CARE INTERNATIONAL ETHIOPIA

Awash FGC Elimination Project

Final Evaluation Report

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LIST OF ACRONYMS

CHW	**Community Health Worker**
CPR	**Current Prevalence Rate**
FGC	**Female Genital Cutting**
FGD	**Focus Group Discussion**
FGM	**Female Genital Mutilation**
IEC	**Information, Education and Communication**
MOH	**Ministry Of Health**
NCTPE	**National Committee on Traditional Practices of Ethiopia**
NGO	**Non Governmental Organization**
PHC	**Primary Health Care**
RH/FP	**Reproductive Heath/ Family Planning**
TBA	**Traditional Birth Attendants**
TTBA	**Trained Traditional Birth Attendants**
TOT	**Training of Trainer**
VDC	**Village Development Committee**

Executive Summary

The evaluation study was conducted for the CARE Awash Female Genital Cutting Project (FGC) operating in the Awash Fentale and Amibara Weredas. The evaluation took place from Dec 1-21, 2005. The study involved 400 respondents for the individual questionnaire and 72 persons in the Focus Group Discussion (FGD), including key informant interviews with representatives of government agencies namely Women Affaires Bureau, HIV/AIDS Secretariat, Woreda Health Bureau, Wereda Administration, and Traditional Birth Attendants (TBAs) found in both weredas.

The evaluation was based on the indicators used in the base line survey. The finding of the study disclosed a number of facts. Firstly, the perception of the community on CARE and the FGC Project was extremely satisfactory. It is the conclusion of the Evaluation Team that the FGC Project was at the heart of the community. Secondly, the raised awareness of the community on the effect of Female Genital Cutting (FGC) was the other notable success, where there was a significant leap in awareness. This includes an increase in awareness of the community on FGC, HIV/AIDS, malaria, diarrhea and family planning. When compared with the baseline, the following achievements were recorded: The proportion of respondents who knew one health effect of FGC increased from 54 percent to 90 percent and those who cited two health effects of FGC increased from 24 percent to 86 percent. Similarly, the proportion of respondents who cited one psychological effects of FGC increased from 48 Percent to 72 percent and those who cited two psychological effects of FGC increased from 22 to 38 percent.

The comprehensive health education packages made by the project breaks the silence among the community to discuss about the health effects of the female genital cutting and other harmful traditional practices and allowed the community to discuss and argue among themselves. Besides, the project brought behaviour change among the sexually active population on family planning and other reproductive health issues where they now discuss freely about sexual issues in public. The project significantly empowered women, assisting them to attend and participate in meetings to discuss on health related issues with their male counterparts.

Most of the FGD participants tried to point out the effect of FGC. Interestingly “pain” and “suffering” were the common terms all the children were using: suffering of girls during circumcision, pain during sexual intercourse, and suffering while giving birth.

Similar achievement was also observed in the knowledge and practices of family planning among the community. The proportion of respondents who knew at least a method of contraceptive increased from 41 percent in the baseline survey to 81 percent in the post intervention survey. Those respondents who knew two or more FP methods increased from 30% to 71%. Usage of contraceptive methods increased from 5% to 27% and current use rate increased from 3% to 23%. Open discussion on family planning issues among the couples also improved. About 95 percent of respondents were never discussed family planning issues with their spouse during the baseline survey while in the post evaluation, 51 percent of men and 39 percent of women reported that they were discussing family planning issues with their spouse.

The project was also successful in terms of improving the knowledge of the community on the ways of transmission and modes prevention of malaria and diarrhea diseases. Knowledge on ways malaria transmission increased from 54 to 93 percent and knowledge on modes of prevention increased from 57 to 94 percent as compared to the baseline survey. Similarly, knowledge on ways transmission and modes of prevention of diarrhoea increased from 50 to 86 percent and from 47 to 87 percent respectively.

1. Introduction

1.1. Background

Ethiopian women suffer from violence of various kinds, which are linked with socio cultural roots. Customary laws are entrenched at the grassroots level and require the combined effort of different stakeholders to overcome the negative effects of customary practices on women and girls. Ethiopia is a country with many ethnic groups having diversified and longstanding traditional practices. Different studies have come up with different types of traditional practices, which are harmful to the health, economic, and psychosocial well being of women, children and the society. Some of the traditional practices that affect women and the girl child in Ethiopia are early marriage, female genital cutting, abduction, preference for a male child, massaging the stomach of pregnant women, shaking a mother violently during labour in order to cause the ejection of the placenta, women's lack of decision making power and access and control over productive resources.

Both men and women are victims as well as promoters of harmful traditional practices. However women and children suffer more and are victims of harmful traditional practices. Harmful traditional practices are one of the major causes of women's low position and status in every society.

The Afar Regional State has extremely poor health status compared to other Regional States of Ethiopia. Health services are poorly allocated, inequitably staffed, and underutilized and under budgeted. The community has low understanding about health promotion and disease prevention techniques. Most of the diseases, which are prevalent in the region, are communicable but easily preventable. Harmful traditional practices like cutting/mutilating female genitalia are highly practiced in the region. Presently the practice of female genital cutting of any form is almost 95% to 100%. As a result there is high infant and maternal morbidity and mortality related to childbirth. There is high suffering and death of women, girls and children. Knowledge of family planning and HIV/AIDS within the rural Afar community is generally low. Family planning is most often associated with limitation of family size and because of the high value placed on children and for religious issues, resistance is often encountered. Community members, particularly women, do however recognize the burden that 'too many', 'too close', 'too

early' and 'too late' pregnancy and child birth place on the health of women and children and the danger this can pose.

1.2. The Organization of the Report

This report is the outcome of the evaluation study conducted on the activities of the CARE Awash FGC Project, in Awash Fentale and Amibara Wereda, of the Afar Regional State. The study aimed at evaluating the activities of Awash FGC Project taking into account the indicators used in the baseline survey.

The report is divided into eight sections. The first section highlights the background of the CARE Awash FGC project. The second section explains the summary of the project program and objectives as well as the objective and methodology of the evaluation. The third and fourth parts of the report deal with the quantitative and qualitative results of the evaluation. The fifth part discusses about the project performance in relation to the planned activities. The sixth and seventh parts of the report points out the discussion and lessons learned respectively, and the conclusions and recommendations are presented in the last section.

