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Final Report

Formative Research on Strategies to End Female Genital Mutilation, Including Strategies to Increase Service-Seeking Behaviour, Strengthen Provision of Care and Transform Harmful Gender Norms in Ethiopia

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ABBREVIATIONS AND ACRONYMS

CSP	Card sorting and prioritization
DA	Development agents
FGM	Female Genital Mutilation
GD	Group dialogue
HEW	Health extension workers
HP	Harmful practice
IDI	In-depth interview
NGOs	Non-governmental organizations
PC	Pastoral communities
SNNPR	Southern Nations, Nationalities, and Peoples' Region
ST	Storytelling
TBA	Traditional birth attendants
UNFPA	United Nations Populations Fund
UNICEF	United Nations International Children's Emergency Fund
UN-Women	United Nations Entity for Gender Equality and the Empowerment of Women
WASA	Women and Social Affairs
WDA	Woreda Development Army

Executive Summary

In line with the 1997 inter-agency statement "Eliminating Female Genital Mutilation" (WHO et. al., 2008), the United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) launched a joint program in 2007 entitled "Female Genital Mutilation/Cutting: Accelerating Change". The program aims to contribute to the accelerated abandonment of female genital mutilation/cutting (FGM/C) in one generation, with demonstrated success in 17 countries in Africa by 2012. This feeds into the overall goal set by the 1997 interagency statement, reaffirmed by the 2012 United Nations General Assembly (UNGA) Resolution (UNGA, 2012), to intensify global efforts to eliminate FGM/C (UNICEF, 2017). The UN estimates that 200 million women and girls around the world have undergone FGM, with 80% of the cases occurring in Africa.

In Ethiopia, approximately 25 million women and girls have experienced Female Genital Mutilation (FGM). Given the unacceptably high prevalence of FGM in Ethiopia, where 65% of girls and women aged 15 to 49 years have undergone FGM, the country has been striving to address the issue through the implementation of several strategic and programmatic measures. This study was initiated with the aim of documenting a body of evidence on the role of community norms, key agents, and legal and customary laws in the prevention and elimination of FGM among pastoral communities in three regions.

According to the findings of the first phase of the study, the driving factors for FGM in Ethiopia include culture and social expectations, marriageability, claim of religious obligation, and lack of awareness about existing laws. It was found that girls and women who are from poor households, illiterate, living in rural areas, and from Muslim communities, are inclined to undergo FGM as they tend to support such practices.

The research questions derived from the first phase study included identifying the interventions, approaches and channels likely to effectively challenge FGM, identifying the roles girls and women could play, and exploring the knowledge of pastoral communities (PCs) around legal, health and protection services.

The data for this second phase study were collected from various offices responsible for FGM programs and community members from Afar, Somali and Southern Nations, Nationalities, and Peoples' (SNNP) regions. Group dialogue combined with card sorting and prioritization (CSP), in-depth interviews (IDI) combined with Venn diagrams, and group dialogue combined with storytelling were used to collect the qualitative data. A total of 80 key informant interviews (KII) with Venn diagram, 80 GD with storytelling and 27 GD with CSP were conducted at Asayita, Amibara, and Gewane woredas[1] of Afar region; Warder, Kebridahar, Fik, and Hamero woredas of Somali region; and Dasenech woreda of SNNP regions.

It is expected that the study findings presented in this report will provide the basis of interventions in the target regions and woredas towards ensuring accelerated

[1] District

abandonment of the practices of FGM. As to the findings of this study, the participants in all the three regions, except for some in SNNP (Dasenech woreda), are aware of the impacts of FGM on health of the girls/women, and know that it is punishable by law. Despite this awareness about its legal and health implications, however, FGM (particularly the Sunnah type)[2] is still practiced by many community members in the three regions. Drivers mentioned by the study participants are the beliefs by families and girls themselves that girls who do not undergo FGM will not be able to get married, and beliefs that uncut girls are more likely develop unstable and overly sexual behaviors. Other drivers include complying with cultural beliefs and norms, reducing the sexual urges of girls/women, keeping the honor and good name of the family, considering FGM as a religious obligation (particularly practicing the Sunnah type of FGM), and hoping that FGM would help girls remain virgins before marriage and faithful to their husbands after marriage.

The study has revealed that identifying mothers of both cut and uncut girls from among audiences and stakeholders would be very important to create effective interventions, as they are are the main actors deciding and organizing FGMs for their daughters. Religious leaders were also identified as major targets for awareness-raising given that, unless persuaded to do so, some religious leaders do not speak to the community about FGM and its harmful consequences, even if they are informed about them. Elders and clan leaders are identified in all sites as important influencers/audiences because of their high level of influence in the community.

Possible channels of communication to transmit messages on FGM identified by the participants include specific committees in schools, women's groups, kebele[3] chairpersons, girls' clubs and women's associations. In addition to the channels of communication, the study participants identified key messages to be included in interventions. In all sites, they emphasized the need to provide intensive and extensive awareness-raising and training on the health complications affecting mothers who experienced FGM and their newborns during delivery.

The main recommendations that could be applied to end FGM are the following (please note that region-specific recommendations are provided in the Conclusion and Recommendations unit):

- Religious and clan leaders should be actively engaged in persuading the community members to send their children (both boys and girls) to schools and to stop FGM and other HPs.
- The formation of strong committees at the kebele level is recommended, with representatives from the relevant sections of the community (women, girls, boys, men, elders, etc.) handling and following-up on issues related to HPs, and conducting regular community conversations (e.g., first Friday of every month).

[2] "Sunnah" circumcision is the circumferential excision of the clitoral prepuce, as opposed to the total removal of the clitoris and/or labia minora, and "Pharaonic" FGM (or infibulation), which involves the narrowing the vaginal orifice with the creation of a covering seal.

[3] The smallest administrative unit (subcity

- Since FGM-related incident surveillance, reporting and prosecuting are not common practices in pastoral communities, a reporting mechanism should be designed and implemented, such as suggestion boxes, or anonymous reporting through community-level social workers. Those who report FGM incident should be protected by government bodies.
- In the long run, equality of men and women in decision-making on family matters and ownership of property can only be achieved through education, awareness of rights and the empowerment of women. Due attention should therefore be given to education and economic empowerment for girls.
- Mechanisms to coordinate efforts to implement and utilize the services related to customary and formal laws at community level (community legal centers) should be carefully identified and implemented.
- Strong awareness-raising and education programs should be in place to convince the community at grassroots level to consider the particularly harmful effects of Sunnah FGM.
- Health facilities in the study area should be strengthened in terms of medical supplies and human resources.

Vigorous and effective initiatives should be put in place to raise communities' awareness on the harmful effects of FGM, to change the attitude of boys, men, and the general community about the habitual preference for cut girls over uncut ones for marriage.

CHAPTER 1:

BASELINE STUDY BACKGROUND

This chapter covers the insights and context under which the baseline study was undertaken. It comprises background information, key findings of the meta-synthesis report, the rationale of the baseline study, the research objectives, the scope, thematic areas, and research questions used in the study.

1.1. Background

In line with the 1997 inter-agency statement "Eliminating Female Genital Mutilation" (WHO et al., 2008), the United Nations Population Fund (UNFPA) and United Nations Children's Fund (UNICEF) launched a joint program in 2007 entitled "Female Genital Mutilation/Cutting: Accelerating Change". The program aims to contribute to the accelerated abandonment of female genital mutilation/cutting (FGM/C) in one generation, with demonstrated success in 17 countries in Africa by 2012. This feeds into the overall goal set by the 1997 interagency statement, reaffirmed by the 2012 United Nations General Assembly (UNGA) Resolution (UNGA, 2012), to intensify global efforts to eliminate FGM/C. The UN estimates that 200 million women and girls around the world have undergone FGM, with 80% of the cases occurring in Africa. The African Union Commission (2022) reported that the prevalence rate of FGM in African countries is from 1% to 97% and more than 50 million girls are at risk of undergoing FGM. The countries with the highest prevalence rates include Benin, Ethiopia, Egypt, Kenya, Somalia and the Sudan.

In Ethiopia, women and girls who have experienced FGM are estimated to be 25 million. Among those aged 15 to 49 alone, 65% of women and girls have undergone FGM in Ethiopia (CSA & ICF, 2016). This is unacceptable by any standard. However, Ethiopia has been striving to address the issue through the implementation of several strategic and programmatic measures. The development of a comprehensive national roadmap that aims to achieve the complete abandonment of child marriage and FGM in Ethiopia by 2025 is one such initiative collaboratively taken by the Government of Ethiopia, UNICEF, UNFPA, UN Women, and other partners (MoWCY, 2019). UNICEF Ethiopia is currently working with the Government of Canada to end FGM in a five-year Program[4] and with UNFPA under the Joint Program to eliminate FGM by implementing interventions in five areas: (i) girls' empowerment and life skills; (ii) Social and Behavior Change Communication (SBCC) in communities; (iii) prevention, protection, and health services; (iv) legal policy frameworks; and (v) data and evidence. As part of the intervention on data and evidence, UNICEF, in collaboration with Frontieri Consult PLC., conducted a research project titled "Formative Research on Successful Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior and Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia". Given the lack of adequate evidence-based research on FGM in Ethiopia, particularly in the pastoralist communities of Afar, Somali and SNNP

[4] 1/04/2020 -31/03/2024

regions, the formative research is useful to understand the complexity of the drivers that exist at the individual level (attitudes, beliefs, and agency), group level (community dynamics, social influences and norms), and within the broader enabling environment (governing entities, communication environment, and structural barriers to change).

The research project had two components: meta-synthesis, and Participatory Action Research (PAR). The first component, which was carried out from May to July 2021, focused on conducting a meta-synthesis to provide a systematic overview and analysis by interpreting and synthesizing findings across sources selected from existing legal, policy, and program/project documents, and research reports on FGM. The key findings of the meta-synthesis, including gaps identified for the formative research, were presented in a virtual validation workshop attended by around 45 key stakeholders. The key findings of the meta-synthesis are presented below (1.2). The second component of the research project fills the gaps identified by the meta-synthesis research through primary data collection, analysis and presentations. Some of the research gaps include a lack of adequate evidence on which interventions can effectively reduce the prevalence of FGM in the PCs, on the drivers of FGM in the PCs, on the gender dynamics at play, on the roles of community and religious leaders, and on the inadequate enforcement of FGM-related laws.

1.2. Key findings of the meta-synthesis

The meta-synthesis helped identify the key reasons behind FGM practices, its patterns and trends, key drivers, actors, agents and gatekeepers. It also aimed at identifying which strategies successfully contributed to the elimination of FGM, and which ones did not. The findings are divided into eight broad areas as presented below.

i. FGM patterns and trends in Ethiopia

FGM has shown a progressive decline, but its prevalence is still unacceptably high, at 65 per cent nationally. Although three regions—Afar, Somali, and Harari—have the highest prevalence, pockets of Oromia, Amhara and SNNP also have significant number of FGM cases. Often, the reasons for the practice include fulfilling social expectations (tradition, norms and culture), controlling women's sexuality, protecting virginity with a concern for marriageability, and respecting religious regulations (Mehari et al. 2020). The age range of circumcision varies across regions. The Sunnah cut, which is practiced mainly in Afar and Somali regions, is carried out at a very young age, including just a few days after birth. FGM is performed at the seventh day after birth in Amhara; at 15 years old in Oromia, and at around 10 years old in the SNNPR. It is well documented that girls living with older women; from Muslim households; living in rural areas; from poor households; and without education, are more likely to be circumcised.

ii. Trusted sources of information, channels and platforms

Available evidence shows that religious leaders, culturally compatible communication (such as Dagu, the inter-communal information sharing system common in Afar region), as well as health professionals, teachers and mass media, are the most frequently mentioned trusted sources of information on FGM (Abebaye & Disasa, 2015; Andarge, 2014; Mehari et al., 2020). The media, particularly the radio, was a relevant and trusted source of information for community members of all ages and both sexes in Amhara region.

iii. Key actors and influencers

Existing evidence shows that an effective, comprehensive approach requires involving political leaders, government agencies (e.g. ministries of women and social affairs, health, education, and culture), health care providers including health extension workers (HEWs), NGOs, teachers, women's representatives, family members (mothers, mothers-in-law, fathers), older women and TBAs, religious leaders, chiefs and/or clan leaders (Abebe et al., 2020; Mehari et al., 2020; UNICEF, 2020).

iv. Challenges experienced by girls who have not undergone FGM in Ethiopia

Women and girls who have never undergone FGM face several challenges, such as strong pressure from their mothers-in-law and others. Girls often have no autonomy to make decisions about their physical integrity because some community members claim that FGM is performed to make girls calmer, cleaner, to prevent misbehavior, and to control sexual needs and emotions. Uncircumcised girls are typically believed to be "talkative", "sexy" and prone to quickly agree to sexual intercourse; unable to agree with their husband during sexual intercourse, and intolerant of sexual incompatibility (Kassegne, 2020). All these claims and beliefs come at the cost of women's and girls' suffering, and lead to the violation of their rights. These beliefs also lead some of the girls and women to reconsider their decision not to be circumcised so as to establish good relationships with their mothers-in-law, or for fear of social exclusion.

v. Factors and drivers related to FGM

Several factors play key roles in driving FGM practices. These tend to be related to: cultural and social expectations; perceived criteria and standards for marriageability; the belief that FGM is a religious requirement; widespread acceptance of FGM practices within a community; traditional inequitable gender-norms; inadequate knowledge; weak law enforcement and criminalization, among others. Available evidence shows that FGM can be prevented by comprehensively addressing these drivers (e.g., Mehari et al., 2020; Ababaye and Disasa, 2015).

vi. Gatekeepers of FGM

FGM has shown a sluggish decline in Ethiopia due to the gatekeepers who facilitate its practice. These include family members, such as mothers, grandmothers, mothers-in-law; traditional circumcisers or traditional birth attendants (TBAs); some health care workers and religious teachers. The weak commitment of government agencies to eradicating it, as well as tolerant attitudes towards FGM among the communities themselves are also among the factors that hinder progress.

vii. Successful strategies for reducing FGM in Ethiopia

The following are some of the strategies that have had a progressive impact: awareness-creation, such as communication for development (C4D) strategies, community mobilization; education with integrated curricula (along with other community development efforts); law enforcement; engagement of key stakeholders—such as teachers, traditional and religious leaders, clan leaders, health care workers, TBAs, women, political leaders, school clubs, men and boys. Additional strategies include empowering and engaging women and girls; collaborating through existing government structures to involve faith-based organizations; working with marriage counsellors; involving women and youth associations and youths' clubs, and collaborating with NGOs (Abathun et al., 2016; Mehari et al., 2020). In general, better knowledge and understanding combined with greater motivation to end FGM contribute towards the reduction of the practice.

viii. Unsuccessful strategies in combating FGM practices in Ethiopia

The customary and religious laws used in Afar region were not found to be supportive of the effort to eliminate FGM, and therefore should not be considered an effective source of support for a strategy against FGM. Similarly, the construction of standalone health centers in the pastoralist areas was found to be unsuccessful due to the high mobility of the local community.

ix. Gaps and issues for further investigation

Despite the outward commitment of the Government of Ethiopia (GoE) to eradicating FGM through the introduction of progressive laws and the adoption of several conventions related to rights and protection of children, FGM practice in Ethiopia is still unacceptably high. There is a need for rigorous exploratory studies of the key cultural, religious and social drivers of FGM to inform policies, program design and implementation processes. Approaches that include: a human rights framework; legal mechanisms; community awareness of health risks; training of HEWs and others as change agents; training and converting of circumcisers and TBAs as change agents; and the use of comprehensive development programs, were all found to be successful among sedentary communities. However, they have limited impact among PCs (Ababaye & Disasa, 2015; Abathun, et al., 2016; Abebe, et al., 2020). The studies reviewed in the meta-synthesis identify the following challenges hindering the elimination of FGM in Ethiopia so far: resistance from community members; unsustainability of anti-FGM interventions; poor selection of change agents; religious leaders' reluctance and attachment to conservative norms; and weakness in law enforcement systems. In addition, there is a need for further investigations on the reasons for inadequate law enforcement, and the lack of involvement of boys and men in various interventions. Additional investigation is also required to identify reasons for the failure of customary laws and the construction of health facilities in PCs, as well as for the contradictory findings concerning the selection of change agents, the role of some community members (such as clan and religious leaders), and the laws in operation at the community level.

1.3.Rationale and Objectives

1.3.1. Rationale

The prevalence rate of FGM is very high in Ethiopia, and its reduction has been very slow, despite some efforts by the Ethiopian Government, UNICEF, and other partners. Phase I of this study (review and meta-synthesis) has identified several successful and not-so-successful strategies for the reduction of the practice. Given the paucity of data on FGM practices in pastoralists areas in Ethiopia (i.e., regarding underlying factors, social norms, drivers, etc.), Phase I highlighted a strong need to explore in greater detail the situation in the PCs to inform programming and interventions. This is the main rationale behind conducting this formative research (FR). The specific themes and research questions are listed under a separate unit, below (Section 5 on Thematic Areas and Research Questions).

Usually, FR is done before a program is designed and implemented (Care, 2014). It is understood that FR is a critical activity in the process of developing program strategies, especially when the aim is to change attitudes and behaviors. It gathers information to inform the design and refinement of projects and interventions, in a process that captures information related to the characteristics, perceptions, and behaviors of a specific population. It also helps refining messages to bring about social and behavioral changes more effectively. The FR techniques of data collection will encourage people to share information, values, knowledge, and perceptions that can then inform interventions.

1.3.2. Objectives

The major objective of the FR was to document a body of evidence on the role of community norms, key agents, and legal and customary laws in the prevention and control of FGM in PCs. It consisted in action-based research where the key stakeholders and the affected persons (such as women and cut girls) took part in the discussions and suggested ways of intervening to end FGM in the PCs, ensuring a participatory process in the development of practical knowledge and solutions to FGM. The following are the main objectives of the FR:

1. To examine the role of community attitudes and norms (more specifically gender dynamics and social norms) in the prevention of FGM, at the household and community levels in PCs of Ethiopia.
2. To determine the most effective, acceptable, responsive, and impactful approaches to ending FGM in PCs.
3. To find out the most effective channels, key messages, and communication pathways to persuade the community members to abandon FGM.
4. To understand the potential positive roles of key change agents (uncut girls, community leaders, boys) in the promotion of social norms and gender equality.
5. To assess the power distribution across stakeholders for effective engagement towards prevention and ending of FGM in the PCs.
6. To examine the role of legal and customary law in the prevention of FGM, including access to the services (health, social and legal counselling), barriers, and opportunities.

1.4. Scope of the Baseline

The study covered pastoral communities in regions and woredas with high FGM prevalence rates in Afar, Somali and Southern Nations, Nationalities, and Peoples' (SNNPR) regions. The data were collected from various offices and woreda community members. In terms of methods, Group Dialogues (GD) combined with Card Sorting, In-Depth Interviews (IDI) combined with Venn diagrams and Group Dialogues combined with Storytelling were used to collect the qualitative data. A total of 32 key informant interviews, 56 group dialogues and 124 in-depth interviews were conducted at Asayita, Amibara, and Gewane woredas in Afar; Warder, Kebridahar, Fik and Hamero woredas in Somali; and Dasenech woreda in SNNPR.

1.5. Thematic Areas and Research Questions

The following thematic areas and research questions emerged from the meta-synthesis:

1) Strategies/interventions/approaches that work to end FGM

Description:

The meta-synthesis and the validation workshop have highlighted the need to explore in greater detail what interventions, approaches, and channels are most likely to work to challenge FGM in our target areas, specifically among pastoral communities. What opportunities could be leveraged for effective interventions, including social and behavioral change interventions that effectively reduce FGM as a practice and challenge the underlying gender norms that drive it? The role of men and boys, as well as uncut girls and women as positive agents for change were further explored, with a specific focus on pastoral communities.

