%** of the study participants mentioned that FGM/C is harmful to girls and women, **only 13.0%** of the women had good knowledge[2] about the harmful effects of FGM/C (spontaneously mentioned more than five out of the nine[3] potential responses).
- The most mentioned harmful effect of FGM/C was "complications during childbirth" **(74.2%)** followed by "cause severe bleeding" **(58.1%)**.
- Some of the reasons mentioned during the qualitative study by the FGD and KI participants why girls and women are circumcised include: religious reasons, traditions, and misconceptions (so they will not break materials, they obey to their husbands, not to be isolated by the community)

Experience of study participant on female genital cutting/mutilation

- **87.2%** of the study participants (women) were circumcised. 11.3% of them were reported to be circumcised before their first birth date while 81.4% of the women reported being circumcised before the age of 19 years).
- **57.3%** of the daughters were circumcised within two years after birth.
- Of the 320 daughters aged 0-14 years, **25.6%** were reported to be circumcised and **100%** of them were circumcised by traditional circumcisers.
- **55.2%** of the young girls aged 10-24 years were circumcised.
- Only **20.6%** of the girls have ever engaged in FGM/C movements
- **76.4%** of girls aged 10-24 years old have ever discussed FGM/C-related issues with their parents

Actions by communities and local actors to end FGM/C in the targeted areas

- **25.7%** of the study participants are still in favor of the continuation of circumcision in their communities - have a plan to circumcise their daughters in the future.
- **78.1%** of the study participants believe that actions that support the abandonment of female circumcision within the local community should be strengthened.
- The qualitative findings indicate that while there are encouraging signs that the community is aware of the harmful effects of FGM, there still needs to be more effort to ensure the practice is not continuing secretly.
- Key informants and FGD participants also believe that the FGM/C issue is getting less attention by the government bodies compared to other GBVs like rape and abduction.

[2] *Respondents were asked to give as many responses as possible out of the nine potential answers and during analysis. During analysis, those who responded at least 5 of the 9 possible answers were considered to have good knowledge or to be knowledgeable about the consequences of FGM/C.*

[3] *Severe bleeding, difficulty during urination, pain during sexual intercourse, difficulty during childbirth, reduced sexual desire, reduced sexual satisfaction, predisposition to infection, susceptibility to HIV infection, and psychological disturbances.*

- Partners and the local government are organizing awareness creation sessions for the community; they are working closely with FGM/C response groups in the villages and school health clubs to teach communities and end the practice.
- In some areas, the Geda system has created a conducive environment in the effort of curbing the practice and effect of FGM/C as it does not support women's and girls' circumcision.

Conclusion

This assessment revealed that 79.3% of the women in the reproductive age groups living in the study areas had a favorable/positive attitude towards women's and girls' status in society in general and in a relationship in particular and against FGM and other GBVs. However, still, about 21% of the women had an unfavorable attitude towards women's and girls' status in society and FGM/C. Moreover, more than half of the women had an unfavorable attitude towards their social status and physical violence as many of them believe that wife-beating is justifiable among others. Women living in the study areas were found to have a low level of decision-making status with only 21.0% of the study participants making decisions either alone or at least jointly mainly on household expenditures.

Although the majority of the women think that FGM harms the victims, only 13.0% of the women mentioned more than half of the nine (expected number) effects of FGM on the victims, implying that the vast majority have a poor level of awareness about the negative effects of FGM/C. The most cited negative effects of FGM/C by respondents were complications during childbirth, severe bleeding followed by pain during sexual intercourse, and urination.

The lifetime prevalence of circumcision among women aged between 15-49 years was very high in the study area at 87.2% - higher than the regional estimate (76%). More than half of young girls aged 10-24 years were also circumcised. Similarly, 25.6% of daughters aged 0-14 years were circumcised which is much higher than the national average of the EDHS 2016 at 14% but by far lower than the prevalence among their mothers. The data show that girls are 2.6 times more likely to be circumcised if their mothers are circumcised (72.0% vs 28.0%). The association between the older age group and status of FGM may be due to the effect of the different interventions (awareness-raising activities and the legal measures taken) against FGM which have been implemented by the government and other partners. However, those young women cannot be assumed to be safe as more than half of the women aged between 15-49 were circumcised during or after their adolescence age (>=10 years).

Both the quantitative and qualitative findings of this baseline assessment indicate that there are different excuses used by communities to justify the practice of FGM/C including believing that FGM is a requirement by religion and other misconceptions such as to reduce the sexual desire of the woman, to ensure their loyalty to their marriage/husbands, *to make them obedient and submissive to their husbands, to reduce before-and out of marriage sexual intercourse or childbirth, etc.* Fortunately, religious leaders are against such beliefs which could be a fertile ground to implement SBC interventions.

Though a significant proportion of the study participants believe that actions that support the abandonment of female circumcision within the local community should be strengthened, alarmingly, a quarter of the women still support the continuation of female circumcision and they want to circumcise their daughters in the future. Important efforts are being made by partners and the local government by organizing awareness creation sessions for the community. They are working closely with FGM response groups in the villages and school health clubs to teach communities and end the practice. In some areas, the Geda system has created a conducive environment in the effort of curbing the practice and effect of FGM/C as it does not support women's and girls' circumcision.

Recommendations

- More actions to reduce the lifetime prevalence of FGM/C and its effect on the newborns by raising the awareness of women and by engaging local/religious leaders so they can influence the community against FGM.
- Awareness creation measures are required to improve women's knowledge and attitude towards their daughters and their social and economic status, and their attitude towards physical violence by engaging local/religious leaders so that they can influence the community towards improved women's status.
- The health, social, and legal bodies should strengthen their collaboration in educating the community; detecting, investigating, reporting, providing services to the survivors; and enforcing the existing law to protect women from FGM/C.
- Bring behavioral change to the traditional circumcisers as they are the only ones who perform circumcision practices even secretly. Repeated awareness-raising activities and engaging them in small-scale income-generating activities would facilitate an easy transition for them. Taking legal actions on these groups of individuals may accelerate the immediate abandonment of the malpractice than reaching the whole community which may take longer time and resources.
- Raise the awareness of teachers and school principals to educate their students about the harmful effects of circumcision and advise them on the social and medico-legal measures they can take if they found out that their students were absent from school to get circumcised.

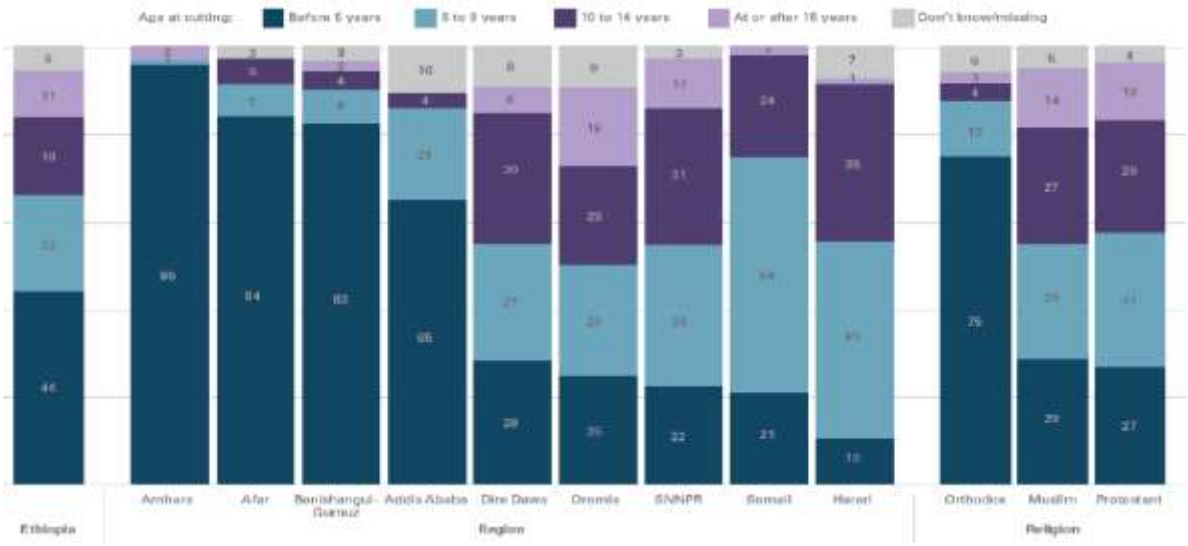
1. BACKGROUND

FGM/C is a violation of human rights held in place by social norms and gender norms. FGM/C is also a critical global agenda included in the Sustainable Development Goal (SDG) targeted for elimination by 2030[4]. The practice can lead to lifelong trauma and has significant cost implications on the healthcare system of the countries in which it is practiced. FGM is a violation of human rights and has been prohibited in Ethiopia's criminal code since 2004[5].

Ethiopia is home to 25 million girls and women who have experienced FGM the highest in absolute numbers (not in prevalence) in Eastern and Southern African countries. According to the 2016 Ethiopia Demographic and Health Survey (EDHS 2016), 60% of women aged 15-49 are circumcised ranging from 23% in Tigray region to 99% in Somali region. Oromia region where this baseline assessment was conducted has the fourth-highest FGM/C prevalence at 76%.

The same evidence shows that according to responses from their mothers, 16% of girls aged 0-14 are circumcised and girls are five times more likely to be circumcised if their mothers are circumcised, compared with girls of uncircumcised women. Younger ages and rural residents are less likely to be circumcised compared to their older and urban counterparts. Infibulation[6] is more common in Somali and Afar while it is least practiced in Addis Ababa and Oromia at 1% and 2% respectively. Removing flesh is the most common form of FGM in Ethiopia as a whole and Oromia region. Among young women in Oromia region who have been cut, 73% were cut before age 15 years (Fig. 1).