2. Summary of Program/Project Objectives and Objectives of the Evaluation

2.1 Program Summary

In response to health problems, CARE Awash, under its primary health care project had worked intensively in Awash Fentale woreda for six years from January 996 up to December 2002 G.C. The main objective of the Project was establishing sustainable community based health systems in the woreda. Following that a new comprehensive and integrated health project focusing on FGC elimination, RH/FP, HIV/AIDS and incorporating some Primary Health Care (PHC) components started and were implemented in two woredas namely the previous Awash Fentale woreda and the new Amibara woreda. This was the CARE Awash FGC Project, which began in January 2003 and was earmarked to conclude in December 2005. The main objectives of the project was to disseminate quality information on the above mentioned issues, advocating for the elimination of FGC in any form, and establishing and strengthening

sustainable community based health systems. Most of the project activities were rural focused and implemented in the rural villages of the woredas.

The major strategies for the implementation of the activities under this project were through civil society advocacy and quality information dissemination at village level in both woredas. In addition, because of the fact that the Afar community is a homogeneous community in culture, tradition and practice, there was a need to reach the whole community for bringing change against such deep-rooted problems. For this purpose, there was a radio program broadcasted in the Afar language and also regional level advocacy workshops were conducted to reach people outside of the project operating area.

2.2. Project Objectives

The overall goal of the project was to “improve the health status of pastoral communities in Awash-Fentale and Amibara woreda of the Afar region focusing on reproductive health aspects of the people”. It is important to note that this did not mean that the project would completely improve the health status of the target communities; rather it meant the project would contribute to the improvement of the health status of the target population. There were various governmental, non-governmental and community efforts made towards achieving this goal. Among others, the Ministry of Health (MoH) is the leading one. The project, thus would support efforts of the MoH and fill some, not all, gaps. By this, it was anticipated the project would contribute to the improvement of the health status of the pastoral communities in the target area.

The project had the following three specific objectives that could be measured by the end of the project period with specific indicators. Additionally, there were qualitative achievements, which could not be measured in figures. The three specific objectives were:

- To raise awareness and knowledge on FGC, HIV/AIDS and FP within the targeted communities
- To strengthen the community based health system
- To advocate for the elimination of FGC/Female Genital Mutilation (FGM)

To achieve the objectives, the project had devised different strategies. The main strategies that were followed during the life of the project included health education and dissemination of quality information on FGC, HIV/AIDS and Family Planning/Reproductive Health, human right and other primary health care issues; radio program broadcasting; establishing and strengthening community managed drug revolving fund systems, establishing and working with village development committees (VDC), TOT and capacity building of the MOH staff,

2.3. Objective of the Evaluation

The objective of this evaluation was to assess the performance of CARE Awash Fentale and Amibara FGC project over. The results of the evaluation are important to gauge the extent to which the project achieved its goal and objectives; understand what went well and what did not and extract lessons for future such programs.

2.4. Evaluation Methodology

Information for the evaluation was obtained through document review, quantitative surveys, qualitative studies (i.e. Focus Group Discussions, key informant interviews and field observation).

2.4.1. Quantitative Survey

The survey utilized a descriptive cross-sectional design to collect data necessary for the evaluation of the project. Among the total kebeles of Awash Fentale and Amibara woredas, which are considered to be beneficiaries of the project, a sample of the population were studied. A total of 12 kebeles were selected, six kebeles per woreda. These kebeles were covered during the baseline survey.

A sample size of 400 respondents was selected using a standard sample size calculation on Epi-info computer package. These respondents were distributed in selected kebeles proportional to the population size of the kebeles.

The survey questionnaire was drafted by the consultants based on the questionnaire used in the baseline survey. The draft questionnaire was reviewed by the program management team members of CARE Ethiopia. Based on the feedback, the final questionnaire was developed in English then translated into Amharic language.

The questionnaire covered a wide range of topics related to the expected outcome indicators of the project. This included social, demographic and economic characteristics of the study population; knowledge on the means of transmission and mode of prevention of malaria and diarrhoeal diseases, knowledge and practice of family planning; knowledge of transmission and prevention of HIV/AIDS; and knowledge, attitude and practice of FGC.

A total of 16 interviewers who spoke the local language were recruited from the project area. The overall field-work implementation was supervised by two supervisors and the consultant team members. Half-day training was given to the interviewers and supervisors. The training consisted of discussion on each topic of the questionnaire. Completed questionnaires were first reviewed in the field by the supervisors and then were taken by the consultant for data entry and analysis. Data was processed using the SPSS statistical software.

2.4.2. Qualitative survey

a. Focus Group Discussions (FGDs)

The qualitative study involved three principal approaches - namely 'focus group discussions (FGDs)', 'key informant interviews' and 'observation'. The objective of the qualitative study was to gather information on the perception of respondents on key issues related to the objective of the project. The participants of the FGDs were identified in selected kebeles of the two woredas. A total of eight FGDs were formed with 7-10 persons in each group. The participants were selected from Kaliber, Kaliat and Yerer kebeles from the Amibara woreda and Alola, Hadia-bour, Kebene and Wasero from Awash Fentale woreda. The breakdown of the sample in both woredas was two children focus groups aged 7-14 years old; two youth focus groups aged 15-25 years; two women FGDs aged 20-24 years; and two mature FGDs aged 35 and over.

A predetermined set of questions related to the objectives of the project was prepared as an instrument to secure reliable data. The discussion questions, among others, revolved around

core issues that could help to generate the views of the community concerning their knowledge, attitudes and practices of FGC, achievement of anti FGC campaign and other project related issues.

Two facilitators, born in the Afar Region and well trained in field work, were assigned (from among the CARE staff) by the CARE Awash Field Office. The facilitators were given orientation focusing on the objectives of FGD and on the procedure to be followed. Then discussion was made on the selection criteria for the villages and the respective social categories who participated in the FGD.

Before conducting the FGD, the purpose of the discussion was explained to the participants; moreover they were confirmed on the confidentiality of their view and identity. The discussion began after confirming the willingness of the participants. The data collected from each FGD was reorganized and edited by the consultants on the same day. Then, clusters of reports were written for the FGD.

b. Key Informants' Interview

Discussions were held with elders, community members and representatives of government agencies namely Women Affaires Bureau, HIV/AIDS Secretariat, Woreda Health Bureau, Wereda Administration, and Traditional Birth Attendants (TBAs). Structured questions related to the objectives of the project were set as an instrument to obtain the views of the stakeholders. Available project documents from the offices were reviewed. The consultant team had also opportunities to visit project areas and talk with relevant bodies.

A semi-structured and/or pre-determined set of questions related to the objectives of the evaluation were set to secure the views of the stakeholders. The discussion questions revolved around core issues that could help to reveal, among others, the views of the stakeholders on:

- their activities related to FGC and the extent of their cooperation with Awash Project
- achievements of anti FGC campaign and other related issues;
- policy issues related to harmful practices; and
- their view on CARE Ethiopia in general and the CARE Awash FGC Project in particular.