Questions:

a) Strategies and interventions to challenge inequitable gender norms

i. What are the key drivers of FGM that are particular to pastoralist communities?

ii. What gender dynamics exist at the individual, household, and community levels? And how is power exercised at different levels to control women and girls?

iii. What are the constraints to gender equality and power relations at the individual, household, and community levels? What are the opportunities for change and how can these opportunities inform programming?

iv. To what extent do boys and men influence the perpetuation of FGM in their respective communities? What positive role do they have, or could potentially have, in challenging FGM?

v. What is the community's understanding of existing gender norms and their impact on girls and women?

vi. What are the assets/norms of the community that could be helpful to end FGM?

vii. What interventions are most acceptable and likely to be impactful in terms of empowering women and adolescent girls, addressing gender inequality, and challenging FGM as a practice?

viii. For the interventions to be effective, what audiences should be targeted, which stakeholders should be engaged, why, and how? What channels or communication pathways should be used to reach the target audience(s)? What key messages should be included?

b)The role of uncut girls and women

i. What stories of uncut girls and women could be useful for advocacy, programming, and policy change? How do they differ from stories of cut women in the same or similar communities?
ii. How can the experiences of uncut women be used to promote social norms and gender norms change – and through what interventions, channels, and messages? How can uncut women be positively engaged?
iii. What are the roles currently played by uncut girls and women in the elimination of FGM? How have they been engaged by their communities, government line ministries, and CSOs? How could they be better engaged?
iv. What is the preference of boys and men in terms of cut or uncut girls for marriage? What could be the reasons for these preferences? Are they changing over time?

2) Demand and supply of services to end FGM

Description:

The meta-synthesis and the validation workshop, along with UNICEF's current interventions have highlighted the need to explore in greater detail pastoralist communities' knowledge around legal, health, and protection services related to FGM. Stemming from an in-depth analysis of the current supply of formal and informal services and existing referral pathways, if any, programmatic, actionable suggestions are to be made by the research team to strengthen the synergy between legal, health and protection services.

Questions:

i. What do community members know about FGM laws?
ii. What customary laws, if any, have been developed by the community= to eliminate FGM?
iii. Is there any form of community surveillance?
iv. How coordinated is formal or customary law enforcement? What were the challenges and opportunities in enforcing or implementing customary laws or bylaws?
v. Does the community know about the existence of services (both formal and informal) to prevent, support, and manage FGM cases?
vi. Are there any impediments for communities to report FGM cases to the relevant government law enforcement agencies? If yes, what are they and how can reporting and demand for legal services be improved?
vii. What are the main barriers and opportunities for these communities in terms of seeking out and reaching health services for FGM specifically, and reproductive/maternal health services more broadly?
viii. What synergies are there between health, protection, and legal services to end FGM?
ix. What are opportunities in the sectors for better synergies at the individual, community, and system levels? What approaches would enable these synergies at each level?

CHAPTER 2:

METHODOLOGY

This chapter presents the study methodology in terms of survey design; study population; sampling methods; data collection methods; data collection tools and data analysis methods.

2.1. Study Design and Process

This study used a qualitative cross-sectional research design called Participatory Action Research (PAR). PAR is a collective, reflective and systematic research approach where researchers and communities/respondents engage as equal partners in the research design and execution (Borda, 2006; Kindon, et al, 2007). The design aligns with an ontology of participatory reality and an epistemology of experiential and participative knowing (Kindon et al, 2007). Put differently, this research design relied on accessing lived realities and experiences through direct social interaction.

The PAR approach in this study combined several data collection methods and used different sources of information to consider a diversity of perspectives and cross-check the data obtained. Given that FGM is anchored in the religions, cultures and norms of local communities, PAR offered an ideal approach for mapping peoples' perceptions, attitudes, and practices towards FGM.

Research phases

Implementation of the baseline study consisted of five sequential phases, namely: a preparatory phase; desk review, study design and piloting; data collection; reporting; and dissemination, validation and feedback.

Details of each phase are as follows:

Phase I: Preparatory:

During this phase, UNICEF and the consultants, Frontieri Consult PLC, undertook several activities to prepare for the implementation of the baseline study. These activities included addressing contractual issues, clarifying the terms of reference (ToRs), providing necessary literature for the preparation of the inception report and study tools, and recruiting the data collection team.

Phase II: Desk review and study design:

In this phase, a literature review on FGM was carried out by the consultants to guide the development of an inception report with a key focus on refining the methodology to ensure that the data and study findings matched the study objectives, outcome and output indicators. The desk review was vital in preparing the study tools, informing baseline data analysis, and reporting on the study findings. UNICEF review teams provided substantive comments and feedback on the inception report and study tools. The consultants then proceeded to train the data collection team using the draft tools, to pre-test and validate core elements of the inception report (mainly the methodological approach), and to test the study tools under similar field conditions as those in the targeted regions and woredas. Following the pilot mission, a revised inception report and study tools incorporating the pre-test findings

were submitted to the UNICEF review teams for comments and feedback. These were incorporated into the inception report and study tools, and a final set of deliverables was submitted to UNICEF for approval and use.

Phase III: Data collection:

Following approval of the inception report and study tools, the consultants proceeded to the field to carry out data collection in the target woredas for a period of approximately one month. Prior to the commencement of data collection, the data collection team was debriefed accordingly to ensure that any changes in the methodology and content of the study tools were understood.

Phase IV: Reporting:

Using the collected baseline data, the consultants prepared a draft study report. It was submitted to the UNICEF review teams for comments and feedback, which were then incorporated into second drafts that were subsequently submitted for further comments. All these procedures ensured that the baseline study report complied with professional standards while meeting the study objectives and information needs of its intended users.

Phase V: Dissemination, validation, and feedback:

Dissemination and validation sessions were incorporated into the study design to allow for maximum feedback and learning. First drafts were presented to the UNICEF teams, whose feedback was subsequently incorporated. The second draft was subjected to a validation exercise with the National Alliance Committee to End FGM and Child Marriage, and community members in all the study locations. This was to ensure that the findings of the study were in line with the positions of the participants on FGM in their respective communities.

2.2. Study areas

The study was conducted in three regions (Afar, Somali and SNNPR). Below we briefly describe the socio-economic context in each region of the study.

Afar:

This study was conducted in three woredas, namely Amibara, Gewane and Asayita. The region has a population of approximately two million. More than 90 per cent of inhabitants reside in rural areas and are predominantly pastoralists. One of the unique characteristics of this region is Dague (a cultural way of orally transmitting information in Afar society). The region has strong, clan-based political systems where clan leaders are responsible for the administration of their clan's affairs and many aspects of social life (Masresha, 2014). Based on data from the 2016 Ethiopian Demographic and Health Survey (EDHS), Afar has the second highest FGM prevalence in the country. The overall rate stands at 91 per cent for the region but goes up to 98 per cent in rural areas. The prevalence decreased very little over time, from 98.6 per cent in 2000 to 91.2 per cent in 2016. The figures from EDHS 2016 are alarming, as FGM is currently more common among younger age groups (15-19 years) than among older age groups (20-24 years). In Afar, 89.5 per cent of girls are cut before the age of five (UNICEF, 2019).

SNNPR:

This study was conducted in Dasenech woreda. The region is a multi-ethnic regional state with numerous nations and nationalities living together. There were 56 nations and nationalities before Sidama and South-West Ethiopia regions became self-ruled regional states. The region's population (before the split into four regions), accounted for 20 per cent of the total population of the country (CSA, 2007 & 2021).
The projected populations of Sidama and

South-West Ethiopia are about 4 and 2.3 million inhabitants, respectively (CSA, 2021). Before the split, in SNNPR, 62 per cent of women aged 15 to 49 had undergone FGM and most (87.1 per cent) were cut before the age of 15. The share of pastoralist communities living in the southern part of SNNPR (by the Kenya border) would be large, though actual reliable figures are not available by zone or woreda. Pastoralist communities in SNNPR mainly herd cattle, camels, goats, and sheep.

Somali:

This study was conducted in Warder, Kabridahar, Dhanan and Gode woredas. Somali regional state is the second largest region in terms of geographical size following Oromia. The projected population size of the region is about six million (CSA, 2021). More than 90 per cent of the population lives in rural areas, identifies as Muslim and follows a pastoralist lifestyle. Somali region has the highest FGM prevalence (99 per cent), with a lower prevalence (95 per cent) among younger girls (15-19 years) as compared to other age groups. In Somali, 85.1 per cent of girls are cut between the ages of five and fourteen. FGM prevalence in the region has been constant and remains a major concern, with a very slow reduction from 99.7 per cent in 2000 to 97.3 per cent in 2005, followed by a rise to 98.5 per cent in 2016. Infibulation, which is the most severe type of FGM, was practiced on about 73 per cent of girls in 2016. This practice declined by about eleven percentage points from 2015 up to 2019 (UNICEF, 2019).

2.3. Study participants

The data for the study were collected from various offices responsible for FGM programs, and from community members in the three regions. A Group Dialogue with card sorting was conducted with experts in health, education, Women and Social Affairs (WASA) and Justice Bureaus. Non-governmental partners (such as the National Alliance for FGM), police officers, health professionals in health centers and mobile health and nutrition teams (MHN), and schoolteachers were also involved in the group dialogue. Community members such as religious leaders, mothers of cut and uncut girls, and cut and uncut women/girls also took part in IDIs with Venn diagrams. Group Dialogue/Storytelling was conducted with in- and out-of-school adolescent girls and boys, adult men and women, clan, community, and religious leaders depending on location, and health extension workers (HEWs).

2.3.1. Sampling Methods

The study population was drawn from eight woredas/districts in the three regions (Afar, Somali and SNNPR). The study woredas are annexed (Annex A). In the first stage of sampling, six zones were drawn from the three regions (one from SNNPR; three from Somali, and two from Afar) using purposive sampling techniques.

At the second sampling stage, eight woredas (one from SNNPR; four from Somali and three from Afar) were selected using purposeful sampling techniques. The selection of the regions, zones and woredas was guided by UNICEF and took into consideration at least four criteria: having a pastoralist population; being targeted by both health and protection programs (with the exception of SNNPR, where only the Child Protection Section was working); being of particular interest/significance for UNICEF's programming, and the current security situation.

In the third sampling stage, two kebeles/ informal settlements were selected from each of the eight woredas, bringing the total number of kebeles to 16. A list of kebeles was made available by each woreda's administration. The kebele selection was entirely purposeful: in each woreda, one kebele from a dominantly agro-pastoralist and one kebele from a pastoralist were selected. Based on information from the woreda administration, the kebele selection also considered the distance from services and FGM prevalence as criteria. Once the selection of regions, woreda and kebeles was complete, the next step was selecting the target population for data collection.

2.3.2. Sampling and Data Collection Methods

Group Dialogues (GD) combined with Card Sorting, In-Depth Interviews (IDI) combined with Venn diagrams and Group Dialogues combined with Storytelling were used to collect the qualitative data. Each of the methods is discussed below.

i. Group Dialogue combined with Card Sorting/Prioritization

Participants targeted for this data collection method were selected according to the following criteria: health professionals who have considerable knowledge and experience with FGM, and those currently responsible for providing FGM-related services in institutions, offices and facilities. Researchers selected participants in consultation with the heads of bureaus and offices, since they were more familiar with the knowledge and experience levels of their staff.

Regional bureaus (Health, Education, Women and Social Affairs (WASA), Justice, National Alliance for FGM) and woreda offices (Health, Education, WASA, Police) were also included. Staff from health centers and schools and Mobile Health and Nutrition Teams (MHNTs) in the sampled kebeles/informal settlements were also included in this study.

The research team conducted three Group Dialogues with Card Sorting/Prioritization, with one session for each region. At the woreda level, there were eight group dialogues, one for each woreda. In addition, there were 16 group dialogues in kebeles/ informal settlements. At the regional level, each Group Dialogue with Card Sorting/ Prioritization included five participants (one from each of the five bureaus). There were eight participants per Group Dialogue at the woreda level (two from each of the four offices), and nine per Group Dialogue at the kebele/informal settlement level (three from each of the three facilities/MHNTs).

ii. In-Depth Interview (IDI) combined with Venn Diagrams

Mothers of cut and uncut girls, cut and uncut girls, as well as religious leaders participated in IDIs combined with Venn Diagrams as described below. Participants were selected from among residents in the sample kebeles/ informal settlements. Information collected from these informants related to perceptions of gender inequality and the distribution of power with respect to FGM/child marriage in their communities and families. Participant selection was done using snowball sampling methods. Given that TBAs, health extension workers (HEWs) and kebele administrators were familiar with community health needs related to FGM and cases of complications, the research team relied on them to identify the most appropriate respondents. On the other hand, religious leaders were selected using purposive sampling.

After the Venn Diagram exercise, the research team identified the relations between formal and informal institutions and the distribution of power between them. Following this, the research team continued interviewing the respondents using semi-structured questions prepared for this purpose.

iii. Group Dialogue combined with Storytelling

Five Group Dialogues combined with Storytelling were conducted in each kebele/informal settlement with men, women, Women Development Army (WDA) workers and HEWs, adolescent girls who were in- and out-of-school, and adolescent boys (in- and out-of-school)

A snowball sampling strategy was used to select Group Dialogue participants. An initial participant was identified from each of the five different groups by the research team in consultation with heads of health centers who are known and trusted by the community they are serving. Then each person identified for each group brought another two people (second stage) to join the groups. Finally, each of those persons selected in the second stage brought another two persons (third stage) to join the groups. Through this process, there were about seven people participating in each group. The criteria used for participant selection were: the participants had to be residents of the kebele/informal settlements (for all groups); either in- or out-of-school adolescents (for the respective groups); have a diversity of opinions on FGM for the men's and women's groups, and be women who serve their community as HEWs and WDAs (both active and inactive).

2.3.3.Method of Data Analysis

The Frontieri research team employed thematic analysis to analyze the data. The thematic analysis, which applied minimal description to data sets, was also complemented by qualitative analysis using ATLAS.ti. Coding the data began once all the interviews and group discussions were fully transcribed. Initial coding was based on prior conceptual categories (with multiple coders for cross-checking) and further coding concepts were derived from the data (inductive coding). This included exploring coded data to further analyze it, such as querying the data to find out frequently occurring concepts and themes, or relationships among codes and themes. In general, data analysis aimed to address the key dimensions of the study: describe community attitudes and norms (more specifically gender dynamics and norms); identify effective, acceptable, responsive and impactful interventions (including the channels through which they can be implemented, and messages about the negative effects of FGM); summarise the roles of key change agents; map the distribution of power and influence across key stakeholders; and assess the ease of access to key services associated with FGM (health services, social and legal counselling), as well as relevant barriers, and opportunities.

2.4. Data quality assurance

Frontieri's internal quality assurance system was implemented at different stages of the study, including but not limited to pre-data collection, data collection, and post-data collection. Pilot-testing and adequate training for the enumerators were part of ensuring data quality. Internal quality control ensured that data collected was of high standard through the daily monitoring of recorded audio and notes at the field level, and through

quality checks on selected audios recordings by office-level supervisors, who also received daily updates from field supervisors. Data cleaning and transcription/translation was part of the data quality monitoring. This continuous process was used to check for formatting, completeness and consistency. Each audio translation was reviewed to make sure they fully have captured the responses and discussions.

2.4.1. Training of research assistants (field staff)

Prior to carrying out a pre-test of the survey tools and the data collection, a total of 19 research assistants comprising nine women and ten men were trained on specific areas that included: familiarization with the baseline study ToRs; survey questions and questionnaire flow; recording of information; household selection; interviewing techniques; integrity during data collection; informed consent, confidentiality and gender considerations as key components of research ethics, as well as familiarity with the UNICEF child protection policy and manual.

The research assistants were selected based on their qualification and experience with FGM or other health/social science research studies. In Somali region, nine field staff (research assistants) were deployed (two female and seven males). In Afar region, eight research assistants were deployed (six females and two males), while in SNNP, one female and one male research assistants took part in data collection. The gender breakdown and qualifications of field staff are provided in Annex E.

2.4.2. Piloting the data collection tools

Piloting the data collection tools was conducted to examine the feasibility of the proposed approach and tools at a larger scale. The pilot survey took place over three days (July 29th-31st) in two kebeles: Dubdub Kebele (Fentale woreda) of Afar region, and Muli Kebele (Meiso woreda) of Somali Region, which were chosen to represent the two study regions (Afar and Somali). Upon assessing nearby PCs, Frontieri found Fentale and Meiso woredas to be suitable for data collection, despite being 200 and 300 km away from Addis Ababa, respectively. Teams deployed to each woreda established rapport, obtained permission from woreda-level Health and Women and Social Affairs bureaus, and conducted the piloting. During the piloting, two group dialogues with card sorting/prioritization, two group dialogues with storytelling, and nine in-depth interviews with Venn diagrams were conducted.

2.5. Ethical considerations

The highest standard of research ethics was ensured during the entire study process. This involved adhering to standards of UNICEF research guidelines, standard good practices and professional integrity. All applicable participant protection laws were respected, and the study was guided by the "Do no harm" principle. Ethical clearance was obtained from the Ethiopian Society of Sociologists, Social Workers and Anthropologists (ESSSWA). The issue of FGM being very sensitive, ethical protocols were put in place and strictly followed throughout the research, through the preparation of training and data collection guides that gave adequate attention to ethical considerations

and potential risks for both participants and researchers, with particular emphasis on adolescent girls and women. The Frontieri research team members trained the field staff (supervisors and data collectors/facilitators) to ensure the quality of data collection.

A verbal/written consent form was prepared and translated into local languages to provide enough information to allow research participants to make informed decisions. The form explained the objective of the study, the role of the participants, the information required from them, the expected duration of participation, and their right to not partake in the study or withdraw from the research at any stage. Interviewers provided the form to respondents so that they could read, sign or fingerprint it before the start of each interview. For people who could not read or write, the data collector read and explained the form. They then gave their oral consent, which was recorded, and interviews were carried out upon their agreement to participate. In the case of adolescent participants (aged between 10-14 and 15-18), consent was obtained from parents or guardians and then consent/oral affirmative agreement was obtained from the child before each interview or discussion.
The Frontieri research team gave due attention to ethical concerns including confidentiality, anonymity and privacy, as well as ensuring child-friendly and protective protocols. Strict data protection measures were followed in order to maintain the privacy of the data collected from respondents. This included rigorous data transfer protocols, such as limiting the use of the data only for the agreed purposes, allowing access to data only to research personnel, as well as ensuring the transfer of data to a password-protected computer immediately after data collection. Each audio file was anonymized and given a unique identification code.

2.6. Limitations of the study

During the pre-test and data collection proper, some challenges were encountered.
A detailed account of these challenges and mitigation strategies are provided in Table 1 below:

Table 2.1: Challenges and mitigation strategies during pre-test and fieldwork

Challenges encountered	Mitigation strategies
The support letter from the Ministry of Health for the piloting was delayed.	The team went to the Ministry in-person to facilitate the release of the letter.
At the beginning of the survey, we received alarming reports on the security situation in Somali region, Shebele zone, Gode woreda (sampled woreda).	Frontieri and UNICEF jointly decided to replace Gode and Dahnan woedas with Fik and Hamero woredas, which have better security situations.
The company that Frontieri rented its vehicles from refused to go to Shebele zone, Gode woreda, which resulted in a three-day delay for the field team.	Three extra days were given to finish the data collection.
Security problems in Afar region were of concern.	All teams were advised to carry the support letter and IDs, and to take all necessary precautions en route to the field. The initial route was changed to travel through more secure locations (through Kombolcha – Bati – Mile- Semera).
Sector office experts identified for a group dialogue with card sorting were busy with another urgent assignment, and unavailable to participate in the study on several occasions.	The group dialogue with card sorting was conducted after field staff described the objective of the survey to government officials and arranged a more convenient time for the participants.
Uncut girls and mothers of uncut girls could not be found in selected research sites.	Data were collected from uncut girls and mothers of uncut girls from the nearby adjacent woredas and kebeles (decision taken in consultation with UNICEF).
Teachers and members of the Mobile Health and Nutrition Team (MHNT) were unavailable at the kebele level, as schools were closed.	Data collection was conducted at the woreda level (decision taken in consultation with UNICEF).
Few grammatical errors in the transcript were noted and corrected.	The transcripts were sent back to the transcribers to be corrected.

CHAPTER 3:

STUDY FINDINGS

The findings section of this study is organized by regions (Afar, SNNPR and Somali). It addresses issues related to:

3.1. Drivers/Promoters of FGM
3.2. Community Knowledge, Attitude and Practice (KAP) on Issues Related to FGM
3.3. Awareness on Formal Laws related to Reporting FGM cases and Implementation of Laws related to FGM 17
3.4. Constraints against Gender Equality at Various Levels
3.5. Utilization of protection and health services
3.6. Decision-makers/influencers/gatekeepers to do FGM
3.7. Key change agents/influencers
3.8. Influence of boys and men for continuous perpetuation of FGM
3.9. Effective Messages and Channels for Specific Targets
3.10. Suggested interventions, which are most acceptable, responsive, and likely to be impactful for girls/women to end FGM

3.1.Drivers/Promoters of FGM

Afar

The study participants in Afar region indicated that mothers are the primary decisionmakers and are responsible for preparing girls for FGM. Attaching circumcision to marriageability, considering FGM a religious obligation, and obeying cultural norms and values, are some of the driving factors for practicing FGM.