Figure 1: Percentage distribution of women aged 20 to 24 years who have undergone FGM by age at cutting, by region, and religion[7]



[4] *Sustainable Development Goals | United Nations Development Programme (undp.org) or SDG Indicators — SDG Indicators (un.org)*

[5] *The Criminal Code of the Federal Democratic Republic of Ethiopia, Proclamation No.414/2004.*

[6] *The most pervasive form of female genital mutilation/cutting—infibulation—involves the almost complete closure of the vaginal orifice by cutting and closing the labia to create a skin seal. A small opening remains for the passage of urine and menstrual blood.*

[7] *United Nations Children's Fund, A Profile of Female Genital Mutilation in Ethiopia, UNICEF, New York, 2020.*

While the Ethiopian FGM/C prevalence rate has declined in recent years, from 80% to 65% between 2000 and 2016[8]. With annual population growth, UNICEF estimates that progress must be significantly faster to reach the target set out in the Ethiopian National Costed Roadmap to end Child Marriage and Female Genital Mutilation[9,10].

In Oromia, our target region, FGM/C prevalence is 76%. Due to the large population (35M), more girls were cut here than anywhere else in the country. However, there is an appetite for change with over 70% of people wanting to see the practice end[11].

Within the target zones of Arsi, West Arsi and East Shewa FGM/C rates are as high as 88%, highlighting the urgent need for interventions. There is a mix of Muslim and Orthodox Christians, with FGM/C among both faiths and 27% of people believing it is religiously required[12].

2. PROJECT OVERVIEW

Through our program and using a proven community-led model and national advocacy this project aims to ensure: communities are motivated to choose to abandon FGM/C; FGM/C is understood not to be a religious requirement; positive change is welcomed at local and national levels, and better status and opportunity for women and girls.

This project involves the collaboration between the Consortium of Reproductive Health Associations (CORHA), Harmee Education for Development Association (HEfDA), and Talent Youth Association (TaYA) aimed at reducing FGC and other harmful practices in the West Arsi, Arsi, and East Shewa woredas of the Oromia region in Ethiopia. The project is funded by Orchid Project. Orchid Project is a UK-based NGO that is catalyzing the global movement to end female genital cutting (FGC). Orchid partners with trailblazing grassroots organizations around the world, and shares knowledge and best practices to accelerate change. It also advocates among governments and global leaders to ensure work to end FGC is prioritized. The project aspires to create a world free from FGC together with its partners and local actors[13].

3. BASELINE ASSESSMENT OBJECTIVES

The purpose of the baseline study is to determine the current situation concerning the main elements of the project and more specifically to:

- Assess the knowledge of and attitudes towards FGM/C, gender and power relations, women and youth participation in decision making amongst the targeted community members within the identified woredas
- Assess the level of community action to end FGM/C in the targeted areas

[8] *EthiopiaDemographic Health Survey, The DHS Programme, funded by USAID (2016)*
[9] *"An investment for the future", UNICEF (2018)*
[10] *National costed roadmap to end child marriage and female genital mutilation in Ethiopia, Ethiopian Ministry of Women, Children and Youth and National Alliance to End FGM and ECM (2019)*
[11] *Ethiopian Demographic Health Survey, The DHS Programme (2016)*
[12] *ibid*
[13] *Orchid Project What We Do - Orchid Project*

- Assess the level of engagement and commitment from local, regional, and national civil society stakeholders towards ending FGM/C and other harmful practices

The study will help CORHA and its partners establish critical baseline figures for the project's key indicators, and constitute the basis to measure the project performance. The findings of the baseline study will also be used as evidence-based advocacy and influencing tool.

4. METHODOLOGY

4.1. Study area

The baseline study was undertaken in the three project intervention zones of East Shewa (Liben Cuqalla woreda), Arsi (Munessa woreda), and West Arsi (Heban Arssi woreda) in Oromia region.

4.2. Study design

The evaluation approach for this baseline assessment employed a mixed-methods approach using a cross-sectional study design conducted with women and adolescent girls to address issues related to a measurable reduction of FGM/C, knowledge, and attitudes towards FGM and qualitative exploratory design involving Key Informant Interviews and Focus Group to substantiate findings of the quantitative survey.

4.3. Study population

Quantitative study population: The quantitative approach of the study constituted women aged 15-49 and their living daughters aged 0-14 years, that were addressed through a household survey. The age bracket of the study population was determined as per the project's expected results and will also enable us to compare findings with other similar surveys such as EDHS.

The quantitative structured questionnaire was adopted from the International Men and Gender Equality Survey (IMAGES), the World Health Organization's multi-country study on violence against women, and Ethiopia Demographic and Health Surveys. As such, pre-testing of the tools was not mandatory but data collectors performed mock exercises to ensure that they have understood the tool.

Qualitative study population: The study population for the qualitative approach involved men, women, adolescent girls and youth, community leaders, and local authorities.

4.4. Sample size and sampling procedures

4.4.1. Household survey

To estimate the sample size needed for women and adolescent/youth girls participants for this study (to ensure external validity), we used EpiInfo StatCalc for population survey ($n = [DEFF*Np(1-p)]/[(d^2/Z^2_{1-\alpha/2}*(N-1)+p*(1-p)]$) while considering the 2019 projected population size for the three Zones in Oromia region. Hence, a total of 415 women aged 15-49 and their respective living daughters aged between 0-14 years for assessment of the prevalence of FGM in this age group and empowerment level

of adolescent girls were reached with a 100% response rate. The parameters considered in the sample size determination process include 78.1% prevalence of study parameters (positive attitude towards the practice of FGM/C in the region, which gives a larger sample size than the other variables) in the target zones, the confidence level of 95%, a significance level of 5%, design effect of 1.5. We also considered a 5% non-response rate.

***Sampling technique for quantitative approach*:** In this baseline survey, large rural villages were considered as sampling frames. A two-stage sampling technique was employed to select the households and ultimately the study population. In the first stage, a total of 14 clusters/villages were selected with probability proportional to population size (Table 1). In the second stage, a fixed number of an average of 30 households per village were selected with an equal probability using a systematic selection from the households in the selected enumeration area/village.

Table 1: Sample size for quantitative approach by study Zones

Name of Zone	Name of woreda	2019 estimated woreda popn size	Popn proportion	Sample size (women; 15-49[14])	# selected kebeles	#Enumeration Areas (30 respondents per village)
East Shewa	Liben Cuqalla	99,038	0.24	101	1	3
Arsi	Munessa	233,113	0.57	237	3	8
West Arsi	Heban Arssi	76,204	0.19	77	1	3
Total		**408,355**	**1.00**	**415**	**5**	**14**

4.4.2. Qualitative approaches

Qualitative data are meant to explore more about a range of issues related to the attitudes and be of younger and older men issues. In this study, a range of qualitative data was collected using key informant interviews (KIIs), focus group discussions (FGDs), and in-depth interviews (IDIs) with girls and women, government officials, health service providers, health officials, religious leaders, and community gatekeepers or influencers in the project sites.

4.4.3. Focus group discussion

Focus group discussions were conducted with selected adolescents and youth, men and women mainly to bring context-appropriate data and facilitate understanding of the real circumstances in knowledge about: their SRH rights; attitude/belief and norms of the community against HTP/GBV; the abandonment of FGM/C; the interventions in the target districts by service providers, women groups, traditional and religious leaders related to FGM among others; and culturally appropriate activities they can take forward to support the abandonment of FGM/C.

[14] M

4.4.4. Key Informant Interview

Key Informant interviews were conducted with Woreda Health Experts, Women and children Affair experts, Police Officers, and religious leaders (Table 2). The KII aims at collecting data on availability and accessibility of social services for FGM survivors; the influence of policies and actions to end FGM/C; level of community action to end FGM/C in the targeted areas; and the level of engagement and commitment from local, regional, and national civil society stakeholders towards ending FGM/C and other harmful practices.

4.4.5. In-depth interview with community gatekeepers

In this study, interviews were conducted with gatekeepers (clan/community leaders and religious leaders) to examine the level of awareness, attitude/belief and norms of the community against HTP/FGM/C, attitude and practice of gatekeepers, and their influence on HTP and SRH rights, availability of social services and social protection, the perception of community leaders about women's decision-making empowerment on SRH related issues including FGM/C.

Table 2: Summary of sample size distribution by data collection method and zone

Name of Woreda	Focus Group Discussion (Female Group)	Focus Group Discussion (Male Group)	Key Informant Interview	KII with Gatekeepers
Liben Cuqalla (East Shewa)	1 Female in-school group (Aged 10-14 & Rural aged 15-29) 2 Female married out-of-school groups (15-29, 30-39 age)	1 male out-of-school aged 15-29 years group	1 Woreda Health Official 1 Health Service providers 1 Legal officer	1 Clan leader
Munessa (Arsi)	2 Female out of school group (1 married rural 15-29 years, 1 never-married aged 15-29 years) 1 Female in-school group aged 15-19 years	1 Males never-married/in-school group (15-24 years) 1 Male married (25-39 years)	1 Woreda Health Official 1 Woreda Women, Children and Social Affairs Official 1 Legal Officer	1 School Principal 1 Woreda Youth and Sport Office
Heban Arssi (West Arsi)	2 Female out-of-school group (1 married rural 15-29 years, 1 never-married aged 15-29 years) 1 Female in-school group aged 15-19 years	1 Males never-married/in-school group (15-24 years) 1 Male married (40-59 years)	1 Health Service provider (HC) 1 Woreda Women, Children and Social Affairs Official 1 NGO representative	1 Representative from an organization 1 Religious leader
5 Woredas	**9 Female FGDs**	**5 Male FGDs**	**9 Key Informants**	**5 Gatekeepers**

4.5. Data collection preparation and administration

Training of data collectors: In this assessment, we employed 10 data collectors (3 females[15]). Training of data collectors was done in Amharic to ensure concepts and questions are understood easily by each

[15] *All of our respondents for the HH survey were women and every data collector –male or female- interviewed them regardless of gender sensitivity. In other words, women were not interviewed by female data collectors only.*

data collector. Data collectors were given the chance to share their experiences including challenges that could be faced in the field from previous similar exposures. Ten data collectors that are familiar with the study areas were trained for one day on the key concepts being researched and interviewing techniques. The qualitative data collectors received orientation on the different semi-structured FGD, KII, and in-depth interview guides. After training of the data collectors and mocking exercise using the android version tools, the data collection tool was reviewed before the final copies are configured on the electronic data collection system.