First Information was gathered from the Awash FGC Project on the location of the respective offices of the stakeholders. Each interview was made by two consultants. Before starting the interview, the objective of the survey was explained as well as their cooperation for giving the interview was solicited.

Although the client didn't indicate other qualitative method except FGD and key informants interview, the consultancy team conducted informal interview on selected target groups. This includes teachers and community members who were not included in the FGD and in the Key informants' interview. The method could strengthened the reliability and validity of the findings of the study.

- **Literature Review**:

The consultant team also reviewed project related documents including proposals, baseline survey report and mid term assessment report. The findings from the literature review were used to guide the development of a survey questionnaire and were used to support interpretation of data collected.

3. Results of the quantitative Survey

3.1. Background Characteristics of Study Population

Age distribution is important to any study of fertility, contraceptive behaviour and reproductive health. To show the age distribution of respondents, five-year age groups were formed and the results are presented in Table 1. Note that eligibility criterion for women is the age range 15-49 years and for men it is 15-60 years. Accordingly, it was found that most of the respondents, both women and men were middle aged between 25 and 39. The proportions of young men and women of age 15-24 were nine percent and 22 percent, respectively. These figures indicate that male respondents were much younger in most cases than women. Respondents above 30 years of age account for 41 percent of the male and for about a quarter of the female population (see Table 1).

Table 1. Percentage distribution of respondents by background characteristics

Background Characteristics of Respondents	Category	Sex		Group Total
		Males	Females	
Age Group	15-19	3.5%	10.3%	5.8%
	20-24	5.4%	11.7%	7.5%
	25-29	19.1%	23.5%	20.3%
	30-34	16.7%	25.0%	19.8%
	35-39	14.2%	15.3%	13.88%
	40-44	13.2%	8.7%	10.0%
	45-49	10.8%	5.7%	5.8%
	50-54	7.8%		7.8%
	55-60	9.3%		9.3%
Group Total		100.0%	100.0%	100.0%
Literacy Status	Literate	11.3%	3.1%	7.3%
	Illiterate	88.7%	96.9%	92.7%
Group Total		100.0%	100.0%	100.0%
Level of education	Read and write only	52.2%	80.0%	57.1%
	Grade 1-6	39.1%		32.1%
	Grade 7-8	8.7%		7.1%
	Grade 9 and Over		20.0%	3.6%
Group Total		100.0%	100.0%	100.0%
Marital Status	Single	17.2%	7.7%	12.5%
	Currently Married	70.6%	80.6%	75.5%
	Divorced/Separated	9.3%	10.7%	10.0%
	Widowed	2.5%	1.0%	1.8%
	Not Stated	.5%		.3%
Group Total		100.0%	100.0%	100.0%

Education is another important variable associated with fertility and rates of growth of the population, because education levels attained are known to influence attitudes towards and perceptions about contraception and family size. Data on educational attainment and literacy status were collected for all study populations. Each respondent was asked whether he/she attended or was attending formal or non-formal education.

The percentage of literate respondents, classified by sex is presented in Table 1. The compiled data indicates that the literacy rate was low in the community, where only 11 percent of men and three percent of women were literate.

Marital status is also one of the primary direct determinants of reproduction in any population, and may be used for identifying the degree to which women of reproductive age are sexually active. The survey categorised marital status into five main groups; namely 'never married', 'living with a man (consensual marriages)', 'currently married', 'widowed' and 'Divorced or separated'.

The patterns of marital status of respondents showed that overall more than three fourth of respondents were married at the time of the survey (71 percent of males and 81 percent of females). About 17 percent of males and eight percent of females were single. The survey result further showed that one in 10 respondents were divorced or separated and three percent of men and one percent of women were widowed.

3.2. Knowledge of Prevention and Transmission of Malaria and Diarrhoeal Diseases

3.2.1 Knowledge of Transmission and Prevention of Malaria

An inquiry was sought to investigate the knowledge of transmission of malaria and whether respondents in the target population knew means of prevention of malaria.

The survey included questions about respondents' knowledge of transmission and prevention of malaria and diarrhea diseases. As shown in Table 2, there seems to be improvement in the knowledge level of transmission and prevention of malaria and diarrhea.

Table 2. Knowledge of Transmission and Prevention of Malaria

Category	Baseline	Post-intervention	Percent increased
Malaria transmission	53.5	93.5	40.0
Malaria prevention	57.5	93.5	36.0

3.2.2. Knowledge of the Means of Transmission of Malaria

The post-intervention survey result suggested that knowledge of malaria transmission among men and women increased from the baseline value of 54 percent to 94 percent. Increase in the awareness about malaria transmission among men was from 64.3 percent to 94.3 percent as compared to women from 45.5 percent to 93.1 percent

3.2.3. Knowledge of Prevention of Malaria

The result of the post- intervention survey regarding knowledge of prevention of malaria as compared with the baseline result was relatively high. As the data indicates, the level of knowledge of malaria prevention increased among men and women in the interval between baseline and post intervention survey from 58 percent to 94 percent.

Mosquito was recognized by a high proportion of respondents (76 percent) as a means of transmission of malaria. Spray of DDT was recognized by a high proportion of respondents as a means of preventing malaria.

3.2.4. Knowledge of Transmission and Prevention of Diarrhea

To get information on the knowledge of Diarrhea transmission, respondents were asked whether or not they knew ways of Diarrhea transmission. The results concerning ways of Diarrhea transmission are presented in Table 3.

Table 3. Knowledge of Transmission and Prevention of Diarrhea

Category	Baseline	Post-intervention	Percent increased
Diarrhea transmission	49.5	86.5	37.0
Diarrhea prevention	47.0	87.0	40.0

The study revealed that 86.5 percent of men and women had knowledge of diarrhea transmission. The result shows that knowledge of Diarrhea transmission has been improved substantially both for men and women respondents since the time of the baseline survey. At the time of the baseline survey, 49.5 percent of men and women mentioned at least two ways of Diarrhea transmission. The proportion that mentioned at least two ways of Diarrhea transmission reached 86.5 as a result of the project intervention.

3.2.5. Knowledge of Diarrhea Prevention

Respondents were asked whether or not they knew ways of preventing Diarrhea. Those who reported affirmatively were asked to spontaneously mention what they knew.

The level of knowledge of diarrhea prevention increased among men and women in the target population in the interval between baseline and post-intervention survey from 47.0 percent to 87.0 percent. The results of the post-intervention survey indicates that respondents who did not know how to avoid getting Diarrhea decreased by about 40 percent, showing that people in this area had significantly increased their knowledge in this aspect.