Several Gewane woreda study participants indicated that though fathers and grandmothers are also responsible for FGM, mothers are the most responsible as they make the final decision. One Amibara GD participant indicated that "these days many things are changing." Some community members are accepting that uncircumcised girls/women have better health, self-confidence and social relations with men.

The key driver of FGM is the belief by the family and the girls themselves that if not cut, the girls will not get husbands. A participant from Amibara mentioned that "if a girl is not circumcised, she will not be stable, she will break things at home, and be lustful."

Other drivers of FGM reported by the participants include respecting cultural beliefs and norms to reduce sexual desires of girls/women, keeping the honor and good name of the family, claiming to respect a religious obligation (particularly for Sunnah), and ensuring girls remain virgin before marriage and faithful to their husbands. One Asayita interviewee reflected the community's concern saying, "if girls are not circumcised, they would ask men for sex and this is unacceptable in our culture."

Such generalization and issues related to ethics, morality, and proper behavior are part of socialization and character formation that need to be addressed by schools, faith organizations and families at large.

Somali

An adolescent boy from Fik woreda thinks that it is the culture and the community that push parents to get their daughters circumcised. On the other hand, experts from Dolo-Warder GD indicated that the young men of marriageable age are the ones who seem to prefer mutilated girls for marriage, on fear that uncut girls might engage in extramarital affairs and refuse to obey them. Some participants reported a case of divorce on the next day of marriage after the husband discovered that his wife was not mutilated. A female woreda expert at Erer-Fik GD stated: "Men are the problem, and more work/ education should be done with them."

Another participant from the same woreda thinks that mothers are very influential people in the community: unless the mother agrees to the FGM, the father cannot influence his daughter. Since mothers in Somali region are the primary decision-makers for their daughters, they have to be targeted through effective awareness-raising and other communication strategies.

SNNPR

The fact that uncut girls are not selected for marriage, which also denies parents bridal gifts; the community pressure on people who report FGM cases to legal bodies; social expectations to conform to cultural values and norms, and discrimination against uncut girls and their parents; are considered as driving factors to perform FGM in SNNPR. It is reported that according to Dasenech culture, persons reporting FGM case, "will be cursed and that will affect the person" (Omorate GD Adult male). Both parents and the clan leaders want girls to be circumcised and would like to maintain their culture. They also claim that it is sin not to be circumcised despite the suffering the practice inflicts on the women. It is reported that families of uncut girls will be insulted, discriminated against, and even get ostracized by the villagers. SNNPR participants in Dasenech woreda recommended incorporating FGM in school curricula, creating social organizations to implement strong awareness-raising and surveillance, and enforcing the available customary and formal laws, as practices that could help stop the practice of FGM.

3.2. Community Knowledge, Attitude and Practice (KAP) on Issues Related to FGM

Afar

Findings from this study indicated that communities in Afar understand why people do FGM, know its acute and chronic consequences, and have better knowledge on the consequences of child marriage, such as school dropout, and the importance of marriage by choice. The findings indicated that currently in Afar region, the Sunnah type of circumcision is considered as the correct practice.

Various community members were asked about the community's understanding of existing gender norms and their effects on FGM practice. The study participants indicated that there is a better understanding of the reasons for cutting girls and the consequences of the practices now than in the past, due to improved awareness. For instance, participants of a group dialogue in Amibara indicated that "cultural traditions related to sex, morality and marriageability, religion, and low knowledge about negative

health consequences and male sexual enjoyment" have been contributing to the continuation of FGM. However, the same group participants indicated that FGM has complications such as pain, excessive bleeding, swelling, and problems of wound healing, urinary retention, back pain, prolonged labor, post-partum bleeding, still birth, and the death of mothers. Complications during child delivery, anaemia, scar formation, urethral damage, painful sexual relations and genital hypersensitivity were also mentioned.

A cut girl reported that nowadays, the advice to the parents is to let their daughters go to school and complete their education before marriage. Parents nowadays consult the girls and ask for their preference between marriage or continued schooling. However, some participants indicated that girls should help their parents with household chores and do not need to go to school.

In relation to marriageability, a cut girl who participated in an in-depth interview participant indicated: "The girls who are not circumcised will not be married, as men do not want them." On the other hand, a cut girl from Asayita reported that "in the past, the FGM practice was severe, but now only the tip of the female genitalia is cut though FGM involves complications and pain."

Community members' awareness about the consequences of FGM was been manifested in different ways. For example: the mother of a cut girl from Asayita regretted that:

"We did not get much education and did not know the consequences of FGM on the health of our daughters [before]…. Now women are getting education and they know everything about FGM. They know that they have the right to choose to decide to get cut or not and the pressure on women is decreasing now."

Overall, it can be noted that, while community members are aware of the negative consequences of FGM, the tradition is so entrenched that people continue to raise concerns about their daughters' marriageability and religious obligations, and claim that FGM as practiced today is less harmful than in the past. It is to be noted that even WDA and HEW group discussion members (who could be expected to be more aware of the harmful effects due to their education level) at Gewane woreda, Biriefora kebele, 'agreed' that the Pharaonic type of FGM should be stopped, but said that the Sunnah type does not have complications or negative effects.

Somali

The findings in Somali region showed that most people in this region are aware of the adverse health impacts of FGM and the fact that the practice is punishable by law. A GD respondent from Duduma kebele (Erer-Fik woreda) stated that girls are cut due to their mothers' pressure and are experiencing health complications. She further noted that:

"Whatever belief the community members might have on FGM, and regardless of whether my daughters would be able to get married or not, I will not allow my girls to get cut." This community also has a positive attitude towards the idea that mothers of uncut girls (such as the abovementioned respondent) should be considered role models.

GD participants from Simane kebele (Fik woreda) seem to agree that the entire community believes that daughters should be cut at an early age. It is believed that the longer a girl remains uncut, the less likely she will be to find a husband. Generally, the community has mixed feelings on whether FGM is a religious obligation or not. A woman participant pointed out that the Sharia (Islamic

law) requires cutting the tip of the clitoris. Some of the participants stated that, as Muslims, they have to obey their religious leaders' instructions. They indicated that, since community members' awareness on the negative consequences of FGM is low, they will keep practicing FGM, particularly the Sunnah type, which is considered by the Somali communities to be the right practice to fulfil their religious obligations and thought to be less harmful than other FGM types. They further noted that even if the punishment is harsh, they will continue practicing it secretly.

Men GD participants also confirmed that the community is aware of the effects of FGM and that, most of the time, it is practiced due to the traditional or cultural belief that FGM will prevent women/girls from having premarital sexual desires. Participants from Kabridahar and Hamero woredas also had similar responses.

SNNPR

Findings from SNNPR show a general improvement in the level of knowledge, attitude and practice towards FGM.

The participants of the study in various kebeles of Dasenech woreda in SNNPR indicated improvements in the knowledge of and attitude towards FGM. A mother of four girls (Lobet village) stated that her two elder daughters are circumcised, but the younger ones in school are not. She stated:

"We are now aware of the negative consequences of FGM so we will not let our daughters be circumcised." She added that "particularly after hearing about (or observing) the child delivery conditions for both cut and uncut women in health facilities, many community members of her acquaintance have decided not to cut their daughters as cut mothers suffered more."

A traditional leader at Lobet has also agreed with a statement by the abovementioned mother that the practice of FGM is declining because of the awareness-creation programs provided by the government and non-governmental organizations. This shows a positive change in the level of awareness among community members about the negative impacts of FGM practices on the girls and women. However, some of the adult women participants indicated that some community members still practice FGM in secret, despite the education given to them to prevent it. An in-depth interview participant reported: "since 2019 there is a radio program launched in local language by local journalists (Debub FM Radio), and it has been providing education on FGM. A large number of community member are having access to it, and some changes have been observed since then."

3.3. Awareness on Formal Laws related to Reporting FGM cases and Implementation of Laws related to FGM

Afar

This survey reported that residents of Afar region were generally aware of the existence of formal laws against the practice of FGM. On the other hand, they were also observing that the enforcement of these laws was not visible and perpetrators were not getting appropriate punishments.

When participants were asked if they were aware of the laws pertaining to FGM, a GD participant in Asayita said: *"The law is on paper... and has never been practically implemented to punish the perpetrators". Another participant added: "Family law has not been approved at regional level. Perhaps, if family law had been in place, the legal entities would have enforced the law. If change is desired, schools, women and children, as well as conventional and*

Sharia courts, need to work together. There is also a need to create awareness among the public and implement the way the formal law works together with customary law. The laws on FGM are well heard/known in various forums. Everybody knows about the law, but knowing the law and practicing or obeying it is different. Other participants noted: "Community members might know that FGM is punishable by law and that is why it (FGM) is done secretly."

Participants in Semera (GD with card sorting) indicated that although most members of the community might know the laws and the negative consequences of FGM, more community education, follow-up and surveillance are needed for its effective implementation.

Regarding reporting of FGM cases, participants from Amibara indicated that the issue of FGM did not come out as a serious problem in community life. Monitoring, reporting and prosecuting the perpetrators were not seen as common practices, though the need to do these things came up in conversations and workshops.

One Amibara participant (GD card sorting) clearly stated: *"Personally, I do not see any coordination between formal and customary laws." Another participant argued that 'there is no customary law prohibiting the practice of FGM, rather customary law supports the continuation of FGM, in the form of Sunnah." It has also been pointed out that "the Afar community has a clan structure and unwritten laws by which members are governed."* An expert in Asayita mentioned that the laws did not matter and that the practice will end only if women's associations, relevant leaders, courts, youth associations, educational institutions, health extension officers, tribe leaders and other sectors' leaders hold meetings and decide to stop it. Other participants noted the difficulty to eliminate a practice that has been "inherited from their ancestors". Besides, it is a common practice that breaches to the law or other social problems are only be reported to the authorities (police, courts) if the community/traditional leaders cannot solve it. The findings indicate that it is a big challenge to implement the laws, to coordinate efforts, and achieve a common stand among different actors in the community. An expert from Semera (GD card sorting) stated that reporting FGM incidents to the authorities is discouraged by the community, and people who do so face threats and intimidation. For example, a person who reported a recent FGM incident in Harsis Kebele was repeatedly intimidated and threatened.

Somali

In Somali region, the community members – particularly urban residents - know about laws on FGM, and most are aware that penalties exist for preforming FGM. However, a substantial proportion of community members still practices it. A GD participant (Warder kebele 04) indicated that people conduct FGM in daylight and no one reports the case to the authorities. None of the participants stated that there are customary laws to eliminate FGM; rather the trend seems to motivate the practice of Sunnah-type FGM. For instance, an Erer-Fik Simane GD participant indicated that there are no customary laws developed by the community in their kebele that prohibits FGM, further noting, *'Islam strictly prohibited FGM, except for the Sunnah cut. It is obvious that the confusion is widespread, even concerning Sunnah'.*

SNNPR

The community members in SNNP Region (Dasenech) know that there are laws related

to FGM and they are also aware that they could be arrested and punished if they practiced it. They are also aware that they are expected to report to the police or kebele if they know of recent FGM cases. A respondent in relation to this reported: *"These days the teachings about the negative effects of FGM is everywhere (via teachers, health workers and women and children's affairs); most people should know that it is illegal to circumcise girls."* An adult woman in Omorate indicated: *"Any person should report if she/he hears that someone is practicing FGM."*

According to the participants, it was hardly possible to identify a person who has been punished so far for practicing FGM, even though the community has set a punishment of 15 cattle on fathers caught involved in their daughters' FGM. It is reported that in some villages (Omorate area), committees were established to report any FGM practices to the authorities.

One participant noted that *"the committee members usually follow up on the conditions of girls in their respective villages. If a girl has been missing for a while, they investigate why she is missing. If it is because she was cut, they immediately report to the health and legal services providers."* This participant thinks that putting the perpetrators in jail for a few years is not enough, and that punishment should instead involve the seizure of cattle, to which the community members are more sensitive.

An adult woman (Omorate GD) reported that she is not aware of any customary laws, but said she knows that government laws exist. HEW and WDA experts explained that awareness-raising activities at different levels (from woreda to village level) are significant and have shown some results in reducing FGM. These experts also reported that there is a community agreement (law) that those involved in the FGM practice shall pay ETB 500 to 5,000 depending on the level of their involvement. However, no cases have been reported from such village committees. Another participant (CSP) indicated that despite some efforts to change the practice, there is not much reduction in the prevalence of FGM. The participant further elaborated that *"there seems to be an agreement that the cutting type be restricted to the cutting of the tip of the clitoris (Sunnah) rather than other types of FGM. There is some unwillingness to abandon FGM completely. It is only in the urban areas, with educated families, that the change is observed."*

When asked if there is community surveillance to track the practice of FGM, the participants reported that there is no surveillance (or they are not aware of it) regarding the occurrence of FGM. However, they noted that there is education on gender equality, on sharing work in the family between husbands and wives, and on the negative effects of FGM. Adult women group discussants at Lobet pointed out that there is no coordination effort for the enforcement of formal and customary laws. According to them: *"Currently the government and local/ community laws are focusing on punishing the fathers, but the mothers and traditional healers are the main perpetrators of the act and the punishment should be expanded to the mothers and practitioners (cutters)."*

Further, participants reported some challenges faced in the implementation of the laws. The remoteness of villages, lack of education, obsessive attachments to culture, and the community not reaching out for services, were the major challenges indicated. A CSP expert mentioned that

in some cases, the traditional healers and parents of circumcised girls were charged and arrested. The main reason is not for performing FGM, but for doing it the 'wrong' (life-threatening) way. An adult woman participant reported: *"I myself am a 'spy' in this kebele to follow up HPs including FGM, and all community members are willing to report misconduct. The laws are being implemented in some communities."* However, as the other participants reported, the evidence on the ground is that there is no reporting of FGM incidents.

It was noted that the reporting mechanism has to improve in order to reduce/end FGM. Omorate GDs from WDA and HEW recommend *"the establishment of a committee at village level and giving the responsibility of reporting cases of FGM to HEW, and HEW should report to legal bodies"* and that *"police should be strengthened', the law should be enforced, and punishment should be strict."* Also, continuous awareness-raising and convincing influential members of the community are recommended. Furthermore, a girl at Omorate GD recommended that the girls who refuse to be cut and report to the relevant authorities should be protected by the Government and even be provided material support to go to school. Many participants reported that the community or committee member are not prevented from reporting FGM cases out of fear, but rather because of the hidden nature of the practice and difficulty of finding evidence and witnesses for reporting, investigating and prosecuting.

3.4. Constraints against Gender Equality at Various Levels

Ensuring gender equality is among the Sustainable Development Goals (SDG 5). Efforts to ensure gender equality in the three study regions have been constrained by a number of factors discussed below:

Afar

Participants reported the prevalence of gender inequality/unequal power distribution in the community. Information obtained from Amibara GD participants indicates that inequality prevails at individual, household and community levels. Inequality is related to culture, specific roles assigned to men and women in the community, cultural and religious restrictions, the lack of female leaders and the prevalence of gender stereotypes, women farmers lacking title deeds to their land, women belonging to cooperatives where men are the majority, and women being confined to their homes. The findings from Asayita and Gewane woredas are similar to these.

Somali

According to the study participants of Somali region, men did not treat their wives as equal. Group dialogue discussants at Dolo-Warder kebele 04 indicated that women's rights are not respected due to cultural practices. It was recommended that, to improve the situation, women should participate in community meetings, trainings, kebele administration, and other forms of public participation. A male adult participant stated: *"to my understanding lack of education is the major constraint against gender equality"* (Erer-Fik Simane GD storytelling). He indicated that there are improvements in economic decision-making and in limiting family size, but reducing FGM needs more

work and interventions. An expert at woreda level (Dolo-Warder GD CSP) recommended that religious leaders be used as assets in the creation of awareness towards the elimination of FGM, followed by educating of the youth. She stated: *"Religious leaders know that FGM is bad, but they do not talk about it openly. They have to preach how bad FGM is to the people/community members."*

SNNPR

The long-lived cultural values allowed men to consider their wives as one of their properties at household level, as expressed by a participant in SNNP. All the responsibilities at household level are also left for women. It was reported that after repeated awareness-raising sessions, there has been a slight change in improving the decision-making role of women at household level. Regarding the constraints against gender equality, a male participant at Omorate (GD with storytelling) remarked: *"the long-lived culture of the community, especially of the pastoralists, which considers a wife a property of the husband, is the main constraint though there were some small changes since the last few years. The notion of males and females being equal and having equal power in making decisions at family level is being taught."*

The mother of a cut girl (Lobet IDI) reported that males and females are not considered to be equals in the community and at family level. She reported that males leave every responsibility and activities to females/wives and present themselves only to eat whatever the females prepared. She said she could only eat her husband's leftovers.

Another participant (from Omorate GD with Storytelling) also stated that fathers get some gifts (15 to 30 cattle) when girls are married, and circumcised girls get married earlier than uncircumcised girls. The moment a future husband provides the dowry to his in-laws, he immediately considers his wife is a property bought to serve him. In an optimistic note, some mothers and cut girls (Omorate Kebele IDI and Lobet IDI with Venn diagram) reported that they are currently witnessing changes and that gender equality is being reflected in some families.

The formation of committees at village level, and the availability of HEWs in most kebeles are appreciated and considered opportunities to encourage change and to assist in the intervention programs' development. Also, the possibility to enforce FGM laws is appreciated by some community members (e.g., Omorate GD adolescents).

3.5. Utilization of Protection and Health Services

3.5.1 Knowledge about existence of health services (both formal and informal) to prevent, support, and manage cases of FGM

Afar

Health services related to FGM were provided by health facilities combined with other health services under the coordination of the health sector. It was indicated that low emphasis was given to FGM by the system in Afar region. According to the report from participants in Afar region, the WASA bureau is the body responsible to coordinate all non-health efforts of different bodies to eliminate FGM. Though protective and health services were available, the community has a very low level of awareness on the use of these services. Integration and coordination of the enforcement of formal and customary laws at community level is recommended by the study participants as a mechanism to eliminate FGM from the region.

Participants of group dialogue/card sorting session (woreda-level experts) from Amibara reported that they don't have any specialized health facilities for FGM. Instead, the service is given at any health facility along with other health services. It was also reported that the activities related to FGM in the woreda, which are implemented by different governmental and non-governmental institutions, are coordinated by the woreda WACA Bureau/office.

Participants of group dialogue/card sorting in Halaydegi indicated that most community members in their catchment areas are aware of the existence of formal protective and health services related to FGM. Though the services are available, the awareness level of the community regarding service utilization was reported to be very low, especially among those residing in rural areas. Moreover, most community members from rural areas have greater difficulty in accessing legal services pertaining to FGM issues. One of the participants of the group dialogue/card sorting sessions said: *"My daughter has never attended either health facilities or legal institutions for FGM-related issues."*

Group dialogue/card sorting participants from Semera suggested the need for integrating and coordinating formal and customary laws at the community level. As it stands now, there is poor service coordination and integration, resulting in low motivation of parents to bring their daughter to the attention of the legal institutes.

Somali

Communities in Somali region are aware of the availability of health and legal services to survivors of FGM. Though the legal services are available, participants claim that actions to punish FGM practitioners is as strong as the crime they did, which resulted in a weak system to stop FGM. Moreover, there is a misunderstanding by the communities who think the Sunnah type of circumcision is allowed by the law. A participant stated, *"As far as I know there is no strong law enforcement agencies that take serious legal action towards those practicing FGM."*

Adolescent girl participants of GD/storytelling in Fik woreda, Duduma kebele, claimed that they know the availability of the health and legal services which provide them with the necessary remedy to the health challenges and social problems (divorce and family disintegration) resulting from FGM. Participants said that the legal service providers are not effective in taking firm action against circumcisers and other perpetrators. Women respondents from the same kebele said that they are interested in taking their daughters, if they become FGM survivors, to health and protection service providers. Though parents are reported to take their daughter to service providers, there seems to be misunderstandings about the correct services to receive. In relation to this, one of the participants of the women group dialogue/ storytelling session in Fik, Duduma kebele reported: *"my daughter had only Sunnah type, which is simple. Only small parts of her body were cut and she could recover within days."*

This statement indicates that people in Somali region do not take *Sunnah* FGM as a type of circumcision that needs medical service, and that it is an accepted and normal procedure.

SNNPR

According to the participants, communities in SNNPR are aware of the availability of and are willing to use the protective and health services for FGM. In this region, there are community-level social workers who are assigned to identify and report the FGM cases at the community level to the concerned bodies. Though there are still considerable proportions of people in the region who are practicing it, FGM is showing a tendency for reduction.