Data collection using a structured questionnaire: Data collection took place from October 12-18, 2021. The quantitative data were collected using android tablets. To avoid the risk of interruption in the data collection process because of a lack of electric power, power banks were handed over to the data collectors. Supervisors also moved to the field with copies of paper-based questionnaires to fill gaps following any irregularity that may happen to the electronic data collection tools. Data were transferred to the central server at the end of each day when internet connectivity was good which allowed timely (real-time) data quality checks by the research team.

Data collection using qualitative tools: To conduct FGDs, groups were formed in such a way that homogeneity was maintained such as by age and sex so participants can share common interests and feel comfortable in expressing their views and opinions in front of the other group members. Each FGD session has members ranging from 8-12 participants - a size that gives scope for a large enough range of different viewpoints and opinions while enabling all participants to make contributions without having to compete for time.

4.6. Data management and analysis

Statistical analysis: Descriptive analysis was run using absolute numbers and proportions or percentages. The analysis was presented as per the project's key performance indicators and other supplementary variables of interest as indicated in the TOR. Composite scores were constructed for some of the variables of interest (Annex-2).

Qualitative analysis: All qualitative interviews were audio-recorded. The digitally recorded interviews were transcribed and translated into English by qualitative study experts with experience in qualitative methods. The transcriptions were used to substantiate the findings of the household survey.

4.7. Data quality assurance

Ensuring validity and reliability: The structured questionnaire was adapted from standard tools which contribute to its validity. Accurate data collection methods were applied by deploying skilled data collectors to maximize the response rate. To establish reliability in this survey, enumerators were trained effectively to minimize errors that might arise because of the misunderstanding of the purpose and content of the instrument and incorrect recording.

Quality control measures in the field: The tablet programming was done in such a way to ensure that the necessary *data checks* are established including the skip pattern instructions and required fields among others. Some of the quality control measures that were strictly applied during the fieldwork include:

- A clear movement plan was handed over for each team so that they wouldn't waste time due to unplanned movement and to avoid fatigue among the data collectors and interviewees.
- Field level close supervision and provision of on-spot feedback to the data collectors.
- Real-time reporting/synchronization of data, whenever possible, facilitated the identification of errors, providing immediate feedback for timely corrections.
- Frequent data transfer helped to reduce/avoid the risk of loss of data due to damage or loss of electronic devices.

4.8. Ethical Considerations

To conduct this study, ethical approval was obtained from the Ethiopian Public Health. Support letters were also obtained from the respective Woreda health offices for the fieldwork. This was facilitated by CORHA and its project consortium partners.

4.9. Limitation of the assessment

This baseline assessment tried to apply all possible robust scientific approaches to generate as valid evidence as possible such as the use of mixed-method to triangulate the evidence and employed appropriate statistical methods to determine the sample size of the household survey, and all possible quality assurance measures were applied as indicated above. However, the assessment cannot be free of limitations. The following need to be taken into consideration while interpreting the findings of this assessment:

- The sample size for young girls may not be adequate as only those young girls who were available in the selected households were interviewed.
- Despite the efforts made to reassure the study participants to give us accurate information by explaining the objective of the study, confidentiality of the information, and by ensuring privacy during data collection, there might still be social desirability biases to some of the responses especially to those related to circumcision practices. In other words, since circumcision is punishable by law while the practice is being done secretly, mothers may not dare to tell the right information regarding their daughters' circumcision status which might have underestimated the prevalence of FGM/C.
- The association of selected sociodemographic characteristics doesn't account for potential confounders as the assessment was mainly designed for descriptive analysis.
- Because of the sensitive nature of the study subject, study participant women may not have provided the right detailed response regarding the negative effects of FGM/C especially those related to sexual desire, pain during sexual intercourse, and sexual dissatisfaction.
- Since the study was conducted in only three Woredas and because of the wide soci0-cultural differences, the findings of the assessment may not represent the realities in the zones and Oromia region as a whole.

5. RESULT

5.1. Sociodemographic characteristics of respondents

A total of 415 women aged between 15-49 were interviewed with a 100% response rate[16]. More than half of the participants were from Arsi zone. Additionally, 165 adolescent and youth girls who were available in those visited households were interviewed. Fifty-seven percent of the study participants were aged 25-39 years. Only 41.7% of the study participants were literate. Forty-four percent of the study participants were Orthodox Christians followed by Muslims (33.5%) and 96.1% of the participants were ethnic Oromo. Twenty-eight percent of the women were heads of households. Occupationally, 53.3% of the women were farmers followed by a housewife[17] (37.1%). Eighty-nine percent of the women were married or in a consensual union during the survey. Concerning economic activities, 47.7% of the women earn the same as or more income than their husbands/partners and 53.0% of the women classified their household economic status as a medium compared to their neighbors (Table 3, Annex-1).

Table 3: Distribution of the study participants by zone, woreda, and kebele, October 2021

Zone	Woreda	N	%	Selected Kebeles	N	%
Arsi	Munessa	237	57.1	Doba Ashee	85	20.5
				Garambota lole	61	14.7
				Guru Dangago	91	21.9
East_shewa	Liben Cuqalla	101	24.3	Adele Mecha	101	24.3
West Arsi	Heban Arssi	77	18.6	Shopa Bultum	77	18.6
Total		**415**	**100**	**Total**	**415**	**100**

5.2. Attitude of respondents towards women and young girls' status, FGM, and other GBV

5.2.1 Attitude of respondents towards women status

Eight variables were employed to assess the study participants' attitude towards women's status in society in general and in a relationship in particular (Table 4, Annex-2). The assessment showed that only 44.8% of the participants had a favorable (positive) attitude towards women's status at the household and society level. A significant proportion of the study participants believe that "*a woman's most important role is to take care of her home and cook for her family*" (71.6%); "*take caring of children is the mother's responsibility*" (71.6%), "*a woman should tolerate violence to keep her family together*" (68.4%), and "*a man should have the final word about decisions in his home*" (65.0%) (Table 4).

Table 4: Attitude of respondents towards women's status, October 2021

[16] *Each data collector was assigned for the number of households that she/he was expected to reach with the unique codes of the households. The 100% response rate was achieved through daily and real-time follow up and feedback using the eData collection and reporting system. Completeness of sample sizes assigned to each data collector was part of the monitoring so they could manage before they leave their sites.*

[17] *Women were asked about their main occupation (no multiple response).*

Characteristics	Strongly agree		Agree		Disagree		Strongly Disagree	
	N	%	N	%	N	%	N	%
Rights for women mean that men lose out on some rights	12	2.9	79	19	257	61.9	67	16.1
A woman's most important role is to take care of her home and cook for her family.	149	35.9	148	35.7	87	21	31	7.5
Take caring of children is the mother's responsibility.	149	35.9	148	35.7	102	24.6	16	3.9
It is a woman's responsibility to avoid getting pregnant.	60	14.5	133	32	178	42.9	44	10.6
A man should have the final word about decisions in his home	135	32.5	135	32.5	122	29.4	22	5.3
A woman should tolerate violence to keep her family together.	128	30.8	156	37.6	113	27.2	18	4.3
A man should decide his wife's use and types of family planning method.	27	6.5	100	24.1	211	50.8	77	18.6
Gender equality, meaning that men and women are equal, has come far enough already	58	14	127	30.6	148	35.7	82	19.8
The overall proportion of respondents who have a positive attitude towards women status (who have a sum score of >=20)			**186 (44.8)**					

5.2.2 Attitude of respondents towards FGM

Eight variables were employed to assess the study participants' attitudes towards FGM/C (Table 5). The assessment revealed that 85.3% of the study participants had an unfavorable (negative) attitude towards FGM/C. However, 40.5 % and 33.7 % of women believe respectively that "*uncircumcised girls and women are more promiscuous than circumcised girls*" and "*uncircumcised girls and women break household utensils more often* [compared to circumcised women]". Alarmingly, 25.7% of the women have a plan to circumcise their daughters in the future (Table 5).

The qualitative data also supports the views of the household survey participants. According to a male FGD participant from Heban Woreda, "*the community thinks that uncircumcised women cannot control their [sexual] desire but if they are circumcised they will be calm and also they will be considerate for their families as well as for their marriages. That is why they are being circumcised*."

The quantitative result showed that 17.1% of the respondents believe that FGM is a requirement by religion. A religious leader from Munesa Woreda agrees with this idea. He said, "a*ccording to sharia, girls should be circumcised just on the 7th day of birth like her hair [is shaved] but our communities do this at different age levels. Some are keeping sharia law and do it at 7th day, some when the girl is about to get marred- ceremonial."*

On the contrary to the views of this small proportion of respondents, a religious leader from Heban Woreda disagrees with their views.

> *Women circumcision is not supported by the Muslim religion, as well as it is forbidden by law, but if you ask me the existence of female genital mutilation in the Woreda, my answer is yes*

it is practiced somehow. But it is possible to stop participating and teaching the community because it is not also supported by religion.