3.3. Knowledge and Practices of Contraceptive Methods

3.3.1. Knowledge of Contraceptive Methods

Information about the knowledge of contraceptives was collected from each respondent by asking whether he/she had heard of a specific family planning method that a couple can use to delay or avoid pregnancy. As can be seen from Table 4, knowledge of contraceptive methods was found to be higher in the post intervention survey as compared to the baseline data. The level of knowledge of family planning was seen to be slightly higher among women than men. About 88 percent of women aged 15 – 49 years and 78 percent of men aged 15 – 60 years reported to have heard of at least one family planning method. The corresponding baseline figure for all respondents was 41 percent. The proportion of respondents who had heard of two or more contraceptive methods was estimated about 65 percent for males and 77 percent for females. The corresponding figure that was estimated during the baseline survey was 30 percent for all respondents.

3.3.2. Extent of Family Planning Methods Being Used

The men and women who had knowledge of family planning methods were further asked whether they had ever used these methods. The survey data indicates that 28 percent of men and 26 percent of women were using at least one family planning method. The corresponding figure that was estimated during the baseline survey was only 5 percent for both sexes. Those respondents who used two or more contraceptive methods were estimated at 8 percent and 7 percent for males and females respondents respectively.

3.3.3. Current Use of Family Planning Methods

Contraceptive Prevalence Rate (CPR) was calculated as a ratio of those who were using family planning methods at the time of the survey to the total respondents. As can be seen from Table 4 CPR stands at 19.5 for both sexes. That is, about two in ten respondents were using family planning at the time of the survey. The corresponding rate at the time of baseline survey was three percent. Differentials of CPR by sex indicate that about 23 percent of men and 16 percent of women reported that they or their partners were using a method of family planning to space or limit births.

3.3.4. Spousal Communication on Family Planning

Respondents in the survey area were asked whether they were discussing family planning issues with their spouses or partners at the time of the interview. Table 4 shows the current level of spousal communication in the post intervention and baseline surveys.

It can be seen from the tables that spousal communication improved substantially both for male and female respondents. 95 percent of respondents never discussed family planning issues with their spouse during the baseline survey. At the time of the post evaluation, 51 percent of men and 39 percent of women reported that they were discussing family planning issues with their spouse.

Table 4. Distribution of Respondents by level of Knowledge and Practices of Family Planning methods

Knowledge and Practices of FP Methods	Baseline	Evaluation		
		Male	Female	Total
Who knows one FP method	41%	78%	88 %	81%
Who knows two or more FP methods	30%	64.6	76.8%	71%
Ever users of one FP methods	5%	28%	26%	27%
Ever users of two or more FP method		7.6%	7.4%	7.2%
Current users	3%	23%	16%	19.5%
Spousal communication	4.7%	51%	39%	45%

Table 5. Distribution of Respondents' reasons for not using contraceptive

Reason	Males	Females	Total
Religious prohibitions	24.6	11.5	17.6
Want to give birth	36.0	51.9	44.5
Want to become pregnant and Religious Prohibition	4.4	16.8	11.0
Religious prohibition and spousal opposition	13.3	2.3	7.3
Health concern	1.8	1.5	1.6
Problem of access	3.5	0.8	2.0
Not convenient to use	-	0.8	0.8
Other reasons	16.5	14.4	15.2
Total	100.0	100.0	100.0

3.3.5. Reasons for Not Using Family Planning Methods

To get information on reasons why respondents did not use family planning methods at the time of the survey, respondents were asked about the main reasons behind these decisions. Table 5 indicates that the majority of respondents cited 'wanted to give birth' as the main reason why

they did not use the methods at the time of the survey (44.5 percent). A religious prohibition was cited as the second primary reason mentioned by 18 percent of the respondents. About 11 percent of respondents mentioned 'want to give birth' and 'religious prohibition' simultaneously as the main reasons for not using contraceptive and seven percent mentioned 'religious prohibition' and 'spousal communication' as the main reason for not using the method of family planning.

3.4. Knowledge on Ways of Transmission and Mode of Prevention of HIV/AIDS

3.4.1. General

AIDS-related mortality leads to reducing life expectancy and increasing infant and child mortality rates, with life expectancy at birth falling to less than 1950's levels particularly in highly affected countries. Similarly, AIDS has the potential to devastate human development, setting countries to remote back in their efforts to increase infant and child survival and hamper better life chances through education. In the years since its discovery, HIV and AIDS has aroused more concern, research and media coverage than any other health complication (Helen, 2002).

The spread of HIV is fastest in conditions of poverty, powerlessness and social instability; HIV erodes physical, financial and social security and coping strategies of individuals and families. This often results in forced high risk sexual behavior and sexual abuse. Women and girls find themselves coerced into sex to gain access to basic needs such as food, shelter, and security, and became vulnerable to rape. (UNAIDS 2001:5)

In Ethiopia, HIV/AIDS is usually associated with having sex outside of marriage. The disease due to its fatal nature is also widely regarded as a cause of shame, fear, stigmatization and denial. Most people in Ethiopia who know that they are infected with HIV/AIDS try to conceal their status for fear of discrimination and rejection by friends, family, and neighbors.

During this survey, information was collected about HIV/AIDS awareness, transmission, mechanism and ways of preventing the disease. Several questions were used to measure knowledge, but first; all respondents were asked if they have heard of the infection. The survey findings showed that the level of awareness of the community on HIV/AIDS increased by 8.5

percentage point in post intervention survey as compared to the level of awareness that was documented in the baseline survey.

3.4.2. Knowledge of Ways of Transmission of HIV/AIDS

Knowledge of modes of HIV transmission is paramount in order for individuals to protect themselves from contracting the infection. Those who have heard of the infection were further asked to spontaneously mention modes of transmission. The results are shown in Table 6. The result of post-intervention survey regarding knowledge of modes of transmission of HIV/AIDS in the target population increased from the baseline value of 91.5 percent to 100 percent.

During the intervention period, the proportion of women and men that could not cite at least one mode of HIV transmission declined from 12 percent to 8 percent while the population in the target area who could mention two and more modes of transmission of HIV/AIDS increased from 87 percent to 97 percent. This showed that the people were becoming increasingly aware about ways of transmission of HIV/AIDS.