From the discussion held with adolescent girls group dialogue/storytelling in Dasenech woreda, Omorate kebele, it was noted that the community has good knowledge about the existence of formal services which include prevention (awareness-raising sessions on FGM and legal services) and intervention (treatment of acute and chronic complications of FGM and psychosocial and legal support to FGM victims). Moreover, the participants confirmed that they are willing to get legal, psychosocial and health services. GD participants also shared their experience getting services related to FGM. In this line, some of the participants confirmed taking training in FGM issues, organized by the Woreda Women and Children Affair office in cooperation with Save the Children. Some of them received awareness-raising and education from schools focusing on the adverse impacts of FGM.

In order to improve and facilitate the process of the community seeking health services, psychosocial support and legal services, community-level social workers are assigned by the community and get technical support from stakeholders to identify cases (circumcisers and parents hiding circumcised girls) and report to the HEWs. Some of the study participants reported that these community-level social workers are also advising FGM survivors to go to the health and/or legal services, saying they would otherwise report the case to the HEWs themselves. In turn, the HEWs who receive reports from community members and community-level social workers report to the police, so that the necessary actions will be taken on FGM practitioners and those associated with the activity.

Participants of the IDI/Venn diagram session from Dasenech woreda, Lobet kebele reported that, after the law prohibiting the practice of FGM was declared in Ethiopia, practicing FGM in their area was reducing *"from time to time."* They said that the police usually put the FGM practitioners and related people in jail for a few days before releasing the defendants after they signed an agreement to never take part in circumcising girls again. Though these kinds of measures (taken by the communities through community social workers, health system, and legal bodies) seemed to have reduced the practice of FGM in their areas, many people are still practicing FGM in secrecy.

3.5.2. Main barriers and opportunities for these communities in terms of seeking out and reaching health services for FGM

3.5.2.1. Barriers for seeking and reaching health services of FGM

Afar

The absence of legal protection for health professionals, low awareness of girls/parents in PCs about the availability and accessibility of health services, and shortages/lack of medicines and medical equipment in the health facilities, were some of the barriers for seeking and reaching health services related to FGM.

While participants were discussing these barriers, they also discussed the challenges that the health providers face while they are on duty. One of the participants (expert) of GD/card sorting sessions reported: *"it's challenging unless the service provider has legal protection. Sometimes the service providers are beaten by people who are benefiting from the FGM practice."* The group therefore strongly indicated the necessity of availing legal protection for service providers.

An expert from Amibara, Serkamo kebele remarked: *"as I'm health expert, I can see a lot of barriers in our community related to the health services. From the community*

side, most girls are ashamed to come to the health post immediately after FGM. This exposes them to different acute and chronic health complications like fistula. The other challenges are shortages/lack of medical supplies and medicines at health post level."

GD/card sorting-session participants in Amibara, Serkamo kebele indicated that their community is mainly pastoralist and living in rural areas, and that FGM is a deep-rooted cultural practice attached to religious mandates. For these reasons, there are people who strongly oppose the initiatives to end FGM, meaning that health providers' efforts against FGM may be met with violence through moral and physical harm, and even possible murder attempts.

Somali

According to the respondents in Somali region, poor coordination of FGM-related service providers, inaccessibility of the services to the rural communities, shortages/ lack of medicines, and the negligence of government bodies are some of the barriers in accessing and seeking FGM-related services in the region.
According to an adolescent girl respondent of GD /storytelling, limited cooperation between all the service providers, including education institutions, legal bodies, health centers, and the WACA Office, has significantly slowed down the rate of FGM eradication at the community level. However, the proportion of educated people with good awareness about FGM is currently increasing.

Adolescent girl respondents of GD/ storytelling in warder kebele 04 reported that they do not have accessible health facilities which provide them with the required FGM-related health services in their kebele and that when they access hospitals, the necessary medicine is hard to find. The participants also said they do not have access to legal services for FGM survivors, and pointed to the negligence and lack of commitment of government and other stakeholders as further barriers to seeking and accessing FGM-related services.

SNNPR

According to the information from GD/ card sorting sessions conducted in SNNPR, Dasenech woreda, fear of community members' violent reactions against reporting FGM was mentioned as the major barrier to reporting cases but also to services providers' execution of their mandates and responsibilities related to FGM. Most people who are in a position to report a case to legal bodies usually do so secretly out of a fear of community members supporting the practice. Stigmatization of uncut girls, their parents, and close relatives by the community is another strong barrier for seeking and accessing FGM–related services in the short run.

3.5.2.2. Opportunities for seeking and reaching health services of FGM

Afar

Participants of group dialogue/card sorting sessions in Amibara, agreed that in the past, the issue of addressing FGM and its complications was forgotten by the implementing bodies, but nowadays, it is getting attention by different stakeholders (government, non-government, and civic institutions). The session participants agreed that issues related to FGM and accessing FGM-srelated health services can be improved by raising awareness of the community, especially of the rural communities.

Somali

Woreda-level group dialogue/card sorting sessions with FGM experts indicated that all service providers are providing the required health services and are capable of addressing FGM and its complications with a minimum level of difficulty.

SNNPR

Participants of group dialogue/card sorting sessions in Dasenech Woreda reported that the woreda development group members have the knowledge and even the experience of pain from circumcision, and reiterated that they are not feeling fear or shame about reporting FGM cases even when the perpetrators are their close friends and relatives, which is a very good opportunity for the effort to end the practice of FGM. Another important and valuable opportunity for the effort to end the practice is that the woreda development group members have the fear of losing trust from their communities if they leave FGM cases unreported after they witnessed the practice.

3.5.3.3. Synergies between health, protection, and legal services to end FGM

Somali

Group dialogue/card sorting sessions in Warder woreda showed that the WASA bureau is responsible for the coordination and periodic training of stakeholders involved in anti-FGM actions, such as the health bureau, education, kebele administrations, and legal protection services.
Another finding in this aspect is that other FGM-related interventions that can trigger behavioral transformation, including decision-making, life skills development, and resource ownership, have not been sufficiently addressed, which calls for additional assistance and coordination. Currently, only a few kebeles in Warder woreda are making progress in reducing or ending FGM-related practices, while the majority are lagging behind and thus require more training and awareness creation.

Community-level social workers at lower/kebele levels are expected to detect and share any information related to FGM to health and legal offices at woreda level.The most challenging part of the information-sharing is that most of the time, it takes place after community-level social workers find out that FGM was secretly conducted. In addition to getting information, community-level social workers are considered by the service-providing institutions as a channel to collaborate with legal departments, the police, the health bureau, WACA offices, as well as local religious leaders and community elders, to reduce FGM practices. Participants of GD/card sorting sessions in Warder, kebele 04, reported that they are also having community gatherings twice a month to discuss different issues, including FGM, using gatherings as a platform to integrate their efforts towards ending FGM. Moreover, participants (cut girls) of IDI/Venn diagram session reported that many mothers received a 16-day training and are actively participating in the awareness-creation movement in their community. However, some religious leaders and elderlies were found running a misleading awareness-raising session advising their followers to practise *Sunnah*.

IDI/Venn diagram session participants (mothers of uncut girls) reported that they have seen awareness-raising sessions involving government bodies working together (WACA bureaus, police and courts), as well as sessions run by NGOs. They indicated that the awareness-raising session in their community is not given in

an organized and sustainable manner, and they demanded that it should be better coordinated and sustained in time to achieve the desired change.

SNNPR

Religious leaders' active engagement in teaching their followers on the negative consequences of FGM, the contribution of school girls' club in empowering girls to refuse FGM, the efforts of woreda administration supporting positive deviances, or parents of uncut girls who are role models, and the presence of a coordinating body (WASA) are found to be some of the potential avenues to create synergies for FGM-related in SNNPR. In this context, *"positive deviants"* refer to those individuals who have decided that the practice of FGM is wrong and harmful, despite the fact that the majority of people around them perform the ritual on their girls.
According to the report from IDI/Venn diagram session participants, most religious leaders do not support the practices related to FGM and are educating their followers about the negative consequences of FGM. The WACA Office of the woreda gathers girls (cut and uncut) in schools and communities to empower them to reject the practice of FGM. The office also works hard to raise awareness of the community about FGM-related harms and complications through series of meetings. The Woreda Administration Office also provides awards to uncut girls to encourage parents and uncut girls to not undergo FGM, in support of the government's effort to end the practice. Participants from all the sessions (IDI/VD, GD/CSP and GD/ST) in Dasenech Woreda indicated that health facilities provide psychological support and health services for acute and chronic cases of FGM complications, while the police/legal institutions providing FGM-related services are key actors in the prevention of FGM, the protection and treatment of victims, and in the general fight to end the practice. UNICEF Ethiopia was also mentioned by the participants of GD/card sorting sessions as a strong ally of the government to end FGM.

Moreover, participants of the GD/storytelling session conducted among adolescent girls in SNNPR, Dasenech woreda, Omorate kebele, indicated the existence of coordinated activities and synergetic efforts among the community members, health extension workers and police stations, which are vital in the effort to identify, report, and enforce both customary and formal laws in the prevention of FGM and the protection and treatment of victims. Despite these efforts by the government and other social structures, the change in terms of abandoning/avoiding FGM is currently very minimal on the ground.

3.5.3.4. Opportunities in the sectors for better synergy at various levels – individual, community, and system

Afar region

According to the report from GD sessions in Aysaita, different traditional organizations in Afar society (such as the youth and women youth organizations called Fiema) could be developed and enriched to support the fight against FGM. In all kebeles, the WASA bureau organizes and oversees women's associations organized under the kebele with the support of the government and aid agencies.

The same respondents reported that the Afar community is more strongly attached to its traditional values and cultural norms than to formal government laws. For example, awareness-raising sessions and education programs on FGM are more acceptable and effective if they are given by tribal leaders, religious leaders, kebele chairpersons, and *Fiemas*. In Afar, the major problems related

to FGM are linked to gender inequality, especially in decision-making within families, which is exclusive to men, and society encourages girls to work at home instead of going to school. In response, community groups that have been organized to prevent gender inequality and FG in the study areas need to be trained and supported in every aspect.

Since FGM and gender inequality are multifaceted problems by nature, it is necessary to address them through coordinated, integrated and synergetic effort involving various stakeholders (governmental, non-governmental and social organizations), in addition to educating the community to change its attitude towards FGM.

According to the study participants, there are no means of regulations, right now, to the practice of FGM and gender inequality at the community level. There are various organizations where only men are invited to attend meetings, and despite the presence of women associations organized by the WASA bureaus - which should be strengthened - there is no forum organized for women to discuss their concerns and involve them in the effort to end FGM and gender inequality.

This study also identified that in addition to cultural fiemas, women groups against gender inequality, and the women associations, there are women one-to-five and one-to-ten team arrangements at kebele level, but these are not well organized to address issues like FGM and gender inequality. Therefore, it is necessary to strengthen and to reorient the purposes of existing team arrangements.

In the Afar community, many untold customary rules (such as the prohibition of non-Sunnah FGM, and the fact Sunnah is in fact not obligatory in Islam)[5] were used by ancestors, but are not known by the present generation. As religious and tribal leaders have good knowledge about these customary laws, they could be vital stakeholders in the effort to end FGM and gender inequality.

Somali

According to the response from Warder woreda experts who participated in the group dialogue/card sorting session, the efforts of stakeholders in triggering transformations within the community t in terms of decision-making, life skills development, resource ownership, etc., are insufficient: in this line, additional assistance and coordination are required. Currently, some kebeles in Warder woreda are in good progress and are playing critical roles as role model community, in ending or reducing FGM practices, while others kebeles within Warder and other woredas are lagging due to the unequal distribution of efforts related to awareness0raising and other FGM-related services, and thus require additional work to support or strengthen them by providing training, creating awareness, and so on.

According to the response from Warder woreda experts who participated in the group dialogue/card sorting session, there are community level social workers collaborating with the legal department, as well as the health bureau, police, and women's affairs office, local religious leaders and elders, to reduce FGM practice. Moreover, community level social workers serve as a point for interaction, coordination and synergy of stakeholders at community level. Participants of group IDI/Venn diagram sessions within Warder, kebele 04 indicated that: first, community member or community level social workers report FGM cases to the Women and Children Affairs office; second, the Women and Children Affairs office transfer the case to the police, and then through careful steps they arrest and investigate the perpetrators.

[5] It should be noted that Sunnah and all other types of FGM are not allowed in Ethiopia.

SNNP region

The study participants indicated an opportunity for better synergy among various sectors. A GD participant (HEWs) stated that a committee was established at village level to allow community members to report cases to HEWs, who can in turn report to a legal body (usually to the police). This practice has been a good opportunity to support the fight against FGM and should be strengthened.

3.5.3.5. Suggested approaches that would enable these synergies at each level

Afar

Integration among stakeholders: Since FGM and gender inequality are inherently multifaceted problems, it is necessary to address them through a coordinated and integrated manner between various stakeholders (governmental, non-governmental, UN agencies and local community-based organizations). Such stakeholders include: WACA Bureaus, health bureaus/offices/facilities, Education bureaus/schools, police stations, courts, and administrative offices at different levels, Women's associations under the WACA bureau, cultural organizations of youth and women called *"Fiema",* community women groups against gender inequality, or tribal and religious.

Use of Indigenous Knowledge: Religious and tribal leaders have good knowledge about untold customary laws (FGM is prohibited and Sunnah is not obligatory in Islam), which they inherited from their ancestors. In Afar, these people are deemed as *"society's walking library"* and could be vital stakeholders in the effort to end FGM practices and gender inequality. The use of these indigenous resources in the process of making decisions and in developing and implementing strategies to address FGM and gender inequality is vital. They are influencers for their communities and can prevent/reduce the prevalence of these issues.

Integrating FGM/gender inequality into the school curriculum: Since schools transmit moral rules, cultural values and norms to children, education is also a key strategy to end harmful practices (FGM) and gender inequality.

Training provision: Members of Fiema and women/youth associations, together with tribal and religious leaders should be trained with the objective of creating awareness on the adverse impacts of FGM, and on the necessity to work closely with health care providers and law enforcement bodies. The training can also include issues related to decision-making, life skills development, resource ownership, etc.

Somali

Open discussion with circumcisers: An IDI/Venn diagram session participant (uncut girl) in Warder, 04 kebele, reported as follows: *"last time, I have met a circumciser, and I told her to stop this practice, but she replied that women are forcing her to do it; and she said that if they stop insisting on her to do this, she would surely stop."* This conversation indicates that direct and open discussion with circumcisers can be an effective approach to end FGM.

Income-generating activities for circumcisers: The government and/or other stakeholders should design an income-generation program which benefits circumcisers. One of the study participants told the group: *"In our community [Warder, kebele 04] the circumcisers consider circumcision as a means of income."*

Community group mobilization: Participants (mothers of uncut girls) in Warder, kebele 04, reported that they have community groups/youth cadres/women's development army members who are involved in awareness-

raising activities through public mass movements and demonstrations so that community members realize the negative health effects of FGM. Ending FGM necessitates collaborative efforts: Since religious leaders are more accepted by the community, they have a better chance to clarify confusion about FGM and religious obligations. Other bodies, such as the ones mentioned above, can also play a role with close support from the kebele-level administration and the responsible government and non-government bureaus.
Periodic meetings, seminars/conferences: Participants in Warder, 04 kebele reported that *"currently, our community has the opportunity to participate in meetings, seminars or conferences that primarily focus on teaching the community about FGM practices and its complications."*
Integrating FGM/gender inequality into the school curriculum: Participants (FGM experts) in the group dialogue/card sorting session in Warder woreda indicated the need for integrating issues related to FGM practices into the school curriculum, which they think will bring about positive change among boys and girls attending schools. It was presumed that the students will be more likely to use the lessons they get from school to influence their families' attitudes towards FGM.
Neighborhood networking: According to a participant (cut girl) in the IDI/Venn diagram session in Fik, Simane kebele, creating neighborhood women's networks is of paramount importance to enable women to discuss important issues on gender inequality and FGM, including its prevalence and impacts. Neighbors can put pressure on mothers who intend to cut their daughters and, if they refuse to accept the advice given by neighbors, they can report the case to legal bodies who are usually effective in curbing FGM.

SNNPR

Awareness-Raising Movements: Respondents of IDI/Venn Diagram sessions in Dasenech woreda, Omorate kebele and group dialogue/card sorting sessions in Dasenech woreda indicated that awareness-raising activities targeting all members of the community (boys, girls, men and women) will help stop FGM. Visual aids like videos and posters that can clearly convey messages on the harmful effect of FGM should be used as part of an awareness creation movement. Moreover, using school clubs and mini media would be an effective channel to raise awareness about the adverse impacts of FGM.
Training on adverse impact of FGM: Participants also suggested that training on the adverse impacts of FGM should be provided to elders, clan and religious leaders, circumcisers and local healers who are all, in one way another, promoting and supporting the tradition of FGM. Participants in Dasenech woreda, Lobet kebele, reported: *"After the government mobilized and created awareness about the dangers of practicing FGM, we started to have some uncut girls in our community. Not only that, but we also started to observe differences in the health status of cut and uncut girls during sexual acts and at the time of delivery, when we witnessed that the cut girl suffers much more than the uncut girl."*
Improving and strengthening the enforcement of customary and formal laws: Improving and strengthening formal laws on FGM should be combined with awareness-raising sessions on both customary and formal laws. Participants also indicated the need for improving the currently poor radio signal in Dasenech to pass FGM-related information through radio programs.
Involving girls pursuing higher education, or uncut women from government offices:

Participants believe that if girls are educated at institutions outside their community, they will be respected and able to give advice to educate and empower their peers when they come back to their village for vacation. Similarly, women from government offices who remain uncut could join and promote the anti-FGM movement. They could serve as role models for girls, boys and the general community in the process of avoiding FGM.
Providing incentives and psychosocial support to the uncut girls: Providing incentives and psychosocial support to uncut girls, their parents, and boys who dare to marry uncut girls will encourage them to play a significant role in demystifying the myths perpetuating FGM. Moreover, psychological support and incentivizing stigmatized uncut girls and their parents by involving them in awareness-raising programs and trainings in which their actions against FGM are appreciated will help them gain confidence and lead a relatively comfortable life. Moreover, this will help others to consider their decision on either to avoid or to practice FGM.
Coordinating the efforts of multiple stakeholders: Participants in group dialogue/card sorting sessions in Dasenech woreda suggested that it would be necessary to ensure the active involvement of all stakeholders (government, non-government and community institutions) with full coordination so as to enable synergies between them.
Establishing community-level legal protection centers: Establishing *"legal protection centers"* at the kebele level to report FGM incidents and protect the reporting individuals is very important. They should work in partnership with teachers, HEWs and Development Agents (DAs). Establishing a legal protection center run by an assigned staff member with legal training may improve incident reporting of cases, as well as offer protection to girls and service providers at risk. The legal protection center staff themselves will not be condemned for reporting or for facilitating reporting, as such activities are within their work portfolio.
Participants in group dialogue/card sorting sessions in Dasenech woreda claim that customary and formal laws against FGM are not effectively enforced in pastoralist communities, as their lifestyle is different from that of highlanders.

3.6. Decision-makers/influencers/ gatekeepers on FGM

Afar

According to the report from the group dialogue/card-sorting session in Amibara, religious leaders, fathers and mothers are the three main categories of actors making decisions related to FGM and gender inequality for their daughters. Neighbors and community leaders can also be involved in decision-making in the absence of religious leaders and parents.

Somali

According to the participants (religious leaders) in the IDI/Venn diagram session in Fik, Simane kebele, the primary decision-makers on whether the girls should undergo FGM or not are religious leaders themselves, because they can influence the community to practice FGM or to stop doing it.

In most Somali communities, husbands are the heads of the family, and most decisions are in their hands. If a father decides to circumcise his daughter, no one can stand in his way. Therefore, fathers are the second most important decision-makers, next to religious leaders.
The third person who can influence the decision to practice FGM is the mother. In

this community, mothers do not like to have their daughters undergo FGM, but they practice FGM because society will exclude uncut girls from the community, and no one will be willing to marry them.
On the other hand, the IDI/Venn diagram session with religious leaders in Fik, Duduma kebele revealed that the mother, father, and elder sister serve as the primary decision-makers regarding FGM, with aunts coming in last. According to the community's culture, the mother is the primary decision-maker when it comes to FGM, and the role of the father is minimal. From a religious standpoint, the father is the head of the household, and nothing can be done without his consent. It was further pointed out that religious leaders are not involved in anything pertaining to FGM.