5.3. Community actions and readiness to end FGM/C

In this survey, 78.1% of the study participants believe that actions that support the abandonment of female circumcision within the local community should be strengthened. A female FGD participant from Libon Woreda discusses some of the measures that should be taken to abandon FGM practices:

> *"First, it is imperative to raise awareness of those who play a major role in female genital mutilation - mothers are the main actors. Legal action must be taken without mercy if they do not stop practicing FGM after the awareness has been created. There is a problem in society such as not punishing the woman who committed the act [FGM] …. which shouldn't be left for the government [to act]. It should be a concern for everybody who knows the consequence of FGM. So, all those bodies have to expose [the malpractice] honestly without any acquaintances."*

Box 1: Study participants' responses about actions to be taken to end FGM/C practice

Responses on actions to end FGM practice	Respondents
If a legal body doesn't accept our report [of parents who commit circumcision to their daughters] and doesn't give a fair punishment, the practice will spread. My sister was exposed but the case was easily covered up and she remained a fairy-tale. But it is easy to stop the practice if there is a committed body that stands with us to abandon FGM/C.	A female FGD participant from Libon Cukala Woreda
Circumcision must be avoided. I feel like I have to start with my family and teach my friends and neighbors to avoid this practice.	An FGD participant from Munesa Woreda
There is no reason why we should not stop the practice if we work together; …. but if we hesitate to struggle, our children's lives will be ruined as our lives have been.	A female FGD participant from Libon Cukala Woreda
In my opinion, people who do this should be held accountable by law. Because it is the mother, the country, our peace that is affected by FGM. Therefore, criminals must be prosecuted.	An FGD participant from Munesa Woreda
I support the elimination of this FGM and my role will be organizing my friends to create awareness through community mobilization mainly by using the school gender club.	A male FGD participant from Munesa Woreda

Qualitative study participants were also asked about the readiness of communities (parents, religious or clan leaders) and the local government to end FGM/C. Some of the respondents believe that if communities are educated about the dangers and consequences of FGM, it would not be difficult to abandon the practice. However, practically, they believe there is still a lot that needs to be done.

Box 2: Study participants' responses about the readiness of communities to end FGM/C practice

Responses on readiness to end FGM practice	Respondents
Honestly speaking, the issue of FGM is forgotten by government sectors as they focus only on the [publicly] visible HTPs like rape and abduction. People still commit FGM on children at age below 3 years old because they can easily cheat and no one easily notices the practice.	A school principal from Munessa Woreda
When I speak as a Muslim, communities are still circumcising their daughters because people are highly motivated on learning religious teachings. So, as long as they know the order of their religion they are coming to execute the order so it becomes increments. But government bodies are against this they prohibited circumcision which is against our religion.	A religious leader from Munessa Woreda

In our city, where there is a meeting, advice is being given by religious leaders, NGOs, health offices to end FGM…Yes, we are committed and working on it.	A religious leader from Heban Arsi Woreda
If the government and the community work together, for example, if the society exposes the perpetrators- there are no more than 10 women circumcisers, if we can stop those women, we can stop FGM because it is impossible for others to do it without experience.	A clan leader from Libon Chukula Woreda
Our community is ready and committed to eliminating FGM/C because it is a backward culture.	A KI from Heban Woreda Youth and Sport Office
We were organizing awareness creation sessions for the community and it still has to continue strongly. The government is already implementing some activities with FGM response groups in the villages to end the practice. We have school clubs, we teach them and they teach others in their communities. More importantly, the Geda system does not also support women and girls circumcision.	An NGO representative from Heban Woreda
The local community has found it difficult to implement even the government directives. Because they practice circumcision in secret. The community has even forgotten what was previously taught by health professionals. As a result, many people secretly circumcise their children even being health professionals. In one kebele, I heard the health extension worker was circumcised as she is going to be married.	A KI from Munessa Woreda Health Office
…. this time people are showing full readiness to stop this practice, ….. people are fully aware and changed their behavior toward those practices, but the prevalence rate at the villages distant from the center is high compared to the nearest kebeles. The good news regarding on readiness of communities is that girls around the center [town] *are not willing to accept this violence which means their awareness is high and more empowered.*	A KI from Munessa Woreda Women and Children's Affairs Office
In the past, circumcision used to be practiced clearly by preparing a ceremony but now it is done secretly. This may show that things are somehow getting better.	A female FGD participant from Libon Chukula Woreda

The KI from one of the NGOs in Heban Woreda discussed some of the measures that need to be taken to abandon the FGM practice including peer awareness creation activities, focussing on the harm and the consequence of the practices to communities. He also recommends that apart from teaching the community, those who practice this tradition and break the law must be punished.

Table 5: Attitude of respondents towards FGM, October 2021

Characteristics	**Strongly agree**		**Agree**		**Disagree**		**Strongly Disagree**	
	N	**%**	***N***	**%**	***N***	**%**	***N***	**%**
Female circumcision is a harmful tradition for girls and women[18]	151	36.4	168	40.5	70	16.9	26	6.3
Uncircumcised girls and women are more promiscuous than circumcised girls	61	14.7	107	25.8	192	46.3	54	13.0
Uncircumcised girls and women break household utensils more often	69	16.6	71	17.1	203	48.9	72	17.3
Female circumcision is a requirement by religion	32	7.7	39	9.4	163	39.3	181	43.6
Action that supports the abandonment of female circumcision within the local community should be strengthened	126	30.4	198	47.7	76	18.3	15	3.6

[18] *The response values are transposed for overall attitude calculation.*

Severe forms of female circumcision should be stopped (abandoned)	165	39.8	168	40.5	65	15.7	17	4.1
All forms of female circumcision should be stopped (abandoned)	165	39.8	144	34.7	85	20.5	21	5.1
You will circumcise your daughters in the future	35	8.4	72	17.3	139	33.5	169	40.7
The overall proportion of respondents who have a positive attitude against FGM (who have a sum score of >=20)	**354 (85.3)**							

5.4. Engagement and commitment from local actors towards ending FGM/C

Qualitative study participants were also asked about the actions being taken by the local government including the legal bodies and women, children, and social affairs office to end the FGM/C. According to the study participants, the attention given to the FGM/C practice seems relatively low compared to early/childhood marriage and rape. According to the school principal from Munessa Woreda, government bodies seem to forget that FGM is one of the root causes of divorce. He believes that victims of FGM/C prefer to divorce as they fear the pain during childbirth that is caused by the scar of the cutting. He added that working on women's rights is not a one-time agenda and if changes have to come, the local actors need to invest by addressing the rights of women starting from childhood.

According to the religious leader from Heban Woreda, sometimes it is difficult to take action as it is challenging to get evidence of the malpractice as people perform FGM/C secretly unlike previous times. He believes that FGM/C is now abandoning, because of the law that was enacted against it and because of the awareness-raising efforts made at Kebele level by the women, children and youth affair and other sector offices. Similarly, the KI from Libon Chukula Woreda has witnessed that the local actors including the religious leaders, Kebele leaders, women, and children affairs office are teaching the community about the harms of FGM/C. The KI from Libon Woreda Police department said that they are using the community policing established in each of the Kebeles as entry points to teach communities about FGM/C and its legal and medical consequences. He added,

> "*According to our office, a woman who tried or performed FGM would be arrested and taken to the court after we verify her crimes together with the prosecutor. The justice processes are recorded so others can learn from it.*"

5.2.3 Attitude of respondents towards young girls' status-related

Five variables were employed to assess the study participants' attitudes towards young girls' status at family and community levels including their participation in decision-making, dealing with sex issues, and education among others (Table 6). The study revealed that 82.2% of the study participants had a favorable (positive) attitude toward young girls' status. However, some women disagree that "Parents should discuss sex-related issues with their daughters" (61.7 %), "Opinions of young girls should be equally heard in the household/community like that of young boys" (41.4 %), and "Young girls should have more decision-making power in their own lives and within the community" (30.4%).

Evidence from the key informants and FGD participants signifies the deep-rooted problems related to the status of girls in the community starting from their unfair treatment at household levels.

> *Apparently, for example, when a guest comes* [to their house]*, a girl would be obliged to sit outdoor or make coffee; a mother shall say* [to her daughter] *how dare you eat breakfast or drink coffee with guests? and or how dare you integrate with the guests' conversation? Mothers provide a low position to their daughters, there is also a say women don't sit on the chair, rather they sit on plain ground. So, all these things develop inferiority and lead the women to lose their confidence. Likewise, a father would say to his son how dare you sit equal with me?* - [A female FGD participant from Libon Chukula Woreda]

Unfortunately, when young girls got the decision-making power[19] or autonomy in their own lives and within the community, they still seem to be much challenged by the existing harmful traditional thinking and practice. They choose the hardest side of life by continuing the practice voluntarily. In this regard, a key informant from one of the NGOs working in Heban Woreda said,

> "*Previously it was their families who used to make the decision but these days' girls and women decide for themselves. Based on our assessment, those girls and women* [who have better decision-making power] *go out of their village and get circumcised in other places. Then, they will come back to their village to marry. As I said earlier, if they are uncircumcised they are afraid they might be isolated by the community."*

Table 6: Attitude of respondents towards young girls' status, October 2021

Characteristics	Strongly agree		Agree		Disagree		Strongly Disagree	
	N	%	*N*	%	*N*	%	*N*	%
Action that supports young girls' participation within the local community should be strengthened	129	31.1	248	59.8	35	8.4	3	.7
Young girls should have more decision-making power in their own lives and within the community	88	21.2	201	48.4	15	3.6	15	3.6
Parents should discuss sex-related issues with their daughters	31	7.5	128	30.8	136	32.8	120	28.9
Educating girls is as important as educating boys	171	41.2	187	45.1	45	10.8	12	2.9
Opinions of young girls should be equally heard in the household/community like that of young boys	139	33.5	104	25.1	134	32.3	38	9.2
The overall proportion of respondents who have a positive attitude towards young girls' status (who have a sum score of >=12.5)	**341 (82.2)**							

5.2.4 Attitude of respondents against physical violence

Five variables were employed to assess the study participants' attitudes against physical violence. The study revealed that 46.5% of the study participants are against physical violence. The areas which were misperceived or had unfavorable attitudes by more than half of the study participants were "*a husband is*

[19] *The degree of control over material, human, intellectual and financial resources exercised by different sections of society. Power is dynamic, exercised in the social, economic, and political relations between individuals and groups, and can be used for both positive and negative ends. [07LookingInward (powercube.net)]*

justified in beating his wife if she goes out of her house without telling him" (56.4) and "*a husband is justified in beating his wife if she neglects the children*" (54.9%) (Table 7).