Table 6. Knowledge of HIV/AIDS Transmission Prevention Methods

Category	Baseline	Post-intervention	Percent increased
Who mentioned at least one way of HIV/AIDS transmission	91.5	100	8.5
Who mentioned two or more ways of HIV/AIDS transmission	84.0	97.0	13.0
Who mentioned at least one way of HIV/AIDS prevention	87.0	100	13.0
Who mentioned two or more ways of HIV/AIDS prevention	70.0	95.0	25.0

3.4.3. Knowledge of Ways of Prevention of HIV/AIDS

Respondents were asked to spontaneously mention the means of protection against HIV/AIDS if they were aware of any. Table 6 shows the means of protection cited, by respondents. The results of the post-intervention survey indicated that the percentage of respondents who could mention at least one way of HIV/AIDS prevention increased by 13 percent, showing that people were learning that HIV could be prevented. The proportion of men and women who could mention two and more ways of HIV/AIDS prevention methods increased from the baseline value of 70.0 percent to 95.0 percent.

3.4.4. Knowledge, Attitude and Practices of FGC

The traditional practices that involve the removal (cutting) of well functioning female genitalia go under different names. The practice is a highly complex issue that ties into traditional gender roles, religion, superstitions, local concept of health and sexuality.

Even though FGC is practiced in mostly Islamic countries, it is not an exclusively Islamic practice. FGC is a cross-cultural and cross-religious ritual. In Africa and the middle East it is performed by Muslims, Coptic, and Ethiopian Orthodox Christians, members holding various indigenous beliefs, Protestants and Catholics (NCTPE, 2003).

Various reasons are mentioned for practicing FGC. The most frequently mentioned reasons include: respect for tradition; suppressing women's sexuality; to avoid difficulty of penetration or to ease first time penetration; avoid shame and ostracization; as a religious requirement since prayers and offerings by the uncircumcised women are not acceptable.

As cited in the baseline survey on harmful traditional practices in Ethiopia, the prevalence of FGC does not show significant differences by level of education. The finding indicated that among women with ‘no education’, have had ‘primary education’ and have had ‘secondary and higher education’, the prevalence level was 80.4, 78.4 and 78.2 percent respectively, as compared to 80.4 percent prevalence among illiterate women.

This post-intervention survey was undertaken to measure the impact of the CARE Awash FGC project and to make a comparative analysis against the baseline indicators. This chapter

presents the result of comparison of baseline and post-intervention results of selected indicators against demographic and social characteristics.

First, respondents were asked whether or not they had heard female circumcision and were further asked the impact of circumcision on health. Those who reported that they knew the health impact of circumcision were asked spontaneously to mention them. The data clearly showed that the level of knowledge of circumcision, and the health and psychological impact of circumcision increased significantly among both men and women in the interval between the baseline and the post-intervention survey. Approximately 90 percent of men and women in the target population reported to have known at least one health effect of circumcision. This revealed a 41.5 percent increase compared to the baseline survey result that which was 48.5 percent.

With regards to respondents in the survey area which could not mention at least one health effect of FGC, this fell to 14.4 percent from 86 percent during the baseline surrey. The percentage increased in this regard is 61.5 percent as a result of project intervention by CARE Ethiopia.

Table 7. Knowledge of Respondents on the Health Effect of FGC

Category	Baseline	Post-intervention	Percent increased
Who mentioned at least one health effect of circumcision	54.0	90.0	36.0
Who mentioned two or more health effect of circumcision	24.0	85.5	61.5

Female genital cutting may have far reaching consequences. The reduction of woman's sexual experience by FGC is a physical as well as mental health problem. In this regard, the respondents were asked whether or not they knew what psychological problems resulted from circumcision. A significant increase in understanding was observed concerning the psychological effects of circumcision in the findings of the post-intervention survey .The results indicated that 72 percent of men and women could mention at least one psychological effect of FGC during the post – intervention survey which showed a 23.5 percent increase compared to

the baseline result which was only 48.5 percent. The proportion of respondents who cited two or more psychological effects of FGC increased from 22 percent in the baseline survey to 38 percent in the post intervention survey. Stress was mentioned by large proportions (56.7 percent) of respondents in the target population as a psychological effect of FGC.

Respondents were further asked about their intent to curtail FGC in the future. 81 percent of the respondents favored the elimination of FGC. Compared to the baseline result, this shows an increase of 60 percent.

Table 8. Knowledge of Respondents on the Psychological Effect of FGC

Category	Baseline	Post-intervention	Percent increased
Who mentioned at least one psychological effect of circumcision	48.5	72.0	23.5
Who mentioned two or more psychological effect of circumcision	22.5	38	15.5
Who support elimination of FGC in any form	20.0	81.0	60

FGC is prevalent throughout the entire project area, affecting almost all women in the region. According to the post-intervention survey, the prevalence of FGC in the project area was estimated at 85.2 percent. This figure is relatively lower as compared to the regional figure (95%) that was estimated in 2203 (???) by the National Committee on Traditional Practices of Ethiopia (NCTPE, 2003).

3.5. Summary of Key Findings of Quantitative Outcome Indicators

Key findings of the outcome indicators of the project were estimated and presented against the findings of the baseline survey (see Table 9). The findings clearly show that the CARE Awash FGC Project has obtained a remarkable achievement towards increasing the awareness of

people on different health and related issues. Knowledge of respondents on the health and psychological effects of FGC showed a significant difference between the baseline and post intervention survey. The proportion of respondents who knew one health effect of FGC increased from 54 percent to 90 percent and those who cited two health effects of FGC increased from 24 percent to 86 percent. Similarly, the proportion of respondents who cited one psychological effects of FGC increased from 48 Percent in the baseline survey to 72 percent in the post-intervention survey and those who cited two psychological effects of FGC increased from 22 to 38 percent respectively.

Similar achievement was also observed in the knowledge and practices of family planning among the community. The proportion of respondents who knew at least a method of contraceptive increased from 41 percent in the baseline survey to 81 percent in the post intervention survey. Those respondents who knew two or more FP methods increased from 30% to 71%. Usage of contraceptive methods increased from 5% to 27% and current use rate increased from 3% to 23%. Spousal communication on family planning also increased from 5 percent to 45 percent.

Regarding to the knowledge on ways of transmission and modes of prevention of Malaria, it increased from 53 percent to 93 percent and from 57 percent 94 percent respectively. Similar achievement has obtained on the knowledge of ways transmission and modes of prevention of Diarrhea. It increased from 49 percent 86 percent and 47 percent to 87 percent respectively (see details in Table 9 below).