SNNPR

According to the respondents of in-depth interview/Venn diagram sessions with uncut girls in Omorate kebele, girls themselves are the ones to decide whether to be cut or not. One of the participants explained the process as follows: *"Girls go to a nearby river and wash their body and make themselves clean as part of the preparation to be cut. After they cleaned their body, they themselves go to the practitioner to be cut."* A cut girl from Dasenech woreda Lobet kebele reported that she, together with friends, went to the practitioner and got cut without informing her parents.
One of the participants of the group dialogue/card sorting session in Lobet kebele described the events as follows:

"There is a change compared to earlier times, in which cutting was solely seen as an event of celebration, where clans gather, sing, dance, eat and drink. They used to celebrate it openly and cattle were slaughtered, and alcoholic drinks brewed for the ceremony and served. But now, these ceremonial events have faded out. And now, girls are the ones to decide whether to be cut or not"
The mothers and fathers of the girls are also involved in the decision. The father has more decision-making power than the mother. Mothers are the main decision-makers when the father is not around. If the girl to be cut is not living with her parents, the family members (brothers, sisters, grandparents or any other relatives) that she lives with will be responsible in supporting her with her decision. Sisters in particular are responsible to support the girl when making the decision to go through FGM. Since it is assumed that getting cut is the main eligibility criterion to be able to get married, anyone in the family would support her decision to get cut.
Though girls are the ones to decide on their circumcision, fathers argue that *"no one will be interested to marry an uncut girl"* to advise and encourage their daughters to be cut. The girl then accepts her father's advice for fear of ending up unmarried. Parents' preferences and girls' fear of missing out on marriageability are powerful driving forces for practicing FGM.
On the other hand, one of the adult woman participants from Dasanech woreda, Lobet kebele, reported that there is no specific person that decides on practicing FGM. Rather, they all consider FGM as part of their culture inherited from ancestors. She explained:
"We, all the women in the community, believe that our mothers are circumcised, and we do the same. This is true because being uncut is abnormal, so we practice the same with our children. This is because we simply take it as a normal and useful thing to do to our girls."
Unlike the group of adult women, health extension workers and WDAs who participated in group dialogue/storytelling sessions and religious leaders who participated in IDI/Venn Diagram sessions in Dasenech woreda, Lobet and Omorate

kebeles reported that fathers are the main decision-makers on FGM, followed by mothers. In the absence of a father or mother, uncles or brothers or members of the extended family will decide for the girl to be cut. Participants of IDI/Venn diagram sessions with uncut girls reported that grandparents, elders in the village, or the father's friends and neighbors may also provide advice to the girls to be cut.

3.7. Key change agents/ influencers

Afar

Participants in the group dialogue/card sorting session in Amibara indicated that the most effective way to eradicate FGM and gender inequalities in the Afar region is working through the existing cultural structures in the community, given that FGM is deeply anchored in longstanding cultural norms and values. These cultural institutions involve religious leaders, clan leaders, and cultural organizations of youth and women called Fiema. Moreover, working with gender/ girls' clubs in schools and with the kebele administration were also suggested as effective ways of addressing FGM/gender inequality in the region.

Somali

According to the report from participants in the group dialogue with FGM experts/ card sorting session in Warder woreda, religious leaders are the most important community members to be targeted and can play a critical role, as most community members believe that FGM has a religious basis. Mothers too are very influential in the community. Unless the mother agreed to cut her daughter, the father couldn't make this decision alone. Awareness needs to be created by engaging religious leaders, youths and mothers and providing training that encourages them to reject FGM.

The main reason for practicing FGM is meeting men's preferences, because they don't want to marry uncircumcised women. Therefore, more work should be done to change men's norms and attitudes. Grandparents come next to mothers and fathers in terms of decision-making power on whether the girls will be circumcised or not. Circumcisers, of course, are the main promoters of FGM. This is mainly due to the fact that circumcision is the main means of income for their family.

SNNPR

Community members, government sector staff, non-governmental organizations and researchers were identified by the study participants as key change agents and influencers in SNNPR.

Adult women participating in group dialogue/ storytelling sessions in Dasenech woreda, Lobet kebele reported that, in order for the interventions implemented to end FGM to be effective, kebele community members (especially women and cut and uncut girls) should cooperate with governmental organizations (sectoral offices, police and legal institutions). Community leaders (at the woreda, kebele and village level) could change customary rules, and the government sectoral offices should work together with woreda administrators. The community's efforts to eliminate FGM should also be supported by non-governmental organizations to expand outreach and raise awareness more widely. Moreover, researchers and research firms should take part in the effort to make communities understand the complications and harms associated with FGM.

Participants of the HEW and WDA group dialogue/storytelling session in Omorate kebele suggested that health service providers, women leagues and

their members at the kebele level, youth associations, school/girls' club members, teachers, police staff and other influential members of the community like elders or religious and clan leaders should collaborate to effectively teach community members to quit practicing FGM.

3.8. The Influence of Boys and Men in Perpetuating FGM

Afar

According to the information from study participants in Afar region, boys and men tend to prefer cut girls for marriage because of socio-economic influences from the community. For this reason, uncut girls remain unmarried and are usually stigmatized by their communities. These factors are negatively impacting the effort to end FGM and mitigate gender inequality in the region.

Somali

Boys/men have reportedly gone through intensive awareness-raising sessions. Particularly those who were also exposed to religious leaders' teachings, attended regular schooling and those who were members of boys' clubs in schools are changing their attitudes and started marrying uncut girls. With this positive change, those boys/men who received effective behavioral change and communication interventions are found to play a positive role in the effort to stop practicing FGM in Somali region.

Respondents from group dialogue/storytelling sessions in Fik, Siname kebele stated that currently, community attitudes have changed from the past, when boys/men would never marry uncut girls. Because of intensive awareness-raising efforts, nowadays boys and men have started to marry uncut girls. There are also many improvements in relation to gender equity/inequality and decision-making. Though many people feel that FGM is allowed in Islam, more religious leaders are teaching their followers that FGM is prohibited in their religion.
Moreover, most young boys who have passed through formal education are now changing their beliefs on marrying only cut girls. This is mainly due to the fact that awareness has been created about the health complications on FGM and that the low sexual desire of circumcised women (wives) will negatively affect their own sexual gratification.
Respondents from the group dialogue with adolescent boys/storytelling session in Fik, Duduma kebele reported that boys who are members of boys' clubs in schools are involved in investigating why girls are absent from school and whether the absence is related to FGM. If she is absent due to FGM practices, they will inform the school and the community.

SNNPR

Participants in IDI/Venn diagram sessions in Dasenech woreda, Omorate kebele, reported that marriageability is the main factor driving girls to be circumcised. Uncut girls are less likely to be preferred for marriage. The other factor perpetuating FGM is the economic values of cattle (oxen, cows) that parents of the bride receive from the groom's parents as a gift. On the other hand, these days, both boys and girls are getting more education and awareness about the dangers of FGM. As a result, boys have already started to marry uncut girls. Girls and boys have also started to teach their parents with the intention of changing their attitudes.

Participants in group dialogue/storytelling sessions with adult women in Dasenech woreda, Lobet kebele, also confirm that unlike in earlier times when boys had only

been interested to marry cut girls, these days, due to the influence of education, they have started to marry uncut girls. The magnitude of change in attitudes is remarkable in boys compared to men, mainly due to boys' better participation in schooling and awareness-raising sessions, particularly on sexual pleasure, which is important to both partners and is better with uncut girls compared to cut girls. Moreover, the lack of sexual satisfaction within marriage with cut girls is the main driving force for higher divorce rates, which result in family disintegration. For these reasons, boys and men have now started to shift their choice of marriage partners from cut to uncut girls.

HEW/WDA group participants in the same location reported that most girls are still afraid of completely ending the culture of FGM but at the same time have become more aware of its health and psychological dangers. For this reason, they have currently started to remove only the tip of the clitoris (the most sexually sensitive body part), whereas previously the practice was to completely remove the clitoris and labia. Most of the girls still want to stick to the culture, which they consider as their religious obligation. They also mention that they are still unsure about the validity of myths associated with uncut girls and their families, such as fathers turning mad as a result of the girl not performing FGM, curses to the family, or death to family members. These beliefs make it difficult to end FGM in pastoralist rural communities. One of the participants stated: *"Males in the Dasenech tribe are not interested to marry uncut girls because, if a male gets married to an uncut girl, the rest of the community members will insult and stigmatize him, the girl, and her parents."*

3.9. Effective Messages and Channels for Specific Targets

3.9.1. Audiences and Stakeholders Targeted for Effective Interventions

Afar

Participants in the focus group dialogue in Aysaita mentioned that interventions working towards ending FGM previously engaged different relevant stakeholders, such as religious and clan leaders. Establishing and using specific committees such as school clubs, or women's structures at the community level were avenues suggested for continuous intervention. Afar youth and women's community organizations known as *'Fiema'* were mentioned in this regard. It was indicated that there is a need to develop and enrich these cultural institutions because the Afar community abides more by traditional law than formal law. Participants stressed that if clan leaders, religious leaders, kebele chairpersons and 'Fiemas' are used to educate the community, FGM can be avoided. Among the cut girls who participated in the FGD, one of them stressed that the role of these stakeholders is to educate their communities and to enable them to avoid harm. Similarly, one of the cut girls who participated in an IDI stated that *"… a child could be born with birth defects. Female circumcision is known to cause these problems, so stakeholders should teach us that a woman should not be circumcised."* Other major stakeholders are women's associations in all kebeles supported by the government and aid agencies. Participants in Aysaita stated that there is a serious gender equality problem in Afar communities, explaining that women have limited decision-making power. They stressed the importance

of educating the community through awareness-raising, by working together with various stakeholders, including women and girls, men and boys, religious and clan leaders, local authorities and NGOs. One of the participants stated that there are strong women's associations at the organizational level and that it is necessary to strengthen them. Youth associations and mixed-gender, school-based clubs, religious leaders, tribe leaders and female elders were also reported to be useful in educating students and the community on the dangers of FGM. Members of school gender clubs are already educating their parents and community members to stop FGM. Participants also stressed the importance of health extension workers and school representatives, and suggested that their engagement should be continued.

A cut girl who participated in an IDI in Aysaita town stated that the Afar community had a marriage ceremony called *'Absuma'*, where girls get forced into arranged marriage. However, this is not practiced anymore, as women nowadays can marry any man they want. She stressed how important the engagement of health professionals is in helping women who have undergone FGM and who might experience complications during childbirth. Mothers of cut girls who participated in the FGD stated that mothers and fathers should not circumcise their daughters but instead should teach and monitor their children.

In Amibara, FGD participants suggested that religious leaders, circumcisers and community leaders should be engaged to prevent and control FGM effectively. Participants indicated that religious leaders could raise awareness in the community on the impacts of practicing FGM and assure the community that FGM is not a religious requirement in Islam. It was explained that since the community and some religious leaders believe that FGM is related to religion, it is important that well-informed religious leaders educate other leaders about the harmfulness of FGM and correct their misconceptions about FGM being a religious requirement. One of the FGD participants from Aysaita explained this by saying, *"Religious leaders need to be taught on what the religion teaches about FGM."* Another participant from the same site stressed that in addition to raising awareness on the dangers of FGM, religious leaders and elders should teach that girls should not be married at a young age.

Somali

Group dialogues with woreda experts in Dollo indicated that the Women's Affairs Bureau is the responsible bureau for the coordination of anti-FGM activities. The office works in collaboration with other stakeholders such as the Health, Legal Protection and Education Bureaus and kebele administrations, which are members of a working group. They explained that if a girl needs medical assistance, she goes to the health bureau or health post, whereas if she needs legal protection, she goes to the kebele office or police stations. The Education Bureau plays a role in creating awareness, while the Women's Bureau plays a coordinating role and provides periodic training to the working group. In a group dialogue with men in Erer Fik Simane, it was mentioned that schools could play a significant role in the reduction of FGM. They stated that the prevalence of FGM decreased in urban areas, as the awareness level of the community has improved through education.

According to a group dialogue with woreda experts in Fik, elders, youths and men should be educated; local police staff should work closely with the community, because FGM is practiced in secret; and local associations should be supported and engaged to become part of the process. They also stated that religious leaders know that FGM is harmful, but they don't talk about it. It was also suggested that mothers should be engaged,

as they are very influential in the community. A participant stated,

"…Unless the mother agreed to cut her girl, the father alone cannot influence his daughter. Therefore, the mothers' level of awareness should be improved..."

Participants in a GD with male community group in Dollo mentioned that all stakeholders, including teachers, youths, women, and elders, should participate in the process of ending FGM, a strategy also supported by mothers of cut girls. The group dialogue with adolescent boys in Erer Fik similarly indicated that all community members are expected to come together to play their roles. while adolescent girls stated that mothers, who are closest to their daughters during the FGM practice, are important stakeholders. They also indicated that religious leaders, traditional birth attendants (TBA), women's groups, and other community entities should participate in ending FGM. It was explained that TBAs have encountered severe challenges while delivering births for women who have undergone FGM, and they have played a role in saving mothers and convincing them to stop or avoid FGM practices.

The group dialogue with men in Erer Fik Dodoma revealed the existence of women's groups known as *"Saafi* [6]*,"* who are playing an important role in eradicating FGM at the kebele level. These women are very committed and take every action to reduce the practice, which translated into the kebeles making good progress compared to other kebeles in the woreda. The men stressed the need for collaborative efforts with religious leaders, women's groups, committed youths and kebele administration. Another group identified mothers, elders, and youth-led groups as important stakeholders, and underlined that the mother is the main actor in organizing and carrying out such practices. Also, elders should guide the community for the benefit of all members, as they are well respected and considered important stakeholders in ending FGM.

Dialogues with women in Erer Fik Dodoma indicated that mothers are the main decision-makers, followed by fathers. Participants also stated that legal bodies, elders, and religious bodies are collaborating to reduce the prevalence of FGM. One such focus group reported that all members of the community, together with legal bodies, religious organizations and the youth are working hand in hand to avoid such practices. The group dialogue with HEWs in the same location confirmed the findings that all members of the community are involved, including the kebeles and sub-kebele administration, religious leaders, women, and young people of both sexes. According to an FGD with cut girls in Erer Fik Dodoma, the entire community, including the administration, youth, women, and religious bodies, can work towards ending the practice through taking legal action against those who practice FGM.

The FGD with mothers of uncut girls in Erer Fik Dodoma revealed that previously, the members of the anti-FGM committee did not include religious leaders, and it was very difficult to have an impact in the short term. However, after religious organizations joined the committee, results became visible. The FGD with religious leaders showed that they were well informed that FGM is not a religious requirement and even mentioned that Islam prohibits infibulation.

One of them said,

"…Religious leaders should teach the community by clearly stating that "sunnah" is not "Fard" (mandatory) and that the Pharaonic type of FGM (infibulation) is "haram" and prohibited by Islam…"

It was underlined that religious teachings from the Mosque should be strengthened until the community fully accepts the messages presented and stops performing FGM. They indicated that specifically mothers and circumcisers should be warned not to engage in practicing FGM and should be

[6] Women's groups in Fik Dodoma woreda of Somali region

made responsible via legal action.

SNNPR

A cut girl in Dasenech woreda, Omorate kebele who participated in an IDI indicated that local administration officers, elders, particularly in rural areas, and village and clan leaders who are influential in the community, should participate in raising awareness. These influential members of the community can gather the rest of the community and provide guidance. Adult women who participated in FGDs in Dasenech woreda Lobet kebele stated that the woreda administration, which is supported by NGOs, should reach out to as many community members as possible so that awareness can be sufficiently expanded. The FGD with Women's Development Army members from the same area indicated that the kebele task force, which meets every month and has eight members per kebele including youth representatives, elders, religious leaders, police and HEWs, could play a significant role. On the other hand, the IDI with traditional leaders and uncut girls in the same area underlined the importance of elders, clan leaders and chairpersons in changing attitudes and ending FGM.
Cut girls in Dasenech woreda Omorate kebele stated that in rural areas, there are community groups who are considered highly influential. Elders, religious leaders, police, and kebele chairpersons should participate in activities towards ending FGM. On the other hand, the group dialogue with male adult participants revealed that even educated members of the community do not have the courage to discuss ending FGM within pastoral communities. It was further explained that the elders of the community are not receptive to modern messages on ending FGM at all. Thus, the only chance is to work with the youth. One of them said, *"…Trying to raise the elders' awareness and anticipating their cooperation to eliminate the practice is simply a waste of time..."*
In a group dialogue, participants identified traditional elders/clan leaders, fathers and circumcisers as influential, but explained that they would not be worth engaging due to their conflict of interest, as traditional norms and culture are sources of wealth and prestige for them. The group dialogue with adult women indicated that anyone outside the community, such as government staff, NGOs, or motivational speakers can influence the community.

3.9.2. Channels or Communication Pathways Used to Reach the Target Audience(s)

Afar

Cut girls who participated in IDIs in Aysaita Berga indicated that if religious leaders and clan leaders are told that these messages are important to them, they would reach the intended target audiences. An IDI with a mother of a cut girl in the same area revealed that the only way to ending the practice is to bring people together and educate them. During an IDI with an uncut girl in Amibara, she said, *"…I think she (the uncut girl) can contribute to the community by sharing her life experience in relation to FGM..."This was also supported by a cut girl in Gewane saying,* "…Promoting uncut girls will have a good positive influence related to raising community awareness…."
In an IDI with an uncut girl in Aysaita Romayto, the participant explained:
"…I am also uncut and I am sorry for my sisters who are cut. I know female circumcision has negative health and psychological impacts. To be effective, interventions should support uncut girls to get involved in advocacy…"
During a group dialogue with woreda experts in Amibara, they explained that uncut girls are not perceived any differently than other women in their community. They therefore explained that sharing the experiences of uncut girls would be useful to change social and gender norms. However, some

participants had reservations with respect to sharing the experiences of uncut girls in rural kebeles, as it could be challenging unless there is support and engagement by the government. In Aysaita, experts reported that during the last March 8th celebration of International Women's Day, they presented mothers of uncut girls with awards, hoping that they could be seen as good role models. Another expert explained that during arguments, cut girls insult and embarrass uncut girls. Thus, it was suggested to also reward uncut girls as a recognition of their status, before using them as role models and communicators. Experts in Samara indicated that stories of uncut girls and women could be useful in advocacy, programming and policy change. They also supported the idea of rewarding uncut girls and their parents at various events and encouraging them to give their testimonies.

Somali

Woreda experts in Erer Fik indicated that mass awareness campaigns are good pathways for communication on FGM. They also reported that religious leaders know that FGM is harmful, but don't talk about it. Other discussants indicated the importance of local associations as platforms for communication if they are supported and engaged to become part of the process. Information could be shared in mosques, school centers, during public gatherings and from house to house, according to adolescent boys who participated in a group dialogue in Erer Fik Dodoma. Adolescent girls stated that most of the time, people access information from religious institutions and school centers, during community gatherings, and via house-to-house visits, since community members are familiar with one another. Active women's groups and committed youth groups were also identified through a group dialogue with men at the same site. IDIs with mothers of cut girls identified young religious leaders who are educated as potential communicators on the harms of FGM, while mothers of uncut girls mentioned public mass awareness campaigns and demonstrations as effective channels of communication. A religious leader who participated in an IDI in Erer Fik Dodoma identified refresher trainings and seminars as pathways to be used for communication.. It was suggested that these events should be organized for all concerned stakeholders like religious and community leaders, youth, men, women and circumcisers, with the aim of building their awareness and changing their attitudes.

Regarding using the experiences of uncut girls to promote social norms and gender change, experts in Dolo Warder explained that finding any uncut women in the area is very difficult, but this can be done by using women and girls who were circumcised with the Sunnah type of FGM. Kebele experts in the same area confirmed that relying on public advocacy by uncut girls is unrealistic, since there is no way that they could find such girls, as it is considered shameful to be uncut. On the other hand, adolescent girls who participated in the group dialogue in Erer Fik stated that it would be important for uncut girls and women to share their experiences because they give birth without any injuries or challenges and enjoy their marriage without feeling any pain.
This was also supported by a religious leader in the same area who explained by saying, *"…If an uncut girl comes to our community and speaks about the advantages and disadvantages of FGM, our community will welcome her and accept her teaching, because currently our society has changed its perception about uncut girls..."*

SNNPR

A cut girl in Dasenech woreda Omorate kebele who participated in an IDI said, *"Gathering community members and raising their awareness is the only channel that I can suggest."* The group dialogue with

adolescent girls in the same area indicated that community members like youths and elders have a chance of being heard and influencing others. In addition, legal entities and knowledgeable individuals can help raise community awareness on FGM-related laws. The group further indicated that the Women and Children's Affairs office and other governmental bodies and NGOs can also be instrumental in convincing the community. Yet, it was stressed that in order to be heard, an organization should provide community members with some incentive (in cash or in kind) because community members are not interested at all to attend any event unless they get paid.