Table 7: Attitude of respondents against physical violence, October 2021

Characteristics	Strongly agree		Agree		Disagree		Strongly Disagree	
	N	%	*N*	%	*N*	%	*N*	%
A husband is justified in beating his wife if she goes out without telling him.	126	30.4	108	26.0	105	25.3	76	18.3
A husband is justified in beating his wife if she neglects the children.	79	19.0	149	35.9	128	30.8	59	14.2
A husband is justified in beating his wife if she argues with him.	59	14.2	92	22.2	170	41.0	94	22.7
A husband is justified in beating his wife if she refuses to have sex with him.	76	18.3	114	27.5	129	31.1	96	23.1
A husband is justified in beating his wife if she burns the food.	96	23.1	107	25.8	131	31.6	81	19.5
The overall proportion of respondents who have a positive attitude against physical violence (who have a sum score of >=12.5)	**193 (46.5)**							

5.2.5 Attitude of respondents against emotional violence

Six variables were employed to assess the study participants' attitudes against emotional/psychological violence. The study revealed that 79.3% of the study participants had a favorable (negative) attitude towards emotional/psychological violence. However, a substantial proportion of the respondents believe that "*it is ok to a husband to insist on knowing where about of his wife at all times*" (48.5%), and "*to be jealous or angry if his wife talks to other men for any reason*" (45.8%) (Table 8).

Table 8: Attitude of respondents against physical violence, October 2021

Characteristics	Strongly agree		Agree		Disagree		Strongly Disagree	
	N	%	*N*	%	*N*	%	*N*	%
It is ok for a husband to be jealous or angry if his wife talks to other men for any reason	73	17.6	117	28.2	151	36.4	74	17.8
It is ok for a husband to prohibit his wife to meet her female friends	31	7.5	101	24.3	199	48.0	83	20.0
It is ok for a husband to try to limit his wife from contacting her family	14	3.4	33	8.0	235	56.6	133	32.0
It is ok for a husband to insist on knowing where about his wife at all times.	77	18.6	124	29.9	148	35.7	66	15.9
It is ok for a husband to say or do something to humiliate his wife in front of others.	10	2.4	43	10.4	225	54.2	137	33.0
It is ok for a husband to insult his wife or make her feel bad about herself.	9	2.2	48	11.6	206	49.6	152	36.6

The overall proportion of respondents who have a positive attitude against emotional/psychological violence (who have a sum score of <=15)	**337(81.2)**
The overall proportion of respondents who have a positive attitude towards all forms of violence (who have a sum score of <=80)	**329(79.3)**

5.5. Decision-making status of women in the reproductive age in their household/relationship

Seven inter-related variables were employed to assess the decision-making status[20] of the study participants in their households (Table 9, Annex-2). Accordingly, only 21.0% of the study participants had better decision-making autonomy[21]. The areas in which the study participants had the least decision-making power include "decisions on how husband/partner-earning spent" (51.1%), "decision on large investments such as buying a car, or a house, or a household appliance" (49.9) and "decisions on spending money on food and clothing" (48.0%). Only 36.4% of the women reported that their husbands help them with household chores like looking after children, cooking, cleaning the house, and doing other work around the house. Forty-five percent of the study participants were using the modern family planning method during the survey of whom 61.4% reported that the decision on the use of family planning was made by themselves or jointly with their husband (Table 9).

Table 9: Decision-making status of study participants in the household/relationship, October 2021

Statements	**Self**		**Jointly with partner or others**		**By partner or others only**	
	N	**%**	***N***	**%**	***N***	**%**
Who in your family or relationship usually has the final say in how you spend money for food and clothing?	59	14.2	157	37.8	199	48.0
Who in your family or relationship usually has the final say in how you spend money for large investments such as buying a car, or a house, or a household appliance?	43	10.4	165	39.8	207	49.9
Who usually decides how the money you earn will be used?	76	18.3	156	37.6	183	44.1
Who usually decides how your (husband's/partner's) earnings will be used?	47	11.3	156	37.6	212	51.1
Who usually makes decisions about health care for yourself?	78	18.8	168	40.5	169	40.7
Who usually makes decisions about visits to your family or relatives?	67	16.1	188	45.3	160	38.6
Decision on family planning use[22]	27	7	116	28	45	11

[20] *Women's participation in making household decisions-the number of decisions in which women participate either alone or jointly with their husband or partner. This index ranges from 1 to 14 and reflects the degree of decision-making control that women are able to exercise in areas that affect their lives and the level of women's empowerment in a society.*

[21] Who had a composite score of >= 7

[22] *Not used for decision making score because of incomplete data or relevant to very few respondents.*

	Yes always		Yes, sometimes		Never	
	N	%	N	%	N	%
Does your husband help you with household chores like looking after children, cooking, cleaning the house, and doing other work around the house?	12	2.9	139	33.5	264	63.6
	Yes		No			
Are you currently using the modern family planning method?	188	45.3	227	54.7		
The proportion of respondents who had a better decision-making status (who have a sum score of >=7)	**87 (21.0)**					

5.6. Knowledge of the respondents on the effect of FGM on the victims

Ninety-one percent of the study participants think that FGM/C harms circumcised women and girls and mentioned at least one effect of FGM/C on the victims. However, only 13.0% of the women had good knowledge as per the operational definition of this baseline assessment. And only 5.3% of the women mentioned all the effects of FGM (Table 10). The most mentioned effect of FGM on the victims are "results in complications during childbirth (74.2%)" and "causes severe bleeding (58.1%)" (Fig 1).

Table 10: Knowledge of the respondents on the effect of FGM on the victims, October 2021

Statements	**Response**	**N**	**%**
Do you think FGM harms circumcised women and girls?	Yes	378	91.1
	No	37	8.9
The proportion of respondents who mentioned at least one effect of FGM/C		378	91.1
The proportion of respondents who had good knowledge on the effect of FGM (scored more than or equal to the expected average value (>= 5 and above effects))		54	13.0
The proportion of respondents who mentioned all listed effects of FGM		20	5.3

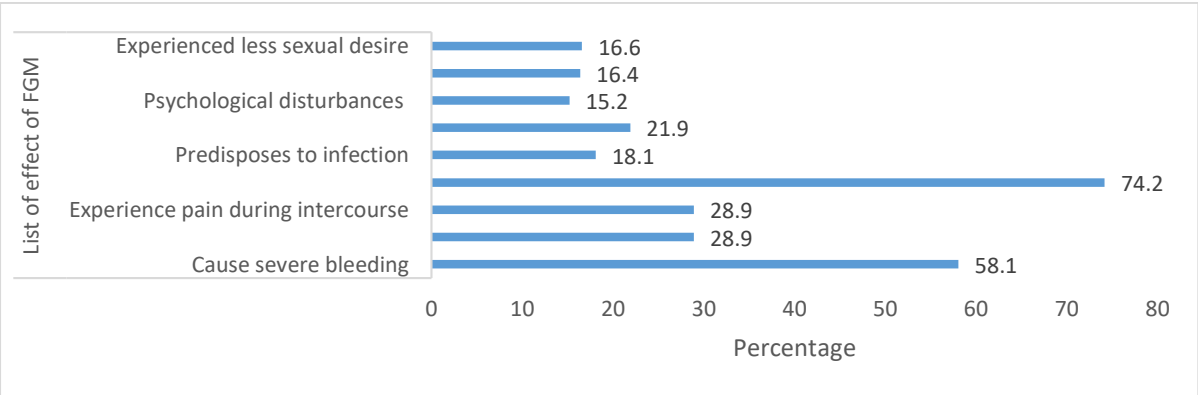


Figure 1: Proportion of women of reproductive age who mentioned the list as the effect of FGM on the victim, October 2021

The qualitative study participants were asked why girls and women are circumcised in their communities. Accordingly, the qualitative study participants shared their knowledge or views as follows.

Box 3: Responses of qualitative study participants on reasons why FGM is practiced in their communities

Perceived and experienced reasons	Respondents
It is due to the backward traditional thought of the community that circumcised women would have a lower sexual desire which does not take into account the effect of circumcision during childbirth. But, no one can limit women's sexual desires since it is created by God.	A religious leader from Heban Woreda]
Women are circumcised to be obedient and submissive to their husbands.	A female FGD participant from Libon Chukula Woreda
People think that women's circumcision is supported by the Muslim religion, but that is the wrong perception, women's circumcision is not supported by the Muslim religion.	A KI from Heban Woreda Youth and Sport Office
The current generation, especially girls, behave abnormally on every occasion. Mothers believe that If their daughters had been circumcised in their [old] times…. they would not have children before or out of marriage, don't break things/materials, and bow down [would be submissive] to their husbands. Related to this there is a concern in every family that girls under the age of 20 can start having sex and humiliate their families. This is one reason for families to practice female genital mutilation on their daughters.	*A KI from Munessa Woreda Health Office*
They should be circumcised for her [girl or woman] not to be out of the norm and ignored by the community	*A religious leader from Munessa Woreda*
Females are circumcised as the community has no awareness about its problems. And … the girl is considered as normless if she doesn't undergo circumcision. There is a belief that she might not obey her husband. She may not have good manners and again [they believe that] circumcised women have good behavior and norms.	*A school principal from Munessa Woreda*
In this community, a girl is proposed for marriage at the age of 13 or 14 when she is at school. So to prevent her from other boys [from having sexual affairs], they cut her organ and they think she loses her sexual desire before she gets married.	*An FGD participant female student from a school in Heban Woreda*

5.7. Prevalence of female genital cutting/mutilation among women age 15-49 years

As shown in the table below, 87.2% of the study participants have been circumcised. Thirty-three percent of them reported that, during the circumcision, the flesh was removed from the genital area while only 6.7% reported that their genital area was sewn closed during the circumcision. While the majority (81.4%) of the circumcisions were conducted before the end of their age of adolescence, 34.5% were circumcised during their adolescence age. Ninety-eight percent of the circumcisions were performed by traditional circumcisers (Table 11).