Table 9. Summary Key-Findings of Quantitative Outcome Indicators

Key Findings (outcome Indicators) of the Awash FGC Project							
Variables	Awash Fentale Woreda		Amibara Woreda		Both Woredas		**% Achieved**
	Baseline	Evaluation	Baseline	Evaluation	Baseline	Evaluation	
Who know 1 health effect of FGC	53%	94%	55%	86%	54.0%	90%	**36.0%**
Who know 1 psychological effects of FGC	64%	66%	33%	79%	48.5%	72%	**23.5%**
Who know 2 or more health effects	37%	81%	11%	90%	24.0%	85.5%	**61.5%**
Who know 2 or more psychological effects	31%	39	14%	37	22.5%	38%	**15.5%**
Who support elimination of FGC of any form	27%	78.8	13%	83.7	20.0%	81%	**60.0%**
Who knows at least 1 F/P methods	43%	81%	38%	81%	40.5%	81%	**40.5%**
Who knows 2 or more F/P methods	37%	71%	23%	70%	30.0%	70.5%	**40.5%**
Spousal communication on FP					4.7%	45%	**40.0%**
Ever-Users of FP Methods					5.0%	27%	**22.0%**
Current use of FP Methods					3.0%	20%	**17.0%**
Who knows 1 way of HIV/AIDS transmission	92%	100	91%	100	91.5%	100%	**8.5%**
Who knows 2 or more HIV/AIDS transmission	88%	95	80%	98.5	84.0%	97%	**13.0%**
Who knows 1 way of HIV/AIDS prevention	89%	100	85%	100	87.0%	100%	**13.0%**
Who knows 2 or more HIV/AIDS prevention	75%	95	65%	95.6	70.0%	95%	**25.0%**
Knowledge of malaria transmission	52%	91	55%	96	53.5%	93.5%	**40.0%**
Knowledge of malaria prevention	65%	93	50%	94	57.5%	93.5%	**36.0%**
Knowledge of diarrhea transmission	49%	82	50%	91	49.5%	86.5%	**37.0%**
Knowledge of diarrhea prevention	46%	83	48%	91	47.0%	87%	**40.0%**

4. Results of Qualitative Survey

4.1. General Overview

This section discusses the findings of the qualitative study. The discussions in the FGDs and the interviews involved different questions related to the project objectives. Here, for the convenience of the reader, the findings are analyzed based on the core issues needed to be drawn from the evaluation study. Following this, the analysis focuses on the following issues: the perception of the community and the stakeholders on the CARE Awash FGC Project; the current level of awareness of the community on FGC; and finally, the views and the perceptions of the stakeholders on CARE and the overall success of the project.

4.2. Project Activities from the Perspective of the Community and Stakeholders

One of the questions forwarded to the FGD participants was 'whether or not there was any activity against FGC in their village?' Without exception, all participants in the eight FGD groups confirmed that there was a movement against the practice of FGC. Every village was positively affected by the anti-FGC campaign. The Final Evaluation Consultants discovered that the the entire credit for the campaign was attributed to the CARE Awash FGC Project. Even small children in both weredas witnessed the wider work undertaken by the Project. Every one of children in the FGD also knew the role of the Project in creating awareness.

Similar questions were forwarded to all representatives of the Bureaus in both weredas. The answers received were consistent with the responses of the FGD participants. The Wereda Health offices, the HIV Secretariats and the Women Affairs offices in both weredas told the evaluators that the task of campaign against FGC was not their main agenda since the CARE FGC Project had already undertaken this with considerable success. All offices unanimously confirmed this fact.

The CARE FGC Project is widely known throughout Awash Fentale and Amibara weredas and is well recognized with health and related issues. During the discussions, the groups confirmed the tasks carried out by the Project such as distributing medicine, providing education on health in general and on FGC in particular.

The groups mentioned that the Project had wide impact and practically offered the example where many villages had already prescribed punishments against those who practiced FGC. For instance, according to the Head of the Women Affairs in Amibara, in certain villages, parents who had allowed their daughters to be circumcised were punished by slaughtering their cows. The meat from the cow was then consumed by the community who passed the punishment at the meeting called for that purpose.

The above views forwarded by the community and the stakeholders, indeed, could serve as measurement in evaluating the performance of the Project. In fact the performance of the Project was weighted positively particularly by the community at large.

4.3. Level of Participation of Stakeholders

According to the stakeholders, there were different occasions that allowed/forced them to work together. One of their co-operations emanated from the common goal they had with the Project. The various anti FGC committees organized by the Project were the reason for working together. In addition, according to the representatives of the Women Affairs in both weredas, their initiation to form anti FGC associations was the result of the relation between them and the Project. The functions of the anti FGC committee were followed up by the project. In addition to that, trainings and workshops were frequently given to members. The relation served the community to carryout the responsibility of the anti FGC project by itself. The sustainability of the awareness and subsequent practical activity was the outcome of the relation between Awash FGC elimination project and the stakeholders.

The other relation concerned with to the implementation of policy formulation. According to the stakeholders a number of meetings and discussions were held on drafting policies against FGC and other harmful practices. This had also enhanced the close relation between the project and the stakeholders. In fact, the issue on anti FGC policy formulation was discussed significantly at the regional level but practically no policy reached at the grassroots level.

The other cooperation could be explained with the meeting conducted every three months. In these meetings, the stakeholders, particularly the Wereda Health Bureau, was always called to listen to the interim report of the Awash Project. The meeting allowed to closely follow up on the activities of the Project. In addition, since questions, clarifications and comments were

entertained in the meetings, such interaction was an additional input for strengthening the cooperation between the Project and the Weredas.

During the actual implementation of the activities of the Project, there were always opportunities for cooperation. This included exchange of information and other issues concerned with bureaucracy. In all cases the relation between them were smooth and accompanied by feelings of partnership aimed at a common goal.

The other smooth relation which was created between the stakeholders and the Project referred to were the trainings/workshops that were sponsored by the Project. Indeed almost all the stakeholders appreciated and acknowledged these efforts as worth mentioning for the encouraging relations between them.

There were also a number of problems that required solutions, but were beyond the Project's capacity and jurisdiction. In such situations the stakeholders claimed that they always stood with the Project. According to them, such unforeseen problems, whether minor or major, remained causes for working together.

For the future, the representatives of the stakeholders interviewed expressed their willingness to continue to work with the Project. However, structurally, the Regional Government has already planned to coordinate the activities of all NGOs at a higher/regional level. For example, the Regional Government of Afar and the Regional Health Bureau had direct and formal relation with CARE at the top particularly on planning and implementation. Thus, this would affect the interaction between the stakeholders and the Project. However, as long the Project continues working in their jurisdiction the co-operation would sustain.