In another group dialogue with adolescent girls in the same location, one participant said,

"In my opinion, if a message on ending FGM is passed through a person from the community, the chance of success will be high. For instance, FGM is more frequent in the pastoralist areas of this woreda, so if an educated member from the same pastoralist community can pass on the message about the dangers of FGM, the probability of being listened to by the rest of the pastoral community is high. As far as I know, sharing the message through a religious leader does not have better chances to reach the pastoral community."

According to adolescent girls who participated in the group discussion in Dasenech Omorate, meetings organized by law enforcement bodies, NGOs, and other governmental bodies and that also provide payment as an incentive for participants can be used as effective channel to pass information onto the community.

One of the participants said,

"In my opinion, a clan member, who is educated and aware of the situation, has a higher probability of being heard by the rest of the community. Based on my observation, pastoral communities are not usually interested to accept advice from members of other clans. Thus, a meeting led by an educated member of their own clan can be organized, and messages on the complications resulting from FGM can be effectively shared so that the communities can put the message into practice."

This finding was also supported by IDIs with uncut and cut girls in the same area. A group dialogue with adult women indicated that existing events or meetings in the community could be effectively used by health service providers to raise awareness on the negative effects of FGM.

3.9.3. Key Messages to be Included

Afar

A cut girl in Aysaita Berga stressed the importance of underlining the health complications resulting from FGM, and that these affect both the mother and the new-born. Furthermore, it was suggested that health professionals should teach women and the community about the damage caused by FGM. During a group dialogue in the same area, HEWs stated that religious leaders and community elders should participate in raising awareness by conveying messages about the impact of FGM, and that stories of uncut girls could also be used for coining key messages. For instance, a cut girl in Amibara Serkamo mentioned during an IDI that:

"We don't have many uncut girls in the community but there are a few and we have heard a lot about them, like the fact that uncut girls have no problems during childbirth, but a circumcised woman will have problems during childbirth and pain during intercourse."

In Aysaita_Berga, an uncut girl explained that a girl who has not been circumcised is healthy and does not feel any pain during menstruation, while having intercourse and during childbirth, thus not facing any birth problems, which suggests that these facts would be good to use as key messages.

Somali

Participants from FGDs and IDIs mentioned that it is important to make the community aware of the problems resulting from FGM by focusing on them as key messages. However, adolescent boys said that it is well known that FGM causes problems, but it is important to discuss how to act and use that as key messages. Dialogue with HEWs in the same area explained more clearly that the message should be about the effects and consequences of FGM practices and the potential legal consequences. Cut girls in Erer Fik Dodoma said that the messages should be not only about the consequences but also about the benefits of not being cut. They suggested telling a story or showing a clip with affected communities performing FGM, a practical demonstration. Adolescent boys who participated in a group dialogue in Erer Fik Simane said that the key messages should be about how FGM affects women's health, particularly at the time of giving birth. In a group dialogue with men in Erer Fik Simane, one participant said, "*…I believe there are no other stakeholders engaged in FGM prevention apart from health service providers and HDAs. They teach the community about how FGM affects women's health particularly during delivery and pregnancy...*"

Another participant indicated that the attitudes of men and boys should also change. If men say *"…I will marry an uncut girl,"* this is likely to reduce the prevalence of the practice. One of the participants of a group dialogue with boys in Erer Hamero Gasangis said, *"The primary message that needs to be communicated to the community should be, 'Stop FGM and child marriage to safeguard your girls' future'…."*

A mother of an uncut girl stated that key messages should focus on the side effects of FGM. HEWs in Dodoma further explained that key messages should be about the complex health, social, and psychological problems that will arise as a result of FGM. A religious leader stated during an IDI that cut girls may encounter a variety of complications because of FGM, including pain during circumcision, bleeding, and infection. He thus suggested that religious leaders should clearly explain to the community that sunnah is not fard (mandatory) and the Pharaonic type of FGM (infibulation) is prohibited by Islam and is haram[7].

Regarding perceptions of uncut girls, adolescent girls stated during a group dialogue that because uncut women are healthy, they have easy birth deliveries and happy and healthy marriages, whereas cut women have complicated health problems, as well as social and family problems.
An IDI participant in the same area supported this by saying,
"Uncut women have a shorter delivery time, and we are avoiding the Pharaonic type of FGM and welcoming the Sunnah type, as the Pharaonic practice results in bleeding, prolonged delivery and a woman being cut repeatedly gets infections."

SNNPR

According to a cut girl who participated in an IDI in Dasenech woreda Omorate kebele, the messaging on the dangers of FGM should state that if a girl is cut, she will suffer from excessive bleeding during the procedure and during childbirth. They should also emphasize the pain that the girl will go through. This was confirmed in a a group dialogue with adolescent girls in Dasenech Omorate, who indicated that key messages should focus on the complications that will occur before and after childbirth.
This was supported by an uncut girl in the same area who said,
"When we come to the key messages to be included, the consequences of undergoing FGM should be the focus. The immediate and

[7] Acts that are haram are typically prohibited in the religious texts of the Quran, and the sunnah category of haram is the highest status of prohibition. If something is considered haram, it remains prohibited no matter how good the intention is or how honorable the purpose is. (Al-Qardawi, Yusuf (1999). The Lawful and the Prohibited in Islam. American Trust Publications. p. 26.)

long-term complications that FGM will bring about on a girl should be told in detail. The excessive bleeding during the cutting, the wound that will be created and hinders the girl to deliver smoothly, the fistula and other consequences should be told in detail."

As for key messages that administrators, clan leaders, elders and educated members of the community should pass onto other community members, HEWs and WDAs in Dasenech Lobet indicated that these should be about FGM-related laws. The group stated that they were preventing community members from getting their daughters cut by immediately reporting it to the authorities. According to this group, the key message that should be used to make community members aware should be that if they get caught practicing FGM, they will be punished.

A cut girl in Dasenech Omorate said that key messages should focus on the dangers of FGM, early marriage and unbalanced marriage (marriages with large age differences), as these can result in unequal power dynamics. She said that, for instance, one can use pictures which show the dangers of FGM, and media messages that can be easily understood by the community and tell stories of cut girls. Using mobile phones to disseminate information about the dangers of FGM can also be helpful to reach educated members of the community.

Another cut girl in Dasenech Lobet explained that religious leaders "…should strictly tell us not to get cut and to open our eyes and even tell us to teach others after we open our eyes." Another cut girl in the same area said that elders, religious leaders and clan leaders should tell the girls not to harm their body by practicing FGM, and that they will experience excessive bleeding during cutting and childbirth. Similarly, adult men indicated that influential individuals should use powerful teaching materials, especially pictures that show complications arising from cutting.

This was supported by WDAs and HEWs in Dasenech Omorate, who stated that the key messages to be disseminated should focus on the health and other complications, both long and short term, which arise from FGM.

3.10. Suggested interventions, which are most acceptable, responsive, and likely to be impactful for girls/women to end FGM

Afar

Study participants suggested it is possible to challenge FGM and inequitable gender norms by strengthening previously employed strategies and interventions, such as engaging religious leaders, clan leaders and women's groups. An interesting suggestion forwarded by woreda experts in Amibara woreda of Somali Region was that interventions should tap into existing cultural institutions, like the Fiema clan structure and religious institutions. Another group of experts in Amibara Serkamo stated that interventions using community dialogue to raise awareness can be effective and including women in these programs can empower them.

Suggestions by another group of experts in the same area underlined the importance of uncut girls as role models in the community. A participant stated, *"It's easy to raise awareness to our community and there are a lot of uncut girls in our community."* The group explained that uncut girls are believed to have safe lives and can therefore act as role models to inform others in the community, as women and as mothers.

Kebele experts who participated in group dialogues in Aysaita Berga suggested that effective interventions should rely on using religious leaders to raise awareness in communities, since they are very influential, as well as engaging with government actors like the Woman and Social Affairs Office, the Justice Bureau or the Police. Creating a

specific committee led by the community itself was also suggested to challenge FGM and inequitable gender norms.

Experts who participated in a group dialogue in Aysaita suggested the use of videos showing the harms of FGM during awareness raising programmes. They also suggested establishing a gender club in schools, and making girls and boys participate in club activities. It was further suggested to cooperate with health extension workers in rural kebeles, who could educate mothers on gender equality.

One of the participants said, *"To ensure women's equality, it is necessary to train not only women but also men. This is because if there is ever to be a systemic change for ensuring women's equality, men should be part of the solution, so every man should start at home."*

The group also suggested educating female students about gender and gender-related norms, so that they can pass this information onto their families and neighbours. An expert justified this by saying, *"If we do well in schools, we can change society".* The group further suggested that selected health extension workers should be appointed as focal persons assigned in each kebele to provide awareness training to the community, and that it is necessary to increase the number of experts working in each kebele.

Woreda experts who participated in group dialogues in Gewane suggested that activities aiming to end FGM should be carried out in collaboration with cultural structures like the Fiema, clan and religious leaders, and women's groups. Various interventions involving religious leaders and different community groups have already been implemented and led to some results; nevertheless, there is very weak enforcement of anti-FGM laws.

Somali

A mother of a cut girl who participated in an IDI in Erer Fik Simane suggested that raising the community's awareness level and creating women networks in each neighbourhood will help reduce FGM. She said,

"Through the network, women can discuss a lot of important issues to stop FGM and its side effects. We can put pressure on the mother who intends to cut her daughter and if she is not accepting our advice, we can report the case to the government, and it can surely discourage the practice of FGM."

Adolescent girls in the same area further suggested that interventions should target boys and men to change their attitudes about cut and uncut girls, and highlight the benefits of stopping FGM for men, women and their offspring.

IDI and group dialogue participants in Dolo Warder kebele, which comprised mothers of cut girls as well as kebele experts, WDAS and HEWs suggested that interventions should center around awareness creation. The group further suggested finding alternative income-generating activities for circumcisers, an idea also brought forward by woreda experts in Erer Fik. Moreover, woreda experts in Dolo Warder suggested providing additional assistance to bring about transformative changes in relation to gender, including decision-making, skills development and ownership of resources. It was explained that some kebeles lead the way in ending or reducing FGM, while others lag behind and require additional support through the provision of training and awareness creation.

When asked which interventions are most acceptable and likely to be impactful in terms of empowering women and adolescent girls, addressing gender inequality and challenging FGM as a practice, woreda experts in Dolo Warder stated,

"To enhance awareness-raising strategies, you should persuade religious leaders to address the issue of FGM during religious ceremonies, and influential members of the community to address issues about the health effects of FGM."

SNNPR

A cut girl in Dasenech Omorate suggested that health service providers, law enforcement bodies, Women and Children Affairs offices, and other governmental bodies should jointly work to effectively prevent FGM practices in the community. On the other hand, adult women suggested that in pastoral communities, the kebele administrators, clan leaders and elders can play significant roles in ending FGM through continuous and consistent teaching and by punishing the practitioners. They further justified their suggestion by explaining that Dasenech community members do not usually listen to uneducated people like themselves. One of them stated, *"Nowadays there are educated persons from the Dasenech community who can be heard by the uneducated ones and can help raise awareness."*

In a group dialogue with WDAs and HEWs in Dasenech Omorate it was suggested that collaborating with educated members from the community will immensely help improve the situation. These relevant community members can be kebele administrators, managers, health extension workers, school principals, police staff, youth representatives, women's representatives, elders and clan leaders. In addition to the above-mentioned stakeholders, governmental and nongovernmental entities can play important roles in providing training and leading the coordination effort to teach the rest of the community.

In Dasenech Lobet, experts explained that in and around urban settings, FGM service providers and parents who forced their daughters to be cut are being arrested and punished, and as a result, cases are declining significantly. Yet, in rural settings, the lack of awareness and unwillingness of community members to abandon their culture make it difficult to bring about change. The group stated that these community members keep on practicing FGM secretly, making it difficult to identify and punish practitioners. Another participant said that there is significant change after legal actions were taken, as community members started to practise FGM in secret and this by itself is an indication of improvement. However, the study team believes that when such practices are done secretly, it could be more difficult to end the practice. One participant said, *"I suggest strengthening the law to identify and punish the perpetrators."*

During a group dialogue with experts at the regional level, it was suggested that the solution is to enhance existing awareness creation interventions, which are fundamental and could be expanded to more locations. They explained that households and the community at large can be reached by regular schools and alternative adult education, and efforts should be organized around the education system. The experts further suggested that UNICEF Ethiopia should scale up its work with mini-media and gender clubs as part of regular schools and alternative adult education. The importance of revisiting FGM laws and advocating for legal reform/law amendment was also discussed, underlining that the punishment currently being enforced against circumcisers is insignificant. The group stated that health extension workers could play a key role in monitoring and reporting FGM incidents, since they are very close to the community.

An uncut girl indicated that interventions should involve elders from pastoralist communities, legal experts, community leaders, and Women and Children Affairs staff. She said that awareness creation activities should target all community members, including the youth and elders, and stressed that to be effective, interventions should be attractive and supported by incentives.

Suggestions by adult men in Dasenech Lobet supported this by stating that they are familiar with activities such as regular meetings and the incentives associated with them. Adult women in Dasenech Omorate suggested capacity building trainings on topics such as gender mainstreaming, human rights and the equality of human beings, as well as involving uncut women as active role models against FGM.

CHAPTER 4:

CONCLUSION AND RECOMMENDATIONS

4.1.Conclusion

The study participants in Afar and Somali regions are aware of the negative effects of FGM and know that it is punishable by law, but it was found that some participants of SNNP region (Dasenech woreda) lack knowledge in this regard. Most of the community members in all the study areas know the existence of formal legal and health services related to FGM. Since FGM in the PCs is a deeply rooted cultural practice attached to religious mandates and a considerable proportion of community members are hard to reach, they could not use available health and legal services. Shortages or lack of medical supplies and medicine to treat FGM cases at health post level were also identified as barriers to seeking health and legal services. As participants from all three regions also know that those who practice FGM are not being punished, they feel that the law is not being implemented, which leads them to maintain the practice. Due to this fact, it is hardly possible to find FGM cases reported to legal bodies. The community members are also afraid of reporting FGM cases because of threat and intimidation by some community members.

Somali participants indicated limited cooperation of service providers, including education providers, legal bodies, health centers, women and children affairs offices, as the major barriers in the effort to end FGM. In SNNP region, fear of reporting cases (due to reactions and stigmatization by the general community), high cultural value given to FGM, and stigmatization against uncut girls and their parents by the community, are found to be the major barriers to the efforts to end the FGM practice. Despite the challenges, some opportunities to end FGM were identified, including the increased attention given to the practice by different stakeholders (government and non-governmental actors, and civic institutions). The participants also identified increased knowledge about FGM and the suffering associated with it as an opportunity in stopping the practice of FGM.

The synergy of religious leaders, Women and Children Affairs offices, Woreda Administration offices, health facilities, police/legal institutions and non-governmental organizations and UN agencies is found to be vital to convince communities to abandon FGM. It is noted that religious leaders, as well as elders and clan leaders, are very important audiences and stakeholders targeted for effective interventions to end FGM in all study sites. Other audiences and stakeholders included girls, circumcisers, representatives of women and youth groups, boys and men, uncut girls, and WACA offices. Traditional structures such as Fiema (an organization of youth and women) in Afar region and Saafi (a women's group) in Somali region should be given serious attention in future programming as possible channels of

communication for transmitting messages on FGM. Key messages to be included in interventions need to focus on health complications resulting from FGM, including excessive bleeding during the cutting and delivery as well as fistula. In addition to these, sharing the testimonies of men/boys affirming that they would marry uncut girls, telling stories of cut and uncut girls, as well as using film clips and mobile messages, are found to be interesting ways for sharing key messages.

4.2. Recommendations

General Recommendations

It is highly recommended that the following be implemented in all study regions, if any progress is to be made towards the reduction and eventual elimination of FGM in all its forms. First, we will present region-specific recommendations, then follow with general/common recommendations.

Afar

- Engaging members of the cultural structure known as Fiema, which is a clan structure in Afar region, to educate the community on the harmful effects of FGM and the benefits of abandoning the practice.
- Engaging mothers in awareness-raising programs on ending FGM and building their capacity on gender equality, including equitable decision-making.
- Educating female students about gender and gender-related norms so that they can pass on the information to their families and neighbors and also report possible FGM incidents before they happen.

Somali

- Educating girls and raising the awareness level of both women and men
- People who report FGM incidents should be protected and able to make anonymous reports, as whistle-blowers tend to be threatened and intimidated.
- Recruiting and training volunteer youths (boys and girls) in each kebele on topics such as gender equality or the disadvantages of FGM. They could serve as role models, advocates, and vigilantes.
- Engaging members of the cultural structure known as Saafi, which is a women's group in Somali region, to educate their peers on FGM and encouraging networking among women to monitor and report at-risk cases before FGM occurs.
- Engaging mothers and educating them on the serious consequences of practicing FGM, the benefits of ending the practice and the importance of educating girls.
- Creating alternative job opportunities for circumcisers with the aim of replacing the income they were gaining from performing FGM with a legal and more profitable income-generating activity and motivating them to support actions towards ending FGM.

SNNPR

- As many participants indicated, general ignorance and lack of awareness about the negative consequences of FGM have contributed to the wide prevalence of FGM and unequal treatment of women. Hence, serious efforts should be made to address these issues. One example intervention could be radio programs targeting specific communities and age groups.

- Involving elders, religious and community leaders in the efforts to reduce or eliminate FGM should be approached cautiously. Some participants have reported that they are the ones who are advocating for continuing these traditions. Only those convinced to eliminate FGM and not prescribing Sunnah should be involved.
- The Government, woreda and kebele administration should openly oppose and address the issue of dowry/gifts to marry girls. It has serious implications on the equal treatment of women in terms of equitable sharing of household chores, decision-making on family matters, GBV, etc. Raising awareness paired with taking harsh measures and establishing effective surveillance committees among community members could help.
- Engaging clan leaders in rural areas to work together with the woreda administration and NGOs, as they are respected by pastoral communities and could communicate effectively on the dangers of FGM and the benefits of abandoning the practice.
- Convincing educated members of the community to be members of anti-FGM committees and engaging them to teach the community on the negative effects of FGM and the benefits of abandoning the practice.
- Working towards ending FGM in all its forms through the joint collaboration of health service providers, law enforcement bodies, women and children affairs offices, and other governmental bodies.
- Utilizing mini-media and gender clubs in regular schools, as well as alternative adult education to build girls' agency to say NO to FGM and child marriage, and educating boys on why uncut girls are preferable as future wives.

General/Common Recommendations

- Religious and clan leaders should be actively engaged in teaching and persuading community members to send their children (both boys and girls) to schools and to stop FGM. It is a futile exercise to move without securing their collaboration. Holding special consultation meetings with them and providing the necessary knowledge and skills, asking them to commit to send clear messages against FGM, paired with the provision of incentives for their time and efforts, etc. could be considered during the planning interventions and evaluation of anti-FGM projects in each kebele.
- Form a strong committee in each kebele, with representatives from relevant sections of the community (women, girls, men, boys, elders, etc.), to handle issues related to HTP and FGM, to follow up on progress and to conduct regular community conversations (e.g. first Friday of every month).
- Since it's not common in pastoral communities to monitor, report and prosecute FGM incidents, anonymous reporting mechanisms should be designed and implemented, such as e.g. leaving a note in a suggestion box or reporting through community-level social workers. Those who report FGM incidents should be protected by Government bodies.
- In the long run, the equality of men and women in decision-making, ownership of property, and on family matters would only come through education and women's awareness of their rights. Therefore, educating and economically empowering the girls should be given due attention.

- Identify and implement a potential mechanism to coordinate efforts to access services related to customary and formal laws at the community level (e.g. a community legal center).
- Strong awareness raising and education programmes should be implemented at the grassroots level to convince the community to recognise Sunnah as a type of FGM and work towards eliminating it.
- Health facilities in the study area should be strengthened in terms of medical supplies and human resources.
- Awareness raising should focus on the harms of being circumcised and changing the perceptions of boys, men and the general community that cut girls are more suitable for marriage.
- The capacity of the Women and Children Affairs Bureau should be strengthened (e.g. in terms of technology, infrastructure, finance, etc.) to enable them to coordinate FGM-related interventions.
- The influence of cultural and informal community groups should be considered during project design and at all stages of the FGM project management cycle.
- Approaches to consider include organizing direct discussions with circumcisers; providing alternative income-generating activities for circumcisers; engaging community groups in meetings, seminars or conferences; and integrating FGM-related knowledge into the school curriculum.
- Training and engaging religious leaders to reach out to their communities on the harmful effects of FGM, the benefits of abandoning the practice and building consensus to end FGM.
- Recognizing the contribution of uncut girls and their mothers towards ending FGM by presenting them with awards in community ceremonies and events and using them as role models to encourage others to follow in their footsteps and uphold the new norms of keeping girls intact.
- Raising awareness on the rights of girls to be physically intact and relish sexual pleasure as well as their right to benefit from reduced pain and be free from health risks, by engaging men and boys with greater emphasis on gender norms' transformation.
- Organizing refresher seminars and trainings and presenting the stories of cut girls or showing films demonstrating FGM being performed, as well as demonstrating the benefits of abandoning the practice.
- Support law enforcement bodies, elders, and religious leaders to work collaboratively in enforcing the law and taking serious legal action against perpetrators.