Table 11: The study participants' experience and perception of female genital mutilation, October 2021

Statements	Response	N	%
Ever circumcised	Yes	362	87.2
	No	53	12.8
Type of genital cutting/circumcision	Nicked without removing flesh	142	34.2
	Any flesh removed from the genital area	118	32.6
	Don't know	102	24.6
The genital area was sewn closed during circumcision	Yes	28	6.7
	No	266	64.1

	Don't know	68	16.4
Age at circumcision	<1 year	41	11.3
	1-9 years	129	35.6
	10-19 year	125	34.5
	20-30 year	17	4.7
	Don't know	50	13.8
Who performed the circumcision?[16]	Traditional circumciser	354	98.1
	Traditional birth attendant	5	1.4
	Nurse/midwife	2	.6

5.8. Circumcision status of the study participants' daughters age less than 15 years

Half of the study participants reported that they have at least one daughter aged less than 15 years. Accordingly, the circumcision status of 320 daughters whose age was between 0-14 years was assessed by asking their mothers. Of all, 25.6% of them were circumcised. About 70.0% and 97.0% of the daughters were circumcised before their fifth and tenth birth dates respectively and 25.6% of the daughters' genital area was reported to be sewn-closed during the circumcision. Traditional circumcisers were reported to be the performers of all the circumcisions (Table 11).

Table 11: Circumcision status of the study participants' daughters age less than 15 years, October 2021

Statements	Response	Freq.	%
Do you have a daughter aged between 0-14 years?	Yes	211	50.8
	No	204	49.2
Number of daughter/s age between 0-14 years	1	134	63.5
	2	55	26.1
	3	12	5.7
	4	10	4.7
Age of the daughter/s	<5 year	78	24.4
	5-9 year	114	35.6
	10-14 year	128	40
What is your daughter's educational status?	Not in school-age	144	45
	Non-formal education	35	10.9
	Primary education	138	43.1
	Secondary education	3	0.9
Is she circumcised or not?	Yes	82	25.6
	No	238	74.4
Age at circumcision	<5 year	57	70
	5-9 years	22	27
	>10 year	30	3
Was her genital area sewn closed?	Yes	21	25.6
	No	61	74.4
Who performed the circumcisions?	Traditional circumciser	82	100

5.9. Adolescent and youth (10-24 years) girls' status

5.7.1 Sociodemographic characteristics of young girls

To assess the decision-making status of adolescent and youth girls (10-24 years), the baseline assessment interviewed 165 young girls who were living in the surveyed households. Half of the girls were at early

adolescent age while 35.7 of them were married by the time of the survey. Eighty-two percent of the young girls were literate (59.3% have primary school level of education). However, 47.9%[23] of them were out of school during the survey (Table 13) and 46.8% of the girls mentioned that the reason for being out of school was "to get married" (Fig 2, Annex-3).

Table 13: Sociodemographic characteristics of young girls, October 2021

Statements	Response	N	%
Age of participant	Early adolescents (10-14)	84	50.9
	Youth (15-24)	81	49.1
	Total	165	100
Literacy	Yes	135	81.8
	No	30	18.2
	Total	165	100.0
Highest level of education	Grade 1 to 6	80	59.3
	Grade 7 to 8	26	19.3
	Grade 9 to 12	26	19.3
	Above grade 12	3	2.2
	Total	135	100.0
Currently in schooling	Yes	86	52.1
	No	79	47.9
	Total	135	100
Current marital status	Never married	106	64.2
	Currently married	54	32.7
	Divorced	5	3.0
	Total	165	100.0

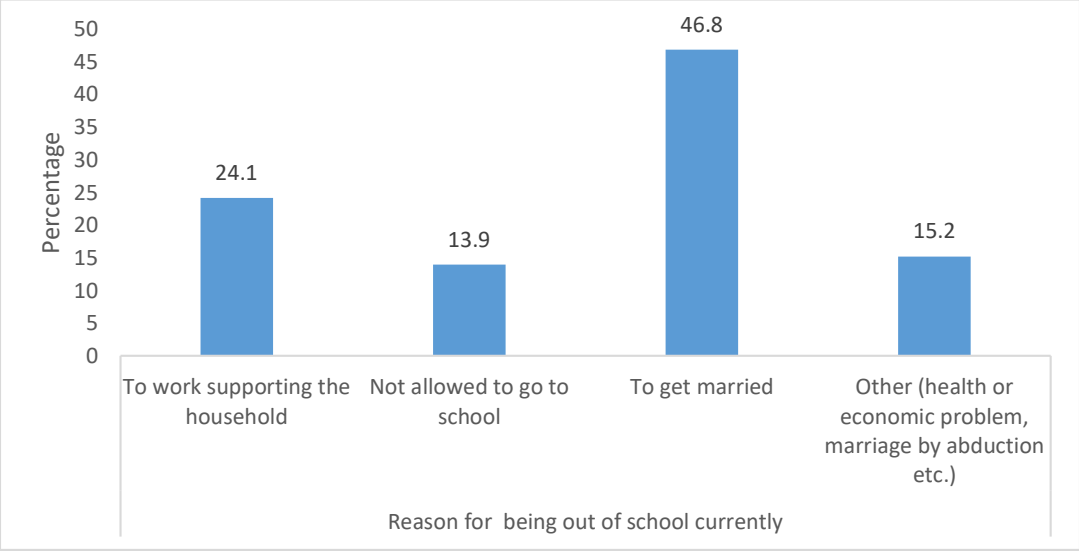


Figure 2: Reasons for young girls to be out of school during the survey, October 2021

5.7.2 Adolescent and youth (10-24 years) girls' overall status

[23] *Further analysis of the baseline data shows that 69.6% of the girls in East Shewa were out of school by the time of the survey compared to 50.0% and 38.5% in West Arsi and Arsi zones respectively.*

Fifty-five of the young girls aged 10-24 years were circumcised. Ever married young girls were more likely to be circumcised than their never-married counterparts (76.1% vs 45.3%). Only 20.6% of the girls are engaged income-generating activities. Thirty-five percent of the girls reported that they never played outside of their homes with friends while 41.2% didn't have a network of friends whom they can play with, discuss different issues and access them easily. Only 43.0% of the girls reported that they at least sometimes participate in community/social moments such as sports and other community groups while 20.6% of the girls have ever engaged in the FGM/C movement (Table 14).

Table 14: Adolescent and youth (10-24 years) girls' overall status, October 2021

Statements	Response	N	%
Have you ever been circumcised?	Yes	91	55.2
	No	74	44.8
Do you have work that generates income for you?	Yes	34	20.6
	No	131	79.4
Do you play outside of your home with friends?	Yes frequently	13	7.9
	Sometimes	94	57.0
	Never	58	35.2
Do you have a network of friends with whom you can play, discuss different issues and access them easily?	Yes	68	41.2
	No	97	58.8
Do you actively participate in community/social moments such as sports and other community groups?	Yes frequently	7	4.2
	Sometimes	64	38.8
	Never	94	57.0
Have you ever engaged in FGM/C movement?	Yes frequently	5	3.0
	Sometimes	29	17.6
	Never	131	79.4
Have you ever discussed FGM-related issues with your parents?	Yes frequently	2	1.2
	Sometimes	37	22.4
	Never	126	76.4
Do you own a mobile phone?	Yes	54	32.7
	No	111	67.3

5.7.3 Adolescent and youth (10-24 years) girls' decision-making status

Overall, five variables were employed to assess the decision-making status of the young girls. In the assessment, only 57.0% of the girls had better decision-making power. The areas in which the girls had the least decision-making power include "decisions on what type of work they should work (37.0%)", "disagreeing with their parents regarding decisions affecting them (34.5%)", and "decisions on their SRH issues (30.9%)" (Table 15).

Table 16: Adolescent and youth (10-24 years) girls' decision-making status, October 2021

Statements	Response	Freq.	%
Who usually decides how the money you earn will be used[24]	No income	131	79.4
	Myself	13	7.9
	Myself and others jointly	20	12.1
	Others only	1	.6
Who usually decides what type of work you should work?	Myself	38	23.0
	Myself and others jointly	66	40.0
	Others only	61	37.0

[24] *Not included in the decision-making calculation as only few of the girls had job generating income.*

Who decides about your marriage (whom and when you get married)?	Myself	52	31.5
	Myself and others jointly	64	38.8
	Others only	49	29.7
Who makes decisions on your other SRH issues?	Myself	56	33.9
	Myself and others jointly	58	35.2
	Others only	51	30.9
Who usually decides about your going to places such as a playground, an adolescent center, a friend's house, etc.	Myself	33	20.0
	Myself and others jointly	91	55.2
	Others only	41	24.8
Do you feel that you can disagree with your parents regarding decisions affecting you?	Yes frequently	8	4.8
	Sometimes	100	60.6
	Never	57	34.5
The proportion of adolescent and youth girls who have better decision-making power (sum score of >=5)		**94 (57.0)**	

5.10. Effect of Participants' socioeconomic-demographic characteristics on, knowledge, attitude, decision-making status, and FGM Practice

The assessment tried to identify factors associated with a positive attitude, women and young girls' decision-making status, knowledge on the effect of FGM/C, and circumcision status of the study participants by conducting a simple bivariate analysis using cross-tabulation together with a chi-square test. However, the findings need to be interpreted with caution as the analysis did not account for the effects of potential confounders.

The assessment showed that (Table 17), the overall positive attitude towards women and girls' status, FGM and GBV were relatively low in West Arsi zone, among farmer women occupationally, poor/very poor households, and whose household economically relies only on their husband/partner. The assessment also revealed that women from West Arsi, those who are not head of the household, housewives, currently married, those earning less than their husbands/partners, and those whose household economically relies only on their husband/partner had low decision-making power than their counterparts. Similarly, those women who were from East Shewa and women who are heads of the households had relatively poor knowledge on the effect of FGM on the victims.