4.4. Current Level of Awareness and Practices of FGC among the Community

To understand the level of awareness, the respondents were asked to identify the source and the causes for their knowledge. Interestingly, almost everyone in the FGD attributed this to (as a source and causes for increasing their awareness) the Project. The consensus on this point was irrespective of age, sex or status. A case in point could be the responses of children. According to the children, initially they heard about the harmful effect of FGC from the field workers of the

Project. The main source and cause for their awareness, therefore, was attributed to the Project. On top of that, the issue of FGC was always talked among the family.

Another important component that deserves mentioning is those who joined school were more exposed to the anti-FGC message than those who did not attend school. They pointed out that at school FGC was discussed, either in the context of a harmful tradition or health.

For the questions raised 'what is wrong with FGC? and what would happen if it continues?', the reaction of all the participants on the effect of FGC seemed identical. However, categorizing the participants into two subgroups – i.e. those who were aware and had also seen the film on FGC, and those who were aware but had not watched the film - provides an impression of the different kinds of reactions.

First, both groups were able to list down the health effects of genital cutting, some examples being: difficulty at delivery, suffering, bleeding and diminished sexual satisfaction. Without exception, all the participants had adequate knowledge on the effect of FGC. However, it was observed that the reaction from the subgroup who had viewed the film had a stronger reaction in favour of eliminating the practice of FGC. The effect of the film on increasing awareness was immense. According to the participants who had watched the film, they claimed to be particularly distressed on viewing the tape. The men voiced that they had never imagined the intensity of the suffering of their children/girls/women during and after circumcision. The Final Evaluation Team found that the impact of the project on raising awareness was impressive and that the project had gone a long way to cull this practice.

Although some children were observed feeling embarrassed when asked about FGC, most of them tried to point out the effect of FGC. Interestingly "pain" and "suffering" were the common terms all the children were using: suffering of girls during circumcision, pain during sexual intercourse, and suffering while giving birth. It was particularly observed that while answering this question, the children were most serious on this issue.

In addition when asked what the staff of the Project had told them to do, the children said, among other things, "They taught us about FGC and health education; they always talked to our parents; they talked to our sisters; they told us not to accept the practice of FGC when we grew up!".

Another question asked was “whether they liked their sisters/friends/ neighbors circumcised?” The response to this was a firm “no”. Not one of the children wanted the practice of FGC to be performed on their sisters or friends. Two boys even went to the extent to say that they would report to the Kebele officials and the police if their parents or neighbors tried to circumcise their sisters. Another two girls repeatedly said that their mothers had assured them that they would not be victims of FGC. Yet another girl, one who had already been circumcised, said that she was ready to defend her younger sister from circumcision.

The current level of the awareness of the entire community was highly impressive, denoting the success of the Project.

However, although the success level was high, there were some problems which deserve mention. There were respondents who still strongly supported the practice of the so called *suna* (cutting the clitoris slightly) instead of mutilating and sewing. The respondents attributed the belief and practice of *suna* to their religion. Indeed, the practice of FGC is highly intertwined with the value of the Afar. Moreover, they attribute the practice as part of the dogma of their religion. Thus, it is not expected to totally eradicate the practice of FGC with three or five years. And it no wonder for certain groups to stick to *sunna*. There is still work to be done in this regard.

5. Project Performance in Relation to Planned Activities

The progress of the project was assessed by comparing the outcomes of the project against the planned activities (see Table 10). The findings showed that almost all activities planned during the project life were accomplished. Some of the major outcomes of the project achieved during the life of the project are as follows:

- The project has developed a comprehensive training curriculum manual in Amharic language for TBAs abd PHWs. This curriculum was developed based on the curriculum that was prepared by the Ministry of Health. A total of 10 health professionals attended a Training of Trainer (TOT) on the training manual and consequently these people have facilitated a number of community trainings at the health facilities and community level. The project also organized basic and refresher trainings to 171 Community Health

Workers and TBAs based on the curriculum and training manual developed by the project. The trainings were facilitated by the woreda government health professionals who previously attended the TOT.

- The project was able to organize Village Development Committees (VDCs) in 80 villages in the project area. Each VDC contained 5 people, who were freely selected by the villagers. It was the role of the VDC to coordinate, lead and monitor health and other development activities in their respective villages.

- The project conducted more than 3,000 health education sessions during the life of the project, exceeding the target. HIV/AIDS, family planning, female genital cutting and other related issues were the main topics covered, where approximately 13,500 people received first hand information on these topics. To reinforce these messages, different IEC campaigns (more than 1,200 sessions) were conducted where approximately 25,000 people were reached. As part of these IEC campaigns, several thousand people had the opportunity to view the video film on Afar female genital cutting. This substantially increased the number of people becoming aware of the risk and health consequences of such harmful traditional practices.

- As stated on the planned activities, the project had also produced four different types of educational materials, flip charts on FGC, HIV/AIDS, family planning, obstetric emergencies and hygiene and distributed to the target population through the community health workers.

- Project extension workers have carried out more than 1,750 support visits to the community health workers, trained traditional birth attendants and pastoral health workers. The efforts made by the extension workers were impressive, where they accomplished more than the targeted support visits. The extension workers carried out about 1,560 home to home counselling sessions on family planning and HIV/AIDS issues, again exceeding their target. As a result of these counselling sessions, 30 women were found to have started using contraceptives, and many others are now discussing the possible use of contraceptives. In addition, 22 persons got tested for HIV.

- The project organized two regional level advocacy workshops aimed to create a more favourable environment to fight the practice of female genital cutting and establishing stronger networking with different stakeholders. A total of 550 participants from the government, religious and traditional leaders, and women representatives attended. In the workshops, female genital cutting was dealt from the viewpoints of the Muslim religion; gender and women rights; and legal and human rights frameworks. These workshops have been of considerable success in disseminating and raising awareness on these harmful traditional practices.

- The project provided support to the Anti FGC association in Doho village of the Awash Fentale woreda. Most of the members of the associations were women and families who decided not to perform FGC on their daughters. Similar associations were established in Amibara woreda. The project also provided capacity building support to the regional anti FGC/harmful practices committee to lead and coordinate anti-FGC efforts in the region. With this support, committees have been formed at the woreda and kebele level in 13 woredas.

- The project procured and handed over different drugs and medical material for community health workers based on the list of drugs recommended for the community health workers. This included painkillers, anti-malaria, and deworming.

- To enhance the quality of service provided by TBAS and PHWs, the project provided kits to 91 TBAs and first aids kits to 80 pastoral health workers.