References

Ababeye, B and Disasa, H. 2015. Baseline/End line Survey: Female Genital Mutilation (FGM) Situation in Six Regions of Ethiopia. Final Report Submitted to Norwegian Church Aid/Save the Children International.

African Union Commission (2022).Getting to Zero FGM in Africa: Strengthening Human Rights, Accelerating Efforts and Galvanizing Accountability. AA

Borda OF. Participatory (action) research in social theory: origins and challenges. Handbook of action research: participative inquiry and practice; 2006. p. 27–37.

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

___[Ethiopia] and ORC Macro. 2006. Ethiopia Demographic and Health Survey 2005. Addis Ababa and Calverton, MD: CSA and ORC Macro.

______ and ICF. 2016.The 2016 Ethiopian Demographic and Health Survey (EDHS) report. Addis Ababa, Ethiopia.

Centers for Disease Control and Prevention. National HIV Behavioral Surveillance System in Men Who Have Sex with Men– Round 4: Formative Research Manual. December 20, 2013. Available from: Gabriela Paz-Bailey (gpazbailey@cdc.gov).

Cordeiro L, Soares CB. Action research in the healthcare field: a scoping review. JBI Database System Rev Implement Rep. 2018;16(4):1003–47.

FDRE(1995). Constitution of the Federal Democratic Republic of Ethiopia. Available at http://www.refworld.org/docid/3ae6b5a84.html.

______. Ethiopia: Criminal Code, Proclamation No. 414/2004 (2005) Available at http://www.refworld.org/docid/49216b572.html.

Kindon S, Pain R, Kesby M. Participatory action research approaches and methods: Connecting people, participation and place. London: Routledge; 2007.

Loewenson R, Laurell AC, Hogstedt C, D'Ambruoso L, Shroff Z. Participatory action research in health systems: a methods reader: regional network for equity in health in east and southern Africa (EQUINET) in association with training and research support Center (TARSC), Alliance for Health Policy and Systems Research (AHPSR), World Health Organization (WHO) and the International Development Research Center (IDRC) Canada; 2014.

Ministry of Women, Children and Youth Affairs (MoWCYA). 2019. National Costed Roadmap to End Child Marriage and FGM/C 2020–2024. Federal Democratic Republic of Ethiopia Ministry of Women, Children and Youth, Addis Ababa.

Ministry of Women, Children and Youth Affairs (MoWCYA). 2013. National Strategy and Action Plan on Harmful Traditional Practices (HTPs) against Women and Children in Ethiopia. Addis Ababa.

MoWCY (2013). National Strategy and Action Plan on HTP against Women and Children in Ethiopia. AA

UN Women (2020. Assessment Report Afar and Somali Regions: Barriers Hindering the Adoption of Family Law

UNDP. 2016. Human Development for Everyone, Briefing note for countries on the 2016 Human Development Report, http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/ETH.pdf.(Accessed on 13 June 2021).

UNFPA, 2017.17 Ways to end FGM Lessons from the Field. UNFPA.

FPA/Drexel Univ. & UNICEF. 2019. The ACT Framework: Towards a New M&E Model for Measuring Social Norms Change around FGM.

UNICEF (undated). Gender Transformative Approaches for the Elimination of Female Genital Mutilation.

UNICEF, 2019a. Situation Analysis of Children and Women in Afar Region.

UNICEF, 2019b. Situation Analysis of Children and Women in Somali Region.

UNFPA /UNICEF. 2013. Joint Evaluation of the UNFPA-UNICEF Joint Program on Female Genital Mutilation / Cutting (FGM/C): Accelerating Change (2008 - 2012).

UNFPA /UNICEF 2020. Validation of Act Framework: Tracking and Measuring Changes In Social Norms Related To FGM: Findings Report On Ethiopia, United Nations Joint Program, April 2020.

UNFPA-UNICEF Joint Program on Female Genital Mutilation/Cutting: Accelerating Change (2015) 2015 Annual Report, p.21. Available at https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_FGM_WEB_FINAL_ENGLISH.pdf

UNICEF (2017). Baseline Study Report on Female Genital Mutilation/Cutting and Child Marriage among the Rendille, Massai, Pokot, Samburu and Somali Communities in Kenya. Nairobi.

UNICEF (2020). A Profile of FGM in Ethiopia. Available at: https://data.unicef.org/resources/a-profile-of-female-genital-mutilation-in-ethiopia/.

UNICEF (2021). Formative Research on Successful Strategies to End FGM: Phase I Report. AA

_______ (2021). RFP for Consultancy to Conduct Formative Research on Successful Strategies to End FGM. AA

______. 2020. A Decade of Action to Achieve Gender Equality: The UNICEF Approach to the Elimination of Female Genital Mutilation

______. 2021. Ending child marriage and female genital mutilation in Eastern and Southern Africa: Case studies of promising practices from across the region.

UNFPA-UNICEF. 2020. Measuring Effectiveness of FGM: A Compendium of Indicators. NY.

UNFPA-UNICEF, 2019. Annual Report 2018, Joint Program on the Elimination of Female Genital Mutilation: Accelerating Change, Au

Annexes

Annex 1: List of sample woredas, by regions and zones

Region	Zone	Woreda
SNNP	South Omo Zone	Dasenech
Somali	Dolo Zone	Warder
	Korahe Zone	Kabridahar
	Nogob Zone	Fik
		Hamero
Afar	Zone-3	Amibara
		Gewane
	Zone-1	Asayita

Annex 2: Tools of data collection

Annex 2A

Group Dialogue with Card Sorting/Prioritizing

I. Background

This tool is designed to collect data for a study entitled "Formative Research on Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior, Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia". The study is commissioned by UNICEF-Ethiopia and is conducted in three regions (Afar, Somali and SNNPR). It employs a Participatory Action Research (PAR) design which involves researchers and participants collaborating to understand the customary and sociocultural origin and the psychosocial impacts of the practice of FGM and take actions to bring about better programming on social norms.
The data collection tools to be used combines Card Sorting/Prioritizing (CSP) and Group Dialogue (GD). The exercise related to Card Sorting/Prioritizing helps the research team ensure healthy relations with participants and understand the thinking framework of participants about services related to FGM and FGM survivors.

II. Participants of Card Sorting/Prioritizing with Group Dialogue

The primary study participants of the card sorting with group dialogue approach will be drawn from regional bureaus of Women and Social Affairs (WASA), Health, Education, Justice, and National Alliance for FGM. At the woreda level, WASA, health and education offices and police stations will be included. Schools, health centers and MHNT will be considered at the kebele level. A total of one group dialogue per region, per woreda and kebele will be conducted.

III. Consent Form

Introduction:

Greetings! My name is ________________. I represent a research team from Frontieri. We are conducting a study on FGM practices in your woreda/kebele (name of woreda/kbele) of the region. Your woreda/kebele is selected by chance.
The purpose of the study is to explore the knowledge, attitudes, perception of community members and their experience regarding FGM. The findings of the study will come up with strategies to increase service seeking behavior to strengthen provision of care in three regions of Ethiopia (Afar, Somali and SNNPR).

Procedure:

You are selected purposively for this interview because you are living in this kebele and have experience with FGM to tell the group. I will ask you few questions concerning your knowledge perception and/or experience about FGM. The discussion will take about 1:00 hour. Participation is voluntary and you can skip any question that creates discomfort to you or stop the discussion at any time. However, your active participation and genuine responses have paramount importance in understanding the problem.
Risks and discomfort: There are no risks involved due to your participation in the discussion process. The discussion may take some of your time. However, we will try to make it as brief as possible.

Benefits:

There will be no direct benefit to you; but the information you provide will help identify gaps and design strategies to reduce FGM practices and its impacts.
Confidentiality: The information that we collect in this study will be kept confidential. Your name will not be written in this form and the information we collect from you will not be shown to anyone outside of this research team. The hard copies will also be kept in a locked cabinet and will not be disclosed to anyone except the researchers.

Are you willing to participate in the study? Yes __ No___(skip to the next Interview)

Signature/finger print of the participant

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Signature/finger print ________________date _______________

Interviewer: Name _______________________Signature____________ Date ___________

Supervisors/Researcher: Name _______________________Signature _______Date ________

Note: In case of any concern, you can communicate the PI (Prof. Habtamu: 0911600059) or the project coordinator (Dr. Dereje; 0911660190).

IV. Procedure/Guideline for Card Sorting/Prioritization with GD

(WASA, health, education and Justice Bureaus and National Alliance for FGM, one from each of the three regions; WASA, health and education offices and police station from each of the eight Woredas; and Schools, health centers and MHNT from each of the eight Kebeles,)

The research team will use a visual method, card sorting, during the group dialogue sessions at bureau/office/facility levels. Card sorting helps the research team design or evaluate the information architecture of respondents at bureau, office and institute levels. In a card sorting session, participants organize ideas and services related to FGM into categories that make sense to them. Card Sorting/Prioritization will be used in this study in combination with group dialogue (GD) at institution level. The following field procedures are followed by the data collectors and supervisors.

Main components:

- In this exercise, small sized cards with different colors will be prepared and messages about FGM (religious and social/peer driving factors, criteria for marriage, FGM preventive methods, rehabilitative measures for FGM survivors… etc.) will be written. The message includes three main categories:
    - Root causes of practicing FGM
    - Impact of practicing FGM
    - Priority interventions

- Each of the three main categories will have sub-components:
  - Root causes of practicing FGM
    - Cultural practice
      - Controlling girl's/women sexual feelings both before and after marriage
      - To avoid pre- marital sex to avoid pre-marital pregnancy
      - To avoid pre-marital pregnancy to protect family's pride
    - Religious obligations
      - "Sunna" is a religious obligation
      - Respecting religious obligations other than "Sunna"
      - To keep girls pure
  - oImpact of practicing FGM
    - Health complications
      - Prolonged labor
      - Urinary retention
      - Pain during menstrual bleeding
    - Psychological complications
      - Fear of sexual intercourse
      - Avoiding relationship
      - Do not get satisfied with sexual play
    - Social complications
      - Disagreement within families
      - Divorce/separation
      - Negative developmental impact on children of divorced/separated parents
  - oInterventions
    - Protective services
      - Having customary laws
      - Enforcing formal laws
      - Community conversation
    - Health services
      - Ante-natal services
      - Skilled birth attendant
      - De-infibulation
    - Rehabilitation services
      - Psychosocial support/ counseling
      - Marriage guidance/ Couples counseling

Instruction for Card Sorting

- A single main category will be written on an A4-size card
- Each of the sub-ideas under the main categories will be written on a card
- Each of the components of sub-ideas will be written on a card
- All cards with different categories and ideas/messages will be presented to the respondents.
- Respondents will be instructed to sort out the three main categories;
    - Sub-ideas under each of the three main categories and
        - Components of sub-ideas under each of sub-ideas.

Instruction for prioritization:

Participants will group the individual card according to one or two or three of the criteria below as time allows:

- Useful vs not useful,
- Valued vs not valued,
- Preferred vs not preferred, as they make sense to them.

By doing the card sorting exercise, the researcher team gains insight into respondents' preferences, values and perspective related to FGM. Moreover, this exercise will add depth to the discussion with the respondents.
The prioritization exercise will help the team understand, for example, what is important in motivating the target people to engage (approaches/interventions) and change behavior related to religion, peer influence and utilizing FGM-related health services. Card sorting and prioritization generally help the researcher team to understand respondent's preferences and priorities and to ensure rapport with them.

Record of Outcomes of Card Sorting/Prioritizing:

All the outcomes of card sorting, and prioritization will be recorded by the research team using the space provided under each category below.

- Main category-1
    - Sub-idea of main category-1
        - Components of sub idea of Main category-1

- Main category-2
    - Sub-idea of main category-2
        - Components of sub idea of Main category-2

- Main category-3
    - Sub-idea of main category-3
        - Components of sub idea of Main category-3

V. Leading questions for Group Dialogue

1.Strategies/interventions/ approaches/ that work to end FGM

a.Strategies and interventions to challenge inequitable gender norms

i. What are the key drivers of FGM in pastoralist communities? (Please probe more on key supporters, presence of religious obligations, cultural factors, perceived benefit of practicing FGM, consequences of being an uncut girl in a given community…etc.).
ii. Are there any current strategies and interventions led by the community members challenging inequitable gender norm?
iii. What are the assets/norms of the community that could be helpful to end FGM? Can the key agents such as uncut girls, community leaders and boys play positive roles in the promotion of new social norms and gender equality? How can they inform programming?
iv. Are aforementioned group members FGM interventions able to trigger transform other gender aspects including decision making, skills development, resource ownership etc.? If yes, how?
v. What interventions are most acceptable, responsive, and likely to be impactful in terms of empowering women and adolescent girls, addressing gender inequality and challenging FGM as a practice? (Please probe more on the type and nature of interventions to improve the role of girls/women as well as community members on how these (listed) intervention contribute to empower girls/women system).

b.The role of uncut girls and women as positive drivers

I. Why are uncut girls and women important? are kebeles/woredas/family whose girls are not cut and why.
II. How are uncut girls and women viewed by the community? What happens within schools, social places and community spaces if a girl is uncut and believe she should remain intact?
III. Are uncut girls and women voices and opinions respected within their own communities?
IV. How can the experiences of uncut women be used to promote better social and gender norms? (Please probe more on how uncut girls are viewed by their community, how the community/local government engage them in the prevention of FGM, etc).

2.Demand and supply of services to end FGM

i. What do the community members know about the laws on FGM? (Please probe more on the source of information, implementation/enforcement of the law at their own area, if there are synergies between health, education, protection and legal authorities, if there are community surveillance and their findings?)

ii. How coordinated is the formal and customary laws enforcement? And what are some opportunities in the sectors for better synergy at various levels – individual, community, and system, is there established linkage between formal and customary laws? What challenges and opportunities are there to coordinate customary and formal laws?

iii.Are there any impediments for the service provider (police, prosecutors, and judges…etc) to receive report of FGM cases and manage them accordingly? If yes, what are they and how can the FGM reporting case be improved in terms of increased reporting and demand for legal services.

iv. Are there any impediments for the communities to report FGM cases to the relevant government law enforcement agencies? If yes, what are they and how can the FGM reporting case be improved in terms of increased reporting and demand for legal services.
v. Do you have any idea about the availability of service which address issues of FGM, decision making? What service are you getting from police?, prosecutors?, and judges?
vi. What are the main barriers and opportunities for these communities in terms of seeking out and reaching legal services as well as health services for FGM specifically reproductive/ maternal health more broadly? Probe key barriers and opportunities (awareness on complications that result from FGM the availability of service which address issues of FGM).

vii. What are the critical challenges that services providers related to FGM face while executing their mandates and responsibilities.

Annex 2B

Venn Diagram with In-depth Interview (IDI)

I. Background

This tool is designed to collect data for a study entitled "Formative Research on Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior, Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia". The study is commissioned by UNICEF-Ethiopia and is conducted in three regions including Afar, Somali and SNNPR". It employs a Participatory Action Research (PAR) design which involves researchers and participants collaborating to understand the customary and sociocultural origin and the psycho-social impacts of the practice of FGM and take actions to bring about better social norms.
Two data collection tools: Venn Diagram (VD) and In-Depth Interview (IDI) are used together to elicit information about FGM practices, impacts and possible interventions. A Venn Diagram is commonly used to map and compare the power distribution among different community elements and cut/ uncut girls/women and to draw a stakeholder matrix. The exercise related to Venn Diagram helps the researcher ensure healthy relations with participants and understand the thinking framework of participants about FGM survivors and influencers.

II. Participants of Venn Diagram with IDI

The participants of Venn Diagram with IDI will be identified from selected (sample) kebeles and includes mothers of uncut girls, mothers of cut girls, uncut girls/women, cut Girls/women and religious leaders.

III. Consent Form

Introduction:

Greetings! My name is ________________. I represent a research team from Frontieri. We are conducting a study on FGM practices in selected areas of the region.
The purpose of the study is to explore the knowledge, attitudes and perception of community members and their experience regarding FGM. The findings of the study will come up with strategies to increase service seeking behavior to strengthen provision of care in three regions of Ethiopia (Afar, Somali and SNNPR).

Procedure:

You are selected purposively for this interview. I will ask you few questions concerning your knowledge, perceptions and/or experience about FGM. The discussion will take about 1:00 hour. Participation is voluntary and you can skip any question that creates discomfort to you or stop the discussion at any time. However, your active participation and genuine responses have paramount importance in understanding the problem.

Risks and discomfort:

There are no risks involved due to your participation in the discussion process. The discussion may take some of your time. However, we will try to make it as brief as possible.

Benefits:

There will be no direct benefit to you; but the information you provide will help identify gaps and design strategies to improve FGM practices and its impacts.

Confidentiality:

The information that we collect in this study will be kept confidential. Your name will not be written in this form and the information we collect from you will not be shown to anyone outside of this research team. The hard copies will also be kept in a locked cabinet and will not be disclosed to anyone except the researchers.

Are you willing to participate in the study? **Yes** ____ **No**___ (skip to the next Interview)

Signature/finger print of the participant
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Interviewer: Name______________________Signature___________ Date __________
Supervisors/Researcher: Name______________________Signature _______Date ________

Note: In case of any concern, you can communicate the PI (Prof. Habtamu: 0911600059) or the project coordinator (Dr. Dereje; 0911660190).

IV. Procedure/Guideline of Venn Diagram

A Venn Diagram is a visual tool used **to compare and contrast** two variables including the **extent of relationships** of the community elements to FGM survivor girls/women and the **magnitude of power** the community elements have on the act of FGM. The distance or overlapping areas between circles represent a community, elements from the circle representing FGM survivors (located at the center) indicate the closeness/relation of the community element to the FGM survivors. The size of the circle represents community elements and indicates the magnitude of power to decide on survivor girls/women to be circumcised or not. The closeness of a circle represents how supportive, serving and caring the community element is to the survivor girls/ women. The size of the circle representing a community element indicates the power of the community as decision-maker and prominence in influencing the decision of whether the girl/ women should be circumcised or not.

How to draw a Venn Diagram: A Venn diagram consists of drawing separated or overlapping circles representing all community elements (mothers, fathers, elders, religious leaders, Women, and Social Affairs bureau/office, health facilities/HEWs, UNICEF, NGOs) in relation to cut/uncut girls/women. The followings are the steps to be followed during data collection:

- The first step to creating a Venn diagram is to place a descriptive title (Comparing the relation and power magnitude of community elements to FGM survivors) at the top of the page.
- Draw a circle representing FGM survivors at the center of A4 size drawing paper.
- Make a circle for each of the community elements around the circle representing FGM survivors:
    - Spatial relation (nearness/farness) between circles show the interrelation/tightness of community elements with the FGM survivors;
    - The size of the circle shows the power and ability to influence the decisions related to FGM by the community elements on survivors.
    - Near or inside each circle, place the name of the community elements which the circle represents.

Materials Required: Drawing a Venn Diagram requires the following items:

- Markers of different colors
- A4 size drawing paper
- Plasters

Role of data collectors: During the drawing of the Venn Diagram, data collectors will provide the study participants with adequate information on the purpose of the study, take consent, clearly explain the steps and procedures, provide them with a sample diagram and guide them during the drawing. They will also collect all complete Venn Diagram as one or two Venn Diagram(s) will be taken for the purpose of incorporating it in the final meta-synthesis report.

V. Leading questions for IDI

3.Strategies/interventions/ approaches/ that work to end FGM

a.Strategies and interventions to challenge inequitable gender norms

i. What are gender dynamics at various levels: individual, household, and community levels? And how is power exercised at different levels to control women and girls? (please probe more on main decision-makers on FGM, social institutions supporting or against FGM)

ii. What is the understanding of the community about existing gender norms and their impact on girls and women? Please probe on the immediate and long-term health complications and psychosocial impacts of FGM on girls?

iii. What are the roles of religious leaders in perpetuating/preventing FGM in their communities?

iv. In order for the interventions to be effective, what stakeholders (elders, mother-in-law, men and boys, religious and traditional leaders, parents, women and youth led groups, men associations, circumcisers etc.) should be engaged? Why and how? What channels should be used to reach the target audience? What are the key messages that should be included?

b.The role of uncut girls and women as positive drivers

i. What are some stories of uncut girls and women that could be useful in advocacy, programming and policy change? How do they differ from stories of cut women in the same or similar communities?