The prevalence of female circumcision was high among women who were from East Shewa[25], older age groups, who did not attend school, or cannot read and write, those with larger family size, who are not head of the household, whose husband didn't attend school, or cannot read and write, and whose households economically rely only on their husband/partner (Table 17).

[25] *The data for this baseline assessment shows that 100% of the study participants from East Shewa zone were non-Muslims while 63.6% of the study participants from West Arsi were Muslims by religion (Annex-3).*

Table 17: Association of selected socioeconomic-demographic characteristics with participants' positive attitude, women decision-making status, good knowledge on the effect of FGM, and circumcision status

Characteristics	Category	Overall positive attitude towards women and girl status, FGM and GBV		Positive women's decision-making status		Good knowledge of the effect of FGM		Circumcision status	
		Yes N (%)	*P-value*	*Yes N (%)*	*P-value*	*Yes N (%)*	*P-value*	*Yes N (%)*	*P-value*
Zones	Arsi	174 (73.4)	.003	62 (26.2)	.011	40 (16.9)	.005	197 (83.1)	.000
	East Shewa	88 (87.1)		15 (14.9)		4 (4)		100 (99.0)	
	West Arsi	67 (87)		10 (13)		10 (13)		65 (84.4)	
Age category of the women	20-24	56 (76.7)	.803	14 (19.2)	.221	11 (15.1)	.318	53 (72.6)	.000
	25-29	73 (76.8)		15 (15.8)		11 (11.6)		78 (82.1)	
	30-34	45 (77.6)		11 (19)		8 (13.8)		48 (82.8)	
	35-39	69 (82.1)		19 (22.6)		16 (19)		80 (95.2)	
	40-44	46 (85.2)		18 (33.3)		4 (7.4)		52 (96.3)	
	45-49	40 (78.4)		10 (19.6)		4 (7.8)		51 (100)	
Have you attended school, or can you read and write?	Yes	142(82.1)	.233	39 (22.5)	.504	27 (15.6)	.184	140 (80.9)	.001
	No	187 (77.3)		48 (19.8)		27 (11.2)		222 (91.7)	
What is your religion?	Muslim	110 (79.1)	.117	28 (20.1)	.564	21 (15.1)	.300	109 (78.4)	.001
	Orthodox	137 (75.7)		42 (23.2)		25 (13.8)		164 (90.6)	
	Others	82 (86.3)		17 (17.9)		8 (8.4)		89 (93.7)	
To which ethnic group are you belonging?	Oromo	318 (79.7)	.289	83 (20.8)	.686	52 (13)	.950	349 (87.5)	.465
	Amhara	11 (68.8)		4 (25)		2 (12.5)		13 (81.3)	
Number of individuals living with	<=5	179 (79.2)	.968	53 (23.5)	.173	25 (11.1)	.197	187 (82.7)	.003
	>5	150 (79.4)		34 (18)		29 (15.3)		175 (92.6)	
What is your relationship to the head of the household	I am head of the household	92 (80.7)	.659	41 (36)	.000	7 (6.1)	.010	107 (93.9)	.013

What is your occupation?	Wife or other	237 (78.7)	.000	46 (15.3)	.043	47 (15.6)	.120	255 (84.7)	.721
	Farmer	158 (71.5)		47 (21.3)		32 (14.5)		194 (87.8)	
	Housewife	139 (90.3)		26 (16.9)		14 (9.1)		132 (85.7)	
	Others	32 (80)		14 (35)		8 (20)		36 (90)	
What is your marital status?	Married/ Consensual union/living with partner	294 (79.5)	.793	62 (16.8)	.000	46 (12.4)	.314	319 (86.2)	.076
	Others	35 (77.8)		25 (55.6)		8 (17.8)		43 (95.6)	
How old is your partner/husband?	<=29	46 (79.3)	.089	10 (17.2)	.907	8 (13.8)	.896	39 (67.2)	.000
	30-34	48 (77.4)		13 (21)		9 (14.5)		48 (77.4)	
	35-39	28 (65.1)		6 (14)		7 (16.3)		38 (88.4)	
	40-44	54 (78.3)		11 (15.9)		8 (11.6)		64 (92.8)	
	45-49	39 (81.3)		9 (18.8)		5 (10.4)		44 (91.7)	
	>=50	79 (87.8)		13 (14.4)		9 (10)		86 (95.6)	
What is your partner's/husband's occupation?	Farmer	270 (79.9)	.514	57 (16.9)	.858	43 (12.7)	.583	291 (86.1)	.826
	Others	24 (75)		5 (15.6)		3 (9.4)		28 (87.5)	
Has your husband attended school or can he read and write?	Yes	202 (78)	.286	50 (19.3)	.045	32 (12.4)	.945	215 (83)	.006
	No	92 (82.9)		12 (10.8)		14 (12.6)		104 (93.7)	
Do you and he both earn the same amount of money, or does he have more money or do you have more money?	Same or more	143 (81.3)	.473	40 (22.7)	.004	22 (12.5)	.985	155 (88.1)	.315
	He earns more	151 (78.2)		22 (11.4)		24 (12.4)		163 (84.5)	
What is your household's monthly income from all possible sources?	Can't quantify	130 (91.5)	.000	42 (29.6)	.001	9 (6.3)	.014	122 (85.9)	.780
	<500 birr or no income	99 (79.2)		27 (21.6)		21 (16.8)		111 (88.8)	
	>500	100 (67.6)		18 (12.2)		24 (16.2)		129 (87.2)	
Who provides the source of income in your home?	Self	105 (86.8)	.000	36 (29.8)	.002	16 (13.2)	.893	116 (95.9)	.002
	Partner/others	105 (69.1)		19 (12.5)		21 (13.8)		124 (81.6)	

	Both self and partner	119 (83.8)		32 (22.5)		17 (12)	122 (85.9)	
Does your household currently get any government/other partner's welfare supports such as safety net program?	Yes	10 (76.9)	.832	0 (0)	.059	3 (23.1)	.273	12 (92.3)	.577
	No	319 (79.4)		87 (21.6)		51 (12.7)		350 (87.1)	
If you compare the monthly income of your household with your neighbors, where do you put the economic status of your family?	Poor/very poor		.000		.827		.960		.824
	Medium/rich	122 (70.5)		37 (21.4)		22 (12.7)		150 (86.7)	
		205 (85.8)		49 (20.5)		30 (12.6)		209 (87.4)	

6. CONCLUSIONS AND IMPLICATIONS

This assessment revealed that overall, 79.3% of the women in the reproductive age groups living in the study areas had a favorable/positive attitude towards women's and girls' status in society in general and in a relationship in particular and against FGM and other GBVs. However, still, about 21% of the women had an unfavorable attitude towards women's and girls' status in society and FGM/C. Moreover, more than half of the women had an unfavorable attitude towards their social status and physical violence as many of them believe that wife-beating is justifiable among others.

Women living in the study areas were found to have a low level of decision-making status with only 21.0% of the study participants having better decision-making status (make decisions either alone or at least jointly) mainly on household expenditures. Women also get very poor support from their husbands on household chores.

Although the majority of the women think that FGM harms the victims, only 13.0% of the women mentioned more than half of the nine (expected number) effects of FGM on the victims, implying that the vast majority have a poor level of awareness about the negative effects of FGM/C. The most cited negative effects of FGM/C by respondents were complications during childbirth, severe bleeding followed by pain during sexual intercourse, and urination.

The lifetime prevalence of circumcision among women aged between 15-49 years was very high in the study area at 87.2% of which 6% had a severe form of genital cutting (reported that their genital area was sewn closed during the circumcision). This is higher than the regional estimate (76%) but comparable to the prevalence estimate for EDHS[26]. Fifty-five percent of young girls aged 10-24 years were also circumcised during the survey. Similarly, 25.6% of daughters aged 0-14 years were circumcised which is much higher than the national average of the EDHS 2016 at 14% but by far lower than the prevalence among their mothers. This might not however show the daughters are safe from FGM/C as 53.0% of the women aged 15-49 were circumcised during or after their adolescence age (>=10 years). On the other hand, this low prevalence could be because of the actual reduction in FGM/C as a result of interventions (awareness-raising activities and the legal measures taken) by the local government and implementing partners in the study areas.

The practice of FGM/C seems to have an inter-generational effect within a family which can be supported by the evidence that girls are 2.6 times more likely to be circumcised if their mothers are circumcised (72.0% vs 28.0%). The association between the older age group and status of FGM may be due to the effect of the different interventions against FGM which have been implemented by the government and other partners. However, those young women cannot be assumed to be safe as more than half of the women aged between 15-49 were circumcised during or after their adolescence age (>=10 years).

Both the quantitative and qualitative findings of this baseline assessment indicate that there are different excuses used by communities to justify the practice of FGM/C including believing that FGM is a requirement by religion and other misconceptions such as to reduce the sexual desire of the woman, to ensure their loyalty to their marriage/husbands, *to make them obedient and submissive to their husbands, to*

[26] *Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.*

reduce before-and out of marriage sexual intercourse or childbirth, etc. Fortunately, religious leaders are against such beliefs which could be a fertile ground to implement SBC interventions.

With regards to young girls' status, even though 81.8% of the young girls had attended school, or can read and write, 47.9% of them were out of school during the survey mostly "to get married" (46.8%). More than a third (35.7) of the girls already had to get married during the survey. The participation of young girls in community/social including FGM/C movements was low. They reported that they rarely discuss SRH issues including FGM with their parents. It is also noted that more than two-thirds of the mothers don't support discussion on sex-related issues with their daughters. By implication, the more number of out-of-school girls, the highly likely it that they will get married early, they will be less empowered socially and economically, and they will be less likely to safeguard their daughters from getting circumcised if at all they do not support the continuation of the malpractice.

Though a significant proportion of the study participants believe that actions that support the abandonment of female circumcision within the local community should be strengthened, alarmingly, a quarter of the women still support the continuation of female circumcision and they want to circumcise their daughters in the future.