Table 10. Project Performance against planned activities

Planned Activities	Activities Performed	% Achieved
Prepare and review training manual on HIV/AIDS , FGC and FP	Training Manual in Placed	100%
Provide TOT to 10 MOH staff on training manual and facilitation skill	10 MOH's staff trained	100%
Provide 2,650 health education sessions to the community	3000 education sessions conducted	113%
Carry out 980 Mass IEC campaign sessions conducted	1200 IEC campaign session conducted	122%
Prepare, print and disseminate 4 kinds of IEC materials	Five type of different IEC materials developed, printed and disseminated	100%
Provide 1600 support visits to TTBAs and PHWs	1,700 support visits carried out	106%
Provide 1,200 home based counselling sessions on Family Planning	1,560 home based care counselling carried out	130%
To broadcast 78 radio program	78 educational program broadcasted	100%
Construct one education centre in Dudub village	Education centre constructed	100%
Organize basic and refresher trainings to Civil society	3 Influential people for each village were trained on basic and refresher trainings on FGC and Civil society advocacy	100%
Conduct Regional advocacy workshop	Two regional level advocacy workshops were carried out	200%
Conduct woreda level advocacy workshops in 29 woredas	Woreda level advocacy workshop carried out in 13 woreds	45%
Provide basic and refresher training to 80 PHWs and 91 TBAs	80 PHWs and 91 TBAs took basic training	100%
Provide drug and medical instruments to CHWs	Different drugs and medical materials handed over to CHWs	100%
Provide basic and refresher training to 400 Village Development Committee (VDC) mebers	400 VDC members attended basic and refresher trainings	1005
Provide kits to 91 TBAs and first aid kit to 80 trained pastoral health workers	91 kits and 80 first aid kits were provided to 91 TBAS and 80 PHWs	100%

6. Discussion

The CARE Awash FGC Project in general was found successful in building trust and recording achievements when compared to the original targets. Almost all of the women and young participants (in the FGDs) for example confirmed that much progress was made on the issue of FGC. Many of the FGD participants went as far as to say that they believed they had enough information/awareness on FGC, and to some, the message was getting tedious. However, when interviewing key informants, in both Woredas, there was a feeling among some of these respondents that more work was required to ensure sustainability.

In fact as earlier discussed, the anti-FGC committees organized by the project in all villages and other committees initiated by the Women Affaires were found successful in sustaining the awareness of the many villagers had already began to seriously punish those who were practicing FGC. Such practice is indeed, an indication for higher level of awareness which was also proved in the quantitative data (60 percent increase, compared to the baseline survey).

Various reasons were given why the *sunna* was openly defended. These include inter-village marriage where villages not under the FGC campaign are reluctant to wed girls from neighboring villages who are uncircumcised. Hence, according to a respondent from Hadya Bour, they were forced to perform FGC on their girls. This view was also confirmed by the Women Affairs Bureau representatives in both Weredas. According to them the awareness of the people in remote areas remained a serious barrier in the sustainability of the anti-FGC practice.

The second reason for supporting the *suna* was cultural values. According to the participants of both the FGDs and the in-depth interviews, the Afar people are deep rooted in cultural and traditional mindsets. The elder expressed that *"The age-long cultural practice cannot evaporate within a few years*" . This means, parents still exist who do not accept the anti-FGC teaching. These parents thus resort to the secret circumcision of their daughters. Except for the children where all were in favors of discontinuing this practice, in the adult groups there was at least one participant who was in favor of the *Suna.* According to this latter group an "untouched vagina" is either a curse or deemed to be unattractive.

In future interventions, particularly the Womens Affairs Bureau, would like CARE to engage in the educational sector. According to them, education should be taken as a key factor to assure the sustainability in the awareness raising of, not only FGC, but also on other harmful traditional practices.

Indeed the effect of education on change of behavior on FGC was also emphasized by individuals in the informal interviews. According to a teacher at Kebena Camp, students have more exposure than other children not attending school on issues around traditional harmful practices. The curriculum, as the teacher explained, involved learning items on harmful traditional practices in addition to the normal curriculum.

7. Lessons Learned

- The roles of religious leaders were found to be significant in sustaining the awareness achieved and changing it into practice quickly. This is because the Afar people revere, support and accept the words of their religious leaders. The attempt made by the project in collaboration with the Regional Administration, the Muslim Affairs and Religious leaders proved this very fact.

- The need for focusing on children is the other lessons learnt. The Afar children were found to be highly sensitive to FGC. They exhibited strong commitment to join the anti-FGC campaign. Thus, the children should be helped and encouraged in the battle against FGC.

- The role of the anti-FGC film is the other lesson that should be given due attention. Many of the respondents who got the chance of watching the film developed a strong resistance against FGC. According to these respondents, they were completely changed after having watched the film. Thus, the role of the film is found as one of the instruments in the suitability of eliminating FGC and other harmful tradition practices.

8. Conclusions and Recommendations

The evaluation survey conducted on the CARE Awash FGC Project produced a number of facts. All in all, the project has registered a number of achievements. The acceptance of the

community and their positive feeling towards the project was impressive. Encouraging work has been done in mobilization which has resulted in, for example, organization of anti-FGC committees and associations which in turn have achieved big success. Following this, CARE has a wider opportunity to launch other development activities in the future.

The achievements of the project are also observed in the increased awareness of the target communities in all health related issues. As discussed in the main body of the report, encouraging developments were recorded concerning the awareness of the community on RH/FP, HIV/AIDS and FGC. Project performance was the other major success of the project where the project reached all of its targets and more, as set out in the original activity plan.

To better promote and protect the concept of anti-FGC, it is recommended that more needs to be done in the remoter areas by strengthening linkages with the religious leaders and possibly focusing on children. This is an important segment to be considered as villages are interconnected through cross-marriages, where men from remote villages are unwilling to marry uncircumcised girls. This would aid in the sustainability aspect of anti-FGC practice.

In general, the project has performed its activities in line with the project objectives. The results achieved are encouraging and valued by the community. Based on the findings of the study the following recommendations are forwarded.

Recommendations

- Additional efforts are required to work with the community to strengthen the sustainability of the results and the positive outcomes.

- The Afar are said to be more traditional and homogeneous society with communal life style and tend to conform to societal norms, values, attitudes. Thus CARE should continue to work with religious figures, traditional community leaders and the government for sustainability of the achievements. This is because that the practice of FGC has been deep rooted in the value of the community and considered as “justified” by their religion. The best approach to totally eliminate the practice of FGC, therefore, should be through the religious and community leaders who are better trusted, accepted and followed than any other social group and/or institution.

- Disseminating video films in all localities at large. It was found the effect of watching film enhanced the feeling of anti-FGC significantly.

- Strengthening relation with stakeholders at woreda level by involving them more in the actual activities of the project so that they would consider the success as part of their effort.