Note: A story on an uncut girl will be presented to the participants, then, the participants will be asked about their feelings about the story, share similar story in their community (if any), and what then answer the question "what roles can the uncut girls/women play to eliminate FGM"

ii. How can the experiences of uncut women be used to promote social norms and gender? How are uncut girls/women in your community promoting social norms change and gender equality?

2. Demand and supply of services to end FGM

i. Was there community surveillance? Please probe when that was done,

Annex 2C

Storytelling with Group Dialogue

(For adolescent boys and girls)

I. Background

This tool is designed to collect data for a study entitled "Formative Research on Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior, Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia". The study is commissioned by UNICEF-Ethiopia and is conducted in three regions: Afar, Somali and SNNPR. It employs a Participatory Action Research (PAR) design, which involves researchers and participants collaborating to understand the customary and sociocultural origins and psycho-social impacts of FGM in order to take actions to bring about better social norms.

Two data collection tools, Storytelling combined with Group Dialogues (GD), are used together to elicit information about FGM practices, their impacts, and possible interventions against FGM. The purpose of storytelling is to uncover in-depth information related to social norms, values, and drivers of FGM that is known to participants.

II. Participants of Storytelling with Group Dialogue

For the purposes of this research, participants are identified from each of the selected (sample) kebeles. Two group discussions will be conducted in each selected kebele, one with adolescent girls (both in- and out-of-school) and one with adolescent boys (in- and out-of-school boys).

III. Consent Form

Introduction: Greetings! My name is ________________. I represent a research team from Frontieri. We are conducting a study on FGM practices in selected areas of the region.
The purpose of the study is to explore the knowledge, attitudes and perception of community members and their experience regarding FGM. The findings of the study will come up with strategies to increase service seeking behavior to strengthen provision of care in three regions of Ethiopia (Afar, Somali and SNNPR).

Procedure: You are selected purposively for this interview. I will ask you a few questions concerning your knowledge, perception of and/or experience with FGM. The discussion will take about one hour. Participation is voluntary and you can skip any question that creates discomfort to you, or stop the discussion at any time. However, your active participation and genuine responses are of paramount importance in understanding the problem.

Risks and discomfort: There are no risks involved due to your participation in the discussion process. The discussion may take some of your time. However, we will try to make it as brief as possible.

Benefits: There will be no direct benefit to you; but the information you provide will help identify gaps and design strategies to reduce the prevalence of FGM practices and its impacts.

Confidentiality: The information that we collect in this study will be kept confidential. Your name will not be written in this form and the information we collect from you will not be shown to anyone outside of this research team. The hard copies will also be kept in a locked cabinet and will not be disclosed to anyone except the researchers.

Are you willing to participate in the study? Yes __ No___(skip to the next Interview)

Signature/finger print of the participant
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Signature/finger print _______________date _______________
Interviewer: Name______________________Signature____________ Date ___________
Supervisor/Researcher: Name______________________Signature _______Date ________

Note: In case of any concern, you can contact the PI (Prof. Habtamu: 0911600059) or the project coordinator (Dr. Dereje; 0911660190).

IV) Procedure/Guideline for Storytelling

Storytelling is meant to turn the respondents into characters in the story prepared and told to them by the researcher. After presenting the story prepared for this purpose to the group of participants, follow-up questions will be asked to initiate discussion. Storytelling will be used in this study in combination with group dialogue (GD).
The data collectors (the ones who guide the story telling) begin with telling the following story to the participants of the two groups.

Story-1 The Story of Hirut

Hirut is a 17-year-old girl. During her early childhood, neighbors, relatives and elders from their village came to Hirut's parents and gave them the advice to take Hirut to the local healer for circumcision. Though Hirut's parents were afraid about the procedure, they took her to the local healer and she was circumcised. Immediately after the circumcision, the baby girl started to bleed and became very weak. For this reason, she was taken to the nearest hospital and treated. In the hospital, Hirut started to have fever, loss of appetite and generalized weakness. She was diagnosed with a wound infection after circumcision and treated with antibiotics for about a week. Finally, after staying in the hospital for three weeks, Hirut was discharged.

Now, at the age of 17, Hirut is married to a 40-year-old man who is a close friend of her father. She became pregnant at the age of 17 and her pregnancy was complicated, with symptoms like general weakness, severe vomiting at the early stage, loss of appetite, continuous headaches, foot and leg swelling and slight vaginal bleeding at the late stage. Hirut didn't attend antenatal checkups during the whole gestational period of her pregnancy, but she went to the nearest hospital when nine months pregnant, due to the aforementioned symptoms. The attending physician took the necessary medical history, did a physical examination and laboratory tests, and told Hirut that all these symptoms are due to her marriage and getting pregnant at a very young age, before her body was fully developed and prepared for pregnancy. As a result, the physician admitted Hirut and started the necessary medication and follow-up treatment. When Hirut started labor, the birth took a very long time because of an obstructed birth canal caused by severe scarring from Hirut's circumcision. The fetus became distressed and Hirut finally needed a caesarean section in order to give birth to a baby girl with low birth weight.

Follow-up questions and discussion: After presenting the story, the researcher will raise the following follow-up questions to facilitate discussion among participants and record the group's answers and general understanding of each question.

1.How do you feel about the story in general? Probe
2.What is your feeling/impression about Hirut's history? Probe
3.How do you relate this story to the practice in your community?
4.Why do you think people like Hirut's mother are practicing FGM? Probe
5.If you were Hirut, would you consider cutting your daughter?

V. Leading questions for group dialogue (adolescent boys and girls)

4.Strategies/interventions/approaches that work to end FGM

a.Strategies and interventions to challenge inequitable gender norms

i. What are the key drivers of FGM in this community? (Please probe more on the key supporters, presence of religious obligations, cultural factors…etc.)
ii. Are there any current strategies and interventions led by community members to challenge inequitable gender norm?
iii. With whom do you feel comfortable to talk about the negative and positive consequences of FGM/gender equality?
iv. What are the gender dynamics and norms at the individual, household, and community levels? And how is power exercised at different levels to control women and girls? Norms supporting or against FGM.
v. What are the constraints against gender equality at the individual, household and community levels? What are the opportunities for change and how can these opportunities inform programming?
vi. To what extent do boys and men influence the perpetuation of FGM in their respective communities? Are there any current interventions led by boys and men to correct and change this? Do you see changes in attitudes towards cutting and any change in preferences for marriage (cut or uncut girls)?
vii. What is the understanding of the community about existing gender norms and their impact on girls and women? Probe on why community members are practicing FGM. What are the immediate and long-term complications of FGM?
viii. What are the assets/norms of the community that could be helpful to end FGM? Can key agents such as uncut girls, community leaders and boys play positive roles in the promotion of new social norms and gender equality? How can they inform programming?
ix. In order for the interventions to be effective, which stakeholders (elders, mothers-in-law, men and boys, religious and traditional leaders, parents, women and youth-led groups, men's associations, etc.) should be engaged, why and how? What channels should be used to reach the target audience? What are the key messages that should be included?

b.The role of uncut girls and women as positive drivers

i. Why are uncut girls and women important? Are there any kebeles/woredas/families where girls are not cut? Why are they not cut?
ii. How are uncut girls and women viewed by the community? What happens within schools and community spaces if a girl is uncut and believes she should remain intact?
iii. Are the voices and opinions of uncut girls and women respected within their own communities?
iv. What are some stories of uncut girls and women that could be useful in advocacy, programming and policy change? How do they differ from stories of cut women in the same or similar communities?

Note: A story on an uncut girl will be presented to the participants, and then:

v. How can the experiences of uncut women be used to promote a change in social and gender norms? (Please probe more on how the community/local government engage them in the prevention of FGM).

5.Demand and supply of services to end FGM

i. What do community members know about laws on FGM? Do you have any information about the law enacted by the government to prevent FGM? What is your perception/view on the implementation/enforcement of the FGM law? (Please probe more on the source of information and awareness of the enforcement/implementation of the law).
ii. What customary laws have been developed by the community (if any) to eliminate FGM and why? What were the challenges and opportunities to implement these customary laws or bylaws? Who is following/enforcing the implementation of the customary laws?
iii. Does the community know about the existence of services (both formal and informal) to prevent, support, and manage cases of FGM?
    - If you or your daughter(s) have FGM-related health problems, are you willing to seek out legal and health services?
    - Have you or your daughter(s) ever received these FGM-related health and legal literacy/aid services?
iv. Are there any impediments for the communities to report FGM cases to the relevant government law enforcement agencies? If yes, what are they and how can FGM reporting and demand for legal services be improved?
    - What are some opportunities in your area for better synergies between health, protection, and legal services to end FGM at the individual, community, and system/law enforcement levels?
v. What are the main barriers and opportunities for these communities in terms of seeking out and reaching legal and health services for FGM specifically and reproductive/maternal health more broadly?

Annex 2D

Group Dialogue with Storytelling

(For adult men and women)

I. Background

This tool is designed to collect data for a study entitled "Formative Research on Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior, Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia". The study is commissioned by UNICEF-Ethiopia and is conducted in three regions: Afar, Somali and SNNPR. It employs a Participatory Action Research (PAR) design, which involves researchers and participants collaborating to understand the customary and sociocultural origins and psycho-social impacts of FGM in order to take actions to bring about better social norms.

Two data collection tools, Storytelling combined with Group Dialogues (GD), are used together to elicit information about FGM practices, their impacts, and possible interventions against FGM. The purpose of storytelling is to uncover in-depth information related to social norms, values, and drivers of FGM that is known to participants.

II. Participants of storytelling with Group Dialogue

For the purposes of this research, participants are identified from each of the selected (sample) kebeles. Three groups discussions will be conducted in each selected kebele: one with a male-only group including parents and elders; one with a women-only group including women of all ages; and one with Health Development Army (HAD) members/health extension workers (HEW).

III. Consent Form

Introduction: Greetings! My name is __________________. I represent a research team from Frontieri. We are conducting a study on FGM practices in selected areas of the region. The purpose of the study is to explore the knowledge, attitudes and perception of community members and their experience regarding FGM. The findings of the study will come up with strategies to increase service seeking behavior to strengthen provision of care in three regions of Ethiopia (Afar, Somali and SNNPR).

Procedure: You are selected purposively for this interview. I will ask you a few questions concerning your knowledge, perception of and/or experience with FGM. The discussion will take about one hour. Participation is voluntary and you can skip any question that creates discomfort to you, or stop the discussion at any time. However, your active participation and genuine responses are of paramount importance in understanding the problem.

Risks and discomfort: There are no risks involved due to your participation in the discussion process. The discussion may take some of your time. However, we will try to make it as brief as possible.

Benefits: There will be no direct benefit to you; but the information you provide will help identify gaps and design strategies to reduce the prevalence of FGM practices and its impacts.

Confidentiality: The information that we collect in this study will be kept confidential. Your name will not be written in this form and the information we collect from you will not be shown to anyone outside of this research team. The hard copies will also be kept in a locked cabinet and will not be disclosed to anyone except the researchers.

Are you willing to participate in the study? **Yes** ____ **No**___ (skip to the next Interview)

Signature/finger print of the participant
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________
Signature/finger print _______________date ______________

Interviewer: Name______________________Signature___________ Date ___________
Supervisors/Researcher: Name______________________Signature _______Date ________

Note: In case of any concern you can communicate the PI (Prof. Habtamu: 0911600059) or the project coordinator (Dr. Dereje; 0911660190).

IV. Procedure/Guideline for Storytelling

Storytelling is meant to turn the respondents into characters in the story prepared and told to them by the researcher. After presenting the story prepared for this purpose to the group of participants, follow-up questions will be asked to initiate discussion. Storytelling will be used in this study in combination with group dialogue (GD).

The data collectors (the ones who guide the story telling) begin with telling the following story to the participants of the three adult groups (men, women and HAD/HEWs groups).

Story-1 the Story of Zehara

(taken and modified from Role Model Academy: prepared by Thikplace and Frontieri)

Zehara is a mother who underwent FGM as a child and has had health problems and pain from it as an adult. Because of this, she has decided not to cut her young daughters, but it has not been an easy decision. Her husband is also against cutting and supports her decision.

Zehara's mother is also cut and believes this is essential for any girl in order to be respected by the community and to get married. She insists that the daughters must be cut and will be considered 'bad' otherwise. Her mother has put a great deal of pressure on her to cut her daughters and this has strained their relationship. She is also afraid that her mother may take her daughters to be cut without her knowledge.

More and more women around Zehara are deciding not to have their daughters cut, but she is very concerned that if she does not do what her mother wants, she will be a bad daughter.

Follow-up questions and discussion: After presenting the story, the researcher will raise the following follow-up questions to facilitate discussion among participants and record the group's answers and general understanding of each question.

1. How do you feel about the story in general?
2. What is your feeling/impression about Zehara and her daughters?
3. Is this something that women in your community face? What do they do about it? Who decides on cutting?
4. Why do you think people like Zehara's mother are practicing FGM?
5. Do people have the same beliefs (on circumcision, avoiding premarital sex or having a child before marriage…etc) about boys?
6. What would you do if you were in Zehara's place in the story?
7. What would you advise Zehara to solve her problem?

V. Leading questions for group dialogue (adults)

1.Strategies/interventions/ approaches/ that work to end FGM

a.Strategies and interventions to challenge inequitable gender norms

x. What are the key drivers of FGM in this community? (Please probe more on the key supporters, presence of religious obligations, cultural factors…etc.)

xi. Are there any current strategies and interventions led by community members to challenge inequitable gender norm?

xii. With whom do you feel comfortable to talk about the negative and positive consequences of FGM/gender equality?

xiii. What are the gender dynamics and norms at the individual, household, and community levels? And how is power exercised at different levels to control women and girls? Norms supporting/against FGM.

xiv. What are the constraints against gender equality at the individual, household and community levels? What are the opportunities for change and how can these opportunities inform programming?

xv. To what extent do boys and men influence the perpetuation of FGM in their respective communities? Are there any current interventions led by boys and men to correct and change this? Do they see changes in attitudes towards cutting and any change in preferences for marriage (cut or uncut girls)?

xvi. What is the understanding of the community about existing gender norms and their impact on girls and women? Probe on why community members are practicing FGM. What are the immediate and long-term complications of FGM?

xvii. What are the assets/norms of the community that could be helpful to end FGM? Can key agents such as uncut girls, community leaders and boys play positive roles in the promotion of new social norms and gender equality? How can they inform programming?

xviii. In order for the interventions to be effective, which stakeholders (elders, mothers-in-law, men and boys, religious and traditional leaders, parents, women and youth-led groups, men's associations, etc.) should be engaged, why and how? What channels should be used to reach the target audience? What are the key messages that should be included?

b.The role of uncut girls and women as positive drivers

vi. Why are uncut girls and women important? Are there any kebeles/woredas/families where girls are not cut? Why are they not cut?
vii. How are uncut girls and women viewed by the community? What happens within schools and community spaces if a girl is uncut and believes she should remain intact?
viii. Are the voices and opinions of uncut girls and women respected within their own communities?
ix. What are some stories of uncut girls and women that could be useful in advocacy, programming and policy change? How do they differ from stories of cut women in the same or similar communities?

Note: A story on an uncut girl will be presented to the participants, and then:

x. How can the experiences of uncut women be used to promote a change in social and gender norms? (Please probe more on how the community/local government engage them in the prevention of FGM).

2.Demand and supply of services to end FGM

i. What do community members know about laws on FGM? Do you have any information about the law enacted by the government to prevent FGM? What is your perception/view on the implementation/enforcement of the FGM law? (Please probe more on the source of information and awareness of the enforcement/implementation of the law).
ii. What customary laws have been developed by the community (if any) to eliminate FGM and why? What were the challenges and opportunities to implement these customary laws or bylaws? Who is following/enforcing the implementation of the customary laws?
iii. Does the community know about the existence of services (both formal and informal) to prevent, support, and manage cases of FGM?
    - If you or your daughter(s) have FGM-related health problems, are you willing to seek out legal and health services?
    - Have you or your daughter(s) ever received these FGM-related health and legal literacy/aid services?

vi. Are there any impediments for the communities to report FGM cases to the relevant government law enforcement agencies? If yes, what are they and how can FGM reporting and demand for legal services be improved?
    - What are some opportunities in your area for better synergies between health, protection, and legal services to end FGM at the individual, community, and system/law enforcement levels?

vii. What are the main barriers and opportunities for these communities in terms of seeking out and reaching legal and health services for FGM specifically and reproductive/maternal health more broadly?

Annex 3: Name, sex and qualification of research assistants

Region/ team	Name	Sex	Qualification (field of study)
Somali	Juhar Mohamed Ahmed	M	BSc (Public Health)
	Huessn Beshir	M	BSc (Clinical Nursing)
	Sead Mussae	M	BSc (Clinical Nursing)
	Muna Abduwasi	F	BSc (Clinical Nursing)
	Feruza Aliyi	F	BSc (Public Health)
	Mohamed Kalife Adem	M	BSc (Clinical Nursing)
	Feysel Abdulsemed	M	BSc (Clinical Nursing)
	Abdkarim Omer	M	BA (Anthropology)
	Abdurazak Ahmed	M	BSc (Clinical Nursing)
Afar	Ibrahim Sied	M	BA (Anthropology)
	Hasna Ali Buruli	F	BSc (Public Health)
	Fatuma Yasin	F	BSc (EDPM)
	Sada Ahmed Mohammed	F	BSc (Public Health)
	Aregahegn Mulgeta	M	BA (Management)
	Momina Humed	F	BSc (Public Health)
	Hassna Bori Ahmed	F	BSc (Environmental Science)
	Jemila Ahmed	F	BSc (Clinical Nursing)
SNNPR	Erdaro Wodebo	M	BSc (Epidemiology)
	Martha Woranna	F	BSc (Public Health)

Annex 4: Ethical Clearance

Ethiopian Society of Sociologists, Social Workers And Anthropologists
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Reference No. ESSSWA/L/AA/0247/2022

Date: July 14, 2022

ESSSWA's Institutional Review Board (ESSSWA's-IRB)

Certificate of Protocol Approval

ESSSWA'S IRB meeting no. IRB/ESSSWA/015/2022

To: Habtamu Wondimu (PhD), Principal Investigator

From: Melese Getu (PhD), Chairperson, Institutional Review Board (IRB)

Protocol Title:	Formative Research on Strategies to End FGM, Including Strategies to Increase Service Seeking Behavior, Strengthen Provision of Care, and Transform Harmful Gender Norms in Ethiopia
Protocol Number	024/2022
Principal Investigator	Habtamu Wondimu (PhD)
Institute	Frontieri Consult PLC
Study site/s	The formative research will focus on three regions (regions with pastoral communities and have high FGM prevalence) which are covered through the UNJP and GAC programmes. The regions are Afar, Somali, and SNNP.
Decision	The Institutional Review Board of ESSSWA has approved the above mentioned research protocol which involves human study participants.
Date of final approval issued	14 July 2022
Expiration date of this approval certificate	13 April 2023

Obligations of the PI

1. Should comply with the standard international and national scientific and ethical guidelines.

2. All amendments and changes made in the protocol and consent forms must have prior IRB approval.

3. The PI should report all serious and/or unexpected side effects or unanticipated problems (SAE) in writing within 10 days to ESSSWA's IRB by email (melese88@yahoo.co.uk and/or hmulugeta1977@gmail.com) or in person.

4. Brief progress report of the study should be given to the IRB when the data collection activity is completed

5. A hard copy of the final report of the study should be given to the IRB.

Note: If this project continues after the expiry date of approval indicated above, then it must be renewed as specified by the IRB guidelines. A renewal application consists of a brief report which summarized the results obtained during the past period and a short statement of the research plan for the coming year.

Melese Getu (PhD)

Chairperson, IRB

Sig: ______________

Date: 14/07/2022

CC: ESSSWA's IRB Secretary

Name: Me

Chairperson, IRB

Annex 5: Research assistants training manual

Annex 6: Number of GD with CSP, GD with storytelling and KII with Venn diagram per region

Region	GD with CS/P	GD with storytelling	KII with Ven diagram
Somali	13	40	40
Afar	10	30	30
SNNP	4	10	10
Total	27	80	80

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