Important efforts are being made on the ground to avert the practice of FGM/C. Partners and the local government are organizing awareness creation sessions for the community; they are working closely with FGM response groups in the villages and school health clubs to teach communities and end the practice. In some areas, the Geda system has created a conducive environment in the effort of curbing the practice and effect of FGM/C as it does not support women's and girls' circumcision. The encouraging and promising signs of the impact of the interventions can be exemplified in that girls are becoming more empowered especially around the center/urban areas and ceremonial circumcision is no more real. However, because of fear of the legal consequences, communities are still circumcising their daughters in secret.

7. RECOMMENDATIONS

The following recommendations are forwarded based on the findings of the baseline assessment:

- Awareness creation measures are required to improve women's knowledge and attitude towards their daughters and their social and economic status, and their attitude towards physical violence by engaging local/religious leaders so that they can influence the community towards improved women's status. More targeted approaches may be employed to reach those with a negative attitude towards theirs and their girls' social and economic status such as women residing in West Arsi zone, women from poor households, and who economically rely on their husband/partner.
- Educate communities including children about the inter-generational effect of FGM/C, the long-term impacts of FGM/C, the actions they have to do if they face the problem, the available medico-legal, and social services, etc. More focus could be given to those having relatively low knowledge levels including women in East Shewa, and those women who are heads of the households.
- The different misconceptions of community members prompt the need for a more focussed educational or awareness-raising campaign using different modalities including community volunteers and mass media by identifying those radio[27] programs with large numbers of listenership in the locality.

[27] Most of the community is rural.

- The lifetime prevalence of circumcision was very high among the study population and alarmingly a significant proportion of the participants still support its continuation. This dictates the need for more actions to reduce the prevalence and its effect on the newborns by raising the awareness of women and by engaging local/religious leaders so they can influence the community against FGM. More emphasis could be given to women in East Shewa, older age groups, who did not attend school, or cannot read and write, who were in other categories religiously, who were living with a larger family number, who was not head of the household, whose husband/partner was in older age group, whose husband didn't attend school, or cannot read and write, and those households that economically depend only on their husband/partner's incomes or economic activities.
- Interventions need to target the improvement of the status of women with a special focus on decisions related to household expenditures and support of the husband on household chores by engaging men in general and husbands in particular in the initiatives. More focus could be given to those with a low level of women's decision-making status such as women in West Arsi, housewives, married women, those who earn less than their husbands/partners, and those households that economically depend only on their husband/partner's incomes or economic activities.
- A significant number of young girls were out of school to get married and a third of the young girls (10-24) are currently married. Therefore, interventions improving enrolment of young girls and their stay in school should be implemented by engaging woreda education and Women, Children and Youth Affairs offices as education is an important tool to empower girls and women and improve their economic status and decision-making autonomy.
- The health, social, and legal bodies should strengthen their collaboration in educating the community; detecting, investigating, reporting, providing services to the survivors; and enforcing the existing law to protect women from FGM/C.
- Bring behavioral change to the traditional circumcisers as they are the only ones who perform circumcision practices even secretly. Repeated awareness-raising activities and engaging them in small-scale income-generating activities would facilitate an easy transition for them. Taking legal actions on these groups of individuals may accelerate the immediate abandonment of the malpractice than reaching the whole community which may take longer time and resources. The actions to be taken on the traditional circumcisers could be guided by doing further qualitative research on why they perform the practice, their readiness and commitment to stop the practice, the types of support they need from the local community, local government, and stakeholders.
- Raise the awareness of teachers and school principals to educate their students about the harmful effects of circumcision and advise them on the social and medico-legal measures they can take if they found out that their students were absent from school to get circumcised. Teachers can explore from kids if the malpractice is about to be performed onto them. School clubs may play a great role in this.

8. ANNEXES

8.1. Annex-1: Socio-demographic characteristics of the study participants, October 2021

Characteristics	Category	Frequency	%
Age category of participants	15-19	9	2.2
	20-24	64	15.4
	25-29	95	22.9
	30-34	58	14.0
	35-39	84	20.2
	40-44	54	13.0
	45-49	51	12.3
	Total	415	100.0
Have you attended school, or can you read and write?	Yes	173	41.7
	No	242	58.3
	Total	415	100.0
What is the highest level of school you attended?	Illiterate	242	58.3
	Not formal schooling but read and write	18	4.3
	Grade 1 to 6	72	17.3
	Grade 7 to 8	36	8.7
	Grade 9 to 12	42	10.1
	Above grade 12	5	1.2
	Total	415	100.0
What is your religion?	Muslim	139	33.5
	Orthodox	181	43.6
	Protestant	79	19.0
	Catholic	7	1.7
	Others	9	2.2
	Total	415	100.0
To which ethnic group are you belonging to?	Oromo	399	96.1
	Amhara	16	3.9
	Total	415	100.0
Average (SD) number of individuals living with		5.5 (2.4)	
With whom do you live?	Alone	2	.5
	Only with husband/partner	41	9.9
	With husband/partner and children only	222	53.5

	With husband/partner, children, and other extended family members	150	36.1
	Total	415	100
What is your relationship to the head of the household	I am head of the household	114	27.5
	Wife	296	71.3
	Other	5	1.2
	Total	415	100
What is your occupation?	Farmer	221	53.3
	Housewife	154	37.1
	Merchant	29	7.0
	Jobless	8	1.9
	Housemaid	2	.5
	Student	1	.2
	Total	415	100.0
What is your marital status?	Married	269	64.8
	Consensual union/living with partner	101	24.3
	Single	4	1.0
	Divorced	9	2.2
	Widowed	25	6.0
	Separated	7	1.7
	Total	415	100.0
How old is your partner/husband?	<=29	58	14.0
	30-34	62	14.9
	35-39	43	10.4
	40-44	69	16.6
	45-49	48	11.6
	>=50	90	21.7
	Total	370	100
What is your partner's/husband's occupation?	Farmer	338	91.4
	Others	32	8.6
	Total	370	100.0
Has your husband attended school or can he read and write?	Yes	259	70.0
	No	111	30.0
	Total	370	100.0
What is the highest level of school your husband attended?	No formal schooling but read and write	29	11.2
	Grade 1 to 6	80	30.9
	Grade 7 to 8	57	22.0

	Grade 9 to 12	81	31.3
	Above grade 12	12	4.6
	Total	259	100.0
Do you and he both earn the same amount of money or does he have more money, or you have more money?	Same	145	39.3
	I earn more	31	8.4
	He earns more	193	52.3
	Total	369[28]	100.0
What is your household's monthly income from all possible sources?	Can't quantify	142	34.2
	<=500 birr or no income	125	30.1
	501-1000	45	10.8
	1001-2000	39	9.4
	>2000	64	15.4
	Total	415	100.0
Who provides the source of income in your home?	Self	121	29.2
	Partner	148	35.7
	Both self and partner	142	34.2
	Self or Partner's parent	3	.7
	Pension/ other govt support	1	.2
	Total	415	100.0
Does your household currently get any government/other partner's welfare supports such as safety net program?	Yes	13	3.1
	No	402	96.9
	Total	415	100.0
If you compare the monthly income of your household with your neighbors, where do you put the economic status of your family?	Very poor	64	15.4
	Poor	109	26.3
	Medium	220	53.0
	Rich	19	4.6
	I can't say	3	.7
	Total	415	100.0

8.2. Annex-2: Measurement of variables

Coding/Assumptions for calculation of composite scores

Attitudes

9. For the overall proportion of respondents who have a positive attitude, the sum of all responses from the original score was computed and those who scored >= the mean expected value (eg. for women status (1+2+3+4)/4*(8 variables) =20) were classified as having a positive attitude.

[28] One respondent was unable to respond for this question

NB: ther response of all variables with oposit statements were transformed before summing up the responses for the composit score.

Decision-making status

10. For decision-making overall prevalence, self-decision was coded as "2", jointly with a partner or someone else as 1, and by a partner or someone else only as "0". And for husband assist in the household chore, always as 2, sometimes as 1 and never as 0.
11. For the overall prevalence of decision-making status, the sum of scores for the 7 variables was taken and those respondents with value>= the average expected value ((0+1+2)/3)*7=7 are classified as having favorable decision-making status

Knowledge on effect of FGM

12. To determine the proportion of respondents who have good knowledge, the "yes' value for each list is coded as "1' and that of "no" as "0". Then those respondents who have a sum score of more than or equal to the average expected value (5 out of 9 lists) we classified as having good knowledge.

Adolescent and youth (10-24 years) girls' decision-making status

13. To determine the overall decision-making status of adolescent and youth girls, self-decision was coded as 2, jointly with others as 1 and by others as 0. And frequently as 2, sometimes as 1, and never as 0. Then those girls with a sum score of >= the average expected value ((0+1+2)/3)*5 variables=5 are classified as having favorable decision-making status.

13.1. Annex-3: Educational status and religion by zone of residence

Background characteristics	Arsi	East Shewa	West Arsi	Total
Religion (Women 15-49)	N(%)	N(%)	N(%)	N(%)
Muslim	90 (38.0)	0 (0.0)	49 (63.6)	139 (33.5)
Orthodox	125 (52.7)	40 (39.6)	16 (20.8)	181 (43.6)
Others	22 (9.3)	61 (60.4)	12 (15.6)	95 (22.9)
Total	237 (100.0)	101 (100.0)	77 (100.0)	415 (100.0)
Attended school, or can you read and write (Age 10-24)				
No	20 (22.0)	5 (13.9)	5 (13.2)	30 (18.2)
Yes	71 (78.0)	31 (86.1)	33 (86.8)	135 (81.8)
Total	91 (100.0)	36 (100.0)	38 (100.0)	165 (100.0)
Currently in school (Age 10-24)				
No	35 (38.5)	25 (69.4)	19 (50.0)	79 (47.9)
Yes	56 (61.5)	11 (30.6)	19 (50.0)	86 (52.1)
Total	91 (100.0)	36 (100.0)	38 (100.0)	165 (100.0)